



FOCAS

In collaboration with
USAID/BHR/PVC,
ARHC, MEI and OBDC

Mid Term Evaluation

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PVO Child Survival Grants Program

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United States Agency for International Development
Bureau for Humanitarian Response
Office of Private and Voluntary Cooperation
PVO Child Survival Grants Program

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ACRONYMS

ARHC	Andean Rural Health Care
ARI	Acute Respiratory Infection
BCG	Tuberculosis Vaccine (Bacillus Calmette-Guerin)
BHR/PVC	Bureau of Humanitarian Response, Office of Private and Voluntary Cooperation
BLM	Bellevue la Montagne Commune
CHA	Community Health Agent
CRS	Catholic Relief Services
DIP	Detailed Implementation Plan
DPT	Diphtheria/Pertussis/Tetanus Vaccine
EPI	Expanded Program for Immunizations
FOCAS	Foundation of Compassionate American Samaritans
FP	Family Planning
HIS	Health Information System
IEC	Information, Education, Communication
IMR	Infant Mortality rate
KPC	Knowledge, Practice and Coverage
MEI	Mission Evangelique International
MSP	Ministry of Public Health
NGO	Non-Governmental Organization
OBDC	Oeuvres de Bienfaisance et de Developpement Communautaire
ORS	Oral Rehydration Solution
PVO	Private Voluntary Organization
SCM	Standard Case Management
TA	Technical Assistance
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
USAID	United States Agency for International Development

FOCAS/MEI/OBDC
Mid-term Evaluation CS XIII

1. SUMMARY

1.0 Introduction

This program marks a new venture in USAID Child Survival programming at many levels. The first level is a new mentoring relationship between two American organizations (ARHC and FOCAS/USA) with technical and financial assistance from USAID. The second level of mentoring is between the technical and financial experts of ARHC and FOCAS/USA with their Haiti representative, FOCAS/Haiti. The third mentoring level is that of the Haiti FOCAS umbrella and the technical and managerial transfer of expertise to two clinic and field-based experienced indigenous health and development organizations (MEI and OBDC). The three tiered mentoring relationship and its impact on the technical and managerial skills, field processes for health and future sustainability of the indigenous programs is under scrutiny as this mid-term evaluation begins. It remains to be seen if three levels of mentoring are a viable model given logistical constraints, communication barriers and the transient nature of external personnel in-country.

1.1 Programs and Objectives

The MEI and OBDC programs had been providing curative and preventive health services in the greater Port-au-Prince area for many years before the initiation of this new program. For the past twenty years, the clinic and mobile rally posts of MEI have complemented religious, educational and relief programs that has a reach to many more areas than that of the health program. OBDC has been providing clinical care for more than nine years in a rural area and peri-urban 'marginal' slum.

The implementation of a community-based, rigorous Child Survival Program for 77,000 people made great demands on a primarily volunteer, medically-oriented group of providers. Since the DIP was submitted in April 1997, the staff have put into place many of the processes necessary to provide high quality child survival services. The emphasis of the program is on *improvement of nutritional status of children (25%); the implementation of a program of Acute Respiratory Infection (ARI) case management (20%); the improvement of vaccination coverage for children under five years and women of reproductive age (10%); case management of diarrhea (10%); strengthening of child spacing services (25%); and maternal care (10%.*

1.2 Main Accomplishments

The main accomplishments of the program since the submission of the DIP are:

- a. The process of clinical, technical transfer has been established from ARHC to FOCAS/USA to FOCAS/Haiti to the partner NGOs;

- b. The Headquarters of FOCAS has begun the process of improving its technical and management capacity because of the relationship with ARHC;
- c. FOCAS/USA has become an active member of the CORE USAID group and can therefore draw from world-class expertise in improving the field programs;
- d. Partner NGO staff have concrete tools with which to assess the quality of care at the level of the individual beneficiary;
- e. 61% of the estimated population have been registered.
- f. Related to specific objectives, the following is in place:
 - Complete vaccine rates of children 12-23 months improved (74% combined);
 - Coverage of measles vaccine of children 12-23 months has improved (82%);
 - Growth monitoring is rigorously followed in villages and neighborhoods (47% combined improvement) where children are weighed every two months;
 - Staff have been trained in ARI standard case management.

1.3 Main Constraints, Problems and areas in need of further attention

Although there have been notable accomplishments at all levels of the program, there are areas that require attention or some fine-tuning to make this a truly outstanding program.

- g. The lines of responsibility and accountability need to be clearly defined with expectations and time frames.
- h. From the field staff, the fact that the one used program truck is not working enough of the time has hampered the efforts at supervision and collaborative fieldwork. Staff have had to use their own cars for project work.
- i. There is no power or communication between FOCAS-Haiti and the partner NGOs. One has to drive to the other site to perform administrative or program tasks.
- j. The USAID focus on management objectives and indicators is new to the partners so this area will require more attention and clear documentation of processes and structures.
- k. The level of community participation is at the level of utilization and not yet at the level of ownership of the programs.
- l. There are two USAID-funded organizations working in the same rural area and in many of the same villages. The Baptist Mission (CS- USAID Haiti) has been in the Bellevue la Montagne area since 1977 with 15 resident health agents. The area has been censused. The 5 new health agents /nurses of MEI have been working in the area since 1968 in a family planning clinic and outreach program. A USAID-funded organization provided family planning support since 1979.

1.4 Capacity-Building Processes

The processes of capacity building from the US-based headquarter level to the Haiti field office to the village level sites of service delivery are being established during these early years. The emphasis to date has been on retraining of employees with many years of service, recruiting and training new staff, establishing technical quality for Child Survival services and data management systems. The strengthening of financial planning, monitoring, reporting has begun. Areas that will be addressed in the coming two years include: strengthening the capacity of the clinics and laboratories, establishing strong and practical links to the communities and designing a sustainability plan. Haitian nationals and expatriate experts will be called upon to assist in these processes.

1.5 Processes Related to Sustainability

These processes are beginning with headquarters fundraising, the plan to sell ORS, the continued use of clinic revenues and investigation of grants from other sources (Food for the Poor, CIDA, Japanese Embassy of Haiti) An official plan will be produced by FOCAS by December 2000.

1.6 Main Recommendations

Resolve overlap of services: Within three months, FOCAS needs to resolve the program overlap with the Baptist Mission.

Need for reliable vehicles. In past 12 months the vehicle worked about 1 month.

Improvement in Program Management: Write a plan for organizational capacity building (in management) for NGOs, FOCAS field and FOCAS HQ, implement plan (including use of management tools for upper-level management and QI training), and assess the plan. Develop a business plan as soon as possible with participation of all levels of staff.

Revise plan for expansion: Revise the plan within the next month taking into account the solution found for the overlap of services and provides full coverage for primary project areas. Decide whether to expand to secondary project areas.

Reapply Hearth Model: The Hearth method is being used without counting calories and grams of protein. *Monitrice* need to be taught this skill and to count calories and protein each time they create a menu. The CORE USA nutrition-working group may help. Also, increase number of Volunteer Mothers to a maximum of 10 with 5-7 children each. Do another trial closer in where the staff can supervise the work every day. Try to have ARHC/FOCAS HQ staff participation.

Improve the use of Health Information: Give more attention to Mother's registers, to community feedback, and how to use the data in the HIS. The immediate need is to develop graphs to help monitor whether the productivity is adequate (e.g., number of

vaccine doses given each month, number of children that should be seen at rally posts, etc.). Send monthly reports to both ARHC and FOCAS representatives using a revised technical report format.

Increase contact with children during first 30 days after birth.

Improve ARI Case Management: Look at a field-based project to see how they implement ARI. Establish a plan for where and how they will do pneumonia education and tracking of episodes.

Provide technical assistance for the partner organizations in financial management.

2. Assessment of Progress towards Achieving Program Objectives

Technical Approach: Intervention Areas

2.A.1. Nutritional Improvement

OBJECTIVE	PROGRESS ON INTERMEDIATE STEPS TO DATE	MONITORING STRATEGIES	MODIFICATIONS IN TECHNICAL APPROACH
% of Hearth participants by 1 Standard Deviation within 12 months of enrollment.	Two <i>monitrices</i> hired and trained for the FDN project in each partner area. 5 Sessions of the (FDN) Nutrition Demonstration Foyers have been held to date in the MEI zones and 8 in OBDC. 12 months have not yet elapsed	A manual monitoring form has been developed. GOMEZ classification is used. No computerization to date using EPI NUT software.	When reporting on recuperation in the OBDC zones, the membership in the clinic CRS dry ration program will be noted.
Increase the percent of infants breast fed immediately after birth from 52% to 65% in the EDJ (OBDC) Project.	15 midwives trained with message between December 1998 and March 1999. Colostrum and immediate breast-feeding are not apparent in the curriculum. Total of 30 midwives in OBDC zones. IEC messages developed and used. (Modified MSPP flip chart) Nutrition education of staff included breast-feeding.	KPC tool Behavior Box attached to the Road to Health card	Visits planned to women in the third trimester of pregnancy will be intensified to increase immediate breast feeding post-partum.
Increase the percent of	6 midwives trained between December 1998 and March 1999.	KPC tool	Visits planned to women in the third

<p>infants breast fed immediately after birth from 57% to 70% in the BLM (MEI) project.</p>	<p>Colostrum and immediate breast-feeding message not apparent in the curriculum. 11 "old" midwives in the MEI areas.</p> <p>IEC messages developed and used.</p> <p>Nutrition education of staff included breast-feeding.</p>	<p>Behavior Box attached to the Road the Health card</p>	<p>trimester of pregnancy will be intensified to increase immediate breast feeding post-partum.</p>
<p>Increase the percent of complete breast-fed infants in the EDJ (OBDC) project from 5% to 35% for the first 4 months of life.</p>	<p>IEC messages developed.</p> <p>Session in mother's group meetings (17 mothers groups already meeting)</p> <p>Assessment of clinic and hospital practices not yet completed.</p>	<p>KPC tool</p>	<p>Breastfeeding completely or near completely for the first <u>6</u> (not 4) months of life.</p>
<p>Increase the percent of complete breast fed infants in the BLM (MEI) project from 3% to 30% for the first 4 months of life.</p>	<p>IEC messages developed.</p> <p>Session in mother's group meetings (Mother's groups formed October 1999)</p> <p>Assessment of clinic and hospital practices not yet completed.</p>	<p>KPC tool</p>	<p>Breast feeding completely or near completely for the first <u>6</u> (not 4) months of life.</p>
<p>OBJECTIVE</p>	<p>PROGRESS ON INTERMEDIATE STEPS TO DATE</p>	<p>MONITORING STRATEGIES</p>	<p>MODIFICATIONS IN TECHNICAL APPROACH</p>
<p>Increase the % of children 6-72 months with 2 doses Vitamin A per year from 16% to 75% in EDJ (OBDC) project.</p>	<p>28,000 people registered 15% children under 5+ 7% age 6 and 7=22% 28000 X .22 = 6,160 children X 2 doses X 75%= 9,240 capsules to be distributed between 9/98 and 9/99 (including clinics) Actual = 5,211**</p> <p>Vitamin A is given at rally posts, home visits and clinics</p>	<p>Child roster</p> <p>Vitamin A marked on each child's Road to Health Card.</p> <p>Report of doses given at each site per month.</p> <p>Project Area</p>	<p>Vitamin A is given until 83 months of age.</p> <p>Will initiate a requisition tracking form for stock outs of Vitamin A as of 11/99.</p>

