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Santé pour le Développement et la Stabilité d'Haïti (SDSH)

Quality Basic Health Services Support to Haiti

End of Project Report — August 2007 to September 2012

Contract No. GHS-I-00-07-00006-00

End of Project Report

August 3, 2007 to September 30, 2012

Santé pour le Développement et la Stabilité d'Haïti — Pwojè Djanm
Contract No: GHS-I-00-07-00006-00
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Table of Contents

Acronyms

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral (medicine)
BCC	behavior change communication
CA	Contracts and Administration
CBD	community-based distribution
CBO	community-based organization
CM	community mobilization
CONASIS	*Comité national Comité National d'appui au système d'information sanitaire*
CS	*centre de santé* (health center)
DRI	Direct Relief International
DTP3	diphtheria, tetanus, pertussis, third dose
FBO	faith-based organization
FP	family planning
FY	fiscal year
GUC	grants under contract
HIS	health information system
HIV	human immunodeficiency virus
MIS	management information system
MSH	Management Sciences for Health
MSPP	*Ministère de la Santé Publique et de la Population* (Ministry of Public Health and Population)
NGO	nongovernmental organization
OFDA	Office of US Foreign Disaster Assistance [USAID]
PBF	performance-based financing
PCR	polymerase chain reaction (HIV test)
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMP	Performance Monitoring Plan
PMS	*Paquet Minimum de Services*

PMTCT	prevention of mother-to-child transmission
PNLT	*Programme National de Lutte contre la Tuberculose*
PSPI	*Paquet de Services Prioritaires Intégrés,*
RH	reproductive health
SADA	Service and Development Agency
SCMS	Supply Chain Management System (PEPFAR USAID-administered project)
SDSH	*Santé pour le Développement et la Stabilité d'Haïti*
STI	sexually transmitted infection
TB	tuberculosis
TBA	traditional birth attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	US Government
VCT	voluntary counseling and testing (for HIV)
WHO	World Health Organization
WINNER	The Watershed Initiative for National Natural Environmental Resources (Project)
ZC	*Zone Ciblée*

Executive Summary

In the past five years, Haiti has endured some of the greatest catastrophes in its history: social and political unrest, hurricanes, mudslides, the devastating January 2010 earthquake, and the cholera outbreak that followed. Throughout, USAID's flagship health project in Haiti—*Santé pour le Développement et la Stabilité d'Haïti* (SDSH, Health for Development and Stability in Haiti)—worked toward its goal "to improve the health status of vulnerable populations so that they can become more productive members of society to promote stability within their communities and participate in the economic and social development of Haiti." To this end, SDSH **increased access to basic health care services for nearly half of the national population** through a network of 28 local nongovernmental organizations (NGOs) that operate 81 private health facilities and through 79 public-sector sites in 33 geographical areas (target zones) known as *zones ciblées* (ZCs).

Management Sciences for Health (MSH) implemented SDSH from August 2007 through September 2012 using innovative performance-based financing (PBF) agreements, technical assistance, and integrated health care services rooted in the community. The network—which began and grew under USAID-funded Haiti Health Systems 2004 (HS-2004) and Haiti Health Systems 2007 (HS-2007)—has delivered services to some of Haiti's most vulnerable people, virtually uninterrupted by the countless challenges the country has faced.

Each year, SDSH has helped an **average of 95, 838 people receive HIV tests** and learn their status, has made it possible for **12,649 women on average deliver their child with assistance from a facility-based, skilled provider,** and has reached an average of **489,338 children with nutrition programs.** In the SDSH network, **upwards of 89 percent of infants under one were fully vaccinated** in four of the program's five years. In the final project year, **SDSH increased the number of sites offering antiretroviral therapy** (from 6 to 8) to help mitigate the impact of HIV in Haiti.

To help decentralize health care services and better manage health sector resources, SDSH strengthened the capacity of the *Ministère de la Santé Publique et de la Population* (MSPP, Ministry of Public Health and Population) at the central and departmental levels to perform critical functions such as strategic and work planning, financial management, and clinical supervision. **SDSH mobilized strategic private partners to provide more than US$86 million worth of lifesaving equipment and commodities** to the health facilities in the communities served by the US$81.4-million project's network. Contributions range from biosand filters that provide schoolchildren with potable water to operating room equipment that allows health facilitates to provide women with emergency obstetric care.

SDSH staff and partners suffered personal and professional losses during the unprecedented and devastating disasters that marked the project cycle, but managed to succeed in the face of adversity.

- The unusually destructive hurricane season and lingering floods of 2008 left 160,000 without shelter. Although not designed as a relief project, SDSH's network of facilities and community health agents helped to **efficiently deliver donations from small and large relief organizations or agencies to people and areas in need.** SDSH also helped the MSPP coordinate its response, including a **nationwide epidemiological surveillance plan, water treatment, and the mobilization of disinfection and fumigation specialists** to help control vector-borne and waterborne diseases.
- The devastating earthquake of 2010 killed more than 230,000 people and displaced more than 1.5 million. SDSH staff **quickly resumed project operations** from an employee's home to ensure support to partner NGOs and network sites. Some staff members **worked in partner health facilities delivering emergency clinical services,** and others mobilized to **conduct a detailed post-earthquake needs assessment** that provided the basis for SDSH's contingency plan to reinforce the partners' capacity. SDSH also received several direct grants from partners to provide health services to displaced persons, support reinforcement of damaged infrastructure, assess health services provision in the camps, and provide badly needed pharmaceutical supplies.

Years of generous support and lasting commitment to Haiti have impacted the lives of some of the country's most underserved populations. SDSH, its predecessor projects, and the health facility network they supported have been critical to Haiti's steady and lasting improvements in the health system across public and private sectors.

Introduction

The *Santé pour le Développement et la Stabilité d'Haïti* (SDSH, Health for Development and Stability in Haiti) Project was USAID's flagship health project from August 2007 through September 2012. SDSH's overarching goal was "to improve the health status of vulnerable populations so that they can become more productive members of society to promote stability within their communities and participate in the economic and social development of Haiti." To this end, SDSH **increased access to basic social services for nearly half of the national population**. SDSH supported basic health care service delivery in each of Haiti's ten departments[1] through performance-based financing (PBF) subcontracts with 28 local nongovernmental organizations (NGOs) that operate 81 private health facilities, and with the public sector delivery services through 79 public sites in 33 geographical areas (target zones) known as *zones ciblées* (ZCs).

SDSH helped provide access to the *Paquet de Services Prioritaires Intégrés* (PSPI, Priority Package of Integrated Services), a basic package of integrated health services, for 4,460,896 million people in Haiti's ten departments. The project's first five results areas were developed around components of this services package: improvements in (1) HIV prevention, care, and treatment; (2) tuberculosis prevention, detection, and treatment; (3) maternal health for reduced maternal mortality; (4) child health for reduced infant mortality and malnutrition; and (5) access to and use of family planning, including long-term and permanent methods. Because SDSH worked through private-NGO and public health care facilities, the project's sixth result area focused on improving the ability of the *Ministère de la Santé Publique et de la Population* (MSPP, Ministry of Public Health and Population) to function more effectively at the central and departmental levels.

[1] Haiti is divided into ten administrative units called departments.

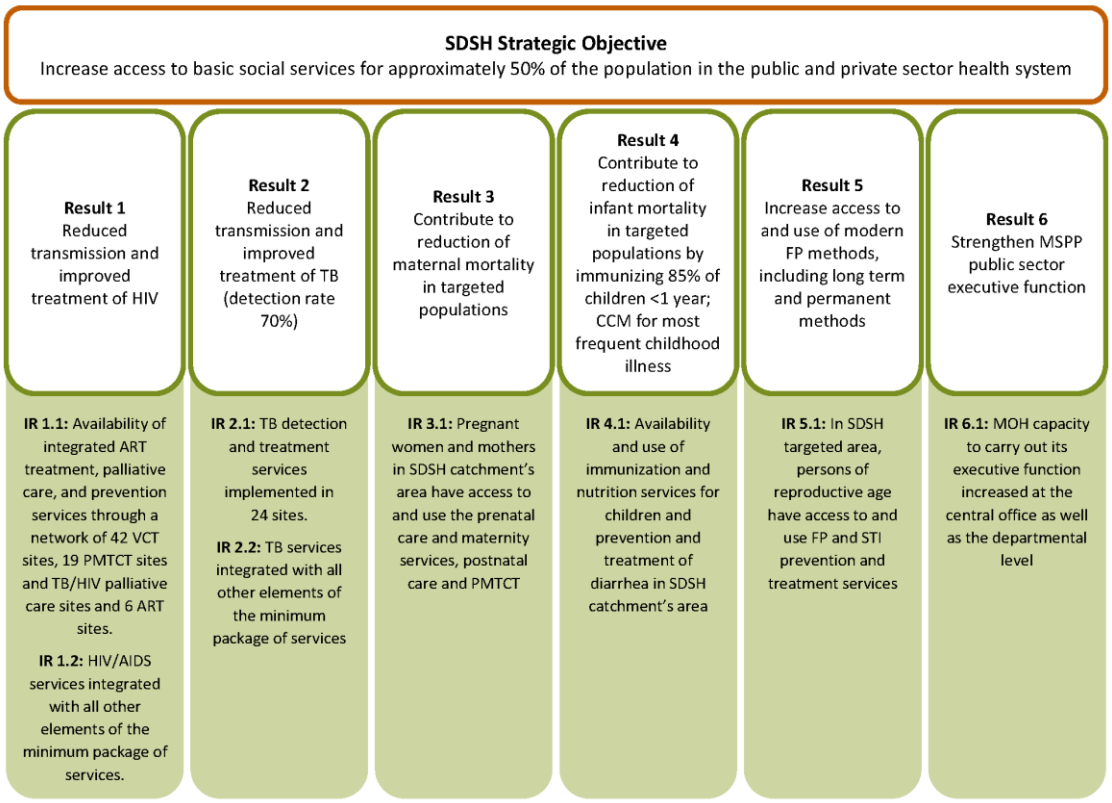

Figure 1: SDSH Results Framework

In support of these results areas, SDSH conducted a number of activities in other domains: grants under contract (GUC) to community-based organizations for grassroots, health-related initiatives; strategic partnerships with private-sector partners to leverage additional resources in pursuit of shared health goals; capacity building to improve financial and administrative systems strengthening at the facility, departmental, and central levels; and infrastructure improvements creating the space for health care delivery and management.

USAID awarded the three-year SDSH project to Management Sciences for Health (MSH) in August 2007. The project was subsequently extended, increasing the life-of-project funding from US$42.5 million to US$81.4 million and changing the completion date to September 30, 2012. SDSH built on the successes and lessons learned from earlier MSH projects, namely Haiti Health Systems 2004 (HS-2004) and Health Systems 2007 (HS-2007). SDSH was differentiated from earlier projects in part by its heightened focus on public-sector institutional strengthening and capacity building, and its expansion of PBF—a model that has proven successful with private-sector NGO partners—to the public sector.

