CONCERN WORLDWIDE

USAID Child Survival & Health Grants Program
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October 2005 – September 2010

DETAILED IMPLEMENTATION PLAN

The Urban Health Project for Five Disadvantaged Neighborhoods of Metropolitan area of Port-au-Prince

Delmas Commune: St. Martin and Cite Okay-Jeremie
Petion-Ville Commune: Jalousie and Bois de Moquette in
Port-au-Prince Commune: Descayettes

A Partnership of Concern Worldwide, FOCAS, and GRET with the Ministry of Health West Department

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ACRONYM LIST

AED	Academy for Educational Development
AMTSL	Active Management of the Third Stage of Labor
ASON	National Association of People Living with HIV/AIDS
BC	Bureau Communal of the MSPP
CAMEP	Centrale Métropolitaine d'Eau Potable
CDS	Centres pour la Développement et la Santé a Haitian NGO
CSHGP	USAID-funded Child Survival and Health Grants Program
CSSA	CORE/CSTS Sustainability Assessment
CTC	Community-based Therapeutic Care
DHS	Haiti Demographic Health Survey
DIP	Detailed Implementation Plan
FOCAS	Foundation of Compassionate American Samaritans
FONKOZE	A Haitian micro-finance institution
GENESIS	A Haitian public health management and technical consulting firm
GRAIFSI	Groupe d'Appui pour l'Intégration de la Femme du Secteur Informel
GRET	Groupe de Recherche et d'Echange Technologique
GRIEAL	An organization specializing in education and local development
HMIS	Health management information system
ICF	Interim Cooperation Framework
ID	Initiative Development
IMCI	Integrated Management of Childhood Diseases
IR	Intermediate Results
IAP	Indoor Air Pollution
ISA	Institutional Strengths Assessment
KDSM	Federation of CBOs operating in St. Martin "Kowodinasyon pou Devlopman Sen Maten"
KPC	Knowledge, Practices and Coverage survey
LQAS	Lot Quality Assurance Sampling
MEI	Local NGO "Mission Evangelique Internationale" working in Bois Moquette
MOST	Management and Organizational Sustainability Tool
MSH	Management for Science and Health
MSPP	Ministre de la Santé Publique et de la Population (Ministry of Health)
MUAC	Mid-Upper Arm Circumference measurement
OBDC	Local NGO « Oeuvres de Bienfaisance et Développement Communautaire » working in Jalousie
OR	Operations Studies
ORS	Oral Rehydration Salts
PRAG	Partners Research and Action Group
PROMESS	Essential Medical Supply Store
PSI	Population Services International
SNELAK	Local CBO operating in Descayettes, "SOSYETE NEG LAKAY"
TBAs	Traditional Birth Attendants
UCS	Unités Communales de Santé
WHO	World Health Organization

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Annexes

1 Executive Summary

This is a five-year USAID Child Survival & Health Standard Grant Program led by **Concern Worldwide**, and is the fruit of a strategic partnership led by Concern Worldwide Haiti joined with **Groupe de Recherche et d'Echange Technologique (GRET),** and **Foundation of Compassionate American Samaritans (FOCAS).** Together, these three agencies work hand in hand with the Ministry of Health **(MSPP)** at the **Ministry of Health West Department (DSO)** with the aim of improving the health status of vulnerable maternal, child and youth populations living in five disadvantaged urban neighborhoods of Cite Okay/Jeremie, Descayettes, Jalousie, Bois Moquette, and St. Martin of the Port-au-Prince metropolitan area of Haiti.

Urbanization and Health. Over the past 15 years the urban population in Haiti has swelled from 29.5% to 38.8%[1] leaving the urban extreme poor as the fastest growing population in the country. While national health indicators have improved over the past 20 years, the urban areas have been particularly affected by unplanned growth and public service neglect. Two-thirds of Port-au-Prince residents earn less than $25 US per month, making it one of the poorest cities in the world.[2]

Insecurity. The past two years have been particularly difficult as the collusion of political violence and economic frustration have resulted in physical violence, mental anguish, population displacement,– and death, things that cannot be described in an opening paragraph. While elections of February 2006 have brought calm and sense of renewal, on March 2006, UNICEF issued a Child Alert for Haiti, marking it as one of the most challenging places on earth for children. Haiti's biggest cities were spotlighted as traps locking mothers and children into a "perpetual cycle of violence, poverty and abuse that is almost impossible to break."

Health Status. Despite overall decline over the past 20 years, the national child mortality rate is among the 40 highest in the world, with infant mortality rate estimated at 74/1,000 and under-five mortality at 117/1,000[3]. The major causes of mortality for children under-five are pneumonia, diarrhea, and malnutrition. One-quarter of all child deaths occur among newborns during the first month of life. Infections, traumatic delivery, and respiratory distress are the primary causes of newborn deaths. The maternal health status has improved, but the maternal mortality ratio is the highest in the western hemisphere at 523 deaths per 100,000 live births.[4] Major causes of maternal death are hypertension, obstructed labor and hemorrhage. HIV/AIDS prevalence has also dropped over the past 5 years, but remains the highest outside Africa with an estimated adult seroprevalence of 3.5%[5]. Some sources considered the prevalence to be closer to 5 or 6%.

Objectives and Outcomes. ***The strategic objective of the urban health project is sustained improvements in the health status of mothers, children and youth in five disadvantaged urban neighborhoods of Port au Prince, reaching about 10 percent of the city's population.*** The total project population includes 218,490 residents including 32,555 children under five years of age (including 7,990 infants 0-11 months, 6,227 young children 12-23 months, and 24,565 children 24-59 months), and 53,967 women of reproductive age (15-49 years).

This program focuses on six key interventions which closely match the principle causes of child and maternal mortality: HIV/AIDS (20%), maternal & newborn care (20%), control of diarrheal disease (25%), nutrition (15%), pneumonia case management (10%); and immunizations (10%). These are modified from the original application and further described in the "Revision" section 5.3. Highlights of specific measurable progress planned from this intervention include[6]

Improved preventive child health practices

- Increase from 22% to 35% infants age 0–5 months exclusively breastfed during the last 24 hours
- Increase from 51% to 80% children 12-23 months fully vaccinated (verified with card) by first birthday

Improved care for sick child

- Increase from 66% to 75% children 0-23 months with cough and fast, rapid or difficult breathing in past 2 weeks who were seen by trained provider
- Increase from 13% to 45% mothers with a sick child aged 12-23 months who increase fluids and maintain feeding during the illness

Improved maternal and newborn care

- Increase from 70% to 90% mothers of children age 0–11 months who had three or more antenatal care visits during their last pregnancy
- Increase iron folate intake for 90 days or more by mothers of children aged 0-11 months from 4% to 20%
- Increase from 16% to 35% of mothers of infants 0-11 months who attended postpartum care check-up with the newborn within 7 days of birth

Enhanced youth HIV/AIDS protection

- Increase by 35% the number of youth aged 15 to 24 who become new acceptors of modern contraceptive methods
- Increase from 12.6%7 to 20% number of sexually active, out-of-union youth, aged 15 to 24 years, who use a condom consistently for the past 3 months

The following intermediate results encompass the strategy and activities required at the household, neighborhood, health service and political level. Together, these will enable the above, long-term goals for improved health to be realized.

IR 1: Empowered communities with increased knowledge and interest in maternal, child and youth health promotion. Working with 5 neighborhood health networks of numerous active and respected CBOs, 1,136 youth leaders, 60 TBAs and health center personnel, build skills to identify needs, develop strategies and actions for health promotion, resource activities, and monitor effectiveness.

IR 2: Enhanced availability of and access to reproductive and child health services for disadvantaged households in urban areas. Working with 5 health facilities, improve availability and management of essential drugs and supplies, leverage availability of subsidized national programs, and learn from cost sharing strategies

IR 3: Increased quality of reproductive and child health services in selected government and private non-profit health centers. Working with five focal health facilities to develop a quality assurance and monitoring team approach, develop and test models for performance incentives, organize trainings on key skill areas, organize joint NGO/BC supervision on a quarterly basis.

IR 4: Improved policy environment for the urban populations, putting emphasis on protection for the poorest people. Developing exchange and applied research platform to build evidence and consensus for effective urban health strategies, documenting and disseminating experience,

advocating on environmental health intervention by government and donor community, and supporting DSO in initiating an urban health strategy development process.

Note that in all intervention areas, other agencies are providing health facility based HIV services including STI screening, facility based care and support, PMTCT and VCT services, safe blood, etc. Therefore, this project complements them with a strong youth prevention and integration of HIV services with maternal and newborn care. Indicators related to HIV/AIDS health services are excluded from this project scope but the program will contribute to monitoring for complementary projects in the area.

Special Studies and Documentation. Given the unique nature of application of approaches in five neighborhoods with youth, mothers, and community leaders in the forefront health promotion, a level of operations research and documentation is deemed appropriate. A process documentation and research organization, **GENESIS** will monitor changes in each of the neighborhoods in terms of community organization and health center capacity, as well as assess the urban health policy environment. Further given concerns about availability of care for severe malnutrition and other expressed needs from community and health center level, a nutrition and livelihoods survey and local production regulations for ready to use therapeutic food assessment, will be completed by the end of year two to decide the **feasibility of a community-based therapeutic care intervention**.

This Detailed Implementation Plan (DIP) is the product of the devotion of all the partners and collaborating agencies including Dr. Desinor of the USAID mission. The DSO focal point, GRET, FOCAS, KDSM, SNELAK, MEI, OBDC, HaitiMed, and the Pilot Committee of CBOs in Cite Okay/Jeremie fully participated in the design and implementation of baseline studies, analysis of findings and development of the five-year workplan. Baseline studies included KPC survey of 380 mothers of children 0-23 months, rapid assessment of five health centers, and group discussions with local CBOs in the intervention neighborhoods. Consultations on the design were held with MSH, MSF/Holland, AMESADA and the MSPP IMCI and Reproductive Health Focal points.

While lead authors are Michelle Kouletio, Concern Worldwide US's Health Advisor (who also backstops Child Survival Grants in Bangladesh and Rwanda) and Dr. Andre-Paul Venor, the Health Coordinator of Concern Worldwide Haiti, substantial input and review comments were provided by Dr. Henrys of GRET and Gabrielle Vincent of FOCAS

The project is supported by a USAID-funded Standard Category Child Survival & Health Grant (CSHGP) which began on October 1, 2005 and will end on September 30, 2010. The total CSHGP funding is $1,500,000 and Concern will provide a cash match of $908,779.

2 CSTS Form

3 Steps in DIP Development

The past 18 months have been marked by wide-scale political and social instability and violence in Haiti and particularly in the urban slums of Port-au-Prince. Violence and temporary displacement of residents as well as the CBO leaders in these urban neighborhoods severely limited any access to the areas from the time of notification of the grant award through September, and then again in the period leading up to the presidential elections in January-February 2006. Further the offices of some of the Bureaux Communales and health centers had been closed due to insecurity in their locale. This was particularly a barrier in the neighborhoods of St. Martin and Descayettes.

Instability was a major limitation to the planning and assessments that are required to establish a five-year DIP, as by nature this requires significant consultation and participation at the neighborhood level. Through proactive planning, however, and a short-extension of the submission deadline to USAID/W, the majority of essential steps to develop the DIP have been completed and areas to catch-up on have been included in the workplan and are highlighted in section 5.2. Fortunately, since the presidential elections in early February 2006, the security situation has calmed and residents have returned to their homes. While Haiti remains at UN Security Stage III, we are anticipating a return to normalcy over the next year and have become operational in all five targeted neighborhoods.

Table 1: Events Leading to Development of this Detailed Implementation Plan

Event	Dates	Purpose	Who Participated
Mini-University	June 2005 (5 days)	Familiarization with baseline studies & DIP process and familiarization with new grantees from Haiti (HHF & GHA)	Concern Worldwide Haiti Health Coordinator and Child Survival Manager (2)
Mini-University Feedback and Orientation	June/July 2005 (2 days)	Review of project design and focus Feedback on Mini-University Expectations for DIP	Concern, GRET, FOCAS, USAID/H
Baseline Study Design Workshop	October 2005 (1 day)	Review KPC survey instrument, selection of sampling methodology, identifying supervisors and interviewers, outlining health facility assessment and other participatory research plans	Concern, GRET, FOCAS, HaitiMed, M&E Consultant With FOCAS & Concern Health Backstops
Collaboration Meetings with MSH	Nov/Dec 2005	Orientation of program plans Identifying geographic overlap Resolution of replacement neighborhood for Cite Eternal	Concern, MSH, GRET, DSO and USAID
BEHAVE Training	Oct 2005 (2 days) & Jan 2006 (5 days)	Assess strengths and weakness in Concern Haiti behavior-change interventions Orient to BEHAVE framework Develop priorities for formative research and monitoring work	All Health Program Managers for 2 day review and two staff for CORE BEHAVE training in San Diego
Preparation for DIP	Jan 2005 (10 days)	Translation, mapping, assessing security	Concern, GRET, & FOCAS
KPC Survey	Feb – March 2006 (5 weeks)	Pre-test questionnaire Training team by Karunesh Tuli KPC in safest areas first – Jalousie/Bois Moquette and Cite Okay (Feb/Mar) followed less secure areas of Descayettes & St. Martin	Concern, GRET, & FOCAS with 8 supervisors and 24 data collectors

Event	Dates	Purpose	Who Participated
		(Mar/Apr)	
Rapid Health Facility Assessment	March 20-27, 2006	Site assessments to HaitiMed, St. Martin II, Salvation Army, Descayettes and Jalousie health centers Review service availability, infrastructure, drugs, management and community involvement	Health Advisor and Community Health Officer
Consultation with CBOs : KDSM, CBOs with Pilot Committee in Cite Okay/Jeremie, and SNELAK	March 20-24, 2006	Assess collaboration situation Discuss importance of health to the institutions and their perspective on roles Priority health problems for men, women and children Operational opportunities for reaching households and reporting on vital events	Health Advisor and Community Health Officer & Org Development Officer
DIP Planning Workshop	March 29-30, 2006	Review preliminary baseline findings Strategies and key activities Roles and coordination Vision for 2010	Concern, GRET, FOCAS, DSO, BC Delmas and Port au Prince, KDSM, SNELAK, St. Martin II, Haiti Med
Workplan Meetings with Implementing Partners	March 31 – April 7, 2006	Detailed activity plans by intervention Roles and responsibilities of staff Management Discussion on critical issues	Concern, FOCAS & GRET
DIP Workplan Review	April 4, 2006	Reviewed workplan Identified complementary programs Disccussed resolution of potential duplication of effort	Same as DIP Planning Workshop plus USAID, UNICEF
Exchange visit to Bangladesh	May 20-29	Community mobilization in urban environments C-IMCI and how PVOs can contribute Lessons learned CM and CIMCI for projects in Bangladesh, Burundi, Haiti and Rwanda	

See Annex C for list of participants of the DIP consultation and workplan meetings and Annex G-1 for participants of the KPC surveys.

The process of developing the DIP was initiated upon receiving notification that the project had been recommended for funding in early May 2005. Steps have included orientation and planning meetings with our implementation partners at GRET, FOCAS, the Ministry of Health West Department, and the local USAID mission and its flagship health program operated by Management Sciences for Health (MSH). Efforts were also made to learn more about the work of other child survival grantees including Project Hope, the Haitian Health Foundation (HHF), Global Health Action (GHA) and AMESADA. The USAID/Haiti mission has been heavily consulted regarding the program design, negotiations with the DSO and MSH regarding geographic areas, baseline study plans and findings and general directions of the DIP.

The DIP workshops provided a forum to bring together partners to review and discuss preliminary KPC and HFA findings, debate approaches for working with youth and performance incentives, review and finalization of the strategic results framework, set targets for key objectives, discuss

roles and responsibilities of all key actors, review workplan, identification of areas for synergy / complementarity, and discussion on local planning and avoidance of duplication of efforts.

Agreements. During this period subagreements have been developed and signed with GRET and FOCAS (see Annex D). Following a competitive selection process, in April 2006 an initial one-year contract was awarded to GENESIS for process documentation and research. Written MoUs with the DSO, St. Martin II, and HaitiMed are underway, and are based on the roles and support outlined in table 9 in section 5.4 f.

While the DIP was primarily written by Concern Worldwide's Health Advisor, drafts were reviewed and commented on by the three partners in country, the DSO and the local USAID mission. Budget revisions were prepared according to the workplan and included as Annex H.

Baseline population surveys were delayed due to insecurity and resulting lack of access but by February the team was able to complete this work in two of the easier access communities. In March work was also completed in St. Martin but eruptions of conflict forced team evacuations in the middle of the month, lengthening the process. Descayettes survey was completed in April, although violence in that area was high during the month of March making the health facility assessment and interview with SNELAK difficult.

Follow-Up Action. The following are action points that came out of the events detailed in Table 1:

In June, GRET, FOCAS, and Concern will each negotiate agreements with their respectively supported health facilities to firmly define and document the performance incentives guidelines for application. These will be sealed with signed MoUs outlining the roles and responsibilities as indicated in section 5.4.

In June/July, GENESIS will work with CBOs to develop capacity assessment tools to monitor and guide growth, and they will ensure the health facility assessment guides include MSPP level 1 standards. Full capacity assessments are planned for year two of the program. A copy of their first year contract is attached as Annex E-5.

In July, the first post-DIP **urban health platform meeting** will be convened. The agenda will include: Development of benchmarks for community groups with GENESIS, DIP review feedback, HMIS assessment review by Mme. Hecdivert, and CBO inventory feedback from FOCAS.

In July, a nutrition assessment will be completed covering the areas of Descayettes, St. Martin and City Okay. This will allow reporting for rapid catch indicator of weight-for-age, as well as other key anthropometric and food security measures. GRET will include its module on "willingness to pay" in the survey instrument in anticipation of future work with mutuelles. The methodology is based on LQAS using 26 supervision areas with 21 randomly selected households with a child under 59 months. **The survey will only include the neighborhoods of St. Marin, Descayettes and Cite Okay as the FOCAS areas do not have a nutrition intervention.** The sample size of 521 assumes a 2% severe acute malnutrition and 8% general acute malnutrition. Results will be analyzed against both the new WHO 2006 growth standards as well as the more traditional international reference standards and interpreted with consultation with CW/US Nutrition Advisor and FANTA.

In August, a baseline of the youth sexual behaviors, will be completed. These behaviors were not included in the KPC survey which, due to limited time and resources, was restricted to mothers of children 0-23 months. As such, we are planning focus group discussions led by GENESIS in June/July to ascertain generalizability of youth sexuality surveys in Port-au-Prince (SSSR 2003 and DHS 2005) and information on determinants to shape behavior-change strategy HIV/AIDS intervention section for more details. **See Section 7 for the detailed May-September 2006 workplan.**

4 Revisions

While the workplan retains the original thrust of reducing maternal and child mortality in five disadvantaged urban neighborhoods and strengthening the capacity of the local health system, some changes in the design have been necessary based on findings from the baseline studies, expert recommendations from application reviewers, and changes in geographic areas of other health actors in Port-au-Prince.

Three significant changes are proposed as a result of preparatory work for the DIP. These include: 1) substitution of the Cite Eternal neighborhood with Descayettes in Port-au-Prince Commune; 2) modification of the levels of effort to the intervention mix, and the inclusion of a nutrition-specific intervention. These changes have been fully discussed with Dr. Desinor at the USAID local mission and have been flagged to USAID/CSHGP prior to submission of the DIP; and 3) increase in Concern Worldwide cash match contribution to reflect increased costs of project design. The rationale for each of the changes is described here.

Change of Neighborhood Rationale: In between the original application submission in December 2005 and funding decision in May 2006, Management Sciences for Health (MSH) and FONDEF started health promotion activities in Cite Eternel, the intervention neighborhood proposed by GRET. The concern of potential duplication was raised by the Ministry of Health West Department Office (DSO) and carefully reviewed by all parties with USAID/H. It was agreed that FONDEF should continue to take lead for health in Cite Eternel, and that Concern and GRET should review the initial list of potential neighborhoods developed in 2004 during the design needs assessment to select another neighborhood.

From this review, Descayettes, a mountainside, un-planned neighborhood, with an estimated population of 50,000, was selected on the basis that it met original criteria; and that GRET had a ten-year presence in the area supporting a local community based organization, SNELAK. SNELAK promotes water and sanitation projects, and a private, non-profit health center. This area had received temporary support from MSF/Holland since 2004, but that support was withdrawn in January 2006. The inclusion of Descayettes has resulted in an estimated increase 5,000 in total target population size, after factoring in population growth since the proposal.

Change in Intervention Mix Rationale: Based on limited coverage, survey information, and changes in types of services provided and supported in the urban area, it was necessary to review levels of effort devoted to the initial five interventions in the original proposal. Using the baseline assessment information, and advice from expert reviewers of the proposal, a sixth intervention of nutrition has been added. This has resulted in bringing the IMCI components to 60% of the total

effort, while Maternal & Newborn Care and HIV/AIDS are readjusted to 20% each. Notes on rationale and details of modifications are included in table below.

Table 2: Changes in Levels of Effort by Intervention

Intervention	**Original**	**DIP revision**	Brief Notes on Rationale
HIV/AIDS	25%	**20%**	Scaled down care & support component outside FOCAS neighborhoods due to availability of multiple actors under Global Fund and PEPFAR funding.
Maternal & Newborn Care	25%	**20%**	Collaborating institution supporting tertiary-level obstetric care for referral services
Control of Diarrhea Disease	20%	**25%**	Given the high prevalence of diarrhea and CBO interest, greater effort on hand washing and water purification, focused work on feeding practices
Pneumonia Control	20%	**10%**	Scaled down non-formal private practitioner component as fairly low utilization of their services as per KPC findings; most activities overlap with diarrhea due to IMCI strategy; pulled-out nutrition as own intervention; removed the Indoor Air Pollution (IAP) advocacy
Immunizations	15%	**10%**	Slight change as KPC showing higher coverage; continues to be major focus of MSPP, WHO, UNICEF, and MSPP so retained as intervention.
Nutrition	0%	**15%**	USAID strategy and current situation requires a more comprehensive nutrition program and absence of referral service for severe malnutrition requires feasibility assessment for Community-based Therapeutic Care

Budget increase: As a result of these changes, some budget modifications were necessary resulting in an increased total program cost of $302,830, all of which is borne by the Concern Worldwide match.

Summary of budget adjustments

Category	**Original Application**			**Revised Application**			**Difference revised to original budget**	**Remarks**
	USAID	**Match**	**Total**	**USAID**	**Match**	**Total**		
Personnel	423,778	141,259	565,037	499,998	214,285	714,283	149,247	Increased technical backstop to 50% time; increased project staff
Fringe Benefits	44,392	14,797	59,190	49,815	21,349	71,164	11,974	
Travel	15,570	9,927	25,497	0	53,085	53,085	27,588	Increased participants for exchange visits, increased DIP and CORE participation
Equipment	-	46,000	46,000	-	45,000	45,000	-1,000	
Supplies	58,830	56,759				131,128		

Category	Original Application			Revised Application			Difference revised to original budget	Remarks
	USAID	Match	Total	USAID	Match	Total		
			115,588	53,833	77,295		15,539	
Contractual	151,110	55,890	207,000	98,905	46,505	145,410	-61,590	Steamlined consultancies
Construction	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Other	657,672	221,267	878,939	667,437	372,492	1,039,929	160,990	Training costs increased
Total Direct	1,351,351	545,900	1,897,251	1,369,988	830,011	2,199,999	302,748	
NICRA	148,649	60,049	208,698	130,012	78,768	208,780	82	NICRA decreased from 11% to 9.49%
Totals	1,500,000	605,949	2,105,949	1,500,000	908,779	2,408,779	302,830	

Specific changes that contributed to these changes include increased number of Community Health Officers to one per neighborhood, as well as reallocating resources from hospital assessments and emergency obstetric care training to the nutrition intervention, including a full nutrition survey for the area, feasibility assessment for Ready to Use Therapeutic Food (RUTF) production and national consultation meetings and orientation to Community-based Therapeutic Care (CTC) methodology. A revised budget is included as Annex H.

5 Workplan

5.1 Program Site Information

The Port-au-Prince metropolitan area is home to one out of every four Ha?tians, or about 2 million people, with an average household size of 4.72. The city is growing at 5% per year, which is heavily precipitated by rural migration.[8] Population density is very high; as an illustration St. Martin has over 75,000 residents residing in one square kilometer.

Residents of these poor neighborhoods are employed, if at all, in the informal sector of petty trade and hawking. There is significant migration within and across the slums due to violence, economic hardships, and natural disasters from flooding and fires. Female headed households are most vulnerable to poor health outcomes; 51% female headed in the metropolitan area compared to 38% in rural areas. Two-thirds of Port-au-Prince residents earn less than $25 US per month, making it one of the poorest cities in the world.[9]

a) The Area. Most of the very poor live in marginal neighborhoods or slums characterized by unplanned urbanization. There is a severe lack of public services, and little regulation of schools or health services, resulting in unacceptable quality and access across sectors. The state of housing, overpopulation, and hygiene is at its worst in the poorest of the poor neighborhoods, which are situated along the coast, water ways through the city (i.e., Rockefeller Canal), or on hilltops. These also are the neighborhoods that are most vulnerable to natural disasters, such as floods and

landslides. Readers should see the map of the neighborhoods and location of health service sites in Annex B.

b) Population Estimates. 2006 estimates of the project areas are summarized in the table below. The project staff are awaiting feedback from Bureau of Statistics to collect 2003 census population data for the areas selected, so these figures are based on best current available information.

Table 3: Estimated Population for Project Area, 2006

Project Area	0-11 Mo	12-23 Mo	24-59 Mo	Total U5	W 15-49 yr	Total Population
St. Martin	2,625	2,138	6,413	**11,175**	**18,525**	75,000
Cite Okay/Jeremie	875	713	2,138	**3,725**	**6,175**	25,000
Decayettes	1,750	1,425	4,275	**7,450**	**12,350**	50,000
Jealousie	1,917	1,561	4,682	**8,159**	**13,525**	54,758
Bois de Moquette	481	391	1,174	**2,046**	**3,392**	13,732
Total Population Estimates	***7,990***	***6,227***	***24,565***	***32,555***	***53,967***	***218,490***

Sources: Sub-population estimates are derived from MSPP 2000: WRA (15-49 yrs – 24.9% of total population); children under 5 years (14.7% of total population), infants under 12 months (3.5% of total population). Populations for Jalousie and Bois de Moquette based on census updates from FOCAS 2003, St. Martin – 1996 CAMEP assessment with annual growth estimates of 2.96%; Cite Okay – Concern site estimation September 2004; Descaytettes – GRET estimate 2006.

C) Health Status. The national child mortality rates place Haiti among the 40 highest in the world, with infant mortality rate estimated at 74/1,000 and under-five mortality at 117/1,000[10]. Estimates of urban mortality rates are very close to national, indicating that the rates among upper class families is masking the reality of elevated levels among the poor. In 2005, estimates of urban mortality were at 87.0 /1,000[11]. The major causes of mortality for U5 are pneumonia, diarrhea, and nutrition. One-quarter of all child deaths occur among newborns during the first month of life. Infections, traumatic delivery, and respiratory distress are the primary causes of newborn deaths, The maternal health status has also improved, but the maternal mortality ratio is the highest in the western hemisphere at 523 deaths per 100,000 live births[12] Major causes of maternal death are hypertension, obstructed labor and hemorrhage. The HIV/AIDS prevalence has also dropped over the past 5 years, but remains the highest outside Africa with an estimated adult seroprevalence of 3.5%[13].

Only about half of the urban population has access to improved sanitation facilities, such as latrines.[14] There is no urban sewage system. Only 40% of the urban population has access to potable water.[15] If you are lucky enough to have access to the public system, water is available one or two times per week, for two to three hours each time. The majority of residents must purchase water for about 7-8 Gourdes per litre (about $0.20). As a result, families spent about 10% of their income to purchase about 12 liters of water per day.[16] A FOCAS water survey in Petion-Ville found that 97% of all tested drinking water sources were fecally contaminated.[17]

The majority of homes in these slum areas can be accessed only by means of small 'corridors,' which criss-cross the neighborhoods. These corridors serve not only as a means of access but also as living spaces where people wash, cook, eat, and where children play. A majority of corridors are unpaved and form a muddy, dirty environment where rubbish and sewage collect next to homes, creating serious health risks to children. There are no garbage removal services. In St. Martin, there are only 294 latrines, representing one-tenth the minimum standards set by the humanitarian community.[18]

d) Factors Influencing Health:

Education. Forty-nine point eight percent of the national population is reportedly literate, with males (52%) slightly better educated than women (47.8%).[19] The net primary school enrollment (i.e., the proportion of the total eligible population actually attending school) is 68%, and girls have 0.5 to 2.0 fewer years of schooling than do boys.[20] Fourteen percent of mothers with children less than five years of age have no schooling, and only 18% have completed secondary school or higher.[21] The baseline survey indicated great diversity in education status of residents in targeted neighborhoods with 22% of the mothers of young children without any schooling, while 51% achieved post-primary education.

Decision Making. The primary decision maker for care outside the home is the father. However, in female headed-households (51% in this area), the mother herself decides but her income is often much more restricted.

Religion. About 80% of the population is reported to be Catholic, 16% protestant and/or evangelical, and 4% are "other" (voudou and traditional faiths). Traditional beliefs influence care seeking towards informal providers, see Sub-section e) for further information.

Information Sources. According to the 2006 KPC survey, 52% of the target population receives health information from radio, 32% television, 28% from a community health worker in the area, and 20% from newspaper.

Poverty. Two-thirds of Port-au-Prince residents earn less than $25 US per month, making it one of the poorest cities in the world.[22] Inflation is high due to devaluation, political crisis, and isolation; in recent years it has fluctuated around 10%. [23]

Violence. Poverty, unemployment and drugs fuel gangs of armed youth. In some neighborhoods, wars between gangs based on territorial control or political conflicts have paralyzed activities for weeks and forced families to flee for their lives. Over the past year, Glencree Center of Reconciliation, based in Ireland, worked with Concern and KDSM in St. Martin to develop skills in conflict resolution, safe passageways and eventually gang mediation. UN peacekeeping activity is high in many of these neighborhoods as they try to hold together post-election peace.

Gender. The role of women has improved since the development of Women's Rights and Affairs in 1991, which is aimed at eradicating violence and discrimination against women. Female participation in the labor force is 58.8%, up from 49.8% in 1990. Under the last regime, 9.1% of parliamentary seats were held by women. [24]

e) Current Status of Health Services:

Overview. The Ministry of Health West Department is responsible for the coordination and supervision of public and private health services in the Port-au-Prince metropolitan area, comprised of: Port-au-Prince, Delmas, Carrefour, Petion-ville, and Kenscoff. There is a Bureau Communale (BC) for each of these areas, responsible for supervising local health agencies and facilities. The project is working hand in hand with a DSO focal point, Dr. Gourdet and the three BC Directors of Port-au-Prince, Delmas and Petion-Ville that serve the participating program neighborhoods.

The MSPP describes a minimal package of essential health services to be provided to the whole population. These include integrated care for children; reproductive health; youth and adolescent health; minor surgical care; dental care; STIs/AIDS, TB, Malaria and Filariose control; health

education and communication; eye care; medical care for violence victims; fight against tobacco for youth; and mental Health. However, due to severe resource and capacity constraints, as well as disperse policy adherence by the plethora of private formal and informal, unregulated sector providers, these norms are not well observed.

Table 4: Description of Formal Health Service Providers:

Zone	Health Providers	Principal Referral Point(s)	
		Maternity	Sick Child
Cite Okay/Jeremie	**(1) Siclait Health Center (HaitiMed)** Food for the Poor – outreach services 2 days/week in Jérémie	General Hospital (government)	Grace Children's Hospital (private, non-profit)
Descayettes	**(2) Health Center (SNELAK)**	General Hospital (government)	General Hospital (government)
Saint Martin	**(3) St Martin II (govt)** Salvation Army HC (mixed)	St. Jude Ann (private, non-profit)	General Hospital (government)
Jalousie et Bois Moquette	**(4) Jalousie Health Center (OBDC)** **(5) Bois Moquette Health Post (MEI)**	General Hospital (government)	Nos Petits Freres et Soeurs (private, non-profit)

** Facilities indicate key implementing partners of the program; however, strategic linkages are also promoted for coordination and partnership with other service providers.

Findings from the 2006 urban health facility assessment in the project area indicated some important service information:

Clients. The majority of centers were seeing between 20 to 40 clients per day and the biggest clientele were sick children with respiratory infections, fever and/or diarrhea.

Laboratory. All but one have on-site laboratory facilities, these include blood slide microscopy, stool investigation, and three out of five provide HIV rapid testing. A fourth is planned to open at St. Martin II later this year.

Pharmacies. All facilities had a basic pharmacy on site run by pharmacy aides with training. Supply of essential antibiotics, micronutrient supplements, IV fluids, oral rehydration salts and other essential items was good. Very few stock-outs in the past six months were reported although there has been a supply chain problem with ORS and polio vaccine. Some products are subsidized by the government, international agencies or a sponsoring NGO, but most items have to be purchased.

Costs. All providers charge for consultation visits anywhere from US$1 to $3 plus drugs and laboratory tests. A few programs such as child vaccination, Tuberculosis, and family planning, are provided free of charge.

Table 5: Hours of Service

Health Facility	Monday-Friday	Weekend
St. Martin II	8:00 to 4:00pm	Closed
HaitiMed	8:00 to 2:00pm	Closed
Descayettes	7:30 to 4:30pm	Saturdays 7:30 – 12:30
Jalousie	8:00 to 3:00pm	Closed

IMCI. Two sites have not been trained in IMCI. However, even at the sites with trained personnel, there are no algorithms posted nor evidence of supervision of case management. The other providers had never heard of IMCI even though it has been policy since 1997.

Vaccinations. The vast majority of health facility staff have had regular re-fresher training over past three years at all five sites. While generally very available at the facility site, HaitiMed in Cite Okay did not offer services, as its site served as an outreach area for Grace Children's hospital making service available only once per month. This is problematic for early vaccination during newborn care and in terms of not having a routine stock of Vitamin A, as it is only available to EPI providers.

Maternal and Reproductive Health Services. No centers provided delivery services, as they could not operate 24 hours per day. All offered antenatal and neonatal care, however there is very low use of postpartum care service. All providers are trained in syndromic management of Sexually Transmitted Disease and several provide PMTCT services. Family planning services are available at all service points, but by far are the least used service.

Nutrition. While all services had capacity for routine growth monitoring for weight-for-age, no sites currently offered any rehabilitation service (two had received short-term support from WFP during the political crisis but this ended after February 2006). Referral, in theory, should be to the hospital, as there is no special care available for severe malnutrition.

Personnel/Community Linkages: Staffing levels are substantially lower among the non-profit versus the government facilities, however, the actual level of staff present at the government facilities is low due to problems of transportation to the site, insecurity and overall under management of staff, particularly for the medical doctors. Connections with community resources is generally present but in many varieties…

…at the Jalousie/Bois Moquette centers they have trained and meet monthly with 31 TBAs and pay for 14 auxiliary nurses who provide full-time outreach services of growth monitoring, vaccination, and health education;

…at Descayettes, the founding CBO SNELAK runs the facility, which is comprised of water and sanitation committee members. They also have trained and meet monthly with 20 TBAs;

…at St. Martin II they have organized joint health education and periodic tracking of vaccination drop-outs with the umbrella CBO KDSM, but the neighboring facility of Salvation Army was unaware of the groups existence;

…at HaitiMed one staff member participates in a recently formed "pilot committee" that is liaising with over 16 CBOs to work towards a health forum, but otherwise there is limited reach into the community

Table 6: Summary of Targeted Health Agents by the Project in all Neighborhoods

Neighborhood	Number of nurses & doctors	Number of auxiliary nurses	Community Health Agents	CBOs	Youth Clubs	Trained TBAs
Cite Okay/Jeremie	2	4	0	Pilot Committee with 16 CBOs	Yes	0
Descayettes	2	3	0	SNELAK	Yes	20
Saint Martin II	6	14	20	KDSM – federation of 13 CBOs	Yes	14 known but not trained
Jalousie et Bois Moquette	2	3	14	Still being inventoried	Yes	31

All health staff teams interviewed were familiar with some of the informal health service providers, including numerous "charlatans/quack doctors," described as largely untrained providers with no formal education who practice a mix of modern and 'traditional' medicines; several "Medecin Feuilles," or traditional herbal practitioners; active traditional birth attendants, as well as privately operating auxiliary nurses; and mobile/unregulated drug vendors.

Initial KPC survey data sheds much light on care-seeking patterns for maternal, newborn, and sick child care. About 2/3 of all sick children (65%) are first taken to either a hospital or health center. Interestingly, another 11% seek care from a friend or relative, 10% from a private clinic, 4% pharmacy, and 10% from an informal source such as a Houngan, Quack, TBA, etc. When asked about second-line of advice/treatment, the levels were: hospitals (37%), health centers (30%), and private clinics (7%). Private clinics remain about the same, but it appears that consultation to the informal sector increases (22%), while friend's advice and consultation to a pharmacy/drug seller declines considerably. Delays in seeking care are common, with 62% of caretakers waiting 2 or more days before seeking any advice or treatment outside the home. Further, half the caretakers waited 3 or more days (52%). Fortunately there are some caretakers who take action quickly. The urban health survey found that 23% sought care outside the home within 24 hours for pneumonia symptoms.

f) Vulnerable and Marginalized Populations. The crux of Concern's work is to "make lasting improvements to the quality of life the **most vulnerable of the poor,"** female-headed households, adolescent mothers, and families affected by HIV will be carefully considered in community health support strategies and in the development of a health insurance protection scheme that GRET is initiating in Descayettes. Community leaders will pay particular attention to their situation and organize support. The program will also network with UNICEF, WFP and other major national programs to ensure that free preventive and curative services are made available in the urban neighborhoods.

The Urban Health KPC 2006 survey provides further insight into inequities and vulnerabilities. There is no noted sex-of-child discrimination. However, a proxy indicator of income poverty, the Household Dietary Diversity Score developed by FANTA, was included in the Urban Health KPC survey to assess equity of coverage. It scores households based on the numbers of different types of foods consumed (12 types), with lowest food diversity assumed to those that are the "poorest." The results show considerable differences in coverage of key healthcare practices among the poorest compared with other groups, especially in certain categories such as antenatal care, vaccination of

children, and prenatal tetanus vaccination for mothers, among others. Specific odds ratios on HDDS for key indicators will be analyzed and discussed in the first annual report.

g) Linkages and Complementary Activities: The following health sector actors have been identified as important stakeholders that the program will work with so as to avoid duplications and to leverage resources that promote health for our population:

Management Sciences for Health (MSH). MSH has a very strong presence and influence in the Haitian health system, covering 9 departments and working with a mix of 28 local and international NGOs. In the metropolitan zone of Port-au-Prince, they work with ICC in Cite Okay area of Delmas, FONDEF with 29 health centers including Cite Eternel; with FOCAS in Jalousie/Petion-Ville; OBCG in Carrefour; and just recently started to work with the St. Martin II Health Center where they trained and placed 20 community outreach workers on performance contract through September 2006. An important difference in methodology is that MSH employs outreach auxiliary nurses to provide household level services, while our approach relies on engagement of local community organizations for health promotion activities at that level. However, the risk of duplication of work is high and negotiations with USAID, DSO, MSH and Concern are underway to review and recommend changed working areas according to the revised health system map that is under development.

Meetings with Dr. Marie Gurlaime Raymond, the Ministry of Health West Department Director, as well as Dr. Mallet, the Child Survival Coordinator of MSH, indicated a keen interest in advancing work in urban health, ensuring access to services for disadvantaged populations, improving coordination and sharing, and contributing to an urban health strategy in the country. MSH has a second staff member at DSO level with whom the Project Manager will coordinate.

Population Services International. is active in Port-au-Prince in the social marketing of mosquito nets, oral rehydration salts (Sel Lavi), condoms, oral contraceptives, and water purification powder (PUR). These are readily available in the neighborhoods and prices are fixed. Some of the products are also sold at the health centers pharmacies. The program will collaborate with PSI in training of community distributors, provision of initial stock paid by the project, and sharing of product communication materials. We will also explore collaboration at youth rallies and other major organized health gatherings.

MSF/Holland. has been present in Haiti on and off since 1992. Currently, they are reinforcing primary and tertiary health care in Cite Soleil in Port-au-Prince and are preparing to initiate a three-year maternal health and emergency obstetric care program at St. Jude Ann Hospital. This is a free service at a 64 bed hospital neighboring St. Martin (see map in Annex B). During prenatal care, women will be screened for complications and high risk profiles. Free delivery service is available for cases with medical complications and those pre-screened for potential high risk. This child survival program will complement MSF/H's effort by vetting and applying the high risk screening tool and referral forms for inclusion into the MSF/H program, and by enabling exchange visits by health center staff and TBAs, which will serve to strengthen personal networks and awareness of services. As described in the maternal and newborn care section, our project strategy is to ensure universal awareness among men and women of early danger signs, and to mobilize communal support to get the mother to the hospital for care.

World Food Programme. At the time of developing the DIP, WFP was reviewing its priorities and objectives for 2006 with partners PADF, MINUSTAH, and EU. Currently their operations include

distributing food to health centers and schools in the West, North and Northeast Departments as well as in Port-au-Prince. They are looking into the option of producing and distributing fortified biscuits (cassava mamba) to the children of the schools in Grande Riviere in the Northern Department. WFP coordinated a UN task force on Cite Soleil to discuss a possible joint evaluation mission on site and the development of a coherent UN joint strategy to this needy neighborhood. WFP will be invited to share its plans at the urban health platform at least once per year to maximize potential synergies.

UNICEF Haiti. UNICEF operates six programs including 1) The Health and Nutrition Programme (focusing on 0 to six years of age), which includes breastfeeding promotion, immunization, improved feeding practices, micronutrients and the Integrated Management of Childhood Illness initiative 2) The Adolescents and Youth Programme, which focuses on preventive and reproductive health, including HIV/AIDS prevention and control, providing information and primary health care services to target antenatal care, and maternal health and safe motherhoodprograms 3) The Basic Education and Early Childhood Care and Development Programme This programme, for 0 to six years of age, provides increased care and stimulation, with an emphasis on low-cost models to serve the poor and community-managed initiatives. For seven to 12-year-olds, it focuses on creating child-friendly schools, with an emphasis on improved quality, retaining girls, access to child/adolescent-friendly health services, and HIV/AIDS curriculum development and teacher training 4) The Child Protection Programme activities (focusing on 0 to 18 year olds), targets street children, child servants, orphans, minors, those orphaned or made vulnerable by HIV/AIDS, victims of natural disasters and all those unregistered at birth. Activities include legislative reform, institutional strengthening, birth registration, access to health and educational services, promoting a rights culture, and social integration of those suffering exclusion, exploitation, violence and abuse. 5) The Capacity-Building, Monitoring and Evaluation Programme includes child rights-based indicators, research and reporting, to have a basis to hold duty bearers accountable for their obligations to children. It focuses on strengthening the capacity of institutions to plan, manage, monitor and evaluate, as well as the capacity of families and communities to respect and protect rights. And 6) The Advocacy, Information, Communication and Participation Programme seeks to motivate behavioural change and mobilize civil society partners and government for rights fulfilment.

UNFPA. UNFPA has several reproductive health and population programs including the "Right to Know Project" initiated by UNICEF in 14 countries, including Haiti. The purpose of this project is to seek a more effective means of communication addressing vulnerable groups, particularly young people, in order to reduce the rate of HIV infections. The project is implemented by national NGO, **Foundation for Reproductive Health and Family Education (FOSREF).** Another UNFPA programme funded by the Japanese Trust Fund for Human Security, and subsequently by Canada (CIDA), supports family planning and emergency obstetric care in departmental hospitals. The urban health project is only beginning discussions of complementing efforts in reproductive health and youth.

Others. There are additional NGOs operating the Port-au-Prince area of the project including the Salvation Army, FONDEF, Food for the Poor, and Grace Children's Hospital. Many of these agencies are receiving funds from MSH for basic child survival type programming and Tuberculosis control. To minimize risk of any duplication of resources, to leverage opportunities for exchange, and to promote collaborative contributions to an eventual urban health strategy, the project team will actively seek out participation of these groups at the Urban Health Platform, as well as at local level annual planning where these groups share geographic areas.

Concern Worldwide Haiti (CW/Haiti) has several urban area programs in the areas of HIV/AIDS, Microfinance, Peace building, and Waste Management. The HIV/AIDS program focuses on improving quality of HIV/AIDS/STI services in 7 health centers, including start-up at St. Martin II. The Urban Microfinance project aims at improving the capacities of partner ID to deliver quality microfinance products to the poorer segments of the urban population. KDSM, a federation of CBOs and Concern's local partner in Saint Martin, will receive support to organize community services for removal of solid waste, emptying of septic tanks and building of family latrines. KDSM will also coordinate the implementation of the Schools Health Project in Saint Martin. These projects will have synergistic effects with this urban health project through quality integration of maternal and HIV services at the clinic, initiation of quality assurance processes in all clinics, improved environmental health determinants, management support for HC funds, referral services for destitute patients in the clinics, and BCC in schools.

Synergies with other Concern Programs: With support from the Irish Glencree Centre for Reconciliation, and in partnership with KDSM and the local Human Rights organization Justice and Peace, Concern has also started an intervention aimed at reducing violence and marginalization in both areas of Saint Martin and Cite Okay/Jeremie. Through training and support for small economic activities the project will work to strengthen the communities' ability to manage their conflicts in a nonviolent way. By reducing violence in the project areas, this intervention will guarantee better access to beneficiaries and less disturbance of the implementation of other project activities in these areas.

GRET works in Haiti through a local, structured and partially autonomous team specialised in urban social engineering. The GRET-Haiti experience grew during the implementation of a drinking water supply programme in poor neighbourhoods of Port-au-Prince. This project was launched in 1995 and continues to this day. A local office run by Daniel Henrys pilots the activities, co-responsibility for which is shared with the GRET-France team. Currently they are involved in three main projects:

The Drinking Water Programme with CAMEP (the Port-au-Prince Metropolitan Water Company) Each management committee forms a single client for CAMEP. They manage the street fountains in their neighbourhoods and ensure network maintenance. The sale of water makes it possible to finance the scheme, pay CAMEP bills and make a profit. The committees are representative and legitimate and have the necessary authority in their neighbourhoods. CAMEP has adopted this policy and is now expanding it to a total of 35 neighbourhoods.

Community Initiative Support Project to Reduce Maternal Mortality in Two Port-au-Prince Shantytowns aims to improving community response to reproductive health–related problems in Cité l'Eternel and Dupont. This improvement takes several forms. It increases community capacity to provide pregnant women and women of childbearing age with quality maternal health care, such as the provision of basic gynaecologic care and routine and emergency obstetrical care, via existing health care structures in the project's intervention sites for. It enhances the development of community and institutional health education activities to alter behaviours among the population regarding lower-risk pregnancy, STDs/HIV/AIDS, family planning, perinatal care, and nutrition. It promotes crosscutting gender equity, social engineering and community development activities fostering access to the available health care services. And it initiates the implementation of community insurance policy programmes, furthering access to health care for all. GRET is more specifically in charge of implementing the mutual health insurance system with the community grassroots organisations of the targeted neighbourhoods, and it oversees coordination of the project.

Synergies with the GRET projects will be obtained through exchange of learning between the Urban Health Project Officers in charge of community mobilization and GRET's experienced Animation Team on social behavior change. Also, learning exchanges will happen through project teams and health clinic staff on promotion of quality maternal and neonatal care, example of health-agents who are employed by a CBO umbrella organisation, possible expansion of a successful mutuelle model to other neighborhoods and increased access to health care for the poor, collaboration with water committees to promote appropriate technologies for handwashing points, and to promote hygiene and sanitation practices, and point-of-use water treatment strategies.

In 1997, **FOCAS** initiated its first child survival program in two districts serving a population of about 100,000 in both the rural and peri-urban areas of Petion-Ville just outside of Port-au-Prince. This was made possible with matching grant funds from USAID. FOCAS combined this funding with existing resources from its long involvement in Haiti (since 1986); a mentoring relationship with Curamericas; and partnerships with local health organizations in Haiti, Mission Evangelique Internationale (MEI) and Oeuvres de Bienfaisance et de Developpement Communautaire (OBDC). Following a successful evaluation in 2003, including a 31% reduction in child mortality, the local USAID mission funded continuation under a five-year grant from MSH for work in maternal and newborn care, nutrition, diarrhea, and pneumonia. However, they do not receive any USAID funds for HIV/AIDS prevention and youth programming.

Synergies with FOCAS' work will include sharing and building on lessons and tools from child survival experience, especially in regards to monitoring and evaluation and quality assurance; providing an example for transitioning from a paid community health agent model to a voluntary, Community Based Organization led in health promotion model; and greater exchanges with MSH funded projects.

5.2 Summary baseline findings

a) Types and Methodologies. There were three primary tools utilized for formal baseline assessment. Copies of reports on the KPC and Health Facility assessment are available in Annex G.

Urban Health KPC 2006. Using Lot Quality Assurance Sampling (LQAS), the area was divided into four coverage areas: 1) Jalousie/Bois Moquette, 2) St. Martin, 3) Cite Okay/Jeremie, and 4) Descayettes. Each area was sub-divided into five supervision zones and detailed housing maps were developed for random selection. Nineteen mothers of children 0-23 months in each supervision zone. A total of 374 mothers of young children 0 to 23 months were included including 225 mothers with children aged 0 to 11 months of age and 149 mothers of children 12 to 23 months.

While we originally intended to collect 95 samples of each age group in each neighborhood, the survey team reduced this to 95 samples for the combined age group of 0-23 months in an effort to complete the survey during a short time period from the subsiding of significant insecurity in the neighborhoods up to the dates of the DIP workshop. This resulted in very wide confidence intervals for several indicators when reviewed by neighborhood; however, the overall coverage results are

within in the standard 95% confidence interval. Population surveys for the midterm and final evaluations are planned to be collected with 95 samples of each of the two respondent age groups as well as the youth module, assuming the security situation permits such extensive surveys.

Data was collected just after the Presidential Elections from late February to April 2006. Questionnaires were developed based on the CORE/CSTS KPC 2000+ modules for interventions of HIV/AIDS, Maternal & Newborn Care, Immunizations, Nutrition, Diarrhea, and Pneumonia, as well as the Rapid Catch Indicators. The median age of mothers with children aged 0 to 23 months interviewed in the KPC survey was 27 years. In all neighborhoods, the majority (86.6%) of the mothers is not working, and the most common employment activity was street vending/shop-keeping (8.7%). There was a considerably higher ratio of children 0 to 11 months than 12 to 23 months included the survey, 3:2, which may reflect a bias towards mothers who weren't working, as respondents we contacted during the daytime. Data collection in the evenings was not an option due to security concerns. Income earned outside the home and household type will be reassessed as part of the nutrition and livelihoods survey in July 2006 as the findings are not considered to be representative of the area.

Rapid Health Facility Assessment. The rapid health facility assessment of six health centers serving our population was completed between March 20-24, 2006. The purpose of the assessment was to gain information about the availability of maternal and child health services, staffing and training, health information systems, management and availability of drugs, facility hygiene and waste management, referral points, costs, and linkage with community.

Interviews with CBOs. Each group interview conducted was about 90 minutes, and included the three community based partners of SNELAK in Descayettes, KDSM in St. Martin, and a "Pilot Committee" of community leaders and CBO representatives in Cite Okay/Jeremie. During these group discussions, which were held in Creole, the topics included perceptions of the health situation for men, women and children; CBO interest in health as an activity; and, ideas for reaching households and reporting on important data in communities. Information from these discussions has been integrated into the project strategies and training plan.

b) Up-to-date Coverage Estimates by Intervention. The following data is reported from the 2006 Urban Health KPC Survey for the neighborhoods of Cite Okay/Jeremie, Jalousie/Bois Moquette, St. Martin and Descayettes.

Immunizations

- According to our survey, the full vaccination coverage (as confirmed by card) before 1st birthday was 51% while those fully vaccinated by 12 to 23 months at time of survey was 60%.
- The vaccination drop-out rate was 17%
- Measles coverage was 61% based on card and mothers' recall.
- Only 19% reported receiving 2 or more tetanus-toxoid vaccines during last pregnancy

Overall vaccination coverage levels have greatly improved since the 2000 DHS findings for metropolitan Port-au-Prince where fully vaccinated by 1st birthday was only 31% and drop-out DPT1 to DPT3 was 34%.

Nutrition

- All children had been breastfed at some stage, including 60% during first hour of birth.
- Of the children 6 to 9 months, 52% received breastmilk and complementary foods
- Of the children 0 to 5 months, 28% were exclusively breastfed (range 21% to 69%)
- Vitamin A coverage was 51% among infants 6 to 11 months and 68% among children 12-23 months (overall age-specific coverage was 61% for children 6 to 23 months). [25]
- 1.9% of children aged 12-23 months had a mid-upper arm circumference (MUAC) less than 125 mm indicating severe wasting.

Diarrhea

- The point prevalence of diarrhea was 50%
- Sick child feeding and rehydration practices are sub-optimal, with less than 13% providing more fluids and at least maintaining normal food intake. Of mothers with sick child, 49% reported giving less food than usual and 34% gave less fluids than normal.
- ORS use by mothers with child with diarrhea was 50%.
- 32% treat their drinking water with bleach, PUR, a socially marketed purification product, or filter it at home
- Only 3% washed hands with soap before preparing food, before feeding children and after defecation. However, 68% reported hand washing after own defecation.

Pneumonia

- Point prevalence of cough and rapid or difficult breathing in the two weeks prior to the survey was 21%
- Awareness of the term "pneumonia" is low, as most people are more familiar with asthma, bronchitis. Only one mother, could cite two danger signs of pneumonia. For example, the most well known danger signs identified by mothers were fast or difficult breathing cited by 8% and 7% respectively. No respondent mentioned chest in-drawing.
- Of the children with cough and rapid or difficult breathing in the two weeks prior to the survey, 66% were seen at a health facility,
- Of children with symptoms of pneumonia, 23% of mothers sought care outside the home within the first day while 52% waited three days or longer.
- Feeding practices during illness: 20% received less breastmilk, 56% less food, and 29% less fluids than normal. Overall, only 10% of children with cough and rapid or difficult breathing received more fluids and the same or more foods than usual.

HIV/AIDS

- Just over one-third (34%) of mothers of infants 0 to 11 months have been tested for HIV/AIDS and know their status
- Positive attitudes regarding support to PLWHAs (purchasing food from a vendor, caring for a sick relative, sending child to classroom teacher, accessing healthcare) was only 9%.
- Awareness of two or more modes of HIV transmission was nearly universal at 91%
- 73% of mothers knew of other STIs and half (49%) of them knew three or more signs and symptoms*
- The is very low use of family planning services by youth

Maternal and newborn care

- 79% of mothers attended 3 or more antenatal care visits and 51% four or more, most of these consultations were made by a medical doctor
- Only 4% received at least a 90 day supply of iron folate supplements during last pregnancy
- Nearly half of deliveries (44%) were conducted by a skilled attendant; data from two neighborhoods indicated that 40.5% deliveries took place in a hospital and only .5% in a Health Clinic
- 34% of mothers of child 0 to 11 months knew at least one maternal danger sign during the postpartum period. Most frequently cited indication was fever (22%). Additionally, 38% knew two or more newborn danger signs. The most frequently cited were fever (60%), poor feeding (7%), redness around the cord (90%), and dehydration (20%).
- Only 22% of mothers received care by a skilled provider within first week of delivery whereas 16% of newborns did

c) Potential Constraints. There are several natural and man-made risks that the program must be vigilant about and work to mitigate the effects of.

Natural Disasters. Anticipating very active hurricane seasons for the next five years, the program expects risks of flooding, and risks of fire in densely populated and poorly ventilated dwellings.

Man-Made Disasters. As we've seen in the past, gang violence and political conflicts could potentially undermine the ability of the state to provide basic services to the poor, and may again force the evacuation of residents from unplanned settlements

Concern's Disaster Risk Reduction team is currently implementing emergency mitigation strategies on La Gonave in close collaboration with national civil protection authorities. They will extend this to the urban areas in 2007, working with local stakeholders to identify main risks in the area, set up mitigation projects and prepare disaster response teams. Strategies will certainly include much of the initial violence mitigation efforts already underway in St. Martin, such as rerouting clients to safer sites during crises within Delmas BC; creating safe corridors to health centers; and working with clear memoranda of understanding with key government institutions.

5.3 Program description

5.4 Overall strategy

a) Strategic Results Framework. The overall strategic objective of this five-year child survival program is to achieve **sustained improvements in the health status of mothers, children and youth in five disadvantaged urban neighborhoods of Port au Prince, reaching 54,000 women of reproductive age and 32,500 children under-five.**

Specific Measurable Changes. The following changes will be targeted to achieve sustained health improvement and maternal and child mortality declines.

Improved preventive child health practices

- Increase from 28% to 35% infants age 0–5 months who were exclusively breastfed during the last 24 hours
- Increase from 32% to 50% households with children 0-23 months who purify their drinking water
- Increase from 61% to 80% children 6-24 months receiving Vitamin A supplement within past 4-6 months (according to age)
- Increase fom 51% to 80% children 12-23 months fully vaccinated (verified with card) by first birthday

Improved care for sick child

- Increase from 50% to 70% children 0-23 months with diarrhea who have received ORS
- Increase from 66% to 75% children 0-23 months with cough and fast, rapid or difficult breathing in past 2 weeks who were seen by trained provider
- Increase from 13% to 45% mothers with a sick child aged 12-23 months who increase fluids and maintain feeding during the illness

Improved maternal and newborn care

- Increase from 79% to 90% mothers of children age 0–11 months who had three or more antenatal care visits during their last pregnancy
- Increase iron folate intake for 90 days or more by mothers of children aged 0-11 months from 4% to 20%
- Increase from 16% to 35% of mothers of infants 0-11 months who attended postpartum care check-up with the newborn within 7 days of birth

Enhanced youth HIV/AIDS protection

- Increase by 35% the number of youth aged 15 to 24 who become new acceptors of modern contraceptive methods (estimated at 3.2% as per DHS 2000)
- Increase from 12.6%[26] to 20% the proportion of sexually active out-of-union youth, aged 15 to 24 years, who use a condom consistently for the past 3 months.

An additional set of seven individual and health provider behavioral indicators will be monitored as stipulated in the behavior change tables of the intervention-specific sections; however, no specific targets are set at this stage. Baseline measurements are available in the 2006 Urban Health baseline assessment report for population based practices.

Intermediate Results. The strategic framework includes four intermediate results (IRs), or project outputs, designed to ensure achievement of the strategic objectives. These IRs and summary activity areas to deliver them include the following:

IR 1: Empowered communities with increased knowledge and interest in maternal, child and youth health promotion. Key strategies include:

- Capacity building and federation forging of community based organizations for health & development in five neighborhoods
- Annual action planning and reviews at neighborhood level
- Community health promotion events implemented rallies, campaigns, fairs, group education organized year round
- Youth involvement with 1,136 leaders in neighborhood health
- Organization of community-level HIV/AIDS prevention and control

IR2: Enhanced availability of and access to reproductive and child health services for disadvantaged households in urban areas. Key strategies include:

- Establishing IMCI services in Descayettes, St. Martin and Cite Okay/Jeremie
- Promoting focused pre and post-natal care
- Assess feasibility and pilot community based therapeutic care for severe malnutrition
- Develop pro-poor protection strategies for vulnerable families
- Intensification of EPI activities
- Strengthen essential drug and supplies management system
- Reinforce the obstetric care referral system from the household to hospital level

IR 3: Increased quality of reproductive and child health services. Key strategies include:

- Capacity building for supportive supervision of health services by three Bureaux Communales
- Foster better health information system implementation and data for decision making skills
- Institutionalization of participatory capacity assessments for health facilities
- Establishing quality assurance approach with performance incentives at 5 HFs
- Strengthening EPI logistics through quality assurance teams and strengthening connections with national program

IR 4: Improved policy environment for the urban populations, putting emphasis on protection for the poorest people. Key strategies include:

- Start-up and support of an Urban Health Platform in Port-au-Prince metropolitan area
- Advocacy for improved environmental health in poor urban neighborhoods to government, donors and private sector
- Popularization of learning from the urban health initiative experience
- Support of the DSO in the initiation of an urban health strategy for the Ministry of Health West Department

The table below outlines the key actors by operational level that are center to the achievement of the goal and intermediate results of the Urban Health Program.