	All staff trained in the protocol of vitamin A for prevention and treatment during the nutrition education sessions in 7/98 and 4/99	Report Form	
Increase the % of children 6-72 months with 2 doses Vitamin A per year from 21% to 75% in BLM (MEI) project.	<p>19,000 people registered with MEI project. $22\% \times 19,000 = 4180$ children $\times 2$ doses $\times 75\% = 6,270$ capsules to be distributed between 9/98 and 9/99 including clinics Actual = 3.445**</p> <p>Vitamin A is given at rally posts, home visits and clinics.</p> <p>All staff trained in the protocol of vitamin A for prevention and treatment during the nutrition education sessions in 7/98 and 4/99</p>	<p>Child roster</p> <p>Vitamin A marked on each child's Road to Health Card.</p> <p>Report of doses given per month at all sites.</p> <p>Project Area Report Form</p>	<p>Vitamin A is given until 83 months of age.</p> <p>Will initiate a requisition tracking form for stock outs of Vitamin A as of 11/99</p>
Increase the % growth monitored within 30 days of birth from 54% to 90% in EDJ (OBDC) project.	<p>Only 4% of women in the third trimester of pregnancy received a visit from the health agent (record review of 3 health agent rosters and 10 women in each roster)</p> <p>In a record review of 10 children in 3 different health agent's census areas, Documentation of growth monitoring within 30 days was zero. Decrease from the baseline KPC. NOTE: three newest health agents do not have baby scales.</p> <p>Some midwives have a weighing device for low or normal birth weight.</p>	<p>-Road to Health cards</p> <p>-Child Roster in place</p> <p>-Scheduled rally posts and home visits for monitoring found on health agent quarterly planning sheet</p> <p>-Supervisor scheduling planned using Quarterly Planning Sheet.</p>	<p>Weighing pants only are available currently and newborns have to be weighed on a scale in a clinic. A baby sling will be introduced into the programs for fieldwork.</p>
OBJECTIVE	PROGRESS ON INTERMEDIATE STEPS TO DATE	MONITORING STRATEGIES	MODIFICATIONS IN TECHNICAL APPROACH
Increase the %	Only 3% of women in the third	-Road to Health	Weighing pants only

<p>growth monitored within 30 days of birth from 37% to 85% in BLM (MEI) project.</p>	<p>trimester of pregnancy received a visit from the health agent (record review of 3 health agent rosters and 10 women in each roster)</p> <p>In a record review of 10 children in 3 different health agent's census areas, documentation of growth monitoring within 30 days of birth was 37%. No change from the baseline KPC.</p>	<p>cards & Child Roster in place.</p> <p>-Scheduled rally posts and home visits for monitoring established but workers don't have weighing slings.</p> <p>-Supervisor scheduling planned using supervisor quarterly planning sheet.</p>	<p>are available currently and newborns have to be weighed on a scale in a clinic. A baby sling will be introduced into the programs for field work</p>
<p>Decrease the use of bottles (age 0-12 months) from 65 to 52% in the EDJ (OBDC) project</p>	<p>Mother's exit interviews at rally posts (N=37) showed 13 months was the mean duration of breast feeding. 29 of 37 used breast milk for the initial feed.</p> <p>Group education messages developed using MSPP flip chart.</p> <p>No individual counseling strategy or key message card developed yet.</p>	<p>Behavior box used on front of Road to Health cards.</p> <p>Child roster</p>	<p>Report final KPC findings in age blocks. Use of bottle in a one-month-old is more serious than an 11-month-old.</p>
<p>Decrease the use of bottles (age 0-12 months) from 73% to 63% in the BLM (MEI) project</p>	<p>Mother's exit interviews at rally posts (see above for aggregate analysis)</p> <p>Group education messages developed using MSPP flip chart.</p> <p>No individual counseling strategy or key message card developed yet.</p>	<p>Behavior box used on front of Road to Health cards.</p> <p>Child roster</p>	<p>Report final KPC findings in age blocks. Use of bottle in a one-month-old is more serious than an 11 month old.</p>
<p>Increase % children 0-2 years weighed 6X/year from 11% to 80% in EDJ (OBDC) project.</p>	<p>Growth monitoring quality check list institutionalized.</p> <p>Expectation of weighing frequency written and known by all staff.</p> <p>Record review of 10 records in each</p>	<p>Road to Health Card</p> <p>Child Roster</p> <p>Schedule of priority visits to</p>	<p>Increase supervision of field contacts with children and documentation.</p> <p>Improve program</p>

	of three different health agent census sites. Improvement from 11% to 31% noted	children is written.	management
Increase % children 0-2 years weighed 6X/year from 68% to 90% in BLM (MEI) project.	Growth monitoring quality check list institutionalized. Expectation of weighing frequency written and known by all staff. Record review of 10 records in each of three different health agent census sites. Decrease in frequency of weighing noted from 68% to 63%.	Road to Health Card Child Roster Schedule of priority visits to children is written.	Increase supervision of field contacts with children and documentation. Improved program management

Special Outcomes or Constraints:

** The calculation of vitamin A cannot be based on the period from September 1998 because the census was not complete until May 1999 and there were several shortages of Vitamin A. Vitamin A capsules were not given during the census effort. The new calculation therefore is for 5 months (one dose only can be expected.) Therefore

4620 doses is the 75% coverage target for OBDC. Actual was 5,211

3135 doses is the 75% coverage target for MEI. Actual was 3,445

Therefore, one can suggest that there were sufficient doses given to provide one dose to more than 75% of the children in the service area.

Technical competence in the area of nutrition education, growth monitoring and consistent documentation on the Road to Health cards is a particular strength of the organizations. The implementation of the quality check list for growth monitoring and key messages for expected growth are practical and useful tools. In addition staff use the behavior box sticker which is affixed to each child's road to health card as a reminder to health workers about topics of special importance concerning growth and feeding.

All interventions are geared to improving health inputs above the baseline level of the two partner NGOs. However, the fact that each has a mix of rural and peri-urban zones is not addressed in the planning, resource allocation, execution or monitoring of progress.

The implementation of the Hearth (Nutrition Demonstration Foyer) Program has been slow and difficult. FOCAS co-sponsored a five-day training in May 1999. All levels of staff attended the national-level training and the technical advisor from ARHC reinforced the training. However, community participation was not enlisted beyond an announcement to

selected leaders. The development of specific MENUS was done based on positive deviant mothers but without calculation of calories and protein. *The Monitrices*, (locally trained health educators) were charged with the program and may not have had adequate training. (Five days of theory and four days of field observation in Save the Children sites) The assessment of kwashiorkor may not be rigorous enough. *Animatrices* (positive deviant mothers) have not been able to run the program. Volunteer mothers have been enlisted instead to buy and cook the food only.

According to staff interviews in both PVO areas, the communication between the midwives and the CHAs is informal. The midwives tell the health agent that a woman has delivered a baby. Supervision and stocking of the midwife supplies occurs at the level of the program clinics by the nurse supervisors.

Also, the communication between the field staff and the clinic appears to function at a reasonable level. Staff are notified of newborns if they are seen at the program clinics. There is no referral system, however, with any of the other practitioners or facilities in the area (See Staff interviews in ANNEX V).

Next Steps:

The staff has already identified the need to refine the Hearth Nutrition Demonstration programs. *Monitrices* may need additional training (Drs. W. and G. Berggren suggest a 6-week intense training). Continuing education sessions are planned to assist with calculations of calories and protein. The creation of local, seasonal menus for a certain amount of money may need adjusting depending on whether the area is a peri-urban slum or a rural agricultural area. Staff need additional training on the calculations of protein and calories and need to transmit that skill to the field staff. The program needs to be documented because since the National level training in May 1999, no other Haitian institution has tried to implement the model. The technical aspects of the program will be refined in the coming months.

Home visits to mothers in the program areas in the third trimester will be a priority in the coming months. Even though many of the women receive prenatal care in partner clinics and from private practitioners, the field staff will contact the women again in order to reinforce the messages of immediate breast feeding post partum, the care of the newborn and the registration of the child into the program. Continuing education will highlight the prioritization of visits at the community level. Additional attention will be spent on verification of the documentation of maternal care at the village level by the supervisors and record keepers.

2.A.2. Case Management of Diarrhea

OBJECTIVE	PROGRESS ON INTERMEDIATE STEPS TO DATE	MONITORING STRATEGIES	MODIFICATIONS IN TECHNICAL APPROACH
<p>Increase the % of children given same or more fluid during diarrhea episodes from 63% to 80% in EDJ (OBDC) project.</p>	<p>Field staff training was held in September 1999.</p> <p>Key messages have been developed concerning fluids during diarrhea episodes. (MAPP flip chart)</p> <p>Quality check list new Some mother's groups formed</p>	<p>KPC at final evaluation</p> <p>Mother's group anecdotal reports post episode suggests that message is incorporated into behavior.</p>	<p>None.</p> <p>Compared to the 1997 baseline of the USAID Mission organizations, 27% moms reported more liquid given during diarrhea episode (not including breast milk) The behavior is already far above the norm.</p>
<p>Increase the % of children given same or more fluid during diarrhea episodes from 69% to 80% in BLM (MEI) project</p>	<p>Staff training September 1999</p> <p>Key messages have been developed concerning fluids during diarrhea episodes. (MSPP flip chart)</p> <p>Quality check list is new.</p> <p>Mother's clubs are beginning.</p>	<p>KPC at final evaluation</p> <p>Anecdotal reports post episode that message is incorporated into behavior.</p>	<p>None.</p> <p>Compared to the 1997 baseline of the USAID Mission organizations, 27% moms reported more liquid given during diarrhea episode (not including breast milk) The behavior is already far above the norm.</p>
<p>Increase the % children given same or more food during diarrhea episodes from 59% to 75% in EDJ(OBDC) project</p>	<p>Same as above</p> <p>Post test scores of staff show improvement in knowledge.</p>	<p>Same as above</p>	
<p>Increase the % children given same or more food during</p>	<p>Same as above</p> <p>Post test scores of</p>	<p>Same as above</p>	

diarrhea episodes from 55% to 75% in BLM(MEI) project	staff show improvement in knowledge.		
Increase the % of mothers reporting they can find ORS from 46% to 80% in both project areas.	There have been stock-outs of rehydration salts since August 1999. ORS packets are given out at the house of a volunteer mother. They are not sold by FOCAS. Some mothers report availability in boutiques for 5 gourdes (\$0.30).	Report of mother's perception and behavior on final KPC evaluation.	There is a preliminary plan to join the PSI social marketing campaign of offering ORS packets for sale. PSI suggests selling the lemon-flavored ORS at 3 packets for 5 gourdes.

