PROJECT HOPE

Integrating Child Survival and IMCI Activities into Six Target Communities in the North-East Department of Haiti

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Third Annual Report

Project Location: Department of the North-East, Haiti

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ACRONYMS

AOPS	Association des Oeuvres Privées de Santé (Private Sector Assistance Organisation)
ARI	Acute Respiratory Infection
BCC	Behavior Change & Communication
BF	Breastfeeding
COSAM	Breastfeeding Support Committee
CBD	Community-Based Distributor
CDS	Center for Development and Health
CS	Child Survival
DIP	Detailed Implementation Plan
DSNE	Department of Health for the North-East
EBF	Exclusive Breastfeeding
FOSREF	Fondation pour la Santé de la Reproduction et l'Education de la Famille (Foundation for Reproductive Health and Family Education)
GIK	Gift-in-Kind
HFA	Health Facility Assessment
HH	Household
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
LAM	Lactational Amenorrhea
LQAS	Lot Quality Assurance Sampling
MCH	Maternal Child Health
MOH	Ministry of Health
MSPP	Ministry of Public Health and Population
NGO	Non-Governmental Organization
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PaP	Port au Prince
PSI	Population Science International
SDMA	Service Delivery and Management Assessment
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TdN	Trou du Nord
TR	Terrier Rouge
TTV	Tetanus Toxoid Vaccine
UCS	Community Health Units
VCR	Verbal Case Review
VDH	Volontariat pour le Developpement d'Haiti (Voluntary for Haiti Development)
VHC	Village Health Committee

CSHGP Project Data Sheet

Child Survival Grants Program Project Summary

Third Annual Submission: Oct-25-2004
HOPE Haiti

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Project Description:	Child Survival project covering population of 98,000 in Haiti, with implementation of IMCI, breastfeeding, diarrhea, ARI, immunization, nutrition and micronutrients including child spacing, maternal health, and HIV/AIDS. The project aims to improve both health services and case management by auxiliaries in clinics, and community practices through outreach promoters, women's and men's clubs, community based distribution of contraceptives, and breastfeeding support groups.
Partners:	CDS (Centres pour la Developpment ft la Sante) DSNE (the Department of Health for the NorthEast Department
Project Location:	6 communes in the western portion of the North East Department of Haiti

Grant Funding Information:

USAID Funding:(US $)	$1,300,000	**PVO match:(US $)**	$1,300,000

Target Beneficiaries:

Type	Number
infants (0-11 months):	4,922
0-59 month old children:	16,517
Women 15-49:	23,665
Estimated Number of Births:	4,261

Beneficiary Residence:

Urban/Peri-Urban %	Rural %
20%	80%

General Strategies Planned:

Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Organizational Capacity Assessment with Local Partners
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication
Peer Communication
Support Groups

Capacity Building Targets Planned:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (General)	Local NGO	Traditional Healers	Dist. Health System Health Facility Staff	Health CBOs Other CBOs CHWs

Interventions:

Immunizations 15 **%**
** IMCI Integration
** CHW Training
** HF Training
Nutrition 10 **%**
** IMCI Integration
** CHW Training
** HF Training
Vitamin A 2 **%**
** IMCI Integration
** CHW Training
** HF Training

Micronutrients 3 **%**
** CHW Training
** HF Training
Acute Respiratory Infection 10 **%**
** IMCI Integration
** CHW Training
** HF Training
Control of Diarrheal Diseases 15 **%**
** IMCI Integration
** CHW Training
** HF Training
** CHW Training
Maternal & Newborn Care 15 **%**
** CHW Training
** HF Training
Child Spacing 10 **%**
** IMCI Integration
** CHW Training
** HF Training
Breastfeeding 15 **%**
** IMCI Integration
** CHW Training
HIV/AIDS 5 **%**
** CHW Training
** HF Training

Indicator	Numerator	Denominator	Estimated Percentage	Confidence line
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	75	590	12.7	5.4
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	185	303	61.1	10.9
Percentage of children age 0-23 months whose births were attended by skilled health	61	588	10.4	4.9

personnel				
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	65	590	11.0	5.0
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	82	185	44.3	14.3
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	51	87	58.6	27.0
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	0	0	0.0	0.0
Percentage of children age 12-23 months who received a measles vaccine	121	234	51.7	12.8
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	24	590	4.1	3.2
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	360	590	61.0	7.9
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	58	392	14.8	7.0
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	312	590	52.9	8.0
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	38	590	6.4	7.7

Comments
6.8% of children 12-23 months are fully immunized, by verbal recall.

TB Indicator			
Indicator	**Numerator**	**Denominator**	**Estimated Percentage**
% of new smear positive cases who were successfully treated	0	0	0.0

SUMMARY

The Project is a five-year program aimed at reducing infant and child mortality rates and improving reproductive health in the underserved North-East Department of Haiti focusing on a largely rural population of 98,907 in six communes: Trou du Nord, Terrier Rouge, Caracol, St. Suzanne, Perches and Vallieres.

Haiti has the lowest per-capita income and the highest infant mortality, child mortality, and maternal mortality rates in the Western Hemisphere. The leading causes of infant and child death are diarrhea and respiratory infections. One third of children suffer from malnutrition. Exclusive breastfeeding during the first six months of life is low. Unofficial figures estimate IMR in the target areas to be greater than 100/1000 (compared to the national rate of 72/1000).

The health services in the North-East Department are delivered in the eastern part of the department by CDS with support from USAID via a contract with MSH and with some supplies and manpower from the Ministry of Health (MSPP). The CDS/HOPE project provides assistance to the six western communes (i.e., the other half of the Department) to strengthen their capacity and directly deliver services to this underserved area.

The project began with difficulties, and was nearly terminated, but the possibility of partnership between CDS and Project HOPE gave it a new life. Beginning December 1, 2002, activities were initiated in the two most populous of the six communes, Trou du Nord (TdN) and Terrier Rouge (TR), with the establishment of a CDS field office located in TdN. In the two initial communes, CDS has trained auxiliaries and selected and trained promoters. The project interventions are being delivered through a combination of facility-based services and community-based activities including:

- rally posts run by the promoters and health agent;
- fixed points of service, which adds an auxiliary healthcare worker to the implementing group, to provide prenatal care;
- community-based distribution of ORS, family planning supplies, and other medications;
- home visits by the promoters; and
- establishment of community-level mothers' and fathers' clubs.

While progress in achieving the project objectives has been difficult, due in part to the political disturbances and a devastating hurricane, many activities have been accomplished. Moreover, the rate of achievement is steadily increasing so that the project should ultimately achieve its objectives. During the past year, however, Project HOPE was forced to acknowledge that it could not raise the full $1.3 million it had committed to match with USAID's equal $1.3 million. Discussions are ongoing with CDS as well as USAID/Haiti regarding how to strategize the next phase of the project, including whether to continue to target activities in all six communes or to limit efforts to the initial two communes.

I. ACCOMPLISHMENTS AND ACHIEVEMENTS

In spite of the enormous difficulties that have challenged the country, including an almost three-month period of societal upheaval, political battles, and a major disaster in Gonnaives because of the destruction caused by a hurricane, the Child Survival Project partnership including Project HOPE, the Ministry of Public Health (MSPP) and the Center for Development and Health (CDS) has accomplished many of the objectives defined in the DIP document.

The partnership: For the past four months, Project HOPE and CDS (both represented by Dr. Joanel Mondestin) and other partners (PLAN-Haiti), PSI, FOSREF, VDH, AOPS) have held regular monthly meetings, named "Forum des partenaires,"organized by the Department of Health for the North-East (DSNE). The objectives of these meetings are to:

- harmonize and coordinate the interventions and avoid duplication,
- exchange experiences,
- put in place a council in order to manage the departmental drug management warehouse,
- establish management norms for the warehouse,
- elaborate an intervention plan for year 2004-2005, and
- evaluate the results of the interventions of each partner.

Meetings: During 2003-2004, monthly meetings were held by field staff as listed below.

Participants	O	N	D	J	F	M	A	M	J	J	A	S
Project Staff + Facility Staff	10	12	6	8	2	3	8	12	16	16	14	13
Field Director + UCS Staff	2	1	1	1	0	1	3	4	6	4	6	6
Field Director and MOH (DSNE)	5	4	3	3	2	0	1	5	6	8	6	4

In addition to these meetings in the field, recently CDS has met frequently with the newly appointed Minister of Health in Port au Prince and her staff. This has allowed progress in reaching agreement on the "Tripartite Agreement" between HOPE, CDS, and the MOH defining the roles of the three organizations. As of this writing it appears as if this document will be signed within the next two weeks.

