



USAID | HAITI
FROM THE AMERICAN PEOPLE

Services de Santé de Qualité pour Haïti (SSQH) Central and South Contract No. AID-521-0-13-00011

FY 2015

Semi- Annual Report: October 1, 2014 – March 31, 2015



May 2015

This publication was produced for review by the United States Agency for International Development (USAID). It was produced by Pathfinder International, in collaboration with Deloitte Consulting, LLP, Zamni Lasante, Partners In Health, GHESKIO, CDS, FOSREF, and Dimagi.

Table of Contents

ACRONYMS.....	4
EXECUTIVE SUMMARY	5
INTRODUCTION.....	7
OBJECTIVE 1	8
HIV/AIDS	9
TUBERCULOSIS.....	12
MATERNAL AND CHILD HEALTH.....	13
FAMILY PLANNING AND REPRODUCTIVE HEALTH	16
GENDER-BASED VIOLENCE AND CHILD PROTECTION	19
COMMUNITY-BASED ACTIVITIES.....	21
OBJECTIVE 2	23
SUPPORT FOR CHWs.....	23
POINT-OF-CARE DIAGNOSTICS FOR HIV/TB.....	25
MOBILE MENTORSHIP TEAMS.....	25
OBJECTIVE 3	26
CONTINUOUS QUALITY IMPROVEMENT	26
FINANCIAL SYSTEMS	26
CLINICAL RECORD SYSTEMS.....	27
HEALTHCARE WASTE MANAGEMENT	27
DATA MANAGEMENT	27
INFECTION CONTROL.....	28
PERSONNEL MANAGEMENT	28
SUPERVISION.....	28
OBJECTIVE 4	30
SUPPORTING DEVELOPMENT OF DEPARTMENTAL MANAGEMENT SYSTEMS.....	30
RESULTS-BASED FINANCING.....	32
MANAGEMENT, MONITORING, AND ADMINISTRATION	34
PROJECT MANAGEMENT.....	34
MONITORING SYSTEMS.....	35

ADMINISTRATION.....	37
ENVIRONMENTAL COMPLIANCE.....	37
SUCCESS STORIES	40
MOBILE HEALTH CHANGES LIVES IN HAITI.....	40
HAITIAN HEALTH CENTER TAKES FIRST STEP TOWARD IMPROVED CARE	40
ANNEXES.....	42

ACRONYMS

ANC	Antenatal care	LTFU	Lost-to-follow-up
ART	Antiretroviral treatment	M&E	Monitoring and Evaluation
ASCP	Agent de Santé Communautaire Polyvalent	MESI	Monitoring, Evaluation and Surveillance Interface
BEST	Bien et al Santé Timoun Project	MMT	Mobile Mentoring Team
CAL	Centre avec lits (center with beds)	MNH	Maternal and Newborn Health
CAN	Centre Ambulancier National	MSPP	Ministère de la Santé Publique et de la Population
CDS	Centres pour le Développement et la Santé	NGO	Non-governmental Organization
CHW	Community health worker	OVC	Orphans and Vulnerable Children
CP	Child protection	PDI	Plan Départementale Intégré
CQI	Continuous Quality Improvement	PEPFAR	President's Emergency Plan for AIDS Relief
CSL	Centre sans lits (center without beds)	PIH	Partners in Health
CYPRESS	Capacity, Performance, Results, Sustainability	PLHIV	People living with HIV
DDS	Direction Départementale Sanitaire	PMP	Performance Monitoring Plan
DHIS2	District Health Information System 2	PMTCT	Prevention of Mother-to-Child Transmission
DPEV	Direction Programme Elargis	PNLT	Programme National de Lutte contre la Tuberculose
FP	Family Planning	RBF	Results-based financing
FOSREF	Fondation pour la Santé Reproductrice et de l'Education Familiale	SCMS	Supply Chain Management System project
GBV	Gender-based Violence	SDSH II	Santé pour le Développement et la Stabilité d'Haïti II project
GHESKIO	Groupe Haïtien d'Étude du Sarcome de Kaposi et des Infections Opportunistes	SSQH-CS	Services de Santé de Qualité pour Haïti Central-South project
GOH	Government of Haiti	TA	Technical assistance
GTT	Groupe Technique de Travail	TB	Tuberculosis
HTC	HIV Testing and Counseling	UADS	Unité d'Appui au Direction Sanitaire
HIFIVE	Haiti Integrated Financing for Value Chains and Enterprises project	UAS	Unités d'Arrondissement de Santé
HMIS	Health management information system	UEP	Unité d'Évaluation et de
LAPM	Long-acting and Permanent Methods	USAID	United States Agency for International Development
LMG	Leadership, Management, and Governance project	USG	United States Government
LMS	Leadership, Management, and Sustainability project	WASH	Water, Sanitation, and Hygiene
		YFS	Youth-friendly services
		ZC	Zone Ciblées
		ZL	Zanmi Lasante

EXECUTIVE SUMMARY

SSQH-CS is pleased to present its year two (Y2) first semester progress and performance report. With critical groundwork laid in Y1, SSQH-CS sustained activities while deepening its relationship with MSPP, DDS, and health facilities and providers. Key foci during this semester were improved integration of programmatic implementation and partner leveraging to affect the greatest outcomes in service delivery and health systems strengthening. To support this, SSQH-CS personnel conducted 175 technical assistance site visits at 71 facilities during the semester. Notable accomplishments include ART and PMTCT sites upgrades, the establishment of a CD4 diagnostic hub facility, the expansion of the ASCP network, the launching of the CHW Supervisor module under the mSanté program, the development of facility and departmental CQI plans, and the increase in joint supervision visits involving DDS personnel.

Overall, SSQH-CS is on track to achieving many of its expected results for the year. Most service delivery indicators for HIV/AIDS, TB, MCH, FP, and nutrition performed as expected or even surpassed mid-point expectations, while referral network and HSS indicators excelled across the board, many of them already reaching or in some cases outperforming Y2 targets. Essential to this success are partnerships: MSPP/central, national programs (HIV and laboratory), individual DDS, and USG partners all played critical roles in helping the project achieve. Selected highlights from the semester are below:

Success Highlights

For **HIV/AIDS**, SSQH-CS is on track to either meeting or surpassing targets for five of six indicators with contract-mandated expected results that report semi-annually. Some indicators that exceeded expected performance to date include: people with advanced HIV receiving ART; registered TB patients screened for HIV; percent of HIV+ pregnant women receiving ART to reduce MTCT; and people known to be alive and on treatment 12 months after ART initiation. **Tuberculosis (TB)** indicators posted impressive results this semester, with 94.1% of the Y2 target already met for patients receiving isoniazid preventive therapy (IPT), and 86.9% of the Y2 target met for TB patients tested for HIV.

In the area of **child health (CH)**, SSQH-CS is on track to meet Y2 targets for number of children under 5 who receive vitamin A and number of children under 5 reached by nutrition programs. **Family Planning (FP)** output indicators fared exceptionally well, with 98% of target met for sites providing FP counseling and/or services and 61.4% of target already met for number of youth (aged 15 – 25) accessing RH services.

As part of **Objective 2**, the project has already reached 71.3% of its Y2 target for the **number of CHWs** per catchment population of USG-supported health referral networks.

Substantial headway has been made under **Objective 3**, with the project already reaching 97% of the Y2 target for sites implementing **CQI Plans**. Impressive progress is seen for sites maintaining **auditable financial statements**, with 63% of the Y2 reached to date. Intense project efforts to work with sites to establish and staff CQI teams that meet regularly have led to results of 137% of the indicator target.

In support of **Objective 4**, the project continued its high performance, with 50% of the indicators already exceeding the Y2 targets (percent of sites addressing recommendations from site visits [127%] and percent of DDS that hold meetings at least once per quarter to analyze and use data for planning [133%]). During the past six months, the number of sites receiving **joint supervision visits** with DDS staff increased from 14 to 43, leading to a 68% achievement rate of the Y2 target.

Still, the semester experienced challenges that tempered overall performance. A handful of indicators are not yet on track for year's end. GBV, WASH, and critical care indicators stand out as needing improved performance, and the project intends to double its efforts in these areas during the next semester to bring indicators back on track. In general, training activities delayed during the first semester contribute to the performance of these indicators. A delay in subcontract approval with Dimagi has unfortunately sidelined that partner during the semester and delayed new CommCare module (HIV and WASH) development and rollout. This will move forward once subcontract approval is in place. Continued support for facility- and community-level data collection and reporting is necessary to ensure accurate results, with emphasis on improved data collection tools such as registers and CommCare. Key personnel transitions and post vacancies impacted continuity of project leadership, with the COP, M&E Specialist, and F&A Director all leaving the project during the course of the semester. Interim leadership was brought on and active recruitment has led to top candidates being selected and presented to USAID for approval.

In November, the project held an implementing partners retreat to review Y1 results and challenges, and plan for Y2. A key result from the retreat was a blueprint for improving clinical and HSS technical assistance integration through a new team-based framework. Over the course of the semester, the project established management foundations for this new framework and started implementation in February/March.

Looking forward to the next semester, SSQH-CS will maintain support for service delivery and community mobilization across the project network, while focusing TA support on priority sites established by PEPFAR and the project. Further ART and PMTCT upgrades and TB co-infection management support will be coupled with FP/MCH/YFS integration. Focused trainings in WASH, GBV, and CP will help the project get on track with related indicators and acceleration of the mSanté program will add key technical modules in HIV, WASH, and commodity management. Data quality assurance and improved reporting practices from community and facility levels remain a key concentration for the project. Finally, the procurement of supplies and equipment is necessary to help facilities deliver quality services and accurately report results on time.

INTRODUCTION

The Services de Santé de Qualité pour Haiti- Central and South (SSQH-CS) Project is a three-year (with the option of a two-year extension) health service delivery initiative in Haiti funded by the United States Agency for International Development (USAID). SSQH-CS supports the Ministère de la Santé Publique et de la Population (MSPP) to improve the health status of the Haitian population. Led by Pathfinder International, the SSQH-CS consortium includes Centres pour le Développement de la Santé (CDS); Deloitte Consulting, LLP ; Dimagi ; the Fondation pour la Santé Reproductrice et de l'Éducation Familiale (FOSREF); the Groupe Haïtien d'Étude du Syndrome de Kaposi et des Infections Opportunistes (GHESKIO); Partners In Health (PIH); and Zamni Lasante (ZL).

SSQH-CS has four objectives:

- (1) Increase the utilization of the Ministère de la Santé Publique et de la Population's integrated package of services at the primary care and community levels (particularly in rural or isolated areas;
- (2) Improve the functionality of the USG-supported health referral networks;
- (3) Facilitate the sustainable delivery of quality health services through the institutionalization of key management practices at both the facility and community levels; and
- (4) Strengthen departmental health authorities' capacity to manage and monitor service delivery.

SSQH-CS works in six of the ten departments in Haiti, including West, Center, South, South-East, Nippes, and Grand Anse, providing clinical and community-based services for the catchment area's nearly 2.65 million people (approximately 25% of the country's estimated 10.4 million population in 2015). Service delivery entails the provision of MSPP's Essential Package of Services, which includes services in HIV/AIDS (including clinical and psychosocial service support to Orphans and Vulnerable Children [OVC]); Tuberculosis (TB); Maternal and Child Health (MCH) (including Water, Sanitation and Hygiene [WASH], and Nutrition); and Family Planning (FP). In addition, SSQH-CS supports Gender-Based violence (GBV) and Child Protection (CP) services at selected sites, as well as the provision of training and limited support for basic critical care (accident and emergency) for project sites within the Port-au-Prince and parts of the St. Marc USAID Development Corridors. A critical link between communities and facilities reinforced and supported by SSQH-CS is the Agents de Santé Communautaires Polyvalents (ASCP), who provide first level services in MCH, FP, STI/HIV/AIDS, TB, and nutrition. SSQH expects to support 1,000 ASCPs by project's end.

