Integrating Child Survival and IMCI Activities in Six Target Communes in the North-East Department of Haiti

DETAILED IMPLEMENTATION PLAN (DIP)

Cooperative Agreement #: HPF-A-00-01-00031-00

Project Location:
Department of the North-East, Haiti

Project Duration:
September 30, 2001 to September 29, 2006

Submitted by
Project HOPE, The People-to-People Health Foundation, Inc.
Millwood, Virginia 22646
Tel: (540) 837-2100
Fax: (540) 837-1813

June 30, 2003

Authors:
Robert S. Northrup, M.D. Senior Technical Advisor, Project HOPE
Pierre Despagne, M.D., Director, CDS
Joanel Modestin, M.D., Field Project Manager, CDS

Contact persons:
Administrative: **Petra Reyes, ScD, MPH, Regional Director, Africa and Haiti**
Email: preyes@projecthope.org

Technical: **Dr. Robert Northrup, Senior Technical Advisor**
Email: rnorthrup@projecthope.org

TABLE OF CONTENTS

Page

APPENDICES

ACRONYMS

ARI	Acute Respiratory Infection
CORU	Community Oral Rehydration Units
COSAM	Breastfeeding Support Committee
CRUDEM	Center for Rural Development of Milot
CBD	Community Based Distributor
CDS	Center for Development and Health
CS	Child Survival
DIP	Detailed Implementation Plan
DSNE	Department of Health for the North-East
EBF	Exclusive Breastfeeding
EPI	Expanded Program for Immunization
GHESKIO	Grup Haitien d'Etude de Syndrome Kaposi et des Infections Opportunistic
GLV	Green leafy vegetables
HC	Health Center
HHF	Haitian Health Foundation
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
INHSAC	Institut Hatien de Sante Communautaire
LAM	Lactational Amenorrhea
LOE	Level of Effort
LQAS	Lot Quality Assurance Sampling
MSPP	Ministry of Public Health and Population
NGO	Non Governmental Organization
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
SDMA	Service Delivery and Management Assessment
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TdN	Trou du Nord
TOT	Training of Trainers
TR	Terrier Rouge
TTV	Tetanus Toxoid Vaccine
UCS	Community Health Units
VCR	Verbal Case Review
VHC	Village Health Committee

A. EXECUTIVE SUMMARY

This Detailed Implementation Plan describes a collaborative project between Project HOPE, Centre pour le Developpement et la Sante (CDS), and the Ministry of Public Health and Population (MSPP) to reduce infant and child morbidity and mortality rates and improve reproductive health in the underserved North-East Department of Haiti over 3.5 years of implementation following submission of this DIP. To accomplish this, the program incorporates a number of innovative new approaches and emphasizes institutional capacity-building of the MSPP and communities and families, to increase the potential for sustainability.

The North-East Department of Haiti is a relatively new administrative zone. The Department is administered from Fort Liberte and is organized into four Arrondissements and 13 Communes. The total population is 248,764, of whom 80% live in rural areas. The economy is primarily agricultural. The Department suffers from a lack of basic infrastructure and public services. Six communes in the most underserved western section of the North-East Department – with a total population of 98,907 – are targeted for the program: Trou du Nord, Caracol, St. Suzanne, Terrier Rouge, Perches and Vallieres. See map in Appendix 1.

Haiti's inter-related health and economic problems are well documented. The country has the lowest per-capita income and the highest infant mortality, child mortality, and maternal mortality rates in the Western Hemisphere. The leading causes of infant and child death are diarrhea and respiratory infections. One third of children suffer from malnutrition. Exclusive breastfeeding during the first six months of life is very low. Unofficial figures estimate IMR in the target areas to be greater than 100/1000 (compared to the national rate of 72/1000). Complete immunization coverage for 12-23 month-olds in the six target communities is only 17%.

Compounding the health problems in these target communities, health services in the North-East Department are among the least developed in the country. One referral hospital in Ft. Liberte serves the entire population. There are two health centers (one with beds) and 11 dispensaries (both government and private-NGO).

The total number of direct beneficiaries of this proposed program is 41,244 – 16,517 children under five and 24,727 women of reproductive age.

The program aims to help Haitian families and outreach workers at the community level and Haitian health care providers at health facilities to be as effective as possible in improving mother and child health, while limiting the addition of external resources in order to maximize the sustainability of the interventions.

Program objectives include implementation of IMCI; increased immunization coverage; improved case management of diarrhea and pneumonia/ARI; improved case management of severe malnutrition; increased Vitamin A and iron supplementation; improved exclusive breastfeeding and weaning practices; improved use of prenatal care; increased contraceptive prevalence; increased knowledge of HIV/AIDS; increased numbers of condoms distributed; increased care-seeking and treatment for STIs and improved pregnancy and delivery management.

Program strategies will build on the activities and approaches of CDS in six other communes of the North-East Department as well as strengthening the capacity of the Department of Health for the North-East (DSNE) at every level. Major operational approaches are:

- Training of village-based health promoters in technical skills and adult education methodologies.
- Development and support for mothers' clubs and fathers' clubs at village level to facilitate health education and provide peer support for new behaviors.
- Training of peer 'animatrices' to motivate and support new mothers.
- Development and support to community health committees to provide leadership and motivation in health improvement of their communities.
- Training and support of MOH auxiliaries and supervisors.
- Assessment and improvement of MOH health facilities in the target communes.
- Capacity development at the village, health facility, Community Health Units (UCS), and departmental MSPP levels through training and technical assistance and strengthened public-private sector coordination.

Activities will be implemented in two phases – targeting first the two UCS communes in Year 1 (Dec 2002 to Dec 2003) (Trou du Nord and Terrier Rouge); then adding and extending activities to the remaining four communes in the following year.

Specific program interventions and level of effort include: immunization (20%), nutrition/ micronutrient deficiencies (20%), breastfeeding (10%), control of diarrheal disease (10%), and pneumonia case management (10%), all via an IMCI strategy, as well as child spacing (10%), maternal health (10%), and HIV/AIDS/STIs (10%), as well as substantive interventions in capacity development at every level.

CDS, HOPE's implementing partner, is a Haitian NGO with long experience in health services in various parts of Haiti. CDS currently administers the health facilities in the eastern portion of the North-East Department for the MSPP with funds from USAID via MSH's HS2004 project, and more recently has taken on tuberculosis control in all the Department's communes. CDS will take primary responsibility for on-the-ground implementation of activities, while HOPE will provide technical assistance and managerial guidance. Both these partners will work directly with the MSPP, assisting MSPP to deliver facility based and community level services more effectively.

The project is funded by the USAID Child Survival program in Washington, DC, under the "new" programs category with $1.3 million in USAID funding and an additional $1.3 million match from Project HOPE. The project began October 2001 and is scheduled to end September 2006. Delayed startup and development of the partnership between CDS and HOPE may lead to extension of the completion date. The original authors of the project were Bettina Schwethelm, Project HOPE; Robert Northrup, Project HOPE; and Al Henn, Consultant. The USAID/Haiti official consulted regarding the project proposal was Dr. Yves-Marie Bernard, Child Survival and Nutrition Advisor. The contact persons for Project HOPE are Petra Reyes, Regional Director for Africa and Haiti, and Robert Northrup, M.D., Senior Technical Advisor. The DIP was prepared by Drs. Northrup, Despagne, and Mondestin.

B. CSGHP PROJECT DATA FORM

insert printout from the CSTS website

C. DESCRIPTION OF THE ORGANIZATION & NEW LOCAL PARTNER

Project HOPE, founded in 1958, is an independent, international non-profit organization which strives to achieve sustainable improvements in health and health services throughout the world, through partnership and education. Project HOPE began working in Haiti in the mid-1980s, implementing a laboratory training program in partnership with the National Medical University. Between 1994 and 2001, Project HOPE worked in four communes of the Department of the North with funding from the Child Survival program, in collaboration with the Ministry of Health of the Department of the North and CRUDEM (Center for Rural Development of Milot).

For its work in the North-East Department, HOPE will partner with CDS (Centre pour le Developpement et la Sante). CDS is a health NGO active widely in Haiti, with substantial USAID funding in the past and at present, via the USAID funded MSH project HS2004. These HS2004 activities are targeted to the seven eastern communes in the North-East Department including Fort Liberte, the home of the single referral hospital in the Department. CDS works directly with MSPP in delivering services, which are delivered by a combination of MSPP and CDS/HS2004 staff. The CDS activities there target improved immunization coverage, improved child nutrition, improved utilization of prenatal and postnatal care and deliveries by trained personnel, improved use of modern contraception by both men and women, and effective care for sexually transmitted infections (STIs). These targets are tracked with a project based reporting and information system, and a percentage of the payment CDS receives from HS2004-USAID is determined by achievement of performance targets in each of these areas. An annual survey of community outcomes provides objective documentation of coverage and use levels, and an annual assessment of facilities (the Service Delivery and Management Assessment or SDMA) documents the quality of services from the health system. CDS has been meeting these performance targets fully, and is acknowledged by both USAID and MSH to be highly effective in facilitating the delivery of these services by the health system.

CDS has also been increasing the income to the system from fees charged for care at the MSP facilities it runs. In this current year, 25% of the cost of the services will be recovered by this mechanism. This has required substantial effort to initiate accountability in the system for these funds. This increasing percentage of costs being recovered is also required by CDS's MSH contract and its performance payments, and it has succeeded in annual increases during the four years of the project.

Within this project, CDS will take direct responsibility for implementing the project's activities under the guidance and management of Project HOPE. This project thus represents an extension of CDS activities to include six additional communes. It differs as well from CDS previous activities in the North-East Department in that CDS directly, and HOPE indirectly through CDS, will collaborate fully with MSPP, with MSPP taking active responsibility for many of the activities and services of this project. This has not been the mode of operation in CDS's activities in the eastern communes, where CDS runs the health services directly. As a new area, and because of this active role of the departmental health team (DSNE-MSPP), the project's targets are set at much lower levels than in CDS's current six communes. Nevertheless, the new project will utilize the skills and methods that have been so successful in the eastern communes, including the cost-recovery approach and the methods of ensuring quality services and coverage.

D. DIP PREPARATION PROCESS

In September 2001, in response to the Final Evaluation of the previous CS project in the North Department, HOPE restructured its Haiti project management. Instead of utilizing existing senior staff from CS-13 to implement this new project in the North-East Department, HOPE recruited new senior staff.

An aggressive recruitment effort was begun for a project director; a suitable candidate was identified and began to work in January 2002. The Project Director:

- began negotiations with the departmental division of the MSPP (DSNE),
- organized office and field sites in the area,
- engaged a local survey firm (Intell Consult) to carry out a KPC survey,
- began to identify community health promoters (who were to be the major intervention mechanism to reach communities and families with children),
- defined with counterparts the intervention activities to be discussed in the DIP.

The Project Director left the program in June 2002. In consultation with USAID/Haiti and Washington, various project management options were explored, including the possibility of returning funds to USAID. Given Project HOPE's limited capacity in the new target department, it was decided that collaboration with a local partner would enhance rapid startup and implementation success. Among the potential partners for this NE Department, CDS, due to its existing programs and strong track record, promised to be the strongest partner.

CDS, a Haitian NGO is already carrying out highly effective health services in the same North-East Department with USAID funds. Active interaction with CDS began immediately to reach agreement on the components and implementation mechanisms for a reborn project was pursued, with multiple visits to Haiti, and exchange of multiple drafts of role descriptions and project activities. The Haitian government Ministry of Health (MSPP) was consulted, and requested that a description of the project and its plans be agreed to by the Regional Director as well as HOPE and CDS prior to his approving the project and giving permission to proceed.

During the 6-month period between June and November 2002, the DSNE director with whom the original project had been planned left his position, and a new DSNE Director was appointed with no knowledge or history with the project. In addition, the Haitian economy was going through a period of extreme stress, with the local currency (the gourde) falling in value by half (from 25 to 58 gourdes to the dollar), causing disturbances among employees and the population. Despite these barriers, in November 2002 a six-month agreement (see Appendix 2) between Project HOPE and CDS to initiate some focused activities on the basis of a 6-month limited contract was reached, a field project director was hired by CDS, and active project implementation began with a service delivery and management assessment (SDMA) of the health facilities, implementation of a census of the houses, early training of facility staff, and recruitment of promoters.
As of this writing (mid-April 2003), HOPE and CDS are completing budget and activity negotiations as part of a process of reaching a long-term partnership agreement between CDS, MSPP, and HOPE. A "restitution workshop" to review findings of the three baseline assessments (KPC, SDMA at UCS and lower levels, and census) was held on April 22-23 in Terrier Rouge,

with an observable increase in ownership of the findings and support of planned project activities by the auxiliary, UCS, and Departmental staff (see recommendations in the baseline assessment section below). The three parties expect to finalize the budget and complete negotiation regarding contracts/agreements among themselves for the project by the end of May, including signing of these agreements. As of April 25, there appear to be no significant impediments to full agreement for the project and its planned activities as reflected in this DIP. (See Appendix 7 for draft Tripartite Agreement.)

Extensive interchange of ideas and draft documents between HOPE and CDS was part of the discussion and negotiation process. This interaction included three visits to Haiti by Dr. Northrup during which further intensive planning of activities and interventions occurred. Additionally, a 5-hour meeting with DSNE Director and senior staff along with CDS was conducted in February 2003. At this time the project as a whole, its implementation approach, and the objectives and indicators for each intervention were discussed in detail. A Restitution Workshop was held on April 22-23 in order to facilitate collaboration. Subsequently, a meeting to define roles and accountability among CDS, MSPP and HOPE. Additional hours were spent in detailed discussions between HOPE and CDS in order to complete the DIP draft by the end of April.

As CDS is currently working in the contiguous North-East Department communes implementing both the primary care and the referral health services for the region through the government's system of facilities and staff, CDS is intimately aware of the challenges of each of the interventions of the project. CDS is also aware of the challenges of working with the MSPP's DSNE as an organization with meager infrastructure, minimal management and supervision of operations, severely inadequate funding, poor work performance on the part of many staff, and stockouts of drugs and vaccines over which it has little control. Accordingly, the project plans proposed in the original application to USAID have been revised in this DIP to take into account these realities of the situation, by limiting the activities to a critical core group of actions, defining clearly the expectations of both CDS and DSNE regarding roles and behaviors of staff required, and shifting some of the emphasis of the project from one which had put almost total emphasis on the community level activities to a plan which recognizes the large effort which will be needed to work with and develop the capacity of the DSNE in a project with limited resources. The field activities budget has also been rewritten by CDS to reflect these new implementation arrangements (partnership between CDS and HOPE, full involvement of DSNE, etc.).

E. CHANGES IN DIP FROM ORIGINAL PROPOSAL

The major changes which have been made in this DIP from the original proposal are as follows:

1. Partnership with CDS

In the new structure of the project, HOPE will work through CDS to implement the project. There will be no Project HOPE office per se in Haiti. Three of the project employees will work directly for HOPE, but will be working in the implementation team in the North-East under the direction of the Field Project Director. These HOPE positions will be: the Project Administrator, the secretary/accountant, and the statistician/data manager, all located in Trou du Nord.

All other Haiti positions will be CDS employees. Within CDS, Dr. Joanel Modestin will serve as Field Project Director, located in Trou du Nord in the target area, in the HOPE/CDS office and residence there. He will be supervised by Dr. Pierre Despagne, Executive Director of CDS, located in Port au Prince. Dr. Lionel Barthelmy will provide technical direction and active technical support from Port au Prince and in the field (he has organized and run the baseline census and SDMA, for example), and Dr. Evelyne Ancion will provide technical assistance and participate in training and operations research. Both of these persons have already carried out the training of promoters for the census in February, along with Dr. Modestin. Dr. Reginald Boulos, President of CDS, will also provide direction and technical support to the project. Drs. Modestin, Despagne, and Boulos have been part of the DIP writing team along with Dr. Northrup. CVs for these CDS persons are provided in Appendix 3.

Interviews for the HOPE Project Administrator and Statistician/Data Manager were held for the two best candidates on April 21 in Port au Prince by Dr. Northrup, following the screening interviews of a large number of candidates by CDS along with USAID and MSH to identify these final pairs, and procedures set in place to hire the two successful candidates – Emmanuel Jean Simon as the statistician-data manager, and Louis Harry Mercier as the project administrator, as well as the successful secretary-accountant candidate. Recruitment for the secretary-accountant is continuing, after a chosen candidate was rejected.

2. Non-participation by previous HOPE Milot/CRUDEM team

The original proposal indicated that the former project director of HOPE's child survival team from the North Department (the Milot Hospital and CRUDEM), along with a number of senior nurses and administrators from that project, would play an active role in this North-East Department project. Those persons will not be involved, as explained above in the DIP development description section.

3. Addition of maternal health and pregnancy outcome intervention

Since the development of the original proposal, the MSPP has issued national guidelines for health system development[1]. This policy document places its number one and highest priority on the reduction of maternal mortality, with the double target of improving maternal health and reinforcing the global functioning of the system of maternal care. MSPP has also, in discussions with CDS and HOPE, specifically requested that this component be added to the project, since it had not been included in the original proposed plan. Accordingly, this component has been added as an additional CS intervention, with consequent adjustments to the LOE for the other interventions. See the Interventions section of this DIP for details of this added intervention.

4. Elimination of Malaria as one of the project interventions

In recognition of the difficulty of the target geography, the limitations on the budget caused by the false start of the project, and the low level of malaria in the targeted communes according to DSNE

[1] Republique d'Haiti Ministere de la Sante Publique et la Population (MSPP) Un Agenda pour l'Action – Octobre 2002-Septembre 2003

information, the project decided to eliminate malaria as a defined objective, although case management of fever will still be part of the educational programs aimed at all actors.

5. Budget revision

A revised budget and budget justification are submitted along with this DIP, reflecting the revised project structure and activities (see Appendix 4).

6. Changes in Management Plan

a. Organizational Structure (see Appendix 8)

CS programs including this Haiti project are planned, administered and evaluated by staff within Project HOPE's Division of International Operations under the supervision of the Senior Vice-President for International Operations (SVP-IO). Technical support to the project will be provided by Dr. Robert Northrup, Senior Technical Advisor, who has extensive experience in maternal and child health programming. Additional expertise exists in the areas of health information systems and income generation. A Health Information System (HIS) Specialist (J.C. Alegre) accesses technical information for the project and supports the on-site HIS specialist. All of the above positions report to the SVP-IO. Direct administrative support is provided by the Regional Director, and Assistant Regional Director, for Africa and Haiti. The Regional Directors also report to the SVP-IO.

At the field level, CDS will take responsibility for implementing the project according to the DIP. Within CDS, the Field Project Director (Dr. Joanel Modestin) located in Trou du Nord, will be responsible for the direction and field operations of the project. He will be assisted by the Field Project Supervisor (Dr. Kesnel Benoit) and the Project Administrator (Louis Harry Mercier), who will manage the administrative aspects of the project (transport, office and residence, communications, finance, reports) and the administrative staff in the field (accountant-secretary, statistician-data manager, drivers, security). This team will be responsible for collaboration with the MSPP/DSNE.

The Project Coordinator (Dr. Pierre Despagne) in Port au Prince will supervise the Field Project Director and be responsible for overseeing the formal organization-to-organization relationship between CDS and HOPE, although HOPE technical interaction with the field team will be direct to the Field Project Director as well as through him. The CDS Project Leader (Dr. Reginald Boulos) will provide oversight and technical advice to the Project Coordinator and as the President of CDS is ultimately responsible for the subcontract with HOPE and its success. He participates actively in planning and technical communications and in fund-raising from non-USAID sources for the project. The Technical Director (Dr. Lionel Barthelmy) provides active technical actions and inputs (curriculum development, training, tools development, field assessments, operations research) to this project as well as to other CDS projects.

The new HOPE Field Project Administrator and Secretary/Accountant will receive extensive training in the policies and procedures of the HOPE Foundation. The CDS Field Project Director and selected staff from the Port au Prince CDS office will also receive selected portions of this training so that they are well informed as to the HOPE administrative and financial reporting requirements. As CDS is involved routinely in meeting USAID requirements for its Haiti Mission HS2004 project, and HOPE's procedures are also oriented toward meeting USAID requirements, we do not anticipate difficulties in

this area of activity. The training is based upon an Administrative Procedures Manual that has been developed for international program sites and is maintained by the Division of International Medical Operations. This manual specifically instructs field program directors and staff on how to initiate, develop, implement, manage and administer a program. Topics include communications, finance, personnel, procurement, shipping, reports, and setting up and closing down a program. A fiscal year budget will be developed by CDS and the headquarters team and reviewed monthly by HOPE's regional financial administrator and the regional team.

Program planning has been taking place as part of the development of an agreement between HOPE and CDS, which has incorporated the process of defining and assembling this DIP. As the current 6-month agreement terminates May 31, and a new agreement will have been signed for the remainder of the project by that time, this planning process will have concluded by that time. The DIP lays out the activities for the project. This will be revised annually to reflect actual progress and problems. More detailed activity plans are defined every six months. A monthly review of progress and an updated plan for the next month is revised as necessary, and implemented. Quarterly and annual reports summarize progress and review problems and their solutions. Reviews and refinements of project objectives and strategies and activities are also made during the preparation of annual reports and the mid-term evaluation. Dr. Northrup is responsible for monitoring the activities of the project relative to the workplan and target achievements, and for working with CDS to identify problems and overcome them.

Management issues are addressed through ad hoc e-mail, bi-weekly or weekly phone calls; monthly, quarterly, and annual reports; and annual or semi-annual site visits by Headquarters staff. Formal performance reviews will be conducted of HOPE project staff by HOPE Center personnel based on assessments by their CDS supervisor as well as HOPE assessments. A similar HR performance review mechanism is being implemented currently at CDS. HOPE Center staff will work with CDS field team supervisors to remediate any concerns. Technical training needs of the HOPE and CDS field staff will be assessed at the end of the first year, and appropriate training arranged.

The promoters, auxiliaries, and UCS nurse hired by the project to complete the basic personnel formation to provide basic services will be supervised by the field project team in collaboration with DSNE supervisory staff, along with the parallel staff who are paid by DSNE. TBAs, animatrices, CBDs and other volunteers are all volunteer participants. Their participation and productivity will be monitored through monthly reports; bi-monthly and routine supervision; tracking of project indicators through the HIS; record review of children referred to health facilities; and observational assessments of home visits. Quarterly assessments will include exit interviews and verbal case reviews (VCRs) as well as LQAS data gathering at household level. Participation will be sustained through their involvement in formal mechanisms of project evaluation, solicitation of input for project improvement, and supportive supervision.

Resumes and more detailed job descriptions are included in Appendix 3.

Title and Individual	**Person-Months (pm)**	**General Function**
Project Staff (CDS & HOPE)		
Field Project Director,	12 pm/yr	Overall program planning & implementation; liaison with MSPP, CDS

Title and Individual	Person-Months (pm)	General Function
Joanel Modestin MD		HQ, HOPE, USAID, local partners, others; training, monitoring and management of project progress.
Field Project Supervisor, Jean Kesnel Benoit MD	12 pm/yr	Training, monitoring/supervision of rally posts and health facilities, with DSNE counterparts, technical planning and problem solving, quality improvement facilitation.
Project Manager/Administrator Louis Harry Mercier	12 pm/yr	Support Director/Medical Director administratively and logistically; manage administrative & transport staff, vehicles, buildings, equipment; arrange meetings, trainings, conferences; draft reports, letters, other communications; solve non-program problems.
Information Specialist, Emmanuel Jean Simon	12 pm/yr	Manage the project's HIS system; develop and manage surveys and instruments; carry out statistical analysis; train field staff in data collection methods, enter and analyze data; prepare tables for reports.
Secretary/Accountant, TBN	12 pm/yr	Track project expenditures based on yearly budgets, prepare financial reports; assist senior field staff, arrange meetings, typing and other secretarial services.
CDS Headquarters (Port au Prince)		
Project Coordinator Pierre Despagne, M.D.	2.6 pm /yr	Supervise Field Project Director, Technical Director; general project oversight, manage relationship with HOPE, reporting, etc., participate in planning, budgeting, reporting.
Technical Director Lionel Barthelmy MD	4.1 pm/yr	Provide technical assistance to all project activities; develop and test tools and curricula, provide on site leadership in training, data collection, ops research.
CDS Project Leader Reginald Boulos MD	0.96 pm/yr	Provide technical and organizational oversight to project; raise supplemental funds; participate in project relationships with agencies donors.
Other Field Personnel		
UCS Nurse Supervisors, *(one MSPP, one to be named and hired by project)*	12 pm/yr	Plan and coordinate all training activities with MSPP; supervise all field services in daily activities; assist coordinator in developing curricula, supervisory checklists, and monitoring tools; manage program for their UCS area.
MSPP and CDS Auxiliary Nurses (10 CDS auxiliaries)	35 hours/wk	Training and supervision of promoters, animatrices, CBDs, and theater groups; assist in the training and supervision of mothers and fathers clubs and health committees; conduct rally posts; provide CS/FP/STI services at dispensaries; provide data on activities.
Health Promoters (81)	35 hours/wk	Organize rally posts; conduct mothers' and fathers' clubs; conduct CORUs, make household visits, facilitate village health committees, provide community level care for sick children, liaise with CBDs.
CBDs (60) volunteer	Variable	Provide FP/child spacing education and condoms and oral contraceptives, also ORS, vitamins, iron, other as appropriate.
Animatrices (30) -- volunteer	Variable	Provide individual education on EBF in support groups; also promote other specific CS behaviors.

b. Financial Management

The field office Secretary/Accountant will prepare a monthly accounting of financial activity and receipts. This will be submitted to the CDS central office accountant, and combined with the expenses of the central office (salaries, etc.), and a monthly report with receipts approved by the CDS Finance Director and submitted to HOPE. Financial data from the field is entered into the General Ledger by Operational Accountants, who provide for imprest reimbursement to the field offices, request payment from USAID, and provides the necessary reports to USAID as stipulated

in the agreements. An annual audit confirms the accuracy of these accounts, both in Haiti and at HOPE Center.

