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USAID HAITI CHILD SURVIVAL STRATEGY

FY 89 - FY 91

Port au Prince, Haiti

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Executive Summary

The overall objective of the USAID Child Survival Strategy is to reduce early childhood mortality by 20% from the current level of 101/1000 over the next five years. Through a carefully selected set of interventions that reflect A.I.D. child survival priorities and Haitian reality, USAID/Haiti feels that this goal is attainable. Therefore, within the strategy period, the USAID global strategy for our child survival program will focus on the following areas:

A. Promotion of improved cooperation between the MOH and PVO health service providers;

B. Expansion of the delivery of key child survival interventions, specifically:

1. increase vaccination coverage (especially measles immunizations and tetanus toxoid),
2. increase the utilization of ORS for prevention of dehydration due to diarrhea,
3. improve infant feeding practices,
4. promote birth spacing;

C. Extension of PVO-operated health and CS services with an increased emphasis on urban and peri-urban slum populations;

D. Provision of technical assistance to assist PVOs to better plan, manage and implement their CS programs and improve the outreach effectiveness of CS services delivery;

E. Strengthening of PVO service support agencies, so that these in turn are able to provide sustained technical and management assistance to the services-delivery agencies. Specifically, USAID will:

1. Provide assistance to the Child Health Institute (CHI) to strengthen its role as a center for operational research, technical assistance, evaluation, documentation and information dissemination;

2. Provide support to the Haitian Community Health Institute (INHSAC) to strengthen its role as a public health training institution;

3. Strengthen PROFAMIL to become a broader family planning service delivery association that will function also as a family planning resource center for training, information and education for other agencies;

D. Development of the child survival potential of the three major PVO-administered feeding programs which distribute PL-480 commodities to preschool children;

E. Promote low-cost water technology as a catalyst for child survival programs. Low cost, potable water systems will be supported as an entry point and/or reinforcement for child survival interventions. Operations research will be undertaken to determine how low access to water affects diarrhea and home management with ORT;

F. Encourage and strive for stronger donor coordination and collaboration to make efficient use of scarce resources, and to avoid duplication and overlap. Though donor coordination process USAID will strive to apply concerted pressure on the GOH to make meaningful policy and structural changes in the public sector.

Given present control levels, USAID/Haiti expects to program approximately six million dollars in DA funds in FY 89, eight million dollars in DA funds in FY 90, and seven million dollars in DA funds in FY 91 to support our child survival efforts. These resources will be augmented by approximately four million dollars in food aid per year over the strategy period targeted to vulnerable groups. Local currency support to our child survival program should total 3.5 million dollars in FY 89, but future year funding is not certain at this time, given the present restrictions on USG aid to Haiti. The Mission has requested an additional health officer position in order to manage our expanding child survival program.

The USAID/Haiti child survival program is oriented towards sustainability in the long term. During the brief strategy period, program focus will center upon maximizing the effective and efficient delivery of child survival services by PVOs. Accent will be placed on the development of administrative self sufficiency of the PVOs we work with in order that their programs can later be absorbed by the government of Haiti, or by other donor agencies.

USAID/Haiti
Child Survival Country Strategy (CSCS)

I. Introduction

USAID/Haiti's top priority is to reduce child mortality and its concomitant miseries in Haiti. Through a health portfolio largely focused on child survival interventions, and detailed in our 1989 Interim Country Development Strategy and our FY 90-91 Action Plan, the Mission seeks to develop a sustained capacity in the public and private sectors to deliver child survival services.

In November 1987, the USG terminated its assistance to the GOH. However, legislation specifically stated that humanitarian assistance could continue to be provided to Haiti through Non-governmental Organizations (NGOs). Even before the termination of USG assistance to Haiti, A.I.D. policy had been to work predominately with private voluntary organizations. Therefore A.I.D.'s cutoff changed only a portion of the Mission's overall health sector strategy, as the core assistance program for PVO development was already in place.

The effect of the termination of aid on the Haitian public health sector has been substantial. The fragile MSPP primary care delivery system, almost exclusively dependent on USAID-derived sources for its operating budget, is severely strained for resources. Major loan projects are being negotiated by the GOH with the World Bank and the Interamerican Development Bank. These projects, though not sectoral, in addition to providing critical infusions of capital (beginning 1990), are expected to have beneficial effects on structural and systemic elements of primary care services delivery.

USAID recognizes that the ultimate responsibility for providing services will continue to rest with the GOH, and that while development of PVO capacity will represent a significant extension of child survival services, sustainable services ultimately can only be achieved through public-private sector partnerships supported by local communities. While USAID is constrained from funding the MSPP directly, development of MSPP capacity for meaningful involvement in leadership of the National Child Survival Program is essential to program sustainability.

II. Problem Statement

A. General background

Haiti, a small, mountainous but densely populated country of roughly 6 million people, has captured international attention since 1987 with its convulsive attempts to shake off its burden of political and economic oppression. The long period of GOH indifference to rural needs of all kinds, the lack of grass-roots organization in Haiti, and the concentration of all services for the benefit of a tiny minority have made external development support very difficult to implement.

As a result of more than a decade of political and economic degeneration, public health development efforts are faced with three critical constraints:

- a) There has been a serious demographic response to a lack of social investment. More and more rural poor are migrating into urban areas. Slum conditions are deteriorating, as basic services infrastructure are unable to cope.
- b) The lack of grass-roots organization in Haiti is a serious handicap to mobilizing community support for health improvement efforts; and
- c) The public sector has suffered from a pattern of centralized decision-making, of central indifference to and even hostility to initiative at the regional and district levels of government, and a reluctance of operational level personnel to accept responsibility for plans formulated at the center. This system also provides neither encouragement or rewards for excellence, nor, sanctions for non-performance.

In human terms, this legacy has turned Haiti into one of the poorest countries in the world, with high rates of illiteracy and a bleak future. Haiti's health problems reflect chronic poverty and the country's inability to grasp the benefits of development.

B. Health Services Factors

Access to basic social and health services is seriously inequitable, particularly for rural populations. Health facilities are poorly distributed, and it is estimated that only about one half of the population have physical access to health centers. Under the MSPP's "New Orientation", various outreach strategies were intended to extend services coverage. In reality, this strategy has been less than successful, because 90% of GOH resource allocations are destined to pay personnel, and much of this workforce is concentrated in Port-au-Prince. As a result, USAID estimates that the private sector provides one half of health services delivery in Haiti.

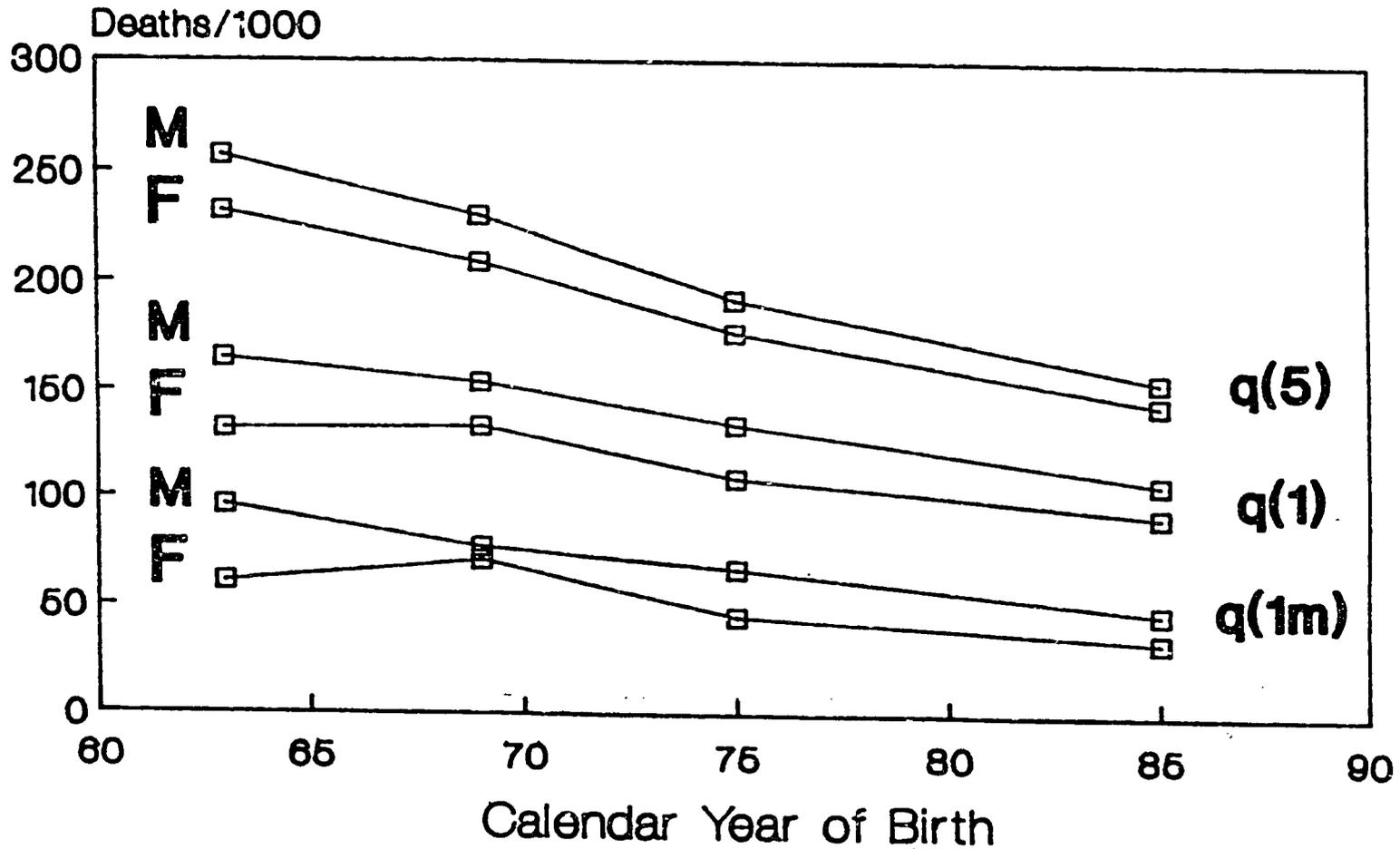
C. Health Status and Infant Mortality Risk Factors

In spite of a very substantial reduction in mortality since 1960 (Table II-1), the present infant mortality rate (IMR) in Haiti of 101/1000 is still one of the highest in the Western Hemisphere. Child Survival (CS) programs appear to have had considerable impact on mortality reduction, largely in Port-au-Prince. Urban-rural and subregional differentials in the IMR suggest that little has changed in the underserved rural areas. With the decline in the average IMR, estimated by the 1987 National Survey, EMMUS, Haiti now enjoys a lower IMR than Bolivia (est. 120-130/1000), and is moving closer to that of Peru. Of increasing concern is Haiti's ability to maintain this IMR reduction in the face of direct impact on mortality from AIDS, and the concomitant competition the AIDS epidemic will have on financial and human resources.

The fertility rate in Haiti is high and appears to have increased dramatically over the past ten years, from 5.8 to 6.4. Chronic and widespread malnutrition has not declined despite substantial food imports and efforts to improve agricultural production. Low overall literacy 26% and particularly female literacy, and low access to safe water and sanitation, particularly in the rural and periurban slums, make the cycle of infectious disease and malnutrition difficult to break. Nonetheless, the potential for continued major improvement in child survival and well-being is still high.

TABLE II-1

Trends in probabilities of dying by Ages 1 month, 1 year, and 5 years by sex Haiti (1960 -87)



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Documented causes of infant mortality derive from very unrepresentative and inadequate services statistics. Diarrheal disease, though under-represented in clinic statistics, remains the predominant cause of death in under-fives. Neonatal tetanus, measles and acute respiratory infection (ARI) are known to be major causes of death and/or debilitating illness. The synergistic deleterious effect of these diseases upon nutritional status is well documented, and malnutrition is also an underlying factor in many infant deaths in Haiti. Other vaccine preventable diseases - pertussis and diphtheria, contribute to deaths, and together with polio account for considerable morbidity in young children. The contribution of malaria to infant mortality, especially in malarious areas is presumed to be significant. Data now 10 years old suggests that 300,000 malarial episodes contribute to possibly 3,000 young child deaths per year.

Given the poor information base it is not possible to determine the exact contribution of each major cause of mortality in infants and children. In addition, it is important to take into consideration the various factors and their interactive relationship that serve as the causal "process" of mortality. For example, short birth interval, grand multiparity, and high fertility in general, are not causes of infant deaths per se, but are key influences in the mortality picture. In Haiti, child under-nutrition and high fertility are known to be particularly serious risk factors to child survival.

It is possible, however, to identify and group most of the contributing causes and factors both underlying or interactive to child survival in Haiti, and assign to these a relative "risk factor" rating (See Table II-2). For each risk factor, the entirety of known countervailing intervention(s) can be identified, with an assessment of the potential effectiveness of each intervention. This exercise may be further used to make judgments of the short-term and longer-term feasibility (under present and projected Haitian conditions) of each intervention and its relative cost.