Operational level	Units	Actors
Metropolitan area	1	Urban Health Platform : MSPP, PVOs, NGOs, Health Facility personnel, agencies, donors
Neighborhood	5	Community Health Forum (Health Facility staff, CBOs, Youth Leaders, Project staff, and other political and opinion leaders)
Sub-zones of approx 1,000 HHs	40	1 CBO lead 25-30 youth leaders 2-3 TBAs (only in 26 zones; excludes FOCAS areas)

Neither the Ministry of Health West Department Health Direction nor do the Bureaux Communales have full authority, or the human and physical capital required, to adequately assess and customize national health strategies for the urban poor. As a result, despite the recognition of need, the unique needs of marginalized urban populations are largely ignored. Indeed, implementing programs in these marginalized areas presents unique challenges including environmental degradation and the need for a multi-sectoral, integrated approach to improve health; weak social networks; a highly mobile population; the limited availability of women's time for health services and child care due to economic survival; financial and psychological barriers to accessing health services, and the poor quality of services offered; and a plethora of under-regulated, and perhaps dangerous, private formal and informal services.

b) Working at Scale: Inspired by global efforts to achieve greater coverage and impact of child survival interventions, this project will specifically contribute to scale in the following ways:

- Engagement in the development of a national community IMCI strategy applicable in urban setting
- Developing youth leadership for health and peer suppor
- Community Based Therapeutic Care feasibili care/integration into IMCI case management protocols f
- Developing and disseminating lessons from experience v

c) Sustainability Strategy. As part of the DIP worksl BCs and DSO to develop a shared vision among partn years out. It is an image of greater coordination sha Concern, GRET, FOCAS, the DSO with USAID. Sustainability Framework will be introduced and its el monitoring and evaluation system has been developed Survival Sustainability Framework, in addition to he capacity. However, the specific strategic elements will b community competency and external environment cc Research Organization, GENESIS, will consult with Cl develop these areas, adapting from tools developed Bangladesh.

Figure 1: Child Survival Sustainability Framework

d) Quality Improvement Strategy. Based on Demming's principles, a quality improvement approach is central to addressing systemic and motivational barriers to the delivery of good services. This program promotes quality improvement in all five health facility staff at all levels, from the non-technical custodians to doctors and nurses, through team approach. Using this QI approach, the program will promote self-assessment of the capacity and quality of maternal and child health services and develop plans and targets for improvements. This method is based on the PRIME II Stages, Steps, and Tools for performance improvement and will be introduced and applied following the participatory health facility assessments at the beginning of year two and after each technical training with facility staff.

Stage 1: Consider Institutional Context. Complete directed, self-facilitated Health Institution Capacity Assessment with the Process Documentation & Research Organization, GENESIS.

Stage 2: Obtain and Maintain Stakeholder Agreement. Based on assessment, develop health facility action plan for short-term period over the next one year, and for the medium-term of 3-5 years. Invite CBO and youth leaders to this planning session.

Stage 3: Define Desired Performance. Following technical trainings, the QI team will lead a review of the service provided against standards learned in the training sessions.

Stage 4: Describe Actual Performance. Based on the assessment, the QI team will describe the actual situation. For example, gap in mother counseled on feeding of the sick child.

Stage 5: Describe Performance Gaps. The QI team will share with the health facility staff and representative youth and CBO leaders the desired performance against actual and jointly identified gaps, and will collaboratively prioritize a response.

Stage 6: Find Root Causes. The participants will use fishbone diagrams and other investigation techniques to assess the underlying causes of the performance gaps. From there, they will identify which ones are within the teams control, and which ones they need to influence externally.

Stages 7, 8 & 9: Select and Design Interventions, Implement & Evaluate. From the list the QI team will propose an intervention plan with timeframe, responsible persons, and targets for making improvements, as well as a monitoring plan to assess performance.

The cycle continues based on annual planning and follow-up to further technical trainings. Other data sources include the HMIS and Client Satisfaction Survey findings.

e) Roles of Major Partners. Following consultations and a group review at the DIP design workshop in March 2006, the following table represents the primary roles and program support that will be provided by each of the major partners by level. Further roles and responsibilities of individual internal and external human resources are included in Annex H-2 and H-3.

Table 9: Roles and Support for Key Partners

Partner Type	Specific Roles for this Project	Support Required by the Program
DSO WITH ITS BUREAUX COMMUNALES OF PORT-AU-PRINCE, DELMAS & PETION VILLE	Advise the Project on national standards, tools and other urban health actors Conduct training and clinical supervision of health workers trained in IMCI and maternal & newborn care Ensure supply of essential drugs and supplies for health providers Develop, implement and monitor annual action plans at DSO level that integrates urban health project work Maintain a routine supervision calendar Supervise at least once per quarter and motivate both public and private sector health workers Chair the Quarterly Urban Health Platform Manage the HMIS (data collection, analysis, feedback, and respond to reported diseases/epidemics)	Participate in and support the DSO annual activity plan Co-facilitate and animate quarterly Platform meetings. Manage input from GENESIS. Ensure coordination and regular meetings Fully implement and review committed activities. Share experiences and tools used with the urban health project
GRET	Develop, implement and assess annual workplans at community and health facility level in Descayettes. Manage quality improvement and performance incentives approach in working area. Share tools and lessons for willingness to pay and social insurance schemes Share best practices in community mobilization for hygiene and sanitation Advise program on advocacy and urban health development Implement all interventions in Descayettes and take responsibility for achievement of results Budget for and conduct all neighborhood level trainings as per training plan Designate and support full-time personnel to implementation of workplan in Descayettes Write monthly and quarterly activity and financial reports for activity in Descayettes Actively participate in monthly staff meetings, quarterly management reviews, quarterly Urban Health Platform meetings, as well as baseline, midterm and final assessments	Clear monitoring and evaluation plan Provision of program-level trainings and meetings Provision of information, education and communication materials as established under BEHAVE strategy for interventions Supervision of performance in designated working areas Challenge assumptions and assess impact on most vulnerable populations. Facilitate sub-population specific strategies.

Partner Type	Specific Roles for this Project	Support Required by the Program
FOCAS	Develop, implement and assess annual workplans at community and health facility level in Jalousie & Bois Moquette Manage quality improvement and performance incentives approach in working area. Share community monitoring tools and techniques from former child survival program Provide technical leadership and share best practices in working with youth in HIV/AIDS programming Conduct annual review of HIV/AIDS programming in all five intervention areas Implement HIV/AIDS interventions in Jalousie & Bois Moquette and take responsibility for achievement of results for this intervention only. Budget for and conduct all neighborhood level trainings as per training plan Designate and support full-time personnel to implementation of workplan in Jalousie and Bois Moquette Write monthly and quarterly activity and financial reports for activity in Jalousie & Bois Moquette Actively participate in monthly staff meetings, quarterly management reviews, quarterly urban health platform meetings, as well as baseline, midterm and final assessments	Clear monitoring and evaluation plan Provision of program-level trainings and meetings Provision of information, education and communication materials as established under BEHAVE strategy for interventions Supervision of performance in designated working areas Challenge assumptions and assess impact on most vulnerable populations. Facilitate sub-population specific strategies.
CONCERN	Provide overall leadership in technical quality of program Lead development of detailed workplan, annual Lead monthly staff and quarterly management meetings with partners Facilitate development of advocacy strategy for urban environmental health Write monthly and quarterly activity and financial reports for activity in St. Martin & Cite Okay/Jeremie Compile monthly and quarterly progress reports Lead annual reviews and writing of the annual report which is submitted to USAID. Manage the baseline, midterm and final evaluation assessments for all five neighborhoods Engage in national strategy development for community IMCI, youth, and other relevant themes to this health initiative Oversee the work of the Process Documentation & Research Consultant and the M&E Consultant Convene monthly staff meetings	Learning and exchange of experience with partners Extension of liaison and information collection with Descayettes, Bois Moquette, and Jalousie neighborhoods Sharing of tools and best practices

e) Behavior Change, Training & Community Mobilization Strategy

The Urban Health Project will apply an intervention wise roll-out of well researched practices and behaviours followed by training at the health facility and community leaders level and subsequent intensive community mobilization efforts at the neighbourhood/sub-zone level. This is referred to the "drip and cascade" method and includes the following components on an approximately six month cycle:

- BEHAVE strategy development by intervention including completion of formative research and adaptation of materials
- Strengthening service at health facility: training, quality assurance processes, performance incentives and supervision
- Training of trainers and cascade training of small groups of youth and CBO leaders by intervention
- Community mobilization based on themes planned at neighborhood and sub-zone levels

What	**Who**	**How**
Behavior change (intervention wise every 6 months)	Task force: Health Officers, Community Dialogue Trainers, BC, MSPP	Complete formative research Establish key factors, activities & monitoring plan Adapt materials & tools
Quality assurance	Health facility staff (entire team @ 5 HFs)	Assess situation and identify gaps following trainings Analysis shortcomings and establish plan Monitor and evaluate
Training of 16 Community Health Promoters	Adult Education Consultants with Project Manager	Adult learning methodologies Topical based following existing FFH materials
Community Mobilization	CBO & Youth Leaders with leadership from Community Health Forum	2-3 day training by Community Health Promoters Local priorities and action plan; communication materials/strategies from Task Force
Health facility Activities	Nurses, Docs, Auxillary Nurses, Managers	Routine care as per standards Manage essential drugs Train community health actors HMIS entry and use Leadership in community health forum planning, data compilation

While there is enthusiasm to do all interventions at once, phasing of interventions is necessary. Intervention schedule shown below was determined based on baseline assessments and stakeholder prioritization:

Topic Area	BEHAVE Strategy	Health Facility Training & QA	Community Training	Community Mobilization Starts
HIV/AIDS	Jan-Mar '06	NA	Apr-Jun '07	Jul-Sept '07
MNC	Apr-June '07	Apr-June '07	July-Sept '07	Oct-Dec '07
Sick Child/ IMCI	Oct-Dec '07	Oct-Dec 06	Jan-March '08	Apr-June '08
Infant &Young Child Feeding	July-Sept '08	Jul-Sept '07	Oct-Dec '08	Jan-March '09
Vaccination	Apr-Jun '09	*IMCI Oct-Dec 06* Jul-Sept '08 Jul-Sept '09	Youth: Oct-Dec '06 Refresher: Apr-Jun '09	Youth: Jan-Mar '07 Community: Jul-Sept 09

g) Behavior Change. The process for developing the urban health behaviour change strategy is embodied by the AED/CORE BEHAVE Framework. This tool is designed to help planners (the committee on behaviour change of the urban health platform) to improve strategic thinking about behavior change and avoid a "rush to tactics," which can result in ineffective programming. The goal of the committee is to end up with a sentence, which encapsulates the program logic: "In order to help [audience] to [behavior] we will focus on [key factors] through [activities]." All of these key decisions (audience, behavior, key factors and activities) must be based on real data from audience research.

Through the baseline studies and DIP workshops, target behaviours and priority groups have already been integrated into the monitoring and evaluation strategy. This is represented in the strategy outlined in Table 8 on the following page, which is a work in progress.

To better inform the priority of key factors that if addressed effectively will facilitate mothers (actual and expecting) to practice these behaviors, a doer/non-doer analysis, focus group discussion, and observation will be conducted as part of the development of intervention-wise BEHAVE frameworks. Further areas for qualitative research have been highlighted under each technical section. The first theme will focus on HIV/AIDS to be developed in October-December 2006.

The behavior change committee members will be taught to use the BEHAVE methodology by the CW/US Health Advisor with trained staff from CW/Haiti. They will jointly plan the analysis of information, and will organize community assessments and consultations with residents based on key questions identified within the emphasis behaviours tables under each intervention sections. Community Health Forum members on the Behavior Change Committee will plan activities to specifically address the key factors during their regular meetings. The committee meets every six months to share promising activities, discuss progress from monitoring reports, and to continue the capacity building of team members.

Table 8: Work in Progress - Behaviour Change Strategy using BEHAVE Framework

GROUPS		BEHAVIOR	KEY FACTORS	ACTIVITIES (Designed based on key factors they address. The following are illustrative of options and focus)		
PRIORITY	SUPPORTING			**Channels**	**Tools/ Media**	**Message/Content**
Maternal and Newborn Care						
All pregnant women	Husbands, TBAs, CBO leaders	Mother accompanies newborn to health facility for postpartum care within 3 days of delivery	To be confirmed: Actual consequence Access Self-Efficacy Perceived social norm	Potential channels include: • CBOs • Youth • HC staff • Mass media • TBAs • Shopkeepers • Aunties	Potential tools / media include: • Songs • Picture books/flip charts • Billboards • Group discussions • Provider counseling • "Miking" / loud speakers • Fairs • Health days • Meetings • Street theatre / skits • Radio • Word of mouth • Peer to peer • Etc.	To be developed based on review prioritized key factors, review of national messages, and field-testing by Committee members
All pregnant women	Husbands, TBAs, CBO leaders	Recognize danger signs of pregnancy, postpartum and newborn and go straight to the hospital				
All pregnant women	Health Workers	Take iron folate daily for at least 3 months during pregnancy				
All pregnant women	Mother & Mother-in-law, husband	Attends3 or more ANC visits				
HIV/AIDS						
Youth 15-24 out of union	Partner, condom vendors, peers	Consistently use condoms during sexual activity				
Youth 15-24		Consistently use modern contraceptive while sexually active				
IMCI						
Mothers	Friends	Increase fluids and maintain normal feeding while child sick with diarrhea				
Mothers	Fathers, school age child	Disinfect home drinking water				
Mothers	Fathers, school age child	Recognize fast, rapid and difficult breathing as danger signs of pneumonia and seek treatment at the health center				
Health Providers	CBO & Youth Leaders, Mothers	Screen and vaccinate sick children to close gap on missed opportunities				
Nutrition						
Mothers	Friends, father	Exclusively and frequently breastfeed infant every day from 0-5 months				
Mothers	Father, friends, TBAs	Continue to breastfeed and provide 3 complementary feedings every day for child 6-9 months				
Mothers	Fathers, school age child, TBAs	Assess child's growth monthly and implement advice given by the nurse				

h) Overall Training Plan. Based on baseline findings and planned activities, the overall training plan has been significantly modified from that proposed in the original application. This plan includes much more upfront work with training of trainers and consultation with MSPP on module adaptations and standards from the original proposal. Further it focuses on building facilitation and adult learning skills among CBO and youth leaders in addition to Health Center personnel. The revised basic structure involves a core set of trainers that will develop modules based on needs assessment, MSPP curriculum, and global best practices, and then provide training at community and health facility levels.

The Health Facility Training Plan Includes:

- Health service review and action planning skill building workshop
- Quality assurance processes
- Dialogue on nutrition education
- Training on technical topics including pre and postnatal care, IMCI, and immunization

Trainings will include pre and post tests and quarterly joint supervision by the Health Services Capacity Officer, partner organization and Bureau Communales. Each of these stakeholders will assess and coach on application of content from the training. The Community Health Officers will supervise neighborhood health trainings in their areas. GENESIS will regularly assess community knowledge, attitudes and practices, and will include the health center as part of the community assessment (see M&E section for further details).

The Community Training Plan Includes:

Youth Leader Development will involve identifying 1136 elected youth who will be invited to gather in groups of 20 for 3 days to learn about youth leadership, negotiating of youth roles in health promotion, life skills self-assessment and improvement plans, and technical areas of immunizations and reportable diseases. This way they can start contributing to immunization far before the development of a specific behavior change strategy for completing vaccination status by the child's first birthday.

The staged Community Health Promotion Capacity Promotion Approach is centered around a "master dialogue education trainers team" for each neighborhood, which is comprised of the Community Health Officer, 2 HC staff, and 2-8 community leaders (varies depending on population size). This team will be trained by an expert adult learning facilitator on dialogue education, focusing on interpersonal communications, planning for health education, as well as key messages and rationale for HIV/AIDS, safe motherhood and newborn care, and community IMCI. 30 master trainers will deliver trainings to 4-19 groups of 25 youth and CBO leaders with rolling intervention topics over the first three years of the project. Each training will be 2-3 days resulting in about 2-3 training sessions per master trainer per topic per semester.

Trainings will follow the core principles of adult learning of creating a safe learning environment; giving feedback to participants and praising efforts; letting participants know that the trainer is also a learner; using small groups to help involve participants; and showing respect by valuing the participants' knowledge and experience with the health topic.

Reorienting and updating of TBAs will involve a network of 60 highly used TBAs who will be trained by trainers from the BC and Health Facility at the Health Center on revised TBA curriculum. The curriculum is under development by MSPP with MSH technical support. Trainings will be implemented once the curriculum is finalized and MSPP trainers are available; by the end of year three. See the maternal and newborn care section for further details.

For the complete training plan, including participants, trainers, specific content, and duration, refer to section 8 of this DIP.

5.5 Intervention Specific Approaches

HIV/AIDS Prevention – Level of Effort 20%

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****This is the only intervention implemented in all five neighborhoods****

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Note that in all intervention areas, other agencies are providing health facility based HIV services including STI screening, facility based care and support, PMTCT and VCT services, safe blood, etc.; therefore we are requesting the CSHGP to fund ONLY HIV/AIDS community prevention and community support of PLWHA. All other services will be funded through other mechanisms.) This project complements them with a strong youth prevention and integration of HIV services with maternal and newborn care.

Objectives.

- Increase by 35% the number of youth aged 15 to 24 who become new acceptors of modern contraceptive methods
- Increase from 12.6%[27] to 20% number of sexually active, out-of-union youth, aged 15 to 24 years, who use a condom consistently for the past 3 months
- Increase from 9% to 65% mothers who express accepting attitudes towards PLWHA, resulting in reduced stigma and discrimination.
- 1136 Youth Leaders active in health promotion
- 5 Health Centers certified as "youth friendly"

This intervention comprises mobilization of youth groups, selection and orientation of Youth Leaders who oversee surrounding households for reproductive and child health promotion, development of well researched and effective youth focused behavior change strategies, training of community leaders on HIV/AIDS prevention and stigma reduction, community mobilization and integration of maternal care and HIV services at the health facility.

Youth represent both an opportunity and a vulnerability, and are therefore central to the strategy to fighting HIV/AIDS. They represent nearly 20% of the urban population, some are students, others involved in some form of petty business, and many are fluctuating between the two points.

The MSPP Strategy 2005-2010 reports that nearly 1 in 5 (17.7%) youth have never heard of AIDS, 14.7% don't know transmission routes, and over half of them do not know the symptoms of any sexually transmitted infections (STIs). The careseeking practices of youth with STIs is affected by stigma and financial barriers to health services. Most were ashamed to have to ask for money for a consultation and were concerned about confidentiality. Consequently, they tend to seek care from informal and traditional sectors. Poor levels of awareness and poor access to health services, coupled with very low condom use (12.6% used condom in last 12 months), put youth at high and unnecessary risk for HIV infection.

The report continues to tell us that while most adolescents become sexually active while in the age group of 15-19 years, only 3.2% use modern contraceptives. It is not surprising then that many youth are also parents; nearly a quarter (23%) of women already bearing children before reaching age 19. The MSPP Strategy 2005-2010 shines light on the facts that the infant mortality rate (IMR) is 130.8/1,000 if a child is born to a mother under 20 years of age, while that rate drops to 83/1,000 if a child is born to a mother aged 20 to 29 years. Note: 83% of infant deaths among adolescent mothers are post-neo-natal.

Reaching highly vulnerable groups of youth aged 15-24, particularly women both in an out of union is the focus of this intervention. The 2003 Youth Sexual and Reproductive Health Survey conducted in the three largest cities in Haiti indicated both a low level of understanding and personal risk, as well as the centrality of peer to peer information (and misinformation), and radio about sexuality and HIV/AIDS. The survey indicated low levels of communication and trust with parents and very little contact with health staff.

Youth Leaders networks will be developed in each of the neighborhoods, building on the potential of over 40,000 youth living in these areas. Discussions with exiting youth clubs and CBOs have been undertaken and the initial response has been positive. However, data has also informed us that previous promises have been made to involve youth in programs with very little real engagement after proposals were funded. Also, it has been noted that, while youth have some free time, they value leisure and fun and would have to have motivational benefits. We will not infiltrate clubs with this program but rather will work youth clubs into the design and recruitment plans, in order to ensure sincere involvement of individuals who will themselves decide to join the youth leaders network in July-September 2006. During the early part of year two, local meetings of groups of less than 35 households will be held to nominate and elect youth leaders. The roles of these leaders will include:

- Developing and apply skills in peer counseling, family planning and condom use negotiation, as well as essential maternal and child health education
- Monitoring pregnancies, births, deaths and reportable diseases
- Collaborating with HF staff in tracking vaccination drop-outs
- Participating in monthly meetings of leaders and learning about life skill development
- Serving as resource person for FORUM health events
- Keeping a journal of activities and reporting at monthly meetings

Behavior Change. From the baseline assessment and feedback during the DIP planning workshops, the following youth practices will be emphasized:

Table 10: Behavior Change Strategy Situation: HIV/AIDS

Behavior	Facilitators	Barriers	Further formative research questions for project
Consistent use of condoms by youth aged 15-24 while with a non-union partner	Condoms widely available free of charge through several community outlets Influence by peers	Difficulty for female youth to negotiate condom use Availability of condoms Image of women who request condoms	What differentiates those who are out of union who regularly use condoms from those who do not, for both sexes? What difficulties do youth faith in using the condom? What questions do they have? What skills are needed to negotiate safe sexual practices? Where are "safe" distribution points for condoms for both young men and women? What is the social norm regarding condom use?
Sexually active youth use modern contraceptive method	Widely available free of chare at HC Favorable government policy towards family planning methods	Negative attitude among group about contraceptives Perception of stigma at health services Real side-effects	Attitudes about adolescent pregnancy among young men and women? How accessible are health services to youth? What contraceptives do youth like best and why? What problems have youth had using contraceptives?
Delay first sexual intercourse encounter of adolescents	Value system Strength of social norms to set standards	Some youth believe desirable to start child rearing early Poverty / sexual favors for gifts	Factors influencing sexual debut

Formative research will be led by the Community Health Officer with the Behavior Change Task Force members in their respective neighborhoods to learn about the questions in the last column of the above table. Their work will be supported by GENESIS who will undertake focus group discussions with youth. As this is the first set of behaviors researched in-depth, the time period is extended from July 2006 – January 2007 just prior to the BEHAVE strategy development.

Community Mobilization on HIV Prevention and Stigma reduction will be provided to women, men and their families during clinic visits, group meetings, rallies, and home visits, resulting in desired positive changes in high risk behaviours, and an increased demand for clinic-based services, such as STD testing and treatment, VCT and PMTCT services *(funded by other mechanisms)* and counseling. This will be led by the CBO & Youth Leaders and incorporated into the Health Forum annual plans based on the BEHAVE strategy and training topics.

Preventive education and materials will be offered to community leadership groups, churches and other organizations, in order to raise awareness, change attitudes and behaviors, and mobilize community action to form PLWHA support groups. According to the situation analysis, there is no current linkage between health centers and PLWHA support groups. Community Health Forum leaders comprised of CBOs and youth will seek out information about existing groups and will be supported by the Community Health Officer to build bridges for care and support with the health center, the national AIDS organization (ASON) and, if necessary, will provide appropriate education and support in all the neighborhoods. Actions taken by these support groups will be documented during project period. As a result, we will increase from 9% to 65% mothers who express accepting attitudes towards PLWHA, resulting in reduced stigma and discrimination.

Quality of Health Services. All the facilities offer free condoms, free family planning consultation and contraceptives, and each offers HIV counseling and testing, except the health post at Bois Moquette. However, despite the need, utilization of these services by youth is very low. While there are many internal barriers to youth themselves seeking services, youth surveys have indicated that they also feel unwelcome and worry about confidentiality. Through youth leader networks, the criteria for youth friendly facilities will be debated and refined for local application. CBO leaders and the Community Health Officer will facilitate self-review by each health facility quality assurance team, and will analyze strengths and gaps in servicing these "youth friendly" criteria. Youth networks will be invited to review health facility plans and to provide feedback for adjustment. The youth leaders will monitor certification of "youth friendly" services and renew status on an annual basis.

Individuals who test positive for STDs will consent and participate in partner notification activities. At the least, we anticipate 75% of youth (15-24 years) will be able to state three ways HIV is commonly transmitted and three ways that risk of transmission can be reduced. A measurable number also will commit to abstention or to the use of condoms with partners for dual protection.

Free condoms are already available through shopkeepers and health centers. Youth groups will consider accessibility in their neighbourhoods, talk to their friends about the situation, and identify better "space" or locations to seek out condoms. The number of condoms distributed over time, by mode of distribution, will be increased by at least 50% over baseline measures from these sources, and condoms will be available through the clinics at least 90% of the time, as well as offered by CBO volunteers and through other community outlets.

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**** The following interventions are only for the geographic areas of Cite* Okay/Jeremie, St. Martin, and Descayettes***

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Diarrhea Prevention & Control – Level of Effort 25%

Diarrhea is one of the most prevalent childhood illnesses (during the project baseline survey over half of children 0-23 months had diarrhea in past two weeks) and is a major cause of mortality. Following years of essential water and sanitation hardware

installation and with local community management committees, the need to also focus on quality hygiene promotion and behavior change is gaining recognition by the program partners. This design applies the wisdom of the Hygiene Improvement Framework, as well as IMCI, to shift focus towards individual behavior change to prevent disease transmission; improving primary care treatment at the home and the health facility; advocating for necessary water and sanitation investment; and fostering an enabling environment that includes improving access and equity of in informal and formal sector services.

Objectives.

- Increase from 13% to 45% mothers with a sick child aged 12-23 months who increase fluids and maintain feeding during the illness
- Increase from 50% to 70% children 0-23 months with diarrhea who have received ORS
- Increase from 32% to 50% households with children 0-23 months who purify their drinking water
- Three Health Centers delivering IMCI operating at good level according to supervision

In order to manage diarrhea the following is needed:

Community level:

- Effectively transmitted information about danger signs written in Creole and locally-understood terms by CBO & Youth Leaders
- Low cost oral rehydration solution through social marketing and leveraging partnership with UNICEF
- Access to water and sanitation facilities through local assessments and advocacy

Health facility level:

- Skilled staff trained and supervised in IMCI for effective assessment, classification, treatment and counseling of the sick child
- Availability of oral and syrup antibiotics and oral rehydration solution: Dysentry – 3 x for 5 days amoxycilline as first line and ampicilline 4 x 5 days for second line
- Improving access to ORS. While most facilities have socially-marketed Sel Lavi which costs 10 Gourdes for 2 packs, free supplies available at national level from UNICEF have been largely out of stock since October 2005.

Behavior Change. From the baseline assessment and feedback during the DIP planning workshops, the following father and mother practices will be emphasized to have a maximum effect on reduced morbidity and mortality from diarrhea in this context:

Table 11: Behavior change Strategy Situation, Diarrhea

Behavior	Facilitators	Barriers	Further formative research questions for project
Families treat home drinking water with chlorine and store in proper storage container with narrow	Social marketing of PUR tablets and upcoming social marketing of chlorine solution Community distribution of	Cost of treatment Cost of storage container	What kind of home water storage containers are used? Are proper ones available? How much do they cost?

Behavior	Facilitators	Barriers	Further formative research questions for project
neck	household amounts of commercial chlorine solution (JIF is a commercial name) Taste indicates that its "clean" High level of risk perception	Some family members don't like taste	Who treats the water at home and how well do they measure solution amounts? What do they use? What differentiates those who treat their water from those who do not?
Mother increasing fluids and maintaining frequent feeding of child with diarrhea	Mother wants child to recover quickly Most children are breastfed	Very strong belief in "drying" the child Lack of child appetite	What are local beliefs about causes and treatment of diarrhea (by each of the 3 types)? What kinds of inexpensive complementary foods can be promoted? How can busy mothers best find time to care for feeding needs of sick child? How skilled are mothers in active feeding?
Caretakers of children with diarrhea correctly prepare and give ORS	Vending points readily available Most mothers are familiar with ORS Mothers prefer to treat at home to save time and money	Only 40% knew how to accurately prepare ORS Cost: Distribution sites biased to sell Sel Lavi a socially marketed product instead of free packets from UNICEF Stock-outs of both social marketing and subsidized products.	Do mothers think that ORS is effective? What do they think it does? How many packets do the "doers" usually give to child and for how long? Do mothers understand the concept of dehydration? What are known symptoms in Creole? How much are mothers willing and able to pay for ORS? Who do they trust to get ORS from? Who can best help mothers to learn how to prepare ORS? What needs to improve in their understanding on how to prepare it?
Promptly seeking care at the Health Center when child presents bloody diarrhea or persistent diarrhea of 14 days or more, or if acute watery diarrhea persists after ORS treatment	Health centers staffed with nurses and usually a doctor nearby	Fee for consultation $1 - $1.50 + lab and treatment costs	What are local terms for acute watery, persistent, and bloody diarrhea (by each of the 3 types)? What are perceived causes and how is each treated? Acceptability and factors influencing timeliness of visit to health center

Behavior	Facilitators	Barriers	Further formative research questions for project
Handwashing at critical times with soap	Availability of low cost soap and some access to cash More educated groups aware of risks of disease spread through hands	Extremely limited and expensive water supply Public facilities including at HCs have no handwashing facility	Acceptability and options for handwashing points in the home Options for public handwashing points (building on paid showers)

Formative research will be completed by the Behavior Change task force members from each of the neighborhoods in October to December 2007. Findings will be used to complete the BEHAVE strategy and inform the focus on the roll-out of training at the health facility and community level.

Point of use water treatment: Purification of water with prepackaged PUR and communal distribution of chlorine is available in all neighborhoods. The Community Health Forum will mobilize water committee members to demonstrate use and social marketing of this product with technical support from PSI.

Quality of Health Services. Neither St. Martin Public Health Center nor HaitiMed health centers have had staff trained in Integrated Management of Childhood Illness (IMCI), despite its national introduction in 1997. Further, none of the service providers at any of the 3 clinics have held a refresher training on standard case management of diarrhea or nutrition counseling in the past three years. There is a great need for these trainings, as the majority of clients seen at these facilities are sick children. All facilities have at least one consultation room and skilled personnel to provide standard case management of diarrhea. However, there is a tendency to oversubscribe antibiotics, and the provider has very little time and skill to effectively provide treatment instructions or feeding advice to the caretaker.

The IMCI Protocol is attached in French as Annex F. Under the "Assess and Classify" section it includes general observations of children (i.e., lethargy, irritability), and inquiries about the type of diarrhea, the checking of eyes, and the ability to drink (i.e., performing a skin pinch to check for dehydration). Classifications include: dysentery, persistent severe diarrhea, diarrhea with dehydration, persistent diarrhea without dehydration, and diarrhea without dehydration. Most cases can be managed at all three health centers during clinic hours. All centers have nurses and doctors on staff, IV fluids, and observation beds. While it is hoped that the centers will eventually be capable of providing direct care, children with diarrhea, or any general severe danger sign, are currently referred to the General Hospital for care. Referrals are tracked in clinic registers, however, follow-up is not very common due to lack of communications between the levels of care.

Supervision. Each health center will receive a joint project/ MSPP quarterly IMCI clinical supervision visit. The team will apply the MSPP IMCI supervision checklist, which includes observation of case management, availability of drugs, provider skills, and service utilization. The DSO has 2 IMCI trainers who are also skilled in

supervision. During the full 11-day training for St. Martin and Cite Okay/Jeremie health centers, four BC supervisors will also be trained as to step up IMCI supervision capacity.

The program will focus on supervising monitor and coach providers who will completely assess children's status according to IMCI protocol; counseling mothers on management of diarrhea and nutrition; and training relevant staff on IMCI treatment prescription protocol. Overprescription of antibiotics is a problem in Port-au-Prince, particularly for diarrhea. According to the protocols, only children with diarrhea who have dysentry symptoms (i.e, bloody stools) should receive antibiotics.

ACCESS

Policy Implications. Improved ORS with Zinc is not yet standard policy but this project will support MSPP and USAID to promote the adaptation and introduction of zinc and improved ORS, building on the collective experience of CORE members working in Mali, Chad, and DRC. Clearly USAID and MSH will be more influential in promoting this change. The next step in Haiti appears to be a cross-department consultation to review the potential adoption of best practices for prevention and case management of diarrhea, including zinc therapy and improved low osmolarity ORS. If and when this policy is adopted, the program will adjust its information and distribution of ORS combined with 10-14 day zinc supplements to promote access. The Health Coordinator and Project Manager will actively engage with USAID and MSPP/DSO on this important issue.

Water & Sanitation. While not specifically a component of this program, the environmental conditions in these urban environments must improve if our efforts to combat diarrhea are to really have an impact, particularly given that the poorest residents are most vulnerable to low access to these increasing privatized commodities. In this line the following action will be taken under this project:

Step One: participating CBOs will complete participatory assessments of their sub-neighborhoods to map availability of water and latrine points and identify opportunities for handwashing stations, waste collection, drainage improvements such as paving, and latrine block maintenance and expansion.

Step Two: The Project Manager and DSO will participate in key meetings to share findings of the water and sanitation situation, including within their own institutions (to raise awareness and leverage resources to address opportunities identified from the local mapping). These findings will be built into the neighborhood plans. Project staff will support KDSM and SNELAK to address quality funding requests for sanitation projects to appropriate donors.

Step Three: Project and DSO staff will review plans of government and donors for environmental health in Port-au-Prince and will complete mapping of opportunities and gaps. With outputs of step one these findings will be written up in an advocacy piece targeted at government, donors and financial institutions on improving sanitation and water supply.

Pneumonia Control– Level of Effort 10%

While most acute respiratory infections are viral, mild and self-limiting, our focus is on the identification of acute lower respiratory infections, which are likely to be pneumonia, a leading killer of children, particularly newborns, in Port-au-Prince. In these areas access to formal health services to diagnose and treat children is not as significant of a barrier as is indicated in the KPC; 66% of children with early danger signs of infection are seen by health workers. However, problem in this population is that few mothers were aware of what pneumonia was and how to recognize it.

Objectives.

- Increase from 66% to 75% children 0-2 months with cough and fast, rapid or difficult breathing in past 2 weeks who were seen by trained provider
- Increase from 10% to 45% mothers with a sick child with pneumonia symptoms aged 12-23 months who increase fluids and maintain feeding during the illness
- Increase awareness to 65% of mothers of children 12-23 months of two danger signs for pneumonia

This project will focus on improving recognition of and prompt care seeking of pneumonia, particularly for the newborn; improving standard case management of pneumonia; and improving compliance of treatment and feeding practices in the home. The approach is integrated with the diarrhea interventions stated in the previous section.

Behavior Change. From the baseline assessment and feedback during the DIP planning workshops, the following mother practices will be emphasized to have a maximum effect on reduced morbidity and mortality from pneumonia in this context:

Table 12: Behavior Change Strategy Situation: Pneumonia

Behavior	Facilitators	Barriers	Further formative research questions for project
Mothers promptly identify danger signs of the newborn and child and promptly seek care at the Health Center	Health centers with staffed with nurses and usually a doctor nearby Most sick children seen first at health center	Some mothers tendency to first seek care from informal providers Quality of case management Pneumonia as a illness is not known and considered with variety of respiratory problems such as asthma Fee for consultation $1 - $1.50 + treatment costs	What are the respiratory diseases known by mothers? Do they distinguish specific symptoms of pneumonia and what are local terms for these? Acceptability and factors influencing timeliness of visit to health center
Health providers effectively assess, classify, treat and counsel mothers	Mothers want to learn and receptive to health worker advice Providers willing to learn	Overlapping presentation of symptoms of malaria and pneumonia Limited standard case management skill of	Provider beliefs about sick child feeding Consultation time analysis and patient flows

Behavior	Facilitators	Barriers	Further formative research questions for project
		health providers, absence of job aides Availability of laboratory services to confirm malaria parasites Consultation time only 5-10 minutes maximum	Antibiotic prescription beliefs, attitudes and practices
Mothers provide full treatment of antibiotics and increased fluids and maintain feedings for sick child with pneumonia	Antibiotics available for low cost at health facility Health providers willing to work harder to counsel mothers Mothers want child to recover quickly and not get sick again	Perceived need to share antibiotics with other family members to protect them from the illness Difficult to feed sick child, lack time, skills and confidence	Common home remedies for children with pneumonia symptoms Beliefs and attitudes about sharing drugs in the home Beliefs about feeding sick child and recuperative feeding

Formative research will be completed by the Behavior Change task force members from each of the neighborhoods in October to December 2007. Findings will be used to complete the BEHAVE strategy and inform the focus on the roll-out of training at the health facility and community level.

Community mobilization with focus on improving prompt recognition, care-seeking and quality of care provided to sick child.

- Raise awareness of general danger signs through materials written in Creole and locally-understood terms i.e., fast or difficult breathing, child looks unwell, child not feeding or drinking well, lethargy or change in consciousness, vomiting everything, high fever, and chest in-drawing
- Increase speed of action to seek care outside of the home from the current average of 2 or more days to 24 hours by raising awareness of the risk of quick onset of death for children with specific symptoms, and clarifying the difference between cough & cold and pneumonia.
- Enhance compliance with treatment and counseling advice of health worker to complete antibiotics and optimal feeding of child

QUALITY OF CARE

Health facility level: As stated in the diarrhea prevention and control section, the focus of the program is on improving standard case management using the national IMCI protocol at the Health Center level at HaitiMed, St. Martin II and Descayette. The training will aim to:

- Strengthen skills of health center workers to assess, classify, treat and counsel mothers with sick children through IMCI training, refreshers, and quarterly clinical supervision using the national IMCI checklist.
- Institutionalize use of clinical symptoms, particularly respiratory rate counting and screening co-infections with malaria through strengthened laboratory techniques.
- Promote rational use of antibiotics through Essential Drug Management training, providing stock support for essential oral and syrup antibiotics and oral

rehydration solution. Note: Current case management standards in Haiti for pneumonia are 2 age-specific doses of cotrimoxazole for 8 days as first line treatment, and 3 age-specific doses of amoxycilline for 5 days as second line.

- Build provider counseling skills to help mothers learn how to give antibiotics to child and effective feeding and rehydrating practices for sick child through adult-centered learning methodologies

Referral services at for severe cases to the General Hospital is available and used by most residents of these areas, even for less severe illness. A review of the effectiveness of the referral system by the Health Services Capacity Officer with Health Facility Personnel will look at acceptability, efficiency, and communications. Findings will be shared with the DSO and Bureau Communale of Port-au-Prince for further action. Note that there are no additional financial resources available through this grant to for direct intervention at the hospital level at this time.

A note on malaria: Port-au-Prince is a malaria-endemic zone with peaks in June-August following the rainy season. A CDC/OPS/WHO study in 1995 found 3.9% prevalence of malaria among fever cases; there is no recent study known regarding chloroquine resistance, which remains the front-line treatment. Health providers will include consideration of malaria as a potential source of child fever and the project will continue to monitor potential epidemics with the Bureau Communale and DSO.

ACCESS:

Informal providers. The baseline assessment showed that use of informal providers is fairly low with less than 10% seeking advice from these sources first outside of the home. However, we are aware that this could be underreported given the prominence of some providers in certain neighborhoods. Over the course of the project CBO Leaders will continue to assess the situation and review as part of the midterm evaluation for potential negotiated practices intervention.

Prevention of Pneumonia. Several interventions undertaken through this project will contribute to preventing pneumonia cases and severity of disease including increased coverage of measles and pertussis vaccines, and improved nutritional status of children through Vitamin A supplementation and exclusive and complementary breastfeeding practices (refer to Immunization and Nutrition technical sections for further information). Note that the haemophilus influenzae tybe B vaccine is not yet available in Haiti due to low overall EPI coverage.

In addition to handwashing promotion the project will stay abreast of advances in global evidence base for behavioral and technological interventions to reduce indoor air pollution (IAP) in slum-type settings. However, at this stage no IAP activities are planned. According to the KPC, the primary cooking fuel in this area is wood, which is known for high levels of contaminant particles that contribute to respiratory infections.

Immunizations – Level of Effort 10%

Tremendous efforts nation-wide have been made to improve vaccination coverage in Haiti over the past three years and resulting in higher coverage and this program aims to support the DSO and its partners to continue to raise coverage towards its national goal of 90% coverage. While striving towards the national target, given the high mobility and hard to reach nature of the urban slum populations, a more realistic goal of 80% has been set for achievement over the next five years.

Objectives.

- Increased proportion of children 12-23 fully vaccinated (verified with card) by first birthday increased from 51% to 80%
- Reduced EPI drop-out from 17% to less than 5%
- Increased of mothers of children 0-11 months who received at least 2 doses of TT from 19% to 40%
- Three HCs achieving EPI standards in terms of vaccine supply logistics, cold chain, biomedical waste management

According to KPC baseline data, there is a high access and high drop-out scenario with DPT1 coverage of 85% and drop-out of 17%. Measles vaccination of all children aged 12-23 months is 61% according to cards and mother's recall. The focus of this strategy is to place vaccination as a pillar of health care, emphasizing the improvement of service delivery of vaccines, and avoiding missed opportunities by forging joint community-health provider micro-planning and action points, which will raise equitable coverage.

ACCESS:

Community level: Given the geographic challenges of a densely populated zone with high mobility and extreme poverty, the neighborhoods of Cite Okay/Jeremie, St. Martin and Descayettes will be subdivided into 26 operational zones of about 1,000 households, and will encompass a lead CBO and 25-30 youth leaders. Mapping the operational areas will be completed with the participation of the CBOs and youth, following up on preliminary work completed in laying out the five supervision zones in each neighborhood used for the Knowledge, Practice and Coverage Survey's Lot Quality Assurance Sampling (LQAS).

Health vaccination registers will be re-organized to match the operational zones. In these zones, youth leaders will support health staff who will list children under 24 months in need of vaccinations and they will help field-test the adaptation of the "My Village My House" methodology for tracking vaccination coverage. These zones will be essential in organizing outreach services to low coverage subpopulations; to forecasting vaccination needs and targets; to identifying low coverage follow-up with drop-outs; and to countering misinformation and rumors about vaccinations.

Routine Vaccination Availability. The rapid health facility assessment indicated that vaccination services are normally available Monday through Friday in St. Martin and Descayettes, the latter also provides a Saturday morning service. However, during periods of escalating violence, which can last from a matter of days to several weeks, these centers do close and the population is left without a local service point. In Cite

Okay/Jeremie, Grace Children's Hospital provides an outreach service once a month just outside HaitiMed's health center in Siclait, and Food for the Poor provides outreach services on Monday and Wednesdays in Jeremie.

Advocacy. While at the national level a proactive vaccination supply system is in place to deliver supplies to various regional Departments, this approach is not paralleled with EPI plus supplies of ORS and Vitamin A. The Urban Health Platform will actively take up this matter.

QUALITY OF CARE:

Disease Surveillance and Response: A major contribution of this program is the establishment of community-level surveillance of vaccine-preventable diseases (measles, neonatal tetanus, and acute flaccid paralysis (AFP)) by Youth Leaders in collaboration with health staff, both of whom will spread simple case definitions of related diseases. The program is working with the DSO to establish a clear reaction plan that includes frequency of reporting from the Youth Leader to the Health Center to the Bureau Communal and on up to national level. Each reported case will be investigated against the child's vaccination status providing a crude indicator of vaccine efficacy. MSPP disease control strategies will be rigorously applied in the event of an outbreak. This is include in the initial orientation of the Youth Leaders and an important component of their monthly meetings.

Efficacy of Vaccines. The national vaccination program includes the multiple dose vial policy permitting safe storage of open vials of DPT and TT for up to four weeks, as long as the principles of respecting expiration dates, cold chain maintenance between 2 to 8 degrees C, and the Vaccine Vial Monitor (VVM) is valid. Note: Measles and BCG vaccines must be disregarded within six hours of opening. This method is already in place at the health facilities and staff are well trained in standards and monitoring. Nonetheless, some problems were identified in monitoring the temperature of the vaccine refrigerator, including missed afternoon controls and recording temperature consistently below 2 degrees at one site.

Quarterly Vaccination Supervision. Building on frequent EPI training base, supervision is key to ensure quality of care. Vaccination supervision will be undertaken by the Health Services Capacity Officer with the Bureau Communal. The team will utilize the national EPI supervision assessment guide, which includes availability of working supplies (vaccines, auto-lock syringes, cold chain, sharp and waste disposal containers), observation of screening child's vaccination status and administration of missed vaccines, as well as review of registers and performance tracking.

Equipment and Supply Availability. Provision of supplies is not anticipated as a major area of emphasis, as a currently existing, good-quality system is in place with a national proactive stock strategy implemented at the Department level. The Japanese Government subsidizes all vaccinations, and GAVI and PEPFAR provide free auto-disable syringes. If vaccines are to be stored at the HaitiMed clinic, a refrigerator may be required and could be supported if included in the health facility action plan. The other clinics have infrastructure necessary for cold chain maintenance. The greatest contribution of this program will be improved communications and supply

management between the health center and the Bureau Communale. These improved communications will work to ensure no-stock outs of essential vaccine supplies. Required inputs include: vaccines, VVMs, syringes, safe disposal boxes, maintenance, gas/electricity/storage.

Quality Monitoring. Monitoring activities will include tracking the availability of working supplies, maintenance of cold chain, sharps and waste management, community mobilization, DPT1 access proxy, DPT1-DPT3 drop-out, and measles and $TT2_+$ coverage of pregnant women. This analysis will be completed by Health Facility staff and support by the M&E Technical Advisor during her annual health information system reviews at the neighborhood level (one neighborhood per quarter).

Only when health providers themselves discover their strengths and weaknesses, articulate priorities and analyze underlying causes of the problems will real improvements in quality and performance be addressed. Health teams will work with CBOs and youth leaders to plot routine administrative data against targets on cumulative monitoring charts; graph drop-out rates by sub-neighborhood; and will complete community household mapping to pin-point high and low access and drop-out areas. Quality assurance teams will prioritize problems, analyzing underlying causes, and developing action plans to improve vaccination performance.

BEHAVIOR CHANGE:

While the focus of the intervention is on access and quality, further work will be done to increase demand. Formative research shows that a mother's free time, limited hours of service at the health facilities, and attitudes about the importance of vaccinations and their side effects, are the primary factors that influence a mother's vaccination-seeking behaviors. Through quality assurance teams at each of the health centers, providers' behaviors will also targeted, training providers to proactively seek to vaccinate patients, even when the child is sick.

Table 13: Behavior Change Strategy Situation: Immunizations

Behavior	Facilitators	Barriers	Further formative research questions for project
*Health providers screen vaccination status of all children and administer vaccine	Reliable supply of vaccines and staff to provide vaccination at two of the health facilities Child card includes vaccination status Providers motivated to achieve high coverage of vaccination Screening step included in national IMCI protocols	Belief that better to postpone vaccination of a sick child Counseling efficacy of service provider to persuade mother that vaccination is safe One facility does not have routine vaccination service on-site Limited skill of health providers Consultation time only 5-10 minutes maximum	Observation of case management of sick child and missed opportunities Attitudes and beliefs of service providers about administration of vaccines to sick child Opportunities for extending vaccination services at non-fixed site at Cite Okay

Behavior	Facilitators	Barriers	Further formative research questions for project
Mothers of children under-one bring child to health facility every month for first 3 months and before 1st birthday for the purpose of vaccinations	Mothers want child to be healthy for peace of mind and conserve caretaking time Mothers understand importance of vaccines Vaccines are free	Mothers awareness of vaccination schedule Health facility crowded and long waiting times Sometimes has to pay consultation fee Misperception of side effects of vaccinations	Mother's awareness of what vaccinations do, the schedule Convenience and improvements in service schedule Community involvement in organization of services
*Health providers proactively seek tetanus toxoid protection for women of childbearing age	High participation of mothers in antenatal care TT status including on mother's card Health workers motivated to eliminate neonatal tetanus	Difficulty knowing TT status lifetime Conservatism in opening TT vial Mothers don't ask for the TT	Beliefs and practices of health workers Perceptions and beliefs of mothers

Formative research on these issues will be completed in April-June 2009 after the neighborhoods have had time to correct the issues they already are aware of it during the first two years to enhance access and quality. Spacing of this work, is required to allow for community health forums to address higher priority topics such as maternal and newborn care and care of the sick child. Given the increasing levels of vaccination coverage and efforts already planned to improve early newborn care, focused antenatal care, and intensification and re-organization of vaccination services. This fine tuning of the strategy will be disseminated through facility based IMCI refreshers, CBO & Youth leader training and intensified community mobilization.

Nutrition – Level of Effort 15%

According to UNICEF, an estimated 32% of urban households suffer from food insecurity on a daily basis and 26% are often food insecure. The 2006 KPC Urban Health Survey included a Household dietary diversity module that showed that 20% of households consumed 4 or less types of food the day prior to the survey (out of 12 types including bread, vegetables, fruit and eggs), while 63% consumed 5 to 8 types. This data indicates a high level of nutritional vulnerability in these communities.

According to the 2000 DHS 13.1% of children under 36 months were moderately underweight and 2.7% severe underweight (weight-for-age), while 6.8% had moderate acute malnutrition and 0.6% acute severe malnutrition (wasting, weight-for-height). According to the MSPP 2005-2010 plan, 9.5% of pregnant women are < 18.5 kg/cm2 in urban areas, and 56% of urban women have anemia, which is believed to be caused by low meat intake due to poverty, intestinal parasites (anklyostomes), and short birth spacing intervals).[28]

While the 2006 urban health KPC survey did not include weight-for-age measurements, mid-upper arm circumference levels were assessed to screen for severe acute malnutrition given the recent turmoil in these areas. The survey data revealed a 1.9% prevalence of severe acute malnutrition among children 12-23 months of age, prompting a full nutrition assessment in the neighborhoods of Descayettes, St. Martin and Cite Okay.

Objectives.

- Increase from 28% to 40% the proportion of infants aged 0–5 months who were exclusively breastfed during the last 24 hours
- Increase from 52% to 65% the proportion of infants aged 6-9 months who received breastmilk and complementary foods during the last 24 hours
- Increase from 61% to 80% the proportion of children 6-24 months receiving Vitamin A supplement within past 4-6 months (according to age)
- Feasibility assessment of CTC completed and discussed with UNICEF and MSPP

The nutrition component of this program will follow the **Essential Nutrition Action** recommendations for feeding the child:

Child Feeding

- Immediate and exclusive breastfeeding to 6 months
- Complementary foods introduction at 6 months
- Breastfeed frequently and on demand until 24 months or older
- Practice responsive/active feeding
- Safely prepare and store complementary foods
- Increase quantity gradually
- Increase food consistency and variety gradually
- Meal frequency and energy density enhanced
- Use vitamin-mineral supplements or fortified products for infant and mother
- Feed a variety of foods to ensure nutrient needs are met – animal source, Vitamin A rich foods, avoid drinks with low nutrient value (tea, coffee, sugary) and limit juice to avoid displacing nutrient-rich foods.

Vitamin A supplementation

- Postpartum supplementation for mother 200,000 IU within first 42 days
- Routine supplementation among children 6 to 59 months (one dose of 100,000 IU in past 4 months if aged 6-11 months, and one dose of 200,000 IU every 6 months for child aged 12-59 months)
- Treatment for children with persistent diarrhea (one age appropriate dose unless received preventive megadose in past 30 days)
- Treatment for children with measles (two age appropriate daily doses unless received preventive megadose in past 30 days)

Optimal nutrition for women

- Appropriate maternal dietary intake – 285kcal/day more or about one additional meal
- Lactating period intake – 500kcal/day more for demands of lactation
- Iron/folic acid supplementation of 90 days or more for pregnant women (and consider postpartum supplementation continuation for 3 months where anemia is > 40%)

- Protein requirements 40% increase from usual – 71g protein/day
- Adolescent pregnancies at greatest risk for poor nutritional care due to lower awareness, less control over food security, and lack of access to health services
- HIV/AIDS increased energy requirements – increased energy expenditure, poor absorption of micronutrients, lower food intake, greater risk to opportunistic infections, and complex metabolic changes all lead to weight loss and wasting. Need to increase energy intake and develop food-medication management strategies to prevent interactions

Prevention of anemia: Promote intake of iron-rich foods, especially animal products such as eggs among female youth, pregnant and postpartum women, and children. Iron/folic acid supplementation through daily consumption for 90 or more days. Deworm children > 12 months, pregnant women after 1st trimester, and lactating women (albendazole 400mg tablets). Malaria is not considered a significant cause of anemia in this area.

ACCESS

We are in the process of completing a nutrition and food security assessment which should concretize our understanding of the situation in these neighborhoods and advocate for Community Therapeutic Care (CTC) if appropriate with MSPP, WFP, an UNICEF to manage and mitigate severe malnutrition. A feasibility assessment of need, acceptability, and local production of Ready to Use Therapeutic Food (RUTF) and including an inventory accessible, nutrient foods and therapeutic food registration. Findings will be shared a national reflection meeting on severe malnutrition at the end of year two with support from Concern Worldwide Global Nutrition Advisor and VALID International. Note that Save the Children USA may also have an interest in engaging in this activity in Haiti.

Cognizant of the struggle of household food insecurity in these neighborhoods, the project focus is on improving feeding practices based on the local capacities, Vitamin A and iron supplementation, maternal nutrition improvement, reviewing and advocating for case management of malnutrition, and feeding of the sick child as described in the diarrhea and pneumonia sections. Behavior change strategies will be based on positive deviant practices, practical foods and feeding approaches that are already being applied by mothers from low resource households.

Through the Management of Essential Drugs training and real linkages with UNICEF and MSPP we will focus to ensure continuous supply line of Vitamin A supplements (provided to children 6 to 11 months at 100,000 IU every 4 months and children 12-59 months at 200,000 IU every six months), iron folate and deworming medicines.

BEHAVIOR CHANGE

Building on the Essential Nutrition Actions, this project will focus on key practices identified from the baseline survey as highlighted in table 14 below.

Table 14: Behavior Change Strategy Situation: Nutrition

Behavior	Facilitators	Barriers	Further formative research questions for project
Mother frequently and exclusively feeds infant under six month breastmilk	Breastfeeding is a social norm Free Actual consequences in terms of reduced incidence of diseases	Mother works outside the home, baby can't always be with her Mother tired, needs time Mother's perception that she doesn't have enough milk	Beliefs about breastfeeding, its adequacy Types of problems and local terms that mothers face with breastfeeding Differences between doers and non/doers of exclusive breastfeeding after 3 months
*Mother provides at least 3 complementary feeds plus breastmilk for infant 6-9 months	Breastfeeding is a social norm Availability of health facility staff and community social leaders to advise	Availability of weaning foods in the home Mother's self-efficacy for active feeding	Local availability of complementary foods Norms and taboos about weaning
*Complementary foods for child are stored in clean and covered containers and cooked with boiled or treated water	Mother motivated to keep child healthy and low maintenance	Unsafe water in very limited quantities Extremely poor families more likely to purchase foods in small quantities from vendors rather than cook at home (money for fuel)	Observation of food storage practices Mothers beliefs and attitudes about food hygiene
Mother seeks Vitamin A supplementation every six months for child 6 to 59 months	Organized campaigns achieve good coverage Regular supply at HC Free	Importance of Vitamin A not well known Children who don't go to HC have poor access	Doer/Non-doer analysis Beliefs about Vitamin A supplements, local terms

Formative research: The infant and young child feeding practices behavior change promotion strategy is planned for development in the quarter of October-December 2008 and will be rather intensive including doer/non-doer analyses, FGDs on beliefs and attitudes, positive deviance investigations. This is planned just after the midterm evaluation, given the strengthened community health forums 2 ½ years for focused intervention on these important, yet complex issues. Research will be completed by the BC Task Force.

Training of community leaders on nutrition and infant and young child feeding will be completed based on the FFH guide, "Infant & Child Feeding: Helping Young Children to Eat & Grow Well." As per the training plan, they will train small groups of CBO & Youth Leaders on the topics.

Community mobilization will focus around misperceptions and harmful practices in the local area. We will seek innovative approaches with the Community Forum to best reach mothers through mother groups and other existing networks about child

feeding practices as it CBO & Youth Leaders may not have established the level of credibility to influence mothers' feeding practices. However, if previous interventions have much success and the Leaders are seen to be adverting maternal and child deaths, they may be much more effective that can be foreseen at this time.

QUALITY OF CARE

A focus of the IMCI training will be on nutrition counseling – an area often the least retained an applied by health workers. To make this more effective, health staff will be trained on the AED/Linkages "Training Methodologies and Principles of Adult Learning: Application for training in Infant & Young Child Nutrition," a five day course including 3 days hands on applied learning. A focus on iron folate and post partum Vitamin A supplementation will be added to this training.

Facility based growth monitoring will continue in all health facilities and where necessary, outreach services will be considered; however, for long term sustainability we would prefer to promote health facility based service given that distances are not very far at all (less than 1km).

Through counseling and informed consent, some HIV positive mothers may decide to discontinue breastfeeding after six months of exclusive feeding. For non-breastfed children, the program will ensure referral to a facility that receiveds food support and can promote adequate intake of 800-1200ml fluids per day and frequent food feeding 4-5 times per day, with 1-2 snacks with intake of 600 k/cal day for children 6-8 months, 700 k/cal for 9-11 months and 900 k/cal 12-23 months. It must be noted that safe, alternatives to breastmilk are not readily available to this population, and that the risk of mortality from diarrhea and malnutrition are significant.

A note regarding the nutrition rapid catch indicator: during the baseline assessment, weight-for-age malnutrition will only be collected for the St. Martin, Descayettes, and Cite Okay neighborhoods as part of a wider nutrition and food security assessment. However, in the midterm and final evaluation this indicator will be included for all 5 neighborhoods.

Maternal and Newborn Care – 20% Level of Effort

While maternal mortality ratio has decreased from 1,000/100,000 live births in 1970-75 to 523/100,000 live births in 1995-2000, it is still highest in the Western Hemisphere, and UNFPA estimates that it has increased to 680[29] from 2000 to 2005. According to a 2000 audit of 216 maternal registered deaths the major causes were hypertension/eclampsia, hemorrhage, anemia, and infections and complications of abortions. The prevalence of debilitating complications, including vaginal fistulae, uterine prolapse, chronic pelvic infection, and infertility, is considered by all stakeholders to be very high.

Given policy restrictions that no maternal delivery service is allowed in facilities that cannot offer full 24 hour services the emphasis of this intervention is at three levels and the reality that about 60% of all deliveries take place in the home:

1. Emphasis 1: Birth preparedness, early identification and referral of complications with support of HF staff and TTBAs.

2. Emphasis 2: Quality/focused antenatal and postpartum care services
3. Emphasis 3: Production and social marketing of clean delivery kits with the aim of every woman equipped with hygienic tools for deliver irrespective of the place (59% deliveries at home + cost barrier of supplies at hospital)
4. Emphasis 4: promotion of postpartum care and newborn care practices

Objectives.

- Increase from 79% to 90% mothers of children age 0–11 months who had three or more antenatal care visits during their last pregnancy
- Increase iron folate intake for 90 days or more by mothers of children aged 0-11 months from 4% to 20%
- Increase from 16% to 35% of mothers of infants 0-11 months who attended postpartum care check-up with the newborn within 7 days of birth
- 65% of mothers who deliver at home use a clean delivery kit packaged by the TBA association
- Strengthen networks of 60 trained TBAs with health center personnel

We will achieve identified outcomes through a number of inter-related actions and strategies that address the identified, underlying causes of maternal and neonatal death. Crucial causes include the need for better antenatal attention and knowledge of danger signs among pregnant women; lack of skilled attendants during delivery; weak emergency referral systems; comprehensive and timely post-natal follow up of the mother and the neonate; and promotion of immediate and exclusive breastfeeding. Improvement of the quality of clinical services will also be crucial for improved outcomes to be achieved.

Behavior Change: From the baseline assessment and feedback during the DIP planning workshops, the following youth practices will be emphasized:

Table 15: Behavior Change Strategy Situation: Maternal & Newborn Care

Behavior	Facilitators	Barriers	Further formative research questions for project
Families recognize danger signs of pregnancy, postpartum and newborn and go straight to the hospital	Parents and family want safe outcome of pregnancy Availability of multiple information channels to reach men and women Efforts underway to improve obstetric service quality at hospitals	Low skills in identifying urgent danger signs Insecurity to travel at night out through some parts of the neighborhood Fear that going to hospital will be very expensive and mother will have to have a C-Section.	What experiences are known in each of the communities of problems during pregnancy, postpartum and the newborn? What are local terms and believed underlying causes?

Mothers purchase and use a clean delivery kit	Desire to protect mother and newborn	Scarce disposable income (kit available at low price of less than 80 gourdes)	Awareness of the three cleans Current sanitary practices of home deliveries – surface, hands, cord cutting & tying Willingness to pay
Mother accompanies newborn to health facility for postpartum care within 7 days of delivery	Parents realizing the importance newborn care services Health services located within 1 km of homes Mothers want to recover and get back to regular activities Mothers want respect of their other women	Mothers physically tired, difficult to leave the home Traditional belief exists about danger of evil spirits No real postpartum care service provided at HC Waiting time at HC if child is not sick	What real services and benefits are available to mothers who attend facility? What can be done to reduce waiting time for this group to receive the service? Does policy allow some scope for early postpartum visit in the home? Could supervised TBAs perform these functions? What are the root beliefs regarding leaving home after delivery?