Result 1: Reduced Transmission and Improved Treatment of HIV

Exacerbated by decades of poverty and instability, Haiti's HIV prevalence peaked at 3.6 percent in the mid-1990s and has been approximately 2 percent since the early 2000s. The beginning of the millennium brought awareness, education, and affordable treatment through efforts including those of the MSPP, the US President's Emergency Plan for AIDS Relief (PEPFAR), and various donors. While lower than many countries in sub-Saharan Africa, Haiti's HIV prevalence is the highest in the western hemisphere and has been devastating to thousands of families across the country.

HIV Voluntary Counseling and Testing

Combating stigma and inadequate access, SDSH expanded facility-based voluntary counseling and testing (VCT) for HIV to supported public and private facilities (at least 29 sites each year and 40 sites in the final project year), and provided testing through mobile clinic outreach and events such as *Carnaval* and *fêtes champêtres* (annual celebrations) in cities and villages across Haiti. SDSH-supported providers routinely offered HIV testing during other services such as tuberculosis care and treatment, family planning, and maternal health visits. SDSH made it possible for an average of 95,874 people and 50,662 pregnant women to learn their HIV status every year. In Year 5 alone, 102,305 people and 55,682 pregnant women learned their HIV status. Empowered with this knowledge, individuals could make decisions to protect themselves, their partners, and their children, accessing care and treatment as necessary.

Each site has a lab technician able to perform rapid HIV tests, and who was trained by the USAID-funded Supply Chain Management Systems (SCMS) project to manage stock and medicines. SDSH also supported renovations and provided technical assistance to sites in order to improve overall service organization, patient flow, and resource availability.

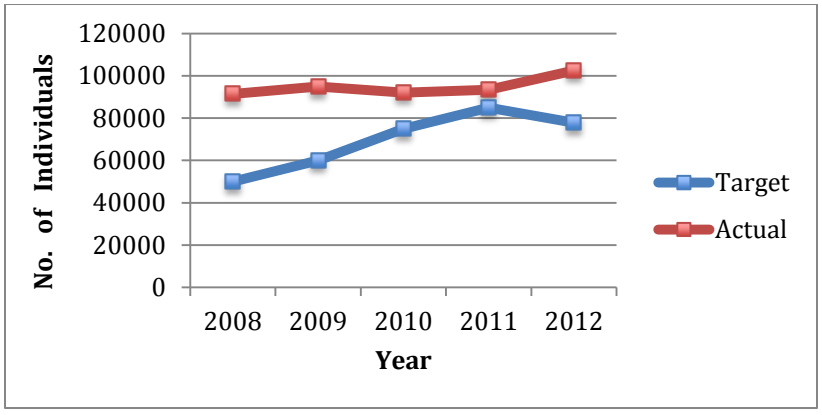

Figure 2: Number of people in the SDSH network who received counseling and testing for HIV and received their test results

HIV Palliative Care and Support

SDSH worked with support groups and other community organizations to reduce HIV-related stigma and discrimination in communities and bring people living with HIV and their children into supportive services such as nutrition, income-generation, and assistance for orphans and vulnerable children. Through networked facilities, patients and families were also linked to psychosocial services and home-visits from social workers, health agents, and other people living with HIV. SDSH facilities provided palliative care to a total of 20,481 individuals at the end of the PY5 period.

During the nation-wide responses to Haiti's devastating 2010 earthquake and 2010–11 cholera outbreaks, community palliative care and support (including assistance to orphans and vulnerable children) dwindled as providers struggled to meet more immediate patient needs. In June 2011, SDSH re-launched community palliative care interventions. Representatives of 26 partner institutions participated in a two-day workshop to refocus their roles and work, based on lessons learned and taking into account the new context. A training workshop was also organized with the support of Measure Evaluation to enable SDSH partners to use the community-based information system for the monitoring and reporting of their activities.

HIV-Tuberculosis Co-infection

Haiti's overwhelming tuberculosis burden—one of the highest in the western hemisphere—is particularly concerning given the number of people living with HIV (PLHIV) also infected with tuberculosis or at risk of Co-infection. (WHO estimates that one-third of the PLHIV globally are also infected with tuberculosis) In the first years of SDSH, other donors and programs were expected to provide tuberculosis services and inputs for patients in SDSH-network catchment areas (see Tuberculosis section). These activities did not come to fruition but SDSH tried to make contributions within its mandate.

SDSH network sites integrated testing and treatment referrals for tuberculosis, and their staff were trained in detecting the two diseases. The percentage of tuberculosis patients who were tested for HIV and received their results increased from 47 percent to 66 percent from year one to year five.

Prevention of Mother-to-Child Transmission

Prevention of Mother-to-Child Transmission (PMTCT) challenges in Haiti include those common in most developing countries: human resource shortages (e.g., most health centers do not have a nurse midwife); powerful stigma, taboos, and traditional beliefs associated with HIV; and logistical and technical barriers to a formal and functional referral and counter-referral system at institutional and community levels. SDSH employed three major strategies to improve

PMTCT in network facilities: (1) strengthen linkages between institutional and community levels to improve follow-up of pregnant and lactating women identified as HIV-positive; (2) increase access to maternal health through outreach such as mobile clinics; and (3) support MSPP in the update of national PMTCT norms and rolling those out through SDSH-network facilities.

Detecting HIV in Newborns

An important aspect of preventing mother-to-child transmission and the first step in improving health outcomes for HIV-positive newborns is early HIV testing for infants known to be exposed to the virus. Since an infant carries its mother's antibodies for as long as 18 months, a test other than the adult HIV test is necessary for newborns. A partnership between SDSH and Caris Foundation made these infant tests possible at network sites offering antiretroviral therapy and prevention of mother-to-child transmission services.

Community health agents and traditional birth attendants (TBAs) were critical in reaching women at the community level, encouraging HIV testing and maternal care (which includes PMTCT), and developing birth and adherence plans for HIV-positive mothers. SDSH network facilities made great strides in helping pregnant women learn their HIV status, particularly through outreach and HIV testing during prenatal visits. In PY5, 55,682 pregnant women learned their HIV status and 795 HIV-positive pregnant women received PMTCT services through the SDSH network. On average, every year 50,662 pregnant women learned their HIV status, and 614 who tested positive received PMTCT services at one of the SDSH network sites. At the end of September 2012, 31 SDSH network sites offered the minimum package of PMTCT according to national and international standards—well above the target of 22.

The project offset the costs associated with prenatal care visits (striving for the standard four appointments) and institutional births by subsidizing transport fees incurred by pregnant HIV-positive women, providing direct support to the birthing institutions, and giving birth attendants a small sum to offset costs they faced—for example, the cost of their time and direct costs associated with referrals and follow-up of the mother and newborn. When HIV-positive women give birth in facilities, providers can help ensure that both mother and newborn receive antiretroviral drugs to prevent HIV transmission.

To reach HIV-positive mothers who gave birth at home, SDSH worked with TBAs to ensure that they could administer antiretroviral medication to HIV-positive mothers and their exposed infants. These *matrons* also checked on the health of mothers and newborns—regardless of their HIV status or exposure—during visits in the first three days after birth. All HIV-positive pregnant women were strongly encouraged to choose an *accompagnateur*—a traditional birth attendant, community health worker, family member, or friend—to accompany the pregnant woman to prenatal health center visits, help administer prophylaxis medication to the mother and help bring the newborn in for a follow-up visit no more than 72 hours after birth.

The project also provided technical assistance to the MSPP to revise PMTCT standards in PY5. The *Direction Sante de la Famille* (Directorate of Family Health) is preparing to print and disseminate these standards as of project close-out in September 2012.

Antiretroviral Therapy

SDSH was designed to focus on HIV prevention and care, but the practical advantages of and critical need for comprehensive antiretroviral treatment (ART) were evident by 2012 when the project, with USAID encouragement, expanded its treatment centers from 6 to 9 in just six months. To improve the quality of care —particularly follow-up—network ART patients receive, SDSH collaborated with GHESKIO to provide trainings and refreshers to health providers, and with SCMS to ensure that medicines and related commodities were continuously available to patients. As a result of these combined interventions, 3,429 people received antiretrovirals from SDSH-network facilities at the end of the PY5 period.

SDSH also strengthened referral systems within the network and collaborated closely with community organizations and resources to provide critical services to HIV patients outside of the clinic. Links with assistance included services such as psychosocial care, support groups, income-generation, clean water, or nutrition counseling.

Result 2: Reduced Transmission and Improved Treatment of Tuberculosis

Haiti bears the largest tuberculosis burden of any country in the Caribbean region: in 2010, the prevalence was 314 per 100,000 people (compared to an average regional prevalence of 36 per 100,000).[2] PLHIV are particularly vulnerable to contracting the disease. Once contracted, mortality rates among HIV-positive patients are considerably higher than those who are HIV negative. SDSH was designed in 2007 to support DOTS implementation for the *Programme National de Lutte contre la Tuberculose* (PNLT, the National Program to Fight Tuberculosis) by helping to ensure tuberculosis prevention, detection, and treatment in the SDSH network. PNLT would supply medicine, training, and equipment to network facilities. At the time, PNLT had substantial Global Fund support, but that support ended in 2010 and no stakeholders were able to fill that gap in the remaining project years. (See the HIV-Tuberculosis Coinfection section for other SDSH efforts related to tuberculosis.)

SDSH worked to mitigate the impact of HIV-tuberculosis coinfection by:

- training personnel for HIV-tuberculosis detection and case management;
- integrating testing and treatment referrals for tuberculosis into supported sites;

[2] WHO Country Health Profile: Haiti. http://www.who.int/countries/hti/en/ Accessed 26 September 2012.

- improving laboratories and the supply system for tuberculosis drugs;
- addressing tuberculosis- and HIV-related cultural barriers and stigma using behavior change communications and community mobilization.

To this end, SDSH trained 52 staff to screen for HIV and tuberculosis and 27 providers in DOTS.

In May 2012, SDSH participated in the joint evaluation of Haiti's TB program effectiveness in collaboration with the PAHO team. Subsequently and with the support from the MSH Global lead on TB, SDSH worked with PNILT and USAID to review the strategies for TB infection control and developed a plan to address case detection and care in Haiti on TB and TB/HIV in the SDSH network. This plan will inform the work on TB during the SDSH II contract.

Result 3: Contribute to Reduction of Maternal Mortality in Targeted Populations

Maternal mortality in Haiti is 300 per 100,000 live births, as compared to 85 across Latin America and the Caribbean.[3] Many factors contribute to this dire reality, including poor maternal nutrition, closely spaced births, and inadequate access to medical care throughout a woman's reproductive life. Yet a number of cultural and behavioral barriers inhibit many women in Haiti from seeking the care they need before, during, and after pregnancy. SDSH worked to overcome these barriers by (1) improving access to and uptake of prenatal and postnatal care, (2) increasing the number of institutional births and the number of attended home births, and (3) expanding access to emergency obstetric care.

Meeting the Needs of Expectant Mothers

The smallest, seemingly insignificant thing can inform a patient's life-or-death decision. When a recent sociological and behavioral survey revealed that many pregnant women said they did not plan to deliver in a health facility because they couldn't afford the dignity of a clean robe or simple sandals to wear after giving birth, SDSH worked with its partner Direct Relief International to provide both in prenatal kits for expectant mothers. In 2008, total institutional deliveries were at 13%. By September 30, 2012, they reached 15%.