Key project strategies for reaching these objectives include (1) strengthen the technical knowledge, skills, and capacity of health care providers at facility and community levels; (2) train and mentor health care leadership in management practices; (3) establish and strengthen service networks extending from the household to hospitals; (4) assess and where feasible, refurbish physical infrastructures and supply equipment to facilities; (5) promote community involvement and mobilization; and (6) implement the MSPP results-based financing (RBF) scheme.

This semi-annual report covers the first semester of Year Two (Y2) activities and project results from October 2014 to March 2015. The report is divided into three main sections: semi-annual performance by objective (1-4); management, monitoring, and administration; and success stories. Performance tables for indicators with a semi-annual reporting frequency for contract-mandated expected results and semester highlight boxes are included throughout the report. The full PMP with data for indicators with semi-annual reporting frequency is in Annex A and the list of SSQH-CS site visits conducted during the semester is in Annex B.

OBJECTIVE I

INCREASE THE UTILIZATION OF THE MSPP INTEGRATED PACKAGE OF SERVICES AT THE PRIMARY CARE AND COMMUNITY LEVELS

Semester Highlights

- ✓ 96.4% of Y2 target met for percent of persons known to be alive and on treatment 12 months after initiation of ART
 - ✓ 100% PEPFAR sites providing integrated voluntary FP services
- ✓ 260.9% of Y2 target met for health care workers who successfully completed an in-service training program

SSQH-CS ensures the delivery of health services in USAID-supported networks and scales up access and use of MSPP’s essential package of services at facility and community levels. The project supports the delivery of services at 80 sites and their surrounding communities. Grounded in the continuum of care from the community to facility level, the project brings essential services to the lowest possible levels

while improving the quality of services along the continuum. Focused technical assistance targets the improvement of service quality and integration, and support for CHW broadens the delivery of services at community levels. Mobilization and support of community groups work to increase demand for and use of these improved services. Finally, the project

acknowledges the efforts and good work carried out by the health sector personnel at the 80 participating service delivery sites, which managed a transition from the previous USAID-funded SDSH II project to SSQH-CS seamlessly, and played a pivotal role in the SSQH-CS’s performance.

Each technical area in this section includes a data table highlighting contract-mandated indicators with semi-annual reporting, as set by the Performance Indicators Reference Sheet (PIRS). A full Indicator Summary Table for all project indicators *with semi-annual reporting frequency* is found in Annex A. The full PMP results for all indicators will be presented in the SSQH-CS Y2 Annual Report.



Figure 1: SSQH-CS supported facilities [data source: SSQH-CS Site Database]

HIV/AIDS

Indicators	Y2 Annual Target ¹	Total Achieved for 6-months	% Target Achieved
Number of adults and children with advanced HIV infection newly enrolled on ART	2,382	608	25.5%
	Comment: Indicator is short of this semester's expected result but has the potential to achieve Y2 target if project carefully manages new PEPFAR strategy that prioritizes high volume, high impact sites.		
Number of adults and children with advanced HIV infection receiving ART	2,736	3,359	122.8%
	Comment: Indicator has surpassed Y2 target already.		
Percent of registered TB patients screened for HIV at project-supported sites	91%	79.1%	86.9%
	Comment: 428/541; indicator is expected to surpass annual target.		
Percent of HIV+ women who receive ART to reduce the risk of MTCT	93%	71.0%	76.3%
	Comment: 180/255 receiving ART; indicator is expected to surpass annual target.		
Number of HIV+ eligible adults and children provided with a minimum of one care service	4,400	3,886	88.3%
	Comment: Indicator is expected to surpass annual target.		
Percentage of adults and children known to be alive and on treatment 12 months after initiation of ART	77%	74.2%	96.4%
	Comment: 380/512; indicator is expected to surpass annual target.		

Table 1: HIV indicators with semi-annual reporting frequency for contract-mandated expected results

SSQH-CS continued its support to PEPFAR-funded facilities for the delivery of HIV testing and counseling (HTC), palliative care, ART, PMTCT, OVC, and TB services. By the end of March, the project network included 24 sites offering HTC, 21 providing palliative care, 16 delivering ART, 22 offering PMTCT, and 22 serving OVCs. This year, the project is in the process of upgrading two additional sites in ART and two more in PMTCT. Community focus during the semester included the training of ASCPs² in HIV and service referral. Strong coordination with PNLS, the national lab, and SCMS led to improved personnel capacity and better equipment availability at key sites. At the central level, strong leadership and policy clarification reinforced service integration. A seminal announcement by MSPP in early March mandated all service providers regardless of specialization to take responsibility in delivering HIV services³.

Despite these important gains, however, some obstacles to improving HIV services tempered some of the project's advancements. Several sites face ongoing staffing deficiencies (such as nurses, data clerks, and social workers), which affects services availability and results reporting. Other barriers included inaccessibility to internet for data entry, unreliable electricity, insufficient laboratory equipment, and a general need to improve Direction Départementale Sanitaire (DDS) ownership of service delivery.

¹ Y2 Annual targets for HIV are set per the PEPFAR FY15 Country Operational Plan.

² ASCP refers to those CHWs who have completed the MSPP five-module training. SSQH-CS supports both CHWs and ASCPs. CommCare trainings target ASCPs.

³ "Note Circulaire aux Hôpitaux Universitaires, aux Hôpitaux Départementaux et Hôpitaux Communautaires de référence," MSPP, March 5, 2015.

Security also posed obstacles for project technical assistance support and service delivery itself in some areas of the country. In Cité Soleil, for example, CSL CNSRR (Rosalie Rendue) experienced delays in registering HIV patients in its newly upgraded PMTCT services due to shutdowns caused by riots, looting, and attacks on site personnel. Other challenges have emerged from PEPFAR's evolving program priorities. Only facilities that serve a minimum number of HIV patients per year will continue to receive funds for scale up of ART activities. For facilities not meeting the minimum number of patients, HIV services will be maintained at current levels or reduced if not discontinued altogether. In Cornillon, for example, the site expects to have a newly trained doctor manage the recently upgraded PMTCT services. Yet the new PEPFAR directives now call into question the future of these services and the project risks losing the investments already made. Furthermore, no clear plan yet exists with MSPP to address how trained personnel may be relocated to other priority sites.

ART Services

Specific activities undertaken during the semester targeted quality improvement of ART services at 16 sites and service upgrade efforts focused on making the facilities at Lahoye and Bel Air ART sites. This constitutes 100% of the Y2 target for the corresponding indicator already attained. Mentoring and coaching visits by project advisors built health provider capacities in ART reporting, the proper use and maintenance of patient files (for improved adherence monitoring), palliative care provision, laboratory chemistry and management, and commodity management. Onsite technical assistance also supported HIV integration with FP, MH, and GBV services, while offsite trainings provided focused, in depth HIV/TB instruction to selected staff. A mobile mentorship team comprised of a medical doctor, a nurse, a laboratory technician, and project coordinator conducted mentorship visits at six (6) priority HIV sites. Coaching for providers at FOSREF MARPs and youth centers within project-supported catchment areas helped to improve HTC and youth-friendly HIV services while strengthening referrals for key populations to project-supported ART sites.

At the community level, the project continues its training of ASCPs to build community awareness and referral for HIV services. The project developed a community "accompagnateur" model and operation plan to augment retention and adherence rates and address cases of LTFU. The model engages PLHIV to act as accompanists for newly-enrolled patients in treatment and care (ART and when appropriate, DOTS), as well as trains ASCPs on community monitoring and encourages social support groups to play valuable roles in the strategy. Training of ASCPs in this model begins next semester. A key need identified by the project is applying a standard definition LTFU across the catchment area so providers appropriately report figures. Inconsistent reporting practices have sometimes led to sites counting patients as LTFU when in reality they either sought services elsewhere or died. The project is making efforts to standardize the application of LTFU across SSQH-CS sites. Under the mSanté program, SSQH-CS is developing an HIV module to the CommCare application that will guide ASCPs through prevention and treatment support at the household level. Rollout of this module is scheduled for May.

HIV/TB Co-Infection

To address cases of HIV/TB co-infection, the project works with sites to routinize the HIV screening of all TB patients. Seventy-five percent of SSQH-CS-supported sites offering HIV services also include TB screening and treatment services (18 of 24), and one additional site (Bel Air) offers treatment exclusively. This alignment of HIV and TB services facilitates the management of co-infection. During the reporting period, the project mentored health providers at seven ART sites⁴ to address co-infection through screening of TB patients for HIV and vice versa. First semester Y2 results show that the project

⁴ CSL Abricots, CAL Les Anglais, HCR ICC Grace, CAL AEADMA, CAL Matheux, CAL Martissant, and CSL Maissade.

has already reached 86.9% of its annual target for TB patients tested for HIV. Project TA visits reviewed site procurement plans for rapid testing supplies and coached providers on adherence with national TB care guidelines. However, several sites only had HIV guidelines available and none for TB; a priority for the second semester is to provide these sites with the full guidelines as well as follow-up mentoring on their proper use.

While a majority of ART sites also have TB diagnostic and treatment capacities, there remain a couple that do not. In such cases, the project-supported HIV site has to refer clients to TB sites outside of the network. Project TA to these ART sites focuses on strengthening referrals between institutions. Another challenge experienced is that in certain publically-managed sites, HIV medical providers do not want to add TB service responsibility without an increased compensation. SSQH-CS will work on resolution of these in coordination with the relevant DDS.

While less and less emphasis is placed on laboratory support under PEPFAR, the project nonetheless provided coordination among national bodies like PNLS and the national lab, USG partners such as SCMS, the DDS and individual facilities to support lab capacities and resource availability. In Nippes, SSQH-CS advised the PNLS on selection of a site for allocation of a PIMA CD4 machine. CAL Dame Marie was chosen, received the machine from SCMS, and clinical staff were trained in its use from technicians the national lab. The project also helped other facilities receive equipment. Delmas 75 now has a reflowtron analyzer and OBCG has a spectrophotometer, and facility staff received training for using the equipment.

PMTCT Services

PMTCT services are offered at 22 project-supported sites, including CNSRR, which enrolled its first HIV patients (17) this semester in February and March. Providers at these sites received supportive supervision and mentoring visits covering MESI access and data reporting, patient file maintenance and usage, and commodity management. ANC nurses received mentoring on HTC and PMTCT service delivery, including instruction on counseling and patient flow management. Semester data shows that of the overall 89 infants exposed to HIV at PMTCT sites, 78 (87.6%) were put on ARVs within 72 hours. Of the 12 sites reporting cases, 11 sites saw 100% cases put on ARV within 72 hours, with only one site falling below this standard.

Areas of additional instruction are the importance of infant feeding practices and exclusive breastfeeding. The availability of national protocols and guidelines are often available, but these tend to be in manual form and few sites have wall flow-charts visible to both provider and patient. During ANC and post-partum visits, HIV+ women receive information on contraception methods and the importance of dual protection, but only a few sites (i.e. CNSRR) have been successful in including male partners in PMTCT services.

Other HIV clinical care services

Broader support and care for HIV+ adults and children includes psycho-social, legal, and educational services, while health providers integrate HIV/FP services and provide risk-reduction counseling. The project continued its collaboration with the USAID/BEST project to broaden OVC services at SSQH-CS sites. This collaboration works to strengthen provider capacities in the early infant diagnosis (EID), PMTCT, pediatric HIV, data collection, lab support, and pediatric treatment protocols. Additional services supported by the agreement are school enrollment, vocational training, household economic strengthening activities, and provision of medical and non-medical supplies (e.g., antiparasitics,

Paracetamol, and mosquito nets). The HIV strategy for community engagement targets community support groups for PLHIV and OVCs to help increase access to psychosocial care.

HIV Next Steps

A Key priority for next semester is refining project strategy and support for upgrading HIV services (ART, PMTCT) at selected facilities to better align with the new PEPFAR priorities. This will include the maintenance of HIV services at some sites, while upgrading others; this will also entail the curtailing or phasing out of services at some sites that functioned well but did not have the minimum number of ART patients to qualify for continued PEPFAR assistance. Priority activities during the second half of the year include the pilot and rollout of the community HIV adherence and retention strategy (including LTFU tracking at three sites) in coordination with the rollout and scale up of ASCP trainings in HIV monitoring, referrals (including PCR testing), and the CommCare module. The team will also implement the OVC plan developed during the semester in collaboration with USAID/ASKE and USAID/BEST projects. Continued support to health providers in identifying and providing services for key populations will be critical.