Project HOPE Central has maintained regular telephone, instant messaging, and vClass contact and meetings with both the Port au Prince (PaP) and the TdN offices of CDS as well as with Drs. Mondestin and Despagne. These telecommunication discussions occur 2-4 times weekly and cover many items, especially important are those discussions regarding solutions to both administrative and technical issues. In addition, the HOPE technical advisor, Dr. Northrup, has made two visits to the project in the past year.

Special tool for monitoring and evaluation: A tool called "Fiche de suivi des familles" (see **Annex 1)** has been prepared and is being tested in order to improve the effectiveness of one of the principal activities of the promoters, namely, the home visit. As designed in the project, it is the responsibility of the Promotor to visit all the families assigned to him every month. Using this new tool, the promoter evaluates the behavior and the knowledge of the family in a number of predetermined areas (indicators) and grades each family by assigning a color for each indicator, depending on whether the behavior or the knowledge is:

- good (green color),
- fair (orange color), or
- bad (red color).

If a family receives 70% or more red areas, the family is placed in the RED category and must be visited more frequently. If between 40% and 70% is red, the family is placed in the ORANGE category and receives less attention, while a score 20% or less red, places the family in the GREEN category, indicating that the family needs only occasional attention. By using this visual tool, the promoter's task of developing a weekly workplan is simplified, and supervision is also simplified as the supervisor can review the red cases and assist the promoter in managing them. Early experience with this tool is quite promising.

Census Activity: During this reporting year, the census for the communes of Vallières, Ste Suzanne, Perches and Caracol was completed. The final results are shown in the accompanying table.

Commune	Houses	0-11 months	12-23 months	24-59 months	5-14 years	Men 15-49	Women 15-49	50 and more	TOTAL
Caracol	1,541	143	177	352	1,500	1,165	1,304	759	5,400
Perches	1,374	200	194	574	2,159	1,904	1,909	1,674	8,614
Ste Suzanne	5,215	639	603	2,096	5,874	5,322	5,197	4,063	23,794
Vallières	4,634	476	523	1,568	5,016	4,377	4,289	2,689	18,938
Trou du Nord	9,100	296	1,179	4,292	8,850	7,508	8,167	5,200	35,492
Terrier Rouge	5,144	176	687	2,289	5,075	4,629	5,035	3,395	21,286
TOTAL	27,008	**1,930**	**3,363**	**11,171**	**28,474**	**24,905**	**25,901**	**17,780**	**113,524**
		2%	**3%**	**10%**	**25%**	**22%**	**23%**	**16%**	**101%**

The experiences gained from the previous census activities have been very useful. Many mistakes have been avoided, and the results obtained at the different steps (mapping, training, numbering, data collecting and counting) were more efficiently accomplished. As a result, project staff have been able to do a better job of planning and implementation of field activities, such as choosing the promoters and locating the exact places for the rally post and fixed points.

Choice of Promotors: Because of the reduction in the global project budget (discussed at length below), it was necessary to reduce the total number of promoters in the four new communes. Only twelve (12) were ultimately selected from a total of fifty. The community and non-chosen promoters received this information like a bucket of cold water; however, after the initial shock subsided, members of the community assisted in choosing the right persons to serve as promoters as shown below.

	Total Sectors	Health Agents (total)	Promotors Selected	Community Providers (total)
Caracol	9	3	1	4
Perches	13	2	2	4
Ste Suzanne	28	2	5	7
Vallières	25	0	4	4

Training Activities: During the year, a number of training activities of various cadres of workers has been conducted, including:

- Training of all the promoters (35) and Health Agents (5) from TdN and TR has been completed.
- Training of the promoters (13) and agents (7) from the other four communes is taking place. It will end in January 2005. In order to accelerate the implementation of the interventions in the field, some changes have been made. For example, now after every training session the promoters and the agents spend one or two weeks in the field to help the new trainees implement the activities they have just learned. This helps avoid the gap between knowledge acquisition and program implementation.
- Training of the auxiliaries and nurses (except for "supervision" and "reproductive health") is 90% completed.

Activities in the field: The specific locations for the rally posts and fixed points have been selected in all six (6) communes. Each of the promoters and health agents are responsible for covering at least two rally posts per week as shown below.

	Total community Providers	# post / week per provider	Total Posts per week	Total Fixed Points (Places)
Caracol	4	2	8	2
Perches	4	2	8	2
Ste Suzanne	7	3	21	6
Vallières	4	3	12	3
Trou du Nord	25	2	48	4
Terrier Rouge	14	2	24	3
	58		**121**	**20**

During a rally post session, promoters and agents, with the assistance of members of the community, accomplish the following tasks:

- Preparation for the fixed point activity (preparation of the materials to be used, timing of revisits to the community, using the usual channels to broadcast the date of fixed point sessions),
- Reception of the visitors (provide health education talks, give information on activities in the community etc.),
- Recording of the patient information (number of pregnant mothers, women, children for vaccination or weighing),
- Weighing of infants and children,
- Individual or collective education,
- Immunization,
- House searches,

- Sharing of information, training of the members of the community, etc., and
- Completion of the activities and cleaning of the rally post site.

Involvement of Facility Staff: After many meetings with the director of DSNE and many talks with the staff of the facilities, the auxiliaries are finally well involved in the project. Moreover, the health agents in the field are now being supervised by all the auxiliaries (paid by the Minister of Health), and they are all organizing and participating in the activities at the fixed points (mainly doing prenatal examinations and other activities, see below).

During the fixed point sessions, the promoters do the same tasks as during rally post sessions. The auxiliaries participate in:

- conducting prenatal consultations,
- supervising the activities of the promoters, and
- visiting some families with problems.

A breakdown of their activities is summarized in the following table.

	# auxiliaries	Supervise activities (%)	Participate at fixed points (%)	Organize meeting with promoters (%)
UCS Trou du Nord				
Trou du Nord	2	90%	100%	70%
Roche Plate	3	20%	10%	20%
UCS Terrier Rouge				
Terrier Rouge	2	100%	100%	100%
Grand Bassin	2	100%	100%	100%
Phaeton	1	70%	70%	100%

I.A. FACTORS CONTRIBUTING TO PROGRESS

1. Good community involvement has been very important. For example**:**

- Meetings held with members of the community have permitted them to understand the importance of the project, and the benefit their community can get from its implementation.
- The community has been involved in almost all the phases of the assessment (census). Organizations and leaders of the community have participated actively in choosing the promoters and the places to organize the rally post and the fixed points.

As a result, the community has been the principal actor in implantation of the various activities, resulting in increased investment and ownership by the community of the project.

1. Ability to draw on experiences in the other half of the North-East Department where CDS is wholly responsible for service delivery using funds from USAID. This experience has provided forms and methods useful in the new western portion.

2. Network of friends the field project director has had in the area, based on his long experience there. This has helped significantly in avoiding destruction or theft during the political upheavals and has allowed the development of alternative ways of approaching a problem when collaboration with DSNE was not proceeding smoothly.

3. The skills and dedication of the CDS team, both at the CDS central office in PaP and in the field office in TdN.

I.B. TABLE: PROGRESS TOWARD ACHIEVING THE OBJECTIVES

The results to date in achieving the project objectives are summarized in the following table, complete with specific comments dealing with each activity. (The data from which this table was compiled is presented in **Annex 2**.)

