KOMBIT PROJECT

Kominote Oryante pou Mere ak Bebe via Inovasyon e Teknoloji
(Communities Organized for Mothers and Babies With Innovation and Technology)

Innovations in Maternal-Newborn and Child Health
Detailed Implementation Plan

HAITIAN HEALTH FOUNDATION
DIP for the Child Survival and Health Grants Program (CSHGP)
RFA Number M/OP/GH/HSR-04-003

2004-2009

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ii ACRONYMS

ACNM.....American College of Nurse Midwives
AIDS..... Acquired Immune Deficiency Syndrome
APHA.....American Public Health Association
ARV..... Anti Retro Viral
BCC.....Behavior Change Communication
BF.....Breast Feed, Breast Feeding
BHR/PVC…….Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation
BMI.....Body Mass Index
BP/CR..... Birth Preparedness, Complication Readiness
BS.....Birth Spacing
CARE.....Cooperative for Assistance and Relief Everywhere
CASEC[1]..... Conseil d'Administration des Sections Communale
CBO.....Community-Based Organization
CDC-P ..... Centers for Disease Control and Prevention
CHI ..... Haitian Child Health Institute
CHW…..... Community Health Worker (Health Agent)
CMM.....Cervical Mucus Method
CONGA ..... Coalition of NGOs in the western Grand Anse
CORE .....Child Survival Collaborations and Resources
CPI .....Community Participation Index
CS ..... Child Spacing
CSHGP…….Child Survival and Health Grants Program
CSTS.....Child Survival Technical Support
DHS.....Demographic Health Survey
DIP .....Detailed Implementation Plan
DOSA .....Discussion Oriented Organizational Self Assessment
DSGA ..... Health Department of the Grand Anse
EDC…….....Expected Date of Confinement
FP……..…….....……Family Planning
FBO…….....……Faith Based Organization
GHESKIO….....Group Haitian d'Etude du Sarcome de Kaposi et des Infection Oportunistes
GNP…….....Gross National Product
HA…….....……..……..……Health Agent

[1] Communal/County Section Council: three member body that governs each of Haiti's 535 communal sections

HBLSS.....Home Based Life Saving Skills
HHF .....Haitian Health Foundation
HIS .....Health Information System
HIV .....Human Immunodeficiency Virus
HPNE.....Health Population, Nutrition and Education Office of USAID
HQ Staff.....Headquarter Staff
ICD-10 ..... 10th Version of the International Mortality and Morbidity Codes
IEC .....Information Education Communication
IMCI.....Integrated Management of Childhood Infections
IOM..... International Organization for Migration
IR..... Intermediate Results
JHPIEGO……John Hopkins Program for International Education in Gynecology and Obstetrics
KOMBIT.....Communities Organized for Mothers and Babies with Innovation and Technology
KPC .....Knowledge, Practice and Coverage Survey
LAM…… ..... ……..Lactation Amenorrhea Method
LBW..... Low Birth Weight
LQAS.....Lot Quality Assessment Sampling
MCH .....Maternal and Child Health
MD..... Medical Doctor
MIS .....Management Information Systems
MM .....Maternal Mortality
MNC ..... Maternal and Newborn Care
MMR..... Maternal Mortality Rate
MNH .....Maternal Newborn Health
MOH .....Ministry of Health
MOST ..... Management Organizational Sustainability Tool
MPH..... Master of Public Health
MSH..... Management Sciences for Health
MSPP .....Ministry of Public Health and Population in Haiti
MWH.....Maternal Waiting Home
N/A ..... Not Applicable
NFP…….....…….Natural Family Planning
NGO .....Non-Government Organization
NNMR.....Neonatal Mortality Rate
NRC…….....…….Nutritional Rehabilitation Center

OB ..... Obstetrics
OMS ..... Organization Mondial de Sante (PAHO)
OR ..... Operations Research
ORS ..... Oral Rehydration Solution
PAHO ..... Pan-American Health Organization
PEPFAR ..... President's Emergency Plan for AIDS Relief
PHACT ..... Public Health Active Census Tracking (HHF Health Information System)
PHC ..... Primary Health Care
PHNO ..... Population, Health and Nutrition Office
PSI ..... Population Services International
PVO ..... Private Voluntary Organization
QA ..... Quality Assurance
QA ..... Quality Assurance
RAMOS ..... Reproductive Age Mortality Survey
RN ..... Registered Nurse
RPR ..... Rapid Plasma Reagent (Syphilis Test)
SDM ..... Standard Day Method of Family Planning
SGS ..... Sisters of the Good Shepherd
SO ..... Strategic Objective
STI ..... Sexually Transmitted Infections
TA ..... Technical Assistance
TB ..... Tuberculosis
TBA ..... Traditional Birth Attendant
TOT ..... Training of Trainers
TT ..... Tetanus Toxoid
UCS ..... Unite Communal de Santé (Country Health Unit)
UCS 2 ..... The counties of Jeremie, Bonbon, Abricots and Roseaux in West Grand'Anse
UCONN ..... University of Connecticut
UNICEF ..... United Nations Children's Education Fund
USAID ..... United States Agency for International Development
VMSM ..... Volunteer Mothers for Safe Motherhood
WHO ..... World Health Organization
WRA ..... Women of Reproductive Age

A. EXECUTIVE SUMMARY

Executive Summary

KOMBIT (pronounced Kum-bee't) is a Haitian Creole word for an assembly of people who have come together for a common goal. Haitian women and newborns have the highest mortality rates in the western hemisphere. The estimated Maternal Mortality Rate (MMR) for 2003 (WHO) is 680 women per 100,000 live births. Neonatal mortality is 36/1000, and infant mortality is 80/1000 according to the Haitian Demographic and Health Survey (2000 DHS). There is a dearth of effective, coordinated, community and facility-based services for women and newborns. Our common goal is to come together with our partners to build capacity to improve and sustain health. The proposed program will result in a significant increase in survival for the women and children of Haiti.

