

**An Evaluation of the Second Part of the
Resources in Community Health Education Support Project
(RICHES II)**

CARE- Haiti

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ACRONYMS

ALRI	Acute Lower Respiratory Infection
AOPS	Association of Private Health Workers
CBD	Community-Based Distribution (of Contraceptives)
CBP	<i>Comite de Bienfaisance de Pignon</i>
CHWs	Community Health Workers
CINECO	Community Integrated Nutrition and Education Center – Outreach Project
CONGA	Consortium of Grande Anse Non Governmental Organizations
CRS	Catholic Relief Services
CO	Community Organizer
CPR	Contraceptive Prevalence Rate
CS	Child Survival
DIP	Detailed Implementation Plan
HHF	Haitian Health Foundation
HIS	Health Information System
MSP	Ministry of Public Health (<i>Ministere de la sante publique</i>)
NGO	Non-Governmental Organization
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PMS	Professional Management Services
PROFAMIL	<i>Association pour la promotion de la famille haitienne</i>
PSFP	Private Sector Family Planning Project
PSI	Population Services International
PVO	Private Voluntary Organization
RICHES	Resources in Community Health Education Support Project
SOE	<i>Service Oeucumenique d' Entraide</i>
STD	Sexually Transmitted Disease
TA	Technical Assistance
TBAs	Traditional Birth Attendants
UCS	Communal Health Unit (<i>Unite communale de sante</i>)
USAID	US Agency for International Development
VACS	Voluntary Agencies for Child Survival Project
VSC	Voluntary Surgical Contraception

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1.0 Executive Summary

- With the end of the second phase of the Resources in Community Health Education Support Project (RICHES II), CARE has been implementing child survival projects in Haiti for 10 years. The most discernible trends of the decade's three CARE projects have been 1) the shift from being disbursed geographically to being consolidated in one region, 2) ever increasing community involvement and control, and 3) the shift from direct service provision to the provision of technical and managerial assistance.
- The series of CARE-Haiti child survival projects have often been criticized for their relatively high cost per capita. CARE has probably helped feed this criticism by not correctly defining what the organization has been doing with its three projects of the last decade: The organization's projects have probably expended at least as many resources developing appropriate child survival technologies and models for Haiti as they have for service delivery. The results of these expenditures are: 1) An acclaimed health education package for persons with low or no literacy which has been adopted by many other health organizations; 2) a community-based family planning model which has produced possibly the nation's highest rural contraceptive prevalence rate which is being assessed for replication; and 3) a sexually transmitted diseases and AIDS prevention program which has probably achieved the highest knowledge levels nationally.
- RICHES II is a community-based approach to child survival for isolated communities with limited access to medical facilities. The project covers the Commune of Moron and a small portion of the neighboring Commune of Abricots in the remote, mountainous western part of the Grand Anse Department. In collaboration with the Ministry of Public Health (MSP) and key nongovernmental organizations, RICHES II focuses on the development of community-based human resources to promote and carry out a diverse menu of services: immunizations, oral rehydration therapy promotion, growth monitoring and promotion, screening for high-risk pregnancy, vitamin A and iron supplementation, community-based contraceptives distribution, and health and family planning education. The project served 37,000 women and children for basic child survival activities, and 33,000 women and men for family planning activities in 263 isolated western Grand Anse localities.
- Immunization coverage was much lower than planned. However, in addition to the project's highly touted educational package, RICHES II has achieved many positive outcomes. These include a well trained and highly motivated staff and highly motivated community participants who are generally knowledgeable health service consumers who display many positive health seeking behaviors at significantly higher levels than the national average.

- As CARE-Haiti shifts from child survival service delivery to the provision of technical assistance, it has had a two prong approach for sustainability: 1) Devolvement of responsibility for the continuation of limited services to the communities themselves, and 2) transfer of responsibility to another nongovernmental organization with a longer term commitment to the western Grand Anse. Three years are hardly sufficient for skills transfer and empowerment and the community devolvement approach has yet to be perfected. However, the second alternative would appear to be the only viable possibility at this present time. The Ministry of Public Health and the donor community should be made aware that if the Haitian Health Foundation (HHF), who proposes to take over the catchment area currently served by RICHES, does or can not assume responsibility, these communities on which so many resources have been expended and in which so much has been achieved, will be abandoned.
- In terms of sustainability, it is further recommended that CARE-Haiti, given its past achievements in developing success models for rural preventive health care, should take on the development of a community devolvement model as its next major child survival task.

2.0 Background

2.1 History

With the end of the second phase of the Resources in Community Health Education Support Project (RICHES II), CARE has been implementing child survival interventions in Haiti for 10 years. Its first such project was the Community Integrated Nutrition and Education Centers - Outreach Project (CINECO) which was implemented from 1985 through 1988. In 1989, CARE-Haiti inaugurated RICHES I, followed by RICHES II in 1993. In October of 1996, CARE-Haiti will begin a new decade of child survival activities with the implementation of its fourth project, RICHES 2000.

One major trend of CARE-Haiti's child survival (CS) projects during the past decade was toward geographical consolidation. While CINECO was implemented in 33 communities scattered literally from one end of the country to the other, RICHES I was implemented in seven contiguous in the *Chaine des Mattheiu* and 12 geographically distinct communities in the Departments of the West and Grand Anse, respectively. RICHES II further consolidated service delivery by covering only the Grand Anse's Commune of Moron and two localities in the Commune of Abricots which are adjacent to Moron.

Another major trend of these child survival projects, perhaps a corollary of geographical consolidation, was toward increased community involvement and control. CINECO, which was implemented in the preschool centers of newly constructed

Government of Haiti/World Bank schools, involved school officials perhaps more than it did community members. In contrast, although it continued to work in several CINECO communities, RICHES I moved out of the preschool centers and into locations under direct community control. Community involvement and participation were an integral part of project design. RICHES II continued this trend and even intensified it. Implicit in the design of this latest child survival effort was the devolvement of some service delivery responsibility from CARE-Haiti to community members at the project's end.

By and large, these past projects were successful as attested in two positive final project evaluations (Conway, 1988; Alvarez, Berggren and Gay, 1993). In several critical areas of maternal/child health, CARE-Haiti's projects have been the undisputed leaders. For example, its projects have created culturally appropriate, nonformal health education packages for persons with no or low literacy which have become the standard in Haiti by which all other such efforts are judged. These packages have been adopted by many other nongovernmental organizations (NGOs) working in the field and research strongly suggests that women taught this methodology exhibit many positive health seeking behaviors (refer to RICHES II Mid-term Evaluation, Professional Management Services, 1993).

However, despite its obvious successes in executing child survival activities, CARE-Haiti has been criticized for the cost of its projects. RICHES II, for example, services a population of only 37,000 at a cost of US \$1,074,493 budgeted for three years, or approximately US \$9.68 per participant per year. Critics at USAID/Haiti, which financed most of RICHES I, said that that project cost approximately 25-35 percent more per participant than others receiving the USAID mission's child survival monies. Furthermore, while they did not dispute either the quality of RICHES I nor its achieved results, these critics stressed that the project also provided fewer services. Implicit in this criticism was the fact that CARE-Haiti as an international organization could not compete with local NGOs in terms of cost per capita.

Perhaps partially in response to these criticisms, CARE-Haiti's health sector has been changing its *modus operandi* somewhat during the past four years. For the first time, it has expanded its range to include four projects involved with providing technical assistance in reproductive health service provision and management to existing institutions. One of these, the STD/AIDS Prevention Project which was implemented in the Grande Anse, will be discussed below in terms of its relationship to RICHES II.

According to the proposal for the new project, RICHES 2000 will move away from direct service provision. By the second year, the project will be providing only reproductive health, managerial, and technical assistance to western Grand Anse health institutions. CARE-Haiti's success with its three health technical assistance projects, including the STD/AIDS Prevention Project, certainly must have influenced this new CS direction. By the beginning of the project's second year, responsibility for the communities participating in

RICHES II will have been transferred to another NGO or the communities themselves will be expected to take responsibility for providing some services.

2.2 The Evaluation

According to the guidelines provided by USAID, the overall goal of the final evaluation of a Child Survival IX project is "to assess the impact, effectiveness and the sustainability of the project. The report is to include:

- a) a narrative report, addressing the topics and questions contained in the....Guidelines (see Attachment One);
- b) a final evaluation survey; and
- c) a final pipeline analysis."