Child Health - Household Level

Objective # 1: Improved preventive actions to maintain child health

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
80% of children 12-23 months completely immunized;	Good	More than 90% of the objective has been reached in TDN and TR
30% of children 12-23 months with two doses of vitamin A in the past year;	Good	Vitamin A distribution is taking place, but the data are being wrongly collected and therefore wrongly analyzed. So new tools will be put in place in October 2004.
70% of women respondents (mothers) vaccinated with at least TTV2;	Poor	TT2 immunization is taking place regularly in facilities and during rally posts and fixed points and also during campaigns. But the target of the DIP is much higher than the MOH's target (50%). We propose modifying the target to 50%, in accordance with the MOH. Also, it is necessary to maintain BCC interventions.
30% of mothers keep *Sel Lavi* at home to prevent dehydration;	Fair	Mother's clubs have not been initiated. HH monitoring (LQAS) needed to measure the results.
20% of mothers with EBF during the first six months;	Fair	same as item above.
50% of children under two weighed in the four months preceding the survey;	Yes	This activity is regularly taking place. But a wrong interpretation of the indicator had produced a wrong tool to collect the data. So a new tool will be in place this October.
12 communities participating in HEARTH – Petit Foyer.	no	Activity cancelled because of reduction in project budget

Objective # 2: Improved home management of common childhood illnesses

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
60% of mothers used ORT in last diarrhea episode;	Fair	Promoters and auxiliaries are providing education during rally posts, fixed points, facility visits, and home visits, but no concrete data is available to track the success of these activities. HH data collection planned to take place in next three months.
80% of mothers know signs of dehydration and how to prepare ORS correctly;	Fair	
60% of mothers provided the same or more liquids/solids during a disease episode;	Poor	
60% of mothers know to complete prescribed treatment to the child following prescription by a provider;	Fair	
50% of mothers report increased number of meals to a child recovering from illness.	Fair	

Objective # 3: Improved care-seeking practices

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
70% of mothers took child under two with key signs of illness to a trained health provider;	Fair	HH data collection planned to take place in next three months; also VCR to assess provider practices.

60% of mothers can explain when to return to the health facility for follow-up for a sick child.	Fair	

Child Health – Community Level

Objective # 4: Increased community participation in child health and disease prevention activities

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
80% promoters conducting monthly rally posts and track defaulters;	Good	All the promoters are organizing rally post and tracking defaulters (see reports).
80% of communities have functioning CBDs for ORS;	Just started	More than 70 CBD will be functional by November 2004. The promoters and some members of the community will be trained on "management" this month
50% of communities with VHCs;	no	The VHCs and mother's and father's clubs will be put in place during the training of members of the community which will take place from January to September 2005. This way, those VHC will be more prepared to get involved in the health activities like rally post, fixed points and home visit etc.
400 mothers' and fathers' clubs graduated;	no	
30 animatrices promote good BF practices;	no	The recruitment and the training of the animatrices will start in March 2005.
ARI promoters Rx with antibiotics and refer pneumonia cases in pilot (if allowed by MSPP).	no	Although the agents and promoters have been trained to manage ARI, they are not yet allowed to treat sick children with antibiotics. CDS/HOPE is working to convince policy makers to allow this pilot.

Child Health - Health Facility Level

Objective # 5: Improved management of child health and community outreach

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
70% of common child illnesses managed according to case management/IMCI protocol;	Fair	All the auxiliaries of the staff, auxiliaries, nurses and doctors have been trained in IMCI. The Project plans a HFA mini-survey to check the current status of this targeted behavior.
Reported stock-outs of antibiotics for pneumonia and STIs, ORS packets, and antimalarials decrease by 50%;	Good	In spite of many difficulties, few stocks-out have been reported. Alternative mechanisms used to obtain drugs during Gonnaives hurricane difficulties.
80% of clients express satisfaction with services received;	Poor	Verbal Case Review (VCR) or KPC will be carried out in order to measure the results. The major problem is the attitude of the providers.
18 of 27 auxiliaries support rally posts (fixed points) at least bi-monthly;	Good	Until last month auxiliaries paid by the MOH have been reluctant participants. With change in leadership of DSNE last month all the auxiliaries are now involved in the activities.
18 of 27 auxiliaries conduct regular volunteer supervision.	Good	

Child Spacing

Objective # 6: Improved knowledge and practices

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
35% of women who do not desire a pregnancy in the next two years who use a modern contraceptive method or LAM;	Fair	HH data collection planned to take place in next three months.
60% of women can cite 2 or more modern FP methods;	Good	
The % of women whose last two children are spaced at least two years apart increases by 20%.	good	

Objective # 7: Increased community participation

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
30 CBDs providing barrier methods and oral contraceptives.	Just started	More than 70 CBD will be functional by November 2004. The promoters and some members of the community will be trained in "management" Oct 04.
VHC's leading communities in advocating contraceptive acceptance;	No	The VHCs and mother's and father's clubs will be put in place during the training of members of the community which will take place from January to September 2005. This way, those VHC will be more prepared to get involved in the health activities like rally post, fixed points and home visit etc.
Each promoters put in place 2 clubs per year.	No	

Objective # 8: Improved access and quality of services

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
Auxiliairies at 100% of Health facilities trained in counseling and provision of modern contraceptive methods, stock management;	Good	The MOH has organized the training of all the auxiliaries of the department.
Quality of FP services is improved by 50%;	Fair	Mini-HFA will be held in next three months in order to measure the results.
Number of health facilities reporting stock outs for modern contraceptives reduced by half.	Fair	Very few reports of stock-out have been reported; mini-HFA planned.

HIV/AIDS/STIs

Objective # 9: Improved knowledge and practices

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
80% of women and men can name at least two ways to protect themselves from HIV/AIDS/STIs;	Good	HH data collection planned in next three months.
15% of men/women who used a condom in their last sexual intercourse;	Poor	
30% of women and men who can name at least two signs indicative of an STI;	Good	
40% of women and men with symptom of STI seeking treatment;	Good	

Objective # 10: Increased community participation

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
75% of selected community organizations meet regularly and discuss health.	No	This will take place after the training of members of the community which will begin on March 2005.

Objective # 11: Improved access and quality of services

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
70% of STI correctly treated based on syndromic approach and counseled;	Good	Mini-HFA including VCR planned in next 3 months.
80% of ARI treated according to protocols;		
75% of mothers report that when ARI treatment sought, treatment obtained;	Fair	HH data collection planned in next three months to collect measures of these achievements.
80% of mothers feel that during last visit for any problem, they have obtained services at the clinic/rally post;	Fair	
70% of mothers got important information about services at rally post;	Fair	
80% of mothers were able to ask a health provider an important question.	Good	

Pregnancy and delivery management

Objective # 12: Improved knowledge and practices

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
60% mothers cite 3 or more danger signs during pregnancy and 2 or more signs during delivery;	Fair	HH data collection planned in next three months to collect measures of these achievements.
60% mothers receive 3 or more prenatal exams from health professional;	Good	This activity is regularly taking place and the result is good (more than 60%).
50% pregnant women counseled to have VCT.	Fair	The tool to measure this indicator must be put in place in the facility.

Objective # 13: Improved access and quality of services

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
85% of TBAs trained and 75% competent in safe prenatal & delivery techniques and signs of problems requiring referral;	Fair	This is a regular activity held by the MOH since years. But in the commune of Vallieres and Ste Suzanne this activity will start in February.
85% of home deliveries assisted by trained TBAs;	Good	This data is available at the facility and will be collected. The TBA must report every month to the facility how many deliveries she/he assisted.
85% of home deliveries use clean delivery kit;	Good	All trained TBA receive sterile delivery kit. And they have to report how many they have used (see report).
60% of mothers receive vitamin A within 7 days post-natal;	Good	The result is more than 100% -- see statistical table.
75% of births receive domiciliary visit by promoter within 7 days;	Good	See results in the report.
30% of mothers make post-natal institutional visit.	Good	The result is almost 80%.

Capacity Building -- HOPE

Objective # 14: HOPE management and technical expertise strengthened

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
Improved documentation of HOPE methods and experiences;	Fair	Direction of HOPE's MCH division has been filled and then almost immediately emptied again. A newly appointed interim director is taking steps to specifically focus on these issues, and expects to make progress over the next year.
Improved use of Monitoring and Evaluation to identify lessons learned;		
Improved access to methods and lessons learned through an improved bank of methods and experiences with an improved interface with users; and		
Improved active dissemination of lessons learned between HOPE projects and to other organizations through publications.		

Capacity Building -- Local partners CDS & MSPP (Sustainability Objectives)

Objective # 15: Community Level

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
80% of promoters graduate at least two mothers / fathers clubs per year	No	The Clubs and VHC will be put in place during the training of members of the community which will take place from January to September 2005.
VHC's formed and functioning regularly	No	
Volunteer animatrices support new mothers in EBF;	No	The recruitment and training of animatrices will take place in February
Mothers demonstrate appropriate knowledge & practices at target levels	No	HH level data collection planned in next 3 months
50% of the communities have active health committees (VHC)	No	The VHC will be put in place during the training of members of the community which will take place from January to September 2005.
90% of promoters use correct basic health education messages	Good	The promoters have been providing health education at rally posts and home

		visits, as well as community gatherings.