Community level: We plan to raise the **awareness of rights** and build **demand for services** among both women and men. Working with federations of CBOs, individual CBOs, health center staff, matrones (traditional birth attendants, or TBAs), health agents, and youth leaders we will provide adapted training and ensure key maternal health messages reach target populations through multiple channels, including community groups, churches and schools. This is possible because of the existing relationships that our PVO partners have already developed with their community-based partners, and that includes the development of annual action plans, monitoring plans, and supervisory processes. These relationships will be expanded to **more local partners in our new service areas**, and will be **based upon** an established process of **ongoing capacity development and support.**

Health facility level: During prenatal care, mothers will be taught the four delays of obstetrical care (e.g., recognition of a problem, decision to take action, actively seeking services, and receiving quality care), and when and how to seek appropriate care. Pregnant women who visit the clinics for prenatal care will receive at least 90 days iron and folate, develop a birth preparedness plan, and receive a clean birthing kit if requested. Men and women will be better informed about the importance and availability of specific reproductive and child health services, about maternal nutrition, the danger signs of pregnancy, the importance of birth planning and the presence of a trained health attendant during delivery, care and follow up during the post-partum/neonatal period, immediate and exclusive breastfeeding, and family planning through CBO and Youth Leaders organized community information events.

Since about 60% of pregnant women choose to deliver in their homes, we will train matrones (TBAs) to improve their skills in providing clean deliveries, and to recognize danger signs and immediately refer such cases during delivery and the post-partum/neonate period. An older MSPP curriculum is available but we would prefer to will work with the MSPP to review and update the curriculum prior to implementation. Once the curriculum is ready, and trainers from MSPP are trained,

we will work with CBOs and mothers to select regularly used TBAs for training; by the end of year 3 or early year 4. During monthly meetings, health center staff will provide refresher training to TBAs, and will record reports on activities and critical incidents. Overall, our objective will be to ensure that 85% of the deliveries are attended by a trained attendant that uses either clean materials supplied by the health facility, or a clean delivery kit distributed by the health centers

Clean delivery kits will be socially marketed by the TBA networks in St. Martin, Descayettes and Cite Okay/Jeremie. The kits will be priced under $2 and will include gloves, soap, gauze, soap, razor blade and cord tie. The project will provide an initial supply to cover 3,000 pregnant women. Revenue will be managed by the association and used to restock and package kits. Technical support in fund management will be provided by the Community Development Officer.

An important strategy will also be to strengthen linkages with referral hospitals that manage obstetric and newborn complications, and other urgent cases requiring hospitalization. The two key maternity hospitals are the General Hospital in Port-au-Prince and St. Jude-Anne near St. Martin (see map in annex B). To achieve this, visits will be organized for health center personnel and eventually the CBO Leaders and TBAs. We will also coordinate with UNFPA and MSH/Holland to strengthen referral systems from the neighbourhoods to the maternities, and involve them in social audits and case studies of deaths and near misses.

Women fear delivering at the hospital because of perceived high costs. Cost, as well as security, are considered to be significant barriers to referring mothers to the hospital. We will support CBO federations and other social associations to establish neighborhood emergency delivery funds in selected service areas. Great care must be used not to disrupt existing informal community relationships that serve the same purpose, and to be sensitive to the perception among some communities that such funds function like 'cooperatives,' which have fallen into general disfavor because of previous failures and losses of community resources. The experience of Concern's work with ward health committees in Bangladesh will be reviewed in May 2006 during a learning exchange visit.

New mothers and their infants who have experienced a home delivery will receive one or more **post-natal visits** by the TBA during the first few days after delivery and will be strongly encouraged to attend a post-natal visit at the health center within the first 7 days after delivery. Women delivering at the hospital will be encouraged to attend post-natal care at the neighbourhood health center.

Ultimately, the project will improve the quality of clinic services in five existing public and private non-profit clinics by providing technical assistance to strengthen needs based training, advocacy/short term support for essential supplies and equipment, management (including drugs and human resources) and financial systems, and team building and motivation. The health centers will receive at least one quarterly supervision visit focused on pre and postnatal care services. GENESIS will conduct annual client satisfaction surveys as part of the community assessment. We anticipate that the proportion of "excellent" services will increase to 90% by end of project, based on changes made as a result of agreed upon study recommendations.

5.6 Program Monitoring & Evaluation

This section describes how we will monitor and evaluate performance towards the project's strategic framework, which is presented in figure 2 below:

Figure 2: Strategic Framework of the Urban Health Program

SO: Sustained improvements in the health status of mothers, children and youth in five disadvantaged urban neighborhoods of Port au Prince

IR 1: Empowered communities with increased knowledge and interest in maternal, child and youth health promotion	IR2: Enhanced availability of and access to reproductive and child health services for disadvantaged households in urban areas	IR 3: Increased quality of reproductive and child health services in selected government and private non-profit health centers	IR 4: Improved policy environment for the urban populations, putting emphasis on protection for the poorest people.
1.1 Capacity building and federation forging of community based organizations for health & development in five neighborhoods	2.1 Establishing IMCI services in Descayettes, St. Martin and Cite Okay/Jeremie	3.1 Capacity building for supportive supervision of health services by three Bureaux Communales	4.1 Start-up and support an urban health public-private platform in Port au Prince metropolitan area
1.2 Community health promotion events: rallys, campaigns, fairs, group education organized year round	2.2 Assess feasibility and pilot community based therapeutic care for severe malnutrition	3.2 Foster better health information system implementation and data for decision making skills	4.2 Advocacy for improved environmental health in poor urban neighborhoods to government, donors and private sector
1.3 Youth involvement in neighborhood health leadership	2.3 Develop pro-poor protection strategies for vulnerable families	3.3 Institutionalization of particpatory capacity assessments for health facilities	4.4 Popularization of learning from the urban health initiative experience
1.4 Organisation of community-level HIV/AIDS prevention and control	2.4 Intensification of EPI activities	3.4 Establishing quality assurance approach with performance incentives at 5 HFs	4.5 Support the DSO to initiate an urban health strategy for Haiti
	2.5 Reinforce the obstetric care referral system from the household to hospital level	3.5 Strengthening EPI logistiques through quality assurance teams and strengthening connections with national program	

Current Information System. While health facilities maintain patient registers, and maternal and child health cards are largely available, initial assessments indicate that the information from these sources are rarely used. In fact, the notion of service coverage areas and population-based information are nearly non-existent with the exception of the FOCAS intervention areas of Jalousie and Bois Moquette.

The 2006 rapid assessment showed that each facility was submitting monthly reports to either their managing agency or the Bureau Communale depending on the type of facility. Most private facilities are not using national Systeme Information Sanitaire (HMIS) forms although similar information is available. Private facilities report to their organization headquarters who then provide monthly reports, mostly on EPI, to the Bureau Communale. While the private facilities received regular feedback from their supervisors regarding trends in patient flows, both positive and negative, the public facilities received little commentaries and found little use of the reports themselves. There was no evidence of any recent training of government staff in use of data for decision making and in all health facilities visited there was no visual presentation of monitoring of health service use, tracking EPI coverage, etc.

Over the next four years health information at the community and health facility levels will significantly increase in value to workers on the ground as well as at the Bureau and DSO levels. This will be led by the M&E Advisor to the program who will ensure that data collection, analysis, target setting and tracking is incorporated in technical trainings and annual reporting at the health facility level. As part of the baseline assessment she completed a review of the current HMIS in each of the neighborhoods at the community health worker and health facility levels. While quality assurance of data is the responsibility of all stakeholders of the information system, the M&E advisor will review the implementation of the community and HF HMIS in each neighborhood on a quarterly basis and work with the Project Support Officer to analyze and flag outliers and other potential errors in the system. Through this close monitoring and coaching process, we should be able to ensure quality of data collected and used for decision making.

Monitoring Tools. There are several systems in place in Haiti for monitoring project performance at both health facility and community level.

Health facility monthly report: These are completed based on a diversity of registers at the five health centers that cover areas required in the MSPP Level 1 Monthly Report format (see Annex G-4). In most cases, information is compiled by non-technical personnel and supervised by the facility Administrator.

LQAS monitoring of 19 key indicators at the practice and some knowledge and attitudes level annual in each of the neighborhoods. These assessments will coincide with the neighborhood assessments that are spread over the four neighborhoods, one per quarter during each year.

Table 15: Monitoring System Tools to be Developed

Tool	Use	Frequency	Status	Plan to finalize
Community Health Officer Report	Collect monitoring data from multiple sources in neighborhood Triangulate community and HF information	Monthly	Not developed	June-July 2006
Community Assessment Tools	Capacity of CBOs, Youth Leaders and Client Satisfaction	Annually	Examples exist from various projects, notably Ward Health Committee assessment from CW Bangladesh	June/July 2006
Health Institution Capacity Assessment	Health Facility	Years 1, 3, and 5	Management capacity areas completed but need to update to include technical	Nov/Dec 2006
Key practices, attitudes and knowledge LQAS monitoring	Monitor probable coverage in each of the neighborhoods Identify and focus on areas not improving Recognize and learn from areas doing better	Annually	Questions available in Creole in KPC survey but the 19 questions need to be compiled in monitoring survey tool, tabulation tables set and decision rules set by survey period	Starts August 2006

A detailed M&E plan is attached as Annex D with indicators, data sources, frequencies, and use.

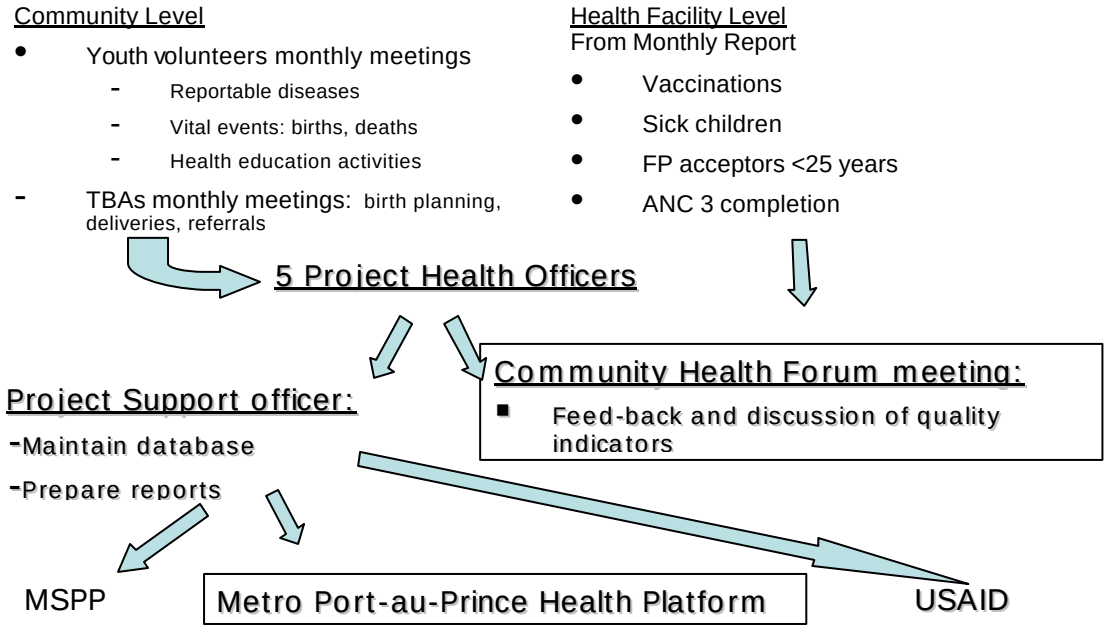
Data Collection System.
As shown in the figures below, information is concentrated around three levels:

Community-level: Monthly activity reports from youth and CBO leaders and traditional birth attendants. These are compiled with health facility staff by the Community Health Officer and shared at the quarterly community health forum.

Health facility level: Monthly compilation of facility registers on vaccinations, Vitamin A, sick children, reportable diseases, etc. by Government facilities are submitted directly to the Bureau Communale while private clinics send first to their headquarters with a copy to the BC. In the initial phase the Community Health Officer may serve as an intermediary for compilation of this information until the health center involvement in the health forum is institutionalized.

Program-level: Compilation of information from each neighborhood through routine data gathering from Community Health Officer, HMIS report as well as triangulated area assessments from GENESIS. This is reviewed on a quarterly basis.

Figure 3: Project Information Flow



A Process Documentation and Research Organization, GENESIS, has been tasked in the first year to complete several M&E functions including:
Task 1: Develop assessment tools and implement baseline: This includes a Community Health Capacity assessment tool adapted from the CW Bangladesh Ward Health Committee model; fixing a monitoring questionnaire to use a 19 LQAS sample to gauge coverage and practices; and short focus Group discussion guides for mothers

Task 2: Adaptation of health facility assessment tool – using HICAP already used in Haiti (modified from MOST) plus MSPP Level 1 Health Center standards
Task 3: Facilitate the Urban Health Platform participants to define its policy vision, stakeholders, and learning objectives

The function of GENESIS as an semi-independent body for M&E to the program is illustrated in the following figure.

Figure 3 : Function of the Community Health Forum, Process Documentation & Resource Organization, and Urban Health Platform in Information Flows and Use

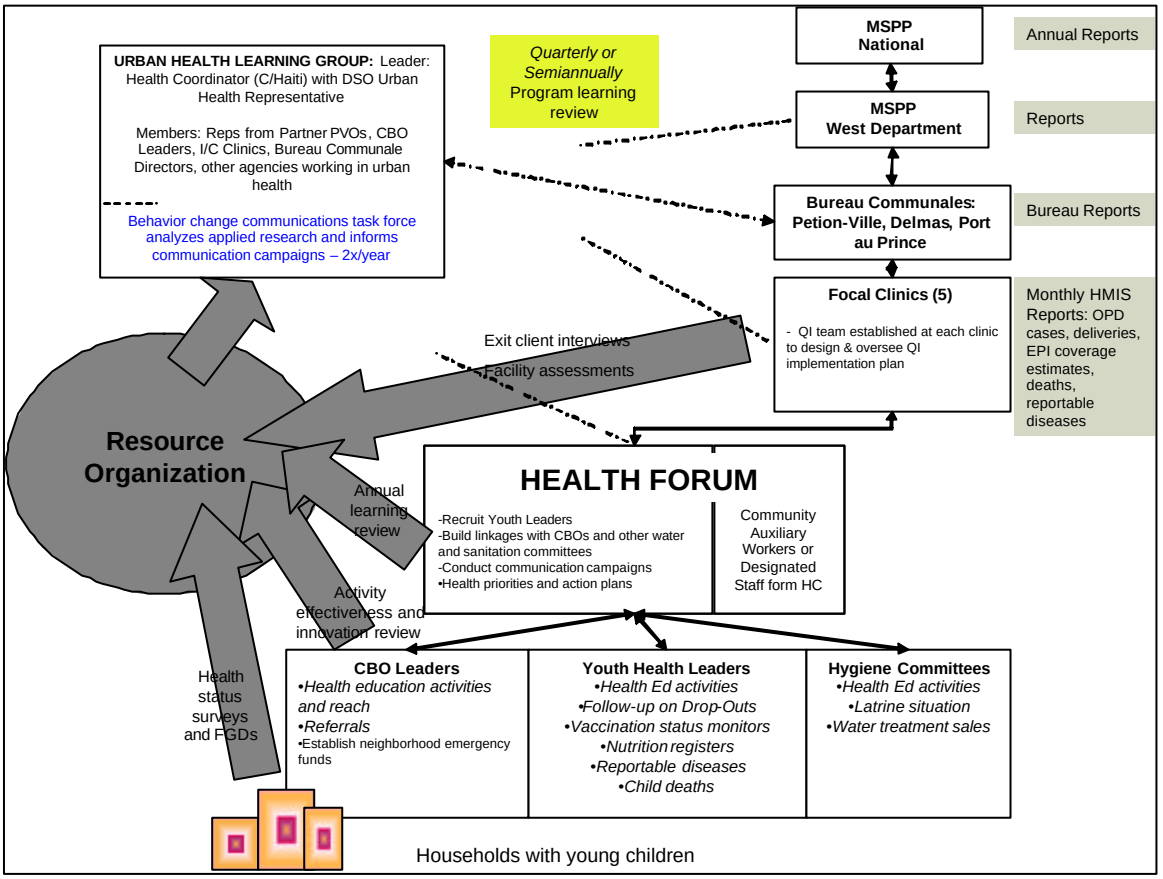


Table 16: Data Collection Table

Source	Type of Info	Frequency	Who Receives it?	Quality Control
Youth Leaders Journals	Health education Births, Deaths, and Pregnancies Reportable diseases	Monthly	FORUM Leaders	Community Health Officer and M&E Consultant
Trained TBAs	Deliveries Referrals Neonatal Tetanus Clean Delivery Kit sales	Monthly	HC Nurse	Community Health Officer and M&E Consultant
CBO Leaders	Health education Community Distribution Points & sales	Monthly	FORUM Leaders	Org Development Officer and M&E Consultant

Source	Type of Info	Frequency	Who Receives it?	Quality Control
`Health Center Registers	Vaccinations Sick children Family planning acceptors < 25 years of age Completion of 3 ANCs Postnatal care	Monthly	BC	BC and Health Service Capacity Officer
Neighborhood Assessment	Capacity of CBOs, Youth Leaders and Health Facility Client Satisfaction Mothers KAP	Annually	Urban Health Platform	Health Coordinator and Health Advisor

Data analysis will be conducted at the following levels

- Project Level: Review Community Health Officers report at monthly project team meetings and post at Health Center and neighborhood health forum space for discussion at their meetings and tracking. More data driven management meetings will be held quarterly.
- Community Health Forum Level: preliminary input in Community Health Officer's report with Community Health Forum input at quarterly meeting
  Monthly Report HF Report by Quality Assurance teams review, analyse and chart progress and develop action decisions; utilize annual neighborhood assessment by GENESIS as part of annual planning process
- Urban Health Platform: quarterly review of implementation report with achievements, constraints, and plans for next quarter.
- Internal annual evaluations: Review neighborhood assessments, monitoring data, and stakeholders perspectives against planned actions and targets by intermediate result to determine achievements, challenges and constraints for forward planning.

Externally-led Evaluations. External evaluations are planned to include a midterm process evaluation to in August 2008 to review the probability of achieving project results, achievements, constraints and recommendations for modification and a final evaluation to assess results, achievements and lessons learned in July 2010. Both evaluations will include a household KPC survey in all the neighborhoods.

Fit to USAID/ CSHGP Program Management Plan (PMP)

This project also directly addresses all four CSHGP Program Results under the new PMP:

PR1: Improved health status of target populations. The intermediate results of the Urban Health Program emphasize increasing knowledge and improved health practices and behaviors related to the leading causes of child and maternal mortality in the target population; improving the quality and availability of services; and increasing the capacity of community health forum in each of the 5 neighborhoods. Through reporting in changes in community organization and urban health platform capacity on an annual basis assessed by GENESIS. This will build on learnings from capacity areas of CW/Bangladesh work and dialogue with CSTS+ on refinements to the strategic element areas of the Sustainability Framework.

PR2: Increased scale and equity of health interventions. This program will contribute to achieving scale in its own right by working with multiple faucets of civil society through Community Health Forums as a potentially sustainable means of community health engagement to reach all families covering 10% of all children under-five; by fostering a growing and more inclusive Urban Health Platform as a way to share best practices and influence policy; and the application of the Household Dietary Diversity Score to assess equitable coverage of health among families within the project area.

PR3: Increased contribution of CSHGP to the global health leadership agenda for child survival and health. Through the CSHGP, Concern Worldwide has largely increased increased its voice in global health agenda through contributions at global and regional conferences on successful and promising approaches, serving as a delegate in the Child Survival Countdown 2015 and Wye River Declaration for Innovations in Supporting Local Health Systems for Global Women's Health. We are working towards establishing organizational membership in the Global Partnership for Maternal, Newborn and Child Health. CW consistently seeks opportunities for dissemination and publishing of highly effective strategies to contribute to body of evidence as demonstrated through our Community Therapeutic Care for work for malnutrition

PR4: Expanded partnerships. The USAID mission is a key institution for leveraging institutional linkages with multilateral agencies, the Ministry of Health, and networks of PVO actors. The program will support the mission to organize regular sharing and strategy meetings with the CSHGP grantees to collectively contribute to national dialogue on performance incentives, the C-IMCI strategy and reaching newborns, and the adoption of revised diarrhea case management protocols with zinc and new ORS guidelines. With the CTC feasibility assessment and national dialogue on management of malnutrition, this grant we will convene WFP, UNICEF, food production industry, pharmaceutical board, donors, PVOs, PEPFAR partners, and other nutrition experts to start to come to terms with the issue of wasting, both among children and PLWHAs.

Fit to USAID/Haiti Results. The USAID Mission is in the process of developing its new Strategic Plan. During a preview we learned that the health sector strategy will be quite similar to the 1994-2004 objective but with more emphasis on nutrition and vaccinations: **SO3 - Achieve desired family size** which implies both reducing child morbidity and mortality through child survival interventions and improving access to reproductive health services with indicators of reduced TFR from 4.8 to 4.0 and child mortality rate reduced from 131 to 112 (currently 117), and child malnutrition down from 27% to 20%. The SO covers multiple intermediate results. The IRs most pertinent to this project and its indicators include:

IR 3.1: Increased use of quality child survival and nutrition services. The mission aims to increase measles and Vitamin A coverage and increase ORT use. The project will report on these indicators as well as all the Rapid Catch Indicators.

IR 2: Increased use of RH services. The mission aims to increase Contraceptive Prevalence Rate and expand the range of contraceptive methods available at health service points. The project contributes to this by increasing youth acceptors of family planning services and strengthening essential drug supply management.

IR 3: Improved public policy environment for reproductive health and child survival programs. While the last strategic plan primarily focused on RH policy, this project will contribute to maternal and child health policy environment including influencing the development of a pro-poor urban health strategy, strengthening health information systems, and contributing to national guidelines for community IMCI and the new TBA curriculum.

IR 4: Women empowered to make RH decisions. The mission strategy focuses on building up the determinants of basic education, violence/advocacy support access, and micro credit access. The project will promote social support for obstetric care actions and facilitate social program linkages through the community health forum so that women can better access.

IR 5: Youth better prepared for and men more engaged in responsible family life. The mission strategy focuses on safer sexual practices including abstinence, fidelity, consistent condom use, and increasing use of family planning services. This project will greatly contribute to this IR through the strengthening of youth leaders, creating "youth friendly clinics", and reporting on youth utilization of family planning and condoms.

5.7 Program Management

Internal Staffing Management Structure. A high quality, committed and experienced team has been assembled to implement this five-year urban health project. The team includes a core set of full-time employees who are referred to at "The Project Team", "The Project Support Team", and the HQ backstopping Team.

The Project Team serves as the day-to-day project planners, implementers and monitors of performance. It includes the following regular project staff:

1. Urban Health Project Manager, Concern Worldwide Haiti (CW/Haiti)
2. Health Services Capacity Building Officer, full project area, CW/Haiti
3. Project Support Officer, full project area (CW/Haiti)
4. Organization Development Officer – Cite Okay/St. Martin, CW/Haiti
5. Community Health Officer – St. Martin, CW/Haiti
6. Community Health Officer – Cite Okay, CW/Haiti
7. Community Health Officer – Descayettes, GRET
8. Community Development Coordinator – Jalousie/Bois Moquette, FOCAS
9. CBO Liaison Officer - Jalousie/Bois Moquette, FOCAS

Given the nature of this team, we are proposing a change in Key Position of Field Manager to Ms. Guerda Debrosse of Concern Worldwide Haiti. She has over 5 years experience including management of health system programming in Haiti and expertise in maternal and child health technical areas.

The Project Support Team: This team pulls together the next higher step in management in each of the partner's agencies. The role of this team is to oversee quality and effectiveness of the project, partnership building, documentation and lessons learned facilitation.

The team comprises of (% indicates time devoted to project)

- Concern Worldwide Haiti Health Coordinator (40%) and Research Officer (50%)
- GRET Director (10%) and Urban Program Manager (50%)
- FOCAS Project Manager (20%)

In order to coordination communications, local planning, and respond to emerging issues squarely, the following levels of meetings is established outline in table 17.

Table 17: Coordination & Meeting Schedules

Mtg	Frequency	Purpose	Participants
Monthly Staff Mtgs	Monthly – ½ day	Communications Planning Updates Problem Solving	Project Manager and Officers, Community Animator and CDC
Quarterly Mgmt Mtgs	Every 3 months – 1-2 days	Quarterly Planning Financial and Program Review Reporting Relationships	All staff including Managers from GRET & Focas
Coord Mtgs	Monthly, 1 hour	Planning Coord w/External Agencies Documentation	Project Manager Health Coordinator DSO
Platform	Every 3 months	Progress and constraints Observations Planning with external agencies Documentation & Learning	DSO, BC, PM, Mgrs FOCAS & GRET, HCs, BCs, CBOs, rep of Officers

Headquarters Technical, Financial and Administrative Support. The role of this group is to ensure technical quality, transfer skills and tools for program implementation, monitoring and evaluation, financial and administrative adherence, and promotion of organization learning. This group includes:

- CW/US Health Advisor based in New York (50%). This position devotes a large amount of time for technical and administrative desk and field support, including two trips per year to Haiti for 2-3 weeks for system development, technical monitoring, skill transfer, and documentation support.
- Concern Worldwide Financial Director (10%) This position is responsible for financial monitoring and reporting as well as skill transfer to CW/Haiti management. This position travels to Haiti in years 1, 3, and 5 for financial backstopping and budget reviews and USAID regulation adherence.
- FOCAS Program Director (20%) This position will ensure adherence of FOCAS to USAID regulations, reporting, as well as provide overall leadership in sharing best practices in working with youth and HIV/AIDS as well as reviewing field level experience in each of the neighborhoods at least once per year.

Concern Worldwide US, Inc has a field visit monitoring tool that it uses to guide staff in information seeking and reporting. A copy of the tool is attached as Annex G-3.

Supervision System. Supervision will occur in three ways: first, supportive supervision of external human resources/collaborators to the program, supervision of key partners of GRET & FOCAS, and internal supervision of CW/Haiti and US staff.

Supervision within Health Services: According to MSPP policy, all formal service providers are supposed to be supervised once a month; however, lack of human resources, transportation, insecurity in these neighborhoods and fragmented private sector linkages, government facilities are seen only about 3 times per year and most private facilities in the project area are not directly supervised by the Bureau Communale. However, when supervision is done, it is considered by health staff as very useful, of good quality, and comprehensive. Both private and public facilities require a closer link to the Bureau Communale and in reality find themselves in their offices several times per month, particularly for procurement and communication purposes.

This program will make phone lines available at St. Martin and HaitiMed at St. Ciclair to facilitate communications with the hospital administration as well as with the Bureau Communale to organize supervision visits and to make procurement requests and check on progress.

Private facilities are largely supervised by their agency headquarters personnel and these visits are frequent, often weekly.

Implementing partners of GRET and FOCAS supervise and manage their staff appointed to the project. They report to Concern on achievements, obstacles, new ideas. Performance issues of the subgrantee, as outlined in the written agreements are the initial responsibility of the Concern Health Coordinator but ultimately the CW/Haiti Country Director.

CW staff performance management system will be fully operationalized for all of its staff, including those funded under this project. This is based on assessing individual performance based on job description, annual objectives, as well as peer review.

The following table outlines the external human resources essential for the design, implementation, monitoring and evaluation of this program. The project with emphasis the highest level of participation of each of this cadres to maximize ownership, appropriateness, and potential for sustainability of the efforts.

Table 18: External Human Resources

Who	Supervisor	% time to project	Compensation
36 Health facility personnel	MSPP/BC for Public and NGO HQ for Private	10%	Performance incentives no greater than 50% salary
Community Facilitation Trainers	Community Health Officer	15%	Per diem for trainings
95 CBO leaders	Community Development Officer	10%	KDSM/SNELAK – management support by Concern and GRET Others – fund to support community plans
1136 Youth Leaders	CBO Leaders in Sub-Zone	10%	No direct compensation –social outlet, business and life skills, working tools, fund to support community plans, leisure
60 TBAs	TBA Trainers at Health Facility	10%	No direct compensation – capitalization of clean delivery kits, traditional payment for support.

For further details on the human resources management, refer to annex E for organization charts, roles and responsibilities by position, supervision lines, and status of recruitment for posts.

Performance Incentives. Based on a negotiated agreement between each of the HC staff teams and Concern. Staff will set quarterly performance targets and annual bonus targets for payment incentives to enhance motivation and provide financial remuneration in a more sustainable manner than direct payments or salary top-ups. Concern and the HC management, with a reputable microfinance firm, will establish low interest revolving loan funds to each center and dedicate funds according to success of performance targets, as well as sound management of the revolving fund. While each of the partners of GRET, FOCAS and Concern may use different approaches based on previous experience with their local NGO partners, key principles embedded in the project's systems include:1) compensation is rooted in quality assurance performance monitoring; 2) incentives cannot exceed 50% of salary; and 3) good management of the fund at the health facility is a factor in future allocations. Individual agreements will be included in the first annual report.

6 Training Plan

Table 18: Training Plan

Topic	Content	Duration (in days)	Who	Trainers
PLATFORM LEVEL				
1. Population MCH Surveys	▪ Coverage Surveys ▪ Sampling ▪ Interviewing techniques ▪ Data Analysis	3	5 HC, 8 Project Staff, 3 CBOs	Consultant
2. Training of Quality Assurance Trainers	▪ Dimensions of quality ▪ Team work ▪ Prime II – 9 stages of performance improvement ▪ Problem identification and analysis ▪ Action plans ▪ Monitoring	3	5 HCs, 3 BC Nurses, 1 DSO, 1 Capacity Building Officer + Health Ed Officer (11)	CW/Haiti trainer
3. Strategic Behavior Change	▪ Behavior change thinking ▪ Social change theory ▪ BEHAVE Framework ▪ Doer/non-doer analysis ▪ Message development and field-testing ▪ Monitoring effectiveness	5	4 Community Health Officers, 5 CBO Leaders, 5 Health Center Staff, 3 BC	CW/US Health Advisor and 2 CW/Haiti BEHAVE graduates
4. Training of TBA trainers	▪ Adult learning ▪ Traditional practices ▪ Roles of TBAs ▪ ANC services ▪ Danger Signs ▪ Clean Delivery ▪ Post partum ▪ Newborn Care ▪ Reporting	5	3 HCs, 2 BC Nurses, 4 Staff (total 9)	MSPP/RH and MSH
5. Training of Trainers for Pre & Postnatal care	▪ Adult learning ▪ Focused ANC ▪ Integration PMTCT & STDs	3	1 DSO, 2 BCs, 3 Staff	MSPP/RH and MSH

Topic	Content	Duration (in days)	Who	Trainers
	▪ Why Postnatal care? ▪ Newborn care ▪ Reporting ▪ Working with community			
6. National Reflection on Malnutrition and orientation on CTC	▪ Malnutrition in Haiti and urban areas ▪ Chronic/Acute malnutrition ▪ Accessibility of care ▪ RUTF ▪ Community therapeutic care – malnourished child ▪ CTC – PLWHAs ▪ Recommendations/next steps	2	MSPP, UNICEF, WFP, USAID, DSO, BC, 5 HCs, 5 Forum reps, key NGOs, key donors (approx 40)	Concern HSU; VALID
7. TOT in Health Education and Adult Learning	▪ Adult learning ▪ Interactive teaching methods ▪ Planning health education ▪ Helping trainers	5	5 HC, 5 Staff; 24 Community	Consultant/Michelle
HEALTH CENTER LEVEL				
8. Annual review, use of HMIS and action planning	• Data analysis and using it as information • Review performance on last year's workplan • Triangulation of community suggestions and CBO plans • Translating priorities into actions • Setting targets, responsibilities and time frames.	2	All 36 health facility staff Initial training for 4 days to include capacity assessment; remaining years for 2 days	M&E Consultant, PM, BC
9. Quality Assurance Team Orientation	▪ Dimensions of quality ▪ Team work ▪ Prime II – 9 stages of performance improvement ▪ Problem identification and analysis ▪ Action plans ▪ Monitoring	3	36 Staff from all 5 health facilities	QA Trainers - BC/DSO, and HC rep

Topic	Content	Duration (in days)	Who	Trainers
10. Refresher training on pre and post-natal care for health provideres	• Focused Antenatal care services • Integration with VCT and STI services • Birth preparedness and danger signs • Information about available maternity care from referral hospitals • When and why do mothers and children die? • Post-partum care services • Newborn care services • Strategies to encourage post-partum visitation	5	6 doctors and nurses consulting on child illnesses daily from x 3 Health Centers	2 trainers from Platform team
11. EPI refresher	• Norms • Principles • Safety • Reporting • Monitoring	2	All staff from 3 Health Centers	BC
12. IMCI Training: St. Martin & HaitiMed	• General danger signs • Assess and classify the child • Treat the child • Counsel the caretaker on care • Practical field work • Record keeping, data collection and analysis	11	4 Health workers per center (8) [may add more to bring up to 15-20 people)	2 DSO IMCI trainers + CB Officer
13. Refresher on IMCI	• General danger signs • Assess and classify the child • Treat the child • Counsel the caretaker on care	2	6 nurses, doctors x 3 HCs of St. Martin, Site Okay, and Descayettes (total 18)	2 IMCI trainers
14. Essential medicines and drug management	• Essential drug list • Procurement • Stock keeping • Inventory	5	2 Pharmacy Aides + 2 Administration Personnel x 5 HCs (20 participants)	Local Trainer

Topic	Content	Duration (in days)	Who	Trainers
	• Pricing • Account maintenance			
15. Training of Trainers: Training Methodologies and Principles of Adult Learning. Application for Training in Infant & Young Child Nutrition and Related Topics Adapted from AED/Linkages	• Concepts and Principles of Adult learning • Planning a training/learning event • Developing learning objectives • Facilitation Skills • Technical Updates: Nutrition: 0-5 months, 6-9 months, 10-23 months; HIV/AIDS, sick child • Training Methods • Audio and visual aids • M&E • Designing Lesson Plans • Practice & Supervision	5 (2 days technical & 3 days practical)	1 MD/Nurse and 3 auxiliary nurses x 3 Health Centers (12 people)	Staff
Community Level				
16. Developing annual action plan for Community Health Platform in 5 Neighborhoods	• Planning with community voice • Participatory decision making and prioritization • Workplan development • Monitoring • Assessment & Learning	3	25 CBO members, HF staff, and other social leaders	Community Health & Dev Officer
17. Orientation for Youth Leaders for Health	• youth leadership • spirit of volunteerism and support needs • negotiating of youth roles in health promotion, • immunization basics • Reportable diseases • life skills self-assessment and improvement plans	3	1136 Youth Leaders	Commmunity Health and Development Officers

Topic	Content	Duration (in days)	Who	Trainers
18. Training TBAs on revised maternal and newborn care	• role of TBA • importance of TBA in the community • infection prevention and disposable of wastes • anatomy and physiology of reproductive system • pregnancy • prenatal care • birth preparedness • VCT/PMTCT • Delivery • neonatal and postpartum care • family planning • epidemiology • TBA monthly report • Synthesis & evaluation	10	60 Traditional birth attendants	Community Health Facilitation Team
19. Facing AIDS Together: HIV/AIDS prevention and care facilitators guide, FFH	• Adult-Learning Principles • Creating safe environment • HIV/AIDS is our problem • How people get HIV/AIDS • Protecting ourselves and others • Talking about HIV/AIDS • Protecting our children • Testing for HIV/AIDS • Talking with our partner • How to use a condom • Living with AIDS • Preparing for the future • Commiting ourselves to action	3	1136 Youth, and 187 CBO leaders	Neighborhood training teams: HC, Staff and Community trainers
20. Infant & Child Feeding: Helping Young Children to Eat & Grow Well	• Breastfeeding • Learning how to eat • Helping Children eat • Feeding frequency and quantity from 6-12	2	St. Martin, Cite Okay and Descayette: 780 Youth, and 130 CBO leaders	Neighborhood training teams: HC, Staff and Community trainers

Topic	Content	Duration (in days)	Who	Trainers
	months • Preparing nutritious foods • Feeding beyond 12 months of age • Protecting your food/protecting your children • Helping your community raise healthy children			
21. Training core sand of CBOs, Youth Leaders & TBAs on sick child and C-IMCI: FFH Guide "	• The Most Common Childhood Illnesses • The Four Critical Danger Signs • Diarrhea Danger Signs • Cough Danger Signs • Fever Danger Signs • The Medical Examination • Choosing Medical Care Providers • A Checklist for Quality Medical Care • Caring for Sick Children—Important Steps to Follow	2	780 Youth, and 130 CBO leaders	Neighborhood training teams: HC, Staff and Community trainers
22. Facilitating maternal and newborn care for youth and CBO leaders	▪ Maternal and newborn health situation ▪ Why do women and babies die? Medical and social causes with the 4 delays ▪ Danger signs – pregnancy, childbirth and postpartum ▪ Birth planning and preparedness ▪ Importance of antenatal care ▪ Clean deliveries ▪ Getting to know your hospital ▪ Community support for referrals ▪ Importance of postnatal care ▪ Planning for action	2	780 Youth, and 130 CBO leaders	Neighborhood training teams: HC, Staff and Community trainers

The following training guides will be used to shape the trainings. Given their volume they are not included in hard copy but available upon request.

- GoH/MSPP (1997). Training Modules for IMCI. Port-au-Prince, Haiti.

- PRIME II Project (2003). "Stages, Steps and Tools: A Practical guide to faciltitate improved performance of healthcare providers worldwide." CD-ROM tool. Chapel Hill, NC.

- AED/Linkages (2005). Training of Trainers: Training Methodologies and Principles of Adult Learning. Application for Training in Infant & Young Child Nutrition and Related Topics. Washington, DC.

- Freedom From Hunger (2005). Infant & Child Feeding: Helping Young Children to Eat & Grow Well. Davis, CA.

- Freedom From Hunger (2005). Facing Illnesses That Attack Our Children: Trainer Manual. Davis, CA.

- Denman, V., Davis, R. and Vor der Bruegge, E. (2002). Facing AIDS Together: HIV/AIDS Prevention & Care. Trainer Manual and Facilitator Guide. World Relief & Freedom from Hunger, Davis, CA.

- Ross, S. (1998). Promoting Maternal and Newborn Care: A Reference Manual for Program Managers. CARE, Atlanta, GA.

7 Workplan Matrix

The following pages include the May-September 2006 monthly work plan by and a five-year detailed plan with quantifiable targets, quarters – organized by Intermediate Results.

WORKPLAN 1: MAY – SEPTEMBER 2006

Activity	May	June	July	August	Sept	Responsible
IR 1: Empowered communities with increased knowledge and interest in maternal, child and youth health promotion						
Work with CBOs to inventory possible hand washing stations and distribution points for ORS and water treatment				X	X	Community Health Officers
Identification and dialogue with youth groups; develop selection process and criteria; develop motivation strategy	X	X	X	X	X	Community Health & Development Officers
Youth groups identification of condom distribution points	X	X	X	X	X	Community Health & Development Officers
Annual action planning with CBOs by neighbourhood			X	X		Community Development Officers
Set community health forum capacity benchmarks and targets; draft tool design		X	X	X		GENESIS
Selection of Community health education trainers				X		Community Health & Development Officers
Training of Trainers on Adult Centered Learning					X	Project Manager with FFH contractor
IR 2: Enhanced availability of and access to reproductive and child health services for disadvantaged households in urban areas.						
Organize basic supplies for community distribution points					X	Health Services Capacity Officer
Essential drug mgmt training					X	Health Services Capacity Officer/Consultant
Order initial essential drug support - 1st stock				X	X	Project Manager with Support Officer
Planning with Dept IMCI trainers					X	Health Services Capacity Officer
IR 3: Increased quality of reproductive and child health services in selected government and private non-profit health centers						
Establish performance incentives guidelines	X	X				Project Manager
QA training with Concern HIV team		X				Project Manager
Complete letters of understanding with roles and performance incentives guidelines with Haitimed, St. Martin II, and DSO		X	X			Project Manager

Activity	May	June	July	August	Sept	Responsible
Solidfy ANC screening and referral w/MSF				X		Project Manager
IR 4: Improved policy environment for the urban populations, putting emphasis on protection for the poorest people.						
platform mtg start (DIP Feedback, community assessment tools)			X			Project Manager with GENESIS
Mapping health partners w/bureaux communales			X	X	X	Project Manager w/DSO
Complete year one contract and workplan with GENESIS	X	X				Health Advisor & Health Coordinator
Complete urban nutrition and livelihoods survey		X	X			Health Coordinator with GSD
MANAGEMENT: team development and leadership						
Refine Job Descriptions, recruit and orient additional staff (Health Services Capacity Officer, Health Education Officer, & Project Support Officer)	X	X	X	X		Project Manager
Initiate Monthly Team Meetings		X	X	X	X	Project Manager
Exchange visit to Bangladesh on C-IMCI and Community Mobilization		May 20-27				Health Advisor & Health Coordinator
DIP feedback and negotiation w/USAID			X			Health Advisor & Health Coordinator
Start Monthly Reports			X	X	X	Project Manager with ACD Program

[1] Country Profiles from Population and Reproductive Health. Policy Reports and Indicators 2005 – Joint UNFPA/Population Reference Bureau Publication.

[2] The Challenge of Poverty, The World Bank, 1998.

[3] Ibid

[4] UNICEF, State of the World's Children 2006

[5] Gheskio 2005

[6] Baseline data based on Preliminary KPC Survey Report from project area Feb-April 2006

[7] EMMUS III, metropolitan Port-au-Prince, 2000

[8] National census, 2003.

[9] The Challenge of Poverty, The World Bank, 1998.

[10] Ibid

[11] Country Profiles from Population and Reproductive Health. Policy Reports and Indicators 2005 – Joint UNFPA/Population Reference Bureau Publication.

[12] UNICEF, State of the World's Children 2006

[13] Gheskio 2005

[14] USAID Health Statistical Report, March 2003.

[15] USAID Health Statistical Report, March 2003.

[16] Solid Waste Study in St. Martin, Concern Ha?ti, 2003.

[17] FOCAS (July 2002). Water Quality Analysis Summary in 9 sectors of Petion-Ville, Ha?ti. Department of Geology, Miami University, Oxford, OH

[18] Sphere Project (2004). Revised Handbook Humanitarian Charter and Minimum Standards in Disaster Response. Geneva.

[19] USAID Health Statistical Report, March 2003.

[20] World Bank (2004). Interim Cooperation Framework 2004-2006. [ICF '04-'06]

[21] Ibid.

[22] The Challenge of Poverty, The World Bank, 1998.

[23] MSPP Strategic Plan 2005-2010, Port-au-Prince

[24] UNFPA/PRB, 2005

[25] Differences are attributed to insecurity in these neighborhoods over the past 12 months affecting delivery channels

[26] EMMUS III, metropolitan Port-au-Prince, 2000

[27] EMMUS III, metropolitan Port-au-Prince, 2000

[28] MSPP Strategic Plan 2005-2010

[29] UNFPA/PRB, 2005

Major Activities	Year 1		Year 2				Year 3				Year 4				Year 5				Responsible		Benchmark/	Activity Focus*
	Apr-Jun 2006	Jul-Sept 2006	Oct - Dec 2006	Jan - Mar 2007	Apr - June 2007	Jul-Sept 2007	Oct - Dec 2007	Jan - Mar 2008	Apr - June 2008	Jul-Sept 2008	Oct - Dec 2008	Jan - Mar 2009	Apr - June 2009	Jul-Sept 2009	Oct - Dec 2009	Jan - Mar 2010	Apr - June 2010	Jul-Sept 2010	Partner	Staff	Target	
IR 1: Empowered communities with increased knowledge and interest in maternal, child and youth health promotion																						
Behavior Change Strategies at Platform Level																						
Develop BEHAVE strategy for safer sexual practices among youth and pregnancy prevention				X															Behavior Change Committee	*Project Manager*	Strategy documented and monitored	BC
Adapt and develop BCC materials for HIV				X															Behavior Change Committee	*Project Manager*	Qty materiels developpes	BC
Develop MNC BEHAVE strategy for: Postpartum visit in 7 days; delivering at Hospital in face of danger signs					X														Behavior Change Committee	*Project Manager*	Strategy documented and monitored	BC
Adapt and develop BCC materials for MNC					X														Behavior Change Committee	*Project Manager*	Qty materiels developpes	BC
Develop BEHAVE strategy for: rehydrating and feeding sick child; referring pneumonia cases; treating drinking water							X												Behavior Change Committee	*Project Manager*	Strategy documented and monitored	BC
Adapt and develop BCC materials for sick child							X												Behavior Change Committee	*Project Manager*	Qty materiels developpes	BC
Develop BEHAVE strategy for: exclusive and complementary breastfeeding										X									Behavior Change Committee	*Project Manager*	Strategy documented and monitored	BC
Adapt and develop BCC materials for Infant & Young Child Feeding										X									Behavior Change Committee	*Project Manager*	Material sets developed and distributed	BC

Major Activities	Year 1		Year 2				Year 3				Year 4				Year 5				Responsible		Benchmark/	Activity Focus*
	Apr-Jun 2006	Jul-Sept 2006	Oct - Dec 2006	Jan - Mar 2007	Apr - June 2007	Jul-Sept 2007	Oct - Dec 2007	Jan - Mar 2008	Apr - June 2008	Jul-Sept 2008	Oct - Dec 2008	Jan - Mar 2009	Apr - June 2009	Jul-Sept 2009	Oct - Dec 2009	Jan - Mar 2010	Apr - June 2010	Jul-Sept 2010	Partner	Staff	Target	
Develop BEHAVE strategy for completing all vaccinations by 1st birthday													X						Behavior Change Committee	*Project Manager*	Strategy documented and monitored	BC
Community Mobilization																						
Work with CBOs and Youth Groups to identify and elect Youth Leaders for health promotion within the sub-zones	X	X	X																KDSM, SNELAK, Comite Pilotage	*Community Development Officer*	1136 certified Youth Leaders, Ratio of Leaders to HH <30	A
Youth Leaders report on births, deaths, and reportable diseases monthly to the health center				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Youth Leaders & HC Staff	*Community Development Officer*	# births by place # deaths by age and sex # maternal deaths # cases refererred to hospital	A, Q, BC
Hold monthly meetings with Youth Leaders incorporating life and business skills for their development and motivation					X	X	X	X	X	X	X	X	X	X	X	X	X	x	KDSM, SNELAK, Comite Pilotage	*Community Development Officer*	% meetings held in past month, # participants	Q
CBOs organize community meetings to plan emergency support plans for hospitalization							X	X	X	X									KDSM, SNELAK, Comite Pilotage	*Community Development Officer*	% sub-zones with concrete plans	A, BC
CBOs organize community meetings to review unsafe practices and take action (quarterly)							X	X	X	X	X	X	X	X	X	X	X	X	KDSM, SNELAK, Comite Pilotage	*Community Development Officer*	% sub-zones with meeting in past quarter	Q
CBO & Youth Leaders organize community dialogue events on maternal and newborn danger signs and importance of postpartum visits							X	X	X	X	X	X	X	X					CBO, Youth, HC	*Community Health Officer*	# events, # people reached	BC

Five Year Workplan: April 2006 - September 2010

Major Activities	Year 1		Year 2				Year 3				Year 4				Year 5				Responsible		Benchmark/	Activity Focus*
	Apr-Jun 2006	Jul-Sept 2006	Oct - Dec 2006	Jan - Mar 2007	Apr - June 2007	Jul-Sept 2007	Oct - Dec 2007	Jan - Mar 2008	Apr - June 2008	Jul-Sept 2008	Oct - Dec 2008	Jan - Mar 2009	Apr - June 2009	Jul-Sept 2009	Oct - Dec 2009	Jan - Mar 2010	Apr - June 2010	Jul-Sept 2010	Partner	Staff	Target	
CBO & Youth Leaders organize community dialogue on HIV transmission, prevention, misinformation, VCT/PMTCT serivces, and stigma						X	X	X	X	X	X	X	X	X	X	X	X	X	KDSM, SNELAK, Comite Pilotage	*Community Health Officer*	% sub-zones with meeting in past quarter	BC
CBO & Youth leaders organize community dialogue on C-IMCI practices, including vaccination and water & sanitation								X	X	X	X	X	X	X	X	X	X	X	KDSM, SNELAK, Comite Pilotage	*Community Health Officer*	# events, # people reached	BC
CBOs organize meeting with mothers by sub-zones to select TBAs for training									X	X									KDSM, SNELAK, Comite Pilotage	*Community Development Officer*	26 sub-zones mapped and undestood by the CBO & Youth Leaders	A
CBOs and Youth Leaders organize community dialogue on infant and child feeding											X	X	X	X	X	X	X	X	KDSM, SNELAK, Comite Pilotage	*Community Health Officer*	% sub zones with meeting in past quarter	BC
Refresher training of CBOs & Youth Leaders on Vaccinations and disease surveillance													X						HC Staff	*Community Health Officer*	# successfully trained	BC
Training																						
Orientation for Youth Leaders			X	X															KDSM, SNELAK, Comite Pilotage	*Community Development Officer*	# successfully trained	
Training of CBO and Youth Leaaders on "Facing AIDS Together"					X														KDSM, SNELAK, Comite Pilotage	*Community Health Officer*	# successfully trained	Q
Training of CBO & Youth Leaders on community mobilization for maternal and newborn care						X													Community Education Trainers	*Community Health Officer*	# successfully trained	A, BC

Five Year Workplan: April 2006 - September 2010

Major Activities	Year 1		Year 2				Year 3				Year 4				Year 5				Responsible		Benchmark/	Activity Focus*
	Apr-Jun 2006	Jul-Sept 2006	Oct - Dec 2006	Jan - Mar 2007	Apr - June 2007	Jul-Sept 2007	Oct - Dec 2007	Jan - Mar 2008	Apr - June 2008	Jul-Sept 2008	Oct - Dec 2008	Jan - Mar 2009	Apr - June 2009	Jul-Sept 2009	Oct - Dec 2009	Jan - Mar 2010	Apr - June 2010	Jul-Sept 2010	Partner	Staff	Target	
Training of CBO & Youth Leaders on Community IMCI concept (diarrhea prevention and care, pneumonia care, vaccinations)								X											KDSM, SNELAK, Comite Pilotage	*Community Health Officer*	# successfully trained	BC
Training of CBO & Youth Leaders on Infant and Young Child Feeding											X								KDSM, SNELAK, Comite Pilotage	*Community Health Officer*	# successfully trained	BC
IR2: Enhanced availability of and access to reproductive and child health services for disadvantaged households in urban areas																						
Identification, selection, and orientation of distributers for condoms targeting youth aged 15-24 years with Youth Clubs	X	X																	KDSM, SNELAK, Comite Pilotage	*Community Development Officer*	# vendors oriented	A
Water and Sanitation Committees conduct situation analysis on opportunities for public hand washing stations and distribution points for ORS and Pur/Chlorine		X	X																KDSM, SNELAK, Comite Pilotage	*Community Development Officer*	# stations identified, # plans developped, # points fonction	A, BC
Training on Essential Drugs Management		X																	BC	*Health Services Capacity Officer*	20 Health Workers trained and all 5 HHC have action plan	A
Capitalization of essential drugs for health centers		X		X		X									X				BC	*Health Services Capacity Officer*	Dollar value of essential drugs received and accounted for	A
Health workers deliver quality health education on sick child danger signs and feeding in the waiting area			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	HC	*Health Services Capacity Officer*	% HHC with routine schedule for MNC group education in past month	A, BC
HC personnel deliver information on maternal health and HIV/AIDS				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	HC	*Health Services Capacity Officer*	% HHC with routine schedule for HIV group education in past month	BC

Five Year Workplan: April 2006 - September 2010

Major Activities	Year 1		Year 2				Year 3				Year 4				Year 5				Responsible		Benchmark/	Activity Focus*
	Apr-Jun 2006	Jul-Sept 2006	Oct - Dec 2006	Jan - Mar 2007	Apr - June 2007	Jul-Sept 2007	Oct - Dec 2007	Jan - Mar 2008	Apr - June 2008	Jul-Sept 2008	Oct - Dec 2008	Jan - Mar 2009	Apr - June 2009	Jul-Sept 2009	Oct - Dec 2009	Jan - Mar 2010	Apr - June 2010	Jul-Sept 2010	Partner	Staff	Target	
Reorganization of Vaccination register by Sub-zones to facilitate tracking with CBO & Youth Leaders						X	X												KDSM, SNELAK, Comite Pilotage	*Community Health & Dev Officers*	Mapping of 26 sub-zones	A
Procure posters, algorithms on IMCI in the health centers							X	X	X	X	X	X	X	X	X	X	X	X	HC	*Health Services Capacity Officer*	% HC with good visibility of information score	Q
Joint DSO/BC/Project social authopsy review of 2-3 maternal and child deaths per quarter							X	X	X	X	X	X	X	X	X	X			DSO	*Programme Manager*	At least 2 cases presented at last platform meeting	A, Q, BC
Organize EPI outreach for low coverage, high drop-out sub-zones							X	X	X	X	X	X	X	X	X	X	X	X	HC	*Programme Officer*	# posts needed % posts received EPI outreach in past month	A
Learn more about exisiting groups of PLWHA and work with HC to bridge their needs									X	X	X	X	X	X	X	X	X	X	HC	*Health Services Capacity Officer*	# HHC supporting PLWHA groups	A, Q
Training of TBA trainers on new Curriculum										X									DSO	*PM*	At least 1 master trainer from each HF in place	A, Q
Train and initiate associationTBAs											X								HC	*Health Services Capacity Officer*	60 TBAs trained and active in association	A, Q
Establish social marketing of clean delivery kits										x	x	x	x	X	X	X	X	X	DSO	*PM*	# kits sold; # kits in stock	A
IR 3: Increased quality of reproductive and child health services in selected government and private non-profit health centers																						
Training health workers in St. Martin & Cite Okay on IMCI			X																DSO	*Health Services Capacity Officer*	At least 8 workers trained	Q
Training of Quality Assurance Facilitators			X																DSO/BC	*Community Health Officer*	At least 26 staff succesfully complete training	Q

Five Year Workplan: April 2006 - September 2010

Major Activities	Year 1		Year 2				Year 3				Year 4				Year 5				Responsible		Benchmark/	Activity Focus*
	Apr-Jun 2006	Jul-Sept 2006	Oct - Dec 2006	Jan - Mar 2007	Apr - June 2007	Jul-Sept 2007	Oct - Dec 2007	Jan - Mar 2008	Apr - June 2008	Jul-Sept 2008	Oct - Dec 2008	Jan - Mar 2009	Apr - June 2009	Jul-Sept 2009	Oct - Dec 2009	Jan - Mar 2010	Apr - June 2010	Jul-Sept 2010	Partner	Staff	Target	
IMCI quarterly joint supervision to 3 health centers				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	DSO/BC	*Health Services Capacity Officer*	Supervision tool, % HHC supervised last qtr	Q
Health facility staff deliver quality maternal and newborn care dialogues to groups waiting for care				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	HC	*Community Health Officer*	3 HCs with routine schedule for MNC group education	BC
Training of health center staff on adult learning and nutrition						X													BC	*Health Services Capacity Officer*	# trained	BC
HC staff deliver quality information on growth monitoring and nutrtion counsellng						X	X	X	X	X	X	X	X	X	X	X	X	X	HC	*Community Health Officer*	3 HCs with routine schedule for MNC group education	BC
Monthly meetings of TBAs with trainers at Health Center											X	X	X	X	X	X	X	X	HC	*Community Health Officer*	# mtgs, % TBAs attending last meeting	A, Q
Quality assurance teams analyse promotion of IMCI counseling and handwashing and water treatment promotion					X	X				X	X			X	X				HC	*Health Services Capacity Officer*	3 HC with QA plan, status	Q
Refresher training on pre and post natal care for health service providers					X														BC	*Project Manager*	12 people trained (4 x 3 HCs)	Q
Quality assurance team analysis and address ANC services integration and education					X	X													BC	*Health Services Capacity Officer*	3 HCs with quality improvement plan	Q
Collaborate with MSPP on refresher package for prestataires on antental care with HIV/AIDS integration and post partum care								X											DSO	*Health Coordinator*	Training Package Available	Q
Establish quarterly team supervision for MNC in conjunction with EPI supervsion								X	X	X	X	X	X	X	X	X	X	X	DSO/BC	*Health Services Capacity Officer*	# supervisons/ quarter	Q
Refresher training on IMCI										X				X					DSO	*Health Services Capacity Officer*	At 3 staff trained in past 3 years at 3 HCs	Q

Five Year Workplan: April 2006 - September 2010

Major Activities	Year 1		Year 2				Year 3				Year 4				Year 5				Responsible		Benchmark/	Activity Focus*
	Apr-Jun 2006	Jul-Sept 2006	Oct - Dec 2006	Jan - Mar 2007	Apr - June 2007	Jul-Sept 2007	Oct - Dec 2007	Jan - Mar 2008	Apr - June 2008	Jul-Sept 2008	Oct - Dec 2008	Jan - Mar 2009	Apr - June 2009	Jul-Sept 2009	Oct - Dec 2009	Jan - Mar 2010	Apr - June 2010	Jul-Sept 2010	Partner	Staff	Target	
IR 4: Improved policy environment for the urban populations, putting emphasis on protection for the poorest people.																						
Quarterly Urban Platform meetings	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	DSO	*Project Manager*	1 strategy agreed upon at high standards	A, Q, BC
Contribute to revision of the national TBA curriculum with MSPP, MSH, UNICEF, and other CS grantees	X	X	X	X															DSO	*Health Coordinator*	1 strategy agreed upon at high standards	A, Q
Collaborate with DSO in annual urban health planning and review through the Platform			X				X				X				X				DSO	*Project Manager*	Annual Plans reflect joint work	A, Q, BC
Establish regular links with UNICEF, WHO, UNFPA to ensure coordination of programs and subsidized services			X				X				X				X				DSO	*Health Coordinator*	Plan represents contribution from subsidized national programs	A
Orientation visits to Jude Anne and LHUEH and develop patient information package for referrals			X	X						X	X								HC	*Health Services Capacity Officer*	Information guide available for clients	A
Engage with MSPP in the development of the national C-IMCI strategy with particular accent on malnutrition			X	X	X	X													DSO	*Health Coordinator*	# meetings attended	A
Quarterly review of HMIS system at DSO, BC and neighborhood level				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	DSO	*M&E Consultant*	% months with no stock-out of vaccines	A
Host nationl reflection on management of severe malnutrition and orientation to community based therapeutic care approach						X													DSO	*Health Coordinator*	Workshop objectives achived, decision point and next steps made	A
Special Studies/Tools																						

Five Year Workplan: April 2006 - September 2010

Major Activities	Year 1		Year 2				Year 3				Year 4				Year 5				Responsible		Benchmark/	Activity Focus*
	Apr-Jun 2006	Jul-Sept 2006	Oct - Dec 2006	Jan - Mar 2007	Apr - June 2007	Jul-Sept 2007	Oct - Dec 2007	Jan - Mar 2008	Apr - June 2008	Jul-Sept 2008	Oct - Dec 2008	Jan - Mar 2009	Apr - June 2009	Jul-Sept 2009	Oct - Dec 2009	Jan - Mar 2010	Apr - June 2010	Jul-Sept 2010	Partner	Staff	Target	
Nutrition, Livelihoods & Willingness to Pay Survey in 3 Neighborhoods	X	X																	DSO	*Health Coordinator*	Situation report	A
Review KPC data on careseeking and use of informal sector with Platform and CBO Leaders	X	X																	DSO	*Health Coordinator*	1 strategy agreed upon at high standards	A, Q
Feasibility review of local production of ready to use therapeutic food with CW/US support		X	X	X	X														CW/US	*Health Coordinator*	Feasibility report available	A
Nutrition situation analysis for PLWHAs in disadvantaged urban neighborhoods					X														DSO	*Health Coordinator*	1 strategy agreed upon at high standards	A, Q
Establish criteria for "Youth Friendly Health Centers" and integrate into MNC supervision tools					X	X	X												DSO avec partenaires	*Project Manager*	Definition and assessment tools exist and used	A, Q
Review of environmental health funding and projects planned for Port-au-Prince									X	X									DSO	*Health Coordinator*	1 strategy agreed upon at high standards	A
Develop and act on advocacy strategy for key environmental health measures										X	X	X	X	X	X	X	X	X	DSO	*Project Manager*	Evidence of influence on advocacy issue	A
Youth rallies at metropolitan level for all neighborhoods										X					X				Chef Leaders des Jeunes	*FOCAS Community Dev Coord*	# evenements; # participants; # medias	BC

Major Activities	Year 1		Year 2				Year 3				Year 4				Year 5				Responsible		Benchmark/	Activity Focus*
	Apr-Jun 2006	Jul-Sept 2006	Oct - Dec 2006	Jan - Mar 2007	Apr - June 2007	Jul-Sept 2007	Oct - Dec 2007	Jan - Mar 2008	Apr - June 2008	Jul-Sept 2008	Oct - Dec 2008	Jan - Mar 2009	Apr - June 2009	Jul-Sept 2009	Oct - Dec 2009	Jan - Mar 2010	Apr - June 2010	Jul-Sept 2010	Partner	Staff	Target	
Document unmet need for obstetrical care in disadvantaged urban neighborhoods											X	X							DSO	*Process Doc & Research Org*	Report well-known among peers	A, Q
Management																						
Establish agreements and guidelines for performance incentives with 5 health facilities	X	X								X	X					X			DSO	*Program Manager*	Guidelines in place, agreements signed with HC et DSO	Q
Monitoring & management of performance incentives and quality assurance			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	BC	*PM*	Amount disbursed, performance levels	Q
HC Staff conduct annual review and workplan development based on Health Facility & Community Information			X				X				X				X				BC.HC staff	*Health Services Capacity Officer & M&E Consultant*	Annual review and plans exist	Q, BC
Develop relationships and linkages with UNFPA/UNICEF/ LHUEH / Jude Anne and MSF/H for coordination of maternal & newborn care			X	X	X	X				X				X				X	DSO/BC	*Program Manager*	Number of exchanges	A
Refine HICAP tool to ensure inclusion norms of MSPP 1st Level Health Center			X																DSO	*Process Doc & Research Org*	Tool completed	A
Project Management Meetings	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	None	*Project Manager*	Quarterly meeting held, participation	A,Q,BC
Project Annual Review & Report		X				X				X				X			X		DSO	*Project Manager*	Annual Report	Q
Project External Evaluations										X								X	DSO	*Health Coordinator*	Evaluation Recommendations and action plan	A,Q,BC

ANNEXES

ANNEX A: RESPONSE TO APPLICATION DEBRIEFING

The following highlights weaknesses identified in the initial application and how addressed in this DIP. A copy of the summary score sheet and the external reviewer comments follow this table.