Special Outcomes or Constraints:

- The training of field staff occurred in September 1999, the week before the mid-term evaluation.
- Observation of 2 mother's club meetings showed that the staff has already been using the MSPP flip chart to discuss the causes of diarrhea, prevention, ORS and food and fluid during and after episodes of diarrhea.
- The lack of consistent stock of ORS is a problem since the incidence of diarrhea in the program areas is higher than the national average. The PSI initiative may take care of this problem.
- There has been no progress on the capping of springs to date (DIP p.68).

Next Steps:

Discuss the FOCAS policy of selling ORS packets and determine whether an association with the PSI social marketing of the newly flavored packets is an option to increase availability of the solution to caretakers. A list of all distribution sites will be created in the coming months.

Activate the ARHC-FOCAS program for capping springs to prevent diarrhea in the program areas.

2.A.3. Case Management of Pneumonia

OBJECTIVE	PROGRESS ON INTERMEDIATE STEPS TO DATE	MONITORING STRATEGIES	MODIFICATIONS IN TECHNICAL APPROACH
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<p>Increase % mothers who seek assessment/Tx for child with cough or difficult breathing from 53% to 70% in EDJ (OBDC) project.</p>	<p>Training of all staff in the ALRI algorithm on January 1999. Timers available in April 1999. Key messages for mothers developed and added to the MSPP flip chart. The case finding and use of protocol has not been implemented completely.</p>	<p>Quality assessment check list developed.</p> <p>Date of pneumonia episode in child roster.</p> <p>KPC will be conducted during final evaluation to assess changes.</p>	<p>Zithromax used by FOCAS instead of cotrimoxazole as is in the protocol.</p> <p>Epidemiological surveillance is linked to the most recent episode of pneumonia only.</p>
<p>Increase % mothers who seek assessment/Tx for child with cough or difficult breathing from 44% to 65% in BLM (MEI) project.</p>	<p>Training of all staff in the ALRI algorithm on January 1999. Timers available in April 99. Key messages for mothers developed and added to the MSPP flip chart. The case finding and use of protocol has not been implemented completely.</p>	<p>Quality assessment check list developed.</p> <p>Date of pneumonia episode in child roster.</p> <p>KPC will be conducted during final evaluation to assess changes.</p>	<p>Zithromax used by FOCAS instead of cotrimoxazole as is in the protocol.</p> <p>Epidemiological surveillance is linked to the most recent episode of pneumonia only.</p>
<p>Increase proportion of children with ALRI assessed and/or treated correctly by health agents or in the clinic</p>	<p>No staff Quality check lists completed since training. The staff said that they don't see children with cough or difficulty breathing.</p>	<p>Quality assurance checklist has been developed for the nursing staff.</p>	<p>Community participation aspects of case finding have not been applied.</p>

Special Outcomes or Constraints:

The ALRI training of field staff occurred in January 1999. There have been no continuing education sessions to date. An episode form is not used. Rather, the most recent diagnosis of pneumonia by a health agent is noted by date in the child register. Non registered children are not recorded. The ALRI UNICEF timers were not available at the time of training so there was a delay in the application of the new skill.

There is no written protocol for triage or back referral other than that in the protocol itself (refer after the first dose of antibiotic for severe pneumonia and severe disease). There is no way of tracking the follow-up visit within four days of diagnosis.

Next Steps:

Provide continuing education for all staff. The “cold Check” stations will be established when the program is functional at the level of the supervisor nurses and field nurses. The staff will assess the monitoring system and perhaps include the other classifications of disease in the ARI protocol (cold, severe pneumonia and severe disease) The staff will clarify the triage, referral and follow-up visits with all children diagnosed with an ARI.

2.A.4.Immunization

OBJECTIVE	PROGRESS ON INTERMEDIATE STEPS TO DATE	MONITORING STRATEGIES	MODIFICATIONS IN TECHNICAL APPROACH
Increase the access of infants to immunizations from 54% to 85% in the EDJ (OBDC) Project.	Quality rating over 90% on vaccine posts; Children 12-23 months completely vaccinated: 17% baseline, 65% Oct 1999 (N=30 children in 3 areas)	§ Road to health cards; § Child Roster (Registre); § Monthly statistics form; § Monthly trends.	Continuing education to reinforce the EPI national policy. Review BCG technique.
Increase the access of infants to immunizations from 82% to 90% in the BLM (MEI) Project.	Quality rating over 90% on vaccine posts; Children 12-23 months completely vaccinated: 51% baseline, 83% Oct 1999 (N=30 children in 3 areas)	§ Road to health cards; § Child Roster (Registre); § Monthly statistics form; § Monthly trends	Continuing education to reinforce the EPI national policy. Review BCG technique.
Increase the % of infants fully immunized from 31% to 80% in the EDJ (OBDC) Project.	IEC messages used (MSPP flip chart)	Same as a above	Consider counting all doses in the HIS and not using the DPT 3 proxy.
Increase the % of infants fully immunized from 67%	IEC messages used (MSPP flip chart)	Same as above	Same

to 85% in the BLM (MEI) Project.			
Increase the % of children immunized with measles** vaccine from 28% to 75% in the EDJ (OBDC) Project.	Baseline: 28% October 1999: 76% Record Review: 3 Health agent zones, 10 children under 2 in each zone.	Same	BRAVO ! No change
OBJECTIVE	PROGRESS ON INTERMEDIATE STEPS TO DATE	MONITORING STRATEGIES	MODIFICATIONS IN TECHNICAL APPROACH
Increase the % of children immunized with measles** vaccine from 58% to 80% in the BLM (MEI) Project.	Baseline: 58% October 1999: 90% Record Review: 3 Health agent zones, 10 children under 2 in each zone.	Same	BRAVO ! No change
Decrease the vaccine drop out from 39% to 6% in the EDJ (OBDC) Project.	Monthly vaccine posts established; (rarely at home) Clinics are giving vaccines every day. Vast majority of children came to the 4 posts with FOCAS-labeled cards.	Monitor reality of requisition and delivery of vaccines because stock outs occur.	No change
Decrease the vaccine drop out from 16% to 6% in the BLM (MEI) Project.	Monthly vaccine posts established; (rarely at home) Clinics give vaccines every day. Vast majority of children came to the 4 posts with FOCAS-labeled cards.	Monitor reality of requisition and delivery of vaccines because stock outs occur.	No change
Increase the % of pregnant women with 2+ TT doses from 9% to 30% in the EDJ (OBDC) Project.	Women's roster being used since July 1998. Toxoid IEC card and MSPP flip chart used: Tetanus Toxoid doses sometimes marked with a check mark or mother not in roster when baby is.	Same statistical reporting forms as for children. Women's health Roster. Mother's often do not bring their vaccine cards to rally posts.	Will verify date of birth and not age on card; Revise women's vaccine tracking to include date(s) of all doses: Consider special "women health days" to

			increase coverage.
Increase the % of pregnant women with 2+ TT doses from 11% to 30% in the BLM (MEI) Project.	Women's roster being used since July 1998. Toxoid IEC card and MSPP flip chart used; Tetanus Toxoid doses often marked with a check mark or woman not in roster when baby is.	Same statistical reporting forms as for children.. Women's health roster . Mother's often do not bring their vaccine cards to rally posts.	Same

**** NOTE:** There was a national vaccine campaign in 1998. Both PVO organizations participated in the effort.

Special Outcomes or Constraints:

One of the most remarkable changes seen to date in the program is the dramatic improvement in the vaccine coverage rates of children under the age of 5 years and the use of the health information system.

COLD CHAIN:

There is a need for additional refrigerators and vaccine carriers now and as the program expands. The temperature of vaccines is maintained on a reporting form.

STOCK OF VACCINES:

There is a requisition form used to obtain vaccines and supplies from the government Department office (MSPP). While staff mentioned stock outs, there was no documentation of the lack of concurrence between what was asked for and received. A logistics form will be maintained so that lost opportunities for vaccines will be held against expectations of project performance.

DOCUMENTATION:

The processes of documenting individual and aggregate vaccination information are in place at the community and clinic levels. The fact that the census form noted women's vaccines as logical data and not as real dates created a problem for follow-up doses. This will be rectified. The parents or caretakers maintain the Road to Health cards. The idea of keeping duplicates in the clinics in case one is lost has not yet been fully implemented.

There is some duplication of vaccination effort in the Bellevue la Montagne area. There are 15 resident health agents from the Baptist Mission in the same area as the 5 new non-resident nurse health agents of the MEI NGO. Staff stated that mothers have two cards – one for each organization.

Next Steps:

The processes of vaccination for children is well established. The senior staff will address the areas of duplication of effort in the coming month. The process of women's vaccine rates is not as well established (the baseline levels are lower than the children's are). Staff will devise an action plan to reach more pregnant women and improve documentation of all contacts with pregnant women in the coming trimester.

2.A.5. Child Spacing and Maternal Care

OBJECTIVE	PROGRESS ON INTERMEDIATE STEPS TO DATE	MONITORING STRATEGIES	MODIFICATIONS IN TECHNICAL APPROACH
Increase the % of mothers using modern contraceptive methods from 13% to 25% in the EDJ (OBDC) project zones.	See chart below of family planning users in both clinic and field sites. IEC messages not yet developed.	The women's roster has the capacity to show the current method. Changes are erased as the method changes. Same statistical reporting forms used as for children	Consider adding the USAID accepted (1994) modern method of <i>Lactation Amenorrhea</i> , which will increase the number of users.
Increase the % of mothers using modern contraceptive methods from 15% to 30% in the BLM (MEI) project zones.	The MEI clinic and field workers were primarily family planning focused for many years. See chart below. IEC messages not yet developed.	The women's roster has the capacity to show the current method. Changes are erased as the method changes. Same statistical reporting forms as for children	Consider adding the USAID accepted (1994) modern method of <i>Lactation Amenorrhea</i> , which will increase the number of users.
Improve FP counseling by clinic staff through training.	<u>No progress to date</u>	A quality checklist will be developed for verifying quality of care.	
OBJECTIVE	PROGRESS ON INTERMEDIATE STEPS TO DATE	MONITORING STRATEGIES	MODIFICATIONS IN TECHNICAL APPROACH
Increase the proportion of mother's delivered by trained personnel from 72%	16 TBAs trained between December and March 1999.	Focus group interviews *****? perhaps	Given the variety of facilities and practitioners used by women registered in the program.

to 90% in the EDJ (OBDC) Project zones.	Mother's interview showed 70% delivered by trained personnel. See table 2 below.	should be on women's roster?*****	a more formal referral or information system might bring this objective to nearly 100%
Increase the proportion of mother's delivered by trained personnel from 82% to 94% in the BLM (MEI) Project zones.	6 TBAs trained between December and March 1999. Mother's interview showed 70% delivered by trained personnel. See Table 2 below	Same	same