Objective # 16: Health Facility Level

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
80% of trained auxiliaries follow IMCI, FP, and STI management protocols;	Fair	All the auxiliaries have been trained in FP, STI (by DSNE) and IMCI (by Project HOPE).
85% of auxiliaries engaged in regular community outreach, supervision, and rally support activities;	Fair	Except for the auxiliaries of Roche Plate, all the auxiliaries (80%) are involved in the supervision of promoters and participating in the realization of rally posts.
70% of auxiliaries use data to identify performance problem, coverage levels, and to manage and plan their own and promoter services and activities.	Fair	The auxiliaries are being coached to use data to identify performance problem, coverage levels, and to manage and plan their own and promoter services and activities.

Objective # 17: UCS and Departmental MSPP

Outcome indicators and Targets	**PROGRESS**	**COMMENTS**
Supervision carried out regularly by UCS nurses/supervisors using modern methods;	Fair	The staff of the UCS regularly (once every week) supervise the Facilities. But they have not been trained yet in "Modern Supervision". This training will take place at the beginning of November 2004.
Regularly monthly auxiliary management at UCS review reports, identify problems, plan responses, check results;	Fair	The nurses of the UCS organize bi-monthly meeting with all the auxiliaries review reports, identify problems, plan responses, check results.
Regularly departmental level management meetings review reports, identify problems, plan responses, check results;	Poor (30%)	Major difficulties in collaborating with DSNE. Efforts will be continued to get the DSNE to organize a regular meeting.
DSNE manages quarterly Project advisory Council meetings;	Poor	
DSNE uses data to plan for and provide regular supply of vaccines, drugs, and essentials supplies;	Poor (40%)	The project regularly (once a week) supervises the Facilities to verify any stockout. But it's not evident that the DSNE plans on the basis of the data collected. Efforts are continuing to correct this problem.
DSNE & UCS Staff use routine reported data and KPC and qualitative data to identify problems & adjust/reprioritize health activities;	Poor	But it's not evident that the DSNE plan on the basis of the data collected. Efforts will be made to correct this problem.
DSNE increases recovery of costs and use for DSNE facility development by 200%.	Poor	The project has avoided interfering with these funds, given the difficulties in collaboration with DSNE. This may not be feasible to effect in current circumstances.

II. TABLE: FACTORS IMPEDING PROGRESS AND ACTIONS TAKEN TO COUNTER THEM

In the following table, listed are the factors that have impeded progress toward achievement of the project objectives and the actions taken (or being taken) by the program staff to overcome them.

Factors impeding Progress	Actions
A/ <u>Political Situation in Haiti</u>: The political situation in Haiti has been and continues to be a serious problem in the implementation of the activities in the field. From January to March 2004, there were road blockades in Gonaives and Trou du Nord. So the activities were almost paralyzed during three months. As a consequence of that situation:	
• Fuel shortage in the North for more than two months (February and March).	A small quantity was bought at high prices on black market and consumption of fuel for generator and vehicles was drastically reduced.
• One vehicle of the Project has been seized by rebels for more than one week.	Long negotiations took place in order to recover the vehicle.
• Restriction to use vehicles because of the fears to have other vehicles seized.	Two motorcycles have been loaned to the project in order to continue cautiously the activity.
• Stock out of medicine and materials, propane gas and vaccines.	Doctors without Borders (MSH) and PROMESS used airfreight in order to send boxes of material, vaccines and medicines to the Health Center. Gas for refrigerators was brought in Dominican Republic.
B/ <u>Low involvement of DSNE and Health Facility Staff</u>: For various reasons, the employees paid by the MOH were very reluctant to participate actively in realizing the activities. This attitude has been interpreted as if there were two different projects. Consequences:	
• Impossible to get the data of the activities made by the institution.	Many meetings have been organized with the Director of DSNE and also the staff of the DSNE, the UCS and the Health Centers in order to: • Explain to them the objectives of the project. • Hand them copies of the budget. • Explain to them the benefits to the department, the community, the center and themselves from having this project.
• Duplication of the activities on the field.	
• Promoters were not supervised (in Roche plate).	
• Very low collaboration of DSNE Staff.	
• Director of DSNE was not too enthusiastic to take decision to correct those problems. The Director was more interested in the reinforcement of the Department by acquisition of vehicles and materials from the project instead of solving the problems and planning together the interventions needed in order to get results.	
C/ <u>Weather situation</u>: It's almost unbelievable. During a large portion of the period, the weather has played a key role as a constraint for the activities. It has rained almost 150 days from October 2003 to September 2004. Rivers have swollen. Roads are in horrible condition, making travel nearly impossible. And, to make things worse, a violent hurricane hit Gonaives. Consequences:	
• Stock out of medicines, propane gas for refrigerators.	Negotiations with PROMESS in order to send medicine by plane. Gas is brought in by PROMESS.

Factors impeding Progress	Actions
• Fuel shortage in the North (since October 18th until now).	Fuel is brought at high cost in black market.
• Reduction of the vehicle trips.	Use of motorcycles.
• Slowing down of the field activities.	Realization of the principal activity. Mainly the rally post.
D/ <u>Administrative procedures at CDS Central very slow</u>. For example, the purchase and the supplying of some essential materials and equipment takes a long time (sometimes even months) to get to the field. The provision of funds to carry out field activities has been slow. Consequences:	Continuous and regular interventions of the Field Director to correct this situation.
• Difficulty to start some activities in some places (for example, the fixed points, the community meetings etc…).	
• Reduced performance.	
• Loss in credibility to partners and to the community.	
E/ Difficulty for Project HOPE to raise adequate funds to meet the required 50% match. The consequences of the shrinking budget are:	
• Bad perception of Project HOPE by the community and the MSPP staff at different level.	Many meetings have been, or will be held, by BRGNNE in order to explain to MSPP Staff and members of the community the mechanism to raise funds. This situation has been used by CDS to push the promoters and the community to be more involved and give better performance and results.
• Frustration at community level.	Lessons have been learned. This situation can be use to force the community to get better organized in order to participate actively even in searching funds.
• Frustration at facility level, mainly the facilities which have been expecting this project to bring changes.	In some of the facilities like Ste Suzanne and Vallieres, meetings with the staff have been held. They agreed to continue to use the "promotors" as voluntary collaborators while they are organizing themselves to look for funds in order to give better services.
• Frustration from some employees of the TdN office who have not received what has been promised to them.	Decision will be taken in order to adjust their salaries.
• Loss of credibility.	Having meetings with organizations and leaders in the community to help them understand the situation, and get their help in finding solutions.

III. TABLE: STRATEGIES AND ACTIVITIES TO IMPROVE PERFORMANCE

INDICATORS	DECISIONS / ACTIVITIES
80% Children 0-23 months completely immunized	Use a catching up strategy after rally posts to get children who did not present for imm.
	Prepare after post the list of the children who didn't present to the rally post
	Track those children. Implement home visits
80% Children 0-23 months weighed in the last four months	Prepare and put in place a new tools in order to closely follow the children 0-23 months
	Reinforce the education and awareness of the mothers on the importance of weighing the children
	Reinforcement of home visits in order to track those children (12-23 months)
30% Children 12-23 months receiving Vit A last year	Prepare and put in place a new tools in order to closely follow the children 0-23 months
	Reinforce the education and awareness of the mothers on the importance of giving Vit A to their children and to come to rally post
	Reinforcement of home visits in order to track those children (12-23 months)
70% women from 15-49 years vaccinated with TTV2	Immunization campaign in High School
	Reinforcement of BCC
70% Pregnant women vaccinated with TTV2	Reinforcement of the activities and mobilization to invite the pregnant women to come to the Fixed Points
Three pre natal visits (60% of pregnant women)	Regular meeting conducted by the auxiliaries with TBA who usually are well informed about what women are pregnant in the community
	Prepare list of pregnant women in the Zone and Sector
	Home visit by the promotors of all pregnant women who didn't present to Fixed points
80% assisted deliveries	Regular meeting conducted by the auxiliaries with TBA to receive report on deliveries
	Promotors to participate at those meetings
30% post natal home visited	Prepare list of pregnant women in the Zone and Sector
	Health education during community meetings
	Reinforcement of supervision
	Reinforcement of home visits by promoters
60% women in Post natal receive Vit A	Have an emergency stock in TDN office to prevent any stock out
	Prepare list of pregnant women in the Zone and Sector
	Health education during community meetings
	Reinforcement of supervision
	Reinforcement of domiciliary visits
30% mothers keep sel Lavi at home	Sign a contract of social marketing with PSI in order to have ORS
	Open 110 CBD in all the sectors
	Reinforce the sensibilisation in the community

IV. TECHNICAL ASSISTANCE

Project HOPE is continually providing assistance in the technical aspects of the project, via email, vClass discussion, and provision of various materials (training packages, job aids, etc). In addition, during the past year Dr. Northrup carried out a mini-course in LQAS for the CDS team. The project does not anticipate additional international technical assistance needs at present.