TUBERCULOSIS

Indicators	Y2 Annual Target	Total Achieved for 6-months	% of Target Achieved
Case notification rate in new sputum smear positive pulmonary TB cases per 100,000 population in USG-supported areas	91/100,000	64	70.6%
	Comment: Indicator is expected to surpass annual target.		
Percent of project-supported facilities that have adopted an infection control plan	60%	15%	25%
	Comment: n=12 sites implementing an infection control plan. While more sites have plans in place, shortages of basic infection control supplies prohibit some sites from implementing the plan.		
Percent of patients receiving isoniazid preventive therapy	95%	89.3%	94.1%
	Comment: 577/646 reported. Indicator is expected to surpass annual target.		

Table 2: TB indicators with semi-annual reporting frequency for contract-mandated expected results

TB Diagnostic and Treatment Services

In coordination with the DDS, facilities, and community-based services, SSQH-CS supported the intensified case finding, notification, and treatment of TB patients. Working at the departmental level, project advisors conducted joint meetings to help define strategy and plans for linking HIV resources to support TB services and to identify diagnostic equipment needs. Eighteen (18) project-supported sites have the capacity for diagnostic services while 19 can provide treatment (treatment sites include the 18 diagnostic sites). Coordination with the DDS reinforced the availability of TB protocols at sites, while mentoring visits supported their use. However, equipment and supply shortages hinder sites' ability to adhere to protocols and greatly limit diagnostic capabilities. The project coordinates with SCMS and MSPP institutions for equipment needs, but demand far too often outweighs supply and unanticipated budget constraints limits how much support the project can directly offer sites. Nonetheless, SSQH-CS has prioritized light equipment procurement to support TB services in the coming semesters.

Site level TA focuses on addressing co-infection, making sure HIV patients are screened for TB and supporting providers to enroll those testing positive in treatment. The team worked with HIV care providers on the provision of isoniazid preventive therapy (IPT) and coordinated with SCMS to ensure IPT availability at HIV/TB sites. By the end of the first semester, the project had reached 94.1% of its annual target for patients receiving IPT. Related ASCP trainings covered community outreach, active case identification strategies, and instructions for making appropriate referrals for diagnosis and treatment.

TB Infection Control

The project worked with facilities to adopt infection control plans through mentoring visits and remote support. Often project advisors would assess what was already in place and provide feedback for improvement; at other sites, advisors would co-design plans on site with the providers. The project developed an infection control plan template and helped 15 PEPFAR facilities either develop a plan or verified its presence during the semester. The template covers multiple aspects of managing infection control, including management committees, training needs, monitoring and reporting, and environmental considerations. Yet even with plans in place, adherence can be problematic. Some facilities experienced stock outs of basic infection prevention supplies such as masks and gloves. Despite the project’s efforts to coordinate with the DDS and SCMS to respond and provide supplies, some sites continue to face shortages or stock outs. To fill this gap, the project may procure basic infection control supplies for sites in the future.

TB Next Steps

Selected activities prioritized for next semester include ongoing health provider trainings in HIV/TB co-infection care and case management and ASCP trainings in community case detection and referral support. Additional support to facilities in terms of posters/job aids (i.e. promoting use of IPT) and infection control supplies are needed to strengthen providers’ capacity to adhere to national guidelines and protocols. The project will also start shifting its TA and material support foci in preparation for FY16 realigned PEPFAR priority sites.

MATERNAL AND CHILD HEALTH

Indicators	Y2 Annual Target	Total Achieved for 6-months	% Target Achieved
Number of children <5 who have received Vitamin A from USG-supported programs	174,015	80,753	46.4%
	Comment: Indicator is on track to reaching annual target.		
Number of children <5 reached by USG-supported nutrition programs	422,218	217,072	51.4%
	Comment: Indicator is on track to reaching annual target.		

Table 3: MCH indicators with semi-annual reporting frequency for contract-mandated expected results

Maternal and Neonatal Health

SSQH-CS continued its support for basic maternal-neonatal health (MNH) care at community and institutional levels through service delivery financing, provider trainings, technical assistance, and equipment provision. Twenty-two (22) sites benefited from coaching and mentoring visits during the semester. These visits reinforced the use of national protocols in ANC, safe delivery, post-partum, and essential newborn care. Both institution-based and mobile clinic-based providers (doctors, nurses, and auxiliaries) benefited from this assistance. ANC visit data supports progress in the number of women reached with exclusive breastfeeding messages, with the project already at 47.9% (n= 27,402) of its Y2 target at the halfway mark. The number of women who received at least three (3) ANC visits is progressing, with n= 17,629 for the semester. This suggests an approximate retention rate of 64% for clients completing their third ANC visit. In support of PAC, advisors coached providers in services and standards, but many facilities faced shortages of appropriate equipment to effectively deliver them.

The site visits also allowed project personnel to assess equipment and supply needs at facilities. The project distributed 36 delivery/obstetric tables to 30 sites. Priority was given to sites that either had no tables at all or had ones in disrepair. Other equipment needs identified includes sphygmomanometers, stethoscopes, and anti-shock garments, particularly to support mobile clinic operation. Procurement of these items is scheduled for next semester.

In November 2014 SSQH participated actively in a two-day workshop, organized by JHPIEGO, on Reduction of Maternal Mortality in Haiti. About 80 stakeholders participated including representatives of the MSPP, USAID, FOSREF and other USAID partners, and three hospitals that had been identified as future sites for maternal health training (Mirebalais in the Center Department, St. Boniface in the South, Milot in the North). It was agreed that SSQH-CS will collaborate with JHPIEGO on training sessions to be held in the Center and South Departments. A follow-up meeting to discuss details of the collaboration is envisioned for next semester.

At the community level, 191 ASCPs received training to recognize and identify danger signs of pregnancy and anemia, promote the importance of breastfeeding and iron and folic acid supplementation, and to refer cases via MCH networks as appropriate. ASCPs provide basic MNH services through home visits and rally posts, identifying pregnant women and encouraging them to attend ANC visits. ASCPs trained and supported to use CommCare accessed job aides for complete MNH consultations and made 418 referrals for pregnant women.

Child Health and Nutrition

Site-level technical assistance at 18 facilities evaluated and strengthened provider capacities to monitor and promote child health and nutrition. Evaluations surveyed tools and resources available for vaccination and malnutrition programs, including availability of deworming drugs, syringes, antigens, and vitamin A. TA to facility personnel reviewed and shared best practices for using tools such as vaccination daily journals and inventory management forms. Project advisors worked with site providers and managers on infant and young child feeding best practices and reinforced correct and consistent usage of growth monitoring and reporting tools, including technical forms, national registers and dashboards, activity calendars, and monthly reports. Results to date support these efforts. For example, the project has achieved more than 46.4% of its Y2 target to date for children under five receiving vitamin A.

The project built health provider capacities and supported site stocks to advance nutrition objectives. Three (3) trainings on acute malnutrition, done in coordination with the West and South-East DDS provided instruction to 82 facility health providers, covering nutrition concepts and education (i.e. exclusive breastfeeding), malnutrition screening and anthropometric measurements, norms and protocols, mobilization and community participation, and case studies and practical exercises (i.e. effective use of data collection and reporting). Specialized sessions on community screening for acute malnutrition and appropriate referrals engaged 29 CHWs, while the ASCP module trainings instructed 191 in child health. Once providers received training in malnutrition prevention and treatment, project staff worked with facilities to develop distribution plans for RUTF (ready-to-use therapeutic food). During the semester, the project distributed 1,060 boxes (159,000 sachets) of the RUTF Plumpy Nut to sites. Another round of distribution (96,000 packets) is scheduled for April 2015. In the first semester for Y2, SSQH-CS trained 273 individuals in child health and/or nutrition, approximately 42.9% of the Y2 target.

At the departmental and central levels, the project coordinated with DDS/DSO to support the availability of materials and resources (scales, rulers, and malnutrition registers, etc.) for sites that benefited from trainings. When approximately 50 facilities in the West department experienced stock outs in CH and other vaccines (i.e. measles, mumps, and rubella), SSQH-CS helped identify where in the supply chain blockages were occurring (regional UCS/UAS levels) and coordinated with MSPP to help resolve the dilemma. With the approval of MSPP to implement, SSQH-CS worked with NGOs with strong logistics capacity to transport vaccines from the DPEV level to the regional UCS/UAS level. MSPP allowed project-supported NGOs to receive vaccines for not only their own network sites, but arrange for all other non-network health facilities in their coverage area to order vaccines through their NGO for pick up at the UCS/UAS. In some cases when no NGOs were available for non-network facilities in the area, SSQH-CS delivered products directly to the UCS/UAS on their behalf or directly to the facility site.

Water, Sanitation, and Hygiene

Results from Y1 WASH assessments (n=25) identified sites needing rehabilitation work to improve water and sanitation facilities. Assessment data also mapped training needs in WASH-related content. The project developed a WASH rehabilitation plan for six (6) sites, from which the work for two sites is currently in procurement. CS Delmas 75 will have toilets, sinks, and drainage installed while the existing sanitary block will have cosmetic and minor refinishing work completed. The project anticipates the contractor will break ground in May. Similar work will be undertaken in Martissant. This is discussed further in the EMPR section of the report [see Management, Monitoring, and Administration].

Activities to increase health provider knowledge in WASH methodologies and tools use continued during the semester. In March, the project trained 29 facility staff in this content area and health providers learned how to develop WASH management plans for their respective facilities. Participants also engaged with the WASH assessment findings from their respective sites, which opened broader discussions about WASH norms and standards. Community engagement in WASH promotion also saw some solid successes. For Global Hand Washing Day (October 15), the project hosted awareness campaigns at Delmas 75 and Martissant. Project staff promoted basic prevention messages, held demonstrations on hand-washing techniques, and emphasized door-to-door sensitization by CHWs. An estimated 1,500 community members participated in the two events.

Despite these efforts, WASH activities remain behind schedule, with both rehabilitation work and WASH-focused trainings for ASCPs experiencing delays. The project had expected to have a WASH curriculum for community health workers developed by now. While the project trained 282 ASCPs in

WASH methods in Y1, it did not have an established curriculum that was approved by MSPP. With only 29 providers trained in WASH methodologies in the first semester of Y2, the project is far behind its annual target for this indicator (only 8.2%). Next semester will ensure all ASCP trainings include WASH content to improve performance of this indicator.

At the request of USAID, the project will henceforth report on the new hand-washing indicator (number of households with hand-washing stations). While SSQH-CS does not have any activities that can clearly and directly be linked to household hand-washing per se, the project may influence such behavior through its WASH promotion and education sessions. The project will do its best to identify cost-effective ways to capture this data (e.g. using CHW registers and CommCare modules). If the cost of capturing this new data becomes prohibitive, SSQH-CS will discuss options with USAID.

MCH/WASH Next Steps

MNH priority activities for the second half of the year include the procurement of additional ANC and safe delivery supplies and small equipment; and acceleration of the new ASCP CommCare trainings as well as continued support for those trained during Y1. A key element for success in this latter activity is the rollout of the CHW supervisor module to engage supervisors in the routine CommCare use by ASCPs. Focus for child health and nutrition activities will be on the continuation of health provider mentoring and trainings, as will the project’s continued coordination with health sector partners to address disruptions in vaccine stocks. Under the WASH component, priorities are the completion of infrastructure improvements identified in the project rehabilitation plan and the increased investment in training ASCPs in WASH content. Development of a WASH curriculum is paramount in making progress in this domain. The project also plans to develop a WASH module for CommCare in partnership with SSQH-Nord to assist cholera prevention messaging and data collection on number of household hand-washing stations.

FAMILY PLANNING AND REPRODUCTIVE HEALTH

Indicators	Y2 Annual Target	Total Achieved for 6-months	Total of Target Achieved
Number of youth (aged 15-25) accessing reproductive health services	75,983	46,660	61.4%
	Comment: This indicator is well on its way to reaching the annual target.		

