PD-AAG-583

521-0087
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CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) – PART I

Report Symbol U-447

1. PROJECT TITLE	2. PROJECT NUMBER	3. MISSION/AID/W OFFICE
MCH/FP II	521-0087	Haiti

4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY)
521-80-3

☒ REGULAR EVALUATION ☐ SPECIAL EVALUATION

5. KEY PROJECT IMPLEMENTATION DATES
A. First PRO-AG or Equivalent FY 72
B. Final Obligation Expected FY ___
C. Final Input Delivery FY 81

6. ESTIMATED PROJECT FUNDING
A. Total $ ___
B. U.S. $ 1,775,000

7. PERIOD COVERED BY EVALUATION
From (month/yr.) 2/76
To (month/yr.) 6/10
Date of Evaluation Review 6/30/80

8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., a cable, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
- GOH/USAID decisions regarding evaluation recommendations contained in Section V of this PES.		

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

- ☐ Project Paper
- ☐ Financial Plan
- ☐ Logical Framework
- ☐ Project Agreement
- ☐ Implementation Plan e.g., CPI Network
- ☐ PIO/T
- ☐ PIO/C
- ☐ PIO/P
- ☐ Other (Specify) ___
- ☐ Other (Specify) ___

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT
A. ☐ Continue Project Without Change
B. ☐ Change Project Design and/or ☐ Change Implementation Plan
C. ☐ Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)
J. Russell, PHO Jerry Russell
S. Gibson, PHO S. Gibson

12. Mission/AID/W Office Director Approval
Signature Allan R. Furman
Typed Name Allan R. Furman
Date Oct 30, 1980

AID 1330-15 (3-78)

Summary

I. Assessment of Progress and Current Status of the Program

During the first two years, the MCH/FP program met most of its quantitative targets, but at the end of phase I the evaluation team noted many weaknesses, including numerous administrative and logistical deficiencies (e.g., defects in training of staff, lack of coordination and integration within the department of Public Health and with external donors, failure in education and relationships with the public).

In Phase II, when the program tried to extend into peripheral rural areas, these weaknesses became more apparent, and have persisted to the present time.

As the population base expanded, relatively smaller portions of the population received services and the program's progress, in quantitative terms, leveled off. Because of its numerous field observations, the evaluation team was able to take a deeper look into the program with respect to the quality of the services offered. The team found serious defects in logistical support, crucial gaps in the provision of essential drugs, indifferent performance by many of the staff as evidenced by failure to weigh babies, unsterile techniques in immunizations, lack of proper examination of pregnant women and little face-to-face public education. At the higher levels of planning and management, there was serious lack of coordination of parallel programs within the Department of Health and uncoordinated efforts by donor agencies. Public acceptance of and support for the program was generally poor.

The team identified the following as the major cause of program failure:

1. Lack of properly trained and motivated administrative and support staff at district levels with resulting inadequate support to peripheral units.
2. Failure to involve the people of rural communities, resulting in lack of popular understanding and support.
3. Inadequate and sometimes incorrect training of the technical staff, particularly of the auxiliaries at the dispensaries and of the health agents at community levels.
4. Extensive dependence on the doctors and resident physicians, who lack motivation, interest and indoctrination in rural public health administration and who provide poor leadership and direction.
5. Serious gaps in supplies and equipment and a poor system for the repair or replacement of broken equipment.
6. Inconsistencies in administrative practices, such as fee charges, which tend to alienate the rural poor
7. Insufficient and often incorrect public education.

The program has, from an overall viewpoint, also been distorted and disrupted by unsynchronized efforts in both the Department of Public Health and from external donors . Efforts to strengthen the existing health delivery system without

reference to the parallel systems that have evolved from the MCH/FP program have resulted in fragmented and non-integrated services.

II. Background

The Division of Family Hygiene (DFH) was incorporated into the national health system of Haiti by the law of August 26, 1971. It is a technical support division within the Department of Public Health. As such, it can prescribe standards (norms), establish methodology, conduct applied research and plan and coordinate external assistance.

Its programs must be implemented through the existing health delivery system, which is weak and in a transitional phase under a new plan for decentralization that will incorporate the country's 11 districts into five regions. The Division is also in the process of being integrated within the Department of Health where other divisions -- notably, the Bureau of Nutrition, the Division of Nursing and Paramedical Training and the Division of Statistics-- have functions which overlap with those of the DFH.