To improve access to and uptake of prenatal and postnatal care, SDSH supported intense community mobilization, improved linkages between community health workers and health facilities, revitalized training activities for traditional birth attendants, and encouraged mobile clinics. From the first to the final project year, the percentage of pregnant women in supported facilities that had their first prenatal visit during their first trimester increased from 28 percent to 39 percent; and the percentage of pregnant women that had at least three prenatal visits during their pregnancy increased from 42 percent to 49 percent. Additionally, an average of 45,249 women every year received a home visit from a community health agent or birth attendant within 72 hours of delivery. During this visit, providers made sure that both

[3] Population Reference Bureau. *The World's Women and Girls 2011 Data Sheet*.

mother and newborn were healthy and received antiretroviral medication if the mother was HIV positive.

Skilled birth attendants can identify delivery complications before they become irreversible and help women in labor seek emergency obstetric care, improving birth outcomes for mothers and their newborns. To this end, SDSH encourages all women to deliver in health facilities with a skilled birth attendant. Ninety-two percent of pregnant women in SDSH network facilities had birth plans (a statement of how the mother would like her birth to proceed) in the last project year, up from 10 percent at the end of the first project year and readily surpassing the PY5 target of 75 percent. More than 63,000 women gave birth with assistance from a facility-based skilled attendant during SDSH's five years (see Figure 3). Acquired knowledge, social support, and modest stipends to cover travel costs for pregnant women and birth attendants helped increase institutional deliveries for pregnant women under SDSH.

Recognizing that most women in Haiti deliver at home and have limited access to other options, SDSH promoted *attended* home births as an option for those not able to give birth at a health facility. The program worked with MSPP to recognize the valuable role traditional birth attendants can play in maternal and child health, and helped expand traditional birth attendant skills. These attendants can develop birth plans with pregnant women, recognize signs of a potentially difficult birth, and encourage these women to deliver in health facilities. SDSH also made birth kits available to improve the quality of attended home births. More than 268,000 women had a trained traditional birth attendant present during labor and delivery during the project's five years.

Physical access to health facilities is an obstacle for many patients across Haiti, yet few patients feel an arduous journey to a health facility as acutely as a mother in a difficult or complicated labor. To improve transportation options for women in need of emergency obstetrical care, SDSH promoted context-specific solutions. In some communities, members with access to a vehicle agreed to share responsibility for transferring mothers in labor to facilities. SDSH also supported the purchase or maintenance of boats for communities on Haiti's remote islands. In one high-profile example, SDSH, with a special authorization from the Mission Director, procured a rapid boat to provide ambulance services from the very remote Ile-a-Vache public health center to the hospital on the mainland in Les Cayes.

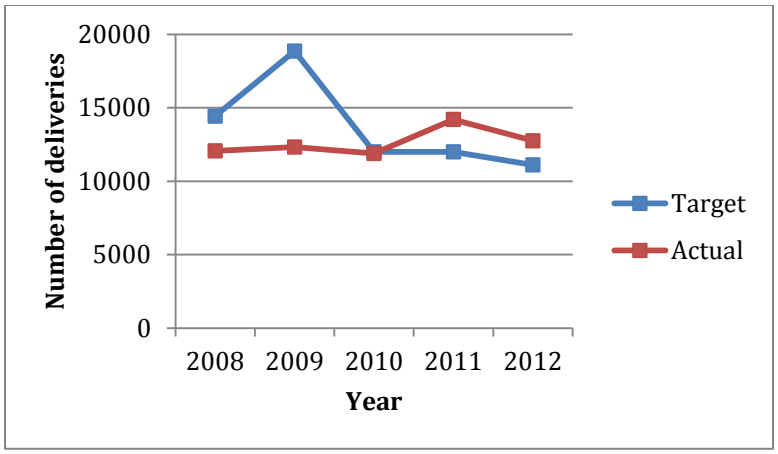

Figure 3: Number of deliveries with assistance of a facility-based skilled birth attendant

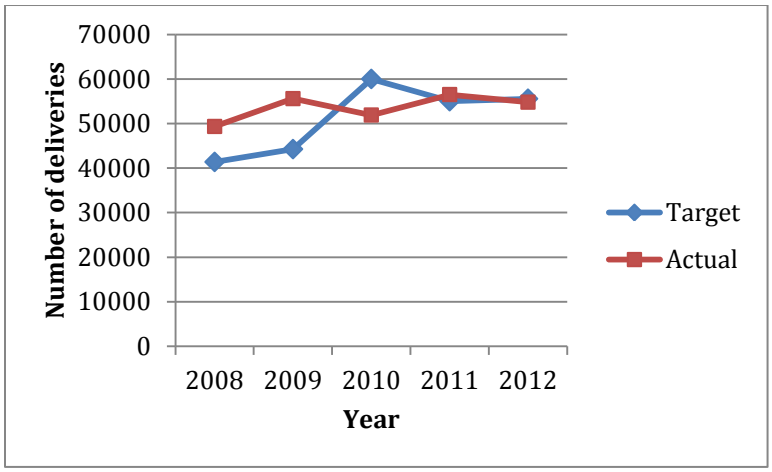

Figure 4: Number of deliveries with assistance of a trained traditional birth attendant

Result 4: Contribute to Reduction of Infant Mortality in Targeted Populations

Children in Haiti face a multitude of preventable and treatable childhood diseases such as measles, diarrheal disease, and pneumonia, and the country's poverty is too often reflected in the poor nutritional state of young children. SDSH promoted and delivered comprehensive under-five immunizations, nutritional counseling and support, and hygiene education.

Through community outreach programs, SDSH helped train 152,744 caregivers in diarrhea prevention and 152,236 in diarrhea management (exceeding each year's targets). The project also trained health providers and agents at facility and community levels to prevent, identify, and manage other common childhood illnesses. Network facilities provided antibiotic treatment to thousands of children with pneumonia, surpassing targets in project year two through five*. The SDSH network also maintained an annual average of 350,860 children under the age of five receiving Vitamin A supplementation.

SDSH inherited HS-2007's successful vaccination coverage but also brought new facilities into the network specifically because their communities were underserved (the *zones ciblées*, or targeted zones). This decreased the average in the first project year, but SDSH's performance-based financing, technical assistance, and strategic partnership support quickly increased vaccination coverage beyond its initial level, and largely maintained it even through the January 2010 earthquake and the cholera outbreak of 2010–2011. After Year 1, vaccinations for children less than one years of age across the SDSH network were at 89 percent or more through the end of the project.

SDSH interventions made great strides in providing essential child health services such as immunization and IMCI, and strived to maintain those services during the intense cholera response in 2010 that pulled resources and attention from primary child health care. In fact, the community network and the existing knowledge and mobilization around diarrheal prevention and care provided a critical foundation for the cholera response.

***Activités Intensives pour la Santé de* l'Enfant 2012**

To reinvigorate immunization results in 2012, SDSH supported the MSPP in organizing and implementing vaccination campaigns with support from USAID, UNICEF, PAHO/WHO, and CIAD. One highlight of these efforts was the 2012 Intensive Child Health Activities (*Activités Intensives en Santé Infantile* – AISE-2012) in April/May 2012. SDSH participated in inter-agency consultation meetings and helped organize field activities through Departmental Directorates. The project also mobilized 1,544 community health agents from across the 160-facility SDSH network; the health agents' contributions were critical to the planning and provision of services during AISE-2012. SDSH also facilitated the donation of five million syringes through Direct Relief International.

*A target for this indicator was not set in PY1

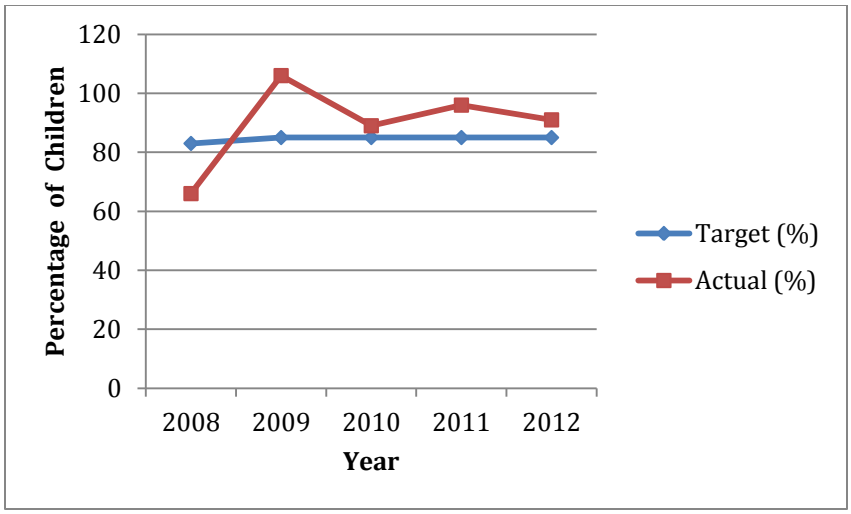

Figure 5: Percentage of children 0–11 months, fully vaccinated

Result 5: Increase Access to and Use of Family Planning Methods

Across Haiti, women suffer the health risks of narrowly spaced pregnancies and families struggle to provide sustenance and opportunity to their children. Family planning can ease the economic burdens and help improve the health of women and their children. To expand availability and voluntary uptake of family planning, SDSH worked to increase knowledge of and access to modern family planning services through community outreach, behavior change communications, and provider education. The project also made family planning services and commodities more accessible through efforts such as mobile clinics and community-based distribution (CBD). SDSH rolled out CBD to the entire project network, and advocated for health agents to provide injectable contraception, making longer-lasting protection available as close to home as possible.

At health facilities, SDSH improved service quality by building the capacity and knowledge base of providers, integrating services, and helping sites maintain a reliable stock and wide range of family planning methods. The number of network sites that offered at least five modern methods of family planning increased from 16 percent to 51 percent over the five-year course of the project. SDSH coordinated closely with the MSH-implemented Leadership, Management and Sustainability (LMS) program that manages family planning commodities for sites in Haiti. In one measure of retention in Year 5, 93 percent of Depo-Provera clients received their next shot on schedule, suggesting accessible services, informed clients, and reliable supplies.

At the outset of SDSH, NGO facilities (previously supported by HS-2007) had contraceptive use rates four times higher than the public sector sites (new to the network and PBF). By the end of SDSH, the rate in public sites improved, and the entire network provided 289,834 couple-years

protection and averaged 31 percent contraceptive use, including nine percent of clients using long term or permanent methods.

SDSH supported MSPP production of several posters and technical guidelines on topics relating to family planning side effects, management of obstetric emergencies, PMTCT, and syphilis. The documents were validated by the Department of Family Health as of project close-out.