7. Changes in Capacity Building

Substantial changes in the approaches to capacity building have been developed in collaboration with CDS. The reformulated capacity development activities are described as Capacity Development Interventions in the detailed description of the interventions, beginning on page 37.

F. RESPONSES TO TECHNICAL REVIEW AND RECOMMENDATIONS

To avoid inserting eight pages of review comments and recommendations, we have attached the reviewer's comments as Appendix 5. The following responses to comments and recommendations are arranged as is the review, by sections of the proposal.

***Problem Analysis & Strategy Options**:* Project HOPE is now partnering fully with CDS, and together with CDS is taking on the challenge of working partially through MSPP to deliver the planned services to the population. MSPP both at central and departmental levels, with new actors in place and making the decisions rather than those who had originally approved the project, was not willing to give permission for the project to proceed without substantial involvement and the opportunity to develop its capacity. As CDS/HOPE are hiring directly a number of auxiliaries, one UCS nurse supervisor, and all the promoters, the project will not be completely dependent upon MSPP for performance achievement.

Program Approach: CDS is currently running the only referral hospital in the Department, the MSPP hospital in Fort Liberte, and has brought its services to an acceptable level of quality. The health center with beds in Trou du Nord will receive some equipment paid for by the project, some donated equipment and supplies, and some minimum repairs; CDS and HOPE will seek other support for more comprehensive repairs to the facility.

The project has eliminated the work with school children, to allow more focus on fewer activities. The project does not expect to put emphasis on collaboration with the Peace Corps; if an opportunity presents itself and appears likely to be beneficial, it will be considered. CDS is in constant dialogue with the national level as well as in its role as one of the 32 HS2004 grantees/ contractors. HOPE will take advantage of this channel to advocate for necessary changes or revised policies. By strengthening departmental MSPP capacity at departmental and peripheral level, including management capacity, the Project will facilitate improvements needed at those levels in a decentralized system.

Sustainability: HOPE and CDS recognize that a minimum level of funding is needed to support even the most basic health services, including community outreach and education. At present, and for the foreseeable future, neither MSPP nor the community are able to provide that minimum level of funding. The staffing, facility, transportation, and supplies that such funding would purchase are lacking. Accordingly, the project will hire staff at UCS, facility, and community levels and provide facility upgrading and transportation in order to provide these minimum necessary services with some degree of equity among persons living in different parts of the six communes.

With successful community education and strengthening of community capacity, e.g., village health committees (VHCs), family knowledge and behavior patterns, it will be possible to bring about continuation of family and community level health behaviors in those families reached by the project's education activities, and perhaps even some community health services on a volunteer basis – e.g., animatrice support of breastfeeding -- without further input from the CDS hired promoters. The trained and well-supervised MSPP auxiliaries and improved management at UCS and Departmental levels will similarly be able to continue some improved health services of quality at their facilities.

Without the project hired promoters or project provided transportation, however, neither the outreach community services such as rally posts provided by project hired promoters or supervision or fixed point services provided by the auxiliary, both at levels of frequency adequate to maintain coverage targets, will be feasible. While fees collected from patients can help somewhat, the levels anticipated by the end of the project will not be sufficient to both maintain facility services of high quality and support the provider services critical to high levels of community health behaviors in a population with a constant input of new mothers.

This said, we have planned a project-long transition process that will provide, we believe, a mechanism for the retention of many if not all of the promoters, some of their outreach activities, and ongoing activities at community level via the Village Health Committees and other CBOs which will shift significant responsibility for health services to the community as active participants.

The project will actively undertake activities which will seek to create elements in the community and the health system in DNE which will sustain both the improved health status achieved during the project in the population and the services which support that improved status. The description here discusses these activities relative to the Child Survival Sustainability Assessment (CSSA) Framework and its three dimensions (E. Sarriot. CSTS/USAID/ORC Macro 9/2002)

First dimension: Primary Health goals of the local system

This first dimension covers two areas, population health status, and the health and social services approach and quality. The majority of this DIP describes how this project will work to achieve the first of those areas, improvements in population health status through the second area, improvements in the health services. Training and supervision will seek to improve provider competence and the quality of services, as well as efficiency and coverage of services, access to quality services via implementation of a carefully supervised promoter network as well as efforts to reach particularly those in underserved areas where the promoter to population ratio will be higher than in the more central areas. Through VCRs, the project will seek to maximize client satisfaction with services. Costs will be kept as low as possible, but we will not sacrifice access to services by reducing the number of outreach workers (promoters) who represent the critical missing link between the formal health system stopping at the dispensary and auxiliary, and respond to the needs of the community by bringing both services and demand creation to the community level. Our aim is to ensure that the services are effective both objectively and as perceived by the community/client population. Our emphasis on quality control and improvement (see elsewhere in

this DIP), on problem identification through both supervision and the use of data, and on problem solution in response are the means by which we will achieve both aspects of quality.

Second dimension: Local institutional capacity and viability

Our efforts to enhance the capacity of MSPP/DSNE at departmental and UCS levels as well as in the supervision efforts of the auxiliaries aimed at the promoters, described elsewhere in this DIP, are most of the first half of this dimension. Much of our specific sustainability efforts thus will aim at the promoters themselves, at providing a range of mechanisms by which we will be able to continue many if not all of the promoters, thus representing efforts to assure the viability of the service system, the second half of this second dimension.

The following strategies for promoter retention without project funds will be pursued:

- The promoters will be trained to function as CBD points, but with an active posture. Rather than merely responding passively to requests for ORS or condoms, the promoters will be trained to sell the items at a fixed profit margin, to generate income for the promoters.
- We will seek to expand the range of products to include common over-the-counter products (aspirin, vitamins, iron for pregnancy) for illnesses beyond child and maternal health. We will seek access to bulk purchasing of such products from PROMESS, to obtain the lowest prices. To more effectively characterize the nature of these CBD points, we will rename them as "Postes Prevention et Traitement" or **PPT**.
- The project will link support of the promoters in these roles, and their access to subsidized low-cost (that is, higher profit) items to their continued participation in rally posts and providing regular services from fixed posts so as to ensure ongoing outreach to more isolated communities, and an active desire on the part of the promoters to continue in preventive activities.
- Train some promoters as TBAs. Work with them and provide support to some of their initial efforts to develop viable practices and generate income from assisting at deliveries
- The project will develop with the promoters a Federation of Promoters, initially in the project area, rapidly expanding to the rest of the department where CDS already works with promoters, and over time potentially expanding nationally. This Federation – a professional organization – would lead efforts of peer quality control, setting standards of quality of services and defining protocols for use of drugs as well as safety standards to prevent reuse of needles, a common source of HIV infection. Promoters wishing to participate in the PPT activities would need to be accredited by the Federation, and to participate in continuing updating education, for example. By supporting the organization of this organization, and bringing it to a state of self-sufficiency, the project will be developing a private sector entity with the potential to maintain and upgrade the skills of these community level care providers. With the involvement of this organization, an incentive is created for promoters to deliver quality care: one must be continually certified by the Federation in order to be able to participate in these income-generating activities.
- The project will involve Plan International and Caritas, two donor groups already active in the project area, in developing these plans. It is expected that they would see the benefit to their clientele of supporting these activities, possibly by providing funds through the Federation or through CDS to promoters working in their target areas, possibly by supporting some of the

supportive activities such as Auxiliary supervision of the participating promoters. Both organizations currently support microenterprise activities in the area, and may also find attractive the opportunity to develop a microenterprise program specifically to support these new health provider entrepreneurs.

Third dimension: Community and social/ecological systems

As the project will have little control over the social and ecological systems affecting the communities, activities in this dimension will aim at Community Competence and Capacity.

- engage communities from the outset, by
    - facilitating a participatory assessment of the community regarding its health and the factors which influence health, so that they themselves define their needs and feel ownership of the process
    - facilitate a community process to establish the Village Health Committee from existing clubs or organizations, so that the choice is a community choice
    - facilitate a community process to develop a site to be available for conducting health post, either rally post or fixed post; if repair or painting is necessary, facilitate the community doing that – again to bring about ownership
    - train VHC members regarding technical aspects of health and their role in interacting with village members to disseminate information facilitate utilization of health services such as immunization, weighing, condom use, and family planning
- define the characteristics and activities of posts (rally or fixed) so that they are community activities with technical input by the auxiliaries and promoters, not health system activities with no or unimportant involvement by the community. Take active measures including training of auxiliaries and promoters and supervision of them with observation as posts are conducted to ensure that shift of ownership of the post to the community is happening. Community members may do weighing of children, registration, giving health talks to waiting mothers, advising mothers of malnourished children about healthy diets, preparing reports. A community person should be in charge of the post, speak to the women coming, etc.
- provide VHCs with regular monthly reports of project progress in their area (see the comments on feedback in the Project Monitoring Plan subsection); when problems are occurring, form teams from community as well as health system and follow a quality improvement process until the problems are solved. Track "demand" for various health services (e.g. packets of ORS distributed from PPTs, vaccination coverage/utilization rates, contraceptive usage levels) and report to the Committee, and facilitate their planning on how to increase demand and thereby increase these rates.
- provide to the Committee reports of quality assessments (VCRs) of care by health workers responsible for their area, such as TBAs during delivery and auxiliaries taking care of various health problems and seek their support and advocacy in encouraging improvement.
- give VHCs nominal management responsibilities for the promoter responsible for their area. This would include the VHC keeping its own records of his/her visits, asking her to report to a representative of the community after a visit regarding findings and problems and soliciting suggestions , and to submit regular reports of health status and problems (including reports on progress with targeted "red folder" families), and asking VHCs to participate in performance reviews of promoters.

- asking VHCs to work with pregnant women and their families to develop plans for transportation of the delivering mother if complications occur during delivery
- train mothers and fathers from the community in mothers clubs and men's clubs and develop roles for them following their "graduation" in supporting health in the community, for example, by supporting them in giving health talks to the community
- form a federation of VHCs across the region. Bring representatives together to discuss problems and learn new health methods and share problem solving approaches.
- Seek new funds from sources such as Plan International and Caritas (both have extensive local activities), and channel those funds (or microcredit capital) through the VHCs to those promoters who are certified for quality of service by the Promoter Federation and whose VHCs have consistently filed reports over the preceding year expressing high satisfaction with the services they have been providing.

With constant emphasis on these aspects by project staff during visits, and by MSPP as well, the VHCs will gradually assume responsibility and a sense of ownership of the services in their areas. Through initial and follow-up training, community representatives and the VHC will become capacitated to lead in health.

The project will then plan with the community and the relevant promoter or promoters how to deal with the end of funds from the project, with potential loss of promoter manpower. By such joint planning everyone will feel bound by the decisions taken, such as raising prices in the CBDs, providing some support for a minimum number of promoters through an increase in community fees, etc.

Through these various activities aimed at promoter capacity development, development of other health related sources of income, development of a federation aimed at assuring quality of services, and development of relations with communities, a feeling of community ownership over health and health care, and the building in of incentives for promoters to want communities to judge them well (community approval used as criterion for loan) and to be judged by their peers in the promoter federation as competent and delivering high quality services, we anticipate that we can work out mechanisms for many or even most of the promoters to be able to continue their jobs of reaching families in their homes and communities and bringing access to care as close as possible to citizen homes., even after the project is terminated.

Child Survival Interventions:

IMCI: The Project will use the standard nationally approved curricular materials and the IMCI trained trainers from the MSPP to deliver IMCI training. The major variation in this will be the insertion of periods between training sessions when trainees will be asked to carry out assignments at home.

Nutrition/Micronutrient Deficiencies: The main focus of the project with regard to distribution is micronutrients – vitamin A to children under 5 along with immunization, and for mothers post delivery (via Promoters), and iron folate to mothers during pregnancy, along with prenatal care and also via Rally Posts and Promoters. Weighing programs will emphasize education of mothers regarding diet for children underweight, and promoters will follow up such children as part of their follow-up of red folder risk families.

The project's Hearth efforts will be limited to a few pilot areas, again related to limitations in the budget available to support the 'monitrice' (monitor) needed to mobilize the community and facilitate the feeding sessions. CDS is familiar with the Hearth approach, and will be implementing it based on their knowledge. If non-USAID funds are obtained, the Project will expand the scope of the Hearth activities. If a national Hearth group forms, the Project will participate in it.

Breastfeeding: HOPE/CDS will focus on the use of neighbor role models in EBF support groups (animatrices). This approach was very effective in increasing EBF levels in the previous project in the Department du Nord.

CDD: See the description of the CDD intervention in the Intervention section at the end of this DIP.

Pneumonia Case Management: It is not known at this writing whether the use of antibiotics by Promoters will be allowed by MSPP, despite the positive experience of the Haitian Health Foundation (HHF) with this strategy. If this is not allowed, the project will emphasize identification of danger signs suggesting pneumonia to promoters and parents, and appropriate referral to an auxiliary for consideration of antibiotic treatment.

Child Spacing: It is the intention of the project to focus during this period on increasing the numbers of users of modern contraceptives, an effort in which CDS has had good success in the eastern communes. See the intervention description below. CBDs will be a major element of the strategy, and will be trained to advocate against sexual behavior at high risk for HIV/STI infection and promote condom use.

Maternal Care: As requested by the government, the Project will incorporate maternal care as one of the CS interventions. See the intervention description below.

Performance Monitoring & Evaluation: The project census, completed in March 2003, will be the basis for promoter activities and the project information system at community level. The Project will discuss computerized information systems with ADRA, to learn from their experience with a CS project in Carrefours. LQAS will be used in monitoring Project progress.

Management Plan: The management plan is now different from that described in the proposal, because of the new partnership between HOPE and CDS. It is described in the section describing differences from the Proposal in a subsection of that name. The Project has scrupulously followed both USAID and national guidelines regarding payments to MSPP staff. The new HOPE financial system is now in place.

G. PROGRAM MONITORING & EVALUATION PLAN

1. Current Haiti North-East Department Information System

The current information system of the MSPP is limited to collecting information about service utilization and service activities by disease category and use of consumables. The forms at the dispensary level, which are completed by the auxiliaries, are extremely complex, with many data points inappropriate for the targeted facility. Analysis of the data collected is not taught to the auxiliaries. Feedback is rarely received unless outputs are dramatically low. There are no defined targets for performance or coverage, evidence for the lack of concern for the denominator. There are no regular meetings at which performance is reviewed based on reported results, and no regular efforts to manage performance or solve performance problems identified by reported results.

2. Monitoring Tools and Data Collection

The Tools Table in this M&E section characterizes the tools that will be used to gather project data. In some cases the tools are in existence and in use – for example, the current facility reporting tools – and the project will not plan efforts to change these tools. In others – e.g., the new style supervisory form/checklist – tools are in existence and use elsewhere and must be imported and adapted to the situation in these six communes and DSNE. In still others – e.g., the analysis tool – the tool does not exist and must be created, tested, and implemented.

The table also describes who will collect the data, what function or person the data will be used by, who will analyze and use the data (often both the supervisor for monitoring activities and the project statistician for documenting project performance) and the source of the tool or of the guidelines which will be used to develop the tool.

The project Workplan table also indicates relative to specific activities and objectives what indicators will be tracked.

3. Monitoring Plan

Principles of Project Monitoring

As stated elsewhere in this section, the fundamental principle which overrides all others is that data collected is analyzed and used in improving the performance of the project. We have already described the regular meetings and supervisory visits which will allow such use of data in identifying and solving performance problems. We will track these activities by maintaining a locality specific record of problems identified, actions planned, and results of those actions in overcoming the problem as determined by subsequent assessment **(Project Problem List)**.
Other principles to be emphasized include:

- participation by those monitored in the monitoring and in the planning and implementing of problem solutions, for example, involvement of the DSNE statistician in planning and managing these monitoring efforts
- communication both vertical and horizontal regarding results of monitoring
- use of monitoring to build team spirit
- local partnering
- decentralized decision making (e.g., on the spot participatory decisions about how to resolve an identified problem, rather than merely forwarding a report to a higher decision making level

Monitoring Activities and Data at each Project Level

The table of monitoring tools which is part of this section of the DIP, and the Workplan at the end of the DIP text both define in some detail the indicators being tracked, the nature of the tool to be used to collect the data for those indicators, the person who will be administering the tool, the frequency of administration, who will analyze the data (often the person collecting it!!), and who will use the data for problem solving and performance improvement. This subsection of the Monitoring Plan extends this defining process by providing the perspective of each of the various project levels on the monitoring activities to be carried out at that level.

a) Community Level

The monitoring efforts at this level must support and enhance the participation of the community and its appreciation of its own health status and the services being provided to it, and engage them in the solution of the health and service problems detected. The community becomes involved through the various groupings present: the village health committee, the clubs of mothers and fathers, the satisfied or not satisfied clients of health services, the animatrices and the support groups for breastfeeding. These groups provide the channels for communication of the project's progress and for engaging the community in the activities of health development.

The major source of data at this level is the **promoter**. Elements of data produced include:

- Family folders for each targeted household (under 5 children, women of reproductive age, sick persons including TB and/or HIV/AIDS, family planning clients), including the changing classifications (red, yellow, etc) of those folders and families to indicate risk, need for additional attention, or behavior change target (e.g. potential user of contraceptives)
- Weekly or biweekly verbal report on progress during regular meetings with the supervising auxiliary
- Monthly written report of home visits made, progress as a result of those visits based on changes in the family folder classifications and solution of family problems such as illness, events (reports of community meetings (village health committee, mothers club sessions, COSAM activities, other), visits completed, problems identified, and progress in resolving problems previously identified. Each promoter will have activity targets by indicator, and these reports will document achievements relative to these targets, as well as failures. Analysis of achievements, problem identification, plans for problem solution, and reports of the success of such problem resolution will make decisions and planned action part of these reports.
- Monthly vital statistics reports (births, deaths, migration)
- Rally post report of attendance, growth, immunization
- VCR of the quality of delivery assistance by local TBAs
- Reports of contact tracing for STIs or TB

An additional report about this level but by the auxiliary will be:

- Reports from the regular supervision of the promoter and the village by the supervising auxiliary or the UCS nurse supervisor

Another report will be:

- LQAS studies of maternal behaviors, initially quarterly, later 6 monthly (by the Project statistician in collaboration with the DSNE statistician and UCS nurse supervisors)

The promoter is expected to not only report data, but to analyze it, identify problems, and take action to solve them (decentralized decision making). Instilling and enhancing this process and skill will be an important component of promoter ongoing support and supervision by the auxiliary and by the project.

Reports of data directly from the community itself may be obtained. We will experiment with the usefulness and desirability of requesting reports from the following:

- Village health committee meetings and/or progress (quarterly report?)
- Mother's and Father's Clubs (directly, from the facilitating auxiliary, or from promoter observations, both during the formal curriculum, and following graduation). We will experiment with developing a *VCR of mother's club sessions*, as a means of monitoring the quality and effectiveness of those teaching sessions.

- Animatrice support groups for exclusive breastfeeding (COSAM)
- TBA activities – perhaps from TBA reporting to the supervising auxiliary as she is resupplied with vitamins or supplies following a delivery

b) Health Facility Level

The **auxiliary** or if a health center the **nurse** is the source of most data from this level. Data includes both reporting of auxiliary activities and those of the dispensary or health center, and collated data from the communities and promoters in the facility's catchment area. Here too the project will take active steps to ensure that data is used to identify and solve problems. Data types include:

- monthly facility activity report (visits, illnesses, immunizations, family planning activities, pregnancy related activities, TB care, etc, also facility financial management). The project will develop an analysis tool to allow immediate appreciation of variation in specific items of data relative to targets, and will expect these reports to contain comments and action plans regarding such variations (problems). This basic report using MSPP forms will be augmented to include self monitoring by the auxiliary of the quality of care being delivered, including items in facility assessment (e.g. occurrence of stockouts of critical drugs, vaccines, or supplies; results of ongoing client satisfaction assessment; cold chain management, and progress in solution of previously identified problems {related to the Project Problem List})
- monthly area reports – the collated data from promoters and communities – again with automatic analysis and problem identification and action plans
- supervisory reports from promoter supervision
- reports of village club sessions led, and other village activities participated in (process data)

An additional report about this level but by the level's supervisor or project field data collection will be:

- Supervisor's report on auxiliary and health facility performance, including progress in solving previously identified problems, including observations of the quality of care being delivered (sick child/IMCI, prenatal care; family planning care), and exit interviews
- LQAS reports (quarterly initially, later 6 monthly) on client satisfaction, family planning use rates, etc
- VCRs of quality of child illness care by the auxiliary/nurse, carried out by the Project, at 6 monthly intervals

c) UCS Level

This level of monitoring will include both reports from nurse supervisors and reports from Project monitoring, including:

- Monthly collated reports from the facilities and communities of the UCS. Here too targets will be established by indicator and incorporated into automated spreadsheets providing immediate analysis and display of variation/problems based on both numerators and denominators (rates). The UCS reporting units will be expected to include in these reports discussion of problems newly identified and plans to deal with them (immediate action, or further data collection to confirm the presence of a problem or to understand its possible causes). Presentation of results will be important here – it will be set up so that a manager can assess achievements at both the UCS level as a whole and the levels of the communes and sectors and communities/promoters which make up the UCS.

- Reports from regular monthly review of 5% to 10% of folders and registers at facilities by the UCS supervisors to verify data, assess the correctness of diagnosis and treatment, etc
- Reports of the timeliness of execution of the activity calendar of the project at all levels
- Stock and cold chain reports
- Reports from monthly reporting and planning meetings of the auxiliaries in the UCS led by the UCS supervisors and based on the auxiliaries' reports and on the additional data from project and supervisory visits will both identify issues and present them to higher management and further reinforce the process of problem identification, analysis, solution through action, and assessment of problem resolution as part of the Project's active performance management.

d) Higher Management Level – CDS BRG and DSNE

Nearly daily meetings as well as formal monthly reviews will assess operationally the progress of the project based on the various reports described from the lower levels. A three monthly workshop of local stakeholders will review progress and identify problems suggesting strategic redirection or reinforcement. A 6 monthly major review of the three partners with additional stakeholders will similarly assess progress in achieving targeted indicators, and prepare plans for strategic and operational changes as needed.

Feedback of Information

This subsection on monitoring has dealt operationally primarily with the sources of information. It must be stressed additionally that this project will, as part of both its capacity building and its behavior change approaches, feed back the information collected to the sources of that information, as well as expecting consideration of the information by that source prior to submitting it. For some entities, more information than provided will be fed back. For the Village Health Committee, for example, the Project will feed back the data submitted by the promoters and the auxiliary/dispensary who serve that village, including data such as attendance at rally posts, % of children growing as expected, family planning user rates, quality assessments, and the like. Initially the project will facilitate meetings of the VHC to review the data, analyze it relative to the issues of the village, and plan actions in response. As the skills of the VHC grow, these reviews will be managed within the capacity of the VHC itself, with occasional monitoring by the Project to identify problems and help in their solution, as well as to track this increase in capacity as part of the Project's capacity building efforts. The same sort of facilitation process will be done with promoters, auxiliaries, and UCS supervisors, including the tracking of increasing capacity in identifying problems, analyzing them, and taking action – effective or not – to solve them.

