

USAID/Haiti Maternal and Child Health and Family Planning Portfolio Review and Assessment

August 2008



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Printed September 2008



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This report was made possible through support provided by the US Agency for International Development, under the terms of the Leadership, Management and Sustainability (LMS) Program, Cooperative Agreement Number GPO-A-00-05-00024-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the US Agency for International Development.

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I. ACRONYMS AND ABBREVIATIONS

ACDI/VOCA	A US nongovernmental organization (formed by a merger of Agricultural Cooperative Development International and Volunteers in Overseas Cooperative Assistance)
AIDS	Acquired Immunodeficiency Syndrome
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
BND	Bureau de Nutrition et Développement
CAD	Canadian Dollars
CDAI	Centres Departementaux d'Approvisionnement en Intrants (Departmental Drug Depots)
CHW	Community Health Worker (<i>Agent de Santé</i>)
CIDA	Canadian International Development Agency
C-IMCI	Community-based Integrated Management of Childhood Illness
colvols	<i>Collaborateurs Volontaires</i>
CPR	Contraceptive Prevalence Rate
CRS	Catholic Relief Services
DALY	Disability-Adjusted Life Year
DHS	Demographic and Health Survey [MEASURE]
DOTS	WHO-recommended first-line treatment for tuberculosis
DPEV	Directorate of the Expanded Program of Immunization
EPI	Expanded Program of Immunization
FBO	Faith-Based Organization
FFP	Food for Peace Program
FP	Family Planning
FY	Fiscal Year
GDP	Gross Domestic Product
Global Fund	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
GOH	Government of Haiti
HHF	Haitian Health Foundation
HIV	Human Immunodeficiency Virus
HS 2004	Haiti Santé 2004 Project
HS 2007	Haiti Santé 2007 Project
HTG	Haiti Gourdes
ICC	Inter-agency Coordinating Committee
IDB	Inter-American Development Bank
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
IOM	International Organization for Migration
KATA	Kombit Ak Tèt Ansanm [USAID] (in Creole, "Working Together")
LMS	Leadership, Management and Sustainability Project [MSH]
MCH	Maternal and Child Health
MCHN	Maternal and Child Health and Nutrition

M&E	Monitoring and Evaluation
MEASURE	Monitoring and Evaluation to Assess and Use Results [USAID]
MIS	Management Information System
MPS	Minimum Package of Services
MSH	Management Sciences for Health
MSPP	Ministry of Health (Ministère de la Santé Publique et de la Population)
MWH	Maternity Waiting Home
MYAP	Multi-year Assistance Program
NGO	Nongovernmental Organization
OB-GYN	Obstetrics and Gynecology
ORS	Oral Rehydration Solution
PADESS	Health System Development Support Project (Projet d'Appui au Développement du Système de Santé)
PAHO	Pan-American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief [USG]
PL480	[US] Public Law 480 (Food For Peace)
PLWHA	People Living with HIV/AIDS
PMP	Performance Management Plan
PMTCT	Prevention of Mother-to-Child Transmission
PPH	Postpartum Hemorrhage
PROMESS	PAHO's Essential Drugs Program
SCMS	Supply Chain Management System
SDMA	Service Delivery and Management Assessment [protocol or tool]
SDSH	Santé pour le Développement et la Stabilité d'Haïti, or Pwojè Djanm, Project
SO	Strategic Objective
SOG	Soins Obstétricaux Gratuits ("Free Obstetric Care," pilot program)
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
USD	US dollars
USG	US Government
WHO	World Health Organization

II. ACKNOWLEDGMENTS

The members of the team thank the Government of Haiti and the USAID Mission in Haiti for this opportunity to visit Haiti and learn about maternal and child health/family planning programs in this fascinating country.

We also thank the USAID Health team and the staff of Management Sciences for Health's Leadership, Management and Sustainability (LMS) Program and Santé pour le Développement et la Stabilité d'Haiti (SDSH) Project for their constant support and responsiveness to our many requests and demands and for making our time in Haiti pleasant and rewarding.

We thank the many people, from the Ministère de la Santé Publique et de la Population (MSPP), international donor partners, other USAID projects, and health facilities as well as colleagues who shared their precious time and experience to provide us with the information and insight without which this report would not have been possible.

Special thanks go to Sharon Epstein for her constant availability, her many detailed questions and suggestions and her detailed contributions to this final document; to Karen Poe, Paul Auxila, and Antoine Ndiaye for their hospitality and thoughtful contributions to our analysis; and to Reginalde Masse, Pierre Mercier, and Wenser Estime for their kindness, support, and extensive information.

III. EXECUTIVE SUMMARY

This report is the result of a health sector assessment and review conducted at the request of USAID/Haiti in August 2008. The team consulted more than 115 documents, interviewed nearly 90 health professionals, and made field visits to four provinces (known in Haiti as departments) and more than 10 health facilities.

The team concluded that the most fundamental determinants of poor health status in Haitian women and children are extreme poverty, poor governance, societal collapse, infrastructural insufficiency, and food insecurity. Together, these factors undermine the ability of the Haitian state to efficiently and effectively manage its scarce resources to improve access to and the quality of health services and the ability of the Haitian people to maintain their health and respond effectively to personal health issues.

Poverty in Haiti is both widespread and deep and is not likely to be diminished for many years to come. Haiti is now the most corrupt country in the world and suffers at the central and lower levels of government from weak management capacity, insufficient numbers of trained and motivated staff, an absence of documentation and information management, a lack of transparency, and a highly centralized, hierarchical decision-making process. Donors, while they are the lifeline that has sustained health services to a significant portion of the Haitian populace, also contribute barriers to progress through insufficient coordination, funding priorities that do not always reflect the real situation and needs in Haiti, creating parallel systems to compensate for Government of Haiti institutional weaknesses, and repeatedly disrupting program continuity.

At the community and family levels, high rates of violence, economically motivated migration, and high death rates from HIV/AIDS and other causes contribute to the instability of community and family bonds, which increases the vulnerability of women and children. Serious infrastructural insufficiencies, including poor roads, lack of sufficient water and sanitation services, and a fragmented and poorly staffed and supplied health system that covers only 60 percent of the population further contribute to the poor health status of Haiti's women and children.

The review team concluded that the USAID Mission portfolio correctly addresses the primary challenges to maternal and child health (MCH) in Haiti through a portfolio that focuses on improved stability through economic growth and jobs creation, improved rule of law and responsive government, and increased access to social services. Except for the striking disproportion of HIV/AIDS funding, overall Mission resource allocation seems to be on track.

The principal MCH issues in Haiti are hunger and high and increasing levels of malnutrition; high and increasing levels of maternal mortality; high levels of child and infant morbidity and mortality, especially for neonates; and low and stagnating levels of contraceptive prevalence. At least one in three Haitians go to bed on an empty stomach each night. Poor nutrition starts for many at birth with low birthweight (4 percent) and increases until, by age five, almost one in four is chronically malnourished and one in 10 is acutely malnourished. It is estimated that

nearly one-half the Haitian population is undernourished. Chronic malnutrition is the underlying cause of high maternal, child, and neonatal mortality in Haiti.

Sharp increases in maternal mortality are largely attributable to the high incidence of home deliveries (75 percent), leaving many women with inadequate prenatal, delivery, and postnatal care and exposing their infants to high risks of neonatal mortality. Even women delivering in health facilities face significant risk due to poor quality of service and insufficient availability of equipment and supplies. Emergency obstetrical and neonatal care is largely unavailable. Donors have, until very recently, ignored this aspect of maternal and child health in Haiti, particularly in health facilities.

Family planning (FP), a key intervention to prevent maternal and child mortality, has been a neglected programmatic area in Haiti. Only 18 percent of Haitian women currently use a modern method of contraception, and 25 percent of women “in union” with a partner do so. Adolescent fertility is high: by age 17 more than one in 10 Haitian adolescent females have had a child or are pregnant. This is a key target group for increased FP interventions. The other key group is Haitian women who have reached their desired family size and wish to limit future births. Access to long-term methods is exceedingly low and needs to be increased dramatically.

The principal causes of under-five child mortality in Haiti are diarrheal diseases (16 percent of deaths) and acute respiratory infections (20 percent of deaths). Overall immunization coverage remains insufficient, despite regular mass campaigns, due to poor coverage of routine vaccinations. Integrated Management of Childhood Illness (IMCI) is the WHO-recommended strategy for addressing high child morbidity and mortality rates through the provision of integrated care at each child visit to a health provider. This strategy was adopted by the Haitian Ministry of Health, le Ministère de la Santé Publique et de la Population (MSPP), in 1997, but has not yet been successfully integrated into the care routine at most health facilities. Community-based IMCI is provided through USAID-funded programs.

Management system inadequacies frustrate efforts to address high levels of maternal and child morbidity and mortality. Three principal issues were addressed by the review team: (1) highly centralized and poor health system management by the MSPP; (2) the chaos in health sector logistics; and (3) the poor quality of the management information system. The USAID-funded SDSH/Pwojè Djanm Project has started to address MSPP management issues through central-level institution building and through the strengthening of departmental-level planning capacity. Health sector logistics are managed by the MSPP through the WHO PROMESS Project and by USAID and other donor projects through parallel systems created to address immediate needs. Both approaches have resulted in frequent and sometimes prolonged stock-outs of key drugs and supplies. Management of health information is overwhelmed by the volume of indicators required by donors, leading to poor use of existing data for decision-making at all levels.

USAID is addressing MCH issues principally through the flagship SDSH/Pwojè Djanm Project, through PL480 Title II programs, and through some of its HIV/AIDS activities. Primarily through strengthening of community-level services, complemented by improved referral to upgraded fixed facilities, these programs have significantly improved key MCH/FP indicators in their coverage areas compared with overall Haiti health statistics (increasing vaccination

coverage rates, contraceptive prevalence, the rate of deliveries assisted by skilled personnel, and other indicators). USAID programs complement a host of other donor interventions, principally those supported by the Canadian International Development Agency (CIDA), United Nations Population Fund (UNFPA), UNICEF, PAHO/WHO, and the Global Fund. Donor collaboration is characterized by goodwill but lacks sufficient practical operational and strategic coordination.

The review team concluded that the USAID MCH/FP portfolio was generally well targeted to meet overwhelming needs given budget availability and local constraints. The team especially appreciated the recent emphasis on public- and private-sector collaboration; the integrated management of key maternal and child health issues, including HIV/AIDS; the focus on communities; the departmental-level institution-building; the excellent collaboration between Multi-year Assistance Programs (MYAPs) and SDSH; the strengthening of collaboration among donors, especially at the departmental level, but also at the national level; and the use of performance-based contracting as a mechanism to strengthen institutional capacity.

Key recommendations include the following:

1. Continue to strengthen donor collaboration by creating national- and departmental-level mechanisms to engage donors and the MSPP in detailed operational and strategic planning of key sectoral issues (e.g., family planning, neonatal health, logistics).
2. Consolidate gains in geographical areas currently covered by USAID programs through increased attention to quality of care issues; continued strengthening of community-based interventions; improved logistics management; and increased behavior change communication. Do not expand beyond current geographic foci in the near future, except as guided by epidemiological data and to complete coverage in selected “health districts” (Unités Communales de Santé). Work with other donors to create an electronic health-sector map to guide planning and strategic decision-making.
3. Address the two priority issues of reducing maternal and neonatal mortality and increasing contraceptive prevalence. The USAID Mission should seek additional Child Survival and Health (CSH) and Maternal Health Plus-up funds to address these issues.
4. Given worrisome increases in malnutrition rates, the Mission is encouraged to seek additional PL480 funds by April 2009.
5. Address maternal and neonatal mortality through improvements in current programs by evaluating, and possibly scaling up, local “best practices” (e.g., Maternity Waiting Homes, “Super Matrones,” integrated health care models); as well as by improving quality of community-based interventions; intensifying behavior change communication (BCC) efforts; improving logistics and access to necessary equipment and supplies (in collaboration with other donors); and targeting studies to identify behavioral barriers to care-seeking.
6. Work with other donors to conduct a thorough evaluation of the SOG (Free Obstetrical Care) pilot program.

7. Reactivate the Repositioning of Family Planning initiative, paying particular attention to the needs of adolescents and access to long-term methods.
8. Work with other donors, with USAID/Washington, and with existing projects to address the weaknesses in the logistics and management information systems.
9. Take practical steps to increase cross-sectoral synergies by operationalizing joint programming and reporting of health-sector activities with relevant interventions in other sectors (e.g., KATA [in Creole, “Working Together”] and International Organization for Migration [IOM], Ministry of Education and Youth and Sport). Begin to strengthen advocacy skills in community-level health groups.

IV. INTRODUCTION

This report is the result of a health sector review and assessment conducted at the request of USAID/Haiti in August 2008. It was carried out by three senior consultants furnished by Management Sciences for Health (MSH)/Leadership, Management and Sustainability (LMS) Program and one USAID/Washington staff member. The purpose of the exercise was to “provide the USAID Health and Education/Investing in People Team with strategic, programmatic, technical and funding recommendations to help focus, target and improve the quality of MCH/FP strategies and interventions.” The team was not asked to review USAID HIV/AIDS or social marketing activities. The Scope of Work was broad and comprehensive, including a review of the following: USAID MCH/FP inputs over the past decade; demographic, epidemiological, and health program data; other donor inputs; factors related to need and demand for, and quality of and access to, MCH/FP services; logistics of MCH/FP commodities, indicators and monitoring and evaluation (M&E) plans; cost of services; gaps in services; the role of the Ministry of Health; and more specific questions related to prenatal care, obstetrical emergencies, postnatal care, family planning, postabortion care, and child health. (The complete Scope of Work can be found in Annex 1.)

The team consulted more than 115 documents and interviewed nearly 90 health professionals, including health facility staff, donor representatives, project personnel, and Ministry of Health staff. Field visits were made to four departments and more than 10 health facilities.

V. BASIC DETERMINANTS OF POOR MATERNAL AND CHILD HEALTH IN HAITI

The most fundamental determinants of poor health status in women and children in Haiti are the following:

- Extreme poverty
- Poor governance
- Societal collapse
- Infrastructure insufficiency, including health facilities and roads
- Food insecurity

Haiti is unlike the vast majority of states with similar economic, social, and health parameters. The apparent similarities to the African context, which strike the first-time visitor, are chimerical and nonrobust. Haiti can validly be described as a “failed state,” where a tiny elite struggle among themselves to capture the increasingly scant resources of the state for their own benefit, leaving the vast majority of citizens to satisfy the most basic needs of life by whatever means possible. This basic underlying reality is at the root of the inability of state institutions to make effective use of existing resources to serve the needs of the Haitian people, as well as the disengagement of a significant majority of Haitians from their government, communities, and even families. While there have been better and worse periods for the Haitian people in the past, today’s problems have deep historical roots, dating to the very foundation of Haitian society. These are the conditions that frustrate the efforts of donors and citizens alike to combat the poverty, hunger, educational insufficiencies, infrastructure and human resource weaknesses, and societal disintegration that are the fundamental causes of Haiti’s high morbidity and mortality statistics, as well as of their relative intractability. Solving these fundamental problems is a necessary precondition to rapid progress in the health sector. This will take time. However, without continued intensive support to MCH/FP interventions, maternal and child health statistics in Haiti are likely to remain largely static or even to deteriorate.

Although these underlying causes of poor health have existed for many decades, remarkable progress has been made in the health status of Haitian women and children. While still among the highest in the world, mortality rates of women, children, infants, and neonates have been progressively declining over the past decades. HIV prevalence has decreased significantly. Many more people living with HIV/AIDS (PLWHA) are receiving antiretrovirals and appropriate care and support. More children are receiving treatment for acute respiratory infection (ARI) and are given oral rehydration solution (ORS) when they have diarrhea. More women are receiving prenatal care. However, improvements in maternal and child morbidity and mortality have not kept up with the results attained in most other developing countries and lag far behind those in the rest of Latin America and the Caribbean.

There are signs that conditions may be worsening: Over the past five years, the rate of increase of maternal mortality has steepened, as has the percentage of children affected by malnutrition. In urban areas, fewer women are receiving prenatal care. Use of contraceptives has increased dramatically over the past 40 years, but appears to have leveled off over the past five.

a. Demography

Haiti occupies about one-third of the island of Hispaniola, which it shares with the Dominican Republic. A current population of 8.4 million occupies a landmass of 27,800 square kilometers, making Haiti the second-most population-dense country in the Americas after Barbados, with approximately 300 inhabitants per square kilometer. With an estimated population of a little over 3 million in 1950, the current population growth rate of about 2.2 percent will increase Haiti's population to around 12.3 million by 2030.¹ There is some evidence that the rate of growth is slowing as the proportion of the population under 15 years of age is decreasing and women's fertility is dropping. However, Haiti's is still a young population, with 60 percent under age 23 and 23.5 percent between 15 and 24 years of age.²

The majority of the country's population, 62 percent, still resides in rural areas, but rural-urban migration has accelerated over the past decades: the urban population has grown from 24.5 percent of total population in 1982 to just over 40 percent by 2003. More than two of three Haitians moving from rural to urban areas since 1982 have moved to the West Department and especially to the metropolitan area of Port-au-Prince, which now harbors 21 percent of the total population. In absolute terms, both rural and urban populations are increasing. Nearly a million people have been added to rural areas since 1982.³

Haitians are a mobile people. Not only do substantial numbers move from rural to urban areas but also many temporarily or permanently leave the country in search of a better life. Since at least 1958, net outward migration has exceeded the population growth rate. Around 500,000 Haitians currently reside in the Dominican Republic, and more than a million live legally in North America. This large diaspora contributes significant financial resources to the Haitian economy, sending remittances of between 700 million US dollars (USD) and USD 1 billion per year to family, a figure representing on average approximately 25 percent of Haiti's annual gross domestic product (GDP) and three times annual foreign assistance budgets.⁴

b. Poverty

That poverty is among the top underlying causes of poor health in Haiti is demonstrated by two recent incidents. This year the Ministry of Health (MSPP), PAHO/WHO, and the Canadian International Development Agency (CIDA) initiated a pilot project to provide free obstetric care (SOG: Soins Obstetricaux Gratuits) in 49 Haitian maternities. Prior to the initiation of this project, many health professionals in Haiti did not believe that cost of services was a major impediment to access to care for pregnant Haitian women. During the first month of the project, after the initiation of free services, the number of births in these maternities increased by between 51 percent and 224 percent. Another example comes from Catholic Relief Services (CRS) Title II staff, who reported that during a recent stock-out of food supplements, attendance at pre- and postnatal consultations and vaccinations fell by 90 percent. The 2005 MEASURE Demographic and Health Survey (DHS) showed that the primary reasons for not visiting a health facility in case of illness were cost (43.8 percent) and distance (19.5 percent overall; 25.8 percent in rural areas). These factors could be expected to play an even greater role in use of preventive services or treatment seeking for illnesses not perceived as life threatening.

Poverty in Haiti is both widespread and deep. In 2004, 56 percent of Haiti's people lived on less than USD 1 per day and 76 percent on less than 2 USD. Most social indicators show that poverty has increased since the mid-1990s. Between 1980 and 2003, the Haitian economy declined at a real average annual rate of 0.82 percent. GDP declined from USD 632 in 1980 to USD 332 by 2003, the lowest in the Latin America and Caribbean region.⁵ Inflation was estimated at 15 percent in the 1999 to 2000 time period, and the price of food increased by 10.2 percent during the same time.⁶ From August 2007 through April 2008, food prices were estimated to have risen by as much as 65 percent,⁷ leading to food riots.

While people living in the metropolitan area of Port-au-Prince suffer relatively less poverty than those in other areas (20 to 23 percent in absolute poverty; average household income is four times the average rural household income), there is little difference in poverty levels between other urban residents and rural populations, with absolute poverty rates in both settings approaching 60 percent⁸; however, 77 percent of Haiti's extremely poor people live in rural areas. There are also geographical differences in poverty levels, with those living in the Northeast and Northwest suffering the highest poverty rates. In the West Department,⁹ where the capital city is located, median per capita incomes are five to six times higher than in the Northeast. There are also significant differences in poverty levels between individuals and households based on sociological and other characteristics: the young are less likely to be poor than the old; women are more likely to be poor than men; those with low levels of education are more likely to be poor than those with secondary or higher education; those working for others are more likely to suffer poverty than those who are self-employed; and those who have migrated within Haiti are more likely to be poor than those who have stayed in place. Also, a household headed by someone who is a member of one or more local organizations has more "social capital," and is less likely to be poor than one that is not.¹⁰ These statistics provide clues to assist in the shaping of MCH/FP programs: They suggest, for example, that both rural and urban areas should be targeted and that the north will present special challenges. Health program strategies that increase "social capital" by strengthening community organizations, such as support groups and "mothers' clubs," may also increase avenues to improve household income by strengthening networks of mutual support.

Haiti's poverty is not likely to be substantially diminished for many years to come. According to a 2008 World Bank report, "Even if the country was able to generate a record high growth rate resulting in 5% or 10% growth in per capita income, this would need to be sustained for 10 years to bring the extreme poverty rates down to 33.5 and 22.9 percent respectively."¹¹ A more realistic sustained rate of growth at a level of 2 percent would bring extreme poverty down by only 3.3 percent after 5 years, and after 10 years 42.2 percent of Haitians would still be living in extreme poverty. While donor efforts to achieve poverty reduction are an essential part of the development effort in Haiti, direct donor support to health, education, and other services aimed at improving the lives of ordinary Haitians will remain essential for decades to come, not simply for humanitarian reasons but also to provide the political stability which is the sine qua non of Haiti's long-term evolution toward national viability as a modern nation.

c. Governance

This year, Haiti has been rated the fourth most corrupt country in the world¹², just above Iraq, Myanmar and Somalia. Corruption is pervasive and affects all aspects of life. Haitian politics is essentially a battle of a few key families for the power to grow and maintain wealth in an environment of decreasing resources. “In the zero-sum game of Haitian politics, there is little notion of rewarding the opposition as a means to keep them engaged and to maintain constructive avenues of participation. As a result, every election has renewed the threat of political monopoly, as those left out of the new regime have seen few legitimate options for engagement, and instead, have often turned to political stonewalling, and in some cases violence, to achieve their political ends.”¹³ Haiti’s leaders have historically been unresponsive to the needs of their constituencies, using their discontent only to mobilize for the next round of political infighting and ignoring them afterward. Within government, administrative positions are the reward of loyal followers. Those in power have little reason to develop effective personnel, budgetary, or financial systems that would lead to more effective and efficient use of government resources for the greater good and to greater transparency. At each change of government, those leaving have no reason to assure an orderly transition. Weak management capacity, insufficient trained and motivated staff, absence of documentation and information management, and chronic meager financing has created a bureaucracy that defeats the best intentions of donors and Haitians trying to reform the system. Interministerial cooperation is weak or nonexistent.