Table 1: Child Spacing Aggregate Field Report

*May – July 1999**

Program Area	MAY		JUNE		JULY	
	New	Actual	New	Actual	New	Actual
MEI	1	3	0	8	6	0
OBDC	25	58	29	70	22	127

* Clinic services do not receive support from USAID

Table 2: Reproductive Health Facilities/Practitioners in the Service Area

Area	Facility	Affiliation	Service
Callabasse	Clinic 6 days/week	MEI	Prenatal/FP Portable Lab
Petionville	Notre Dame d C. 5 days/week	Private	Prenatal/FP
Grenier	Mossanto Clinic 5 days/week	OBDC	Prenatal --FP
Laboule	Mossanto Clinic 5 days/week	OBDC	Prenatal --FP
Petionville	MSPP clinic 5 days/week	MSPP	Prenatal-FP
Fermathe	Clinic and Hospital 7 days/week	Baptist Mission	Complete women's health center (No C-Sections)
Petionville	City Med clinic 7 days/week	Private (MEI patients)	OB and GYN
PHASE	Hospital and Clinic 7 days/week	Private	OB and GYN
Isai Jeanty	7 days/week	Private	OB and GYN

Hospital			
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Source: Interviews with all staff at both NGO sites, October 1999

Special Outcomes or Constraints:

An assessment of the current practices and strengths and weaknesses of the clinics in the area of family planning has not yet been conducted. Also, the official training of clinic and field staff in the counseling and service delivery aspects is planned for early 2000. This part of the technical program is not yet as functional as it will be when the training, quality checklist forms and protocols are established.

Staff stated that many midwives do not come to the clinics for meetings, reports or re-stocking of materials.

Next Steps:

The assessment of current practices by staff is essential so that the training might be tailored to the needs of such variation in staff as family planning nurses, public health nurses, field auxiliaries and new village health workers (CHAs). The phase-in of training and application will follow the DIP – which skills will be built on previous competency. In addition, the LAM as a modern method (which is used in Haiti) could be added to the modern mix of methods. Other practitioners in Haiti have adapted teaching materials for all methods (Profamil and CARE International)

Document continuing education effort with midwives. Investigate collaboration of health agents with midwives in the field to decrease long walks to the partner clinics. Collaborate with other organizations that support midwives in the area for joint training and supervision.

2.B. Cross Cutting Approaches

In each section in Part B. the following will be addressed:

- Impact on the program
- Lessons learned to date
- Links to future activities

2.B.1. Community Mobilization

Objectives/ Targets	Approaches used	Timing	Participants	Location	Technical Areas
What impact do	Health Agents	9 years	CHAs	OBDC	all

factors such as security, politics, roads, mass media have on program implementation.	live in work areas				
What is the progress on community participation?					
	Mentoring built on established NGOs	20 years MEI 9 years OBDC	Church affiliation	Both NGO old zones	all
	Selected Community Meetings	Before new Interventions	Community leaders	MEI-rural MEI marginal OBDC-rural OBDC-marginal	Vaccines FDN

Impact of Community Mobilization on the FOCAS Program:

Because the partner NGOs have been in sections of the service area for between 9 and 20 years, issues of access to villages, security, acceptance of personnel by village/neighborhood members is not a new issue. In Haiti, the political climate changes rapidly, crime is on the rise including car jacking and daylight murder, and there is a general feeling of unrest due to the ever-increasing cost of living.

There have been no remarkable events that have occurred to the FOCAS, MEI or OBDC staff since the inception of the program that put their lives or the program activities at risk.

The partner NGOs have been in the service area for many years. Before the ARHC/FOCAS mentoring project, mobile medical teams had provided a variety of services with residents including eye care and dental care. In the MEI area there are other, non-health activities supported by the MEI church and affiliate American churches e.g.: primary and secondary schools, a technical school, a scholarship program, food and clothing aide and an evangelical movement.

Likewise, additional services have been provided by the OBDC organization that have a wider scope than that of a child survival health program.

Therefore, in terms of **community mobilization for UTILIZATION** of services offered by the FOCAS/MEI/OBDC triad, there is objective proof that this is the norm. Women do bring their children to rally posts and receive vaccines. The dramatic rise in the measles coverage rate shows high utilization of services.

A systematized incorporation of the program into village and neighborhood life has not occurred yet. Communication is with the leaders of the area. Mothers' groups are functional in the OBDC organization and are only beginning in the MEI zones. This may have had an impact on the Nutrition program (FDN) as will be discussed later in the document.

Lessons learned to date:

In the marginal zones of Port-au-Prince and the rural sections above the cities, it is important to work with Haitian organizations that have already established a presence in the area to increase the likelihood of program reach and decrease danger to the staff.

In terms of the condition of the roads in the service areas, the marginal zones (Jalousie and Bois Marquette) are compressed masses of blockhouses built into the side of a mountain. Roads are not the issue but mud is. The unpaved roads in the rural zones are the typical picture for the peasants of Haiti. The condition of the roads is of great concern, though, to program staff since materials and staff are sometimes unable to reach the villages in heavy rains. Utilization is evident but participation is not.

Links to future activities:

In order to extend the scope of mobilization of community members from utilization to true participation, these organizations that already have a history of involvement in many of these sectors will activate practical steps toward this end. For example, establishing a mechanism for written communication from the community members to program administrators and back provides a consistent community link. Another example is to enlist the aide of community members to assure the security of the working staff, or to keep the water source barricaded.

2.B.2. Communication for Behavior Change

Objectives/ Targets	Approaches used	Timing	Participants	Location	Technical Areas
The Program approaches to behavior change* are:	1. IEC messages 2. Demonstration 3. "Witnessing"	Group education Individual counseling	Mothers or Caretakers	Rally Posts Home Visits	Growth monitoring and counseling

Are they appropriate and effective?	4. Use of positive deviant mothers				Breast feeding
Are the IEC messages technically up-to-date?	Factor analysis exercises used with the staff to develop culturally and technically appropriate messages.	IEC messages designed or adapted from within the Haitian context BEFORE implementation.	ARHC brought process of factor analysis to FOCAS/NGO team. Staff used other PVOs in Haiti also.		Growth monitoring and counseling Nutrition/ micronutrients Diarrhea -new ARI
How are IEC activities measured? What are the tools used?	Quality assurance checklists developed initially by ARHC and now FOCAS & NGOs.	Mother's understanding is assessed within the activity. Staff approach to teaching is assessed by performance checklists.	IEC activities mostly group education and individual counseling. No community activities to date.	Rally Posts Home visits Clinic contacts	Quality assurance check lists used for: Growth monitoring ARI
Objectives/ Targets	Approaches used	Timing	Participants	Location	Technical Areas
Who uses data gathered regarding the effects of IEC activities?	As above Quality assurance check lists.	Periodically. Each staff member has list of assessments conducted on their approach. No written assessment of mothers or village-level change.	Supervisors CHAs New CHAs Record Keepers Program Managers	Rally posts Home visits	Same as above
How have communities	No community "health fairs" or	To be determined by	Field health agents	Village or neighborhood	Same as above

used these data to reinforce or promote behavior change?	other strategies yet implemented	field staff in coming months	Mother's club members Supervisors	levels	
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* One particular strength of the FOCAS/ARHC approach to child survival is the use of the supervision quality assessment processes. These strategies draw out the emphasis on community or family-based behavior change to encompass the staff as well. Whereas there are steps to apply in the process of individual education, there are steps to apply the process of health services education.

Impact of communication for behavior change strategies on the FOCAS Program:

There have been two levels of emphasis by FOCAS/ARHC and OBDC/MEI in the area of IEC and behavior change. The first level is to develop within the staff a consistent approach toward behavior change through appropriate education and follow-up. Examples include: the use of the factor analysis exercise by the staff to determine the basis for health behaviors; the use of a behavior box by the field staff to remind them of the timing of key messages; and the initiation of mother's clubs for the transmittal of key messages, and the continued development of staff-generated messages for new interventions such as diarrhea and ARI.

The second level of emphasis is the application of key messages and practical steps toward behavior change among the beneficiaries of the health services and education. Using demonstrations of how to mix oral rehydration solution, asking mother to provide a return demonstration of selected health behaviors, and reinforcing positive behavior change in beneficiaries as in the case of breast feeding.

Lessons learned to date:

- Factor analysis exercises when used by field staff can provide important information in establishing strategies for behavior change.
- The behavior box on the road to health card provides a good reminder of the timing of key messages.
- Non-formal educational techniques are important (witnessing, demonstration, songs) and effective.

Links to future activities:

- Community-oriented strategies will require an effort in the coming months to cement behavior change strategies in a wider area. (Including feedback of health data to community members)

- Assessment of behavior change is not documented (although anecdotal information exists based on mother's statements) and will need more attention in the coming months.

2.B.3.1 Capacity Building Approach: ARHC's Mentoring of FOCAS

A. What are the ARHC capacity building strategies for FOCAS?

On-Site assistance with fund raising is planned for early 2000. ARHC to date was worked technically as an equal with FOCAS/USA. ARHC program specialists have come to work with staff in Haiti more frequently than FOCAS/USA has. Each USA professional from ARHC and FOCAS contributed to the FOCAS/Haiti program with specific skills. With the new FOCAS/USA program director, there will be more technical transfer from ARHC to FOCAS.

B. What assessment tools were used as the baseline ?

There was no documented assessment tool used to assess the strengths and weaknesses of FOCAS/USA by ARHC.

C. How are changes in capacity of FOCAS/USA and FOCAS/Haiti being measured

Technical reports

D. Is there a plan for technical capacity building?

Page 23 of the DIP describes the following:

- a. Institutionalize KPC Surveys;
- m. Implement ARHC CBIO methodology;
- n. Expand field capacity in Child Survival technologies;
- o. Develop in-house capacity for curriculum, education and supervision;
- e. Institutionalize the health information system (HIS)

E. Is there a plan for management technical assistance for strengthening capacity?

This was basically "understood" since without management capacity, services cannot be delivered with maximum effectiveness and efficiency. However, a documented path to lead us there should be noted.

- **What activities have been accomplished to build organizational capacity between ARHC and FOCAS?**

At the level of ARHC headquarters administration, with FOCAS headquarters administration,

there have been numerous conversations and one meeting official meeting in November, 1998.

At the level of ARHC headquarters (health program) with FOCAS headquarters (health program),

the have been collaboration between equals in the area of health program implementation. There have been joint visits to the FOCAS field site with ARHC and FOCAS headquarter program staff. The first was for the preparation of the DIP in March, 1998. The second was a joint visit to the ARHC project in Bolivia in February 1999 to determine areas of technical transfer. The third joint visit was in April, 1999 to prepare for the mid-term evaluation and develop and action plan.

At the level of **ARHC headquarters with FOCAS-Haiti**, there has been a concrete transfer of skills in the training and delivery of many of the CS interventions and implementation of the CBIO primary health care method.

