

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

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Fourth Annual Report

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ACRONYMS

ARI	Acute Respiratory Infection
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
IMCI	Integrated Management of Childhood Illness
LQAS	Lot Quality Assurance Sampling
MOH	Ministry of Health
MSP	Ministry of Public Health and Population
NGO	Non-Governmental Organization
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PSI	Population Science International
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
UCS	Community Health Units
VCR	Verbal Case Review
VHC	Village Health Committee

A. Main Accomplishments in 2004-2005

Haiti is a country that is continuously challenged by political problems and natural disasters, and this year (October 2004 – September 2005) was no different. Civil uprisings and severe weather conditions in Northeast Department hampered project progress. Although the most severe political unrest was focused in Port-au-Prince those problems forced CDS, the local implementing partner, to close their office and for a time the Director and his family relocated to Miami while the threats of violence and kidnapping subsided. During the period of unrest, a project vehicle, computer and other valuables were vandalized or stolen. Although the situation in the Northeast Department was calmer, there was still sufficient unease to make evening activities impossible.

Weather-wise, the Northeast Department suffered long periods of heavy rain, substantially in excess of previous years. This produced days during which communication by satellite between Project HOPE and the field offices was impossible, and movement in the communities by vehicle was similarly hindered as roadways were blocked.

Despite these obstacles, substantial progress was made toward meeting the objectives as presented in the Project Progress tables below. This report focuses on three particular areas of success as follows:

- 1) Improving access to medicines and health products by training Community-Based Distributors (CBD).
- 2) Improving behavior change promotion by training local community organizations.
- 3) Using the Red Dot/Green Dot Approach to help health promoters focus their energy and use their resources more effectively

1. Training Community-Based Distributors (CBD)

In order to increase access to basic medicines in communities that are typically quite distant from a health facility, the project trained 60 community-based distributors (CBDs). These CBDs, who are primarily small business owners, underwent a two-day training regarding the use of various basic medicines and health products and learned some basic counseling skills. The products are purchased from Population Services International (PSI – a social marketing group) and include contraceptives pills, condoms, water treatment pills (PUR), oral re-hydration salts (ORS), acetaminophen, bed nets, albendazole and iron tablets. This initiative is very much appreciated by the local population. (See the Highlight page for more details).

2. Capacity Building of Local Community Organizations

Strengthening the ability of local community organizations to promote healthier child care practices among mothers and child care givers is one way to improve child health. Therefore, in an effort to increase the capacity of local community organizations to promote better health practices among mothers of young children, the project first took an inventory of the community organizations in the three target communes Trou du Nord, Terrier Rouge and Caracol. Certain members of the community groups were then chosen for training as trainers. A curriculum was developed in accordance with the educational/experience levels of the participants and Promoters, Health Agents, Auxiliary Agents were trained as trainers. Thus far about 2000 people

have been trained (see training table below) and it is expected that an additional 400 people will complete the training by the end of December 2005. The training curriculum covers the following topics.

- Management of common children illness (mainly ARI)
- Management of Diarrhea
- Hygiene
- Malaria
- Tuberculosis
- Pre and postnatal cares
- Family Planning
- STI/HIV/AIDS
- Nutrition
- Breastfeeding

Numbers of persons trained:

	Auxiliaries And Hygienist nurses	Total sessions for Group I	participants in each group	Group I (total members)	Session for Group II	Participant In each group	Members of group II trained by First group
Trou du Nord	2	5	20	100	50	10	500
Roche Plate	3	3	20	60	30	10	300
Terrier Rouge	3	4	20	80	40	10	400
Grand Bassin	2	4	20	80	40	10	400
Phaeton	1	1	20	20	10	10	100
Paulette	0	1	20	20	10	10	100
Caracol	1	1	20	20	10	10	100
Jacquezil	1	1	20	20	10	10	100
Totals	13	20	160	400	200	80	2000

3. The Monitoring Red and Green Dots Tool

One of the challenges of any behavior change effort is to focus attention on those people who most need to receive the key message. This focus might be due to non-compliance or because the child or mother is at higher risk than others. To address this issue and help project health promoters to use their energy and scarce resources effectively, an innovative approach was developed called the “Red Dot/Green Dot Tool.