Power and decision-making remain highly centralized. The decentralization mandated in the 1987 constitution has never been implemented. The legal framework for decentralization exists in a series of unpublished decrees, but despite President Préval’s stated commitment to decentralization in June 2006, these have not been implemented. Only the Ministry of Health (MSPP) has made any serious efforts at deconcentration of its planning and budgeting procedures. Supported by MSH, starting in 2006 departmental annual plans were developed based on communal plans. Although this effort has increased transparency and participation, lack of engagement of the Ministry of Finance has meant that the plans cannot be followed except to the degree that donor funding is allocated. The Ministry of Finance disburses insufficient funds irregularly throughout the year, resulting in a disorderly and wasteful procurement process that undermines implementation.¹⁴

Within the health sector, the decades of government mismanagement and lack of management have had severe consequences, leading to a serious breakdown of the provision of health services by the public sector: health facilities fell into disrepair and lacked the trained personnel to function at even minimal levels; medical equipment, drugs, and supplies were generally in short supply and subject to frequent stock-outs; and community-level programs were undermined by neglect. For many years, most health services in Haiti were supplied by the private sector or by traditional healers. Government failure to improve other basic infrastructure and services, such as roads, water and sanitation systems, and education, has further exacerbated health problems.

Within the last two to three years and with donor support, the MSPP has developed a number of instruments intended to reorganize and rationalize health sector activities. In 2005 the ministry published the *Plan Stratégique Nationale pour la Reform du Secteur de la Santé*, which described a new approach and a strategy to deliver basic integrated health services. This was

complemented by the *Plan de Réduction de la Mortalité Maternelle* and a *Plan Opérationnel de Santé Reproductive*. At a July 2006 donor conference, the Government of Haiti (GOH) articulated health sector priorities: expanded access; maternal and infant health (nutrition, vaccinations); national and equitable coverage; decentralization targeting the most difficult to reach communities; improved sustainability (trained personnel); and improved infrastructure. A Minimum Package of Services was developed and published, as were norms and standards of care, which generally correspond to international guidelines. Donors have established a national-level working group to help the MSPP implement the interventions described in these documents. In 2007, the *Plan Opérationnel Intégré* (POI) was developed with support of the USAID-financed Pwojè Djanm Project and the Canadian Health System Development Support (Projet d'Appui au Développement du Système de Santé [PADESS]) Project. Progress is, however, almost totally dependent on donor inputs, as the MSPP budget is minimal and the ministry remains largely dysfunctional at the central level due to staffing and other issues.

d. Role of Donors

It is necessary to acknowledge that, without the support and commitment of the international community and private-sector providers, very few Haitians would have any access to quality health care at all. Since the early 1990s, however, finding the balance between emergency assistance, humanitarian intervention, and long-term development has been a challenge to donors. While the Haitian Government bears the major portion of the responsibility for the poor health status of the country's women and children and the slow pace of improvements, international donors and nongovernmental organizations (NGOs) have also contributed barriers to progress. Poor governance is the greatest impediment to effective development assistance, but "post conflict states are unlikely to resolve their own governance issues."¹⁵ While convincing head offices of the need for adapting bureaucratic and programmatic mandates to the very special circumstances of Haiti can be challenging, it is necessary for Haiti-based donor representatives to do so if longer-term improvements are to be built on the gains made today. This means more predictable and sustained assistance that is better coordinated among both national and international partners and more practically and strategically focused on priorities based on data and thorough analysis of local realities. Donor priorities, often driven by mandates from central offices in Washington, Geneva, New York, and elsewhere exert a heavy influence on the use of scarce human and material resources and create distortions in health services provision. As elsewhere, donors engage in Haiti on the basis of their own agendas. This has often resulted in misalignment between donor programming and Haitian realities, as shown in the following examples:

- The massive influx of HIV/AIDS funding has been to the detriment both of funding necessary for economic development and other peace and security interventions and of inputs in support of overall mother and child health, especially interventions aimed at reducing maternal and neonatal mortality and increasing contraceptive use. The current rate of HIV prevalence in Haiti is estimated at 2.3 percent in urban areas and 2 percent in rural areas overall, less than in Washington D.C. While the number of PLWHA has increased to approximately 120,000, the annual number of AIDS deaths has been declining since 2000 and now stands at 8,000 (whereas more than 100,000¹⁶ under-five children

currently die every year, mostly of preventable causes). Forty percent (40 percent) of PLWHA are currently covered by antiretroviral therapy programs.¹⁷ The US Government's (USG's) HIV/AIDS budget for Haiti at present dwarfs funding for general maternal and child health programs by approximately 10 to 1 and represents five times the budget of the Haitian Ministry of Health—and USG funding represents only a portion of the total donor inputs for HIV/AIDS.

- Severe disruptions in program continuity resulting from abrupt changes in funding levels, policy changes, donor administrative processes, and constraints, as well as frequent program and technical strategy changes contribute to the poor quality of health services, low morale among health staff, and citizen distrust of local government. Assistance to Haiti has been characterized by periods of substantial investment followed by sudden substantial reductions or withdrawals of aid in response to political crises and other circumstances both within Haiti and within donor countries, repeatedly undermining gains and increasing the skepticism and disengagement of the Haitian people. In a 2004 review, CIDA observed that Phase 2 of their programming, which “focused on strengthening the public sector ‘produced disappointing results, in part due to a disconnect in sequencing of programming which did not align with the political situation in Haiti.’ This resulted in termination of support to state institutions and a subsequent emphasis on civil society that ‘contributed to the creation of parallel systems of service delivery.’”¹⁸ Other donors followed a similar strategy. One recent smaller-scale operational example is the USAID decision earlier this year to limit US provision of contraceptives to USAID project areas due to concerns regarding respect of the Tiahrt¹⁹ amendment and possible theft of contraceptives. However necessary this decision may have been within the USAID context, the sudden withdrawal of contraceptives from some areas of the country exacerbated the already serious problem of reliable access to contraceptives, which has hampered family planning activities for decades.
- Lack of detailed operational coordination among donors has led to both overlaps and large gaps in specific coverage in some geographical and technical areas. One result is that the Haitian health care system can be compared to a “crazy quilt”²⁰ with huge holes in it. The patches are made of a plethora of health care providers, including national and international NGOs and faith-based organizations (FBOs), and health facilities in both public and private sectors and specific program interventions supported by a variety of international donor projects. The weak government capacity for management, planning, oversight, and strategic direction has meant that each organization has been able to determine its own coverage area, apply its own standards, and pick and choose the range of interventions offered. While many try to adhere to MSPP policies and guidelines, others don't. The “holes” represent uncovered populations (between 20 and 40 percent of Haitians) who have no access to care or who don't have access to the full range of basic MCH/FP services. At present there is wide donor recognition that coordination is necessary, and a variety of coordinating bodies meet regularly at the national level. However, detailed strategic and operational coordination among donors is still weak. The departmental health sector planning exercises supported by the USAID-funded SDSH Project bring together public- and private-sector providers at the local level and are a step in the right direction.

- The creation of parallel systems to compensate for GOH weaknesses is resulting in serious distortions in the health system. Two examples in the health sector are the chaotic health logistics system and the multitude of health information systems designed primarily to meet donor needs.

e. Societal Dysfunction

Overall Instability

Unlike many similar states, Haitian society lacks much of the traditional social cement that holds countries, communities, and families together in interest groups with similar concerns and objectives. There are almost no tribal, geographic, religious, or community loyalties that support and unite people. Haitians are an individualistic people whose ties to others are largely driven by economic concerns. Haitian villages are made up of individual compounds, often dispersed over wide areas, with little sense of common purpose. Urban neighborhoods tend to be transitory communities of frequently dysfunctional households with no traditional hierarchies of authority, including police and governmental authority. Apart from the immediate, and to a lesser extent, extended, family, the only traditional social groupings are the “eskwad,” reciprocal work groups for men organized around adjoining farm plots, and the “Pratik” mutual support relationships between market women. Instead, Haitian society is stratified through a system of patronage, which is essentially a system of exclusion primarily serving the interests of those with preexisting economic and political power, a small minority. These already weak social relationships have been further eroded by migration, poverty, high unemployment, high death rates (including from HIV/AIDS), and repeated episodic violence linked to political instability.²¹ Political and economic elites have stepped into this void by using the alienation and dissatisfaction, especially of the youth, to support their political agendas.

Health sector programs have provided one of the few avenues for the creation of legitimate social support networks. The establishment of a variety of mothers’, fathers’, and youth groups organized around health issues has provided a venue of organization, and eventually advocacy, grouping people with similar interests and concerns. The large number of Haitian NGOs and the large number of Haitians actively involved in addressing health issues both attest to the power of health as a motivator for civic participation and organization.

Violence

The high levels of violence in Haiti affect the health status of women and children both directly and indirectly. Direct effects include trauma, both physical and psychological, unwanted pregnancy and abortion, family dissolution, and child abandonment. Indirect effects include the steady deterioration of health infrastructure and lack of equipment and supplies in health facilities (looting); logistical problems in supplying health facilities in violence-prone areas with necessary drugs and supplies; difficulties in training medical personnel (for example, midwives training at the midwifery school cannot reach health facilities for practical training because public transportation is too dangerous and the school lacks its own bus); flight of medical

personnel abroad; reluctance of donor project personnel to work in high-violence areas (“hot spots”); and suspension or reduction of donor assistance. The overall impact of these indirect effects is very likely greater than that of the direct effects, hampering both access to health services and quality of care for large numbers of people who are not direct victims of violence.

Violence in Haiti takes three principal forms: (1) mass violence, like the food riots earlier this year; (2) targeted violence generally related to political and criminal activity, including kidnapping, the drug trade, and politically motivated intimidation and brutality; and (3) domestic violence, including violence against women. All these forms of violence have pervaded Haitian society for decades, if not longer, and are symptomatic of the severe competition for resources that has led to the further dissolution of Haitian societal cohesion at all levels, but especially in urban areas.

Violence against women is particularly serious and seems to be growing more severe. According to the 2005 DHS, 27 percent of Haitian women admit that they have been targets of physical violence. Six percent declare that they have experienced physical violence during pregnancy. Overall, in 46 percent of these cases the aggressor was someone other than the partner or spouse. These figures in all likelihood represent a severe underreporting of the true level of violence against women. Other sources report that 70 percent of women have experienced some kind of violence, of which 37 percent is sexual.²² Groups involved in providing assistance to rape victims have reported an increase in the torture and depraved beating of rape victims.²³

Urban gangs have their historical roots in “Papa Doc” Duvalier’s Tonton Macoutes. President Aristide, in the early 1990s, then recruited urban youth to create political pressure through street demonstrations and blockades. During this period, these groups were heavily armed, a process that continues today. The groups then loosened their ties to political interests as they became increasingly involved in the drug trade. Today, many of these groups are largely autonomous and have organized themselves into disciplined criminal gangs who engage in kidnapping and drug trafficking. While their leaders are generally motivated by profit and political power, the “foot soldiers” are often simply engaged in meeting their basic economic needs in the only way open to them, as noncriminal employment is exceedingly scarce.

Other gangs are organizations of neighborhood youth, territorial “groups of friends” who sometimes call themselves a *brigade de vigilance* or *groupe d’autodéfence*. They have, to a certain extent, filled the void left by the state, organizing to defend their communities, enforce curfews, and, often violently, protect against rival gangs. In slums such as Cité Soleil, these “neighborhood organizations” are often the only organized guarantor of their community’s security, livelihoods, and other basic needs.²⁴ Access for outsiders, including health and development program staff, to urban neighborhoods in “hot spots” must often be mediated through these groups or local leaders able to talk to them.

Family Instability

The combined pressures of poverty, violence, economically motivated migration, HIV, and a cultural heritage rooted in the aggression of slavery have combined in Haiti to create unusual instability in family structure that has far-reaching effects on mother and child health.

The 2005 DHS shows that Haitian women are subject to precarious relationship patterns. Among women between the ages of 15 and 45, only 18 percent are married; 26 percent are in a more or less stable relationship referred to as “place,” which is a form of common law marriage dating to the historical period when plantation owners would take a female slave as a concubine; 14.5 percent are in less stable unions referred to as “vivavek” or “vit ensemble,” living with a partner “in union,” and 32 percent are single. Among men, 47 percent consider themselves single. Forty-four percent of Haitian households overall and 53 percent in urban areas are headed by women. The cultural expectation is that women will be “serially monogamous,” while men are expected to have more than one partner: almost 18 percent of women currently in union believe their men have other partners, although only 9 percent of men admit to this. Especially in urban areas, it is common for women to have numerous children, each with a different father.

f. Infrastructure and Services

Poor governance and poverty in Haiti have also contributed to a lack of access to basic infrastructure and services.

Transportation

Lack of transportation is a major obstacle to access and use of health services. Only 5 percent of rural Haitians have direct access to a paved road. An additional 33 percent have access to a dirt road.²⁵ The condition of most roads is very bad. Haiti is a mountainous country harboring many isolated communities whose residents may have to walk six or more hours to reach the nearest health facility. Even for those living near a road, transportation is infrequent and difficult. The most recent DHS shows that, among seriously ill people who had visited a health facility within the past 30 days, for 20 percent the distance to the facility was more than five kilometers, which, given the mountainous terrain can represent many hours of walking. In rural areas, 47 percent of those who visited a health facility reached there on foot or on the back of an animal. In rural areas, almost one-quarter of these ill people traveled more than two hours to reach their destination.²⁶

Poor access to roads also hampers outreach programs. Because of the time and distance involved in reaching many communities with mobile services, mobile health teams may visit a given community as little as four times per year. Health personnel may have to walk for many hours in order to supervise community-based health workers or provide basic care. Poor transportation also undermines access to drugs and supplies and is one factor in the poor condition of the cold chain and the uncertainty about the viability of vaccines used for routine and even campaign

immunization efforts (vaccine losses of up to 100 percent have been reported due to cold chain failure.)

Water and Sanitation

Haiti ranks 147 out of 147 countries on the Water Poverty Index. According to a 2006 World Bank Report, despite an investment of over USD 200 million over the past 25 years, only 55 percent of Haitians get their drinking water from a safe source and 35 percent lack any sanitation facilities. Diarrheal and gastrointestinal illnesses are related in part to lack of access to adequate sanitation and cause 5 percent of all deaths in Haiti, making these the second-leading cause of death, after HIV/AIDS. Acute diarrheal disease remains the top health problem among children under five.²⁷

g. Health Care

Despite donor support spanning the past 40 years, Haiti's formal health care system reaches only 60 percent of the population. At least 40 percent rely largely on traditional medicine for their health needs.²⁸

Health Facilities

There are significant regional differences in access to fixed-facility health care. Sixty-two percent of hospitals, 58 percent of health centers, and just under 10 percent of dispensaries are located in the West Department, which harbors 39 percent of the population, including 65 percent of the total urban population and 22 percent of the total rural population. The total number of operational facilities has grown by approximately 13 percent over the last 10 years, but distance and other issues still limit access. The 2005 DHS showed that, overall, 27 percent of people suffering a serious illness or injury during the last 30 days had not visited a health facility, although this percentage was lower for children (14 percent of those under age 15). These percentages were considerably higher in certain departments: Nippes (40.9 percent), Grande'Anse (35 percent), Northeast (33 percent), and Center (31 percent).

The dominant role played by private-sector providers (Table 1) and the multiplicity of both large and small donors and actors, including local and international NGOs and faith-based organizations, many of which have been working in Haiti for decades, has led to a fragmentation of the health care system. There is little standardization of health care provision in Haiti. Quality of care varies widely in both the public and private sectors.

Table 1. Haitian Health Facilities by Type and Sector, 2005 and 2000*

Sector	Hospitals	Health Centers with Beds	Health Centers without Beds	Dispensaries	Total	Percentage
Public ²⁹ (percentage)	25 (39.7)	28 (51.9)	42 (21.2)	174 (43.3)	269	37.5
Private ³⁰	34	10	124	160	328	45.7
Mixed ³¹	4	16	32	68	120	16.7
Total in 2005 (percentage)	63 (100)	54 (100)	198 (100)	402 (100)	717	100
In 2000*	47*	217* (all health centers)		371*	635*	

Source: MSPP/Measure and PAHO.³²

Project and NGO coverage areas rarely overlap, either with political boundaries (*communes*) or health system–defined “districts” (Unités Communales de Santé). Until recently, little effort has been made to coordinate inputs among donors or public- and private-sector organizations operating in the same departments or communities, leading both to overlap of services and to significant gaps in coverage of some or all basic services in some geographical areas. For example, some NGO providers offer only natural family planning methods. Others do not support community-based services. This has hampered consistent implementation of public health strategies and diminished the ability of these strategies to reduce overall morbidity and mortality rates.

Until recently there was also no overall map of Haitian communities, leaving some isolated communities “forgotten” when it came to outreach activities or other community-level activities, such as vaccination campaigns. This was corrected by a recent census in which every home in Haiti was located on the global positioning system (GPS), the potential basis for a health sector mapping tool that would be invaluable for planning and monitoring health sector interventions.

In recognition of the role that extreme poverty plays in access to health services, many Haitian health facilities and the organizations that support them have instituted various cost-recovery programs as well as experimented with the provision of free services. There appears to be no standardization of fee schedules even within geographical zones, such as communes or departments. The review team was unable to locate any cost or willingness and ability to pay studies that could serve as the basis for the development of information-based cost-recovery standards. Piecemeal or “seat-of-the-pants” costing of services can undermine the ability of already severely financially strapped Haitian health facilities to provide services that meet basic national standards of care as well as constitute a potential barrier of access to care for the poorest Haitians. However, that cost is not the only issue considered by even poor Haitians in health care–related decisions is demonstrated by the most recent DHS, which notes that for almost 43 percent of sick children under age 15 there existed a health facility that was closer than the one selected. The reasons given for selecting a more distant facility included less costly (25.6 percent), better equipped (39.6 percent), and more competent personnel (34.9 percent).

Health Personnel

The World Bank estimates that, in 2004, 2.9 percent of public expenditure (i.e., of GDP) was spent on health care by the Government of Haiti (World Bank 2004).³³ Most of this is spent on salaries. This is reflected in the reality that less than 50 percent of fixed-site services are directly supported by the public budget. Private expenditures for health are estimated at around 4.7 percent of GDP (World Bank 2004).

In 1998, Haiti had 2.4 doctors for every 10,000 people, 1 nurse per 10,000 population, and 3.1 auxiliary staff per 10,000 people. There are, however, wide regional differences: in the West Department, for example, there are more than 7 physicians per 10,000 population, a proportion almost nine times greater than for any other department and 35 times greater than in the departments of Center and Grand'Anse.³⁴ The motivation of, especially, public-sector health personnel is undermined by irregular payment of salaries, which, in any case, have not kept up with inflation. Another important obstacle to effective staffing of health facilities is the lack of any coherent personnel policy on the part of the MSPP, which, until recently, did not even know for sure how many personnel were actually working: a recent survey revealed that out of the 6,500 personnel on government payrolls, only around 4,500 are actually engaged in MSPP activities.³⁵ According to the 2005 DHS, 88 percent of women said that lack of health personnel was the main obstacle to seeking health care (78 percent mentioned lack of money, and 43 percent said that the health institution was too far away). The sex of the health care provider was also important to many: 43 percent declared they did not seek health care for fear that the provider would be male.³⁶

A very large percentage of health personnel are supported either directly or indirectly by donors (including faith-based and other NGOs with access to external sources of funding from private donors overseas). Many are direct employees of donor-supported projects and programs. Others receive benefits such as per diems for training and access to donor-supplied equipment and supplies, sometimes used for personal gain. During the past decade, Cuban doctors have reinforced existing Haitian staff. In 1999, Cuba signed a bilateral agreement with Haiti to furnish 500 Cuban doctors while training 120 Haitian physicians. These trainees signed agreements to return to their communities to practice medicine for at least 10 years. Some of these Haitians have now returned and seem to be respecting their agreements, but there are now an estimated 1,200 Cuban physicians working in Haiti.

Visits to health facilities revealed a striking percentage of very young Haitian physicians. This is a reflection of the “brain drain” of more experienced physicians to North America and other destinations and to administrative and other positions within the private sector/donor programs within Haiti. Several of these young physicians working in private (NGO-supported) facilities admitted to the assessment team that one of the principal reasons for their commitment to their current jobs was that the training and experience provided would give them the skills required to move on to positions overseas or to higher-paying jobs with donor projects. Access to advanced training and contact with international professionals were powerful motivators for performance.

Access to modern basic health care through fixed facilities is further extended through community-based “health agents,” trained local birth attendants, mobile clinics, community

volunteers, and community-based organizations such as family planning acceptor clubs, breastfeeding support groups, HIV/AIDS support groups, youth groups, and others. These outreach activities provide local access to health information, growth monitoring and food supplementation, vaccinations, some family planning methods (primarily natural family planning, condoms and, sometimes, pills), pre-and postnatal care, and basic curative care. Where available they provide referral services to fixed facilities. However, these community-based services are largely available only in certain donor-supported programs. Community health agents (*agents de santé*) have existed in Haiti for decades. They have in the past been part of the GOH-supported health system and some are still government employees. However, many of these agents have not benefited from active formative supervision or training in many years. Numerous donor programs have more recently recruited (and are paying salaries to) thousands of new agents and provided additional training and support to existing ones.