In order to meet these requirements, the evaluation was divided into three components. The first component, the narrative report and the collection of qualitative data, was led by a Caribbean Resources International consultant, an anthropologist with over 14 years of experience in the health field in Haiti. In addition to her general health field experience, from 1985-1988, this consultant worked for CARE-Haiti as the coordinator of its first child survival project, CINECO; in 1989, she designed RICHES I, CARE-Haiti's second child survival intervention; and from 1990-1995, while working for USAID/Haiti, she was responsible for RICHES I and, in part, RICHES II oversight. The curriculum vitae for this consultant is provided as Attachment Two. At different times during the fieldwork stage, this component's team also included the RICHES II Project Coordinator, the Regional Field Coordinator, the four health monitors, the Community Organization Coordinator, and the three community organization specialists. The major portion of the data collection was conducted in the Grande Anse from August 15 through the 23rd. In addition to interviews with CARE staff at the Jeremie field office, the qualitative team participated in RICHES activities for nursing women and their infants in three communities, observed the training of traditional birth attendants at one community, conducted focus groups and individual interviews with participating mothers in two communities, and conducted in-depth interviews with field staff both individually and in a group setting.

The second component, the quantitative knowledge, practices, and coverage (KPC) survey, was conducted by staff from CARE-Haiti's Health Sector Office with experience in survey research and eight other experienced surveyors who were contracted for the work. SOGESEP, a local research consulting firm, provided assistance in field surveyor training curricula, and in sampling procedures and selection. This team conducted the survey in the Commune of Moron and the small area in the Commune of Abricots from August 17-24, and performed subsequent data entry and analysis in the main office in Port au Prince. The

Finance Office at CARE-Atlanta conducted the third evaluation component, the pipeline analysis of project expenditures.

3.0 Project Accomplishments & Lessons Learned

3.1 Project Overview

RICHES is a community-based approach to health education and the delivery of CS services in isolated communities with limited access to medical facilities. In collaboration with the Ministry of Public Health (MSP) and key NGOs, RICHES focuses on the development of community-based human resources to promote and carry out a diverse menu of CS services: immunizations, oral rehydration therapy promotion (ORT), growth monitoring and promotion, screening for high-risk pregnancy, vitamin A and iron supplementation, community-based contraceptives distribution (CBD), and health and family planning education. The project originally serves approximately 37,000 women and children for CS activities and 33,000 women and men for family planning activities in 263 isolated western Grand Anse localities.

As mentioned above, the RICHES II catchment area covers the western Grand Anse Commune (county) of Moron and a small portion of the neighboring Commune of Abricots which is contiguous to Moron. This is primarily an isolated, rugged mountainous area which is bisected by one of the few roads in this region and the Grand Anse River. During the rainy season, the river swells and the greater portion of the area is often inaccessible for weeks at a time. There are 263 small localities in the area covered by RICHES II, and these are divided into five service zones with 26 rally posts. Although as planned, no *participant* has more than an hour and a half walk to the locality where the rally post, meetings and some training are held, some rally post *localities* are as much as a five hour walk from the road. Each field monitor supervises approximately five rally posts and lives in a rented house within her zone. Although all field monitors are women from the western Grand Anse, they are usually not natives of the communities in which they presently work.

Rally posts are held weekly at each locality's service centers, which are usually wood and straw shelters to protect participants from the sun built by the community. To permit her presence at each RICHES day in her zone, each locality serviced by a particular field monitor has a different rally post day. A locality's weekly rally post day each week is also scheduled to forestall conflict with other competing attractions, particularly local markets.¹ For example, if a locality has its rally posts on Monday, the first Monday of each month will be devoted to pregnant women, the second Monday to nursing women and their infants, the

¹ Generally in Haiti, each major town or village in an area has its own market day or days.

third to children 13 to 36 months, and the fourth to the general community to address subjects such as family planning and AIDS and sexually transmitted disease (STD) prevention.

An organizational chart for the RICHES II is included as Attachment Three. As can be seen in this chart, the highest responsibility for the project resides with the Health Sector Coordinator who is based at CARE-Haiti's headquarters. Several other staff with programmatic input also reside at the Port au Prince office, including the Assistant Health Sector Coordinator, the Training Specialist, and the Monitoring and Evaluation Specialist. The Health Sector Coordinator and other headquarters staff frequently visit the project area, and there is daily radio or telephone communication between the headquarters and the Jeremie field office. The majority of project staff are based at the field office, including the Project Coordinator, the Field Coordinator, the Community Organization Coordinator, five field monitors/supervisors, and three community organization specialists (COSs). The field monitors and the COS live in the communities in which they work during the week, however, and are generally only at the field office for end-of-the-month meetings. Every RICHES field office employee is a western Grand Anse native.

An important part of the RICHES II implementation strategy has been its plan for sustainability at the project's end. Project documents clearly state that CARE will leave all RICHES II communities at the end of the project. This sustainability plan has two prongs: 1) CARE will work to transfer service provision responsibilities to another NGO working in the same or neighboring areas, and 2) after intensive consciousness raising and other forms of assistance, RICHES will devolve responsibility for the provision of a more limited number of services chosen by the communities to the communities themselves.

Finally, one cannot discuss the context of any project which began implementation in Haiti in October 1993 without first noting the particular, extreme sociopolitical context of that period. The political situation, which had generally been difficult since the coup d'état of 1991, nevertheless deteriorated significantly precisely at this time. In the project's first month, the United Nations-brokered agreement to return deposed President Aristide broke down and, as a result, international sanctions became increasingly strong. For example, the price of gas went as high as US \$20 per gallon and travel was severely restricted until March of 1994 when fuel was provided to PVOs as part of UN humanitarian assistance support. By May, the UN had made the sanctions even tighter and security issues became paramount. This situation did not improve until the US military intervention which brought about the return to constitutional government in September of 1994. In other words, the situation only improved 12 months into the project, or after roughly one-third of the project's implementation time had elapsed. RICHES II performance then must be viewed as taking place within this context.

3.2 Accomplished Versus Planned Objectives

The goals of RICHES II are to:

1. Decrease maternal and child mortality, and,
2. Increase community responsibility for health activities.

The project is responsible only for its objectives as listed in the Detailed Implementation Plan (DIP) then modified in the "Report of the Community Baseline Study for the Communes of Moron and Les Abricots in the Grand Anse" (CARE-Haiti, April-June, 1994). RICHES II achievements in reaching these proposed objectives are as follows:

3.2.1 Vaccination Coverage: Immunizations are possibly the least successful of all RICHES interventions, especially in terms of anticipated outcomes. As can be seen in Table 1 below, tetanus toxoid coverage (TT2) for all women of reproductive age was less than half that expected and complete immunization coverage for children 0-24 months was also half that anticipated. According to the latest survey, the complete immunization coverage rate for young children nationally in rural Haiti is 24 percent and for pregnant women it is approximately 49 percent (Mortality, Morbidity, and Utilization of Services Survey II- EMMUS II, 1995).

Possibly the most important reason for lack of success in reaching the anticipated vaccination coverage is the level of expected achievement itself. Given the results of the baseline study—even anticipating results in this under-served region—it was surely unreasonable to expect outcomes of such magnitude during a three year period. The logistical problems involved in establishing the cold chain in such a topographically challenging area alone are immense and time consuming.

Other reasons for this lack of success, especially when compared with the project's positive results in other areas, are not readily apparent. Field office staff cite periodic vaccine shortages at the local MSP office but the Health Sector Coordinator discounts this reason. According to her, even during the embargo, CARE was usually able to send critically needed supplies to Jeremie on a small passenger plane which flew the route periodically or by road. Nor do these somewhat lack luster results appear to be from lack of knowledge on the part of participants of the positive impact of immunization. According to the RICHES II 1994 baseline, for example, slightly over two-thirds of women interviewed responded that the tetanus toxoid vaccine would protect themselves and their child against tetanus and the immunizations would protect children against diseases. When interviewed, participants also invariably cite immunizations as one of the valued services the project has brought to the area. Furthermore, according to the COS, the health committees in some localities have opted to try to continue immunization services by themselves after the

project ends. On other hand, although immunizations in themselves may be valued, it also appears that they are only imperfectly understood. According to the survey, despite the project's educational efforts in this area, only slightly over half of mothers understand how many doses constitute complete coverage and less than half understand the age a child should be immunized against measles.

Table 1: Vaccination Coverage Objectives/ Key Indicators

Indicator	1994 Baseline	Expected 1996	Achieved 1996
EPI Access (aged 12-23 months & received DPT1)	3.0%	60%	59.9%
EPI Access (aged 12-23 months & received OPV3)	0.0%	60%	21%
Measles coverage (12-23 months & received vacc.)	0.0%	60%	44%
Drop-out rate (% change between DPT1 & OPV3)	3.0%	10%	10%
Tetanus Toxoid Coverage (TT2) Women 15-49	06%	60%	26%
Complete Schedule for Children 0-24 months	04% ²	40%	20%

Although as will be discussed below there are no health information system (HIS) which generates lists³ of persons in the target groups, perusal of project records and observations seem to concur that attendance at rally posts is generally quite good vis a vis the estimated target populations. Per usual in Haiti, there seem to be more pregnant women attending the posts than either nursing women and their infants or mothers with their children 12-36 months. The four rally posts which were observed, however, all had relatively high numbers of attendees in this latter category. Each post had at least 50-60

² This data is all children 0-59 months in the catchment and comes from the household census, not the baseline study

³ Project staff did conduct a census in each locality in 1994 but, as will be discussed in 3.2.10, these data were never completely operationalized. However, the field staff, in particular the *local women volunteers*, know their communities so intimately that with these census data they appear to have maintained up to date population estimates.

young children and most were receiving immunizations, and the cold chain seemed correctly and efficiently organized. Staff interviews also concurred that the present logistics/cold chain system appears to be functioning properly. All this would appear to suggest that if lack of client acceptance of immunizations, or lack of vaccines, or poorly or improperly organized vaccination posts were previously problems which led to low coverage rates, they no longer are. What is not so apparent is whether the present follow up system for clients who have yet to complete their immunization series is efficient. Field staff say that they know which participants have or have not completed vaccinations and that they do follow up with these clients, but there were no lists of such clients or other evidence as to how and when such participants are contacted.