The MCH/FP program was developed in three stages:

1. A Pilot Project, March 1973/July 1974 limited to the University's Maternal and Child Health Center and the Isaie Jeanty Maternity Unit, both in Port-au-Prince.
2. A Phase I of the actual program activities, April 1974/December 1975, which extended the program to 18 more health installations, mainly in provincial urban areas spread throughout the country.
3. A Phase II of the program, January 1976/until the present, which attempted to extend to the rural areas from the provincial urban sites established during Phase I.

The objectives and targets of the program have remained constant (although the population covered has expanded) namely:

1. To increase prenatal coverage of pregnant women from 10 percent to 75 percent and immunize all pregnant women seen in prenatal care against tetanus (at least two shots per pregnant woman).
2. To increase the utilization of maternity beds from 20 percent to 80 percent capacity.
3. To improve home delivery for rural women by training the traditional matrones.
4. To provide postpartum care to 50 percent of recently delivered women.
5. To increase the percentage of children under five immunized against diptheria, whooping cough, tetanus, tuberculosis and polio fron 10 percent to 80 percent.
6. To provide health screening for 80 percent of children under five, with particular attention to identification and management of malnutrition.
7. To supply family planning services for 20 percent of women aged 15 - 44. (It was expected that 10 percent of family planning acceptors would be male)

The measures used to accomplish the above objectives were:

1. The provision of MCH/FP supplies, equipment and vehicles.
2. Salary supplements.
3. Training of staff both in-country and abroad.

4. Preparation and publication of standards manuals for administrative procedures; training of staff; supervision; data collection; statistical compilation and reports; and immunization and nutrition.

5. Production of material and use of communication media for education of the public.

6. Field visits and supervision.

7. Research studies.

8. Use of mobile teams and community agents.

In addition to the clinic-based services, the program also experimented with the following methods of extending family planning services outside the health structure:

1. Household distribution of contraceptives (pills, condoms and foam) by nonhealth agents.

2. Community-based rural and urban service units, using collaborateurs and volunteers; identification of each target group by household; and a follow-up system for recruitment of clients for MCH/FP services.

3. A four-year study in the Petit-Goave area of the delivery of low-cost MCH/FP services by the use of para-professionals working in collaboration with community volunteers under a system of community organizations.

4. A commercial program for sale of condoms (2¢ each) by use of condom machines in Port-au-Prince.

5. Extention of family planning services into factories.

During the last five years, total foreign assistance to the MCH/FP program has been about $6.5 millions. The bulk of this (approximately $4.5 million) has been provided by the United Nations agents (UNFPA and PAHO). AID's contribution has been relatively small, averaging approximately $250,000 a year for a total of approximately $1 million. Smaller inputs came from the Pathfinder Fund, the Center for Research for International Development (Canada) and Brot für die Welt (Germany). Although the GOH is credited with contributing more than half of the cost of the program, most of this (other than that for base salaries) came from generated counterpart funds. The Department of Public Health has an annual nondevelopmental budget of only about $8.4 million (i.e., about $1.70 per capita for all its health programs). This represents approximately 11 percent of the total GOH budget--a relatively high proportion compared with that of most lesser developed countries.

III. Evaluation Scope and Methodology

A joint evaluation of the Haitian Maternal Child Health/Family Planning (MCH/FP) program was conducted by the Government of Haiti, the United Nations' Fund for Population Activities, the Pan American Health Organization, and the Agency for International Development during the period of September 19 - October 16, 1976. The purposes of the evaluation were to:

-- Review and analyse past program activities and achievements of the Division of Family Hygiene (DFH);
-- Assess the current status of MCH/FP activities in quantitative as well as qualitative terms;

-- Identify and discuss problem areas and specific impediments to service delivery;

-- Discuss future strategies in MCH/FP with Haitian program officials; and

-- Draft a report and list of recommendations which may serve as a guide for future MCH/FP activities in Haiti. The recommendations should specify the role of the DFH and decentralized services and the inputs required from each donor for the continuation and strengthening of the national MCH/FP plan.