VI. ISSUES IN MATERNAL AND CHILD HEALTH AND FAMILY PLANNING

This section of the report will highlight the most important issues in mother and child health and family planning in Haiti.

a. Hunger

Hunger is a reflection of the deep poverty in Haiti: 70 percent of the average household budget is spent on food.³⁷ The combination of poor socioeconomic conditions, infectious diseases, low knowledge of optimal health practices, deficient health infrastructure, and weak community organization contribute to a continuing cycle of chronic malnutrition in Haiti.

The 2005 DHS showed that, in the course of the seven days preceding the study, 34 percent of those interviewed went to bed on an empty stomach. In rural areas, the proportion was 40 percent. For 16 percent, this situation had lasted for two days and for 10 percent of rural inhabitants for three days. The World Bank estimated that, in 2002 to 2004, 46 percent of the Haitian population was undernourished (World Bank Profile, 2004). Twelve percent of women suffer from chronic energy deficiency. About 46 percent of women have some form of anemia, with 50 percent of pregnant women suffering from anemia.

Child malnutrition continues to be a serious problem in Haiti, although rates have steadily fallen over the last 25 years. However, the 2005 DHS reports that 24 percent of children under five are stunted (a 6 percent increase from 2000), 22 percent are chronically malnourished (a 27 percent increase over the previous DHS), and 9 percent suffer from acute malnutrition, with over 16 percent in the 18–23 month age group acutely malnourished. Stunting is worse in rural areas: 28 percent, versus 15 percent in urban areas.

Poor nutrition starts at a very young age. According to the 2005 DHS, approximately 4 percent of Haitian children weigh less than 2.5 kilograms at birth, but 11 percent in the Port-au-Prince metropolitan area do so. Only 60 percent of Haitian babies are exclusively breastfed during the first two months of life. Unfortunately this percent falls to 41 percent between two and four months of life, and 24 percent between four and five months of life. Forty percent (40 percent) of mothers stop breastfeeding altogether between 12 and 23 months. Between 20 percent and 25 percent of Haitian children were bottle fed between the ages of zero and six months. At two months of age, 25 percent of children have already been given another liquid in addition to breast milk.

A little more than one-half of children under three years of age living with their mothers (56 percent) eat foods rich in vitamin A, and the percentage is lowest for the 6–8-month age group (36 percent). Only 29 percent of Haitian children receive vitamin A supplementation, as do 29 percent of their mothers during the postpartum period. Sixty-one percent of children have some degree of anemia. Only 3 percent of Haitian children live in a household that has iodized salt. In fact, 90 percent of all households in Haiti, regardless of socioeconomic status, do not use iodized

salt. The Ottawa-based Network for the Sustained Elimination of Iodine Deficiency, the World Food Program, and UNICEF have discussed plans for clarifying and addressing the situation.³⁸ While there have been steady improvements in the nutritional status of Haitian children over the last thirty years, there are indications that at present the situation is worsening. (See Table 2.)

Table 2. Child Malnutrition in Haiti, 1978–2005

	1978	1990	1995	2000	2005
Height for age	39.6	33.9	31.9	22.7	24
Weight for age	37.4	26.8	27.5	17.3	22

Source: World Development Indicators, World Bank 2004, and (for 2005) Enquête Mortalité, Morbidité, et Utilisation des Services (EMMUS) IV.

Efforts are currently underway to locally produce a “Ready-to-Use Therapeutic Food” (RUTF) prescription food for treatment of childhood malnutrition. Studies in other countries demonstrate that these foods are more effective than standard cereal/legume blends in treating child malnutrition.³⁹ Called Medica Mamba, this is a peanut-based high-protein supplement. A complete course of treatment with Medica Mamba requires about 15 kilograms and costs around USD 75. The team was not able to pursue additional information concerning this product. Dr. Jon Rohde recommended its possible use in combination with Program Against Malnutrition (PAM) and Title II programs. This possibility should be further explored.

More detailed descriptions of some of the issues around hunger can be found in Annex 2.

b. Maternal and Neonatal Health

Maternal Mortality

The 2005 DHS shows that, in Haiti, the overall death rate of women between the ages of 15 and 49 appears to have decreased significantly over the past 5 years. It is interesting to note that the overall death rate for women is 6 percent higher than that for men. The rate of *maternal mortality* has, however, increased to 630 deaths per 100,000 live births in 2005 from 523 in 2000 and 460 in 1995.⁴⁰ This level of mortality means that 1 out of 37 Haitian women is at risk of dying from pregnancy-related causes during her reproductive years. The primary cause of maternal death in Haiti is eclampsia (35.7 percent).⁴¹ Hemorrhage, the most common cause of maternal death in most other developing countries, comes in second place, with 22 percent. (It is possible that these cases are undercounted, as the women affected die before they can get to a health facility and are thus not counted among maternal deaths.) Other causes include infection (20 percent), gynecological disorders (11 percent), and other conditions, such as anemia (16 percent). The majority of these conditions can be easily managed and treated if skilled health care professionals monitor them. Worldwide, complications occur in approximately 40 percent of pregnancies.

Maternal deaths related to these factors are also significantly linked to neonatal and child death rates. A study conducted in Haiti of maternal deaths between 1997 and 1999 in Jérémie showed

that a family that had experienced a maternal death has a 55 percent greater chance of also losing a child less than 12 years of age.⁴² In families where the mother died of causes not related to childbearing, no difference in child death rates was found compared to those in families where the mother had not died.

Haiti's generalized high maternal and infant mortality can be attributed in large part to home deliveries: 75 percent of all women give birth at home. Fifty-two percent (52 percent) of women in Port-au-Prince and 85 percent of rural women delivered at home. Women are more likely to have their *first* child in a health facility, however, with only 57 percent of first time mothers giving birth at home. Of the women delivering at home, 53 percent were attended by a person with no formal training of any kind. A traditional birth attendant (TBA) with delivery kit (*avec boîte*), one who had received some training, assisted the remaining 47 percent. Of the 25 percent of women who gave birth in a health facility, almost 60 percent did so in public health facilities, which are generally less equipped than private facilities. In urban areas around 28 percent of all women delivered in a public facility as compared to only 7 percent in rural areas.⁴³

Even for women delivering in health facilities, the poor quality of care carries significant risks. A 2008 UNFPA report⁴⁴ lists obstacles to reduced maternal mortality related to the provision of obstetrical care in public sector maternity services:

- Ineffective management of health programs due to a deficit of skilled administrative staff at the departmental (and health facility) level.
- A lack of effective strategy for deploying the much needed midwives now graduating from the midwifery school, which was reopened in 2000: Graduates are dispersed throughout the country so that no hospital maternity has sufficient staff to apply existing obstetrical care norms. Also, student midwives do not have access to adequate practical training.
- A shortage of human resources in anesthesia.
- An insufficiency of transfusion supplies and services.
- Materials and supplies for management of obstetrical emergencies either unavailable or unaffordable.

The high levels of home deliveries are not solely attributable to the access, quality, cost, and distance factors already mentioned. Other important reasons that women choose to deliver at home include sociological and cultural factors: a preference for a female attendant at birth, an adherence to traditional birth practices (which include an herbal “cleansing” after birth), and a traditional period of seclusion of the mother after birth. One additional factor was mentioned to members of the assessment team: In the highly hierarchical society of Haiti, some health personnel allow their behavior toward patients to be negatively influenced by their perceived superiority to their clients, especially when dealing with the poor. This behavior may have an especially strong impact in care-seeking behavior of pregnant women, who are more likely to want and need positive support at delivery. When asked about what prevented them from seeking facility-based health care, 28 percent of women responded that they did not want to go alone.⁴⁵

In many community settings, TBAs,⁴⁶ most over 60 years of age, have little contact with the formal health care system. This problem has been addressed in some donor-supported MCH initiatives through training programs for traditional birth attendants aimed at improving linkages between the modern and traditional birth care systems while increasing TBA skills. In these programs, TBAs are encouraged to accompany their clients to the health facilities for prenatal and delivery care and are empowered and trained to provide effective community-based pre- and postnatal care.

The *super matrones* program initiated at Pignon is an effort to improve the quality of care provided by TBAs. *Super matrones* are the literate daughters and/or nieces of traditional birth attendants. They are trained in basic obstetrics, FP, and prevention of mother-to-child transmission (PMTCT). The primary responsibilities of the *super matrones* are to identify pregnant women in their communities, conduct prenatal visits in the home, convince these women to go to the hospital maternity for delivery and accompany them there, and to conduct postnatal visits within three days of birth, referring any cases of complications to the hospital. In interviews, the staff of the Pignon maternity claimed that these *matrones* are considered an integral part of the maternity team. The review team was unable to evaluate this program and did not meet any of the *super matrones*. Pignon staff reported that the number of women giving birth with a trained provider in a facility in Pignon is double the national average and that births in facilities are up 57 percent because *super matrones* are clearly linked with the referral facility, pregnant women have birth plans, and these *matrones* have a good working relationship with service providers. Pignon has trained and worked with groups of *super matrones* for five years.

Prenatal Care

The proportion of Haitian women completing at least one prenatal visit with a qualified health professional has increased from 79 percent to 85 percent over the last five years. However, while access to prenatal care is apparently improving in rural areas, the rate of prenatal care in urban areas has dropped over the last five years from 78 percent in 2000 to 71.5 percent in 2005⁴⁷.

Overall, 8 out of 10 pregnant Haitian women have seen a qualified health professional at least once prior to their most recent delivery and 49 percent have seen a physician. Nearly 54 percent of women have completed the WHO-recommended four or more prenatal visits and 27 percent have had two to three. Two-thirds of women had their first prenatal visit within the first four months of pregnancy, but more than one in 10 waited until after the first six months. The poorest 20 percent of women are 15 percent less likely to have visited a health professional than those in the next-highest economic quintile. Access to prenatal care has been expanded in recent years through mobile health clinics and the training of community-based birth attendants, including *super matrones* in some localities. This may account for the increasing number of rural women who are receiving at least one prenatal visit. However, the quality of prenatal care needs to be improved. Only 43 percent of women were informed about the signs of pregnancy complications during the prenatal period. Thirty percent did not have a blood test. Only 63 percent of women who have given birth in the last five years were fully protected against tetanus; 11 percent were partially protected and 25 percent were not protected⁴⁸.

In Pignon, the team was told that many prenatal visits were conducted by trained traditional birth attendants or *super matrones*. These visits are not counted as “official” prenatal consultations, however, until the pediatrician has signed them off. Studies have found that prenatal care provided by midwives and general practitioners was associated with improved perception of care by women when compared with specialist care. Clinical effectiveness was similar.⁴⁹ With regular formative supervision, confidence in the abilities of *super matrones* to conduct effective prenatal consultations should grow.

The USAID-funded Haitian Health Foundation and Kombit sites are using a “birth plan” as a mechanism to assure that prenatal care at the community level is following a standard format and that mothers and their families are prepared for the challenges they will face in giving birth to a child in Haiti. Given the problems of access to health care, the use of the birth plan is a potentially effective mechanism to strengthen the partnership between the mother, her family, the community-based health care provider, and the health facility to reduce maternal and neonatal morbidity and mortality. The use of the birth plan provides an opportunity for the community health provider to educate the mother about simple actions she can take to protect her own health and that of her baby. It alerts her and the TBA to possible danger signs, provides an opportunity to encourage her to seek necessary prenatal care, to make arrangements for her to deliver at a health facility if at all possible, and to develop a relationship with a knowledgeable provider that can serve as the basis for postnatal follow-up. Even in a country where health services are not always accessible or of high quality, much can be done to improve pregnancy outcomes by the use of birth plans and by working with the resources that are available (TBAs, community health agents, auxiliaries, women and their families, community leaders, transporters).

The use of the birth plan is one element of the risk-based approach to the reduction of maternal deaths that has been adopted in Haiti. Using the birth plan form, community health providers and health auxiliaries are to identify women at risk of complications to refer them to a nearby maternity for delivery. Despite the positive elements of the birth plan approach, it should be remembered that worldwide experience shows that the majority of obstetric complications are unpredictable. For example, one study in Zaire found that 71 percent of women who developed obstructed labor were not predicted and 90 percent of women identified as “at risk” did not develop obstructed labor⁵⁰; a maternal audit reported in *British Medical Journal* found that only 6.3 percent of women “at risk” of postpartum hemorrhage suffered PPH in delivery. Prenatal screening for high-risk pregnancies cannot predict who will have complications at the time of delivery although it is effective in treating conditions that could lead to obstetric emergencies if left untreated (e.g., hypertension, anemia, diabetes, preeclampsia, HIV). Thus, maternal health programs need to focus on getting as many women as possible to give birth in a well-equipped facility with skilled providers. Obviously, in Haiti, it will take many years before even the majority of women will have access to the requisite level of care and simple community-based interventions will of necessity be the primary avenue to reducing maternal and neonatal mortality.

Under the USAID Haiti SDSH Project, the Four Delays Model⁵¹ is used to guide safe motherhood efforts. The model recognizes and addresses both medical and nonmedical factors that contribute to maternal deaths:

- Failure of the pregnant woman to recognize danger signs
- Cultural and socioeconomic factors that delay the decision to seek care
- Access and distance factors that delay arrival at an adequate facility
- Health system inadequacies that delay the provision of appropriate care

The model emphasizes the importance of rectifying inadequacies in health services because they affect all these delays. For women to decide to seek care, they must know that they can get appropriate care from skilled providers at a health facility that has adequate resources and is accessible.

Jon Rohde and Malcolm Bryant⁵² in their recent review made a number of concrete suggestions to improve community level prenatal care within the context of the USAID-funded SDSH Project:

- Introduce the birth plan at the level of TBAs (as well as patients) to provide closer oversight and guidance and continued plan improvement (a far simpler guide is required).
- Institute monthly meetings for all TBAs—review birth plans and any referrals each has made, reinforce referral mechanisms, and review danger signs and actions to take.
- Review all referrals made at TBA meetings and use the discussion to reinforce practical measures taken in the community and to motivate other TBAs.
- Make simple checklists (or use existing ones) for all maternal and infant deaths and review as a team (not for blame!).
- Simplify norms and standards to ensure policy reflects practical field activities rather than the present detailed norms, which cannot be instituted.

Obstetrical Care

Interventions to reduce maternal and neonatal deaths are a relatively neglected component of maternal and child health programs in Haiti. This is especially true at the health facility level. Recent significant increases in the availability of USAID funding for HIV/AIDS services, including for PMTCT in conjunction with programs of other donors such as UNFPA and UNICEF, has provided an opportunity to improve obstetrical and neonatal care at maternities. As noted above, a major constraint to reducing maternal mortality is the lack of adequate staffing, equipment and supplies, especially those needed to deal with obstetrical emergencies, and including regular stock-outs of basic antibiotics. Use of HIV/AIDS funds is generally restricted to activities for PLWHA. However, it is a fact that the needs of HIV-positive women and their infants cannot be adequately met in a context of poor overall care for pregnant women and their newborns. Among other issues, restricting quality services to HIV-positive women risks exacerbating stigma and discrimination in care provision. Therefore, HIV funds should be used, in part, to upgrade obstetrical and neonatal care services for all women.

The SOG (Soins Obstétricaux Gratuits) pilot program was designed to increase access to facility-based obstetrical care by eliminating the barrier of cost of services. Started in April 2007 with a one-year budget of USD 4,222,403⁵³ provided by CIDA, supported by PAHO/WHO, and implemented by the MSPP, the SOG was initially applied in nine hospitals. The program now covers 49 health institutions throughout the country, most located in the West, Center, and Artibonite Departments. The catchment areas of these 49 facilities contain 72 percent of the population of Haiti. SOG pays participating health facilities a stipend of 800 Haiti gourdes (HTG) (1 USD = 38 HTG) per delivery. Participating hospitals agree to provide the entire continuum of maternity services free to all clients, including free prenatal and postnatal visits, laboratory tests, provision of drugs, transportation, and delivery. An initial 165 persons were trained on the Prenatal Information System and Management tools. Contracts with participating institutions were signed in February and March 2008. When the project was conceived, a 40 percent increase in institutional deliveries was expected. These targets were exceeded within the first month of implementation. Documents and interviews indicated that all institutions conducting free obstetrical services have exceeded the target: institutional deliveries increased by 52 percent in Hôpital St-Boniface in the South and up to 224 percent in Hôpital de Fort Liberté in the North East.⁵⁴ The USAID-funded SDSH Project is also implementing SOG in its geographical coverage area.

This initial success represents a clear demonstration that cost is a major impediment to care seeking. However, there are no data to indicate whether the increased access to facility-based services has had any impact on maternal mortality. There are several other important issues to be considered prior to further expansion of this program:

- The HTG 800 allocation per delivery reportedly covers less than one-third the actual cost of providing services, estimated at between USD 75 and 80 by donor representatives and health facility administrators interviewed by the team. The difference has to be covered from meager health facility budgets. Some smaller facilities, especially, are reporting that the great increase in the number of women delivering at their facility is creating a serious financial burden that may undermine other services. In addition to the heavy costs borne in the provision of care, the SOG is undermining preexisting cost-recovery programs that were the primary source of discretionary budgets, especially for public institutions. At least one major hospital, Albert Schweitzer in Artibonite, reportedly refused to participate in the SOG program for this reason.
- The SOG program did not include any support to participating institutions to improve the quality of care, no equipment and supplies, no health provider training, no supervision. The only result measured is the increase in facility-based births. There has been no attempt to collect data regarding improved maternal outcomes, in terms of either maternal or neonatal morbidity or mortality. One donor representative told the team that he believed that there was very little control over how the funding was spent.
- Donor-supported free care increases the vulnerability of the whole health care system to changes in levels of donor funding or donor policies. The SOG program was initially funded for one year. At the time of this writing a second year's funding of the same magnitude had been obtained. It has been suggested that continuation of the program could

be funded through debt relief funds. There is no clear long-term strategy to maintain the program, which is scheduled to end in 2010. It is unlikely that either the MSPP or the participating institutions will be able to pick up these costs if no additional donor funding is located.

Another relatively recent innovation, initially introduced in Haiti in 2001 by the Haitian Health Foundation (HHF), is the establishment of a Maternity Waiting Home (MWH) facility at major hospital maternity centers. These facilities provide lodging to pregnant “at risk” women to stay at the hospital prior to delivery for a period of days or weeks. Criteria of eligibility include presence of “danger signs” (multiparity, history of hypertension, diabetes, short stature [under 1.45 meters], low weight [under 45 kilograms], youth [under age 17], advanced age [over 35]), and nonclinical factors such as living far from the health facility. The length of stay is limited to the minimum required by severity of risk, in order to accommodate as many women as possible. The MWH is staffed by a midwife or pediatrician available around the clock. Women are provided education about delivery, newborn health, birth preparedness, breastfeeding, and other related issues. The HHF-supported MWH, Foyer de l’Espoir in Jérémie, was established in 2001 and has 30 to 40 beds. Twelve hundred to 1,500 pregnant women come there each year for prenatal care. The hospital at Pignon has started construction of a similar facility.

Postnatal and Neonatal Care

Internationally, the proportion of child deaths that occurs in the neonatal (less than one month of age) period was estimated at 38 percent in 2000. Three-quarters of neonatal deaths happen in the first week—the highest risk of death is on the first day of life. Globally, the main direct causes of neonatal death are estimated to be preterm birth (28 percent), severe infections (26 percent), and asphyxia (23 percent). Neonatal tetanus accounts for a smaller proportion of deaths (7 percent), but is easily preventable. Sixty to 80 percent of neonatal deaths arise in low-birthweight babies. Maternal complications in labor carry a high risk of neonatal death, and poverty is strongly associated with an increased risk.⁵⁵

A study conducted at the Albert Schweitzer Hospital in Artibonite Department noted that 35 percent of the under-five deaths occurred in the first month, and among the neonatal deaths, 27 percent occurred in the first day of life and 80 percent within the first 10 days. Of these deaths, it is estimated that 9 percent were the result of neonatal tetanus.⁵⁶ Given that only one-quarter of Haitian mothers give birth in health facilities, it is likely that most of the neonatal mortality in Haiti goes unrecorded.

Preventing deaths in newborns has not been a focus of the USAID or other donor programs. In 2005 and 2006, a total of 144 persons, including 23 doctors, 68 nurses and midwives, and 53 auxiliaries were trained on maternal and newborn care.⁵⁷ No training on maternal and newborn care was conducted in 2007 and 2008. Many neonatal deaths can be prevented through effective postnatal care. In Haiti, among the majority of women who gave birth at home, less than 13 percent had a postnatal consultation within two days after giving birth, while more than 80 percent had no such consultation. Of those who delivered in a health facility, 74 percent benefited from a postnatal visit within two days of the birth. Nearly 21 percent, however, did not have any postnatal consultation.

The 2005 *Lancet* Series on Neonatal Survival identifies cost-effective strategies to reduce neonatal mortality and estimates the percentage reduction on neonatal mortality of each type of intervention (Table 3). Interventions include those to be implemented during the prenatal, intrapartum, and postnatal periods, both facility based and community based.

Table 3. Evidence of Efficacy of Key Interventions to Reduce Neonatal Mortality*

Intervention and Period of Intervention	Percentage Reduction in All-Cause Neonatal Mortality or Morbidity/Major Risk Factor (Effect Range)
Preconception	
Folic acid supplementation	Incidence of neural tube defects: 72% (42%–87%)
Prenatal	
Tetanus toxoid immunization	33–%58%
Syphilis screening and treatment	Prevalence dependent
Preeclampsia and eclampsia prevention (calcium supplementation)	Prematurity: 34% (1%–57%) Low birthweight: 31% (1%–53%)
Intermittent presumptive treatment for malaria	32% (1%–54%)
Detection and treatment of asymptomatic bacteriuria	Incidence of prematurity/low birthweight: 40% (20%–55%)
Intrapartum	
Antibiotics for premature rupture of membranes	Incidence of infections: 32% (13%–47%)
Corticosteroids for preterm labor	40% (25%–52%)
Detection and management of breach (cesarean section)	Perinatal/neonatal death: 71% (14%–92%)
Labor surveillance (including partograph) for early diagnosis of complications	Early neonatal deaths: 40%
Clean delivery practices	58%–78%
Postnatal	
Resuscitation of newborn baby	6%–42%
Breastfeeding	55%–87%
Prevention and management of hypothermia	18%–42%
Kangaroo mother care for low birthweight infants in health facility	Incidence of infection: 51% (7%–75%)
Community-based pneumonia case management	27% (18%–35%)

*Source: Darnstadt, G. L., et al. 2005. "Evidence-based, Cost-effective Interventions: How Many Lives of Newborn Babies Can We Save?" *The Lancet Neonatal Survival Series*.