4. Data Analysis and Use for Decision Making and Management

The activities which are planned for enhancing the quality and usefulness of supervision and data-based decision making and management are described in some detail in the Intervention section under Capacity Development of MSPP. The tools in almost every case are aimed specifically at facilitating self analysis and use of data in planning activities (e.g., analysis tool for supporting analysis of monthly report data from dispensary and related community activities by auxiliary, promoter planning tool) as well as use of the data by a supervisor/manager to identify performance problems, allow for feedback, and facilitate improvement as well as tracking changes from initial corrective input to correction of the problem identified.

Relative to community level activities, promoter derived data emerging from initial household assessments and subsequent visits will be used by the promoter to self-assess his own effectiveness in converting red chart families (families with risk or extra attention characteristics such as being behind in immunizations, malnourished, pregnant, or a likely family planning user) to yellow or green status. The same data will be used by the promoter's supervisor (the auxiliary) to assess promoter performance and also to assess the effectiveness of the promoter's use of the data in planning activities (in essence assessing capacity development of the promoter), while at the same time facilitating discussion and problem solving with regard to difficult family cases which the promoter needs help in dealing with (e.g., needs an auxiliary home visit).

By consolidation of data at higher levels through the use of new analysis tools noted in the Tools Table, it will become almost unavoidable for managers and supervisors to see those units or promoters whose performance is either better or worse than the norm for the group, as well as to compare the current situation with the population based targets for that particular moment in time. As noted in the Capacity Development description, the mechanism for that process will be review meetings – weekly at dispensary between auxiliaries and his/her group of promoters, monthly by auxiliaries meeting with UCS supervisors, monthly by UCS supervisors and department heads meeting with the Director of Health at departmental level. These meetings will be preceded by the submission of data organized to feature the identification of problems as well as excellent performance (using the analysis tools), and will provide the opportunity for the higher level supervisor or manager to request explanations of the group being supervised regarding performance, and determine together approaches to diagnosing the causes of problems and taking action to overcome them, as well as following up on previous problem solutions in progress.

The HOPE/CDS team will play an active role in facilitating this whole process, from the lower level collection and organization/display of the data in upgraded denominator-sensitive reports, to the pre-meeting analysis of the data submitted from lower levels by the receiving supervisors/ managers, to the meetings themselves and their management decision making, to the follow-up of those decisions with diagnostic activities in the field and/or problem solving efforts when the causes are clear. Meetings are planned to occur as follows:

- promoters with supervising auxiliary – weekly (every Monday) for activity planning and monthly for more in-depth performance reviews (individual supervision at rally posts and during home visits in addition).
- auxiliaries with supervising UCS nurse-hygienist – monthly (individual supervision on site or during fixed point sessions or during mothers club educational sessions in addition).
- TBAs with supervising auxiliary – monthly as well as after each delivery for reporting and resupply of vitamin A – will review results from VCR of delivery obtained by promoter.
- UCS nurse-hygienists with Director of Health DSNE and other division heads monthly, with quarterly in depth reviews based on quarterly reports. Individual supervision by specific divisions (e.g., training, information system/statistician, drug supply/logistics) in addition.

5. Tools Related to Quality of Service

The Tools Table presents a variety of tools related to quality of services – in some senses almost all the tools are aimed at quality. Those aimed at clinical case management include the VCR/exit

interview tools, the VCR of TBA deliveries, and the case management observation tools. The SDMA addresses the factors relative to the infrastructure, to case management factors (e.g., availability of the clinical algorithms/protocols for specific case management of diarrhea, ARI, STIs, etc.), and to management procedures (e.g., frequency of supervision, use of supervisory checklists), which are present in clinical facilities and in management practices of the relevant staff. The supervisory forms address quality issues both of current practices of the supervisee (e.g., promoter practices, auxiliary practices) and issues of the quantity and coverage of supervisee work (e.g., achieving coverage targets, carrying out supervision tasks, etc.).

Tool	Purpose	Admin-istered by	Frequency	Exists?	Needs adapt-ation?	Who responsib?	Data anal by	Data used by	Source of model tool
KPC Survey	Assessment of mother knowledge, practices, and coverage (mother or child)/ mothers 15-49 with child to evaluate project progress	External survey firm	baseline, midterm, final	yes	yes	Barthelmy	HOPE/CDS Statistician	CDS/MSPP Community & auxiliaries	CSTS
LQAS	same as above	UCS supervisors	6 monthly	no	yes	Barthelmy	HOPE/CDS statistician	managers to identify per-formance problems	CSTS for LQAS method, KPC for content
Initial HH assessment & planning + priority setting	To define health needs of household and set priorities for promoter activities; identify families needing extra attention	promoters	initial contact, then modify as changes occur	no	develop from KPC	Barthelmy, Modestin, Simon	statistician, promoter	promoter to identify red file families for ↑ attention	KPC, census tool
SDMA	Assess quality of facility, services, supplies, mgt of activities, for defining improvement needs and assessing progress in improvement	CDS & MSPP	ANNUAL	YES	NO	NA	CDS Tech Director	whole team for planning system improvement s	MSH
Drug inventory management form	Tracking drug inventory at facility level, for ordering and prevention of stockouts	auxiliary	weekly	YES	YES	Dr Modestin	Auxiliary and Suprvsr for supvsn	Auxiliary for stock mgt Supervisor for assessment	MSH/'CDS activ in E Communes
VCR/ Exit interview – sick child	Assessment of quality of clinical case management by asking mother about provider practices carried out during recent encounter	promoter, supervisor	quarterly, then 6 monthly	yes	yes	Northrup, Barthelmy	statistician, supervisor	Supervisor for identif service quality prob-lems, tracking improvement	Northrup, from BASICS study
VCR/exit interview – STI/FP/ Pre- + post-partum	Assessment of quality of clinical case management by asking mother about provider practices carried out during recent encounter	promoter, supervisor	quarterly, then 6 monthly	no	yes	Northrup, Barthelmy	statistician, supervisor (UCS nurse)	Supervisor for identif service quality prob-lems, tracking improvement	Northrup, from BASICS study

Tool	Purpose	Admin-istered by	Frequency	Exists?	Needs adapt-ation?	Who responsib?	Data anal by	Data used by	Source of model tool
VCR - TBA delivery assistance practices	Assessment of quality of TBA assistance at delivery by asking postpartum mother about TBA practices during her delivery	promoter	during postnatal home visit after every delivery	no	develop from TBA guidelines	Northrup, Barthelmy	statistician, supervisor (auxiliary)	Supervisor for identif service quality prob-lems, tracking improvement	Northrup, from BASICS study
Observation of clinical encounters – sick child	Assessing quality of auxiliary services and correctness of practices	UCS nurse supervisor	quarterly?	yes	yes	Northrup, Barthelmy	supervisor (UCS nurse)	Supervisor for identif service quality prob-lems, tracking improvement	IMCI algorithm, VCR
Supervisory form - promoter	Assessing quality and quantity of services	auxiliary as supervisor	quarterly?	yes	yes	Barthelmy	supervisor (auxiliary)	Supervisor	CDS supervisory form in E. Communes
Supervisory form - auxiliary	Assessing quality and quantity of services	UCS nurse supervisor	quarterly?	yes	yes	Barthelmy	supervisor (auxiliary)	Supervisor	CDS supervisory form in E. Communes
Observation of clinical encounters – woman	Assessing quality of auxiliary services and correctness of practices	UCS nurse supervisor	quarterly	no	develop from clinical guidelines	Barthelmy	UCS supervisor, statistician	supervisor for identifying quality problems	clinical guidelines for RepHlth care
Clinic register-/monthly report form	Reporting activity of dispensary in previous month	auxiliary	monthly	yes	no	--	auxiliary, UCS spvsr, DSNE	each level to identify performance problems	register/form already in use in DSNE
Analysis worksheet – for each level	Guides analysis and interpretation of monthly dispensary report to facilitate active management/planning on basis of data	auxiliary herself, also UCS and DSNE levels	monthly	no	--	Barthelmy, statistician, Northrup	self (each level) and supvisr - manager	each level to assess perf rel to popul denominators	develop by facilitating calculation of rates & comparisons
Training supervision form	Monitors the quality of training activities to allow objective feedback and improvement by trainer	CDS, UCS supervisor, DSNE TOT	during supervision of training activities	no	--	Northrup	training supervisor	supervisor to identfy probl & track improvement	develop from training-adult learning guidelines

Tool	Purpose	Admin-istered by	Frequency	Exists?	Needs adapt-ation?	Who responsib?	Data anal by	Data used by	Source of model tool
Promoter monthly report	Reporting activity of promoter in last month	promoter	monthly	yes	yes	Barthelmy, Benoit	self, supervisor, statistician	self, supervisor, MSPP – track activ-ities & per-formance	current CDS tool used in eastern NE communes
Household visit tool – family record	Defines status of mother & child health, records actions, illnesses, provides basis for improvement	promoter	daily	yes	yes	Barthelmy, Benoit	promoter	promoter	current CDS tool used in eastern NE communes
Promoter planning tool	Facilitates organization of family and community data for easy seeing priorities and setting activities for next time period	promoter	weekly and monthly	no	--	Barthelmy, Benoit, Northrup	promoter	promoter	develop from promoter work guidelines
Rally post report	Records activities and identifies non-attendees – both numerator and denominator data used	promoter	monthly	yes	yes	Barthelmy, Northrup (strengthen denominator emphasis)	promoter, auxiliary, supervisor, DSNE	each level to track/assess promoter & system perf-ormance	current CDS tool used in eastern NE communes
Analysis tool	Facilitates analysis of monthly data to identify problems and plan actions to correct them	auxil @ facil nurse @ ucs mgr @ DSNE	monthly, quarterly	no	--	Barthelmy, Northrup	auxiliary, supervisor, DSNE	each level	devel relative to project & DSNE targets
Promoter weekly meeting tool	Organizes weekly report/support meeting of auxiliary with promoters	auxiliary	weekly	no	--	Modestin	tool does not produce data	NA	good meeting guidelines
Village health committee meeting report	Documents meeting agenda, attendees, decisions made, tasks to be done, and items to be followed up at next meeting. Serves as proof of the meeting taking place	VHC secre-tary, promoter	monthly	no	--	Modestin	statistician,	VHC at its next meeting, statistician	purposes of VHC
CBD report form	Records movement of items in and out, and patient flow	CBD volunteer	daily, monthly	no	--	Modestin	auxiliary as supervisor, statistician	CBD itself, auxiliary for ordering	stock mgt tool

Tool	Purpose	Admin-istered by	Frequency	Exists?	Needs adapt-ation?	Who responsib?	Data anal by	Data used by	Source of model tool
TBA delivery report form	Records clin data from delivery and TBA actions	TBA	each delivery	yes	yes	Barthelmy	auxiliary as supervisor, statistician	auxiliary, project	CDS tool
TBA initial assessment/ interview form	Defines TBA KPC and sets priorities for improvement	UCS nurse or CDS supervisor or auxiliare???	initial encounter, any new TBA	no	--	Barthelmy	auxiliary as supervisor, statistician	auxiliary, project	CDS tool
Mother/Father club form - register	Records meeting, attendance, and topics discussed	Secretary of club with the auxiliary	each meeting	no	--	Barthelmy	statistician	project – to track comm activities	club meeting guidelines
Animatrice BF support group form	Records meeting, attendance and topics discussed	BFG secy with the animatrice	each meeting	no	--	Barthelmy	statistician	project – to track comm activities	club meeting guidelines
Focus group discussion outline forms- various topics	Provides guide for questions to be asked of participants in FGD as part of defining BCC messages	FGD facilitator (CDS staff)	each FGD	yes	yes	Modestin	tool does not produce data	FGD leader – facilitator to guide discussion	CSTS web site

6. Capacity Building in M & E

All tools will be developed and/or adapted in close collaboration with the appropriate counterparts from DSNE. All supervision activities will be initiated with the CDS supervisors carrying out the supervision using the appropriate tools along with the DSNE counterpart observing this demonstration of the correct methods. This will be followed by the counterpart doing the supervision with direct CDS partnering and observation/mentoring, as well as obtaining feedback from supervisees. When skills have reached acceptable levels, the CDS supervisor will reduce the frequency of accompanying supervision visits, and depend on supervisor reports to identify issues or problems that require closer attention and follow-up. Meetings which are intended to foster data-based decision-making and management will be initially designed (developing agendas) by CDS staff with DSNE counterparts, and meetings held with active CDS facilitation. When these meetings are progressing well, the CDS will pass along the tasks of agenda development and facilitation to DSNE counterparts, while remaining involved in the meetings. In all cases, reports will give evidence and respond to indicators of competence in these various M&E competencies.

7. Operations Research

- *IMCI.* As IMCI is newly being implemented in the North-East Department, we will study the factors which influence the effectiveness of implementation of the new protocols including the types and frequencies of supervisory inputs, and the effectiveness of feedback from VCR and exit interviews of the quality of child and maternal services by auxiliaries. This will be carried out over the first two years of CDS activities, and the results used to improve the IMCI support to the auxiliaries during the following two years.
- *Promoters' involvement in ARI Case Management*. We are still in negotiation with DSNE as to whether it will allow promoters to dispense antibiotics for pneumonia treatment, a decision which depends on national policy as well. If permission is granted, pneumonia case management training will be provided using the IMCI national protocols simplified for promoters in a pilot area. A carefully tailored monitoring system will allow effective determination of promoter capability and actual performance, as well as monitoring inappropriate use of the antibiotics for other illnesses, and a comparison of the effectiveness of the treatment at village level earlier in the course of illness than in areas where treatment can be obtained only from Auxiliaries.
- *CBDs*. A comparison of villages with CBDs and those without will be carried out using the data from CBD reports and the project KPC surveys with regard to both knowledge of CS and maternal issues which the CBD persons are teaching to their communities, and contraceptive use rates.
- *Hearth (Ti Foyer).* The Hearth or Ti Foyer model of nutrition practice modification was originally developed and pilot tested in Haiti, and CDS has applied for funding Hearth activities to UNDP for their current eastern area. Due to budgetary limitations, the Hearth activities for this project will cover a pilot set of villages over a total of two years, with a single monitrice as the community facilitating agent for the process of positive deviant identification and the two-week feeding period with the local practical diet. The project will assess the cost of the activity as compared with the impact of the intervention on the level of malnutrition in children participating in the feeding program over the following year, and the impact of Hearth activities on other mothers of malnourished children in these villages through mothers' clubs.

H. BASELINE ASSESSMENTS AND FINDINGS

Three baseline assessments have been completed – the KPC, the SDMA of the health system from UCS level down, and the census -- with one remaining to be performed – the Management Assessment (MA) of MSPP at Departmental Level. The initial analysis of the KPC is completed with one-way tables, but the analyses of some of the more complex indicators (e.g., exclusive breastfeeding) is still in progress (see required CSHGP form and note remaining blanks). The census analysis will be available on May 22.

Knowledge, Practices, and Coverage Survey

A complete summary table of the results of the KPC survey according to the analysis so far is attached as Appendix 6. The most important findings relative to the content of the project include the following:

- High levels of malnutrition among children less than 24 months – 3-4% severe malnutrition and 10 to 13% moderate malnutrition
- Delayed initiation of breastfeeding following delivery (as high as 30% two days or more after delivery) and low exclusive breastfeeding rates[2]
- Poor rates of vitamin A supplementation received in the past 6 months – only 15% by card and only 35% by card plus history
- Very low rates of complete vaccination – 16% -- and corresponding low rates of vaccination for particular antigens
- Low knowledge of the signs of illness in a child among the mothers – especially dehydration from diarrhea[2]
- High rates of child illness – 67% sick in the past two weeks overall , 42% sick with diarrhea, and 40% with respiratory infection
- Lack of knowledge of how to mix ORS, and failure by many mothers to give additional fluids or additional feedings during diarrhea
- Very low rates of mothers who washed their hands following each of the recommended 5 situations[2]
- High rates of inadequate prenatal care – 23% with none at all, an additional 23% with less than three visits, with even higher rates in the mountainous areas (Ste Suzanne and Vallieres communes
- Very high levels of mothers having received no tetanus toxoid immunization during their pregnancies – 81% by card, and 31% by card and history
- Very low levels of mothers having received vitamin A after delivery – only 5% by card, 29% by history
- Surprisingly high rates of postnatal visits to a health facility – 59% , but a big difference in rates of home postnatal visits in Terrier Rouge versus Trou du Nord – 21% vs. 71% !!
- Fair knowledge of modern contraceptive methods – 77% knew two or more methods – but very low rates of modern contraceptive usage – 81% non-users
- Nearly complete knowledge of HIV/AIDS – 97% -- but mediocre knowledge of methods effective in preventing HIV/AIDS infection -- some 40% of respondents citing the condom as a

[2] (final analysis still pending)

means of HIV/STI prevention, 55% citing fidelity to a single partner, and 13% citing limiting the number of sexual partners as the three methods cited the most frequently
- no knowledge of the two new VCT centers in the eastern communes, the only such facilities in the Department
- Only half of the mothers knew about other infections transmitted sexually, and specific signs were also poorly known
- Only 6% and 19% of women at TR and TdN respectively declared that they had had a STI in the previous 12 months

Service Delivery and Management Assessment (SDMA) at UCS and Facility Levels

CDS and MSPP together conducted a SDMA using the SDMA tool developed by MSH for use in the HS2004 project in Haiti. The tool covers general aspects of facilities and procedures, child survival related findings, reproductive health, STIs/HIV/AIDS/TB, community services organization, supplies & logistics, behavior change communication, information system, human resources management, and financial management. All facilities in the target area were assessed individually. The following summarized the findings in each area:

GENERAL ASPECTS OF FACILITIES AND PROCEDURES
- General state of buildings: reasonably good – solid structures, but with cracks and poorly maintained
- Identification as health institutions: the majority are not identified, nor are the services identified by signs or other mechanism
- Distribution and use of space: space is used for multiple purposes – inadequate utilization at Grand Bassin, Phaeton, RochePlate, and Caracol and Ste Suzanne
- Water system is defective and non functional in the service sites visited with the exception of TR
- Lighting: needs reinforcement at TR and TdN
- Security of the buildings: with the exception of TdN the majority of visited sites are not well secured, including absence or inadequate locks
- System of medical waste disposal: not consistent with standards; sharps found on the ground; absence of wastebaskets in rooms and corridors

CHILD SURVIVAL
- The IMCI protocol is being implemented incompletely at TR
- Inadequate provider knowledge on complete child immunization; infants presenting with fever or grippe are not systematically vaccinated at Grand Bassin
- The algorithm for treatment of diarrhea and ARI is not available in the majority of service sites visited
- Vaccination is available only once a month in the majority of dispensaries (Roche Plate, Dupity, Vallieres, Phaeton)
- Cold chain: in general is not operable; problems in conservation of vaccines outside refrigerator (use of thermos), lack of propane tanks, freezer not functioning
- Materials for demonstration of ORT: not available in the majority of service sites

- Providers in need of retraining or training in case management of ARI, diarrhea, breastfeeding, and immunization

REPRODUCTIVE HEALTH

- In general the auxiliaries and TBAs are not involved in reproductive health
- Promotion of three prenatal visits is not being done systematically
- Lack of a mechanism for tracking and follow-up in reproductive health
- No prenatal register at TR and TdN
- In the majority of sites visited there is no program of post-natal following (neither institutional or community
- 90% of deliveries are assisted by TBAs
- General lack of adequate mechanism for registration and notification of births assisted by TBAs (verbal report)
- Distribution of family planning methods at community level is limited, with only 1 or 2 methods available
- Predominance of methods of short duration (95%)
- Dropout rates very high – 50% -- and no mechanism for preventing it in place
- Family Planning register availability: not available at Phaeton, Perches, Dupity; in Grand Bassin, Caracol the register lacks a column for addresses of the user
- In general the staff would benefit from retraining in pre and post natal care and in family planning at both facility and community levels
- TBA inventory and training needs to be done in all the service sites

STIs/HIV/AIDS/TB

- No structured program for case management of STIs or AIDS
- Lack of training of staff
- Cost of treatment very high at Grand Bassin – gourdes 350
- In general the patients suspected of co-infection (TB-HIV) are not receiving HIV testing
- The picture album for education of the DOTS supporter is not used at Perches and Caracol
- In general a mechanism for tracking and pursuing dropouts from DOTS (TB) does not exist
- No TB program at Dupity or Roche Plate
- At Grand Bassin the results of the second and third sputum microscopy are not recorded in the register, and at SteSuzanne the second sputum exam (at two months) is not being done.

COMMUNITY SERVICES ORGANIZATION

- In general the community health services are not structured:
    - no workplan
    - auxiliaries do not know the population being served
    - auxiliaries cannot cite program objectives
    - home visits and community meetings are being done only informally (no tools, no reports)
    - no supervision of auxiliaries or TBAs

BEHAVIOR CHANGE COMMUNICATION

- In general no plan for BCC

- Insufficient BCC support materials, teaching aids, etc.
- Personnel are not trained in interpersonal communication

SUPPLIES & LOGISTICS
- Requisitions/orders are not consistent with the standards of the essential drug program
- No monthly use report, inventory management tools do not exist
- Classification of medicines is incorrect
- Stock storage is in conditions inconsistent with standards
- Because of shortages in the peripheral depot certain facilities are ordering by alternative methods
- In a majority of facilities stockouts of propane containers were observed; in Phaeton this stockout continues for 8 months!

INFORMATION SYSTEM
- Registers for prenatal and postnatal care are generally not present in facilities
- Medical records are generally poorly maintained; at Grand Bassin they are not consistent with standards
- Generally no system for analysis and interpretation of the data generated by the facility
- Lack of materials for information storage (calculator, ruler, file cabinets)

HUMAN RESOURCES MANAGEMENT
- General lack of personnel files, no job descriptions, no standard procedures
- At TdN the personnel files are incomplete, also the attendance records are incompletely filled out
- No standard personnel procedures exist at facility level
- General lack of system to control attendance or to plan annual vacations
- No system for performance evaluation
- No supervision plan
- No retraining plan
- No plan for continuing education

FINANCIAL MANAGEMENT
- With the exception of TdN, a system of financial management does not exist in the facilities:
    - Registers for recording and monitoring income and expenditures are not present
    - Receipts to support expenditures are not available
    - No purchasing procedures
    - No financial reports
- A list of prices (patient fees) is not posted in all the facilities
- At Grand Bassin the income is insufficient to cover all the expenses including the salaries

I. PROGRAM DESCRIPTION INCLUDING CHANGES IN APPROACH

Goal

The goals of this project are to reduce infant and child mortality and morbidity and to improve reproductive health in six communes in the North-East Department of Haiti.

Objectives and Interventions

The objectives set for the project (unchanged from the original objectives) are listed here, with identification of the interventions planned to reach these objectives. A detailed description of the actions planned for the interventions is provided in the intervention descriptions by intervention at the end of this section, as well as in the workplan, where the listing of actions is organized by objective.

Child Health - Household Level

Objective #1: Improved preventive actions to maintain child health
Objective # 2: Improved home management of common childhood illnesses
Objective # 3: Improved care-seeking practices

Child Health – Community Level

Objective # 4: Increased community participation in child health and disease prevention activities

Child Health - Health Facility Level

Objective # 5: Improved management of child health and community outreach

The interventions directed at these five objectives include: IMCI, immunization, nutrition/micronutrients, breastfeeding, control of diarrheal diseases, pneumonia management, and capacity development of local partners.

Child Spacing

Objective # 6: Improved knowledge and practices
Objective # 7: Increased community participation
Objective # 8: Improved access and quality of services

The interventions directed at these three objectives include: Child Spacing, and Capacity Development of local partners

HIV/AIDS/STIs

Objective # 9: Improved knowledge and practices
Objective # 10: Increased community participation
Objective # 11: Improved access and quality of services

The interventions directed at these three objectives include: HIV/AIDS/STIs and Capacity Development of local partners

Pregnancy and delivery management

Objective # 12: Improved knowledge and practices
Objective # 13: Improved access and quality of services

The interventions directed at these two objectives include: Safe Motherhood and Capacity Development of local partners

Capacity Building -- HOPE

Objective # 14: HOPE management and technical expertise strengthened.

The intervention directed at this objective is: Capacity Development of HOPE

Capacity Building – Community, MSPP, and CDS

Objective # 15: Community Level
Objective # 16: Health Facility Level
Objective # 17: Departmental MSPP
Objective # 18: CDS

The interventions directed at these four objectives include: Capacity Development of CDS and Capacity Development of MSPP.