Weaknesses	Response
PVO APPLICANT DESCRIPTION	
Description of partners could be more detailed. More evidence-based results (data) from applicant's (Concern) past performance would be important to include.	**More information about programs and synergies indicated in section 5.1.g.**
More situational analysis data from FOCAS and GRET needed.	**Baseline assessments and key informant interviews provided substantial information about the situation in each of the neighborhoods. This information is included in the section 5.**
SITUATIONAL ANALYSIS	
Rationale for mix of interventions for MNC, immunization, CDD and ARI are clear given the target population. However, the rational for adding HIV/AIDS intervention at 20% LOE is less clear, especially given the size of the target population for the HIV activities.	**The intervention mix has been modified and nutrition added. See section for DIP revisions.**
PROGRAM STRATEGY AND INTERVENTIONS	
Given level of malnutrition, it would seem the project might offer a somewhat higher level of effort to address the problem (current addressed under CDD). But the level of effort for CDD is equal to PCM and only slightly more than EPI, while it is likely that CDD will require more effort.	**See above comment.**
A clear picture of how the project will actually work at the community level is lacking. Need better discussion and description of CBOs and community associates that the project intends to work with and are relied upon for mobilization and dissemination. Need a description of the CBOs, who they represent, their capacities, and their coverage/reach in target areas, types of services offered and indication of support/interest for proposed program. Each PVO partner has only one	**This has been developed and described in the Monitoring and Evaluation section.** **Staffing increased to include one full time Community Health Officer for each of the neighbourhoods as well as at least 50% time Organization Development Officer of each of the neighbourhoods.**

Weaknesses	Response
FT community mobilization staff person…difficult to evaluate whether sufficient.	
Reviewers found it difficult to determine which partners were doing what activities and where. A Venn Diagram would be helpful. A table spelling out who is doing what would also be helpful.	**All the activities are being done in all neighborhoods except Jalousie & Bois Moquette as they are covered under the FOCAS subagreement and only include the HIV/AIDS intervention given that they have local mission funding for their other child survival interventions.**
Commodities issues are not addressed – will the project rely on existing health systems? It is necessary to keep commodity security/logistics management in mind as a high priority since they are key to planned programs (condoms, HIV kits, ORS, antibiotics, zinc, vaccines).	**Through the Health Facility Assessment and discussion with MSPP and UNICEF we have a clear understanding of the essential drug support system in these areas. Specific commodity needs and sources are included in the technical intervention section. We recognize need to supplement clinic drug funds as well as enhance management. Our strategy is to train key HF staff on essential drug management and to provide up to 4 sequenced stock supports over the course of the project. HIV testing kits are not included in this project as funding is available through other sources such as PEPFAR, Global Fund, EU, etc.**
Although ANC activities are well thought out, this component needs further description and emphasis on neonate and postpartum care. In addition, what are the roles of the 40 TBAs mentioned in the HR table?	**Intervention refocused based on situation assessment to prioritize the postpartum care, clean deliveries and focus on antenatal services such as TT, iron folate, STI and HIV screening, nutrition counselling and emergency planning. TBA numbers are 60 and their roles are outlined in Annex E-3.**
PERFORMANCE M&E	
Measurement of impact is adequate but monitoring system is less clear.	**M&E plan has been revamped to focus on the monitoring progress towards intermediate results and the overall objective. See the M&E section and the M&E plan in Annex D-1.**
M&E table refers to rapid assessments, but these are not explained. What info will they assess and how much work will they entail? Unclear if M&E staff is an advisor	**Rapid assessments are conducted by the Process Documentation Contractor, GENESIS, once per year in each of the neighbourhoods. It includes assessing**

Weaknesses	Response
or a consultant.	capacity of the HF, community organizations, and qualitative information on IR 1. Findings are shared at the quarterly platform meetings and tracked through the CSSA. The M&E Advisor is a consultant focused on reviewing the HMIS, developing reporting formats and systems between community and HF actors, and building capacity of the system users at all levels. A 50% Research Officer is a Concern employee who serves all projects to strengthen impact assessments and operations research. Both positions report to the Health Coordinator.
Clear that partners will use information generated, but less clear how it might be used directly at health facility or community level. Proposal under-emphasized use of logistic management and utilization data; these are potential tools for quality improvement at the facility level.	This process is key and is described in the M&E section.
Concrete monitoring data not outlined in M&E system. This is particularly important having three different partners to ensure all activities are on track. This is likely to be a particular challenge with this design and needs to be carefully addressed.	See comment above.
Further development or explanation of the PLAG would have been helpful to address the above comment about monitoring.	The Platform is further described in the Overall Strategy section and under Management.
MANAGEMENT PLAN	
It is difficult to assess how much community level support and input will be required and expected.	As part of the baseline we have interviewed the community organizations which are of mixed levels development. KDSM and SNELAK are the strongest. To enhance support we have increased project staff to each of the neighbourhoods, refocused process monitoring, and built in more training of trainers into the strategy to ensure necessary support to the community

Weaknesses	Response
	level to achieve desired changes.

GH/HIDN Child Survival and Health Grants Program
Debriefing Summary Sheet
FY 2005

PVO: Concern Worldwide
Country: Haiti
Category: Standard

Categories	Entry	Standard	TB	Expanded
Number reviewed	11	12	8	10
Number funded	4	5	2	4
Highest score	N/A	97.78%	N/A	N/A
Lowest score	N/A	82.20%	N/A	N/A
% Overall Funded	25%	35%	15%	25%
PVO App. Rank	N/A	1	N/A	N/A
PVO App. Score	N/A	97.78%	N/A	N/A

Individual Category Scores for Standard: (Maximum Points in Parentheses)

ecutive mmary	PVO Applicant	Situational Analysis	Program Strategy and Interventions	Performance M&E	Management Plan	Collaboration w/USAID Mission	Total Points
(2)	(8)	(25)	(25)	(25)	(10)	(5)	(100)
	8	24.53	24.38	24.06	9.81	5	**97.78**

SUMMARY COMMENTS

Name of PVO Applicant: Concern Worldwide International (CWI)

Name of Country: Haiti

Application Category: Standard

EXECUTIVE SUMMARY

Strengths

The executive summary was complete, concise, and clearly presented the project. It definitely presented the problem and the justification for the selection of the country and the set of interventions.

The partnership approach in this project is innovative, offering sub-contracts to two other U.S. PVOs to implement child survival activities in areas where they are already working rather than Concern proposing to implement project activities in those areas.

Weaknesses

None noted.

DESCRIPTION OF THE PVO APPLICANT

Strengths

This organization clearly has both child survival experience and a track record of working in Haiti. CWI has been strengthening the ability of their New York office to support child survival projects; they have managed successful child survival projects in both Rwanda and Bangladesh, and are active participants in the CORE Group. They have also started internal annual health workshops so different countries can benefit from the health experience gained through child survival and other health activities.

The organization has been working in Haiti since 1994, in a variety of sectors including food security, microenterprise development, community and school health, and HIV/AIDS. They have developed strong partnerships in the country, both with government and local NGOs.

The proposal effectively describes the strengths and value added of the two partner implementing organizations that will be receiving the sub-contracts.

This project is consistent with the organization's stated mission of addressing the problems of people in absolute poverty in a sustainable way.

Weaknesses

Description of main partners could be more detailed. More evidenced-based results (data) from applicant's past performance would be important to include.

SITUATIONAL ANALYSIS

Strengths

This was a complete situational analysis making a clear case for the selection of location and interventions. It covers the status of both the formal and informal health services, and the health status of the population. There was good presentation of secondary data while explaining their limitations. Descriptions of other health programs, including USAID field missions were provided and some areas and opportunities for synergies were mentioned. Available information on household behaviors such as care-seeking, breast feeding, immunizations, HIV prevention, and constraints to care-seeking were covered. The target population, including the difference between the population for HIV/AIDS activities and the other child survival activities, was clearly presented.

The implementation partnership involving three PVOs brings a wide variety of experience and expertise to the project. Beyond that, each of these has a series of local partners with whom they work, expanding the potential reach of this project considerably. Each of these partners also bring a variety of synergistic activities in their project areas, including in-depth work in HIV/AIDS, micro-finance, community information systems, water and sanitation, and (perhaps most importantly) already-established and successful programs in each of the slum areas where they will be working. Moreover, while circumstances in Haiti have somewhat "sidelined" the role of MSPP, this project appropriately proposes to involve them in all aspects of project development and decision-making, recognizing that building their capacity is essential for Haiti in the long term.

Several ad hoc needs assessments were also done to complement the secondary data and improve information for project design. Initially, Concern undertook a general mapping exercise of all the PAP slums in order to identify those with greatest need as well as potential partners. A health service mapping exercise was done in order to clarify the relative roles of the formal and informal health sectors, as was a maternal and neo-natal health care needs assessment.

The section on the "Uniqueness of Haiti's Urban Slums" addressed the challenges of this environment and presented an image of the significant challenges this project faces. This understanding is important to appreciate the project design.

Letters of endorsement were included. A letter from GRET was missing but noted.

Weaknesses

More situational analysis data from FOCAS and GRET is needed.

The rationale for the mix of interventions for MNC, immunization, CDD and ARI are clear given the target population. However, the rationale for adding the HIV/AIDS intervention at 20% LOE is less clear, especially given the size of the target population for HIV/AIDS activities.

PROGRAM STRATEGY AND INTERVENTIONS

Strengths

The program strategies are focused, well-targeted, and are clearly based on the situational analysis. For each intervention, multiple complementary elements are addressed which should lead to achievement of the project goals and objectives. The proposal's partnership approach is an innovative response to the specific challenges of the urban situation. Possibilities for linkages and synergies with other PVOs and partners are described. This aspect is very important because of limited resources. Its flexible design allows for activities based on specifically identified health needs and gaps in program services with each partner and in each program area. Intervention components are thorough and well explained.

Of particular interest (as also noted by USAID/Haiti) is the package of interventions for strengthening maternal/newborn health and delivery care. Training of TBAs will offer improved access to information and services at the community level, which will be complemented by pregnancy tracking and maternal health education. It will also be complemented by strengthened responses and services (including limited hospital strengthening) to address obstetric and newborn emergencies. The strengthening of community TBAs and the limited and targeted approach to facility quality improvement through use of self-assessment tools seem particularly appropriate.

Like with the MNC interventions, the project also takes comprehensive approaches to addressing the other intervention areas. Each of these interventions includes activities, which address access to and quality of services, in addition to increasing knowledge and demand at the community level. The proposed package of activities is appropriate given the identified needs and globally accepted "best" practices, and the training plan appears adequate. The provision of limited essential equipment, supplies, and renovation (to be negotiated during the DIP planning) is an essential complement to the "softer" inputs.

The partnership approach, both for implementation and for collaboration, is a real strength of this proposal. The potential for synergy is well described (e.g. Global Fund HIV/AIDS activities including VCT, PMTCT, and drug treatment; micro-finance and food security addressing malnutrition, and water and sanitation activities assisting with addressing diarrhea). While it is difficult to outline all the pertinent synergies, partner-specific design adaptations, and management implications, the benefits of maximized

expertise and experience both technically and in the target areas have been clearly presented. The partner letters of support and Memoranda of Understanding reflect the work and reflection that have already gone into this effort.

The proposal does an excellent job of presenting how its activities reflect both the strategic objectives and intermediate results of the child survival program and the local USAID Mission. The Mission letter of support highlights this.

The program approach is consistent with MOH policies for all except introduction of zinc in case of diarrhea. The project proposes to pilot this intervention in its target areas and use the experience for advocacy with MOH. It will take advantage of technical assistance from a local research group for documentation.

The project has a realistic contingency plan for dealing with the violence that potentially could arise within the project area during the course of the project. It considers staff safety, but also considers strategies for maintaining continuity of service through potential involvement of service points outside of the immediate areas affected by violence and the use of the CBOs who will be on the ground regardless of what happens.

Weaknesses

Given the level of malnutrition, it would seem the project might offer a somewhat higher level of effort to address this problem. At the moment malnutrition is addressed within the CDD intervention and includes appropriate interventions (vitamin A, zinc, exclusive breast feeding) given the likely challenges to addressing the problem. However, the level of effort assigned to this intervention is the same as that for PCM and only slightly more than for immunizations, while it is likely that relatively more effort would be appropriate.

A clear picture of how this project will actually work at the community level is lacking. There needs to be a better discussion and description of the local CBOs and community associates that the project intends to work with and who are being relied on for dissemination and mobilization activities. This would include a description of who the CBOs are and who they represent, their capacities, their coverage/reach in the target areas, types of services offered and an indication of their support/interest for the proposed program. In addition, each implementing partner has only one, full-time community mobilization staff person, and it is difficult to evaluate whether this is sufficient.

Reviewers found it difficult to determine which partners were doing what activities and where. A diagram (i.e., Venn diagram) would be helpful. A table spelling out who is doing what would also be helpful.

Commodities issues are not addressed--will the project rely on existing health systems? It is necessary to keep commodity security/logistics management in mind and as a high priority, since commodities (i.e. condoms, HIV test kits, ORS, antibiotics, zinc, vaccines) are key to the planned programs.

Although the ANC activities under the MNC component are well thought out, this component needs further description and emphasis placed on neonate and post partum care. In addition, 40 TBAs were mentioned as part of the HR table in the annex but their role was not discussed in the program strategy.

PERFORMANCE MONITORING AND EVALUATION

Strengths

The objectives represent concrete behaviors, the indicators are globally accepted, and the targets indicate the project expects to have a significant impact on these behaviors within the duration of the project.

The information system for documenting overall impact with the definition of clear indicators and use of appropriate surveys is well-developed and adequate. For monitoring, the system for gathering, analyzing, and utilizing project data uses a mixture of primary assessment and MSPP data. The partners' learning and action group offers a great forum for regular review and use of the data.

Appropriate baseline, midterm, and final surveys are planned and budgeted for using the LQAS methodology. This is particularly appropriate in this instance because it will be useful to track changes with each of the three different implementing partners without using a survey methodology that is unnecessarily complicated.

Weaknesses

While the plan for measuring impact is adequate, the propopsed monitoring system is less clear.

The M&E table refers to periodic (semi-annual) rapid assessments, but these were not explained. It is not clear what information these assess, or how much work they will entail. It is unclear if the proposed M&E staff is an advisor or a consultant.

It was clear that the partners would use the information generated, but it was less clear how it might be used directly at the health facility or community levels. Use of logistic management (distribution and/or availability of delivery kits, condoms, vaccines, Iron/folic acid, etc.) and utilization data (pre-natal care, pneumonia and diarrhea cases, referrals, complicated deliveries, etc.) were under-emphasized in the proposal and are potential tools for quality improvement at the facility level.

Concrete monitoring data (e.g. tracking of activities or other intermediate indicators) were not outlined in the M&E system. This is an issue particularly with having three different implementation partners to ensure that all activities are on track with all partners. This is likely to be a particular challenge with this design, and needs to be carefully addressed. Further development or explanation of the PLAG would have been helpful to address this.

MANAGEMENT PLAN

Strengths

Within CWI itself, all of the management structures including the organizational chart, human resource management, clear definitions of roles and responsibilities (job descriptions), and financial reporting systems are in place. Sufficient and appropriate technical and backstopping resources have been identified.

With respect to the sufficiency of human resources, they appear to be realistic. With respect to the implementing partners, the Memoranda of Understanding clearly define information sharing and financial reporting expectations. All elements of the project will also benefit from technical backstopping from all three organizations, with staggered visits to Haiti planned in order to maximize the frequency of support visits in the field.

The work plan is complete, realistic, and accurately reflects proposed project activities.

Weaknesses

It is difficult to assess how much community level support and input will be required and expected.

COLLABORATION WITH USAID FIELD MISSIONS

Strengths

The proposal clearly presents how it contributes to the Mission Strategic Objectives / Intermediate Results. It also reviews the discussions held with the Mission staff during proposal development.

The letter of support that is included clearly describes how the Mission staff see this project as complementary and the particular innovative elements (use of TBAs, increasing financial access to health services, linking health centers working in PAP, and potential points of collaboration for sharing of tools and strategies) they are also interested in.

Weaknesses

None noted.

OVERVIEW COMMENTS

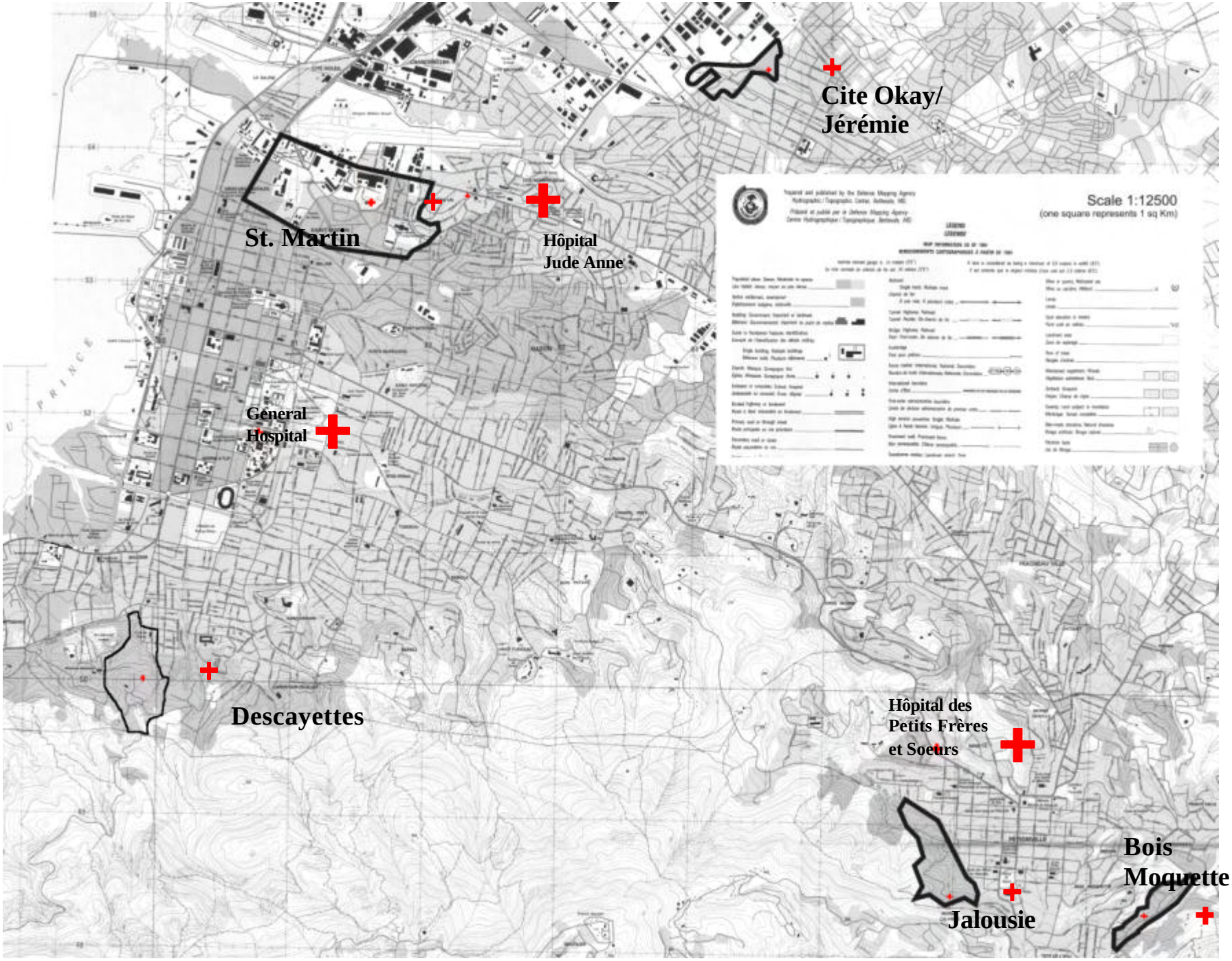
This is an exciting proposal offering concrete interventions and strategies for improving the health of people living in Haiti's slums. It makes excellent use of partnerships to take advantage of different competencies and coverage. The project has also clearly adapted its strategies to the specific situation in Haiti's slums and has significant potential for offering strategies and lessons learned that could be useful elsewhere. They have concrete plans (using local technical assistance) to document these.

Because of the underserved population of the slums living in Port-au-Prince, this project has a potential for bringing basic health care to a significant number of people including vulnerable groups such as women (pregnant women) and children. Training of TBAs, improvement of immunization coverage, breastfeeding, diarrhea prevention, treatment of acute respiratory diseases, prevention and treatment of HIV/AIDS are all examples of interventions that should improve the health condition of this population. Besides, the possibililty of linkages and a good referral system should improve accessibility to health care and help create a network for leveraging resources.

The project's willingness to share the money and the responsibility with other PVO implementing partners working in the slums in PAP is particularly impressive. This approach maximizes the complementary experience and strengths of each organization, as well as and taking advantage of each organization's working relationships on the ground and will also enhance the potential impact of this project. As part of the situational analysis the strengths and gaps in each partner's program were identified, and this project proposes to use its resources to address the gaps in a tailored and targeted way.

With respect to other partnerships, the project will be working with MSPP as well as CBOs to maximize local capacity in increasing both the availability and quality of health services. For each of the interventions the project proposes an appropriate and complementary package of interventions. Of particular interest is the range of maternal newborn activities from community mobilization to TBA training and strengthening of emergency services.

ANNEX B: Urban Health Partnership Program Area Map – General and Project Area Detailed


Cite Okay/
Jérémie
St. Martin
Hôpital
Jude Anne
General
Hospital
Descayettes
Hôpital des
Petits Frères
et Soeurs
Bois
Moquette
Jalousie
Scale 1:12500
(one square represents 1 sq Km)

ANNEX C: PARTICIPANTS OF DIP DEVELOPMENT WORKSHOPS MARCH-APRIL 2006

FAMILY NAME	FIRST NAME	INSTITUTION	POSITION
Remy	Marie Yoleine	AMSADA	MD/Project coordinator
Decastro	Marie Yolène	BC Delmas MSPP	Directrice
François	Fleurimond	Comite de pilotage Citéau Cayes	Coordonateur
Vénor	André Paul	CONCERN	Coordonateur de programme Santé
Roenen	Carine	CONCERN	Directrice Regionale
Rémy	Gabrielle	Concern	Officier de projet
Hecdivert	Marie Charleine.	CONCERN	M&E Consultant
Debrosse	Marie Guerda	CONCERN	Manager de projet SU
Kouletio	Michelle	CONCERN	Conseiller en Santé
Jerome	Reynold	CONCERN	Officier en dvp communautaire
Denis	Jacques	CS Saint MartinII	Directeur medicale
Gilles	Edvard	CS Saint Martin II	Administrateur
Prosper	Viviane	CS Saint Martin II	Nurse midwife
Gourdet	Winest	DSO/MSPP	MD/Chef de service
Vincent	Gabrielle	FOCAS	Directrice Cincinaty
Alabré	Leila Emmanuelle	FOCAS	Coordonatrice de Devp communautaire
Emile	Lynda	FOCAS	Superviseur
Baguidy	Micheline	FOCAS	Directrice Focas/Haiti
Bernard	Viergelie V	FOCAS	Infirmiere
Bonhomme	Charmant Wolfy	GRET-H	Animateur
Henrys	Daniel	GRET-H	Directeur
Cadet	Jean Ronald	GRET-H	Responsable projet Santé
Ulysse	Marie Bernadette	Haiti Med	Responsable CS
Ostrel-Sanon	Margaret	Haiti-Med	Directrice
Jean Pierre	Joseph	HUEH	Doctor
Gabriel	Hélène Noeymie	KDSM	Coordonatrice
Joseph	Jean Alix	KDSM	Responsable comite santé
Beaubrun	Jimmy	MSPP	DCP-au-Prince(BCP)
André	Lenord	SNELAK	Administrateur
Tabuteau	Léonne	SNELAK	Directrice CS Descayette.

Additional participants for the workplan Review on April 4, 2006

Raymond	Dr. Guirlene	MSPP	Director, West Department
Olbeg	Dr. Desinor	USAID	HPN Officer
Delorme	Dr. Patrick	UNICEF	Health Officer

ANNEX D: MONITORING AND EVALUAION

D-1 M&E Plan

D-2 Sample monthly report (French)

D-3 Sample child card (French)

D-4 Sample mother card (French)

Annex D-1: M&E Plan

Strategic Objective/Intermediate Results	Indicator	Method	Who Collects	Frequency	Baseline Value	EOP Target	Intervention (Input)
SO: Sustained improvements in the health status of mothers, children and youth in five disadvantaged urban neighborhoods of Port au Prince							
Improved preventive child health practices	Proportion of children age 0–5 months who were exclusively breastfed during the last 24 hours	KPC Survey	Process Doc & Research Org	Biennual	22%	35%	Achievement of intermediate results and maintenance of project assumptions
		LQAS 19 Sample	Community Health Officer	Annual			
	Proportion of households with children 0-23 months who purify their drinking water	KPC Survey	Process Doc & Research Org	Biennual	32%	50%	Achievement of intermediate results and maintenance of project assumptions
		LQAS 19 Sample	Community Health Officer	Annual			
	Proportion of children 6-24 months receiving Vitamin A supplement within past 4-6 months (according to age)	KPC Survey	Process Doc & Research Org	Biennual	61%	80%	Achievement of intermediate results and maintenance of project assumptions
		Extract from monthly HC reports	Health Center	Quarterly			
	Proportion of children 12-23 fully vaccinated (verified with card)	KPC Survey	Process Doc & Research Org	Bi-annual	51%	80%	Achievement of intermediate results and maintenance of project assumptions
		Extract from monthly HC reports	Health Center	Monthly			Achievement of intermediate results and maintenance of project assumptions
	Number of measles vaccinations administered	Extract from monthly HC reports Descayettes, Cite Okay, St. Martin	Health Center	Annual	61%	80%	Achievement of intermediate results and maintenance of project assumptions
	Proportion of children age 6-9 months who received breast milk and complementary foods during the last 24 hrs	KPC Survey	Process Doc & Research Org	Biennual	52%	65%	Achievement of intermediate results and maintenance of project assumptions
		LQAS 19 Sample	Community Health Officer	Annual			

Strategic Objective/Intermediate Results	Indicator	Method	Who Collects	Frequency	Baseline Value	EOP Target	Intervention (Input)
Improved care for sick child	Proportion of children 0-23 months with diarrhea who have received ORS	KPC Survey	Process Doc & Research Org	Biennual	50%	70%	Achievement of intermediate results and maintenance of project assumptions
		LQAS 19 Sample	Community Health Officer	Annual			
	Proportion of children 0-23 months with fast and difficult breathing in past 2 weeks who were seen by trained provider	KPC Survey	Process Doc & Research Org	Biennual	66%	75%	Achievement of intermediate results and maintenance of project assumptions
		LQAS 19 Sample	Community Health Officer	Annual			
	Proportion of mothers with a sick child aged 12-23 months who increase fluids and feeding during the illness	KPC Survey	Process Doc & Research Org	Biennual	13%	45%	Achievement of intermediate results and maintenance of project assumptions
		LQAS 19 Sample	Community Health Officer	Annual			
Improved maternal and newborn care	Proportion of mothers of children age 0–11 months who had three or more antenatal care visits during their last pregnancy	KPC Survey	Process Doc & Research Org	Biennual	79%	90%	Achievement of intermediate results and maintenance of project assumptions
		Extract from monthly HC reports Descayettes, Cite Okay, St. Martin	Health Center	Quarterly			
	Proportion of mothers of children age 0–11 months who took iron folate supplements for at least 90 days during last pregnancy	KPC Survey	Process Doc & Research Org	Biennual	4%	20%	Achievement of intermediate results and maintenance of project assumptions
		Extract from monthly HC reports Descayettes, Cite Okay, St. Martin	Health Center	Quarterly			
	Proportion of mothers with child 0-11 months who attended postpartum care check-up with newborn within 7 days of giving birth	KPC Survey	Process Doc & Research Org	Annual	16%	35%	Achievement of intermediate results and maintenance of project assumptions
		Extract from monthly HC reports Descayettes, Cite Okay, St. Martin	Health Center	Semi-annual			

Strategic Objective/Intermediate Results	Indicator	Method	Who Collects	Frequency	Baseline Value	EOP Target	Intervention (Input)
	Number new acceptors of modern contraceptive methods of youth aged 15 to 24	Monthly Health Center report	Community Health Officer	Monthly	N/A	35% increase from Baseline year 2006	Achievement of intermediate results and maintenance of project assumptions
Enhanced youth HIV/AIDS protection	Proportion of sexually active youth aged 15 to 24 years, who are not in a stable relations of one or more years, who use a condom consistently for the past 3 months.	EMMUS IV Metropolitan reviewed against FGDs (baseline) and KPC Survey (mid & final)	Process Doc & Research Org	Bi-annual	12.6%	20%	Achievement of intermediate results and maintenance of project assumptions
		LQAS 19 Sample	Community Health Officer	Semi-annual			
IR 1: Empowered communities with increased knowledge and interest in maternal, child and youth health promotion	Number of people reached (by sex) with safe motherhood information in Descayettes, Cite Okay, and St. Martin	Reported from youth notebooks	Community Health Officer	Monthly	TBD	TBD	Training CBO and youth leaders in effective health education, delivering group dialogues, and organizing community health fairs and events; youth rallies
	Number of people reached (by sex) with diarrhea and hygiene information in Descayettes, Cite Okay, and St. Martin	Reported from youth notebooks	Community Health Officer	Monthly	TBD	TBD	
	Number of people reached (by sex)with sick child danger signs in Descayettes, Cite Okay, and St. Martin	Reported from youth notebooks	Community Health Officer	Monthly	TBD	TBD	
	Number of people reached (by sex) with infant and young child feeding information in Descayettes, Cite Okay, and St. Martin	Reported from youth notebooks	Community Health Officer	Monthly	TBD	TBD	

Strategic Objective/Intermediate Results	Indicator	Method	Who Collects	Frequency	Baseline Value	EOP Target	Intervention (Input)
	Number of youth and OBC leaders skilled in maternal and newborn health education (post test result >80%)	Training report with post-test results by neighborhood	Community Health Officer	Monthly	0	910	
	Number of youth and OBC leaders skilled in child health education and sick child danger signs (post test result >80%)	Training report with post-test results by neighborhood	Community Health Officer	Monthly	0	910	
	Number of youth and OBC leaders skilled in infant and young child feeding education (post test result >80%)	Training report with post-test results by neighborhood	Community Health Officer	Monthly	0	910	
	Proportion of mothers of children age 0–23 months who know at least two signs of childhood illness that indicate the need for treatment	KPC Survey	Process Doc & Research Org	Bi-annual	33%	60%	
	Proportion of mothers of children age 0–11 months who know at least two signs during delivery and postpartum requiring immediate medical attention	KPC Survey	Process Doc & Research Org	Bi-annual	Est. 10%	50%	
	Index of participation of youth in health promotion activities and vital events reporting	Resource Org Process Monitoring	Process Doc & Research Org	Quarterly (1 per neighborhood per year)	Low	High	Selection, orientation, and development of youth leadership network through monthly club activities and training
	Number of youth selected and oriented to health leadership, by neighborhood, by sex	Training report with post-test results by neighborhood	Community Development Officer	Monthly	0	1,136	
	Proportion of youth leaders reporting on activities on monthly basis	Register of youth activity report (tot number: 1136)	Community Development Officer	Monthly	0%	80%	

Strategic Objective/Intermediate Results	Indicator	Method	Who Collects	Frequency	Baseline Value	EOP Target	Intervention (Input)
	Number of health meetings that brought together 3 or more CBOs in past month	Review of meeting minutes	Organization Development Officer	Monthly	2	5	Capacity development support to expand community organizations' role in promoting and monitoring maternal and child health.
	Number of major health fairs or events, estimated number of people reached	CBO meeting minutes	Organization Development Officer	Monthly	TBD	TBD	
	Index of the existence and the capacity of a federation of civil society organizations for health and development, by neighborhood	CSSA Capacity Assessment	Concern Capacity Building Officer	Bi-annual	N/A	N/A	
	Availability and use of community health action plan	Community assessment (FGDs, strength of groups, key informants)	Process Doc & Research Org	Quarterly (1 per neighborhood per year)	2	5	
	Proportion of mothers with children 12-23 months who demonstrate an accepting attitude of PLWHA	KPC Survey	Process Doc & Research Org	Bi-annual	9%	65%	Organizing local groups, behavior change to influence attitudes, youth leadership building, HIV/AIDS dialogues
	Number of people reached (by sex) through HIV/AIDS dialogue Jalousie, Bois Moquette, Descayettes, Cite Okay, and St. Martin	Reported from youth notebooks	Community Health Officer	Monthly	TBD	TBD	
	Number of youth and CBO leaders skilled in HIV/AIDS dialogue (post test result >80%)	Training report with post-test results by neighborhood	Community Health Officer	Monthly	0	1,296	
	Index of community support group for PLWHAs	Community assessment (FGDs, strength of groups, key informants)	Process Doc & Research Org	Quarterly (1 per neighborhood per year)	Low	Moderate-High	

Strategic Objective/Intermediate Results	Indicator	Method	Who Collects	Frequency	Baseline Value	EOP Target	Intervention (Input)
IR2: Enhanced availability of and access to reproductive and child health services for disadvantaged households in urban areas	Proportion of health centers providing IMCI services	Facility assessment	Concern Capacity Building Officer	Annually	2	5	IMCI training, quarterly supervision and refresher training; essential drug management; connection to national program support; reorganization of EPI registers and tracking with youth
	Feasibility assessment of community therapeutic care for malnutrition and stakeholder reflection	Activity report	Health Coordinator	Year Two	0	1	
	Drop-out rate DPT1 - DPT3 by sub-neighborhood	KPC Survey EPI registers	Resource Org with partners HC QI team with I/C	Bi-Annual Quarterly	13%	<5%	
	Number of ORS packets received by caretakers and ratio of sales to distribution points	CBO Leaders Monthly Activity Report	Organization Development Officer	Monthly	TBD	TBD	Identification and orientation of community distribution sites for ORS, PUR, condoms, and JIK; logistic support and supervision; production and social marketing of clean delivery kits by TBAs and HC
	Number of condoms distributed	Youth Leader Monthly Activity Reports	Community Health Officer	Monthly	TBD	TBD	
	Number of PUR & JIK sold	CBO Leaders Monthly Activity Report	Organization Development Officer	Monthly	TBD	TBD	
	Number of clean delivery kits sold	TBA Activity Report compiled with HC	Community Health Officer	Monthly	0	Target 85% of pregnant women - 425	
	Number of health facilities with hand washing station for clients	Supervision checklist	Health Service Capacity Officer	Quarterly	1	5	Participatory location assessment, pilot and exchanges, support to CBO & HC plans
	Proportion of HH with hand washing station with soap	KPC Survey	Process Doc & Research Org	Biannual	N/A	TBD	
	Number of latrine blocks with hand washing station	CBO Leaders Monthly Activity Report	Organization Development Officer	Monthly	0	TBD	

Strategic Objective/Intermediate Results	Indicator	Method	Who Collects	Frequency	Baseline Value	EOP Target	Intervention (Input)
	Proportion of expected number of pregnant women receiving TT2+ according to HC report	Monthly Health Center report	Community Health Officer	Monthly	19%	40%	Pre and postnatal care training, quarterly supervision, essential drug management, connection to national program support; training and support of TBAs
	Number of HC with formal referral system with Maternity Hospitals	Supervision checklist	Health Service Capacity Officer	Quarterly	0	5	
	Number of referrals of pregnant women by TBAs	TBA Activity Report compiled with HC	Community Health Officer	Monthly		15% over Baseline	
	Number of health centers with functional exemption system for extreme poor residents	Supervision checklist	Health Service Capacity Officer	Quarterly	0	2	Willingness to pay assessments, system reviews, mutuelle pilot in Descayettes, information exchange, and HHDD analysis of KPC data
	Index of client satisfaction, by health center, based on HH follow-up survey	HH follow-up survey of 5 mothers per neighborhood	Process Doc & Research Org	Annually (qtrly each site)	N/A	N/A	
	Ratio of extreme poor in health coverage statistics	KPC Survey using HHDD index	Health Coordinator	Bi-annual	TBD	N/A	
IR 3: Increased quality of reproductive and child health services	Number of health centers with active quality improvement team	Project supervision report	Health Service Capacity Officer	Quarterly	0	5	Participatory capacity assessments and annual evaluation and planning; QA training, team support in analysis and planning, supervision, performance incentives linked to QA efforts
	Number of health centers receiving supervision visits from BC in past month	Supervision report review	Health Service Capacity Officer	Annually	0	5	
	Number of HCs certified Youth Friendly as per norms	Supervision checklist	Health Service Capacity Officer	Quarterly	0	5	
	Level of performance incentives compensation	Project supervision report	Health Service Capacity Officer	Quarterly	0	TBD	

Strategic Objective/Intermediate Results	Indicator	Method	Who Collects	Frequency	Baseline Value	EOP Target	Intervention (Input)
	Index of Health Center capacity in management, leadership, logistics, service deliver, and community participation, by facility	Adapted MOST Facility Assessment	Process Doc & Research Org	Bi-annual	N/A	N/A	
	Index of the utilization of HMIS at HC, Bureau Communal, and DSO levels	System assessment	M&E Consultant Assessment	Baseline then once quarterly (1 per neighborhood per year)	Low	High	System assessment, update tools and registers, information reporting and analysis included in topical trainings and supervision, HMIS review and OJT by M&E consultant, Bureau Communale data management support; training and equipping youth leaders and TBAs on vital event and reportable diseases
	Number of HCs submitting complete HMIS on time, by month	Bureau Communale	Health Service Capacity Officer	Monthly	5	5	
	Functioning vital events information system from household to health center to DSO level	System assessment	M&E Consultant	Annual	0	5	
IR 4: Improved policy environment for the urban populations, putting emphasis on protection of the poorest people	Proportion of urban health partners who attended the last quarterly meeting of the Programme Learning & Action Group	Attendance register	DSO with Project Manager	Quarterly	0	75%	Quarterly platform meetings, organize information exchange and training opportunities; assess and document environmental health and unmet need for obstetric services in the disadvantaged neighborhoods, participate in MSPP, USAID, UNCIEF and other key health actors events
	Number and quality of advocacy initiatives raised by the PLAG	Key informant interviews with PLAG and coalition members and influential groups	Process Doc & Research Org	Bi-annual	0	2 High Quality	
	An annual workplan with at least 75% of activities achieved for disadvantaged urban neighborhoods	Annual review workshop	DSO with Project Manager	Annual	0	75%	

Strategic Objective/Intermediate Results	Indicator	Method	Who Collects	Frequency	Baseline Value	EOP Target	Intervention (Input)
	Number of institutions - Donors, Practitioners, Govt who know the urban health project	Key informant interviews from select institutions	Process Doc & Research Org	Annual	TBD	TBD	
	Proportion of institutions(donors, NGOs, Governmental) who can cite at least two major lessons learned from the urban health initiative	Key informant interviews from select institutions	Process Doc & Research Org	Annual	0	TBD	
	Index of development of an urban health policy in Haiti	Key informant interviews from select institutions	Resource Organization	Annual	Low	Mod/ High	

Annex D-2: Sample monthly report (in French)

REPUBLIQUE D'HAITI

MINISTÈRE DE LA SANTE PUBLIQUE ET DE LA POPULATION (MSPP)

RAPPORT MENSUEL DES SERVICES DE SANTE

Page 1/4

Institution	Niveau	Commune	Département

1) FREQUENTATION DE L'INSTITUTION

Mois / Année _____

Population desservie: _____

Visites	Visites/Nombre	
	Nouvelles	Subséquentes
Institutionnelles		
Non institutionnelles		

Consultations générales

Catégories	Total des Consultations
Enfants (< 1 an)	
Enfants (1 - 4 ans)	
Enfants (5 - 14 ans)	
Femmes enceintes	
Clientes de PF	
Autres adultes	

2) ETAT FINANCIER

Sorties	Gourdes
Contractuels	
Achats services	
Médicaments	
Matériels fongibles	
Matériels non fongibles	
Equipements	
Divers	
Total	
Balance	

Entrées	Gourdes
1. Balance antérieure	
2. Allocations	
3. Dons	
4. Recettes:	
• Consultations	
• Pharmacie	
• Odontologie	
• Laboratoire	
• Radiologie	
• Hospitalisation	
• Autres	
Total	

3) COMMUNICATION ET EDUCATION POUR LA SANTE

	Discussion de groupe	Causeries	Assistance Conseil	Forum	Réunions communautaires	Autres
Prise en charge de l'enfant						
Santé reproductive						
Hygiène personnelle						
Hygiène de l'environnement						
Maladies transmissibles						
Autres thèmes						

4) SOINS BUCCO-DENTAIRES

	Nombre
Patients vus	
Extractions	
Prophylaxies	
Amalgames	

5) EXAMENS DE LABORATOIRE

Type d'examen	Total	Positifs
Malaria Test		
Bacilloscopie		
VIH		
RPR		

6) URGENCES

Causes	Nombre
Accident de la route	
Accident du travail	
Accident domestique	
Autres	
Type de prise en charge	
Médicale	
Chirurgicale	
Obstétrico/Gynécologique	
Urgence relative	
Devenir	
Soignés	
Référés	
Décédés	
Partis sans autorisation	

7) MEDICAMENTS ESSENTIELS

Type de médicaments essentiels	Disponible tout le mois	
	oui	non
Amoxicilline	☐	☐
Cotrimoxazole	☐	☐
Fer/acide folique	☐	☐
Paracétamol	☐	☐
SRO	☐	☐
Chloroquine	☐	☐

8) PRISE EN CHARGE DE LA FEMME

Nombre de grossesses attendues: _____

8.1) Consultations pré/postnatales

Consultations prénatales

1ères Visites			2e Visites	3e Visites	4e Visites et plus	Total Visites
0 - 3 mois	4 - 6 mois	7 - 9 mois				

Grossesses à risque :	
Cas d'anémie :	

Vaccination antitétanique	TT2	TTR
Femmes enceintes		
Autres Femmes 15 - 49 ans		
Autres		

Consultations postnatales	

Distribution de Vit. A, Fer, Chloroquine

Fem. recevant Vitamine A	
Fem. recevant du Fer	
Fem. recevant de la Chloroquine	

8.2) Accouchements

Age des mères	Institutionnels			Domiciliaires
	Norm.	Cesar.	Autres	
< 15 ans				
15 - 19 ans				
20 - 34 ans				
35 ans et plus				
Inconnu				

Naissances Vivantes

< 2,5 kg				
2,5 kg et plus				
Non pesés				
Mises au sein immédiatement				

Décès

Mort-nés				
Décès maternels				

Matrones

Certifiées pour le mois	
Supervisées pendant le mois	

8.3) Consultations PF: _____

Utilisation et Acceptation Contraception

Femmes	Utilisateurs	Acceptants	
		< 25 ans	≥ 25 ans
LoFemenal			
Ovrette			
Depo-provera			
Noristérat			
Norplan			
DIU (stérilet)			
Tablettes vaginales			
Condom			
CCV			
Total Femmes			

Hommes			
Condom			
CCV			

Contraceptifs distribués

	Unité	Quantité
LoFemenal	*Cycle*	
Ovrette	*Cycle*	
Depo-provera	*Vial*	
Noristérat	*Vial*	
Norplan	*Implant*	
Stérilets	*Pièces*	
Tablettes vaginales	*Tab*	
Condom	*Pièces*	

Opérations de CCV

Ligature	
Vasectomie	

9) PRISE EN CHARGE DE L'ENFANT

Population < 1 an : _____

Population 1 - 4 ans : _____

Services fournis / Caractéristiques	Enfants / Age	
	< 1 an	1 - 4 ans
Total vus		
Pesés		
Poids normal		
Poids très faible pour l'âge		
Prise en charge		

Vaccination	Enfants / Age	
	< 1 an	1 - 4 ans
BCG dose unique		
DTP 3		
DTP Rappel		
Polio 3		
Polio Rappel		

Vaccination (suite)	Enfants / Age		
	< 1 an	1 - 4 ans	5 ans & +
Rougeole dose unique			
Vaccination complète	0 - 11 mois	12 - 23 mois	24 - 59 mois

Vitamine A	< 1 an	1 - 4 ans	5 - 7 ans
Dose 1			
Dose 2 & +			

Formations PCIME / PCIMA	Méd.	Inf.	Aux.
Certifiés			
Supervisés			

10) NOUVEAUX EPISODES DE MALADIE

Maladies / Symptômes	Nouveaux épisodes/Age												Total Cas Référés	Total des Décès
	< 1 an		1 - 4		5 - 14		15 - 49		50 +		Total Cas			
	F	M	F	M	F	M	F	M	F	M	F	M		
Anémie														
Asthme														
Bubon Inguinal														
Problèmes bucco-dentaires														
Charbon														
Conjonctivite néonatale														
Autres Conjonctivites														
Coqueluche														
Dengue														
Dengue hémorragique														
Diabète														
Diarrhée aqueuse														
Diarrhée sanguinolante														
Diphtérie														
Douleurs abdominales basses														
Douleurs, brulûres d'estomac														
Ecoulement urétral														
Filariose														
Goître														
Hémorragie														
HTA														
Ictère fébrile														
Intoxication alimentaire														
Infections Respiratires Aigues (IRA)														
Kwashiorkor/ marasme														
Lèpre														
Leptospirose														
Malaria (Rx chloroquine) Femmes enceintes														
Malaria (Rx chloroquine) Total														
Malaria (cas confirmés) Femmes enceintes														
Malaria (cas confirmés) Total														
Malaria (cas résistants)														
Malaria (cas hospitalisés)														
Méningite														
Méningite Méningococcique														
Morsures par chien/chat														
Oreillons														
Paralysie flasque aigue														
Parasitose intestinale														

10) NOUVEAUX EPISODES DE MALADIE (suite)

Maladies / Symptômes	Nouveaux épisodes/Age												Total Cas Référés	Total des Décès
	< 1 an		1 - 4		5 - 14		15 - 49		50 +		Total Cas			
	F	M	F	M	F	M	F	M	F	M	F	M		
Pertes vaginales														
Pneumonie														
Rage humaine														
Rougeole (cas suspects)														
Rougeole (cas confirmés)														
Sarcoptose														
Septicémie														
Septicémie néonatale														
SIDA														
Syndrome d'érruption fébrile														
Syphilis congénitales														
Syphilis														
Suspects de TB														
TB (microscopie positive)														
Tétanos néonatal														
Tétanos														
Tuméfaction du Scrotum														
Tumeurs														
Typhoïde (clinique)														
Typhoïde (confirmé)														
Ulcérations génitales														
Xérophtalmie														
Autres maladies														

CAPACITE INSTALLEE / UTILISATION

	Péd.	Méd.	Chir.	Matern.	Gynéco.	Autres
Lits disponibles						
Jours-Lits						
Jours-Patients						
Hospitalisés						
Exéatés vivants						
Décès Av. 48 hres						
Décès Ap. 48 hres						
Jours d'hospitalis.						

COMMENTAIRES / REMARQUES

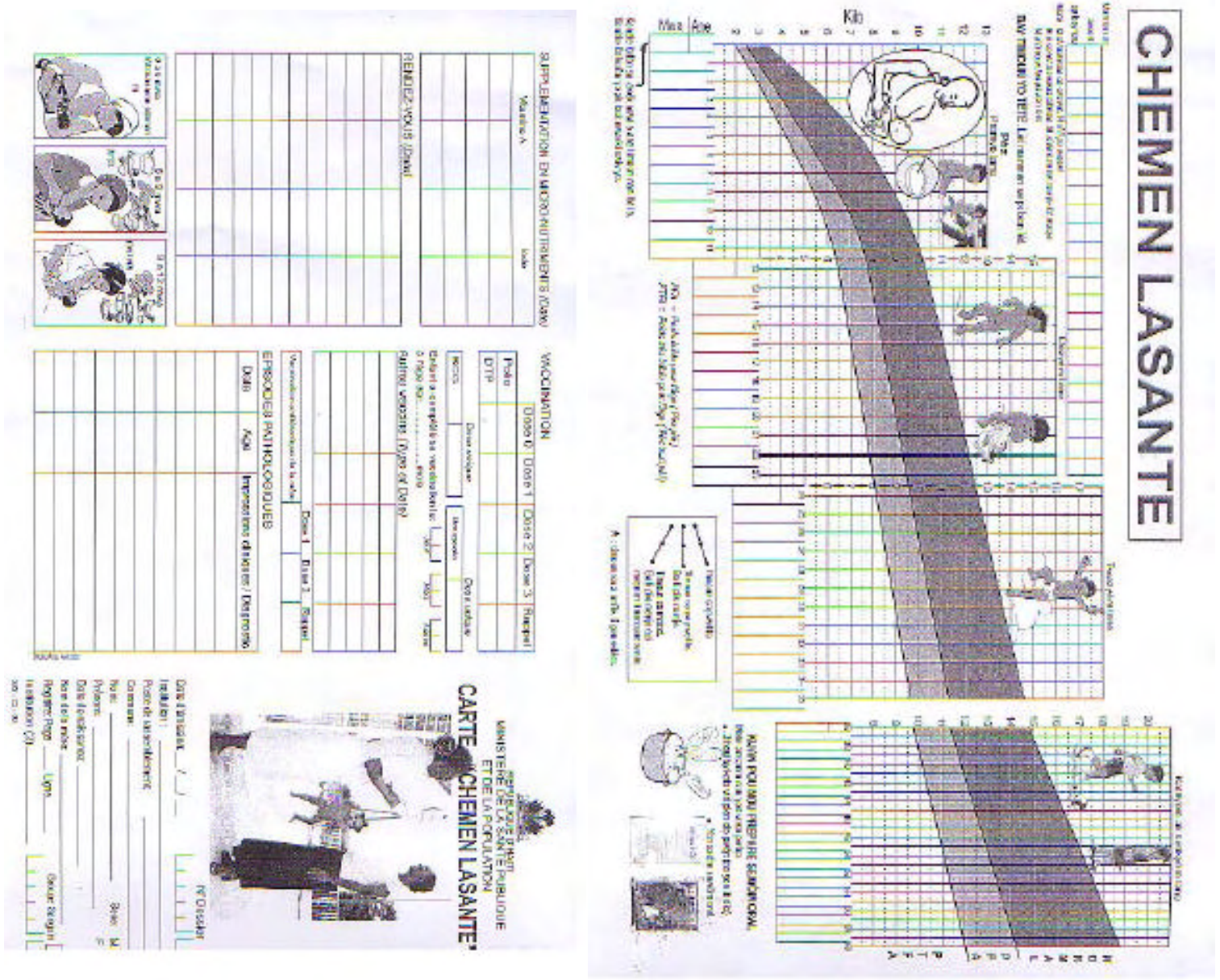
Préparé par: _____ Date : _____

Approuvé par: _____

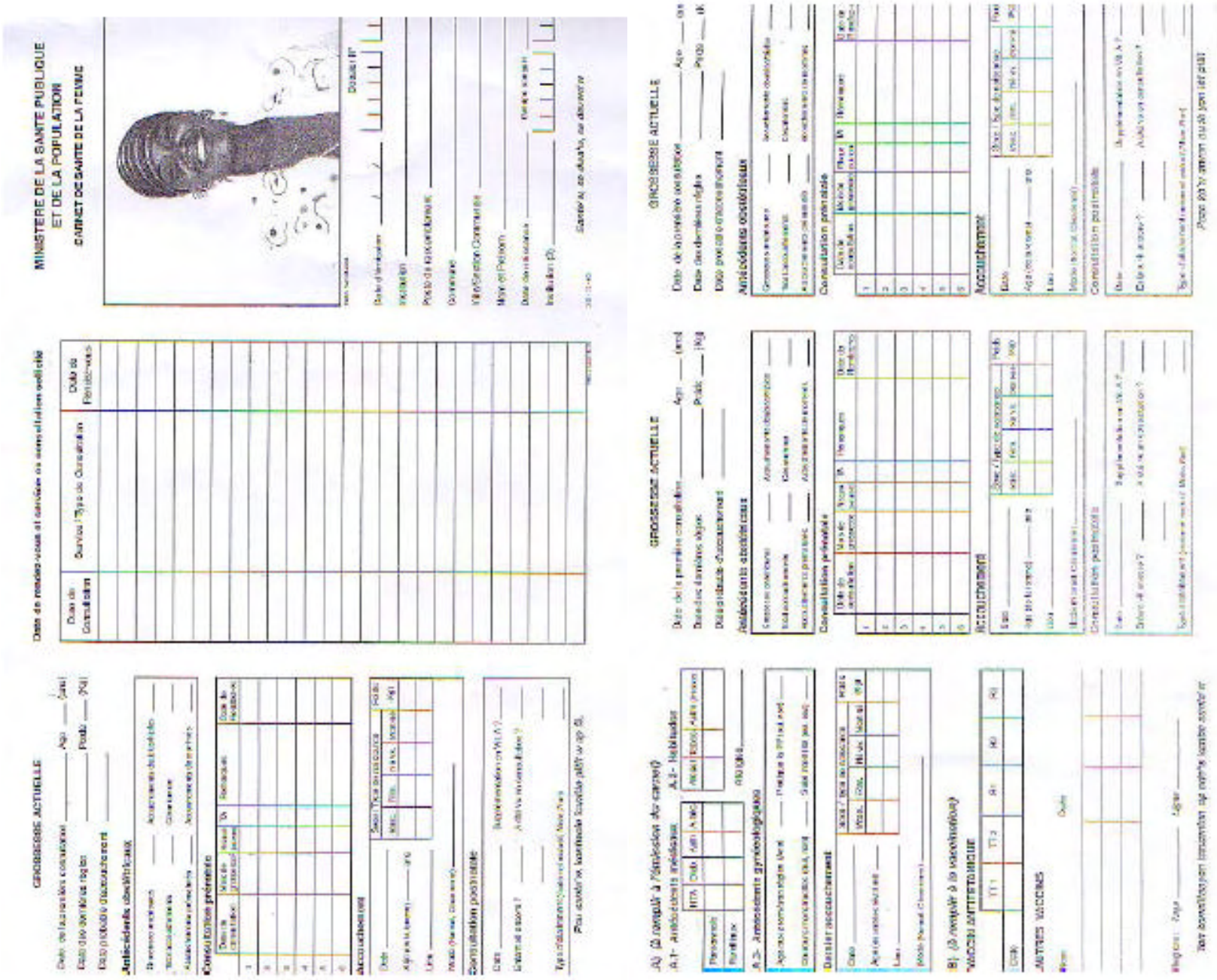
Reçu par: _____

Date : _____

Annex D-3: Sample child card (in French)



Annex D-4: Sample mother card (French)



Annex D-5: Program Monitoring by Concern Worldwide US

Concern US staff member:

Position:

Country:

Program Visited:

Dates Visited:

Please note that this is an internal reporting document for Concern US, not for dissemination. Thank you.

Funding Available by Concern US—USAID—OFDA:

Program Name	Amount Pledged	Period

1. Description of Program Objectives and Activities

o Please list program objectives and beneficiary targets *(see grant agreement for reference point)*:

o Description of activities observed during visit:

o Actual Number of Beneficiaries served (vs. expected):

o How are beneficiary numbers collected and tracked

1. Description of Program Objectives and Activities continued

o Geographic Area of Program (please be as descriptive as possible; i.e., rural/urban, distance from an economic center, etc.):

o Has there been an evaluation of the program or is one planned?

2. Has there been a change of scope in the program or a significant change in the situation (i.e., security consideration, staffing changes/challenges, increased food insecurity, increased/decreased # of beneficiaries, etc.)

3. How do the budget expenditures correspond with program objectives and activities?

- General Observations:
- Are the expenditures in keeping with the program budget and activities
- Are there any budget line item under and overspends? If so, why?

4. Document and itemize any significant equipment viewed while making the site visit (refer to the grant agreement for reference).

5. Document any meetings held with community groups/partners during the site visit, commenting on the nature/date of the meeting and any significant discussions that may relate to achieving the program objectives

6. Document any challenges/concerns raised by Concern staff in terms of program implementation, administrative burdens and human resource considerations/recruiting issues? Other challenges?
7. Does the staff anticipate further funding needs for certain program areas?
8. Document any success stories and attach any photos documenting the program. ***(If possible, include the beneficiary's name, age, family size, situation, impact of the program on his/her life, location and personal quote)***
9. List the primary staff, position and location of those who facilitated the site visit.

10. Items specific to USAID/OFDA funded programs:

o Name of USAID/OFDA Contact person in county:

o Nature of Concern's relationship with the USAID office:

o Have any USAID/OFDA representatives visited the program? If so, who and when.

o Please share and discuss Concern's USAID guidelines, reporting schedule and USAID's current country profile

o Have there been any difficulties meeting reporting requirements? If so, why and what could be done to improve the process?

o Have there been any difficulties with Time Sheets? If so, what are the major challenges?

o General observation of financial records (i.e., maintaining financial reports, retaining financial documents for three years after the close of the grant, etc.?) and procurement procedures (e.g., is there a competitive bidding procedure for equipment?)

o If there are sub-grants or sub-contracts to partners, how are the partners chosen, what is the nature of the relationship, does the partner report on program activities, etc.?

o Does the staff anticipate further funding needs/plan on submitting another USAID/OFDA proposal? No-cost extension or budget revision for current grant?

o Are there any large companies with a presence in-country or do any foundations have a presence in-country?

General Monitoring Note:

Pre-Visit suggestions:

- Draft *Terms of Reference*, which should include purpose (what do you need to learn?), specific tasks and expected outputs such as a narrative of key issues discussed, an internal trip report that includes follow-up activities, case studies and photographs.
- Work with the field to plan a realistic itinerary which included time with staff and beneficiaries, if possible.
- Research the county programs and consult the Annual Plan, Project Profiles, Narrative Reports, Concern US staff who have visited the country, etc.