V. PROGRAM CHANGES FROM THOSE IN THE DETAILED IMPLEMENTATION PLAN (DIP)

Although mentioned earlier in the report, this section will describe more fully the circumstances which have led Project HOPE to request changes in: (1) the type of match to be provided to the project, and (2) the ultimate functional cash project budget and related activities.

In the second quarter of this project year, Project HOPE was forced to face squarely the fact that it had not been able to realize the level of donations to this project, and to Haiti in general, that would enable them to fulfill their commitment to an equal cash match of USD$1.3 million with that of USAID. Instead, HOPE management was only able to commit to a cash match of $700,000 with an gift in-kind (GIK) match of a minimum of $600,000. (It is anticipated that it will, in fact, be possible to exceed that amount of GIK donations.) On the basis of this recognition, Dr. Northrup began to work with Drs. Despagne and Mondestin to develop a revised project activity and staff plan and budget within these limits. During a visit in late April 2004, Dr. Northrup assisted these two colleagues in developing a revised budget, which appeared to cut some $350,000 from the existing budget, based on some changes in staffing for the new communes. More detailed analysis by the CDS team, however, revealed that additional trimming was needed, but the hurricane damage in Haiti interfered with further progress on defining how these additional reductions could be made.

At this point, it appears to be impossible to eliminate $600,000 from the overall budget without some combination of: (1) shortening the duration of the project, and/or (2) reducing the scope of project coverage and activities. As an example, during preparation of this Third Annual Report, it became clear that a reasonable option would be to limit the target area for community level activities to the two initial communes, TdD and TR, where substantial progress already has been realized. Activities in the four additional communes would be limited to support of initiatives already undertaken with the auxiliaries and health facilities. With this approach, tentative estimates of expenditures indicate that it probably would be possible to continue activities in the two communes until the end of March 2006. (Calculations at HOPE Center are under way to complete analysis of expenditures overall to date in order to confirm whether this will be possible.)

The alternative to this refocusing of activities would be to continue community level activities in the full original target area and population, that is, in all six communes. This would require a substantial increase in the monthly "burn rate" and thus lead to further shortening of the duration of the project. Unfortunately, the cost calculations regarding the various options could not be completed prior to submission of the Third Annual Report. (The costs of project evaluations also need to be included in these calculations.)

In summary, Project HOPE has already informed USAID of these issues and the need for projected changes both verbally and more recently in writing. Once the cost calculations are completed, Project HOPE will submit to USAID a formal request for changes, based on the above, with a revised overall project plan and workplan as well as a revised budget.

VI. RESPONSES TO DIP RECOMMENDATIONS AND REQUESTS

We noted in last year's Annual Report that the requests at the time of the DIP review were largely confined to requests for additional information. This information was largely provided in the final version of the DIP ultimately submitted, as well as in the KPC analyses reported in last year's Annual Report. The remaining request was for the three parties involved in implementing this project to reach an agreement on how they would work together. The results are reported in the management section which follows and also are listed in the table in **Section I.B. Progress Toward Achieving The Objectives**.

VII. PROGRAM MANAGEMENT

As detailed in the Second Annual report, the project has had to deal with two management structures, the Project HOPE management structure in Millwood, Virginia and the CDS management structure in PaP and TdN.

Financial Management: CDS is a well-running organization with long experience in financial reporting according to USAID guidelines, and their accounts have been complete and accurate. In addition, their financial unit is preparing for annual audit by USAID, but the audit will be late this year. (Expectation is that the audit will be completed by Nov 15, 2004.) Some delays in receiving accounting reports from CDS have led to corresponding delays in Project HOPE providing funds to CDS, which in turn has at times led to lack of funds in the field to carry out training or other activities involving extra expenditures. CDS has usually been able to advance their own funds from cash reserves to handle these situations. At times, however, this has delayed some field activities slightly. The current recognition of inability by Project HOPE to meet its full match commitment has led to difficulties in projecting future activities and expenses. For example, the recent provision by the government to raise the pay of government employees some 35% has raised expectations within project staff that they should receive a similar increases in salary. How to deal with this situation will be addressed in the overall budget reduction planning. We anticipate, however, that those employees remaining on staff will receive an increase of salary, but less than the government increase. Not unexpectedly, these increased expenses coupled with corresponding difficulties in determining the level of funding needed to support CDS activities in the field, has lead to disappointments among community and health system partners. In addition, and as mentioned above (Section V), Project HOPE is preparing its analysis of expenditures since the beginning of the project and prior to formal submission to USAID of a request for a budget and match modification that would include a reduction in the cash match to approximately $700,000 from the original $1.3 million. The projected GIK match of more than $600,000 already has been shipped and was received in October in PaP where it is now waiting clearance by Haitian customs.

Human Resources Management: The project has followed CDS standard human resource policies and procedures in hiring staff and setting salaries. Project HOPE was requested by the

USAID mission in Haiti to have some of the project staff on direct HOPE salaries, and for them to report to HOPE in addition to their reporting to the field project director and CDS. For expediency, all field staff were hired initially by CDS, and have been reporting through customary CDS reporting channels. The Field Project Director, formally a CDS employee, communicates and reports directly to the Senior Technical Advisor and Regional Management Team at HOPE Center, as well as to CDS management. With the long delay in reaching agreement on the Tripartite Accord (HOPE, MSPP, and CDS), these employees have continued to be paid by CDS up to the present. Under the circumstances, we plan to continue their positions as CDS salaried positions for the remainder of the project. We have already noted in the previous section on Financial Management the recent increase in MSPP salaries and the expected response of CDS with regard to project employees.

Technical Management: The HOPE Senior Technical Advisor, Dr Northrup, communicates regularly with Dr. Joanel Mondestin in the field and Dr. Pierre Despagne in PaP regarding technical matters, including making on site visits to Haiti as noted earlier in this report. We anticipate this close technical relationship to continue, shifting to new issues as the project moves into the demands of reaching its operational and strategic targets. To accomplish this will require ongoing information regarding performance success from the LQAS assessment combined with the routine reporting as previously noted. Because of the difficult field conditions during the past nine months, the field director has been unable to provide technical reports every six weeks as presented in last year's annual report. We are hopeful this will improve with resolution of the environmental problems as well as conclusion of a clear plan for the next phase of the project. One reason for the delays in reporting has been the difficulty in obtaining readable reports regarding the regular activities occurring at the facilities and promoters documentation of such indicators as children weighed, immunizations completed, etc. CDS has responded to this difficulty by adapting methods used in their health service activities in the western part of the Department, changing the forms and guidelines for reporting such that the reports will now directly respond to the project's specific indicator definitions and thereby facilitate processing and completion of project reports. This will also allow more active management of project performance to better ensure achievement of project targets.

Partner Relationships: This report has already emphasized the challenges of CDS and HOPE dealing with MOH and DSNE. The formal agreement among the three partners – the Tripartite Accord – has been held up by the DSNE director, who hopes that it would be possible to convince CDS and HOPE to increase goods and materials donations to DSNE. With his absence from the country on scholarship, it seems likely that MSPP central will sign the agreement within weeks of this writing. (The CDS CEO, Dr. Despagne, has succeeded in increasing his contacts with the central MSPP leadership, which has facilitated impending agreement on activities as well as signing of the formal Accord.)

On an operational basis, auxiliaries, who had been reluctant to collaborate with the CDS field team in carrying out planned supervision of promoters and implementation of fixed point sessions in the community, have now become willing to collaborate. We are hopeful that this will result in more rapid progress toward achieving project operational (process) targets.