Posters

- Initial prenatal assessment
- Targeted prenatal consultation
- Management of severe preeclampsia
- Guideline for the management of preeclampsia
- Active management of third stage of labor
- Reanimation of the newborn
- Management of shock
- Protocol for the management of shock
- Handling of instruments in the context of infection prevention

Technical Guidelines Sheets

- Self-breast exam
- Spotting under combined oral contraception
- Migraine under combined oral contraception
- Hypertension under combined oral contraception
- Amenorrhea under combined oral contraception
- Spotting under oral progesterone contraception
- Amenorrhea
- Bleeding under injectables
- Headache under injectables
- Amenorrhea under injectables
- Bleeding with implants
- Sore head with implants
- Amenorrhea under implants
- Cramping and pain with intrauterine device

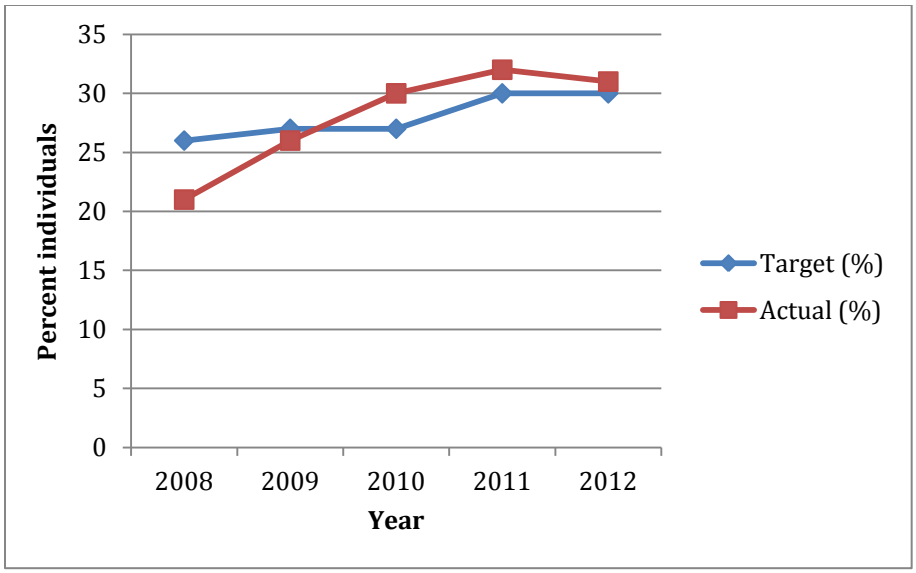

Figure 6: Percentage of people of reproductive age using modern methods of contraception for family planning

Result 6: Strengthen MSPP Public Sector Executive Function

In the years preceding SDSH, social and political instability moved many donors and their projects to work *around* rather than in collaboration with the Government of Haiti and the MSPP. SDSH predecessors HS-2004 and HS-2007 positioned themselves as technical partners to public and private stakeholders in the health sector and distanced themselves from political parties or administrations. As the political context began to stabilize, SDSH continued and expanded the work of HS-2007 by partnering with the MSPP and providing technical and organizational support to the ministry at central and departmental levels. By strengthening the organizational capacity of the MSPP—in particular its executive functions—SDSH supported health system decentralization and helped to reinforce the ministry's leadership and legitimacy.

In collaboration with the MSPP and taking into account national priorities, SDSH supported four main areas of MSPP executive function: (1) strategic planning and decentralization, (2) performance-based financing, (3) governance and financial management, and (4) health information systems (HIS). In these domains, the project interventions were carried out at central and departmental levels as described below.

SDSH Support for National Policy Development

SDSH supported MSPP in planning and executing efforts to streamline technical and policy documents such as behavior change communication and community mobilization (BCC/CM) for the National Program to Fight Sexually Transmitted Infections (STIs) and HIV & AIDS, vaccination promotion for the World Health Organization's (WHO's) Expanded Program on Immunization (EPI), and contributing to the updated Repositioning Family Planning Framework.

Strategic Planning & Decentralization

Improved departmental-level capacity to manage resources and oversee service delivery at the facility level is a cornerstone of successful decentralization of health services in Haiti. SDSH expanded on HS2007's "departmental strategy"—an approach to build capacity and offer mentoring to department-level staff—by placing SDSH staff in each of the 10 departmental directorate offices. These staff worked shoulder-to-shoulder with and offered training and technical assistance to their MSPP counterparts in clinical oversight, strategic planning, financial management, and other management areas. The support helped MSPP staff to develop and implement strategic plans, to purposefully coordinate donors and other health providers, and to participate in joint clinical supervision.

Resources and capacity at the departmental level vary greatly, but SDSH saw improvements in most areas by the end of the project in September 2012:

- All 10 departments were implementing their operational plan.
- Seven (one more than the six originally targeted) health departments had a mechanism to coordinate health-related activities planned by donors in their jurisdiction.
- All 10 departments were implementing service-delivery supervision plans for their facilities.

These efforts helped make the most of critical donor resources and are precursors to sustainable delivery of high-quality services throughout Haiti. The SDSH Project also supported key governance activities by the departmental directorates such as work planning sessions, supervision visits, training, and coordination meetings.

As part of institutional capacity building, SDSH procured computers, printers, and copiers for the ten Departmental directorates towards the end of the project, to continue strengthening MSPP's financial management system at the Departmental level.

Performance-Based Financing

To improve primary health care in a system lacking both resources and the ability to deliver adequate services, MSH piloted PBF in 1999 under the USAID-funded Haiti Health Systems 2004 (HS-2004). Funding for facilities was often inadequate, and many well-intentioned NGOs lacked the capacity to effectively plan and manage their meager resources. Rather than paying for inputs or making grants to institutions with minimal accountability, PBF tied reliable funding to verifiable reporting and actual services delivered. By the end of SDSH in late 2012, the project managed performance-based contracts with 28 NGOs running 81 health care facilities across Haiti's ten departments. A similar performance-based mechanism was

put into place in March 2010 to fund 79 public-sector facilities in the designated *zones cibleés.*
An independent study commissioned by MSH headquarters confirmed that PBF helped to improve health care delivery in Haiti.[4] Examining data (2008 to 2011) from 27 NGO-managed facilities in the SDSH network, the study found that

- Performance-based incentives delivered by SDSH increased the quantity of key services by 39 percent more than training and technical assistance alone;
- The increase in services for children younger than one year and for pregnant women were statistically significant at a range of 1.7 to 2.2 times baseline rates;
- Incentives were more effective and less expensive than training and technical assistance alone.

Over the years, providers and managers noted that PBF influenced a shift in how they approached their work, focusing on results, cost-effectiveness, and accountability, and emphasizing building capacity to maintain a higher level of sustained functioning. PBF helped each site receive the technical and material resources that it needs to deliver crucial results. Additionally, the collection and careful documentation of patient data required for PBF reporting also helps providers improve care for their patients and supports health information systems.

The MSPP plans to make PBF a national policy and is looking to the SDSH model with increased emphasis on quality.

SDSH staff have become globally respected experts for their work designing and implementing PBF in Haiti. In July 2010, SDSH staff participated in a national conference on PBF organized by MSPP with OMS/PAHO, the World Bank, and USAID. SDSH presented the experiences, alternative models, and lessons learned during more than 10 years of USAID-funded health programs in Haiti. A film on MSH PBF experience in Haiti was presented in September 2010 at a meeting organized by the Clinton Global Initiative (CGI) in Haiti, and also at the CGI annual meeting in New York City.

Financial Management

Decades of underfunding and neglect had left the MSPP with limited systems or skills to effectively manage even modest funds. MSH began providing financial management support to MSPP (central and departmental levels) under HS-2007, and expanded those efforts under SDSH. With improved financial management systems, MSPP will be better positioned to directly receive US government funding and to successfully manage performance-based contracts with public and private health facilities; these are both near-term MSPP goals.

[4] Zeng, W., M. Cros, K. Dilley, and D.S. Shepard. "Impact of performance-based financing on primary health care services in Haiti," Health Policy and Planning (forthcoming).

SDSH helped the MSPP to improve its overall financial systems, to start using appropriate accounting software, and to train staff to better manage and audit funds. The central MSPP office and nine of the ten departments were equipped with modern financial and accounting management software systems (Peachtree and QuickBooks, respectively). Furthermore, the SDSH supported the development of a financial management manual. These investments will help the Ministry of Finance in the process of standardization of financial management systems for the MSPP.

Toward the end of SDSH, the project supported the MSPP to conduct a cost and revenue analysis for the basic package of essential health services in Haiti. This effort was designed to help the MSPP understand the actual costs of basic health services, and to provide a rationale for evidence-based budgeting and financing and management of health care service delivery through performance-based contracting mechanisms. Preliminary SDSH findings revealed a wide variation of data, much of which seemed to be linked to differing and hard-to-predict health uptake in different populations. SDSH gave the data set to MSPP for further analysis. To support MSPP participation in or leadership of future costing exercises, SDSH trained 10 MSPP staff to use the CORE Plus costing tool. Support to the MSPP is expected to continue under the Leadership, Management and Governance (LMG) project that is also funded by USAID and implemented by MSH, and will help the MSPP roll out nationwide PBF and enable the public sector to improve social services through results-based management.

Health Information Systems

To support the MSPP's health information systems (HIS)—a key component of any functional health system—SDSH worked at central, departmental, and facility levels. SDSH played an important role in the central *Comité National du Système d'Information Sanitaire* (CONASIS, or Committee for the Support of the Health Information System). The program helped the MSPP to design indicators and tools (for data collection and reporting), reporting plans, and data analysis methods; SDSH also supported MSPP in drafting an HIS manual for Haiti. Within the SDSH network, the project provided program-specific trainings to staff so they could better collect and report data, and make data-driven decisions at site and departmental levels.

In response to changing demographics such as population shifts due to the January 2010 earthquake, SDSH modified the application used to track service delivery results and worked with Departmental Technical Advisors and NGO and *zone ciblees* partners to adjust Year 5 project plans (targets, payment schedules, etc.) accordingly. The project also collected GPS coordinates for all facilities to accurately map the SDSH

> USAID and SDSH conducted a joint data quality assessment in PY5 and observed no major weaknesses that could impact the reliability of SDSH network data. Reliable data helps decision-makers at all levels better serve patients through improved clinical care, site management, supervision, budget allocations, and improved national guidelines and policies.

network. The SDSH network produced high-quality data for the HIS: monthly data reports from each site (required for PBF) fed into the project's monthly progress reports and into the nationwide HIS. The SDSH network provided nearly half of Haiti's population with access to health care, so these contributions to the national data set are noteworthy.

SDSH Responding to Disasters

Development work in Haiti requires implementers to plan for the unexpected and respond to the unimaginable. During the SDSH project, three events challenged our work as rarely—if ever—before.

2008's Hurricane Season

During a few short weeks in Haiti during 2008, four back-to-back hurricanes and tropical storms—and lingering floods—hit Haiti, leaving an estimated 160,000 people without shelter, and severely damaging already-fragile infrastructure. Although not designed as a relief project, SDSH's network of facilities and community health agents helped to efficiently deliver donations from small and large relief organizations or agencies to people and areas in need. SDSH also helped the MSPP to coordinate its response, including a nationwide epidemiological surveillance plan, water treatment, and the mobilization of disinfection and fumigation specialists to help control vector-borne and waterborne diseases.