Table 4: FP/RH indicators with semi-annual reporting frequency for contract-mandated expected results

Contraception Use and Availability

A central focus for SSQH-CS is to increase access to and use of modern contraception among women of reproductive age. Project interventions included facility- and community-based provider trainings, site-level action planning, departmental coordination and joint supervision, and commodity management. Currently, 64 sites offer at least four contraceptive methods (condoms, pills, Depo, and implants) and nine (9) sites offer IUDs. To date, the project has reached 96.9% of its target for percent of sites (n=76) providing FP counseling and/or services. Seventy (70) sites have regular FP activities at the community level included in their annual workplans.

Trainings aimed to build the capacity of providers to offer method mix and make referrals as appropriate. The trainings included DDS technical staff and MSPP/DSF personnel when possible. During the semester, 36 providers received training in long-acting and permanent methods (LAPM). As part of

the ASCP trainings, 191 received instruction on providing FP and referring clients for LAPMs at facilities, while 50 CHWs received in-service training on contraceptive technologies. The project works with providers to integrate family planning with other services (such as HIV and ANC) and offers training and mentoring in the appropriate provision of mixed methods. Indeed, this year the project trained 22 HIV providers (nurses and auxiliaries) in contraceptive technology and FP counseling. Finally, FP cue cards designed to help providers offer complete information on mixed methods were procured in March and distribution to FP sites will begin early next semester.

However, despite the strong work the project has accomplished to build capacity in contraceptive services, systemic challenges affect data collection/reporting and contraceptive commodity access. Indeed, the project found semester CYP rates to be rather low, with only 23.9% of the annual target met to date (n=110,351), suggesting a poorer performance in contraceptive use. However, a closer examination of the situation reveals a different understanding of this indicator while illuminating major gaps in the health system. The project found that 49/76 (64%) of FP sites cannot post results on MESI or DHIS2, and cannot email them. With many sites not having MSPP FP registers either this past year, data reporting is greatly compromised and many FP services that are provided do not find their way into the national HMIS. Only NGO facilities tend to have the means to record FP data on notebooks in the absence of FP registers. In fact, the project found that 27/76 FP sites end up not sending FP reports at all. In terms of commodity availability, IUD stock outs are not a major concern, as MSPP and LMS have committed to ensure their availability across the network. Yet despite the availability of IUDs, not every site with properly trained personnel to deliver the method can do so. Basic medical supplies needed to perform IUD insertions (e.g., Betadine, gauze, gloves, and bleach) are not always on hand, which prevents providers from delivering this service. Limited facility budgets prevent them from purchasing these supplies directly, thus making them dependent on outside sources for their provision. SSQH-CS has included these basic supplies in its draft procurement plan for next semester.

National planning and strategy workshops help to increase contraceptive commodity availability and reinforce the integration of FP into other services. Project advisors participated in a MSPP-hosted workshop promoting the national PMTCT strategy, which emphasized the integration of FP services. Coordination with MSPP, LMS, and SCMS supported the availability of contraceptive commodities for sites within the SSQH-CS network. National quantification workshops helped identify site-level FP commodity needs and coordination meetings with SCMS facilitated the provision of needed FP commodities at selected sites.

Youth-Friendly Services

Efforts to increase the number of youth (aged 15 – 25) accessing reproductive health services, including contraception, involved assessments of 18 project-supported facilities to deliver youth-friendly services (YFS). This includes assessing the number and type of providers on site, hours of operation, separate space for serving adolescents. Once YFS capacities were assessed, project advisors developed site-specific TA plans to help improve youth outreach and services offered. Execution of the TA plans started this semester, with project staff providing coaching visits covering HIV/FP/MH and GBV service integration with a focus on youth. Project efforts may already be making a mark in this area: the first semester saw 61.4% of the Y2 target reached for youth (aged 15 – 25) accessing RH services. A key priority for next semester will be to continue working with these facilities to improve their ability to serve adolescents and youth and strengthen linkages between the sites and community outreach groups.

Technical assistance to reinforce the integration of FP services with HIV, maternal health, and GBV services for key populations such as commercial sex workers (CSW) continued. FOSREF has several MARPs and youth centers within the project's catchment area. Onsite mentoring in FP integration at these centers improves services provided while strengthening referrals to SSQH-CS network sites for follow-up care.

USG Compliance

USG Compliance activities continued during the semester. Project staff received an annual training in USG legislative and policy requirements for FP. For service delivery partners, technical and managerial staff received compliance trainings, copies of "Tiahrt posters" in French, and DVDs with guidelines and monitoring tools. Compliance visits at both clinics and implementing partners' central offices verified USG compliance files and reviewed content with providers. Monitoring visits showed an understanding of the regulations among site providers, but revealed needed areas for improved documentation and highlighted gaps between some NGO central bureaus and their affiliate service delivery sites. Strengthening the monitoring and technical support relationship between NGO central bureaus/DDS and service delivery sites is a keystone in ensuring compliance across the project network, as the project relies on the former to monitor compliance for their sites. Focus during the second semester will aim to reinforce this link.

FP Next Steps

Key FP activities envisioned for the second half of the year include additional provider trainings in LAPM, including the provision of IUDs within 48 hours post-partum, in collaboration with departmental technical staff. SSQH-CS will train providers in long-acting methods at 10 facilities. ASCP trainings and mentoring visits with supervisors will further build the capacities for LAPM referrals from the community. The procurement of basic medical supplies will enable sites capacitated to deliver long-acting methods such as IUDs to do so. The project is also exploring options for providing FP registers at sites to ensure data is appropriately recorded and reported. Technical assistance to strengthen YFS and FP integration will target priority sites, and the team will distribute FP theater sketch DVDs produced last year and FP cue cards procured in the first semester to facilities. Finally, continued work with NGO and ZC technical staff on USG Compliance is needed to reinforce and monitor adherence.

GENDER-BASED VIOLENCE AND CHILD PROTECTION

Indicators	Y2 Annual Target	Total Achieved for 6-months	% Target Achieved
Number of people reached by a USG-funded intervention providing GBV services	231	0	0.0%
	Comment: Data was not yet available to report.		
Number of health institutions providing clinical assistance and referrals of child protection cases to legal and social services	31	35	112.9%
	Comment: Indicator has surpassed its annual target.		
Number of children reached by child protection services	4,456	0	0.0%
	Comment: Data was not yet available to report.		
Number of community and clinical health staff and community-based actors trained to recognize and refer GBV and child protection cases to appropriate legal and social services	353	33	9.4%
	Comment: Delays in developing a GBV curriculum to incorporate with ASCP trainings has been problematic for the project's progress in this indicator.		

Table 5: GBV/CP indicators with semi-annual reporting frequency for contract-mandated expected results

GBV

Facility capacity assessments of GBV services that started in Y1 continued during the first half of Y2. Evaluations verified the availability of GBV services, personnel (including social workers and psychologists), and provided initial feedback on how to improve services. The project identified 10 priority sites and trained 33 health providers in GBV services (including interviewing techniques) and data collection/reporting. Mentoring and coaching visits at 18 facilities helped integrate and strengthen GBV and youth-friendly services.

In support of community level screening and referrals, the project started training ASCPs in Y1 in GBV. Unfortunately delays in the development of a GBV curriculum have prevented the project from fully incorporating the subject content in the ASCP trainings. Supplemental instruction on GBV provided to ASCPs in Y1 also experienced setbacks in the first half of Y2, presenting a missed opportunity for the project to harness CHWs as agents for increasing access to GBV services. The project looks to improve coordination to address and correct this during the second semester. Community leader and group engagement and sensitization on GBV progressed, however, with many sessions realized by youth peers during the semester. FOSREF youth centers within the SSQH-CS catchment area also provide GBV referrals to project-supported facilities. Strengthening linkages between youth centers and community groups and project facilities is another priority for the second half of the year.

Child Protection

SSQH-CS Child Protection (CP) staff conducted mentoring visits to 11 sites in Grand Anse, Nippes, and West departments to check and update OVC lists for accuracy and compliance with PEPFAR guidelines, support the establishment and effective use of OVC psychosocial charts, and follow up on monitored interventions. Mentoring visits included the coaching of social workers on clinical care for OVCs and on working with CHWs to properly identify and refer OVCs for services. Project CP advisors also met with OVCs and parents at FONDEFH Martissant, Delmas 75, and ICC.

Collaboration with the USAID/BEST project continues to support critical support to OVCs and their families. EID, pediatric HIV, and lab support strengthens clinical services while education (i.e. subsidies for school fees), housing, mothers clubs, and economic development assistance expands psycho-social support networks. Health provider trainings, including the one mentioned in the section above that trained 33 people, include CP content and capacitated participants in interview techniques and social work services.

GBV and CP Next Steps

While the project has made strides to improve service delivery capacity and quality in GBV and CP through evaluations, trainings, and mentoring visits, increased momentum is needed to augment performance in the related expected results. The project remains behind target for provider and CHW training to recognize and refer GBV and CP cases to appropriate legal and social services. While structured trainings for ASCPs in these areas during Y1 helped set this activity in motion, the delay in developing a GBV curriculum has not helped move this activity forward. Community group engagement will need to continue during the rest of the year as well, to strengthen linkages with the appropriate services.

CRITICAL CARE

Indicators	Y2 Annual Target	Total Achieved for 6-months	% Achieved to Date
Percent of project-supported sites certified to serve as critical care stabilization centers	36%	0%	0.0%
	Comment: Data not yet available to report.		

Table 6: Critical Care indicators with semi-annual reporting frequency for contract-mandated expected results

In February, the project co-hosted a training session in critical care at Mirebalais, located in the Center department. Nine (9) health providers from seven SSQH-CS facilities participated in modules covering basic life support and patient stabilization, advanced cardiac life support, pediatric life support, advanced trauma life support, and patient shock management. The project planned to continue its mSanté coordination and referral strengthening with the Centre Ambulancier National (CAN) during this year’s Carnival celebration. However, an unfortunate accident during the event caused carnival goers to stampede, which in turn prevented the active and effective deployment of ambulances and resulted in the celebrations being called off early. The crisis underscored some of the vulnerabilities critical care responders face in emergency situations in Haiti.

Critical Care Next Steps

The project recognizes critical care services as an area needing increased attention and support. Project performance under this technical area lags behind successes shared in other domains. A refocus of strategy during the second semester will help the project reclaim lost ground and bring performance up to appropriate levels. A structure of support to better monitor critical care services at certified sites and identified steps to augment the number of certified sites are necessary.

COMMUNITY-BASED ACTIVITIES

Indicators	Y2 Annual Target	Total Achieved for 6-months	% Achieved to Date
Number of sites providing care and support for vulnerable groups	23	33	143.5%
	Comment: Indicator has surpassed annual target.		
Number of service providers trained who serve vulnerable persons	75	33	44.0%
	Comment: Indicator performance is slightly below expected half-way mark but has the potential to meet its Y2 annual target with the development and implementation of training curricula.		

Table 7: CBA indicators with semi-annual reporting frequency for contract-mandated expected results

Community Engagement

Two principle resources essential for engaging community members are a community mobilization strategy and the Pathways to Change (P2C) tool. While the first is only partially in place, the second resource has been used extensively with great success (see below). The project developed a HIV community approach as part of its overall HIV strategy which harnesses and builds upon home visits, community support groups (i.e. *clubs des meres*), CommCare, psychosocial services, and peer accompaniment to reinforce and promote service delivery. This approach will inform the finalization of an overall community mobilization strategy, expected to be finished early in semester two.

A second thrust involves using P2C, a board game designed by Pathfinder International to engage community members to identify facilitators and barriers to service access and use. SSQH-CS has oriented MSPP and individual DDS on the use of P2C and incorporated the tool in ASCP trainings, and MSPP has even adapted the tool for its own use. The game uses different scenarios to engage participants to discuss behavior patterns around HIV, GBV, FP, and MCH and nutrition. This information is then shared with technical advisors both within the project and among service providers and health managers at the facility levels. During the semester, the project engaged providers at 12 ZCs in 216 P2C games played.