A review of risk factors and possible interventions suggests that key A.I.D. priorities for child survival programs, i.e. immunizations, diarrheal disease control, nutrition and child spacing are clearly interventions appropriate to the Haitian situation.

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TABLE II-2

MAJOR CHILD SURVIVAL RISK FACTORS, HAITI*

MAJOR RISK FACTORS	MORTALITY RISK	HEALTH AND NUTRITION INTERVENTIONS	POTENTIAL EFFECTIVENESS	FEASIBILITY		RELATIVE COST
				SHORT-TERM	LONG-TERM	
Diarrheas	High	ORT	High	Moderate	High	Low
		Measles Immunization	High	Mod-High	High	Low
		Water and Sanitation	High	Low	Mod-High	High
		Hygiene ED (depends on water & San.)	High	Low	Mod-High	High
Infant/Child Malnutrition (Interactive, Underlying)	Moderate to High	ORT for Diarrhea	High	Moderate	High	Low
		Feeding During & After Diarrheal Episode	High	Low-Mod	High	
		Breastfeeding (Maint.)	High	?	?	Low
		Improved Weaning Practices	High	Low	Moderate	Moderate
		Targeted Supplementary Feeding	High-Mod	Low	Moderate	Mod-High
		Vitamin A, Iron, Folic Acid	Mod-High	Low	Moderate	Moderate
		Growth Monitoring	Moderate	Low	Moderate	High
Deworming	Mod-High	Low	Moderate	High		
Neonatal Tetanus	High (Undocumented)	TT (2) to Pregnant Women	High	Moderate	High	Low
		TT (2) to Girls & Women of Reprod. Age	High	Moderate (Politically/ Culturally Problematic)	High	Moderate
		TBA Training	(Low-Mod)	Low-Mod	Mod-High	Moderate
Measles	High (Undocumented)	Measles Immunization	High	Mod-High	High	Low
Acute Respiratory Infections (ARI's)	High	Pertussis Immunization	High	Moderate	High	Low
		Measles Immunization	High	Mod-High	High	Low
		Presumptive Antibiotic Rx	?	Low	Low-Mod	High
		New Vaccines	?	Unknown	High	?
		Health Education	?	Low	Moderate	High

*With the exception of diarrheas, the relative position of each presumed risk factor is not known, and the interactive nature of these factors makes weighting of factors hypothetical.

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TABLE II-2 (page 2)

MAJOR CHILD SURVIVAL RISK FACTORS, HAITI*

MAJOR RISK FACTORS	MORTALITY RISK	HEALTH AND NUTRITION INTERVENTIONS	POTENTIAL EFFECTIVENESS	FEASIBILITY		RELATIVE COST
				SHORT-TERM	LONG-TERM	
Low Birth Weight/Maternal Nutrition	High	Targeted Feeding during Pregnancy & Lactation	Moderate	Low-Mod	High	Variable High
		Iron/Folic Acid	Mod-High	Low-Mod	High	Moderate
		Malaria Treatment and Prophylaxis	Mod-High	Mod-High	High	Low-Mod
		Antibiotic Treatment	Unknown	Low	Low-Mod	High
		Education on Feeding	Moderate	Low	Low-Mod	
		Antenatal Care/Referral	Mod-High	Low-Mod	Moderate	High
		TBA Training	Low	Low-Mod	Mod-High	High
		Delaying First Birth	High	Low	Moderate	
		Spacing Births	High	Low	Moderate	??
High Risk Births	Moderate	Delay 1st birth	High	Low	Mod-Low	?
		Spacing Methods	High	Low	Moderate	?
		(Multi. 4+) terminal contraception	High	Low	Low	?
Malaria	Moderate (direct & underlying)	Chemotherapy (Chloroquine)	High	High	High	Moderate
AIDS	High	?	?	?	?	?

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However, much of rural Haiti lacks a basic infrastructure of health clinics and dispensaries which are adequately staffed and functioning. This shortage makes a program of integrated, sustainable child survival interventions very difficult. Cooperation among PVOs, and between the MSPP and PVOs is fundamental to an extension of geographic coverage and populations served by child survival interventions.

The success of the CS effort will depend upon a more effective administration of the public health system and all its elements. Organizational changes must be made to decentralize authority and responsibility for decisions taken and results achieved. Sanctions must be made for failure to perform. The MOH has to develop the ability to provide systems support for supply delivery, supervision and encouragement of workers at the periphery.

III. Government Policy and Programs

The official MSPP health policy, referred to as the "Nouvelle Orientation" was developed in 1982 with considerable help from a USAID supported technical assistance team. The MSPP health policy emphasizes six priority public health programs: immunization, family planning, diarrheal disease control, tuberculosis control, nutrition program, and malaria control.

At present, the vaccination program is the only priority program that is operational on a country wide scale and demonstrating significant impact. This is due in large measure to donor emphasis and resources, and dynamic leadership from the MOH officials in charge of the EPI.

Given a lack of human resources and a deteriorating economy that have led to a 25% reduction in the MSPP budget in FY 89, the acclaim of the immunization program has been at the expense of the diarrheal disease control program. As the EPI has become increasingly successful, the DDC program has slipped from an initial success that was acclaimed worldwide to a relatively ineffective and dysfunctional program.

The malaria program, whose personnel costs were funded entirely by USAID, either directly or indirectly for the entire twenty-five years of its history, is devoid of resources, both human and financial. The new malaria policy of the MSPP is to carefully integrate malaria control with other PHC programs at the the district level. This is a policy strongly supported by PAHO and UNDP, who will provide resources to the government to support this effort.

The public sector tuberculosis program has never been adequately staffed or accorded significant financial resources. Given the relationship between AIDS and TB, however, this program will benefit from a pending World Bank loan that is in the final stages of project development.

The public sector nutrition program is equally disfunctional but may also be rejuvenated as part of an Inter American Development Bank loan now in the design phase.

In 1988, the MSPP revised the "Nouvelle Orientation" to add AIDS control as the seventh priority program. This program shows much promise, given the present donor interest and available resources. However, given the human and financial resource constraints in Haiti, one has to wonder if the priority programs are not somewhat of a zero sum game where the progress and success of one program is to the detriment of another.

However, most would agree that "Nouvelle Orientation" is a particularly appropriate policy because it targets the principal determinants of infant and child mortality. Further, the policy emphasizes the need to give priority to community level interventions through the development of a network of low cost, sustainable community health workers. Unfortunately, in reality and in direct opposition to its written policy, the MSPP has been uninterested in or unable to redirect its chief resource, its personnel whose salaries consume 90% of the Ministry budget, away from the capital to the countryside.

The official MSPP policy also promotes better collaboration between the MSPP and PVOs providing health care in Haiti. Once again, this policy objective has been largely ignored until the present Minister took office six months ago. The present Minister, who was formerly the executive director of the AOPS (Association of Private Health Organizations), an A.I.D. supported coordinating agency for PVO health providers, understands the contribution PVOs can make to public health in Haiti.

Under the present Ministry of Health it is fashionable among MSPP personnel to seek better working relationships with PVOs. The MOH has entered into contracts with a series of PVOs to manage MSPP facilities and personnel located in the contracted PVO catchment areas. Although these public/private partnerships were opposed by traditionalists in the MSPP, USAID is convinced that their value will become evident to the skeptics, and that this initiative will become the lynchpin for a rejuvenated public sector PHC program if the political situation evolves favorably.

The most urgent health policy reform that faces the MOH is related to personnel training and deployment. The MOH must cease to train highly skilled persons, and place greater emphasis on training and support of auxiliary nurses and community health agents. A large number of personnel need to be redeployed from the cities to the rural areas. These reforms will be very difficult for a weak military government, or even for a popularly elected government, to effect. There is reason to be optimistic, however, because all donors and particularly the World Bank (WB) and the IDB agree that sooner or later these actions must be taken. USAID is working closely with the WB, PAHO, and UNICEF to coordinate action in this area.

IV. Private Sector Programs

The Haitian Association for Voluntary Associations (HAVA) has registered roughly 400 PVOs operating in some aspect of the social services sector, of which approximately 200 offer some form of health service. Many, but not all, offer one or more child survival interventions, usually immunization, ORT promotion and/or growth monitoring. Unfortunately, most of these PVO activities are clinic based. These agencies vary enormously in size, resources, management and technical capabilities, and above all, in their institutional philosophy and services objectives. In recognition of the need for coordination, technical and other assistance by this group of services providers, three PVO services support agencies were created to strengthen PVO health programs:

1. AOPS, the Association of Private Health Organizations, was created in 1982 to coordinate PVO participation in the National Health Programs and to promote a standardized services delivery model utilizing "Rally Posts" to extend service coverage from the institution to the community. AOPS continues to be financed principally by USAID.

2. The Child Health Institute (CHI) , established in 1985, is primarily a research and technical resources center, to assist in information dissemination, promotion, monitoring and evaluation of CS efforts; and

3. The Haitian Community Health Institute (INHSAC), established in 1986, provides training in community outreach and epidemiology to all levels of community health personnel. INHSAC, through its community-outreach training, complements AOPS and CHI and together they are instrumental in expanding PVO services coverage..

Approximately one half of the services providers hold paid AOPS membership, and provide nearly a half million people with some or all of the priority Child Survival Interventions. The services are provided through a population-based community health outreach system which begins with a complete census of the coverage area (10,000 - 50,000 people), then delivers priority PHC services to targeted segments of the population.

A variety of USPVOs provide health services in Haiti, either with assistance from AID/W or from USAID/Haiti grant support. These agencies include Adventist Development and Relief Agency (ADRA), CARE, Foster Parents Plan, International Child Care, Salvation Army World Service Organization, World Vision, The Haitian Health Foundation (HHF), the Development Agency of the African Methodist Episcopal Church (SADA), and World Concern. Together these USPVOs aspire to provide PHC services to over 500,000 people.

These USPVOs have worked with indigenous Haitian PVOs to establish, with USAID support, a Child Survival Coordinating Committee, which serves as a mechanism for collaboration among Haiti's child survival programs. The Child Survival Coordinating Committee is also a forum for information, ideas and resources. This Committee, for the first time, has brought together many Haitian and U.S. PVOs to plan joint undertakings to further their own child survival programs. Member PVOs have agreed to share training facilities in an effort to share resources and standardize child survival training programs. They have also taken steps to coordinate their technical assistance needs, and all have agreed to allow the Child Health Institute to monitor their CS programs.

The mechanisms for strengthening PVO programs for child survival are in place and functioning in Haiti. Two important issues for expansion of PVO coverage, however, must be addressed: a) the absorptive capacity of the agencies themselves, and b) the sustainability of expanded PVO services.

V. USAID's Global Approach to Child Survival Assistance

The overall objective of the USAID Child Survival Strategy is to reduce early childhood mortality by 20% from the current level of 101/1000 over the next five years. The USAID global approach to child survival assistance builds upon the four key A.I.D. child survival priorities: expanded programs for immunizations, diarrheal disease control, nutrition and child spacing. The USAID/Haiti child survival program will be largely implemented through PVOs, and assistance will be provided to PVOs to develop sustained, efficient and effective delivery of child survival services. Within the strategy period, the USAID global strategy for our child survival program will focus on the following areas:

A. Promotion of improved cooperation between the MOH and PVO health service providers;

B. Expansion of the delivery of key child survival interventions, specifically:

1. increase vaccination coverage (especially measles immunizations and tetanus toxoid),
2. increase the utilization of ORS for prevention of dehydration due to diarrhea,
3. improve infant feeding practices,
4. promote birth spacing;

A. Extension of PVO-operated health and CS services with an increased emphasis on urban and peri-urban slum populations;

B. Provision of technical assistance to assist PVOs to better plan, manage and implement their CS programs and improve the outreach effectiveness of CS services delivery;

C. Strengthening of PVO service support agencies, so that these in turn are able to provide sustained technical and management assistance to the services-delivery agencies. Specifically, USAID will:

1. Provide assistance to the Child Health Institute (CHI) to strengthen its role as a center for operational research, technical assistance, evaluation, documentation and information dissemination center;

Provide support to the Haitian Community Health Institute (INHSAC) to strengthen its role as a public health training institution;

Strengthen PROFAMIL to become a broader family planning service delivery association that will function also as a family planning resource center for training, information and education for other agencies;

D. Development of the child survival potential of the three major PVO-administered feeding programs which distribute PL-480 commodities to preschool children;

E. Promote low-cost water technology as a catalyst for child survival programs. Low cost, potable water systems will be supported as an entry point and/or reinforcement for child survival interventions. Operations research will be undertaken to determine how low access to water affects diarrhea and home management with ORT;

One of the Mission's more indirect strategic approaches is to increase effective dialogue with the donors in the health sector. USAID will encourage and strive for stronger donor coordination and collaboration to make efficient use of scarce resources, and to avoid duplication and overlap. Though donor coordination process USAID will strive to apply concerted pressure on the GOH to make meaningful policy and structural changes in the public sector. It must be recognized, however, that USAID enters into the policy dialogue process with a handicap in that USAID no longer has a bilateral relationship with the GOH. USAID will rely on PAHO, UNICEF, the World Bank and the IDB as proxies to promote key policy dialogue issues in their direct relationships with the GOH/MSPP.