January 12, 2010 Earthquake

January 2010's devastating earthquake in Haiti killed more than 230,000 people, displaced more than 1.5 million, and affected the entire nation. Already-fragile infrastructure was destroyed and demands for emergency trauma and mental health services placed additional burdens on health facilities. Catchment populations also changed dramatically as displaced citizens moved into camps or migrated outside the earthquake impact zone. The SDSH network was forced to adapt almost overnight to dramatic changes in their patient population and service demands in order to quickly re-establish health delivery systems. USAID was not able to provide additional funding to SDSH specifically to respond to the emergency.

The SDSH office was damaged in the quake and SDSH staff—facing deep personal losses and trauma themselves—quickly resumed project operations from an outdoor porch at one employee's home to ensure that partner NGOs and network sites would have the support they needed. Some staff members worked in partner health facilities delivering emergency clinical services, and others mobilized to conduct a detailed post-earthquake needs assessment of nearly all SDSH sites. This rapid assessment provided the basis for SDSH's contingency plan to reinforce the partners' capacity and by March 2010, the team began to see improvements. SDSH also received several direct grants from partners to provide health services to displaced persons,

support reinforcement of damaged infrastructure, assess health services provision in the camps, and provide badly needed pharmaceutical supplies.

Along with the staggering loss, the earthquake also served as a much-needed call to action. Health care reform could no longer be delayed and needs assessments called for billions of dollars to rebuild infrastructure, strengthen human resources, and secure supply chains. SDSH built—and SDSH II will continue to build—on this vital chance to make change.

Other Domains

Grants Under Contract

Envisioned as small grants (about US$5,000) for community-identified and led initiatives that support health care services and healthy behaviors—and, by extension, strengthen decentralization—the grants under contract initiative built on project community mobilization efforts that reached back as far as HS-2004. The program started slowly while USAID explored mechanisms through which to issue the funds and SDSH worked with communities and MSPP representatives at central and departmental levels to build consensus and raise awareness of this new program. Additionally, the 2010 earthquake put all nonessential activities on hold temporarily. SDSH made eight awards to umbrella organizations (reaching 43 community-based organizations across eight communes) under the first phase (April to September 2011) and 12 under the second (February 2012); as of September 2012, 142 small community organizations in 20 communes participated in the grants under contract program and received a total of US$532,320.

Popular grant initiatives included efforts to improve access to potable water and sanitation; to make physical improvements at health centers; and to support community education about hygiene and HIV prevention. Unique programs included a cervical-cancer screening program in Corail and the construction of 50 market tables to allow for more hygienic displays in a Petit Trou de Nippes fish market. With SDSH support, umbrella community organizations also improved their capacity to write proposals, design work plans, supervise activities, and manage funds, improving their chances for receiving other grants from other donors to continue their work.

To review progress and give the two groups (Phase 1 and Phase 2 grantees) a chance to share experiences with the GUC program, SDSH hosted a workshop in February 2012. At that workshop, representatives from participating community-based organizations expressed their satisfaction with the program and associated coaching, but also that they particularly appreciated choosing their own interventions for the grant. SDSH staff noted that the experience taught them to better recognize that even the poorest and most remote communes may have dynamic leaders, the ability to contribute time or some material resources, and ideas to solve their own development challenges.

Strategic Partnerships

To effectively leverage the US government's investment through SDSH, the project was designed to include leveraged contributions in kind or in cash (20 percent, or US$8.5 million, for the first three years). The global economic crisis and riots over rising food prices in 2008 (in which many private-sector businesses in Les Cayes and Port-au-Prince were attacked) made direct fundraising nearly impossible. In response, SDSH adapted and cultivated partnerships to solicit material donations consistent with SDSH's mission and the needs of the country, rather than cash. The project gathered more than US$86 million worth of commodities and other complementary support—*ten times* the initial goal.

Highlights from SDSH strategic partnerships included

- making clean water available in 1,767 schools and orphanages, 244 health sites, and 1,071 households (at "point of use")—Pure Water for the World (PWW)
- donating pharmaceuticals, materials, and equipment to health facilities and prepositioning emergency hurricane kits in five particularly vulnerable departments—Direct Relief International (DRI)
- providing early infant diagnosis (through DNA-PCR testing) of infants born to HIV-positive mothers—Caris Foundation

SDSH and DRI: Complementary Missions, Synergistic Impact

Introduced to SDSH by network partner Konbit Sante, Direct Relief International (DRI) solicits many of its material donations directly from manufacturers and brings resources upon request to areas and facilities in need of that specific contribution. In the aftermath of four consecutive hurricanes or tropical storms battering Haiti in 2008, DRI and SDSH first collaborated to distribute relief supplies throughout Haiti and went on to regularly preposition relief supplies near areas typically affected by seasonal storms and flooding.

The partnership came to fruition after the 2010 earthquake in Haiti during which SDSH worked with USAID to facilitate customs clearance for relief and rebuilding supplies, and helped DRI distribute them to areas in need. The MOU established between DRI-Konbit Sante and SDSH for the earthquake response was specifically drafted to support hospitals and health facilities both within and outside of the SDSH network. This collaboration brought more than US$54 million worth of funding and goods to Haiti within weeks of the quake. DRI also provided continuous and direct support (capacity building) to SDSH partners including Konbit Sante and Hôpital Universitaire Justinien in Cap-Haïtien.

Infrastructure and Renovation Work

In response to needs assessments, SDSH managed various degrees of renovations at nearly all network facilities; improvements ranged from basic repairs such as mending fences or wall cracks, to expanding private counseling or laboratory spaces for better service quality, to improving sanitation and facility staff living quarters. Where appropriate, SDSH leveraged strategic partnerships to drive or complement the improvements. For example, DRI supported improvements to maternity departments in Saint Raphael health center and Hôpital de Bienfaisance.

Renovation of Four ARV Sites

SDSH issued Request for Proposals (RFPs) to recruit an engineer consultant to supervise the renovation of four potential ARV service delivery sites: AME-SADA Matheux, l'Hôpital Claire Heureuse, Pierre Payen, and La Fossette health centers. The selected candidates (SONED, Entreprises Therassa and GTC) signed consultant agreements and completed renovations of all four sites by the end of the project. It is important to note that it was not possible to activate ARV services at SADA Matheux as planned due to different understanding of associated costs between the management of SADA and SDSH. Nevertheless, the renovated laboratory facility and additional energy sources supported by Tetra-Tech for the lab will serve the new B+ PMTCT program expected to grow at all sites. The ARV sites of l'Hôpital Claire Heureuse, Pierre Payen, and La Fossette health centers are functional bringing the total number of ARV sites to 11 by the end of the project in September 2012.

Conclusion

SDSH built upon 15 years of MSH work in Haiti and generous support from the American people, expanding and adapting to the needs of those who were always our priority: the people of Haiti. Children reached their first and fifth birthdays because of vaccination services and education for their family and health caregivers about preventable diarrheal and respiratory diseases. Mothers survived complicated deliveries, chose to space future pregnancies, and accessed prenatal and obstetric care when they did become pregnant. Women and men discovered their HIV status, received care and treatment if they were positive, and learned to protect themselves from HIV infection if they were negative. And all of this continued in spite of political struggles, numerous hurricanes, an alarming outbreak of cholera, and an earthquake whose effects are still visible around nearly every corner. The progress is remarkable, yet the remaining need is undeniable. SDSH has strengthened the very foundation of Haiti's health system by establishing and reinforcing results-focused, community-based health care services. Network facilities and providers have evolved to manage greater resources and produce greater results. As PBF is taken to scale in Haiti and lessons learned through MSH's long years in the country are applied, the health system—and all of Haiti—will thrive.

Annexes

Annex A: SDSH Service Institutions and Services, and Sites by Department

Annex B: SDSH Program Results as of 30 September 2012

Annex C: Performance Bonuses for 2011 - 2012 by Institution

Annex A: SDSH Service Institutions and Services, and Sites by Department

SDSH List of Service Institutions and Services, and Sites (PPS) by Department

NGOs													
					Services Offered								
Departments	**NGOs**	**Sites / PPS**	**Commune**	**Population 2011-2012**	Maternal Health	Child Health	Family Planning	Voluntary Counseling and Testing	Palliative Care	ARV	PMTCT	TB (Diagnostic & Treatment)	TB (Treatment)
Artibonite	**HAS**			**114,772**									
		Deschapelles	Verrettes	33,623	√	√	√					√	
		Liancourt	Verrettes	43,522	√	√	√						
		Tienne	Verrettes	15,474	√	√	√						
		Bastien	Verrettes	22,153	√	√	√						
	HCH			**151,071**									
		Claire Heureuse	Dessalines	16,118	√	√	√	√	√		√	√	
		La Croix	Dessalines	21,362	√	√	√						
		Célio	Dessalines	20,772	√	√	√						
		Niel	Dessalines	23,506	√	√	√						
		Déseaux	Dessalines	25,288	√	√	√						
		Poste Pierrot	Dessalines	7,644	√	√	√						
		Grande Hatte*(Act. Comm.)	Dessalines	7,644	√	√	√						
		Coupe-à-L'inde	Dessalines	7,644	√	√	√	√					
		Sanoix	Dessalines	21,090	√	√	√						
	Ppayen	CS de Pierre Payen	Saint Marc	**35,748**	√	√	√	√	√		√	√	

				72,176									
	Medishare	Marmont	Hinche	16,712	√	√	√						
		Casse	Thomonde	55,464	√	√	√						
				48,298									
Centre	**SAVE**	Bourg de Maïssade	Maissade	15,850	√	√	√	√	√		√	√	
		Ossenande	Maissade	12,445	√	√	√						
		Cinquième	Maissade	7,887	√	√	√						
		Selpêtre	Maissade	12,116	√	√	√						
				167,611									
	HHF	Klinik Pèp Bondyé	Jérémie	137,997	√	√	-	√	√		√		
		Klinik St Joseph	Jérémie	29,614	√	√	-						
G'Anse	**Ste Hélène**	CS de Ste Hélène	Jérémie	**37,525**	√	√	√	√	√		√		
	L.Coicou	CS Léon Coicou	Abricots	**12,364**	√	√	√					√	
	AEADMA	CAL de Dame Marie	Dame Marie	**29,668**	√	√	√	√	√	√	√	√	
				72,513									
	CBP	Hôp. de Pignon	Pignon	38,490	√	√	√	√	√	√	√	√	
				0									
				0									
Nord		CS La Victoire	La Victoire	9,376	√	√	√						√
		CS Ranquitte	Ranquitte	24,647	√	√	√					√	
	Dugué	CMC Dugué	Plaine du Nord	**63,516**	√	-	√	√	√		√		
	CDS Nord	CS La Fossette	Cap-Haïtien	**138,251**	√	√	√	√	√		√	√	
	Konbit Sante	Fort St Michel	Cap-Haïtien	**41,951**	√	√	√					√	
				173,245									
N'Est	**CDS N'Est**	Hôp.de Fort Liberté	Fort-Liberté	32,739	√	√	√	√	√	√	√	√	