Community-based Services

Support for community-based services continued through service delivery agreements (NGOs and ZCs) and ASCP trainings. Decentralization of services to the lowest possible level occurs through facility-led mobile clinics and community health agents, who conducted home visits, organized rally posts, and made referrals for service delivery in the project catchment area. Technical assistance to CHW supervisors aims to build capacity in monitoring and managing CHWs in the network. This is reinforced by the expansion of the mSanté program to include a CHW supervisor module, and trainings have already begun. CommCare has helped improve the quality of data collection at the community level and linked results to referral facilities (see Obj. 2).

Community-based Activities Next Steps The community mobilization strategy will be ready for implementation in June and provide a strong foundation for increasing demand for services. The strategy will also incorporate feedback mechanisms for community health management support. The project will employ this strategy in concert with existing efforts made by community agents, peer mobilizers, and facility-based mobile services. Intensified ASCP trainings, including work under the project's mSanté program, will arm more CHWs with the knowledge, skills, and tools to deliver services

through home visits and rally posts. Engagement of CHW supervisors, particularly through CommCare, will strengthen the referral link between facilities and CHWs, and help to ensure the quality of care delivered at the community level is high. Also important will be the ongoing monitoring of health services at the community level to ensure results are accurate, timely, and make their way to the national HMIS.

OBJECTIVE 2

IMPROVE THE FUNCTIONALITY OF THE USG-SUPPORTED HEALTH REFERRAL NETWORKS

Semester Highlights:

- ✓ 71.3% of Y2 target achieved for number of CHWs active in project health referral network
- ✓ 270% increase in regular CommCare use among ASCPs after supervisor module launched
 - ✓ 23 sites networked to use PIMA CD4 diagnostics

SUPPORT FOR CHWs

SSQH-CS continued its ongoing assistance for CHWs, including salary, supplies, and supervision support. Through service delivery mechanisms, SSQH-CS mobilizes CHWs, outfits them with health promotion materials, and provides TA to CHW supervisors to strengthen CHW-managed service delivery. Additional procurement is underway to provide CHWs with minimum supplies to facilitate their work (e.g., backpacks, ponchos, and flashlights). The project has already reached 71.3% of its Y2 target for the number of CHWs per catchment population of USG-supported health referral networks, with 888 active CHWs.

One focused level of support includes the comprehensive training of CHWs to bring them to a standard level for polyvalent agents, or ASCPs. Building off the foundation laid by an earlier USAID project, SDSH II, which trained CHWs in three of the five module MSPP curriculum, the project trains participants in the final modules (II and III), which include health teams, communication, ethical behavior, health education, community diagnostics, family health and home



Figure 2: An ASCP provides a consultation during a rally post

visits, and community service organization. A key aspect of this training is reinforcing the linkage between the CHW and facility for supervision, support, and service referral. During the first half of Y2, the project trained an additional 191 ASCPs, bringing the total from project start to date to 672 ASCPs. The project aims to have 1000 certified ASCPs active and trained in CommCare by September 2016. However, while these ASCPs have all received the full MSPP curriculum training, they have not yet received official ASCP certification from MSPP. The project has begun coordinating with MSPP on the finalization of this last step in the process and expects to see many trained ASCPs receive their certification during the second semester. While the project supplemented the ASCP curriculum with

focused content in WASH and GBV, comprehensive curricula in these technical areas have not yet been developed. As identified under Obj. 1, this is a priority for the next semester.

mSanté Program

SSQH-CS further developed its *mSanté* program despite delays in the approval process for renewing the subcontract with CommCare-developer Dimagi. Building off the successes in Y1, during which MCH and FP modules were built and rolled out, the project finalized a CHW supervisor module this semester. SSQH-CS is currently in the process of developing HIV and WASH modules to roll out in the second half of the year. In coordination with SSQH-Nord, the project also aims to add a commodity management module to the CommCare application and train ASCPs in its use. CHWs being trained in the ASCP curriculum are targeted for trainings in CommCare. Finally, to help the project rollout the mSanté program, SSQH-CS received direct funding from another USAID project, HIFIVE, to procure 700 additional Haitian-made tablets. These tablets arrived in February/March and are currently being programmed with CommCare for future use.

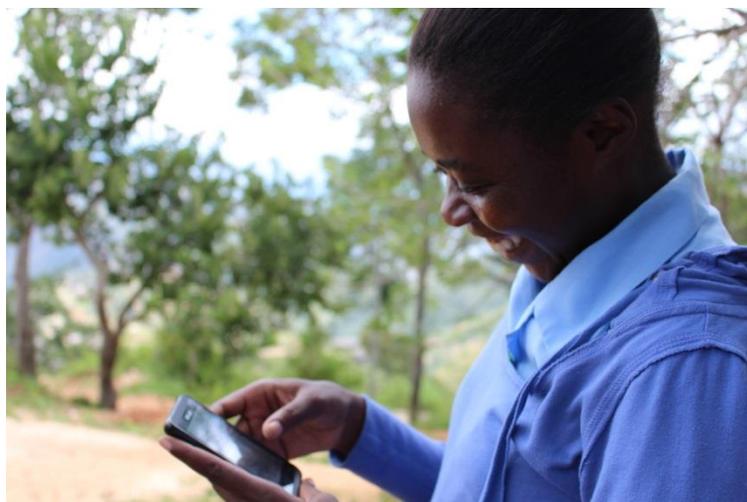


Figure 3: An ASCP uses CommCare

Ongoing TA for the ASCPs trained in CommCare during Y1 continued, with project advisors monitoring usage and providing remote and in-person troubleshooting help. Despite these efforts, the project noticed only about 60 of the 309 ASCPs trained to use CommCare were actively doing so in Y2. Use remained sporadic for the rest of the CHWs. Identifying the CHW supervisors as key links to supporting ASCPs and reinforcing the use of CommCare, the project finalized the supervisor module and trained 34 supervisors at Fermathe and FONDFEFH sites in the West

Department. Once supervisors began using CommCare and knew how to support their CHWs, the number of ASCP active users increased significantly. By March 2015, the number of ASCPs trained in Y1 who actively used CommCare more than doubled to 162 from October 2014.

One key next step for ensuring the success of mSanté is to coordinate directly with MSPP and USAID to reinforce the roll of CommCare vis-à-vis the national HMIS. The MSPP/UEP expressed reservation in fully supporting CommCare due to a misunderstanding that the platform would somehow replace DHIS2. Quite the contrary, CommCare has the potential to feed directly into DHIS2 to strengthen data reporting by eliminating opportunities for data reporting errors as community level moves from register to report. SSQH-CS hopes to work with the MSPP to enable this feature and improve data management from community to national HMIS levels. USAID will be a key ally in coordinating this discussion and clarification between the ministry and project.

POINT-OF-CARE DIAGNOSTICS FOR HIV/TB

Strong gains were made in support of HIV/TB point-of-care diagnostic capacitation this semester, and the project advanced plans made during Y1 to develop “hub” facilities for point-of-care CD4 diagnostics. As mentioned under Obj. 1, after PNLs made site-level recommendations to establish CD4 capacities, SSQH-CS reviewed them and made suggestions to help identify the most appropriate site. The project was successful in lobbying PNLs and the National Lab to select CS Dame Marie in Grand Anse for the site of a PIMA CD4 unit. SSHQ-CS coordinated with SCMS to deliver the unit and provided laboratory and clinical mentoring to capacitate facility providers. As a hub facility, Dame Marie could serve populations in Abricots. The addition of this diagnostic function at Dame Marie contributes greatly to the project’s success for the indicator measuring the number of referral network sites using diagnostic units (n=23).

MOBILE MENTORSHIP TEAMS

Since the end of Y1, the project has deployed mobile mentorship teams (MMT) to key facilities. Originally capacitated to provide mentorship in HIV/TB, the MMT has expanded its role to provide onsite and extended mentorship to doctors, nurses, and lab technicians in FP and MCH integrated services. During the semester, the MMT provided mentorship visits to six (6) facilities. Working side-by-side with facility personnel, the MMT reviews the use of registers, assess how well providers follow established protocols/guidelines, and mentors staff on new HIV services recently added to selected sites. Commodity stocks and consumption reports, MSPP registers, and individual patient charts are also included in the review. The MMT makes recommendations to the facility and relays these to the wider SSQH-CS project for follow-up coordination.

General finding by the MMT showed key technical improvements that could be made onsite as well as larger systemic challenges facing the facility. Issues such as insufficient staff, lack of electricity, or insufficient equipment (i.e. lab or computer hardware) are difficult for the project to help the facilities address. However, budget-permitting, SSQH-CS plans to procure some minimal equipment to improve facility capacity. The MMT was also able to help facilities access MESI and supported data entry through the provision of internet USB dongles as needed.

Future direction for the MMT is to expand its mandate to include other technical areas such as WASH, GBV, and child health, as well as managerial technical assistance in accordance with the facility’s CQI plan. Another aspect needing reinforcement is engaging the DDS personnel during mentorship visits. The project informs the DDS of MMT site visits, but it has been challenging to secure DDS participation in the mentorship visits. SSQH-CS will intensify efforts to address concerns and ensure DDS participation during the next semester.

Objective 2 Next Steps

During the next semester, SSQH-CS will continue its ASCP trainings and scale up the mSanté program. Inclusion of GHV, CP, and WASH content in the ASCP trainings is paramount and SSQH-CS will ensure it happens during the second semester. A key step in the ASCP training process is to certify ASCPs who have completed all MSPP module trainings. SSQH-CS will coordinate with MSPP in this final step and will provide support for the ceremony and necessary resources (i.e. certificates). It is expected the current procurement of CHW minimum supplies will conclude during the second half of the year and the project will be able to distribute the items to CHWs. MMT expansion to include other technical areas and CQI harmonization in more facilities is an identified priority for the second half of the year, as is improved coordination with each DDS for MMT site visits to ensure DDS participation.

OBJECTIVE 3

FACILITATE THE SUSTAINABLE DELIVERY OF QUALITY HEALTH SERVICES THROUGH THE INSTITUTIONALIZATION OF KEY MANAGEMENT PRACTICES AT FACILITY AND COMMUNITY LEVELS

Semester Highlights

- ✓ 93% sites with CQI plans that incorporate a system to identify and follow-up on issues
 - ✓ 100% NGO sites maintaining auditable financial statements
 - ✓ 100% HIV sites experienced no stock outs in HIV commodities

SSQH-CS made significant progress during the semester with both department- and facility-level personnel in improving key management practices. A combination of mentoring visits, joint supervision, focused trainings, and capacity workshops helped facility and department personnel identify management and service quality needs, develop continuous improvement plans, improve data collection and reporting capacities, and increase competencies in financial and commodity management. The project refined its site profile dashboard, which draws from assessment data collected in Y1, and presented it and data analyses to the departments in a series of workshops to engage all six DDS with their data and inform decision-making.

CONTINUOUS QUALITY IMPROVEMENT

The SSQH-CS approach to supporting continuous quality improvement (CQI) builds upon established national quality management efforts (HEATHQUAL) where appropriate, and draws from performance goals set by the facilities themselves. Project staff worked with the HEATHQUAL team to expand the platform to include non-HIV content, including other service programs like FP and MCH as well as management issues. Concurrent to this process, the project helped facilities design or refine CQI plans that can eventually streamline with HEALTHQUAL. Using Deloitte's participatory CYPRESS model to help facilities translate performance targets into capacity development actions to improve health system performance, SSQH-CS helped facilities identify goals and deficiencies obstructing their attainment. Workshops designed to present CQI and joint supervision planning engaged facility and DDS staff from all six departments. These activities covered CQI exercises and tools, health indicator lists, orientation to joint supervision, and data collection and use for decision-making. By the end of the semester, 76 facilities had CQI plans developed and quality committees established (including identified members, roles and responsibilities, and next quality meetings); and all six DDS developed joint supervision plans.