3.2.2 Management of Diarrhea Disease: According to the survey results in Table 2, diarrheal control appears to be an area of high project accomplishment. Interviews with RICHES mothers also confirm that they are highly knowledgeable in terms of correct feeding practices during diarrhea episodes: They understand they should continue or intensify the present feeding pattern of their infant and/or children. That is, if an infant is still being exclusively breast fed, they know to continue the same or even more breast feeding; or, if the child has been weaned, they know that they should give the same or even more fluids and solid food.

Table 2: Management of Diarrhea Disease Objectives/Indicators

<i>Indicator</i>	<i>1994 Baseline</i>	<i>Expected 1996</i>	<i>Achieved 1996</i>
Continued breast feeding (same amount or more milk)	83%	90%	96%
Continued fluids (same amount or more liquids)	73%	80%	91%
Continued foods (same or more solids/semi-solids)	62%	80%	93%
ORT use	89%	100%	100%

The percentage of mothers who claim to have used oral rehydration therapy (ORT) during their child's last diarrheal episode is phenomenally high. To this evaluator's knowledge, it is the highest ORT usage rate ever recorded in Haiti. Certainly survey bias, or the surveyee saying what s/he supposes is correct or what the surveyor wants to hear, must have played a role in the mother's reports. Even if they do not use it, women in RICHES communities have at least learned that they *should* be using it and thus report ORT

use to the surveyors. The desire to say what one knows one should say must be especially strong when some members of the survey team are also involved in the project. As reported in 2.2 above, the team included two RICHES employees, and the *kolabartris* (local women who are recruited and trained as project community health workers) served as guides.

Reported utilization of ORT was also high for the RICHES I final evaluation survey. During this 1993 survey, 74 percent of the women registered in the project—and even 46 percent of those not registered—reported ORT use during the last diarrheal episode (Louis-Jean et al, 1993). ORT use nationally during this same period was only an estimated 38.2 percent (VACS, 1993). Survey bias may also have been operant in the RICHES II baseline survey which included several older project communities (CARE-Haiti, 1994). In this survey, 89 percent of the women interviewed with children who had recently had diarrhea reported use of ORS packets. This is surprising because 1) RICHES has always promoted home-based ORS or cereal-based as the most readily available, least costly treatments; 2) ORT packets are only rarely available in rural areas; and 3) all other data concur that home remedies are the most widely used treatment nationwide. Additional research, especially ethnographic research, is needed to understand these phenomena.

3.2.3 Infant & Child Nutrition: As seen in Table 3, infant and child nutrition appears to be another area of high RICHES achievement. For example, according to the most recent nation data (EMMUS II, 1995), the national rate for exclusive breast-feeding until four months is less than one percent. In comparison, RICHES reports 74 percent or nearly three-fourths of all infants being exclusively breast fed at four months.

Table 3: Infant & Child Nutrition Objectives/Indicators

<i>Indicator</i>	<i>1994 Baseline</i>	<i>Expected 1996</i>	<i>Achieved 1996</i>
Gives breast within 8 hours after birth	64%	80%	89%
Exclusive breast-feeding 0-4 months	49%	65%	74%
Introduction of solid/semi-solid food to 5-9 mth olds	89%	90%	93%

The exclusive breast feeding rate appears suspiciously high, even given the project's past successes in this area. Again, these survey data should be verified with observational and other data. The Haitian Health Foundation (HHF), a private voluntary organization which works in an adjacent area to the east, is also a leader in the promotion of exclusive breast-feeding. For a recent study for UNICEF, HHF tracked infant weights and then analyzed the data based on the mothers' reports of "exclusive", "partial", or "token" breast feeding in accordance with the accepted international definitions. Despite all HHF's efforts in this area since 1993, which have probably been as intense as those of RICHES, HHF found only 57 percent exclusive breast-feeding at 4 months (HHF personal communication, 1996). This suggests that, while the exclusive breast feeding rate is undoubtedly high, mothers in the RICHES catchment area may nevertheless be over-reporting their positive behaviors. Also, for comparative purposes, it would be helpful in the future if all organizations doing breast feeding research asked questions in accordance with the international definitions cited above.

Breast feeding promotion is one of the strongest areas in the RICHES health education package and one for which the project has received well deserved national attention. For example, when it recently celebrated the first anniversary of its national breast feeding campaign with a major conference, UNICEF brought a group of RICHES mothers to the capital to give testimony and to present their breast feeding songs and skits. According to many observers, the mothers' presentation was the high point of the conference.

The previous two final evaluations have also commented on the strength of the RICHES approach in this area, in particular the dangers of bottle feeding (Conway, 1989) and the value of colostrum (Alvarez, Berggren, & Gay, 1993). The project has presently gone far beyond the "uprooting"⁴ of the baby bottle, however. In fact, the communities seem to have progressed so far that bottles are not a real concern anymore. The present preoccupation in this lesson is teaching women to breast feed correctly. The field staff have done an incredible job in terms of taking the latest scientific findings on breast milk and translating them for women with low or no literacy. As she watched the breast feeding lesson, this evaluator had to wonder just how many women even in the developed world are as well versed in the composition of breast milk and know the reasons for emptying one breast for putting the infant to feed on the other?

One critical child nutrition recommendation in the RICHES I final evaluation concerned "...the need for targeted and time-limited interventions for children with growth faltering." While largely complimentary of the project's growth monitoring/promotion

⁴ In the original breast feeding lesson, use was made of the then currently popular and politically loaded term, *dechoukaj*, which referred to the forceful "uprooting" of Jean Claude Duvalier.

educational techniques and its ability to motivate mothers, the evaluators also commented that, "The purpose of a weight monitoring program....is not to 'weigh children to death' but rather to rapidly identify those who require further interventions (Alvarez, Berggren, and Gay, 1993). Thus, the DIP for RICHES II mentioned a new project direction; in year two, "the project will devise a strategy to support local institutions in nutritional rehabilitation" (CARE-Haiti, 1994). Ultimately, the strategy developed was a collaborative one with the successful Catholic Relief Services (CRS) CS project funded by USAID/Haiti. CRS is the Food for Peace cooperating sponsor with responsibility for the entire southern peninsula and its CS project works with public, private, and mixed⁵ medical facilities throughout the south to promote CS services and recuperate severely malnourished children through the use of PL- 480 food. According to the plan devised by staff of the two projects, CRS would initiate project activities in the Moron MSP clinic and would also train RICHES *kolabaratri*s and other local volunteers to identify and refer severely malnourished children to the clinic. Unfortunately, due to a number of factors, none of which were under the control of RICHES II management, only a minimal portion of this plan has thus far been achieved—the training of RICHES II and staff and *kolabaratri*s. The clinic has yet to function as a malnutrition recuperation unit and there is concern that this may never happen. On the other hand, it is impossible to imagine that RICHES management, given the creativity of its project staff, could not find an alternative way to intervene with severely malnourished children if they were motivated to do so—and considering that CARE-Haiti is one of the three cooperating sponsors for PL480 foodstuffs in Haiti.

3.2.4 Maternal Care: Maternal care also appears to be an area of successful intervention. National statistics indicate that one out of three women receives no prenatal care. In comparison, as can be seen in Table 4, this number in the RICHES area catchment area drops to approximately one woman out of ten. Perusal of a sample of the participants' "Women's Road to Health" cards during rally post visits also verified that pregnant women are invariably being referred to the nearest medical facility for ante-natal visits.

Table 4: Maternal Care Objectives/Indicators

<i>Indicator</i>	1994 Baseline	<i>Expected 1996</i>	<i>Achieved 1996</i>
One or more ante-natal visits	58%	80%	86%
Contraceptive prevalence rate women in union 15-49	< 1%	25%	22%

⁵ Mixed facilities are usually those run by nongovernmental organizations which receive MSP assistance, usually in the form of personnel.