In Haiti, the strengthening of community-based postpartum programs will continue to represent a key means to reduce neonatal mortality. Using birth plans, trained TBAs can instruct mothers on the simple essential care elements (e.g., prevention of hypothermia by skin-to-skin contact,

covering the newborn's head, delaying the first bath; breastfeeding soon after birth and on demand; kangaroo care for low-birthweight infants; cord care; and infection recognition). TBAs should be empowered to conduct postnatal visits of all women giving birth in their community as well as to provide appropriate care during and after delivery. Existing community-level health support groups can be mobilized to increase awareness about the causes of maternal and neonatal mortality and to help families learn about effective care.⁵⁸ Building strong links to existing health facilities, as is being done in the Pignon *super matrones* program, will further reinforce the impact of these community-based activities.

Abortion and Postabortion Care

The performance of abortions is governed by the provisions of the Haitian Penal Code, which is based on Article 317 of the French Penal Code of 1810. Any person performing an abortion is subject to imprisonment, whether the woman consented to the abortion or not. A pregnant woman who performs her own abortion or permits an abortion to be performed on her is also subject to imprisonment. A medical professional who performs an abortion will be punished with forced labor. Nonetheless, an abortion can be performed to save the life of the pregnant woman.

The incidence of abortion in Haiti is believed to be relatively high, particularly in urban areas. The 1994–1995 Demographic and Health Survey found that 3 percent of women admitted to at least one abortion since the onset of sexual activity; the proportion was 6 percent in Port-au-Prince and 3.5 percent in other urban areas. A 2007 UNFPA study speculated that Haiti's stagnant contraceptive prevalence rate (CPR) and decreasing fertility rate might be partially explained by the use of abortion as a regulatory fertility method in the absence of access to contraceptive methods. The official abortion rate was calculated at 7 percent and the number of women suffering complications from abortion 32.5 percent.⁵⁹ A culturally unacceptable practice in Haiti, abortion remains a taboo subject; thus it is difficult to obtain statistics on abortion practice in the country. Some health care workers admitted that the practice is more common and widespread than reported. In the health facilities visited by the team, health care providers said that postabortion care was routinely provided as part of obstetrical care.

The incomplete reporting and taboo nature of the topic was evident in a 2008 Family Planning Situation Analysis conducted by the Population Council. It revealed that hospital statistics for postabortion care were worse than for those of deliveries. Interviewees from six of the nine hospitals studied said that they kept a record of the number of women who had received postabortion care, but only one hospital was able to show the records.

Many women may be using both traditional and modern medications to effect abortions. At least 20 plants reportedly in use are said to have contraceptive and abortifacient properties. Women, especially in urban areas, may be using misoprostol (available in Haitian pharmacies under the brand name Cytotec) to induce abortion, because it has fewer complications than more traditional abortion methods. Some women reportedly use high doses of antimalarial drugs.

c. Family Planning⁶⁰

Family planning is currently the poor stepchild of maternal and child health services in Haiti, despite a recent initiative to revitalize FP services by “repositioning” them.⁶¹ Family planning services were first introduced in Haiti in the late 1960s in private-sector health programs, followed several years later by their introduction in public facilities. After substantial reductions in FP funding in the late 1980s, services in public institutions diminished, leaving private institutions, including NGOs, as the main providers of FP services. For the last 20 years, family planning services have suffered from a range of management and operational problems, including frequent stock-outs, inadequate provider knowledge, poor quality of care, poor counseling, limited method mix, and limited access due to uneven distribution of services throughout the country.⁶²

Contraceptive prevalence for women in union climbed steadily in Haiti from an estimated 7 percent in 1979, to 13 percent in 1994, to 22 percent in 2000 and to its current level of 25 percent, according to the 2005 DHS. However, CPR in Haiti lags well behind the 60 percent average for the Latin America and Caribbean region as a whole. The rate is only slightly higher in areas covered by current USAID MCH/FP projects (29.5 percent), as recorded in the 2007 MSH Final Project Report. Recent data seem to indicate a leveling off of the rate of increase in CPR, despite continued reductions in overall fertility of Haitian women.

Role of Family Planning in Maternal and Child Health

Family planning is a powerful intervention for the reduction of maternal, infant, and child mortality. Increases in contraceptive prevalence have been shown in many studies to be closely linked to substantial reductions in

- Maternal mortality
- Infant and child mortality
- HIV/AIDS morbidity and mortality

Studies in Bangladesh and other countries have shown that, even without improvements in obstetric care, a 10 percent reduction in pregnancies will lead to a 10 percent or greater reduction in maternal deaths. Risk of maternal death is 1.5 to 3 times higher for women with five or more children than for women with two to three children.⁶³

The relationship between increased birth intervals and infant and child mortality is well documented. Longer birth intervals affect the mortality risk of both the preceding child and the current one. With birth intervals of less than 18 months the preceding child has an increased risk of death of 50 percent. The average risk of death in infancy increases by 60 percent to 70 percent for children born less than two years apart. Increases in birth interval can also have a substantial effect on child nutritional status, leading to substantial reductions in stunting and chronic malnutrition.⁶⁴ In Haiti, children born less than two years after their next-youngest sibling face a nearly 30 percent greater risk of dying before their fifth birthday than those born more than two years later and a 52 percent greater risk than those born three years later. A child born less than two years after the preceding child is nearly two times more likely to die than one born three

years after his or her sibling. An increase of the average birth interval from current levels to 36 months could avert 38,907 child deaths.⁶⁵

Family planning reduces HIV morbidity and mortality through reducing the risk of transmission between partners (condoms) and the risk of mother-to-child transmission as well as by reducing the health effects of pregnancy on the HIV-positive woman and reducing the stress of pregnancy and childbirth on family resources in the families of PLWHA. In one health facility in Haiti, the rate of transmission of HIV from mother to child dropped from 30 percent to 8 percent after family planning services were introduced.⁶⁶

Fertility Patterns

Culturally in Haiti, children are an essential element in cementing a relationship between a man and a woman. Haitian men recognize their responsibility for the care of their children and, for Haitian women, having a child thus represents a claim on a man's resources and one of the few ways to access the resources of another person.⁶⁷

Although overall fertility rates have decreased steadily over the past decades from 4.8 children per woman on average in 1995 to 4.0 more recently, and this pattern holds true across all age groups—fertility is still high and childbearing begins early in a woman's life. Haitian women enter into union at an early age, at least in part due to the economic pressures they face. By age 15, nearly 7 percent have already been in union and by 18 years of age, 29 percent have. Sixteen percent have had their first sexual encounter by age 15 and nearly one-half by the age of 18. By age 17, 11.4 percent of Haitian adolescent females have had a child or are pregnant. By the age of 19, this is true for 29 percent. Also, 22.2 percent in this age group have a second child within 18 months and an additional 27 percent have a second child within two years. Child spacing tends to increase with the age of the mother, with an overall average of 34 months between births, close to the optimum delay recommended by health professionals. In the 20–29-year age group, spacing between births has increased to an average of 31 months. Forty-five percent of births, on average, occur more than three years after that of the next-oldest sibling.⁶⁸

This suggests that adolescents are a key target group for family planning information and services, with an emphasis on delaying sexual activity and childbirth and increased spacing of births. Women over 35 are the other key target group, with an emphasis on increased information about and access to long-term methods of family planning, including intrauterine devices (IUDs) and surgical contraception. Given the pressure on Haitian women to have children in order to establish a relationship with a male partner, increased income-generating activities for young women, combined with increased access to reproductive health information and services, would be a potent strategy to increase women's ability to manage their reproductive choices.

Use of Contraceptives

As confirmed by a 1998 WHO study, Haitian women tend to use contraceptives more frequently when they are not in union. The frequent break-up of relationships may also be one of the factors in the high level of abortions. It was suggested to the team that women may abort a fetus when

their current relationship has ended before the child is born, or when the woman is entering a new relationship with a man who is not the father of the child she is carrying.

The 2005 DHS reports that, overall, 42.6 percent of all Haitian women have used a modern contraceptive method, including 16.5 percent of adolescents. Among women in union and sexually active women not in union, this proportion increases to 56 percent and 58 percent, respectively. However, only 18 percent of all Haitian women and 7.5 percent of adolescent females are currently using a modern contraceptive method. For women currently in union, 24.8 percent do so, and for those that are sexually active but not in union, the proportion is 31.5 percent. Urban women use contraceptive methods more frequently than rural women: 28.2 percent of urban women and 22.3 percent of rural women are currently using a modern contraceptive method. In addition, 5 percent of all women and 2.3 percent of adolescents use a traditional method.

Almost 60 percent of women not currently using a contraceptive method say they plan to use one in the future. Injectables are the most popular method, with 52 percent of women who are not currently using a contraceptive method, but intending to use one in the future citing this method as their preferred choice. Pills (18 percent) and Norplant (14 percent) are the second and third choices.

Knowledge of Contraceptives

The 2005 DHS reports that knowledge of contraceptive methods is high: almost all Haitian women know at least one modern method. The lowest levels of knowledge relate to the female condom (65 percent know of it), nine-month lactational amenorrhea method (MAMA-9, 66 percent), vasectomy (51 percent), and the morning-after pill (13 percent). However, despite high levels of general knowledge, Haitian women currently have few opportunities to acquire additional information about family planning methods or to clarify their concerns about the possible negative effects of contraceptive methods. Only 46 percent have heard about family planning through the mass media during the last couple of months. The least educated, the youngest (ages 15 to 19), the oldest (ages 44 to 49), and rural women are the least likely to have had access to information concerning family planning through the mass media (respectively, 38 percent, 37 percent, 48 percent, and 41 percent of these women had received family planning information through the mass media during the previous months). Most of these women are also not receiving family planning information from health care providers. Overall, 87 percent of women who were not currently using a contraceptive method had received no information about family planning from health providers during the past 12 months.

Unmet Need and Demand

The 2005 DHS showed that nearly 50 percent of Haitian women in union do not want any more children and over 30 percent desire to space their next child by more than two years. Unmet need for family planning, that is, the proportion of women in union who wish to space or limit their children, but are not currently using a contraceptive method, has increased since 1995 from 27 percent to around 38 percent over each of the last five years. The desire to limit births among women in union who are not currently using contraception has decreased since 1995 from 23.5

percent to 20 percent in 2005, while the desire to space births has increased from 10 percent in 1995 to 17 percent today. Given that long-term methods are not widely available, the drop in demand for limiting is perhaps not surprising. When combined with the number of women currently using a contraceptive method, overall demand for family planning in Haiti can be estimated at 70 percent. This means that currently only 36 percent of overall demand is being met.⁶⁹

Nearly 50 percent of women aged 30 to 34 wish to limit their family size, but only a very small percentage are using a long-term method. By age 30 to 34, 58 percent want no more children, and by age 35 to 39, 68 percent desire to limit their family size. Among the younger age groups of 15 to 19 and 20 to 24, 77 percent and 61 percent, respectively, wish to wait more than two years for their next child. In these age groups, 50 percent of adolescents in union and 35 percent aged 20 to 24 wish to space their births but are not currently using a contraceptive method.⁷⁰

Reasons for the high levels of unmet need include the following:

- Lack of access to contraceptive methods due to the frequency of stock-outs of contraceptives (see section on logistics) and a limited range of method choice in most health facilities. This is especially true for long-term methods.
- The lack of systematic integration of FP services in all maternal and child health interventions: While family planning counseling appears to be relatively well integrated into prenatal consultations (62 percent receive some family planning information during prenatal visits), it is rarely a part of postnatal care. A recent study showed that nearly three-quarters of women interviewed after childbirth said that they had received no family planning information during their hospital stay for delivery, and only 14 percent of these women said that a provider had explained the risk of a new pregnancy. When such information was provided, multiparous women were more likely to receive it than nulliparous or primiparous women. One-third of the hospitals surveyed had no OB-GYN provider specifically assigned to provide family planning services.⁷¹ Only 25 percent of mothers were provided with family planning counseling during postpartum check-ups.⁷²

Furthermore, FP does not seem to be systematically addressed in the course of other mother and child contacts with health agents. At the health sites visited by the team, all claimed to address FP issues during group education sessions in the waiting room, but not systematically during individual consultations. Although family planning services are provided through community outreach programs, transportation constraints mean that these contacts can be infrequent. There are thus many missed opportunities.

- Women's fear of potential side effects: Among women not currently using a contraceptive method and who did not intend to use one in the future, 26.9 percent declared that they feared side effects and 19 percent cited other health issues as the reason for not wanting to use modern contraception. Only 7 percent said they were opposed to FP, 7.5 percent cited religious reasons and only 2.3 percent said their partner was opposed. Other reasons were cited by less than 1 percent of women interviewed.

- Frequent migration interrupts access to contraceptives and also makes it more difficult for health personnel to conduct follow-up with current users.
- Weak family structures and precarious living conditions lead to poor sexual choices and unstable relationships.
- Condoms are not seen as a family planning method, but as a method of prevention of HIV and sexually transmitted infections (STIs) so they are frequently not used by couples in union, as to do so would be to admit unfaithfulness.
- Despite a high level of awareness about the existence of various methods of contraception, there appears to be considerable misunderstanding about how they function. For example, some women seem to believe that pills are an ineffective method, as the woman continues to have her period; men believe that vasectomy will render them impotent; knowledge about the period of fertility is very weak: according to the most recent DHS, only 21 percent of women can situate the fertility period in the menstrual cycle.

Postpartum Family Planning

Only 23 percent of Haitian women use family planning within the first year after the birth of a child, although only 2 percent of these women say they want another child within the next two years. For those aged 15 to 19 years, fewer than 15 percent use a contraceptive method in the first year postpartum. Despite that, 76 percent of women recommence sexual activity within 4 to 6 months. For 34 percent, menses returns during this same time period, and only 24 percent of infants are exclusively breastfed at this age. Thus these women have a high risk of becoming pregnant again before they want to do so. Nearly 50 percent of 15-to-20-year-old mothers give birth within the following two years; while just over 15 percent of mothers aged 20 to 29 years do so. Unmet need for spacing and limiting of births reaches 80 percent in the first three months postpartum and over 60 percent by the end of the first year. Among those women who do use contraceptives postpartum, the majority use injectables.⁷³

Apparent Contradiction between Stagnating CPR and Decreasing Fertility

Overall fertility decreased to four children per woman while use of contraceptives remained largely stagnant between 2000 and 2005. This apparent contradiction may be partially explained by the following factors:

- Increasing destabilization of family and other bonds between men and women resulting from migration, increased mortality, partially related to HIV/AIDS, as well as increased fragility due to poor nutritional status and other factors (apparent increase in maternal mortality) and high levels of violence both within the community and within families. This may be leading to longer periods of time that women are not in union and/or not sexually active.
- The apparent increased use of contraceptive methods by men and women who are not currently in union, both for STI (HIV/AIDS) prevention and pregnancy prevention.

- Reductions in the desired number of children. According to the 2005 DHS Haitian men and women currently consider their ideal number of children to be three.
- Limited data indicate that high rates of abortion are contributing to fertility decrease, especially among younger age groups.

Role of Social Marketing

Social marketing programs have been present in Haiti for nearly twenty years, with the introduction of Panté, a male condom, in 1989. Though primarily aimed at preventing HIV/AIDS, Panté and Reyalite, a female condom introduced in 1996, can also be considered dual protection products as they also are a form of family planning contraceptives. Two additional contraceptives were introduced in 1996; namely, Pilplan, an oral contraceptive, and Confiance, a three-month injectable. Additional social marketing products to address maternal and child health soon followed. In 1998, Sel Lavi, an oral rehydration salt, was introduced, and in 2005 and 2006, respectively, Babyfer, a micronutrient supplement, and Dlo Lavi, a water purification system, were first marketed in Haiti.

Though the precise impact of socially marketed products on health indicators cannot be determined, mainly due to a lack of data collection in this area, their contribution to improving family planning/reproductive health and maternal and child health should not be underestimated. Sales in 2007 of Panté were nearly 4.8 million, Reyalite sales were approximately 113,000, more than 226,000 cycles of Pilplan were sold, and sales of Confiance were nearly 143,000. Likewise, sales for Sel Lavi and Babyfer typically average more than half a million per year.⁷⁴ Population Services International (PSI), one of the main social marketing organizations in Haiti, has estimated that from 2003 to 2007 the gains were: 78,000 disability-adjusted life years (DALYs)⁷⁵ for HIV-related products (condoms are included in this category), 11,575 DALYs for FP-related products, and 6,029 DALYs for MCH products.

However, it should be noted that the branding and selling of health products has not been the only contribution that social marketing has made to family planning and maternal and child health in Haiti. Through both its generic mass media campaigns and targeted education materials and peer education, social marketing has contributed to changing behaviors. Further, through developing local NGO capacity to market, distribute, and sell the products, social marketing is contributing toward a more sustainable health system in Haiti.

d. Child Health

Overview

Infant and child mortality levels in Haiti are among the highest in the world. Nevertheless, the latest Demographic and Health Survey (2005) shows a steady decline in infant and child mortality in Haiti over the past 30 years. Since 1986, infant mortality declined by 48 percent, from 190 per 1,000 live births to 57 per 1,000 live births, and under-five mortality has declined by 42 percent from 156 per 1,000 live births to 86 per 1,000 live births. Neonatal (before the age

of one month) and postnatal mortality (between one and two months after birth) have also declined dramatically: compared to 1994, infants in 2005 had a 24 percent diminished chance of dying before one month of age and a 40 percent decreased chance of dying between one and two months of age.

In rural Haiti, however, children have a 46 percent greater chance of dying before their fifth birthday than their counterparts in urban centers. Also, children born in the Departments of Center (excluding the metropolitan area), West, Artibonite, and Northeast have a much greater probability of not reaching their fifth birthday than children born in other locations. Children of nonliterate mothers are much more likely to die than those whose mothers have had some postprimary school education (infant mortality of 87/1,000 and 53/1,000, respectively).⁷⁶

Serious illnesses in children commonly occur sequentially or concurrently before death. For example, measles is commonly complicated with pneumonia and diarrhea. Underweight status and micronutrient deficiencies also cause decreases in immune and nonimmune host defenses, and should be considered underlying causes of death. In children with vitamin A deficiency, the risk of dying from diarrhea, measles, and malaria is increased by 20 percent to 24 percent.⁷⁷ Acute respiratory infection (ARI), particularly pneumonia, and diarrheal diseases are the main causes of mortality in children under five years of age in Haiti.⁷⁸

In 2005, the DHS reported that the prevalence rate for diarrhea was 24 percent among children under five, with children aged six to 11 months most affected (41 percent prevalence). Sixteen percent of child deaths before the age of five years was attributable to diarrheal diseases.⁷⁹ While diarrheal prevalence does not appear to be affected by access to a safe water source, children living in households with improved sanitary facilities are less likely to experience an episode of diarrhea than those without (19 percent versus 24 percent under-five prevalence). Nearly 26 percent of children with diarrhea received no treatment whatsoever. Thirty-two percent were taken to a health facility for care in 2005. This is more than double the proportion that received health facility-based care in 1995.⁸⁰

Ninety-seven percent of mothers know about ORS as the treatment for diarrhea. There has been an 83 percent increase in the use of oral rehydration solutions, including ORS packets (40 percent), home solutions (7.4 percent), and increased liquids (25.5 percent) for the treatment of diarrhea since 1995 (57 percent overall today compared to 31 percent previously). Poor and uneducated mothers still provide ORS less frequently than somewhat wealthier mothers, however. Use of ORS packets is also affected by frequent stock-outs.⁸¹

Despite these successes, care of children with diarrhea, especially in the home, is still insufficient. Especially worrisome is the large percentage of mothers who reduce the quantity of liquids (32 percent) and food (53 percent). In 5 percent of cases food was completely withheld.⁸²

Twenty percent of under-five deaths are attributable to pneumonia.⁸³ The 2005 DHS showed that although there has been an increase in the percentage of children with ARI who are treated in a health facility, from 27 percent in 2000 to 35 percent in 2005, this rate of referral is still very low. Children in the Nippes and South Departments are even less likely to receive medical care for an episode of ARI: only 12.5 percent in Nippes and 16 percent in South are referred to a

health facility. Overall, only 5 percent of children with ARI received antibiotics. In Nippes and the West, only 2 percent did so. This is in part a reflection of the lack of drugs in health facilities. In almost all facilities visited by the team there was a shortage of antibiotics. Some facility staff reported using stocks provided for the care of HIV-positive people to treat all children.⁸⁴

The prevalence of fever in children under five is 28 percent. Only 5 percent seek care, and 4 percent are treated with chloroquine.⁸⁵

The overall immunization coverage rate for children under the age of 12 to 23 months is 41 percent, and only 33 percent of children fully are immunized before 12 months. Thirteen percent have not received any vaccine. Coverage of pregnant women and women of childbearing age is low (tetanus toxoid reported at 55 percent for 2005). This is in large part due to a high percentage of mothers who give birth at home and do not have regular contact with prenatal services. The low overall rate of coverage could also be due to low coverage of urban areas by NGOs and disruptions in coverage due to ongoing urban violence.⁸⁶

Integrated Management of Childhood Illness

According to the 2003 *Lancet* Child Survival Series, simple proven interventions can prevent 63 percent of current under-five mortality. Breastfeeding and oral rehydration therapy alone are estimated to be able to prevent 13 percent and 15 percent of all under-five deaths, respectively. Other interventions include complementary feeding (6 percent); antibiotics for pneumonia (6 percent); zinc to reduce diarrhea and pneumonia death (5 percent); insecticide-treated materials (7 percent); and antimalarials (5 percent). Many of these interventions can be applied at the community level. At the facility level, IMCI is a widely recognized effective approach to assure that each child visit to a health facility provides an opportunity to review and intervene in the whole range of major causes of child mortality.