Approach

The major thrust will be to strengthen health care and behaviors at family and community levels, so as to develop capacity for continuation of preventive and some curative services following termination of the project without depending on the health facility. Given the almost non-existent community level services and severely deficient facility level services, the project will support the addition of a minimal number of staff, particularly promoters (outreach) and auxiliaries (outreach and facility services), sufficient to bring the numbers of staff to a level adequate to deliver a minimum package of services to patients and to the community, to ensure the development of community level capacity, and to demonstrate that coverage and quality standards are achievable in this severely impoverished environment.

Activities will include:
1) determining the health status of the target population and the factors influencing it through participatory assessment;
2) community mobilization and development of supportive community structure;
3) extensive training and capacity development at the community level to improve community level prevention, home-based management of illness, and appropriate care-seeking;
4) improving information systems to enhance local understanding of health issues and trends and to improve management and decision-making;
5) enhancing access to and the quality of provider services at facility level and in the community; and
6) enhancing the capacity of the DSNE to deliver the minimum package of services and to manage service quality and outcomes for adequate performance.

HOPE and CDS will carry out a phased approach to implementation. The baseline KPC survey was conducted in June/July 2002, and a draft report was issued in September 2002. A SDMA capacity assessment of CDS itself including its Port au Prince headquarters was completed in November 2002. A SDMA baseline capacity assessment of the 13 health facilities in the six communes was completed in December 2002, and a MA of the departmental DSNE (Health Department of the North-East) is planned for June-July 2003. Recruitment and selection of 40 promoters and a census of the two communes initiated implementation activities at community level in two communes of the six, those with the UCS offices – Trou du Nord and Terrier Rouge. The third year (of five) we will add the remaining four communes, two in each UCS. This phased

expansion of coverage will allow dealing in the second year with only two communal teams for initial training and for development of trainers and supervisors at the UCS level. Implementation of facility based activities and community activities led by the UCS team in a single commune can be more readily monitored and problems solved, and supervisory skills strengthened. Then the following year, building particularly on those supervision and management skills, the activities can be more effectively extended by the two UCS teams to the two additional communes each.

Additional activities to be carried out include the following (in order of neither priority or timing):

- putting in place the coordinating team in each UCS and for the overall project, including HOPE, DSNE, and CDS in regular review and collaborative management decision making
- meeting with community leaders and forming village health committees from existing community groups
- hiring additional health promoters living in the communities (50% women and 50% men)
- hiring facility staff as needed to complete MSPP basic staffing standards
- training or retraining personnel (facility and community based) at each level
- renovating health facilities (not with USAID funds)
- providing facilities with missing and critical equipment

The major operational approaches to implement this general strategy and to achieve the project goals are:

- Training of village-based **Health Promoters** in technical skills and adult education methodologies to
    - Organize and implement effective **rally posts** that will provide health education; EPI vaccines and TTV; weighing of children under two and nutritional counseling; provision of iron folate to pregnant women; vitamin A to children under six; family planning education and methods; counseling regarding STIs/HIV/AIDS
    - Teach **mothers' and fathers' clubs** in preventive behaviors, illness recognition, home management, appropriate care-seeking for childhood illnesses, and pregnancy danger signs;
    - Conduct home visits to all households quarterly and more frequent home visits to "red folder families" (priority or 'high risk' families) and new mothers within seven days of delivery
    - Facilitate meeting s of Village Health Committees
- Pilot testing the **Hearth (Ti Foyer) nutrition improvement** model, taking lessons-learned from mothers that have successfully integrated feeding behaviors for their children in this high risk area
- Training of 30 **peer animators**, usually mothers who themselves practice/have practiced exclusive breastfeeding (EBF), to motivate and support new mothers in their neighborhoods
- Training of **traditional birth attendants (TBAs)** in prenatal and post-natal care and safe delivery conduct and referral for complications
- Developing **village health committees** by working with local existing committees and groups (at least one per habitation) to take on health as a concern and interact officially with the project and the MSPP to monitor progress and provide leadership and motivation in health improvement of their communities.
- Training and support of **MSPP Auxiliaries** in adult education methods, community mobilization and leadership, IMCI case management, family planning services, delivery of

services at fixed posts, prenatal care, and syndromic approach to treating STIs, as well as education of mother/father groups and supportive supervision of promoters and rally posts as well as animatrices and Breastfeeding Support Committees

- Assessment and improvement of the **13 MSPP health facilities** in the target communes to enable them to provide effective IMCI care to sick children, family planning services, and syndromic STI care
- Training and direct support of auxiliaries and MSPP supervisors by Project staff in **supportive supervision** of health promoters, CBDs, animators, and community mobilization activities
- Development and pilot **novel approaches** successful elsewhere to increase community knowledge and practices, including
  - training of promoters and volunteers as **community-based distributors (CBDs**) of condoms and oral contraceptives;
  - use of innovative monitoring tools – the **VCR (Verbal Case Review) and LQAS (lot quality assurance sampling)** – to provide data for the management of improvements in the quality of case management of child illnesses by providers and the quality of delivery assistance by TBAs (traditional birth attendants)
- **Capacity development at village level** (mothers' clubs, fathers' clubs, village health committees, CBDs (community based distribution), and trained promoters who live in their territories and can treat childhood illnesses as well as trained TBAs for improved pregnancy outcome
- **Capacity development of CDS and MSPP/DSNE** starting with an initial assessment of capacity (the MSH SDMA -Service Delivery and Management Assessment) followed by preparation of a plan for capacity development, and implementation of the plan, with HOPE playing the role of facilitator and technical assistance. provider. This will include both departmental development (improvement of MSPP training, planning, management, information systems, human resource management, and logistics) and development at health facility and UCS level (improvement of facilities and equipment, service access, quality and coverage, outreach services to communities, and supportive supervision). Activities will include training and mentoring, technical assistance, provision of critical equipment and supplies, and strengthened public-private sector coordination.

Behavior Change Approach

The project will emphasize **person-to-person interactions (counseling), group interactions** through the Health Committees and clubs, **modeling** of appropriate behavior by animators and promoters, and **peer support and pressure**.

To facilitate effective counseling and education methods, all agents, including project staff as well as MSPP auxiliaries and health promoters, will be **trained in adult learning strategies and effective communication methods**. ***CDS staff,*** in particular ***CDS* trainers,** will ***model*** these techniques at each level and with each type of trainee, then ***support/mentor*** agents (auxiliaries, promoters, animators, CBDs) as they take over gradually using these methods in group meetings and individual health education encounters at household level. Finally they will ***monitor*** both

methods and effectiveness through ***direct observation*** as well as ***obtaining feedback*** from health workers and volunteers, club participants, and community members.

The project also will seek out ***peer models*** -- women who are carrying out exclusive breastfeeding, use family planning methods, take their children regularly to rally post sessions for immunization and weighing, and/or have well-nourished children -- and ***train*** them as animators as well as mothers' club organizers and activists, so that their modeling of appropriate behaviors will help to convince the reluctant to adopt those behaviors too. Such ***positive deviants*** will also provide model diets for pilot Hearth demonstrations.

The project strategy emphasizes village health committees and mothers' and fathers' clubs as mechanisms to provide ***peer interaction*** and facilitate mutual support as individuals try new behaviors and overcome difficulties associated with them. Mothers (and fathers) will go as a mothers' club or fathers' club group through a set curriculum adapted from HOPE's curriculum used in the North Department as well as the CDS mothers club curriculum. On their "graduation", they become a ***peer support network***.

The project will utilize the ***key messages and information*** for each intervention from the Haitian IMCI and other policy documents. Parents will learn about both the ***actions that health workers are supposed to take*** (e.g., for every child with suspected pneumonia count respiratory rates, assess for danger signs, assess for chest in-drawing, explain treatment to caretaker, explain when to come back), as well as ***actions parents are responsible for*** (complete prescribed treatment, increase liquids, watch for danger signs and seek care if needed, return for follow-up visit). These mutual expectations are reinforced through the verbal case review method (VCR) described below.

To promote behavior change at the department/UCS level, the project will organize a ***Project Advisory Council*** which will meet quarterly to discuss policy, coordinate methods and interventions, unify approaches to ensure uniformity in messages between communities, review monitoring data including behavioral data, and identify additional areas needing attention. Such a consortium will involve Project HOPE, MSPP, CDS, CDS, PLAN International, Caritas and the missions in the area, and village health committee representatives.

Behavior change approaches for ***providers*** – including MSPP auxiliaries, promoters, and TBAs -- will emphasize ***training, provision of required minimum equipment and supplies,*** *and* ***monitoring and supportive supervision*** with periodic ***feedback*** based on data from VCRs**.** The project will both model appropriate intervention-specific ***training methods*** and train Departmental trainers in such training methods including ***adult learning techniques*** as already mentioned. Training will be ***competency based***, and will include opportunity for ***practice*** under trainer observation. Curricula based on the same principles will be adapted for family planning, STIs, and reproductive health/maternal health from INHSAC and GHESKIO existing modules, in addition to specific training in communication and counseling, and in work management.

The initial baseline assessment of health facilities has identified equipment and supply needs directly related to IMCI and other intervention implementation. The Project will provide some such needs within budgetary and USAID restrictions, and will seek other resources for remaining needs. The project will **monitor auxiliary, promoter, and TBA behaviors** using supervision,

exit and Verbal Case Reviews (see also section on New Approaches), and will feed back such results to providers during supervisory visits and monthly meetings, identifying areas where implementation of desired behaviors seems to be a problem, and using participatory discussion to develop solutions and facilitate adoption of the desired behaviors.

Quality Improvement of Health Services

The project will incorporate a number of the elements which are part of Quality Improvement (QI) in its efforts to change provider behaviors, although QI type efforts will not address only behavioral contributors to (or detractors from) Quality. QI principles stress the following characteristics of efforts to improve quality:

1. involving a team of persons involved with the process experiencing the quality problem
2. using participatory methods which incorporate as equals persons involved with the process; non hierarchical team interactions.
3. emphasizing data in characterizing the quality problem, and showing that the solution has worked
4. emphasizing that most problems are caused by difficulties in the process or system, not by individual bad behavior

The process to be used in improving quality will follow the following fairly formal sequence: When monitoring or supervision has identified a quality problem which cannot be solved easily and quickly with a simple intervention, for example, dissatisfaction of clients with the services, or failure of a provider to follow the IMCI protocol, responsible manager will identify a team of persons at all levels involved with the process in which the problem has occurred (a "quality improvement team"). This team will then work to solve the problem with the following steps:

- brainstorm the possible causes of the problem,
- prioritize these possibilities and select one to work on
- carry out a 'study' to confirm the cause if necessary or feasible,
- propose possible solutions to deal with the cause of the problem and choose among them,
- implement the chosen solution
- gather and analyze data to determine whether the solution has worked, that is, whether the intervention has led to improved quality as measured by a data based technique
- if necessary, repeat the cycle

While this approach may seem at first glance to be tedious and drawn-out, experience with QI has shown that involving the persons who are part of the process in all these steps sharpens the identification of the cause, improves the choice of intervention, avoids the sense of guilt and resentment inherent in the usual supervisory criticism and corrective action, and leads to ownership of both the problem and the solution, so that improvement can be sustained.

Problems may be identified at the level of communities, a group of communities, a facility, a group of facilities, and so on. If the problem points to an individual promoter or auxiliary, the QI "team" will be made up of the person pointed to and the supervisor, who will together follow the sequence noted. If the problem occurs at levels involving more than one person (e.g. poor attendance at a particular rally post) the team will consist of the promoter, the supervisor, and some members of

the community, either mothers or Village Health Committee members. The nature of the team to be organized will be based on the nature of the problem.

Health Policy Related Advocacy

The project will maintain continuous dialogue with the MSPP at the departmental level regarding operational policy issues, in particular, IMCI policy as it relates to practicality in the field. However, at this point, the project does not foresee engaging advocacy at the national level regarding fundamental policy issues. Dr. Jean Denis, Medical Director of DSNE, introduced a recent project related workshop for DSNE staff by speaking of the project as providing a national model for effective services delivery as well as collaboration with a supporting NGO. The project will actively provide the support and data needed to present this model convincingly at national as well as international levels, while passively following the lead of Dr. Jean Denis in national advocacy.

Approach to Training

Planning for training has been and will be participatory, involving key stakeholders from the North-East Department. Training and follow-up for promoters will focus on two communes in Year 2 (through November 2003), with the initiation of the training for the promoters in the remaining four communes to take place from 3-6 months following completion of the first group's training, in order to allow adequate learning from the implementation of the trained skills so as to enable modifications to occur based on these lessons. Auxiliary training will take place for the whole six communes together, so that facility services can be upgraded as soon as possible, although it remains to be seen if new auxiliary staff can be hired in time to participate fully in these training sessions.

For all but the auxiliary IMCI training, interventions will be presented in modular form with assignments to the trainees and follow-up and practice (the "sandwich" approach) prior to the introduction of the following intervention. The IMCI training will follow the standard 11-day curriculum adopted by Haiti. Monitoring of training effectiveness will include direct observation of training methods and assessment based on adult learning criteria, pre- and post-tests of trainees at the time of training, trainee evaluation and comment on the training, and objective follow-up assessment of trainee implementation of the new skills in their home work settings.

Training methodologies will include some didactic processes but a strong emphasis on adult learning approaches. Concepts will be taught, demonstrated, and then a practicum experience provided. Intensive supervision of promoters by auxiliaries and auxiliaries by DSNE UCS staff partnering with CDS staff will be provided for reinforcement of new skills. Refresher trainings will be focused on the findings of the supervision visits and client satisfaction assessments. HOPE will also take advantage of special technical and community leadership skills as they emerge in some of the more experienced promoters. As feasible, such individuals will be asked to help mentor some of the more inexperienced promoters or those experiencing difficulties in activities (***peer mentoring)***, for example, jointly supporting rally post realization.

MSPP staff as well as CDS staff filling positions in MSPP slots will be trained as trainers and supervised and mentored by CDS staff as they apply adult learning methods in the program. CDS experience with similar activities in the eastern communes and their curricula will be applied in these activities.

Cost Recovery

One of the performance indicators being assessed for CDS in its activities in the seven eastern communes, and upon which its reimbursement by HS2004/USAID depends, is cost recovery. Actually there are very few institutions in Haiti where the patient does not have to pay some amount for care. That is also the case for public hospitals, health centers or dispensaries. The big concern is to put in place a financial mechanism that guarantees the correct control and use of those funds. To determine the level of overall costs to be budgeted for user fees during each of the years of the new project, we need to be effectively in charge in order to establish some reliable accountant procedures able to control all kinds of funds currently covered in the institutions.

The mechanism generally used at CDS includes different standardized steps such as: paying separately for every curative care or service, centralization of all payments at the cashier level, centralization of buying process, no subvention for medicines, etc.

The level of expenses to be supported by users fees refers to: what is needed to buy medicines or part of lab supplies, one portion of the salary of the personnel directly implicated into laboratory or pharmacy services. We should be able to determine these percentages at the end of the first year of intervention because we will need time to have the present picture and put the system in place.

PLANNED ACTIONS FOR SPECIFIC INTERVENTIONS

1. Child Health Related

Integrated Management of Childhood Illness (IMCI) (LOE to be determined)

The Ministry of Public Health and Population, with the support of WHO/PAHO, JAICA, USAID and UNICEF, has committed itself to the Integrated Management of Childhood Illness (IMCI). Treatment protocols for diarrhea, ARI, measles, malaria, and malnutrition have been adapted for Haiti, training curricula and materials have been prepared, training of trainers has been completed, with one TOT trained in the North-East Department, and training has already been completed in early 2003 for all the relevant doctors and nurses in the North-East department system. Further planned actions are as follows:

1. Complete serviceability of dispensaries and health centers with essential equipment, supplies, and IMCI forms required to carry out clinical integrated case management of sick children according to the IMCI protocol

As of this writing, DSNE has purchased 65 additional propane gas cylinders and ensured functioning refrigerators. Supplies, drugs and forms will be in place by May 15. Auxiliaries will complete a final checklist before coming to their training.

2. Train the auxiliaries from dispensary level.

The auxiliary training will take place May 5-17 using the standard Haiti IMCI curriculum, and using the DSNE's TOT as the senior trainer. The training will emphasize specific actions to be taken by the auxiliary and advice and counseling to be provided to the mothers.

3. Auxiliaries start using IMCI protocol
4. Initiate supervision of auxiliaries.

Supervisors (UCS nurse hygienist or DSNE IMCI trainer with CDS Field Supervisor) will initiate supervision immediately, using Supervisory Form including observation form and carrying out Exit interviews as feasible and appropriate. VCRs will be conducted by supervisors as part of community visits.

For community level IMCI, the project will use two approaches:
1) Training of promoters in simplified case management according to IMCI principles.
2) BCC to communities and families.

A simplified curriculum aimed at Health Agents (corresponding to Project promoters) is in the process of development. The project will await this curriculum prior to initiating specific training. General training including simple case management will be given for each of the Project interventions as part of the basic Promoter training (scheduled for June 2003 for the first two communes). This will also include training in BCC to mothers/families, to be used at rally posts run by the Promoter, during home visits, and as part of promoter support of mothers/fathers groups, junior promoter groups, and village health committees. Following general IMCI training and if the MSPP allows it, special training will be given to a selected group of outstanding promoters in treatment of ARI/Pneumonia with antibiotics, with special operations research follow-up to ensure safety and success (as per the experience by the Haitian Health Foundation).

Immunization (15% of effort)

The recent DHS (1999-2000) reports the complete immunization rate of children 12-23 months as 57.3%, with 83.7% of children having vaccination cards. The 2002 HOPE KPC showed rates in the Terrier Rouge UCS as 21% based on cards, and 27% from a combination of card evidence and history. The corresponding rates in Trou du Nord UCS were lower, 12% and 19% respectively. Regarding TT immunization for pregnant women, the KPC documented levels of coverage by two immunizations or more in TR by card at 9% and by card and history at 41%, but somewhat higher in TdN -- 13% and 54% in TdN. We wondered if this increased level, the opposite to the pattern for child immunization, could be caused by the attractiveness of the TdN Health Center with beds as a source of prenatal care.

The SDMA documented the lack of organization and standardization of community outreach activities; an insufficiency of Health Agents; and lack of supervision of agents; insufficient vaccination sessions –only one per month in the majority of dispensaries; frequent stockouts of propane gas (as long as 8 months in one dispensary) and lack of propane gas tanks; and incorrect use of thermos for temperature preservation. There is little or no data collection other than routine

dispensary reports. Auxiliaries and DSNE staff report stockouts at departmental level caused by non-delivery from central level.

Actions planned include the following:

1. Ensure adequate infrastructure in each facility, based on the deficiencies noted in the SDMA. DSNE has assured the project that this will be completed by May 15. Supervisors will check stocks, supplies, and cold chain functioning on each visit.
2. Train auxiliaries in IMCI, including instruction in avoiding missed opportunities for integrating vaccination with care of illnesses (see IMCI). Follow-up training with routine supervision based on supervision form to ensure quality of services and infrastructure.
3. Standardization of policies in all facilities, aimed at achieving daily availability of vaccination in the facility and outreach vaccination by auxiliaries at fixed points including TT for pregnant women (see maternal health for description of fixed point facilities in community).
4. Hiring and mobilization of promoters and implementation of monthly rally posts including immunization. Following promoter training, auxiliaries will mentor/supervise rally posts for the first 3-6 months, until promoter has demonstrated competence in immunization. From that point on promoters will conduct monthly rally posts with immunization and support fixed point services including TT immunization of pregnant women, and auxiliaries will conduct weekly promoter meetings to review and plan work and coverage and quarterly planning to ensure coverage based on family records.
5. LQAS quarterly to detect area deficiencies in coverage, and take action based on findings.
6. VCR and exit interviews with feedback to auxiliaries to ensure constant efforts to avoid missed opportunities.
7. Focus groups beginning in 3rd year to identify issues which interfere with achieving 100% coverage; based on results, modification of messages being emphasized by all project community education activities.
8. Education of mothers' and fathers' groups on the importance of immunization of child and mother.
9. Home visits by promoters based on priorities including pregnancy, which will advocate for TT injections and prenatal care.
10. Vaccine supply will be assured through logistics management upgrading with the departmental MSPP and PROMESS, also at facility level.(e.g., inventory management).

Nutrition/Micronutrient Deficiencies/Vitamin A (15% of effort)

According to the HOPE KPC, 3.5% of children are severely malnourished, and 11-12 % are moderately malnourished. According to Helen Keller International, there are no relevant data on Vitamin A deficiency prevalence (the most recent information is from 1975) although the rate of xerophthalmia in children under 6 years of age is 1/1,000 (PAHO, 1994). However, the high rates of diarrhea and ARI lead MSPP personnel to believe that children do suffer from Vitamin A deficiency. Current KPC coverage levels of vitamin A supplementation of children, like immunization, are better in Terrier Rouge UCS than in Trou du Nord – 24% by card and 43% by history in TR, versus only 5% and 26% in TdN. The same difference was found in the provision of vitamin A to recently delivered mothers – 7% and 35% respectively by card and by card and history in TR, and only 3% and 24% respectively in TdN. Additional food was given during illness in 14% of the children, according to the KPC.

Actions planned include the following:

1. Focus group discussions to elucidate the beliefs and barriers to desired behaviors will be carried out in the third year of the project, after community activities have been running for a while, in order to identify resistance points and direct improved messages toward them.
2. Nutrition education (BCC) will permeate all levels, from the dispensary to the household. Program efforts will focus on women, through mothers' clubs, and educate them about the nutritional needs of healthy, ill, and recovering infants and young children, and the increased nutritional needs of pregnant and lactating women.
3. Promoters will be trained and supervised in supporting mothers with malnourished children in improving diet via rally post encounters and via household visits at higher frequencies than other low risk families; tracking children who are moderately/severely malnourished and have not returned for follow-up growth monitoring; provide vitamin A at dispensaries and rally posts; provide vitamin A to new mothers (less than six weeks post-partum) and give a special vitamin A supplement at the same time as BCG is given to the newborn.
4. Pilot the Hearth-Ti Foyer approach: Using weighing or the records from village weighing they will identify those mothers whose children are consistently the most well nourished, then through interviews identify the "best practices" that account for this "positive deviance" both with regard to diet (e.g., three meals daily instead of two, use of occasional eggs or green leafy vegetables) and other practices. With these successful mothers or other village level volunteers they will then provide practical, competency-based training of the mothers in their communities who have difficulty maintaining the nutritional status of their children as determined by weighing. A key ingredient to the HEARTH approach is having mothers buy food and prepare appropriate diets based on the locally identified "positive deviant" diet for their children under supervision for two weeks in both a communal setting and later in their own homes.
5. Auxiliaries will be trained in various nutrition related behaviors (BCC). Increased emphasis during training will be placed on educating auxiliaries in counseling women on age-appropriate feeding behaviors, particularly appropriate complementary feeding (feeding frequency, caloric content, and feeding following disease episodes) using IMCI food box findings and information obtained through the piloting of the HEARTH-Ti Foyer approach. As a result of IMCI training auxiliaries will identify through IMCI based encounters with children those who are malnourished, and refer them to the community system for intensive follow-up and tracking as well as (where possible) Hearth intervention.
6. The establishment of fixed points for community based maternal health care by auxiliaries will provide the prenatal encounters with pregnant women, as well as those seeking prenatal care at the dispensary, to distribute iron and folic acid supplements as well as to educate about vitamin A and breastfeeding.
7. Supervision by auxiliaries of promoters and by UCS/CDS staff of auxiliaries will be used to improve the quality of IMCI care to ensure inclusion of nutrition assessment and actions, to improve the quality of promoter-facilitated rally post weighing and nutrition and dietary advice.
8. Maintenance of stocks of iron and folic acid as well as vitamin A supplements at dispensary level and for promoters will be ensured by improved stock management intervention at departmental and facility levels.

Breastfeeding (15%) of effort

The project KPC analysis at this time is incomplete, hence data on the rates of exclusive BF up to 6 months are not known, although the data is present – the analysis will be complete by June 2 at the time of the Mini-University. Only 56% of mothers initiated BF within an hour of birth, and 16% initiated BF two days or more after delivery. Even though over 99% of mothers breastfeed their babies, almost no mother breastfeeds exclusively. Early supplementation is universal, with 97% of mothers giving their child semi-solid foods well before they are 4 months old. This is in part due to the fact that Haitian women do not take their young children with them when they leave the home, to go to the market, collect fuel, or fetch water. Also, many mothers give newborns "lok" to purge them of meconium. The objectives of the project will be to increase the numbers of mothers exclusively breastfeeding their children up to 6 months of age, to reduce the number of mothers delaying BF following delivery, and to increase the levels of knowledge and practice of LAM.