G. What examples demonstrate that FOCAS has increased organizational capacity?

The processes for USA backstopping of a child survival program in Haiti are being established including: financial capacity of FOCAS/Haiti, the ability of Haitian nationals to prepare annual plans and modify strategies 'on the ground' with the support of the headquarters office, and the headquarter staff response to special needs of the Haitian program.

H. Impact of capacity building approaches on the FOCAS Program:

There has been a upgrading of the capacity of the Haitian nationals to move into the child survival program with international-level quality – they are beginning to learn to play “with the big organizations”.

2.B.3.2 Capacity Building Approach: FOCAS' Mentoring of MEI and OBDC

- Did the ARHC assess the capacity of the local partners at the onset? No
- What are the activities realized in technical and management capacity building?

FOCAS, as the second tier in the mentoring relationship, has served as an additional umbrella for MEI and OBDC. Remembering that the two organizations were already functioning in the field for many years, FOCAS serves to augment the clinical, program management and financial reporting skills of the organizations. The processes are being put

into place that will assure that the partner NGOs can continue at a higher level of excellence because of the mentoring relationships.

- **Do the two local partners meet on a regular basis to discuss technical and management issues?** Yes, but these efforts are not documented.
- **What are the roles of the local partners?** Service providers
- **What is the outcome of FOCAS' assessment of the capacity (technical and otherwise) of the 2 partners?** Not documented
- **List improvements in the NGOs that have occurred since 6/98.** Technical
- **What are additional activities planned to strengthen capacity of the 2 NGOs?**
Management training needed according to both program managers

Links to future activities:

The organizations plan to document capacity-building activities as rigorously as the first two years of technical capacity building.

2.B.3.3 Capacity Building Approach: Strengthening the MEI/OBDC Health Facilities

Objectives/ Targets	Approaches used	Timing	Participant s	Location	Technical Areas
Were the clinics of the two partner NGOs assessed for technical and management needs at the onset?	No written documentation of a technical or managerial assessment of the OBDC or MEI clinics.	NA	NA	Clinic-Laboule Clinic-Callabasse Clinic-Grenier	General assessment
What is the plan for technical strengthening of the NGO clinics?	Participation of staff in clinics in technical clinical training.	1999	Clinic nurses	Same	Family planning
What activities have already been accomplished? Where?	None	2000	ARHC FOCAS MEI OBDC	Same	Laboratory strengthening
What assessment tools are used for the local NGO clinic?	None MD assessments not done.			Same	All needed
What is the referral system between the CBOs and the clinics?	The mother's clubs do not have a direct link. Individuals are referred to the NGO clinics.			Same	Referral system uses small cards. No technical follow-up.
What is the formal relationship between FOCAS and other referral organizations?	None formal Informal meetings			Same	TB- Baptist Mission and Grace Hospital for example.
How is FP, ARI and diarrhea referrals handled?	NGO clinics used but also other organizations.			Same	NA

Impact of capacity building approaches in clinic functioning with MEI/OBDC:

No impact to date. There is a lack of staff and the training cycles have not always included them.

The "within" NGO referral system is functional although there is no counter-referral to the field. There is a very weak "external" relationship among other health practitioners and facilities in the area.

NOTE: There is no USAID funding for the clinics and there is a salary difference in the clinics and in the field programs that create conflict.

Lessons learned to date:

Coordination among multiple health providers and facilities is important in providing and documenting high quality health care.

Links to future activities:

1. Establish a closer working relationship among partner NGOs and government health providers in the area. Conduct regular meetings.
2. Perform a clinic assessment of strengths and weaknesses in the technical and managerial areas as soon as possible.
3. Develop a plan for strengthening local NGO clinics.
4. A temporary system of FOCAS field staff working with other clinics (in education or growth monitoring) once a month for a short period would cement the referral-counter-referral system.

2.B.3.4 Capacity Building Approach: Strengthening the Health Worker Performance at FOCAS, MEI and OBDC

Objectives/ Targets	Approaches used	Timing	Participants	Location	Technical Areas
How is the level of skill of health workers measured?	Pre and post tests Quality check lists	Periodically	Supervisors CHAs PVO managers	Field Not Clinic	
Has training of health workers been based on previous level of competence?	See Attachment I page 71	Cannot due to the tight training schedule.	Old nurse CHAs New nurse CHAs New non-nurse CHAs	Same	
Has the addition of new skills been implemented after	Lag in ARI because of lack of timers.			same	ARI not fully implemented.

training?	Otherwise immediately implemented.				
What is the supervision time plan for each intervention?	Not clearly documented. Plan by location not by skill.	Supervisor s work in clinics as well as make field visits.	Nurse supervisors Rarely program managers		
What is done with performance assessments?	Kept at the FOCAS office after analyzed by the NGO managers		All staff	NA	All clinical interventions currently used. (Not FP yet)
What is the program plan for gaps in program performance?	Continuing education	As needed based on individual	Health agents predominantly	field	

Discussion:

Based on staff interviews, it was clear that in both NGO organizations, there is a problem between supervisors and field staff. The problem centers on feelings of inferiority and perceived behavior that is "humiliating". Rather than supervisor being perceived as a guide for technical competence and programmatic expertise, the field staff are reluctant to speak up, even when the work assignment is changed without explanation.

Impact of capacity building approach for health workers on the FOCAS/MEI/OBDC

Program:

Physicians: No approach

Clinic Nurses: FP in the future

Field Supervisors: Good training in techniques of supervision and staff feedback

CHA (Nurses) Standard training as community health agents (CHAs)

CHA (non-nurses) Standard training as community health agents (CHAs)

All nursing and para-professional staff use the quality assessment tools for competence appraisal.

Lessons learned to date:

- There are excellent tools available for the provision of quality health care by all levels of personnel.

- When quality checklists are used for performance appraisal, evaluations are more objective.
 - There is a need for physician standards of care.
4. The use of assessment tools is only as effective as the staff in using them as learning tools and not for "pulling rank".

Links to future activities:

1. A plan for supervision based on the need to integrate the skill depending on the level of training of the staff in critical.
2. The cycle of training of new health agents might afford the opportunity to re-train those who are weak in particular skills.
3. Regular, non-supervision oriented field meetings might ameliorate the conflicts among staff. Senior staff "modeling" of behavior may have a more positive effect.
4. Increase senior staff (FOCAS/MEI/OBDC) in the field to enhance the transfer of technical and attitudinal behavior.

2.B.3.5 Capacity Building Approach: Training: ARHC Mentoring of FOCAS' Mentoring of MEI and OBDC

Objectives/ Targets	Approaches used	Timing	Participants	Location	Technical Areas
What is the training plan?	See Annex I: Training Report Program management not yet in place.	1997 – 1999	Nurse auxiliaries/health agents & Non-nurse health agents TBAs <i>Nutrition Monitrices</i>	FOCAS Office	
Is the training plan on schedule?	Training plan has been modified See discussion below	Some training in 1999 moved to 2000	Same as above		FP Health Education
How has training improved the approach for each partner NGO?	Training health agents every year is perceived as a problem since the first group is not yet through		Same as above		All of the health agent topics will be repeated in 2000 and 2001 for new staff.

	the training.				
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Impact of the training approach on the Program: Discussed elsewhere in the document.

Training in providing high quality services in the field:

The training approach in FOCAS-MEI/OBDC is excellent. The use of participatory techniques such as factor analysis, staff development of educational and IEC tools is well done. The Key Message cards are useful for busy staff and the behavior box reminds all staff what to discuss with mothers on a one-to-one basis. Individual counseling skills have not been reinforced yet. Checklists for selected interventions show the staff that there are quick and effective methods to maintain quality of care.

Training of Staff by qualifications:

There is no difference in training between primary-school educated community health workers and clinic RNs. "No time" is the reason. Some thought might be given to stratifying health services training with a strong common base, but then tailoring additional training for more advanced staff. For example, the ARI pre-test scores ranged from zero to 65. Post-test scores ranged from 20 to 88. Given that ARI (pneumonia detection and treatment) programs are geared to decreasing the second cause of child death, one might consider the following:

- Field staff that do not attain a minimum score of 80 (or 70) cannot be permitted to use the skill;
- Failing staff could be matched with a more experienced one for a short period of time to "make up for deficiencies and then re-take the test;
- Staff tests and field responsibilities should be matched to their skill level:

Field health agents who are nurses should be able to treat cases of pneumonia without referral

Field health agents who are NOT nurses should be authorized (with a passing test score) to diagnose and REFER CHILDREN WITH PNEUMONIA until their level of questioning about danger signs is observed X number of times and deemed correct to the "X" level.

4. A clinic nurse should be able to treat more seriously ill children and should be held accountable.
5. Staff are then evaluated not only on their performance of the skill (ARI) but are also accountable to the level of their education .

Training and Supervising new staff in 2000 and 2001

The staff will have to think about innovative methods to do the following:

- Continue to train new health agents in family planning, first aide, health education and animation, community organization and provide adequate supervision and supplies for these new skills;
- Continue to train new health agents realizing that many are nurses and can be responsible for more advanced care;
- Provide continuing education for what these health agents have already learned eg, : ARI, HIS, Diarrhea case management, etc.
- Hire 10 new health agents (in 2000) and begin the training cycle again and begin a new census;
- Hire 15 new health agents (in 2001) and begin the training cycle again and begin a new census;
- Continue to provide continuing education for all groups depending on speed of acquisition of new skills based on new supervisors reports (performance check lists);
- Upgrade or hire another group of supervisors to monitor all of these health agents. The current ratio of supervisor to health agent is 4:25. By the end of the program with the current plan, it will be 1 supervisor for every 10 health agents.

2.B.4.1 Sustainability Strategy: FOCAS

List the sustainability objectives listed in the DIP

OBJECTIVES	ACTIVITIES	TIME	PROGRESS
Improve technical Capacity of FOCAS and ME/OBDC	Institutionalize KPC Surveys;	1998 and 2001	Baseline done, Final 2001
	Implement ARHC's CPIO method;	1998-2001	Ongoing
	Expand field capacity in Child Survival technologies;	1998 - 2001	Hearth and ARI not 100% Continue through 2000
	Develop in-house curriculum, education and supervision capacity	1998 - 2001	In Process
Develop Administrative Capacity of the Same	Establish office, hire staff, and create policies to guide key administrative activities.	1998-2001	Office OK, more staff to hire, administrative needs unmet: vehicle, communication and computer.
	Build up basic logistic capacity to adequately support field activity	1998 -2001	ARI timers a problem, medicines and vitamins have been a problem.
	Implement an automated financial management system	1998	Yes for FOCAS No for MEI & OBDC
Improve Leadership Capacity	Reaffirm the Mission of the three organizations, and hire staff who can realize these goals;	1998	How is this measured?
	Strengthen FOCAS headquarters capacity in fundraising, and in volunteer BOD	1998 - 2001	December 1999 meeting planned
	Promote mutual respect and a team orientation within the three organizations.	1998 - 2001	How is this measured?
Strengthen Financial Capacity	Develop a business plan to support and expand CS activities during the 10 year period following this initial CS grant period	2001	
	Incorporate local and national support into the plans and budgets of the three organizations.	1998 - 2001	What are the steps in this process?