IMCI was adopted as official MSPP policy as early as 1997 and is included in the Minimum Package of Services (MPS) published by the MSPP in April 2006. In 2000, UNICEF supported the training of health facility staff in some departments, but funding expected from USAID did not follow. In the Department of Grand'Anse, four training sessions on community C-IMCI were conducted and two more are planned with UNICEF funding. IMCI wall charts were posted in almost every health facility visited by the team one, but it was not clear to what extent IMCI practices were routinely followed. Jon Rohde⁸⁷ reported seeing stacks of IMCI forms in clinics "without a single mark on them." In general, insufficient staff has been trained to date and there are an insufficient number at each health facility to create a critical mass of trained personnel to assure a systematic adjustment of child health care practices from the vertical, disease oriented approaches to the integrated management model. In addition, chronic shortages of drugs and equipment, including antibiotics, are a significant barrier to improved quality of care.

There are exceptions to the general lack of facility level IMCI. In HHF, C-IMCI is being well implemented in HHC health clinics. All auxiliaries have been trained in a two-week training program. The form used to assess patients includes identification of danger signs, fever, ARI, diarrhea, nutrition and immunization, weight, treatment, and counseling on a single, easy-to-use page. At the Centre Médical Charles Colimon de Petite Rivière de l'Artibonite, an IMCI form is

being systematically used for patient consultations, although it was not consistently filled out. Community-based IMCI is being implemented within USAID-funded MCH/FP programs using a simplified model.

e. Immunization

Immunizations in Haiti are achieved through two primary strategies: (1) routine immunizations administered at health facilities and in communities during outreach activities (mobile clinics) and (2) periodic campaigns. For many years and at present, large-scale immunization campaigns have been used to fill the large gaps left by the weak system of routine vaccinations. While short-term gains in routine vaccination may be made in specific programs and in geographic areas covered by donor-supported projects, these results can be rapidly undermined when funding is decreased or eliminated.

Routine vaccinations are undermined by several factors:

- Low rates of attendance at clinics
- Regular stock-outs of vaccines
- Poor management of the cold chain (cold chain technicians responsible for cold chain maintenance and repair are often not regularly paid, resulting in considerable staff turnover)
- Transportation problems hampering community outreach to isolated communities
- Missed opportunities for vaccination at the facility level
- Incomplete coverage of the population by fixed facilities

About two years ago, with the IDB funding, MSPP implemented a new strategy designed to strengthen the routine immunization program relying on teams of health agents, called *Brigades*, to reach children living in hard to reach regions. This experience did not achieve the expected results. Lessons learned from this unsuccessful experience led partners into more comprehensive planning at the peripheral level using the “Carte Sanitaire.”

It is unlikely that all of Haiti’s maternal and child vaccination needs will be covered by routine vaccination within the foreseeable future. However, with improvements in the routine coverage, periodic small-scale campaigns, especially against polio and measles, could be used as geographically targeted complements to routine vaccination to maintain coverage.

Immunization activities are managed by the MSPP Expanded Program on Immunization Directorate (DPEV) in Port-au-Prince. It is supported in its efforts by the Inter-Agency Coordinating Committee (ICC). The DPEV unit is understaffed, with two key managerial/technical positions, an Expanded Program on Immunization (EPI) director and a

technical assistant (working with training and program management). Vaccines, equipment, and logistics are managed by the MSPP through the PROMESS logistics system. Vaccines are delivered to the departments and from there to the health facility level by a push system resulting in frequent stock-outs, especially at the periphery: delays in distribution are frequent and/or insufficient quantities of vaccines are sent to departments and communes from Port-au-Prince. Stock-outs are also due to poor stock management at peripheral levels. Moreover, the system at the national level is not responsive to requests for additional vaccine supplies in NGO areas that have increased vaccination coverage in recent years. Despite NGOs' documented increased needs, the central EPI Directorate still uses outdated vaccine distribution calculations.

Rates of coverage in areas covered by USAID -funded projects are considerably higher than the national average, as are rates in some areas covered by other, non-USAID-funded NGOs. According to the SDSH 2007 Final Report, the rate of childhood immunizations increased from 21 percent to 63 percent in public-sector project target areas (population served is approximately 1.5 million). In NGO network areas 93 percent of children are fully immunized before 15 months. SDSH NGO partners are funded under performance-based contracts and thus may be highly motivated to assure less frequent stock-outs of vaccines and regular distribution to sites.

In Haiti, all vaccines are supplied by the donor community, primarily UNICEF, PAHO/WHO, CIDA, and the Japanese International Cooperation Agency. USAID has supported immunization in Haiti for several years, providing funding to the MSH/SDSH project and other NGOs.

Donor efforts, including possible USAID support, to strengthen the role of the DPEV office with recruitment of new qualified personnel, and a structured chart with emphasis on the management of commodities, including vaccines and the cold chain, should improve routine immunization implementation. PAHO/WHO, in collaboration with UNICEF, is supporting reinforcement of the department level with one or two nurses (paid by the project) and a vehicle for coordination and supervision. Management and supervision tools will be developed. This effort to resuscitate the system is vital to increase immunization coverage, but needs to be sustained.

VII. HEALTH SECTOR LOGISTICS MANAGEMENT SYSTEM

The health sector logistics management situation has been anarchic for many years. The national “system” is woefully inefficient and ineffective. This may be due in part to the fact that the current essential drugs procurement agency, PROMESS, was at its inception in 1992, a hastily conceived stop-gap measure to provide essential drugs and supplies to the country during the Embargo period. Envisioned in a moment of crisis, PROMESS seems to have been modeled on the relatively short-lived AGAPCO (Agence d’Approvisionnement de Pharmacies Communautaires), the previous essential drugs agency that was set up under the USAID RHDS Project (Rural Health Delivery Systems, 1981 to 1986).

Although PROMESS is referred to as the “central procurement agency” of the MSPP, it remains a PAHO/WHO project to this day. Designed during a crisis to procure, store, and distribute essential drugs, once the embargo was lifted the MSPP and donors continued to view PROMESS as the central agency in Haiti’s drugs logistics system, without seriously reassessing its status as a WHO project or determining if the hastily established agency responded appropriately to the country’s needs and constraints. The 17 departmental drug depots (Centres Départementaux d’Approvisionnement en Intrants, or CDAI) still have no legal status, and it is unclear who is responsible for their maintenance and upkeep (MSPP central? MSPP regional? WHO?). As a result, most of the CDAIs have not been maintained and are in poor condition, albeit a few of them have benefitted from donor renovations.

Moreover, there is a lack of communication at all levels of the logistics system (between central-level MSPP and the departments, between and within departments; between MSPP central departments and PROMESS). There are frequent stock-outs, untrained and demotivated staff, unclear procedures, poor forecasting, weak supervision and management, deficient technical capacity, and no active distribution of drugs and supplies. While there is general agreement that the logistics system is within the MSPP’s mandate, the MSPP lacks the financial, material, and human resources to manage and maintain the system. The DPM/MT (Direction de la Pharmacie du Médicament et de la Médecine Traditionnelle) is the MSPP regulatory body. Moreover, there are several MSPP technical offices that play a role in the system, even if it is not entirely clear what those roles are. There seems to be little or no coordination of activities, no oversight, and no accountability.

In a November 2007 MSPP-USAID meeting, USAID informed the MSPP that it would no longer provide contraceptives to health facilities that were not supported under a USAID project because, due to heavy staff turnover at the non-USAID sites, it was difficult to ensure that these sites were in compliance with Tiahrt. USAID also told the MSPP that it considered the MSPP’s logistics system to be unreliable and inadequate since batches of USAID contraceptives that had been issued to the MSPP were discovered being sold in the Dominican Republic and in the Bronx, New York. USAID told the MSPP that it would be willing to resume provision of supplies to the non-USAID sites when the MSPP demonstrates a sound, functional drug logistics system. Within 15 days following this meeting, USAID ceased provision of contraceptives to non-USAID sites. MSPP and USAID negotiated with UNFPA to take over provision of these sites on an emergency basis. Problems in securing transportation delayed provision for some

time. For reasons that are still unclear to the team, contraceptives have not been delivered in a timely fashion to USAID sites either. The timing and implementation of the decision continue to have negative consequences for family planning services. There were (and are) frequent stock-outs of contraceptives at all sites. The momentum of the family planning “repositioning” strategy that was starting to take off was broken.

The chronic stock-outs of basic drugs and supplies at health facilities have led to the creation of parallel procurement and distribution systems by international organizations (USAID, the Global Fund to fight AIDS, Tuberculosis and Malaria (hereafter called “Global Fund”), World Vision, Médecins Sans Frontières, and others) and private clinics and hospitals. It is reported that even some public-sector facilities have set up their own drug procurement systems.

The MSPP feels that these parties have usurped its role as manager of the sector’s logistics system while the parties justify their unilateral action (parallel systems) by asserting that the MSPP does not have the capacity to set up and run a viable system. Both sides have legitimate grievances, but to continue the finger pointing is counterproductive. The challenge is to design a system that is cost-efficient and operationally effective in meeting the different needs of health care facilities nationwide. The only good thing about the current dysfunctional situation is that it provides an opportunity to start anew. Once the vision of a new system is clear and agreed upon by all parties, the next challenge is to elaborate a coherent plan and define steps to be taken to set up and launch the system. To be successful, the plan requires widespread support and participation by all concerned parties.

In May of this year, the MSPP issued a “Plan to Strengthen the National Essential Drugs and Supplies System” in a document entitled *Projet de Création du Réseau National de Distribution des Intrants*. The project and plan were developed by the MSPP in consultation with donors (USAID/MSH, UNICEF, WHO, UNFPA) but there is not yet agreement on the vision for the new improved system, nor is there agreement on the plan to redress the situation.

As currently conceived, the proposed system seems similar to the status quo in that PROMESS remains the central procurement agency. Perhaps it is time to close out the 16-year-old WHO project and set up a new procurement body that is a unique GOH entity, with a clear mandate, budget, and position in the GOH MSPP organigram. Lines of authority need to be established and respected, and the relationships with the regional medical departments and procurement centers clearly delineated. Certainly, the location of PROMESS in one of Port-au-Prince’s “hot zones” is not acceptable. A new safe and secure locale is urgently needed. The new system also requires that the MSPP central technical offices (e.g., nutrition, family health, TB, HIV) approve every requisition for drugs for programs under their respective bailiwicks; this seems neither practical nor efficient. The team believes that the MSPP should rethink the role that it has assigned to its central technical offices and identify other mechanisms for ensuring that the types and quantities of drugs, and frequency of ordering, are appropriate (there are logistics software programs that are foolproof and can do this), with periodic oversight from the technical offices.

The private for-profit pharmaceutical sector includes three local production laboratories, 33 import agencies, 22 private distribution depots, and 240 private pharmacies. The sector prefers to import products that enable the largest profit to the detriment of basic essential drugs. From all

accounts, the private sector is not able to satisfy the demand for medicines and its distribution systems are also unorganized. People come to Port-au-Prince to stock up on medicines, going from agency to agency trying to negotiate the best deals. Even the private sector has stock-outs from time to time. This environment seems propitious for a strong social marketing program, if the proper authorities can be convinced of its benefits. The merit of expanding social marketing activities is the subject of another evaluation at this time. Suffice it to say that the needs of the Haitian population are not being met satisfactorily by either the public or private sector.

VIII. INDICATORS AND USE OF DATA

The review team was unable to complete a thorough review of the information management systems of USAID MCH/FP projects. What was clear from interviews and field visits is that the current volume of indicators being collected at all levels, in the words of Jon Rohde⁸⁸, “results in little attention to what the data means,” and therefore to little use of the data to guide implementation. As an example, the team met the regional coordinator of HIV/AIDS activities in one department. When asked about information collection, the highly competent professional pulled out her computer and showed the team chart after chart of indicators. When asked for an estimate of how many people in the department were HIV-positive, however, she was unable to provide an immediate answer. Nor was she able to tell the team how many babies were born HIV-positive in health facilities in her department. Her inability to answer these simple questions without further analysis of the data is a clear indication that the data she had collected on her computer was not used to regularly review and consider progress in addressing the HIV challenges faced in local health facilities.

The USAID Performance Management Plan (PMP) contains 92 health sector indicators. The SDSH/Pwojè Djanm Project is currently collecting 96 indicators. HIV/AIDS represents at least 30 percent of the indicators being collected. The MYAP partners collect additional indicators. Health institutions are also reporting to other donors and to the MSPP with additional lists of indicators. The new MCH Plus-up initiative would require the collection of 19 additional indicators (Annex 5 provides a complete list of indicators).

There is no agreement among the MSPP and donors, and to some extent among USAID and implementing partners, on the minimum necessary indicators of performance for aspects of maternal health, child health, fertility regulation/family planning and HIV/AIDS interventions. With respect to the USAID Performance Management Plan, there are too many mandated HIV/AIDS indicators, which cannot be dropped or modified. While this situation is not likely to change in the short term, that should not mean that adequate numbers of indicators of performance should not be included in the PMP for MCH and FP. There are, arguably, too few indicators of performance for, respectively, maternal health, child health, and family planning in the PMP. Also, in the Rohde/Bryant report, some essential MCH/FP indicators were suggested which could track significant improvement in health status for women and children in the context of a project like Pwojè Djanm. Those few indicators should certainly be reported upward to USAID, and USAID should ensure that those indicators are in the PMP; performance under other USAID projects might also be aggregated and reported against those indicators.

A thorough review of the health information systems and indicator lists of both the MSPP and USAID is in order. While the current collection of indicators may satisfy donor reporting requirements, the current approach does not serve the operational needs of monitoring progress and adjusting strategies and approaches at lower levels, including at the health facility and departmental levels. More attention should be paid to the identification of a few indicators that can be tracked at lower levels of the health system to show local implementers how their activities are affecting the problems they seek to address and whether or not they need to adjust their approaches for greater impact. Every health facility and departmental office should be able

to chart and review progress against a few key indicators at least monthly as part of regular program monitoring and strategic adjustment. PMP indicators for maternal health, child health and fertility regulation/family planning, and indicators that cross-cut these technical/program areas, should be reviewed, and as needed, revised or added to, and less useful indicators in the PMP should be dropped. MCH/FP projects should also report on indicators related to other USAID Mission priorities: governance, employment, transparency, civic participation, and so on.

IX. DONOR PROGRAMS

a. USG-Supported Programs

The United States has a strong interest in promoting stability and economic and social development in Haiti, due in large part to Haiti's close geographical proximity to the United States, as well as a long history of US involvement in the affairs of the island nation dating back to the diplomatic recognition in 1862 and more substantial intervention by the Woodrow Wilson administration shortly after 1915 in response to an American banking crisis linked to Haitian Government debt.

USAID has been supporting health and food security in Haiti since the 1960s and has been Haiti's largest donor since 1973. The history of foreign assistance in Haiti has been marred by repeated periods of withdrawal and/or diminution of resources. The Kennedy administration suspended aid in 1961 after allegations of corruption by the "Papa Doc" Duvalier government. Aid was resumed in 1971 after power passed to his son, Jean-Claude Duvalier. In 1987, USAID withdrew all funding for the public sector to protest the military junta that deposed the Duvalier son. For many years, all foreign aid was channeled through NGOs. The overthrow of President Jean-Bertrand Aristide by a military coup in September 1991 led to an exodus of large numbers of Haitian "boat people" to the United States and to the temporary suspension of 84 million USD in economic and food aid to Haiti.⁸⁹ A US-led embargo from 1991 to 1994 further undermined the Haitian economy, largely destroying the small business sector, which has never recovered. Aid resumed in full with the return of Aristide in October 1994. In 1995, renewed political violence led to the introduction of a UN Peace Force and US troops. The last American troops departed in January 2000. Between fiscal year (FY) 1995 and FY 2003, the United States contributed more than USD 50 million in assistance to Haiti. US assistance to Haiti shrank from a high of about USD 250 million annually just after Aristide's return in 1994 to USD 55 million in 2002. A new round of political violence in January 2004 led to renewed introduction of UN peacekeepers, starting with the arrival of 1,000 American troops in March 2004. Since 2004, the United States has provided over USD 600 million for improving governance, security, the rule of law, economic recovery, and critical human needs. The beginning of the Préval government in 2006 marked a renewed escalation of USG development assistance. The US president's budget request for FY 2007 was USD 198 million.⁹⁰

Haiti is classified as a "rebuilding country" within the US foreign assistance framework. The MCH and FP programs funded by the USG in Haiti are governed by the *New Strategic Framework for U.S. Foreign Assistance* under the heading of "Investing in People." The USAID Strategy for 2007 to 2009 clearly states that the overriding concern of USAID programs in Haiti at this time is to ensure political, economic, and social stability as the sine qua non of any sustainable development. The strategy is focused on three Strategic Objectives: (1) More Employment and Sustainable Livelihoods; (2) Increased Access to Quality Social Services; and (3) Improved Rule of Law and Responsive Government. End dates for these SOs will be September 2010. The portfolio has three key demographic target groups: youth under 25, women, and special concerns groups (such as people living with HIV/AIDS, TB patients, and trafficked persons) and four cross-cutting Intermediate Results: (1) More Effective and Inclusive

Civil Society; (2) Legitimate Local Government Established and Providing Services; (3) More Effective Executive Leadership; and (4) Less Corrupt, More Transparent, and Accountable Government. There are three broad geographical target areas: (1) conflict-vulnerable urban areas, or “hot spots,” including: Port-au-Prince, Cap Haïtien, Gonaïves, St. Mark, Petit Goave, and Les Cayes (these cities have a combined population of over 2.7 million, or 28 percent of Haiti’s total population; (2) targeted watersheds, including Limbé and Montrouis; and (3) other locations that are self-targeted by activity or opportunity for impact. The strategy emphasizes the development of active citizen participation, including expanded civil society capacity for oversight and monitoring and increased constructive interaction between citizens and officials to advocate for policies and services that government can and should provide in a democratic state. Collaboration between government agencies and the extensive local NGO sector and private commercial actors, including public-private partnerships where appropriate and feasible, is also an important priority.

MCH/FP activities incorporate four of six components of the Increased Access to Quality Social Services portfolio and include program component (PC 7: Strengthen Public Sector Executive Function; PC 24: Support Family Planning; PC 32: Improve Child Survival, Health and Nutrition and; PC 33: Improve Maternal Health and Nutrition.

In FY 2008, the USG will provide an estimated \$304.3 million to support Haiti’s efforts to rebuild. USAID manages approximately \$221.7 million of that amount, including approximately \$65.9 million for health. Of this total, \$59 million will be contributed in emergency food assistance to vulnerable populations and \$92 million has been made available through PEPFAR for HIV interventions.

In FY07 and FY08 the USG is providing \$7.9 million and \$9.3 million respectively for child survival; \$11.3 million and \$9.2 million respectively for population/family planning; \$600,000 and \$1.3 million respectively for tuberculosis; and \$78.3 and \$92 million respectively for PEPFAR-financed HIV/AIDS activities, including PMTCT and orphans and vulnerable children (OVC) services. Under the Title II program, funding of \$17.2 million in FY07 and \$15.1 in FY08 of PL 480 Title II food aid supports the delivery of community-based MCH services. During FY07, USAID also programmed \$3.0 million for water/sanitation activities, and is considering an overall Mission commitment of \$6 million over 3 years.

Maternal and Child Health/Family Planning Flagship: SDSH/Pwojè Djanm

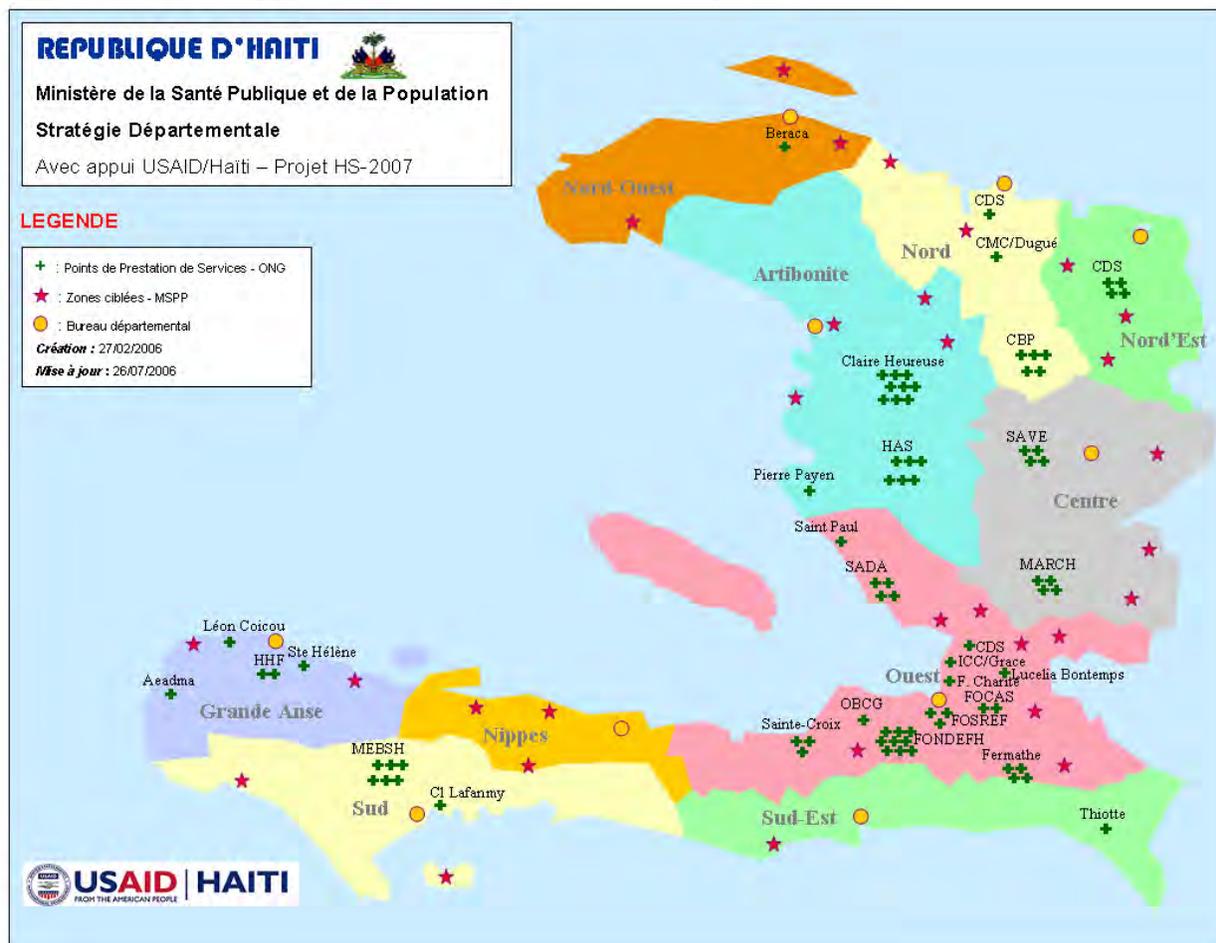
From 1986 to 1996, USAID Humanitarian Assistance supported several vertical projects in Haiti. From 1996 to 2000, USAID funded the Haiti Santé (HS) 2004/I Project, the consolidation of previous mandates into one, with a reduction in funding level of 50 percent. The project focused on service delivery, policy reform, and support systems (information, education, and communication [IEC], MIS, social marketing). The follow-on, HS 2004/II (2000 to 2004), was funded for about USD 37 million and had two components. The first component was implemented through a Strategic Objective Agreement with the Ministry of Health and focused on public-sector financial management, management information systems, and logistics of essential drugs. The second component focused on the private sector. Implemented by MSH, the

project was designed to channel USAID support to 30 selected NGOs and developed and implemented a package of priority health interventions using a community-based approach. This NGO network expanded access to basic health services to nearly 35 percent of Haiti's population at a time when MSPP and public-sector health facilities had nearly collapsed. A performance-based contracting-and-funding model provided a mechanism to strengthen NGO institutional capacity, while expanding services and improving quality of care. This system, which was further elaborated under the HS 2004 to 2007 (HS 2007) project, has improved NGO partners' performance and helped overcome skepticism that NGOs can be held accountable. To improve service quality and strengthen management capacity, MSH introduced the SDMA (Service Delivery and Management Assessment) protocol, a highly participatory self-evaluation tool that promotes dialogue and problem solving within health institutions. Over the course of the project, 20 master trainers and 120 trainers were trained and formed the nucleus of a Haitian cadre of trainers for future health sector training activities.