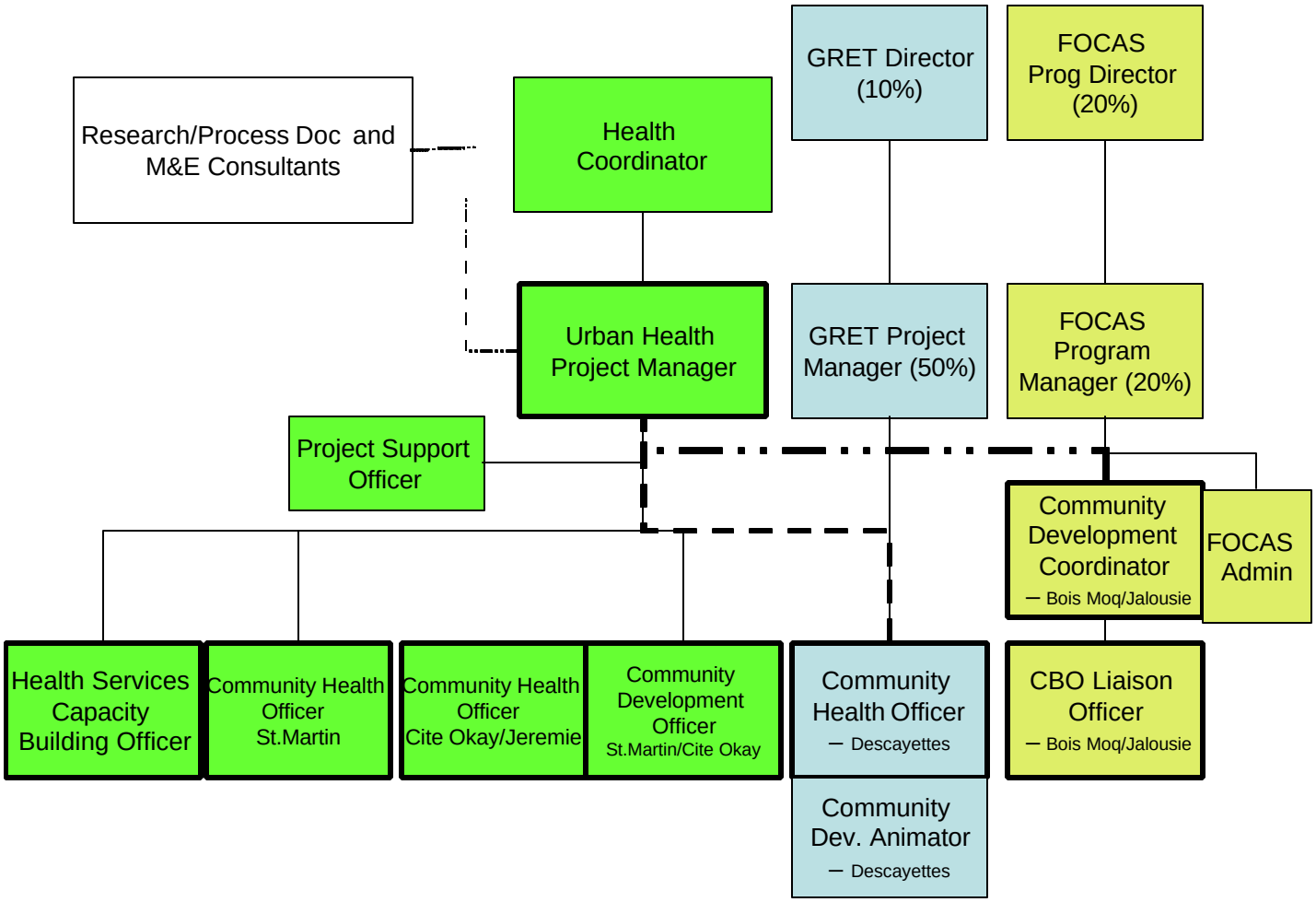
Post-Visit suggestions:

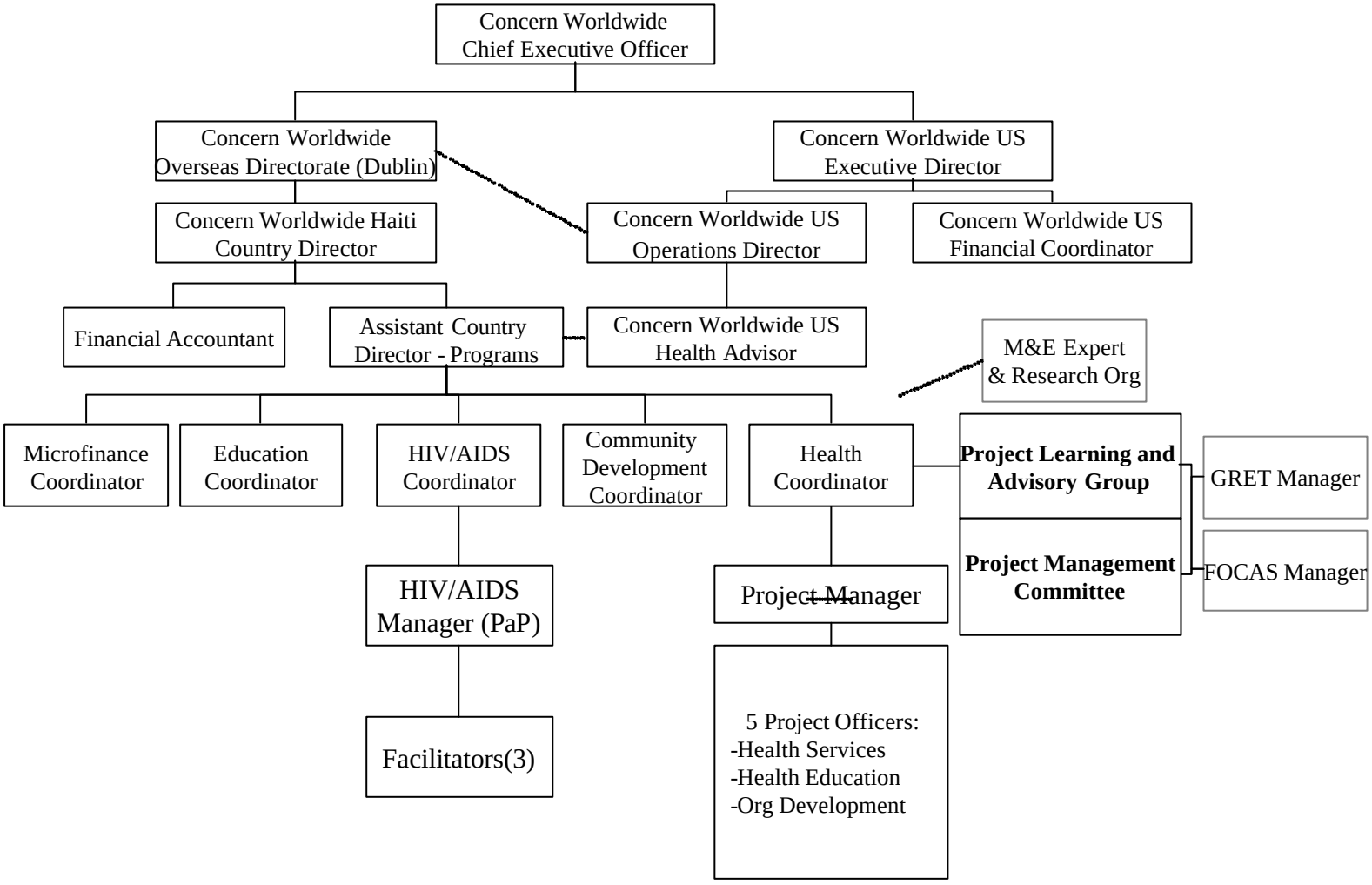
- Internal distribution of electronic version of the reports/photos and file in Shared Folder;
- Preparation for possible Concern US briefing of visit;
- Thank you notes; and
- Follow-up based on visit.

ANNEX E: Human Resources

E-1 Organization Charts
E-2 Project Staff Position Descriptions
E-3 Roles & Responsibilities of External Human Resources
E-4 Change Key Personnel: Field Manager
E-5 Contract GENESIS Year One

E-1: ORGANIZATION CHART: PROJECT TEAM





November 17, 2004

E -2 PROJECT STAFF SUMMARIES

Position	Person in Position	Full-Time Equivalent	Key Roles and Responsibilities	Authorization	Qualifications
CONCERN HAITI STAFF					
Health Coordinator	Dr. Andre-Paul Venor *(until May 2006)*	40%	Ensure coherence of program with Country Strategic plans Coordinate monitoring and technical support with the Concern US Health Advisor Oversee planning, monitoring and evaluation of program and coordinate work from Process Documentation and M&E consultant Provide necessary technical support (advice and training) for all health projects Develop and maintain professional networks in Haiti and reinforce partnerships with urban health program Ensure performance of Health Program Managers and support Concern Haiti HR in staff development	Oversees planning and monitoring of program budget Negotiate ToR with contractors and Policy Advisors Initiate conflict resolution	Masters qualification in public health 5-7 years health program management experience Strong coordination and partnership building experience Training and facilitation skills Technical expertise in maternal and child health programming Excellent communication and negotiation skills Strong English and French language skills Computer proficiency
Program Manager	Guerda Debrosse	100%	Planning and implementation of all program activities Technical and financial reporting Ensure overall quality assurance of interventions Partnership building Leader urban health coalition building Staff performance management Supervision of all 5 project areas Program monitoring and documentation through monthly and annual reports	Prepare payment requests Draft consultant agreements Finalize annual and monthly workplans	University qualification in public health or related field 3-5 years health program management experience Partnership building experience Technical expertise in maternal and child health programming Excellent communication and negotiation skills Strong English and French language skills and computer proficiency

Position	Person in Position	Full-Time Equivalent	Key Roles and Responsibilities	Authorization	Qualifications
Health Services Capacity Building Officer	**Marie Lourdes Thelusma**	100%	Ensuring quality and organization of health facility training Institutionalizing MSPP standards and norms in training and supervision materials Coordinating supervision and technical support to 5 participating health facilities with GRAND & FOCAS and Bureau Communales Actively participate in monthly program team meetings with Concern	Prepare payment requests Drafts consultant agreements for training	Medical qualification with complementary post-graduate degree 3-5 years adult learning and training of trainers experience Excellent facilitation skills Familiarity with IMCI and maternal care Fluent in French and Creole Good English reading and writing skills
Community Development Officer	**Renold Jerome**	**100%**	Identify training needs for community organization development and capacity building Prepare, deliver, and follow-up on training on health and organization development themes for community level actors Facilitate regular local level planning and monitoring Facilitate networking of organizations and development community health & dev FORUM in St. Martin & Cite Okay Coordinate technical support and monitoring visits to the area Write monthly activity report Actively participate in monthly program team meetings with Concern	Prepare payment requests Contribute to monthly team planning	Community development and other relevant social studies university degree 1-3 years community organization experience Conflict management skills Good planning skills Familiarity with low income urban settlements Proficiency in French and Creole Willingness to work in unstable areas
Community Health Officer - St. Martin	**Rode Jean Phillipe**	**100%**	Training needs assessment for community actors Coordinating and ensuring quality of community group health trainings Organizing joint health promotion events with health facilities and FORUM	Prepare payment requests Contribute to monthly team planning	Medical qualification or other related field post-graduate degree 1-3 years health education material development experience Community group training skills

Position	Person in Position	Full-Time Equivalent	Key Roles and Responsibilities	Authorization	Qualifications
Community Health Officer - Cite Okay	**Marie Carmelle Lamur**	**100%**	Monitoring effectiveness of behavior change activities Oversee support of TBAs and other private practitioner networks with Health Center Liaising with Behavior Change sub-committee members for formative research, workshops, and consultative meetings Write monthly activity report Actively participate in monthly program team meetings with Concern		Good organization and planning skills Familiarity with low income urban settlements Proficiency in French and Creole Willingness to work in unstable areas Willingness to work in unstable areas
Project Support Officer	**Vacant**	**100%**	Provide administrative support for communications on behalf of Program Manager Manage project database for M&E and financials Coordinate weekly vehicle schedule requests with Transport Manager Logistic support for all meetings, visitors Supervision of production of behavior change communication materials Coordinate quarterly financial report reviews with Program Manager Provide English and French translation services	None	Business management post-secondary degree or certificate Excellent computer proficiency Ability to draft correspondence in French, English and Creole Very strong organization and interpersonal communication skills
GRET Staff					
GRET Area Program Manager	Dr. Cadet	50%	Technical guidance to partners in developing Mutuelles for urban health and documentation of learning from Descayettes Liaise with Bureau Communale of Port-au-Prince Ensure performance of GRAND Animators in Descayettes Actively participate in quarterly program team meetings with Concern, FOCAS & DSO	Submit quarterly technical & financial reports to Concern Manager Manage performance incentives for SNELAK	Masters qualification in public health Significant health program management Excellent communication skills Expertise community health financing Strong English and French language skills and computer proficiency

Position	Person in Position	Full-Time Equivalent	Key Roles and Responsibilities	Authorization	Qualifications
Community Health Officer - Descayettes	Vacant	100%	Training needs assessment for community actors Coordinating and ensuring quality of community group health trainings Organizing joint health promotion events with health facilities and FORUM Monitoring effectiveness of behavior change activities Oversee support of TBAs and other private practitioner networks with Health Center Liaising with Behavior Change sub-committee members for formative research, workshops, and consultative meetings Write monthly activity report Actively participate in monthly program team meetings with Concern	Prepare payment requests Contribute to monthly team planning	Medical qualification or other related field post-graduate degree 1-3 years health education material development experience Community group training skills Good organization and planning skills Familiarity with low income urban settlements Proficiency in French and Creole Willingness to work in unstable areas Willingness to work in unstable areas
Animator	Charmant Wolfy	35%	Identify training needs for community organization development and capacity building Prepare, deliver, and follow-up on training on health and organization development themes for community level actors Facilitate regular local level planning and monitoring Facilitate networking of organizations and development community health & dev FORUM in St. Martin & Cite Okay Coordinate technical support and monitoring visits to the area Write monthly activity report Actively participate in monthly program team meetings with Concern	Prepare payment requests Contribute to monthly team planning	Community development and other relevant social studies university degree 1-3 years community organization experience Conflict management skills Good planning skills Familiarity with low income urban settlements Proficiency in French and Creole Willingness to work in unstable areas

Position	Person in Position	Full-Time Equivalent	Key Roles and Responsibilities	Authorization	Qualifications
FOCAS STAFF					
Community Development Coordinator	Emmanuelle Alabré	100%	Community FORUM development in Jalousie and Bois Moquette Community organization development and capacity building Facilitating local level planning and monitoring Conduct training needs assessments of local actors Organize local trainings Actively participate in monthly program team meetings with Concern Write monthly report	Plan and oversee implementation of activities Plan and request activity budgets	Advanced community development qualification. 2-3 years community development experience Excellent facilitation and training skills Familiarity with youth and sexuality issues Effective written and verbal communication skills in French, Creole and English Excellent organizational skills Computer proficiency
CBO Liaison Officer	Vacant	100%	Follow-up on training on health and organization development themes for community level actors Facilitate regular local level planning and monitoring Facilitate networking of organizations and development community health & dev FORUM in Jalousie and Bois Moquette Coordinate technical support and monitoring visits to the area Write monthly activity report Actively participate in monthly program team meetings with Concern	None	Community development and other relevant social studies university degree Knowledge and experience in community organizing and team building Effective written and verbal communication skills in French and Creole Good organization and planning skills Familiarity with low income urban settlements
FOCAS Haiti Program Manager	Dr. Micheline Baguidy	20%	Technical guidance to partners in youth and HIV/AIDS programming and documentation Liaise with Bureau Communale of Petion-Ville Actively participate in quarterly program team meetings with Concern, FOCAS & DSO Ensure performance of staff Coordinate planning and communications with MEI & OBDC	Submit quarterly technical & financial reports to Concern Manager Manage performance incentives for OBDC & MEI	Masters qualification in public health 5-7 years health program management experience Strong coordination and partnership building experience Technical expertise in maternal and child health programming Strong English and French language skills Computer proficiency

E – 3 : DETAILED ROLES AND RESPONSBILITIES OF EXTERNAL HUMAN RESOURCES

Position/ Type	Qty	Main Responsibilities	Level of Effort to project Specifically	Entity responsible for remuneration
DSO/Bureau Communale				
DSO and Focal Point for urban health	2	- Overall guidance and leadership in program implementation - Chair quarterly urban health platform meetings - Periodically supervise program activities - Participate in training modules - Assure adherence of MSPP norms and standards - Participate in behavior change strategy development and material production - Promote exchange and learning with other urban health actors - Ensure coordination of NGOs with the program	5%	MSPP (Concern pays for training)
Bureau Communale Focal Point	3	- Support staff involvement allocation of budget for health department - Overall guidance and leadership in WHC activities (formation, planning, implementing, monitoring and financial resource mobilization) - Ensure participation of community leaders (including teachers & religious leaders) in health activities. - Ensure participation of all health service providers in the WHC activities	5%	MSPP (Concern pays for training)
CIVIL SOCIANDY				
Community Based Organization Leaders	SM-30; OK 15; D – 20; JB - 30	- Develop networks with CBOs and other associations to work towards and health & development FORUM - Assess local knowledge, attitudes, practices and priorities to inform program approach and activities - Develop annual collective health action plan with health facility and project staff	10%	Community Development Officer function in each PVO area
Youth Leaders	1300	- Develop and apply skills in peer counseling, family planning and condom use negotiation as well as essential maternal and child health education - Monitoring pregnancies, births, deaths and reportable diseases - Collaborate with HF staff in tracking vaccination drop-outs - Participate in Leaders monthly meetings and life skill development - Serve as resource person for FORUM health events	10%	Community Health Officer
Traditional Birth Attendants of Descayettes, St Martin & Cite Okay	60	- Early identification and referral of pregnant women for ANC visits - Association development of IGA for clean delivery kit materials - Learning and skill development in early identification and negotiating referral for complications - Advise on maternal nutrition and infant feeding - Collaborate with local leaders to prepare for emergency referrals to hospital - Promote early postpartum and newborn care visit to HC - Report births, complications, referrals and deaths at monthly meeting at HF	10%	Community Health Officer
Private Practitioners	20	- Learn about danger signs of children with diarrhea, fever, pneumonia or malnutrition - Understand agreed negotiated practices and abide by them - Attend monthly meetings with moderator from HC and report on	5%	Community Health Officer

Position/ Type	Qty	Main Responsibilities	Level of Effort to project Specifically	Entity responsible for remuneration
		referrals and problem cases - Peer support for improved practices		
HEALTH FACILITY PERSONNEL				
St. Martin Govt Health Center		- Collaborate with community health FORUM in planning and implementing health education activities - Train community health actors - Monitor vaccination coverage, births, deaths and reportable diseases by 10 supervision zones - Strengthen data collection, analysis and use for health facility planning - Quality assurance teams actively assess, action plan and monitor service improvement efforts with community participation - Administration manage essential medicines and staff performance incentives - Lead monthly meetings with participating informal private practitioners (eg. TBAs) - Participation in quarterly urban health platform meetings	15%	Bureau Communale (with performance incentive from Concern)
HaitiMed Health Center		- Collaborate with community health FORUM in planning and implementing health education activities - Train community health actors - Monitor vaccination coverage, births, deaths and reportable diseases by 6 supervision zones - Strengthen data collection, analysis and use for health facility planning - Quality assurance teams actively assess, action plan and monitor service improvement efforts with community participation - Administration manage essential medicines and staff performance incentives - Lead monthly meetings with participating informal private practitioners (eg. TBAs) - Participation in quarterly urban health platform meetings	15%	HaitiMed (with performance incentive from Concern)
Descayettes Health Center		- Collaborate with community health FORUM in planning and implementing health education activities - Train community health actors - Monitor vaccination coverage, births, deaths and reportable diseases by 10 supervision zones - Strengthen data collection, analysis and use for health facility planning - Quality assurance teams actively assess, action plan and monitor service improvement efforts with community participation - Administration manage essential medicines and staff performance incentives - Lead monthly meetings with TBAs - Participation in quarterly urban health platform meetings	15%	GRET
Jalousie Health Center		- Collaborate with community health FORUM in planning and implementing health education activities - Monitor vaccination coverage, births, deaths and reportable diseases by 14 supervision zones - Strengthen data collection, analysis and use for health facility planning - Quality assurance teams actively assess, action plan and monitor service improvement efforts with community participation	10%	FOCAS

Position/ Type	Qty	Main Responsibilities	Level of Effort to project Specifically	Entity responsible for remuneration
		- Administration manage essential medicines and staff performance incentives - Participation in quarterly urban health platform meetings		
Bois Moquette Health Poste		- Collaborate with community health FORUM in planning and implementing health education activities - Monitor vaccination coverage, births, deaths and reportable diseases by 5 supervision zones - Strengthen data collection, analysis and use for health facility planning - Quality assurance teams actively assess, action plan and monitor service improvement efforts with community participation - Administration manage essential medicines and staff performance incentives - Participation in quarterly urban health platform meetings	10%	FOCAS

E-4 Key Position Field Manager

Name : Marie Guerda J. Débrosse
Title : **Child Survival Project Manager**
Supervisor : André-Paul Vénor/ Health program Coordinator
Date : February 1st, 2006

1. **Place of work :** Base in Port-au-Prince at Concern Worldwide's office : 28, Rue Métellus, Pétion-Ville, Haïti, with field visit in the 5 sites.

2. **Work objective :** Plan, organize, monitor and support all program activities related to the project document

3. Direct supervisor of :

- Health Services Capacity Building officer
- Community Development Officer
- Community Health Officers (2)
- Project Support Officer

4. Coordinates with :

Internal:

Health Program Coordinator and Research Officer in CW/Haiti
Urban Project Mangers (HIV /AIDS/ Struggle Violence/Micro finance)
CW/US Health Advisor

External :

Subgrantees: GRET and FOCAS
M&E Advisor Consultant
Process Documentation & Research Organization: GENESIS
Head of West Departement Health Office from MSPP(DSO and Bureau communal) and focal point for Urban health .

5. PRINCIPAL FUNCTIONS

1. Plan with project team and supervise all Child survival project activities.
2. Support Health Services Capacity Building officer for planning and organization of health facility training and capacity activities. Approves modules.
3. Support Community Health officer for planning and organization of health community activities.

4. Monitor and develop project based human resources
5. Represent Concern to project partners and sometimes to the Ministry of Health.
6. Work with M&E Consultant to develop M&E guidelines and management of HMIS
7. Initiate and organize surveys (KPC, HFA, PRA, household census) with Health Program Coordinator and M&E Consultant.
8. Prepare narrative and financial project report
9. Participate to coordination meeting with partners and MSPP (DSO and Bureau Communal)
10. Work actively to create relationships with key partners, MSPP and CBO's in order to keep informed, learn from each other by sharing experiences.
11. Organize meetings of the Urban Health Learning , Research and Actions Group.
12. Lead the quarterly management meetings.
13. Contribute to development of training module for health center staff and CBO's .
14. Initiative process, with Health program Coordinator, related to general plan and project orientation.
15. Other tasks as assigned related to management responsibility, based on needs and the availability.

10, Rue C. Colomb, Rue Léomard, Rue Micaisse Delmas 19

Marie Guerda J. DÉBROSSE

Professionnal Training

Public Nursing School'' Notre Dame de la Sagesse''
Cap Haitien
E.I.N.D.S.
Nursing sciences
1987- 1990 **Diploma**

Post Graduate Training

Hopital Albert Schweitzer,
HAS de Deschapelles.
Physician Extender
1994 – 1995
Certificate

Dina School of Nursing, Bellinson Campus Israel
Nursing care of women during their life style – Women Health
Israel
June – August1998
Certificate

PRAxIS INDIA (NISIET CAMPUS / Hyderabad, INDIA)
PRA (Participatory research approaches)
India
September 18th to 29th, 2005
Certificate

Seminars and workshops

- **Integrated mangement of children illnesses (IMCI)**

  UNICEF / November 1994

- **Breastfeeding**

  UNICEF / March 1995

- **Prevention and fight against Tuberculosis, Intégration of DOTTProgram**

  HAS April 1995

- Prevention of STI/ HIV /AIDS, Counselling pre and post test.
  HAS April 1995

- **Essential drugs management**

MSP P/ Departenmtal office of Artibonite Valley October 1997

- **Hospital prevention and infections control**

University Pennsylvania (UPENN team) in collaboration with HAS

HAS 1999

- **Integration of National Program of Prevention against Tuberculosis. CAT in collaboration with MSPP /Artibonite Departmental Health office .**

  January 2000

- **Efficacity of Leadership**

  HAS February 2000

- **Leadership & Human ressources Basics.**

  Nursing College / University of Pennsylvania /HAS

  March 2001

Certificats / Diploma / Licence

Certificates

- Bacc I.
- Bacc II.(equivalent to college degree)
- Physician Extender
- Nursing Care of Women
- Partipatory research action
- Nursing sciences Diploma of RN
- Registred Nurse (RN) Licence.

Academic background

Secondary School (College)
Collège Pratique du Nord [C.P.N.]
7th to 13th grade
1979 - 1987

Primary schools
Ecole Nationale de Milot
1972 – 1979

Professional Experiences

Hopital Albert Schweitzer, HAS de Deschapelles 1994-2003
Nurse parcticionner / Physician Extender

Principal task :

1. **Screening and clinical evaluation**
1. **Emergency Care,**
2. **Daily follow-up of in patients in ward and weekly evaluation of Tb patients at the TB village.**
3. **Follow-up of walk in and out patients**
4. **Participation to weekly conference and annual evaluation wokshop of Tb program/ resistant case.**
5. **Work in patient care at dispensary level for Hospital reference system .**
6. **Health center (dispensaries) capacity assessment including staff.**

Teacher of Pharmacology Basics & Posology
March-May 2004
Faculté des Sciences Infirmières , Université Lumière
Co-facilitator of focus group discussion for community evaluation of Health institution and program

1. Planning (questionnaire, logistics)
2. Animation of Focus group
3. Report
4. Presentation of data.

Hopital Albert Schweitzer, HAS de Deschapelles Feb-April 2000
Nurse parcticionner / Physician Extender

- **Physician Extender Program Coordonator / Head Departement of Physician Extender.**
  1. Chargée de la planification et de l'implantation du Programme
  2. Elaboration of training Curriculum and organization.
  3. Budget planning
  4. Supervision of staff activities related to the Program(clinical practicing)
  5. Assure Coordination for HAS and University of Ohio / PA College for training team.
  6. Team scheduling and human ressources management.

Hopital Albert Schweitzer, HAS de Deschapelles Jan 2001 – April 2003

- Women's Heath Program steering Comitee member.

CONCERN WORLD WIDE HAITI **May 2004 – Aug 2005**
School Health Assistant Project Manager

CONCERN WORLD WIDE HAITI **Sept 2005 – Jan 2006**
School Health Project Manager

CONCERN WORLD WIDE HAITI **Feb 2006 – present**

Urban Health Project Manager

COMPUTER PROFICIENCY

- Proficient with Mcrosoft Word, Windows, Excel
- Some experience with EPI Info and ACCESS

LANGUAGES

- **TRILINGUAL WRITTEN AND ORAL FRENCH, ENGLISH & KREYOL**

E-4 WORKPLAN FOR GENESIS YEAR ONE

(extracted from contract)

Purpose: The role of the Consultants is to lead high quality, objective, process documentation of the effects and processes of the urban health project in five underserved communities of Port-au-Prince.

Tasks: The tasks to be undertaken by the Consultants:

1. Develop toolkit for process monitoring at neighborhood level of organization capacity, client satisfaction, mother's awareness and attitudes, and overall strength of coordination of health promotion activities

2. Field-test quarterly assessment tools in three project neighborhoods

3. Conduct focus group discussions in all five neighborhoods to assess similarities with DHS IV and the 2003 national youth study findings regarding sexual practices and pregnancy.

4. Co-facilitate quarterly research and action for urban health platform and develop learning agenda

5. Refine health facility capacity assessment tool and facilitate 5 participatory health facility capacity assessments

c) Outputs: The Outputs expected from the Consultants over the term of the agreement:

1. Toolkit for process assessment at neighborhood level

2. Report on community baseline assessment from three neighborhoods

3. Focus Group Discussion Report with expert conclusion on generalizability of DHS and Youth Study Findings to local area.

4. Updated health facility self-assessment guide

5. Baseline capacity assessment report from 5 health facilities

6. Learning agenda for urban health platform for the initial two-years

Accountability and Support: The Consultants will report to Michelle Kouletio, the Child Survival & Health Advisor based in New York for approval of quarterly workplan and assessment tools as stipulated in the workplan. Day to day support and

communications will be directed to Dr. Andre-Paul Venor, Health Coordinator of Concern Worldwide Haiti, based in Petion-Ville.

2. **Duration and Location:** This consultancy is for the period of one year from May 15, 2006 through April 31, 2007 for a maximum value of $XXX The Consultants are responsible for ensuring that they have adequate numbers of staff with the appropriate experience to successfully complete the tasks outlined herein. An inability to access staff which results in a prolonged delay in completion of a deliverable constitutes immediate grounds to end this agreement, without further payment to the Consultant, including any unbilled hours already worked.

Based upon highly satisfactory performance and actual need, this contract may be renewable on an annual basis at the discretion of the Contractor. Such an amendment must be made in writing and signed by both parties prior to the expiration of this agreement.

ANNEX WORKPLAN May 15, 2006 – April 31, 2007

	Time Period	**Person Days**			**Deliverable**	**Deadline**
		Principal Investigator	**Sr consultants / assoc experts**	**Statistician**		
Deliverable 1: ToolKit for Community Assessment						
1. Draft tools based on summary methodology and core process indicators	May-June 2006	2	3	1	Draft tools and methodology outline	June 15, 2006
2. Refine tools with partners	Jul-06	3	1	0	Finalized tools	July 30, 2006
Deliverable 2: Community Assessment Baseline in 4 Neighborhoods						
Field Test –- Neighborhood 1	Sept 2006	4	2	1	Report	30-Sep-06
Field Test –Neighborhood 2	Dec 2006	4	2	1	Report	31-Dec-06
Field Test – Neighborhod 3	Mar 2007	4	2	1	Report	30-Mar-07
Deliverable 3: Informed Conclusion regarding youth sexuality practices						
Conduct 9 FGDS to assess similarities with Emmus IV and youth study findings (men 15-19 and ladies 15-19 in 4 neighborhoods)	June-August 2006	2	14	0	7-10 page report on Methodology, findings, and conclusions	August 31, 2006

	Time Period	Person Days			Deliverable	Deadline
		Principal Investigator	Sr consultants / assoc experts	Statistician		
Delvierable 4: Health Facility Assessment Toolkit and Baseline Report						
planning/tool revision	July-Sept 2006	4	1		Assessment Guide	August 31, 2006
orientation to HF teams (5 x 1 day)	Oct-Dec 2006	5.5	1		Calendar and actors	November 10, 2006
facilitate analysis – 5 HFs x 1.5 days	Oct-Dec 2006	4	4		5 HF findings & action plans	December 15, 2006
Finalize synthesis report	Jan-March 2006	2			1 synthesis report with overall indicators and targets	January 31, 2007
Deliverable 5: Establish learning agenda and structure of urban health platform						
Participation in planning/follow-up	July 2006-June 2007	3			Key issues, session plans	Meeting schedule: July, October, Jan, April
Co-facilitation of Meeting	July 2006-April 2007	3			Minutes from meetings; learning agenda	Meeting schedule: July, October, Jan, April

ANNEX F: NATIONAL PROTOCOLS IMCI

ANNEX G: BASELINE STUDIES

G-1 KPC Report
G-2 Rapid Health Facility Assessment
G-3 Interview Guide for CBOs

ANNEX G-1: KPC REPORT

USAID Child Survival & Health Grants Program
GHS-A-00-05-0018-00
October 2005 – September 2010

The Urban Health Project for Five Disadvantaged Neighborhoods of Metropolitan area of Port-au-Prince

A Partnership of Concern Worldwide, FOCAS, and GRET with the Ministry West Department

Project Period: October 1, 2005 - September 30, 2010

Revised June 26, 2006

Prepared by: Karunesh Tuli

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

The author would like to thank the following individuals for there excellent work serving as survey team members for the duration of this assessment.

- Bazinette Denise, FOCAS
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- Emile Pierre Faucher, GRET
- Charles Marie Chantale, GRET
- Pierre Louis Louis Marjory, KDSM
- Alexandre Jean Julmé, Concern
- Jerome Reynold, Concern
- Remy Gabrielle, Concern
- Debrosse Marie Guerda, Concern

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- Eugène Emmanuel Narlhem
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- Mackenson Sylvestre
- James Junior Alexandre
- Jean Claude Balthazar
- Jean Addony Thezalus

Finally he would like to express his sincere gratitude to all the health personnel and CBO members from each of the neighbourhoods for their excellent support in community mobilization and assistance with the surveys.

1 BACKGROUND

A. Description of Project Area

The project area comprises five urban slum areas of Port-au-Prince, in Haiti, with a total population of 218,490. The number of total direct beneficiaries is estimated to be 85,169 (32,555 children under five years of age and 52,614 women of reproductive age). The beneficiaries live in slums characterized by unplanned urbanization. There is a severe lack of public services, including health services, resulting in unacceptable quality and access. Just over one-half of households are female headed. Only about half of the Port-au-Prince population has access to improved sanitation facilities, such as latrines, and only 40% have access to potable water. Table 1 summarizes population estimates for the five slums.

Table 1: Estimated project population

	Project Area	*Partner*	*Commune*	*Total Population*
1	Senmaten	Concern	Delmas	75,000
2	Site Okay/Jeremie	Concern	Delmas	25,000
3	Dekayet	GRET	Port-au-Prince	50,000
4	Jalouzi	FOCAS	Petion-Ville	54,758
5	Bwa Mokèt	FOCAS	Petion-Ville	13,732
			Total	***218,490***

Source: Project proposal, 2004; Population of Dekayet – GRET estimate 2006.

B. Health Status of the Project Population

The health situation in Haiti is appalling. At 523 deaths/100,000 live births, the maternal mortality rate is the worst in the western hemisphere. Major causes of maternal death are obstetric complications during home delivery resulting from poor or no professional care. HIV/AIDS is a growing cause of women's illness and death during their reproductive life. National child mortality rates in Haiti are the worst in the western hemisphere. National infant mortality is estimated to be 80.3 deaths/1,000 live births, and under-five mortality is 118.6/1,000. One-quarter of all under-five deaths occur among neonates during the first month of life. Infections, traumatic delivery, and respiratory distress are the primary causes of newborn deaths, while major causes of mortality for under-five children are acute respiratory infections, diarrhea, and nutrition. HIV/AIDS is quickly eroding gains made in maternal and child health with an estimated adult seroprevalence of 3.5%.

FOCAS and its non-governmental organization partners conducted a maternal and neonatal health care assessment in Petion-Ville Commune from February – March 2002, and found the following serious problems: trained matrones (traditional birth attendants) demonstrated basic deficiencies in quality of care, especially in recognizing and seeking care for life-threatening obstetrical complications during labor and delivery; many women delayed seeking emergency obstetrical care because they did not have the money to pay for transportation or for the hospital care; many women believed they would receive poor quality care if they did go to the hospital; and community members and community-based organizations were not involved formally in the prevention of, and in the response to, obstetrical and neonatal emergencies.

Separately, Concern conducted an immunization coverage survey in Senmaten during July 2002, and found that only 14% of children were completely vaccinated, although 40% had completed their vaccinations schedules for polio and DPT. BCG and measles coverage rates were 84% and 64%, respectively. Less than 50% of pregnant women in Senmaten had two TT injections prior to delivery. Concern found both institutional barriers (high number of clinic visits required to complete all vaccinations, many missed opportunities, periodic stock-outs, and limited hours of

service) and client barriers (lack of women's time to bring a child for services, and lack of knowledge among parents regarding the importance of vaccinations in general, and the vaccination schedule in particular).

Also, a 2001 nutritional study conducted by Concern in Senmaten indicated a daily struggle among families to secure food. Parents generally demonstrated knowledge regarding ideal foods, but their consumption depended upon daily income. Among other important results, the study found that most mothers did not exclusively breastfeed for six months, and the introduction of liquid and solid foods commonly occurred by the third month.

C. Socioeconomic Characteristics of the Population

Haiti's current population is just under 8 million. Forty percent of the population is 15 years old or younger, and the annual growth rate is calculated to be 2.08%. Given its relatively small land mass, Haiti has one of the highest population densities in all of Latin America. The national fertility rate is calculated to be 4.8%, while the average life expectancy is 53 years. An additional 2 million people are believed to be living outside the country. Seventy percent of the population lives in absolute poverty, with a per capita annual GNP of $507.

Half the national population is reportedly literate, with males (52%) slightly better educated than women (47.8%). The net primary school enrollment (i.e., the proportion of the total eligible population actually attending school) is 68%, and girls have 0.5 to 2.0 fewer years of schooling than do boys. Fourteen percent of mothers with children less than five years of age have no schooling, and only 18% have completed secondary school or higher.

The Port-au-Prince metropolitan area is home to one out of every four Haitians, or about 2 million people, with an average household size of 4.72. The metro area population growth rate is 5% per year, including significant rural in-migration. Two-thirds of a representative sample of the population of Port-au-Prince earns less than $25 US per month, making it one of the poorest cities in the world. Residents of these neighborhoods are employed, if at all, in the informal sector of petty trade and hawking. There is significant migration within and across the slums due to violence, economic hardships, and natural disasters. The majority of households are female headed in the metropolitan area (51%), with fewer (38%) in the rural areas.

Most of the very poor live in marginal neighborhoods or slums characterized by unplanned urbanization. There is a severe lack of public services, and little regulation of schools or health services, resulting in unacceptable quality and access across sectors. The state of housing, overpopulation, and hygiene is at its worst in the poorest of the poor neighborhoods which are situated along the coast, water ways through the city, or on hilltops. These also are the neighborhoods that are most vulnerable to natural disasters, such as floods and landslides.

Only about half of the urban population has access to improved sanitation facilities, such as latrines. There are no urban sewage systems in the country. Forty-nine percent of the country's urban population has access to potable water, 40% in Port-au-Prince. FOCAS recently conducted a water quality study in Petion-Ville that found 97% of all tested drinking water sources were fecally contaminated. Families spent about 10% of their income to purchase about 12 liters of water per day.

The majority of homes in the slum areas can be accessed only by means of small 'corridors,' which crisscross the neighborhoods. These corridors serve not only as a means of access but also as living spaces where people wash, cook, eat, and where children play. A majority of corridors are unpaved and form a muddy, dirty environment where rubbish and sewage collect next to homes, creating serious health risks to children. There are no garbage removal services.

Poverty, unemployment and drugs fuel gangs of armed youth. The police largely are absent in Port-au-Prince slums, and the justice system is non-functional, creating a climate of insecurity and fear. In some neighborhoods, wars between gangs based on territorial control or political conflicts have paralyzed activities for weeks and forced families to flee for their lives.

D. Project Goal and Objectives

The goal of the project is to lower maternal and childhood mortality through improved health service provision and usage within five slum areas of Port-au-Prince, reaching about 10 percent of the city's population. Specific objectives include:

- Increase the proportion of women who had four antenatal care visits during their last pregnancy
- Increase the proportion of women whose last birth was attended by a trained provider
- Increase the proportion of unmarried youth 15-24 years who report abstaining from sex for 12 months
- Increase the proportion of men and women aged 15-49 years who have been tested for HIV and know their status
- Increase the proportion of households with children in which drinking water is purified
- Increase the proportion of children less than two years with diarrhea who receive ORS and zinc
- Increase the proportion of children 12–84 months who received Vitamin A supplement within the past 4 months
- Increase the proportion of children under two years of age with symptoms of pneumonia seen by trained provider
- Increase the proportion of children 12-23 months of age fully vaccinated by their first birthday

E. Project Strategy and Interventions

The project will:

- Strengthen the quality and range of government and non-profit health clinic services
- Build family and community capacity to prevent unnecessary illness and death
- Increase the capacities of key Ministry of Health structures and of partners to implement, integrated, community-based health projects in urban settings

The anticipated level of effort for this project is as follows: maternal and newborn care (25%); HIV/AIDS prevention (20%), control of diarrheal disease (20%); pneumonia case management (20%); and immunization (15%).

F. Objectives of the Survey

The objectives of the survey were:

- To obtain population-based information on key knowledge, practices and coverage from mothers of children age 0-23 months.
- To prioritize interventions and refine targets for the project.

II. METHODS

A. Questionnaires

Two survey questionnaires were designed, the first for mothers with children 0-11 months of age and the second for those with children 12-23 months. Two modules were included in both questionnaires (demographic information and management of childhood illness). The questionnaire for mothers with children 0-11 month also included modules on maternal and newborn care and nutrition. The one for mothers with children 12-23 months contained modules on water and sanitation, HIV/AIDS and other sexually transmitted infections, childhood immunization, and sources of health information.

The questionnaires were initially prepared in French and then translated into Kreyol by the project team. See Annexure for a copy of the questionnaires.

B. Sampling Design

The survey utilized simple random sampling within each of two survey sites (Bwa Mokèt and Jalouzi comprised one site and Site Okay/Jeremie the second). The sampling method was similar to that used in the lot quality technique. However, the purpose of the sampling was not to determine if lots were "adequate" or not in terms of health knowledge, practices, and coverage but to estimate aggregated values for health indicators for each site. However, methods applied during the survey can form the basis for future monitoring efforts based on the lot quality technique.

In both survey sites, survey teams delineated five supervision zones which were more or less comparable in terms of population size and can be useful for future planning, assigning supervisory responsibilities, and monitoring. Streets, corridors, and prominent buildings were all used in identifying boundaries of the zones.

Within each zone, maps were prepared for nineteen randomly identified sub-divisions. One household was randomly identified in each sub-division for the survey team to visit on the interview date for that area.

C. Training of Supervisors and Interviewers

Training of supervisors and interviewers was carried out by the survey Core Team (comprised of representatives of Concern, FOCAS, and GRET). Supervisors were also drawn from the three organizations. HaitiMed, an organization that provides health care services in Site Okay/Jeremie, also contributed a supervisor. Similarly, Concern, FOCAS, and GRET identified staff from community-based organizations to conduct interviews.

Supervisors joined the Core Team on the first day of training. This was followed by three days of training for both supervisors and interviewers, of which one was used for practice interviews in St. Claire, a community that is not part of the Child Survival project.

D. Data Collection

The survey was conducted over a two-week period from March 6 – 17, 2006. There were eight teams with two interviewers and one supervisor in each team. The supervisor of each team was responsible for randomly selecting the starting household and helping the interviewers in randomly identifying a household for interview if the first household did not have any eligible mothers. Supervisors also observed at least one complete interview each day.

In order to obtain consent and assure respondents of confidentiality, interviewers read out a consent form to the mother before starting the interview. Interviews took between 20 and 45 minutes to complete.

E. Data Analysis

Data were entered into a computer database using EpiInfo. The same software package was used for data analysis. The Household Dietary Diversity Survey (HDDS) was applied as a proxy for social-economic status. Mothers were asked about the types of food family members ate the previous day. Interviewers mentioned twelve types (such as bread, vegetables, fruit, and eggs) and noted for each whether the mother reported the food as having been consumed. Results were categorized into quintiles and key coverage and practice indicators stratified by HDDS quintile to assess equity of health status at baseline.

III. RESULTS

Table 2: Baseline Survey Results: Child Survival Project Indicator Values

Indicator	Num	Den	%	LCL (%)	UCL (%)
Proportion of mothers of children age 0–11 months who had four antenatal care visits during their last pregnancy	115	225	51	44	57
Proportion of mothers of children age 0–11 months whose last delivery was attended by a traditional birth attendant	104	225	46	40	53
Proportion of mothers of children age 0–11 months who have been tested for HIV and know their serological status	77	225	34	28	41
Proportion of mothers of children age 12–23 months who demonstrate an accepting attitude toward people living with HIV/AIDS	14	149	9	5	15
Proportion of mothers of children age 12–23 months who purify drinking water	48	149	32	25	40
Proportion of children less than two years old with diarrhea in the past two weeks who received oral rehydration solution	92	185	50	42	57
Proportion of children less than two years old with diarrhea in the past two weeks who received oral rehydration solution and zinc	4	185	2	1	5

Indicator	Num	Den	%	LCL (%)	UCL (%)
Proportion of children 6-11 months who have received a Vitamin A supplement within the last 6 months	60	117	51	42	61
Proportion of children 12-23 months who have received a Vitamin A supplement within the last 4 months	101	149	68	60	75
Proportion of children under 2 yrs of age with symptoms of pneumonia in the past two weeks who were seen by trained medical personnel	51	77	66	54	77
Proportion of mothers with a child 0-23 months who increased fluids and maintained feeding during pneumonia in the past two weeks	8	77	10	5	19
Proportion of mothers with a child 12-23 months who know at least three symptoms of pneumonia	1	149	1	0	4
Proportion of children age 12–23 months who have received the DPT1 vaccine	86	101	85	77	91
Proportion of children age 12–23 months who have received the DPT1 vaccine but not DPT3 vaccine (Drop Out Rate)	15	86	17	9	26
Proportion of mothers of children age 0–11 months who received at least 90 days of iron and folate in last pregnancy	9	225	4	2	8
Proportion of mothers and newborns who received care in the first week of life by a skilled healthcare provider	36	225	16	12	22

Note: (1) Num = Numerator, Den = Denominator, % = Percent, LCL = Lower confidence limit, UCL = Upper confidence limit (2) All values have been rounded. (3) Percent values were calculated using actual values of numerators and denominators, which because of weighting often contained fractional parts. If percent values are computed using the rounded numerators and denominators displayed here, they may not match values in the table exactly.

Table 3: Baseline Survey Results: Rapid CATCH Findings

Indicator	Num	Den	%	LCL (%)	UCL (%)
Proportion of children age 0–23 months who were born at least 24 months after the previous surviving child	74	107	69	59	78
Proportion of children age 0–11 months whose births were attended by skilled health personnel	98	225	44	37	50
Proportion of mothers with children age 0–11 months who received at least two tetanus toxoid injections before the birth of their youngest child	43	225	19	14	25
Proportion of children age 0–5 months who were exclusively breastfed during the last 24 hours	31	108	28	20	38
Proportion of children age 6–9 months who received	38	74	52	40	64

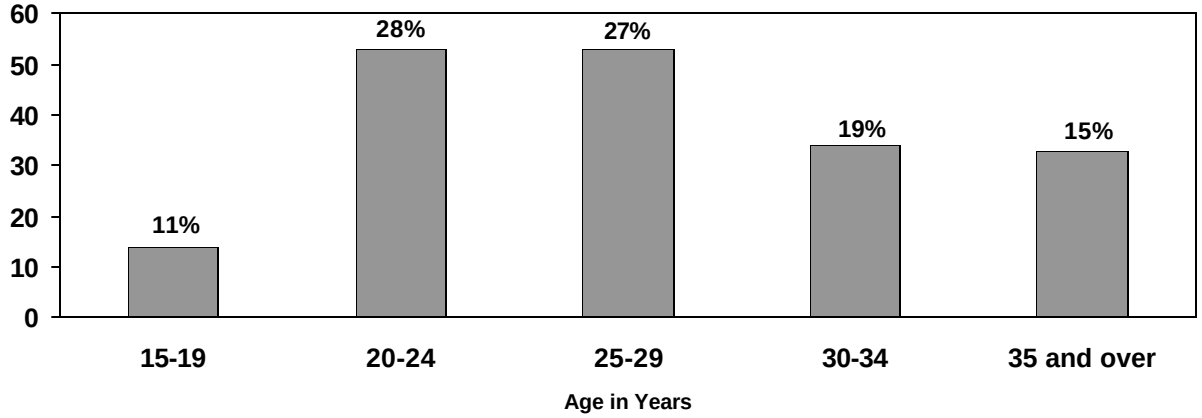
Indicator	Num	Den	%	LCL (%)	UCL (%)
breastmilk and complementary foods during the last 24 hours					
Proportion of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	51	101	51	40	61
Proportion of children age 12–23 months who received a measles vaccine	62	101	61	51	71
Proportion of children age 12–23 months who slept under an insecticide-treated net the previous night	4	149	3	1	7
Mothers with children age 12–23 months who cite at least two known ways of reducing the risk of HIV infection	133	149	89	82	93
Proportion of mothers with children age 12–23 months who report that they wash their hands with soap before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	4	149	3	1	7
Proportion of mothers of children age 12–23 months who know at least two signs of childhood illness that indicate the need for treatment	47	149	32	24	40
Proportion of children age 0–23 months who received increased fluids and maintained feeding during an illness in the past two weeks	38	297	13	9	17

Note: (1) Num = Numerator, Den = Denominator, % = Percent, LCL = Lower confidence limit, UCL = Upper confidence limit (2) All values have been rounded. (3) Percent values were calculated using actual values of numerators and denominators, which because of weighting often contained fractional parts. If percent values are computed using the rounded numerators and denominators displayed here, they may not match values in the table exactly.

A. Demographic Information

In the Port-au-Prince Child Survival Project target area, the mean age reported by mothers who were interviewed was 27 years. Graph 1 below shows the age distribution of mothers.

Graph 1: Age Distribution of Mothers



Among the children in the survey, 60% were under the age of one year (11 months of age or younger) and 40% of the children were 12-23 months of age. The mean age of children in the survey was 10 months. Of the 374 children, 54% were male and 46% were female. The age and sex distribution of children is presented in Table 4.

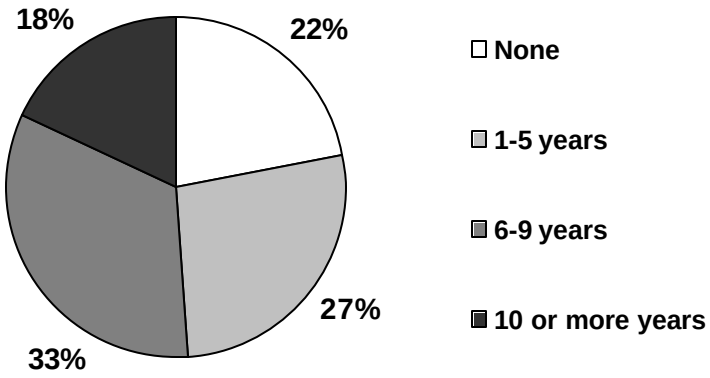
Table 4: Age and sex of children

AGE	MALE	FEMALE	TOTAL
0-5 months	55	53	108
6-11 months	67	50	117
12-23 months	80	69	149
Total	202	172	374

Most mothers (87%) said they did not work outside the home. Of those who reported working outside the home, 67% said they were shopkeepers or street vendors. Husbands, partners, grandmothers, and other relatives cared for the children while mothers were away at work. Graph 2 shows the educational attainment of mothers. Twenty-two percent had not attended school. Only 18% had attended school for 10 or more years. With nearly half the mothers

reporting only a primary education or none at all, health education messages need to be delivered through non-literate materials in project areas.

Graph 2: Years of School Attended by Mothers



B. HIV/AIDS and other Sexually Transmitted Infections

Knowledge

Mothers with children 12-23 months of age (149) were asked if they had heard of AIDS. All but one answered in the affirmative. They were also asked about ways of reducing the risk of getting infected with HIV (having just one sex partner who is not infected and who has no other partners, using a condom, and abstaining from sexual intercourse). Ninety-six percent of mothers recognized at least one way; seventy percent recognized three. Mothers with children age 0-11 months were asked about ways of transmission of HIV from a mother to the child. Sixty-nine percent recognized at least two ways; 46% recognized three (see Table 5).

Table 5: Mothers' recognition of ways HIV/AIDS can be transmitted from mother to child

NUMBER OF WAYS HIV/AIDS CAN BE TRANSMITTED FROM MOTHER TO CHILD	NO. (%) OF MOTHERS
0	30 (13%)
1	40 (18%)
2	52 (23%)
3	103 (46%)1
Total	225

Mothers with children 12-23 months were also asked whether they had heard about other infections transmitted through sexual contact, apart from HIV. Seventy-three percent reported that they had heard about other infections. Forty-nine percent of the mothers who had heard about other infections knew three or more signs and symptoms of such sexually transmitted infections.

Attitudes

[1] Throughout the report, percentages in tables may not add up to 100% due to rounding.

In addition to assessing knowledge, survey interviewers asked questions to ascertain attitudes of mothers with children 12-23 months towards people living with HIV/AIDS. Sixteen percent said they would buy food from a vendor known to be HIV-positive. If a relative of the mother became infected with HIV, 69% said they would not want it to remain a secret. Forty-eight percent reported they would be willing to care for a relative if he or she became sick with the AIDS virus.

C. Diarrheal Disease Management and Prevention

Knowledge

Mothers with children 12-23 months of age (149) were asked to describe how they would prepare oral rehydration solution if needed. Sixty-eight provided a correct description (46%).

Practice

One hundred eighty-five mothers with children less than 24 months of age (50%) reported that their child had experienced an episode of diarrhea in the two weeks prior to the survey. Ninety-two said they gave oral rehydration solution to the child (50%).

Table 6 presents information on the breastfeeding practices of mothers during the child's diarrheal episode. Of the 150 mothers who were breastfeeding the child before the episode, 121 breastfed the same or more than usual during the episode (81%).

Table 6: Breastfeeding practices of mothers for children with diarrhea

BREASTFEEDING DURING DIARRHEA EPISODE	**No. (%) OF MOTHERS**
Less than usual	27 (15%)
Same as before diarrheal episode	50 (28%)
More than usual	71 (39%)
Child not breastfed (before and during diarrheal episode)	32 (18%)
Mother did not know	1 (1%)
Total	182

Table 7 summarizes the feeding practices of mothers during the child's diarrheal episode. Of the 139 mothers who were giving foods other than breast milk to the child before the episode, 48 gave the same or more amount of food during the episode (35%).

Table 7: Food given to children with diarrhea

FEEDING DURING DIARRHEA EPISODE	**No. (%) OF MOTHERS**
Less than usual	90 (49%)
Same as before diarrheal episode	27 (15%)
More than usual	21 (11%)
No food (other than breast milk)	45 (24%)
Mother did not know	1 (1%)
Total	184

Table 8 describes the practice of mothers in giving fluids during the child's diarrheal episode. Of the 173 mothers who were giving fluids other than breast milk to the child before the episode, 64 gave more fluids during the episode (37%).

Table 8: Fluids given to children with diarrhea

FLUIDS DURING DIARRHEA EPISODE	**No. (%) OF MOTHERS**
Less than usual	63 (34%)
Same as before diarrheal episode	45 (25%)
More than usual	64 (35%)
No fluids (other than breast milk)	11 (6%)
Mother did not know	1 (1%)
Total	184

Interviewers also asked mothers of children 12-23 months (149) about drinking water and sanitation practices. Forty-eight mothers (32%) reported purifying their drinking water.

Table 9 presents information about 128 mothers who responded to a question about their hand washing practices. Sixty-five percent reported washing their hands with soap after defecation. Only four mothers said they washed their hands with soap at all four times (before preparing food, before feeding children, after defecation, and after attending to a child who has defecated).

Table 9: Mothers' hand washing practices*

WHEN RESPONDENTS WASH HANDS WITH SOAP	***NO. (%) OF MOTHERS***
Before preparing food	*47 (37%)*
Before feeding children	*40 (31%)*
After defecation	*87 (68%)*
After attending to a child who had defecated	*32 (25%)*

** The sum of numbers is greater than 128 and the sum of percentages exceeds 100% because multiple responses were allowed.*

D. Nutrition

Practice

All mothers (374) were asked about the types of food family members ate the previous day. Interviewers mentioned twelve types (such as bread, vegetables, fruit, and eggs) and noted for each whether the mother reported the food as having been consumed. Table 10 summarizes responses given by mothers.

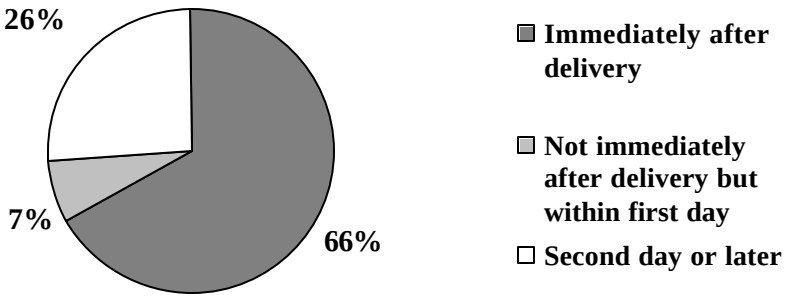
Table 10: Number of food types eaten by family members the previous day

NUMBER OF FOOD TYPES	No. (%) OF MOTHERS
Four or less	67 (18%)
Five to eight	239 (64%)
Nine or more	68 (18%)
Total	374

Mothers with children 0-11 months (222) were asked if they ever breastfed the child. Two hundred sixteen (97%) responded positively. As shown in graph 3, of the 214 mothers who

remembered when they first put the child to the breast, 66% said that they put their child to the breast immediately after delivery.

Graph 3: Initiation of Breastfeeding



One hundred seventy-seven (82%) mothers remembered giving colostrum to the child. Two hundred five were still breastfeeding the child at the time of the survey. Of 108 children 0-5 months of age, 31 were exclusively breastfed (28%). Of 74 children 6-9 months of age, 38 received breast milk and complementary foods (52%) during the last 24 hours.

One hundred sixty-one of 266 mothers of children 6-23 months of age reported that the child recently received a dose of vitamin A (61%). For children younger than 12 months, this meant a dose within the last six months, and for older children, within the last four months.

E. Pneumonia Case Management

Knowledge

As shown in Table 11, few mothers knew the symptoms of childhood pneumonia. Of 149 mothers of children 12-23 months, only one knew three or more symptoms.

Table 11: Mothers' knowledge of symptoms of childhood penumonia*

SYMPTOM	NO. (%) OF MOTHERS
Fast breathing	12 (8%)
Difficult breathing	*11 (7%)*
Fever	*4 (3%)*
Chest indrawing	*0 (0%)*

** Multiple responses were allowed.*

Practice

Seventy-seven mothers of children 0-23 months (21%) reported that their child had an illness with cough and rapid or difficult breathing in the two weeks prior to the survey. Sixty (78%) reported they sought advice or treatment for the illness. Fifty-one children (66%) were taken to a health facility for the illness.

Of 60 mothers who responded to a question about the day on which treatment was sought after noticing symptoms, fourteen (23%) said "same day" (see Table 12).

Table 12: Time taken to seek treatment for child with cough and rapid or difficult breathing

DAY ON WHICH TREATMENT SOUGHT AFTER NOTICING SYMPTOMS	NO. (%) OF MOTHERS/CAREGIVERS
Same day (day 0)	14 (23%)
Next day (day 1)	9 (15%)
Day 2	6 (10%)
Day 3 or later	31 (52%)
TOTAL	60 (100%)

Table 13 presents information on the breastfeeding practices of mothers during the child's illness. Of the 61 mothers who were breastfeeding the child before the illness, 47 breastfed the same or more than usual (77%) during the illness.

Table 13: Breastfeeding practices of mothers for children with cough and rapid or difficult breathing

BREASTFEEDING DURING ILLNESS WITH COUGH AND RAPID OR DIFFICULT BREATHING	No. (%) OF MOTHERS
Less than usual	14 (20%)
Same as before illness	16 (21%)
More than usual	31 (42%)
Child not breastfed (before and during illness)	13 (17%)
Total	74

Table 14 summarizes the feeding practices of mothers during the child's illness. Of the 56 mothers who were giving foods other than breast milk to the child before the illness, fourteen gave the same or more amount of food during the illness (25%).

Table 14: Food given to children with cough and rapid or difficult breathing

FEEDING DURING ILLNESS WITH COUGH AND RAPID OR DIFFICULT BREATHING	No. (%) OF MOTHERS
Less than usual	42 (56%)
Same as before illness	7 (10%)
More than usual	7 (9%)
No food (other than breast milk)	18 (25%)
Total	74

Table 15 describes the practice of mothers in giving fluids during the child’s illness. Of the 66 mothers who were giving fluids other than breast milk to the child before the illness, 19 gave more fluids during the illness (29%).

Table 15: Fluids given to children with cough and rapid or difficult breathing

FLUIDS DURING ILLNESS WITH COUGH AND RAPID OR DIFFICULT BREATHING	**No. (%) OF MOTHERS**
Less than usual	29 (38%)
Same as before illness	19 (25%)
More than usual	19 (26%)
No fluids (other than breast milk)	9 (11%)
Total	75

In all, eight of 77 children 0-23 months (10%) with cough and rapid or difficult breathing received more fluids and were fed as before.

F. Vaccine Coverage

Of the 149 children 12-23 months in the survey, interviewers were able to examine vaccine cards for 101 children (68%). Table 16 presents card-confirmed coverage with specific vaccines among the 101 children. If children are classified as vaccinated if they received the vaccines any time before the interview date, seventy children (70%) were found to be fully vaccinated against diphtheria, pertussis, tetanus, polio, and measles. Sixty-five children (65%) were fully vaccinated against these five diseases and tuberculosis.

If children are classified as vaccinated only if they received the vaccines by their first birthday, 51 were fully vaccinated (51%) against diphtheria, pertussis, tetanus, polio, and measles. Forty-two children (42%) were fully vaccinated against these five diseases and tuberculosis. The drop out rate between the first and third dose of the vaccine against diphtheria, pertussis, and tetanus was 17% (as 86 children received the first dose and 71 the third dose).

Table 16: Card-confirmed vaccine coverage for children 12-23 months of age

VACCINE	**VACCINES RECEIVED ANY TIME BEFORE INTERVIEW DATE**	**VACCINES RECEIVED BY FIRST BIRTHDAY**
	No. (%) OF CHILDREN	**No. (%) OF CHILDREN**
BCG	88 (88%)	77 (77%)
Polio 1	96 (95%)	90 (89%)
Polio 2	90 (90%)	78 (77%)
Polio 3	79 (78%)	66 (66%)
DPT 1	96 (96%)	86 (85%)
DPT 2	92 (92%)	83 (82%)
DPT 3	85 (84%)	71 (70%)
Measles	76 (76%)	62 (61%)
Fully vaccinated (against five diseases)	70 (70%)	51 (51%)
Fully vaccinated (against six diseases)	65 (65%)	42 (42%)

Measles vaccine coverage was 68% (101 of 149 children 12-23 months) if information from vaccine cards was supplemented with maternal recall.

1.1 G. Maternal and Newborn Care

Knowledge

Mothers of children 0-11 months (225) were asked about signs of danger after birth indicating the need for a woman to seek health care for herself. Of the 222 mothers who responded, ninety (40%) mentioned at least one of three danger signs (fever, excessive bleeding, or smelly vaginal discharge). Table 17 presents mothers' responses to the question.