What is the exit strategy of FOCAS ?

This document will be written in December 2001.

What are the plans for financial sustainability?

Fundraising and grants writing.

Is there community involvement in a sustainability plan?

To date sustainability is limited to in-kind participation in community activities

Impact of sustainability strategy on the FOCAS Program:

One issue that might be considered in the sustainability strategy of all three organizations, is to use this opportunity to assure that the health ministry recognizes field staff. There is a certification process for community health agents and nurse auxiliaries. When they are trained by government nurses or attend a government-sanctioned nursing school, staff receive an "official" diploma or certificate. By making sure that FOCAS staff are not only recognized by the government but also have the excellent training offered by this program, it is more likely that this cadre of health worker can find other employment if or when this program ceases. Likewise, in securing funding from other donors, workers such as "community educators" or collaborator volunteers cannot receive backing.

Links to future activities:

Perhaps the future training of health agents could be contracted out to government nurses so that the new workers are more likely to be employable in the future and also to lighten up the training load on FOCAS.

2.B.4.2 Sustainability Strategy: MEI

List the sustainability objectives listed in the DIP

OBJECTIVES	ACTIVITIES	TIME	PROGRESS
Improve technical Capacity of MEI	Institutionalize KPC Surveys;	1998 and 2001	Baseline done, Final 2001
	Implement ARHC's CBIO method;	1998-2001	Ongoing
	Expand field capacity in Child Survival technologies;	1998 - 2001	Hearth and ARI not 100% Continue through 2000
	Develop in-house curriculum, education and supervision capacity	1998 - 2001	In Process
Develop Administrative Capacity of the Same	Establish office, hire staff, and create policies to guide key administrative activities.	1998-2001	Administrative needs unmet: vehicle, communication and computer needed.
	Build up basic logistic capacity to	1998 -2001	ARI timers a problem.

	adequately support field activity		medicines and vitamins have been a problem.
	Implement an automated financial management system	1998	Not yet for MEI
Improve Leadership Capacity	Reaffirm the Mission of the three organizations, and hire staff who can realize these goals;	1998	How is this measured?
	Strengthen FOCAS headquarters capacity in fundraising, and in volunteer BOD	1998 - 2001	NA for MEI Look to the president of MEI for fundraising.
	Promote mutual respect and a team orientation within the three organizations.	1998 - 2001	How is this measured?
Strengthen Financial Capacity	Develop a business plan to support and expand CS activities during the 10 year period following this initial CS grant period	2001	Not yet written for MEI
	Incorporate local and national support into the plans and budgets of the three organizations.	1998 - 2001	What are the steps in this process?

What is the exit strategy of MEI?

Not documented yet.

What are the plans for financial sustainability?

No documentation of plans for financial sustainability.

Is there community involvement in a sustainability plan?

In-kind participation only.

Impact of the sustainability strategy on the MEI Program:

Cannot comment on this at this time.

2.B.4.3 Sustainability Strategy: OBDC

List the sustainability objectives listed in the DIP

OBJECTIVES	ACTIVITIES	TIME	PROGRESS
Improve technical Capacity of OBDC	Institutionalize KPC Surveys:	1998 and 2001	Baseline done, Final 2001
	Implement ARHC's CBIO method:	1998-2001	Ongoing
	Expand field capacity in Child Survival technologies:	1998 - 2001	Hearth and ARI not 100% Continue through 2000

	Develop in-house curriculum, education and supervision capacity	1998 - 2001	In Process
Develop Administrative Capacity of the Same	Establish office, hire staff, and create policies to guide key administrative activities.	1998-2001	Administrative needs unmet: vehicle, communication and computer needed.
	Build up basic logistic capacity to adequately support field activity	1998 -2001	ARI timers a problem, medicines and vitamins have been a problem.
	Implement an automated financial management system	1998	Not yet for OBDC
Improve Leadership Capacity	Reaffirm the Mission of the three organizations, and hire staff who can realize these goals;	1998	How is this measured?
	Strengthen FOCAS headquarters capacity in fundraising, and in volunteer BOD	1998 - 2001	NA for OBDC Look to the president of OBDC for fundraising.
	Promote mutual respect and a team orientation within the three organizations.	1998 - 2001	How is this measured?
Strengthen Financial Capacity	Develop a business plan to support and expand CS activities during the 10 year period following this initial CS grant period	2001	Not yet written for MEI
	Incorporate local and national support into the plans and budgets of the three organizations.	1998 - 2001	What are the steps in this process?

What is the exit strategy of OBDC? None documented

What are the plans for financial sustainability? None documented

Is there community involvement in a sustainability plan? Not other than utilization

Impact of the sustainability strategy on the OBDC Program: Cannot comment on this at this time.

Links to future activities: Plan and document all clinical, social and financial plans for sustainability.

3. Program Management

It is important to note that these evaluation items related to specific management processes were not in place when the program was approved and the DIP was written in 1997. These evaluation criteria were distributed on June 11, 1999. Therefore, adherence to a particular management plan is not possible. It is understood by the ARHC/FOCAS organizations that NEW processes will need to be activated rapidly for the success of the program.

3.A. Planning:

3.A.1. What groups have been involved in program planning?

The Program managers of MEI (a physician) and OBDC (administrator) were involved in the proposal but, they said, not the DIP in terms of personnel or budget items. The ARHC Senior technical advisor, the FOCAS/USA Program Director and the FOCAS/Haiti Program Manager (a physician). There were no scheduled community-level meetings or specific discussions with field staff.

The annual plan in 1997 was closely written with the FOCAS/US Program Director and the Haitian nationals. The writing of the 1998 annual plan had more independent input from the Haitian nationals with oversight by the FOCAS/USA Program Director. The 1999 plan will be written with an even greater role played by the FOCAS/Haiti team and the NGO partners.

3.A.2. Is the work plan on schedule?

The work plan has been and will be modified since the DIP was written in the following manner:

- The information exchange trip to the ARHC project in Bolivia was later than planned;
- Training has been adjusted by consensus for a variety of reasons for the "old" and year 2 "new" community health workers;
- There is no allotment for repeated training sessions for year 3 new-hire community health agents (CHAs) WAS NEVER IN THE WORKPLAN;
- The number of technical assistance trips by ARHC HQ and FOCAS/USA were not as often as planned;

3.A.3. Do the ARHC staff understand the program objectives?

The Senior Technical Specialist understands the program objectives, indicators and activities very well and in the Haitian context. In fact, he guaranteed that the staff had copies of the objectives in Haitian Creole located in the first pages of the "Field Roster Usage Guide". Other HQ staff were not contacted for their understanding of specific objectives.

3.A.4. Do the FOCAS staff understand the program objectives?

The President of FOCAS/USA understands the objectives and planned activities well although he does not speak French or Haitian Creole. The Health Program Director is new to the organization and learned the objectives, indicators, activities and processes currently in place during the evaluation exercise. The FOCAS/Haiti Program Manager (a Haitian physician) understands the technical objectives, indicators and activities as outlined in the DIP. The objectives are not displayed in the office for rapid reference.

3.A.5. Do the 2 local partner staff understand the program objectives?

The program managers of MEI and OBDC know the objectives and where to find the specific indicator benchmarks in the DIP in their offices. The objectives are not posted in the FOCAS office for all staff as a reminder of the goals of the program. The field supervisors and experienced CHAs know the intervention areas related to specific objectives but not the specific indicators.

3.A.6. Do all parties have a copy of the program objectives?

The Program managers have copies of the objectives in the DIP. There is one copy in French but it was in the FOCAS office and not with the non-English speaking program manager of OBDC. The field staff and record keepers have copies of the "Roster Usage Guide" in Creole produced by the ARHC Technical Specialist. They do not refer to it often.

3.A.7. Do all parties have a copy of the program monitoring and evaluation plan?

There is not a specific monitoring and evaluation plan. However, the processes are in place for monthly trend analysis of aggregate data by health agent area.

3.A.8. How is monitoring data used to make decisions or revise the program?

The technical report for July 1999 was reviewed to assess the problem-solving strategies based on results of aggregate data analysis by program managers. In the case of the Nutritional Demonstration Foyer, there was a section on "lessons learned" and some suggestions for decreasing the cost per child. The differences, for example between the rural areas where mothers bring some food to the pot and the marginal peri-urban areas where everything must be purchased was not noted. Also, the results of the first Nutrition Foyers were disappointing to FOCAS staff. But, ideas for the coming month to improve the community participation were not put forth.

The section of the technical report by NGO partners is a compilation of statistics but there is little analysis or discussion of program adjustments based on field findings. For example, there were 22 children per rally post in MEI areas and 50 children per rally post in the OBDC

zones. Were the differences due to more work in the marginal areas? What is the impact of another organization's health agents in the same areas as MEI? Do they (the other organization's health agents) give vaccines every month too? Only 36 pregnant women were given tetanus toxoid vaccine in all of the MEI areas and 121 in OBDC. What accounts for the differences by NGO zone? Do program adjustments need to be made? There were eight child deaths in MEI program noted in this July's technical report but no indication that verbal autopsy meetings were held or that there was no epidemic under way. The number of family planning acceptors was 6 in MEI and 27 in OBDC. The family planning services have continued in these clinics even though the field component is on hold until staff receive further training. Why is the rate so low?

In general, facts are given about program inputs (number of vaccines, number of weights, number of family planning users) but there is not the level of analysis demonstrated or program re-orientation or resource allocation changes that would be expected. The denominator should be given so that both ARHC and FOCAS/USA technical advisors can verify information. (the denominator is the total number in the target groups eg.: women 15-49, pregnant women, newborns, and children 0-5 years, etc). The example technical report prepared by FOCAS/Haiti is included in Annex 2.

3.B. Staff Training:

3.B.1. How effective is the process for continual improvement in the knowledge, skills and competencies of the program's staff, including needs assessment, training methods, content and follow-up assessment?

Technical Training: As discussed in previous sections, the training to date has included IEC messages, processes for quality improvement through use of check lists, and an administrative plan for supervision that includes the quality check list for the supervision approach. Training in the FOCAS/ARHC and NGO partners is very well done. Implementation and supervision are well monitored in the areas of growth monitoring, rally post management, nutrition counseling and micronutrients and de worming. Areas that still need attention are the ARI implementation and supervision plan, the Nutritional Demonstration Foyer program, family planning and the counseling skills of all staff in the area of child spacing.