FINANCIAL SYSTEMS

Building off some early successes in Y1 with financial reporting for a number of the NGO-supported facilities, the project expanded its engagement on facility and department financial systems strengthening. The project surveyed financial procedures and documentation maintained at a sample of the four different levels of ZC facilities in Center and Nippes departments (dispensary, CSL, CAL, and referral hospital) and found inconsistent availability of MSPP guidelines on financial reporting and weak bank reconciliation and expenditures tracking practices. With this information, advisors drafted standardized financial management models by facility type that vary in terms of reporting

responsibilities yet are simplified and promote increased transparency and controls. The project collaborated with USAID/HFG⁵ and SSQH-Nord to adapt national system tools and processes to allow sites to present auditable financial reports. Capacity building workshops with DDS staff and the project's six financial managers (one assigned to each target DDS) introduced financial management objectives and trained participants in tools (i.e. bank reconciliation forms and auditable financial statement formats), procedures, and manuals. The financial managers at each department are now custodians of these tools and processes and liaise with DDS staff directly. The project provides routine follow-up mentoring with these finance managers. The departmental finance staff developed training schedules for next semester to roll out financial management tools and processes to facility staff.

During the semester, the project saw the number of facilities producing auditable financial statements increased by 22% from Year 1 (from 41 to 50), for an overall rate of 63% of the Y2 target met for this indicator. This included a 100% success rate for NGO-managed facilities, a success supported by making financial statements a sub-contract deliverable. With ZCs, the project had to adjust its approach since it does not have the contractual leverage it shares with the NGOs⁶. To help ZC facilities maintain auditable financial statements, the project works through the embedded finance managers and DDS staff to collect, track, and support reports in all six departments.

CLINICAL RECORD SYSTEMS

Project advisors supported service providers in maintaining and using complete patient files during supportive supervision and mentoring visits. They reviewed existing files for completeness with providers, advised them on how to improve the quality of records, and mentored them in the use of the data for improved service quality and reporting. DQA visits verified data transposition into registers and helped data clerks authenticate monthly statistical reports.

HEALTHCARE WASTE MANAGEMENT

Governance and leadership support provided to sites by the project incorporated elements of healthcare waste management. Participatory methods engaged facility staff in developing action plans that address capacity to receive, manage, and dispose of health commodities. More support in this area will be necessary as the project moves forward to ensure sites have efficient resources to monitor and manage healthcare waste management. All NGO and DDS service delivery agreements include regulations and guidance on proper waste management. See EMPR section under *Management, Monitoring, and Administration* section for more.

DATA MANAGEMENT

The project supports service providers in data collection, management, and reporting through onsite mentoring and data validation exercises, and remote follow-up assistance. Data reporting TA helped providers accurately record results in both MESI and MSPP registers, as well as compiling data for monthly statistical reports for the project. SSQH-CS M&E officers conducted data quality validation site visits for 21 facilities (including 88% of ART sites), testing results for selected HIV, TB, and FP indicators.

⁵ Health Finance and Governance Project

⁶ The project has subcontracts with NGOs and MOUs with Departments for service delivery at ZCs. SSQH-CS made financial statements a deliverable under the NGO subcontract. However, the MOU mechanism does not enable a financial statement deliverable since expenses are not paid directly to departments or facilities.

These visits also enabled the project to record data for selected HIV/TB indicators reported in MESI, such as the 12-month ART retention rate. Project advisors also supported the development and roll-out of new MSPP facility registers; 35 facilities received registers and training on how to properly complete forms, collect data, store, and submit to the project.

INFECTION CONTROL

As part of the project's TA for HIV/TB services, advisors worked with facility staff to reinforce the presence and implementation of TB-infection control standards and protocols. For TB sites without an infection control plan, the advisors helped facility staff develop one using a project-designed template [see Obj. 1 TB for detail]. Onsite mentoring visits provide regular verification that plans are in place at facilities; and follow-up supervision visits to providers are conducted to monitor implementation. While the total number of facilities with plans is higher, only 12 are actively implementing infection control plans. A chronic lack of basic infection control supplies hampers execution of the plans. SSQH-CS coordinates with SCMS and other partners in an effort to obtain supplies but quantities needed are often not available. To encourage implementation of the plans until a more sustainable solution is identified, SSQH-CS is considering the procurement of some supplies and making them available to project-participating sites.

PERSONNEL MANAGEMENT

Site-focused improvement workshops in the South department helped facility personnel identify and design solutions to management and leadership challenges such as weak morale, low performance, and constant absenteeism. Using the CYPRESS methodology, project advisors facilitated a participatory process in which facility personnel from Les Anglais developed a site/organizational chart and job descriptions, identified roles and responsibilities, created a framework for talent development plans for staff. The process empowered facility staff to make the changes themselves and an output from the workshop was the participatory development of



Figure 4: Les Anglais facility personnel during workshop

an improvement plan to address leadership, vision, human resources management, commodities/supply chain management, and financial management. While this approach was very productive and helpful for facility staff, the level of effort for conducting individual site-focused workshops does not make a scalable model to reach all project facilities. However, the project maintained support for personnel management in the larger, departmental-focused capacity building workshops held in February/March.

SUPERVISION

Departmental heads and staff and facility personnel attended capacity building workshops this semester designed to help participants develop and monitor implementation of CQI plans, review and discuss facility data and use it for decision-making, and develop joint supervision team visit plans. Project advisors facilitated sessions that defined supervision and how it relates to the DDS and facilities, reviewed supervision principles and steps, and co-designed supervision plans with the DDS. Hosting 106

staff from ZC and NGO facilities and all six DDS, the workshops led to the creation of 5 departmental supervision plans⁷ for the rest of the year. [See Obj. 4 for more detail]

Prior to the development of these plans, the project coordinated directly with each DDS on joint supervision visits to facilities within the department. While these yielded results, joint visits were largely initiated by SSQH-CS staff and not led by the departments. The supervision plans developed with the DDS as a mechanism for implementing quality improvement initiatives encourage joint supervision visits to be initiated by the departments. At year's mid-point, 43 sites received at least two comprehensive supervision visits and reports by DDS staff per semester.

SUPPLY-CHAIN MANAGEMENT

SSQH-CS continued to support supply chain management at the facility level and liaised with SCMS and DPEV to ensure adequate stock of health commodities. Facilities submit monthly commodity consumption reports to the project and advisors help identify low inventory levels and follow-up support on resupplying. The accurate and timely submission of consumption reports plays a critical role in reducing stock outs at facilities and enables sites to enter additional orders of commodities when prior SCMS deliveries do not align with demand. Onsite TA builds the capacity of facility logisticians in commodity management. Project support at 16 facilities and follow-up trainings for 9 sites during the semester assessed capacities and developed action plans to help facilities receive, manage, and dispose of health commodities. Twenty-five (25) sites received training in job aids, stock cards, forecasting methods, and consumption reporting. During the semester, all 26 HIV sites experienced no stock outs of HIV or three essential OI commodities, and the project saw a 93% timely consumption rate for HIV commodities at HIV facilities. Additionally, the project has reached 42% of its annual target to date in percent of sites experiencing stock outs of vital products⁸.

During the reporting period, SSQH-CS staff learned that expired TB medication had been delivered to some SSQH-supported sites. Staff sprang into action to retrieve the expired drugs and swiftly placed replacement orders to prevent stock outs. In another instance, when vaccine stock outs were experienced in the West department, the project coordinated with the site in question, with the DDS, UAS, UCS, and DPEV to identify needs and facilitated delivery of stocks as appropriate.

Objective 3 Next Steps

Given the many achievements reached under Obj. 3 during the first semester, next steps largely entail maintaining momentum through monitoring progress of CQI implementation. Project staff will focus on bringing the ZC facilities up to par with NGO facilities in terms of financial management reporting and work with DDS staff to strengthen financial management capacity at sites. Now that 95% sites have CQI plans established, SSQH-CS will monitor and support the implementation of those plans in coordination with site-level quality improvement teams. Under commodity and logistics, SSQH-CS identifies the expansion of vital medicines in supply chain support as important, and capacity building for facility stock managers as essential to scale up successes from this semester. Finally, support for basic infection control supplies to identified facilities will help enable providers to successfully adhere to infection control plans developed during the semester.

⁷ DDS Central Plateau was not able to design a supervision plan due to illness and an early departure from the workshop. Project advisors will follow-up individually with the DDS.

⁸ Vital products include Cotrimoxazole, Paracetamol, and iron and folic acid.

OBJECTIVE 4

STRENGTHEN DEPARTMENTAL HEALTH AUTHORITIES' CAPACITY TO MANAGE AND MONITOR SERVICE DELIVERY

Semester Highlights:

- ✓ 114% of Y2 target met for sites that address recommendations from site visits
- ✓ 133% of Y2 target met for DDS that hold meetings quarterly to analyze data for programming
- ✓ 47 sites received comprehensive supervision visits and reports by DDS staff

SUPPORTING DEVELOPMENT OF DEPARTMENTAL MANAGEMENT SYSTEMS

The second half of Y2 saw important gains in SSQH-CS's capacity building activities with the DDS. The project invested in departmental budgeting and planning, awareness and utilization of data systems, and strengthening and systematizing supervision. Preparation for implementing the MSPP's RBF scheme continued at sites as SSQH-CS collaborated with USAID to find an appropriate mechanism for RBF contracting.

Departmental Budgeting and Planning

In the beginning of Y2, SSQH-CS assisted each DDS in preparing their workplans and budgets for the year's activities. The project asked departments to submit their individual workplans ahead of the project's annual workplan submission to USAID. DDS activities that clearly coincide with SSQH-CS objectives and priorities were then incorporated into the project workplan, taking into account budget and other needs and considerations specific to each DDS. This helped to ensure that SSQH-CS activities aligned with the DDS integrated plan, or plan départementale intégré (PDI), which outline the DDS's multi-year strategies and goals. In hand with this process, the project reviewed and agreed upon joint DDS budgets which the project would support. SSQH-CS staff focused on: standardizing costs across budget items (e.g., gasoline, insurance, confirming staff are paid at least the minimum wage, etc.) and ensuring that mandated SSQH-CS activities such as trainings, mobile clinics, and supervision visits were included.

In February, the project held a department-wide workshop that included DDS and ZC personnel. All six department directors and representatives from 10 ZCs joined SSQH-CS staff to disseminate project documents; clarify payment mechanism and documentation requirements; discuss ZC personnel benefit eligibility; reinforce the DDS in their role in supervision, regulation, and management; reinforce ZC-managed community activities; outline communication lines between DDS and project; and address any burning issues/questions. The workshop also provided updated guidance on M&E support and RBF rollout.



Figure 5: Participants from 6 DDS and 10 ZCs met in Petion-ville in February 2015

Data Use for Decision-Making

SSQH-CS developed two tools during Y1 to better facilitate project, department, and facility data use and analysis. The Site Profile and Data Dashboards use site assessment data and are designed to house updated data from site visits with the goal of sharing this with departments and facilities for decision-making. During the semester, the project expanded the database to include information on the availability, accessibility, and use of national protocols at SSQH sites. The inclusion of these criteria will assist the project team and departments in monitoring and improving site utilization of national norms and protocols.

Capacity building workshops held in March hosted 106 representatives from all six departments, including 10 UAS/UCS representatives and covered the importance of data, how to use facility data for decision-making, and presented the existing SSQH-CS tools (mentioned above) to demonstrate how the project currently uses facility data. In the Pre/Post-test of the workshop, participants showed significant improvement in the area of using data for decision making (moving from a 4.69/10 to a 7.41/10). In the future, review of the Site Profile and Data Dashboard will be folded into SSQH-CS's participation in the annual Table Sectorial for each department, therefore reinforcing the practice of data review and analysis in departmental planning. In future quarters, project staff will review indicator and financial management results with each department individually.

Supervision:

Support for joint supervision site visits involving DDS personnel continued during Y2 and focus has been to invest in supervision as a function owned and led by the departments. The capacity building workshops referenced above included supervision as a key topic, defining the term for participants⁹,

⁹ MSSP defines supervision as: "Routine supervision to assess strengths and weaknesses, provide immediate guidance, and make recommendations; monitoring to assess the effects of routine supervision and check how the recommendations were taken into account; and support or special supervision to support the level supervised in solving problems whose solution requires special support and guidance." Manuel de Supervision: A l'usage des Directions Centrales, Départementales, UCS et Institutions de Soins, MSPP, July 2008.

developing supervision plans, and training participants on supervision tools and key practices. These workshops were essential steps to further building collaboration with the six DDS and making progress on quarterly supervision of sites. During the workshop, five DDS developed supervision plans for all facilities in their regions, included both public and privately run facilities. Only the Central Plateau department missed the supervision planning session and could not develop a plan during the workshop. The project followed up with the department after the workshops to facilitate the completion of the plan.