Actions planned by the project to achieve these behavioral objectives include the following:

1. Focus Group Discussions on exclusive BF and early BF following delivery, beginning in Year 3 of the project, to improve the quality and effectiveness of the messages being used by auxiliaries, promoters, and animatrices.
2. Training and supervision of auxiliaries in prenatal and postnatal care, especially with regard to counseling regarding breastfeeding. VCRs and/or exit interviews to identify problems in the quality of such counseling and provide feedback and support to the auxiliaries.
3. Close monitoring of pregnant women by promoters (as high risk families receiving more frequent visits) with BCC re EBF and early BF, and follow-up BCC at the post-natal home visit and subsequent visits emphasizing EBF. Supervision of promoters in these activities by auxiliaries.
4. IMCI training of auxiliaries to include assessment of BF practices and counseling where they can be improved; VCR/exit interviews to assess implementation of this element of case management with feedback to the auxiliary.
5. Training of village based volunteer animatrices, selected as women who are or have been breastfeeding successfully and exclusively, to advise and assist new mothers in developing good lactation practices and promote exclusive and persistent BF and to form BF Support Committees (COSAM). These animatrices and COSAM to be supervised and supported by auxiliaries. The project will identify 60 interested women, approximately 10 per commune, to serve as such animatrices.
6. Include breastfeeding education in the mothers' clubs curriculum.

Control of Diarrheal Diseases (15%)

According to the 1999-2000 DHS national results, 26.5% of children under five had diarrhea in the two weeks preceding the survey, and 19.6% of mothers had ORS sachets and 13.5% increased liquids, for an overall ORT rate of 30.7%. This is much lower than the ORT rate for the Department of the North (44.4%). The Project KPC documented 42% children who had had diarrhea in the previous two weeks, and 8% who had had bloody diarrhea. Nearly all the mothers had heard of ORS/SelLavi (88% and 97% in TR and TdN respectively) although only 35% and 56% could explain correct mixing of the packet. Only 31% offered more liquids than usual, and only 14% more food than usual. Most of those using oral rehydration preferred the sachet (94%) – only 7% used homemade ORS. Although the analysis is not completed yet, an extremely low percentage of mothers were able to cite the five required situations on which they were to wash their hands (e.g., after defecating, after cleaning the child who had defecated, etc.)

BCC education aimed at the community will focus on the prevention of diarrheal diseases (exclusive breastfeeding, family hygiene/handwashing, reduction in the use of "lok", etc.), as well as on the prevention of dehydration (increased use of ORS packets and home-available fluids, including breastmilk), as well as improved feeding during and following the diarrheal episode. Appropriate home management of dehydration, and recognition of the danger signs of dehydration and appropriate care-seeking will also be emphasized. BCC education aimed at the auxiliary and promoter will stress counseling skills to convey these family competencies to mothers as well as case management of dehydrated children and those with bloody diarrhea.

Actions planned to achieve these objectives include the following:

1. Focus Group Discussions to understand resistance factors to appropriate behaviors will be carried out in Year 3 of the project.
2. IMCI training and supervision of auxiliaries to improve and ensure the quality of clinical case management of children with diarrhea including the content and effectiveness of counseling and education of parents especially on home case management and recognition of danger signs as well as prevention (EBF, handwashing). Auxiliaries will carry materials for demonstration of ORS mixing when they go to the community and make home visits.
3. Promoter training, first general aimed at diarrhea and covering ORT and preventive education (BCC) as well as counseling and adult education skills, later when curriculum is developed to include IMCI training for both community diarrhea prevention and case management. Promoters will have demonstration supplies in their work kits for demonstration of ORS mixing during home visits as well as at rally post sessions as needed.
4. Mothers' and fathers' clubs will include diarrhea disease prevention and home case management and care seeking.
5. Village Health Committee education/BCC: Women often face family pressure to care for their children using traditional strategies which may be inappropriate. To help combat this pressure, Village Health Committees will be trained to support women's efforts to appropriately manage cases of diarrhea, promote the use of ORT and home-based fluids, and support exclusive breastfeeding.
6. Availability and distribution of ORS: Availability of ORS sachets will be ensured at facility, promoter, and CBD level through intervention to improve logistics and inventory management at departmental and facility level. Auxiliaries will supply promoters at weekly meetings, CBDs during community visits. Stocks will be maintained at facility level for all these "retail" suppliers.
7. Development of Community Based Distribution (CBD) sources: Local village level retailers of small household supplies (salt, matches, sugar, soft drinks) will be trained to sell various health related products including ORS and to give appropriate education along with the product. USAID BHR grantee PSI is active in the social marketing of ORS sachets as *SelLavi* in Haiti, and these sachets are already being sold in the North-East Department. CDS/HOPE is in process of establishing a formal collaboration with PSI that will include ORS social marketing via these CBDs.
8. Quality of case management monitoring through the use of VCRs and exit interviews with timely feedback to the providers.

Pneumonia Case Management (10% of effort)

Pneumonia is the second leading cause of death in Haitian children under five. It accounts for 25% of all deaths, and ARIs are the cause of 30-60% of consultations and 30-40% of hospitalizations. Despite these facts, based on HOPE experience in the Department of the North, caretakers do not know the primary danger signs of pneumonia and often seek no care or late care. In the current Project KPC, only an average of 21% of respondents named difficulty breathing as a danger sign of illness. In the past the health facilities have had frequent stockouts of cotrimoxazole and providers had not been trained to follow standard case management norms.

The objectives of this intervention are improvement of the quality of case management of ARI and improved care seeking for ARI symptoms.

Actions planned include the following:

1. Focus Group Discussions in Year 3 of the project, to identify issues interfering with desired behaviors and improve messages.
2. Training of promoters in assessing danger signs and educating families about them; promotion of promoters as a source of advice in the community for families concerned about dangerous symptoms and wondering if they need to seek professional care. This will include provision of a sign to identify promoters as a source of such "first-aid" care.
3. Mothers' and fathers' clubs will be educated by auxiliaries using curricula that include ARI home management and care seeking
4. Village Health Committees will be educated on the dangers of ARI and the importance of appropriate case management.
5. Intervention to improve drug inventory management and distribution at departmental and facility level will ensure constant availability of cotrimoxazole at dispensary and health center levels.
6. Training of auxiliaries in IMCI and subsequent supervision and performance of VCRs/exit interviews with feedback will support the achievement and maintenance of quality case management by auxiliaries.
7. Pilot initiation of promoter case management of ARI using antibiotics. To increase access to care at the community level in the more isolated and difficult parts of the project target area, and if MSPP approves allowing promoters to dispense antibiotics for this particular purpose, a group of 10-15 promoters with good technical skills and from habitations distant from the next dispensary, will be selected for further training. These promoters will be carefully trained in pneumonia diagnosis, treatment, and referral and permitted to prescribe cotrimoxazole. Particularly intensive follow-up and supervision/data collection will be carried out in an operations research approach, to be able to demonstrate both that this approach is effective in Haiti and that promoters do not abuse the availability of antibiotics.

Control of Malaria

Eliminated as a defined intervention, although education/BCC of all actors will continue to include management of fever, and inventory management and logistics interventions will also include malaria drugs.

Safe Motherhood (15% of effort)

According to the Project's KPC, 23% of the mothers had no prenatal care at all during their last pregnancy, and an additional 23% had less than three prenatal examinations.

The goals to be achieved by this intervention are improved maternal morbidity and mortality and improved pregnancy outcome. The actual objectives to be achieved are the means to those goals, and include improved knowledge and practices of mothers, families, and communities, and improved educational and pregnancy related services.

Actions planned to achieve this set of objectives will include the following:

1. Focus Group Discussions in Year 3 of the project with mothers to determine barriers to their appropriate care seeking and pregnancy and delivery related practices.
2. Initial assessment and identification of possibilities for transportation of pregnancy and/or delivery complications (ideally fetal transport) to secondary facility (hospital in Fort Liberte) where OB-Gyn specialist is available.
3. Mothers' and fathers' club training to enhance understanding of healthy pregnancy management, the importance of prenatal and postnatal care, signs of pregnancy and delivery complications, signs of newborn difficulty, and the need to prepare for the possible occurrence of complications during pregnancy by arranging transport and funds if needed.
4. TBA inventory, training, and support: identification, initial assessment of KP by interview, and training of TBAs in correct pregnancy and delivery management including signs requiring referral, also neonatal management and signs requiring referral.
5. Monitoring of TBA activities through VCR of delivery practices by promoters at the time of post-natal home visit, with feedback to TBAs by auxiliary to improve quality of care.
6. Promoter training and subsequent supervision by auxiliary in promoter activities to identify pregnant women and increase frequency of home visits and assessments during pregnancy, ask about and recognize signs of complications during pregnancy (e.g., headache, swollen ankles) also inappropriate maternal behaviors (smoking, drinking), provide IEC including promotion of appropriate behaviors including referral if appropriate and preparation of plans for transport and funds for possible complications; carry out post-natal visit with administration of vitamin A and advocacy of post-natal visit at health facility, and performance of delivery VCR.
7. Promotion of use of delivery kits via mothers' groups and village health committees.
8. Supervision of TBAs by auxiliaries at time of reporting births and replenishing supplies.
9. Regular meeting of TBAs in locality (run by auxiliary) including updating and reinforcing education.
10. Provision of basic equipment at dispensaries for assessment of pregnancy and delivery complications.
11. Training of auxiliaries in management or referral of pregnancy and delivery complications. Initial training will comprise a one-day refresher course for all auxiliaries. As the frequency of contact with auxiliaries for these purposes becomes apparent, and if this care-seeking is sufficiently frequent, selected auxiliaries will be sent to the hospital in Pignon for a 5-day course offered there for this purpose. As auxiliary skills increase, the messages to be promoted by Promoters at family and village level will be adjusted to include or bypass auxiliaries, that is, to define the criteria for referral to the nearest auxiliary or to the hospital in Fort Liberte (the only source of higher level care in the Department) or to Cap Haitien (located in the neighboring North Department).

Child Spacing (10% of effort)

According to the Project KPC, some 13% of women know not a single modern method to prevent, and an additional approximately 35% could cite only one or two methods (46% in TR but only 24% in TdN). Only 37% of respondents in TR could cite three or more methods, however, while 64% of those in TdN cited that many methods. Despite this knowledge, contraceptive use rates were low – 17% in TR and 22% in TdN

The project aims to increase these usage rates to 35% of women who do not desire a child in the next two years, and to increase the percentage of respondent families with spacing between the most recent children of two years by 20%. To reach these rates, improvements in knowledge of contraception, motivation to use contraception, and access to contraceptive methods are planned.

Actions planned to achieve this set of objectives will include the following:

1. Focus Group Discussions to identify barriers to contraceptive acceptance by mothers and families, to take place in Year 3 of the project, followed by modification of messages and approaches as appropriate.
2. Identification of families not wishing another child in the next two years and not using a modern contraceptive by means of an initial household assessment carried out by the promoter in developing his family records. Subsequently the promoter pursuing a more intensive approach of home visits and other advocacy activities (e.g., soliciting a member of the VHC or a local contraceptive user to talk to the mother/family) until the mother accepts FP or becomes pregnant. Supervision of the promoter in these activities by the auxiliary.
3. Training of auxiliaries in FP methods and related clinical skills including communication with the patient (BCC) and improvement of patient reception at the dispensary/health center.
4. Monitoring of the quality of FP clinical encounters by VCR/exit interview, including post natal visits and auxiliary care at fixed points as well as at the dispensary, followed by feedback of the results to the auxiliary by the supervisor.
5. Supervision of auxiliaries to improve or ensure the quality of services, especially the relationship and communication between client and provider.
6. LQAS every 6 months to track improvements in mother knowledge and contraceptive use, followed by action to deal with low performing areas.
7. Establishment of Community Based Distribution of contraceptives: To increase access to condoms, oral contraceptives, LAM, and a simplified approach to natural family planning, the project will develop a new cadre of volunteer, the community-based distributor, a male or female recruited from the owners of tiny “shops” selling a few common household supplies in a village (e.g., soap, matches) and willing to sell and promote child spacing/family planning methods along with their usual sales products and other health products including ORS (SelLavi). 30 CBDs, five in each commune, will be trained in family planning counseling and referral. They will use the hormonal checklist to determine which clients qualify and which not for the oral contraceptives. A five-day curriculum developed in Malawi will be adapted for local use. CBDs will be supervised and resupplied by the auxiliaries during their visits to the community to supervise promoters or provide services at fixed points. At that time, CBDs will also provide their activity reports and discuss operational issues with the auxiliary. To assess the effectiveness of this intervention, the project will monitor the productivity of each CBD in

couple year protection (CYP) provided to the community, as well as monitoring movement of products through a standardized CBD report submitted regularly. The project will purchase initial supplies for these activities for 30 CBDs, and obtain additional supplies from external sources.

8. Establishment and regular use of fixed points for services in the community: From the experience of CDS in the eastern communes, the establishment of a room or facility where the auxiliary can examine a pregnant woman or a woman considering contraception in locations more than ½ hour walk from a dispensary is critical to achieving high levels of contraceptive use. These fixed points are typically a room used at other times for other purposes (a family living room, a room in a local office) in which the simple table and few tools needed can be stored and brought out for the conduct of the fixed point session. The auxiliary comes to this facility regularly to provide a wider range of services than can be made available at rally posts. Clients can reach this facility easily, enhancing access to prenatal care and contraceptives. The project plans to establish 50 fixed points, the total being defined by estimates of the number of locations in the six communes which are > 30 minutes from a MSPP dispensary or private clinic.
9. Improvement of contraceptive inventory management and distribution at Departmental and dispensary level, via inventory management training and recurrent assessment and supervision, aimed at reaching a no-stockout situation throughout the target area.

HIV/AIDS/STIs (5% of effort)

While almost all Haitians have heard about HIV/AIDS, and about half of women in the rural areas and three-fourths of men know at least one method to prevent HIV transmission according to the 1999/2000 DHS, only a minimal percentage of adults have used a condom in their last sexual contact, indicating the need for intensive education and behavior change. The project KPC found similar results in the six target communes, with some 40% of respondents citing the condom as a means of HIV/STI prevention, 55% citing fidelity to a single partner, and 13% citing limiting the number of sexual partners as the three most frequent means. There appeared to be no knowledge of the two new VCT centers in the eastern communes, the only such facilities in the Department. Only half of the mothers knew about other infections transmitted sexually, and specific signs were also poorly known. Only 6% and 19% at TR and TdN respectively declared that they had had a STI in the previous 12 months.

The objectives of this intervention are to improve the knowledge and practices of men and women in the target area including prevention, seeking treatment, and seeking VCT for HIV, enhance involvement of the community in actively advocating for improved behaviors and referral for treatment, and to improve the treatment of STIs.

Actions planned to achieve this set of objectives will include the following:

1. Focus Group discussions to be carried out in Year 3 of the project, to identify local issues preventing or inhibiting appropriate behaviors.
2. Promoter education and supervision in HIV/AIDS and STI prevention and sources and indications for care/referral.
3. Education of mothers and fathers clubs in these issues.

4. Education of VHCs in these issues, and facilitation by the community promoter of their active involvement in activities in the community in advocating for appropriate behaviors.
5. Establishment of fixed points in the community for improved access to auxiliary services (see description in Child Spacing above).
6. Establishment of CBDs and their promotion and sales of condoms (via partnership with PSI project).
7. Training/refresher training of auxiliaries in syndromic management of STIs and BCC/communication skills for advocating behavior change to clients.
8. Supervision of auxiliaries and promoters in these activities.
9. LQAS on six monthly basis to track effectiveness of community KP promoting activities.

CAPACITY DEVELOPMENT (LOE not calculated)

a. Capacity Development for HOPE

Assessment of HOPE's capabilities and strategic planning taking place between 2001 and 2003 have identified Knowledge Management as the area most in need of strengthening at HOPE, and have established objectives for capacity development in this area.

These include

- improved documentation of HOPE methods and experiences;
- improved use of monitoring and evaluation to identify lessons learned;
- improved access to methods and lessons learned through an improved bank of methods and experiences with an improved interface with users; and
- improved active dissemination of lessons learned between HOPE projects and to other organizations through publications.

HOPE will carry out the following activities to accomplish these activities:

- Formally document the curricula, tools, and methods used in this Haiti project, review them, make revisions as needed to allow accommodation to other locations, and publish them internally for circulation.
- Formally document lessons learned from monitoring with "white papers" describing situation, results, conclusions, and lessons learned, with assessments quarterly to identify such lessons in progress. Where possible to predict, special data collection to confirm lessons will be set up in advance, so that supportive data will be more objective (mini-operational research).
- Develop a data bank and key word computer based access system that will allow easy access to reports, lessons learned, survey and project results, and other project related information.
- Develop six monthly lessons learned newsletter disseminating lessons learned to other HOPE projects.
- Make reports and other documents available on HOPE web site.

- Publish findings from this and other projects in refereed journals.

Specific dissemination channels will include the following:

- Headquarters workshops, including during the annual Fall Leadership Conference, which includes all country directors.
- Field-to-field learning including staff visits between the various programs which include Child Survival and more formal activities such as the recent (November 2000) Child Survival Sustainability workshop in Nicaragua, which included HOPE CS staff from Nicaragua, Guatemala, and Peru.
- HOPE web site.
- Sharing among programs of site visit reports, evaluation reports, etc.
- Increased documentation of project impact and methods, and sharing of same throughout HOPE.

b. Capacity Development for CDS:

CDS's central office was assessed externally using the SDMA instrument in 2001 and has been working to correct the deficiencies in its central office identified at that time. CDS will reassess its progress in those corrections as part of this project and plan actions to deal with areas left uncovered. This reassessment will take place in July-August 2003, at which time a plan will be prepared for completion of this capacity development, indicators of progress and success defined, and actions initiated with the support and technical assistance of Project HOPE.

More than this, however, this project represents a major change in the role of the organization's central office toward the project activities in the field, as well as the role of the organization as a whole with regard to MSPP. From being an organization delivering services – its role in the eastern six North-East department communes – it will be an organization providing technical assistance and advocacy for a project. These new or evolved roles and activities (certainly the central CDS office is also already providing technical assistance to its field offices and activities in the eastern six communes, but without the explicit interaction with and through MSPP) represent the skills – the capacity – which CDS wants to develop and consolidate in the three plus years of this project which are ahead.

Through the project, CDS will enhance its skills and capacity in the following areas

1. Project design and management
    a. project planning, preparation of detailed implementation plans which are realistic
    b. development of indicators of progress and outcomes
    c. monitoring project implementation: tracking activities, ensuring timely implementation and completion of planned tasks
    d. managing monitoring and data collection, and evaluation activities and outputs from M&E activities
    e. preparing ongoing reports which comprehensively represent useful and accurate measures of project progress
2. Provision of technical assistance and advocacy

a. assessing current situations to identify specific needs for technical inputs and/or changes in activities/methods to enable more effective functioning of services and/or management
b. provision of concrete technical inputs which respond to these needs in a timely fashion and are both acceptable to the client and effective in dealing with the issue at stake
c. carrying out effective advocacy for a set of activities perceived as needed and appropriate: marshalling evidence, preparing proposals using that evidence, negotiating decisions, defining roles of CDS and MSPP in the particular area

3. Capacity development – skills transfer
    a. defining and assessing needed areas of capacity/skills development (e.g., supervisory skills and methods, planning, human resources management)
    b. defining with the client (MSPP) on the basis of the assessments the process and actions needed to bring about these skills – training, mentoring, observation/assessment and feedback, supervision, etc.
    c. developing these methods concretely, again in a participatory fashion with the client (e.g., tools development, supervision methods and planning, etc.) including methods and indicators for assessing the changes in skills/capacity
    d. implementing the planned inputs with the client (training, follow-up support, etc.) and monitoring the results
    e. reporting to the client and jointly planning subsequent activities as needed
4. Tools development and testing
    a. identifying and defining specifically the need for a tool or instrument (e.g., supervisory checklist, job aid, training curriculum)
    b. seeking examples of similar tools developed by others for adoption or adaptation, as a desired alternative to developing the tool
    c. assigning to a CDS or external technician the task of adapting or developing the tool, and managing that process to achieve the desired output (a draft tool) in a timely fashion
    d. developing and implementing formal or informal review and testing of the tool for usefulness, practicality, and validity; making and incorporating revisions in the tool as appropriate from these reviews and tests (***efficacy*** testing and improvement)
    e. developing a process of training and supporting clients in the use of the tool
    f. implementing this process, monitoring and testing (e.g., operations research) the effectiveness of the tool implementation, and its ***effectiveness*** as a tool for its particular purpose when applied in reality by the client system, and making changes as needed
    g. final "consolidation" of the tool, preparation of final documentation, and publication and dissemination within CDS, nationally in Haiti, and globally (both articles and presentations)

With the completion of this DIP, it is now possible to appreciate the full range of these actions by CDS in collaboration with HOPE. All of these activities are at the heart of project planning and implementation, hence are in one sense being tracked and monitored and assessed by the basic tracking and monitoring and evaluation mechanisms of the project. During the month of May 2003, we will identify small subsets of project activities representing these four areas of capacity development for which additional more targeted monitoring and assessment can take place. Such mini-studies will be planned to augment the overall assessments of project implementation

progress and project success. These will serve as representative examples documenting in more specific detail CDS capacity development in each of these four areas, while overall project progress assessments will track CDS capacity development as well but in less detail for each area. We will define these mini-studies during this period and be prepared to discuss them at the mini-university review.

c. Capacity Development for DSNE/MSPP:

CDS has been able to substantially augment the capacity of the MSPP in the seven eastern communes in which it has been working for the past seven years, in that the MSPP staff and its facilities have been upgraded (training, supervision, repairs and maintenance, adequate equipment and supplies) and delivering high quality effective services during this period. But with CDS running and managing these services, not MSPP, there has been little development of MSPP capacity to deliver these services on its own. The missing element is management, with an emphasis on supervision and quality improvement.

As of this writing (April 2003), SDMA baseline assessments have been carried out for MSPP in the western six communes at UCS and facility level, and the project's activities are designed to focus primarily on strengthening those levels of the system. With regard to the departmental level management structure, however, the planned baseline Management Assessment has not yet been completed, and is scheduled to be carried out at MSPP Departmental level in May-June 2003. The lower level SDMA assessments have established the service, infrastructure, and management deficiencies in MSPP at UCS, facility, and community levels, and, as part of the SDMA assessment reports, have generated plans to correct these deficiencies. These reports and plans are provided in the baseline assessments (Appendix 6) for two of the facilities, and a summary of the findings for all the dispensaries are provided in the same appendix. As already stated, the project activities as a whole are aimed at correcting these deficiencies. Plans for departmental level capacity development will be able to be finalized when the results of the MA are available.

The baseline SDMA done at UCS and facility level has clearly identified monitoring/supervision, and the use of data for management of service performance and quality as priorities for capacity development. The following actions are planned:

Supervision/Monitoring:

1. Review and adaptation of the supervisory forms and processes currently being used by CDS in the six eastern communes; to be done with participation and involvement of MSPP counterparts (e.g., the UCS nurse-hygienists and auxiliaries who will use these procedures, DSNE departmental level supervisory staff).
2. "Training" or introduction of the tools and methods formally, with input from MSH (the methods were developed from MSH models, as the eastern communes project is a MSH project).
3. Joint supervision activities using the new procedures, with a CDS staff member (Dr. Benoit) and a MSPP staff member (e.g., TR nurse supervisor) together conducting supervisory visits, preparing reports, assessing effectiveness of the supervision.
4. Obtaining feedback from supervisees following new style supervisory visits, by interview or anonymous survey form, and using this input to improve the supervisory process.

5. Gradual shift of the lead in visits to the MSPP staff member, while maintaining some monitoring of the process as well as the outcome (improved quality of services by the supervisees).
6. Development of training activities for training auxiliaries in supervision, jointly by CDS supervisor and the two UCS nurse-supervisors).
7. Training by the MSPP nurse-supervisor of the auxiliaries in the use of the forms and processes developed for auxiliary supervision of promoters; CDS trainer and supervisor to participate and mentor this training.
8. Implementation of supervision by auxiliaries with support and mentoring by UCS nurse-supervisor as well as CDS supervisor.
9. Ongoing monitoring, mentoring, and on the job training/support in supervision skills by CDS supervisor working with both UCS nurse-supervisor and auxiliaries as they carry out supervision and supervision mentoring/support.