Based on the objectives presented in the detailed implementation plan, a questionnaire was developed which identifies the knowledge and behavior changes expected. The promoters were then instructed, as stated in their regular activities, to visit all of the houses in their area in order to assess each care givers child care knowledge and practices. Depending on the answer the promoter put a green point (if positive) and red (if negative).

If 10% of the responses to the questions are negative (red), the family is considered to be “red” This designation means that the family has been flagged and will be visited more often in order to correct the problem or promote the desired behavior change until it changes from red to green.

In some cases a family is considered “red” even if all the other points are green. Those cases include:

- A family with malnourished children
- Persons living with AIDS and not receiving treatment

- Persons living with TB and not receiving treatment
- Children lacking immunizations or not fully immunized
- A family with more than three children and not using a family planning method

The monitoring and evaluation of these activities has shown that most of the families have knowledge, but the behavior has not yet been adopted.

This Red Dot/Green Dot Approach is very useful and successful in helping promoters identify the families with whom they need to spend more time. It permits to the Health Agent to know within a very few months the health status of the families under his or her charge. After the first visit has been completed the Health Agent can focus on the houses flagged for follow-up.

Project Progress – October 2004-September 2005

Child Health - Household Level			
<i>Objective #1: Improved preventive actions to maintain child health</i>			
<i>Major Activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> • Training of 40 promoters and 10 health agents (in adult ed. methodologies, facilitation of mother's & father's groups, CS interventions, weighing, counseling) to conduct rally posts, implement mothers'/fathers' clubs; • recruit and educate mothers and fathers in health curriculum; • MSPP support and supply rally posts; • development of supervision checklists for promoters; • supervision of promoters. 	yes yes yes yes	100% 80% 100% 100%	Fully accomplished in November 2005
<i>Objective # 2: Improved home management of common childhood illnesses</i>			
<i>Major Activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> • Training of 48 promoters and 30 auxiliaries; • implementation of mothers' and fathers' clubs. 	Yes Yes	100% yes	Fully accomplished in January 2005 Fully accomplish in Oct 2005
<i>Objective # 3: Improved care-seeking practices</i>			
<i>Major Activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> • Training of promoters; • mothers' and fathers' clubs. 	Yes yes	100% 80%	Fully accomplished in Oct 2005
Child Health – Community Level			
<i>Objective # 4: Increased community participation in child health and disease prevention activities</i>			
<i>Major Activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> • Training and supervision of promoters (rally post, clubs); • provision of supplies, vaccines, equipment for rally posts. 	Yes	80% 100%	Lack of supervision in Roche Plate

Child Health - Health Facility Level			
Objective # 5: Improved management of child health and community outreach			
<i>Major Activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> Health facilities and organizations assessed, plans for capacity development made; All auxiliaries trained in technical interventions, community outreach, and adult education; Exit interviews and VCRs conducted regularly and feedback given to providers on timely basis. 		Yes Yes No	With loss of manpower on project team, it was not possible to accomplish this task.
Child Spacing			
Objective # 6: Improved Knowledge and Practice			
<i>Major activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> 20 auxiliaries, 30 CBDs, and 40 promoters trained; implementation of mothers' and fathers' clubs. 	Yes Yes	100% 80%	Fully accomplished in November 2005
Objective # 7: Increased community participation			
<i>Major activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> Adaptation of CBD curriculum; training and supervision of CBDs; 	Yes	100%	
Objective # 8: Improved access and quality of services			
<i>Major activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> Training and supervision of auxiliaries; work with MSPP on assuring contraceptive supply. 	Yes Yes	100% 80%	Frequent stock outs continue due to problems at national level; project cannot intervene at national level.
HIV / AIDS / STI			
Objectives # 9: Improved knowledge and practices			
<i>Major Activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> Training of 20 auxiliaries and 40 promoters; implementation of mothers' and fathers' clubs; training of CBDs. 	Yes Yes Yes	100% 80% 100%	Fully accomplished in November 2005
Objective # 10: Increased community participation			
<i>Major Activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> Identification and training of 20 VHC every year; Identification and training of Mothers and fathers club. 	Yes Yes	80% 80%	Fully accomplished in November 2005 Filly accomplished in November 2005
Objective # 11: Improved access and quality of services :			
<i>Major Activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> Training and supervision of auxiliaries; provision of drugs for dispensaries and rally post. 	Yes Yes	1000% 80%	Frequent Stock out of Iron and Vit A