B. Immunization

1. The Problem

Among vaccine-preventable diseases, neonatal tetanus and measles are the major contributors to infant and child mortality in Haiti, and should be the priority immunizations for the EPI program. Findings from a Cite Soleil Measles study (Boulos and Halsey, JHU) have contributed to the understanding of measles epidemiology in Haiti and worldwide. The Cite Soleil study documented that by age 11 months, 34% of infants in Haiti have suffered from naturally acquired measles, and had a significantly lower nutritional status than those who had not had measles. Infant mortality was significantly lower among those vaccinated against measles.

In 1969 Albert Schweitzer Hospital (HAS) documented that neonatal tetanus contributed to 25% of infant deaths before a concentrated immunization effort essentially eradicated neonatal tetanus in the HAS service area. Neonatal tetanus has been insufficiently documented in Haiti, but given the low coverage levels of tetanus toxoid (TT) immunization, and the large proportion of deliveries attended by untrained personnel, it may be assumed that neonatal tetanus remains a major factor in infant mortality in the Haitian countryside. Though the HAS success with TT was internationally recognized, this experience has never been sufficiently acclaimed in Haiti itself so as to have led to a national TT Program. Reduction of neonatal tetanus mortality still represents a major challenge and opportunity at this time.

The role of pertussis in mortality, directly or indirectly as acute respiratory infection (ARI), is not known, but as with measles and tetanus, it is presumed to be of significant priority. Polio is considered to be an important disease to which PAHO and the GOH attach priority status.

The Haitian expanded program of immunization (EPI) is by far the most effective public health program in Haiti at the present time. Excellent donor coordination, and impressive MOH leadership have led to a series of National Vaccination Days that appear to have doubled immunization coverage for all major antigens in the past year. However, present coverage levels of approximately 30-40% of target populations for measles and tetanus toxoid are extremely low. Major efforts are required to accelerate immunization coverage in Haiti, especially at the level of routine delivery of vaccination services at health facilities, to insure that a sustainable program can evolve from major investments in the Haitian EPI program.

2. The Present Country Program.

The current EPI country program dates from 1985 and provides for immunization using six standard antigens. National program targets are those of WHO: to achieve 80 percent coverage of infants under age one with all six antigens by 1990. The Haiti program, in line with a PAHO regional initiative also stresses the eradication of polio from the Americas by 1990. In 1987 USAID demands that this goal to be unrealistic in Haiti's situation and reduced its immunization targets to 50-60% coverage by 1991, and 80% by the year 2000.

Following a cut in resource levels for FY89, especially in the loss of 3 million dollars per year in local currency, USAID revised downward its FY89-90 Action Plan immunization targets for measles and tetanus toxoid to 30 and 35%, respectively. Given the momentum from the recent mass campaign success, and an FY 89 grant to PAHO that will commit 1.2 million dollars in DA resources to the EPI program until FY 91, the FY 90-91 Action Plan submission has re-established FY 91 immunization targets at 50% for measles and tetanus toxoid coverage. USAID has, for the immediate future, accepted the decision by other donors to move toward polio "eradication" -- provided that progress is made toward addressing more critical threats to child survival in Haiti posed by measles and neonatal tetanus.

The Haiti EPI program employs three different service delivery activities to accelerate immunization coverage. Routine institutional delivery of services from fixed health facilities is at the base of the Haiti EPI program, but to date has been the least effective.

Community outreach activities, carried out by health agents at village rally posts, or by roving teams of vaccinators on horseback are operant to some extent throughout the country to reinforce routine vaccination services. On a periodic basis these activities are supplemented by communal vaccination days, which are mass community outreach activities targeted to inaccessible or traditionally underserved areas within health districts. Communal vaccination days are implemented by central level personnel in collaboration with regional and district staff.

Finally, an annual national vaccination campaign approach of two or three immunization days has been used in addition to routine community outreach strategies and fixed clinic-based services. In FY 88 the first-ever national immunization campaign was credited with doubling vaccination coverage in the country. While coverage data has not yet been verified by a national coverage survey, most agree that the campaign was incredibly successful, especially in light of the fact that the campaign days took place during a period of political unrest and natural disaster.

Since clinic-based immunization services account for only a minor portion of vaccination coverage, largely due to the fact that the national public health infrastructure is inadequate and fragile, it is apparent that the campaign approach, organizationally and financially beyond the ability of the MOH to maintain, cannot yet be abandoned. Further, to achieve polio eradication, yearly mass campaigns will continue to be required in the near term.

National immunization coverage has increased noticeably since 1985 through employment of the above-mentioned strategies. As table V-1 suggests, the principal contributor to this success has been the mass campaign carried out in 1988. It should be noted that USAID feels the 1988 MSPP data is exaggerated to some extent, and will need to be verified by a coverage survey. However, this data suggests that the campaign approach has helped the EPI to double national coverage from previous levels. Routine MOH vaccination efforts have been stymied due to political turmoil during the past two years. During this same period, PVO vaccination coverage in limited target populations made impressive advances. Table V-2 demonstrates that in major A.I.D. supported PVO programs, institutional delivery of measles immunization has already attained USAID FY 91 AP target of 50% coverage of children less than one year of age.

PVO programs already make a major contribution to Haiti's immunization coverage. Approximately a half million people are served by A.I.D. supported PVO child survival programs in Haiti at the present time, and this population should triple by FY 91 to serve approximately a quarter of the Haitian population. This expansion of PVO beneficiaries is expected to result in improved national immunization rates.

Unfortunately, inadequacy and incompatibility of immunization reporting still make routine measurement of immunization coverage in Haiti very difficult, if not impossible. Estimated coverage rates from MOH data are misleading, primarily due to over-reporting of children less than one properly vaccinated. Coverage rates from independent surveys are conflicting, due to differing estimates of the numerators and denominators of populations provided with services.

The EPI program is supported by a collaborative consortium of donors led by PAHO. Planning and procurement of vaccine and supplies is the responsibility of UNICEF. PAHO supports local training. USAID, through some local currency, and DA funds channeled through REACH project, the PAHO Accelerated Immunization Program for the Americas, and through a grant to the local PAHO office finances more than a third of the national program. USAID assistance finances operating costs for logistics and supervision, and supports the cold chain and communications components of the program. PAHO, UNICEF and USAID together have been providing technical assistance for all aspects of program implementation and management.

3. Implementation Problems and Constraints

- The MSPP systems support for immunization - including logistics, supervision and training, is weak and has not improved with the interruption of support to the overall public sector. Vaccine supplies and other immunization materials are unreliable and may not be adequate, as needles and syringes have become highly marketable consumer items;
- The PVO immunization program is dependent on the MSPP for supplies and materials;

HAITI EPI VACCINATION COVERAGE
1985 - 1988
(CHILDREN LESS THAN ONE YEAR OF AGE)

VACCINS	1985	1986	1987	1988
DPT	23.2	26.53	29.59	54%
POLIO	22.2	30.72	29.51	54%
BCG	70	74.93	46.3	48%
MEASLES	—	21.74	23.93	62%

SOURCE: MSPP 1989

IMMUNIZATION COVERAGE
IN SELECTED AID-SUPPORTED PVOS, 1988

TABLE V-2

INSTITUTION	SITE	REGISTERED POPULATION	DPT (3)	POLIO (3)	BCG	MEASLES	COMPLETE
MARCH	Mirebalais	84966 *	50	52	84	48	38
HOP. PIGNON	Pignon/ St. Raphael	52292	57	76	86	55	39
SAVE THE CHILDREN	Maissade	20987 *	43	43	75	42	30
HOP. BON BERGER	Thiotte	25355 *	29	31	47	37	16
UEH	Carrefour-Poy	50000					42
MISSION BAPTISTE	Fermathe	50381	63	63	76	50	38
PHASE	Freres	28117	56	57	74	55	40

* Data refers to old and new sectors

Immunization coverage refers to samples of children 12-23 months old.

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- The cold chain requires amplification and sustained maintenance to support the current and projected program;
- Lack of an immunization surveillance system;
- Insufficient effort has been made to develop outreach programs in communities to help galvanize participation in immunization;
- Absence of a well-developed and tested communications program to support the EPI.
- A serious maldistribution of health workers favoring Port-au-Prince and other urban centers inhibits potential expansion of clinic-based immunization services;

4. USAID's Strategy for Immunization

USAID's immunization strategy for the FY89-91 is three-fold:

- a) orient the focus of the national EPI to the district and communal level to strengthen sustainable, routine institutional delivery of vaccination services, especially measles and tetanus toxoid;
- b) promote the rapid expansion of PVO service coverage through grants provided from the VACS project;
- c) strengthen the planning and management capacity of PVOs to provide expanding immunizations coverage.

USAID will provide PAHO and the national EPI 1.2 million dollars over the next three years to continue present vaccination efforts and to support an orientation towards decentralized immunization service delivery. Through the VACS project, USAID will provide grants and technical assistance to at least 20 PVOs to expand their immunization programs.

Through the REACH project and support to the Child Health Institute, USAID will conduct a series of studies and evaluations of various vaccination strategies employed in Haiti to determine a cost-effective mix of activities that are sustainable within the Haitian context.

5. Goals and Objectives

USAID strategic immunization objectives are:

1. 50% of children less than one year of age will be immunized against measles by 1991;
2. 50% of women of reproductive age will have received 2 doses of tetanus toxoid;
3. By 1991, 50% of health centers nationwide will have a reliable stock of vaccine and regularly give vaccinations to appropriate children and mothers.

6. Elements of USAID's Strategy

With assistance from other donors and the MOH, re-orient EPI program to a decentralized effort that offers routine delivery of immunization services at the district and communal level in Haiti;

Use operations research and rapid assessment techniques to determine resources and action required to improve routine immunization services in fixed clinics at the communal level

Through the REACH project, provide focused support to the extension and maintenance of the cold chain;

Through REACH assistance, develop and implement a strategic communications plan for the national, regional and district EPI program;

Increase grant assistance and management assistance to PVOs offering vaccination services at the community level.

Provide technical assistance to strengthen MOH/PVO collaboration, especially in regards to EPI program planning at the communal level, logistical support, and for surveillance and monitoring;

- Provide assistance to accent tetanus and measles immunization efforts at all levels. This will include developing a immunization component to PL 480 feeding program to vaccinate girls with tetanus toxoid in secondary schools, evaluating present TT and measles coverage with a national coverage survey, and retraining health services personnel on the importance of measles and TT immunizations to child survival;

- Support the development of a national immunization information system incorporating routine service statistics of PVO programs.

7. Benchmarks/Impact

- The success of USAID efforts will be measured by coverage surveys and information provided from strengthened health information systems. In 1991, USAID will also support a second round of the National Morbidity and Mortality survey (EMMUS II) that will provide information on national vaccination coverage. USAID expects that:

By 1990, measles and tetanus immunization coverage will attain 40% in target populations;

By 1990, 35% of health facilities nationwide will offer routine immunization services;

By 1991, 50% of children less than one year of age will be immunized against measles;

By 1991, 50% of women of reproductive age will have received 2 doses of tetanus toxoid;

3. By 1991, 50% of health centers nationwide will have a reliable stock of vaccine and regularly give vaccinations to appropriate children and mothers.

8. A.I.D. Inputs

Technical Assistance: to PVOs and the MOH to improve management and planning of community level immunization programs, to develop health information systems, to develop monitoring and surveillance systems, to strengthen the cold chain, and carry out evaluations;

Commodities: equipment and supplies will be provided to expand the cold chain; vehicles and motorcycles will be provided to strengthen logistical and supervisory support of the MOH and PVO programs; computers and other materials will be provided to develop routine monitoring and surveillance of the EPI;

- Operations Research: to solve routine immunization service delivery problems and to develop viable vaccination strategies;
- Communications Support: to develop and implement a national communications plan for the EPI at the central, regional, district and communal level.

C. Diarrheal Diseases

1. The Problem

Diarrheal diseases are the chief cause of infant and child mortality in Haiti, causing an estimated 25,000 child deaths annually. Case fatality rates for children hospitalized with diarrheas are still greater than 20% in even the best regional hospitals and up to 70% in some PHC facilities. The 1987 National Morbidity and Mortality Survey (EMMUS) found no change in diarrhea prevalence since 1973: 41% of under-fives experienced an episode of diarrhea within two weeks previous to the survey round, and 10% - 15% during the previous 24 hours. As expected, incidence peaks in the 6-23 month age group, a period when supplementary feeding and weaning usually occurs. In Haiti, diarrhea is also surprisingly prevalent in the first six months of infancy, reflecting the Haitian pattern of supplementing breastfeeding with other liquids that are prone to be contaminated.