For the past 17 years, the Haitian Health Foundation (HHF) has been a leader in Haiti, providing essential maternal and child health services in the remote and topographically challenging Grand Anse Department. Two million US dollars has been allocated (1.5 million from USAID, 500,000 from HHF) to implement a 5-year Standard Grant with the primary goal of reducing maternal and neonatal mortality in the Grand Anse-Jeremie area and nearby regions.

The KOMBIT project will support achievement of this goal by improving family, community and clinic-based maternal and newborn services, including support for child spacing and breast feeding. KOMBIT builds on the USAID Haiti mission sponsored HHF-MSH Child Survival Program and the HHF STI-HIV program and the mission sponsored "Pre-KOMBIT" program. KOMBIT will be implement project components in facilities and communities with health agents, called Health Agents (HAs) in selected villages in Jeremie and the counties of Roseaux, Bonbon and Abricots. HHF's major partners in KOMBIT are the Ministry of Public Health's (MSPP's) Grand Anse Health Department (DSGA) which coordinates four Unite Communale de Sante (UCS) with a combined population of 707,902, and the Sisters of the Good Shepherd (SGS), an established, private health provider within the KOMBIT Project area. Other local community based organizations will function as collaborators to implement KOMBIT activities in areas where HHF in not implementing its mission funded child survival project.

Project interventions are Maternal/Newborn Care (60%), Breastfeeding (20%), and Child Spacing (20%). The project will achieve its goal by achieving the following results.

KOMBIT Objectives/Expected Results

Maternal/Newborn
Increase from 25% to 50% of women who can identify at least 2 danger signs of pregnancy, from 9% to 40% of women who can identify at least 2 danger signs post partum and from 18% to 50% of women who can identify at least 2 newborn complications
Increase from 0 to 20% of villages with written and posted emergency OB and newborn transportation plan
Increase from 0 to 40% of women adopting a pregnancy delivery/ post partum plan
Increase from 0 to 60% of maternity service sites with satellite phones, communication to referral centers for OB emergencies
Increase from 10 to 15% of women who deliver with a trained attendant
Increase from 0 to 50% of patients divided into causes of referral or diagnosis to the next level of care

Increase from undocumented to 50% of completed referrals to the next level of care
Increase number of neonates examined by a HA within 72 hours of birth from 15% to 30%
Increase to 80% of post partum women examined by a HA within 72 hrs from 20% to 30%
BREASTFEEDING
Increase from 69 to 85% of mothers who BF within first hour or from 11% to 85% before placenta expulsion
Increase from 60 to 85% of mothers who exclusively BF for the first 6 months
CHILD SPACING
Increase from 4 to 15% of mothers who complete LAM
Increase from 4 to 10% of women using NFP methods (CMM, SDM)
Increase from 24% (9% HHF) to 35% of women using any method of CS
CAPACITY BUILDING
Increase % of villages with active CBOs in partner areas
Increase clinic competency in recognition and management of maternal/newborn danger signs/ emergencies
Establish audit process, increase number of maternal morbidity/mortality reviews in KOMBIT project area
SUSTAINABILITY
Increase % of HAs supported by MSPP and private providers
Assist the MSPP to modify policies (if necessary) to include tested home-based safe motherhood components
Strengthen MSPP ability to track pregnant women
Increase % of Mothers' Clubs and Volunteer Mothers for Safe Motherhood Groups that meet monthly
Increase community participation in the maintenance of emergency transport system

KOMBIT will employ 3 major strategic concepts that support one another: 1.) BCC to develop and disseminate behavior change messages; 2.) Improve quality of care at the community and clinical levels; and, 3.) Access to improve number and accessibility of services.

Strategies
Quality Improvement strategies Implement the American College of Nurse Midwives Home Based Life Saving Skills (HBLSS) program in the KOMBIT region through training of Health Agents (HAs), nurses and mothers in the community. Implement Georgetown University's Standard Day Method (SDM) in the entire KOMBIT area through training of HAs, nurses and mothers Conduct PAHO Neonatal IMCI training for HAs Conduct training in prenatal, postpartum and newborn care for personnel at all 8 dispensaries in the KOMBIT project region
Training in and implementation of the PAHO Perinatal Tracking system Training in management of obstetric emergencies for all nurses in the KOMBIT project area Conduct interpersonal communication training for personnel at all 8 dispensaries Workshop to develop danger sign educational messages based on KPC results Continue the reproductive age mortality survey and follow up maternal mortality audit process and facilitate regional Maternal mortality reviews committee meetings and recommendation development Additional training in Child Spacing using Cervical Mucous (CMM) of family planning for KOMBIT partners as well as the Lactation Amenorrhea Method (LAM) PAHO Perinatal software tracking program training with referral and counter referral system training

BCC Strategies Expand danger signs in pregnancy and neonatal period messages, and promote breastfeeding and NFP messages to community based organizations (CBOs) by training HAs to engage Mothers' Clubs, Fathers' Clubs, local leaders and Mobile Theater Troupes Community participation (FBO's, CBOs and providers) in development of emergency evacuation plan using local resources and satellite phones BP/CR activities, Village evacuation plan, Education on danger signs, Increased use of Maternal Waiting Home (MWH) Mobile Theater Troupes
Access Strategies Provide 6 remote sites and the hospital maternity unit with satellite phones for 24-hour monitoring of pregnancy complications coverage and advice for community based stabilization, care and transport arrangements. Training of nurses and HAs in pregnancy tracking. Establish pregnancy records so that home visits are emphasized and adapt maternal post partum assessments of infection, anemia and breast feeding problems for home setting Develop an ambulance service.