Pregnancy and delivery management			
Objective # 12: Improved knowledge and practices			
<i>Major Activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> • Auxiliary & promoter training in IEC methods; • mother's clubs courses; • VHC & community mobilization; 	Yes Yes Yes	100% 80% 80%	Will be fully accomplished in November 2005. Will be fully accomplished in November 2005.
Objective # 13: Improved access and quality of services			
<i>Major Activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> • Community TBA inventory; • TBA training; • supervision & support of promoters; • mother's clubs; • VHC activities. 	Yes Yes Yes Yes Yes	100% 100%	
Capacity Building – HOPE			
Objective # 14: HOPE management and technical expertise strengthened			
<i>Major Activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> • Conduct assessment; • define objectives; • develop, implement, and monitor capacity-strengthening plan; • Evaluate capacity at project end. 			
Capacity Building – Local partners CDS & MSPP (Sustainability Objectives)			
Objective # 15: Community Level			
<i>Major Activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> • Regular performance feedback provided to promoters and volunteers; • Auxiliaries engage in supportive supervision practices. 	Yes Yes	100% 70%	In one facility (Roche Plate) the auxiliaries refuse to be involved in supervision.
Objective # 16: Health Facility Level			
<i>Major Activities</i>	In Progress	Achieved	Comments
<ul style="list-style-type: none"> • Regular performance feedback to auxiliaries, supportive supervision, also by departmental levels MSPP staff. 	Yes	50%	The auxiliaries in some Facility don't give the feed back to the community.
Objective # 17: Departmental MSPP			
<i>Major Activities</i>	In Progress	Achieved	Comments

B. Factors Impeding Progress

Constraints & Obstacles	Propositions/Solutions	Results
<p>The vehicles were not always available when needed. Sometimes they were broken.</p>	<p>Trips postponed until vehicles could be repaired.</p>	<p>Some activities could not be done on time.</p>
<p>The personnel paid by the Minister at some facilities refuse to support project activities.</p> <p>a) In Trou du Nord, except the auxiliary paid by the project, all the others are not involved. Even the hygienist nurse who is in charge of the community activities in the Hospital has openly refused to collaborate because the project does not pay the per diem of this person.</p> <p>b) A Roche Plate, the nurse in charge and also the auxiliaries have never supervised the community activities, leaving the responsibility to a health agent, because the project does not pay the per diem of this person.</p> <p>c) In Grand Bassin, the health agents paid by the Ministry have systematically refused to use the data tools put in place by the project and to write their monthly report using the forms prepared for this because the project does not provide a “tip” to these people.</p>	<p>On many occasions , verbally by letter and in monthly reports the DSNE and even the general director of the Ministry has been informed and their back-up have been solicited in order to solve the problems.</p> <p>The budget has been revised and “tip” was introduced for the supervisor with the obligation by them to present a report of supervision .</p>	<p>No formal intervention has been made in order to correct the situation and make it clear to the personnel that this is a Ministry activity and Project HOPE is only providing assistance to the Ministry.</p> <p>The auxiliaries and the health agents insisted on receiving the amount without having to give a report.</p>
<p>The health personnel in Roche Plate (nurse and auxiliaries) don’t reside in the community as stipulated in their contract. They only work from 10:00 am to 1:00 PM. The pretext: they don’t have a house where to stay.</p> <p>(Note: During the afternoon and during the night the population has no trained personnel available. In case of emergency, they have to walk 2 to 3 hour to go to the nearest facility.)</p>	<p>The DSNE has been informed and it was suggested to:</p> <p>a) rent a house for the personnel</p> <p>b) replace them</p>	<p>a) The personnel refused all the housing options proposed to them.</p> <p>b) The DSNE has NEVER intervened to take the final decision.</p>
<p>Limited collaboration of the hygienist nurses (paid by the project) working in the UCS.</p> <p>Finally, after having applied some pressure (even salary reduction) the project obtained agreement from them to give a monthly report and schedule of supervision.</p>	<p>The hygienist nurses of the UCS have been instructed to come to the Coordination office at least once a week to discuss their schedule of supervision and to plan activities.</p>	<p>Recently (at the end of July 2005) they are showing more willingness to collaborate and have been supervising.</p>
<p>The Director of the UCS of Terrier Rouge is ALWAYS absent.</p>	<p>The DSNE is well aware of this problem.</p>	<p>Nothing has been done to solve the problem.</p>
<p>The social and political environment in Haiti, with accompanying violence, has had a very negative influence. Although the situation in the Northeast Department was better (quieter) the situation in P-a-P has affected the activities in the field:</p> <p>a) Regular meetings were not held in P-a-P between the director of BRGNNE, CDS Central and the Minister</p> <p>b)The CDS truck used in the NE for the transportation of medicine and health materials was high jacked and stolen by armed bandits.</p>	<p>The project slowed the pace of implementation and activities when necessary. Trips in remaining vehicles had to include multiple objectives, at less efficiency.</p>	<p>Project progress continued but less rapidly than projected.</p>