Finally, the inability of HOPE to fulfill its financial commitment to the project has led to a lack of credibility regarding HOPE, which has affected also the credibility of CDS in the field. The field team plans efforts to build consensus with facility and community partners and

beneficiaries in response to this disappointment aimed at recognition of the improvements that will remain possible under the more limited budget of the project.

Capacity Assessment and Response: We have already mentioned the SDMA (Service Delivery and Management Assessment) carried out by CDS on the facilities and management in the project area. As noted, the project is working to respond to the recommendations and specific actions requested in the report of that activity, both as part of the training and service support activities associated with delivery of services to the target population, and as additional nonintegrated actions. A mini-health facility assessment is scheduled for the next three-month period to assess what progress has been made.

Because of non-cooperation from DSNE, it has been impossible to carry out the SDMA planned for the DSNE office activities themselves. This non-cooperation has made it unlikely that it will be possible for the project to bring about significant improvements in the capacity and activities of that office in terms of its overall management of the activities. We will continue to attempt to support and develop that office and its staff, but are not sanguine about the likelihood of significant change, nor how it would be measured because we have no baseline assessment upon which to judge any improvements that take place.

VIII. WORKPLAN

The project workplan for the next year is provided as **Annex 3.** It should be noted that this workplan does **NOT** take into account the changes in activities resulting from the anticipated decrease in overall funding coupled with a possible reduction of activities in the four additional communes. A revised workplan will be provided to USAID when agreement has been reached on the details of budget and projected activities for that new plan. We anticipate this will happen within the next month.

IX. HIGHLIGHTS

We believe that the innovative, home visit assessment tool using colors to target families needing increased promotor attention will be appropriate for a highlight in the future, but are awaiting the results of field-testing and full implementation before proposing this as a project highlight.

X. OTHER RELEVANT PROGRAM ASPECTS

We have no additional program aspects to cover at this point.

Annex 1

PROJET MSPP / HOPE / CDS

Feuille de Suivi des Familles

Nom Famille ..... Promoteur (Agent) .....

Commune ..... Section ..... Habitation .....Zone ..... Secteur .....

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PROJET MSPP / HOPE / CDS

Suivi des familles

Signification des couleurs

		ANNEE_____											
PRO GRAMME	**INDICATEUR**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Fev**	**Ma**	**Av**	**Mai**	**Ju**	**Jui**	**Aou**
Planification Familiale	**Femme en âge de procréer** et avec plus de trois (3) enfants **utilise une méthode de Planing**												
	Femme nourrice utilise une méthode PF												
	Femme qui de NE desirent pas être enceinte utilise une méthode PF												
	Femme peut **citer au moins deux (2) methodes PF**												
	Femme ayant des enfants avec espace de temps de moins de deux ans **utilise une méthode PF**												
Tuberculose	Personne avec des **signes et symptômes de Tuberculose** suit un **traitement**												
	Patient anterieurement **sous traitement et N'a PAS abandonné**												
Pre natale	Mère peut citer au moins **trois (3) signes de danger durant la grossesse**												
	Mère peut citer au moins **deux (2) signes de danger pendant l'accouchement**												
	Femme enceinte a reçu au moins deux **(2) doses de Toxoide Tetanic (TT)**												
	Femme enceinte de plus de 6 mois a reçu trois **(3) consultations prénatales** d'une personne formée												
	Femme enceinte a sa **carte de vaccination**												
	Mère a un **kit pour accouchement** préparé **à la maison**												
Post natale	Accouchée ne présente des signes d'infection (douleur, fièvre, odeur)												
	Accouchée n'a pas d'hémorragie												
	Mère s'est presenté au Centre avec enfant nouveau né												
	Nouveau né ne présente des signes de maladie												
	Accouchement a été fait par une personne formée (matrone, promoteur, auxiliaire, infirmière, etc…)												
Vaccination	**Enfant** de 12-23 mois est **complètement vacciné**												
	Enfant de moins d'un (1) an a sa **carte de vaccination**												
	Enfant de moins d'un (1) an a été **déjà vacciné**												
	Femme en âge de procréer a reçu au moins **deux (2) doses de TT**												
	Femme enceinte a reçu au moins **deux (2) doses de Toxoide Tetanic (TT)**												
Surveillance Nutrition Pesée	Enfant de moins de 24 mois a été **pesé depuis les quatre (4) derniers mois**												
	Enfant a un **poid normal**												
	Enfant de 6 a 9 mois recoit le **lait maternel + d'autres aliments**												

Recherche de Traitement en cas de maladie	**Parents peuvent citer** au moins **deux signes de danger** indicant que l'enfant nécessite un traitement												
	Parents amènent l'enfant malade, de moins de deux ans, au dispensaire ou au **Centre de santé**												
	Parent peut expliquer quand il doit retourner pour **rendez-vous au centre** avec l'enfant malade												
Controle des maladies Diarrhéiques	Parents d'enfants de 0 a 23 mois ont du **Serum oral (SRO) à la maison**												
	Parents d'enfants de 0 a 23 mois savent comment **préparer le Serum Oral (SRO**)												
	Enfant de 0 a 23 mois qui a eu la **Diarrhee** il y a quinze jours a été **réhydraté avec du serum oral**												
	Parents peuvent **citer au moins deux (2) signes de deshydratation**												
Soins à l'enfant malade	**Parents avec enfant** de 0 a 23 mois **malade augmentent la quantité de liquide et de solides**												
	Parents avec enfant de 0 a 23 mois **malade continue de nourrir normalement l'enfant**												
	Parents avec enfant de 0 a 23 mois **en** convalescence augmentent le nombre de repas												
	Parents d'enfant malade **savent** comment exécuter **(suivre**) les indications et **Traitement**												
IST / VIH / SIDA	Hommes et femmes peuvent citer au moins **deux (2) façons** de **se protéger contre les IST/VIH/SIDA**												
	Hommes et femmes utilisent le **condom** au cours de leur **dernier rapport sexuel**												
	Hommes et femmes peuvent citer au moins **2 signes** indiquant qu'une personne a un **IST ou du SIDA**												
	Hommes et femmes vont au Dispensaire ou au Centre pour **se faire traiter d'un IST**												
	Résident de la maison ayant des **signes et symptômes du VIH va** pas au centre **pour counselling**												
	Résident de la maison sous **traitement IST/VIH/SIDA** et qui a **N**'a **PAS abandonné**												
	Hommes ou Femmes **connaissent** au moins **deux (2) méthodes** de prévention **contre les STI/VIH**												
	Femmes enceintes **acceptent de faire un test VIH**												
	Femmes savent **où aller** pour faire un **test VIH**												
Allaitement maternel	**Mère alimente son enfant de moins de 6 mois exclusivement au sein**												
	Mère alimente son enfant au sein immediatement après naissance												
Vit A	**Enfants** agés de 12 a 23 mois **ont recu de Vit A** l'année dernière												
	Mère accouchée prend de la Vit A												
Hygiene	**Parents lavent les mains sales des enfants** de moins de deux (2) ans												
	Parents se lavent les mains après toilette, avant de donner à manger aux enfants et après les avoir nettoyé. Protège les aliments contres les mouches												

	TOTAL POINTS												

<u>Assignation des couleurs :</u>
Pour les réponses négatives on met une marque (ou un point) en rouge :
Pour les réponses positives on met une marque (ou un point) en vert

Pour 35 Rouge : le résultat est Rouge
De 34 à 10 rouge : le résultat est Orange (ou Bleu)
Moins de 10 rouge : le résultat est Vert