Implementing these strategies to achieve the expected results will lead to the development of the managerial and technical capabilities of HHF and its local partners to focus on maternal, family, and care delivery.

The project's first two years will focus on baseline assessments, the development of a coordinated plan to address the findings of these assessments, and training programs in the major project strategies and methods to begin implementation of services in the Commune of Jeremie and, to the extent possible, in adjoining areas. Years 3-5 will expand services to all KOMBIT areas and fully implement the scope of interventions.

The estimated number of beneficiaries is 171,703, of which 22% (37,776) are women between the ages of 15 and 49 years and 15% (25,755) are children under the age of five years. Approximately 4% of women will have a pregnancy each year (6,870) and an additional 6,870 newborns will be expected to receive services (2002 DSGA Health Profile, unpublished).

KOMBIT has been discussed extensively with the USAID-Haiti Mission, is consistent with its strategic and intermediate objectives, and has the full endorsement of the HPNE Director Christopher Barrett, the new CSHGP Liaison Dr Desinor, and other staff in the USAID health office.

B. CSHGP DATA FORM

Child Survival Grants Program Project Summary

DIP Submission: Apr-16-2005

HHF Haiti

General Project Information:

Cooperative Agreement Number: GHS-A-00-04-00020-00

Backstop Person: Judy Lewis

USAID Mission Contact: N/A

Project Grant Cycle: 20

Project Start Date: 2004-9-30

Project End Date: 2009-9-29

Project Type: Standard

Project Field Program Manager:

First Name: Sister Maryann
Last Name: Berard
Address: 10 Rue Rochasse
City: Jeremie
State/Province:
Zip/Postal Code:
Country Haiti
Telephone: 011-509-284-5216
Fax: 011-509-284-6526
E-mail: Maryann@haitianhealthfoundation.org
Project Web Site: www.haitianhealthfoundation.org

Alternate Field Contact:
First Name: Bette
Last Name: Gebrian
Address: Same as above
City:
State/Province:
Zip/Postal Code:
Country:
Telephone: 011-509-284-5242
Fax: same
E-mail: Bette@haitianhealthfoundation.org
Project Web Site: same

Grant Funding Information:
USAID Funding:(US $): $1,500,000 **PVO match:(US $)** $514,924

Project Information:
Project Description:
The primary goal is to reduce maternal and neonatal mortality initially in the Grand Anse-Jeremie area, then expanding to the other communes of the Department. The program will be implemented in stages, testing innovations initially with CHWs in selected villages.

Project Location:
Selected villages in the Jeremie, Roseaux, Bonbon, and Abricots.

Project Partner Information:
Partner Name Partner Type USAID $ Allocated
MSPP Ministry of Public Health and Population Collaborating Partner (N.A)
Sisters of the Good Shepherd Collaborating Partner (N.A)

Project Location/SubAreas Information: N/A

General Strategies Planned:
Private Sector Involvement
Strengthen Decentralized Health System

MandE Assessment Strategies:
KPC Survey
Health Facility Assessment
Organizational Capacity Assessment with Local Partners
Lot Quality Assurance Sampling
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change and Communication (BCC) Strategies:
Social Marketing
Interpersonal Communication
Peer Communication

Capacity Building Targets Planned:
PVO Non-Govt
Partners
Other Private
Sector Govt Community
US HQ
(General)
Field Office HQ
CS Project
Team
Local NGO
Networked Group
(None Selected) Dist. Health
System
Health Facility
Staff
Health CBOs
Other CBOs
CHWs

Interventions:
Maternal and Newborn Care 60 **%**
Child Spacing 20 **%**
Breastfeeding 20 **%**

Target Beneficiaries:
Infants < 12 months: N/A
Children 12-23 months: N/A
Children 0-23 months: N/A
Children 24-59 months: N/A
Women 15-49 years: 37,776
Population of Target Area: 171,703

Rapid Catch Indicators:

Indicator	**Numerator**	**Denominator**	**Percentage**	**Confidence Interval**
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	**35**	**245**	**14.3%**	**4.4**
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	**86**	**126**	**68.3%**	**8.1**
Percentage of children age 0-23 months whose births were attended by skilled health personnel	**25**	**247**	**10.1%**	**3.8**
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	**77**	**247**	**31.2%**	**5.8**

Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours
54 83 65.1% 10.3

Percentage of infants age 6-9 months receiving breastmilk and complementary foods
49 51 96.1% 5.3

Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday **52 94 55.3% 10.1**

Percentage of children age 12-23 months who received a measles vaccine
78 94 83.0% 7.6

Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only) **1 247 0.4% 0.8**

Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment
Missing

Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks **9 194 4.6% 3.0**

Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection **112 247 45.3% 6.2**

Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has Defecated **12 247 4.9% 2.7**

Percentage of new smear positive cases who were successfully treated **N/A**

Comments for Rapid Catch Indicator
The danger signs of childhood illness were inadvertently omitted from the KPC.
There was one child who was 24 months old.