C. Technical Assistance Needed

An external evaluator will be hired to lead the final evaluation of the project in February 2006. Aside from this no additional technical assistance needs are anticipated.

D. Changes in Program from Revised Plan

The overall project plan was revised substantially at the end of calendar year 2004, and those changes were submitted in last year's annual report. The changes included a reduction in the number of districts and population to be covered, and an elimination of the objectives of enhancing the capacity of the departmental health office, due to lack of collaboration by that office. During this past project year, implementation of the revised plans has proceeded as planned, with the obstacles noted in section B above, which impeded efficiency and timely completion of certain tasks and activities. We have no further changes to propose at this time.

E. Sustainability Issues and Actions

This project was planned to be a pilot model of partnership between different entities, the PVO (Project HOPE), the local partner (CDS), and the Ministry of Health in the Northeast Department of Haiti. The project was designed to demonstrate the best way of providing health services in communities. It was focused to improve the MSPP operational structure and functional capacity in providing those services. Activities were planned and implemented to increase the knowledge of the various target audiences (existing organizations, community leaders, mothers and families) and improve their capacity to thrive in the face of adverse health conditions.

Unfortunately, as noted in the Obstacles section above, the Ministry of Health (MSPP/DSNE) and the sub-regional management structure (the UCS) did not participate in the project as planned which prevented them from learning as much as they could have, especially about community level health promotion. Hence no significant improvement in community level service delivery by the Ministry is anticipated.

What remains are activities at the community level. Not dependent on the capability of the Ministry of Health, village structures are intrinsically self-sustaining when they are in existence prior to project activities, and are utilized as such for health activities. The project has trained such community groups to be sources of information regarding the treatment of sick children, preventive child health activities, management of pregnancy, and breast-feeding, as well as prevention of sexually transmitted infections and HIV/AIDS. The project has also trained the owners of small shops or kiosks with some items needed in the home to stock and sell essential health products like ORT, Pills, Condoms, Chloroquine, etc. We feel that both these community groups and these community-based distribution sources can sustain the knowledge and some of the practices being promoted by the project, in particular providing household care to children with diarrhea, cough, and fever.

The final months of the project will continue to support these community activities, provide additional training as needed, develop re-supply mechanisms for the CBD outlets, and in other ways, seek to consolidate these potentially sustainable structures and activities.

It should also be noted that the activities of this project have provided useful input to CDS regarding these interventions and approaches. CDS is continuing its activities in these areas with support from the bilateral MSH project. As these interventions have become part of the CDS available tools, we anticipate that CDS will continue to apply these approaches in their future projects, as well as in their current ongoing MSH project. By engaging some specific agencies such as PSI in this CBD initiative, we have also created a potential sustainable set of collaborative activities.

Finally, while it may be that the interaction between CDS and MSPP/DSNE has not been ideal, it may well be that ideas and perhaps practices have been conveyed to the nurse supervisors at UCS level, to auxiliaries at the health facility level, and to health agents who will continue to provide services and to bridge the connection between health facilities and the community through health rally posts.

F. Phase Out Expectations

The project plans a three-month phase-out process, with detailed discussions planned to begin in December 2005. It is expected that some promoters will be laid off beginning in January 2006 while others will continue to participate in the collection of data for the KPC and facility assessments. An external evaluator will conduct the final evaluation in February 2006. The project will terminate on March 31, 2006.