Table 17: Mothers' knowledge of danger signs after birth indicating the need for a woman to seek health care for herself*

DANGER SIGN	NO. (%) OF MOTHERS
Fever	*48 (22%)*
Excessive bleeding	*25 (11%)*
Smelly vaginal discharge	*26 (12%)*

** Multiple responses were allowed.*

Mothers of children 0-11 months were also asked about danger signs among newborns indicating the need to seek immediate medical attention. Eighty-six mothers (38%) mentioned two or more signs. Table 18 lists the signs mentioned by mothers.

Table 18: Mothers' knowledge of danger signs among newborns indicating the need to seek immediate medical attention*

DANGER SIGN	NO. (%) OF MOTHERS
Fever	*135 (60%)*
Dehydration	*45 (20%)*
Vomiting	*31 (14%)*
Redness around the cord	*20 (9%)*
Convulsions	*18 (8%)*
Poor feeding	*16 (7%)*
Fast breathing	*15 (7%)*
Red or discharging eye	*3 (1%)*
Not active	*2 (1%)*
Jaundice or skin discoloration	*2 (1%)*

** Multiple responses were allowed.*

Coverage

1. Antenatal Care

Mothers of children 0-11 months (225) were asked if they sought antenatal care during their last pregnancy. Of the 222 mothers who responded, 192 did so in the affirmative (86%) and said they sought care from a doctor, nurse, or midwife. Table 19 presents information about provider of care for 192 mothers.

Table 19: Source of antenatal care during last pregnancy*

CARE PROVIDER	NO. (%) OF MOTHERS
Doctor	*150 (78%)*
Nurse/midwife	*39 (20%)*

Auxiliary midwife	*6 (3%)*
Community health worker	*4 (2%)*

** The sum of numbers is greater than 192 and the sum of percentages exceeds 100% because multiple responses were allowed.*

Of the 190 mothers who responded to a question about the number of antenatal visits, 115 (60%) mothers said they had at least four antenatal visits. Table 20 provides a summary of the number of visits.

Table 20: Number of antenatal visits during last pregnancy*

NUMBER OF ANTENTAL VISITS	**No. (%) OF MOTHERS**
One	18 (10%)
Two	21 (11%)
Three	35 (19%)
Four	21 (11%)
Five	16 (8%)
Six	14 (7%)
Seven	14 (7%)
Eight or more	50 (26%)

** One mother said "zero" in response to the question about the number of antenatal visits.*

Nine of 225 mothers said they received at least 90 days of iron and folate in their last pregnancy (4%).

2. Tetanus Toxoid Injections

Of 225 mothers of children 0-11 months 43 reported that they received at least two tetanus toxoid injections before the birth of their youngest child (19%).

3. HIV Testing

Mothers of children 0-11 months (225) were asked if they were tested for HIV during their antenatal visits. Seventy-seven said they were tested and know their serological status (34%).

a.i. 4. Delivery and Postpartum Care

Ninety-eight of 225 mothers of children 0-11 months (44%) reported that the birth of their youngest child was attended by skilled health personnel. One hundred and four said a traditional birth attendant assisted them during the delivery (46%). Thirty-six reported that they and their newborn child received care in the first week after delivery from a skilled health care provider (16%).

H. Management of Childhood Illness

Knowledge

Forty-seven of 149 mothers with children 12-23 months knew at least two signs of childhood illness that indicate the need for treatment (32%).

Practice

Of 374 children 0-23 months, 297 were reported to have been ill in the two weeks prior to the survey (79%). Thirty-eight of these children received increased fluids and maintained feeding during the illness (13%).

I. Sources of Health Information

Table 21 presents the sources of health messages reported by mothers of children 12-23 months (149). The most common sources were radio and television.

Table 21: Sources of health messages

SOURCE OF HEALTH MESSAGES	% OF MOTHERS/CAREGIVERS
Radio	77 (52%)
Television	48 (32%)
Community Health Worker	42 (28%)
Newspaper	30 (20%)
Member of basic organization (health educator)	27 (18%)

** The sum of numbers is greater than 149 and the sum of percentages exceeds 100% because multiple responses were allowed.*

ANNEXURES

BASED ON JALOUSIE/BOIS MOQUETTE & CITE OKAY ONLY

Annexure 1: Additional Results (Supplementary Data Analysis)

Table A1: Child survival project indicator values for household dietary diversity score groups

INDICATOR	Indicator value (%)		
	HDDS Group 1 (lowest score)	HDDS Group 2	HDDS Group 3 (highest score)
Proportion of mothers of children age 0–11 months who had four antenatal care visits during their last pregnancy	34	41	73
Proportion of mothers of children age 0–11 months whose last delivery was attended by a traditional birth attendant	48	40	51
Proportion of mothers of children age 0–11 months who have been tested for HIV and know their serological status	25	30	45
Proportion of mothers of children age 12–23 months who demonstrate an accepting attitude toward people living with HIV/AIDS	8	8	13
Proportion of mothers of children age 12–23 months who purify drinking water	30	25	43
Proportion of children less than two years old with diarrhea in the past two weeks who received oral rehydration solution	51	36	60
Proportion of children less than two years old with diarrhea in the past two weeks who received oral rehydration solution and zinc	3	0	3
Proportion of children 6-11 months who have received a Vitamin A supplement within the last 6 months	49	41	60
Proportion of children 12-23 months who have received a Vitamin A supplement within the last 4 months	72	60	73
Proportion of children under 2 yrs of age with symptoms of pneumonia in the past two weeks who were seen by trained medical personnel	71	63	66
Proportion of mothers with a child 0-23 months who increased fluids and maintained feeding during pneumonia in the past two weeks	15	0	17
Proportion of mothers with a child 12-23 months who know at least three symptoms of pneumonia	0	0	2
Proportion of children age 12–23 months who have received the DPT1 vaccine	80	89	85
Proportion of children age 12–23 months who have received the DPT1 vaccine but not DPT3 vaccine (Drop Out Rate)	22	13	16
Proportion of mothers of children age 0–11 months who received at least 90 days of iron and folate in last pregnancy	3	4	6
Proportion of mothers and newborns who received care in the first week of life by a skilled healthcare provider	13	13	21

Note: % = Percent, HDDS = Household dietary diversity score.

Table A2: Rapid CATCH findings for household dietary diversity score groups

INDICATOR	Indicator value (%)		
	HDDS Group 1 (lowest score)	HDDS Group 2	HDDS Group 3 (highest score)
Proportion of children age 0-23 months who were born at least 24 months after the previous surviving child	70	76	63
Proportion of children age 0-11 months whose births were attended by skilled health personnel	39	48	44
Proportion of mothers with children age 0-11 months who received at least two tetanus toxoid injections before the birth of their youngest child	9	22	25
Proportion of children age 0–5 months who were exclusively breastfed during the last 24 hours	20	29	36
Proportion of children age 6–9 months who received breastmilk and complementary foods during the last 24 hours	51	52	53
Proportion of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	39	56	55
Proportion of children age 12–23 months who received a measles vaccine	54	64	65
Proportion of children age 12–23 months who slept under an insecticide-treated net the previous night	1	4	4
Mothers with children age 12–23 months who cite at least two known ways of reducing the risk of HIV infection	92	88	87
Proportion of mothers with children age 12–23 months who report that they wash their hands with soap before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	3	3	3
Proportion of mothers of children age 12–23 months who know at least two signs of childhood illness that indicate the need for treatment	43	26	28
Proportion of children age 0–23 months who received increased fluids and maintained feeding during an illness in the past two weeks	17	7	15

Note: % = Percent, HDDS = Household dietary diversity score.

Table A3: Child Care Practices and Coverage by Child's Sex: Child Survival Project Indicator Values

INDICATOR	Female			Male		
	Num	Den	%	Num	Den	%
Proportion of children less than two years old with diarrhea in the past two weeks who received oral rehydration solution	24	44	57	18	44	41
Proportion of children less than two years old with diarrhea in the past two weeks who received oral rehydration solution and zinc	0	44	0	2	44	5
Proportion of children 6-11 months who have received a Vitamin A supplement within the last 6 months	10	20	50	18	31	58
Proportion of children 12-23 months who have received a Vitamin A supplement within the last 4 months	31	46	67	32	42	76
Proportion of children under 2 yrs of age with symptoms of pneumonia in the past two weeks who were seen by trained medical personnel	8	14	57	15	24	63
Proportion of mothers with a child 0-23 months who increased fluids and maintained feeding during pneumonia in the past two weeks	1	14	7	1	24	4
Proportion of children age 12–23 months who have received the DPT1 vaccine	29	35	83	25	30	83
Proportion of children age 12–23 months who have received the DPT1 vaccine but not DPT3 vaccine (Drop Out Rate)	5	29	17	1	25	4
Proportion of mothers and newborns who received care in the first week of life by a skilled healthcare provider	5	45	11	11	57	16

Note: Num = Numerator, Den = Denominator, % = Percent.

Table A4: Child Care Practices and Coverage by Child's Sex: Rapid CATCH Findings

INDICATOR	Female			Male		
	Num	Den	%	Num	Den	%
Proportion of children age 0–5 months who were exclusively breastfed during the last 24 hours	5	25	20	8	26	31
Proportion of children age 6–9 months who received breastmilk and complementary foods during the last 24 hours	6	13	46	12	22	55
Proportion of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	18	35	51	19	30	63
Proportion of children age 12–23 months who received a measles vaccine	22	35	63	23	30	77
Proportion of children age 12–23 months who slept under an insecticide-treated net the previous night	3	46	7	1	42	2
Proportion of children age 0–23 months who received increased fluids and maintained feeding during an illness in the past two weeks	7	71	10	8	80	10

Note: Num = Numerator, Den = Denominator, % = Percent.

Table A5: Selected child survival project indicator values and Rapid CATCH findings for young mothers (less than 25 years of age)

INDICATOR	Value		
	Num	Den	%
Proportion of mothers of children age 0–11 months who had four antenatal care visits during their last pregnancy	15	36	42
Proportion of children age 0-11 months whose births were attended by skilled health personnel	9	36	25
Proportion of children age 0–5 months who were exclusively breastfed during the last 24 hours	5	18	28

Note: Num = Numerator, Den = Denominator, % = Percent.

Annexure 2: Questionnaires in English

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CHILDREN 0 - 11 MONTHS

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CONCERN, FOCAS, AND GRET
WITH MINISTRY OF HEALTH, REPUBLIC OF HAITI
URBAN HEALTH, PORT-AU-PRINCE
RAPID KNOWLEDGE, PRACTICES, AND COVERAGE (KPC) SURVEY

VERSION 04 MARCH 2006

Project site ☐ Senmaten - 1, Site Okay - 2, Dekayet - 3, Jalouzi/Bwa Mokèt - 4

Supervision zone ☐

Sampling area number ☐☐☐

Household number ☐☐☐

Description of house _____

Record number ☐☐

Name of interviewer _____

Name of supervisor _____

Verified by _____.
Supervisor

Interview date ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Rescheduled ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Mother's name _____ _____
Name Surname

Mother's age ☐☐ years

Name of youngest child _____ _____
Name Surname

Gender Female ☐ Male ☐

Date of birth ☐☐ ☐☐ ☐☐☐☐ ASK FOR vaccination card or other card
Day Month Year

Age of child ☐☐ months

CONSENT FORM

Good morning/Good afternoon. My name is _____, and I am working with _____). We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help _____and the Ministry of Health to plan health services and assess whether they are meeting their goals to improve children's health. The survey usually takes **30** minutes. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask anything about the survey ?

Signature of interviewer: _____
Date: _____

RESPONDENT AGREES TO BE INTERV IEWED RESPONDENT DOES NOT AGREE TO BE INTERVIEWED

RESPONDENT BACKGROUND INFORMATION

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1.	How long have you lived in this area?	Years ☐☐ Month ☐☐	
2.	Who is the head of this household?	MOTHER (RESPONDENT).... 1 HUSBAND / PARTNER ..... 2 OTHER _____ 8 (SPECIFY)	
3	How many children living in this household are under five years of age?	☐ Children	If only one child →**7**
4.	What is the date of birth of your own child older than (NAME)?	☐☐ ☐☐ ☐☐☐☐ Day Month Year	
5.	Name?	Name_____ Surname_____	
6	Gender	Female ☐ Male ☐	
7	Have you attended school?	No……1 Yes……2	→**9**
8.	What was the highest grade you completed? CONVERT GRADE TO NUMBER OF YEARS.	☐☐ years	
9	Do you work? IF YES, What kind of work do you do? IF NO, CIRCLE « NO WORK ».	NO WORK.....1 HANDICRAFTS.....2 HARVESTING .....3 SELLING FOODS .....4 SHOP KEEPER/STREET VENDOR .....5 SERVANT/HOUSEHOLD WORKER.....6 SALARIED WORKER.....7 OTHER _____ 8 (SPECIFY)	→**11**
10	Who takes care of (NAME) when you are away?	Mother (RESPONDENT).....A HUSBAND/PARTNER ..... B GRANDMOTHER ..... C NEIGHBOR/FRIENDS…….E MAID/SERVANT .....F OTHER _____ x (SPECIFY)	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
11	Where do you usually prepare food?	Inside living area of home…… 1 Separate room in the house..... 2 Outside but near door of house.. 3 Outside, away from house.....4 Other _____ .....8 (SPECIFY)	
12	What is the primary cooking fuel used in the house?	Wood ..... 1 Charcoal ..... 2 Alcohol ……..3 Kerosene ..... 4 Electricity ..... 5 Gas ..... 6 Other _____ . 8 (SPECIFY)	
13	Do you usually have smoke in the house while cooking?	NO ……1 YES…….2 DON'T KNOW……...9	
14	Now I would like to ask you about the food that you and members of your family ate yesterday. READ ALL OF THE FOLLOWING CATEGORIES: a. Rice, bread, spaghetti, gruel, corn, corn flakes, biscuits? b. Potatoes, sweet potatoes, manioc? c. Vegetables? d. Fruit? e. Beaf, pork, or other meat? f. Eggs? g. Fish, crab (sea food) h. Nuts? i. Cheese, milk, or milk products? j. Food with oil, butter, or lard? k. Sugar or honey? l. Tea or coffee?	**NO** **YES** 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1	

PRENATAL CARE

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
15	Did you see anyone for prenatal care while you were pregnant with (NAME) ? IF YES: Whom did you see? PROBE FOR THE TYPE OF PERSON AND RECORD ALL PERSONS MENTIONED BY THE MOTHER.	**HEALTH PROFESSIONAL** DOCTOR .....A NURSE/MIDWIFE……B AUxILIARY/MIDWIFE ..... .C **OTHER PERSON** TRADITIONAL BIRTH ATTENDANT..... D COMMUNITY HEALTH AGENT .....E OTHER _____ x (SPECIFY) NO ONE Z	 →**24**
16	How many times did you see someone for care during the pregnancy?	NUMBER OF TIMES .....☐☐	
17	Do you have a maternal health card for your pregnancy with (NAME)? IF YES: Can I see the card?	YES, SEEN……1 NOT AVAILABLE .....2 NEVER HAD A CARD.. 3	 →**20** →**20**
18.	LOOK AT THE CARD AND RECORD THE NUMBER OF PRENATAL VISITS WHILE MOTHER WAS PREGNANT WITH (NAME).	NUMBER OF VISITS ☐☐	
19.	LOOK AT THE CARD AND RECORD THE DATES FOR EACH TT INJECTION LISTED ON THE CARD.	DAY MONTH YEAR First ☐☐ ☐☐ ☐☐☐☐ Second ☐☐ ☐☐ ☐☐☐☐ Third ☐☐ ☐☐ ☐☐☐☐ Fourth ☐☐ ☐☐ ☐☐☐☐	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
20	During any of the antenatal visits during your pregnancy with (NAME), did anyone talk to you about: READ ALL OF THE FOLLOWING: a) Babies getting the AIDS virus from their mothers? b) Things you can do to avoid getting the AIDS virus? c) Getting tested for the AIDS virus?	**No Yes Don't know** a) …… 1 2 9 b) ……. 1 2 9 c) …… 1 2 9	
21	I don't want to know the results, but were you tested for the AIDS virus as part of your antenatal care ?	NO ……1 YES ……..……2	→**24**
22	Where was the test done?	**NOTE THE PLACE HERE** _____ (SPECIFY THE PLACE)	
23	Remember, I don't want to know the results, but did you get the results of the test ?	NO ……1 YES ……2	
24	Before you gave birth to (NAME), did you receive an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth ?	NO .....1 YES .....2 DON'T KNOW..... 9	
25	When you were pregnant with (NAME), did you receive or buy any iron and folic acid tablets or syrup? SHOW SYRUP.	NO .....1 YES .....2 DON'T KNOW.....9	→**27** →**27**
26	How many days did you take the tablets or syrup? IF THE ANSWER IS IN WEEKS OR MONTHS, CALCULATE THE NUMBER OF DAYS.	NUMBER OF DAYS ☐☐☐ DON'T KNOW.....999	
27	What are the symptoms during pregnancy indicating the need to seek health care ? RECORD ALL MENTIONED.	FEVER .....…….A SHORTNESS OF BREATH ..... …. B VAGINAL BLEEDING…….. C HEADACHE …… D SWELLING OF THE BODY/HANDS/FACE…. E	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		OTHER_____ x (SPECIFY) DON'T KNOW..... …Z	→29
28	Which is the first place you would go for care if you had these symptoms?	Hospital …….. ……..1 Health center…… ……..2 Private clinic …… 3 Nurse …….. 4 Auxiliary nurse …….. 5 Trained traditional birth attendant…… 6 Untrained traditional birth attendant ……7 OTHER _____... ….....8 (SPECIFY) DON'T KNOW ……..9	

1.2

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
29.	When can the AIDS virus be transmitted from a mother to her baby? READ ALL OF THE FOLLOWING: a) During pregnancy? b) During delivery? c) Through breastfeeding?	**No Yes Don't know** a) During pregnancy . … . 1 2 9 b) During delivery ……. .1 2 9 c) Through breastfeeding … 1 2 9	
30	If a mother knows that she is HIV-positive, should she breastfeed her baby?	NO ……1 YES ……..……..2 DON'T KNOW …….…….9	
31	If a mother is unsure whether or not she is HIV-positive, should she breastfeed her baby?	NO ……1 YES ……..……..2 DON'T KNOW …….…….9	

1.3

DELIVERY AND POSTPARTUM CARE

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
32	Where did you deliver (NAME)?	**HOME**	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		YOUR HOME……..……..1 OTHER HOME ……...……..2 **HEALTH FACILITY** Hospital …….. ……3 Health Center …… ……..4 OTHER_____ 8 (SPECIFY)	**→34** If she delivered at a health facility go to Q. 34
33	Why do women give birth at home? RECORD ALL MENTIONED.	Hospitals are too expensive.....A No problem to deliver at home……B Not received well at hospital .....…. D Hospital too far.....…E Have to take care of children at home … .....F Lack of transportation .....G Hospital delivery may be caeserian.....H Lack of doctor/midwife at hospital .....I Poor quality of care at hospital….....J OTHER .....x (SPECIFY)	
34	Who assisted you with (NAME'S) delivery? RECORD ALL MENTIONED.	**HEALTH PROFESSIONAL** DOCTOR.....A NURSE/MIDWIFE .....B AUxILIARY/MIDWIFE .....C **OTHER PERSON** TRAINED TRADITIONAL BIRTH ATTENDANT ……D UNTRAINED TRADITIONAL BIRTH ATTENDANT ….. .. …E (Name_____) HEALTH AGENT.....…… …F FAMILY MEMBER_____.... …G (SPECIFY) 1.3.a.i.1.1 OTHER_____..... ……..x (SPECIFY) NO ONE……..Z	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
35.	Was a clean birth kit used?	NO .....1 YES ..... 2 DON'T KNOW..... 9	
36.	What instrument was used to cut the cord?	NEW RAZOR BLADE ..... 1 OTHER INSTRUMENT 2	
37	Who cut the cord?	**HEALTH PROFESSIONAL** DOCTOR..... 1 NURSE/MIDWIFE ..... 2 AUxILIARY/MIDWIFE ..... 3 **OTHER PERSON** TRAINED TRADITIONAL BIRTH ATTENDANT .....4 UNTRAINED TRADITIONAL BIRTH ATTENDANT ....5 (Name_____) HEALTH AGENT..... …6 FAMILY MEMBER_____.... ...7 (SPECIFY) 1.3.a.i.1.2 OTHER_____..... .....8 (SPECIFY) NO ONE.....9	
38.	What was put on the stump after cutting the cord?	OIL ..... 1 CLOTH ..... 2 DETERGENT/SOAP ..... 3 TALCUM POWDER ..... 4 ANTIBIOTIC/ANTISEPTIC ..... 5 ALCOHOL..... 6 NOTHING ..... 7 OTHER _____ ..... 8 (SPECIFY) DON'T KNOW 9	
39.	Was (NAME) weighed at birth?	YES.....1 NO ..... 2 DON'T KNOW.....9	
40.	After (NAME'S) birth, did anyone check on your health?	NO .....1 YES 2	→**46**
41	How many days after the delivery did the first check take place? RECORD <<00>> DAYS, IF SAME DAY.	DAYS AFTER DELIVERY WEEKS AFTER DELIVERY DON'T KNOW 99	
42	Who checked on your health at that	**HEALTH PROFESSIONAL**	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	time? PROBE FOR THE MOST QUALIFIED PERSON.	DOCTOR..... 1 NURSE/MIDWIFE ..... 2 AUxILIARY/MIDWIFE ..... 3 **OTHER PERSON** TRAINED TRADITIONAL BIRTH ATTENDANT ……4 UNTRAINED TRADITIONAL BIRTH ATTENDANT ….. .. …5 (Name_____) HEALTH AGENT.....…… …6 FAMILY MEMBER_____.... …7 (SPECIFY) 1.3.a.i.1.3 OTHER_____..... ……..8 (SPECIFY) NO ONE……..9	
43	What did they check?	Nothing ……..……...A Bleeding .....……B Fever..... …… C Vaginal discharge.....D Blood pressure.....E OTHER_____ .....x (SPECIFY)	
44	What did they do for (NAME)?	Nothing ……A Asked about breastfeeding..... …B Checked cord.....……C Gave vaccine...……E Checked breathing……F OTHER_____.....x (SPECIFY)	
45	During your postpartum check, were you counseled on the following? NOTE ADVICE GIVEN BY ANYBODY. READ ALL OF THE FOLLOWING: Child spacing Infant nutrition Childhood immunizations Diarrhea among children Danger signs of infant illness	**No Yes** Child spacing 1 2 Infant nutrition 1 2 Childhood immunizations 1 2 Diarrhea among children 1 2 Danger signs of infant illness 1 2	
46	In the first two months after delivery, did you receive a vitamin A dose like this ? SHOW VITAMIN A.	NO.....……1 YES.....2 DON'T KNOW ……9	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
47	What are the signs of danger after giving birth indicating the need for you to seek health care ? RECORD ALL MENTIONED.	FEVER ....A ExCESSIVE BLEEDING ..... B SMELLY VAGINAL DISCHARGE.....C OTHER_____.. x (SPECIFY) DON'T KNOW..... Z	
48	What are the signs to watch for that may indicate that a newborn baby is ill and needs to be taken to hospital without delay? RECORD ALL MENTIONED.	Poor appetite .....A Not breastfeeding .....B Fever .....C Vomiting .....D Convulsions .....E Fast breathing ..... F Not active ..... G Redness around the cord .....H Red/discharging eye ..... I Jaundice/skin discoloration .....J Dehydration .....K OTHER_____ x (SPECIFY) DON'T KNOW..... Z	

1.4

BREASTFEEDING AND CHILD NUTRITION

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
49	Did you ever breastfeed (NAME)?	NEVER .....1 YES 2	→55
50	How long after birth did you first put (NAME) to the breast ?	IMMEDIATELY/WITHIN FIRST HOUR .....1 AFTER FIRST HOUR BUT WITHIN FIRST DAY .....2 SECOND DAY OR LATER.....3 DON'T REMEMBER.....9	
51	Did you give (NAME) colostrum after birth? COLOSTRUM (FIRST MILK) IS THE LIQUID THAT COMES FROM BREASTS AFTER DELIVERY.	YES .....1 NO .....2 DON'T KNOW.....9	
52	Did you give (NAME) sugar and water or a liquid like LÒK after birth?	YES .....1 NO .....2 DON'T KNOW.....9	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
53	Are you currently breastfeeding (NAME)?	YES .....1 NO .....2 DON'T KNOW.....9	→55
54	For how long did you breastfeed (NAME)? IF LESS THAN ONE MONTH, RECORD « 00 ».	☐☐ MONTHS	
55	Did (NAME) drink anything from a bottle (or other object) with a nipple yesterday or last night?	NO .....1 YES ……..……2	
56	Now I would like to ask you about the types of liquids (NAME) drank yesterday during the day and night. Did (NAME) drink any of the following liquids yesterday during the day or night? READ THE LIST OF LIQUIDS. MOTHER'S MILK WITH WATER WATER SWEET WATER FRUIT JUICE MILK POWDER TEA/INFUSIONS HONEY BREASTMILK	MOTHER'S MILK WITH WATER ….A WATER ……B SWEET WATER..... ....C FRUIT JUICE…… D MILK POWDER……E TEA/INFUSIONS……..F HONEY ..... G BREASTMILK……H OTHER_____x (SPECIFY)	
56a	Are you giving (NAME) any solid, semi-solid, or soft foods other than liquids ?	NO .....1 YES……..……2	→57
56b	How many times did (NAME) eat solid, semi-solid, or soft foods other than liquids yesterday during the day and at night ?	NUMBER OF TIMES .....☐☐ DON'T KNOW.....9	
57	Did (NAME) receive a Vitamin A dose like this during the last six months?	NO .....1 YES 2	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	SHOW CAPSULE.	DON'T KNOW ……..9	

1.5

SICK CHILD

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
58	Did (NAME) experience any of the following in the past two weeks? READ ALL OF THE FOLLOWING: Diarrhea? Blood in stool? Cough? Difficult breathing? Fast breathing or short, quick breaths? Fever? Malaria? Convulsions?	DIARRHEA..... A BLOOD IN STOOL ..... B COUGH ..... C DIFFICULT BREATHING……...D FAST BREATHING/SHORT, QUICK BREATHS..... E FEVER……..F MALARIA ..... G CONVULSIONS ..... H OTHER_____.....x NONE ……Z	→ END
59	Did you seek advice or treatment for (NAME)?	NO ……..1 YES … ……..2	→ 65
60	How long after you noticed (NAME'S) symptoms did you seek treatment?	SAME DAY .....0 NExT DAY.....1 TWO DAYS.....2 THREE DAYS OR MORE…...3	
61	Where did you first go for advice or treatment?	**HEALTH FACILITY** Hospital …… …….. …… 01 Health center…… ……02 Private clinic ……03 Other hospital…….....04 Midwife.....05 **OTHER SOURCE (NON-FORMAL)** Traditional healer ……..06 Quack ……07 Houngan ……..08 Street vendor…….. ….....09 Shop ……10 Pharmacy ……...11 Community distributor ……..12 Friend/Relative……13 Other non-formal	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		_____.....88 (SPECIFY)	
62	Who decided that you should go there for (NAME'S) illness? RECORD ALL MENTIONED.	RESPONDENT HERSELF.....A HUSBAND/PARTNER.....B GRANDMOTHER ..... C RESPONDENT'S MOTHER-IN-LAW ... D FRIEND / NEIGHBOR .....E OTHER_____..... x (SPECIFY)	
63	Did you go anywhere else for advice or treatment for (NAME)?	NO.....1 YES.....2	→ 65
64	Where did you go next for advice or treatment?	**HEALTH FACILITY** Hospital …… …….. …… 01 Health center…… ……02 Private clinic ……03 Other hospital…….....04 Midwife.....05 **OTHER SOURCE (NON-FORMAL)** Traditional healer ……..06 Quack ……07 Houngan ……..08 Street vendor…… ….....09 Shop ……10 Pharmacy ……...11 Community distributor ……..12 Friend/Relative……13 Other non-formal _____.....88 (SPECIFY)	
65	During (NAME'S) illness, did you breastfeed him/her less than usual, about the same amount, or more than usual?	LESS.....1 SAME .....2 MORE .....3 CHILD NOT BREASTFED ….4 DON'T KNOW.....9	
66	During (NAME'S) illness, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	LESS.....1 SAME .....2 MORE .....3 NOTHING TO DRINK .....4 DON'T KNOW.....9	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
67	During (NAME'S) illness, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?	LESS.....1 SAME .....2 MORE .....3 NOTHING TO EAT .....4 DON'T KNOW.....9	
68	During the period when (NAME) was recovering from illness, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	LESS.....1 SAME .....2 MORE .....3 NOTHING TO DRINK .....4 DON'T KNOW.....9	
69	**REFER BACK TO QUESTION 58 AND LOOK AT THE MOTHER'S RESPONSES.**	**CHECK WHICH MODULES APPLY**	
	IF **A OR B:** ADMINISTER **DIARRHEA MODULE**	MODULE C (DIARRHEA)	→ **72**
	IF **C, D, OR E:** ADMINISTER **RESPIRATORY PROBLEM MODULE**	MODULE A (RESPIRATORY PROBLEM)	→ **70**
	IF **F, G, OR H:** ADMINISTER **MALARIA MODULE**	MODULE B (MALARIA)	→ **71**
MODULE A : TREATMENT FOR CHILD'S RESPIRATORY PROBLEM			
70	Which medicines were given to (NAME) for the respiratory problem? RECORD ALL MENTIONED. IF MOTHER IS UNABLE TO RECALL DRUG NAME(S), ASK HER TO SHOW THE DRUG(S) TO YOU.	NOTHING ..... A ASPIRIN.....B ACETAMINOPHEN .....C AMOxICILLIN.....D ERYTHROMYCIN.....E AMPICILLIN..... F COTRIMOxAZOLE ……G DON'T KNOW …… ……..Z OTHER _____ x (SPECIFY)	
MODULE B : TREATMENT FOR CHILD'S FEVER			
71	Which medicines were given to (NAME) for his/her fever? RECORD ALL MENTIONED. ASK MOTHER TO SHOW THE DRUG(S) TO YOU.	NOTHING……A ASPIRIN…… ……...B ACETAMINOPHEN ……..…..C COTRIMOxAZOLE… ……D CHLOROQUINE …… E QUININE.....F DON'T KNOW ……..Z OTHER _____ x (SPECIFY)	
MODULE C : DIARRHEA CASE MANAGEMENT			

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
72	What was given to (NAME) to treat the diarrhea? RECORD ALL MENTIONED. IF MOTHER IS UNABLE TO RECALL DRUG NAME(S), ASK HER TO SHOW THE DRUG(S) TO YOU.	NOTHING .....A ORAL REHYDRATION SOLUTION .....B HOME-MADE FLUID ..... C PILL OR SYRUP ..... D INJECTION .....E INTRAVENOUS (IV) FLUIDS .....F HOME REMEDY/TRADITIONAL REMEDY..... G DON'T KNOW..... Z OTHER_____ x (SPECIFY)	
73	Was (NAME) given zinc for the diarrhea?	NO .....1 YES .....2 IF YES, for how many days ? __ __	

END

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CHILDREN 12 – 23 MONTHS

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CONCERN, FOCAS, AND GRET
WITH MINISTRY OF HEALTH, REPUBLIC OF HAITI
URBAN HEALTH, PORT-AU-PRINCE
RAPID KNOWLEDGE, PRACTICES, AND COVERAGE (KPC) SURVEY

VERSION 04 MARCH 2006

Project site ☐ Senmaten - 1, Site Okay - 2, Dekayet - 3, Jalouzi/Bwa Mokèt - 4

Supervision zone ☐

Sampling area number ☐☐☐

Household number ☐☐☐

Description of house _____

Record number ☐☐

Name of interviewer _____

Name of supervisor _____

Verified by _____.
Supervisor

Interview date ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Rescheduled ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Mother's name _____ _____
Name Surname

Mother's age ☐☐ years

Name of youngest child _____ _____
Name Surname

Gender Female ☐ Male ☐

Date of birth ☐☐ Day ☐☐ Month ☐☐☐☐ Year ASK FOR vaccination card or other card

Age of child ☐☐ months

CONSENT FORM

Good morning/Good afternoon. My name is _____, and I am working with _____). We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help _____and the Ministry of Health to plan health services and assess whether they are meeting their goals to improve children's health. The survey usually takes **30** minutes. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask anything about the survey ?

Signature of interviewer: _____

Date: _____

RESPONDENT AGREES TO BE INTERVIEWED RESPONDENT DOES NOT AGREE TO BE INTERVIEWED

RESPONDENT BACKGROUND INFORMATION

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1.	How long have you lived in this area?	Years ☐☐ Months ☐☐	
2.	Who is the head of this household?	MOTHER (RESPONDENT)....1 HUSBAND / PARTNER .....2 OTHER _____ 8 (SPECIFY)	
3	How many children living in this household are under five years of age?	☐ Children	If only one child →**7**
4.	What is the date of birth of your own child older than (NAME)?	☐☐ ☐☐ ☐☐☐☐ Day Month Year	
5.	Name?	Name_____ Surname_____	
6	Gender	Female ☐ Male ☐	
7	Have you attended school?	No……..1 Yes.……..2	→**9**
8.	What was the highest grade you completed? CONVERT GRADE TO NUMBER OF YEARS.	☐☐ years	
9	Do you work? IF YES, What kind of work do you do? IF NO, CIRCLE « NO WORK ».	NO WORK ..... 1 HANDICRAFTS ..... 2 HARVESTING..... 3 SELLING FOODS ..... 4 SHOP KEEPER/STREET VENDOR .....5 SERVANT/HOUSEHOLD WORKER ..... 6 SALARIED WORKER..... 7 OTHER _____ 8 (SPECIFY)	→**11**
10	Who takes care of (NAME) when you are away?	Mother (RESPONDENT)..... A HUSBAND/PARTNER .....B GRANDMOTHER .....C NEIGHBOR/FRIENDS…….E MAID/SERVANT ..... F OTHER _____ x (SPECIFY)	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
11	Where do you usually prepare food?	Inside living area of home…… 1 Separate room in the house..... 2 Outside but near door of house.. 3 Outside, away from house.....4 Other_____ ..... 8 (SPECIFY)	
12	What is the primary cooking fuel used in the house?	Wood.....1 Charcoal.....2 Alcohol ……..3 Kerosene.....4 Electricity.....5 Gas.....6 Other _____ .8 (SPECIFY)	
13	Do you usually have smoke in the house while cooking?	NO ……1 YES……2 DON'T KNOW……...9	
14	Now I would like to ask you about the food that you and members of your family ate yesterday. READ ALL OF THE FOLLOWING CATEGORIES:	**NO** **YES**	
	a. Rice, bread, spaghetti, gruel, corn, corn flakes, biscuits?	0 1	
	b. Potatoes, sweet potatoes, manioc?	0 1	
	c. Vegetables?	0 1	
	d. Fruit?	0 1	
	e. Beaf, pork, or other meat?	0 1	
	f. Eggs?	0 1	
	g. Fish, crab (sea food)	0 1	
	h. Nuts?	0 1	
	i. Cheese, milk, or milk products?	0 1	
	j. Food with oil, butter, or lard?	0 1	
	k. Sugar or honey?	0 1	
	l. Tea or coffee?	0 1	

WATER AND SANITATION

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
74	I would like to ask you some questions about water supply and toilet facilities. What is the main source of drinking water for members of your household?	FREE PUBLIC WATER SUPPLY.....1 PAID WATER SUPPLY.....2 WATER SUPPLY IN HOUSE.....3 CISTERN .....4 RIVER .....5 SPRING .....6 WELL .....7 RAIN WATER .....8 LÒT _____x (SPECIFY)	
75	Do you treat your water in any way to make it safer for drinking?	NO .....1 YES 2	→**78**
76	What do you usually do to the water to make it safer to drink? CIRCLE MORE THAN ONE RESPONSE ONLY IF SEVERAL METHODS ARE USUALLY USED TOGETHER.	SEDIMENTATION .....A STRAIN WATER THROUGH CLOTH...B BOIL WATER .....C ADD BLEACH OR CHLORINE.....D FILTER.....E SOLAR DISINFECTION .....F OTHER _____x (SPECIFY) DON'T KNOW.....Z	→**78**
77	When did you treat your water the last time using this method?	TODAY.....1 YESTERDAY.....2 OVER ONE DAY AGO BUT LESS THAN ONE WEEK.....3 ONE WEEK AGO OR MORE BUT LESS THAN A MONTH.....4 ONE MONTH AGO OR MORE.....5 DON'T REMEMBER.....9	
78	What kind of toilet is used by the household? IF MOTHER SAYS "PUBLIC LATRINE", ASK ABOUT THE TYPE, CIRCLE 2 FOR QUESTION 79 AND GO TO QUESTION 80.	NO TOILET/NATURE.....1 FLUSH LATRINE.....2 OTHER LATRINE.....3 PIT.....4 VENTILATED PIT..... 5 OTHER_____.....8 (SPECIFY)	→**80**
79	Do you share this toilet with other households ?	NO .....1 YES.....2	
80	What do you do with the stools of babies or young children who can't go by themselves?	THROWN IN LATRINE..... .....1 BURIED IN THE YARD .....2 NOT DISPOSED/LEFT ON GROUND ....3 OTHER_____.....8 (SPECIFY)	
81	What do you do with your garbage?	THROWN IN OPEN PIT.....1 PUT IN CLOSED PIT .....2 PUT ANYWHERE .....3 BURNED.....4 GARBAGE COLLECTION SERVICE 5	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		OTHER _____ 8 (SPECIFY)	

CHILD IMMUNIZATION

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
82	Do you have a card where (NAME'S) vaccinations are written down? IF YES, May I see it?	YES, SEEN BY INTERVIEWER ….. 1 NOT AVAILABLE/LOST/MISPLACED… 2 NEVER HAD A CARD…… 3 NEVER HAD VACCINE..... 4 DON'T KNOW.....9	 →**86** →**86** →**88** →**86**
83	WRITE DOWN THE VACCINATION DATE FOR EACH VACCINE FROM THE CARD.	WRITE «11/11/1111» IF THE CARD SHOWS THAT A VACCINATION WAS GIVEN BUT NO DATE IS RECORDED **DAY MONTH YEAR**	
	a. BCG	BCG....	
	b. POLIO 0 (POLIO GIVEN AT BIRTH)	P0.....	
	c. POLIO 1	P1.....	
	d. POLIO 2	P2.....	
	e. POLIO 3	P3.....	
	f. DPT 1	DPT 1…	
	g. DPT 2	DPT 2…	
	h. DPT 3	DPT 3…	
	i. MEASLES	MEASLES…	
	j. VITAMIN A (MOST RECENT)	VIT. A...	
84	CHECK THE CARD OF (NAME) TO SEE IF THE CHILD HAS BEEN WEIGHED IN THE LAST FOUR MONTHS.	NO .....1 YES .....2 NO PLACE IN CARD FOR RECORDING WEIGHT…9	
85	Has (NAME) received any vaccinations that are not recorded on this card, including vaccinations received during a national immunization day campaign?	NO .....1 YES .....2 DON'T KNOW ……9	→**88** →**87** →**88**
86	Did (NAME) ever receive any vaccinations to prevent him/her from getting diseases, including vaccinations received during a national immunization day campaign?	NO .....1 YES .....2 DON'T KNOW ……9	→**88** →**87** →**88**

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
87	Please tell me if (NAME) received any of the following vaccinations:		
87a	BCG vaccine against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar?	NO .....1 YES .....2 DON'T KNOW.....9	
87b	Polio vaccine, that is, drop in mouth?	NO .....1 YES .....2 DON'T KNOW.....9	→**87e** →**87e**
87c	When was the first dose of polio vaccine received?	JUST AFTER BIRTH .....1 LATER 2	
87d	How many times was the polio vaccine received?	NUMBER OF TIMES… ☐☐	
87e	DPT vaccine, that is, an injection given in thigh or buttocks, sometimes given at same time as polio drops?	NO .....1 YES .....2 DON'T KNOW.....9	→**87g** →**87g**
87f	How many times?	NUMBER OF TIMES… ☐☐	
87g	An injection to prevent measles?	NO .....1 YES .....2 DON'T KNOW.....9	
88	Did (NAME) receive a vitamin A dose like this during the last four months? SHOW CAPSULE.	NO .....1 YES .....2 DON'T KNOW.....9	

MOSQUITO BEDNET USE

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
89	Do you have a mosquito net?	NO ……1 YES……..2	→**92**
90	Has the bednet ever been treated with insecticide?	NO .....1 YES.....2 DON'T KNOW.....9	
91	Did (NAME) sleep under the mosquito net last night?	NO ……..……1 YES……..2	

CHILDHOOD ILLNESS

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
92	What are the signs and symptoms of illness in a child indicating the need for treatment? RECORD ALL MENTIONED.	Not eating/drinking/breastfeeding .....A Looks unwell/Not playing normally .....B Fast or difficult breathing .....C High fever .....D Unable to sit up unassisted .....E Vomiting .....F Lethargic / Unconscious .....G Convulsions .....H OTHER _____ ..... x (SPECIFY) DON'T KNOW.....Z	
93	What are the symptoms of pneumonia in a child? RECORD ALL MENTIONED.	Convulsions .....A Fast breathing .....B Difficult breathing.....C Chest indrawing.....D Fever.....E OTHER _____ ..... x (SPECIFY) DON'T KNOW.....Z	
94	What are the signs and symptoms that would cause you to seek advice or treatment for diarrhea for your child? RECORD ALL MENTIONED.	Diarrhea lasting three days or more.....A Blood in stools .....B Dehydration / Dry lips .....C Sunken fontanelle .....D Decreased urine .....E Fever .....F Loss of appetite .....G Sunken eye .....H Restless / Irritable .....I Floppiness .....J OTHER _____ ..... x (SPECIFY) DON'T KNOW.....Z	
95	What causes malarial fever? RECORD ALL MENTIONED.	MOSQUITO BITES .....A SORCERY .....B INJECTION OF DRUGS .....C BLOOD TRANSFUSION.....D INJECTION .....E SHARING OF BLADES .....F OTHER _____ x (SPECIFY) DON'T KNOW.....Z	
96	Have you heard of oral rehydration solution? IF YES, ASK MOTHER TO DESCRIBE PREPARATION OF THE SOLUTION. IF NO, CIRCLE 3 (NEVER HEARD OF ORAL REHYDRATION SOLUTION). AFTER MOTHER HAS PROVIDED A DESCRIPTION, RECORD WHETHER SHE DESCRIBED SOLUTION PREPARATION CORRECTLY OR INCORRECTLY. CIRCLE 1 (CORRECTLY) IF MOTHER HAS MENTIONED THE FOLLOWING: • USE ONE LITER OF CLEAN WATER (1 LITER = 3 BOTTLES OF COLA) • USE ENTIRE PACKET • DISSOLVE POWDER FULLY	YES ( ) NO ( ) DESCRIBED CORRECTLY .....1 DESCRIBED INCORRECTLY ..... 2 NEVER HEARD OF ORAL REHYDRATION SOLUTION..3	→98
97	Where can you find oral rehydration solution? RECORD ALL MENTIONED.	Street seller.....A Shop .....B Pharmacy.....C Community distributor .....D Friends / Family .....E Health center.....F OTHER_____ x	

		(SPECIFY) DON'T KNOW ..... Z	

CHILD SPACING

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
98	Are you currently pregnant?	NO .....1 YES .....2 UNSURE 8	 → **101**
99	Do you want to have another child within the next two years?	NO .....1 YES .....2 UNSURE 8	→ **100** → **101** → **100**
100	Are you currently doing something or using a method to delay or avoid pregnancy? IF NO, CIRCLE «01» 'NO METHOD' IF YES, ASK : « What is the main method you or your husband/partner are using now to avoid or delay pregnancy ?» CIRCLE THE APPROPRIATE RESPONSE.	NO METHOD .....01 NORPLANT .....02 INJECTIONS .....03 PILL .....04 INTRAUTERINE DEVICE .....05 BARRIER METHOD/DIAPHRAGM.....06 CONDOM .....07 FOAM/GEL.....08 TUBAL LIGATION.....09 VASECTOMY.....10 LACTATIONAL AMENORRHEA (EXCL. BREASTFDNG) 11 RHYTHM.....12 ABSTINENCE .....13 WITHDRAWAL.....14 OTHER_____ .....88 (SPECIFY)	

HIV/AIDS AND OTHER SExUALLY TRANSMITTED INFECTIONS

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	Now I would like to talk about something else. Have you heard of an illness called AIDS?	NO .....1 YES 2	→ **111**
102	Can people get the AIDS virus by having just one partner who is not infected and who has no other partners?	NO .....1 YES .....2 DON'T KNOW ……9	
103	Can people get the AIDS virus by using a condom every time they have sex ?	NO .....1 YES .....2 DON'T KNOW ……9	
104	Can people get AIDS virus by sharing food with a person who has AIDS?	NO .....1 YES .....2 DON'T KNOW ……9	
105	Can people get the AIDS virus by abstaining from sexual intercourse?	NO .....1 YES .....2 DON'T KNOW ……9	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
106	Would you buy food from a shopkeeper or vendor if you knew that the person had the AIDS virus ?	NO .....1 YES .....2 DON'T KNOW ……9	
107	If a member of your family got infected with the AIDS virus, would you want it to remain a secret or not ?	YES, REMAIN A SECRET ……..…..1 NO…….……..……..……..…….. 2 DON'T KNOW/NOT SURE/IT DEPENDS.....3	
108	If a member of your family became sick with the virus that causes AIDS, would you be willing to care for him or her in your own house ?	NO .....1 YES .....2 DON'T KNOW ……9	
109	Do you personally know someone who had been denied health services in the last twelve months because he/she is suspected to have the AIDS virus or has the AIDS virus ?	YES.. 1 …….…..……..……..…..1 2 NO…. ……..……..……..…….. 3 2 8 DO NOT KNOW ANYONE WITH HIV/AIDS…….. 3 DON'T KNOW/NOT SURE.……..…9	
110	Do you agree or disagree with the following statement: People with AIDS virus should be blamed for bringing the disease into the community.	NO .....1 YES .....2 DON'T KNOW ……9	
111	CHECK QUESTION 101: ❑ [IF HAS HEARD ABOUT AIDS, ASK:] Apart from AIDS, have you heard about other infections that can be transmitted through sexual contact? ❑ [IF HAS NOT HEARD ABOUT AIDS, ASK:] Have you heard about infections that can be transmitted through sexual contact?	NO .....1 YES 2	→113

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
112	Please describe the symptoms of sexually transmitted infections in women. **[DO NOT READ OUT RESPONSES ALOUD.** **FOR EACH SYMPTOM, CIRCLE '1' IF NOT MENTIONED. CIRCLE '2' IF MENTIONED.]** a) ABDOMINAL PAIN b) GENITAL DISCHARGE c) FOUL SMELLING DISCHARGE d) BURNING PAIN ON URINATION e) GENITAL ULCERS/SORE f) SWELLING IN GROIN AREA g) ITCHING h) OTHER i) NO ANSWER	**NON WI** Y N a) ABDOMINAL PAIN 1 2 1 2 b) GENITAL DISCHARGE 1 2 1 2 c) FOUL SMELLING DISCHARGE 1 2 1 2 d) BURNING PAIN ON URINATION 1 2 e) GENITAL ULCERS/SORE 1 2 f) SWELLING IN GROIN AREA 1 2 g) ITCHING 1 2 1 2 h) OTHER _____ 1 2 i) NO ANSWER ……..9 1 2	

HEALTH CONTACTS AND SOURCES OF INFORMATION

No.	QUESTIONS AND FILTERS	CODING CATEGORIES			SKIP
113	During the last month, how often have you come in contact with each of the following : READ EACH CATEGORY AND ASK IF SHE CAME IN CONTACT WITH THE PERSON FREQUENTLY, SOMETIMES, OR NEVER.	FREQUENTLY (4 times or more)	SOMETIMES (1-3 times)	NEVER (0 times)	
	DOCTOR?	1	2	3	
	NURSE/MIDWIFE?	1	2	3	
	HEALTH AGENT?	1	2	3	
	MEMBER OF BASIC ORGANIZATION?	1	2	3	
	NUTRITIONIST?	1	2	3	
	TRAINED TRADITIONAL BIRTH ATTENDANT?	1	2	3	
	TRADITIONAL HEALER?	1	2	3	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
114	In the past month, did you receive any health messages from the following? (By which means?) READ EACH CATEGORY AND CIRCLE 1 OR 2. YOU MUST CIRCLE 1 OR 2 FOR EACH CATEGORY.	NO YES RADIO? (Station _____) 1 2 NEWSPAPER? 1 2 TELEVISION ? 1 2 MEMBER OF BASIC ORGANIZATION? 1 2 HEALTH AGENT? 1 2 OTHER (SPECIFY)_____) 1 2	

1.6

SICK CHILD

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
115	Did (NAME) experience any of the following in the past two weeks? READ ALL OF THE FOLLOWING: Diarrhea? Blood in stool? Cough? Difficult breathing? Fast breathing or short, quick breaths? Fever? Malaria? Convulsions?	DIARRHEA..... A BLOOD IN STOOL ..... B COUGH ..... C DIFFICULT BREATHING……...D FAST BREATHING/SHORT, QUICK BREATHS..... E FEVER……...F MALARIA..... G CONVULSIONS ..... H OTHER_____.....x NONE ……Z	→131
116	Did you seek advice or treatment for (NAME)?	NO ……..1 YES … ……2	→ 122
117	How long after you noticed (NAME'S) symptoms did you seek treatment?	SAME DAY.....0 NExT DAY.....1 TWO DAYS.....2 THREE DAYS OR MORE.... 3	
118	Where did you first go for advice or treatment?	**HEALTH FACILITY** Hospital …… …….. …… 01 Health center…… ……02 Private clinic ……03 Other hospital…….....04 Midwife.....05 **OTHER SOURCE (NON-FORMAL)** Traditional healer ……..06 Quack ……07 Houngan ……..08 Street vendor…….. ….....09 Shop ……10 Pharmacy ……...11 Community distributor ……..12 Friend/Relative……13 Other non-formal _____.....88 (SPECIFY)	
119	Who decided that you should go there for (NAME'S) illness? RECORD ALL MENTIONED.	RESPONDENT HERSELF .....A HUSBAND/PARTNER.....B GRANDMOTHER .....C RESPONDENT'S MOTHER-IN-LAW .....D FRIEND / NEIGHBOR..... E OTHER_____..... x (SPECIFY)	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
120	Did you go anywhere else for advice or treatment for (NAME)?	NO ..... 1 YES 2	→ 122
121	Where did you go next for advice or treatment?	**HEALTH FACILITY** Hospital …… …….. …… 01 Health center…… ……02 Private clinic ……03 Other hospital…….....04 Midwife.....05 **OTHER SOURCE (NON-FORMAL)** Traditional healer ……..06 Quack ……07 Houngan ……..08 Street vendor…….. ….....09 Shop ……10 Pharmacy ……...11 Community distributor ……..12 Friend/Relative……13 Other non-formal _____.....88 (SPECIFY)	
122	During (NAME'S) illness, did you breastfeed him/her less than usual, about the same amount, or more than usual?	LESS..... 1 SAME ..... 2 MORE ..... 3 CHILD NOT BREASTFED ….4 DON'T KNOW..... 9	
123	During (NAME'S) illness, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	LESS..... 1 SAME ..... 2 MORE ..... 3 NOTHING TO DRINK ..... 4 DON'T KNOW..... 9	
124	During (NAME'S) illness, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?	LESS..... 1 SAME ..... 2 MORE ..... 3 NOTHING TO EAT ..... 4 DON'T KNOW..... 9	
125	During the period when (NAME) was recovering from illness, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	LESS..... 1 SAME ..... 2 MORE ..... 3 NOTHING TO DRINK ..... 4 DON'T KNOW..... 9	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
126	**REFER BACK TO QUESTION 115 AND LOOK AT THE MOTHER'S RESPONSES.**	**CHECK WHICH MODULES APPLY**	
	IF **A OR B:** ADMINISTER **DIARRHEA MODULE**	MODULE C (DIARRHEA)	→ **129**
	IF **C, D, OR E:** ADMINISTER **RESPIRATORY PROBLEM MODULE**	MODULE A (RESPIRATORY PROBLEM)	→ **127**
	IF **F, G, OR H:** ADMINISTER **MALARIA MODULE**	MODULE B (MALARIA)	→ **128**
MODULE A : TREATMENT FOR CHILD'S RESPIRATORY PROBLEM			
127	Which medicines were given to (NAME) for the respiratory problem? RECORD ALL MENTIONED. IF MOTHER IS UNABLE TO RECALL DRUG NAME(S), ASK HER TO SHOW THE DRUG(S) TO YOU.	NOTHING ..... A ASPIRIN..... B ACETAMINOPHEN ..... C AMOxICILLIN..... D ERYTHROMYCIN..... E AMPICILLIN..... F COTRIMOxAZOLE ……G OTHER _____ x (SPECIFY) DON'T KNOW …… ……..Z	
MODULE B : TREATMENT FOR CHILD'S FEVER			
128	Which medicines were given to (NAME) for his/her fever? RECORD ALL MENTIONED. ASK MOTHER TO SHOW THE DRUG(S) TO YOU.	NOTHING……A ASPIRIN…… ……..B ACETAMINOPHEN ……..…..C COTRIMOxAZOLE… ……D CHLOROQUINE …… E QUININE.....F OTHER _____ x (SPECIFY) DON'T KNOW ……..Z	
MODULE C : DIARRHEA CASE MANAGEMENT			
129	What was given to (NAME) to treat the diarrhea? RECORD ALL MENTIONED. IF MOTHER IS UNABLE TO RECALL DRUG NAME(S), ASK HER TO SHOW THE DRUG(S) TO YOU.	NOTHING .....A ORAL REHYDRATION SOLUTION .....B HOME-MADE FLUID ..... C PILL OR SYRUP..... D INJECTION.....E INTRAVENOUS (IV) FLUIDS .....F HOME REMEDY/TRADITIONAL REMEDY……. G OTHER_____ x (SPECIFY) DON'T KNOW…… Z	
130	Was (NAME) given zinc for the diarrhea?	NO ……1 YES ……2 IF YES, for how many days ? __ __	

ANTHROPOMETRY

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
131	Has (NAME) received a medicine against worms in the last six months?	NO.....1 YES.....2 DON'T KNOW 9	
132	ASK MOTHER FOR PERMISSION TO MEASURE ARM CIRCUMFERENCE FOR (NAME). IF SHE AGREES, RECORD INFORMATION IN SPACE BELOW.		

ARM CIRCUMFERENCE

		mm

HAND WASHING

133	Does your household have a special place for hand washing?	NO .....1 YES.....2	→**END**
134	ASK TO SEE THE PLACE USED MOST OFTEN FOR HAND WASHING AND OBSERVE IF THE FOLLOWING ITEMS ARE PRESENT:	**NO YES** (A) WATER/TAP.....1 2 (B) SOAP/DETERGENT ...1 2 (C) WASH BASIN.....1 2	
135	When do you wash your hands with soap? RECORD ALL MENTIONED.	NEVER ..... ……..A BEFORE PREPARING FOOD .. ..B BEFORE FEEDING/BREASTFEEDING .....C AFTER DEFECATION.....D LÈ W FIN N NETWAYE YON TIMOUN AFTER CLEANING A CHILD WHO HAS DEFECATED … E OTHER _____ 8 (SPECIFY)	

1.7 Annexure 3: Questionnaires in Kreyol

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TIMOUN 0 - 11 MWA

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CONCERN, FOCAS, AK GRET ANSANM AVEK MINISTE SANTE PIBLIK REPIBLIK DAYITI

SANTE IBEN NAN POTOPRENS

Ankèt Rapid sou Konesans, Pratik e Kouveti (KPK)

VÈSYON 04 MAS 2006

Zon pwoje a ☐ Senmaten - 1, Site Okay- 2, Dekayet-3, Jalouzi/Bwa Mokèt-4

Zòn sipèvisyon-an ☐

Nimewo echantiyon nan blok la ☐☐☐

Nimewo kay nan echantiyon an ☐☐☐ (pami kantite kay ki nan bok la)

Deskripsyon kay la _____

Nimewo rejis ☐☐

Non enketè a _____

Non sipèvizè a _____ _____

Verifye pa _____.
Sipevizè a

Dat entèvyou a ☐☐ ☐☐ ☐☐☐☐
jou mwa ane

Ranvoye pou ☐☐ ☐☐ ☐☐☐☐
jou mwa ane

Non manman-an _____ _____
Non Siyati

Laj Manman -an ☐☐ an

Kouman w rele pitit ki pi piti a _____ _____
Non Siyati

Se yon Tifi ☐ Tigason ☐

Dat li te fèt ☐☐ ☐☐ ☐☐☐☐ MANDE KAT Vaksen ou lot kat.
Jou mwa ane

Laj timoun nan ☐☐ mwa

OTORIZASYON MOUN KI REPONN

Bonjou/Bonswa. M rele _____, e m ap travay pou _____). N ap fè yon enkèt, nou ta swete w patisipe ladan. M ta renmen poze w kèk kesyon sou sante w, epi tou sou sante pitit ou ki pi piti a, sa ki gen mwens pase dezan. Enfòmasyon sa yo pral sèvi _____ak Ministe sante piblik pou planifye sèvis sante l yo e pou l evalye si yo koresponn ak objektif li yo pou amelyore sante timoun nan. Ankèt la pran nòmalman **30** minit. Nenpòt enfòmasyon ou bay la, l ap rete sekrè, e pèsonn p ap konnen l.

Patisipasyon nan ankèt sa a li volontè, e ou ka deside pa reponn ak kèk kesyon pèsonèl oubyen nenpòt ki lòt kesyon. Men, nou swete ou patisipe nan ankèt sa a, piske sa ou panse a trè enpòtan.

Koulye a, èske ou gen kesyon pou poze m sou ankèt la ?