The ultimate cause of diarrhea is contamination resulting from a lack of sanitation, access to safe water and associated poor hygienic practices. Less than 50% of the households surveyed nationwide by EMMUS had an acceptable water supply and some form of a toilet facility or latrine. In rural areas, these figures dropped to 34 and 32 %, respectively. At the present rate of population growth, considerable investment will be required just to maintain per capita access to adequate water and sanitation systems.

On the national level, the national diarrheal disease control program has slipped from world renowned success to a skeletal activity devoid of any apparent impact. On a positive note, local production of ORS has continued to increase, from 200,000 packets in 1985 to over 600,000 in 1988, due to the initiative and vision of a local pharmaceutical producer. Recent attempts by the MOH to revive the national DDC program through concerted donor investment suggest that it may be possible to build on the gains made by the program in its heyday. Knowledge about ORT is still relatively high, and there remains a nucleus of health personnel trained in ORT use who could be catalysts to such an effort.

2. The Present Country Program

PRONACODIAM, the MSPP program to promote the use of ORT, to increase breast feeding and to improve weaning practices, was launched in July, 1983. With carefully coordinated support from USAID, UNICEF, and PAHO, the program made great advances in its first two years, as documented in 1985 by a national KAP Survey, and by a multidonor evaluation. During the height of the campaign, 90% of women in the capital Port-au-Prince knew about ORT, and 80% reported having used it for their child's last episode of diarrhea.

Following an initial burst of activity, the public sector ORT program took a back seat to the politically visible immunization campaigns, and consequently lost its momentum and early acceptance. As a result, training given to many health professionals lacked the followup necessary to instill the concept of ORT to treat diarrheal episodes as a method of choice within the health establishment.

However, A.I.D.-supported PVO programs in Cite Soleil; Mirebalais, Pignon and Maissaide, and elsewhere (see table V-3) continue to show increasing ORT use rates. Stagnation of the national ORT program is partly due to the limited human resources and competing programs, in particular the priority now given to EPI. A second factor may have been the original decision to distribute ORS packets only through commercial channels in order to assure sustainability. This decision is now thought to have limited the appeal of ORS to impoverished populations.

Another problem was that ORT social marketing messages promised, or were interpreted as promising, to stop diarrhea, creating disappointment and loss of confidence by mothers. However, in PVO programs with multiple communications reinforcement and face-to-face interaction, this problem appears to have been overcome.

By 1987, the EMMUS survey revealed that reported ORT use had slipped to 14%, and amongst mothers using ORT, half were not using ORT correctly. The extent and use of home-mix solutions is not known, and it is doubtful that the majority of home solutions are both efficacious and safe. PRICOR-supported studies in Haiti have demonstrated that more face-to-face instruction will be required to increase correct ORT use in the general population.

ORT Knowledge, Competence and Use
in Selected A.I.D. Supported PVOS, 1988

TABLE V-3

ORT
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INSTITUTION	SITE	KNOWLEDGE		COMPETENCE		USE	
		Packet	Home	Packet	Home	Packet	Home solution
MARCH	Mirebalais			64%		44%	7%
HOP. PIGNON	Pignon/ St. Raphael	82%	43%	39%		72%	
SAVE THE CHILDREN	Maissade			41%		60%	
HOP. BON BERGER	Thiotte	73%	33%	50%	20%	53%	17%
UEH	Carrefour-Poy	97%	47%	52%	30%	70%	33%
MISSION BAPTISTE	Fermathe	93%	17%	27%	7%	69%	10%
PHASE	Freres	96%	NA	61%	4%	75%	17%

-
- ORT knowledge is defined as having heard of ORT
 - ORT competence refers to the correct preparation of the solution
 - ORT use refers to the most recent diarrhea episode (last two weeks)

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ORS supply is locally produced by one manufacturer who is interested in testing new formulations. Product quality is good and production could be expanded rapidly to meet increased demand. Production data from the supplier indicate that approximately 600,000 packets are now used annually, but most likely not in the targeted high risk population.

In 1989 the national DDC program shows evidence of resurrection. UNICEF continues to be the lead donor in national DDC efforts, and renewed emphasis is being placed on how to make the stagnant program more effective. Recent steps taken by the MOH have accented the role of the private sector in the DDC program. In FY 89, the local producer of ORS will be contracted to assure supplies of ORS to all MOH facilities, including delivery. A grant has also been made to the producer to increase distribution of ORS to private vendors in rural areas.

The hiatus in U.S. local currency support for government programs is seriously affecting program implementation, since these funds have traditionally served as government counterpart to UNICEF and other donor assistance. Present USAID funding support for the national DDC program is channeled through grants to PVOs that offer ORT as an integral component of their child survival programs.

3. Implementation Problems and Constraints

- Lack of professional acceptance of ORT;
- Low credibility of ORT in the community and on part of health services workers;
- Limited success of commercial ORS distribution;
- Inadequate MSPP logistical capacity for reliable ORS distribution through fixed-facility channels;
- PVO reliance on MSPP ORS distribution system
- Lack of effective public sector health education capacity.

4. Priorities for AID Assistance

In 1987 USAID had given top priority to the revitalization of the institutional bases for ORT, the public sector PRONACODIAM and the PVOs, which if effectively combined, are in the best position to jointly promote the use of ORT. The critical factors in promoting ORT are a) to re-sell ORT in a climate of negative public opinion and b) to increase household accessibility to and use of packets. Given the bilateral constraints and the commensurate cut in U.S. resources, USAID will focus its immediate and continuing support on PVO diarrheal disease control programs. USAID, however, is aware that it is unrealistic to expect to influence the national program indirectly. It is important to recognize that the GOH is already struggling to implement two national programs - Immunization and AIDS, and that there is unfortunately a trade-off effect.

Hence, within these constraints, USAID's first priority is to ensure that all our PVO grantees develop effective and efficient ORT programs. Our second area of focus will be to augment local ORS production and increase commercial sale and distribution of ORS through the private sector. We will also support limited public sector DDC activities through the aegis of UNICEF, or if local currency becomes available, by direct assistance to the MOH. Finally, to a limited extent, USAID will support small grants to PVO's to develop water and sanitation components to augment ongoing child survival programs.

5. Goals and Objectives

USAID has adjusted downward the Agency's goals and its own to fit the realities of the Haitian situation. In the present context, USAID's goal to achieve 40% use of ORT by 1991 may not be achievable, as it requires direct institutional support to the public sector. USAID, however, has opted to maintain the goal and will attempt to encourage other donors to provide the requisite support.

a. To increase ORT use by mothers from current level to 40% by the year 1991.

b. As a long-term goal, beyond the immediate funding constraints, USAID still seeks to reduce the risk of diarrhea and related malnutrition through increased access to safe water and sanitation, and through promotion of early exclusive breastfeeding.

6. Elements of USAID's Interim Strategy:

Increase and improve the promotion and distribution of ORT through PVO rally posts in rural and urban health programs;

Provide management support to the PVOs for ORT program implementation;

Continue to assist public sector distribution of ORS with local currency when available, and through grants to other donor agencies such as UNICEF and PAHO;

Expand commercial distribution through direct grants to private sector businesses, including grant assistance to develop a prototype cereal-based ORS to respond to demand for a product that can reduce stool volume (subject to approval by GC/LAC);

Integrate water and sanitation components into on-going child survival programs;

Integrate DDC/ORT education and distribution into ongoing and new PVO water and sanitation projects;

Encourage PVO community to promote exclusive breastfeeding for the first four months, as part of their nutrition emphasis;

Use CHI Operations Research capability to improve private sector ORT services delivery and DDC efforts, including water and sanitation;

7. Benchmarks/Impact

By 1991, increased ORS access; and 40% of infants/children (0-59 mos) with diarrhea will be treated with ORT;

By 1991, 60% ORS availability and routine institutional use by all A.I.D. supported PVO health service delivery programs;

8. AID and other Complementary Inputs

Technical assistance - AID management support to PVO child survival programs in planning, logistics, supervision and the information system requirements of ORT programs; communications TA through REACH to UNICEF, PVOs, and the private sector;

Communications - limited material and TA support to PVOs for the promotion of ORT; direct support to UNICEF, the MOH (when possible), and private sector firms that produce or distribute ORS

Operations Research - AID support for research and development of prototype cereal-based ORT and distribution through the private sector; TA and logistical support for KAP studies and program evaluation;

Commodities - communications materials and supplies; limited assistance for pumps, pipe, cement, and hardware for water and sanitation programs.

E. Nutrition

1. The Problem

Malnutrition contributes to more than 60% of infant deaths in Haiti. Under-nutrition initiates a vicious cycle of infections and further deteriorating nutritional status, resulting either in death or in stunted growth. According to the 1978 National Nutrition Survey, more than one tenth of children in Haiti aged 3-59 months, or approximately 120,000 children, suffer from severe nutritional wasting. Traditionally, infant under-nutrition has been more prevalent in rural Haiti. However, with migration and related economic factors, malnutrition is becoming increasingly prevalent in the urban areas. Malnutrition is most heavily concentrated among children of weaning age, but it is important to recognize that the downward spiral to malnutrition begins during early infancy, when children first contract diarrhea, measles and other illnesses. The 1987 EMMUS Survey confirmed that while breastfeeding duration still stands at 17.5 months, breastfeeding is decreasing among urban woman, especially those working in factories. It also documented a strong relationship between reported infant deaths and absence of breastfeeding. Of equally important concern is the finding that only 13% of infants are exclusively breastfed during the first three months of life. As discussed in the Diarrheal Diseases Section, early supplementary feeding, even if only with other liquids, becomes a vehicle for infection.

Other surveys have demonstrated a high prevalence of Vitamin A deficiency in young children, and iron deficiency anemia is widespread among children and their mothers. Available statistics suggest that anemia is under-represented. Parasitic infections, including malaria and intestinal parasites, contribute to both anemia and malnutrition. In children under age 5, for example, worms rank as the third cause of morbidity seen in health centers. Worms are also responsible for one third of health center visits.

A number of ecological, socio-economic and cultural factors contribute to infant and child malnutrition. Among these, the most important that are subject to short-term interventions are the following:

a. Excessive infant and young child morbidity. The incidence of diarrhea, measles, intestinal parasites and acute respiratory infections may be the most salient, synergistic determinants of under-nutrition and infant mortality in Haitian children. Any major morbidity reduction will improve nutritional status.

b. Problems of access to sufficient food for children. While this is determined in part by agricultural production and economic status, other more addressable concerns include poor infant feeding and weaning practices that contribute significantly to malnutrition in Haiti -- especially the wide-spread failure to feed children adequately during and after bouts of diarrhea and other illnesses; inadequate or inappropriate weaning foods; and the decline of breastfeeding among young, urban mothers.

c. Poor maternal nutrition and the resultant low birth weight contributes directly to early infant mortality.

2. The Present Country Program

The national nutrition program in Haiti has declined from once being a model for the world to one that is virtually inactive and ineffective, reflecting the general disruption of MSPP programs. Through Title III resources, USAID has supported limited activities of the nutrition service to improve infant feeding practices through traditional nutrition education programs, promotion of AK-1000 (a weaning supplement), and Vitamin A capsule distribution. Government interest in nutrition, however, has remained low.

PVO efforts in promoting nutrition are more promising. Many PVOs in the country include growth monitoring activities in their child survival program. Outreach of these programs is limited, and growth promotion through delivery of a set of nutrition interventions is not carried out on a large scale. Vitamin A capsule distribution programs are perhaps the most widespread nutrition intervention among all PVOs. Taken together, however, the combined results of public and private sector nutrition activities is not impressive. The EMMUS survey found that 16% of under-fives nationwide had road-to health cards that had recorded weights; and 13% had a health card that recorded one dose of Vitamin A treatment.

The PL 480 Title II program in Haiti has evolved into a program predominantly oriented to feeding school children, and while there is a demonstrated nutritional need in primary school students, only 30% of Title II resources are targeted to mothers and preschool children who many argue are the most nutritionally at-risk groups in the country.

USAID has taken the lead in promoting a multi-donor response to the nutrition problem in Haiti. At present the World Bank, the IDB, the World Food Program, FAO, UNICEF, PAHO, and USAID have begun to meet on a regular basis to discuss a collaborative approach to address the deteriorating nutrition situation in Haiti.

3. Implementation Problems and Constraints

Declining per capita food production which has resulted in a per capita calorie deficit that is the fifth worst in the world;

Lack of GOH political commitment, policies and resources;

Lack of proven, effective, affordable nutrition interventions suitable to the Haitian context;

Lack of public and private sector infrastructure to carry out effective nutrition interventions;

Difficulty in targeting PL 480 resources to nutritionally at risk mothers and pre-school children.