Program Management Training:

There was no management needs assessment at the onset of the program. Although specific training on the management of the child survival program, there were aspects of

program management integrated in many of the training sessions conducted by ARHC and FOCAS/USA staff including:

- The joint development of the annual implementation plan in year one and more Haiti input on the second implementation plan (FOCAS/USA, Dr. Robinson);
- The process involved in program supervision (ARHC, Mr. Davis);
- The implementation of the manual health information system (ARHC, Mr. Davis)
- The integration of the computerized financial management system (FOCAS/USA, Mr. Steve Schubart)
- Field trips to Bolivia (ARHC), and within Haiti: Maissade (Save the Children) were made jointly to see "on the ground" management of other child survival program with similar interventions and management requirements for success.
- An "Annual Performance Review" form is used for yearly evaluations of staff but follow-up on weak areas is not documented.

The FOCAS/MEI and OBDC senior staff said in independent interviews early in the evaluation process that they need management training. The level of management in a small clinic with mobile outreach is different, they said, from a multifaceted, community based program with many more staff members. This requires more skill than they have currently.

3.B.2. How are new skills monitored?

See Attachment I on HIS for a discussion on the manner in which technical skills are monitored. There is no similar checklist for management capacity and skill. However, as noted previously, the level of administrative skill can be assessed through technical reports that address problems and how the staff solved them. This needs to be addressed with clear expectations at all levels of the mentoring relationship. This is a critical feature of a sustainability plan.

3.B.3. Are adequate resources allocated to staff training?

Since the work plan did not address the fact that the entire training plan has to be repeated in year 3 and year 4, there is a lack of training staff and sufficient supervisors to monitor them once they are trained. Training costs have also exceeded expectations and will have to be addressed in the budget and the annual implementation plan.

3.C. Supervision of Program Staff:

3.C.1. What is the supervisory schedule for the community level?

In an assessment of 2 of the supervisors, it was found that they spent time assisting in rally posts, accompanying health agents in home visits, working as clinic nurses for curative care and taking care of administrative duties. The schedule is made out at the end of the previous

month. Since most rally posts in the MEI area occur on Mondays, they spend their time in this effort on most Mondays. The Quarterly Planning Sheet is not yet in use.

The field community health workers noted that there is lack of adequate field-level supervision. They said that they see the nurse supervisors once or twice during the month (new health agents). The schedule is perceived as insufficient. The staff also noted that they would like to see the program senior staff in the field more often as this is important for community involvement.

See Annex VII for Senior staff supervision in the field and Annex V for staff comments regarding supervision.

3.C.2. What is the supervisory schedule for the supervisor level?

The program managers evaluate supervisors. One of the tools developed with ARHC is the quality of supervision checklist. (*Lis tcheke e amelyore kalite: zouti supevize*) All of the nurse supervisors were evaluated in June 1999 using the Annual Performance Review form. See ANNEX 9. The form is only in English and will need translation for staff.

3.C.3. What is the supervisory schedule for the data management level?

The program managers evaluate the record keepers. No special assessment form was observed to be used that is specific to the unique tasks of the record keepers.

3.C.4. What is the supervisory level for the program managers from the US-based PVO?

The supervision that has been documented by FOCAS/USA for the FOCAS/Haiti senior management (using the annual performance review form in ANNEX IX) was completed in November 1998. The tool was completed during a joint meeting between the FOCAS/US Health Program Director and the FOCAS/Haiti Project Manager. The MEI and OBDC Program Managers are not evaluated by FOCAS (according to the FOCAS/USA Health Program Director).

3.C.5. How does change in program implementation occur?

Many of the program decisions have been made by the FOCAS/Haiti executive director and the NGO program managers in close contact with the ARHC Senior technical specialist. Many detailed e-mail documents were reviewed concerning ARI training, the rally post quality checklist, the quality of the technical reports, etc. Changes seem to come from these contacts.

3.C.6. What are the supervisory tools used for technical interventions?

These have been described elsewhere and are one of the strengths of the program.

3.C.7. What are the supervisory tools used for the management activities?

There are none according to the staff.

3.C.8. Are the numbers, roles and workload of personnel appropriate for meeting the technical and managerial needs of the program at the PVO level?

The FOCAS/USA staff have been preparing the FOCAS/Haiti staff with technical training and tools. The technical aspects of the program have been well supported through the efforts of FOCAS/USA and the ARHC senior technical specialist. Financial reporting assistance has been of benefit (from FOCAS). There is a need for financial and program management training and clear, documented administrative tasks.

3.C.9. Are the numbers, roles and workload of personnel appropriate for meeting technical and managerial needs of the program at the PARTNER level?

The MEI/OBDC program managers noted the lack of physicians and other staff at the clinic level, the record keepers said that they need more of this line worker to get to the field frequently. All levels mentioned the need for more supervisors, especially after the training of the new cadre of health agents. The staff is insufficient for a move to computerization of the HIS at this time.

3.D. Human Resources and Staff Management:

3.D.1. Comment on the program's personnel management system

There are processes in place for periodic and OBJECTIVE assessment of health and supervisors for clinical and education skills. The same level of assessment tools do not seem to be available for upper level management or for clinic staff (who perform more advanced clinical activities) The field staff (Annex V) discussed problems in both NGO areas with supervisors treating them unprofessionally. There seems to be a "keep quiet" policy with newer staff that needs attention to rectify.

There is a personnel policy used by FOCAS/USA staff. A FOCAS/Haiti personnel policy that includes the Haitian Labor laws was not available in French or Creole.

3.D.2. Job Descriptions in place at FOCAS/USA

The FOCAS/USA job descriptions were not available at the time of the evaluation.

3.D.3. Job Descriptions for FOCAS/Haiti

The Haiti Project Manager (Dr. Ferrus) has a job description in Creole, but does not have a contract.

3.D.4. Job descriptions for Partner NGOs?

Job description were available in French for the MEI and OBDC staff including community health workers, record keepers, bookkeepers, nurse supervisors and the head supervisor. There was no job description for clinic staff, the program managers or community health workers who are also nurses. The program managers drafted job descriptions.

3.D.5. Describe morale, cohesion and working relationships of program personnel and how this impacts program implementation.

See 3.D.1. for discussion. At the senior staff level, there are close working relationships. The OBDC and MEI program managers have worked together for many years. The three senior staff members often make field trips together.

3.D.6. Describe staff turnover and its impact.

Many of the staff of the two partner organizations have been affiliated for many years. In OBDC the years in the organization range from 4 months (monitrices) to 10 years (one CHA and the Program Manager). In the MEI project, there range is from 8 months (CHAs) to 14 years (record keeper) Only one staff person has left the program since 1998.

3.D.7. What are program strategies for staff retention?

The senior staff would like to promote some of the health agents into the role of supervisor because of the problem with increasing the number of health agents but not supervisors in the program plan. They realize that an amendment is necessary and that other staff line items may have to be adjusted.

3.D.8. What plans does the project have for facilitating staff transition to other paying jobs when the project ends?

No plan currently.

3.E. Financial Management:

3.E.1. Discuss the management accountability for program finances, budgeting and financial planning for sustainability of both the program and NGO partners.

The Headquarters of FOCAS use the same chart of accounts and computerized accounting system. FOCAS also keeps a manual system because of the unreliability of power in Haiti. The tracking of exchange rates occurs frequently and well.

Budgeting:

Budgeting is accomplished using inputs from the NGOs and FOCAS Haiti with the headquarters negotiating and approving the final budget. A full four-year budget is prepared and continually revised, as new information is added to the equations. Approximately 80% of the budget is for personnel.

Constraints:

The cost of medicines was underestimated. They were not considered in the initial budget because it was thought that other donors would provide medicines. This has not proven to be the case. Financial and program managers are working to minimize these costs.

Training has been more expensive than originally planned according to the FOCAS/Haiti office.

FOCAS cost sharing:

25% of the funds for activities of FOCAS in Haiti were to be provided in addition to the USAID portion.

Financial Sustainability Plan:

The ultimate objective is to have each NGO functioning separately as fully sustainable organizations using indigenous personnel with adequate management and technical expertise. The first two years of this program have contributed to the FOCAS/Haiti and partner's financial expertise. The partner NGOs are not yet computerized but FOCAS plans to equip and train them in computerized financial management by the end of the project in 2001. FOCAS/Haiti expense reports are sent monthly to the HQ office in Cincinnati where they are incorporated into the main accounting system. Additionally, cash flow analysis is kept for the Child Survival Project that tracks all income and expenses of the project.

A financial sustainability plan will be produced by FOCAS with the assistance of ARHC by December 2000, according to the FOCAS headquarter spokesperson.

1998 Audit:

In 1998, an A133 audit was conducted with an unqualified report from the auditors. (This audit review is ANNEX 9)

3.F. Logistics

3.F.1. What impact have procurement and distribution of EQUIPMENT had on the implementation of the DIP?

The senior staff described the following issues related to equipment (in a group discussion):

- **Computer technology:** There has been “great frustration” with procurement and distribution of equipment. The lack of many pieces of equipment have affected their ability to carry out critical tasks. While the FOCAS office has one MAC and one IBM computer, this equipment is in need of updating. The ARCH specialist cannot send work on disks since either computer does not read them. This has brought about unnecessary stress to the three senior staff as technical information is difficult to obtain. While the IBM computer is in the Petionville office, it is old and the memory is insufficient for a program of this magnitude and complexity.
- **Photocopy Services:** All photocopies (of hand-generated reports and the like) must be physically brought to the FOCAS office for copying by the MEI and OBDC staff . There is no transportation for this activity so the senior administrators must use their own cars to go to the office to perform these tasks. Use of photocopy services off-site is possible but is time-consuming.
- **Computer Printer:** There is one available at the moment in the FOCAS office. Another is needed.
- **Power:** There is no power at the MEI office/clinic site. Because of this limitation, important laboratory functions cannot be conducted as planned in the DIP. OBDC has variable power at the field office/clinic. The staff suggest investing in a solar panel/inverter-battery system.
- **Project Vehicles:** While the project is in possession of a vehicle, it is considered very unsafe and costly to maintain. It is not a practical vehicle for the project has been out of use for 12 of the 24 months of the project to date. The lack of a reliable vehicle has made field trips difficult and has resulted in missed opportunities. Project staff have been forced to use their own vehicles for work-related trips.
- **Communication:** The staff described the difficulties in communication between the office in Petionville and the partner offices. There is no way for the offices to communicate at this time. As problems arise in the field, this has caused a delay in resolving the problem and in service delivery.

The staff has prioritized their needs in the following way:

POWER

VEHICLE

COMMUNICATION SYSTEM

3.F.2. What impact have procurement and distribution of SUPPLIES had on the implementation of the DIP?

The procurement and distribution of supplies has had an effect on the implementation of the DIP.

The "timers" used in the assessment of respiratory rate for the ARI Program were not available through UNICEF as expected. The project had to spend a great deal of money on them in the US. These timers were just purchased in April 1999 causing a delay in the implementation of the program.

The FOCAS program is committed to the distribution of micronutrients to women and children. The correct dose of IRON was finally found in a pharmacy in Port-au-Prince for purchase. The multivitamins needed for pregnant women were just recently purchased in the US in September, 1999.