The period of implementation of HS 2007 was marred by increased instability and violence with repeated evacuations within the donor community. MSH was able to meet these challenges through a flexible approach that allowed quick adaptation to changing circumstances and attainment of most of the project's intended results. The HS 2007 Project focused on the increased use of quality maternal and child survival services, including immunizations, increased use of quality reproductive health services, and reduced transmission of selected infectious diseases (tuberculosis and HIV/AIDS), with an increased emphasis on care management and support systems, and integration of behavior change communication (BCC), as key components of reproductive health. PEPFAR was introduced as a vertical program.

The project started to shift from exclusive support to NGOs to a more balanced public-private approach. USAID selected 29 target zones (*zones ciblées*) in all 10 departments to reestablish the public sector's ability to manage the delivery of basic services. Central to the program was the belief that good governance and health are inextricably linked. MSH and its partners worked with central and departmental levels of the MSPP to develop management and service delivery capacity, including a departmental approach for improving availability of and access to priority commodities (logistics) for the delivery of the Paquet de Services Prioritaires, or PSP. MSH helped develop a financial management system within the MSPP and worked with each of the 10 departments to develop integrated departmental annual plans while establishing strong public-private sector collaboration. Because of the vacuum in leadership within the MSPP, some donors perceived MSH as a sort of "shadow ministry" during this period. The SDMA was carried out in all 26 health institutions covered by the project and 10 departmental hospitals.

Figure 1 USAID Supported Sites Under HS 2007 Project



As a result of the HS 2007 Project, the rate of childhood immunizations increased from 21 percent to 63 percent in public-sector target areas (population of approximately 1.5 million). In areas covered by the NGO network, the rate was 93 percent. The number of deliveries attended by skilled personnel rose from 17 percent to 26 percent in public-sector areas and to 68 percent in NGO areas. The use of modern contraceptives went up to 8 percent from 2 percent in public-sector zones, while in NGO areas the rate was 32 percent. The number of people tested for HIV increased from 38,381 to 101,793 in all HS 2007 areas. In addition, HS 2007 expanded maternal health interventions at facilities and community levels and designed and implemented protocols for prenatal care, assisted deliveries, and postnatal care. HS 2007 improved the collection, verification, and use of program data for decision-making within NGOs.

In August 2007, USAID awarded MSH a contract for the implementation of a new task order, Santé pour le Développement et la Stabilité d’Haïti— Pwojè Djanm (SDSH, or Pwojè Djanm). The purpose of the project was “to improve the health status of vulnerable populations so that they can become more productive members of society to promote stability within their communities and participate in the economic and social development of Haiti.” The project targets approximately 50 percent of the Haitian population through 152 public and private sites

and aims to increase use of an integrated package of basic priority health services that includes maternal and child health care, “repositioned” family planning services, and prevention and control of diseases of major importance, including HIV/AIDS. The project will strengthen both public (*zones ciblées*) and private- (nonprofit) sector health care delivery while building on earlier efforts to develop the institutional capacity necessary to improve the MSPP’s ability to carry out its executive function at the central and departmental levels: development of realistic, action-oriented policies, cost-effective implementation of the delivery system, and effective coordination of international community contributions, including mobilization of the private sector and engagement of the Haitian diaspora. While SDSH is not a national program per se, its interventions areas touch all departments and include conflict-vulnerable areas (“hot spots”), targeted watersheds, and other locations that are self-targeting by activity (e.g., departmental health offices, food insecure areas, vulnerable populations). The project also specifically targets children and youth under 25 years of age, women, and special concerns groups, such as PLWHA and tuberculosis patients. SDSH is strengthening local communities to be better health partners, active in local development and effective promoters for stability and democracy. Due to a series of delays related to USAID contracting procedures and local political problems, implementation of the project did not really get underway until early 2008.

Title II Maternal, Child Health, and Nutrition Programs under USAID’s PL480 Multi-Year Assistance Program

To address food insecurity and widespread malnutrition, USAID recently launched three PL480 Title II Multi-Year Assistance Programs (MYAPs) that target Haiti’s most vulnerable citizens (orphans, institutionalized elderly and disabled, and people affected by HIV/AIDS or TB). The total anticipated funding for the MYAPs is USD 178.1 million over five years, of which USD 68.5 million is for maternal and child health and nutrition (MCHN) activities and feeding support (see Table 4 below). This is a substantial amount of funding, and if activities are well coordinated and implemented as planned, with significant community participation in health care decision-making, they should produce quite satisfactory results.⁹¹

Table 4. USAID PL480 MYAP Funding per Activity, FY08–10 (USD)

Title II MYAP Partners	A. MCHN (Includes Commodities)	B. Value of MCHN Commodities (Included in MCHN Total)	C. Other Activities⁹² (Includes Commodities for These Activities)	Total A + C
World Vision	36,616,000	9,300,000	42,990,000	79,600,000
CRS	24,440,000	10,500,000	36,660,000	61,100,000
ACTI/VOCA with MSH & BND	7,480,000	1,500,000	29,920,000	37,400,000
Total	68,536,000	21,300,000	109,570,000	178,100,000

BND = Bureau de Nutrition et Développement.

While the review team was impressed with the integrated development approach of the MYAP partners, it was beyond the scope of work of the present review to evaluate all the activities

under the MYAPs. Thus, the present report focuses primarily on the partners' MCHN ongoing and/or planned activities.

The Title II cooperating sponsors, or partners, include World Vision, Catholic Relief Services (CRS), and ACDI/VOCA. The MYAPs' MCHN objectives are to increase access to health services, to improve the quality of services, and to address the immediate food security needs of vulnerable people in target areas.⁹³ Their respective programs are carried out in areas of the country that have high food deficits and scarce potable water (termed "hot spots" by USAID).

World Vision works directly in six communes in the Central Plateau and provide only supplemental ration to Pregnant/Lactating women, to children aged six to 24 months as prevention and children aged six to 59 months as recuperation in five other communes in partnership with MARCH, SAVE, and HAS (Albert Schweitzer Hospital) and in La Gonave (West Department). CRS works in 13 of 18 communes in the South, one of 12 in the Grande'Anse (food distribution only), and two of eight communes in the Nippes. ACDI/VOCA, which is just now ramping up operations (the others began in April), plans to work in three or four out of 10 communes in the Southeast. The partners have worked and will continue to work closely with GOH departmental and communal authorities, other donors, private sector organizations, and other USAID partners to identify needs and gaps in services in the target communes to ensure that USAID MYAP activities do not overlap with existing interventions. The target communes were chosen judiciously based on needs (food security situation, malnutrition in the population, environmental conditions, presence or lack of other donors in the area, possible synergies with existing USAID projects).

The Title II MCHN activities respond to USAID's overall goal of fostering stability in Haiti, and to the Mission's strategic objective of "increased access to quality social services" by improving the quality of health and nutrition services in targeted areas of the country. Specifically, the programs will improve maternal and child health and nutrition status, reduce incidence of disease, and support preventive health care activities. The MYAPs will also contribute to the Mission's governance strategic objective by supporting that Strategic Objective's program component 8: "strengthening local governance and decentralization." The MYAP's partners will use community health issues and community health plans to initiate dialogue with communities, to build consensus, and to establish productive relationships with government representatives.

The MYAP partners have a wealth of experience and a strong commitment to working with communities to identify, prioritize and address community health problems and related social needs (e.g., planning for emergencies, promotion of preventive practices, improving basic hygiene, addressing clean water issues). While partners have similar overall objectives, each has its unique strategies and operational plans. This provides an excellent opportunity to compare the effectiveness of these different approaches for addressing malnutrition and other maternal and child health needs.

The typical "package" of services includes a continuum of care for mothers and children: prenatal, delivery, postnatal care, vaccinations, vitamin supplements (iron, vitamin A), deworming medicine, basic hygiene, family planning, growth monitoring, screening and treatment of infectious diseases (diarrhea, respiratory infections), oral rehydration therapy,

promotion of iodized salt, and distribution of food staples. Services are supported by IEC and health education activities in the community and in other sectors.

In the Center Department, World Vision is directly involved in health service provision through the operation of its mobile clinics, rally posts, home visits, and food distribution points. It also collaborates with some fixed site facilities (MSPP, NGO sites in the lower Central Plateau and Lower Artibonite Department). In those sites supervised by MARCH, SAVE, and HAS, World Vision complementary interventions consist of the targeting of pregnant/lactating women, of children aged six to 24 months for malnutrition prevention and six to 59 months malnourished children for recuperation and the distribution of a monthly ration.

In La Gonave, World Vision uses a different model, which is appropriate for prevailing conditions on the island. World Vision works very closely with the MSPP at public sector sites in support of the MSPP Unité Communale de Santé (health district) decentralization strategy. Over the life of project in La Gonave, World Vision will build six clinics and a badly needed pharmaceutical warehouse. It will also upgrade one facility to provide secondary (hospital) level services. World Vision will renovate two clinics in the Center Department to expand access to services along the Dominican border where currently none exist on the Haiti side. Training will be provided to 20 new MSPP auxiliaries and nurses, 600 community health agents, and 300 TBAs. World Vision will promote the formation of mothers', fathers', farmers', and grandmothers' clubs to maintain high levels of involvement by community members in addressing common health care concerns.

In the South Department, CRS works in 13 of 18 communes, in the Nippes two out of eight, and in one commune in the Grand'Anse. In Jérémie, to complement the technical and logistical support to HHF providers and MSPP under the SDSH/Pwojè Djanm (USAID's SDSH Project), CRS gives a supplemental ration to pregnant/lactating women as well a monthly ration to the children aged six to 59 months that are registered under the recuperation program. CRS follows a community-based approach that is linked with public or NGO facilities where food is distributed and MCHN health services rendered by community volunteers and facility staff respectively. CRS is associated with 24 health centers (and approximately 25 rally posts for each center). CRS provides training in MCHN interventions to facility staff to ensure that when referrals are made in the field clients will be welcomed and will receive quality services at the referral institutions.

Over the life of project, CRS will also train community health workers (n = 500) and traditional birth attendants, or matrones (n = 500), and will initiate the formation of mothers' clubs (n = 400). CRS plans to partner with Population Services International social marketing program for the distribution of low-cost quality products such as oral rehydration salts and water purification packets. CRS's idea to involve the CHWs in social marketing activities is promising: it will increase access by the population to health-related products and will provide a modest income for the CHWs. CRS is a partner with the PEPFAR-supported AIDSRelief and in this capacity will train CHWs to provide palliative care and psychosocial support to PLWHA and their families.

ACDI/VOCA's subgrantee for MCHN work, MSH, will use the network services support model that was developed by MSH under previous USAID projects (HS 2004, HS 2007) and is

currently used under MSH's SDSH project, which supports 72 public and 80 private sector sites throughout the country. The network model will provide technical assistance, quality assurance and other support for public- and private-sector facilities in approximately 11 health centers in three or four of the 10 communes in the Southeast Department. Six doctors and six nurses will be hired to compensate for the insufficient number of staff at target facilities. Unlike World Vision and CRS, MSH will not be directly responsible for food distribution activities. This will be done by another ACDI/VOCA partner, the Bureau de Nutrition et Développement (BND), which will coordinate food distribution plans with MSH health care activities. Materials developed and used successfully under other MSH projects will be used under this MYAP. Forty health agents, 90 community health volunteers (colvols) and TBAs will be trained to provide health education, preventive health services, and referrals to health centers. Links will be made with agricultural extension workers and other groups participating in ACDI/VOCA's diversified livelihood activities.

During the review team's site visit to a Title II beneficiary in the Nippes Department, the team learned just how valued the food distribution program is, as the mandatory IEC and preventive care sessions were packed to overflowing with mothers and children.⁹⁴ However, the team also learned that, during the setting up of the new MYAP, CRS had to go through the process of a phasing out of certain sites. In the Grand'Anse area particularly, it was reported that at these sites,⁹⁵ attendance at sessions and services (vaccination, prenatal, postnatal) fell by 90 percent, indicating that much remains to be done to educate people about the value of these preventive interventions in and of themselves. The team was also told that in FY06 the MCHN program was impacted negatively by a substantial budget cut due to the need to address unforeseen emergencies elsewhere in the country; as a result, supplementary feeding for women and children was reduced by 50 percent. When such unpredictable and unforeseen situations arise, program managers find themselves between the proverbial rock and a hard place as they are forced to either reduce the amount of rations given to individuals or cut the number of beneficiaries—neither option is satisfactory.

Interactions between USAID Health Programs and Other Mission Programs

USG-supported health programs are making important contributions to other (non-health sector) Mission strategic objectives:

- The USG, through its maternal and child health and family planning health sector programs is increasing wage employment and skills for sustainable livelihoods, including for the most vulnerable populations: Thousands of health personnel working in both private and public health facilities and in communities are directly employed by USAID projects and programs. These include physicians, nurses and midwives, auxiliary health workers and community-based health workers such as community health workers (*agents de santé*). Many thousands of these essential health personnel are receiving training and work experience that provide them with essential skills for future employment, a fact that was recognized as a valuable motivator for performance by some of the health personnel the team talked to on their field trips. In addition, thousands of jobs are being created within projects and programs, including local NGOs and FBOs as a result of USG health

sector funding. Almost all project staff in Haiti is Haitian. These jobs create opportunities for better-paid employment for well-qualified Haitians who might otherwise emigrate.

As with all USG-supported employment creation efforts, this is a two-edged sword. Especially in the case of higher-echelon health personnel (physicians, nurses, and midwives), increased skills also provide increased opportunities for employment abroad, thus stimulating the brain drain. This USG strategy also increases dependence on donor support for the effective functioning of the health system. This is especially worrisome, as no strategic longer-term personnel plan seems to exist for the MSPP and therefore there is little preparation for an eventual phase-out of direct donor employment of health personnel. However, it should be borne in mind that no substantial improvement in health outcomes can be achieved without these complementary, donor-supported personnel.

- Mission-supported MCH/FP programs are actively supporting the legitimization of local government. Health is the only sectoral program actively engaged in the support of decentralization/deconcentration of central government decision-making to the departmental level. The MSH activities in support of the development of annual Departmental Health Plans based on input from communal-level representatives and coordinating both public and private sector, including donor, NGO and other sector programs is a vital contribution to decentralization. These activities have allowed for (1) a more rational deployment of private and public sector resources, including donor funded activities, to meet key public health objectives; (2) provision of vital experience and training to departmental and central ministry health officials in decentralized planning and program management; and (3) to a certain degree, legitimization of the responsibility of departmental staff in program planning and management. While problems remain, especially in relation to realistic budgeting, Ministry of Finance support of Departmental Plans, and the clear definition of roles and responsibilities of both departmental and central ministry staff (including central ministry department directors), this USAID health sector initiative is an important contribution to USG efforts to strengthen local government and decentralization.
- USAID health programs are contributing effectively to the development of a More Effective and Inclusive Civil Society, including human rights strengthening. With their emphasis on community-based programs, USAID MCH/FP programs and projects are strengthening the community's role in the provision of basic services, providing training and experience to community-based groups in the implementation, management and, to a more limited extent, oversight of health programs, and strengthening the experience and perception of poor Haitians of access to health care as a basic human right.
- USAID MCH/FP programs are contributing to an increase in transparency and accountability through performance-based contracting with local NGOs, FBOs and public sector health facilities. Annual audit requirements and results-based reporting are two mechanisms through which USAID-funded health programs promote transparency.

Other USAID sector programs are contributing to and provide opportunities for synergy with health sector programs to achieve MCH/FP program objectives. Examples include the following:

- Increased employment opportunities for women will have a larger impact on child nutrition than increased employment for men. More generally, increased economic stability helps to reduce family dysfunction and impacts indirectly on the health of mothers and children.
- Increased stability with a concomitant reduction in community level violence, including violence against women, not only has a direct effect on the health status of women and children but increases access to health care in vulnerable communities.
- Increased food security not only contributes directly to improved nutritional status of women and children, thus reducing the risk of complications of pregnancy and childhood illness, but also frees family resources to cover vital health care related expenses.
- Other sector programs work through networks of community, departmental, and national organizations which can be mobilized for health interventions: these include labor groups, schools and training programs, mayors and other local leaders, community action groups, media, and so on.

b. Other Donor Programs

USAID programs complement other donor inputs. While relations between donors appear to be cordial and there is a general willingness to collaborate, strategic and practical coordination is limited largely to ad hoc responses to specific issues and/or crises such as the recent unexpected need to provide contraceptives in geographic areas from which USAID had suddenly withdrawn its support to which UNFPA responded. However, several donors, including USAID, are working closely with the MSPP at central and departmental levels to strengthen national capacity to assure coordination and synergy of donor and national resources and approaches in the health sector through monthly donor coordination meetings. A Health Sector Donors Meeting has been established to address health sector issues. More detailed coordination has occurred at the departmental level through the departmental planning exercises supported by MSH. UNFPA has also recently approached USAID to conduct a “mini-SWAP” in the Southeast and Nippes Departments to improve coordination of reproductive health efforts.

Canadian International Development Agency

The Canadian International Development Agency (CIDA) is the second-largest bilateral donor in the health sector and has targeted primarily four departments for health sector support: Artibonite, Southeast, Nippes, and Northeast. With a total budget from 2005 to 2011 of approximately 90 million USD for health-related interventions, CIDA currently supports six projects:

1. PADESS (Projet d’Appui au Renforcement du Système de Santé de Haïti), which supports central level strengthening of the MSPP (2006 to 2011: 18.7 million Canadian dollars [CAD]).

2. PALIH (Projet d'Appui à la Lutte contre les IST-VIH/SIDA en Haïti) against HIV/AIDS in Artibonite Department focuses on governance issues (2006 to 2011: CAD 19 million).
3. PARC (Projet d'Appui au Renforcement des Capacities en Gestion de la Santé en Haïti), implemented with the University of Montreal, to provide Haitian health administrators with a master's degree in health management (2006 to 2011: CAD 17.5 million).
4. PALM (Projet d'Appui à la Lutte contre la Mortalité Maternelle) (2005 to 2010: CAD 8.2 million). This project is implemented in collaboration with UNFPA and PAHO/WHO and will improve quality of obstetrical care in two or three reference hospitals, including support of training of TBAs and emergency obstetrical care.
5. PAPEV (Projet d'appui au Programme Élargi de Vaccination). In collaboration with Brazil and PAHO/WHO, this project was just initiated and will inject 17.5 million CAD over four years to improve the immunization program.⁹⁶ CIDA provides flexible, broad-based support for routine immunization, campaigns and vaccine-preventable disease control efforts, and epidemiological surveillance and has been an important technical assistance member of the technical committee for EPI. The project, designed in partnership with the DPEV, PAHO/WHO, and UNICEF, will provide assistance to the central-level DPEV and the departments, as well as in targeted zones in at least two communes per department. This includes assistance with DPEV restructuring and staffing, technical support, logistics, financial support (e.g., for supervision), procurement (as necessary), and strategic assistance for increasing coverage through a sustainable systems-building focus. This effort will be complementary to and coordinated with partners like MSH.
6. FSE (Fonds Local en Santé et Éducation du Centre de Gestion des Fonds), which supports, among other things, health facility rehabilitation.

PASR (Projet d'Appui à la Santé de la Reproduction) is a CAD 19.2 million project focused on reproductive health to be implemented in collaboration with UNICEF, UNFPA, and PAHO/WHO, which has recently been approved and will improve quality of RH care in Nippes and Southeast Departments, and provide RH materials and supplies, and mobilize local development organizations and the Ministries of Youth and Sport and Education.