Siyati anketè a: _____

Dat: _____

ANKETE A AKSEPTE POU L ANKETE

ANKETE A PA AKSEPTE POU L ANKÈTE

PATI I: ENFOMASYON SOU MANMAN PITIT LA AK SITYASYON FANMI LI

No	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
1.	Depi konbyen tan ou rete nan katye sa a?	Ane ☐☐ Mwa ☐☐	
2.	Ki lès ki chèf kay la?	MANMAN (ANKETE))..... 1 MARI / PATNÈ ..... 2 LÒT _____8 (PRESIZE)	
3	Konbyen timoun ki gen pi piti pase senk an kav viv nan kay la?	☐ Timoun	Si se yon sèl timoun, ale nan kesyon →**7**
4.	Ti moun ki vin avan-an. (non ti moun nan) la ki dat li fèt	☐☐ jou ☐☐ mwa ☐☐☐☐ ane	
5.	Kijan li rele	non_____ siyati _____	
6	Se yon	Tifi ☐ Ti gason ☐	
7	Eske 'w te ale lekol.	Non……1 Wi……2	→**9**
8.	Nan ki klas ou te rive ? KALKILE KONYEN ANE KLAS LI FÈ-A VO	☐☐ ane	
9	Eske w ap travay ? SI WI, Ki kalite travay w ap fè ? SI NON, ANSÈKLE « PA P TRAVAY »	PA P TRAVAY.....1 ATIZANA .....2 FÈ JADEN .....3 VANN MANJE .....4 KOMÈS / MACHANN NAN LARI ...5 BÒN /TRAVAY KAY MOUN....6 OUVRIYE .....7 LÒT _____ 8 (PRESIZE)	→**11**

No	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
10	Ki lès ki okipe (non ti moun nan) lè w pa la ?	Manman (ANKETE) .....A MARI/PATNÈ ..... B TIMOUN KI PI GRAN .....C VWAZEN /ZANMI …….E BÒN /SÈVANT .....F LÒT _____ x (PRESIZE)	
11	Ki kote w fè manje?	Anndan kay la..... 1 Nan yon pyès ki nan lakou a (kizin). 2 Nan pa pòt kay la ..... 3 Nan lakou a lwen pòt kay la .....4 Lòt kote _____ .....8 (PRESIZE)	
12	Ak ki sa ou kwit manje pi souvan ?	Ak Bwa .....1 Ak Chabon.....2 Ak Alkòl……..3 Ak Kewozèn .....4 Ak Elektrisite.....5 Ak gaz pwopàn.....6 Ak Lòt _____ .8 (Presize)	
13	Eske konn gen lafimen andan kay la lè y ap fè manje?	NON……1 WI……2 PA KONNEN……...9	
14	Koulye a, m vle poze w kesyon sou manje, ou menm oswa lòt fanmi k nan kay la te manje yè. LI TOUT BAGAY SA YO : a. Diri, pen, espageti, labouyi, mayi moulen, konflèks, biskwit, ble, pitimi ? b. Patat, ponmdetè, manyòk? c. Legim ?	**NON** **WI** 0 1 0 1 0 1	

No	KESYON YO AK ENDIKASYON YO	KÒD YO		ALE NAN
	d. Fwi ?	0	1	
	e. Vyann bèf, chochon, oubyen lòt kalite vyann?	0	1	
	f. Ze ?	0	1	
	g. Pwason,krab,lanbi,krevet etc..)	0	1	
	h. Pwa, nwa , pistach?	0	1	
	i. Fwomaj, lèt oubyen lòt bagay ki fèt ak lèt ?	0	1	
	j. Manje ak lwil, bè, oubyen la kochon ?	0	1	
	k. Sik oswa siwo myèl ?	0	1	
	l. Lòt bagay tankou kafe, te oubyen ji ?	0	1	

SWEN PRENATAL YO

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
15	Eske w te al konsilte/we yon moun lè w te ansent (non timoun nan) Si WI: Ki moun ou te wè ? ENSISTE POU KONNEN KI JAN DE PWOFESYONEL, MANDE LI SI PAGEN LOT, EPI EKRI TOUT MOUN MANMAN AN DI.	**PWOFESYONÈL LASANTE** DOKTÈ .....A ENFIMYÈ /SAJFAM…….B OKSILYÈ /SAJFAM ..... C **LOT MOUN** MATWÒN..... D AJAN SANTE KOMINOTÈ.....E LÒT _____ x (PRESIZE) PÈSONN Z	→**24**
16	Konbyen fwa w t al pran swen lè w te ansent la ?	KANTITE FWA.....	
17	Eske w te genyen yon kat sante fanm lè w te ansent (non ti moun na) ? SI WI, kote kat la ?	Wi / verifye……1 KAT LA PA LA.....2 PA T JANM TE GEN KAT.....3	 →**20** →**20**
18.	GADE KAT LA EPI EKRI KANTITE VIZIT PRENATAL LI TE FÈ LÈ LI TE ANSENT (non ti moun nan)	KANTITE VISIT	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
19.	GADE KAT LA EPI EKRI DAT YO POU CHAK PIKI TT KI MAKE SOU KAT LA	JOU MWA ANE 1è ☐☐ ☐☐ ☐☐☐☐ 2èm ☐☐ ☐☐ ☐☐☐☐ 3èm ☐☐ ☐☐ ☐☐☐☐ 4èm ☐☐ ☐☐ ☐☐☐☐	
20	Le w te ale nan klinik pou fanm ansent nan gwosès (non timoun nan), èske gen yon moun ki te pale w de : LI TOUT BAGAY SA YO: a) Kouman manman ka bay tibebe a jèm SIDA . b) Kouman pou fè pou pa pran jèm SIDA ? c) Fè tès SIDA ?	**Non WI PA KONNEN** a) ……: 1 2 9 b) ……. : 1 2 9 c) ……: 1 2 9	
21	M pa bezwen konnen rezilta tès la, men èske ou te fè tès SIDA le w te ale nan klinik pou fanm ansent	NON ……1 WI ……2	→**24**
22	Ki kote ou te fè tès la ?	**EKRI KOTE A LA** _____ (PRESIZE KOTE A)	
23	Sonje, m pa bezwen konnen rezilta tès la, men èske w konnen rezilta tès la ?	NON ……1 WI ……2	
24	Anvan ou te akouche (non timoun na), èske yo te ba w yon piki nan bra w pou anpeche ti bebe a pran tetanòs, sa vle di, fè kriz lè l fin fèt ?	NON .....1 WI.....2 PA KONNEN..... .9	
25	Lè w te ansent (non timoun nan), eske yo te ba w oswa ou te achte kèk grenn oswa siwo ki te gen fè ak asid folik ladan l ? GRENN OSWA POU SAN	NON .....1 WI.....2 PA KONNEN 9	→**27** →**27**
26	Pandan konbyen jou w te pran grenn nan	☐☐☐	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
	oswa siwo a ? SI LI PA KONEN MANDE L APEPRÈ KANTITE SEMEN OU MWA EPI KALKILE KANTITE JOU A	KANTITE JOU PA KONNEN 999	
27	Le yon moun ansent, ki sentòm ou panse ki dwe fe w al chèche swen touswit EKRI TOUT SA LI DI	LAFYÈV.....…….A ESOUFLEMAN ..... …. B BAY SAN PA BA (EMORAJI)….. C MAL TÈT…… D ANFLAMASYON KÒ/ MEN/FIGI….E LÒT_____ x (PRESIZE) PA KONNEN ..... …Z	→**29**
28	Si w ta gen youn nan sentòm sa yo ki kote w ta kouri ale an premye pou kapab pran swen ?	Lopital …….. ……..1 Sant sante…… ……..2 Dokte Prive…… 3 Enfimye…….. 4 Oksilye…….. 5 Matwòn fòme(ak bwat)…… .. 6 Matwòn ki pa fòme/fanmi (san bwat) …7 LÒT _____... ….....8 (PRESIZE) PA KONNEN……..9	

1.8

PTME

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
29.	Eske yon manman ka bay pitit li jèm SIDA ? LI TOUT KATEGORI SA YO: a) pandan gwosès la? b) pandan akouchman ? c) pandan lap bay tete ?	**Non Wi Li pa konnen** a) Pandan gwosès la. … . 1 2 9 b) Nan akouchman an……. .1 2 9 c) Nan bay tete a ……. 1 2 9	

30	Si yon manman konnen li gen jèm SIDA, èske l ta dwe bay ti bebe a tete ?	NON ……1 WI ……..……..2 PA KONNEN …….……9	
31	Si yon manman pa konnen si li gen jèm SIDA ak si li pa genyen l, èske l ta dwe bay ti bebe a tete ?	NON ……1 WI ……..……..2 PA KONNEN …….……9	

1.9

AKOUCHMAN AK SWEN RAPID POU TI BEBE KI FENK FÈT
KOTE A AK ASISTANS AKOUCHMAN AN

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
32	Ki kote w te akouche (non timoun nan) ?	**NAN KAY** KAY PA W……..……..1 LÒT KAY……...……..2 **ETABLISMAN SANITÈ** Lopital …….. ……3 Sant sante…….. ……4 LÒT_____.....8 (PRESIZE)	→**34** Si li te akouche nan yon etablisman Sanitè, ale nan kesyon 34
33	Pou ki sa fanm yo akouche nan kay ? **EKRI TOUT SA LI DI**	Lopital twò chè…….....A Eksperyans pase a/ pa gen pwoblèm avèk akouche kay...B BLopital pa akeyi moun byen .....…. D Distans la twò lwen.....…E Dwe okipe lòt timoun yo nan kay la ….F Pa gen transpò .....G Lopital vle di sezaryèn.....H Pa gen doktè/ Pa gen fanmsaj nan lopital la.....I Kalite swen yo pa bon nan lopital la .....J LÒT.....x (PRESIZE)	
34	Ki moun ki te akouche-w lè w tap fè (non timoun nan) ?	**PWOFESYONÈL LASANTE** DOKTÈ.....A ENFIMYÈ / SAJFAM .....B OKSILYÈ C	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
	EKRI TOUT SA LI DI	**LÒT MOUN** MATWÒN FÒME……D MATWÒN KI PA FÒME…….. .. …E (Bay non matwòn nan_____) AJAN SANTE KOMINOTÈ…… …F MANM FANMI _____.... …G (PRESIZE) 1.9.a.i.1.1 LÒT_____..... .....x (PRESIZE) PÈSONN……Z	
35.	Eske yo te itilize mareyeèl pwòp ?	NON .....1 WI..... 2 PA KONNEN 9	
36.	Ki sa yo te itilize pou koupe kòd lonbrit la ?	JILÈT NÈF..... 1 LÒT BAGAY..... 2	
37	Ki moun ki te koupe kòd lonbrit la?	**PWOFESYONÈL LASANTE** DOKTÈ..... 1 ENFIMYÈ / SAJFAM ..... 2 OKSILYÈ ..... 3 **LÒT MOUN** MATWÒN FÒME……4 MATWÒN KI PA FÒME…… ……. 5 (Bay non matwòn nan _____) AJAN SANTE KOMINOTÈ…… …6 MANM FANMI _____..... 7 (PRESIZE) LÒT_____.....8 (PRESIZE) PÈSONN……9	
38.	Ki sa yo mete sou lonbrit la lè yo fin koupe l ?	LWIL..... 1 MOSO TWAL ..... 2 FAB/SAVON..... 3 POUD DETAC ..... 4 ANTIBIOTIK/ANTISEPTIK..... 5 ALKÒL..... 6 ANYEN ..... 7 LÒT _____ ..... 8 (PRESIZE) PA KONNEN …… ……. 9	
39.	Eske yo te peze (non ti moun nan) lè l te fenk fèt la?	WI……1 NON…… 2 PA KONNEN……..9	
40.	Lè (non timoun nan) te fin fèt , è eske yo te konsilte w	NON .....1 WI.....2	→**46**

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
41	Konbyen jou, aprè akoucheman an ou te al konsilte pou premye fwa ? EKRI <<00>> JOU, SI SE TE MENM JOU A.	JOU APRÈ AKOUCHMAN ☐☐ SEMÈN APRÈ AKOUCHMAN ☐☐ PA KONNEN.....99	
42	Ki lès ki te konsilte w lè sa a ? ENSISTE POU L BA W MOUN KI PI FÒME A .	**PWOFESYONÈL LASANTE** DOKTÈ..... 1 ENFIMYÈ / SAJFAM ..... 2 OKSILYÈ ..... 3 **LÒT MOUN** MATWÒN FÒME.....4 MATWÒN KI PA FÒME..... 5 (Bay non matwòn nan _____) AJAN SANTE KOMINOTÈ..... 6 MANM FANMI _____..... ....7 (PRESIZE) LÒT_____.....8 (PRESIZE) PÈSONN.....9	
43	Ki sa yo te kontwole lè yo te konsilte-w la)	Anyen.....A Emoraji (pase san pa ba).....B Si gen lafyèv ..... C Enfeksyon nan chouchoun ki santi .move...D Kontwole tansyon.....E LÒT_____.....x (PRESIZE)	
44	Ki sa yo te fè pou (non timoun nan)?	Anyen.....A Poze kèk kesyon sou alètman matènèl ...B Kontwole kòd lonbrit la.....C Ba l kèk vaksen.....E Kontwole souf li.....F LÒT_____.....x (PRESIZE)	
45	Aprè akouchman w, èske yo te konseye w sou bagay sa yo: KELKE SWA MOUN LI TE WÈ A **LI TOUT BAGAY SA YO** Kantite tan ki separe timoun yo Manje timoun Vaksen timoun nan Dyare timoun	**Non Wi** Kantite tan ki separe timoun yo 1 2 Manje timoun 1 2 Vaksen timoun nan 1 2 Dyare timoun 1 2	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
	Siy danje maladi timoun	Siy danje maladi timoun 1 2	
46	Pandan de premye mwa aprè akoucheman an, èske w te jwenn yon dòz vitamin A, tankou sa a ?[1] MONTRE L VITAMIN A.	NON.....1 WI.....2 PA KONNEN.....9	
47	Ki siy danje ou wè aprè akouchman an ki ka fe w kouri al chèche swen byen vit ? EKRI TOUT SA LI DI	FYÈV.....A BAY SAB PA BA .....B EKOULMAN CHOUCHOUN KI SANTI MOVE...C LÒT_____..... x (PRESIZE) PA KONNEN.....Z	
48	Aprè akouchman ki a saw panse yon ti bebe ka genyen pou-w ta oblije kouri menen l lopital san pedi tan) EKRI TOUT SA LI DI	Pa gen apeti.....A Pa tete byen.....B Lafyèv.....C Vomisman.....D Kriz.....E Resoufle .....F Pa bouje ..... G Lonbrit la tou wouj.....H Je wouj / malozyè .....I Jonis / Pò blanch .....J Dezidratasyon.....K LÒT_____ x (PRESIZE) PA KONNEN.....Z	

1.10

ALETMAN AK MANJE TIMOUN NAN

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
49	Eske w te bay (non timoun nan) tete?	JAMÈ .....1 WI.....2	→55
50	kilè ou te komanse bay (non timoun nan) tete apre li te fin fèt?	TOUTSWIT APRE AKOUCHMAN/OSINON APRÈ .....1 APRÈ KÈK TAN NAN PREMYE JOU-A.....2 Dezyèm jou a ou pita.....3 Pa sonje.....9	
51	Eske w te bay (non timoun nan) premye lèt jòn nan lè li te fin fèt?	WI.....1 NON 2	

Nº	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
	SE PREMYE LÈT KI SOTI NAN TETEW LÈ TI MOUN NAN FENK FÈT	PA KONNEN 9	
52	Eske w te bay (non timoun nan) dlo sikre oubyen nenpot ki bagay tankou LÒK?	WI.....1 NON .....2 PA KONNEN 9	
53	Eske wap bay (non timoun nan) tete kounyè-a?	WI.....1 NON .....2 PA KONNEN 9	→55
54	Pandan Konbyen mwa ou te bay (non timoun nan) tete? SI SE MWENS KE YON MWA, EKRI « 00 »	☐☐ MWA	
55	Eske ayè, ou te bay (non timoun nan) bwè bagay nan bibwon oubyen nenpot veso ki gen tetin?	NON .....1 WI……..……2	
56	Kounye-a , mwen ta renmen mandew enfomasyon sou kalite likid (non ti moun nan) te bwè ayè, nan nwuit oswa lajounen. Eske (non ti moun nan) te bwè kèk nan bagay sayo ayè, nan nwuit oswa lajounen? LI TOU LIKID KI LAYO DE SOTI NAN a POU RIVE NAN B LÈT maman ak Dlo DLO SIKRE JI FWI LÈT AN POUD TE/TIZAN SIWO MYÈL TETE	LÈT maman ak Dlo……A DLO……B DLO SIKRE ..... C JI FWI .....…D LÈT AN POUD .....E TE/TIZAN .....F SIWO MYÈL..... G TETE……..……..H LÒT_____x (PRESIZE)	
56a	Eske w te bay (non timoun nan) manje labouyi oubyen ti pire, ki ba bagay dlo sèlman ?	NON .....1 WI……..……2	→57
56b	Yè pandan jounen an, konbyen fwa (non		

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
	timoun nan) te manje labouyi oubyen ti pire, ki ba bagay dlo sèlman ?	KANTITE Fwa ..... PA KONNEN 9	
57	Nan sis denye mwa ki sot pase yo, eske (non timoun nan) te pran yon doz Vitamin A, tankou sa a, ? **MONTRE MANMAN-AN KAPSIL LA**	NON .....1 WI.....2 PA KONNEN……..9	

1.11

TIMOUN MALAD

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
58	Eske pandan de dènye semenn ki sot pase yo, (non ti moun nan) te gen youn nan pwoblèm sa yo ? **LI TOUT BAGAY SA YO :** Dyare ? San nan tata ? Tous ? Soufle anlè ? Souf kout ? Fyèv? Malarya? Kriz?	DYARE ..... A SAN NAN TATA ..... B TOUS.....C SOUFLE anlè ……..D RESPIRASYON RAPID /SOUF KOUT……E FYÈV.....F MALARYA.....G KRIZ..... H LÒT _____.....x ANYEN.……Z	→ FIN
59	Eske w te jwenn konsey osinon remèd pou (non ti moun nan) ?	NON ……..1 WI…… ……2	→ 65
60	Lè w te remake sentòm sa yo sou (non ti moun nan) aprè konbyen tan w t al chache yon tretman ?	MENM JOU A.....0 NAN DEMEN .....1 DE (2) JOU .....2 TWA JOU OU PLIS…….....3	
61	Ki kote w te ale an premye pou kapab jwenn yon konsèy oubyen yon tretman ?	**ETABLISMAN LASANTE** Lopital …….. ……01 Sant sante…….. ……02 Klinik prive……03 Lòt Lopital…….....04 Sajfam.....05 **SOUS NON FÒMEL** Medsen Fèy……..06	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
		Chalatan……07 Oungan……..08 Machann grenn nan lari ….....09 Boutik……10 Famasi……...11 Distribitè Kominotè……..12 Zanmi /Fanmi.……13 Lòt non fòmèl _____.....88 (PRESIZE)	
62	Ki moun ki te deside ou ankouraje w, ale kote sa a pou maladi (non ti moun nana) ? EKRI TOUT SA LI DI.	ANKETÈ.....A MARI/PATNÈ .....B GRANN LI ..... C BÈLMÈ ..... D ZANMI / VWAZEN.....E LÒT _____..... x (PRESIZE)	
63	Eske ou te ale yon lòt kote pou pran konsèy osinon pou tretman pou maladi (non timoun nan) ?	NON.....1 WI.....2	→ 65
64	Ki kote w t ale pou chache yon konsèy oubyen yon tretman ?	**ETABLISMAN LASANTE** Lopital …….. ……01 Sant sante…… ……02 Klinik prive……03 Lòt Lopital…….....04 Sajfam.....05 **SOUS NON FÒMEL** Medsen Fèy……..06 Chalatan……07 Oungan……..08 Machann grenn nan lari ….....09 Boutik……10 Famasi……...11 Distribitè Kominotè……..12 Zanmi /Fanmi.……13 Lòt non fòmèl _____.....88 (PRESIZE)	
65	Lè (non ti moun nan) te malad la, eskew te ba l mwens tete pase sa w te konn ba li	MWENS .....1 MENM KANTITE.....2	

Nº	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
	anvan an, oubyen prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	PLIS ..... 3 TIMOUN PA T TETE……4 PA KONNEN..... 9	
66	Lè (non ti moun nan) te malad la, eskew te ba l bwè mwens pase sa w te konn ba li anvan an, oswa prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS ..... 1 MENM KANTITE..... 2 PLIS ..... 3 PA BWÈ ANYEN ..... 4 PA KONNEN..... 9	
67	Lè (non ti moun nan) te malad la, eskew te ba l mwens manje pase sa w te konn ba li anvan an, oswa prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS ..... 1 MENM KANTITE..... 2 PLIS ..... 3 PA MANJE ANYEN ..... 4 PA KONNEN..... 9	
68	Pandan (non ti moun nan) t ap refè pou l sot nan maladi a, eskew te ba l bwè mwens pase sa w te konn ba li anvan an, oswa prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS ..... 1 MENM KANTITE ..... 2 PLIS ..... 3 PA BWÈ ANYEN ..... 4 PA KONNEN..... 9	
69	**ALE NAN KESYON 58 E KONTWOLE REPONS MANMAN AN.**	**KONTWOLE KI MODIL POU APLIKE**	
	SI **A OU B:** APLIKE MODIL . **DYARE**	**MODIL C** (**DYARE**)	→ **72**
	SI **C, D, OU E:** APLIKE MODIL **Pwoblèm respitatwa**	**MODIL A** (**Pwoblèm respiratwa**)	→ **70**
	SI **F, G, H:** APLIKE MODIL **MALARYA**	**MODIL B** (MALARYA)	→ **71**
MODIL A : TRETMANT TIMOUN AK PWOBLÈM RESPIRATWA			
70	Ki medikaman (non ti moun nan) te bwè? **Pwoblèm respitatwa**? EKRI TOUT SA LI DI. SI MANMAN AN PA KA SONJE NON MEDIKAMAN (NON TIMOUN NAN) YO, MANDE LI POU L MONTRE W YO.	ANYEN..... A ASPIRIN..... B ASETAMINOFÈN .....C AMOKSISIILIN.....D ERITWOMISIN..... E ANPISILIN..... F KOTRIMOKSAZÒL……..…G PA KONNEN……..z LÒT_____ x (PRESIZE)	
MODIL B : TRETMAN TIMOUN KI GEN FYÈV			

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
71	Ki medikaman (non ti moun nan) te bwè pou lafyèv li a? EKRI TOUT SA LI DI. MANDE LI POU L MONTRE W YO.	ANYEN……A ASPIRIN……..B ASETAMINOFÈN ……..…..C KOTRIMOKSAZÒL……D KLOWOKIN ...…… E KININ.....F PA KONNEN……..Z LÒT_____ x (PRESIZE)	
MODIL C : SWEN TIMOUN AVÈK DYARE			
72	Ki sa (non ti moun nan) te bwè pou trete dyare a ? EKRI TOUT SA LI DI. SI MANMAN AN PA KA SONJE NON MEDIKAMAN (NON TIMOUN NAN) YO, MANDE LI POU L MONTRE W YO.	ANYEN.....A SEWÒM ORAL .....B PREPARASYON NAN KAY .. C GRENN OUBYEN SIWO..... D PIKI .....E PIKI NAN VENN (IV) .....F REMÈD NAN KAY/ REMÈD TRADISYONÈL…….G PA KONNEN…… Z LÒT_____ x (PRESIZE)	
73	Eske (non ti moun nan) te pran zen pou dyare a ?	NON……1 WI……..……2 Si WI, pou konbyen jou : __ __	

FINI

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TIMOUN 12 - 23 MWA

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CONCERN, FOCAS, AK GRET ANSANM AVEK MINISTE SANTE PIBLIK REPIBLIK DAYITI
SANTE IBEN NAN POTOPRENS
Ankèt Rapid sou Konesans, Pratik e Kouveti (KPK)

VÈSYON 04 MAS 2006

Zon pwoje a ☐ Senmaten - 1, Site Okay- 2, Dekayet-3, Jalouzi/Bwa Mokèt-4

Zòn sipèvisyon-an ☐

Nimewo echantiyon nan blok la ☐☐☐

Nimewo kay nan echantiyon an ☐☐☐ (pami kantite kay ki nan bok la)

Deskripsyon kay la _____

Nimewo rejis ☐☐

Non enketè a _____

Non sipèvizè a _____ _____

Verifye pa _____.
Sipevizè a

Dat entèvyou a ☐☐ ☐☐ ☐☐☐☐
jou mwa ane

Ranvoye pou ☐☐ ☐☐ ☐☐☐☐
jou mwa ane

Non manman-an _____ _____
Non Siyati

Laj Manman -an ☐☐ an

Kouman w rele pitit ki pi piti a _____ _____
Non Siyati

Se yon Tifi ☐ Tigason ☐

Dat li te fèt ☐☐ ☐☐ ☐☐☐☐ MANDE KAT Vaksen ou lot kat.
Jou mwa ane

☐☐

Laj timoun nan mwa

OTORIZASYON MOUN KI REPONN

Bonjou/Bonswa. M rele _____, e m ap travay pou _____). N ap fè yon enkèt, nou ta swete w patisipe ladan. M ta renmen poze w kèk kesyon sou sante w, epi tou sou sante pitit ou ki pi piti a, sa ki gen mwens pase dezan. Enfòmasyon sa yo pral sèvi _____ak Ministe sante piblik pou planifye sèvis sante l yo e pou l evalye si yo koresponn ak objektif li yo pou amelyore sante timoun nan. Ankèt la pran nòmalman **30** minit. Nenpòt enfòmasyon ou bay la, l ap rete sekrè, e pèsonn p ap konnen l.

Patisipasyon nan ankèt sa a li volontè, e ou ka deside pa reponn ak kèk kesyon pèsonèl oubyen nenpòt ki lòt kesyon. Men, nou swete ou patisipe nan ankèt sa a, piske sa ou panse a trè enpòtan.

Koulye a, èske ou gen kesyon pou poze m sou ankèt la ?

Siyati anketè a: _____

Dat: _____

ANKETE A AKSEPTE POU L ANKETE ANKETE A PA AKSEPTE POU L ANKÈTE

PATI I: ENFOMASYON SOU MANMAN PITIT LA AK SITYASYON FANMI LI

No	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
1.	Depi konbyen tan ou rete nan katye sa a?	Ane ☐☐ Mwa ☐☐	
2.	Ki lès ki chèf kay la?	MANMAN (ANKETE))..... 1 MARI / PATNÈ ..... 2 LÒT _____ 8 (PRESIZE)	
3	Konbyen timoun ki gen pi piti pase senk an kav viv nan kay la?	☐ Timoun	Si se yon sèl timoun, ale nan kesyon →**7**
4.	Ti moun ki vin avan-an. (non ti moun nan) la ki dat li fèt	☐☐ jou ☐☐ mwa ☐☐☐☐ ane	
5.	Kijan li rele	non_____ siyati _____	
6	Se yon	Tifi ☐ Ti gason ☐	
7	Eske 'w te ale lekol.	Non……1 Wi……..2	→**9**
8.	Nan ki klas ou te rive ? KALKILE KONYEN ANE KLAS LI FÈ-A VO	☐☐ ane	
9	Eske w ap travay ? SI WI, Ki kalite travay w ap fè ? SI NON, ANSÈKLE « PA P TRAVAY »	PA P TRAVAY.....1 ATIZANA .....2 FÈ JADEN.....3 VANN MANJE .....4 KOMÈS / MACHANN NAN LARI ...5 BÒN /TRAVAY KAY MOUN....6 OUVRIYE .....7 LÒT _____..... 8 (PRESIZE)	→**11**
10	Ki lès ki okipe (non ti moun nan) lè w pa la ?	Manman (ANKETE) .....A	

No	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
		MARI/PATNÈ ..... B TIMOUN KI PI GRAN ..... C VWAZEN /ZANMI ……..E BÒN /SÈVANT .....F LÒT _____..... x (PRESIZE)	
11	Ki kote w fè manje?	Anndan kay la.....…… 1 Nan yon pyès ki nan lakou a (kizin)….2 Nan pa pòt kay la ..... 3 Nan lakou a lwen pòt kay la .....4 Lòt kote_____.....8 (PRESIZE)	
12	Ak ki sa ou kwit manje pi souvan ?	Ak Bwa..... 1 Ak Chabon ..... 2 Ak Alkòl……..3 Ak Kewozèn ..... 4 Ak Elektrisite..... 5 Ak gaz pwopàn ..... 6 Ak Lòt _____ . 8 (Presize)	
13	Eske konn gen lafimen andan kay la lè y ap fè manje?	NON……1 WI……2 PA KONNEN……...9	
14	Koulye a, m vle poze w kesyon sou manje, ou menm oswa lòt fanmi k nan kay la te manje yè. LI TOUT BAGAY SA YO :	**NON** **WI**	
	a. Diri, pen, espageti, labouyi, mayi moulen, konflèks, biskwit, ble, pitimi ?	0 1	
	b. Patat, ponmdetè, manyòk?	0 1	
	c. Legim ?	0 1	
	d. Fwi ?	0 1	
	e. Vyann bèf, chochon, oubyen lòt kalite vyann?	0 1	
	f. Ze ?	0 1	
	g. Pwason,krab,lanbi,krevet etc..)	0 1	
	h. Pwa, nwa , pistach?	0 1	
	i. Fwomaj, lèt oubyen lòt bagay ki fèt ak lèt ?	0 1	
	j. Manje ak lwil, bè, oubyen la kochon ?	0 1	
	k. Sik oswa siwo myèl ?	0 1	

No	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
	l. Lòt bagay tankou kafe, te oubyen ji ?	0 1	

DLO AK SANITASYON

No.	KESYON AK ENDIKASYON YO	KÒD YO	ALE NAN
74	M ta renmen poze w kèk kesyon sou Dlo nou bwè lakay nou yo ak twalèt nou itilize Ki kote nou pi souvan pran dlo pou nou bwè nan fanmi-an?	TIYO PIBLIK GRATIS.....1 TIYO PEYE.....2 TIYO NAN KAY LA /PRIVE.....3 SITÈN.....4 RIVYÈ.....5 SOUS.....6 PI.....7 DLO LAPLI.....8 LÒT_____x (PRESIZE)	
75	Eske ou trete dlo nou itilize pou nou bwè nan kay la ?	NON.....1 WI.....2	→**78**
76	Ki sa ou itilize pi souvan pouw trete dlo nou bwè nan kay la ? ANTOURE PLIS PASE YON REPONS SELMAM SI MOUN NAN ABITYE ITILIZE PLISYÈ POUL TRETE DLO	SEDIMANTASYON.....A KOULE DLO-A NAN MOSO TWAL.....B BOUYI DLO-A.....C METE KLORÒS OSINON JIF NAN DLO-A..D FILTÈ.....E TRÈTMAN AVÈK SOLÈY.....F LÒT_____x (PRESIZE) PA KONNEN.....Z	 →**78**
77	Ki dènye fwa ou te itilize metòd sa-a pouw te trete dlo nan kay la?	JODI-A.....1 AYÈ.....2 DEPI PLIS PASE YON JOU.....3 PLIS PASE YON SEMÈN.....4 YON MWA E MENM L PLIS..... 5 PA SONJE.....9	
78	Ki kalite twalèt moun lakay ou sèvi? SI SE LATRIN PIBLIK, MANDE KI KALITE, ANTOURE NIMEWO 2 NAN KESYON 79 EPI ALE NAN KESYON 80	PA GEN TWALÈT/NAN RAJE.....1 TWALÈT KONFÒMODÈN..... .....2 LATRIN,.....3 TWOU.....4 FÒS VANTILE..... 5 LÒT _____ ..... 8 (PRESIZE)	→**80**
79	Eske twalèt w ap sèvi a gen lòt moun ki sèvi ladann ?	NON.....1 WI.....2	
80	Ki sa w fè ak tata ti bebe yo, e ak tata timoun ki pa ka ale nan twalèt pou kont yo?	JETE L NAN LATRIN..... .....1 ANTERE L NAN LAKOU.....2 LI PA JETE L/LI KITE L ATÈ A 3	

No.	KESYON AK ENDIKASYON YO	KÒD YO	ALE NAN
		LÒT_____.....8 (PRESIZE)	
81	Ki sa w fè ak fatra yo?	JETE L NAN TWOU SAN KOUVÈTI.... 1 JETE L NAN TWOU AK KOUVÈTI.....2 JETE L NENPÒT KOTE .....3 BOULE L.....4 KAMYON FATRA.....5 LÒT _____ 8 (PRESIZE)	

VAKSINASYON TIMOUN YO

Nº	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
82	Eske (non ti moun nan) gen yon kat vaksen osinon lòt kat kote yo ekri tout sa ki fèt pou li? SI WI : M KA WÈ L SIL VOU PLÈ?	WI, ANKETÈ A GADE L …… 1 PA LA / PÈDI/ ANFOURAYE… 2 PA T JANM TE GEN KAT 3 LI PA JANM PRAN VAKSEN 4 PA KONNEN.....9	 →**86** →**86** →**88** →**86**
83	MAKE DAT VAKSEN YO KI SOU KAT LA POU CHAK VAKSEN KI EKRI.	EKRI «11/11/1111» NAN KOLONN SI KAT LA ENDIKE YO TE BAY YON VAKSEN, MEN DAT LA PA ANREJISTRE **JOU MWA ANE**	
	a. BCG	BCG....	
	b. POLIO 0 (POLIO DEPI LI FÈK FÈT)	P0.....	
	c. POLIO 1	P1.....	
	d. POLIO 2	P2.....	
	e. POLIO 3	P3.....	
	f. DTPER 1	DTPER 1.....	
	g. DTPER 2	DTPER 2.....	
	h. DTPER 3	DTPER 3.....	
	i. ROUGEOLE	ROUG.	
	j. VITAMIN A (DÒZ PI RESAN)	VIT. A	
84	KONTWOLE KAT (non ti moun nan) POU WÈ SI YO TE PRAN PWA L PANDAN KAT DÈNYE	NON .....1 WI.....2	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
	MWA YO	PAGEN PLAS NAN KAT LA POU EKRI PWA……9	
85	Eske gen kèk vaksen (non timoun nan) te pran ki pa enskri nan kat sa a, tankou vaksen yo te bay nan jounen kanpay vaksinasyon nasyonal la ?	NON .....1 WI.....2 PA KONNEN……9	→**88** →**8**7 →**88**
86	Eske gen kèk vaksen (non timoun nan) te pran tankou vaksen yo te bay nan jounen kanpay vaksinasyon nasyonal la ?	NON .....1 WI.....2 PA KONNEN……9	→**88** →**8**7 →**88**
87	Eskew ka dim si (non ti moun nan) te pran youn nan vaksen sa yo **:**		
87a	Vaksen BCG kont tibèkiloz, se yon piki yo bay nan bra oswa sou zepòl dwat, ki toujou kite yon mak ?	NON .....1 WI.....2 PA KONNEN 9	
87b	Vaksen polio a, se kèk gout yo lage nan bouch ?	NON .....1 WI.....2 PA KONNEN 9	→**87e** →**87e**
87c	Ki lè yo te ba l premye dòz vaksen kont polio a ?	KOU LI FENK FÈT.....1 APRÈ KÈK TAN 2	
87d	Konbyen fwa yo te ba li vaksen kont polio a ?	KANTITE FWA..... ☐☐	
87e	Vaksen DTPER a, se yon piki yo bay nan kwyis oubyen nan dèyè, pafwa yo konn bay li an menm tan ak gout kont polio yo ?	NON .....1 WI.....2 PA KONNEN 9	→**87g** →**87g**
87f	Konbyen fwa ?	KANTITE FWA..... ☐☐	
87g	Yon piki pou pwoteje l kont lawoujòl ?	NON .....1 WI.....2 PA KONNEN 9	
88	Eske (non ti moun nan) te pran deja yon dòz Vitamin A, tankou sa pandan **4** dènye mwa ki sot pase yo ? MONTRE L AMPOUL LA	NON .....1 WI.....2 PA KONNEN ……..9	

MOUSTIKÈ

No	KESYON AK ENDIKATE YO	KÒD YO	ALE NAN
89	Ou gen moustikè?	NON……1 WI……..2	→ **92**
90	Eske moustikè-a tou vini ak ensektisid ladan?	NON……..……1 WI …… ……..2 PA KONNEN ……..9	
91	Eske (Non timoun nan) te dòmi yè swa anba yon moustikè ?	NON……..……1 WI……..2	

SENTÒM YON TIMOUN MALAD

No	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
92	Ki siy ak sentòm yon timoun trè malad ka genyen ki fè w oblije kouri al chèche swen avèl ? EKRI TOUT SA LI DI.	Li pa ka manje / bwè /tete .....A Sanble l pa pote l byen/ li pa jwe nòmalman .....B Souf kout ..... C Gwo lafyèv ..... D Li pa ka chita pou kont li .....E Vomisman .....F Li kagou / dekonpoze..... G Kriz. .....H LÒT _____ ..... x (PRESIZE) PA KONNEN …….....Z	
93	Ki sentòm yon timoun genyen lè li fè nemoni ? EKRI TOUT SA LI DI.	Kriz .....A Soufle an lè .....B Mal pou respire ..... C Kòt li ap rantre,venn koul detire ... D Lafyèv……..E LOT _____ ..... x (PRESIZE) PA KONNEN …….....Z	
94	Ki siy ak sentòm ki ka fè w al chache konsèy oswa tretman pou lè pitit ou gen dyare? EKRI TOUT SA LI DI.	Dyare pandan 3 jou osinon plis.....A San nan tata .....B Dezidrate /bouch li sèch .....C Mitan tèt la rantre li fon .....D Pipi a tou piti.....E Lafyèv .....F Li pa vle manje .....G Trou je l fon .....H Eksite /Rechinya.....I Kò lage……J LÒT _____ ..... x (PRESIZE) PA KONNEN …….....Z	
95	Ki sa ki ka bay lafyèv malarya? EKRI TOUT SA LI DI.	MARENGWEN .....A LOUGAWOU.....B DRÒG NAN PIKI ..... C TRANSFISYON SAN..... D	

		PIKI .....E PATAJ JILÈT .....F LÒT _____ x (PRESIZE) PA KONNEN .....Z	
96	Eske ou konn tande pale de SEWÒM ORAL ? SI WI, MANDE MANMAN AN P OU L EKSPLIKE W KOUMAN YO PREPARE YON SEWÒM ORAL SI NON, ANSÈKLE 3 (LI PA JANM TANDE PALE DE SA). APRÈ MANMAN AN FIN EKSPLIKE PREPARASYON SEWÒM ORAL LA, EKRI SI LI TE BAY EKSLIKASYON AN KÒRÈKTEMAN OU PA. ANSÈKLE 1 [KÒRÈKTEMAN] SI MANMAN AN TE PALE SOU BAGAY SA YO: • SÈVI AK 1 LIT DLO PWÒP (1 LIT= 3 BOUTÈY KOLA) • VIDE TOUT SACHE POUD LA NAN DLO A • BWASE L JISKASKE POUD LA FÒN	WI ( ) NON ( ) EKSPLIKE KÒRÈKTEMAN……1 PA EKSPLIKE KÒRÈKTEMAN….. 2 PA T JANM TANDE PALE DE SEWÒM ORAL……3	→98
97	Kote w konn jwenn SEWÒM ORAL la? EKRI TOUT SA LI DI	Machann nan lari……A Boutik .....B Famasi.....C Distribitè Kominotè .....D Zanmi /Fanmi .....E Nan sant sante-a.....F LÒT _____ x (PRESIZE) PA KONNEN .....Z	

DISTANS ANT TIMOUN YO

No	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
98	Eske w ansent ?	NON .....1 WI.....2 PA SI.....8	→**101**
99	Eske w ta renmen fè yon lòt timoun nan 2 lane k ap vini yo ?	NON .....1 WI.....2 PA SI.....8	→**100** →**101** →**100**

100	Eske w ap fè yon bagay oswa w ap swiv yon metòd pou pa tonbe ansènt kounye a? SI NON, ANSÈKLE «01» OKENN METÒD SI WI, MANDE : « Ki prensipal metòd ou menm oswa mari w/patnè w ap itilize pou pa tonbe ansent ? » ANTOURE RESPONS KI KOREK LA	OKENN METÒD .....01 NÒPLAN (piki 5 an) .....02 PIKI (3 mwa) .....03 GRENN .....04 ESTERILÈ .....05 METÒD BARYÈ/DYAFRAG .06 KAPÒT .....07 MOUS/JÈL .....08 LIGATIDÈTWOMP .....09 VAZEKTOMI .....10 ALÈTMAN MATÈNÈL. PA GEN RÈG (TETE SÈLMAN .....11 ALMANAK .....12 PA FÈ BAGAY .....13 VOYE DEYÒ .....14 LÒT_____ 88 (PRESIZE)	

VIH/SIDA

No.	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
101	Koulye a m ta renmen pale sou yon lòt bagay. Eske ou konn tande pale sou yon maladi ki rele SIDA?	NON .....1 WI.....2	→**111**
102	Eske moun ka pran jèm SIDA si li fè bagay ak yon sèl patnè ki pa enfekte e ke patnè sa a pa fè bagay ak ankenn lòt moun ?	NON .....1 WI.....2 PA KONNEN …….9	
103	Eske moun ka pran jèm SIDA si li sèvi ak kapòt chak fwa l ap fè bagay?	NON .....1 WI.....2 PA KONNEN …….9	
104	Eske moun ka pran jèm SIDA si li manje nan menm asyèt ak yon moun ki gen SIDA a?	NON .....1 WI.....2 PA KONNEN …….9	
105	Eske moun ka pran jèm SIDA si li pa fè bagay ditou?	NON .....1 WI.....2 PA KONNEN …….9	
106	Eske w t ap achte manje nan men yon machan manje si w ta konnen moun sa a gen jèm SIDA a?	NON .....1 WI.....2 PA KONNEN …….9	

No.	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
107	Si w gen yon moun nan fanmi w ki gen jèm SIDA, èske w ta renmen sa rete sekre ou non ?	WI, RETE AN SEKRE …….1. NON…….2 PA KONNEN/PA SI/SADEPAN…3.	
108	Si yon moun nan fanmi w ta tonbe malad ak SIDA, ou t ap dakò pou okipe l lakay ou ?	NON .....1 WI.....2 PA KONNEN …….9	
109	Nan dènye douz mwa k sot pase yo, èske w te konnen dirèkteman yon moun ke yo te refize ba l sèvis medikal swen paske yo te sispèk li gen jèm SIDA oubyen paske li gen jèm SIDA ?	WI ……1 1 NON …… 2 2 PA KONNEN MOUN AK VIH/SIDA. 3 3 PA KONNEN/PA SI ……9 8	
110	Eske w dakò oswa ou pa dakò ak pawòl ki di : Moun ki gen jèm SIDA yo ta dwe kondane yo paske y ap pote maladi sa a nan kominote a.	NON .....1 WI.....2 PA KONNEN …….9	
111	GADE KESYON 101: ❑ [SI LI KONN TANDE PALE DE SIDA, MANDE L:] Apa SIDA, Eske w konn tande pale de lòt enfeksyon moun ka pran nan fè bagay ? ❑ [SI LI PA KONN TANDE PALE DE SIDA, MANDE L:] Eske w konn tande pale de enfeksyon moun ka pran nan fè bagay ?	NON .....1 WI.....2	→113

No.	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
112	Eksplike sentòm fanm yo konn genyen lè yo pran yon enfeksyon nan fè bagay. **[PA LI REPONS YO FÒ.** **POU CHAK SENTOM, ANSÈKLE '1' SI LI PA DI L. E ANSÈKLE '2' SI LI DI L.]** a) DOULÈ ANBA TIVANT 1 2 b) PÈT VAJINAL 1 2 c) PÈT KI GEN MOVÈZ ODÈ d) KANAL BOULE e) TI BLESE NAN BOUBOUN f) GLANN NAN KWEN LÈN N g) GRATE 1 2 h)LÒT _____ i) PA GEN REPONS ……..99	**NON WI** Y N a.) DOULÈ ANBA TIVANT 1 2 1 2 b) PÈT VAJINAL 1 2 1 2 c) PÈT KI GEN MOVÈZ ODÈ 1 2 1 2 d) KANAL BOULE 1 2 e) TI BLESE NAN BOUBOUN 1 2 f) GLANN NAN KWEN LÈN N 1 2 g) GRATE 1 2 1 2 h)LÒT _____ 1 2 i) PA GEN REPONS ……..9 1 2	

..12

..13

..14

KONTAK AK SOUS ENFÒMASYON SOU LASANTE

N°	KESYON YO AK ENDIKASYON YO	KÒD YO			ALE NAN
113	Mwa pase a, konbyen fwa w t al kote youn nan moun sa yo : LI CHAK MO YO EPI MANDE MANMAN-AN SI LI KON AL KONTAKTE MOUN SA-A SOUVAN, PAFWA OUBYEN JAMÈ DOKTÈ ?	SOUVAN (4 fwa ou plis) 1	PAFWA (1-3 fwa) 2	JAMÈ (0 fwa) 3	

Nº	KESYON YO AK ENDIKASYON YO	KÒD YO			ALE NAN
	ENFIMYÈ/FANMSAJ ?	1	2	3	
	AJAN SANTE ?	1	2	3	
	MANM ÒGANIZASYON DE BAZ ?	1	2	3	
	MOUN RESKONSAB NITRISYON ?	1	2	3	
	MATWÒN FÒME ?	1	2	3	
	MEDSEN FÈY ?	1	2	3	
114	Pandan dènye mwa, eske-w konn tande mesaj sou lasante Pa ki mwayen LI CHAK MWAYEN YO, EPI ANTOURE YOUN OUBYEN 2. OU DWE ANTOURE YOUN (1) OUBYEN 2 POU CHAK MWAYEN		NON	WI	
	RADYO ? (estasyon _____)		1	2	
	JOUNAL ?		1	2	
	TELEVIZYON ?		1	2	
	MANM ÒGANIZASYON DE BAZ?		1	2	
	AJAN SANTE?		2	2	
	LÒT (PRESIZE)_____)		2	2	

TIMOUN MALAD

Nº	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
115	Eske pandan de dènye semenn ki sot pase yo, (non ti moun nan) te gen youn nan pwoblèm sa yo ? **LI TOUT BAGAY SA YO :** Dyare ? San nan tata ? Tous ? Soufle anlè ? Souf kout ? Fyèv? Malarya? Kriz?	DYARE ..... A SAN NAN TATA ..... B TOUS ..... C SOUFLE anlè ……..D RESPIRASYON RAPID /SOUF KOUT……..E FYÈV..... F MALARYA..... G KRIZ ..... H LÒT _____.....x	

N°	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
		ANYEN……Z	→131
116	Eske w te jwenn konsey osinon remèd pou (non ti moun nan) ?	NON ……..1 WI…… ……2	→ 122
117	Lè w te remake sentòm sa yo sou (non ti moun nan) aprè konbyen tan w t al chache yon tretman ?	MENM JOU A.....0 NAN DEMEN .....1 DE (2) JOU .....2 TWA JOU OU PLIS…….....3	
118	Ki kote w te ale an premye pou kapab jwenn yon konsèy oubyen yon tretman ?	**ETABLISMAN LASANTE** Lopital …….. ……01 Sant sante…… ……02 Klinik prive……03 Lòt Lopital…….....04 Sajfam.....05 **SOUS NON FÒMEL** Medsen Fèy……..06 Chalatan……07 Oungan……..08 Machann grenn nan lari ….....09 Boutik……10 Famasi……...11 Distribitè Kominotè……..12 Zanmi /Fanmi……13 Lòt non fòmèl _____.....88 (PRESIZE)	
119	Ki moun ki te deside ou ankouraje w, ale kote sa a pou maladi (non ti moun nana) ? EKRI TOUT SA LI DI.	ANKETÈ .....A MARI/PATNÈ .....B GRANN LI .....C BÈLMÈ .....D ZANMI / VWAZEN.....E LÒT _____..... x (PRESIZE)	

Nº	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
120	Eske ou te ale yon lòt kote pou pran konsèy osinon pou tretman pou maladi (non timoun nan) ?	NON ..... 1 WI..... 2	→ 122
121	Ki kote w t ale pou chache yon konsèy oubyen yon tretman ?	**ETABLISMAN LASANTE** Lopital …….. ……01 Sant sante…… ……02 Klinik prive……03 Lòt Lopital…….....04 Sajfam.....05 **SOUS NON FÒMEL** Medsen Fèy……..06 Chalatan……07 Oungan……..08 Machann grenn nan lari ….....09 Boutik……10 Famasi……...11 Distribitè Kominotè……..12 Zanmi /Fanmi……13 Lòt non fòmèl _____.....88 (PRESIZE)	
122	Lè (non ti moun nan) te malad la, eskew te ba l mwens tete pase sa w te konn ba li anvan an, oubyen prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS ..... 1 MENM KANTITE..... 2 PLIS ..... 3 TIMOUN PA T TETE……4 PA KONNEN..... 9	
123	Lè (non ti moun nan) te malad la, eskew te ba l bwè mwens pase sa w te konn ba li anvan an, oswa prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS ..... 1 MENM KANTITE..... 2 PLIS ..... 3 PA BWÈ ANYEN ..... 4 PA KONNEN..... 9	
124	Lè (non ti moun nan) te malad la, eskew te ba l mwens manje pase sa w te konn ba li anvan an, oswa prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS ..... 1 MENM KANTITE..... 2 PLIS ..... 3 PA MANJE ANYEN ..... 4 PA KONNEN..... 9	
125	Pandan (non ti moun nan) t ap refè pou l sot nan maladi a, eskew te ba l bwè mwens pase sa w te konn ba li anvan an, oswa prèske menm kantite a, oubyen plis pase sa w te konn ba li anvan an ?	MWENS ..... 1 MENM KANTITE ..... 2 PLIS ..... 3 PA BWÈ ANYEN ..... 4 PA KONNEN..... 9	

Nº	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
126	**ALE NAN KESYON 115 E KONTWOLE REPONS MANMAN AN.**	**KONTWOLE KI MODIL POU APLIKE**	
	SI **A OU B:** APLIKE MODIL . **DYARE**	MODIL C (DYARE)	→ **129**
	SI **C, D, OU E:** APLIKE MODIL. **IRA**	MODIL A (IRA)	→ **127**
	SI **F, G, H:** APLIKE MODIL **MALARYA**	MODIL B (MALARYA)	→ **128**
MODIL A : TRETMANT TIMOUN AK PWOBLÈM RESPIRATWA			
127	Ki medikaman (non timoun nan) te bwè pou pwoblèm respitatwa? EKRI TOUT SA LI DI. SI MANMAN AN PA KA SONJE NON MEDIKAMAN (NON TIMOUN NAN) YO, MANDE LI POU L MONTRE W YO.	ANYEN..... A ASPIRIN..... B ASETAMINOFÈN ..... C AMOKSISIILIN..... D ERITWOMISIN..... E ANPISILIN..... F KOTRIMOKSAZÒL……..…G LÒT_____ x (PRESIZE) PA KONNEN……Z	
MODIL B : TRETMAN TIMOUN KI GEN FYÈV			
128	Ki medikaman (non ti moun nan) te bwè pou lafyèv li a? EKRI TOUT SA LI DI. MANDE LI POU L MONTRE W YO.	ANYEN……A ASPIRIN……..B ASETAMINOFÈN ……..…..C KOTRIMOKSAZÒL……D KLOWOKIN ...…… E KININ.....F LÒT_____ x (PRESIZE) PA KONNEN……..Z	
MODIL C : SWEN TIMOUN AVÈK DYARE			
129	Ki sa (non ti moun nan) te bwè pou trete dyare a ? EKRI TOUT SA LI DI. SI MANMAN AN PA KA SONJE NON MEDIKAMAN (NON TIMOUN NAN) YO, MANDE LI POU L MONTRE W YO.	ANYEN.....A SEWÒM ORAL .....B PREPARASYON NAN KAY .. C GRENN OUBYEN SIWO..... D PIKI .....E PIKI NAN VENN (IV) .....F REMÈD NAN KAY/ REMÈD TRADISYONÈL…….G LÒT_____..... x (PRESIZE) PA KONNEN…… Z	
130	Eske (non ti moun nan) te pran zen pou dyare a ?	NON……1 WI……..……2 Si WI, pou konbyen jou : __ __	

ANTWOPOMETRI

Nº	KESYON YO AK ENDIKASYON YO	KÒD YO	ALE NAN
131	Nan sis dènye mwa ki sot pase yo, èske (non timoun nan) te pran medikaman pou vè ?	NON.....1 WI.....2 PA KONNEN.....9	
132	MANDE MANMAN AN SI W MÈT KONTWOLE MEZI BRA (non timoun nan). SI LI DAKÒ, EKRI ENFOMASYON ESANSYÈL YO NAN ESPAS KI PI BA YO		

PERIMÈT BRAKYAL

☐☐☐ **nilimèt**

LAVE MEN			
133	Eske lakay ou a gen yon kote espesyal pou lave men ?	NON.....1 WI 2	→**FIN**
134	MANDE YO POU YO MONTRE W KOTE YO LAVE MEN YO, E GADE SI YO GEN BAGAY SA YO :	**NON WI** (A) DLO/TIYO .....1 2 (B) SAVON/FAB .....1 2 (C) KIVÈT 1 2	
135	Ki lè w lave men w yo ak savon osinon fab? EKRI TOUT SA LI DI.	PA JANM..... ……..A ANVAN PREPARE MANJE .....B ANVAN BAY MANJE/ BAY TETE...C LÈ W SOT NAN TWALÈT.....D LÈ W FIN N NETWAYE YON TIMOUN KI TE SAL AK TATA …….. E LOT_____ 8 (PRESIZE)	

ANNEX G-2: RAPID HEALTH FACILITY ASSESSMENT SUMMARY REPORT

In March 2005, a rapid assessment of five health centers in the project area was conducted by the Concern Worldwide US Health Advisor and the Community Health Officer who is familiar with the project site. This exercise was completed for the purposes of getting a broad picture of the infrastructure, availability os services, profile of staff and capacity, orientation to supervision and HMIS systems, utilization of services, and essential drug management.

The tool used was adapted from the BASICS Health Facility Assessment Tool to focus around the areas of maternal and newborn care, integrated management of childhood illnesses, and vaccinations as well as some areas related to HIV/AIDS and STI services.

The health facilities surveyed are listed in table 1.

Table 1: Facilities surveyed

Neighborhood	Facility	Rationale
Descayettes	SNELAK Health Center	Partner institution
St. Martin	St. Martin II	Partner institution
St. Martin	Salvation Army	Availability of complementary services, collaboration and complarison
Cite Okay/Jeremi	HaitiMed Health Center of Siclait	Partner institution
Jalousie / Bois Moquette	OBDC Health Center	Partner institution

A copy of the tool used is available in French as attachment to this summary.

1. Availability of Services

Health Centers are generally open on weekdays only. In all cases there have been periods of insecurity where the facility had to temporarily close. Both facilites in St. Martin were closed for most of 2005.

Table 1: Service Hours

Health Center	Monday – Friday	Weekends
St. Martin II	8:00 a 16:00	Closed
HaitiMed	8:00 a 14:00	Closed
Armee Salue	7:00 a 14:00	Closed
Descayettes	7:30 a 16:30	Sat 7:30 a 12:30
Jalousie	8:00 a 15:00	Closed

Table 2: Summary of Availability of Service by Type

	St. Martin II	HaitiMed	Armee Salue	Descayettes	Jalousie
Prenatal	✓	✓	✓	✓	✓
Delivery	x	x	x	x	x
Postpartum/ Newborn Care	✓	✓	✓	✓	✓
Vaccination	✓	x	✓	✓	✓
Nutrition Counseling	✓	✓	✓	✓	✓
Therapeutic malnutrition care	x	x	x	x	x
Management of Sick Child	✓	✓	✓	✓	✓
STIs	✓	✓	✓	✓	✓
VCT	x	✓	✓	✓	X
Family Planning	✓	✓	✓	✓	✓
Referrals for Obstetric Care	Jude Anne / General Hospital			General Hospital	General Hospital
Reference Enfant Malades	General Hospital	Grace Children	General Hospital	General Hospital	Petits Freres et Souers

✓ **Service Provide x Service not provided**

2. Quality of Services

Service	Strengths	Weaknesses
Prenatal Care	All 5 HCs offered an antenatal package which included physical examination, TT, iron folate supplementation, breastfeeing counseling, and information on danger signs 3 of the HCs currently officer PMTCT and reference to hospital for care	No facility has capacity to offer delivery services as they cannot afford to function 24 hours per day. There has been no training of staff in antenatal care in 3 of the 5 HCs in the past three years. Women served last where HCs prioritized children to the front of the waiting line.

Service	Strengths	Weaknesses
Postpartum and Newborn Care	All 5 HCs offer systematic physical exam, breastfeeding counseling, and weighing of th newborn. All but 1 HC provide Postpartum Vitamin A and offer BCG/Polio 0 vaccinations NEWBORN CARE is one of the 3-4 most used services as importance of early vaccination is known by the population	Very low use of POSTPARTUM care. Newborn often escorted by another family member rather than mother. Only 1 HC had any staff trained on postpartum and newborn care in the past three years. One HC does not provide BCG/Polio or Vitamine A services as they are an EPI outreach site only. Two HCs do not prescribe tetracycline eye drops.
Vac-cination	EPI is one of the most utilized services There have been no stock-outs in the past six months with the exception of a brief stock-out of Polio among 2 private clinics. Most HCs have several staff recently trained on EPI norms and standards Monitoring systems exist in all 5 HCs.	Quality of monitoring of cold chain – missing afternoon recordings, one fridge consistently recorded at 0 degrees C. Only 2 HCs use a system to identify and track drop-outs. Two HCs have no proper biomedical waste disposal. Two HCs do not offer routine vaccination services and rely on another provider to provide outreach services at their site.
Nutrition	All 5 HCs conduct routine growth monitoring and nutrition counseling All have a reliable stock of albendazole which is usually free	No HCs have capacity to provide therapeutic nutrition care and none are aware of any reference service. All HCs report high levels of severe malnutrition. They had temporarily support from WFP but no longer available. Only 1 HC has outreach GMP services

Service	Strengths	Weaknesses
Outpatient sick child	A Medical Doctor is present during working hours in 4 of the 5 HCs. The remaining HC has a MD visit one day per week. All HCs have at least one consultation room with minimum tools for basic investigations. All children are placed in the front of the waiting line. Amoxycilline and Cotrimoxaole are generally available at all HCs in syrup and capsule form.	Only 2 HCs had any staff ever trained in IMCI. Most workers are not familiar with the term IMCI. There is a complete absence of algorithmes or job aids in the clinics. The prices and availability of stock varies. Antibiotics antibiotiques cost between 30 and 105 gdes per treatment. Two HCs had no ORS since Oct 2005, both were private. Consultation rooms at two private facilities were to dark to adequately consult a client.
STI services and Voluntary Counseling & Testing	All 5 HCs provide STI syndromic mangement and 4 out of 5 also provide lab investigations. All HCs offer free condoms 3 out of 5 HCs offer VCT services and another is planning to offer it starting in 2006. Most health workers have been trained for 10 or more days on HIV/AIDS counseling, testing and lab in the past three years.	Two fo the HCs had a stock-out of condoms the day of the survey but this is viewed as a communications problem within the C team rather than supply problem. No HC is connected to any group of PLWHAs and none offer ARV services (although Descayettes may be preparing to do so but management is unsure. None provide supplementary food for PLWHAs. Price of HIV testing varies from free to 250 Gourdes depending on its source
Family Planning	All HCs offer 2-3 modern methods, including condoms. Supply is generally very reliable and contraceptives are available free of charge	Family Planning is the least used of the surveyed services, very low utilization levels reported Two HCs do not offer Depo even though it is the most popular method

Supervision and Reporting

Public Sector

- While the standard is a monthly supervision visit per month to each HC by the Bureau Communale lack of manpower and transport makes this impossible.
- At St. Martin II, the last supervision visit was three months ago in December 2005. The visit was considered very helpful and comprehensive by the staff. It included observation of the site, meetings with personnel, review of registers and stock of drugs.
- The HC administration finds itself at the BC nearly every week because of the need to actively place and follow up on drug orders.
- The Monthly reports are routinely completed and submitted in copy to the BC. There was no indication the either the staff nor the supervisors were using this information – no feedback and no examples from HC staff on how the use the data or what they find helpful about it.

Private Sector Health Facilities

- The private, non-profit facilities are directly supervised by their head office in Port-au-Prince. Management from the agency makes very regular visits. Due to the frequency staff are unsure if the purpose is communication or supervision.
- The content of supervision varies but usually it focuses in health statistic trends, particularly utilisation of services and stock of medicines.
- HC staff appreciate the feedback from their Head Office and are recognized for good performance as well as when there are problems.
- Monthly reports are based on Head Office format and not necessarily match that HMIS monthly report format of MSPP. The report is submitted to the Head Office who then pass on info to the BC, primarily EPI data.
- Only in the Petion-Ville BC did we find supervision of the private centers.

Costs and Access

- All the health centers recognized that several clients have great difficulty to pay th 20 to 500 Gourdes for consultation, lab exams, and drugs. Most recognized that mothers with young children do not work outside the home.
- No HC has a formal guideline or system to identify and exonerate the extreme poor who cannot afford to pay
- Some basic services like EPI and FP are free, but sometimes people have to still pay the consultation fee
- A few administrators mentioned that they talk with clients who claim they cannot pay and are able to make exceptions to the people they really believe ; however, they are cautious as word gets out to the residents that they make exceptions and then people aren't willing to pay. They have extremely tight operating budgets.
- GRET is working in Descayettes and other urban neighborhoods to pilot the introduction of health insurance schemes called mutuelles. There might be some good data there on willingness and ability to pay.

Attachment : Tool - Situation Bref au Centres de Santé

Centre : _____ Date : _____

Neighborhood : _____ Bureau Communal : _____

Introduction :

- Présentation des interviewers et le projet urbain pour la protection de la santé des enfants et réduire les risques aux jeunes de la VIH au zone urbain, projet de moyen modeste mais un équipe avec beaucoup d'expérience de Concern, GRET, et FOCAS en santé urbain avec le DSO a Port au Prince
- Sujet de la visite – mieux apprendre de la situation actuelle de la service sanitaire
- How info will be used (careful about expectations)
- Confidentialité et demande l'accord de précéder – estimation de temps 1h30 minutes.