Work performed by the evaluation team and the methodology used are explained in detail in the Evaluation Report (APHA).

IV. Recommendations

A. Strategy and Planning Level

Recommendation # 1

The national MCH/FP program should reorient its strategy and planning and concentrate its efforts on extending MCH/FP services to rural communities, using methods that will foster community understanding and participation through better use and support of auxiliaries and health agents and increased involvement of traditional community-based health workers, such as matrones and guerrisseurs.

Recommendation # 2

The MCH/FP program activities should be correlated with Ministry of Health programs for the development of health systems and the plan for regionalization. PAHO and USAID/ Haiti should review their parallel inputs into these programs and better relate them to the system and infrastructure created through activities under the MCH/FP program.

Recommendation # 3

The DFH should review its methodology in the current and future use of mobile teams for providing services through satellite clinics. In general, the mobile team's effectiveness should not depend on the availability and interest of the physicians (or resident physicians). Team operations should be directed by well trained and motivated auxiliaries or, where available, a public health-oriented nurse.

In general, the mobile team should be used to supplement the work of the community-based health units so there is a continuity of services in the interim between team visits.

Recommendation # 4

The DFH, in cooperation with the bureau of Nutrition, should develop a more comprehensive approach to health services for children. Specific areas that need improvement are:

- -- Better training of health staff in recognition and management of malnutrition.
- -- More relevant health education of the public particularly in proper early child feeding.

Better correlation of nutrition recuperative centers (or foyers) with fixed health units.

- - Regular provision of iron and vitamins in under-five clinics.

Recommendation # 5

The DFH in evaluating its MCH/FP program, should give more attention to the quality and public acceptance of services offered and not base evaluations and programs progress so completely on reported quantified service data. The participating agencies should not place as much stress on attaining quantified program targets in the justification for continued support to the program.

Recommendation # 6

The DFH should devote more time and effort to the training and supervision of the administrative staff at district and regional levels.

Recommendation # 7

The DFH should change the patterns of supervisory visits to permit a more penetrating appraisal of MCH/FP activities at all levels, particularly at the periphery. The following are recommended:

- - More prolonged team visits at health units to permit observation of services over a period of several days.

- - Periodic in-depth assessment of activities relating to a specific program area, such as child health care, family planning and prenatal care. This should

- be a vertical assessment down through several service levels so that a more comprehensive pattern of interrelationship of supervision and support become apparent.
- Information gained from such supervisory visits should be more frequently used as a basis for DFH staff conferences with analysis and observations from different sections of the division. The experience thus gained should be used for future program guidance.

Recommendation # 8

Regularly scheduled monthly (or at least bimonthly) coordination meetings should be held between the director of DFH (and relevant staff members) and local representatives from UNFPA, PAHO and USAID/Haiti to discuss problems related to the program and progress to assure better understanding and coordination.

Recommendation # 9

The MCH/FP program should not extend its area or population coverage for the next two years but instead concentrate on working out program problems in an integrated approach with the Department of Public Health in a specific representative area; the ODVA area seems most appropriate for this period of field testing methodology.

B. Management Level

Recommendation # 1

A pilot project should be undertaken to develop and test a new model of training specifically for public health auxiliaries who will be working in nonhospital settings.

Recommendation # 2

Patient recordkeeping procedures should be strengthened at the level of service delivery.

Recommendation # 3

The burden on the auxiliaries and health agents of communicating with the supervisory levels shall be minimized.

Recommendation # 4

The fee collection procedures must be standardized.

Recommendation # 5

A series of in-service courses for all auxiliaries currently working in the program should be provided systematically.

C. Operations Level

Recommendation # 1

The system for supervising auxiliaries at the dispensary level and the health agents and matrones under auxiliary supervision should be strengthend.

Recommendation # 2

Better vehicle control should be instituted and enforced at district and regional levels.

Recommendation # 3

The list of essential drugs furnished to health agents should be revised and limited to the fewest possible varieties. This should be consistent with the requirements for primary health care services performed.

Recommendation # 4

The DFH, with the backing of the Director General of Public Health, should enforce a system of annual MCH/FP equipment inventories at all health installations in the program; the serviceability of each major item should be determined.