UNFPA

With a total budget of 25 million euros (EUR), UNFPA supports the Government of Haiti in the application of the Action Plan of the International Conference on Population through three subprograms: reproductive health (EUR 13.6 million), population and development (EUR 9.2 million) and advocacy (EUR 2.4 million). The program includes a USD 62,000 project in support of Port-au-Prince's street children to increase access to primary health care, including HIV/AIDS, through mobile clinics and fixed medical facilities; a EUR 300,000 project of prevention of violence against women and girls in the Southeast Department in complement to the South-South Project financed by the Brazilian Agency of Cooperation and Oxfam by increasing access of victims of violence to support services; a USD 100,000 project in Port-au-Prince to respond to the needs of industrial sector workers for reproductive health services; a

USD 43,343 project to strengthen reproductive health and HIV/AIDS services in the national police force; a USD 90,000 project (CEPODE) to strengthen institutional capacity through training of health sector staff in research, analysis and production of demographic data; and a USD 90,000 project with the Ministry of Youth and Sports to educate youth on environmental and HIV/AIDS-related issues.⁹⁷

In the context of the UNFPA Thematic Fund for Maternal Health, launched in 2007, UNFPA has designed a USD 1.5 million program to strengthen maternal and reproductive health services in Haiti in 2008 to 2009. As the first country to benefit from Thematic Fund assistance, Haiti will do the following:

1. Improve access to contraception, especially long-term methods, in all institutions providing obstetrical services and, in a second phase, in community-based distribution programs. RH consultations will be strengthened in pre- and postnatal consultations so that no woman leaves the maternity without having received FP information and counseling.
2. Improve the quality of midwifery and anesthesia training through logistical and structural support to the national Midwifery School (École Nationale d'Infirmières Sages Femmes) and technical assistance.
3. In collaboration with Columbia University in New York, conduct a national study to analyze needs and resources in the areas of emergency obstetrical and neonatal care.
4. Strengthen national-level institutional capacity through support for personnel and hospital management training as well as operations research regarding the economics of free care provision programs such as the SOG with a view of integration of the SOG budget into the GOH national budget.

UNFPA has taken over the provision of contraceptives to areas not covered by USAID funded programs. In addition to the activities already mentioned, UNFPA has recently completed a sociological study on cultural barriers to contraceptive use and conducts other studies related to obstetrical care and reproductive health.

UNICEF

UNICEF supports immunization activities, providing technical assistance to EPI in collaboration with PAHO/WHO and managing antigen stocks provided by the Japanese government. UNICEF also distributes vitamin A and provides technical assistance to the National Committee on Nutrition. UNICEF further furnishes medication for AIDS treatment, and, with UNFPA and CIDA, provides technical assistance, BCC and essential materials and supplies to reduce maternal mortality in two departments. To date the USD 6,748,772 project funded through CIDA, which started in 2005 (to 2010) has renovated six maternity wards, trained 131 medical staff, and ensured adequate obstetrical services to 15,000 pregnant women every year. An estimated 75,000 pregnant women are expected to benefit. A Back to School initiative builds new schools and furnishes water and sanitation supplies and hygiene education to 75 schools.

PAHO/WHO

PAHO/WHO has focused activities on humanitarian assistance and postdisaster rehabilitation and technical cooperation for national health development within the Interim Cooperation Framework. PAHO/WHO founded PROMESS in 1992 and continues to provide technical and managerial leadership for the project. PAHO/WHO also provides technical support to the SOG and immunization programs as well directly to the MSPP in support of health sector reform. A project to promote youth leadership and working opportunities collaborates with local communities to provide tools and knowledge to solve environmental problems, including sanitation issues in Cité Soleil. The Family and Community Health Project aims at improving children's health status through collaboration with local partners, including the Catholic Medical Mission Board, to scale up IMCI. WHO also provides technical assistance in support of the management of malnutrition, parasitic infections, water and sanitation, and HIV/AIDS.⁹⁸

International Development Bank

The USD 50 million IDB Project works with the MSPP to develop the Health District, or Unité Communale de Santé, Program, in seven priority geographical areas. The program funds health facility rehabilitation, purchase of medical equipment and supplies, and institutional support at the departmental and central levels.

Global Fund

The Global Fund⁹⁹ provides support to the HIV/AIDS, malaria control, and TB programs, with a total approved funding level of USD 184,335,820, including USD 66,905,477 for the 2003 Round 1 program intended to increase behavior change communications, condom distribution and treatment and targeting 400,000 youth, 12,000 female sex workers, and men who have sex with men. Total funds disbursed under this grant are the USD 6,140,386 approved for Phase 1.

The 2004 Round 3 included USD 14,034,665, to increase case detection for tuberculosis from 35 percent to 70 percent and improve treatment success from 71 percent to 80 percent, expand DOTS coverage from 122 health facilities to 360, improve laboratory facilities, and expand BCC. USD 11,977,831 of this funding has been disbursed. Also under round three a USD 14,431,557 funding request was approved to improve malarial control management structures at the central and peripheral level, strengthen epidemiologic surveillance, strengthen case management, and strengthen community level prevention. USD 11,676,858 has been disbursed.

In 2006, Round 5 was signed for a total request of USD 49,927,567 of which USD 16,943,752 has been disbursed to date. The Project targets PLWHA and their families through the expansion of voluntary counseling and testing (VCT) and antiretroviral treatment through centers of excellence, increased number of PLWHA receiving diagnosis and treatment for opportunistic infections, increased care and support for orphans and vulnerable children, and improved capacity of the MSPP in program governance, coordination, monitoring and evaluation.

Round 7 was approved in August of 2008 for a funding request of USD 15,000,000 to strengthen the capacity of departmental directorates to implement, monitor and supervise the Integrated

Management of Adolescent and Adult Infections (IMAAI), strengthen laboratory capacity, develop more efficient HIV-related social services in 20 of 60 health districts, and develop a maternity, postpartum, and infant medical care package for 9,000 HIV-positive pregnant women and their infants.

European Union

The European Commission has recently provided EUR 3 million to address the needs of victims of the economic crisis in Haiti by providing improved access to food, health care, safe water, and proper hygiene, benefiting around 1.5 million primarily rural people. In 2007, EUR 2 million were allocated to respond to needs in South, Southeast, and Grand'Anse Departments.

France

The French Government has recently started supporting MCH and reproductive health activities in Nippes.

X. STRENGTHS

The review team congratulates the USAID Mission on its overall vision and strategy. Given the particularly challenging conditions in Haiti and funding constraints, the USAID portfolio correctly addresses the primary challenges in Haiti. Overall, Mission resource allocation seems to be on track, with the exception of the striking disproportion of the HIV/AIDS allocation in relation to the range of problems facing the Haitian people. The Mission has also recognized that addressing Haiti's health sector problems is a fundamental component of fostering the stability that is a precondition to future development. While recognizing the humanitarian nature of current mother and child health interventions, Mission policies are contributing to strengthening the fundamental building blocks of longer-term sustainability of these interventions.

The Mission's overall portfolio targets the primary causes of poor maternal and child health: extreme poverty, societal collapse, poor governance, infrastructural insufficiencies, and food insecurity. Solving these fundamental problems is a necessary precondition to rapid progress in the health sector. Together, these underlying conditions directly and indirectly affect the ability of Haitian mothers and children to preserve their health and to address the consequences of poor health. Poverty and food insecurity play a primary role in the high rates of malnutrition that underlie maternal, neonatal, and child morbidity and mortality. Access to quality health care is limited by the ability of Haiti's poor to pay for health services, by the lack of quality services due to lack of sufficient infrastructure, supplies, materials and equipment, trained health personnel, and effective management of limited health resources, which are a reflection of the poor governance and societal collapse that have characterized Haitian society for the past decades. There are indications that conditions may be worsening: more children are affected by malnutrition as compared to five years ago and maternal mortality rates have been increasing for the past 20 years.¹⁰⁰

The USAID Health team is also to be congratulated on their design and implementation of the overall maternal and child health and FP portfolio, including HIV/AIDS interventions. The current program focus and directions are generally well targeted to meet the overwhelming needs given USAID budget availability and local economic, social, and governance constraints and, overall, fit in well with other donor programs and with the Mission's portfolio. USAID-funded programs have had a significant positive effect on the health status of Haitian women and children. Despite decades or more of political, economic, environmental, and sociocultural disasters, the health of Haiti's women and children has steadily improved. Overall mortality has declined and preventive practices such as the use of ORS and contraceptives have increased. In USAID-covered areas the situation as a whole is significantly better than in the country as a whole. For example, vaccination coverage in USAID areas is 82 percent versus national coverage of 41.3 percent; prenatal visits in USAID-covered areas stand at 50.7 percent versus 15.4 at the national level; and the contraceptive prevalence rate is 29.5 percent in USAID-covered areas versus 24.8 percent nationwide.¹⁰¹

However, without continued intensive support to MCH/FP interventions, it is unlikely that Haiti's women and children will continue to see significant improvements in health status.

Specifically, the following aspects were judged by the team to be particularly well conceived:

- The recent inclusion of the public sector as a focus for MCH/FP activities and the increased emphasis on public-private sector collaboration and coordination
- The geographical targeting based on analysis of other donor program coverage, mapping of health facilities in target zones and specific targeting of underserved populations
- The emphasis on key mother and child health issues including integrated management and prevention of key child illnesses and key causes of maternal mortality, including HIV
- The focus on partnership between communities and the formal health system, with significant emphasis on strengthening community-based health approaches, especially in underserved areas.
- The strong emphasis on collaboration with local community groups (mothers' clubs, HIV support groups, youth organizations) that increase the "social capital and cohesion of communities"
- The effort to strategically use the increasing availability of resources through PEPFAR-supported programs to achieve an overall strengthening of facility-based care for mothers and children, including improved quality of maternity and neonatal care, as well as specific aspects of community-based services
- The strengthening of needs-based planning capacity at the department level and capacity building in support of deconcentration of the MSPP
- The strong emphasis on donor collaboration at the departmental level
- The growing excellent collaboration between the MYAPs and SDSH
- The use of "performance based contracting" as a tool not only to increase transparency but also to build NGO institutional management capacity

While significant challenges remain, these can largely be met through adjustments in existing program strategy and tweaking of specific technical approaches.

XI. RECOMMENDATIONS

a. Donor Coordination

1. *The USG and USAID should advocate for and take every opportunity to build on the existing positive will for donor coordination to further strengthen current national and departmental coordination mechanisms and to create additional opportunities for more detailed and practical technical and programmatic coordination in order to increase synergies between donor programs.* The national-level Health Sector Donors Meeting could be made more issue- and action-oriented, perhaps through the establishment of technical-level working groups to address specific programmatic foci (e.g., maternal and neonatal mortality, IMCI, family planning). These efforts should entail technical assistance and support to the MSPP to take charge of donor inputs in order to further effective and efficient use of existing resources.
2. *USAID should consider the assignment of a senior technical assistant, perhaps through the SDSH Project, to work with the MSPP on donor coordination, with an emphasis on detailed programmatic and issue-specific strategic decision-making.* This individual would work with the MSPP and other donors (e.g., CIDA through the PADESS Project) to develop issue and action-oriented agendas, informational papers, and other guidance for donor coordination meetings and assist in organization of meetings and follow-up of decisions taken.

b. Overall MCH/FP Programs

1. *USAID should consolidate gains made in current project areas and resist the temptation to expand coverage further or increase the number of activities under the current projects.* The review team believes that available resources should be used to improve access to and quality of preventive (e.g., routine immunizations) and curative services in areas where the USAID-supported MCH/FP projects are already working, including strengthening the referral hierarchy of health services: hospital, health center, dispensary, and community-based health services.
2. *To this end, USAID MCH/FP programs should focus on the following priorities over the next two to five years:*
 - Improved quality of care in fixed facilities and community settings. USAID Projects should review and implement the specific suggestions listed in Jon Rohde and Malcolm Bryant's recent Mission Report of the assessment they completed of the SDSH Project service delivery component.
 - Continued strengthening of community service delivery activities, including the strengthening of collaboration/synergy of community and facility based interventions to improve access to and quality of key health services.

- Strengthening the *use* of data for decision-making at all levels of the health system.
- Strengthening of family planning activities of all kinds in both community and facility based programs, with a special focus on youth under the age of 24 and on older, multiparous women.
- Improved management of family planning, immunization, and medical supplies logistics. (See below under Logistics.)
- Scaling up both community-based and mass media BCC activities focused on:
 - Increased exclusive breastfeeding.
 - Reproductive health, especially focused on the needs of adolescents and the increased use of long-term methods.
 - Increased awareness of maternal mortality and its causes.

c. Geographical Coverage of USG-Supported MCH/FP Projects

1. *Any expansion of coverage during the next two to five years should be targeted primarily at addressing access to quality services in communes and or health districts (Unités Communales de Santé, or UCS) where the projects are already established in order to “fill the holes” in the current patchwork quilt.* Efforts to assure collaboration, synergy, and lack of overlap between both USAID-financed services and those supported through other donor inputs should be maintained and strengthened while building access to a standard package of basic MCH/FP services (as defined in the Paquet Minimum de Services, or Minimum Package of Services, of the MSPP) for all mothers and children.
2. Within the next two years, USAID should consider a review of demographic, epidemiological and program data as the basis for future decision-making regarding geographical coverage of future MCH/FP activities funded by USAID.
3. In order to strategically plan any enhanced coverage of USC and communes, USAID should collaborate with PAHO/WHO and other key donors to create a complete electronic map of populations and health facilities based on the GPS locating of all Haitian households, which was recently completed. This mapping should identify all health facilities, functional or not, with analysis of the strengths and weaknesses of each, defined coverage areas, and sources of funding and types of support available to each. Such mapping should be possible with a relatively low level of inputs, given the existence of the GPS map and previous mapping of health facilities. It would be a powerful tool for donors and MSPP officials at both national and departmental levels to identify gaps in access to services and strategically target inputs. A similar exercise was completed in Armenia in a relatively short period of time.

d. Additional MCH/FP Funding Needs

1. *The continued rise in maternal mortality over the past 20 years and the stagnation of contraceptive prevalence rates suggest two priority areas for both any future additional funding and for more concentrated attention in current programs:*
 - The strengthening of both *community-based and facility based maternal and neonatal care.*
 - Focused strengthening of *family planning services*, especially those targeted at adolescents and women under the age of 25 and increased access to family planning including long-term methods for older, multiparous women, including the availability of family planning services during the delivery and postpartum periods.

Child Survival and Family Planning Funds

1. *The Mission should push for increased CSH¹⁰² funding and Maternal Health Plus-up resources, perhaps balanced by a concomitant reduction in PEPFAR funds to better reflect the needs of Haitian mothers and children.* Additional programming should focus on strengthening family planning and integrated maternal and neonatal programs. While it is true that PEPFAR inputs benefit mothers and children who are not HIV-positive by upgrading selected health services, CHS funding can do the same for PLWHA by upgrading the same services for all women and has more flexibility to meet the MCH/FP needs of all women and children. In any event, PEPFAR should continue to integrate services for PLWHA into other medical services so as to improve basic maternal and neonatal care for all women and children whenever possible.

Title II Funds

1. *Given the worrisome increase in child malnutrition and the devastating effects of recent food price increases, both in Haiti and in the United States, and recent natural disasters, the USAID Mission should consider requesting additional regular and emergency funds by April of next year to prevent further cuts in rations to mothers and children.*
2. *Currently there are no contingency plans to allow for unexpected cost increases in the US for PL480 food prices. Given the prospect of further price increases next year, the impact of price increases to date on program beneficiaries should be documented.* Cost increases are reducing the amount of food local partners can purchase at current levels and leading to cuts in rations distributed to families. The Mission should review the distribution of Title II assistance in terms of seeking a balance between investments in improving MCH/FP delivery of services and augmentation of food rations to (more) mothers and children.

e. Maternal and Neonatal Mortality

Current Programs

The team believes that more can be done to reduce maternal mortality in Haiti within current programs:

1. *Evaluate the “Super Matrones” program with an eye on possible scaling up.* (The team was unable to accomplish this on their short field visit). While the quality of prenatal consultations conducted by super matrones should be evaluated, the team believes that validation of this role of community health providers could increase the number of women benefiting from pre- and postnatal consultations, especially in outlying communities.
2. *Evaluate the Maternity Waiting Home initiative with a view of scaling this up in select sites.* The team recommends that the SDSH Project and USAID seek funds from private donors and, perhaps the Haitian diaspora to fund additional Maternity Waiting Homes.
3. *Intensify IEC efforts to sensitize local leaders, women and men, regarding maternal and neonatal mortality issues.*
4. *Continue to strengthen community-level activities (see some of the recommendations in the Rohde/Bryant Report). Family planning information should also be incorporated into the birth plans.*
5. *Work with other donors to assure availability in health facilities of key equipment and supplies related to mother and child health, including antibiotics, transfusion supplies, and emergency obstetrical equipment.*
6. *Jon Rohde’s report offers some specific suggestions for immediate improvement of basic obstetric care in maternity hospitals.*
7. *Cultural factors related to women’s reluctance to give birth in health facilities should be further studied and taken into account in strategic programming of interventions. This study could be incorporated in an eventual MCH Plus-up activity.*
8. *The impact of provider attitudes on women’s care-seeking behavior should be further explored and provider attitudes should be specifically addressed in all training activities related to mother and child health.*
9. *A study of patterns of abortion and abortion practices is needed to develop more effective postabortion services.*
10. *In clinics that provide prenatal care, subject to availability of funds and supplies, every attempt should be made to provide a basic package of laboratory tests for pregnant women. These include:*

- Hematology: blood count, sickling test, blood group
- Hemostasis: bleeding time (ST), coagulation time (CT), plateletes
- Serology: HIV, hepatitis, rapid plasma reagin (RPR) test for syphilis
- Blood test for glycemia
- Bacteriology: urine, vaginal discharges
- Parasitology: feces
- Malaria test
- TB test

MCH Plus-up

1. *The availability of significant funding for PMTCT and maternal health programs under PEPFAR and the Global Fund and for combating maternal and neonatal mortality through other donor programs (the Canadian/PAHO PALM initiative, the UNICEF maternal mortality program, and the new UNFPA maternal and reproductive health initiative under the Thematic Fund for Maternal Health), provide an opportunity for USAID to collaborate with other donors to improve facility-based maternal and neonatal services using complementary USAID/Washington Plus-up Funds. The design of such an initiative must be carefully coordinated with these other donors to increase synergies and avoid overlap. It is beyond the scope of this review to design such an initiative; however we recommend that the following elements be incorporated into an eventual design:*

- The aim of the initiative would be to develop a limited number of carefully monitored and evaluated “model” maternal and neonatal health programs, which would serve as “Centers of Excellence” in the area of obstetrics and neonatal care. These centers would provide sites for the practical preservice and in-service training of midwives, physicians, auxiliaries, and possibly super matrones. The program would develop a continuum of care package of services for the mother and child pair during the prenatal, intrapartum, postpartum, and postnatal periods, through the first month of the infant’s life, with special attention to delivery and the first week after delivery. The package would include both community-based and facility-based care.
- Selection of a limited number of maternity facilities, including at least one health center with beds, to upgrade obstetrical and neonatal care at the health facility level, including emergency obstetrical and neonatal care. These facilities should be linked with strong community programs. This will require access to equipment and supplies, including drugs. It may be possible to collaborate with one of the other donors to assure adequate supplies of required drugs and supplies.
- Selection of participating maternity services could be based on a number of criteria, including participation in the SOG program, with preference given to public-sector facilities, willingness to locate or construct an Maternity Waiting Home, existence of community-based activities and a willingness to strengthen linkages between the maternity ward staff and trained community-level health providers, including TBAs. Funding for the MWHs could be sought from private sources, including the diaspora.

- The package should include a strengthening of the quality of community-based pre- and postnatal services focused on simple effective practices to reduce neonatal and maternal mortality including the use of a birth plan, education of mothers and other caretakers in newborn care (see page 27 of this document and the Jon Rohde report) and effective use of trained TBAs to provide prenatal and postnatal consultation. The SDSH Project is already implementing many of these activities.
- The strengthening of community health facility links by reinforcing the TBA-OB-GYN team for the care of mother and child, as has been initiated in the Pignon health facility with the Super Matrones program, would be a part of the program.
- Specific attention should be paid to improve the quality and access to prenatal, postdelivery, and postnatal family planning services, including access to long-term methods.
- HIV/AIDS prevention and care services for mothers and their infants should be completely integrated into core obstetrics and neonatal care, as should postabortion care services.
- A BCC component focused on issues related to what families and communities can do to reduce maternal and neonatal mortality should be implemented.