The supervision tools used by the project have gone through several rounds of discussion and adaptation with MSPP. The process first began with a review of MSPP's Supervision Manual with ministry personnel and recommendations for specific tools, including the development of a checklist to streamline and improve supervision visits by raising awareness of HSS approaches for improving health outcomes. Subsequent efforts in collaboration with MSPP yielded adaptations to the Supervision Checklist tool to include additional components such as community-based activities, facility-based service delivery, commodity and logistics, and CQI. Project staff also adapted a USAID tracking tool for use in the DDS supervision. The checklist and tracking tool were introduced and explained during the capacity building workshops with the DDS. The project looks to roll out the updated supervision tool in coordination with the DDS soon, and main foci will be to streamline and standardize the process of conducting supervision visits while improving effectiveness of those visits.

A final aspect of the workshops for DDS, UAS, and facility representatives covered supervision topics such as how to better plan and execute site visits, and how to address issues identified during the visits. Next semester, the project will continue to work with the DDS in the implementation of their supervision plans, including continued joint supervision visits with the DDS and UAS representatives.

Systematizing Continuous Quality Improvement

To facilitate the integration of DDS with the site-level CQI process, the project drafted a scope of work for departmental quality committees. This SOW includes coordination, monitoring and evaluation of QI implementation within the department, and advising MSPP on QI policy and strategies nationally. In Grande Anse, the DDS piloted the SOW with its newly formed quality committee. The quality committees will be launched for the remaining five DDS next semester. As supervision visits continue, project advisors in coordination with DDS quality committees will develop plans for how to identify QI opportunities at facilities, track progress made, and document lessons learned. This will be further reinforced by the CQI plans themselves, which require facility staff to identify improvement opportunities and incremental steps to make progress in the area.

RESULTS-BASED FINANCING

RBF Financing, Implementation Approach and Contracting Mechanism:

SSQH-CS and USAID have discussed the challenges facing implementation of the MSPP RBF scheme under the project's contract since Y1. The main challenges are that 1) under the RBF scheme, both operational and incentive costs fall on the implementing partner, creating a financial constraint for the project and 2) per the project contract, SSQH-CS cannot enter into a direct subcontracting relationship with GOH entities, thereby preventing the project from directly transferring cash incentives under RBF to ZC facilities.

The project developed two concept notes in Y1 for USAID to consider. One note developed three possible RBF implementation scenarios that could operate within the project's budget. These scenarios involved reducing the amount of operational costs, capping RBF incentive payments, and phasing RBF rollout by department. A second concept note explored potential contracting mechanisms the project could employ to implement RBF at the ZCs. A conclusive finding of this note confirmed that Fixed Obligation Grants (FOGs) would not be appropriate for RBF because it would be impossible to establish pre-determined milestones for service delivery.

In October, USAID conducted a two-day RBF workshop with the two SSQH consortia and USAID/LMG. Together, the participants discussed challenges and potential solutions for implementing RBF as designed by MSPP. SSQH-CS presented proposed implementation plans and budget analyses. Post-workshop, the project submitted a revised implementation concept note based upon the workshop discussion, which included a proposed 10% reduction to all service delivery budgets in order to free funding for RBF incentive payments. This would be implemented at 30 facilities over Y2 and Y3, with 11 starting in Y2.

Due to the fact that the SSQH projects are prohibited from contracting with GOH agencies directly and that both projects would need to reduce funding from current service delivery budgets in order to provide funding to RBF incentive payments, USAID determined the best avenue was for it to pursue the option of managing RBF contracts and payments itself. Under this scenario, SSQH projects would support RBF in implementation, training, and follow up, but not manage incentive payments. In February, SSQH-CS followed up on the status of this transition, and learned that USAID-MSPP discussions on the subject were still ongoing. The SSQH-CS team remains available to assist USAID and MSPP to finalize the payment mechanism processes, procedures and implementation plans.

RBF Implementation

Concurrent to the above process, SSQH-CS began its rollout of RBF preparation to the 11 facilities. All 11 facilities received orientation and training in RBF implementation during a week-long workshop in Grand-Anse and Nippes departments. Facility and DDS staff participated and the training included orientation on the RBF Working Group's (GTT) standardized tools, procedures, and indicators. Post-workshop support by project staff helped the 11 facilities finalize their business plans and budget provisions for RBF. Comités de Pilotage (CDP) were established in both DDS Grand Anse and Nippes and received support materials (SOW and monitoring tools) and orientation in their use.

SSQH-CS also began planning for Phase 2 of RBF rollout, and established necessary criteria. These were presented to the DDS South, one of the departments targeted for Phase 2, during the capacity building workshops in Cayes. Phase 2 sites will be selected and receive trainings in conjunction with MSPP and USAID once the RBF contracting mechanism is established by USAID.

Objective 4 Next Steps

During the next semester, SSQH-CS will continue to coordinate with USAID and MSPP in the implementation of RBF to the 11 facilities in phase 1 (in Nippes and Grand Anse), while rolling out training for phase 2 sites. Ongoing support for implantation of the DDS supervision plans is critical for the next semester, while review sessions to assess success of these supervisions visits will help strengthen their effectiveness. Also essential to this process is to support the improvement of DDS capacities to analyze data and reporting, which the project will support through mentoring and workshops. Finally, SSQH-CS will work with site QI committees to identify quality improvement opportunities.

MANAGEMENT, MONITORING, AND ADMINISTRATION

SSQH-CS supports MSPP in the improvement of the health status of the Haitian population. The project does this in close collaboration with USAID, local implementing partners, and other USG partners. The first half of Year Two saw a further scale up of activities, a deepening partnership with the six DDS and service delivery partners, and improved integration of technical assistance in support of facility- and community-based services.

PROJECT MANAGEMENT

A main thrust during the first semester of Y2 was the improved integration technical assistance the project delivers to health providers, facility management, community agents, and departmental managers. In November, SSQH-CS held an implementing partners' planning meeting to review successes and challenges of Y1 and to discuss, as a group, project management, strategy, and coordination moving forward. The group recognized a need to improve coordination across partners, as well as to use human and financial resources more effectively. The creation of integrated management teams (IMT) emerged as a new mode for implementing the project workplan and liaising directly with each DDS. The goal for these teams is to provide TA that integrates policy, planning, supervision, monitoring, and financial management. It is ultimately a more holistic and streamlined approach for overall site improvement that should yield better quality results. Each of the six assigned team leaders henceforth serves as focal points for one department and works in coordination with other team leaders to assemble cadres of project technical advisors tasked with implementing workplan activities in each department. The IMTs include a mix of clinical and management advisors to deliver an integrated package of technical support at health facilities and departments.

Y2 contract deliverables are on track and include: the Y2 workplan, a revised PMP¹⁰, FY14 APR and SNU reporting, Y2 service delivery subcontracts, Y2 USG Compliance activity matrix, and quarterly financial reports. Upcoming deliverables such as the PEPFAR SAPR, programmatic semi-annual report, and annual tax filing will be submitted per agreed upon deadlines. Key deliverables such as the Y1 annual report and Y2 workplan were translated into French and shared with MSPP counterparts.

In February, the USAID Acquisition and Assistance Office invited Pathfinder to meet and discuss performance and challenges to date. Key topics covered during this meeting included the need for clarity on setting project targets in alignment with the contract versus annual PEPFAR COP and a request to consider the unanticipated cost impacts of salary "support" for 694 ZC service providers. Funding of salaries for ZC staff was not included in the project's approved budget and the need to do so was not clarified until well after the October 2013 post-award meeting with USAID. During the reporting period, Pathfinder articulated these concerns in written correspondence to USAID and is looking forward to working with USAID to identify appropriate solutions that are satisfactory to both parties and will enable the project to achieve its goals.

Also in February, USAID informed SSQH-CS that a program audit of the project would be conducted by the USAID Office of Inspector General (OIG) next quarter in April 2015. In March, OIG auditors introduced themselves to SSQH-CS staff and oriented the project on the audit schedule. SSQH-CS will

¹⁰ During the Y2 first semester, the PMP was revised five times to reflect additional- or modifications to existing- indicators at the request of USAID. More detail is included in the *Monitoring Systems* section. This has slowed down the approval process and the PMP and Y2 workplan have yet to be officially approved. The PMP will be further revised early next semester to harmonize PEPFAR indicators and targets with those in the PMP.

respond to auditor’s questions, provide all requested reports and documentation, and make arrangements and accompany auditors on field trips to SSQH-CS sites, as requested.

Finally, the project’s Change Log is designed to capture changes to its scope, budget, and/or timeline. Each of these changes has an impact on either facilitating or challenging the attainment of project’s results.

Change	Summary of Change	Date Received	Cost Impact
Payment of salaries for health providers at ZCs	The project was asked to pay the salaries of 694 staff from ZCs in an effort to continue service delivery. These costs were unbudgeted and unforeseen as late as February 2014. This cost burden greatly reduces the project’s ability to invest in other programmatic activities.	November 2013	\$2 million annually
Budget shifts in PEPFAR funds	Budget decreases in HIV prevention (PMTCT, prevention, Lab, and HSS) and increases in treatment and care (adult, pediatric, HIV/TB, OVC), per PEPFAR mandate, for COP 2014 (FY15).	May 2014	Increased PEPFAR funds by \$484,861 while realigning areas supported
Addition of non-contract-mandated indicators to PMP	At USAID’s request, the project has added 15 indicators to the Y1 PMP. These include PEPFAR and EPCMD indicators that go beyond the expected results in the contract. In certain cases, indicators for which the project implements no direct supporting activities have been included.	November 2014 – Present	Revision of data collection tools; retraining of CHWs and HPs on collecting data; increased reporting burden

Table 6: Project Change Log

MONITORING SYSTEMS

Data Reporting Systems

During the first half of Y2, SSQH-CS, in collaboration with USAID, made further revisions to the project Performance Monitoring Plan (PMP). The team reviewed indicator definitions and calculation processes established in the Performance Indicator Reference Sheet (PIRS) to ensure that indicators appropriately draw from the national system registers and, subsequently, national health management information systems MESI (for PEPFAR service delivery indicators) and DHIS2 (for non-PEPFAR service delivery indicators). By using these data sources, the project reinforces MSPP’s national HMIS and avoids the inefficiencies and redundancies of creating a parallel monitoring system. To capture and monitor data generated for non-service delivery indicators (largely Obj. 2 – 4, but not exclusively), the project designed data collection forms to be completed by relevant consortium partners. Submitted reports are accompanied with supporting documentation such as training participant lists or other project records to verify indicator results. Many indicators require site visits, as the national reporting systems do not capture them. Such is the case for indicators measuring adherence or the number of people enrolled in TB. Other non-clinical indicators will soon be captured through an electronic TA and Site Visit database. This database houses important data not captured through the national HMIS and archives all

appropriate support documentation. As part of the PMP revision process and per the request of USAID, the project added ten (10) new PEPFAR and five (5) new Ending Preventable Maternal and Child Deaths indicators. The PMP currently consists of 79 indicators in total, 45 of which measure expected results articulated in the contract.

In October 2014 SSQH-CS's M&E systems strengthening work was presented at the American Evaluation Association Conference in Denver, Colorado. Both Deloitte and Pathfinder representatives were on the panel, highlighting the challenges and innovative solutions brought to Haiti by SSQH-CS.

System Strengthening

A major focus for SSQH-CS this semester has been to strengthen the quality of data within the project's performance monitoring system. The team engaged in several data quality assessment (DQA) activities this semester designed to improve data recording and reporting at facilities so as to strengthen the national HMIS. Desk reviews of site-level monthly statistical reports, data entry for 80 facilities into DHIS2, and register and M&E system reviews and mentoring at 21 facilities aimed to improve the quality of data uploaded to the national HMIS. In December, the project engaged an external DQA team to validate Y1 results in 10% of project-supported facilities (8 in total). All these activities have helped strengthen the validity, reliability, and completeness of service data. Site visits included DDS M&E counterparts in order to strengthen their capacity to manage the data review and validation process.