Annex 2

MONITORING ACTIVITIES
JANUARY-SEPTEMBER 2004

Annex 2

PROJET MSPP/HOPE/CDS
MONITORING ACTIVITIES JANUARY - SEPTEMBER 2004

COMMUNE : Trou du Nord
UCS : Trou du Nord

Outcome Indicators & Targts	C_V	VARIABLES	Population	DIP Target	Target/ Month	Target/ Jan-Sept	Realization	Reached %
80% Children 0-23 months completely immunized :	1	0-23 Completely immunized	2,484	1,987	165	1,485	1,407	94.75
50% of children 0-23 months weighted in the four months	2	Children 0-23 months weighted	2,484	1,242	104	932	317	34.03
30% Children 0-23 months receiving Vit A. last year	3	Children 0-23 months receiving VIT A.	2,484	745	62	559	171	30.60
70% of women (mothers) vaccinated with TTV2	11	Women (15-49 years) vaccinated with TTV2	8,234	5,764	480	4,323	1,228	28.41
70% of pregnant women vaccinated with TTV2	12	Pregnant Women vaccinated with TTV2	994	696	58	522	425	81.44
Three Ante-natale Visits (60% of pregnant women	13	Three Antenatale Visits	994	696	58	522	330	63.24
85% Assisted deliveries	14	Assisted Deliveries	994	696	58	522	790	151.38
30% Post natal home visit	15	Post Natal Home Visit	994	696	58	522	623	119.38
60% Women in Post-partum receiving Vit A.	16	Women in post-partum with Vit. A	994	696	58	522	643	123.22
30% Mothers keeping Sel la vi at home	17	Sel lavi (SRO) distribueted by promotors					780	
Familial Planning		Condoms distributed					40,285	
		Pills distributed					215	
		DMPA distributed					977	
		Tablets Vaginals distributed					57	
		Clients in condoms					461	
		Clients in DPMA					256	
		Clients in vaginals Tablets					35	
		Mothers (women) Clients EBF					72	
Formation Community	26	Total Certified TBAs					60	
	27	Total Mothers educated on Immunization					1,117	
	29	Total Women/Mothers educated on HIV/AIDS and ISTs					1,128	
	30	Total Men/Fathers educated on HIV/AIDS and ISTs					594	
	31	Total Mothers educated on family planning					1,172	
	32	Total Mothers educated on Vit. A					458	
	33	Total Mothers educated on utilization of SRO (Sel Lavi)					804	
ACTIVITES COMMUNAUTAIRES	82	Total Home Visits by promotors and auxiliairies					15,942	
	83	Total meeting Community					550	
	86	Total of supervisions done by auxiliaries					79	
	87	Total of supervisions received by promotors					169	
	88	Total of rally post					438	
	89	Total Rally post assisted by auxiliairies					60	
	92	Total new clubs of mothers					7	
	93	Total Mothers educated in the club					1,656	
	94	Total of new Clubs of fathers					4	
	95	Total fathers educated in the Club					276	
Desserved Population	I	Population Desservie	35,492					
	II	Enfants 0-23 mois (POP_DESSx0,07)	2,484					
	III	Pesées attendues (POP_DESSx0,07)	2,484					
	IV	Femmes Enceintes attendues (POP_DESSx0,028)	994					
	V	Accouchments attendus (POP_DESSx0,028)	994					
	VI	Femmes 15 -49 ans (POP_DESSx0,232)	8,234					

PROJET MSPP/HOPE/CDS
MONITORING ACTIVITIES JANUARY - SEPTEMBER 2004

COMMUNE : Terrier Rouge
UCS : Terrier Rouge

Outcome Indicators & Targts	C_V	VARIABLES	Population	DIP Target	Target/ Month	Target/ Jan-Sept	Realization	Reached %
80% Children 0-23 months completely immunized :	1	0-23 Completely immunized	1,665	1,332	111	999	658	65.87
50% of children 0-23 months weighted in the four months	2	Children 0-23 months weighted	1,665	833	69	624	237	37.96
30% Children 0-23 months receiving Vit A. last year	3	Children 0-23 months receiving VIT A.	1,665	500	42	375	81	21.62
70% of women (mothers) vaccinated with TTV2	11	Women (15-49 years) vaccinated with TTV2	5,517	3,862	322	2,896	508	17.54
70% of pregnant women vaccinated with TTV2	12	Pregnant Women vaccinated with TTV2	666	466	39	350	186	53.20
Three Ante-natale Visits (60% of pregnant women	13	Three Antenatale Visits	666	466	39	350	415	118.69
85% Assisted deliveries	14	Assisted Deliveries	666	466	39	350	303	86.66
30% Post natal home visit	15	Post natal Home visit	666	466	39	350	286	81.80
60% Women in Post-partum receiving Vit A.	16	Women in post-partum with Vit. A	666	466	39	350	381	108.97
30% Mothers keeping Sel la vi at home	17	Sel lavi (SRO) distributed by promotors					364	
Familial Planning		Condoms distributed					23,103	
		Pills distributed					554	
		DMPA distributed					1,198	
		Tablets Vaginals distributed					20	
		Clients in condoms					231	
		Clients in DPMA					359	
		Clients in vaginals Tablets					2	
		Mothers (women) Clients EBF					63	
Formation Community	26	Total Certified TBAs					46	
	27	Total Mothers educated on Immunization					1,686	
	29	Total Women/Mothers educated on HIV/AIDS and ISTs					2,257	
	30	Total Men/Fathers educated on HIV/AIDS and ISTs					1,180	
	31	Total Mothers educated on family planning					2,797	
	32	Total Mothers educated on Vit. A					1,067	
	33	Total Mothers educated on utilization of SRO (Sel Lavi)					1,053	
ACTIVITES COMMUNAUTAIRES	82	Total Home Visits by promotors and auxiliairies					5,764	
	83	Total meeting Community					149	
	86	Total of supervisions done by auxiliaries					573	
	87	Total of supervisions received by promotors					1,232	
	88	Total of rally post					184	
	89	Total Rally post assisted by auxiliairies					147	
	92	Total new clubs of mothers					10	
	93	Total Mothers educated in the club					132	
	94	Total of new Clubs of fathers					0	
	95	Total fathers educated in the Club					0	
Desserved Population	I	Population Desservie	23,781					
	II	Enfants 0-23 mois (POP_DESSx0,07)	1,665					
	III	Pesées attendues (POP_DESSx0,07)	1,665					
	IV	Femmes Enceintes attendues (POP_DESSx0,028)	666					
	V	Accouchments attendus (POP_DESSx0,028)	666					
	VI	Femmes 15 -49 ans (POP_DESSx0,232)	5,517					

Annex 3

PROJET MSPP/HOPE/CDS

WORKPLAN
October 2004 to September 2005

1.- TRAINING (Promotor, personnel and Staff)

ACTIVITY	RESPONSIBLE	TIME FRAME											
		O	N	D	J	F	M	A	M	J	J	A	S
1.1- 20 promotors and AS (Group 2 from St Suzanne, Vallieres, Caracol, Perches)													
Community approach and mobilization / CCC	Nurses	X											
Immunization	Nurses	X											
Nutrition	Nurses	X											
Breastfeeding	Nurses		X										
Maternal health	Nurses		X										
Diarrhea , ARI, // TB	Nurses		X										
Family planning	Nurses			X									
STI/HIV/AIDS	Nurses			X									
Community based HIS	BRG				X								
1.2- Auxiliaries and nurses													
26 auxiliaries and nurses in supervision	Nurses					X							
26 aux and nurses in Reproductive health and Norms	Nurses		X										
1.3- DSNE, UCS AND Facility staff													
Supervision	Nurses				X								
Capacity building	Nurses					X							
Management / M&E / community HIS	Nurses					X							

2.- TRAINING (Community organizations and leaders divided in 2 groups)

ACTIVITIES	RESPONSIBLE	O	N	D	J	F	M	A	M	J	J	A	S
2.1- Community Organizations and leaders													
Preparation of curricula on: STI, Nutrition and Child Weighting, Sick Children management, Immunization, TB, Breastfeeding, Pre and Post natal cares	Nurses and BRG		X	X									
Training	Aux., Promotor					X	X	X	X				
Implementation / Implication / Supervision	Aux. , Promotor							X	X	X	X	X	X
2.2- Mother and Father's club / COSAM /and VHC													
Preparation of training curricula	UCS / BRGNNE		X										
Training + implementation	Aux, Nurse						X	X	X				
Supervision (Visit and meeting)	Aux							X	X	X	X	X	X
2.3- 30 Animatrices in Breastfeeding	Nurses												
Recruit animatrice and training	Promotors, aux,			X	X								
Implementation and supervision	Aux					X	X	X	X	X	X	X	X
2.4- Traditional Birth Attendant (TBA) in Terrier Rouge, Vallieres, Ste Suzanne, Caracol, Perches)													
Training	Auxiliaries			X	X	X	X	X	X	X	X	X	
Supervision	Promo						X	X	X	X	X	X	X
2.5- Community Base Distribution													
Adaptation of CBD curriculum	Aux, Nurse	X											
Choice of place	Promotors	X											
Training/supply/resupply/and supervision	Aux		X	X	X	X	X	X	X	X	X	X	X