C. DESCRIPTION OF DIP PREPARATION PROCESS

DATE	ACTION BY	DESCRIPTION
2004		
Oct 19	Technical Backstop, Medical Director	USAID Washington CSHGP Orientation Meeting
Oct 20-23	KOMBIT Admin	KOMBIT program translation from English to French for Partners
Oct 23-24	KOMBIT staff, Technical Backstop, Technical Advisor, HHF Admin	• Review of Washington CSHGP Orientation Meeting • Review KOMBIT activity plan and confirm time frame • List of documents to prepare for the DIP
Oct 26	Grand'Anse Departmental Health Director, UCS2 Director, SGS, Hospital Maternity Chief Nurse, MSPP Statistician, Technical Backstop, Technical Advisor, HHF Admin, Grant Admin, Field Coordinator	• KOMBIT Launch • Distribute French version of KOMBIT program • Indicators reviewed • Partners feedback on their identified facilities needs and actions suggestions • Set up the liaison persons to participate in all KOMBIT planning meetings every Friday at UCS2 office. • Agree on KPC partner participation
Nov 1	Meeting in Connecticut with Technical Backstop and Technical Advisor	Interface between HHF maternal newborn care and KOMBIT discussed.
November 8	Meeting with the American College of Nurse Midwives, Technical Backstop and Technical Advisor	Budget and initial assessment for inclusion in DIP and training discussed. Training tentative July 2005. Initial assessment of capacity in the Grand'Anse will occur in Feb 2005. We also suggested that the St-Antoine Hospital be included lifesaving skills program to facilitate and improve health care in general for maternal new born.
Nov - Ongoing	Meeting with PAHO/MICI and Technical Backstop	Neonatal MICI and software to support clinic and other health delivery in following clinics discussed.
Nov	Grant Admin HHF Volunteer Technical Advisor Medical Director Field Coordinator Data entry/Secretary	KPC Modules reviewed. Selected modules and CATCH were translated into Creole from the Oct 14 French version and back translated into English.
Nov 22	Meeting in Port-au-Prince with Kombit Medical Director, Grand'Anse Departmental Health Director and MSPP Director General	Future meeting with MSPP/USAID discussed. Dr. Desinord USAID liaison CSHGP has yet to confirm his availability despite numerous telephone conversations and invitations.

DATE	ACTION BY	DESCRIPTION
Dec 21	Program Director UCS2 Director SGS MSPP Nurse Medical Director Field Coordinator	• Approve the KPC/CATCH/HBLSS survey's sampling plan • Draw a sample of 19 villages from each communal section of UCS 2 • Finalize survey calendar-activities to start in last week of December 04
Dec 27	Field Coordinator, Nurses overseen by Program Director	KPC and Rapid CATCH Survey started (ended by February 15, 05)
2005		
January 12	Technical Backstop, Grant Admin, Data entry/Secretary	Training in SPSS data management software for KPC data entry and Maternal mortality (RAMOS)
Jan 05 to March	Data entry/Secretary, HHF Volunteer, Grant Admin	KPC "double" data entry, error proofing, corrections
Feb 11 to 18	Program Director KPC Consultant UCS2 Director MDM coordinator Sister of Good Shepherd Medical Director MSPP Maternity Nurse	Facilities Assessment Survey realized in 8 health facilities managed by KOMBIT partners.
March 18	Program Director, Technical Backstop Technical Advisor MSPP and SGS partners, Medical Director, National Chief Epidemiologist, KPC Consultant	• KPC partial results presentation to health partners representing the 3 communes of the UCS2 area. • Facilities Assessment results presentation • Prioritization of needs • Envisioning future of health services access/quality in UCS2
Dec 04 to March 05	Program Director	• Consolidating Partners relationship and their active participation in DIP preparation • Methodology writing • Organizing baseline analysis
Dec 04 to March 05	M and E Administrator/ KPC Consultant	Training plan Training Matrix Monitoring and Evaluation plan M and E Matrix
March-April	Technical Backstop	KPC data analysis

DATE	ACTION BY	DESCRIPTION
March-April	HHF Admin HHF Accounting Technical Advisor	Finalize KOMBIT 5 year Financial plan Review expenditure to date
April	HHF Admin HHF Accounting Technical Advisor Technical Backstop DIP Consultant KPC Consultant Program Director Medical Director Grant Admin Field Coordinator	DIP final draft revision and consolidation

D. REVISIONS

Revisions from the original application (see Annex I)
The original application received a score of 95.82. Very few revisions were requested by the proposal review committee.

D.1. Additional Indicators

The baseline assessments incorporated items from the home based life saving skills (HBLSS) activity to be implemented. As a result, and in response we have added the following indicators:

Percentage of women with 4 or more prenatal visits
Percentage of women who reported that they had received prenatal breastfeeding information and child spacing info
Percentage of women who were immunized with 2 doses of tetanus toxoid vaccine
Percent of women who received birth preparedness counseling
Percentage of women who said they would go to a hospital or health center if they had a danger sign of pregnancy
Percentage of mothers who could describe at least two methods of stopping a post partum hemorrhage
Percentage of women who can name 2 newborn care skills

D.2. Proposal Review Comments

Budget Information
Comment: The technical backstop is shown at 25% with 4 trips to the field planned in the first year which means much of the positions support time will be taken up in field travel.
Response : While much of the time is in travel, ample time has remained for the technical backstop to provided technical assistance, participate in program development and participate in US-based meetings.

Comment: HQ/US support is 30% time, and the reviewers questioned if this was adequate.
Response: HQ has hired a person to manage administrative issues.

Comment: There is no HQ finance Admin staff budgeted to support field operations.
Response: A revised budget and budget narrative are provided in Appendix XX.

Executive Summary
No weaknesses were noted

Description of PVO Applicant or Program
Comment: It was unclear whether HHF has been a US based PVO since 1986, and unclear whether HHF was first a Haiti-based organization that more recently obtained a US base in Connecticut
Response: HHF is a US-based PVO with one service location in Haiti.