As previously planned, CDS, the partner organization, will continue supporting community level activities, as well as some facility-based activities, including activities at the dispensaries and fixed points. Rally posts will continue to take place in the community. While the ratio of promoters to homes will be reduced after the project is terminated, there will continue to be a group of Health Agents, approximately 25% of the total group of community level promoters and agents, who will continue to be employed by the MSPP. A plan will be developed to lay out the approach of how this support will continue, identifying fixed points and rally posts led by Health Agents supported by auxiliary health care personnel.

It is expected that CDS, working on a different contract supported by USAID funds from a bilateral project, along with recent new funding from the Global Fund, will be able to continue to support the child survival activities in the Northeast Department initiated by this project. CDS is already carrying out TB control activities in the Western communes of the Department. It is likely that the child health and TB activities will eventually become integrated. Discussions and planning for these activities are underway currently.

The project has purchased vehicles, a large generator, and other substantial equipment. Distribution of these properties will be negotiated with CDS, the Ministry of Health, and other potential users.

G. Family Planning Support Issues – NOT APPLICABLE

H. Program Management

Financial Management: Project HOPE and CDS use standardized accounting and auditing structures to manage this project financially. The main responsibilities belong to Project HOPE as the lead agency on the USAID Award with CDS as the central implementer of the expenses of the program activities. Through monthly accounting reporting, Project HOPE assures all expenditure are valid and relevant to the project activities and are realized according to the stipulations of the USAID Award.

Funds are obligated from USAID to Project HOPE to CDS. CDS receives funding by way of wired funds to a CDS account located in the United States. Once CDS accounting central service is aware of a wire transfer, a check is prepared in order to transfer this amount from the HOPE/CDS central U.S. accounts to a Haitian bank where the funds are transferred into local currency. Funding after a wire transfer is generally available within 15 working days of receipt.

Local currency is transferred to one account in the same bank and is available to pay for project transactions. Most of these amounts are transferred to the Northeast Departmental regional office account where field activities are implemented. When expenses occur at the regional level the different documents are transferred to the central accounting service to be analyzed. After analysis, the internal audit service approves the different documents in order to be sure that every expense is correctly supported before sending the financial reports to the Project HOPE office.

If there are questions regarding a financial transaction, it is referred immediately to the field office with recommendations regarding actions to be taken in order to explain or correct the transaction with corrected documentation sent back to all parties.

CDS reports to Project HOPE on a quarterly basis as well on every detail of transactions. These reports of transactions are combined with Project HOPE HQ reports and posted to the Project HOPE financial management system. Balances, burn rate, and other aspects are analyzed by the assistant regional Director as well as the accountant assigned to this project. If any questions arise, they are passed back to CDS for further information or correction as needed.

No particular financial management issues have arisen during this project year, other than occasional delays in movement of reports and funds from one office to the other. CDS engages in an annual external financial audit which further ensures the validity of its financial reporting process.

Human Resources: Since the beginning, one field Director has been hired to manage the project. He reports directly to the CDS Executive Director. This individual is in charge of managing the project in all operational aspects, including the human resources component. Other staff members include:

- 1 Physician with public health experience in charge of technical aspects of the project
- 1 Administrator
- 1 Secretary/Accountant
- 1 Statistician
- 2 Drivers
- 2 Security Guards

1 Housekeeper

These personnel report to the Field Director who reports directly to Project HOPE's Senior Technical Advisor and Regional Director for Africa.

Other staff members include:

- 2 Hygienist Nurses (one in each UCS)
- 3 Auxiliary Health Care Personnel
- 36 Promoters

These employees are based at the facility level. They were supposed to be supervised by the UCS Director but as noted above in the section on obstacles, this has not been done. For different reasons, mostly financial, the personnel at the UCS level have not truly become involved in this project. The regional office was in a position of managing all the personnel involved in this project. This has resulted in somewhat lower productivity of the project and has reduced the ability of the project to enhance the capacity of the departmental health office counterpart staff, the UCS staff, and the auxiliaries, all of whom work for the Ministry of Health.

Communication System and Team Development: The field team working in the Northeast Department interacts directly with both the central CDS office in Port-au-Prince and with Project HOPE in Millwood, Virginia. Interaction between the field office and CDS headquarters refers mostly to very specific items, including financial, administrative and technical elements related to the project. CDS headquarters has available technical staff members who have provided consultation to the field activities and have conducted surveys and training activities. Communication with these specialists has been important for the quality of the field activities.