The RICHES II CBD family planning program which has been implemented in the field since January of 1994 also appears to be a great success. Both the quantitative and qualitative data which were collected for this evaluation concur on the positive impact of this program. Based on interviews with participants, the RICHES non-formal family planning education package which includes anatomy lessons as well information on specific methods, does an excellent job informing and motivating clients. In addition to their knowledge of modern contraceptive methods, the nursing women interviewed were knowledgeable about the child spacing benefits of exclusive breast feeding. The *kolaboratris*, who are the program's front line workers, also appear to have a firm understanding of the methods and to be highly motivated. They distribute condoms, oral contraceptives, and vaginal foam, and refer women who want injectables to one of the two nearest medical facilities.

Project staff also facilitate contact between the PROFAMIL mobile team which visits the area periodically to do voluntary surgical contraception (VSC) and NORPLANT insertion and women who want these methods. In the month before the evaluation, CARE organized a group of 30 women who received tubal ligations; apparently due to the positive reports of this group, staff were already registering more women for the next mobile team visit.

The program is also well run in terms of contraceptive logistics and management. As a logistics expert who was visiting the project during the time of the evaluation wrote, "In point of view of logistics management, the loss of contraceptives is zero, the family planning register is completed by the *kolabaratris* almost 100 percent (of the time), and there are few ruptures of stock" (Steele, 1996).

As seen in Table 4 above, the survey indicates that the contraceptive prevalence rate (CPR) for women 15-49 in union in the project area is a approximately 22 percent. In comparison, the national CPR is estimated at 18 percent and that for rural areas is only 13 percent (EMMUS II). Moreover, the RICHES II baseline survey suggests that in 1994 the project's catchment area had a significantly lower CPR than most other rural areas—less than 1 percent. This is a phenomenal increase for rural Haiti in less than two and one-half years, and one that this is certainly due to the efforts of RICHES. These survey data also have independent verification in the acceptor and user data available at the service centers. The numbers of family planning participants listed in four centers visited was uniformly high: the mean number of participants per center was 25.

Although there are no recent survey data for the family planning programs of other nongovernmental organizations (NGOs), the estimated CPRs for a select group of NGOs are as follows: Comite de Bienfaisance de Pignon (CBP), 33.5 percent; Association pour la Promotion de la Famille Haitienne (PROFAMIL), 15.6 percent; Centres de

Developpement pour la Sante (CDS), 16.9 percent; Association des Oeuvres Privés de Sante (AOPS), 23.5 percent; and Hopital St. Croix - Leogane, 24.8% (Private Sector Family Planning Project, Julliet - September, 1995). Most persons knowledgeable about family planning in Haiti believe that these NGOs, which received support under the USAID-Haiti's Private Sector Family Planning Project (PSFP), have the most effective programs and the highest CPRs nationally. One can see that the only NGO family planning programs which have higher CPRs than RICHES are CBP, AOPS, and St. Croix. All three of these NGOs have long established family planning programs, however, which have been running for 9-10 years. Moreover, although most AOPS programs have only CBD, CBP and St. Croix have full-fledged programs which offer all clinical methods, including VSC and NORPLANT.

3.2.5 Acute Lower Respiratory Infection: The results in Table 5 below suggest a high percentage of seemingly appropriate health seeking behavior for acute lower respiratory infection (ALRI) both pre- and post-project intervention. ALRI is believed to be one of the major cause of child mortality and morbidity in Haiti. This is a new education area for CARE-Haiti's CS projects which was introduced only in RICHES II, although the previous project had been instrumental in the development of new national ALRI information, education, and communication materials. Almost all mothers surveyed who report that their child has a respiratory episode during the previous two weeks, also report seeking medical treatment for that child. National statistics suggest that only 27 percent of children who have this often times life threatening illness are taken to a health facility/medical personnel for treatment.

Ethnographic work done in the neighboring HHF catchment area suggest, however, that regardless of what they say, most mothers do not recognize the danger signs of ALRI and/or often attribute the danger signs to other causes. For example, according to the HHF study, mothers often identify noncritical symptoms such as stuffy nose or flu-like symptoms, but do not recognize the real danger signs such as rapid or difficult breathing or rapid rib movement. In fact, they usually attribute rapid breathing to parasite infestation. These ethnographic data thus suggest that many mothers may be incorrectly diagnosing a cold or flu as ALRI and diagnosing ALRI as worms. The 1994 baseline survey essentially concurred with these latter data. Only 39 percent of the mothers whose child had had a recent respiratory illness identified rapid breathing as a distress signal. Rather than seeking medical treatment, a better indicator for this intervention would have been progress in correctly identifying the ALRI danger signals.

Table 5: Acute Lower Respiratory Infection Indicators

<i>Indicators</i>	<i>1994 Baseline</i>	<i>Expected 1996</i>	<i>1996 Results</i>
Medical treatment sought for ALRI	85%	90%	93%

3.2.6 Malaria: Malaria prophylaxis was not programmed in the manner originally planned. First, health workers were resistant to the concept that pregnant women should be given prophylactic malaria medication. A sub-theme of RICHES health education has always been that pregnant women should not take any medication, including home remedies, without the approval of medical personnel and that they should take only those medications which are absolutely necessary. The health workers themselves strongly lobbied for this sub-theme based on their perceptions that Haitians are prone to take too many medications during pregnancy and to take them indiscriminately. The proposed prophylaxis thus appeared to them to contradict one of the project's basic precepts. And second, although CHWs had been taught to provide chloroquine tablets, when the time arrived to begin prophylaxis at the centers, the only form of the medication available was malaquin. Project managers were reluctant to assign CHWS with low literacy the responsibility for dispensing this medication. It is more difficult to measure the proper dosage, and it also closely resembles other popular liquid medications which means the possibility of confusion. Survey results reflect this change in strategy: There were no discernible changes in knowledge or behaviors between the baseline and the final studies.

3.2.7 Health Education: In many ways, health education has always been the major intervention of the CARE-Haiti series of CS projects. In the beginning, this included a set of lessons for the basic CS interventions provided by the projects for pregnant women, nursing women, infants, and young children. This was gradually expanded to include a few more lessons and improved nonformal teaching techniques; then an entirely new set of lessons on sexuality and family planning and more improved techniques; and finally most recently a third set of lessons on sexually transmitted diseases/AIDS prevention. The methodology has always made use of a multitude of traditional expressive forms including songs, riddles, puns, short theatrical skits, etc. From the beginning the idea was 1) that people probably learn better when they are also amused and 2) that mnemonic devices such as songs will help people, especially those with low or no literacy, to remember such things as the recipe for home-mix ORS, the number of immunizations a child needs, etc.

Numerous other PVOs have adopted these health education packages. The packages have also been highly touted in the every evaluation ever over done the past 10 years of CARE-Haiti's CS projects. As the evaluation of the USAID-funded VACS project reported several years ago:

"CARE's RICHES songs appear to have had outstanding results in the transmission and internalization of messages. We interviewed women who knew these (RICHES) songs; those women now knew that the traditional post-partum purgative, *lok*, should be eliminated and the colostrum should be fed to the child rather than thrown away. We

interviewed women who did not know the songs; they still told us of the need to give the child a *lok* purgative and to throw away the first milk (VACS, 1993)."

One criticism in RICHES I final evaluation was that the newer materials lacked the cultural appropriateness and clarity of the original lessons. The theory posited was that the field workers, who were largely responsible for the success of the original materials, had become too sophisticated to create new songs, for example, that were meaningful or intelligible to the average woman enrolled in the program.⁶ The suggestion was that, with a little bit of assistance, the mothers groups themselves could create highly appropriate materials. Based on observations at several rally posts sites, this is exactly what is happening. Mothers groups were rehearsing their own health songs which they were going to perform at a event which would bring together groups from all parts of Moron. These songs were lively, amusing, told an interesting story in colorful Creole, extremely pertinent to the lives of the women participants, and grabbed everyone's attention—in short, they very much resembled the original set of songs. For example, one song told the story of a woman who was breast feeding her infant son when her husband came home from the fields tired and hungry. The husband criticizes the wife for "wasting" so much time in this way with the infant, and a certain amount of jealousy is also implied. The wife then responds by explaining all the advantages of breast feeding and concluding that "since she has only one Toto (the son's name) she has to give him tete (the breast). The song's tune is excellent and the play on words and the repeated alliteration of "Toto-tete" makes for a very amusing number.

3.2.8 AIDS Prevention: Sexually transmitted diseases, especially AIDS, represent a serious problem in Haiti and contribute in a significant manner to maternal and child morbidity and mortality rates. This is particularly true in the western Grand Anse where the project is located. For example, several years ago, 16 percent of all pregnant women tested in this area were seropositive for syphilis. This is the highest known rate nationally for this STD (*Institut Haitien de l' Enfance*, HHF, 1994). Moreover, this evaluator can attest that as little as five years ago the western Grand Anse was probably the most backward area in the country in terms of the population's STD/AIDS knowledge levels.