Situational Analysis
Comment: The applicant would have been strengthened if HHF would offer local indicators/data regarding the extent of MCH issues using PHACT or other sources.
Response: The DIP contains more local program-based information than the proposal, but local population based data is extremely limited.

Comment: The Process used to select the project site were not explained and it would be helpful to learn more about how Grand Anse was prioritized/target (outside of obvious operational realities)
Response: The Grand Anse is one of 10 Departments (states) in Haiti and is the most remote area in the country. Selection of UCS 2 which is one of the 4 Ministry of Health geographical health areas was selected because the KOMBIT partners have had working relationships since the early 90s. UCS 2 also is the site of the Departmental government hospital, the only hospital in this part of the country.

Comment: An explanation of how St. Helene Clinic, the Leon Clinic and FOSREF will work with the proposed program – or at least an indication that there will not be any overlap or duplication would have been useful.
Response: KOMBIT has identified partners and has also engaged collaborating organizations and providers (there are many more than listed above) that will participate in training, share lessons learned and be apprised of joint opportunities with other donors over the next 5 years. Leon Clinic is a partner in KOMBIT.

Comment: The HIV/AIDS situation was not mentioned…it should be mentioned in the situational analysis to set the scene.
Response: **The HIV-AIDS situation in the Grand Anse was noted on pages 4 and 5 of the proposal. The CDC seroprevalence study was completed in 2003, and data were released in 2004. The seroprevalance rate of HIV in the Grand Anse (HHF was the site used for the study) in pregnant women was 4.5%. The national rate is 2.9%. The syphilis rate in pregnant women is 2.6% nationally and 7.0 in the Grand Anse.**

Program Strategy and Interventions
Comment: It would have been helpful to know why… HIV/AIDS was not selected, and how other gaps such as HIV/AIDS prevention and FP (modern contraceptive utilization and access, especially since modern methods such as Depo are favored) are being addressed if HHF will not focus on them
Response: The government hospital, St. Antoine in Jeremie town, was identified as an ARV site supported by PEPFAR and CDC funds and was opened officially in February 2005. HHF has requested a special study by the CDC concerning the persistent high syphilis rate in this area of the country. HHF and all providers in Jeremie are involved with various aspects of prevention, diagnosis, treatment, support and palliative care for HIV/AIDS, as well as all sexually transmitted diseases. Therefore, HIV/AIDS and STIs are not a formal part of the KOMBIT project.
Family Planning was noted in the proposal. KOMBIT is focusing on Family Life Methods. KOMBIT has 2 modern methods (LAM and SDM) as part of the program and one traditional method, CMM. Other providers in the area offer other FP methods when they are available, and women requesting these methods will be referred. Lack of commodities is a major factor in the selection of NFP approaches for KOMBIT.

Comment: The BF section does not appear to be fully developed and the link between BF and NFP is not explained. …it would seem that more intense community level support could be important.
Response: The implementation plan more fully develops the breast feeding intervention and is partly based on the LAM method, which links BF and NFP.

Comment: It is not clear how community entities will be supported to maintain sustainable community level services…
Response: These entities are supported though interactions with health agents (HAs), as has been the history of HHF. Details of this support have been provided in the detailed implementation plan.

Villages without resident village health workers will be the focus of innovative strategies through CBOs to engage families in positive maternal-newborn health behaviors.

Performance Monitoring and Evaluation
Comment: Reevaluate some of the objectives to target BCC and clarify objectives to ensure they are measurable.
Response: A BCC plan for all indicators has been developed in the DIP.

Comment: Proposal reviews suggested that we use community-level ownership and use the data for data gathering purposes.
Response: The proposed plan to post and update those indicators that will be monitored on a regular basis is elaborated upon in this document. In addition, the adaptation of PAHO pregnancy tracking system into the project will increase the opportunity for community based ownership and will certainly provide data for decision making. HHF has incorporated community participation and ownership in all programs, and this approach will be expanded in KOMBIT.

Management Plan
Comment: the KOMBIT organizational chart is not clear in regards to which staff is US based vs Haiti based, the percentage of time dedicated to the project and which positions have proposed or existing staff. A few abbreviated job descriptions of key program staff would have made it easier to understand the proposed organizations chart.
Response: The organizational chart has been clarified for the DIP. Percentage of time devoted to KOMBIT activities is listed in the Human Resources table. CVs and job descriptions that are required were provided in the proposal and updated in the DIP.

Comment: The proposed HQ backstop staff appears to have a strong academic and research background but limited PVO and program management experience. Given that she is the main US based contact besides a secretary, for the project, this is of concern.
Response: Professor Judy Lewis has been associated with the Haitian Health Foundation since 1987 and has extensive knowledge of the rural Haitian reality. In addition, her work in other countries with all levels of workers is a solid foundation she will use to build KOMBIT's capacity; as well as through her representation in the USA in working groups and in other CORE functions. She has the research skill that is lacking in KOMBIT and is essential for the KPC data analysis, operations research, and use of data for the benefit of all partners and beneficiaries. Further, she has extensive program development and operation experience in the US and internationally. One of Professor Lewis' most notable achievements was creating a school based clinic program in the Hartford Public Schools. The grant period was 1975-1980 and supported the development of 2 model programs; due to her leadership, organizational knowledge and skills, a sustainable structure and funding mechanism were developed. This program still exists, providing health, mental health and dental services to 25,000 children.

Comment: The maternal/newborn advisor (Frank Anderson) is noted in the organizational chart (HQ staff) but is listed in the contractual section of the budget.
Response: The maternal newborn advisor is not HQ staff, but is a consultant to KOBMIT in the implementation of portions of the maternal/newborn care intervention.