The Project HOPE Technical Advisor is in regular e-mail, telephone, and electronic conference meetings with the field office Director regarding all aspects of the implementation of the project. Weekly or biweekly reviews of project progress and problems take place with joint decision making regarding solutions. The Technical Advisor provides ongoing input of new information, updated policies and technical details, and organizational news to the field office.

The project initially intended to have regular communication with the departmental health office, including monthly project management meetings, review of data and results of project activities, and joint planning. Due to difficulties in working with this office, these communications have not been active, and there is no interaction between the project and the departmental health office.

At the same time, the project works actively and closely with the subdistricts management structure and facilities, as well as field level health agents and auxiliaries. As reported in the previous section, there have been difficulties in this relationship, but currently communication and interaction appears to be productive. As the project has been drawing to a close, staff are resigning as they seek other opportunities. This has interfered with effective communication at this level due to lack of personnel in the project office. Efforts to fill these empty positions have been active and intense, but new staff has not always been able to be secured rapidly. At present the project lacks a senior medical staff member, who was the major figure in leading field level support and supervision of the promoters in their interaction with the auxiliaries. We are actively

recruiting for a replacement as of this writing, so that the final five months of the project can continue to work toward achieving project objectives

Local partner relationships: Project HOPE as the lead PVO on this project has provided many useful technical inputs to the project but has also presented difficulties to CDS in other aspects of project implementation.

In the technical area, Project HOPE activities and collaboration has been very concrete and contributory since the beginning of the collaboration with CDS. The Project HOPE technical advisor provided technical assistance at various points during project planning and implementation, helping CDS respond effectively to the new project demands. This strong technical support has continued throughout the project. CDS staff has benefited from new and different tools used in the project and new to CDS, including the preparation of the DIP and its practical format guiding monitoring of project activities and for presenting project information effectively for management and implementation. The LQAS as an operational assessment mechanism, with the potential for rapid and relatively inexpensive assessment of the effectiveness of field staff, in particular the promoters; the use of folders with colored dots for identification of families needing additional attention and for management of the family prioritization process; and other such technical innovations and procedures. During meetings between CDS staff and the Project HOPE technical advisor CDS had the opportunity to analyze what could be done in a realistic way so that they could reel realize their full potential.

As far as the financial aspect is concerned, it has been difficult at times to receive timely financial reporting and reimbursement for project activities.

Regarding administration, the interaction between Project HOPE and CDS has been useful in providing CDS field staff with some rules and standards very specific to Project HOPE. Some aspects of which CDS were able to elevate their own internal operations include policy and procedures, particularly with regard to procedures related to inventory process and coding, which has allowed CDS staff to identify project items accurately and prevent problems related to eventual distribution of product.

In contrast, an administrative problem is the different administrative decisions taken during this project life. The most catastrophic one refers to that of reducing the geographic coverage of the project due to Project HOPE's inability to raise the needed level of matching funds. This decision put CDS in a problematic position with the Ministry of Health, even to have the tripartite sub-agreement signed because the revised project did not include all what is said in the document.

PVO coordination/collaboration in country: This project takes place in the western part of the Northeast Department. It provides a base for a very strong collaboration and coordination with other organizations. Different meetings have been held with other PVOs, specifically Caritas and Plan/Haiti in order to consider the possibility of creating a very strong consortium in this department.

Financial and Management Audits: To date only one financial audit has been completed during the project. Until now the first draft has not been provided by KPMG firm which carried it out. It should be available shortly.

I. Mission Collaboration

This project was initiated at time in Haiti when USAID did not give any funds directly to the Ministry of Health. As a result this project represented a way for USAID to provide support to the Ministry of Health and to promote child health in the Northeast Department. When the original partnering arrangement collapsed, Project HOPE worked very closely with the USAID mission to identify an alternative partner, CDS, and to work out the details of the relationship between Project HOPE and CDS.

During the first part of the project CDS met with the relevant Mission staff in order to establish the way the project had to be run. The Project agreed not to use project's funds to increase MSPP personnel salary, because USAID did not want this project to conflict with the mission policy. The Mission was pleased that the HOPE/CDS partnership was working out, and in subsequent intermittent meetings the Mission has strongly supported the project's continuation despite a variety of problems.