		CMS Ouanaminthe	Ouanaminthe	101,297	√	√	√	√	√	√	√	√	
		CMS Mont Organisé	Mont-Organisé	20,324	√	√	√					√	
		Disp. Capotille	Capotille	18,886	√	√	√						√
N'Ouest	**Beraca**	CAL de Beraca	Port-de-Paix	**44,579**	√	√	√	√	√	√	√	√	
Sud	**La Fanmy**	Cl. La Fanmy	Cayes	**33,918**	√	-	√	√					
	MEBSH			**72,301**									
		Plaisance	Plaissance	13,183	√	√	√						
		Labiche	Cavaillon	17,468	√	√	√						
		Changieux	L'Asile	8,358	√	√	√						
		Bonne Fin	Cavaillon	5,810	√	√	√	√	√		√	√	
		Marc	Cavaillon	4,308	√	√	√						
		CS Lumière	Cayes	23,174	√	√	√	√	√	√	√	√	
Sud'Est	**Sacré Coeur**	CS Sacré Coeur	Thiotte	**31,845**	√	√	-						
Ouest	**St Paul**	CS St Paul	Arcahaie	**36,949**	√	√	√	√	√		√	√	
	Filles Charité	CNSRR	Cité Soleil	**48,885**	√	√	-	√					
	FONDEFH			**579,797**									
		CS Cité Canada	Port-au-Prince	60,799	√	√	√					√	
		Cl.Co. Canapé Vert	Port-au-Prince	54,043	√	√	√					√	
		Cl.Co.Martissant	Port-au-Prince	135,109	√	√	√	√	√		√	√	
		CS Bizoton	Carrefour	33,778	√	√	√					√	
		CS ADCEF	Port-au-Prince	54,043	√	√	√						
		CS Main Tendue	Carrefour	33,778	√	√	√						
		CC Delmas 75	Delmas	54,043	√	√	√	√	√		√	√	
		Pétion Ville	Pétion-Ville	74,313	√	√	√						
		Ste Elizabeth	Port-au-Prince	54,043	√	√	√						
		CS Morne	Pétion-Ville	25,850	√	√	√						

		Lazarre											
	FOSREF			**348,286**									
		CEGYPEF	Port-au-Prince	149,930	√	-	√	√			√		
		C.Christ-Roi	Delmas	112,138	√	-	√	√					
		C.Solino	Delmas	86,218	√	-	√	√					
	Fermathe			**59,283**									
		Hôp.de Fermathe	Kenscoff	29,581	√	√	√	√			√	√	
		Disp.Greffin	Pétion-Ville	14,206	√	√	√						
		Disp.Robin	Pétion-Ville	8,891	√	√	√						
		Disp.Bolosse	Kenscoff	6,604	√	√	√						
	ICC Grace	ICC Grace	Delmas	**69,784**	√	√	√	√	√	√	√	√	
	OBCG	CS OBCG	Carrefour	**64,080**	√	√	√	√					
	SADA			**122,872**									
		Matheux	Arcahaie	61,726	√	√	√	√	√		√	√	
		Source Matelas	Cabaret	18,247	√	√	√						
		Bellanger	Cabaret	25,787	√	√	√						
		Fonds Baptiste	Arcahaie	17,112	√	√	√						
	Ste Croix			**167,682**									
		Hop Ste Croix	Léogane	55,795	√	√	√						
		Beausejour	Léogane	2,882	√	√	√						
		Centre M. Infantil	Léogane	40,664	√	√	√						
		Darbonne	Léogane	35,978	√	√	√						
		Fonds d'Oies	Léogane	7,628	√	√	√						
		Palmiste a Vin	Léogane	10,870	√	√	√						
		Petit Harpon	Léogane	5,472	√	√	√						
		Trouin	Léogane	8,392	√	√	√						
	L.Bontemps	CS L.Bontemps	Croix des Bouquets	**42,866**	√	√	-	√				√	

	CDS Ouest	CS PPC	Delmas	**29,794**	√	√	√					√	
				96,194									
	OBDC	CSL Grenier (Laboule 12)	Petion-Ville	16,358	√	√	√						
		CSL Laboule	Petion-Ville	16,516	√	√	√						
		CSL Jalousie	Petion-Ville	63,320	√	√	√						
Total NGOs	**28 NGOs**	**81 sites**		**3,007,821**									

ZONES CIBLEES

Departments	**Zone Ciblees**	**Sites / PPS**	**Commune**	**Population 2011-2012**	Maternal Health	Child Health	Family Planning	Voluntary Counseling and Testing	Palliative Care	ARV	PMTCT	TB (Diagnostic & Treatment)	TB (Treatment)
Artibonite	**Gonaïves**			**167,933**									
		Raboteau	Gonaives	28,680	√	√	√	√			√	√	
		K-Soleil	Gonaives	27,526	√	√	√					√	
		La Branle	Gonaives	10,618	√	√	√						
		Bayonnais	Gonaives	22,700	√	√	√						
		Bassin	Gonaives	50,052	√	√	√						
		Poteau	Gonaives	15,369	√	√	√						
		Pont Tamarin	Gonaives	12,989	√	√	√						
	St Michel			**112,791**									
		CAL St Michel	St. Michel	21,234	√	√	√	√	√	√	√	√	
		PS Lattalaye	St. Michel	11,455	√	√	√						
		PS Platana *(Act. Comm.)	St. Michel	11,228	√	√	√						
		Camathe	St. Michel	8,885	√	√	√						
		Marmont	St. Michel	16,023	√	√	√						

		Bas de Sault	St. Michel	9,937	√	√	√						
		Lermithe	St. Michel	8,226	√	√	√						
		Lacidras	St. Michel	12,108	√	√	√						
		Lalomas	St. Michel	13,694	√	√	√						
	Marmelade	CS De Marmelade	Marmelade	**29,587**	√	√	√	√	√		√	√	
	Grande Saline	Bérée de Drouin	Grande Saline	**17,698**	√	√	√						
Centre	**Belladère**			**68,054**									
		Hôp. de Belladère	Belladère	46,147	√	√	√					√	
		Disp.de Baptiste	Belladère	17,049	√	√	√					√	
		Disp.de Croix Fer	Belladère	0									
		Disp. Roy Sec	Belladère	4,858	√	√	√						
	Cerca la Source			**48,983**									
		Centre de Cerca La Source	Cerca-la-Source	40,161	√	√	√					√	
		Disp.de Tilory	Cerca-la-Source	8,822	√	√	√					√	
	Savanette			**36,146**									
		Centre de Savanette	Savanette	29,008	√	√	√					√	
		Disp. De Colombier	Savanette	7,138	√	√	√						
G'Anse	**Abricot**	CS Abricots	Abricots	**19,885**	√	√	√	√	√		√	√	
	Corail	CS de Corail	Corail	**24,085**	√	√	√					√	
Nippes	**L'Azile**			**22,569**									
		CS de L'Azile	L'Azile	13,046	√	√	√	√	√		√	√	

		Disp. Changieux	L'Azile	5,310	√	√	√						
		Disp.Fleurant *	L'Azile	0									
		Disp. Morisseau	L'Azile	4,213	√	√	√						
	Petit Trou			**30,166**									
		CS Petit Trou	Petit Trou	25,267	√	√	√	√			√	√	
		Disp. Grand Boucan	Petit Trou	4,900	√	√	√						
	Anse A Veau			**46,618**									
		CS Jules Fleury	Anse à Veau	18,988	√	√	√	√	√		√	√	
		Disp. Arnaud	Anse à Veau	17,456	√	√	√					√	
		Disp. St Yves	Anse à Veau	10,173	√	√	√						
Nord	**Acul**			***52,494***									
		CS la Nativité	Acul du Nord	*10,499*	√	√	√					√	
		Disp.Camp Louise	Acul du Nord	*6,824*	√	√	√						√
		Disp.Grison Garde	Acul du Nord	*7,349*	√	√	√						
		Disp.La Bruyère	Acul du Nord	*10,499*	√	√	√						
		Disp.de Pillatre	Acul du Nord	*10,499*	√	√	√						
		Disp. Tovar	Acul du Nord	*6,824*	√	√	√					√	
	Dondon	CS Dondon		**30,787**	√	√	√					√	
	St Raphaël	CS St Raphaël		**47,825**	√	√	√					√	
	Borgne			***62,835***									
		CAL de Borgne	Borgne	*15,709*	√	√	√					√	
		Disp.Ptit Bourg Borgne	Borgne	*47,126*	√	√	√						

	Mombin Crochu			**33,695**									
		CS Mombin Crochu	Mombin Crochu	13,886	√	√	√					√	
		Disp.Bois de Laurence	Mombin Crochu	19,809	√	√	√						√
	Ste Suzanne			**27,291**									
		Disp.de Ste Suzanne	Sainte Suzanne	13,646	√	√	√						√
N'Est		Disp.de Dupity	Sainte Suzanne	13,646	√	√	√					√	
	Disp des Perches	Disp des Perches	Perches	**11,064**	√	√	√						√
	Cs de Carice	CS de Carice	Carice	**13,141**	√	√	√						√
	Vallières			**22,849**									
		Disp.de Vallières	Vallières	9,825	√	√	√					√	
		Disp.de Grosse Roche	Vallières	13,024	√	√	√						√
	La Tortue			**34,361**									
		Ntre Dame des Palmistes	La Tortue	19,088	√	√	√	√			√	√	
		CS Marie Curie	La Tortue	3,339	√	√	√						
		Disp.Aux Plaines	La Tortue	2,194	√	√	√						
N'Ouest		Disp. de La Vallée	La Tortue	3,626	√	√	√						
		Disp.de Mare Rouge	La Tortue	2,795	√	√	√						√
		Disp.de Méyance	La Tortue	3,319	√	√	√						
	Baie de Heine			**24,096**									
		CS Baie de Henne	Baie de Henne	2,807	√	√	√					√	

		Disp.Citerne Remy	Baie de Henne	2,415	√	√	√						
		Disp.de Dupré	Baie de Henne	6,261	√	√	√						
		Disp.de La Source	Baie de Henne	6,343	√	√	-						
		Disp.de Petite Rivière	Baie de Henne	6,269	√	√	√					√	
	Anse A Foleur			**26,587**									
		CS Anse à Foleur	Anse-à-Foleur	13,577	√	√	√					√	
		Disp.de Côtes de Fer	Anse-à-Foleur	5,423	√	√	√						
		Disp. de Dity	Anse-à-Foleur	7,588	√	√	√						
Ouest	**Belles Fontaines**	Belles Fontaines *(Act. Comm.)	Croix des Bouquets	**44,945**	√	√	√						
	Cornillon			**66,113**									
		CS Cornillon	Cornillon	66,113	√	√	√					√	
		CS St Vincent de Paul	Cornillon	0									
		CS St Pierre	Cornillon	0									
	Bel Air	CS de Bel Air	Port-au-Prince	**73,328**	√	√	√						√
	St Martin	CS de ST Martin	Delmas	**73,328**	√	√	√						√
	***Trou d'Eau/Crochu**	Trou d'Eau/Crochu *(Act. Comm.)		**36,665**	√	√	√						√
	Tayfer	Disp.Tayfer	Carrefour	**36,665**	√	√	√						√
Sud	**Les Anglais**	CAL de Les Anglais	Les Anglais	**30,283**	√	√	√	√			√	√	
	Ile A Vache	CAL de Ile A	Ile-à-Vache	**12,070**	√	√	√	√	√		√	√	