Although the project had rather limited objectives in terms of STD/AIDS prevention, RICHES II and its participants benefited greatly from another CARE-Haiti Health Sector project which was implemented in this area. As mentioned above, the STD/AIDS Prevention Project, which was implemented in the western Grande Anse from 1994 to 1996, provided technical and financial assistance to other institutions and projects,

⁶ A song heard during one rally post visit which endlessly enumerates all the medical names of various sexually transmitted diseases confirms this assessment.

including RICHES II. Based on the final project report and knowledge, practices and coverage survey report, and comments of persons both within and without CARE-Haiti, this project was a resounding success. For example, as a result of this project, there is presently the technical capacity in the western Grand Anse to do STD syndromic diagnosis and treatment using WHO protocols and AIDS testing. Moreover, according to the RICHES II final survey results, 99 percent of the women interviewed knew about AIDS; 99 percent knew at least one correct way in which one can contract the illness; and 97 percent knew at least one valid means of prevention. Furthermore, 97 percent knew that condoms are a means of prevention. This evaluator knows of no other area in the country with knowledge at these high levels, and this includes those areas which were served by the USAID/Haiti and AIDSCAP project.

RICHES II's only objective in this activity was to: Distribute condoms through at least two retail points in each rural section. This objective appears to have been met many times over. Promotional materials for *Pante*, the USAID and Population Services International (PSI) socially marketed condom brand which RICHES promotes, were visible at almost every commercial establishment that one passed. Furthermore, spot checks confirmed that these outlets truly had *Pante* in stock. However, while the wholesaler trained by the project is still in place, her present level of activity appears to be more that of a retailer. During an interview she stated that she had sold only three boxes of *Pante* during the last two months. However, she also revealed that she teaches school in a nearby town and is thus absent from her place of business for 4½ days each week. Moreover, two COS reported that several local traders evidently saw greater profits in buying directly from the Jeremie distributor, and thus have become mini-wholesalers in addition to being retailers. In other words, market forces appear to have taken over the distribution system in Moron—which is exactly what everyone involved in a contraceptive social marketing wants to happen.

3.2.9 Geographical Consolidation: Certainly one of the major accomplishments of RICHES II which was outlined in the DIP has been the consolidation of service delivery into one geographical area. To do so, the project simultaneously left some older Grande Anse localities outside of the Moron Commune and not contiguous with it, while at the same time expanded services to cover the entire commune and two small contiguous Commune of Abricots localities. As mentioned above, RICHES I worked in five different western Grand Anse communes which were up to 10 hours of vehicle travel time away from one another. This consolidation has meant management efficiencies since service sites are not scattered over several communes many travel hours away from each other. Logistics and communications, especially, have obviously been enhanced. Higher field staff morale also appears to be a positive result. Field staff are quite vocal about the difficulties of the previous systems and the advantages of the present system. Furthermore, the present consolidated system allows the monitor to live in one of the several localities in her overall area which has a rally post. Based on her past experience

with CARE CS projects, this evaluator judges that project staff are much better integrated into their communities than at any time in the past. In fact, it is obvious that the field staff have become *personaj* (people with respect and authority) in the communities in which they work.

Another critical outcome of consolidation is that no caretaker presently has more than one hour and a half's walk to a rally post. Although this distance is still a long way to have to carry a child, especially during the rainy season when the steep mountain paths become exceedingly muddy and slippery, it is a distinct improvement on the average distance for RICHES I. Furthermore, due to the pattern of relatively high dispersed settlement in these mountains and the cost per rally post, an organization may not be able to do better than a 90 minute minimum walk. Perusal of project data suggest attendance at rally posts has increased over previous projects, and this is probably attributable at least in part to the lesser distances involved.

3.2.10 Health Information System: An important project activity which was detailed in the DIP was the adoption and adaptation of a new population-based health information system (HIS) used by the Haitian Health Foundation, another PVO in the western Grand Anse. In part, this new system was motivated by lower-than-planned immunization coverage under RICHES I and staff inability to recognize that "coverage" is a population-based concept. It was hoped that the new HIS would allow staff to identify correctly which participants are reached and not reached for vaccinations, family planning, pre-natal care, education, and other activities. The system was also adopted because it was believed that this particular HIS would facilitate the production of systematic reports to the communities.

The system was adopted but only became operant for two of the twenty-six rally post communities. The problems with the system appear to have been numerous. First, it appears that none of the project staff in the Jeremie field office are strong proponents of computerized HIS. One can almost hear the relief in their voices when they discuss the computerized system "didn't work" and was essentially abandoned. Second, there was never a full-time staff person with strong computer skills at the field office dedicated to the HIS. If there had been someone like this who could manipulate the data and serve them up in useful ways, perhaps staff attitudes toward the computerized HIS would have changed. And third, project management hired an outside contractor to conduct the census and there was mass confusion in terms of lack of agreement between the locality names on the household registration forms and locality names on a map of the area generated by the team. This confusion was only resolved much later by means of a global positioning system (GPS) instrument and Geographic Information System (GIS) computer-drawn maps of the areas in question. Given all this, it is understandable that a document recently generated by RICHES II staff entitled "Health Sector Lessons Learned: 1991 - present" summarizes the situation thus:

“Monitoring systems in RICHES (II) were cumbersome and not useful for management decision-making. (Given questions of cost-effectiveness, of using a population based, computerized system in a short-term project, CARE needs) to put more emphasis on developing simple, user-friendly systems which meet project monitoring needs.”

According to the HIS originator in the neighboring PVO, on the other hand, the fault was not in the HIS but in the way RICHES staff put it to use. She says that once the census was completed, the data should have been entered and manipulated in the Jeremie field office rather than sent to the capital city. In this way, the data could have been “cleaned” whenever the staff noted inconsistencies and staff would have learned about the system and its uses in the process (Gebrian, personal communication). Both opinions have some substance. The HIS in question has been proven as a very effective tool but it is also very resource intensive, especially in terms of first data entry. In this evaluator’s opinion, it is too resource intensive to be used in a project which will only work three or four years in a given geographical area. The resource investment in this particular HIS is probably only justified in terms of a long term commitment to an area and way too ambitious for a project of relatively short term.

3.2.11 Sustainability Efforts: As mentioned above, the effort to ensure the sustainability of services after RICHES II leaves Moron constituted a major project activity. The approach had two prongs: First, RICHES staff conferred with several other area PVOs which have a longer term commitment to the western Grand Anse, encouraging them to assume service delivery responsibilities at end of FY 97. (CARE-Haiti will use the first year of the new CS project, RICHES 2000, to wind down activities in the RICHES II catchment area.) Second, after several years of intensive consciousness raising and other inputs, another option is for CARE to devolve responsibility for some services to the communities themselves.

Four staff members constituting the Community Organization Team were assigned this activity as a major component of their work. This team, consisting of a Coordinator and three community organizers, are obviously well trained and highly motivated. Every four months, they meet with the *kolabaratri*s, the *mesaje* (literally “messengers” or health committee members), and sometimes other community leaders at each of the 26 rally posts to discuss the situation. These three groups—the *kolabaratri*s, *mesaje*, and various other leaders—form a sort of abbreviated rally post health committee. Unlike RICHES I, there is no attempt to include representatives of all the various community sectors on the committees. In RICHES II, the committee members self select and the committees appear much stronger and much more motivated due to this new approach.

The community organizers have tasked the committees with choosing which services among those offered by the project they want to continue when RICHES II leaves the area. To do so, they must analyze what they are capable of doing, in part by identifying available resources, both within and without the community. In addition to the 52 *kolabaratri*s, there are presently 281 active *mesaje* in the project catchment area. According to the COSs, some committees have thus far identified health education and growth monitoring as services they want continued, others have identified immunizations and others family planning. Interviews with committee members suggest that some believe that RICHES will leave the area while others are somewhat skeptical. They all profess profound appreciation of the services and health education that the project has brought to their communities and many are eloquent about its impact. Furthermore, committee members state that whatever happens, they will try to keep the momentum going.

Although project managers had initially entered into discussions with the Ecumenical Service for Mutual Aid (in French, *Service Oeucumenique d'Entraide* or SOE), another PVO working in the western Grand Anse, concerning transfer of service delivery, present negotiations involve only HHF. SOE was initially interested in accepting the responsibility, but their plans to establish themselves firmly in the area have proceeded more slowly than originally planned. Moreover, a transfer to HHF would be a "better fit" given the strong community orientation of that organization. The CARE-Haiti/HHF negotiations are hinged, however, based on HHF's receipt of CS XIII or other major funding.

Although one wants to commend CARE-Haiti for its concern with sustainability, one needs to question just how well conceived this strategy really is. First, as was written in the RICHES II midterm evaluation, the process of skills transfer is slow and hardly favors short-term empowerment of the population (PMS, 1993). Three years, which is the amount which RICHES II has had in most of its communities, is hardly enough to effect this transfer. Second, although a solid human resource base is the primary precondition for sustainability, even well trained and highly motivated community people have little chance of maintaining services without a small financial resource base. The RICHES II strategy, which considered socially marketing its distribution services but then abandoned the idea for fear of creating *charlatans* (untrained rural "doctors"), presently has no other provision for local income generation, endowment, whatsoever. And third, if another PVO does not provide or if community members are unable to maintain services, a large amount of money has been spent and, to an extent, wasted motivating people to want health services for which they no longer have access. As mentioned earlier, many project communities are five to six hours from the road and the nearest medical facilities. Countless studies have shown that even the most motivated persons are usually intimidated by such barriers to preventive care.