4. USAID's Strategy for Nutrition

USAID will play a major role in coordinating donor support to develop a collaborative, multi-sectoral approach to the nutrition problem in Haiti. Initially, PAHO, FAO, the IDB and USAID will undertake an assessment of the extent, severity and determinants of undernutrition in the country.

As a result of this activity, a nutrition action plan will be developed in collaboration with all donors, the GOH and PVOs to address key nutritional concerns. Specific areas of intervention will be assigned to donors, the GOH and PVOs depending upon individual organizational interest and expertise.

USAID will concentrate on vitamin A programs, operations research and pilot programs to improve breast-feeding, infant feeding practices, and dietary management of diarrhea. USAID will also support the development of low cost community nutrition interventions through PVO programs. Finally, USAID will attempt to maximize the nutritional impact of our Title II feeding program.

5. Specific Goals and Objectives

The objectives of the USAID/Haiti nutrition strategy are:

1. To reduce infant and young child (0-36 months) morbidity, so as to prevent or limit its devastating effect on nutritional status.
2. To develop coordinating mechanisms and agreements to maximize, to the extent possible, the limited resources available to address nutritional problems in Haiti;
3. To develop two affordable, sustainable, efficient and effective nutrition interventions relevant to the Haitian milieu that can be expanded and promoted by other donors, PVOs and the GOH;

6. Elements of USAID's Strategy

USAID will work with the IBD to develop a locus of coordination for nutrition activities in the donor community and the private sector. USAID will sponsor coordination meetings and workshops to promote a collaborative, multi-sectoral approach to the nutrition problem in Haiti.

Given the extent of vitamin A programs operant in Haiti, during the three year strategy period USAID will assess the impact and effectiveness of vitamin A activities in the country. This assessment will address capsule distribution operations, campaigns to promote the production and consumption of vitamin A rich foods, and vitamin A research studies presently being implemented in Haiti. Recommendations that will stem from this assessment will be implemented by reprogramming resources from on-going vitamin A projects in the country.

USAID will also assist in strengthening growth monitoring and promotion in PVO programs through the provision of small nutrition grants to PVOs under the VACS project. While these grants will not affect large numbers of beneficiaries, they will develop models for efficient and effective community-based nutrition interventions that could have potential for replication.

USAID will also support modest operational research and intervention efforts to address infant feeding practices, declining breastfeeding, and dietary management of diarrhea. These efforts will center upon linking promotion of exclusive early breastfeeding (0-4 months) with improved nutritional management of diarrheal episodes.

USAID will accent measles immunization as a priority concern in our support to PAHO and to PVO immunization programs, given the synergistic relationship between measles morbidity, malnutrition, and xerophthalmia.

USAID will support a pilot program to assist PVOs that wish to include deworming activities in their child survival projects. Resources will be made available to evaluate the nutritional impact of anthelmintic products on nutritional status and cognitive ability as well as to develop supportive nutrition education materials.

USAID will provide small grant assistance to cooperating sponsors to develop effective and efficient delivery systems to target food aid to nutritionally at-risk mothers and children. This will include program support for PVOs to conduct operations research to develop ways in which the food distribution system and food resources targeted to school children in nutritionally at-risk geographic areas can also benefit mothers and preschool children.

7. Benchmarks/Impact

In the limited three year strategy period, the effectiveness of the USAID nutrition strategy will be measured by its ability to generate collaboration, resource sharing and research and development efforts that in the longer term will result in significant nutritional impact. PVO nutrition programs will be measured in terms of strengthened program content, effective population coverage and management. Specific research and development activities such as the introduction of anthelmintics into child survival programs will be measured by their cost effectiveness and impact on nutritional status.

Process indicators of program effectiveness will be the following:

By 1991, a national nutrition action plan will exist that will present a series of activities and programs to be implemented by the GOH, donors and PVOs to address key nutritional concerns in Haiti;

By 1991, 80% of A.I.D. supported PVOs will include vitamin A capsule distribution as a component to their child survival programs;

By 1991, 50% of A.I.D. supported PVO programs will have growth monitoring programs that also include a growth promotion component relevant to program context and means;

By 1991, Cooperating sponsors in Haiti will have an increased capacity to target food resources to beneficiaries in nutritional need.

8. AID Inputs

Technical Assistance to assess, design, implement, and evaluate nutrition activities;

Training to develop community nutrition programs, operations research, and nutrition communications programs;

Food to supplement diets of nutritionally at-risk groups;

Commodities such as scales, growth charts, materials and supplies to support program activities.

D. Child Spacing and High Risk Births

1. The Problem

Increased urbanization and other negative aspects of "modernization" are leading to declining age at first birth and shortened intervals of postpartum amenorrhea due to declining trend in breastfeeding and premature food supplementation practices. These changes have led to the predictable increase in the total fertility rate (from levels of approximately 5.5 ten years ago to a level of 6.4 documented by the 1987 EMMUS survey. These behavior changes have also resulted in an increased number of high risk births to very young women and to an increased percentage of births at short intervals. Data from the USAID supported CS project implemented by Eye Care Haiti in Mirebalais indicate that 30% of all births occur less than two years after the previous birth. These data support the conclusions of Maine and Rosenfield that short birth interval results in significant increases in maternal and infant morbidity. Mirebalais data suggest that women who give birth twice in a twelve month interval constitute only 15% of all mothers but contribute to 30% of all infant deaths.

Grand multiparity also contributes to high risk births and increased perinatal mortality. EMMUS data suggest that 20% of pregnant women had five or more births before the current pregnancy.

2. The Present Country Program - USAID and Other Support

There is much reason to be optimistic about the future of the Haitian family planning program in spite of the past fifteen years of poor performance. The MSPP FP program has been heavily supported by USAID and UNFPA since the mid seventies. Nonetheless, at the time of the termination of USAID assistance to the FP program, contraceptive prevalence was only estimated to be 5%, largely due to lack of commitment by policy makers and front line health workers.

USAID is encouraged because the current Minister of Health has just returned from a AID/W population briefing, which he paid for from his own extremely scarce resources, and announced that he intends to organize a seminar within the next two months at which time experts from the Futures Group will assist the dynamic head of the Haitian Population Council to make a RAPID presentation to the President, all members of his cabinet and their chief advisors. The present Minister has much personal experience with family planning. For instance, he is personally committed to register the NORPLANT method in Haiti thereby ending much inappropriate controversy about this method which is well suited to the Haitian context. (He recently organized a seminar to present the results of the Haitian experience with family planning to the medical community.)

The Minister has reorganized the MOH so that a very dynamic, competent obstetrician now heads a smaller and presumably more efficient unit which has replaced the previous family planning division. The previous MOH Division of Family Planning was phlegmatic, and had a history of being managed by a series of unimpressive individuals. The newly created Population Unit's service delivery program will be supported by a modest grant from UNFPA and the Population Council.

Haitian women have proven to be avid, if not completely reliable, family planners any time services are made available to them in a consistent, sensitive manner. The family planning program at the Albert Schweitzer Hospital has, for many years, served more than twenty percent of the target women in its catchment area of almost 200,000 people. Other PVO experiences have had similar long-term successes. The USAID funded Private Sector Family Planning (PSFP) project, although only two years old, is also demonstrating that when PVOs open new programs, women enthusiastically patronize them. Multiple surveys have demonstrated that knowledge about family planning is high among Haitian women and that almost half want no more children.

The combination of a desire for fewer children, knowledge about contraceptives and a dynamic, committed new leadership at the MSPP is reason for considerable optimism about the MSPP's potential to implement an effective program, should the political situation improve.

On the PVO side, the situation is very promising. The PSFP project has established twenty PVO programs which have already enrolled more than 10,000 clients or more than a third of the number enrolled in the public sector program at the time funding was cut. In addition to the PVO support component, the PSFP project has initiated planning efforts to develop a much enlarged sterilization component, a new contraceptive retail sales program, and a more systematic, intensive IE&C component. The project has also funded much useful demographic analysis through buy-ins to the centrally funded RAPID and OPTIONS projects which have been greeted enthusiastically by the leadership of both the public and private public health communities. It is this work which will form the basis of the material soon to be presented to the President and which has allowed USAID to continue to conduct a very positive policy dialogue with the Ministry of Health despite the cutoff of funding to Ministry programs.

3. Implementation Problems and Constraints

- An underfunded public sector program;
- An inadequate IEC program which makes targeting high-risk groups exceedingly difficult;
- Available methods are not well accepted except for Norplant which is only available in very limited quantities, and then only in the context of a field trial which severely constrains diffusion of the method;
- Decrease in breastfeeding and premature food supplementation practices among urban women leading to decreased birth interval.

4. Priorities for USAID Assistance

For the period covered by this strategy, USAID will give continued priority to the development and expansion of family planning programs implemented by the more than 200 PVOs in Haiti. USAID will, when it becomes politically possible, support the MSPP's family planning program to the degree possible given current budget constraints. At current levels of approximately \$1,500,000 per year in the population account, USAID will be able to do little other than support the PVO program. Through buy-ins to the Futures Group and other population policy projects, USAID will continue to give a high priority to the development of a critical mass of opinion leaders sensitive to the urgency of the population problem.

5. Specific Goals and Objectives

To prevent unwanted births by increasing access to family planning programs. To reduce high risk births by sensitizing mothers and health workers to the dangers of short birth interval.

6. Key Elements of the USAID Strategy for Child Spacing

Develop child spacing/HRB communications approach for PVOs in conjunction with messages in support of immunization and ORT;

Develop national access to information on contraception through PVOs, and community-based distribution, which will reach even into the rural areas;

Encourage interested PVOs to integrate family planning contraceptive services with other CS interventions;

Expand private sector community-based programs by utilizing community functionaries to distribute family planning information, along with ORS;

Update audio-visual presentation on impact of rapid population growth on socio-economic development, including relationship between short birth intervals, high parity and infant mortality;

Social marketing of oral contraceptives;

Expansion of PVO VSC capacity;

Work with commercial sector to collaborate in FP service provision to train staffs.

7. Benchmarks/Impact

By 1991, 15% of reproductive aged women in union in the catchment area of USAID funded PVO programs will be using a modern method of contraception;

-By 1990, the GOH will have approved a reasonable population policy which takes cognizance of the population problem described in the work recently prepared with assistance from the Futures Group.

By 1993, there will be a contraceptive retail sales program which is largely self-financing;

Child survival training programs will include modules which train health workers to identify mothers at-risk of an infant death and to counsel mothers in the prevention of high risk births.

8. USAID and Other Donor Inputs

USAID will provide:

Technical assistance to PVOs in service delivery and to opinion shapers in population policy development;

Training of all levels of health workers through the INHSAC and through U.S. based programs;

Operations Research into impediments to increasing contraceptive utilization

Support to a greatly expanded IEC component;

Contraceptives, equipment and supplies;

Local Currency to support the work of community promoters.

F. Other Causes of Infant and Child Mortality

1. AIDS

a. Background

The magnitude and complexity of the AIDS problem will not be discussed in detail in this document because AIDS is primarily concentrated in sexually active adults, and has not yet become a substantial threat to young children. However, as the AIDS epidemic grows, USAID believes that the HIV virus has the potential to elevate infant mortality by the order of 15/1000 in the mid-1990's if something is not done now to halt the spread of AIDS in older populations. USAID will prepare a comprehensive AIDS strategy as it develops a new generation of AIDS control activities for the FY 91 - FY 96 period. The present discussion is intended to present an overview of the problem and USAID's interim response.

Dr. Jean Pape, a Haitian American professor of infectious disease at Cornell University, is one of the world's most experienced scientists dealing with the epidemiology and clinical aspects of AIDS in the developing world. His clinic, supported by Cornell University and the National Institutes of Health, now sees 80% of all the AIDS cases in Haiti. Dr. Pape is now seeing 65-70 new cases a month. Last year, he saw 45-50 new cases a month. He believes this 45% increase is more due to a more inclusive case definition (which now includes the "wasting syndrome" as does the revised CDC case definition) and to more referrals, rather than to a radical increase in the incidence of the disease. He has personally followed more than 2000 cases of AIDS, whereas the MSPP reports only a total of 1600 cases. He receives 800 blood specimens per month for serological testing of which 65-70% are positive for the HIV virus.

The work of scientists from Johns Hopkins University and the Haitian PVO, Centers for Development and Health CDS), demonstrate that seropositivity among pregnant women in Cité Soleil, one of Port-au-Prince's largest slums is approximately 9%. This level has not increased considerably over the past few years when compared to an analysis of blood specimens drawn for other purposes three years ago. Unfortunately, seropositivity among reproductive aged women served by a CDS MCH clinic in Gonaives, a secondary city in Haiti, is very similar to the rate in the capital. Seropositivity among mothers of infants sick with diarrhea in rural areas is approximately half that in urban areas. The only study of randomly selected individuals, sampled at the level of their households in very rural Haiti, demonstrated a seropositivity of 0.5% in 1987. This study will soon be repeated.