3.- FIELD ACTIVITIES (Community)

ACTIVITIES	RESPONSIBLE	O	N	D	J	F	M	A	M	J	J	A	S
3.1- Mother and Father's Club / COSAM and VHC													
Organize and conduct fixed point and rally post	community								X	X	X	X	X
Realize domiciliary visit	community								X	X	X	X	X
Participate actively and regularly in health meeting	community								X	X	X	X	X
Demonstration knowledge & practices at target level	community								X	X	X	X	X
3.2- Organization and traditional leaders													
Realize domiciliary visit	Community				X	X	X	X	X	X	X	X	X
Participate actively and regularly in health meeting	Community				X	X	X	X	X	X	X	X	X
Demonstrate knowledge & practice at target level	Community				X	X	X	X	X	X	X	X	X
3.3- Animatrices in breastfeeding													
Demonstrate knowledge in education and supporting mothers in breast feeding	community						X	X	X	X	X	X	X
Participate at fixed point, rally post and meetings	community						X	X	X	X	X	X	X
Realized domiciliary visit	community						X	X	X	X	X	X	X
3.4- Traditional Birth Attendant (TBA)													
Make safe birth delivery	community	X	X	X	X	X	X	X	X	X	X	X	X
Demonstrate knowledge in PF, BF, STI/HIV/AIDS	community	X	X	X	X	X	X	X	X	X	X	X	X
Be present at continuous training session at the facility	community	X	X	X	X	X	X	X	X	X	X	X	X
3.5- Community Base Distribution													
Supply and resupply the CBD	Promotors, aux		X	X	X	X	X	X	X	X	X	X	X
Promote products ORS, planning method	CBD		X	X	X	X	X	X	X	X	X	X	X

4.- FIELD ACTIVITIES (Promotors)

ACTIVITIES	RESPONSIBLE	O	N	D	J	F	M	A	M	J	J	A	S
4.1- Realize and conduct rally post and Fixed points with members, clubs, COSAM and leaders	Promotors	X	X	X	X	X	X	X	X	X	X	X	X
4.2- Realized home visit (post natal, visit sick persons, track defaulters, …)	Promotors	X	X	X	X	X	X	X	X	X	X	X	X
4.3- Organize and participate at community meeting (for training purposes, educational activities, communicate news and information)	Promotors	X	X	X	X	X	X	X	X	X	X	X	X
4.4- Organize and facilitate ongoing training sessions for community members and organizations	Promotors	X	X	X	X	X	X	X	X	X	X	X	X
4.5- Collect data and write report	Promotors	X	X	X	X	X	X	X	X	X	X	X	X
4.6- Participate at regular (weekly) sessions at the facility	Promotors	X	X	X	X	X	X	X	X	X	X	X	X
4.7- Supervise and facilitate the activities of the VHC	Promotors	X	X	X	X	X	X	X	X	X	X	X	X
4.8- Supervise CBD activities	Promotors	X	X	X	X	X	X	X	X	X	X	X	X

5.- FIELD ACTIVITIES (Auxiliary)

ACTIVITIES	RESPONSIBLE	O	N	D	J	F	M	A	M	J	J	A	S
5.1- Participate at the fixed points activities, gives services: pre natal cares, collective and individual education, FP examinations, Rx	Auxiliary	X	X	X	X	X	X	X	X	X	X	X	X
5.2- Supervise promotors		X	X	X	X	X	X	X	X	X	X	X	X
5.3- Realize selective domiciliary visit		X	X	X	X	X	X	X	X	X	X	X	X
5.4- Organize and participate at training session		X	X	X	X	X	X	X	X	X	X	X	X
5.5- Supply and resupply fixed points with drugs and supplies		X	X	X	X	X	X	X	X	X	X	X	X
5.6- Collect data and write reports		X	X	X	X	X	X	X	X	X	X	X	X
5.7- Give feed back to the promoters and the community		X	X	X	X	X	X	X	X	X	X	X	X

6.- FIELD ACTIVITIES (Facility and UCS)

ACTIVITIES	RESPONSIBLE	O	N	D	J	F	M	A	M	J	J	A	S
6.1- Supervise the activities at fixed points and rally posts		X	X	X	X	X	X	X	X	X	X	X	X
6.2- Organize and participate at training sessions		X	X	X	X	X	X	X	X	X	X	X	X
6.3- Supply auxiliaries and facilities with drugs and supplies for fixed points and rally posts		X	X	X	X	X	X	X	X	X	X	X	X
6.4- Give feed back to auxiliaries and the community		X	X	X	X	X	X	X	X	X	X	X	X
6.5- Organize and Participate at regular meetings with staff of facility, the auxiliaries and nurses		X	X	X	X	X	X	X	X	X	X	X	X
6.6- Participate at regular meeting held by CDS local staff and the DSNE		X	X	X	X	X	X	X	X	X	X	X	X

7.- MANAGEMENT AND CAPACITY ASSESSMENT (DSNE and UCS)

ACTIVITIES	RESPONSIBLE	O	N	D	J	F	M	A	M	J	J	A	S
7.1- Develop interview form	CDS (DTS)												
7.2- Review interview form	CDS (DTS)												
7.3- Test interview form	CDS (DTS)												
7.4- Interview DSNE, UCS Staff staff	CDS (DTS)												
7.5- Analyze the assessment	CDS (DTS)												
7.6- Write report	CDS (DTS)												
7.7- Meeting with DSNE and UCS to discuss result and plan action	CDS (DTS)												

8.- MANAGEMENT AND CAPACITY ASSESSEMENT (CDS Central)

ACTIVITIES	RESPONSIBLE	O	N	D	J	F	M	A	M	J	J	A	S
8.1- Develop interview form	CDS (DTS)												
8.2- Review interview form	CDS (DTS)												
8.3- Test interview form	CDS (DTS)												
8.4- Interview CDS staff	CDS (DTS)												
8.5- Analyze the assessment	CDS (DTS)												
8.6- Write report	CDS (DTS)												
8.7- Meeting with CDS to discuss result and plan action	CDS (DTS)												

9.- MONITORING & EVALUATION

ACTIVITIES	RESPONSIBLE	O	N	D	J	F	M	A	M	J	J	A	S
9.1- Preparing the necessary tools	CDS and UCS Staff	X	X										
9.2- Collecting data		X	X	X	X	X	X	X	X	X	X	X	X
9.3- Analyze data		X	X	X	X	X	X	X	X	X	X	X	X
9.4.- Write report		X	X	X	X	X	X	X	X	X	X	X	X
9.5- Prepare wall chart (for each program)		X	X	X	X	X	X	X	X	X	X	X	X
9.6- Feedback (facility, commu nity)		X	X	X	X	X	X	X	X	X	X	X	X
9.7- Redefine plan and strategies		X	X	X	X	X	X	X	X	X	X	X	X
9.8- Collect and analyze HH data			X	X	X								
9.9- Conduct HFA mini-survey, and analyze results			X	X	X		X	X	X				

10.- SUPERVISION

ACTIVITIES	RESPONSIBLE	O	N	D	J	F	M	A	M	J	J	A	S
10.1- Develop/test supervision checklist & problem solving method	CDS (DTS)												
10.2- Train CDS staff in use, training, mo nitoring by CDS staff	CDS (DTS)												
10.3- Train UCS, DSNE staff	CDS (DTS)												
10.4- Conduct supervision/problem solving with mentoring by CDS staff	CDS field Staff, USC and DSNE												
10.5- Promotors conduct facilitation, supervision, problem, solving with mentoring	CDS field Staff and Auxiliaries												
10.6- Promotors conduct independent facilitation, supervision, problem solving,	CDS field Staff and Auxiliaries												

11.- MANAGEMENT

ACTIVITIES	RESPONSIBLE	O	N	D	J	F	M	A	M	J	J	A	S
11.1- Weekly telephone/v class review CDS/HOPE													
11.2- Quarterly in depth HIS/ monitoring data & progress review													
11.3- Quarterly written Activity and progress report													
11.4- Weekly meeting field team & DSNE managers													
11.5- Monthly HIS/monitoring data review by CDS,UCS,DSNE													
11.6- Monthly financial report to CDS, Hope													
11.7- Preparation For Mid term Review													
11.8- Mid term review													