Collaboration with USAID Field Mission
No weaknesses noted.

D.3. Budget

KOMBIT PROJECT BUDGET
YEAR 1

	HAITI	CONN OFFICE	TOTAL CSHGP	MATCH	TOTAL
PERSONNEL					
KOMBIT Project Director	$ 33,580.00		$ 33,580.00		$ 33,580.00
KOMBIT Grant Administrator	$ 15,000.00		$ 15,000.00		$ 15,000.00
Monitoring and Evaluation Administrator	$ 23,870.00		$ 23,870.00		$ 23,870.00
Has (6 mo)	$ 18,000.00		$ 18,000.00		$ 18,000.00
Field/BBC Coordinator	$ 10,100.00		$ 10,100.00		$ 10,100.00
Medical Director	$ 9,000.00		$ 9,000.00		$ 9,000.00
2 Field Nurses	$ 7,012.00		$ 7,012.00		$ 7,012.00
Maternal Newborn Care Supervisor	$ 5,388.00		$ 5,388.00		$ 5,388.00
2 Clinic Nurses Maternal Waiting Home	$ 5,778.00		$ 5,778.00		$ 5,778.00
Breast Feeding-Child Spacing Supervisor	$ 6,000.00		$ 6,000.00		$ 6,000.00
2 Drivers	$ 3,102.00		$ 3,102.00		$ 3,102.00
Accountant	$ 3,000.00	$ 4,000.00	$ 7,000.00		$ 7,000.00
Data Entry Person / Secretary	$ 2,640.00		$ 2,640.00		$ 2,640.00
MSPP statistician (25%)	$ 2,500.00		$ 2,500.00		$ 2,500.00
Office Assistant	$ 680.00		$ 680.00		$ 680.00
Technical Backstop (Connecticut) including benefits		$ 20,000.00	$ 20,000.00		$ 20,000.00
Secretary		$ 10,000.00	$ 10,000.00		$ 10,000.00
STI-HIV nurses				$ 15,000.00	$ 15,000.00
Physician for Maternal Care				$ 12,000.00	$ 12,000.00
Nurse Midwife				$ 8,000.00	$ 8,000.00
Clinic Nurses Maternal Waiting Home				$ 7,000.00	$ 7,000.00
SUBTOTAL PERSONNEL	**$ 145,650.00**	**$ 34,000.00**	**$ 179,650.00**	**$ 42,000.00**	**$ 221,650.00**

	HAITI	CONN OFFICE	TOTAL CSHGP	MATCH	TOTAL
TRAVEL					
Staff in Haiti (Domestic) Per Diem	$ 6,000.00	$ 3,000.00	$ 9,000.00		$ 9,000.00
Vehicle Operating Costs	$ 2,000.00		$ 2,000.00		$ 2,000.00
International Travel	$ 7,000.00	$ 8,000.00	$ 15,000.00		$ 15,000.00
Vehicle (for maternal transport)				$ 35,000.00	$ 35,000.00
2 Motorcycles				$ 10,000.00	$ 10,000.00
SUBTOTAL TRAVEL	**$ 15,000.00**	**$ 11,000.00**	**$ 26,000.00**	**$ 45,000.00**	**$ 71,000.00**
EQUIPMENT					
Office Equipment	$ 4,000.00	$ 7,500.00	$ 11,500.00		$ 11,500.00
Medical Equipment	$ 4,050.00		$ 4,050.00		$ 4,050.00
Solar Power Inverter System	$ 2,000.00		$ 2,000.00	$ 5,000.00	$ 7,000.00
3 Desktop Computer				$ 7,500.00	$ 7,500.00
OBGYN Exam Tables				$ 5,500.00	$ 5,500.00
SUBTOTAL EQUIPMENT	**$ 10,050.00**	**$ 7,500.00**	**$ 17,550.00**	**$ 18,000.00**	**$ 35,550.00**
SUPPLIES					
Medical Supplies	$ 2,500.00		$ 2,500.00		$ 2,500.00
Office and Educational Supplies	$ 1,000.00	$ 7,000.00	$ 8,000.00		$ 8,000.00
TOTAL SUPPLIES	**$ 3,500.00**	**$ 7,000.00**	**$ 10,500.00**	**$ -**	**$ 10,500.00**
CONTRACTUAL					
HBLSS Consultant	$ 16,200.00		$ 16,200.00	$ 5,000.00	$ 21,200.00
Consultant KPC	$ 8,000.00		$ 8,000.00		$ 8,000.00
Consultant DIP	$ 8,000.00		$ 8,000.00		$ 8,000.00
Medical Advisor	$ 2,000.00		$ 2,000.00	$ 7,000.00	$ 9,000.00
SUBTOTAL CONTRACTUAL	**$ 34,200.00**	**$ -**	**$ 34,200.00**	**$ 12,000.00**	**$ 46,200.00**