In his unpublished dissertation, the draft of which he shared with USAID, Lars Jerker Edstrom estimates that between 40,000 and 70,000 adults will become seropositive in 1991. Between 2600 and 4900 children less than five will similarly become seropositive. Dr. Pape's work indicates that 12% of these newly seropositive individuals will become clinically ill each year and that all of them will be dead within five years of becoming ill. USAID believes that Edstrom's estimate of the current degree of seropositivity in rural areas is inflated and therefore that these numbers may overestimate by 100% the actual number of deaths that will occur due to AIDS in Haiti in the mid-nineties. Even if this is true, between 20,000 and 35,000 relatively young adults in the prime of their productive lives will die annually of AIDS during the next decade.

b. The Present Country Program

The MSPP has only in the past year declared that AIDS control is a priority for the Haitian government. There is little public sector activity at the present time. A dynamic new director has been named to head the AIDS control program, and a donor's conference will be held April 17, 1989 to generate donor support and coordination for the Haiti AIDS control program. The Haiti AIDS control program for the period FY 89-93, as described in the medium term plan prepared by the MSPP with technical assistance from PAHO, includes the following:

<u>Budget Category</u>	<u>(\$000)</u>
- Information Campaign	\$1.735
- Condom Social marketing	\$1.499
- Protect the Blood Supply	\$2.433
- Perinatal Transmission	\$0.014
- Treatment Center	\$0.527
- Research Coordination	\$0.027
- Epidemiologic Surveillance	\$0.710
Total	\$7.600

This program does not include the efforts of multiple PVOs who include an AIDS control activity as part and partial of their normal health program or a more limited number, most of whom receive USAID support and are described below, who have special AIDS control activities.

c. The USAID Strategy and Program

Following the donors conference in April when more is known about other donor interest and intent in AIDS Control activities, USAID will prepare a five-year AIDS control strategy and program. In FY 88, USAID gave a grant to an organization of industrialists and businessmen (The GLAS, which in French stands for "Group to Fight AIDS") to develop an AIDS control program in their places of business. The GLAS project is based on the notion that if employees are informed about the danger posed by AIDS and how to prevent it, they will purchase condoms at their own expense.

In FY 89, as a sub-activity under the new Extended Urban Health Project, USAID will authorize \$900,000 which will be obligated over the next two years to AIDSTECH and AIDSCOMM to provide technical assistance to local PVOs. Funds will also be used provide grants to PVOs wishing to develop programs. In addition to the GLAS, USAID will provide initial funding for the programs described below.

The Red Cross will receive support from AIDSTECH to improve blood screening procedures, particularly to train personnel in the use of rapid diagnostic procedures.

INTERAID, a PVO working with prostitutes in the Port-au-Prince slum of Carrefour, will receive a grant to expand its work.

The Factory Women's Center, a highly successful project initially funded by USAID to provide generic support to the majority of urban factory workers who are women, will receive a grant to supplement its ongoing AIDS control efforts which are funded by the Ford Foundation.

The CDS, a PVO which implements the USAID-supported Urban Health project, will receive a grant to develop an AIDS information and counselling program to complement their important research program already underway with support from Johns Hopkins University.

GHIESKO, a PVO founded by Dr. Pape and other Haitian researchers, will receive a grant to support further epidemiologic research and monitoring activities and to improve patient counselling;

Following the donor conference and the development of a AIDS control strategy, USAID will decide whether to develop a free standing AIDS control program or to continue funding AIDS control activities through some other modality in the future.

d. Benchmarks

USAID has established an program performance indicator of 500,000 people who will benefit from USAID supported AIDS control activities by 1991. We will also establish project indicators that will measure:

- Number of people trained in improved counselling procedures or in the better use of blood screening procedures;
- Number of individuals provided information about the prevention of AIDS in their workplaces;
- Number of new cases of AIDS, or degree of seropositivity reported from sentinel monitoring sites.

- Number of prostitutes counselled about AIDS prevention;
- e. USAID Inputs
 - Short-term technical assistance;
 - Full-time, locally hired advisor to manage and coordinate the multiple grants described above;
 - PVO grant support
 - Local currency support for MSPP program administration (if PL 480 or Title I resources are available)
 - If approved by ST/H and CDC, a CDC Epidemiologist, to be assigned to PAHO as senior technical advisor for the Haitian AIDS control program.
 - Minor amounts of commodities through the AIDSTECH project;
 - In-country and off-shore training.

2. Malaria

a. The Malaria Problem

PAHO and the MSPP estimate that there are approximately 300,000 cases of falciparum malaria per year in Haiti that result in 3,000 deaths. A disproportionate but undefined percent of these deaths occur among children. Surveys in the seventies suggest that parasitemia rates in endemic areas in children under age 10 years are approximately 10%. Parasitemia rates in adults in endemic areas before the major malaria eradication program began were estimated to be approximately 30%.

Among populations residing in the plains, perhaps 50% of the Haitian population, malaria is a major health problem but probably is not responsible for a large percentage of infant deaths. Malaria poses less of a threat to people residing on the hillsides in Haiti, and people who live above 500 meters elevation are not affected unless they descend to lower altitudes.

During the peak of eradication activity, annual case detection efforts only demonstrated 3,000 cases of malaria per year in Haiti. However, with the demise of the vector control program following the termination of USAID funding to public sector programs, USAID assumes that the PHAO estimate of 300,000 cases per year are correct.

b. The Country Program

Malaria control efforts came to an abrupt halt in Haiti following the termination of USG bilateral support. The SNEM, which was formerly responsible for a vertically structured, vector borne disease control program throughout the country, was eventually disbanded by the MOH.

With recent support from other donors, the MSPP, with assistance from PAHO, has adopted a new strategy which calls for the close integration of malaria control activities into normal PHC activities at the District level. PAHO will continue to provide technical assistance to the MSPP to support this effort. The new program will emphasize vector control through environmental modification, thus sparing application of residual insecticides. The program will also rely upon the use of personal protective devices such as mosquito nets, repellents, and the presumptive treatment of all fevers with Chloroquine.

This is exactly the strategy that USAID strongly recommended to the MOH long before terminating support to the expensive and unsuccessful efforts of SNEM to control the malaria vector through the household application of Fenitrothion.

However, the government of Japan, which provides the pesticide Fenitrothion free of charge, continues to encourage other donors to finance salary support for hundreds of workers that are necessary to continue to control malaria through pesticide mediated vector control. At present, there is little possibility the the MSPP will find donor support for this activity.

The MSPP and selected PVOs will carefully monitor for chloroquine resistance in the parasite. Technical assistance for this effort will be provided by PAHO or CDC assistance funded through USAID.

c. USAID Support for Malaria Control

USAID will support the MSPP strategy of integration of malaria control activities into ongoing PHC activities with limited amounts of local currency, should these resources become available. Significant amounts of local currency will not be required given that the MOH feels malaria control is not enough of a priority to warrant diversion of scarce local currency resources from other priority programs such as EPI and AIDS. DA funds will not be used to support major interventions against malaria.

Under special circumstances, such as the aftermath of the hurricane this year, USAID will, funds permitting, support limited emergency applications of pesticides.

In the context of child survival programs implemented by PVOs, USAID will encourage the development of innovative strategies to assure that all fevers in children are promptly and adequately treated with chloroquine. This will involve very little additional expense above and beyond the provision of chloroquine and the development of appropriate educational messages.

USAID, through the VBC project or through the CDC will provide experts to work with Haitian and PAHO counterparts to develop screening programs for the emergence of chloroquine resistance.

d. Benchmarks

- By 1991, 50% of all USAID supported PVO CS programs will provide chloroquine to any child who has a fever.
- BY 1991, 80% of all fevers treated at USAID supported PVO program dispensaries and clinics will be treated correctly with chloroquine when appropriate
- By 1991, monitoring of chloroquine resistance will be ongoing in three sites nationwide

e. USAID Input

- Local currency to support of salaries and per diem costs for training and supervision of the MSPP program to integrate malaria control into ongoing PHC activities

- -Chloroquine for both MSPP and PVO presumptive treatment programs
- Technical assistance to develop sentinel site monitoring capability for chloroquine resistance

3. Acute Respiratory Infection (ARI)

1. The ARI Problem in Haiti

Very little is known about the importance of ARI as a contributing factor to infant mortality in Haiti. Given evidence from around the developing world, however, USAID assumes that ARI has a significant impact on child survival.

There is no on-going ARI program in Haiti at the present time. However, USAID will support research by the Child Health Institute and CDC during the strategy period to examine the knowledge, attitudes and practices of mothers relative to ARI. USAID will also support research to better define the spectrum of causative organisms of ARI. Finally, USAID will examine the cost effectiveness, and potential negative side effects of various antibiotic regimens and antibiotic prescription by minimally trained community health workers in the Haitian context.

VI. Sustainability

Sustainability is a long goal of the USAID/Haiti Child Survival program. However, given the magnitude of problems facing the poorest country in the Western Hemisphere, it is unrealistic to believe we can achieve sustainability for our child survival program in the short or even medium term. Sustainability, or the continued existence of project activities after A.I.D.D.D. funding terminates, can result from financial self-sufficiency, or when A.I.D.'s contribution to the project is assumed by outside entities (other donors or the government).

The financial self-sufficiency of child survival activities is unrealistic since the beneficiaries are simply unable to bear all the expenses related to project services. Economic analyses of our child survival projects show cost benefit far down the road; further, child survival programs produce economic benefits that are reflected in avoidance of costs for major illnesses.

Given the magnitude of the need for assistance in Haiti and limits on donor funding, it is unrealistic to assume that other donors -- who in most cases have also experienced cutbacks in assistance levels -- will assume USAID's cost after a child survival project terminates. Also, we believe that, even with the political will to do so, it is unrealistic to assume that the GOH will be in a position to bear the costs child survival service delivery programs presently being borne by USAID, during the life of the present projects. The GOH currently faces an economic crisis, and is unlikely to overcome administrative weaknesses and an historic lack of commitment to service provision.

In the short term, we will continue to concentrate on maximizing the efficiency and cost-effectiveness of our child survival activities, that is, to achieve project objectives at the least possible cost to USAID. This involves careful examination of alternate approaches to service delivery and management efficiency; such analyses are an important part of design and implementation of our child survival, education and agroforestry activities.

In working with PVOs we emphasize ways that non-USAID inputs, including user fees, contributions from other sources, and contributions from the GOH (in-kind and local currency) can be mobilized. We strongly encourage user fees to be increased where this will not result in non-accessibility of services for needy target groups. And, within projects, we emphasize ways that one activity may generate revenues which help offset the costs of another activity. For example, under a pilot activity in our new urban health project, charges to factory workers for health services will help support the households which can afford to pay for individual connections under our water project help defray the costs of providing water to the rest of the community.

Host country contributions to AID-supported PVO child survival activities will become increasingly important to our program, and are significant, for example, in the development of the new Expanded Urban Health Services project. The current Ministry of Health seems favorably inclined to collaborate with and support PVO health service provision.

Given the Mission's focus on implementation through PVOs, especially indigenous PVOs, we try to assist these organizations to develop sufficient competence and administrative systems (including financial management system) so they will not need expensive technical assistance by the end of a project. This can be termed administrative sustainability, as opposed to financial sustainability, an objective which is realistic for our child survival projects.

Since our child survival portfolio cannot be expected to be fully self-sufficient, or to be fully taken over by the GOH or other donors, at their PACDs, we are trying to assure that the greatest impact in achieving programmatic objectives can be realized at the least cost. We build into our activities measures to assure that an institution we support can operate independently, in administrative terms, even if it must still look for further donor support. The ultimate goal is development of service delivery mechanisms which, in the long run, will be maximally efficient and whose costs can be assumed by beneficiaries, other donors, or the GOH when it is capable of doing so.

VII. Complementary Research

The Misson's previous strategy gave priority to research designed to render existing technologies more effective, and USAID will support the testing of new technologies if justified by the importance of the targeted problem or the particular advantages that the technology may offer to child survival programs or institutions operant in Haiti. USAID will continue to emphasize operational research designed to provide solutions to problems identified as part of the implementation of the priority child survival programs.

USAID will provide a minimum of 1.1 million dollars to support complementary research and evaluation activities over the three year strategy period. These resources will allow the Child Health Institute to carry out complementary research designed specifically to assist PVOs and the MOH to improve child survival technologies and programs in Haiti. These resources will also support a PASA with CDC to provide technical assistance to the CHI to develop a viable and effective research agenda in support of child survival programs in the country. Finally, centrally funded programs such as Eye Care International will provide resources to support complementary research in close collaboration with the CHI.