Challenges

Despite making significant headway in strengthening the project's monitoring system and support for the national HMIS, several challenges strain the team's efforts and pose certain limitations to improving quality data management. A lack of registers at the facility level prevents some service statistics to be reported in full and limits the ability of facility managers and providers to effectively use data for decision making. Additionally, facility personnel continue to need reinforcement in how to use MSPP registers, as some providers remain confused on how to record data for certain indicators (i.e. number of patient visits). Furthermore, strengthening is needed to ensure CHW statistics are properly and completely rolled up into facility reports. While SSQH-CS continues to work to address these factors, their presence remains and affects the project's data management.

Another factor is that the SSQH-CS performance monitoring system itself is not yet at full operational strength. While significant improvements in data quality and reliability have been made over the semester, the SSQH-CS performance monitoring system requires further enhancement, particularly in the timely collection and verification of selected project data. Evidence of this can be noted in specific indicators within this report. Inconsistent M&E leadership for the project has not helped bridge this gap. SSQH-CS aims to have solid leadership and strengthened systems in place by mid-point next semester.

Finally, the evolving PMP requires continual SSQH-CS personnel attention and strains limited M&E resources. As of March 2015, the PMP is 23% larger in terms of number of indicators than what was reported on at the end of Y1 (from 64 to 79 indicators). Fortunately USAID indicated the review and removal of selected indicators to diminish the reporting burden are appropriate. SSQH-CS will work with USAID on this exercise early next semester.

ADMINISTRATION

As of the first semester of FY15, SSQH-CS has two offices (PAP and Cayes), a project team of 34 full time and 45 part time staff, and an operational fleet of 15 vehicles. Changes among three key personnel positions (COP, F&A Director, and M&E Director) unfortunately coincided at the end of the semester, but present new opportunities for leadership in the second half of the project's three-year span. All three positions are expected to be filled by highly-qualified individuals within the next three months. The project consortium includes seven implementing partners¹¹, who support 19 NGO subcontractors and six DDS for service delivery at 80 facilities.

Mobile Money

Since the last quarter of Y1, SSQH-CS has used mobile money services as a means to pay health workers at ZCs in an effort to promote financial transparency and inclusion, while minimizing the project's administrative burden of paying 694 individuals. The project receives timesheets approved by departmental heads and verifies them before making payments. USAID has prioritized the use of mobile money in other sectors, and SSQH-CS is proud to bring it to the health sector. Under the Tcho Tcho Mobile program managed by Digicel, the project makes salary payments to registered workers who then draw down funds from their account from an authorized vendor. By February/March, the project paid 558 workers via the program (those not paid via Tcho Tcho are done so by wire transfer).

The preceding notwithstanding, the use of this service is not problem-free and the project has identified some bottlenecks. A number of individuals have reported having trouble accessing funds in a timely manner. Tcho Tcho Mobile vendors may be located far away from where some workers are stationed and accessing them requires traveling distances and returning with large sums of cash, a safety concern. Other times, authorized vendors may not have enough cash on hand to allow workers to fully withdraw their account, thereby causing them to have to return to access their money. SSQH-CS works with Digicel to identify when and where these challenges occur, and the company has already responded with increasing the number of vendors in the area. Still, other challenges prevent workers from accessing their funds on time. Several people have changed their telephone number without notifying the project, which causes a delay in accessing funds. SSQH-CS is working with the DDS to find ways to ensure that health workers do their part in order to receive their payments in a timely manner.

ENVIRONMENTAL COMPLIANCE

At the recommendation of USAID in mid-2014, SSQH adopted the EMMP that had been in effect under earlier USAID integrated health projects. Previous projects had to address the same environmental issues currently faced by SSQH-CS and its participating health facilities. Like its predecessors, the majority of activities under SSQH-CS do not have negative impacts on Haiti's physical environment or on beneficiary populations and communities. However, there could be some negative impact on the environment if the different kinds of waste products generated by health facilities are not handled correctly according to recognized waste management standards.

SSQH-CS has two civil engineers on staff that regularly advise on and monitor waste disposal, institutional hygiene and sanitation, and environmental maintenance of common grounds around SSQH-supported facilities. In 2014, structural assessments were carried out at 25 SSQH MCH/WASH sites, some of which are also SSQH RBF (results-based financing) sites. Criteria were established and applied in

¹¹ Dimagi's participation within the consortium continues despite delays experienced from USAID's Contracts office in approving an extended subcontract.

order to prioritize sites for eventual renovation work. Ten sites were initially selected. This number was reduced to six (based on different factors) and plans were recently made for work to begin at two facilities (Delmas 75 and Martissant). A local contractor was selected and will begin work imminently at Delmas 75. Contractor selection for Martissant should be completed by early May 2015. The contracts require contractors to implement mitigation measures for rehabilitation/renovation work as necessary (e.g., workplace is protected and marked; site visitors are not disturbed; environment is not destroyed or contaminated, etc.).

Coaching/mentoring on environmental mitigation and infection control is done at all facilities, not just those that have been selected for renovation work. During the assessment and follow up visits, SSQH WASH engineers made recommendations for simple low-cost environmental improvements both inside and outside the facilities. At one site (Petit Trou de Nippes), they discovered that a brand new sophisticated incinerator that had been donated by UNICEF had never been utilized because health facility staff had not been trained in its use. Facility staff had no knowledge of waste management procedures. SSQH provided information and helped arrange training for facility personnel. In a follow up visit to the site, the WASH team reported that the incinerator was being correctly used. They also noted that the grounds and facility itself had been noticeably cleaned up per recommendations made by the team. Similarly, at the CS de St Joseph, it was noted that health authorities made significant improvements to the locale following recommendations made by the team, as can be seen in the before and after photos below.



Figures 6: Before - Poorly maintained latrines with cholera latrine in back area



Figure 7: Ground with biological waste



Figures 8: After - Same courtyard cleaned and cemented with 4 flush toilets

SSQH-CS supported a one-day training in infection control for 282 health personnel in Y1 of the project, and 29 CHWs from ten sites during the current reporting period. Trainees included medical directors, site managers, CHWs and other technical staff. SSQH-CS designed and provided the training modules. Materials on waste management and infection control were subsequently made available on share drives (e.g., Job Box) that could be accessed by all participants. The CommCare application was updated to include reference information for CHWs who use the mHealth tablets.

Over the next six months, SSQH-CS plans to launch bid documents for renovation work at four additional sites: Hôpital de la Communauté Dame Marie (Grande Anse), Centre de santé de Petit Trou de Nippes (Nippes), Centre de santé de Maissade and Centre de santé de Lahoye (Plateau Central). The physical status of another nine sites will be assessed during the May-June timeframe. The number and names of additional sites to be assessed through the end of the fiscal year is currently under discussion.

SUCCESS STORIES

MOBILE HEALTH CHANGES LIVES IN HAITI

For 21 years, Etienne Hilarie has been serving his village as a community health worker. Already a leader in his community, he saw a need for health services and yearned to better serve his community. He now delivers essential health services—anything from immunizations to family planning—to a population of 2,000.

In 2010, Fermathe Hospital promoted Etienne to Supervisor. In his new role, he mentors newer health workers, passing down information and ensuring they provide high-quality care. He has also received training in the new MSPP-approved curriculum for community health workers.

Today, Etienne carries something new: **a mobile tool called mSanté** (a CommCare application developed by *Services de Santé de Qualité pour Haiti Center-South*).

Using the app, he can provide better counseling to women and their families—he follows checklists that guide him through prenatal care for women and immunizations for kids, and plays pre-recorded audio messages about the importance of family planning and HIV testing. The app also includes a referral and counter-referral system through client tracking and record sharing functionalities. The app covers major health services offered by health workers, including integrated maternal and child health, family planning, and HIV services.

Thanks to this mobile application, Etienne can provide better care to women and children in remote areas of Haiti. And as a supervisor, he can see real-time reporting of data by the health workers he oversees.

As of December 2014, the *Services de Santé de Qualité pour Haiti* project had trained 309 community health workers to use this innovative mobile health application, with plans to train up to 1,000 by September 2016. And there are 7,143 family planning users; 2,982 mothers; and 2,885 children registered.

mSanté helps guide the work of community health workers like Etienne and streamline their data collection and reporting. In turn, health workers serve as critical links between Haiti's communities and the facilities that serve them. "We feel proud," says Etienne. "We believe our input was used. That is one of the reasons we say we wish we had CommCare a long time ago."

HAITIAN HEALTH CENTER TAKES FIRST STEP TOWARD IMPROVED CARE

Last year, nurses and doctors at Haiti's Les Anglais Health Center got something they never had before: job descriptions. It might not seem like something worthy of celebration, but to the staff, it was so much more than just job descriptions. It was a sign of commitment: to establishing sound leadership, to claiming a shared vision, to empowering staff, and to providing better services.

The facility had been dealing with low staff morale, absenteeism, and heated internal conflicts. Soon enough, those issues began affecting performance. Add in stock-outs of health commodities and poor waste management practices, and the facility was slammed with low patient satisfaction, poor quality of services, and decreasing community support.

And so the USAID-funded *Services de Santé de Qualité pour Haiti* project led by Pathfinder International approached the facility staff with an innovative solution to address their challenges. The solution included training sessions that focused on identifying their issues, agreeing on a shared vision for the facility, and setting out clear steps to achieving that vision. If it proved successful, it would be used as a model for the SSQH project, with opportunities to take it elsewhere in Haiti to improve the quality of health services.

In September of 2014, representatives from the Department's Health Directorate (called *Direction Départementale Sanitaire* in Haiti) joined 28 staff from Les Anglais for a three-day workshop. During the workshop, the SSQH team used Deloitte's CYPRESS (Capacity, Performance, Results, and Sustainability) method to lead the group through a discussion. They touched on the current state of the facility, the vision and goals of staff and the facility, and any skills and organizational gaps they needed to address.

"We met with nearly *all* the staff," recounts Adrien Demes, Capacity Building Advisor for SSQH. "We asked them about major problems they have, and then we began working to address those problems."

The staff of Les Anglais—with the SSQH team at their side—developed a performance improvement plan to monitor changes in the areas of leadership, human resources management, commodity management, and financial management. At the same time, SSQH staff provided regular trainings in capacity building that would help them reach their goals.

The staff unanimously agreed that the workshop helped them become more aware of the need to focus on performance improvements. They also shared that they felt empowered and united as a group. "The workshop has allowed us to reorganize ourselves, helped improve our performance, and changed our ability to work," said one participant. The sessions gave staff a better understanding of the importance of strong management and leadership in delivering high quality health services.

One of the first tasks after the plan was finalized: develop job descriptions—for the head doctor all the way to the cleaning staff. Everyone had their roles and responsibilities spelled out, and in writing. "With a job description, even the cleaning staff could understand how she could contribute," says Demes. "If the facility is clean, that's part of quality improvement."

Now the facility is implementing their plan and making strides toward their goals. The SSQH team regularly checks in with them, guiding them if issues or concerns have come up. The Les Anglais staff told Demes in a recent visit that they plan to write their mission and vision on the wall so everyone can see it. And the facility managers now use a management committee to make decisions that will affect the whole facility to ensure everyone's voice is heard.

Most visible to Demes during his visit was the cleanliness of the facility. The medical doctor was able to share information with the staff about waste management, and the clinic is much cleaner. Moving forward, Les Anglais will continue to follow their plan to strengthen their processes and improve service delivery.

And thanks to SSQH, the success the Les Anglais facility is seeing will be replicated in other facilities to improve quality of services across the region. "This is a great example of people coming together to address problems in a collective way," explains Demes, "where we have gotten buy-in and ownership to manage such an important issue like quality improvement."

ANNEXES

- A. SSQH-CS PMP Indicator Summary Table with Semi-Annual Results
- B. SSQH-CS Y2 First Semester Site Visit Table