Recommendation # 5

With the cooperation and support of the Director General of the Department of Public Health, the DFH should encourage the Department of Community Health at the medical school to institute a program of public health studies to be carried out by the residents during their "stages" in the provincial areas. Such a program should encourage the young physicians to engage actively and independentely in problem-solving situations commonly experienced in rural and provincial areas.

Recommendation # 6

The DFH should promote more actively the use of all methods of family planning in the MCH/FP program and give particular attention to the expanded use of IUD's and sterilization procedures.

Recommendation # 7

The DFH should expand its efforts to train matrones and develop more precise guidelines for the supervision, support and refresher training of previously trained matrones now working in rural communities.

Recommendation # 8

The DFH should take the initiative in promoting greater efforts within the Department of Public Health to develop programs for safe water in Haiti's rural Communities.

V. RESPONSES TO EVALUATION RECOMMENDATIONS

A. General Comments

The evaluation team failed to distinguish between weaknesses of the Division of Family Hygiene and weaknesses in the Ministry of Health. As a technical division with normative and staff support functions, the Division of Family Hygiene has limited authority to control actual operations at the region and district level. Its only sanction against poor management practices at the district or regional level is a withdrawal of its support which would, in effect, deprive the target group of vital services. While noting the weakness of the Ministry of Health infrastructure, the evaluators failed to recommend actions which would address the causes of the problems but rather focused on the symptoms. For example, increased integration and coordination with the Ministry of Health should be a means to stronger, more effective management of the health system, i.e. increased delegation of responsibility to the regions and sanitary districts and increased accountability of local officials for supplies and equipment received as well as for services performed.

The evaluation was made before AID's Rural Health Delivery System Project had gotten underway. Consequently, the basic complimentarity between this project and the activities and goals of the DFH was not yet clear. Thus, while the evaluators were unable to offer implementable suggestions for improving health sector performance, they did, however, urge the DFH to pursue non-traditional methods of extending family planning/ MCH services through use of the community, the private sector and "traditional" healers and birth attendants. The evaluation report made many recommendations for actions over which the DFH has little actual authority or control. By their all encompassing nature the discussion and recommendations do not help to clarify the proper role and function of the DFH in attempting to create a national program of effective family planning and MCH services. These overlapping functions and roles, reflecting the inadequate Haitian administrative environment would appear to be major constraints to more and better services. The need for a strong commitment from the government in order to implement clear policies and directives aimed at improving the delivery of FP/MCH services is skirted by the evaluators. Thus in creating an administrative environment within the health sector which is truly supportive of DFH programs in MCH/FP, the role of the Health Ministry is ignored and the full burden of FP/MCH program implementation responsibility is left to the DFH.

A series of major program constraints have been identified:

1. Lack of adequate GOH resources;
2. need to improve delivery of program supplies and materials to remote areas;

3. lack of knowledge and understanding of the DFH program;
4. need to improve coordination between DFH and other agencies; and
5. need to develop a strategy for integrating all DFH activities into Ministry of Health operations.

The joint evaluation failed to consider these constraints and instead focused on a myriad of symptomatic remedial activities. In the interim since the evaluation a number of events, including the evaluation report itself, have altered the context and climate in which the DFH operates.

B. Recommendation on Strategy and Planning

Recommendation # 1

The Government's Ministry of Health basic rural health services approach is undergoing considerable change The DFH has in many respects led the way toward this evolution through its assistance to the training of auxiliaries, health and community agents and traditional health workers. Curriculum improvements and improved skill training are envisaged during the next two years. Through integration and improved management assisted by USAID RHDS project, additional program emphasis on rural health services, basically MCH and family planning, will be developed. The DFH will concentrate its efforts on the development of community service links which will extend and compliment DSPP facilities and services.

Recommendation # 2

A plan for the phased integration of the DFH and its present health support functions into the DSPP will be developed in early 1981. Gradual phasing is necessary to assure that activities which are serviced through integration do not lag but rather improve in efficacy.

Recommendation # 3

We agree that the cost-effectiveness of mobile team operations should be carefully assessed. However, physicians do not currently participate on the mobile team. The mobile unit team is composed of nurses, auxiliaries, and promotors or community agents.