Some areas of complementary research that have been identified to be carried out during the strategy period are:

1. Prevention of Low Birth weight through the use of antibiotics during the final six weeks of pregnancy. USAID plans to finance a second study to confirm preliminary findings by Boulos, Halsey, et al, in Cite Soleil, (Haiti), using Erythromycine to achieve a decline in the incidence of low birth weight babies being born to these mothers;

2. Vitamin A: Eye Care Haiti in collaboration with Johns Hopkins University, the Complex Medico Social de la Cite Soleil, and the the HKI, are studying the effect of Vitamin A supplementation on childhood mortality and ocular disease. This research is currently underway in the very arid North of Haiti where previous studies have indicated that the rate of vitamin A deficiency is particularly severe;
3. Vaccine Trials: When ready for field testing, USAID will consider whether the epidemiological situation warrants, and whether necessary support systems exist to support trials for vaccine efficacy of rotovirus, H-influenza, and pneumococcal vaccines in Haiti;
4. Norplant: AID-financed research to test the acceptability and effectiveness of NORPLANT in Haiti has been very successful. USAID will continue to support NORPLANT acceptability trials during the strategy period;
5. Anthelmintics: USAID will support a study to assess the cost and measure the nutritional impact of deworming children on a periodic basis in child survival programs;
6. ARI: assess varying antibiotic regimes as to their cost effectiveness, acceptability and feasibility.
7. ORS: develop, produce and evaluate acceptability and efficacy of cereal based ORS.:

VIII. Measuring Progress

A major objective of USAID over the strategy period will be to develop monitoring capacity for child survival interventions in the PVO sector. USAID will support the services of a Child Survival Fellow to assist the Child Health Institute to work with individual PVOs to develop their institutional capacities to monitor and evaluate their child survival programs.

CHI will carry out periodic evaluations of other donor and MOH child survival activities. CHI will also serve as a clearing house and dissemination point for all information related to measuring the progress of child survival activities in Haiti.

The 1987 EMMUS survey stands as a baseline to measure progress over the strategy period. USAID will provide the CHI with the requisite resources to carry out a second EMMUS survey in FY 91 at the end of the strategy period. This survey will employ Tier I and Tier II indicators used in the initial EMMUS survey and will quantify progress made by the USAID child survival program over the strategy period.

In priority child survival sectors, the following additional activities will be undertaken to measure progress during the strategy period:

- A. The EPI program will develop a reporting system which will be implemented as the EPI program expands routine immunization services through public and PVO fixed facilities. PAHO/WHO will conduct two impact evaluations (1989, 1991) to determine coverage achieved by various EPI strategies.
- B. Nationwide ORT progress will continue to be monitored in several ways. USAID will support CHI to assist both the public and private sectors to assess ORS production, distribution and sales; institutional ORT knowledge and use; and mothers' knowledge and use of ORT. UNICEF and PAHO will develop the institutional capacity of the national diarrheal disease control program to monitor and evaluate program progress.
- D. Current contraceptive prevalence has been established by the EMMUS, another survey will be carried out to assess male knowledge, attitudes and practices in FY 89, and the follow-up EMMUS survey in FY 91 should establish the amount of progress made during the strategy period in family planning.

IX. Other Donor Activity

USAID has excellent relationships with PAHO and UNICEF, the two other principal actors in the Haiti Child Survival Program. USAID representatives meet with representatives of these two organizations at least once a week on issues pertaining to child survival. In key areas of child survival such as the EPI, the national Diarrheal Disease Control program and nutrition, USAID, PAHO and UNICEF consult before taking any major actions. Following the termination of US bilateral support, PAHO and UNICEF have been major conduits for USAID assistance to support MOH activities that affect the operations of our PVO programs. PAHO and UNICEF have also expanded their technical and managerial roles in the operations of the MSPP priority programs following the withdrawal of USAID supported technical advisors to the MOH.

USAID has estimated that donor support to major child survival activities will total approximately 17 million dollars over the strategy period. This will be distributed as follows:

	<u>FY 89</u>	<u>FY 90</u>	<u>FY 91</u>
EPI	1.5	1.5	1.7
Diarrheal Disease Control	1.0	1.3	1.3
Nutrition	.5	.5	.7
Family Planning	.9	.9	.9
CS Related interventions	1.1	1.6	1.6
TOTAL/year	5.0	5.8	6.2

The following sections describe child survival activities presently underway or proposed to be carried out by major donors in Haiti during the strategy period.

A. PAHO

PAHO plays a leading role in providing technical assistance to the MSPP and in coordinating other donor financing for the seven priority programs of the MSPP, particularly for the EPI, Family Planning, and the AIDS programs.

PAHO manages the majority of the budget for the EPI, which is composed of funds granted to PAHO from the LAC Regional Accelerated Immunization Project, buy in funds from USAID/Haiti to the LAC regional project, grant funds directly to the PAHO Haiti office to support the EPI, and local currencies made available to the MOH from the sale of wheat under the former Title III program.

In the case of the family planning program, PAHO is the implementing agency for a UNFPA funded project which supports the sole service delivery effort by the public sector at the present time.

PAHO, with funding from the WHO/Geneva based Global Program on AIDS (GPA), provided \$500,000 to begin the national AIDS control program in 1987. PAHO, with USAID assistance organized two world teleconferences on AIDS which have been pivotal in mobilizing long overdue MSPP involvement and commitment to the program. In April FY 89, PAHO will organize a donor conference to mobilize funding for the Haiti AIDS Control Program five year "medium term plan" that developed by the MSPP with substantial technical assistance provided from PAHOTA from PAHO.

PAHO intends to recruit an epidemiologist to serve as the principal scientific advisor to the MSPP in the development, monitoring, and evaluation of the Haiti AIDS Control program. In spite of wide ranging efforts to identify a qualified individual, PAHO has been unable to find someone who will accept a long term position at the PAHO wage scale. Because USAID believes this position to be essential to the overall coordination and success of the program, and to USAID's felt need to be involved in this process, USAID will attempt to identify a way to jointly fund this position with PAHO during the present strategy period.

Another important PAHO initiative promotes the decentralization of the administration of health services to the district and commune level. PAHO supports this initiative with technical assistance, and also provides a long term technical advisor to coordinate national water and sanitation efforts.

Finally, PAHO provides considerable support to the MSPP for both short and long term training of personnel. PAHO has had considerable success in the development of a national epidemiologist training program that was developed with the assistance of CDC, and is modeled upon highly successful CDC short term training programs carried out around the world. PAHO's access to training opportunities in the Americas directly compliments USAID's somewhat limited scope of training opportunities in the United States, and every effort will be made during the strategy period to harmonize our support for training activities.

B. UNICEF

UNICEF, in Haiti as elsewhere, has been invaluable in the promotion of multisectorial, community based support of the EPI and ORT programs. As the principal advocate of special approaches to mobilize the society at large to become actively involved in the promotion of preventive health services, UNICEF significantly contributed to the success of the three "National Vaccination" days last year which doubled immunization levels in many areas.

UNICEF is the lead donor in the National Diarrheal Disease Control program. UNICEF also links this effort to promotion of nutrition concerns, especially dietary management of diarrhea and the promotion of breastfeeding. USAID will support the leadership role of UNICEF in the national diarrhea disease control program, and in its promotion of selected nutrition activities as described in previous sections of this document.

To institutionalize community wide involvement in the promotion of maternal and child health services, UNICEF has developed a "Family Awareness" program which promotes the psycho-social development of women and children in Haiti. This program employs a variety of approaches and materials to promote family awareness. Recently, UNICEF has used a calendar as a basis for a national campaign to promote aspects of psycho-social development such as breast feeding, ORT and EPI each month. UNICEF implements this campaign through the joint efforts of 22 local institutions and 23 different media outlets. UNICEF also hopes to accentuate the involvement of the catholic and protestant churches in promoting parental education for child survival.

UNICEF is working with the Hopital St. Croix in Logane to develop an integrated PHC program in the Leogane health zone. The Hopital St. Croix is a local PVO engaged in an ecumenical effort of the Methodist and the Episcopal churches to develop an integrated development program that includes water and sanitation activities, literacy, preschools, and set of activities to promote culture, recreation, information, and communication (CRIC), as well implement a package of child survival interventions. In 1987, under a grant from the VACS project, USAID made \$400,000 available to UNICEF to expand the coverage of this program to provide 100,000 additional people with basic child survival interventions.

Finally, in efforts to promote primary education, UNICEF is working with the Ministry of Education to develop public/private partnerships with PVOs and other organizations to expand the enrollment and improve the quality of primary education in the country.

C. The World Bank (WB)

The World Bank is currently developing and negotiating a 28.5 million dollar public sector project with the MSPP, of which the WB will loan 17.2 million dollars. This project will focus on the Western region, one of four regions in Haiti, and will combine decentralized institutional development with primary health care and upgrading of District level infrastructure. The project will address both preventive and curative services, and should favorably influence the implementation of child survival activities in the selected region.

Approximately 70% of project resources will go to the development of basic health services in the West Region, including Port-au-Prince, Petite Gave, and Jacmel. Four percent of project costs will support AIDS control activities. Tuberculosis control (16%), operational research (0.2%), and institutional development (8%) are other activities envisioned under this effort.

D. Inter-American Development Bank

The IDB has just received 2.6 million dollars from the Japanese to finance feasibility studies for a major development effort it plans to undertake in FY 91-FY 92. The majority of IDB assistance is expected to finance the renovation of 12 District hospitals. The IDB also expects to finance an integrated nutrition project as part of its development package in one region of the country. The feasibility studies carried out during the strategy period will provide a framework for the IDB assistance effort.

X. Funding and Staffing Implications for USAID

A. Absorptive Capacity

1. The recent evaluation of AOPS demonstrated many USAID supported PVO programs were only providing services to half of the target populations projected in the original project planning document. Considering the chaos that has reigned in Haiti during the time covered by the evaluation, it is no insignificant achievement that 500,000 people have actually been enumerated in their homes, and that people are being served by community health teams at rally posts, and that their children are being immunized and protected against major childhood diseases.

USAID and PVOs are committed to improve this performance. However, it is now apparant that this effort will require more financial and human resources than USAID previously thought.

There are three reasons for the shortfall in coverage documented by the evaluation:

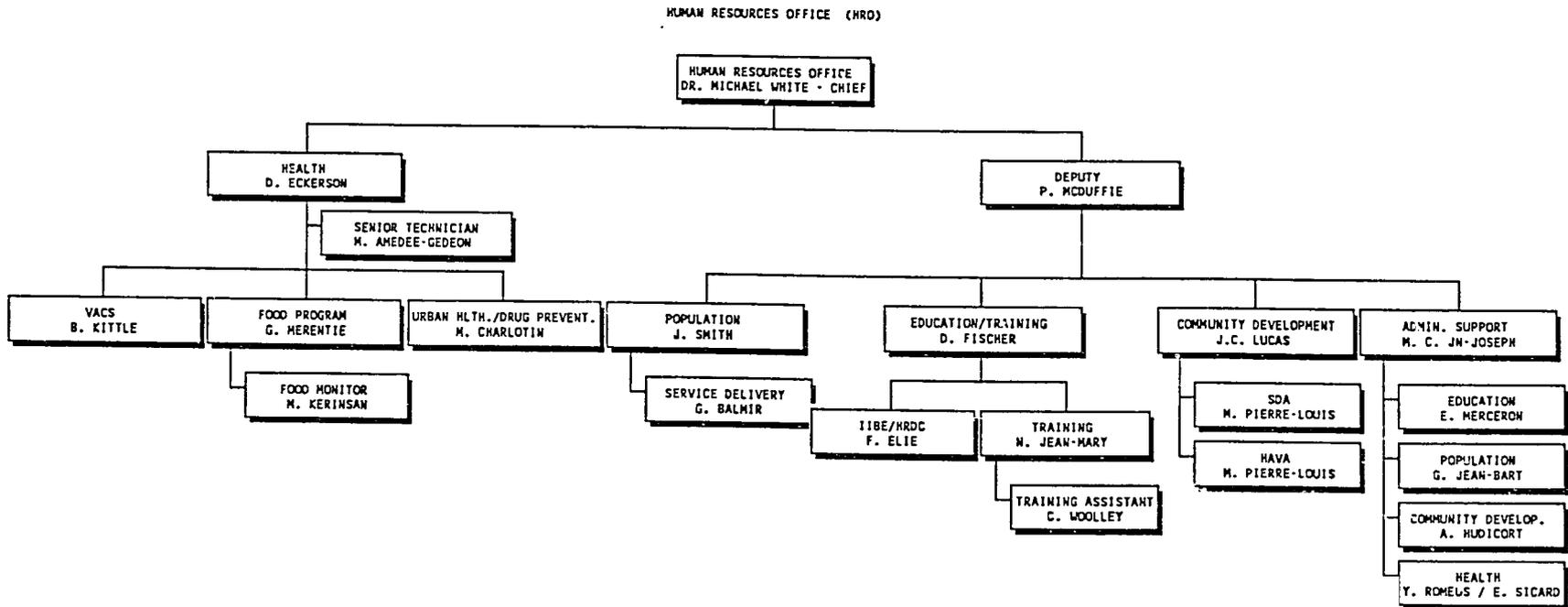
a. Political problems impeded field work and in some cases actually led to the disappearance of the organizations implementing child survival programs;

b. Original projections for the speed at which CS programs would grow were too ambitious and the financial resources provided to the programs were insufficient to allow for rapid, well managed expansion;

c. Staffing of individual PVOs, AOPS headquarters, and USAID Health Office were insufficient to carefully monitor and contribute to the effective expansion of service delivery programs.