The major question is: What will happen to these communities when CARE ends operations in September 1997 if HHF does not receive funding to cover Moron? Among other things, the best community-based family planning and AIDS prevention effort which has probably ever existed in Haiti will cease to function. For example, even highly motivated persons will not be able to find or will not otherwise have access to a full set of modern contraceptive methods or vaccines.

3.2.12 Collaborative Efforts: RICHES II staff initiated many successful collaborative efforts during the life of project which appear to be mutually beneficial to all concerned, particularly the participants, and which expanded and intensified the project's impact. Mention has already been made of the successful reproductive health partnerships developed with PROFAMIL for clinical family planning methods and PSI for the social marketing of condoms. RICHES staff have also been very active in the Consortium of Grand Anse Non-Governmental Organizations (in French, CONGA) which has recently been the major group assisting the MSP to organize the new, government-mandated decentralized service delivery system. Project staff were also among the leaders in the recent national breast feeding campaign organized by UNICEF under the auspices of the MSP. Among other things, RICHES mothers were brought to the capital for a major campaign event where they scored a major media success due to their knowledge and spirited advocacy of breast feeding. Finally, the project has worked with John Snow Incorporated (JSI) to develop a replicable contraceptives logistics system and training program for eventual use by CBD programs elsewhere in Haiti.

3.3 Other Accomplishments

The following are accomplishments which were observed during the evaluation but which were not set forth in the DIP:

3.3.1 Organizational Structure: It appears that regularly scheduled meetings with Port au Prince and field staff and radio and telephone contact facilitate the free flow of communications flow between the two offices, and that major programmatic decisions are informed by group process. There also seems to be a fair amount of field office autonomy. Jeremie project staff do not appear to need to wait for every little decision to be made in Port au Prince. Moreover, it appears that upper management in both offices listen to and heed the counsel of the field personnel. This is extremely important because, in the her 14 year's of health project experience in Haiti, this evaluator has never seen a better trained, more highly motivated field staff. All RICHES II staff are superior, but the field staff are truly in a class by themselves. One suspects that a large part of the success of this project is due to the input of the field personnel. Apparently, management listens when they relate their experiences in the field with participants and use these data to inform project decisions.

3.3.2 Gender Related Issues: One cannot discuss RICHES II without discussing gender. With the exception of two COS, all project implementation staff are women. Moreover, all of the semi-volunteer local community health workers⁷ (CHWs - *kolabartris* or just *kolabs* as they are often called) are women. There are a number of men who are *mesaje*, but the majority are women. More men were involved in the project's past, particularly in the family planning and AIDS/sexually transmitted disease (STD) prevention activities, and men of reproductive age are also targeted for these two activities. But, for the most part, RICHES is a CS project for and by women, and is unique in Haiti for being so. For example, the other USAID-supported CS project in the Grand Anse, that of the Haitian Health Foundation, employs only men as CHWs. Both HHF and RICHES have been national leaders in the development of local human resources; both only hire people for their projects from the western Grand Anse and expend considerable resources on their training and development. To decide to hire only women as CHWs, however, meant that RICHES put the human resource development bar up another notch, as this often means even lower literacy skills and thus even heavier investments in their training. Since women are so often under-represented in health projects in Haiti, CARE should be highly commended for its achievements in this area. As is evident in the case study below, the organization's efforts have resulted in CHWs who are highly motivated and proactive in promoting maternal/child health in their communities.

3.3.3 Traditional Birth Attendant and Consumer Training: In one community, the evaluation team observed a RICHES field monitor training traditional birth attendants (TBAs) on behalf of the Minister of Public Health (MSP)⁸. RICHES uses the standard TBA training program used throughout the country, but to this they add RICHES' own special panache. First, they have translated the French text into Creole, the only language intelligible to their students, and they have translated it in a pithy, colorful way which also makes it more interesting. Second, they have added the RICHES nonformal education approach which is more appropriate to adults with little or no literacy such as the TBAs. There are also songs and other mnemonic devices which both amuse and make learning difficult easier to digest.

On the day of the observed training, twenty-four out of the twenty-five trainees from the communities comprising the post's catchment area were present.⁹

⁷ The CHWs are not CARE-Haiti employees but receive a small monthly stipend roughly equal to US \$27.

⁸ RICHES staff are adamant that this training is done on behalf of the Minister because it is the MSP a) which has authority such practitioners and b) which must supervise the their work after training.

⁹ Since the evaluator's trip to this site was only planned the evening before, it is doubtful this attendance was due to her presence.

Training is scheduled two days per week for four months, and three and a half months of the training have already transpired. Twenty-three students are receiving their first TBA training with this course, but two received their original training some years ago. The group is divided almost equally between women and men¹⁰; ages range from 45 to 70 years although some are not certain of their age; and some have been TBAs since late adolescence while others only relatively recently took up the profession.

The class itself can only be described as lively with everyone participating. It is obvious to any observer that these older students do not feel threatened by the classroom situation; to the contrary, it appears as if they are enjoying the course. Based on the observed responses, difficult anatomical and other concepts have been satisfactorily mastered. The students smile and appear pleased when the teacher praises them for a particularly apt response. The major criticism of the class observed is that the field monitor did not make use of the learner's experiences in order to make certain points. The number of years of experience delivering babies in rural Haiti that the class as a whole represented was at least several centuries; it is inconceivable that their experiences would have no relevance to this training. On the other hand, this was a review class before the final test which would ascertain the student's right to receive the coveted "delivery box" which marks the trained TBA or "*matwon*". It is possible that this technique is used at other times; when concepts are first introduced, for example.

RICHES II is to be highly commended for its TBA training. In the opinion of this evaluator, this is one of the most important CS interventions which can be done in Haiti. At 456 per 100,000, the country has the highest estimated maternal mortality rate in the hemisphere, and the majority of deliveries are performed at home. For example, the RICHES II baseline study documents that 89 percent of all deliveries in its catchment area are performed at home, and 72 percent are performed by TBAs. Regretfully there has been no study of the impact of the RICHES II TBA training.

No matter how well planned and executed, however, TBA training is necessary but not sufficient to improve the quality of maternal care. One study (Alvarez, O'Rourke, and Heurtelou, 198?) suggests that the only real discernible impact of TBA training in one community several years later was a 10 gourdes (US \$.70) price increase per delivery. In the community studied, the authors report that TBAs did not use any of the sterile materials they had been trained to use (e.g. new razor blades), nor did they appear to do referrals for high risk deliveries. Their fees, however, which had been 15 gourdes pre-training, had risen to 25 gourdes. TBA training is obviously a critical intervention in Haiti where the overwhelming majority of deliveries are in the home. However, this training has been done in Haiti for over a decade now without ever any real follow-up or

¹⁰ Haiti may be one of the few countries in which both men and women can become TBAs.

research to ascertain its impact. Moreover, most consumers have never been informed about what they should expect or demand from a trained TBA.

The only consumer training of which this author is aware in Haiti is that done by RICHES. One of the lessons for pregnant women is "preparation for delivery" which specifies what the women needs to purchase/prepare: a new razor blade, a small bar of soap specifically for the TBA to wash her/his hands, a clean cloth specifically for the TBA to dry his/her hands, a container with clean water, string to tie the umbilical cord, and a small container of alcohol. In this lesson, the woman is taught to be prepared for the TBA and indirectly taught what standards the TBA should be observing. The RICHES approach does not depend on the TBA following the correct, sanitary procedures. This is a wise approach. For example, despite the TBA training in RICHES communities, due to familial and other ties, some mothers will still TBAs use who have not been trained and, as the study quoted above suggests, some TBAS will probably not follow correct procedures despite the training.

Empowerment of Community Health Workers: A Case Study

During a meeting with field staff, one *kolabartris* related a incident which illustrates the impact of RICHES on its participating communities. She told the assembled group that the day before, she had just returned home muddy and tired from doing home visits when a *mesaje* arrived at her door asking her to make an emergency visit to a RICHES mother in labor. According to this *mesaje*, the RICHES participant who was experiencing her first delivery had been in labor for over 24 hours, but the labor was making no progress and the woman was visibly tiring. Moreover, the matron in attendance had called in two other matrons to assist but all three appeared powerless to help the woman, nor were they encouraging the woman and her family to seek medical assistance. The *kolab* said that although she was exhausted, hungry and had yet even to wash the mud off her feet, the *mesaje* was so insistent that she immediately accompanied him to the woman's home.