According to the Tripartite agreement among the three parties (PH, CDS, MOH), Project HOPE has the leadership in terms of communicating information to USAID. So data related to field activities has been transferred directly to Project HOPE, and Project HOPE has made them available to USAID as appropriate, through reports and verbal conversations at global level.

J. Timeline for 1 October 2005 – 31 March 2006 (End of Project)

October 2005 to March 2006

1. TRAINING

ACTIVITIES	RESP.	O	N	D	J	F	M
1.1.- Community Organizations and leaders							
Training of members of the community organizations on STI/HIV/AIDS Nutrition and Child Weighting, Sick Children management, Immunization, TB, Breastfeeding, Pre and Post natal cares, Malaria	Nurses and auxiliaries	X	X				
Supervision	Aux, Prom	X	X				
1.2.- Mother and Father's club / COSAM /and VHC in place			X	X	X	X	
1.3.- Continuous training of the promoter and health agents from Caracol and Jacquezil		X	X	X			
1.4.- CBD Training in Caracol and Jacquezil		X					
1.5.- Duplication of the training to the members of the community organizations	Members		X	X			

2.- FIELD ACTIVITIES (Promoters)

ACTIVITIES	RESP.	O	N	D	J	F	M
2.1.- Conduct rally post and Fixed points with members, clubs, COSAM and leaders	Promoters	X	X	X			
2.2.- Conduct home visit (post natal, visit sick persons, track defaulters, ...)	Promoters	X	X	X			
2.3.- Organize and participate in community meeting (for training purposes, educational activities, communicate news and information)	Promoters	X	X	X			
2.4.- Organize and facilitate ongoing training sessions for community members and organizations	Promoters	X	X	X			
2.5.- Collect data and write report	Promoters	X	X	X			
2.6.- Participate at regular (weekly) sessions at the facility	Promoters	X	X	X			
2.7.- Supervise and facilitate the activities of the VHC	Promoters	X	X	X			
2.8.- Supervise CBD activities	Promoters	X	X	X			
2.9.- Participate in KPC and Facility surveys					X	X	

3.- FIELD ACTIVITIES (Auxiliary)

ACTIVITIES	RESP.	O	N	D	J	F	M
3.1.- 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
3.2.- Supervise promoters		X	X	X	X	X	X
3.3.- Realize selective domiciliary visit		X	X	X	X	X	X
3.4.- Organize and participate at training session		X	X	X			
3.5.- Supply and re-supply fixed points with drugs and supplies		X	X	X	X	X	X
3.6.- Collect data and write reports		X	X	X	X	X	X
3.7.- Give feed back to the promoters and the community		X	X	X	X	X	X

4.- FIELD ACTIVITIES (Facility and UCS)

ACTIVITIES	RESP.	O	N	D	J	F	M
4.1.- Supervise the activities at fixed points and rally posts		X	X	X	X		
4.2.- Organize and participate at training sessions		X	X	X	X		
4.3.- Supply auxiliaries and facilities with drugs and supplies for fixed points and rally posts		X	X	X	X		
4.4.- Give feed back to auxiliaries and the community		X	X	X	X		
4.5.- Organize and Participate at regular meetings with staff of facility, the auxiliaries and nurses		X	X	X	X		
4.6.- Participate at regular meeting held by CDS local staff and the DSNE							

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

ACTIVITIES	RESP	O	N	D	J	F	M
5.1.- Develop interview form	CDS (DTS)						
5.2.- Review interview form	CDS (DTS)						
5.3.- Test interview form	CDS (DTS)						
5.4.- Interview DSNE, UCS Staff staff	CDS (DTS)						
5.5.- Analyze the assessment	CDS (DTS)						
5.6.- Write report	CDS (DTS)						
5.7.- Meeting with DSNE and UCS to discuss result and plan action	CDS (DTS)						

6.- MANAGEMENT AND CAPACITY ASSESSMENT (CDS)

ACTIVITIES	RESP.	O	N	D	J	F	M
6.1.- Develop interview form	CDS (DTS)						
6.2.- Review interview form	CDS (DTS)						
6.3.- Test interview form	CDS (DTS)						
6.4.- Interview CDS staff	CDS (DTS)						
6.5.- Analyze the assessment	CDS (DTS)						
6.6.- Write report	CDS (DTS)						
6.7.- Meeting with CDS to discuss result and plan action	CDS (DTS)						