	HAITI	CONN OFFICE	TOTAL CSHGP	MATCH	TOTAL
OTHER					
Communications	$ 1,000.00		$ 1,000.00		$ 1,000.00
Operational Support					
Maternal Mortality Audits	$ 1,000.00		$ 1,000.00		$ 1,000.00
UCS 2 meetings-partners	$ 1,000.00		$ 1,000.00		$ 1,000.00
Meeting/Conference Rooms				$ 6,000.00	$ 6,000.00
Training and Supervision					
HBLSS Training	$ 8,816.00		$ 8,816.00	$ 20,647.49	$ 29,463.49
Neonatal IMCI	$ -		$ -		$ -
BCC interpersonal communication	$ 1,000.00		$ 1,000.00		$ 1,000.00
Post partum care (insititution)	$ 1,000.00		$ 1,000.00		$ 1,000.00
Human and Reproductive Rights	$ 700.00		$ 700.00		$ 700.00
Community Mobilization	$ 2,520.00		$ 2,520.00	$ 2,500.00	$ 5,020.00
Perinatal data management (PAHO software)	$ -		$ -		$ -
Child Spacing Education	$ 1,500.00		$ 1,500.00		$ 1,500.00
Breastfeeding Education	$ 1,000.00		$ 1,000.00		$ 1,000.00
BCC creating of new messages	$ 1,000.00		$ 1,000.00		$ 1,000.00
Maternal mortality audit update	$ 500.00		$ 500.00	$ 4,000.00	$ 4,500.00
SUBTOTAL OTHER	**$ 21,036.00**	**$ -**	**$ 21,036.00**	**$ 33,147.49**	**$ 54,183.49**

TOTAL	**$ 229,436.00**	**$ 59,500.00**	**$ 288,936.00**	**$ 150,147.49**	**$ 439,083.49**

KOMBIT PROJECT BUDGET
YEAR 2

	HAITI	CONN OFFICE	TOTAL CSHGP	MATCH	TOTAL
PERSONNEL					
KOMBIT Project Director	$ 41,200.00		$ 41,200.00		$ 41,200.00
Has	$ 37,080.00		$ 37,080.00		$ 37,080.00
KOMBIT Grant Administrator	$ 30,900.00		$ 30,900.00		$ 30,900.00
Monitoring and Evaluation Administrator	$ 30,900.00		$ 30,900.00		$ 30,900.00
Field/BBC Coordinator	$ 11,330.00		$ 11,330.00		$ 11,330.00
Medical Director	$ 9,270.00		$ 9,270.00		$ 9,270.00
Field Nurses	$ 8,240.00		$ 8,240.00		$ 8,240.00
Maternal Newborn Care Supervisor	$ 8,240.00		$ 8,240.00		$ 8,240.00
Clinic Nurses Maternal Waiting Home	$ 7,210.00		$ 7,210.00		$ 7,210.00
Breast Feeding-Child Spacing Supervisor	$ 6,180.00		$ 6,180.00		$ 6,180.00
2 Drivers	$ 5,150.00		$ 5,150.00		$ 5,150.00
Accountant	$ 3,090.00		$ 3,090.00		$ 3,090.00
Data Entry Person / Secretary	$ 3,090.00		$ 3,090.00		$ 3,090.00
Statistician	$ 2,575.00		$ 2,575.00		$ 2,575.00
Office Assistant	$ 1,030.00		$ 1,030.00		$ 1,030.00
Technical Backstop (Connecticut) including benefits		$ 25,750.00	$ 25,750.00		$ 25,750.00
Secretary		$ 8,523.24	$ 8,523.24		$ 8,523.24
STI-HIV nurses				$ 15,450.00	$ 15,450.00
Physician for Maternal Care				$ 12,360.00	$ 12,360.00
Nurse Midwife				$ 8,240.00	$ 8,240.00
Clinic Nurses Maternal Waiting Home				$ 7,210.00	$ 7,210.00
SUBTOTAL PERSONNEL	**$ 205,485.00**	**$ 34,273.24**	**$ 239,758.24**	**$ 43,260.00**	**$ 283,018.24**

	HAITI	CONN OFFICE	TOTAL CSHGP	MATCH	TOTAL
TRAVEL					
Staff in Haiti (Domestic) Per Diem	$ 14,800.00		$ 14,800.00		$ 14,800.00
Vehicle Operating Costs	$ 3,000.00		$ 3,000.00		$ 3,000.00
International Travel	$ 6,000.00	$ 10,000.00	$ 16,000.00		$ 16,000.00
Vehicle (for maternal transport)			$ -	$ 35,000.00	$ 35,000.00
SUBTOTAL TRAVEL	**$ 23,800.00**	**$ 10,000.00**	**$ 33,800.00**	**$ 35,000.00**	**$ 68,800.00**
EQUIPMENT					
Office and Medical Equipment	$ 2,000.00		$ 2,000.00		$ 2,000.00
Satellite Phones (5)			$ -	$ 4,000.00	$ 4,000.00
Sonogram Equipment			$ -	$ 26,235.00	$ 26,235.00
SUBTOTAL EQUIPMENT	**$ 2,000.00**	**$ -**	**$ 2,000.00**	**$ 30,235.00**	**$ 32,235.00**
SUPPLIES					
Medical Supplies	$ 2,500.00		$ 2,500.00		$ 2,500.00
Office Supplies	$ 2,000.00		$ 2,000.00		$ 2,000.00
TOTAL SUPPLIES	**$ 4,500.00**	**$ -**	**$ 4,500.00**	**$ -**	**$ 4,500.00**
CONTRACTUAL					
HBLSS Consultant	$ 11,200.00		$ 11,200.00	$ 6,555.00	$ 17,755.00
Medical Advisor/Operations Research	$ 2,390.00		$ 2,390.00	$ 7,000.00	$ 9,390.00
SUBTOTAL CONTRACTUAL	**$ 13,590.00**	**$ -**	**$ 13,590.00**	**$ 13,555.00**	**$ 27,145.00**