		Vache										
			68,138									
Sud'Est	**Bainet**	CS de Bainet	Bainet 22,440	√	√	√					√	
		Disp. de saurel	Bainet 8,476	√	√	√						
		Disp. de Bahot	Bainet 9,598	√	√	√						
		Disp.de Chomeille	Bainet 5,944	√	√	√						
		Disp.Brézilienne	Bainet 8,749	√	√	√						
		Disp.Bras de gauche	Bainet 5,161	√	√	√						
		Disp. Oranger	Bainet 7,769	√	√	√						
Total ZC	**33 zones ciblées**	**79 sites**	**1,453,075**									
NGO+ZC		**160 sites ou PPS**	**4,460,896**	**164**	**159**	**158**	**38**	**25**	**8**	**31**	**58**	**12**

Annex B: SDSH Program Results as of 30 September 2012

TARGETS AND RESULTS OF SDSH BY AREA PROGRAMMATIC
PERIOD: 2008-2012

Indicator Codes	Performance Indicators	2008		2009		2010		2011		2012	
		TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT
HIV / AIDS											
3.1.1.9 (F)	Number of service outlets providing the minimum package of PMTCT services according to national and international standards	13	13	15	19	19	22	19	31	22	31
3.1.1.10 (F)	Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	25 000	40 341	25 000	49 196	40 000	48 640	40 000	59 450	38 889	55 682
3.1.1.10. a	Number of pregnant women HIV positive enrolled in PMTCT	1 000	895	1 000	1 105	1 000	613				
3.1.1.10. c	Number of infants born to HIV positive women HIV positive benefiting pediatric care	400	363	400	407	400	355	400	391	389	387
3.1.1.11	Number of HIV positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission in a PMTCT setting	700	434	800	562	700	559	650	722	666	795
3.1.1.12 (F)	Number of health workers trained in provision of PMTCT services according to national and international standards	100	41	36	29	35	17	30	52	15	22

Indicator Codes	Performance Indicators	2008		2009		2010		2011		2012	
		TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT
3.1.1.13 (F)	Number of service outlets providing counseling and testing according to national and international standards	30	29	35	29	24	32	32	37	42	40
3.1.1.14 (F)	Number of individuals who received counseling and testing for HIV and received their results	50 000	91 494	60 000	94 907	75 000	92 109	85 000	98 374	77 778	102 305
3.1.1.14. a	Number of individuals HIV + tested for TB	1 650	1 960	1 700	2 765	3 000	1 261				
3.1.1.16 (F)	Number of people trained in counseling and testing according to national and international standards (trainings to be carried out by other agencies – targets determined by the implementing agency directly financed by USAID)	50	77	80	23	30	3	40	57	15	18
3.1.1.17 (F)	Number of service outlets providing antiretroviral therapy	6	6	7	6	6	6	6	6	6	8
3.1.1.18 (F)	Number of people newly initiating antiretroviral therapy during the reporting period	850	726	700	973	700	712	700	805	737	834
3.1.1.18. a	Number of individuals who ever received antiretroviral therapy by the end of the reporting period.	2 239	2 120	2 686	2 834	3 534	3 513	4 234	4 448	4 971	5 356
3.1.1.19 (F)	Number of people receiving antiretroviral therapy at the end of the reporting period	1 800	1 595	2 283	2 077	2 650	2 413	3 175	3 041	3 977	3 429

Indicator Codes	Performance Indicators	2008		2009		2010		2011		2012	
		TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT
3.1.1.20	Number of health workers trained to deliver ART services, according to national and/or international standards (trainings to be carried out by other agencies – targets determined by the implementing agency directly financed by USAID)			10	53	15	28	10	30	10	20
3.1.1.21 (F)	Number of service outlets providing treatment for TB to HIV-infected individuals (Diagnosed or presumed) in a palliative care setting (A subset of all palliative care outlets)	20	19	20	13	20	13	20	13	24	19
3.1.1.22 (F)	Number of people provided with HIV-related palliative care(including TB/HIV)	7 000	8 398	8 000	11 133	13 000	14 212	15 000	17 413	16 283	xx
3.1.1.22. a	Total number of service outlets providing HIV related palliative care including TB/VIH	20	19	20	17	20	19	24	19	24	24
3.1.1.23 (F)	Number of HIV- infected clients attending HIV care/treatment services that are received treatment for TB disease	500	578	600	730	700	227	700	175	738	233
3.1.1.24 (F)	Number of people trained to provided HIV palliative care (including TB/VIH	400	35	100	104	50	4	20	28	10	39
3.1.1.29 (F)	Number of laboratories with capacity to perform 1)HIV tests and 2) CD4 tests And/or lymphocyte tests	20	29	20	29	35	32	32	37	42	40

Indicator Codes	Performance Indicators	2008		2009		2010		2011		2012	
		TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT
3.1.1.30	Number of people trained in the provision of laboratory related activities (trainings to be carried out by other agencies – targets determined by the implementing agency directly financed by USAID)	-	1	10	20	10	20	10	25	10	55
3.1.1.31 (F)	Number of tests performed at USG-supported laboratories during the reporting period: 1)HIV testing 2)TB diagnostics 3) Syphilis testing and 4)HIV disease monitoring	157 500	223 091	159 500	263 035	207 660	264 393	207 660	311 779	215 333	311 631
TUBERCULOSIS											
3.1.2.1 (F)	Rate of TB notification			75 pour 100 000	96 pour 100 000	10 3 pour 100 000	103.5 pour 100 000	105 pour 100 000	67 pour 100 000	105 pour 100 000	---
3.1.2.1. a	Rate of TB detection			32%	31%	35%	32%	35%	14%	32%	---
3.1.2.3 (F)	Number of people (medical personnel, health workers, community workers, etc) trained in DOTS	50	-	30	---	20	---	10	---	10	27
3.1.2.4 (F)	Percent of all registered TB patients who are tested for HIV	50	-	80 %	34%	40 %	30%	40 %	54%	30 %	66%
3.1.2.4. a	Number of TB patients tested for HIV and having received their test results	4 000	1 487	2 000	1 310	1 735	1 279	1 735	1 568	1928	1 734
3.1.2.5 (F)	Percent of laboratories performing TB microscope analysis with over 95% correct results (the validation tests will be carried out by the National Laboratory in accordance	>95%	>95%	>95%	75%	>95%	---	>95%	---	>95%	---

Indicator Codes	Performance Indicators	2008		2009		2010		2011		2012	
		TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT
	with its mandate)										
3.1.2.6 (F)	Percent of the estimated number of New Smear-positive TB cases that were detected under DOTS	70%	58%	80%	80%						
3.1.2.6. a	Number of service outlets offering integrated TB services (HIV/TB)		83%			20	---				
3.1.2.6. b	Number of people trained for TB and HIV testing.	25	24	30	17	20	---	20	18	10	34
MATERNAL HEALTH											
3.1.6.3 (F)	Number of postpartum/newborn visits in USG-assisted programs in 3 days after delivery	47 670	27 977	30 000	44 019	45 000	47 544	45 000	54 186	44 444	52 519
3.1.6.4 (F)	Number of antenatal care (ANC) visits by skilled providers from USG-assisted facilities	NA	151 271	240 000	247 889	245 000	243 958	245 000	271 303	266 667	236 124
3.1.6.4. a	Percentage of pregnant women in first prenatal visit during the first trimester of pregnancy	65%	28%	40%	40%	40%	34%	37%	36%	35%	39%
3.1.6.4. b	% of pregnant women provided with 3 prenatal visits in USAID supported program	50%	42%	55%	47%	55%	43%	50%	47%	50%	49%
3.1.6.4. c	% of pregnant women having received a 2nd dose or booster of anti-tetanus vaccine	65%	52%	68%	69%	75%	74%	75%	74%	70%	80%
3.1.6.4. d	% of pregnant women with a birth plan	65%	10%	50%	78%	85%	78%	80%	84%	75%	92%
3.1.6.5 (F)	Number of people trained in maternal /newborn health through USG-supported programs (women/men)	1 000	325	300	434	100	---	100	37	100	66

Indicator Codes	Performance Indicators	2008		2009		2010		2011		2012	
		TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT
3.1.6.6 (F)	Number of deliveries with a skilled birth attendant (SBA) in USG-assisted programs	14 430	12 066	18 680	12 326	12 000	11 893	12 000	14 207	11 111	12 753
3.1.6.6. b	Number of deliveries with traditional birth attendant (TBA)	41 370	49 332	44 250	55 582	60 000	51 900	55 000	56 495	55 555	55 373
3.1.6.6. c	% of women provided with postnatal care in USAID supported program	31%	28%	35%	33%	35%	34%	35%	38%	33%	41%
3.1.6.6. d	% of sites with at least one maternal mortality surveillance committee in its service area	30%	-	70%	7%	50%	11%	35%	27%	35%	27%
3.1.6.6 e	Number of mother and gardiennes d'enfants who received nutrition counseling services			67 000	48 307	67 000	71 674	55 000	38 104	55 000	2 700

Indicator Codes	Performance Indicators	2008		2009		2010		2011		2012	
		TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT
CHILD HEALTH											
3.1.6.2	Percent of children less than one year fully immunized	83%	66%	85%	106%	85 %	89 %	85%	96%	85%	92%
3.1.6.7 (F)	Number of people trained in child health care and nutrition	1 000	351	500	526	300	500	300	111	300	72
3.1.6.11 (F)	Number of children reached by USG-supported nutrition programs	315 850	302 477	323 800	431 946	440 000	495 552	450 000	510 968	383 333	489 388

3.1.6.11. a	Percent of weightings for children < 5 years old from which result which result a ration Weight / Age equivalent to PFA/ PTFA	13%	13%	14%	13%	13%	13%	12%	10%	12%	9%
3.1.6.11. b	Percent of weighing of children < 5 years old from which result a evidence of severe malnutrition PTFA	N/A	3%	4%	3%	3%	3%	3%	2%	3%	2%
3.1.6.11. c	Percent of weighing of children < 5 years old from which result a evidence of high risk of malnutrition PFA	N/A	10%	10%	10%	10%	10%	9%	8%	9%	7%
3.1.6.11. d	Number of acutely malnourished children 0-59 months who received nutritional recuperation treatment			11	16	8 800	9 720				
3.1.6.11. e	Number of pregnant and lactating women who received nutritional recuperation treatment and nutrition counseling			635	437						
3.1.6.11. f	Number of Health facilities rehabilitated as a result of HIGHER program			49	150						