7.- MONITORING & EVALUATION

ACTIVITIES	RESP	O	N	D	J	F	M
7.1.- Collecting data		X	X	X	X		
7.2.- Analyze data		X	X	X	X		
7.3.- Write report		X	X	X	X	X	X
7.4.- Prepare wall chart (for each program)		X	X	X			
7.5.- Feedback (facility, community)		X	X	X			X
7.6.- Redefine plan and strategies		X	X	X			

8. SUPERVISION & MANAGEMENT

ACTIVITIES	RESP	O	N	D	J	F	M
8.1.- Weekly telephone/v class review CDS/HOPE		X	X	X	X	X	X
8.2.- Quarterly in depth HIS/ monitoring data & progress review		X	X	X	X	X	X
8.3.- Quarterly written Activity and progress report		X	X	X	X	X	X
8.4.- Weekly meeting field team & DSNE managers		X	X	X	X	X	X
8.5.- Monthly financial report to CDS, Hope		X	X	X	X	X	X
8.6 - Evaluation of each promotor		X	X	X			
8.7.- Preparation of KPC and Facility survey for Final Evaluation				X	X		
8.8.- Implementation of surveys, analysis of data, preparation of report					X	X	X
8.9.- External final evaluation						X	
8.10- Project closeout, preparation of final reports, transition to CDS mgt only						X	X

K. Highlights

Increasing Accessibility to Essential Health Products and Medicines

At the beginning of the 1990's, some national and international NGOs based in Haiti introduced 'ORS sales posts' (les postes de vente de Serum oral) in the communities. The ORS Sales Posts offered community members an opportunity to buy ORS at a very low price prevent dehydration caused by diarrhea. For multiple reasons this initiative was not successful. While no formal study was conducted to explain the failure many factors can be considered:

- The population of the communities was not well informed about the utility and the advantages of the ORS,
- The population didn't participate in the choice of the places to establish the centers and the sellers who would be in charge,
- Only one product was available (ORS), while the population had needs for other products,
- The persons in charge were not trained regarding how to manage the business.

This project took these factors into consideration and initiated another community-based distribution approach which has the following characteristics.

- CBD sites carefully chosen with the participation of the community members. The Community-Based Distributors (CBD) have been placed mainly in remote areas, most of them far from any facility and also with large population.
- Community involvement in the choice of the seller-agents (CBD). Those persons chosen are very stable, with the basic literacy, and most of them have already a small business in the community.
- The project established a list of products and trained the CBDs on the uses of the products. Those products include: ORS, condoms for men and women, oral and injectable contraceptives (Pilplan,) ovules, water treatment pills, chloroquine and acetaminophen, iron and albendazole;
- Discussed the CBDs with the members of the community, including an agreement reached in order to have the product sold at almost the same price as in the towns.
- No subsidies were provided to the CBDs, so all the products were delivered at the same price as the supplier (PSI). They are sold at a price which permits to the sellers to have a profit of 15%.

Aware that one of the most important activities to put in place in order to obtain an important level of sustainability, is to make sure that the community is well trained and/or regularly informed, the project has planned to train (or to inform) the head of all the community organizations on ten (10) topics: FP, Diarrhea (and ORS), Water treatment, TB, STI/HIV/AIDS, Malaria, Hygiene, Maternal and children cares, prenatal and postnatal cares. Those persons will have to duplicate the training to the member of THEIR organizations.

Those CBD's (60 in total) are very important for the population of the area covered by the project. Three communes are concerned: Trou du Nord, Terrier Rouge and Caracol. A population

of approximately 60,000 people (with 15% of children from 0 to 5 years and 25% women from 15 to 49 years) is benefiting from this activity.

MAIN BENEFICIARIES	Trou du Nord	Terrier Rouge	Caracol	TOTAL
Population total	35,492	21,286	5,400	62,178
Children from 0 to 5 years	4,766 (13.5%)	2,605 (12.4%)	672 (12.4%)	8,043 (15%)
Women from 15 to 49 years	8,521 (24%)	5,395 (25.3%)	1,304 (24.2%)	15,220 (24.5%)

With the new availability of the CBDs the population living far from the Health Facility has the possibility to buy the basic medicines at a reasonable price for current sickness or for preventive care.