Data-based management

1. Development of computer based method (spreadsheet based) to calculate activity targets for promoters, auxiliaries/dispensaries, and UCSs based on population as determined by the census and the households assigned to each level of staff (for example, the number of children who should receive measles immunization in a month, the number of mothers who should be examined prenatally, etc.). This method will be developed as much as possible in collaboration with the departmental level statistician.
2. Training as needed to departmental staff in the understanding and development of this method, with the objective of transferring this skill to MSPP.
3. Development of the tool which incorporates these targets into working forms for use by field staff (e.g., monthly report analysis tool for promoter or auxiliary) which incorporates both reporting of actual actions (e.g., actual number of children immunized with measles) with comparison with targets and instructions on responding to failures to achieve targets (e.g., seek cause, correct problem, etc.)
4. Training in use of new tool and preparation of new style reports by auxiliaries, promoters, and UCS nurse-supervisors.
5. Initiation of use of tool, and monthly meetings at each level (promoters at dispensary, auxiliaries at UCS, UCS at department) for supervisor/manager to review results, identify problems, facilitate planning of actions in response to problems, and in subsequent months to review the response to actions taken the previous month. Field supervisor and project director to take active role in developing the format for these meetings, facilitating initial sessions, and mentoring and supporting sessions. Meeting quality to be enforced according to good meeting principles (minutes, agenda, facilitator, etc.).

Additional areas which are likely to be foci for MSPP development include the following:

- Coordination of the fragmented private and public health activities in the target area;
- Training skills and methods (TOT);
- Departmental-level and health facility level planning;
- Logistics (drugs, supplies, health cards, etc.) at both departmental, UCS, and facility level;
- Human resources management (job descriptions, routine performance objective setting and evaluation);

Plans for these areas will be developed in July-Sep 2003 as these areas are assessed and specific targets for improvement become clear.

Indicators and data monitoring plans are being developed to monitor both the implementation of the capacity development plan and improvements in capacity, related to the objectives set for the specific organization. Finally, toward the end of the project, a repeat SDMA assessment will be carried out to document improvements.

J. WORKPLAN

Child Health - Household Level

Objective *#1: Improved preventive actions to maintain child health*

Outcome Indicators & Targets	
80% of children 12-23 months completely immunized; 30% of children 12-23 months with two doses of vitamin A in the past year; 70% of women respondents (mothers) vaccinated with at least TTV2; 30% of mothers keep *SelLavi* at home to prevent dehydration; 20% of mothers with EBF during the first six months; 50% of children under two weighed in the four months preceding the survey; 12 communities participating in HEARTH – Petit Foyer.	KPC surveys at baseline, midterm, and end; OR reports; LQAS 6-monthly monitoring; VCRs and exit interviews; Project IS (promoter reports). Project reports

Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• Training of 81 promoters (in adult ed. methodologies, facilitation of mother's & father's groups, CS interventions, weighing, counseling) to conduct rally posts, implement mothers'/fathers' clubs, and provide direct community level case management;	Feb 03 to Feb 04	DSNE/CDS Trainers	Workplan with objectives per promoters Promoter reports
• recruit and educate mothers and fathers in health curriculum;	Feb 04 to Jul 06	Promoter, Auxiliary	Mothers and fathers knowledge by KPC
• have DSNE support and supply rally posts;	Jul 03 to Jul 06	UCS Nurses, auxil	# of stock outs
• development of supervision checklists for promoters;	Jul 03 to Aug 03	DCS/DTS, Dep.	Check list availability and use
• supervision of promoters;	Aug 03 to Jul 06	Auxiliary	Supervision reports existence
• training 30 animatrices in breastfeeding support & EBF;	Mar 04 to May 04	Auxiliary	auxiliary monthly reports.
• supervision of animatrice EBF support groups;	May 04 to Jul 06	auxiliary	COSAM Existence
• HEARTH methodology piloted and scaled up if successful;	Dec 04 to Jul 06	Monitrice, Auxiliary	# functional HEARTH

Objective # 2: Improved home management of common childhood illnesses

Outcome Indicators & Targets	
60% of mothers used ORT in last diarrheal episode; 80% of mothers know signs of dehydration and how to prepare ORS correctly; 60%/40% of mothers provided the same or more liquids/solids during a disease episode; 60% of mothers know to complete prescribed treatment to the child following prescription by a provider; 50% of mothers report increased number of meals to a child recovering from illness.	6 monthly LQAS KPC survey at baseline, midterm, and final;

Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• Training of 81 promoters and 25 auxiliaries;	Feb 03 to Jul 04	BRG/DD Trainers	# of Aux and prom trained
• implementation of mothers' and fathers' clubs;	Mar 04 to Jul 06	Auxiliary, Promoter	# of clubs/promoters

Objective # 3: Improved care-seeking practices

Outcome Indicators & Targets	
60% of mothers took child under two with key signs of illness to a trained health provider (including promoter) 60% of mothers can explain when to return to the health facility for follow-up for a sick child.	LQAS, KPC surveys

Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• Training of 81 promoters ;	Feb 03 to Jul 04	BRG/Dep Trainers	Training Supervision reports
• mothers' and fathers' clubs; rally posts.	Mar 04 to Jul 06	Auxiliary, Promoters	# of clubs/promoter

Child Health – Community Level

Objective # 4: Increased community participation in child health and disease prevention activities

Outcome Indicators & Targets	
80% promoters conducting monthly rally posts and track defaulters; 80% of communities have functioning CBDs for ORS; 50% of communities have actively meeting VHCs; 320 mothers' and fathers' clubs graduated; 30 animatrices promote good BF practices; ARI promoters Rx with antibiotics and refer pneumonia cases in pilot (if allowed by MSPP).	Project HIS; monthly promoter reports, CBD reports project midterm and final evaluation; key informant interviews; meeting reports from VHC, mothers/ fathers groups, COSAM

Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• Training and supervision of promoters (rally post, clubs, VHCS) • provision of supplies, vaccines, equipment for rally posts; • CBD training & supervision, resupply • Auxiliary teaches m/f club sessions regularly • Aux supports/supervises animatrices, COSAM • ARI pilot runs training supervision data collection	Jul 03 to Jul 06 Jul 03 to Jul 06 Feb 04 to Jul 06 Every 6 month beginning Oct 03	Auxiliary UCS Nurses Auxiliary BRG/UCS/Dept. team	# of training sessions and supervision visits realized # of stock outs # of training sessions realized auxiliary reports; interviews with animatrices/ COSAMs ARI pilot reports, local VCRs from ARI patients

Child Health - Health Facility Level

Objective # 5: Improved management of child health and community outreach

Outcome Indicators & Targets	
70% of common child illnesses managed according to case management/IMCI protocol; Reported stock-outs of antibiotics for pneumonia and STIs, ORS packets, and antimalarials decrease by 50%; 80% of clients express satisfaction with services received; 18 of 25 auxiliaries conduct regular promoter and volunteer supervision.	SDMA assessments; supervision checklists and reports; exit interviews; VCRs.

Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• Health facilities and organizations assessed, plans for capacity development made; • 30 auxiliaries trained in technical interventions, community outreach, and adult education, also in supervision; • auxiliaries mentored in supervision • exit and VCRs conducted regularly and feedback given to providers on timely basis.	Feb 03 and every year May 03 to Oct 03 Oct 03 and every 6 months	CDS/BRG/Dep/ UCS BRG/UCS/Dept trainers BRG/UCS/Dept Team	# of problems identified every year Training session report Meeting report VCR/exit interview reports

Child Spacing

Objective # 6: Improved knowledge and practices

Outcome Indicators & Targets			
35% of women who do not desire a pregnancy in the next two years use a modern contraceptive method; 60% of women can cite 2 or more modern FP methods; The % of women whose last two children are spaced at least two years apart increases by 20%.			LQAS, KPC Promoter, facility reports monthly
Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• 25 auxiliaries, 30 CBDs, and 81 promoters trained; • promoters make home visits to yellow chart families, advocate FP • implementation of mothers' and fathers' clubs.	May 03 to Oct 03 Oct 03 to Jul 06	BRG/UCS/Dept Trainers Auxiliary, Promoter	Training Sessions Report promoter reports; auxiliary supervision reports; # of clubs/promoter

Objective # 7: Increased community participation

Outcome Indicators & Targets			
30 CBDs providing barrier methods and oral contraceptives. VHCs leading communities in advocating contraceptive acceptance			CBD activity reports. VHC meeting reports
Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• Adaptation of CBD curriculum; • training and supervision of CBDs; • formation and support of VHCs	Jan-Mar 04 Apr 04 to Jul 06 July 03 to Jul 06	Barthelmy, Auxiliary Auxil, promoter	Adapted curriculum, training reports Supervision reports, CBD reports monthly LQAS assessing source of contraceptive methods

Objective # 8: Improved access and quality of services

Outcome Indicators & Targets			
Auxiliaries at 100% of health facilities trained in counseling and provision of modern contraceptive methods, stock management Quality of FP services is improved by 50%; Number of health facilities reporting stock outs for modern contraceptives reduced by half.			SDMA; supervision checklists; exit interviews; VCRs.
Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• Training and supervision of auxiliaries; • work with DSNE on assuring contraceptive supply.	May 03 to Jul 04 Jun 03 to Jul 06	BRG/UCS/DSNE BRG/ CDS	Training and supervision reports Monthly DSNE management reports, meeting minutes

HIV/AIDS/STIs

Objective # 9: Improved knowledge and practices

Outcome Indicators & Targets			
80% of women and men can name at least two ways to protect themselves from HIV/AIDS/STIs; 15% of men/women used a condom in their last sexual intercourse; 30% of women and men who can name at least two signs indicative of an STI; 40% of women and men with symptom of STI seek treatment;.			LQAS, KPC surveys.
Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• Training of 30 auxiliaries and 90 promoters; • implementation of mothers' and fathers' clubs; • training of CBDs.	May 03 to Jul 04 Mar 04 to Jul 06 Apr 04	BRG/UCS/Dept Trainers Promoters Auxiliary	Training session and supervision reports, Tchecklist # of clubs/promoter Session report, Tchecklist

Objective # 10: Increased community participation

Outcome Indicators & Targets			
75% of selected community organizations have discussed HIV/AIDS/STIs at meeting in past 6 months			Meeting reports.
Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• mothers/fathers groups meet and receive education • VHCs facilitated by promoters, meet, prepare meeting reports	Oct 03-Jul 06	auxiliary, promoter	monthly promoter reports, auxiliary reports supervisor reports

Objective # 11: Improved access and quality of services

Outcome Indicators & Targets			
70% of STIs correctly treated based on syndromic approach and counseled. 70% STI patients asked about partners, requested to refer partners 70% STI patients counseled to have VCT for HIV			SDMAs; supervision checklists; exit interviews; VCRs.
Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• Training and supervision of auxiliaries; • coordination with PROMESS on drug supply; • provision of drugs without stockouts.	May 03 to Jul 06 Jun 03 to Jul 06 Jun 03 to Jul 06	BRG/UCS/DSNE CDS/Regional Depot	Training sessions, supervision reports # of stock outs # of stock outs

Pregnancy and delivery management

Objective # 12: Improved knowledge and practices

Outcome Indicators & Targets	
60% mothers cite 3 or more danger signs during pregnancy and 2 or more signs during delivery; 60% mothers receive 3 or more prenatal exams from health professional. 50% pregnant women counseled to have VCT	Promoter records from prenatal & postnatal visits; VCR/exit interview, LQAS, KPC surveys.

Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• Auxiliary & promoter training in IEC methods;	May 03 to Jul 04	BRG/UCS/Dept team	Supervision Report, Tcheck list
• mother's clubs courses;	Jan 04 to Jul 06	Auxiliary	Class reports
• VHC & community mobilization;	May 03 to Jul 06	Promoters	# of Health committees
• animatrice training & health promotion;	Mar 04 to Jul 06	Auxiliary	Supervision protocol
• quality improvement of auxiliary services.	May 03 to Jul 06	BRG/UCS/Dept team	Low maternal mortality rate

Objective # 13: Improved access and quality of services

Outcome Indicators & Targets	
85% of TBAs trained and 75% competent in safe prenatal & delivery techniques and signs of problems requiring referral; 85% of home deliveries assisted by trained TBAs; 85% of home deliveries use clean delivery kit; 60% of mothers receive vitamin A within 7 days post-natal; 75% of births receive domiciliary visit by promoter within 7 days; 30% of mothers make post-natal institutional visit;	Training records & community survey; pre/post test at trainings; midterm and final KPC surveys; LQAS management surveys; VCR of delivery methods; routine health info system.

Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• Community TBA inventory;	Jun 03	Nurse, Auxiliary	TBA Listing
• TBA training;	Feb 04 to Jul 06	Nurse, Auxiliary	Low maternal mortality rate
• TBA supervision and feedback of VCR results;	Jul 04 to Jul 06	Nurse, Auxiliary	Meeting report
• promoter training and post-delivery visits including VCRs of TBA delivery practices;	Jul 03 to Jul 06	Auxiliary, promoter	VCR reports, promoter reports, supervision reports/checklist
• supervision & support of promoters;	Jul 03 to Jul 06	Auxiliary	Supervision Reports
• quality improvement of auxiliary services;	Aug 03 to Jul 06	BRG/UCS/Dept	Supervision Reports, VCR/exit interviews
• mother's clubs;	Feb 04 to Jul 06	Auxiliary, Promoter	# of club/promoter
• VHC activities;	May 04 to Jul 06	Auxiliary, Promoter	# of club/promoter

Capacity Building -- HOPE

Objective # 14: HOPE management and technical expertise strengthened

Outcome Indicators & Targets	
▪ improved documentation of HOPE methods and experiences; ▪ improved use of monitoring and evaluation to identify lessons learned, ▪ improved access to methods and lessons learned through an improved bank of methods and experiences with an improved interface with users; and ▪ improved active dissemination of lessons learned between HOPE projects and to other organizations through publications.	availability of project manual and tools in book format newsletters with lessons learned data base on HOPE system reports on HOPE web site publications in refereed journals

Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
▪ Carry out assessment and strategic planning ▪ Formally document and publish Haiti project experiences, methods, tools, results internally for circulation. ▪ Produce white papers on key project issues and activities ▪ Develop computer based database for project documents and products; develop access methods for internal accessing these. ▪ Develop and produce 6 monthly lessons learned newsletter disseminating lessons learned to other HOPE projects. ▪ Post documents on HOPE web site; publish results in referred journals	Jan 02 – Nov 02 Nov 02 – Dec 06	HOPE staff & mgt CDS staff with HOPE staff	Strategic plan produced DIP produced, outputs defined quarterly and annual reports newsletter design approved; newsletters produced project documents on HOPE data base project documents on HOPE web site project papers published in referred journals

Capacity Building and Sustainability

Objective # 15: Community Level

Outcome Indicators & Targets

80% of promoters graduate at least two mothers'/fathers' clubs per year; VHCs formed and functioning regularly; volunteer animatrices support new mothers in EBF; mothers demonstrate appropriate knowledge & practices at target levels	key informant interviews during external evaluations; project HIS.

Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• Regular performance feedback provided to promoters/ volunteers; • auxiliaries engage in supportive supervision practices.	Aug 03 to Jul 06 Jul 03 to Jul 06	Auxiliary BRG/UCS teams	Performance Meeting report Supervision Reports

Objective # 16: Health Facility Level

Outcome Indicators & Targets

80% of trained auxiliaries follow IMCI, FP, and STI management protocols; 85% of auxiliaries engage in regular community outreach, supervision, and rally support activities; 70% of auxiliaries use data to identify performance problems, manage and plan their own and promoter services and activities.	Health center HIS; exit interviews; VCRs; key informant interviews ; SDMA assessments.

Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• Regular performance feedback to auxiliaries, supportive supervision, also by departmental levels DSNE staff.	Aug 03 to Jul 06	BRG/UCS/Dept teams	Performance Meeting, Supervision reports

Objective # 17: UCS and Departmental level MSPP

Outcome Indicators & Targets

Supervision carried out regularly by UCS nurse/supervisors using modern methods Regular monthly auxiliary mgt meetings at UCS review reports, identify problems, plan responses, check results Regular departmental level management meetings review reports, identify problems, plan responses, check results DSNE manages quarterly Project Advisory Council meetings; DSNE uses data to plan for and provide regular supply of vaccines, drugs and essential supplies; DSNE & UCS staff use routine reported data and KPC and qualitative data to identify problems & adjust/reprioritize health activities; DSNE increases recovery of costs and use for DSNE facility development by 200%.	-Project HIS; - UCS monthly meeting reports, - CDS supervisor reports - minutes of PAC meetings; monthly management meetings at UCS, DSNE - project midterm and final evaluations; - final SDMA including DSNE MA.

Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
• UCS and DSNE staff participate in capacity devel trainings • Project staff partner/mentor UCS/DSNE staff, facilitate meetings • Financial management and accounting established at facilities, supervised by CDS/UCS fee collections/ accounting improved.	Feb 03 to Jul 06 Aug 03 to Jul 06 Oct 04 to Jul 06 Oct 03 to Jul 06	BRG/UCS/Dept UCS/Dept Team DG/DSNE, Dept BRG/UCS/Dept	Training Sessions reports, monthly project staff plans/reports Meetings reports, # Stock out of IMCI, vaccines, STI drugs Financial reports.

Objective # 18: CDS			
Outcome Indicators & Targets			
Improved project design and management Improved provision of technical assistance and advocacy Improved transfer of skills & capacity development activities Improved tools development and testing			CS project reports; outputs from CS project including tools, training activities, etc; CS project monitoring activities & achievements; in depth interviews with CDS staff and with recipients of CDS inputs (DSNE) during project and final evaluation
Major Activities	*Time Frames*	*Personnel*	*Process Indicators & Benchmarks/Targets*
Preparation of DIP and revised budget; collaboration with DSNE in developing project activities training of DSNE staff; collaboration with HOPE in tools adaptation, development & testing; CDS facilitation of DSNE activities	Nov 02 to Sep 06	CDS & HOPE senior technicians and managers	DIP production, establishment of project HIS and activities quarterly assessment of progress by CDS managers, 6 monthly assessment of progress by HOPE; project reports and outputs (tools, trainings, visits, meetings)

APPENDIX 1

MAP

APPENDIX 2

AGREEMENTS

Port au Prince, Haiti
November 15, 2002

MEMORANDUM OF AGREEMENT

CDS (Centre Pour le Developpment et la Sante) and Project HOPE hereby state their agreement to work together in implementing certain activities aimed at initiating a maternal and child health services improvement project in collaboration with the Department of Health of the North East (DSNE) aimed at the six western communes in two UCSs covering that area in the Department du Nord-Est. The agreement covers the period Dec 1, 2002 through May 31, 2003. The activities to be carried out and products to be produced as part of this agreement are listed in Attachment A.

CDS agrees to implement the activities listed in the field, and to provide oversight and supervision from its central office in Port au Prince, with a weekly report on progress with regard to each item being provided to Project HOPE.

Project HOPE agrees to provide funds according to the budget listed in Attachment B, to respond to the reports as received with comments and any technical guidance or suggestions needed, and to provide representation at the restitution workshop and in the preparation of the DIP. Funds will be transferred from HOPE to CDS in three tranches, at the initiation of the activities, on Feb 1, and on April 1, based upon the overall budget for the period and the workplan (Attachment C) and on progress in and completion of the planned activities.

It is the intention of the two organizations to complete the planning and budgeting of the total project during this period, based on a project design currently being prepared by adaptation of the original proposal for the project submitted to USAID in December 2000 and subsequently funded by them, on the information produced by the assessments being done as part of the activities of this agreement, on experience gained during this initial six months in the field, and from other information obtained from various sources.

Should either party become dissatisfied with the performance of the other party during the period of implementation of this agreement, that party may dissolve the partnership created by this memorandum as of the end of the six month period, with no further obligation beyond the budget and activities of this agreement by either party. In the absence of such dissatisfaction, the two organizations will complete negotiations and sign another agreement for additional activities to take place as part of the project at any point prior to May 31, 2003.

Dr. Robert S. Northrup
Senior Technical Advisor
Project HOPE
Millwood, Virginia

Dr Reginald Boulos
President du Conseil du
Administration
Centre Pour le Developpment
Et la Sante

ATTACHMENT A

INITIAL ACTIVITIES HOPE – CDS

1) RECRUIT CDS FIELD DIRECTOR AND SECRETARY	Contract signed
2) INITIATE CDS FIELD DIRECTOR ACTIVITIES, WORKING OUT OF HOPE MILOT OFFICE	Reports of activities
3) INITIATE THE ESTABLISHMENT OF CDS FIELD OFFICE IN TROU DU NORD	Reports of activities
4) ESTABLISH CONTACT WITH MSPP REGIONAL DIRECTOR AND UCS DIRECTORS	Reports of activities
5) IMPLEMENT SDMA ASSESSMENT OF HEALTH CENTERS WITH MSH AND CDS CENTRAL BUREAU ASSISTANCE	Reports of activities
6) IDENTIFY AND CONTACT LOCAL ORGANIZATIONS IN TROU DU NORD AND TERRIER ROUGE	Reports of contacts in habitations
7) SELECT CANDIDATES FOR PROMOTORS	Candidates selected
8) TRAIN HEALTH AGENTS (FROM TROU DU NORD AND TERRIER ROUGE) AND PROMOTORS IN CENSUS TAKING	Health agents and promoters trained Contracts signed
9) CARRY OUT CENSUS	Census completed
10) ANALYSE DATA AND PREPARE REPORTS FROM SDMA AND CENSUS	Reports completed
11) CARRY OUT TRAINING OF TROU DU NORD AND TERRIER ROUGE HEALTH CENTERS STAFF	Training completed

ORIENTED TOWARD SERVICES IMPROVEMENT	
12) IMPROVE QUALITY OF SERVICES DELIVERY AT TROU DU NORD AND TERRIER ROUGE HEALTH CENTERS	Reports of services improved, with improvements described
13) PROVIDE LIMITED SUPPORT FOR SUPPLIES AND ESSENTIAL EQUIPMENT FOR TROU DU NORD AND TERRIER ROUGE	Request for supplies/equipment submitted to HOPE; Items purchased
14) CARRY OUT RESTITUTION WORKSHOP WITH DSNE, UCS, CDS, HOPE, AND COMMUNITY REPRESENTATION TO PLAN PROJECT STRATEGIES ON BASIS OF KPC SURVEY, SDMA, AND CENSUS.	Workshop plans completed Workshop carried out.
15) PREPARE DETAILED IMPLEMENTATION PLAN (DIP) AND REVISED BUDGET FOR PROJECT CONTINUATION	DIP draft (including budget) prepared DIP draft revised DIP submitted to USAID

APPENDIX 3

CURRICULUM VITAE
POSITION DESCRIPTIONS
DIVISION OF RESPONSIBILITIES

JOB DESCRIPTION

POSITION: PROJECT COORDINATOR

REPORTS TO: ON SITE

DIRECT REPORT: PROJECT LEADER

INDIRECT
REPORT: DG/MSPP, USAID/PHNE

HQ: Administrative: Regional Director, Africa/Haiti
Technical: Senior Technical Advisor

PRIMARY FUNCTION: Provide technical, administrative and financial management for Project HOPE Child Survival Program in Haiti. These duties include: technicfal and financial document preparation, contact with MSPP authorities at national and departmental levels; communications with Project HOPE technical, administrative and financial authorities; and facilitation of Project HOPE implementation in Haiti.

SPECIFIC DUTIES:

1. Take part in technical and financial Project HOPE document preparation
2. Attend the Council Advisory Meetings
3. Assure that all expenses meet Project HOPE and USAID standards and procedures
4. Approve all technical and financial reports sent to Project HOPE
5. Analyze data currently provided by field operators and assure that they contribute to reach Project HOPE's objectives
6. Assure that the operations are conducted according to their planning
7. Arrange with CDS administrative responsible, for logistical support to short-term consultants and other visiting Project HOPE personnel performing work in Haiti while they arrive or leave Port-au-prince
8. Attend weekly conference calls to keep Project HOPE HQ informed about project activities, constraints, and decision-making processes
9. Provide monthly technical report to USAID Health Section and Project Leader to keep them informed about Project HOPE activities
10. Meet with Project HOPE field director once a month to review the financial, technical and administrative aspects of the project

HOPE-CDS Partnership
Job Description
Project Manager/Administrator

This person will manage and coordinate the administrative and logistics aspects of the project, supporting the Project Director and the Medical Director. He/She will report to the Project Director.
Roles and responsibilities will include the following:

- Support Director/Medical Director administratively and logistically, carrying out tasks as directed, both those to be done by the Manager/Administrator and those to be delegated to other administrative and support staff;
- Supervise the accountant, secretary, drivers, security, housekeeping, and any other administrative staff, as well as contracted workers and projects (construction, purchasing)
- Make arrangements for consultants and other visitors;
- Coordinate staff movements and visitor/consultant movements and arrangements
- Manage administrative & transport staff, vehicles, buildings, equipment;
- Ensure quality and accuracy of administrative and logistical activities and reports, including financial reports
- arrange meetings, trainings, conferences, purchasing;
- Draft or assemble reports, letters, other communications, both administrative and programmatic, as directed
- Identify and solve project problems as directed
- Track project activities and reports to ensure compliance with USAID/HOPE rules and plans
- Manage project records and files to ensure ready access and safety
- Do other tasks as requested.