Soins Obstétricaux Gratuits

1. *The team suggests that USAID work with other donors and MSPP to conduct a careful evaluation of the SOG program, in relation to its impact on overall health facility financial welfare, its impact on other health facility activities, and its impact on maternal and neonatal morbidity and mortality. This should include a client satisfaction component. Given the high per capita cost of the SOG approach, the poor quality of many existing services and the fact that 75 percent of Haitian women still deliver at home, the SOG approach may not be the best choice to achieve a significant reduction in maternal and neonatal mortality at this time. Less costly and possibly more effective alternatives should be considered, including strengthening the role of health centers with beds in provision of deliveries and expansion and improved training of the “Super Matrones.”*
2. *The team further recommends that USAID consider funding an ability- or willingness-to-pay study to assist the MSPP and other health providers in Haiti to develop a strategic cost recovery strategy, which may include free services for some clients or some key services, if necessary. The SOG program represents one possible response to cost as a barrier to care-seeking behavior by providing free services. Such initiatives must be developed with prudence. Cost-recovery mechanisms have been developed in Haiti by a variety of health sector organizations for a long time, be it in a nonstandardized and haphazard manner. Provision of low-cost or free services should favor those primary health services with the greatest potential impact on mother and child morbidity and mortality, including community-based services. Modifications in fee structures must be paired with improvements in the quality of services in order to improve impact on health status.*

f. Family Planning

Within the context of the existing SDSH and HIV/AIDS programs: revitalize family planning activities by pursuing the following:

1. Aggressively promote the implementation of the Repositioning Family Planning initiative. This should include developing strategies to provide adequate FP coverage in zones where USAID partners (CRS, World Vision) and other organizations that do not provide the full range of family planning services, are operating.
2. Intensify FP activities aimed at adolescents (delayed sexual onset, spacing), women under age 25 (spacing and limiting), and multiparous women over 35 who have attained their desired family size (limiting: long-term methods, including IUDs and surgical contraception);
3. Actively promote integration of family planning services into all appropriate mother and child health interventions (including into birth plans and contacts with community health providers), with a special emphasis on improved quality of care, counseling, education, method choice, and equipment and supplies.
4. Integrate FP activities in all USAID programs targeting youth (e.g., income generation, education, professional training—specifically KATA and IOM/PREPEP) and continued and strengthened integration into Ministry of Education and Ministry of Youth and Sports activities.
5. Improve availability of contraceptive methods and a greater method mix by strengthening contraceptives logistics; USAID and MSH should continue to collaborate closely with UNFPA and MSPP on these issues.
6. Increase public education regarding long-term methods through intense education campaigns (integrate with social marketing activities).
7. Conduct a detailed assessment of the decision-making process of Haitian men and women regarding the use/non-use and continuation/discontinuation of contraception. This should include the choice of contraceptive methods, and cultural, financial, knowledge and perceptual factors regarding access to services. Particular attention should be paid to the 15-to-19-year-old age group and to factors related to long-term methods. The assessment should start with a literature review (including anthropological studies) and, perhaps be completed through complementary focus group studies.

g. Child Health

Integrated Management of Childhood Illness

1. *Donor collaboration to develop a more consistent operational strategy and to increase funding is needed to successfully expand the implementation of IMCI. Key partners include, UNICEF, USAID, WHO, CIDA, and NGOs. A special IMCI subgroup of the national level Inter-Agency Coordinating Committee would be a useful mechanism to promote the continued scaling up of locally appropriate IMCI at both the facility and community levels.*
2. *In order to strengthen community-based IMCI, the team suggests that SDSH explore simplified training models being used in some African countries. The USAID-financed AWARE-RH Project has adapted institutional IMCI modules for the community level in a three-to-four-day training program. This might furnish a model for Haiti.*
3. *Several local health services, such the Centre Médicale Charles Colimon de Petite Rivière de l'Artibonite, are implementing effective integrated services. These model efforts should be more thoroughly documented and further assessed for possible expansion of IMCI services into other health facilities supported by USAID Projects. Field visits should be organized to enable interested parties to observe and understand best or promising practices identified.*

Diarrheal Disease

1. *The team noted Dr. Rohde's recommendation to intensify education regarding homemade sugar and salt solutions, but suggests, instead, that emphasis be placed on increased liquids and feeding during diarrheal episodes. USAID should work with other donors to increase access to ORS packets and conduct simple operations research to identify local foods and drinks that can be recommended to mothers as essential components of home-based care.*

Immunizations

1. *USG partners should collaborate more closely with UNICEF, WHO, and MSPP to assure complete coverage of maternal and child vaccinations. While the higher immunization coverage in USAID-supported sites is an important achievement, it does not significantly contribute to overall higher national rates. According to one PAHO official, the problem is the fragmented nature of the overall health care system in which NGOs and projects define their own coverage areas, and sometimes do not clearly define those areas. Improved GPS mapping will make it easier both to define routine coverage zones as well as to assure complete coverage during vaccination campaigns. What is needed is a national EPI strategic plan which assigns clear responsibility at communal/UCS level for cold chain management, coverage for routine vaccination, and campaign management to particular organizations in each area, based on standardized administrative areas (communes, or UCS). Planning of responsibilities for cold chain management, vaccine distribution and complete population coverage should be incorporated into the yearly departmental planning activities. A detailed*

strategic and operational results–based plan should be developed at departmental and UCS levels to improve overall vaccination coverage.

h. Institution Strengthening

Decentralization

- 1. The excellent initiative of departmental annual planning initiated by MSH could be further strengthened.* Participation at the department and even commune levels by national representatives of major donors and other GOH ministries (e.g., Ministry of Finance, Ministries of Youth and Sports, Education), as well as important private sector representatives would provide a feedback mechanism to channel lessons learned at the departmental level to the national level and to influence strategic decision-making by donors and government alike. Invitation of some representatives from other departments could provide opportunities for successful initiatives in one department to influence work in other departments.
- 2. Planning exercises should become more practical, action oriented and realistic, with clearly designated responsibilities for implementation and oversight and detailed budgets based on realistic expectation of funding availability.* Each year, in the context of the departmental/commune planning exercises initiated by SDSH/Pwojè Djanm, the departments should select one or two MCH/FP service delivery issues for such detailed annual planning to gradually improve access to and quality of services across the department. For example, one year a particular attention might be paid to immunizations, while the following year more attention would be focused on improved neonatal care. These detailed plans should be based on real availability of funding and support from both donors and the MSPP. Such an exercise would not only direct attention and resources to reducing key access and quality barriers, but would refine the current planning process by assuring that at least one or two components of the annual plans can be carried out as initially intended.

Logistics

- 1. The logistics system, which is dysfunctional on all levels, must be addressed and strengthened.* Earlier this year, in consultation with donors (USAID/MSH, UNICEF, WHO, UNFPA), the MSPP developed a plan to strengthen the national essential drugs and supplies system, *Projet de Création du Réseau National de Distribution des Intrants*. The Plan is a good starting point for discussions. The review team urges USAID to continue working with UNFPA, PAHO, and the MSPP in this area and to set a deadline (e.g., by December 2008) for clarifying the vision and finalizing the detailed action plan for strengthening the system. USAID can jumpstart the process by brainstorming with its own logistics experts (SDSH, LMS, SCMS) and partners with distribution experience in the country (Title II organizations) and subsequently sharing their insights, recommendations and expertise with the MSPP and other donors that are part of the Réseau Nationale Distribution des Intrants (RNDI) Committee. Regular, at least quarterly, operational meetings among MSPP, UNFPA, PAHO/WHO, and MSH and USAID are needed to move toward better long-term solutions to the existing logistics issues.

It is beyond the scope of this review to design a logistics system for the country. This should be done by the MSPP in close collaboration with donors, health care managers and facilities nationwide. USAID is the largest donor in the health sector and currently supports several parallel logistics systems (through MSH/SDSH, MSH/LMS, and MSH/SCMS). The team understands that there was a need for quick solutions to ensure that family planning and HIV/AIDS interventions received the requisite drugs and supplies in a timely manner. The team also believes USAID can now use its wealth of in-country expertise to assist the MSPP to design and implement a national logistics system that can be managed and progressively sustained by the GOH MSPP.

Norms and Standards

1. *USAID projects should work closely with the MSPP to disseminate existing norms and standards and other policies and official guidelines and report on their implementation.* Overall MCH/FP Norms and Standards are sufficiently well developed, but they are not available at most health facilities and health personnel are not well versed in them.

Management Information System

1. The management information system is overwhelmed by donor reporting requirements. Specifically, the multitude of donor-driven indicators pose a tremendous burden to health facility and project staff and are undermining the systematic use of data for strategic planning, monitoring of progress, and routine adjustment of implementation approaches to improve outcomes. USAID/Haiti should work closely with the MSPP, other donors and USAID/Washington to simplify and standardize reporting requirements and improve the use of data for decision-making at all levels, especially at the departmental and health facility levels. Moreover, SDSH and the Title II partners implement a similar, if not identical package of MCH/FP services and, therefore similar if not identical indicators of performance should be implemented by Title II partners and SDSH/Pwojè Djanm. PMP indicators for maternal health, child health and fertility regulation/family planning, and indicators that cross-cut these technical/program areas, should be reviewed, and as needed, revised or added to, and less useful indicators in the PMP should be dropped. Jon Rohde and Malcolm Bryant's recommendations in this regard should be taken into account.

i. Using Best Practices and Lessons Learned

1. *USAID projects should take advantage of the existence of several best practice models in MCH/FP in Haiti and evaluate them for possible scale-up.*

These include:

- The SDSH experience with the Safe Motherhood Four Delays model.

- The SDSH performance-based contracting model, developed under previous MSH projects, has become a model for other countries.
 - The MYAPs experience with the targeting of nutritional supplementation for all children less than two years (rather than only for children identified as malnourished). Equally the practice of providing sufficient food for four people per child so as to address family nutritional needs and assure the targeted child receives sufficient supplemental food.
 - The Petite Rivière model for integration of HIV services into MCH/FP.
 - The Pignon *Super Matrones* program.
 - The HHS Maternity Waiting Homes model.
2. *The team learned that USAID FFP staff members have proposed regular meetings with MYAP and SDSH staff and the team fully supports this initiative. Moreover, the Team recommends that the appropriate USAID Health staff also participate actively in these meetings. This will enable partners to share materials, curricula, experiences, data and lessons learned and conduct joint planning activities, develop consistent messages and standardized pay and/or incentive packages for health staff, community health agents, TBAs and *collaborateurs volontaires* (colvols). These meetings should focus on practical issues through well defined and previously agreed to meeting agendas, perhaps with a rotating presidency.*
 3. *USAID through the MYAPs and the SDSH Projects now supports several different models of health service delivery. This offers the opportunity to compare and contrast results and identify the most efficient and cost effective implementation strategies for addressing Haiti's chronic malnutrition and other maternal and child health needs.*

j. Cross-Sectoral Synergies

1. *The USG, USAID, and the Health Office should more fully recognize, support, report on, and demand increased accountability for health sector contributions to the overall Mission strategic objectives. At the same time the USG should make a greater effort to identify and implement activities that create synergies between different sectoral programs by assigning specific responsibilities to USAID staff and projects for assuring cross-fertilization and identification and implementation of synergistic activities. One example is to develop linkages between health projects and the KATA and IOM employment creation activities through the introduction of family planning activities into employment and youth training efforts and/or to explore how the urban networks of these projects can help increase health program access to communities in urban danger zones for improved access to health care for their residents.*
2. *USG should, if possible, encourage and support more consistent, open and strategic coordination between the Ministry of Finance and the MSPP in support of the departmental health program planning initiative.*

k. Civic Participation and Advocacy

1. USAID health programs should encourage community organizations (mothers clubs, breastfeeding support groups, HIV support groups, and fathers' clubs) to take on a greater role in responsible advocacy (a rights-based approach?) for improved access to quality health services vis-à-vis the GOH.

XII. ENDNOTES

¹ Verner D, Making poor Haitians count: Poverty in rural and urban Haiti, World Bank Social Development, Sustainable Development Division, Policy Research Working Paper 4571, March 2008.

² USAID, Haiti Conflict Assessment, June 2006

³ Verner D, op. cit.

⁴ Ibid

⁵ Ibid

⁶ PAHO, Health Situation Analysis and Trends, www.paho.org/english/dd/ais/cp

⁷ USAID, Haiti FY 2008 Program Summary

⁸ Verner, Op Cit

⁹ There are 10 departments, or provinces, in Haiti. These are further divided into 41 *arrondissements*, 135 *communes*, and 565 sections *communales*.

¹⁰ Verner, Op Cit

¹¹ Quoted in Verner, D, op. cit.

¹² Transparency International Global Corruption Perceptions Index, 2008

¹³ USAID, Haiti Conflict Assessment, p. 12

¹⁴ USAID, Decentralization report, 2007

¹⁵ Institute for State Effectiveness, Haiti: Consolidating Peace, Security and Development, USAID, p.4

¹⁶ SDSH/MSH-Projet Djanm, Reactivation and Strengthening the Repositioning Family Planning Program in Haiti

¹⁷ UNAIDS, Epidemiological Country Profile on HIV/AIDS (WHO website for Haiti)

¹⁸ Canadian International Development Agency 2004, Canadian Cooperation with Haiti: Reflecting on a Decade of “Difficult Partnership”. December, 2004 as cited in Institute for State Effectiveness, Haiti: Consolidating Peace, Security and Development, USAID, 2006, p.4

¹⁹ Enacted by Congress in 1998, the Tiahrt amendment prohibits funding for any organization or program that supports or participates in coercive abortion or involuntary sterilization. Tiahrt dictates that no quotas or incentives for family planning can be incorporated into projects receiving US funding.

²⁰ This refers to an American traditional art form: A patchwork quilt of pieces of cloth of various shapes, colors, and sizes.

²¹ This information comes largely from the 2006 USAID Gender Assessment

²² USAID, Gender Assessment, 2006

²³ Ibid, p.31

²⁴ Haiti Conflict Assessment, op. cit.

²⁵ Gender Assessment, op.cit.

²⁶ Cayemittes M, Placide MF, Mariko S, Barrere B, Severe B, Alexandre C, Enquête Mortalité, Morbidité et Utilisation des Services EMMUS-IV, Haiti, 2005-2006. Calverton, MD, USA, Ministère de la Santé Publique et de la Population, Institut Haitien de l'Enfance and Macro International Inc., 2007.

²⁷ PAHO, op. cit.

²⁸ Ibid

²⁹ Public facilities are those that are managed and owned by the state. Personnel are provided by the state, but may also include health staff paid by donor projects. Sometimes, donor-paid staff outnumber government-paid staff.

³⁰ Private facilities are those owned and managed by a private entity such as an NGO, FBO, or other organization. Staff work directly for the private organization. Many of these facilities are supported by a multiplicity of donors as well as their own funds.

³¹ Mixed facilities are owned by the state but managed by a private entity. Their staff may consist of both government employees and private personnel, who may be subject to different pay and benefit policies.

³² PAHO/WHO, Health Institutions and Human Resources in Haiti, Presentation, 2004

³³ World Bank Country Data Profile, 2004

³⁴ PAHO/WHO, Health Institutions and Human Resources in Haiti, Presentation, 2004

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- ³⁵ Personal communication based on recent health census data, still unpublished.
- ³⁶ Cayemittes M, op. cit.
- ³⁷ Abt Associates, Food Security in Haiti: A Case Study Comparing the Food Security Frameworks of the Haitian Government, The European Commission and the U.S. Agency for International Development, USAID, May, 2000 , p.8
- ³⁸ See Network for Sustained Elimination of Iodine Deficiency website, country profiles Haiti
- ³⁹ Cf. PATEL, Monika P et al, Therapeutic Food in Malawian Children at Risk, J HealthPop Nutr, December, 2005
- ⁴⁰ UNFPA, Plan de travail annuel 2008-2009 budgétisé du Fonds Thématique pour la Santé Maternelle en Haïti, July, 2008
- ⁴¹ Bezad, Rachid, Petrina Lee Roy, Jeffrey Sanderson and Sreen Thaddeus, Proposition de directions stratégiques pour la réduction de la mortalité maternelle en Haïti, USAID/Haiti, June, 2002
- ⁴² Anderson, Frank, Sarah Morton and Bette Gerbian, Maternal mortality and the consequences on infant and child survival in rural Haiti, Maternal and Child Health Journal, 2007
- ⁴³ Cayemittes, op. cit.
- ⁴⁴ Reduction Mortalité Maternelle: Analyse des obstacles, UNFPA, 2008
- ⁴⁵ Cayemittes M, op. cit.
- ⁴⁶ There are around 11,000 TBAs in Haiti, as cited in Bezad R., P. L. Poy, J. Sanderson, and S. Thaddeus. 2002. *Proposition de directions stratégiques pour la réduction de la mortalité maternelle en Haïti, June 2002*. USAID/Haiti PHNE: Port-au-Prince/Washington, D.C.
- ⁴⁷ Cayemittes M, op. cit.
- ⁴⁸ Cayemittes M, op. cit.
- ⁴⁹ MAQ Antenatal care: Old Myths, New Realities, USAID
- ⁵⁰ Ibid
- ⁵¹ Marge Koblinsky and Susan Rae Ross. Cited in Making Motherhood Safer, Overcoming Obstacles on the Pathway to Care, Population Reference Bureau, February 2002.

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- ⁵² Dr. Jon Rohde and Malcolm Bryant Final Trip Report (August, 2008)
- ⁵³ Projet “Soins Obstétricaux Gratuits aux Femmes Demunies”, présenté par OPS/OMS à l’Agence canadienne de coopération internationale (ACDI) dans le cadre de l’appel transitionnel des Nations Unies pour Haïti, Mars 2007
- ⁵⁴ Projet Soins Obstétricaux Gratuits OPS/OMS – MSSP – ACDI, Rapport d’avancement, Haiti, juin 2008
- ⁵⁵ Lancet Neonatal Series (Joy E Lawn, Simon Cousens, Jelka Zupen, for Lancet Neonatal Survival Steering Team
- ⁵⁶ Perry, Henry et al, “Assessing the Causes of Under-five Mortality in the Albert Schweitzer Hospital Service Area of Rural Haiti”. Pan-American Journal of Public Health, 18(3), 2005, pgs 178 and 182.
- ⁵⁷ MSPP, Sessions de Formations réalisées 2005 – 2008
- ⁵⁸ As one model of such a program see BASICS II: *Newborn Health Interventions in Senegal: The Early Implementation Phase* (www.usaid.gov/pop_health), 2004
- ⁵⁹ UNFPA/JSI TA Mission Report, June 10-29, 2007
- ⁶⁰ Statistical information in this section is primarily from Cayemittes M, op. cit.
- ⁶¹ The national conference on Repositioning Family Planning was held in late 2006 by the MSPP with technical assistance from MSH and participation of the donor community. Implementation of the initiative was delayed due to the late start-up of the SDSH Project. Recent disruptions in contraceptive supplies have further slowed implementation of this important initiative.
- ⁶² See for more detailed information: Fuentes, Ma. Estela Rivero, Ricardo Vernon, Michaelle Boulos and Louis-Marie Boulos, *Situation Analysis of the Integration of Family Planning Services in Postpartum, Post Abortion and Prevention of Mother to Child Transmission Programs in Haiti*, USAID and Population Council, March, 2008
- ⁶³ www.fhi.org/NR/Shared/enFHI
- ⁶⁴ [www.reproline.jhu.edu/english/ifp/ifp_rh/1\)BSI/gifs](http://www.reproline.jhu.edu/english/ifp/ifp_rh/1)BSI/gifs)
- ⁶⁵ SDSH- Pwojè Djanm, Reactivation and Strengthening the Reposition of Family Planning Program in Haiti, April 2008
- ⁶⁶ MSPP, USAID, UNFPA, UNICEF, WHO, MSH, *Cadre Conceptuel et Opérationnel pour le Repositionnement du Planning Familial in Haiti*, Draft. July 2006

⁶⁷ USAID, Gender Assessment, op. cit.

⁶⁸ Cayemittes M, op. cit.

⁶⁹ Ibid

⁷⁰ Ibid

⁷¹ Population Council, Centre d’Evaluation et de Recherche Appliquée, Situation Analysis of the Integration of Family Planning Services in Postpartum, Post-abortion and Prevention of Mother to Child Transmission Programs in Haiti, March, 2008

⁷² Ibid

⁷³ Cayemittes M, op. cit.

⁷⁴ Personal communication with Tim Clary. Unpublished data gathered in preparation of an ongoing USAID social marketing assessment.

⁷⁵ The DALY combines in one measure the time lived with disability and the time lost due to premature mortality. One DALY can be thought of as one lost year of “healthy” life and the burden of disease as a measurement of the gap between current health status and an ideal situation where everyone lives into old age free of disease and disability. This is not a standardized measure in other USAID MCH/FP programs. Social marketing programs should consider adding or revising indicators to be comparable to those of other MCH/FP programs (e.g., CPR)

⁷⁶ Cayemittes M, op. cit.

⁷⁷ Summary of Lancet Child Survival Series: BASICS II

⁷⁸ WHO, Mortality Country Fact sheet, 2006

⁷⁹ Ibid

⁸⁰ Cayemittes M, op. cit.

⁸¹ Ibid

⁸² Ibid

⁸³ WHO, Mortality Country Fact sheet, 2006

⁸⁴ Cayemittes M, op. cit.

⁸⁵ Ibid

⁸⁶ Ibid

⁸⁷ Rohde J, Bryant M. op.cit.

⁸⁸ Rohde, Jon op. cit

⁸⁹ A study published in 2007 showed that “despite continuous availability of preventive services (1989–1996), higher all cause mortality was more strongly associated with a calendar period coinciding with...the embargo.” The incidence of childhood mortality and severe malnutrition were also higher during the period. The findings suggest that future international sanctions, even those with humanitarian/medical exceptions could result in substantial infant deaths. (Reid, B. C., et.al. 2007. “The Effect of an International Embargo on Malnutrition and Childhood Mortality in Rural Haiti.” *International Journal of Health Services* 37(3): 501–513.)

⁹⁰ Background Note Haiti 2008, U.S. Department of State

⁹¹ USAID Food for Peace Program staff worked with the health team, MYAP, and SDSH staff to come up with a set of common indicators to assess the effectiveness and impact of the MYAP MCHN interventions.

⁹² Under its MYAP, CRS carries out four different activities: MCHN, Education (School Feeding), Safety Net/Humanitarian Assistance (Food to Orphanages, Handicapped and Elderly, People with TB or HIV/AIDS) and Agriculture (Livelihood). World Vision and ACDI/VOCA cover MCHN, Agriculture, Livelihood Diversification, with modest Safety Net/Humanitarian Assistance interventions.

⁹³ Each MYAP partner expresses the objectives in their own fashion, but in essence the objectives are the same.

⁹⁴ Those who have been approved for food supplements—because of poor nutritional status—must attend health education sessions on good health practices and preventive measures (e.g., vaccination, family planning, prenatal care) before receiving food.

⁹⁵ Increased prices in the US meant that the food program was only able to procure about 80 percent of the needed commodities.

⁹⁶ Shimp L. (2006) Immunization Review—Port au Prince, Haiti 20-30, June 2006.

⁹⁷ <http://www.unfpahaiti.org>

⁹⁸ PAHO, Health : A Right for All, The Challenge of Haiti

⁹⁹ <http://www.theglobalfund.org/programs/grantdetails>

¹⁰⁰ Cayemittes M, op. cit.

¹⁰¹ MSH HS 2007 Final Report

¹⁰² Child Survival and Health, the account which now incorporates and covers the former Population (family planning), Child Survival and Health accounts, and includes Maternal Health funding also.