When she arrived, the *kolabartris* relates that she well understood the *mesaje's* insistence. The woman had reached the point of exhaustion, her labor was stalled, and the matrons had responded to the situation by trying to perform a sort of episiotomy with their fingernails. According to the *kolaboratris*, despite the vigorous objections of the three matrons and their threats that she alone would be responsible should a death occur, she and the *mesaje* convinced the family that the woman must be taken to a clinic. They then bundled the woman up; put her on a door which they used as a stretcher to carry her to the road; and, upon reaching the road, found a truck driver who was willing to take them to the clinic in Moron. Unfortunately, the young doctor doing his obligatory social service was absent, and so they were faced with the challenge of transporting the woman to the Jeremie hospital.

Although Jeremie is only 18 miles from Moron over a major secondary road, there is little public transportation, especially as late in the day as it was. The truck driver who had brought them to Moron was insistent that he could not do the trip for less than US \$34 and no one had this much money. The propertied father of the baby was disclaiming any responsibility, and the woman's mother sells fried bread along the road for a living. As the *kolaboratris* said, "At one point there, I just knew that my month's stipend from CARE was going to go to help pay for a funeral." Undaunted, however, the *kolaboratris* sent the *mesaje* to the Moron field office of CARE's agriculture project, the PLUS project, to ask the head agronomist if he could

help, while she went to request assistance from the priest. The priest was saying he was willing to help but was unsure about his vehicle when the CARE vehicle pulled up in front of his house.

When the group arrived at the Jeremie Hospital in the CARE vehicle, the auxiliary nurse on duty was the wife of a RICHES community organizer who gave the group immediate attention. A doctor performed a hurried episiotomy and the baby arrived instantly, although it was some time before the infant responded to stimulation. The *kolab* was commended by hospital staff who are quoted as saying that probably the infant and possibly the mother probably would have died without her intervention.

The *kolaboratris* was still somewhat winded from this experience the next day at the time of the telling. Her story was later collaborated by interviews with the *mesaje* and the new mother and her family. As mentioned above, the story is illustrative and it is not an isolated example. The next day, the evaluator experienced another episode which involved a monitor, a *kolaboratris* and several *mesaje* going to the home of a very sick child and pressuring a reluctant father to take the child to the dispensary. The child was diagnosed with typhoid and, when he arrived at the dispensary, had a temperature of 104 and was severely dehydrated. Again, the dispensary staff commended the RICHES staff and participants for their probable live saving action.

4.0 Recommendations

This evaluation is different from many final evaluations in that, as discussed above, CARE-Haiti has decided to move its health sector in a new child survival direction. After a ten years of direct service delivery, its Health Sector Office will only have projects which provide technical assistance. CARE's provision of service in the communities presently served will end in September of 1997. With few exceptions, then, the following recommendations will have less to do with bettering the services assessed above than with suggestions for future directions. In addition, some recommendations will be more pertinent to donors rather than to CARE.

- CARE should consider the development of low cost, effective child survival service delivery models as a legitimate part of its Health Sector's scope of work. In effect, this is a large part of what the organization has been doing during the past decade and all assessments indicate that it has been very successful in doing so. The three CARE child survival projects have not been overly expensive if one factors in the development of its successful service models which are already in use (e.g. the educational packages) or should be put to use (e.g. the family planning package) by other field organizations.
- In this latter respect, CARE-Haiti management should consider the development of service sustainability models as one of the next projects for its Health Sector. Although it failed to achieve a viable model, RICHES II probably came as close to doing so as any project in Haiti has ever done. One suspects that, given the community conscientization

models already developed, this could be done relatively easily by adding innovative income generation projects. CARE-Haiti already has a resident Small Enterprise Advisor who could presumably assist in this effort.

- Every effort should be made to improve immunization coverage before September of 1997. For example, although *kolabaratriis* especially appear to have considerable knowledge as to the immunization status of participants, this knowledge— and that contained in the records kept at each post—should be transferred to lists which are then used by supervisors for effective follow up. The data needed for this follow up exist, either in terms of the cognitive maps of the *kolabaratriis* or post records, but they need to be translated into more efficient management tools.
- The *kolabaratriis* have requested diplomas which can be used as proof of the training they have received after CARE-Haiti leaves the area. To this request, this evaluator would add they should also be given certificates attesting to the amount of time they have served. The *kolabs* have received a heavy training investment and this is an asset to which the MSP or other PVOs should have future access. Diplomas and certificates would assure that other interested organizations are aware of the trained human resources in these communities.
- In fact, the *kolabs* are such valuable community assets that CARE should consider continued use of them in the new RICHES 2000 project which focuses on reproductive health. For example, CBP and the Population Council developed a successful new community health worker model for Haiti called the “super matron”. The *super matron* is essentially a notch above *matrons*, or trained TBAs, in that they are also trained to do some antenatal monitoring such as blood pressure monitoring and post-natal follow up such as family planning promotion. The *kolabs* already have family planning training. Being trained to do deliveries would mean that they would have a chance to continue to use their considerable skills while at the same time making a little money. Their existence as *super matron* in the area would be critical addition to the new project’s other reproductive health interventions.
- Given the proven effectiveness of the other RICHES training packages in eliciting positive behavioral changes, it is strongly recommended that, with donor assistance, CARE should conduct research on its TBA training course. If this evaluation is successful, this training should minimally be included as part of the RICHES 2000 technical assistance (TA) package. There is a urgent need for this training throughout Haiti, particularly as part of the new communal health unit (UCS, or *unite communale de sante*) system decreed by

the MSP. Reproductive health is one four UCS priority health services, and effective TBA training should be part of that package. With a proven effective training package, CARE would be in the best position to provide TA for this service throughout the country.

- Children-to-children health activities would seem a natural outgrowth of the RICHES educational packages. Hearing children in the neighborhoods of the rally posts sing the many RICHES songs by heart certainly raises this interesting possibility. This approach could be especially relevant in those areas, i.e. ORT preparation and vaccinations, where adult caretakers appear to have comprehension problems. Most children even in rural areas have some schooling these days which may make them more adept in understanding and remembering the doses of vaccine needed and in making the home ORT mix. They certainly already know the songs.

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**BHR/PVC GUIDELINES FOR FINAL EVALUATION
OF CHILD SURVIVAL PROJECTS ENDING IN 1996 (CS-IX)**

The final evaluation team should address each of the following points. As far as possible, respond to each point in sequence.

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

1. Compare project accomplishments with the objectives outlined in the DIP and explain the differences. Describe any circumstances which may have aided or hindered the project in meeting these objectives.
2. Describe unintended positive and negative effects of project activities.
3. Attach a copy of the project's Final Evaluation Survey with the survey results

B. Project Expenditures

1. Attach a pipeline analysis of project expenditures.
2. Compare the budget contained in the DIP with the actual expenditures of the project. Were some categories of expenditures much higher or lower than originally planned? Please explain.

C. Lessons Learned

Outline the main lessons learned regarding the entire project which are applicable to other PVO CS projects, and/or relevant to USAID's support of these projects. Be sure to address specific interventions, sustainability and expenditures.

II. PROJECT SUSTAINABILITY

A. Community Participation

What resources has the community contributed and will continue to contribute that will encourage continuation of project activities after donor funding ends?

B. NGO's

What is the current ability of the NGO partners to provide the necessary financial, human and natural resources to sustain effective project activities once Child Survival funding ends?

C. Ability and Willingness of Counterpart Institutions to Sustain Activities

What is the current ability of the MOH or other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?

C. Sustainability Plan, Objectives, Steps Taken, and Outcomes

What are the steps the project has undertaken to promote sustainability of child survival activities once project funds end? Please fill in a table (example below) with sustainability objectives and outcomes.

Goal	End-of-project objectives	Steps taken to date	Outcomes
1) MOH will take on health promotive activities of CS project	1) MOH will supervise and provide refresher training for 50 CHVs 2) Health officer will meet monthly with community health committees	1) 2 MOH nurses trained in CHV supervisory methods 2) Health officer attended 3 health committee meetings	1) 10 CHVs being supervised by MOH nurses (20% of objective) 2) Health officer attended 3/10 meetings (30%)
B)			

III. EVALUATION TEAM

A. Identify by names, titles and institutional affiliations all members of the final evaluation team.

SCOPE OF WORK

RICHEs II Project Final Evaluation

BACKGROUND. RICHES II is a centrally-funded child survival project operating in the communes of Moron and Abricots in the Grand'Anse. A community-based project using local women to provide preventive health services, RICHES II established 26 health posts to reach an isolated rural population of 35,000 people. The project began operations in October 1993, but only began providing a full set of services at health posts in January 1995. Currently, women and children attend the health post once per month. Weights of both women and children are monitored, micro-nutrients distributed, vaccinations given. Referrals are provided for children experiencing growth faltering, for women who display risk signs during pregnancy, for pregnant women, and for people interested in a clinical FP method. Strong emphasis is given to IEC; women participate in non-formal adult education sessions which provide information on key health topics and which encourage reflection on how to apply the information in daily life settings. Volunteer "Messengers," representing local communities, meet every three months with RICHES staff to discuss progress in health coverage, problems in service provision, and how to motivate the isolated communities to take responsibility for certain health problems (eg, lack of access to curative services, attending vaccination posts) which they face.