Candidates should fulfill the following characteristics:
- Graduate of university, ideally with masters of business administation or business management or the equivalent
- Minimum 10 years of managerial experience in a senior management position, ideally in a development or health related organization
- Fluent in French and English as well as Creole
- Demonstrated skills in drafting documents in French, ideally also in English
- Willingness to live in North East Department
- Passion and dedication to previous positions – ready to work at any time as requested.

PROJECT MSPP / HOPE / CDS

Roles and Responsibilities of the Partners

The mission of the Project MSPP / HOPE / CDS is to put in place a functional and efficient program of community health in two UCSs of the Department of the NorthEast. The chosen UCSs are Trou du Nord, including the communes of Trou du Nord, Ste Suzanne, and Caracol, and Terrier Rouge, including the communes of Terrier Rouge, Perches, and Vallieres.

In the process of carrying out this project in a new area, it is imperative to define, in detail, the roles and responsibilities of the different partners, so that the Project can be implemented in an atmosphere of harmony and cooperation and will be beneficial for the population of the 6 communes noted above.

Responsibilities of DSNE

The Direction Sanitaire of the North East (DSNE) is the representative of the Ministry of Public Health and Population (MSPP) at the level of the Department. It is responsible for the progress of the programs, projects and activities in health in its assigned zone. Consequentially, relative to the Project MSPP / HOPE / CDS, DSNE should:

- Monitor the project with respect to the standards, regulations, and procedures of MSPP
- Give its input to the schedule of activities prepared by the CDS Regional Management Office (BRG)
- Give its input to the training curricula as well as the training session plans prpared by the trainers
- Meet at least weekly the BRG representatives to deal with relevant issues
- Meet at least twice a week with UCS representatives to deal with relevant issues
- Supervise daily, directly and/or indirectly (via the UCSs) or jointly with representatives of the UCS or the BRG, the implementation of the programmed activities.
- Give its input on the Budget for the Project prepared by CDS Central
- Invite the employees and representatives of the participating institutions to monthly or extraordinary meetings
- Call together the responsibles from the community as well as other members of the Administration Council to the monthly as well as the extraordinary meetings
- Preside over the bimonthly meetings of the Administration Council
- Implement mechanisms of control to assure the punctual attendance of employees of health facilities at their places of work
- Implement mechanisms of control to assure that each employee provides the number of working hours set by the Ministry
- Designate the employees and apply, if a case merits such, sanctions (consistent with the standards in force at the Ministry) against the employees of the Ministry affected at health Institutions/facilities

- Write a monthly report on the progress of the Project and send it to the BRG, to the MSPP, to Project HOPE, and to CDS Central.
- Communicate to the other partners all decisions taken by the Ministry concerning programs and projects at national or departmental level which could have an impact on the Project MSPP / HOPE / CDS.
- Receive the pay of the employees involved with the project and assure the correct distribution of these salaries.
- Ensure the programming of activities in the field (both those for which the responsibility is to the health facilities and the UCSs)
- Ensure a good realignment of the fixed points and the rally posts jointly with the responsible persons from the health facilities, the UCSs, and the BRG
- Ensure the good utilization of the the material and logistical resources put at the disposition of DSNE, the UCSs, and the health facilities by the Project
- Ensure that all the service points are regularly supplied with needed supplies (vaccines, medicines, etc)
- Oversee and ensure a good financial and administrative management at the UCS and health facility levels.

Responsibilities of the BRG

The Regional Management Office (BRG) is the representative of CDS in the North and the North East. In the framework of the Project MSPP / HOPE / CDS, it provides technical support in the implementation of the Project while also having the responsibility for the financial and administrative management of the Project. Consequentially the BRG should:

- Oversee and ensure the application of the standards in effect within the MSPP system
- Manage the funds of the Project following the standards, procedures, regulations, and principles in effect within the purview of USAID, Project HOPE, and CDS.
- Manage the equipment and supplies according to the standards, procedures, regulations, and principles in effect within the purview of USAID, Project HOPE, and CDS
- Give technical and administrative advice and input to DSNE whenever appropriate and needed
- Prepare the program of activities jointly with the responsible persons from the UCSs and the health facilities and submit them to the DSNE, Project HOPE, and CDS Central for their review and advice.
- Oversee the preparation of the training curricula as well as the training session plans for the traiiners, and submit them for review and advice to the DSNE, Project HOPE, and CDS Central
- Prepare the calendar of activities and submit it for review and advice to the DSNE, Project HOPE, and CDS Central
- Supervise regularly the programmed activities jointly with the DSNE and /or the responsible persons from the UCSs.
- Give input and advice regarding the Budget prepared by CDS Central
- Meet at least once weekly with DSNE to deal with relevant issues
- Meet at least twice weekly the responsible persons from the UCS to deal with relevant issues

- Participate in the monthly and extraordinary meetings called by DSNE with the responsible persons from the health facilities and the UCSs
- Oversee and ensure the convocation by DSNE of the responsible persons from the community as well as the other members of the Administration Council to the monthly meetings
- Write a monthly report on the progress of the project and send it to DSNE, Project HOPE, and CDS Central
- Prepare a monthly financial report and direct it to Project HOPE and to CDS Central, with a copy to DSNE
- Prepare each month the pay statement of the employees who are on the payroll of the Project and assure the correct distribution of the salaries.
- Oversee and ensure the programming of the field activities (those of the responsible persons from the UCSs and the health facilities
- Oversee and ensure a good reassignment of the fixed points and rally posts jointly with the responsible persons from the health facilities, the UCSs, and DSNE
- Oversee and ensure a good utilization of the equipment and supplies placed at the disposition of DSNE, the UCSs, and the health facilities in the framework of the Project.
- Implement the management tools to ensure good utilization of the operational resources affected by the Project
- Ensure the maintenance of the Project and the UCSs vehicles
- Oversee and ensure that all the points of care are provided regularly with needed supplies (vaccines, essential medicines, etc)
- Oversee and ensure a good financial and administrative management at the level of the UCS and the health facilities.

APPENDIX 4

BUDGET

APPENDIX 5

PROPOSAL REVIEW COMMENTS

APPENDIX 6

SURVEY REPORTS AND INSTRUMENTS

Summary of Baseline KPC Survey Draft Analysis
April, 2003

by Robert Northrup

A Knowledge – Practice – Coverage survey was carried out to establish a baseline for the project's community oriented activities. Designed by Project HOPE in collaboration with MSPP and the local survey firm Intell Consult, the instrument used was based on the standard Child Survival KPC and Rapid CATCH with modifications to suit the local situation and the project's specific activities and objectives. Carried out with an overall sample of 300 households for each of the two UCSs (Trou du Nord and Terrier Rouge), the survey interviewed the mothers of chilcren less than 24 months of age. Interviews took place in May and July 2002. Standard methods for calculation of sample size, and sample and household selection. The form Intell Consult and DSNE provided the interviewers. The data was collected and entered into EPI INFO, and cleaned and verified. Analyses were completed using EPI INFO. A detailed draft report was completed in French. After review, it was determined that the analyses were incomplete, as some of the more complex calculations needed to determine the indicators of CATCH had not been included in the initial EPI INFO analyses. These calculations are being completed in April-May 2003, and will be available for the Mini-University.

A summary of the findings from the initial analysis is provided in the following table:

Indicator	Terrier Rouge	Trou du Nord
Age of most recent child		
• 0 – 3 months	25%	19%
• 4 – 6 months	14%	14%
• 7 – 11 months	21%	26%
• 12 – 18 months	28%	27%
• 19 – 24 momths	11%	14%
Total	252	333
% of mothers who had already had their child weighed	79%	75%
% of children less than 5 years with malnutrition – overall	15.1 %	16.8 %
severe	4.4 %	2.8 %
malnutrition	10.7 %	14.0 %
moderate	13.6 %	16.0 %
malnutrition	4.0 %	2.9 %
% of children less than 24 months with malnutrition – overall	9.6 %	13.1 %
severe malnutrition		
moderate		
malnutrition		
Prenatal Care (in percent)		
• none	21	26
• health facility / health professional	74	73
• traditional birth attendant	2	0.3
• health agent / community agent	3	0.6
Frequency (according to mother's reply)		
• never	21	26
• 1 time	7	11
• 2 times	9	18

• 3 times	19	19
• more than 3 times	44	26
Percent of mothers with no prenatal visit in mountainous communes:	30	39
TR = Valieres TdN = Ste Suzanne		
Percent of mothers receiving tetanus toxoid vaccination		
(with/without card none	83 / 36	80 / 27
1	9 / 23	8 / 19
dose	7 / 27	12 / 41
2	1 / 14	1 / 13
doses	7 / 35	3 / 24
3		
doses +	21	71
Percent of mothers receiving vitamin A after delivery	59	59
Percent of mothers with postnatal home visit within 8 days		
postnatal visit to health facility		
Pregnancy & Contraception use: % mothers pregnant at time of interview	10	7
	28	19
wanting another child	72	81
not wanting another child	83	78
using no modern method of contraception	17	22
using one or more modern method		
Knowledge of modern contraceptive methods (% of all mothers)		
do not know any method	16	12
can cite one method	12	7
can cite two methods	34	17
can cite three methods	27	35
can cite four or more methods	11	29
know about male condom	16	23
female condom	2	3
diaphragm	2	2
pill	57	69
injectables	71	81
Norplan	43	71
tying the tubes	8	13
vasectomy	1	10
Breastfeeding : % mothers overall who breastfed their child	98	99
% who initiate immediately or < 1 hour pp	42	70
later the same day	10	11
1 day after delivery	18	10
2 days after delivery	8	3
more than 2 days after delivery	22	6
Vaccination coverage of children 12 to 23 months		
% children who possess Road to Health card	41	14
vaccination notebook	13	33
another type of card	4	23
had a card but lost it	23	17
never had any card	20	12
are completely vaccinated (card / card + history)	21 / 27	12 / 19
	5 / 10	6.8 / 14
have never been vaccinated	33 / 57	27 / 42

have had at least 1 dose BCG vaccine	27 / 40	18 / 29
3 doses of polio vaccine	25 / 32	16 / 24
3 doses of DTP vaccine	38 / 59	21 / 37
1 dose of measles vaccine	24 / 43	5 / 26
have received vitamin A supplement within the past 6 months		
Use of mosquito net: % of all families who – use mosquito net	22	17
-- use impregnated net	6	3
% of mothers who sleep under a net	15	13
% of children who sleep under a net	22	17
Knowledge of signs of illness in child: % mothers who cited each sign	14	20
sadness, lethargy	25	34
lack of appetite	3	8
weakness/ unable to get up	82	88
fever	40	2
difficulty breathing	27	51
vomiting	3	6
convulsions	29	34
skin eruption, itching, rash	18	24
headache	30	40
abdominal pain	60	81
diarrhea	42	59
cough		
Knowledge of signs of dehydration: % mothers who cited each sign		
sunken eyes	29	74
skin tenting	13	58
difficulty in urinating	--	2
dryness of the mouth	1	6
depresion of the fontanelle	10	13
thirst	3	16
Illness of the child during the past 2 weeks (% of children)		
overall	74	61
diarrhea	43	40
bloody diarrhea	9	8
cough	49	31
dyspnea	21	8
fever	47	35
malaria	2	2
convulsions	1	1
Diarrhea treatment by the mother		
knows about ORS	88	97
knows how to prepare ORS	35	56
treatment given to children for their most recent diarrhea episode	31	18
gave less liquid than usual	69	72
gave same or more liquid than usual	59	58
gave less food than usual	41	42
gave same or more food	7	18
gave less breastmilk/breastfeeding	37	33

gave same as usual	56	49
gave more than usual	44	59
gave ORS	23	16
gave home fluids	14	37
gave prescription drug	20	17
care seeking for most recent case of diarrhea		
did not seek any care	46	58
health facility/professional	30	26
parents	12	7
friends	< 1 each	1, 2, <1
pharmacy, traditional healer, shop, mobile drug seller, traditional midwife	1, 2	<1, 3
Hand washing: (% mothers who washed their hands...)		
before preparing meals	27	51
before breastfeeding or feeding infant	14	40
after using the toilet	50	75
after having cleaned infant's feces	10	22
when their hands are dirty	75	89
Knowledge about HIV/AIDS		
have heard about HIV/AIDS	97	96
cite the following methods to prevent HA:		
abstinence	5	4
use of condom	35	47
fidelity to a single partner	48	62
limit the number of sexual partners	14	12
avoid intercourse with prostitutes	2	21
avoid intercourse with persons having multiple sexual partners	7	23
	0	5
avoid sexual relations with same sex	<1	6
avoid sexual relations with drug users	2	4
avoid blood transfusions	1	4
	2	9
avoid injections	2	1
don't use a used syringe	2	1
don't kiss	2	4
avoid mosquito bites	5	11
take traditional remedies		
don't use used razors or combs		
Knowledge about AIDS and Sexually Transmissible Infections (% mthr)	5	6
how to know if a person has AIDS: lab test	5	18
go to health center	0	1
go to AIDS counseling center	29	19
don't know	2	2
by recognizing certain signs of AIDS	2	5
	21	45
chancre	41	54
herpes zoster		
silky hair	76	82

emaciation, physical	20	12
deterioration	0	1
where to get a HIV test	5	6
hospital		
health center		
counseling center		
don't know		
Knowledge of Sexually Transmissible Infections other than AIDS (% of all mothers)		
know about such infection	53	70
don't know	47	30
Signs and symptoms of STIs		
don't know any signs/symptoms	11	8
pelvic pain	4	14
discharge	23	40
purulent discharge	4	23
urinary burning	7	31
erythema of the vulvae	2	8
chancre/ulcer/papule	15	16
bloody urine	0	5
weight loss, emaciation	2	17
infertility	0	3
itching	5	24
STI prevalence by presence of symptom(s) (% of mothers)		
denominator: mothers who could cite $\geq$ 1 STI	6	19
symptom	3	12
all mothers		

MSPP/DSNE, Projet HOPE-HAITI, INTELL CONSULT
QUESTIONNAIRE CPC
Mai 2002

Manman timoun ki gen mwens ke 24 mwa
Questionnaire # |__|__|__|__|__|__|

Vérifié par _____

Date |___|___|/|___|___|/|___|___|
Jour Mois Année Département _____ Commune_____

Localité ou quartier _____ |__| **Urbain** |__| **Rural**

Nom de l'enquêteur_____

Adresse précise de 'enquêté_____

Bonjou, mwen rele …… Mwen nan zòn la pou kapab poze nou kèk kesyon pou ede nou mete sou pye yon pwogwam MSPP ansanm avek Projet HOPE. Ti pale sa-a ke mwen pral fè avek ou, se yon bagay kap rete sekrè, mwen pa pral pale ak lôt moun. Pou tèt sa, mwen ta renmen ke ou reponn tout kesyon yo san pwoblèm eke ou pale verite.

Nom de l'enquêté _____ **Sexe** |__| **H** |__| **F**

CARACTERISTIQUES SOCIO-DEMOGRAPHIQUES		
SD 0.	*Kilès ki reskonsab kay la?* Who is the head of this household (yourself)?	1[__] Mwen menm 2[__] Mari mwen 3[__] Lòt moun
SD 1.	***Nan ki mwa e nan ki lane ou fèt?*** Month and year of birth	|___|___|/|___|___|/|___|___| 88. Pa konnen |__| jou mwa ane
2.	***Ki laj ou genyen?*** (Verifye si laj la koresponn ak ane a) How old are you?	|___|___| ans
3.	*Èske ou te lekòl oubyen nan sant alfabetizasyon?* Have you attended formal school or alphabetization center?	1[__] Wi, Lekol 2[__] Wi, Nan Sant Alfa sèlman 0[__] Non → **AG1**
4.	***Konbyen ane ou te fè lekol?*** How many years have you attended school?	[___]___] lane
ACTIVITES GENERATRICES DE REVENUS		
AG 1.	*Eske ou gen yon aktivite ki pèmèt ou rantre kòb?* Do you work to earn money? *Si wi, eske ou fè aktivite sila andeda kay la oswa deyo kay-la?* If yes, are you working inside or outside the home?	0. [__] Non, mwen pa gen aktivite pou rantre kòb 1. [__] Wi, andedan kay la 2. [__] Wi, deyo kay la
AG 2.	*Ki aktivite ou fè pou rantre kòb?* What activitie(s) do you practice to earn money?	
NOMBRE D'ENFANTS ET SUIVI NUTRITIONNEL		
ENF 1.	*Konbyen timoun kap viv nan kay la ki genyen pi piti pase 5 a* How many children living in this household are under age five?	|___|___| timoun
ENF 2.	*Konbyen nan timoun sa yo ki se pitit ki soti nan zantray ou?* How many of those children are your biological children?	|___|___| timoun
ENF 3.	Eske ou konn mennen timoun yo peze? Have you attended a place where the children have been weighed?	1 [__] Wi 0 [__] Non
ENF 4.	Èske mwen kapab pran pwa timoun yo? May I weigh them?	1 [__] Wi 0 [__] Non

QUESTIONNAIRE CPC

Mai 2002

Pou chak timoun ki gen mwens ke 5 an mande: non li, sèks, ak ki dat timoun sa fèt.
Si manman an dakò, pran pwa timoun nan epi ekri-li. ***KOMANSE AVEK DENYE-A (PI PITI A)***

NON	SEKS	LAJ (mwa)	JOU LI FET	PWA
1.	|___| 1. Gason |___| 2. Fi		|___|___|/|___|___|/|___|___| jou mwa ane	|___|___| . |___|kilogram
2.	|___| 1. Gason |___| 2. Fi		|___|___|/|___|___|/|___|___| jou mwa ane	|___|___| . |___|kilogram
3.	|___| 1. Gason |___| 2. Fi		|___|___|/|___|___|/|___|___| jou mwa ane	|___|___| . |___|kilogram
4.	|___| 1. Gason |___| 2. Fi		|___|___|/|___|___|/|___|___| jou mwa ane	|___|___| . |___|kilogram
5.	|___| 1. Gason |___| 2. Fi		|___|___|/|___|___|/|___|___| jou mwa ane	|___|___| . |___|kilogram

GWOSES AK AKOUCHMAN		
GR 1.	*Eske ou te swiv denye fwa ou te ansent (pandan dènye gwoses la)? Ki moun oswa ki kote?* Did did you see anyone for prenatal care when you were pregant with (last child)? Where or who?	0. [__] **Okenn kote** 1. [__] Sant sante / Doktè / Mis / Oksilyè 2. [__] Saj fanm – matron 3. [__] Ajan sante / Ajan kominotè Lòt _____
GR 2.	*Konbyen fwa pandan gwosès ou te swiv kote sa?* How many times did you see someone for care during pregnancy?	[___]___] fwa
GR 3.	*Dapre ou, ki siy, ki pwoblèm ki ka fè yon fanm ansent kouri ale nan sant sante oswa kay yon doktè?* What are the symptoms during pregnancy that indicate the need to seek health care? ***Kisa ankò?*** **PLIZYE REPONS POSIB**	1. [__]Lafyèv 2. [__] Souf anlè / Pa ka respire 3. [__] Lap bay san 4. [__] Pye anfle 5. Lòt _____
GR 4.	*Ki bò ou te akouche (DENYE TIMOUN LAN)?* Where did you give birth to (LAST CHILD)?	1. [__] A domicile / *Lakay mwen* 2. [__] Chez une sage-femme / *Kay matron* 3. [__] Instititution de santé */ sant sante oswa lopital* 4. Lòt (Presize) _____
GR 5.	***Lè ou te akouche (DENYE TIMOUN LAN) kilès ki te akouche-ou ?*** (Si se matron oswa fanm saj, mande si li te gen bwat). Who assisted you with (LAST CHILD) delivery ?	A [__] Doktè B [__] Enfimyè / Oksilyè C [__] Matron D [__] Matron avek bwat E [__] Ajan sante / Ajan kominotè F [__] Yon manm nan fanmi an (Di kisa moun sa ye pou ou) _____ G [__] Lòt (Di kiyès) _____ Y [__] Pèsòn moun
GR 6.	**SI LI PAT AKOUCHE NAN SANT LAN** *Eske te gen yon pakè tou pare pou akouchman?* **(Mande ki sa ki te nan pake sa).** Was a clean birth kit prepared?	1.[__] Wi 0.[__] Non
GR 7.	*Èske (DENYE FWA OU TE ANSENT) ou te genyen yon kanè fanm ansent oswa yon kat vaksen? Si wi, mande : Eske mwen ka wè-l silvouplè?* Do you (or did you) have a maternal health card for this pregnancy?	1 [__] Wi, (anketè an wè-l) 2 [__] Li pa genyen / li pèdi, li pa nan kay la 3 [__] Pa janm gen kat 8 [__] Pa konnen
GR 8.	**Si manman-an gen kat, gade li epi ekri si se :**	1 [__] Kanè fanm ansent

	If mother has a card, precise the type.	2 [__] Kat vaksinasyon
	Si manman an gen kat oswa kanè, ekri enfòmasyon yo men-m jan ou wè yo sou kat la	**Si manman an pa gen kat, Poze kesyon sila…**
GR 9.	**Nbre de visites prénatales** [___]___] fwa Number of prenatal visits recorded on the card **Nbre vaccins contre TETANOS** [___|___] Number of TT recorded on the card	***Anvan ou te akouche (DENYE TIMOUN LAN), eske ou te resevwa yon vaksen nan bwa-w pou-w te pwoteje timoun nan kont tetanòs?*** Before you gave birth to (LAST CHILD) did you receive an injection in the arm to prevent the baby from getting tetanus? 1.[__] Wi 0.[__] Non ***Konbyen fwa ou resevwa vaksen sa?*** [___]___] fwa How many times did you receive such an injection?
GR 10.	***Èske ou ansent kounye-a?*** Are you currently pregnant?	1 [__] Wi (Passer à la section suivante) 0 [__] Non 8 [__] Pa konnen
GR 11.	***Eske ou ta renmen gen yon lòt timoun?*** Do you want another child?	1 [__] Wi 0 [__] Non

CONNAISSANCE, UTILISATION DE LA CONTRACEPTION

Méthodes **PLIZYE REPONS POSIB**	**PFC. *Èske ou konnen metòd yo itilize a ki anpeche fanm yo pou yo pa ansent osinon pou evite yo fè pitit ke yo pa vle?*** Do you know anything to keep from getting pregnant or getting too many children? **Si wi, Ki metòd ou konnen?** If yes, which method??		***PFPA.* Si li pa ansent, *kounye a eske oumenm oswa mari ou itilize yon metòd?*** If not pregnant, are you (or your husband) currently doing anything to keep from getting pregnant? ***Si se wi, ki metòd?*** If yes, which method?	
0. Aucune méthode	0 [__] → **pase nan NU1**		0	[__]
1. Préservatif masculin	0	[__]	1	[__]
2. Préservatif féminin	1	[__]	2	[__]
3. Mousses, crèmes, gelées	2	[__]	3	[__]
4. Ovules (grenn pou matris)/ Tablèt	3	[__]	4	[__]
5. Diaphragme	4	[__]	5	[__]
6. Pilule (grenn)	5	[__]	6	[__]
7. DEPO / injectable (piki 3 mwa)	6	[__]	7	[__]
8. NORPLAN (piki 5 an)	7	[__]	8	[__]
9. Stérilet /Dispositif intra-utérin	8	[__]	9	[__]
10. Ligature des trompes (rete net pou fi)	9	[__]	10	[__]
11. Vasectomie (rete net pou gason)	10	[__]	11	[__]
12. Abstinence périodique	11	[__]	12	[__]
13. Coït interrompu	12	[__]	13	[__]
14. Régulation mensuelle/Ogyno/Metod rytmik/Natirel	13	[__]	14	[__]
15. Abstinence totale	14	[__]	15	[__]
16. Mama	15	[__]	16	[__]
Lòt (Presize)	_____		_____	