TABLE X-I

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BEST AVAILABLE DOCUMENT

The shortfall in coverage for any given PVO program was most likely explained by some combination of these factors which vary in relative importance from PVO to PVO. USAID has taken a number of steps over the last two years to assure a viable expansion of PVO child survival programs. These include:

- a. The developemnt of an PVO umbrealla project, VACS, which provides two long-term experts in financial and organizational development to assist USAID supported PVOs to strengthen their program planning and management capapcity;
- b. Development of a new generation of PVO support grants which will define program expansion objectives more in keeping with Haitian socio-political realities and available resources;
- c. Requiring PVOs hire appropriately skilled and adequate numbers of staff to assure that program management capacity is consistent with programatic demands;
- d. USAID has added to the staff of the Health Office a USPSC project manager for the VACS project and is recruiting an additional direct hire health officer and foreign service national to compliment the existing staffing pattern;
- e. Finally, USAID will increase PVO grant financing, based on a per capita amount for the population covered, so that the PVOs can more effectively implement their programs.

B. Staffing Implications

The health portfolio is significantly increasing in importance as its level of dollar funding increases. This is consistent with the USAID's highest priority. USAID now believes that a second direct hire health officer will be necessary to adequately manage this growing portfolio. USAID hopes to have the individual at post in early FY 90.

The population portfolio is now managed separately from the health portfolio as an independent division of the Human Resources Office (HRO). Because the USAID support to family planning srvice delivery is mediated by the same PVOs which implement the USAID supported child survival activities, and because USAID is convinced that assuring an adequate birth interval is essential to decreasing child mortality,

it is imperative to have closer coordination between those responsible for the implementation and monitoring of the family planning and the child survival programs in the USAID. To this end, USAID will create a new Health and Population Division of the HRO.

The Health and Population Division will then be configured as follows:

Division Chief - USDH

Deputy Division Chief - USDH

Population Advisor - USPSC

Senior Technical Advisor - FSN

Project Ccordinator, Extended Urban Health - FSN

Project Coordinator, VACS - PSC

Project Coordinator, Private Sector Family Planning - FSN

Administrative Support - 2 FSN

For the deputy position, USAID will attempt to recruit a health officer with some knowledge of family planning programs. An organagram of the restructured Human Resources Office is provided in table X-1.

C. Available Resources

Given present control levels, USAID/Haiti expects to obligate approximately six million dollars in DA funds in FY 89, eight million dollars in DA funds in FY 90, and seven million dollars in DA funds in FY 91 to support our child survival efforts. These resources will be augmented by approximately four million dollars in food aid targeted to vulnerable groups each year over the strategy period. Local currency support to our child survival program should total 3.5 million dollars in FY 89, but future year funding is not certain at this time, given the present restrictions on USG aid to Haiti. A breakdown of obligations by project can be found in annex A, the USAID/Haiti FY 90-91 Action Plan submission for health and child survival.

Expenditures for the child survival program are estimated to be approximately 25 million dollars over the strategy period, excluding food aid. A breakdown by project and child survival interventions are provided in Tables X-1 and X-2.

D. Priorities for Program Expansion

Should USG policy towards Haiti change, and resources for the Haiti child survival program increase, USAID/Haiti would consider developing a bilateral program with the GOH that would strengthen and expand immunization, diarrheal disease control, nutrition and child spacing activities outlined in our present strategy. A bilateral program would also address serious shortages of essential drugs that are crippling the effectiveness of the MSPP service delivery system.

We would use any increased local currencies that become available to support essential GOH costs associated with the national vaccination program, the diarrheal disease control program, the malarial control program and the AIDS control program.

TABLE X-2

ESTIMATED AID ANNUAL EXPENDITURES FOR CHILD SURVIVAL
RELATED PROJECTS
(SOOO) *

<u>DA Resources</u>	<u>FY 89</u>	<u>FY 90</u>	<u>FY 91</u>
1. Mobilizing Mothers		1487 --	--
2. VACS	4000	4736	4450
3. Urban Health & CD	1000 ---	---	
4. Expanded Urban Health	1000	3000	2100
5. Title II/MCH	3809	4030	4030
5. US PVOs/FVA funded	500	400	350
6. Community Water	1118 ---	---	
 Total DA Resources	 12912	 12166	 10930
 <u>Local Currency</u>			
EPI	229 --	--	
Diarrheal Disease Control	114 --	--	
Nutrition	150 --	--	
MCH	157 --	--	
Malaria	580 --	--	
TB Control	151 --	--	
Potable water	140 --	--	
PL 480 Logistical Support	2000 --	--	
 Local Currency Total	 3521		

* Data is USAID/Haiti's most recent estimation of expenditures

TABLE X-3

ESTIMATED STRATEGY PERIOD EXPENDITURES BY PROJECT BY CS INTERVENTION*
(SOOO)

	<u>EPI</u>	<u>ORT</u>	<u>Nut</u>	<u>BS</u>	<u>Other CS</u>	<u>Systems Sup</u>	<u>TOTAL</u>
1. Mobilizing Mothers	372	297	118	89	118	493	1487
. VACS	3297	2637	1055	791	1055	4351	13186
3. Urban Health & CD	250	200	80	60	80	330	1000
4. Expanded Urban Health	1525	1220	488	366	488	2013	6100
. Title II/MCH (2)			11869				11,869
. US PVOs/FVA funded	313	250	100	75	100	412	1250
6. Community Water		559				559	1118
<u>Total</u>	5757	5163	13710	1381	1841	8158	36010

* Data is USAID/Haiti's most recent estimation of expenditures

1 When not able to directly attribute costs to particular interventions, the following estimates were used:

EPI estimated at 25% of project costs;
 ORT estimated at 20% of project costs;
 Nutrition estimated at 8% of project costs;
 Birth Spacing estimated at 6% of project costs;
 Other Child Survival Interventions estimated at 8% of project costs;
 Systems support estimated at 33% of project costs.

Represents dollar value of 30% of PL 480 program commodities, since 30% of the program is targeted to MCH clinics

AID/W Centrally Funded Health Projects Operant in Haiti

AIDSTECH AIDS Technical Support (936-5972) for applied research, surveillance and impact modeling of the AIDS epidemic. Provides limited commodity procurement. Manages small grants programs with PVOs for AIDS control activities.

AIDSCOM AIDS Communication support (936-5972) that provides technical assistance in the design and implementation of communication programs to support AIDS control and prevention efforts

JHU Child Survival Action Program Support (0936-5931) for long and short-term TA (including Child Survival Fellows), applied research and evaluation for improving delivery, use and effectiveness of child survival programs.

MOMSTECH Maternal and neonatal health and nutrition project (936-5966) that provides technical assistance and program support for activities centered upon maternal and neonatal health and nutrition, especially tetanus control programs

REACH Technologies for Primary Health Care: Resources for Child Health (936-5927) for TA to increase immunization service delivery and improve financing of health programs; also short-term TA for PHC management, training, design and evaluation.

VBC Vector Biology and Control ((936-5948) provides field support for the implementation of malaria control programs and other vector born disease control activities.

Vitamin A Field Support Provides technical assistance in the design, implementation and evaluation of Vitamin A programs.

WASH Water and Sanitation for Health (936-1249) provides technical assistance and field support to water and sanitation programs.

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ANNEX A: FY 90-91 Action Plan Submission

OBJECTIVE # 9 : IMPROVE HEALTH AND CHILD SURVIVAL

1. COUNTRY DEVELOPMENT TRENDS INDICATORS

A. Infant Mortality Rate (up to 1 year) per 1,000 Live Births

<u>PERFORMANCE UNDER CDT INDICATORS</u>	1986	1987	1988		1989	1990	1991
	<u>Actual*</u>	<u>Actual**</u>	<u>Project.</u>	<u>Actual</u>	<u>Project.</u>	<u>Project.</u>	<u>Project.</u>
A. Infant Mortality Rate	125	105	100	100	98	95	92

Source: * UNICEF

** 1987 National Infant Mortality Survey (EMUSS), Child Health Institute

2. A.I.D. PROGRAM PERFORMANCE
INDICATORS

- A. Number of people served by AID-supported Child Survival programs
- B. Percent of children under one year of age who are immunized against measles
- C. Percent of cases of diarrhea in children under 5 treated with ORT.
- D. Percent of women age 15-49 who receive two doses of tetanus toxoid .
- E. Number of people benefiting from A.I.D.-supported AIDS Control activities.
- F. Number of people served by new potable water systems under AID-assisted projects (Annual increments)
- G. Number of children fed in MCH and child feeding programs

<u>PERFORMANCE UNDER</u> <u>APP INDICATORS</u>	1986 <u>Actual</u>	1987 <u>Actual</u>	1988		1989 <u>Project.</u>	1990 <u>Project.</u>	1991 <u>Project.</u>
			<u>Project.</u>	<u>Actual</u>			
A. Number of people served by AID-supported Child Survival programs	125,000	227,000	850,000	529,000	900,000	1,350,000	1,350,000
B. Percent of children under one year of age immunized against measles	20	16	25	30	35	40	50
C. Percent of cases of diarrhea in children under 5 treated with ORT	30	15	15	21	30	35	40
D. Percent of women age 15-49 receiving 2 doses of tetanus toxoid	21	26	30	23	30	40	50
E. Number of people benefiting from A.I.D.-supported AIDS Control activities	—	—	1,500	1,500	200,000	370,000	500,000
F. Number of people served by new potable water systems (annual increments)	12,155	21,161	25,000	28,775	43,845	42,877	25,000
G. Number of children fed in MCH and school feeding programs	450,000	510,000	619,700	558,702	647,100	650,000	650,000

Source: A,E,F,G are from project data
 B,C,D are from UNICEF (1986); 1987 data is from 1987 National Infant Mortality Survey (EMUSS), Child Health Institute; 1988 data is from MSPP

Note: Indicators B, C and D refer to all children/mothers, not only those in AID-supported programs.

6. PROJECTS SUPPORTING OBJECTIVE

Title	Number	New (N) or Ongoing (O)	Type of Funding	LOP (\$000)	L/G/ LC	OBLIGATIONS			
						Cum. thru FY 88	FY 1989	FY 1990	FY 1991
Program Development and Support	521-0000	O	DA	—	G	—	150	150	150
Voluntary Agencies for CS	521-0206	O	DA	16,200	G	7,044	3,285**	5,100	4,550
Expand. Urban Health Services	521-0218	O	DA	18,800	G	—	2,110	2,800	2,000
Aba SIDA (AIDS Control)	521-0224	N	DA	5,000	G	—	—	—	400
Community Water Systems	521-0155	O	DA	8,000	G	7,582	418	—	—
Awareness/Prevent. Drug Abuse	521-0221	O	DA	486	G	486	—	—	—
Title II (Food Donation) *			Title II				3,809	4,030	4,030
Immunization Program					LC		229		
Diarrheal Disease Control					LC		114		
Nutrition					LC		150		
MCH					LC		157		
Malaria					LC		580		
TB Control					LC		151		
Potable Water					LC		140		
Title II Feeding Agencies					LC		2,000		

* Represents approximately 30% of total value of regular Title II program commodities applied to MCH activities.

** Includes reobligation of \$985,000 FY 1987 funds.

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ANNEX B: Centrally Funded ? VOs Operant in Haiti

EMERGENCY PROGRAM

PRIVATE SECTOR FAMILY PLANNING 521-0189

	<u>TITLE III</u> <u>FY 1989</u>	<u>TITLE II</u> <u>FY 1990</u>
PAPFO		\$ 40
FORESREF		\$ 43
PIGNON		\$ 162
DASH		\$ 40
SISTER SAGESSE		\$ 50
CORNELL GESKIO (Dr. Pape)		\$ 65
PUBLIC SECTOR...	\$ 400
TOTAL.....	<u><u>\$ 800</u></u>

EMERGENCY PROGRAM

PRIVATE SECTOR FAMILY PLANNING 521-0189

	<u>TITLE III</u> <u>FY 1989</u>	<u>TITLE II</u> <u>FY 1990</u>
	-----	-----
PAPFO	115	\$ 40
FORESREF	263	\$ 43
PIGNON	213	\$ 162
DASH	103	\$ 40
SISTER SAGESSE		\$ 50
CORNELL GESKIO (Dr. Pape)		\$ 65
PUBLIC SECTOR.....		\$ 400
TOTAL.....		\$ 800 =====