SECTION A. ENTREVUE AVEC LE CHARGE DE CENTRES soit EQUIPE DU CENTRE SI POSSIBLE (encircler le cas)

1. Nom de la personnes charges du centre/respondent principal (nom, poste, nombres des annees au CS) _____

2. Décrire le profile de staff ici :

Cadre	Nombre Affecté au Centre	Nombre présent le jour de l'enquête	Qualifications (certificat/diplôme)
Médecins			
Infirmières			
Infirmières Sage Femme			
Laborantine			
Pharmacien			
Auxiliaries - base au CS			
Auxiliaries / agents de sante– base a la communaute			
Prepose aux archives			
Autres ouvriers (gardien, nettoyage, etc)			
ADMINISTRATION			

3. Quels sont les heures de l'ouverture de centre ?

	Heures Normales	Remarques
Lundi-Vendredi		
Samedi		

Dimanche

4. Quand le centre est fermé, où vont les malades ?_____

5. Quels services offrez-vous ici :

Service	Offert ?	Tous les jours ?	Services offert ? (encircler)
CPN	O / N		• Examen physique • TT • Fer/folate • PTME (dépistage + counseling + intervention accouchement) • Education des signes de danger • Conseil sur l'allaitement • Conseil sur le PF
Accouchement	O / N		• Accouchement normal / vaginal • Suivi avec partogramme • Repos avec surveillance post-partum de 24+ heures • Accouchement assiste (vacuum) • Administration d'ergometrine pour le PPH • Transfert assister pour les complications (preciser) :
Soins de nouveau nés (première semaine)	O / N		• Examen physique • Pesée • Vaccination (BCG/ Polio) • Counseil avec observation de l'allaitement • Supplementation Vitamine A pour la mère
Vaccination de l'enfant			• Offrir les 6 vaccines de PEV • Suivi des « abandonnes » • Stock des vaccines sur place • Depot des aiguilles utilises • Incinérateur
Nutrition	O / N		• Pesée au centre • Pesée dans la communauté • Conseil nutritionnel • Distribution des micronutriments • Services thérapeutique pour les sévère (spécifier : _____) ou transfert pour la malnutrition sévère a _____ (préciser l'endroit)
Prise en charge de l'enfant malade de la diarrhée, fièvre, et respiration rapide	O / N		• Système de triage dans la queue • Examen et soin en algorithme PCIME • Surveillance des cas graves • Analyse des selles • Contrôler les respirations • Prendre la température • Regarder la bouche et les oreilles • Counseil nutritionnelle • Supplementation de Vitamine A / Micronutriments
IST/VIH/SIDA	O / N		• IST (syndromique) (investigations labo) • Promotion des condoms • VCT • Groupe de soutien des personnes vivantes avec le VIH • Appui nutritionnel (spécifier) _____ • ARVs • Traitement des infections opportunistes/TB • Autre : _____
Planning familial	O / N		• Pillule

Service	Offert ?	Tous les jours ?	Services offert ? (encircler)
			• Condom • Depo • Norplant • IUD • Vasectomies • Hysterectomies

6. Quelle est votre aire d'attraction ? Savez-vous combien de personne vivent dan cette zone ?

Population	Enfants moins de 5 ans	Femmes en age de 15 a 49 ans	Femmes enceintes annuelles

7. **Comment est que le centre travail avec la communauté ? Faites vous les campagnes, le suivi des abandonnes, l'éducation sanitaire** ? (décrire, fréquence, etc)

8. Connaissez-vous les personnes suivantes dans votre aire d'attraction?

	Nombre connu	Collaboration existe ?	Les capacités a renforcées
Matronnes			
Org de Base Communautaire			
Comite d'eau			
Comite de sanitation			
Tradipractien			
Club des jeunes			
Autres :			

9. Utilisation des services et leurs prix (voir le tableau a la fin de questionnaire pour la classification)

Service	Clients de Jan a Dec 2005 (si disponible facilement)	Classifier les services selon le niveau de utilisation (1 le plus, 10 le moins)	Estimation de coûte moyen par client pour le service
CPN			
Accouchement			
Soins de nouveau nés			
Vaccination de l'enfant			
Malnutrition sévère			
Prise en charge de l'enfant malade de la diarrhée, fièvre, et			

respiration rapide
IST
Dépistage de VIH
Services de personnes avec le SIDA :infections opportunistes, alimentation supplémentaire, régime ARV
Planning familial

10. Existe-il une système pour aider les indigents à accéder le soin ? Expliquer la situation.

_____

11. Qui sont les indigents/plus vulnérables dans votre aire d'attraction ? Comment vous les identifier?

_____

12. Où vont la majorité de vos clients pour le service de référence?

Hôpital	**Distance**	**Moyen de transport typiquement utilise, le temps et coûte d'arriver la bas**	**Prix de consultation**

11. Est-ce qu'au cours des derniers 3 ans quelqu'un dans votre équipe actuel a reçu de formation a un des sujets suivants ?

Service	**Sujet de la formation et la duré**	**Cadre de staff et nombre formé**
Planning familial		
CPN		
Accouchement		
Soins de nouveau nés		
Nutrition		
Prise en charge de l'enfant malade de la diarrhée, fièvre, ou la pneumonie		
Vaccination de l'enfant		
La gestion : de la pharmacie, de la système information sanitaire, des ressources humaines…		
Counseil et dépistage de VIH		
IST		
SIDA – les infections opportunistes, les ARVs, la nutrition		

12. **Qui vous supervise?** _____ Combien de fois devrait-il vient par année ? _____

Et, en réalité combien de fois vient-il ? _____ Faites vous l'evaluation annuel de centre ?_____

Date de la dernière visite ? _____ Qu'est que le superviseur a fait précisément pendant cette dernière visite ? _____

Comment peut la supervision être améliorée? _____

Faites vous les réunions régulières a niveau de Bureau Communale soit DSO ? _____

13. **[SIS]** Comment faites vous les rapports de services ? A quel rythme ? Comment utiliser vous ces informations ?

13b. Avez-vous l'impression que vos rapports sont bien étudiés au niveau supérieur ? Recevez vous du feedback au cours des derniers 12 mois ?

SECTION B : OBSERVATION DE LA CENTRE

14. Demander de faire un tour avec votre hôte de toutes les zones du centre. Chercher a observé les éléments clés et leurs circuler si présent et faites les notes de spécifications.

Zones	Eléments clés	Remarques
Réception/accueil	Vite trouvable	
	Personnel présent	
	Les Prix visiblement afficher	
	Disponibilité des fiches	
Salle d'attente	Suffisance des sièges	
	De l'aire / de l'abri	
	Information sanitaire visible	
	Système de triage évident ?	
Salle de consultation	Quantité des salles ____	
	Algorithmes visibles	
	Stéthoscope	
	Ortho scope	
	Thermomètre	
	Boite autodestructif	
	Balance adulte	
	Balance pédiatrique	
Salle d'observation	Quantité des lits	
	Les drape propres	
	Clipboard pour le dossier	
	Porte sérum	
Salle de petite chirurgie	Stérilité/désinfection	
	Eclairage	
	Lit d'opération	
	Station d'équipement	
	Boite autodestructif	
	Electricité	
	Eau courante	
	Point de lavage des mains	
	Du savon	
	Lit de l'accouchement	
Laboratoire	Propreté	
	Microscope fonctionnel	
	Frigo fonctionnel	
	Centrifuge	
	Intrants (reagents, etc.)	
	Boite autodestructif	
	Electricité	
	Eau courante	
Latrine	Quantité _____	
	Propreté	

Zones	Eléments clés	Remarques
	Accessibilité	
	Point de lavage des mains	
	Du savon	
Eau	Source : _____	
	Fonctionnement régulier	
	Disponibilité de l'eau a boire traitée	
Incinérateur	Propreté	
	Evidence de l'utilisation	
	Protéger contre les personnes	

SECTION C : VISITE A LA PHARMACIE

15. Comment fonctionne le commande et en registration des médicaments ? *Source,* *fréquence, vérification de contenu.*

---

16. Comment faire la gestion de la caisse? Y'a-t'il une comite ? Qui est membre et comment fonction elle ? Suggestions pour l'améliorer ?

---

17. Revoir la disposition des médicaments suivants:

Médicaments	Disponible aujourd'hui ?	Rupture de stock au cours des deniers 6 mois?	Source(s)	Prix pour un dose complete
Amoxycilline – comprimes	Oui / Non	Oui une fois Oui plus d'une fois Non		
Amoxycilline – sirop	Oui / Non	Oui une fois Oui plus d'une fois Non		
Cotrimaxoale – comprimes	Oui / Non	Oui une fois Oui plus d'une fois Non		
Cotrimaxoale – sirop	Oui / Non	Oui une fois Oui plus d'une fois Non		
Liquide tétracycline pour les yeux	Oui / Non	Oui une fois Oui plus d'une fois Non		
Penicillium injectable	Oui / Non	Oui une fois		

Médicaments	Disponible aujourd'hui ?	Rupture de stock au cours des deniers 6 mois?	Source(s)	Prix pour un dose complete
		Oui plus d'une fois Non Oui une fois		
SRO	Oui / Non	Oui plus d'une fois Non Oui une fois		
Fluides IV / Ringer lactate	Oui / Non	Oui plus d'une fois Non Oui une fois		
Paracetemol/aspirine	Oui / Non	Oui plus d'une fois Non Oui une fois		
Chloroquine	Oui / Non	Oui plus d'une fois Non Oui une fois		
Lait thérapeutique (F100 et F75)	Oui / Non	Oui plus d'une fois Non Oui une fois		
Biscuit énergétique BP 5 / BP 10 pour la malnutrition sévère	Oui / Non	Oui plus d'une fois Non Oui une fois		
Condoms	Oui / Non	Oui plus d'une fois Non Oui une fois		
VIH rapid test	Oui / Non	Oui plus d'une fois Non Oui une fois		
ARVs	Oui / Non	Oui plus d'une fois Non Oui une fois		
Fer/folate	Oui / Non	Oui plus d'une fois Non Oui une fois		
Multivitamins	Oui / Non	Oui plus d'une fois Non Oui une fois		
Suppléments de Vitamine A 100,000 IU (dose infantile)	Oui / Non	Oui plus d'une fois Non Oui une fois		
Suppléments de Vitamine A 200,000 IU (dose femme post partum)	Oui / Non	Oui plus d'une fois Non Oui une fois		
Du zinc	Oui / Non	Oui plus d'une fois Non Oui une fois		
Albendazole ou autre vermifuge (préciser : _____)	Oui / Non	Oui plus d'une fois Non		
Contraceptives modernes	Oui / Non	Oui une fois		

Médicaments	Disponible aujourd'hui ?	Rupture de stock au cours des deniers 6 mois? Oui plus d'une fois Non	Source(s)	Prix pour un dose complete

SECTION D: VACCINS

17. Demander de voir les endroits où on garde les vaccines.

Vaccin	Disponible aujourd'hui ?	Rupture de stock au cours des deniers 6 mois?	Source(s) de le vaccin
Polio	Oui / Non	Oui une fois Oui plus d'une fois Non	
BCG	Oui / Non	Oui une fois Oui plus d'une fois Non	
Rougeoles	Oui / Non	Oui une fois Oui plus d'une fois Non	
DPT	Oui / Non	Oui une fois Oui plus d'une fois Non	
Toxoid Tetanus (TT)	Oui / Non	Oui une fois Oui plus d'une fois Non	

18. Observations de la maintenance de la chaîne froide:

Eléments clés	Observation
Condition du frigo: température *de 2 a 8 degré C, propriété, organisation*	
Evidence de control de la température Fiche de suivi, fréquence de control, thermomètre	
Présence de Vaccine Vial Monitors (VVMs): *Ces petites étiquettes change irréversiblement de couleur pour indiquer l'expose à la chaleur qui peut détruit l'efficacité du vaccin. Tous vaccins fournières par UNICEF sont obliges de porter le VVMs.*	

SECTION E: CLOTURE

Remerciements. Mentionner le DIP ateliers et les assurer qu'on donnera du feedback. Il faut le souvenir qu'on utilisera cette information pour améliorer les plans détailles du programme mais qu'on ne serait pas capable d'adresser tous les problèmes comme un seul projet de moyen modeste.

Autres commentaires du personnel :

Autres commentaires des observateurs:

ANNEX G-3: GUIDE DE DISCUSSION DE GROUPE DES ORG BASE COMMUNAUTAIRE

THEME A : L'organisation et la communauté

1. Dites-nous un peu de l'histoire, mission, des activités et les membres de ce groupe? Avez-vous développé les rôles et règlements internes ?

2. Qui sont les autres organisations et institutions importants ici ? (Chercher les églises, des clubs, les institutions sanitaires, les comites d'hygiène)

3. Avez-vous des collaborations avec certains d'entre elle?

THEME B: Perspective sur la Situation Sanitaire

4. En perspective d'expert du quartier de _____, quelle est la situation de la santé de la population ? Où sont les sources de soin – formel et informel ? Mettre en rang les plus utilisée, la distance et le coûte.

5. Souvent les Tradipractien, comme les herboriste, charlatans, Matronnes, etc., sont le premiers sources de secours hors de la maison pour les familles des moyens modestes. Est-ce que c'est le cas ici ? Entre tous les tradipraticiens, qui sont les plus importants, qui voit les enfants malades ? Combien sont ils dans votre quartier ? Les connaissez-vous bien? Que pensez-vous de les impliquer dans les activités santé? Comment faire?

6. Qui sont les familles avec jeune enfant qui ont le plus grande difficulté d'accès aux soins ? Expliquer nous leurs situation et les barrières ? Qu'est que vous pensez pourrir être fait pour leur encourager d'utiliser les services ?

THEME C. Engagement de l'Org Base Communautaire dans la Santé

7. Ou se trouve « la santé des mères, les adolescents, et les enfants » dans vos priorités ? Le plus important, très important, important mais il y a d'autres choses…. Pourquoi vous le classifier a ce niveau?

8. Nous sommes a la recherche des idées de comment réussir une amélioration de la santé qui touche toutes les foyers dans ce quartier. Est-ce que vous avez de suggestions de comment on peut arriver faire les action suivant [en se souvenir que nous sommes un projet de moyens très modeste et que les actions devrait être d'une façon qu'il continuera après sa fin) et que peut être le rôle de votre organisation?

- Diffuser l'information sur les signes de danger des problème de la santé qui devrait être transférer rapidement au centre de santé

- Dessiner les affiches attirement pour le réplication et dissémination dans le quartier

- Organiser les mères, les pères, soit les jeunes (selon le thème de discours) pour les séances intéressant sur la santé?

- Faciliter les séances très attirantes sur la santé pour les spectateurs?

- Retrouver les enfants abandon du programme vaccinal

- Identifier et surveiller les ménages avec les enfants moins de deux ans

- Rapporter sur l'incidence de la naissance, la maladie infantile grave, et les décès infantiles régulièrement

9. Quels sont les ressources communautaire hors de votre organisation même qui peut nous en aider a développer cette intervention? Que pensez vous de la participation des groupes des jeunes a l'école, aux églises?

ANNEX H: BUDGET REVISION

H-1 Revised 424, 424A
H-2 Detailed five-year budget
H-3 Budget Narrative
H-4 Sub-agreements with FOCAS & GRET
H-5 NICRA

AMENDMENT TO MoU BETWEEN
CONCERN WORLDWIDE AND FOCAS

Amendment to MoU signed November 12, 2004 by Mr. Richard P. Taylor, Executive Director of FOCAS (subgrantee) and Kieron Crawley, former Country Director of Concern Worldwide Haiti (lead agency).

Effective September 30, 2005, the **Strengthening Maternal & Child Health in Five Disadvantaged Neighborhoods of the Metropolitan Area of Port au Prince** was awarded a cooperative agreement from USAID/HIGN/NUT/CSHGP, GHS-A-00-05-0018-00 for implementation as established in the Concern Worldwide Child Survival & Health Grants standard grant application submitted on November 20, 2004. A copy of the cooperative agreement is attached as annex 1.

As per the terms of aforementioned MoU, the subgrantee status of FOCAS for this grant is effective from September 30, 2005 – September 30, 2010. As per the terms of this agreement stipulated in the award c.19(e), the subgrantte is requested to comply with the requirements placed on the organization by OMB Circulars, and Federal and USAID regulations with respect to management of, among other things, personnel policies, travel, procurement.

Required forms to be completed prior to initial advance disbursement include certifications attached as annex 2. These include certifications of:

- Terrorist Financing
- Assurance of Compliance with Laws and Regulations Governing Non-discrimination in Federally Assisted Programs
- Certification Regarding Lobbying
- Prohibition on Assistance to Drug Traffickers for Covered Countries
- AAPD 05-04 Certification for HIV/AIDS Program Funds (only for programs implementing HIV/AIDS interventions)

Kindly return these to the attention of our Child Survival Advisor at our US office at Concern Worldwide US, Inc., 104 East 40th Street, Suite 903, New York, NY 10016.

This amendment to the Agreement is signed by:

For Subgrantee:

Name: Richard Taylor

Title: Executive Director

Date: 13 Dec. 2005

Signature: Richard P. Taylor

For the Lead Agency:

Name: Carine Roenen

Title: Country Director

Date: 24 Feb 2006

Signature:

AMENDMENT TO MoU BETWEEN
CONCERN WORLDWIDE AND GRET

Amendment to MoU signed November 12, 2004 by Dr.Daniel Henrys , Executive Director of GRET Haiti and Carine Roenen, Country Director of Concern Worldwide Haiti (lead agency).

Effective September 30, 2005, the **Strengthening Maternal & Child Health in Five Disadvantaged Neighborhoods of the Metropolitan Area of Port au Prince** was awarded a cooperative agreement from USAID/HIGN/NUT/CSHGP, GHS-A-00-05-0018-00 for implementation as established in the Concern Worldwide Child Survival & Health Grants standard grant application submitted on November 20, 2004. A copy of the cooperative agreement is attached as annex 1.

As per the terms of aforementioned MoU, the subgrantee status of GRET for this grant is effective from September 30, 2005 – September 30, 2010. As per the terms of this agreement stipulated in the award c.19(e), the subgrantee is requested to comply with the requirements placed on the organization by OMB Circulars, and Federal and USAID regulations with respect to management of, among other things, personnel policies, travel, procurement.

Required forms to be completed prior to initial advance disbursement include certifications attached as annex 2. These include certifications of:

- Terrorist Financing
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Kindly return these to the attention of our Child Survival Advisor at our US office at Concern Worldwide US, Inc., 104 East 40th Street, Suite 903, New York, NY 10016.

This amendment to the Agreement is signed by:

For Subgrantee:

Name: Dr. Daniel Henrys

Title: Executive Director

Date: 27/04/06

Signature: P.O. Gesner Boutome

For the Lead Agency:

Name: Carine Roenen

Title: Country Director

Date: 2/5/06

Signature: C ROENEN

USAID
FROM THE AMERICAN PEOPLE

NEGOTIATED INDIRECT COST RATE AGREEMENT

October 6, 2005

ORGANIZATION
Concern Worldwide (U.S.), Inc.
104 East 40th Street, Room 903
New York, NY 10016

The rates approved in this Agreement are for use on grants, contracts and other agreements with the Federal Government to which OMB Circular A-122 applies, subject to the conditions in section II.A, below. The rate(s) were negotiated by the U.S. Agency for International Development in accordance with the authority contained in Attachment A, Section E.2.(a), of the Circular.

SECTION I: NEGOTIATED INDIRECT COST RATES

TYPE	EFFECTIVE PERIOD		INDIRECT COST RATES
	FROM	THROUGH	OVERHEAD (a)
Final	01-01-04	12-31-04	9.49%
Provisional	01-01-05	Until Amended	9.49%

Base of Application
(a) Total direct program costs (including fundraising costs), excluding subcontracted services from Concern Worldwide, Ltd. in excess of $100,000 per award per year and subrecipient awards of Concern Worldwide, Ltd. in excess of $25,000 per award per year

U.S. Agency for International Development
1300 Pennsylvania Avenue, NW
Washington, DC 20523
www.usaid.gov

SECTION II: GENERAL

A. LIMITATIONS: Use of the rate(s) contained in this Agreement is subject to all statutory or administrative limitations and is applicable to a given grant, contract or other agreement only to the extent that funds are available. Acceptance of the rate(s) agreed to herein is predicated upon the following conditions:

1. That no costs other than those incurred by the grantee or allocated to the grantee via an approved central service cost allocation plan were included in its indirect cost rate proposal and that such incurred costs are legal obligations of the grantee and allowable under the governing cost principles,

2. That the information provided by the grantee which was used as a basis for acceptance of the rate(s) to herein is not subsequently found to be materially inaccurate,

3. That the same costs that have been treated as indirect costs have not been claimed as directs costs, and

4. That similar types of costs have been accorded consistent treatment.

B. ACCOUNTING CHANGES: The grantee is required to provide written notification to the indirect cost negotiator prior to implementing any changes which could affect the applicability of the approved rates. Any changes in accounting practice to include changes in the method of charging a particular type of costs as direct or indirect and changes in the indirect cost allocation base or allocation methodology require the prior approval of the Office of Overhead, Special Cost and Closeout (OCC). Failure to obtain such prior written approval may result in cost disallowance.

C. NOTIFICATION TO FEDERAL AGENCIES: A copy of this document is to be provided by this organization to other Federal funding sources as a means of notifying them of the Agreement contained herein.

D. PROVISIONAL-FINAL RATES: The grantee must submit a proposal to establish a final indirect cost rate within nine months after its fiscal year end. Billings and charges to Federal awards must be adjusted if the final rate varies from the provisional rate. If the final rate is greater than the provisional rate and there are no funds available to cover the additional indirect costs, the organization may not recover all indirect costs. Conversely, if the final rate is less than the provisional rate, the organization will be required to pay back the difference to the funding agency.

E. SPECIAL REMARKS:

1. Indirect costs charged to Federal grants/contracts by means other than the rate(s) cited in the agreement should be adjusted to the applicable rate(s) cited herein which should be applied to the appropriate base to identify the proper amount of indirect costs allocable to the program.

2. Grants/contracts providing for ceilings as to the indirect cost rate(s) or amount(s), which are indicated in Section I above, will be subject to the ceilings stipulated in the grant, contract or other agreement. The ceiling rate(s) or the rate(s) cited in this Agreement, whichever is lower, will be used to determine the maximum allowable indirect cost on the grant or contract agreement.

3. The rates hereby approved are subject to periodic review by the Government at any time their use is deemed improper or unreasonable. You are requested to advise the Government promptly of any circumstances, which could affect the applicability of the approved rates.

4. You are directed to promptly submit adjustment vouchers or final vouchers for all flexibly priced grants, contracts or other agreements. Audit adjustments should be clearly delineated so as to be readily identifiable for verification by this office. Care should be taken that amounts claimed do not exceed award limitations or indirect cost rate ceilings.

ACCEPTED: Concern Worldwide (U.S.), Inc.

By: _____
Printed or Typed Name
GLENN CUMMINGS

FINANCE DIRECTOR
Title

15 OCTOBER 2005.
Date

James N. Davis
James N. Davis
Contracting Officer
Overhead, Special Cost and Closeout Branch
Cost, Audit and Support Division
Office of Acquisition and Assistance
U.S. Agency for International Development

The Urban Health Project for Five Disadvantaged Neighborhoods of Metropolitan area of Port-au-Prince

A partnership led by Concern Worldwide with FOCAS, GRET and MSPP/West Department

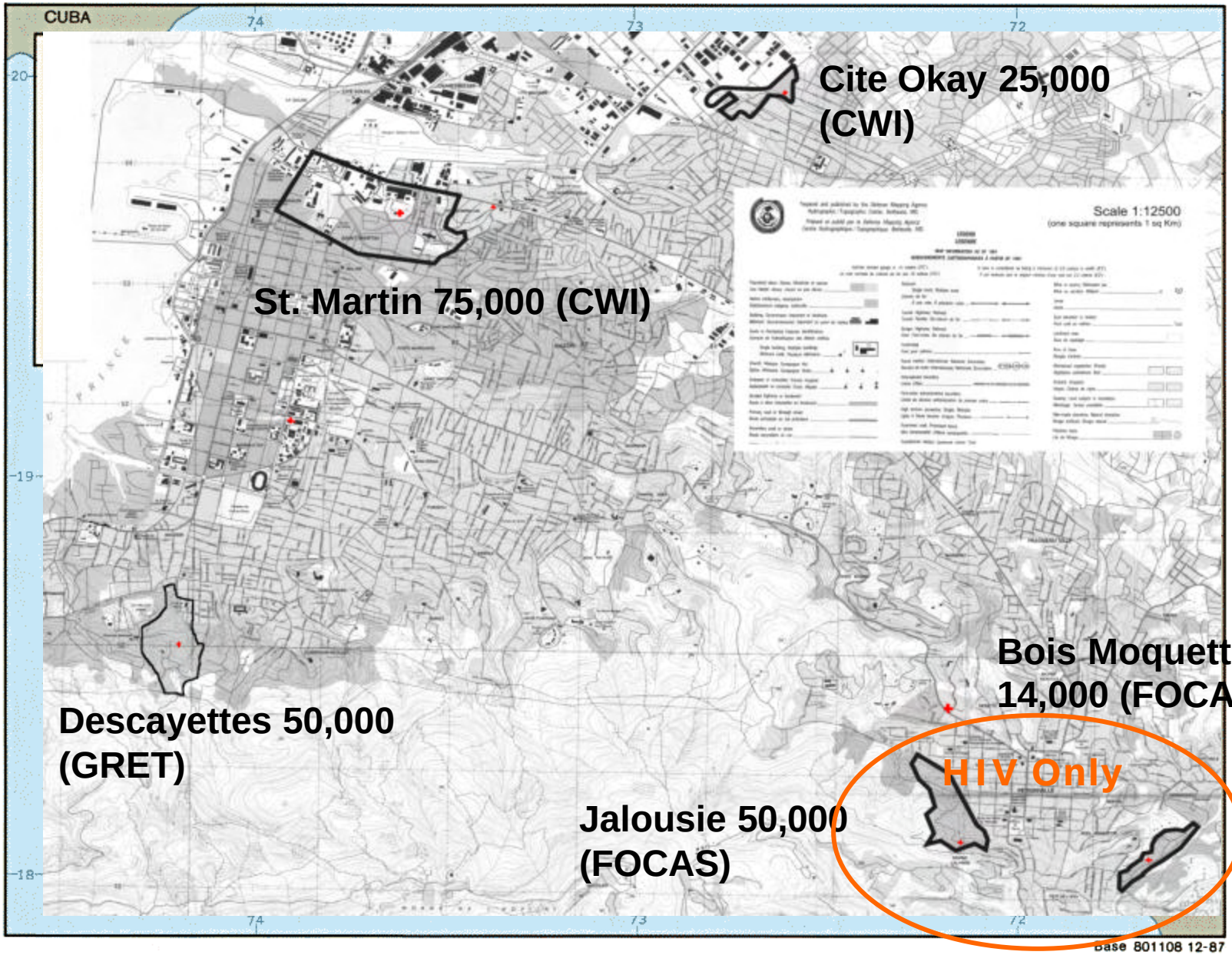
DIP REVIEW SESSION
June 6, 2006

Health Situation

- IMR 74/1,000 and U5MR 117/1,000: major causes are pneumonia, diarrhea, and malnutrition.
- One-quarter of all child deaths occur among newborns.
- Maternal mortality ratio is the highest in the western hemisphere at 523 deaths per 100,000 live births. Major causes are hypertension, obstructed labor and hemorrhage.
- HIV/AIDS prevalence has also dropped over the past 5 years, but remains the highest outside Africa with an estimated adult seroprevalence of 3.5%.

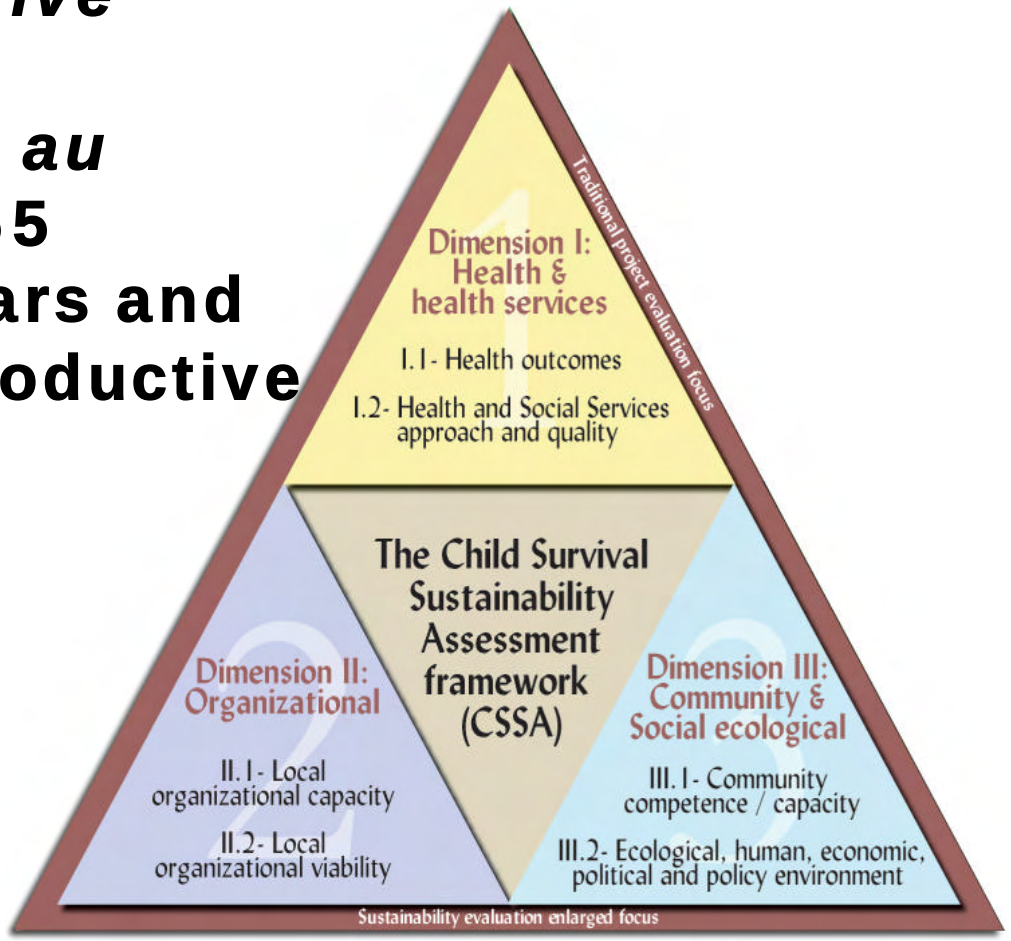
Urban Health Situation

- Urban population in Haiti has swelled from 29.5% to 38.8%, mostly in PaP and almost entirely unplanned
- Overcrowding, no public services, unhealthy environment, poor hygiene
- Mobile population, low social cohesion, and violence
- Two-thirds of Port-au-Prince residents earn less than $25 US per month

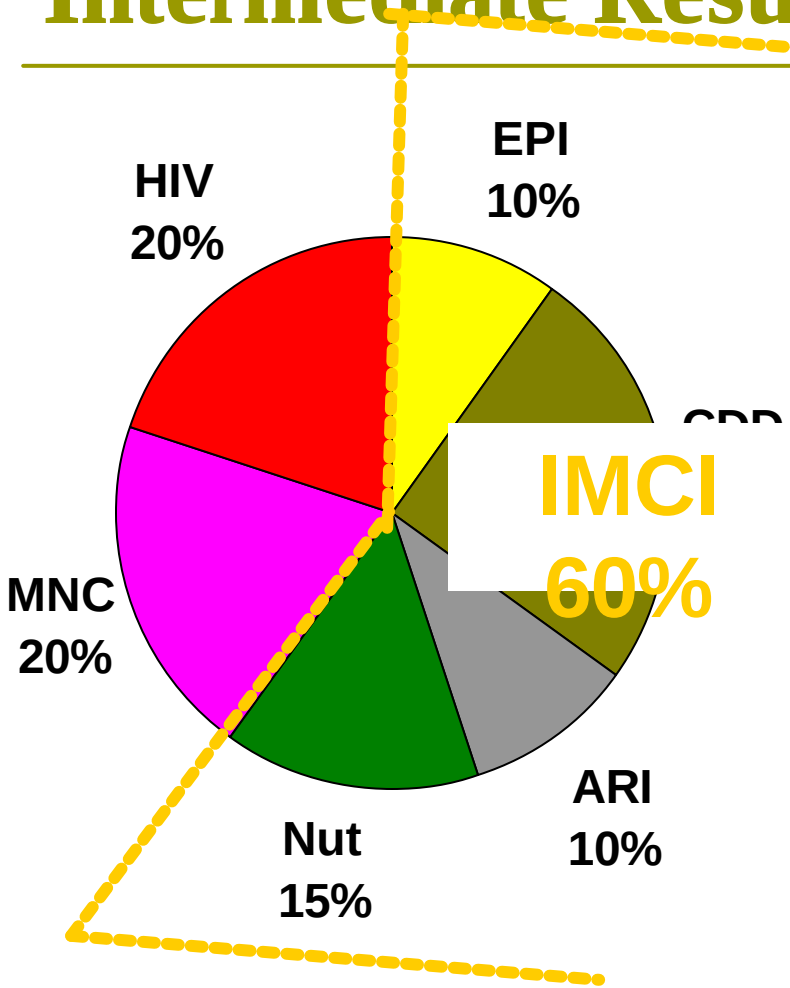

CUBA
74
73
72
20
19
18
Cite Okay 25,000 (CWI)
St. Martin 75,000 (CWI)
Scale 1:12500
(one square represents 1 sq Km)
Descayettes 50,000 (GRET)
Bois Moquette 14,000 (FOCAS)
HIV Only
Jalousie 50,000 (FOCAS)
Base 801108 12-87

Strategic Objective

***Sustained improvements in the health status of mothers, children and youth in five disadvantaged urban neighborhoods of Port au Prince, reaching* 32,555 children under five years and 53,697 women of reproductive age.**



Intermediate Results & Interventions



- Empowered communities with increased knowledge and interest in maternal, child and youth health promotion.
- Enhanced availability of and access to reproductive and child health services for disadvantaged households in urban areas.
- Increased quality of reproductive and child health services in selected government and private non-profit health centers.
- Improved policy environment for the urban populations, putting emphasis on protection for the poorest people.

Intermediate Results

IR 1: Empowered communities with increased knowledge and interest in maternal, child and youth health promotion

- 1.1 Capacity building and federation forging of community based organizations for health & development in five neighborhoods
- 1.2 Community health promotion events: rallys, campaigns, fairs, group education organized year round
- 1.3 Youth involvement in neighborhood health leadership
- 1.4 Organisation of community-level HIV/AIDS prevention and control

IR2: Enhanced availability of and access to reproductive and child health services for disadvantaged households in urban areas

- 2.1 Establishing IMCI services in Descayettes, St. Martin and Cite Okay/Jeremie
- 2.2 Assess feasibility and pilot community based therapeutic care for severe malnutrition
- 2.3 Develop pro-poor protection strategies for vulnerable families
- 2.4 Intensification of EPI activities
- 2.5 Reinforce the obstetric care referral system from the household to hospital level

IR 3: Increased quality of reproductive and child health services in selected government and private non-profit health centers

- 3.1 Capacity building for supportive supervision of health services by three Bureaux Communales
- 3.2 Foster better health information system implementation and data for decision making skills
- 3.3 Institutionalization of particpatory capacity assessments for health facilities
- 3.4 Establishing quality assurance approach with performance incentives at 5 HFs
- 3.5 Strengthening EPI logistics through quality assurance teams and strengthening connections with national program

IR 4: Improved policy environment for the urban populations, putting emphasis on protection for the poorest people.

- 4.1 Start-up and support an urban health public-private platform in Port au Prince metropolitan area
- 4.2 Advocacy for improved environmental health in poor urban neighborhoods to government, donors and private sector
- 4.4 Popularization of learning from the urban health initiative experience
- 4.5 Support the DSO to initiate an urban health strategy for Haiti

Urban Health Platform

- Initially composed of members of the partner PVOs, CBO representatives, clinic staff, and selected MSPP managers
- Meets quarterly, chaired by DSO/MSPP
- Guide the development of selected data collection and information system processes
- systematically review data generated by the project and determine where further operations research is needed,
- Identify and document results and learnings for wider sharing to public health colleagues
- Review project progress and constraints
- Planning with external agencies and leveraging resources

Operational Units

Level	Units	Actors
Metro Port-au-Prince Health Platform	1	MSPP, PVOs, NGOs, Health Facility personnel, agencies, donors
Neighborhood	5	Community Health Forum (HF, CBOs, Youth Leaders, Project staff)
Sub-zones of approx 1,000 HHs	40	1 CBO lead 25-30 youth leaders 2-3 TBAs

Baseline Methods

- KPC 2000+ Survey with sample size 226 mothers with child 0-11 months and 153 12-23 months (N=380)
- Rapid Health facility Assessment at 5 centers
- Group Discussions with CBOs
- DIP Workshops with stakeholders

KPC Survey Results, Targets and Comparisons (revised 6/06)

Objective	Indicator	Baseline 2006	Target 2010	EMMUS III (2000) Metro Area
Improved preventive child health practices	Proportion of children age 0–5 months who were exclusively breastfed during the last 24 hours	22%	35%	32% (<4 mo)
	Proportion of households with children 0-23 months who purify their drinking water	32%	50%	n/a
	Proportion of children 6-24 months receiving Vitamin A supplement within past 4-6 months (according to age)	61%	80%	26%
	Proportion of children 12-23 fully vaccinated (verified with card)	51%	80%	31%
	Number of measles vaccinations administered	69%	80%	61%
	Proportion of children age 6-9 months who received breast milk and complementary foods during the last 24 hrs	52%	65%	73%

Objective	Indicator	Baseline 2006	Target 2010	EMMUS III (2000) Metro Area
Improved care for sick child	Proportion of children 0-23 months with diarrhea who have received ORS	50%	70%	50%
	Proportion of children 0-23 months with fast and difficult breathing in past 2 weeks who were seen by trained provider	66%	75%	34%
	Proportion of mothers with a sick child aged 12-23 months who increase fluids and feeding during the illness	**13%**	**50%**	**38%**

Objective	Indicator	Baseline 2006	Target 2010	EMMUS III (2000) Metro Area
Improved maternal and newborn care	Proportion of mothers of children age 0–11 months who had three or more antenatal care visits during their last pregnancy	79%	90%	75%
	Proportion of mothers receiving at least 90 days supply of iron folate supplements during last pregnancy	4%	20%	16%
	Skilled attendant at last delivery	42%	n/a	57%
	Proportion of mothers with child 0-11 months who attended postpartum care check-up with newborn within 7 days of giving birth	15%	35%	10%

Objective	Indicator	Baseline 2006	Target 2010	EMMUS III (2000) Metro Area
Enhanced youth HIV/AIDS protection	Number new acceptors of modern contraceptive methods of youth aged 15 to 24	**N/A**	**35% increase from Baseline year 2006**	**n/a**
	Proportion of mothers tested for HIV	**35%**	**n/a**	**7% (national)**
	Proportion of sexually active youth aged 15 to 24 years, who are not in a stable relations of one or more years, who use a condom consistently for the past 3 months.	**13%**	**20%**	**13%**

Health Facility Assessment Findings

Working with Five Health Facilities

- St. Martin II HC – Govt
- HaitiMed HC – NGO
- Descayettes HC – NGO
- Jalousie HC – NGO
- Bois Moquette Dispensary - NGO

- Primarily only open on weekdays
- Fees for services
- Past six months good supply of vaccines and essential meds but work hard to maintain
- Low collaboration with community
- No delivery services
- Poor referral system with hospitals

DIP Workshop Consultation Outputs

- Reviewed and discussed KPC and HFA findings
- Debated approaches for working with youth and performance incentives
- Reviewed and finalized strategic results framework
- Set targets for key objectives
- Discussed roles and responsibilities
- Reviewed workplan and areas
- Identified areas for synergy / complementarity
- Discussed local planning and avoidance of duplication of effort

Maternal & Newborn Care Strategy

- No delivery service at health centers
- Some support to St. Jude Anne maternity by MSF/Holland
- Emphasis 1: birth preparedness, early identification and referral of complications with support of HF staff and TTBAs, promotion of newborn care practices
- Emphasis 2: Quality/focused antental and postpartum care services
- Clean delivery kits – purpose every woman has hygenic tools *(62% deliveries at home + cost barrier of supplies at hospital)*

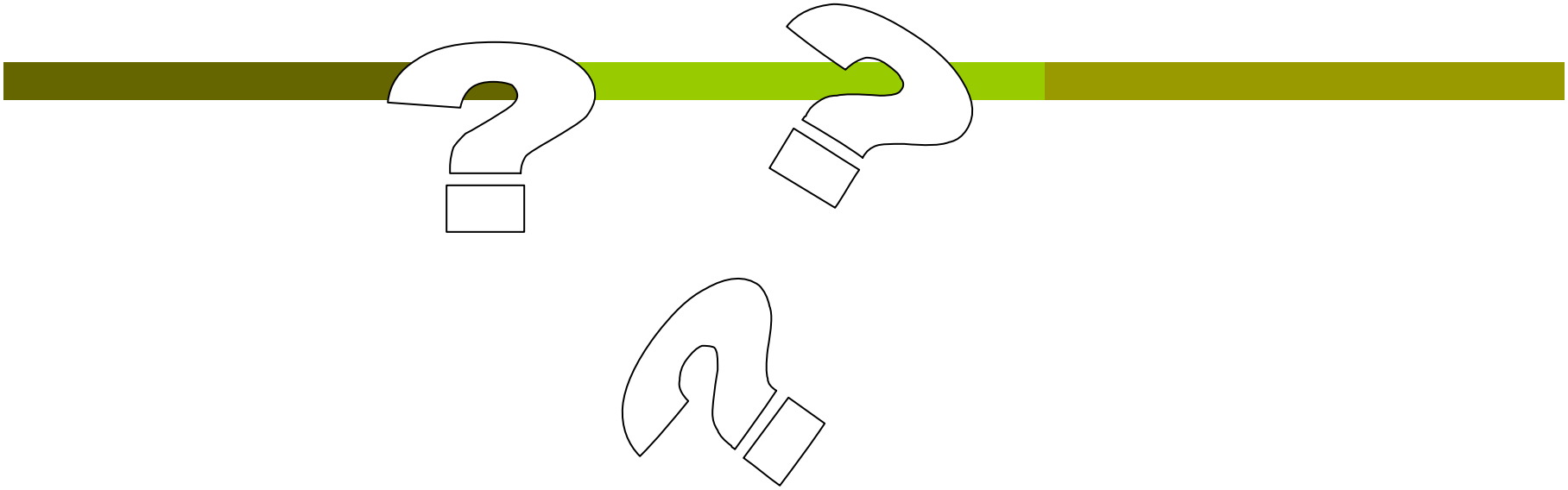
Opportunities for scale

- Urban Health Platform as a way to share best practices and influence policy
- Community Health Forums – Sustainable community engagement in health?
- Model for performance incentives for health personnel motivation
- OR on feasibility of Community Therapeutic Care for malnutrition

Progress Since DIP Submission

- One-year agreement and workplan with GENESIS
- First team monthly meetings
- Exchange visit to Bangladesh on community mobilization and C-IMCI
- Recruitment for additional positions
- Design for nutrition and livelihoods survey
- Security situation still volatile in Descayettes, OK in other neighbourhoods but ...

Response to Questions by Reviewers



New beneficiary numbers

Beneficiaries adjustment based on change of neighborhood and adjustments in population estimates.

Original				DIP			
Neighborhood	***Total U5***	***WRA***	***Total Population***	***Neighborhood***	***Total U5***	***WRA***	***Total Population***
St. Martin	9,126	19,500	78,000	St. Martin	**11,175**	**18,525**	75,000
Cite Okay/Jeremie	3,042	6,500	26,000	Cite Okay/Jeremie	**3,725**	**6,175**	25,000
Cite l'Eternel	**5,265**	**11,250**	**45,000**	**Descayettes**	**7,450**	**12,350**	**50,000**
Jealousie	6,618	11,758	48,852	Jealousie	**8,159**	**13,525**	54,758
Bois de Moquette	1,348	3,606	11,723	Bois de Moquette	**2,046**	**3,392**	13,732
TOTAL	**25,399**	**52,614**	**209,575**	**Total**	***32,555***	***53,967***	***218,490***

Based on 2003 Census population distribution levels:

Under-five 14.9%

WRA 24.7%

Spread too thin with 6 interventions?

Intervention		Original	DIP revision	
HIV/AIDS		25%	**20%**	
Maternal & Newborn Care		25%	**20%**	
IMCI	**Control of Diarrhea Disease**	20%	**25%**	60%
	Pneumonia Control	20%	**10%**	
	Immunizations	15%	**10%**	
	Nutrition	0%	**15%**	

Intervention Roll-Out Strategy

- BEHAVE strategy development by intervention including completion of formative research and adaptation of materials
- Strengthening service at health facility: training, quality assurance processes, performance incentives and supervision
- Training of trainers and cascade training of small groups of youth and CBO leaders by intervention
- Community mobilization based on themes planned at neighborhood and sub-zone levels

Intervention Wise Roll-Out Calendar

Topic Area	BEHAVE Strategy	Health Facility Training & QA	Community Training	Community Mobilization Starts
HIV/AIDS	Oct-Dec '06	NA	Apr-Jun '07	Jul-Sept '07
MNC	Apr-June '07	Apr-June '07	July-Sept '07	Oct-Dec '07
Sick Child/ IMCI	Oct-Dec '07	Oct-Dec 06	Jan-March '08	Apr-June '08
I&YCF	July-Sept '08	Jul-Sept '07	Oct-Dec '08	Jan-March '09
Vaccination	Apr-Jun '09	*IMCI Oct-Dec 06* Jul-Sept '08 Jul-Sept '09	Youth: Oct-Dec '06 Refresher: Apr-Jun '09	Youth: Jan-Mar '07 Community: Jul-Sept 09

Workplan Adjustments

- Revised BEHAVE strategy and community mobilization roll-out quarters
- Introduction of clean delivery kits moved to Apr-Sept ’08 (coincide with TBA training)
- Documentation of unmet obstetric need to 1st quarter of year 4

What	Who	How
Behavior change	Task force: Health Officers, Community Dialogue Trainers, BC, MSPP	Define formative research Analyse results Establish key factors, activities & monitoring plan Adapt materials & tools
Quality assurance	Health facility staff (entire team @ 5 HFs)	Assess situtation and identify gaps following trainings Analysis shortcomings and establish plan Monitor and evaluate
Community Mobilization	CBO & Youth Leaders with leadership from Community Health Forum	Plan, practice, implement, monitor, & evaluate with GENESIS
Health facility Activities	Nurses, Docs, Auxillary Nurses, Managers	Routine care as per standards Manage essential drugs Train community health actors HMIS entry and use Leadership in community health forum planning, data compilation

Community Health Trainings

	St. Martin	Descayettes	Cite Okay/ Jeremie
Trainers (1 Staff, 2 HC, 3-5 Community)	6	6	4
CBO & Youth Leaders to Train	330	327	89
# Training Sessions (max 25 per group)	13	13	4

Who gets paid?

Who	% time to project	Compensation
9 Project Staff (full-time)	100%	Salary & benefits as per organization policies
36 Health facility personnel	75%**	Performance incentives no greater than 50% salary
Community Facilitation Trainers	10%	Per diem for trainings
95 CBO leaders	5%	KDSM/SNELAK – management support by Concern and GRET Others – fund to support community plans
1,136 Youth Leaders (supervised by CBO leader of sub-zone)	5%	No direct compensation –social outlet, business and life skills, working tools, fund to support community plans, leisure
60 TBAs (supervised by health personnel)	5%	No direct compensation – capitalization of clean delivery kits, traditional payment for support.

Performance Incentives

- Learning process
- Principles – rooted in quality assurance performance monitoring, cannot exceed 50% of salary, management of fund factor in allocation
- Different models established based on agencies current practice
- Concern supported facilities – revolving loan fund support

Managing Health Information

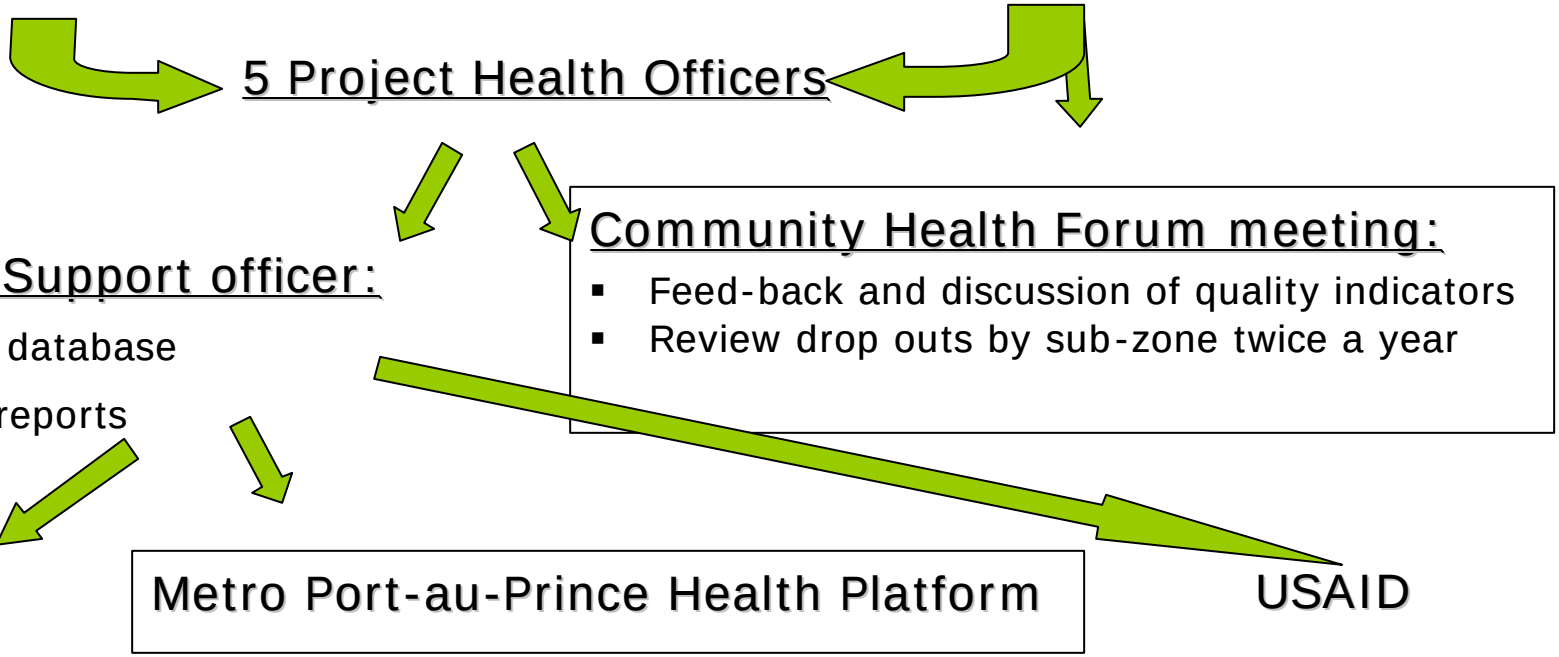
Community Level

- Youth volunteers monthly meetings
  - Reportable diseases
  - Vital events: births, deaths
  - Health education activities
- TBAs monthly meetings: birth planning, deliveries, referrals

Health Facility Level

From Monthly Report

- Vaccinations
- Sick children
- FP acceptors <25 years
- ANC 3 completion
- Iron/Folate distribution
- Postnatal care attendance



Indicators / Measurements

- Limitations of KPC survey at neighborhood level – future surveys increased sample to 95 respondents from both types in each area
- Denominator differences – Skilled attendant and TT2 based on mothers with infants 0-11 months; HIV infection reduction based on mothers of children 12-23 months which was a smaller sample
- Inclusion of 7 family practices from behavior change strategy already in existing KPC survey instrument
- The two health provider practices from the BC strategy assessed in IMCI supervision checklist
- Clarification LQAS monitoring once per year for each neighborhood
- Corrections made to Project Data Summary sheet on-line
- Nutrition survey –prefer to exclude Jalousie/Bois Moquette.

GENESIS Consulting Agency

Intially contracted for one year for process documentation and research support; SoW includes:

- Develop assessment tools and implement baseline:
  - Community Health Capacity – adaptaton WHC tool Bangladesh
  - Monitoring KPC using 19 sample LQAS
  - Focus Group Discussion Guides for mothers
- Adaptation of health facility assessment tool – using HICAP already used in Haiti (modified from MOST) plus level 1 Health Center standards from MSPP
- Working with platform to define urban health policy vision, stakeholders and learning objectives through facilitation techniques

(this defines OR for process documentation)

Child Survival and Health Grants Program Project Summary

Jun-26-2006

Concern Worldwide Incorporated
(Haiti)

General Project Information:

Cooperative Agreement Number: **GHS-A-00-05-00018**
Project Grant Cycle: **21**
Project Dates: **(9/30/2005 - 9/30/2010)**
Project Type: **Standard**

CWI Headquarters Technical Backstop: **Michelle Kouletio**
Field Program Manager: **Guerda Debrosse**
Midterm Evaluator:
Final Evaluator:
USAID Mission Contact: **Olbeg Desinor**

Field Program Manager Information:

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Address: 28 rue Metellus
Petion-Ville
Phone:
Fax:
E-mail:

Alternate Field Contact:

Name: **Guerda Debrosse**
Address:

Phone:
E-mail: guerda.debrosse@concern.net

Funding Information:

USAID Funding:(US $): $1,500,000 **PVO match:(US $)** $908,799

Project Information:

Description:

This is a five-year USAID Child Survival & Health Standard Grant Program led by Concern Worldwide, a strategic partnership with Groupe de Recherche et d'Echange Technologique (GRET), and Foundation of Compassionate American Samaritans (FOCAS). Together, these three agencies work hand in hand with the Ministry of Health (MSPP) at the Ministry of Health West Department (DSO) with the aim of improving the health status of vulnerable maternal, child and youth populations living in five disadvantaged urban neighborhoods.
Urbanization and Health. Over the past 15 years the urban population in Haiti has swelled from 29.5% to 38.8% leaving the urban extreme poor as the fastest growing population in the country. While national health indicators have improved over the past 20 years, the urban areas have been particularly affected by unplanned growth and public service neglect. Two-thirds of Port-au-Prince residents earn less than $25 US per month, making it one of the poorest cities in the world.

Insecurity. The past two years have been particularly difficult as the collusion of political violence and economic frustration have resulted in physical violence, mental anguish, population displacement,– and death, things that cannot be described in an opening paragraph. While elections of February 2006 have brought calm and sense of renewal, on March 2006, UNICEF issued a Child Alert for Haiti, marking it as one of the most challenging places on earth for children. Haiti's biggest cities were spotlighted as traps locking mothers and children into a "perpetual cycle of violence, poverty and abuse that is almost impossible to break."

Health Status. Despite overall decline over the past 20 years, the national child mortality rate is among the 40 highest in the world, with infant mortality rate estimated at 74/1,000 and under-five mortality at 117/1,000 . The major causes of mortality for children under-five are pneumonia, diarrhea, and malnutrition. One-quarter of all child deaths occur among newborns during the first month of life. Infections, traumatic delivery, and respiratory distress are the primary causes of newborn deaths. The maternal health status has improved, but the maternal mortality ratio is the highest in the western hemisphere at 523 deaths per 100,000 live births. Major causes of maternal death are hypertension, obstructed labor and hemorrhage. HIV/AIDS prevalence has also dropped over the past 5 years, but remains the highest outside Africa with an estimated adult seroprevalence of 3.5%.

Objectives and Outcomes. The strategic objective of the urban health project is sustained improvements in the health status of mothers, children and youth in five disadvantaged urban neighborhoods of Port au Prince, reaching about 10 percent of the city's population. The total project population includes 218,490 residents including 32,555 children under five years of age (including 7,990 infants 0-11 months, 6,227 young children 12-23 months, and 24,565 children 24-59 months), and 53,967 women of reproductive age (15-49 years).

This program focuses on six key interventions which closely match the principle causes of child and maternal mortality: HIV/AIDS (20%), maternal & newborn care (20%), control of diarrheal disease (25%), nutrition (15%), pneumonia case management (10%); and immunizations (10%). Some of the specific population changes expected include:

Improved preventive child health practices
- Increase from 22% to 35% infants age 0–5 months exclusively breastfed during the last 24 hours
- Increase from 51% to 80% children 12-23 months fully vaccinated (verified with card) by first birthday

Improved care for sick child
- Increase from 66% to 75% children 0-23 months with cough and fast, rapid or difficult breathing in past 2 weeks who were seen by trained provider
- Increase from 13% to 50% mothers with a sick child aged 12-23 months who increase fluids and maintain feeding during the illness

Improved maternal and newborn care
- Increase from 70% to 90% mothers of children age 0–11 months who had three or more antenatal care visits during their last pregnancy
- Increase iron folate intake for 90 days or more by mothers of children aged 0-11 months from 4% to 20%
- Increase from 16% to 35% of mothers of infants 0-11 months who attended postpartum care check-up with the newborn within 7 days of birth

Enhanced youth HIV/AIDS protection
- Increase by 35% the number of youth aged 15 to 24 who become new acceptors of modern contraceptive methods
- Increase from 12.6% to 20% number of sexually active, out-of-union youth, aged 15 to 24 years, who use a condom consistently for the past 3 months

The following intermediate results encompass the strategy and activities required at the household, neighborhood, health service and political level. Together, these will enable the above, long-term goals for improved health to be realized.

IR 1: Empowered communities with increased knowledge and interest in maternal, child

and youth health promotion. Working with 5 neighborhood health networks of numerous active and respected CBOs, 1,136 youth leaders, 60 TBAs and health center personnel, build skills to identify needs, develop strategies and actions for health promotion, resource activities, and monitor effectiveness.

IR 2: Enhanced availability of and access to reproductive and child health services for disadvantaged households in urban areas. Working with 5 health facilities, improve availability and management of essential drugs and supplies, leverage availability of subsidized national programs, and learn from strategies from GRET's European Union funded program with mutuelles as well as Child Survival experience in Rwanda with social insurance schemes.

IR 3: Increased quality of reproductive and child health services in selected government and private non-profit health centers. Working with five focal health facilities to develop a quality assurance and monitoring team approach, develop and test models for performance incentives, organize trainings on key skill areas, organize joint NGO/BC supervision on a quarterly basis.

IR 4: Improved policy environment for the urban populations, putting emphasis on protection for the poorest people. Developing exchange and applied research platform to build evidence and consensus for effective urban health strategies, documenting and disseminating experience, advocating on environmental health intervention by government and donor community, and supporting DSO in initiating an urban health strategy development process.

Note that in all intervention areas, other agencies are providing health facility based HIV services including STI screening, facility based care and support, PMTCT and VCT services, safe blood, etc. Therefore, this project complements them with a strong youth prevention and integration of HIV services with maternal and newborn care. Indicators related to HIV/AIDS health services are excluded from this project scope but the program will contribute to monitoring for complementary projects in the area.

Location:

The Urban Health Project for Five Disadvantaged Neighborhoods of Metropolitan area of Port-au-Prince works in:
*Delmas Commune: St. Martin and Cite Okay-Jeremie
*Petion-Ville Commune: Jalousie and Bois de Moquette in
*Port-au-Prince Commune: Descayettes

Project Partners	Partner Type	Subgrant Amount
FOCAS	Subgrantee	$371,941.00
GRET	Subgrantee	$350,000.00
Ministry of Health West Department	Collaborating Partner	
Subgrant Total		$721,941.00

General Strategies Planned:

Social Marketing
Advocacy on Health Policy
Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Participatory Learning in Action
Lot Quality Assurance Sampling
Appreciative Inquiry-based Strategy
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Social Marketing
Interpersonal Communication
Support Groups

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
CS Project Team	PVOs (Int'l./US)	(None Selected)	National MOH	Health CBOs Other CBOs

Interventions/Program Components:

Immunizations (10 %)

(IMCI Integration)
(HF Training)

- Polio
- Classic 6 Vaccines
- Vitamin A
- Surveillance
- Cold Chain Strengthening
- Injection Safety
- Mobilization
- Community Registers

Nutrition (15 %)

(IMCI Integration)
(HF Training)

- ENA
- Cont. BF up to 24 mos.
- Maternal Nutrition

Pneumonia Case Management (10 %)

(IMCI Integration)
(HF Training)

- Pneum. Case Mngmnt.
- Case Mngmnt. Counseling
- Access to Providers Antibiotics
- Recognition of Pneumonia Danger Signs

Control of Diarrheal Diseases (25 %)

(IMCI Integration)
(HF Training)

- Water/Sanitation
- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding
- Care Seeking
- Case Mngmnt./Counseling
- POU Treatment of water

Maternal & Newborn Care (20 %)

(IMCI Integration)
(HF Training)

- Neonatal Tetanus
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Delay 1st preg Child Spacing
- Integr. with Iron & Folate
- PMTCT of HIV
- Emergency Transport

HIV/AIDS (20 %)

(HF Training)

- Treatment of STIs
- Behavior Change Strategy
- Access/Use of Condoms
- STI Treat. with Antenat. Visit
- ABC
- PMTCT
- Nutrition
- Home based care
- PLWHA

Target Beneficiaries:

Infants < 12 months:	7,990
Children 12-23 months:	6,227
Children 0-23 months:	14,217
Children 24-59 months:	24,565
Children 0-59 Months	38,782
Women 15-49 years:	33,697
Population of Target Area:	218,490

Rapid Catch Indicators:

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	0	0	0.0%	0.0
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	74	107	69.2%	8.7
Percentage of children age 0-23 months whose births were attended by skilled health personnel	98	225	43.6%	6.5
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	43	225	19.1%	5.1
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	31	108	28.7%	8.5
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	38	74	51.4%	11.4
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	51	101	50.5%	9.8
Percentage of children age 12-23 months who received a measles vaccine	62	101	61.4%	9.5
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	4	149	2.7%	2.6
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	47	149	31.5%	7.5
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	38	297	12.8%	3.8
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	133	149	89.3%	5.0

Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	**4**	**149**	**2.7%**	**2.6**

Comments for Rapid Catch Indicators

Underweight (weight-for-age) not included in original KPC due to logistical difficulties but will be assessed during urban nutrition and livelihoods survey in July 2006 for St. Martin, Cite Okay & Descayettes only. Midterm and final surveys will include this WFA indicator for all sub-areas.
In using LQAS method, we further refine age groups for respondent types of rapid catch indicators:
Skilled attendant respondents are mothers with child 0-11 months
Bednet use respondents are mothers with child 12-23 months
HIV/AIDS knowledge is mothers with child aged 12-23 months
Handwashing is mothers with child aged 12-23 months