Indicator Codes	Performance Indicators	2008		2009		2010		2011		2012	
		TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT
3.1.6.12 (F)	Number of children of less than 12 months of age who received DPT3 in a given year from USG-supported programs	86 070	92 563	90 000	116 451	99 000	108 100	118 000	124 584	108 245	107 303
3.1.6.13 (F)	Number of children under 5 years of age who received Vitamin A from USG-supported programs	300 131	280 579	314 100	314 419	343 000	380 318	350 000	405 331	377 778	373 654
3.1.6.13. b	Number of children under 5 years old who received 2 doses of Vitamin A from USG-supported programs	200 000	117 235	250 000	187 548	257 000	206 545	260 000	250 028	222 889	202 675
3.1.6.14 (F)	Number of cases of children diarrhea treated in USAID-assisted programs	55 000	51 255	57 000	44 066						
3.1.6.14.a	Number of mothers and child caretakers trained on Diarrhea prevention (exclusive breastfeeding , clean water and hygiene)					67 000	75 317	30 000	45 159	20 000	32 268
3.1.6.14.b	Number of mothers and child caretakers trained on Diarrhea management (danger signs and oral rehydration)					67 000	75 317	30 000	45 159	20 000	31 760
3.1.6.19 (F)	Number of cases of child pneumonia of children under 5 years old treated by antibiotherapy.	N/A	7 847	5 000	17 868	7 000	15 887	10 000	14 518	10 000	10 481
REPRODUCTIVE HEALTH / FAMILY PLANNING											
3.1.7.2 (F)	Number of Couple-years of protection (CYP) in USG-supported programs	220 000	191 771	232 000	251 194	260 000	256 161	270 000	282 809	266 667	289 834

Indicator Codes	Performance Indicators	2008		2009		2010		2011		2012	
		TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT
3.1.7.3 (F)	Number of people trained in FP/RH (women/men)	1 000	271	400	1 035	100	354	50	76	50	75
3.1.7.3. a	Number of people trained for the offer of long term FP methods	50	8	50	94	50	26	25	3	25	35
3.1.7.6 (F)	Number of policies or guidelines developed or changed to improve access to and use of FP/RH services		1	0	0	1	0				
3.1.7.8 (F)	Number of USG assisted service delivery points providing FP counseling or services	100	17	20	58	142	142	142	154	142	154
3.1.7.8. a	% service outlets offering at least 5 FP methods of which 2 long term	20%	16%	25%	41%	45%	55%	55%	51%	55%	51%
3.1.7.12 (F)	Number of sites with improved management information system	152	150	10	143	6	9	147	157	147	157
3.1.7.13 (F)	Proportion of total modern contraception prevalence for long term method	14%	14%	15%	12%	13%	10%	14%	10%	14%	9%
3.1.7.13. a	% of people in reproductive age using a modern family planning method in USAID geographic target areas	26%	21%	27%	26%	27%	30%	30%	32%	30%	31%
3.1.7.13. b	Percent of Depo-Provera users who respect the procurement delays	N/A	73%	75%	91%	90%	92.6%	90%	93%	90%	93%

Indicator Codes	Performance Indicators	2008		2009		2010		2011		2012	
		TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT
3.1.7.13. c	Number of new FP users	131 943	106 900	134 200	159 801	162 000	188 425	170 000	196 985	188 889	180 201
3.1.7.14	Number of new STI cases detected and treated	40 000	43 656	45 000	43 248	45 000	39 186	40 000	34 930	35 000	28 888
REINFORCEMENT OF MSPP EXECUTIVE FUNCTIONS											
FE.1	Number of Health Departments with major- donor coordination mechanism	5	10	6	6	6	6	6	6	6	7
FE.2 a	% of Departments implementing the approved strategic plan	100%	100%	30	29	100 %	100%	100 %	100%	100 %	100%
FE.3	Number of PCI being implemented with the support of the project	20	96	60	65	65	56				
FE.3.a	Number of departments implementing a supervision plan for the provision of services			6	10	10	10	10	8	10	10
FE.4	Number of *Zones Ciblées* funded with the PBF strategy	2	-	6	-	12	11	16	18	29	33
FE.4. a	Number of zones ciblées benefitting from the PSPI supported by the project			30	29	30	31	31	33	31	33
FE.5	Number of departments in which the new financial and accounting management system is set up	2	-	6	5	10	7	10	7	10	7
FE.6	Number of communes counting *Zones Ciblées* and where an information system for provision of services is set up and in use	10	-	40	31	29	31	31	33	31	33

Indicator Codes	Performance Indicators	2008		2009		2010		2011		2012	
		TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT	TARGET	RESULT
FE.7	Number of Departments supported to operationalize the National Health Information System	4	-	10	-	6	---	6	---	6	10

Annex C: Performance Bonuses for 2011-2012 by Institution

Analysis of PBF Results 2012

Institution (local NGOs)

2011-2012

No.	***Institution (local NGOs)***	*Number of Indicators Evaluated*	*Number of Indicators for which targets were Achieved*	*Number of validated results*	*% Premium Earned*	*Budget Amount (HTG)*	*Eligible amount of premium (HTG)*	*Amount of premium earned (HTG)*	*Balance (HTG)*
1	AEADMA	6	5	5	7.50%	4,957,668	446,190	371,825	74,365
2	BERACA	6	1	5	1.50%	10,078,270	907,044	151,174	755,870
3	CBP	6	2	5	3%	12,216,059	1,099,445	366,482	732,964
4	CDS	6	2	5	3%	19,324,410	1,739,197	579,732	1,159,465
5	Léon Coicou	5	4	5	7.20%	1,605,220	144,470	115,576	28,894
6	Lucélia Bontemps	6	5	6	7.50%	2,946,543	265,189	220,991	44,198
7	Pierre Payen	6	3	6	4.50%	3,892,412	350,317	175,159	175,159
8	Thiotte	5	0	4	0%	2,404,060	216,365	-	216,365
9	Ste Hélène	6	6	6	9%	2,757,811	248,203	248,203	-
10	CMC Dugué	5	4	5	7.20%	2,232,392	200,915	160,732	40,183
11	Klinik La fanmiy	5	1	3	1.80%	1,942,548	174,829	34,966	

									139,863
12	Clinique St Paul	6	3	5	4.50%	4,635,435	417,189	208,595	208,595
13	Rosalie Rendu	5	3	5	5.40%	3,786,758	340,808	204,485	136,323
14	FONDEFH	6	5	6	7.50%	13,279,628	1,195,167	995,972	199,194
15	FOSREF	5	2	5	3.60%	11,060,788	995,471	398,188	597,283
16	ICC	6	5	6	7.50%	11,746,309	1,057,168	880,973	176,195
17	HAS	5	4	5	7.20%	1,747,580	157,282	125,826	31,456
18	HHF	6	5	6	7.50%	6,595,466	593,592	494,660	98,932
19	Claire Heureuse	6	4	5	6%	5,367,971	483,117	322,078	161,039
20	FERMATHE	6	2	4	3%	5,336,374	480,274	160,091	320,182
21	Konbit Sante	6	1	1	1.50%	3,051,780	274,660	45,777	228,884
22	Hôpital Ste Croix	5	0	0	0%	4,566,803	411,012	-	411,012
23	MEBSH	6	3	6	4.50%	8,374,241	753,682	376,841	376,841
24	OBCG	6	4	6	6%	3,375,133	303,762	202,508	101,254
25	SADA	6	5	6	7.50%	16,323,967	1,469,157	1,224,298	244,860
26	Save The Children	6	3	4	4.50%	4,688,063	421,926	210,963	210,963

27	MEDISHARE	5	2	4	3.60%	3,802,848	342,256	136,903	205,354
28	OBDC	5	2	3	3.60%	3,759,345	338,341	135,336	203,005
						175,855,882 HTG	**15,827,029 HTG**	**8,548,333 HTG**	**7,278,697 HTG**

Analysis of PBF Results 2012

Institution (zones ciblées)

2011-2012

No.	***Institution (zones ciblées)***	*Number of Indicators Evaluated*	*Number of Indicators for which targets were Achieved*	*Number of validated results*	*% Premium Earned*	*Budget Amount (HTG)*	*Eligible amount of Premium (HTG)*	*Amount of premium earned (HTG)*	*Balance (HTG)*
1	Abricots	6	4	4	4%	3,121,650	374,598	249,732	124,866
2	Corail	5	3	4	3.60%	2,333,192	279,983	167,990	111,993
3	Bainet	5	0	0	0%	4,043,783	485,254	-	485,254
4	Anse à Veau	6	0	2	0%	2,688,867	322,664	-	322,664
5	Petit Trou de Nippes	6	1	3	1%	3,936,638	472,397	78,733	393,664
6	L'Azile	6	3	3	3%	3,324,990	398,999	199,499	199,499
7	Trou d'eau Crochu	5	1	1	1.20%	2,025,720	243,086	48,617	194,469
8	Belle Fontaine	5	1	1	1.20%	1,330,800	159,696	31,939	

									127,757
9	Tayfer	5	0	2	0%	1,532,877	183,945	-	183,945
10	Cornillon	5	0	0	0%	2,960,670	355,280	-	355,280
11	St Martin	5	0	0	0%	2,526,558	303,187	-	303,187
12	Bel Air	5	1	1	1.20%	1,615,734	193,888	38,778	155,110
13	Acul du Nord	5	1	1	1.20%	2,602,335	312,280	62,456	249,824
14	Borgne	5	2	2	2.40%	3,153,128	378,375	151,350	227,025
15	Dondon	5	1	5	1.20%	1,828,632	219,436	43,887	175,549
16	St Raphael	5	1	1	1.20%	1,688,466	202,616	40,523	162,093
17	Carice	5	3	3	3.60%	1,809,994	217,199	130,320	86,880
18	Mombin Crochu	5	2	3	2.40%	2,881,120	345,734	138,294	207,441
19	Perches	5	5	5	6%	1,719,659	206,359	206,359	-
20	Ste Suzanne	5	5	5	6%	2,690,399	322,848	322,848	-
21	Vallières	5	4	5	4.80%	2,158,738	259,049	207,239	51,810
22	Anse à Foleur	5	2	3	2.40%	3,157,725	378,927	151,571	227,356
23	Baie de Henne	5	2	5	2.40%	2,606,204	312,744	125,098	187,647
24	Ile de la Tortue	6	4	5	4%	6,061,070	727,328	484,886	242,443

25	Gonaives	6	0	0	0%	7,897,945	947,753	-	947,753
26	St Michel de l'Attalaye	6	2	2	2%	6,081,973	729,837	243,279	486,558
27	Marmelade	6	1	2	1%	4,271,574	512,589	85,431	427,157
28	Grande Saline	5	3	4	3.60%	3,449,335	413,920	248,352	165,568
29	Belladère	5	0	1	0%	2,914,601	349,752	-	349,752
30	Cerca La Source	5	3	4	3.60%	3,403,604	408,432	245,059	163,373
31	Savanette	5	0	2	0%	2,832,209	339,865	-	339,865
32	Les Anglais	6	1	4	1%	3,037,509	364,501	60,750	303,751
33	Ile à vache	6	1	2	1%	2,511,104	301,332	50,222	251,110
						100,198,798 HTG	**12,023,856 HTG**	**3,813,212 HTG**	**8,210,644 HTG**

Eligible Premiums to NGOs & ZCs		**27,850,885 HTG**	**663,116 USD**	
Premiums Earned by NGOs & ZCs		**12,361,545 HTG**	**294,322 USD**	***44%***
Balance for NGOs & ZCs		**15,489,341 HTG**	**368,794 USD**	***56%***