A project baseline KAB study was completed in 1994. The Professional Management Services group conducted a mid-term evaluation in 1995; the great majority of recommendations were implemented by RICHES staff. CARE-Haiti will conduct a final KAB survey in July to measure changes in knowledge, attitudes and service coverage since 1994. Additionally, CARE-Haiti is seeking a consultant, assisted by a CARE Health Sector staff member, to conduct a more qualitative final evaluation which follows USAID guidelines (attached).

CONSULTANT RESPONSIBILITIES:

Review pertinent literature relating to the project: baseline studies, DIP, mid-term evaluation, internal evaluations, eg, lessons learned, results of 1996 KAB study.

Make field visits to project health posts, project participants, non-participants, and staff to gain an understanding of the project functioning in relation to objectives fixed in the DIP.

Conduct field research, as necessary, to collect data for use in the final evaluation.

Determine the level of project sustainability after an additional four years of operation of a follow-on project: Meet with *Société Oecuménique d'Entraide* (SOE) and ministry officials to determine feasibility of SOE taking over the CARE service delivery area.

Write a final evaluation report.

CARE-HAITI RESPONSIBILITIES: During field visits, CARE will provide transport to, from and within the Grand'Anse, and per diem according to CARE-Haiti procedures. Field staff will organize visits and accompany the consultant as necessary. The Health Sector staff assigned to the evaluation team will assist the consultant in group interviews, data analysis, etc. In Port-au-Prince, CARE will provide limited secretarial assistance (tables, graphics, diagrams) to the consultant and provide a laptop computer, if needed.

OUTPUTS: A final report (with diskette containing report) written in English which has been accepted by CARE. The report should follow AIDS guidelines, which follows AID guidelines.

ESTIMATED TIME TO COMPLETE CONSULTANCY: 16 days, including: 2 days of preparatory work, reading documents and working with CARE staff to prepare for field work, 2 days travel time to and from the field, 5 days field work, 5 days to analyse field data and write draft report, 2 days to to finalize report, including discussing evaluation findings with CARE staff in PAP, in order to finalize the document.

(8 May 96)

Attachment Two

NAME Shelagh O'ROURKE

CITIZENSHIP U.S.A.

LANGUAGES English mother tongue, fluent Haitian Creole and conversation French.

EDUCATION

1976 B.A., Oakland University, Anthropology Major
(Honors)

1978 Ed.M, Harvard University, Comparative Human
Development

1981 ABD, Harvard University, Comparative Human Development

PROFESSIONAL EXPERIENCE

1996 - present **Senior Associate, Caribbean Resources International, Inc.** Project development, marketing, and selected consulting assignments in social and economic development.

1990-1996 **U.S. Agency for International Development (USAID), Port-au-Prince, Haiti and Washington, D.C.**

1991-1996 **Program Coordinator, Humanitarian Assistance Program,** Management of US \$6 million program to provide basic health and nutrition services to disadvantaged urban women and children during period of extreme political turmoil. Supervisory responsibility for 20 expatriate and national staff in four institutions. Policy/Program Development in the provision of emergency AIDS prevention, feeding, and maternal/child health services.

Acting Chief, Population Division, Management of \$16.5 million population and family planning program involving public, private

voluntary, and private commercial institution. Supervision of one umbrella management contractor, three national staff, and short-term

contractors. Policy/Program Development in the areas of institutional development, donor coordination, service expansion, quality of services, social marketing, community/factory based contraceptive distribution, and information, education and communication.

Population Advisor, Management of a US \$8.3 million program involving the private and public health sectors. Supervisory responsibilities for an expatriate management team, two national staff, and short-term contractors.

1985-1990

CARE/International; Port-au-Prince, Haiti.

Project Design/Research Coordinator, for an integrated rural development project involving maternal/child health, family planning, AIDS prevention, water and sanitation, income generation, and improved farming practices. Data Analysis for a maternal/child health knowledge, attitude, and practice (KAP) study in twelve rural communities.

RICHEs Project Coordinator, Management of a US \$3.6 million, four year maternal/child health project serving a disadvantaged rural population of 125,000 and employing 40 administrative, technical, and support staff.

Policy/Program Development in the areas of decentralized management systems, small income generating projects, nonformal adult education community-based preventative health care services, and service expansion.

Project Design in the areas of family planning, sex education, and rainwater catchment systems.

CINECO Project Coordinator, Management of a \$2 million, three year maternal/child health project employing 16 administrative, technical, and support staff. Policy/Program Development in the areas of project sustainability and management information systems. Project Design for a \$3.6 million, four year maternal/child health project to serve 31 isolated rural communities.

Interim Pre-Primary Education Project Coordinator Management of a \$500,000 two year project employing 12 administrative, technical, and

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support staff. Policy/Program Development in the areas of transfer of international organization responsibility to local institutions and

participatory teacher training. Project/Design of \$2.3 million, five year effort to provide low cost, effective pre-primary school models for disadvantaged private schools.

1983-1985

Independent Consultant; Haiti and the Dominican Republic
Quantitative/Qualitative Research Design and Implementation in the areas of primary health care, family planning, water and sanitation, and formal and nonformal education.

Project evaluation in education and family planning.

Social Soundness Analysis in technology transfer and family planning.

Policy/Program Development in the areas of family planning, nutrition and health education.

1982-1983

Action Familiale Assessment Coordinator: Harvard University Center for Population Studies; Port-au-Prince, Haiti. Policy/Program Development in the fields of human and other resource development and management, management information systems, donor relations, teacher training, and nonformal education.

1977-1981

Research Assistantships; Harvard Graduate School of Education (HGSE); Cambridge, MA, Management of a \$300,000, three year project employing 15 researches.

Quantitative/Qualitative Research Design and Implementation in 12 metropolitan Boston ethnic communities.

Analysis of demographic and interview data.

Preparation of research reports.

1979-1981

Lecturer; Northeastern University; Boston, MA

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Shelagh O'ROURKE

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Taught medical sociology, sociology of mental health, and social gerontology in three quarter sequence.

1975-1977 **Research and Teaching Assistant; Department of Anthropology/Sociology; Oakland University; Rochester, MI**

SELECTED PAPERS/PRESENTATIONS/PUBLICATIONS

- In Press** "Rural Haitian Primary Health Care Strategies" in Health Seeking Behavior: Household Perspectives on Primary Health Care from Sixteen Developing Countries edited by Susan Scrimshaw, K. Mitzer and N. Scrimshaw, United Nations University. Tokyo. (Coauthored with M. Alvarez and M. Heurtelou.)
- 1991** Social soundness analysis for the AIDS CONTROL Project. AIDSTECH and USAID/Haiti: Port-au-Prince, Haiti.
- 1990** Defining RICHES: the use of social science research in the redesign of a child survival project. Paper first presented at the American Anthropological Association National Meeting. Washington, D.C. (Reprinted as Publication Series: Primary Health Care Report No. 11, Primary Health Care Unit, CARE-USA: New York)
- 1989** Gid kolaboratris pou fe edikasyon nan domèn lasante (Health Education Guide for Community Workers). CARE: Port-au-Prince.
- 1988** Report on the interactions with health care providers: the case of Haiti. Paper presented at the UNU/UNICEF/Ford Foundation Workshop on the Evaluation of Programmes of Nutrition and Primary Health Care. Zagreb, Yugoslavia. (Coauthored with M. Alvarez & M. Heurtelou.)
- The CARE-Haiti experience. Paper presented at the USAID/PVO Child Survival Lessons Learned 1985-88; Africa and Haiti Conference. Bologna, Italy.
- 1985** Water and sanitation knowledge, attitude, and practice in southern Haiti. CARE and USAID: Port-au-Prince, Haiti.

Assessment of a radio-based primary school education program for Haiti. USAID and Inter-American Research Associates: Rosslyn, VA.

1984 "NFP program evaluation and accountability" in Natural Family Planning: Development of National Programs edited by C. Lanctot. International Federation for Family Life Promotion: Washington, D.C.

Teaching health and nutrition education in Haiti. Institute for International Research: McLean, VA.

An evaluation of the Community Integrated Nutrition and Education Centers (CINEC) Project: a HeadStart-type program for rural Haiti. CARE and USAID: Port-au-Prince, Haiti.

1983 Evaluating natural family planning programs in developing countries: considerations and constraints. Paper presented at the IFFLP Third International Conference. Hong Kong.

1980 The nonsocial behavior of young Senegalese children: sex differences and the effects of maternal employment. Paper presented at the Association for the Anthropological Study of Play, University of Michigan. (Coauthored with M. Bloch.)