Although vitamin A is available in Haiti, there were stock-outs in December – February 1999. The County Medical Director, one of the evaluation team members, is aware of this problem.

Educational materials once provided by MSPP are no longer available making IEC programs more difficult to carry out in the field.

On a positive note, the newly produced (MSPP) iodized salt packets are now available for sale.

3.F.3. What logistics challenges will the program face during the remainder of the program?

The problems with lack of oral rehydration packets will be partially solved with the collaborative program between PSI (USAID CS XIII Program) and FOCAS. PSI has a social marketing program for flavored oral rehydration salts that are available for 2.5 gds for 3 packets. They are to be sold for 5 gourdes for 3 packets. FOCAS, MEI and OBDC have given out the packets free of charge to all mothers in the program. There will have to be an administrative decision and new policy established regarding the sale and profit from ORT by health agents and clinic staff.

3.G. Information Management:

Services are provided in MEI and OBDC in a variety of settings: Fixed clinic, mobile clinic (MEI), rally posts and in homes. Summary data are aggregated by month into one FOCAS-level report.

3.G.1. Is there a system in place to measure progress towards program objectives?

Yes, as mentioned previously, the HIS for program inputs is well on its way on a manual basis. Continuing education will assure that the quality of data remain high. The technical report (#2) gives objective-specific monitoring mechanisms that are either in place or planned.

Qualitative data on health education skill by health workers are performed but not other areas in a systematic fashion e.g.: client satisfaction, reports of behavior change, etc.

3.G.2. Is there a systematic way of collecting, reporting and using data at all program levels?

Yes, field data are collected systematically using the child and woman roster, program input statistics sheets, aggregate monthly reports and vital events. Data are collected and collated but not analyzed adequately or disseminated beyond the health agents, USAID and MSPP. (No community feedback yet). In addition, data are not analyzed by rural or peri-urban marginal (slum) area.

3.G.3. How effective is the system?

An assessment of the system at the rally posts and in the record review showed the need for minor corrections (See Annex III for other recommendations). Some health agents commented that the rosters required a great deal of work to maintain. The numbers did not remain on houses after the census effort. Data on women's health requires more vigilance. Processes are not yet institutionalized on the use of data for decision-making. There is no mechanism for monitoring qualitative progress of beneficiaries (there is qualitative monitoring of field staff on selected interventions).

3.G.4. What types of data are generated?

Individual and household data are maintained and aggregate data are reported on all of the Child Survival activities that are quantitative. See the technical report in the beginning of this evaluation for specific data for the intervention areas.

3.G.5. What aggregate data is possible by intervention?

- Number of infants contacted through rally posts;
- Number of infants contacted through home visits;
- Number of children 12-59m contacted through rally posts;
- Number of children 12-59m contacted through home visits;
- Number of rally posts conducted;

- Number/proportion of pregnant women contacted through rally posts;
- Number/proportion of pregnant women contacted through home visits;
- Proportion of children 12-23m fully immunized;
- Number of TT vaccinations given ;
- Number of vitamin A doses given ;
- Number of children dewormed;
- Proportion of children in each nutritional category (i.e., N, M1, M2, M3, K);
- Proportion of mothers educated on key messages (by intervention);
- Proportion of infants contacted who had an illness in the past month (by illness type);
- Proportion of children contacted who had an illness in the past month (by illness type);
- Number of infants, children, and maternal deaths, and deaths of others;
- New and continuing family planning use;

3.G.6. What aggregate data is possible by community activity?

None

3.G.7. Who is involved in collection of data?

Field community health agents, record keepers, and clinic statistician.

3.G.8. Who is involved in analysis of data?

Data cleaning and collation is the job of the nurse supervisor first, then the record keeper, then the PVO program managers and then the FOCAS Program Manager.

3.G.9. Who is involved in the feedback of data?

There is to be a series of quality assurance committees established to use all data collected for feedback and program improvement. These committees are not yet established.

3.G.10. Describe the extent to which the program is using and supporting other existing data collection systems (government)?

The FOCAS programs have worked in the Petionville County for these first 2 years. Reports have been submitted (see copy of MSPP government report in ANNEX X)

3.G.11. How does the program use data to inform management decision-making?

There is a close relationship between program operations and budgetary expenditures. The need for additional staff will be weighed and discussed among all parties in light of budget constraints. In other instances, program needs (such as lack of vitamins or ARI timers) have

brought Haiti-US administrators together to solve program problems at the senior level.

3.G.12. Discuss the purpose, methods, findings and use of any assessments conducted by the program. (focus groups, mini-surveys)

The use of the “factor analysis” exercise that has been introduced by the ARHC Senior technical specialist is an example of an innovative approach to understanding the cultural context of illness behavior. This tool was used in the development of the “pneumonia tool box”. It has been described at length in the DIP.

3.H. Technical and Administrative Support

3.H.1. Discuss the types and source of external technical assistance the program has received to date and how timely and beneficial this assistance has been.

Senior staff assessment has been positive concerning the technical assistance received to date. Annex 11 lists all technical assistance from ARHC and FOCAS to date.

3.H.2. What are the anticipated technical assistance needs of the program in the upcoming two years?

As mentioned previously, staff feel the need for management training and introduction of useful tools to guide their work much as the quality assessment check lists have guided them to excellence in clinical care. Training in financial management for the partner NGOs is needed. As a follow-up to the training received from MACRO international, the senior staff would like this person to return to actually perform the participatory evaluation process so that they might be able to do it alone in the future. TA in the area of the implantation of the HEARTH model or nutritional demonstration foyer is critical since there are many problems at the field level.

3.H.3. Discuss PVO/HQ support of the field program?

The senior staff discussed at length the support that has been received from the US-based staff and consultants. At the same time, they mentioned that “decisions or program promises were made and not kept...” as in the case of communication system (Dr. Robinson) and a vehicle (Mr. Taylor) When asked why FOCAS entered communities that already had resident health agents providing Child Survival services, the response was that that decision was made by MEI and FOCAS chiefs.

The fact that only one of the technical and managerial experts from the US speak French or Creole is seen as an impediment to support for the field. A suggestion was made to hire a translator for US personnel so that the fine nuances of the culture and language do not cause miscommunication in the future.

3.H.4. Approximately how much time has been devoted to supporting this program?

As in the DIP, one visit from the senior manager at ARHC (Mr. Shanklin), quarterly trips from the FOCAS/US program manager, and 63% of the time of the ARHC Senior technical specialist in the first 2 years of the Program.

4. Conclusions and Recommendations

4.1.0 USAID/BHR/PVC

4.1.1. Provide the organizations with final evaluation guidelines based on the DIP;

4.1.2. Maintain the field support through providing expertise (MACRO International consultants) in areas of management and monitoring and evaluation;

4.1.3. Schedule the participatory evaluation model (taught by the MACRO consultant in August 1999) for application with the FOCAS/MEI/OBDC organizations in the year 2000 (when the evaluation questions are not predetermined).

4.2.0. ARHC

4.2.1. Improvement in Program Management: Write a plan for organizational capacity building (in management) for NGOs, FOCAS field and FOCAS HQ, implement plan (including use of management tools for upper-level management and QI training), and assess the plan. Develop a business plan as soon as possible with participation of all levels of staff.

4.2.2. Hearth Model: The CORE USA nutrition-working group may help in resolving the problems associated with the delivery of this implementation. Also, increase number of Volunteer Mothers to a maximum of 10 with 5-7 children each. Do another trial closer in where the staff can supervise the work every day. Try to have ARHC/FOCAS HQ staff participation.

4.2.3. Hearth Training Manual: Engage a consultant (the ARHC Senior Technical Specialist) to

compile all information on working FDN projects in Haiti and write and test a simple, clear, Creole-language manual for field implementation.

4.3.0. FOCAS/USA

4.3.1. Resolve overlap of services: Within three months, FOCAS needs to work something out with the

Baptist Mission. Either the Baptist Mission can pull out of the overlap zone, MEI must pull out, or they must divide up the area amongst them.

4.3.2. Need for reliable vehicles. In past 12 months, the used vehicle worked about 1 month.

4.3.3. Improvement in Program Management: Write a plan for organizational capacity building (in management) for NGOs, FOCAS field and FOCAS HQ, implement plan (including use of management tools for upper-level management and QI training), and assess the plan. Develop a business plan as soon as possible with participation of all levels of staff. Assist the Haiti field staff with its needs for transportation, communication and power. File job descriptions and perform annual performance reviews that are more rigorous, related to job descriptions and with suggestions for improvement. Utilize a translator when budget or program issues are being discussed to prevent miscommunication.

4.3.4. Hearth Model: See above.

4.3.5. Annex III for all other recommendations

4.4.0. FOCAS/HAITI

4.4.1. Revise plan for expansion: Revise the plan within the next month taking into account the solution found for the overlap of services and provides full coverage for primary project areas. Decide whether to expand to secondary project areas.

4.4.2. Hearth Model: See above

4.4.3. Use of Health Information: Give more attention to Mother's registers, more attention to community feedback, and more focus on how to use the data in the HIS. The immediate need is to develop something (e.g., graphs) to help them monitor whether the productivity is adequate (e.g., number of vaccine doses that they should be giving each month, number of children that should be seen at rally posts, etc.). Always send monthly reports to both ARHC and FOCAS/USA representatives.

4.4.5. Sustainability Plan: Investigate additional sources of funding for field activities. Examples include, PSI for rehydration salts and some funds for community mobilization; Food for the Poor for small construction or equipment; other organizations that bring medical supplies into Haiti.

4.4.6. See Annex III for all other Recommendations.

4.5.0. MEI

4.5.1. Resolve overlap of services: Within three months, FOCAS needs to work something out with the Baptist Mission. Either the Baptist Mission can pull out of the overlap zone, MEI must pull out, or they must divide up the area amongst them.

4.5.2. Revise plan for expansion: See above.

4.5.3. Use of Health Information: Give more attention to Mother's registers, more attention to community feedback, and more focus on how to use the data in the HIS. The immediate need is to develop something (e.g., graphs) to help them monitor whether the productivity is adequate (e.g., number of vaccine doses that they should be giving each month, number of children that should be seen at rally posts, etc.).

4.5.4. Increase contact with children during first 30 days after birth.

4.5.5. Increase contact with pregnant women.

4.5.6. Work on ARI Intervention: Look at project in Jeremie to see how they implement ARI interventions. Establish a plan for where and how they will do pneumonia education.

4.5.7. ORS Selling Points: MEI needs to develop a relationship with PSI for the subsidized purchase of ORS packets and the establishment of selling points (ORS outlets).

4.5.8. Annex III for all other recommendations.

4.6.0. OBDC

4.6.1. Revise plan for expansion: See above

4.6.2. Use of Health Information: See above

4.6.3. Increase contact with children during first 30 days after birth.

4.6.4. Increase contact with pregnant women.

4.6.5. Work on ARI Intervention: See above

4.6.6. ORS Selling Points: See above

4.6.7. Annex III for all other recommendations