Recommendation # 4

We generally agree but believe that the lack of a statement of public health priorities constrains both the DFH and the Bureau of Nutrition to effectively implement comprehensive health services for children. Adequate coordination between DFH and BON has not yet been achieved.

Recommendation # 5

Quality of services is of concern to the DFH. During the next four year plan of activities, the need for updated revised service norms, adequate supervision at each level and more appropriate use of service statistics will be studied and DFH and DSPP support service will be modified to improve services.

Recommendation # 6

Responsibility for administration of health services in regions and districts rests with the DSPP. We agree that additional management and administrative training is needed and that the DFH should participate in this training to the extent technical MCH/FP topics present themselves.

Recommendation # 7

We disagree. We believe that concepts of supervision should be revised, that norms and services targets should be clear, that health providers should participate in setting work goals and service targets, and that the service statistics provided by health workers should more clearly indicate critical performance measures rather than gross data. The Health Ministry and the DFH will work towards these ends during the next few years.

Recommendation # 8

Donor coordination is of concern to USAID. Joint planning with UNFPA for the 1981-84 program is underway. Regular meetings to oversee program implementation have been initiated at the DSPP and such meetings at the DFH are anticipated once the Action Plan is agreed to.

Recommendation # 9

We disagree. All health facilities should provide MCH/FP services and in fact most do. Plans are being developed for:

1) a phased increment in staff and voluntary collaboration;
2) staff upgrading through training;
3) Use of community organizations and other sectoral programs to reach out to underserved groups;
4) a commercial program for contraceptives and minor pharmaceutical products.

Upgrading of services will be phased to correspond to staff and funding availabilities.

C. Management Level

Recommendation # 1

In coordination with RHDS the DFH program will support a study of specialized FP/MCH needs and skills required by auxiliaries and develop and test appropriate curricula in both pre and inservice training programs.

Recommendation # 2

Improved collection and use of service statistics will be worked into procedures for supervision and better management of services during the coming year. Service statistics cannot be usefully improved until program goals, targets and staff responsibilities are clearly defined.

Recommendation # 3

As staff supervision and program management techniques are improved, the reporting and administrative burden on auxiliary workers should decline.

Recommendation # 4

We agree but this issue can only be decided by the Minister of Health and only if he is willing to involve sanctions for non-compliance.

Recommendation # 5

The new Minister of Health has indicated strong interest in continuing education for health workers. The RHDS will attempt to build upon this interest to establish regular inservice training programs. The DFH will assist where appropriate.

D. Operations Level

Improved management and supervision at the local and district level will be addressed by the RHDS project. With its available resources the DFH may be able to facilitate this development. Modified drug lists are being studied to be consistent with requirements for basic health. Some general decisions will be made by the end of 1980. Logistics control and supply management and control systems are being studied by the RHDS advisors and their recommendations will be implemented over the next several years. Training for young physicians in community medicine is sorely lacking. During the next two years it is hoped that the community medicine training of medical interns and residents can be completely revised to encourage public health service upon graduation.

The insertion of IUD's as a family planning method requires trained, motivated staff. During the next two years the DFH in conjunction with the DSPP will develop appropriate training modules in obstetrical nursing and FP methods , including IUD insertion for nurses and auxiliaries. In this context training programs for matrones will be evaluated and appropriate curriculum revision made.

Clean safe water is not directly a responsibility of the DFH. Given all the other MCH/FP health priorities which must be addressed, responsibility for potable water must be a community affairs responding to community awareness of the problem. Health education may facilitate local awareness but this is appropriately a responsibility of the Ministry and its RHDS projects.

ANNEX A

FINANCIAL STATUS

OF MCH/FP II (0087)

as of 12/31/79

The following is a financial summary of the Maternal Child Health/ Family Planning II project as of December 31, 1979 (figures in 000's):

Components Control No.	Grant Agreement	Cumulative Obligations	Cumulative Expenditures	Unliquidated Balance
Local Personnel Support 110, 230, 231, 232, 250 & 260	491	370	256	114
Training & Information 200, 201, 202, 240	153	125	112	13
Other Support Costs 120, 130, 150, 160, 170, 180, 190	511	613	418	195
Participants*	--	45	42	3
Unearmarked	--	2	0	2
Total	1,155	1,155	828	327

* Participant costs were included in the grant budget as a component of local personnel costs.