ALÈTMAN AK NITRISYON		
NU 1.	***Èske ou te bay (DENYE TIMOUN LAN) tete?*** Did you breastfeed (LAST CHILD)?	1 [__] Wi 2 [__] Non ***(Pase nan kesyon NU4)***
NU 2.	***Aprè konbyen tan ou te komanse bay (DENYE TIMOUN LAN) tete lè ou te fin akouche?*** How long after birth did you put (LAST CHILD) to breast?	1 [__] Men-m lè a / 1èd tan apre ou fin akouche 2 [__] Pita nan men-m jou a 3 [__] Yon jou apre akouchman 4 [__] De jou apre akouchman 5 [__] Plis ke de jou apre akouchman
NU 3.	***Eske (DENYE TIMOUN LAN) nan tete toujou?*** Are you currently breastfeeding (LAST CHILD)?	1 [__] Wi 2 [__] Non
NU 4.	***Konbyen fwa li te manje aye (lajounen ou lanwit)?*** **Konte tout manje/goute li te pran anplis lèt manman.** How many times did he eat foods yesterday? (Meals / snacks)	[___|___] fwa
NU 5.	***Mwen ta renmen mande-ou ki sot de likid ak manje ke (DENYE TIMOUN LAN) te manje yè pandan lajounen oubyen lanwit lan (24 HEURES).*** Now I would like to ask you about the types of liquids or food that (LAST CHILD) eat yesterday during the day or during the night. ***Èske (DENYE TIMOUN LAN) te manje :*** Did (LAST CHILD) eat: **Li chak repons epi tcheke chak sa-l te manje** **PLIZYE REPONS POSIB**	0. [__] **Pa konnen** 1. [__] Lèt manman 2. [__] Dlo 3. [__] Ji 4. [__] Te 5. [__] Lèt vach 6. [__] Manje yo vann nan makèt / boutik / famasi 7. [__] Lòt likid (cola, café, soup, etc…) 8. [__] Labouyi, pire, solid, oubyen manje ki pa fin solid 9. [__] Manje kay la 10. [__] Lòt bagay ankò? Di kisa _____
SI TIMOUN NAN VAKSINEN OSWA TE RESEVWA VITAMIN A		
VAKS 1.	***Èske (DENYE TIMOUN NAN) genyen yon kat vaksinasyon oswa « chemen lasante »? Si wi, mande :*** ***Eske mwen ka wè-l silvouplè?*** Does (LAST CHILD) has a growth or immunization card?	1 [__] Wi, (moun ki ap poze kesyon an wè-l) 2 [__] Li pèdi, li pa nan kay la 3 [__] Pa janm gen kat 8 [__] Pa konnen
VAKS 2.	**Si timoun lan gen kat, gade kat la epi ekri si se :** If yes, look at the card and write down the type of card	1. [__] Kat vaksen 2. [__] Kat chemen lasante 3. [__] Lòt kat (ekri ki kat) _____

	Si timoun lan gen kat, ekri enfòmasyon yo men-m jan ou wè yo sou kat vaksinasyon-an	**Si timoun lan pa gen kat, Poze kesyon sila…**
BCG	|___|___|/|___|___|/|___|___| jou mwa ane	**Eske timoun lan te resevwa yon vaksen ki kite mak sou bra? *Verifye mak la sou timoun lan*** Did (LAST CHILD) ever receive an injection in the arm that leaves a mark? 1. |___| Wi 0. |___| Non 8. |___| Pa konnen
POLIO 0 **POLIO 1** **POLIO 2** **POLIO 3**	|___|___|/|___|___|/|___|___| jou mwa ane	***Eske timoun lan te resevwa yon vaksen nan bouch? (Fè diferans avec grenn vitamin A ki jòn / rouj)*** Did (LAST CHILD) received a vaccine / drops in the mouth? 1. |___| Wi 0. |___| Non 8. |___| Pa konnen Si wi, konbyen fwa? ***If yes, how many times?*** |___|___| fwa (doz)
DTP 1 **DTP 2** **DTP 3**	|___|___|/|___|___|/|___|___| jou mwa ane	***Èske li te resevwa yon vaksen sou fòm piki, ke yon konn bay menm lè avèk vaksen nan bouch lan ?*** Did he/she received a vaccine as injection, sometimes given at the same time as the vaccine in the mouth? 1 [__] Wi 0 [__] Non 8 [__] Pa konnen
ROUGEOLE	|___|___|/|___|___|/|___|___| jou mwa ane	***Èske li te resevwa yon vaksen kont lawoujòl ?*** Did he/she received a vaccine against measles ? 1 [__] Wi 0 [__] Non 8 [__] Pa konnen
VITAMIN A	|___|___|/|___|___|/|___|___| jou mwa ane |___|___|/|___|___|/|___|___| jou mwa ane |___|___|/|___|___|/|___|___| jou mwa ane |___|___|/|___|___|/|___|___| jou mwa ane	***Èske li te resevwa vitamin A nan bouch (likid jòn andedan yon ti grenn tankou sila)?*** Montre grenn vitamin A Did he/she received a vitame A like this (show it). 1 [__] Wi 0 [__] Non 8 [__] Pa konnen ***Eske li te resevwa-li pandan 6 mwa ki sòt pase-a?*** Did he/she received it during the past 6 months? 1 [__] Wi 0 [__] Non

PREVANSYON SOU MALARIA		
MA 1.	***Èske lakay ou genyen moustikè oswa twal fen (kote granmoun oswa timoun ka domi anba li) ?*** Do you have bednets or fine tissue (where adults or children can sleep under it)?	1 [__] Wi 0 [__] Non **Pase nan lòt seksyon (ME)** 8 [__] Pa konnen **Pase nan lòt seksyon (ME)**
MA 2.	**Kilès ki te dòmi sou moustikè-a yè swa?** Who slept under a bednet last night? **PLIZYE REPONS POSIB**	A [__] Mwen menm B [__] Ti moun ki gen mwens ke 24 mwa C [__] Lòt ti moun ki pi gran D [__] Lòt Fanm ansent E [__] Lòt moun ki nan kay la
MA 3.	***Èske moustikè-a te tranpe / flite avèk yon likid oswa lòt bagay pou marengwen oubyen pinèz pa proche li?*** Was the bednet ever soaked/dipped or sprayed with a liquid or other product to repel mosquitoes or bugs?	1 [__] Wi 2 [__] Non 8 [__] Pa konnen si yo te fè li

MALADI TIMOUN		
ME 1.	***Gen timoun ki konn atrape maladi. yo konn bezwen pou yo pran swen yo. Ki siy, ki maladi ki ka parèt sou timoun ki moutre ke li bezwen tretman?*** ***Ki sa ankò?*** **PLIZYE REPONS POSIB** Sometimes children get sick and need to receive care. What are the signs or illnes that would indicate your child needs treatement? What else?	A [__] Pa konnen B [__] Li tris oswa li pa jwe C [__] Li pa manje ou byen li pa bwè / Pa gen apeti D [__] Feblès e li gen difikilte pou li leve E [__] Fyèv cho (lafyèv) F [__] Respire fò, oubyen difikilte pou respire G [__]Vomisman H [__]Kriz I [__] Bouton / gratel J [__] Tèt fè mal K [__] Vant fè mal L [__] Dyare M [__] Grip / Tous N [__] Lòt (Di kisa) _____ O [__] Lòt (Di kisa) _____
ME 2.	***Èske (DENYEN TIMOUN LAN) li te gen younn nan bagay sa yo nan 2 semèn ki sot pase yo?*** ***Li chak repons epi tcheke sa ki wi yo…*** **PLIZYE REPONS POSIB** Did (LAST CHILD) had any of the following in the past two weeks. Read each answer and check it if mentioned as yes.	A [__] Dyare B [__] Dyare ak san ladan li C [__] Tous D [__] Mal pou respire / Souf anlè F [__] Fyèv G [__] Malarya H [__] Kriz K [__] Li PAT MALAD **(Pase nan kesyon ME8)**
ME 3.	***Lè li te malad, eske nou te ba li bwè : (Li chak repons)*** When (LAST CHILD) was sick, did you/other offer he/she to drink….	1 [__] Mwens ke dabitid 0 [__] Men-m kantite a 8 [__] Plis ke dabitid
ME 4.	***Lè li te malad, eske nou te ba li manje :*** **(Li chak repons)** When (LAST CHILD) was sick, did you/other offer he/she to eat….	1 [__] Mwens ke dabitid 2 [__] Men-m kantite a 8 [__] Plis ke dabitid
ME 5.	**Mande kesyon sa si timoun lan nan tete toujou** ***Lè li te malad, eske ou te kontinye ba li tete :*** **(Li chak repons)** When (LAST CHILD) was sick, did you offer he/she to breastfeed….	1 [__] Mwens ke dabitid 2 [__] Men-m jan 8 [__] Plis ke dabitid
ME 6.	**Si timoun lan te gen dyare mande** u te ba li lè li te gen dyare? Kisa ankò? **PLIZYE REPONS POSIB** What did you give the child when he had diarrhea? What else?	1 [__] Sewom oral sachè 2 [__] Sewom oral lakay 3 [__] Lòt sewòm (Pedyalit, etc…) 4 [__] Remèd kay 5 [__] Remèd doktè… 6 [__] Lòt bagay _____
ME 7.	***Ki kote ou te mande konsèy / ou te ale chache konsèy?*** ***Lòt moun?*** *Lòt kote?* **PLIZYE REPONS POSIB** Where did you seek advice? Who else? Where else?	4. [__] **Aucun endroit** 5. [__] Institution / professionnel santé 6. [__] Pharmacie 7. [__] Guérisseur traditionnel 8. [__] Boutique ou marché 9. [__] *Machann grenn* 10. [__] Sage femme – matrone 11. [__] Parents 12. [__] Amis Lòt _____
ME 8.	***Eske ou tande pale deja de sewom oral?*** *Have* you ever heard of ORS?	1. [__] Wi 0. [__] Non → **lòt seksyon (SID)**
ME 9.	***Ki jan ou konnen pou prepare sewom oral sache?*** **PLIZYE REPONS POSIB**	[__] **Pa konnen** [__] boutèy kola (1 litre dlo) Kantité _____

	How do you know to prepare a packet of ORS?	[__] bouyi avan mezire [__] bouyi apre mezire [__] trete [__] Sache sewom oral [__] Lòt bagay _____
ME 10.	***Ki jan ou konnen pou prepare sewom oral lakay?*** **PLIZYE REPONS POSIB** How do you know to prepare the « home solution »?	[__] **Pa konnen** [__] boutèy kola (1 litre dlo) Kantité _____ [__] bouyi avan mezire [__] bouyi apre mezire [__] trete [__] kiyè sik Kantite (gwo, piti) _____ [__] kiyè sèl Kantite (gwo, piti) _____ [__] Yon ti ji sitwon [__] Lòt bagay _____

HIV/SIDA		
SID 1.	***Èske ou konn tande pale de yon maladi ki rele SIDA?*** Have you ever heard of an illness called AIDS?	1 [__] Wi 0 [__] Non **(Pase nan kesyon sou IST)**
SID 2.	***Èske ou kapab di mwen kisa yon moun dwe fè pou evite SIDA oubyen viris ki koz SIDA a?*** **Kisa ankò?** **PLIZYE REPONS POSIB** Can you tell me how a person can avoid getting AIDS or the virus that causes AIDS?	Z [__] **Pa konnen** A [__] **Pa fè anyen / Pa pwoteje** B [__] Abstinans (pa fè bagay) C [__] Itilize kapòt D [__] Fè bagay ak yon sèl patnè/ rete fidèl a yon sèl patnè E [__] Limite nomb patnè seksyèl nou F [__] Evite fè bagay ak pwostitiye G [__] Evite fè bagay ak moun ki gen anpil menaj H [__] Evite relasyon ak (omoseksyèl, lesbyèn) I [__] Evite fè bagay ak moun ki pran dwòg nan venn yo J [__] Evite transfizyon sangin / Evite pran san K [__] Evite pran piki L [__] Pa sèvi avèk sering ki sèvi deja M [__] Pa bo / anbwase N [__] Pa kite moustik mode-w O [__] Pran remèd tradisyonèl P [__] Evite sèvi avek razwa oswa jilèt ki sèvi deja W [__] Lòt (Di kisa) _____ X [__] Lòt (Di kisa) _____
SID 3.	***Ki jan yon moun ka rive konnen ke li menm oswa mari li gen SIDA?*** How can a person find out of she or he has the virus that causes AID? **PLIZYE REPONS POSIB**	**0.** [__] **Pa konnen** 1. [__] Li fè tes laboratwa 2. [__] Nan sant sante 3. [__] Nan yon sant kote yo bay konsey sou SIDA 4. [__] Cheve swa 5. [__] Lap depafini 6. [__] Zona 7. [__] Chank 8. Lòt _____
SID 4.	***Si ou ta vle fè yon tes pou konnen si ou gen SIDA, ki bò ou ta ale?*** If you wanted an HIV/AIDS test, where would you go? **PLIZYE REPONS POSIB**	**0.** [__] **Pa konnen** 1. [__] Lopital 2. [__] Sant sante 3. [__] Kote yo bay konsey sou SIDA 4. [__] Lòt _____
INFECTIONS SEXUELLEMENT TRANSMISSIBLES		
IST 1.	***Eske ou tande pale de lot maladi ke yon moun ka trape nan fè bagay?***	1 [__] Wi 0 [__] Non **(Pase nan kesyon HYG)**

	Have you heard of any other infections that you can get from sexual infection?	
IST 2.	***Kay yon fanm, sou ki siy maladi ou ka wè ke li pran yon maladi nan fè bagay?*** In a woman, what signs and symptoms would lead you to think that she has such an infection? **Ki lòt ankò?** **PLIZYE REPONS POSIB**	[__] **Pa konnen** [__] Doulè anba ti vant [__] Ekoulman \ Dlo nan bouboun [__] Ekoulman ak odè [__] Canal li boule lè lap pipi [__] Bouboun lan rouj [__] Chank / ulcè / bouton [__] San nan irin li / Irin lan rouj [__] Lap megri / li pèdi pwa [__] Li pa ka fè pitit [__] Gratel / Demanjezon [__] Lòt bagay _____
IST 3.	***Eske pandan douz dènye mwa ki sòt pase-a, ou panse ou trape yon maladi nan fè bagay?*** During the past 12 months have you had a sexually transmitted infection?	1 [__] Wi 0 [__] Non

HIENE DES MAINS		
HYG 1.	***Mwen ta renmen poze yon lòt kesyon. Ki lè nou lave men nou avèk savon?*** **PLIZYE REPONS POSIB** I would like to ask another question. When do you wash your hands with soap?	A [__] Pa sèvi ak savon ditou B [__] Anvan nou prepare manje C [__] Anvan nou bay timoun manje / tete D [__] Aprè nou fin ale nan watè E [__] Aprè nou fin netwaye yon timoun ki te fè tata F [__] Lè menm sal X [__] Lòt (Di kisa)

	Ou ap fini antretyen an pandan ke w ap di*: "Mèsi bokou. Ou te ba mwen anpil endikasyon ki trè itil. Èske gen you lòt bagay ou ta renmen di?* Vous terminerez l'entretien en disant:" Merci beaucoup. Vous m'avez donné des indications très utiles. Y a-t-il quelque chose que vous voudriez ajouter? _____ _____ _____ _____ _____

Ministère de la Santé Publique et de la Population (MSPP)
Direction Départementale du Nord-Est
Projet HOPE HAITI

INTELL CONSULT

C onnaissances,

P ratiques et

C ouverture

en santé de la mère et de l'enfant…

UCS de Terrier Rouge
UCS de Trou du Nord

Mai - Juillet 2002

Guide pour l'Evaluation de l'organisation et de la qualité des services et des systèmes de support en gestion

(Service Delivery and Management Assessment Protocol /SDMA)

Haiti Health Systems 2004 (HS-2004) is supported by the US Agency for International Development under Contract Number 521-C-00-00-00023-00.

HS–2004

HS-2004 est un projet de l'USAID géré par Management Sciences for Health

APPENDIX 7

DRAFT
TRIPARTITE AGREEMENT

(This agreement will be finalized and submitted by October 31st.)

Tripartite Contract

Between:

1) The Ministry of the Public Health and Population (MSPP) seated at the Palace of Ministries, Port-au-Prince, Haiti, represented by the Minister Dr Henri Claude Voltaire, living and resident in Port-au-Prince, Haiti, identified to the number…….. hereafter referred to as the Ministry, (MSPP), undersigned:

---

2) The Centers for Development and Health (CDS) represented by Dr Réginald Boulos, President, living and resident in Port-au-Prince, identified to the number……. hereafter referred to as CDS, undersigned:

---

3) The People-to-People Health Foundation, Inc having its offices in Millwood, Virginia, legally authorized to function in Haiti to the number ……. and hereafter referred to as Project HOPE, represented by……. identified by his/her passport having the number……., undersigned:

---

it has been agreed to that which follows:

Article 1: Object of the Contract and Goal of the Program

The goal of the contract is to carry out, jointly by the three (3) signatory parties, a program of integrated community health in the west part of the Department of the NorthEast at the level of the six (6) following communes: Trou du Nord, Terrier Rouge, Caracol, Sainte Suzannes, Valières, and Perches, as defined in the Project's DIP (Detailed Implementation Plan). The Project will be executed with the external support of the USAID via Project HOPE for the period from …….. to September 28, 2006.

The goal of the Program is to promote and to protect the Health of the population of the selected areas while improving the effectiveness, efficiency, coverage, utilization and quality of the health services, by changing the performance of actors in the system, specifically the suppliers and beneficiaries of cares, the community leaders, and the individuals and families of the communities. Activities will take place at four levels: Individual and Family, Community, Health Facilities, and Departmental Management (UCS and DSNE).

Article 2: Description of the Program.

This program consists of the implementation of health preventive and curative interventions including the following:

- Integrated Management of Childhood Illnesses (IMCI)
- Immunization
- Nutrition
- Breastfeeding
- Diarrhea Disease Control
- Acute Respiratory Illness Management
- Safe Motherhood
- Child Spacing
- STI/HIV/AIDS

These health activities will be supported by the following additional activities:
- education, training, and retraining,
- supervision and monitoring
- quality improvement
- performance management
- community and organizational capacity development
- operational research
- evaluation
- dissemination of results, findings, and lessons learned

ROLES AND RESPONSIBILITIES OF PARTIES:

A) Roles and responsibilities of the MSPP

Article 3: The MSPP, via the DSNE and the two UCSs, will be responsible for the implementation of the activities noted in this contract. Stated alternatively, the MSPP is directly responsible for delivering health care and services to the populations of the six communes concerned, both at the level of health facilities and at the level of the community.

Article 4: The MSPP will fulfill its obligations as noted in articles 5 and following of the present contract and according to norms that support implementation with diligence and efficiency.

Article 5: The MSPP will carry out its activities according to the techniques and practices generally prescribed in the National Plan of Health and according to norms and standard in use to the national level, which will be taken into account by DSNE in evaluating the activities of the Program.

Article 6: The MSPP is responsible for the recruitment, the supervision and the discipline of the personnel involved with the project and for ensuring that their behavior is in accordance with the official norms of the Ministry.

Article 7: The MSPP will prepare a monthly technical report of activities and statistics relevant to the Program, of which a copy will be conveyed to the two other parties along with studies and other documents prepared by MSPP in carrying out its activities.

Article 8: The MSPP will prepare and submit every six (6) months a physical inventory of equipment and other goods made available to its disposition by means of the project, which should be identified by the logo of USAID. A copy of this inventory taken in all six communes of the Program will be submitted to the two other parties.

Article 9: The MSPP will submit to CDS by the fifteenth day of the following month, all receipts and other justifying documents for expenses incurred during the previous month in the setting of the MSPP/HOPE/CDS Project.

Article 10: The MSPP will assure the availability at all times of the supplies and other expendable goods needed for the services which are the object of this contract. It should be noted, however, that MSPP is solely responsible for the acquisition of such goods and supplies and that these goods and supplies will be provided to the facilities concerned based on internal fees.

Article 11: The MSPP is responsible for the payment of salaries and all other benefits (including insurances) of the personnel of the Project which are assigned to its budget.

Article 12: The MSPP guarantees to the two other parties' free access without constraints to the facilities and other sites in the area where the Project is being implemented.

Article 13: The MSPP is obliged to verify the competence of personnel and to control the organization and the quality of their work up to the completion of their regular and contractual liability.

Article 14: The MSPP will assure the regular convening of the technical/administrative meetings which must be held every two months at the local level and, on the basis of a joint agreement with the other parties, will set the dates of the quarterly meetings to be attended by the signatory parties or their representatives. However, any of the three parties can, at any time, convene an extraordinary meeting requiring participation by the Project Parties.

Article 15: The MSPP at the Central level will evaluate the Project periodically and if necessary, in dialogue with the other partners, apply any correctives necessary

B) Role and responsibilities of CDS

CDS is responsible for a range of activities described in the Project DIP as part of the implementation of the Program, including orientation and mentoring, training, supervision, monitoring, management, technical assistance and others, often in collaboration with the MSPP

Article 16: CDS provides to the MSPP the direction and support along with the technical and administrative aid needed to implement in concert with the two other parties the activities of the Project as planned.

Article 17: CDS is responsible for the management of the funds of the Project, in accordance with the norms and standards of USAID and Project HOPE.

Article 18: CDS participates alongside MSPP in all phases of the Project (Planning, Organization, Implementation, Supervision and Evaluation) and at all levels: Individual/Family, Community, Health Facility, Management (UCS/DSNE)

Article 19: CDS will inform the MSPP actively regarding all unusual observations and other findings identified in the course of supervision or during the analysis of technical and administrative reports

Article 20: CDS collaborates with Project HOPE and the MSPP in planning and implementing the monitoring and evaluation of the activities of the Program and is responsible for communicating the results of these assessments to all the participants and stakeholders.

Article 21: CDS, MSPP and Project HOPE are responsible together and individually for the diffusion and dissemination of results and lessons learned during the Project locally, nationally, and globally.

Article 22: CDS prepares and produces the salary checks and other employment benefits of the personnel supported by the Project budget. The distribution of those checks to those personnel will be carried out by the MSPP.

Article 23: CDS aims to execute, in the briefest time possible, requisitions that are submitted to CDS by the MSPP for the purchase of goods or services needed by the Project. These requisitions will be carried out according to the norms and standards of USAID.

Article 24: CDS will ensure the implementation of an annual physical inventory and financial audit of the Project.

Article 25: CDS is responsible for informing the other partners regularly on the progress and evolution of the activities of the Program including a monthly report of activities and progress, along with a plan of activities in the immediate future, quarterly and yearly reports of performance and the achievements of the Program, and for distributing copies to the partners of all reports relevant to the Project. A monthly financial report including copies of all receipts will be prepared for this purpose, as well as the previously mentioned reports of physical inventory and the annual audit.

C) Role and responsibilities of Project HOPE

Article 26: As the recipient of the funds for this Project, Project HOPE is responsible to USAID for assuring the effective implementation of the project, and is accountable for the appropriate disbursement and use of the funds. This responsibility and accountability is carried out directly, and also indirectly, by HOPE monitoring of project activities and reports of the other partners.

Article 27: HOPE is responsible for interaction with USAID, including submission of quarterly and annual financial and technical reports, submission of technical project documents including the DIP, KPC baseline and final evaluation surveys, midterm evaluation report, and other related documents developed in collaboration among the three partners.

Article 28: HOPE is responsible for reviewing tools, curricula, plans, and other technical methods and project documents prepared in Haiti and providing advice and recommendations in a timely fashion as needed for enhancing their appropriateness and effectiveness. CDS is responsible for providing these items and plans in draft sufficiently in advance of the activities in which they will be used so as to allow such reviews and the incorporation of such recommendations as are made into the instruments or planned activities before their application or implementation in the Project's activities.

Article 29: HOPE commits to make available in a timely fashion the funds projected in the aforesaid budget; both HOPE and CDS commit to search independently and together for additional funds to support extended project activities and activities related to the project.

Article 30: HOPE commits to provide to the limits of its capability all assistance to CDS needed to enable CDS to carry out effectively the tasks incumbent in the Project framework and plans.

Article 31: HOPE is accountable, and CDS is operationally responsible, for ensuring that the project is being implemented in accordance with the Project DIP and with the agreed project budget. If changes in project activities or expenditures from those in the DIP and agreed budget appear to be appropriate and/or necessary operationally, CDS must inform HOPE and obtain HOPE's approval for such changes before they are implemented. In some cases, this will require additional approval from USAID.

APPENDIX 8

ORGANIZATIONAL CHART