	HAITI	CONN OFFICE	TOTAL CSHGP	MATCH	TOTAL
OTHER					
Communications	$ 1,000.00		$ 1,000.00		$ 1,000.00
Operational Support					
Maternal Mortality Audits	$ 1,000.00		$ 1,000.00		$ 1,000.00
UCS 2 meetings-partners	$ 1,000.00		$ 1,000.00		$ 1,000.00
Meeting/Conference Rooms			$ -	$ 6,000.00	$ 6,000.00
Training and Supervision			$ -		
HBLSS	$ 4,000.00		$ 4,000.00	$ 7,504.87	$ 11,504.87
Human and Reproductive Rights	$ 700.00		$ 700.00		$ 700.00
Child Spacing Education	$ 500.00		$ 500.00		$ 500.00
Breastfeeding Education	$ 500.00		$ 500.00		$ 500.00
Community Mobilization	$ 900.00		$ 900.00		$ 900.00
Perinatal data management (PAHO software)	$ 500.00		$ 500.00		$ 500.00
Neonatal IMCI	$ 3,000.00		$ 3,000.00		$ 3,000.00
BCC interpersonal communication	$ 500.00		$ 500.00		$ 500.00
Post partum care (insititution)	$ 400.00		$ 400.00		$ 400.00
Maternal mortality audit update	$ 500.00		$ 500.00		$ 500.00
SUBTOTAL OTHER	**$ 14,500.00**	**$ -**	**$ 14,500.00**	**$ 13,504.87**	**$ 28,004.87**

TOTAL	**$ 263,875.00**	**$ 44,273.24**	**$ 308,148.24**	**$ 135,554.87**	**$ 443,703.11**

KOMBIT PROJECT BUDGET
YEAR 3

	HAITI	CONN OFFICE	TOTAL CSHGP	MATCH	TOTAL
PERSONNEL					
KOMBIT Project Director	$ 42,436.00		$ 42,436.00		$ 42,436.00
Has	$ 38,192.40		$ 38,192.40		$ 38,192.40
KOMBIT Grant Administrator	$ 31,827.00		$ 31,827.00		$ 31,827.00
Monitoring and Evaluation Administrator	$ 31,827.00		$ 31,827.00		$ 31,827.00
Field/BBC Coordinator	$ 11,669.90		$ 11,669.90		$ 11,669.90
Medical Director	$ 9,548.10		$ 9,548.10		$ 9,548.10
Field Nurses	$ 8,487.20		$ 8,487.20		$ 8,487.20
Maternal Newborn Care Supervisor	$ 8,487.20		$ 8,487.20		$ 8,487.20
Clinic Nurses Maternal Waiting Home	$ 7,426.30		$ 7,426.30		$ 7,426.30
Breast Feeding-Child Spacing Supervisor	$ 6,365.40		$ 6,365.40		$ 6,365.40
2 Drivers	$ 5,304.50		$ 5,304.50		$ 5,304.50
Accountant	$ 3,182.70		$ 3,182.70		$ 3,182.70
Data Entry Person / Secretary	$ 3,182.70		$ 3,182.70		$ 3,182.70
Statistician	$ 2,652.25		$ 2,652.25		$ 2,652.25
Office Assistant	$ 1,060.90		$ 1,060.90		$ 1,060.90
Technical Backstop (Connecticut) including benefits		$ 26,522.50	$ 26,522.50		$ 26,522.50
Secretary		$ 8,778.95	$ 8,778.95		$ 8,778.95
STI-HIV nurses			$ -	$ 15,913.50	$ 15,913.50
Physician for Maternal Care			$ -	$ 12,730.80	$ 12,730.80
Nurse Midwife			$ -	$ 8,487.20	$ 8,487.20
Clinic Nurses Maternal Waiting Home			$ -	$ 7,426.30	$ 7,426.30
SUBTOTAL PERSONNEL	**$ 211,649.55**	**$ 35,301.45**	**$ 246,951.00**	**$ 44,557.80**	**$ 291,508.80**
TRAVEL					
Staff in Haiti (Domestic) Per Diem	$ 10,000.00		$ 10,000.00		$ 10,000.00
Vehicle Operating Costs	$ 4,000.00		$ 4,000.00		$ 4,000.00
International Travel	$ 3,000.00	$ 10,000.00	$ 13,000.00		$ 13,000.00
Vehicle (for maternal transport)			$ -	$ 35,000.00	$ 35,000.00
SUBTOTAL TRAVEL	**$ 17,000.00**	**$ 10,000.00**	**$ 27,000.00**	**$ 35,000.00**	**$ 62,000.00**

	HAITI	CONN OFFICE	TOTAL CSHGP	MATCH	TOTAL
EQUIPMENT					
Inverter Batteries	$ 1,500.00		$ 1,500.00		$ 1,500.00
Office and Medical Equipment	$ 314.83		$ 314.83		$ 314.83
SUBTOTAL EQUIPMENT	**$ 1,814.83**	**$ -**	**$ 1,814.83**	**$ -**	**$ 1,814.83**
SUPPLIES					
Medical Supplies	$ 2,500.00		$ 2,500.00	$ 2,500.00	$ 5,000.00
Office Supplies	$ 1,500.00		$ 1,500.00		$ 1,500.00
TOTAL SUPPLIES	**$ 4,000.00**	**$ -**	**$ 4,000.00**	**$ 2,500.00**	**$ 6,500.00**
CONTRACTUAL					
Consultant Mid-Term Evaluation	$ 10,000.00		$ 10,000.00		$ 10,000.00
Medical Advisor	$ 3,300.00		$ 3,300.00	$ 7,000.00	$ 10,300.00
SUBTOTAL CONTRACTUAL	**$ 13,300.00**	**$ -**	**$ 13,300.00**	**$ 7,000.00**	**$ 20,300.00**
OTHER					
Communications	$ 500.00		$ 500.00		$ 500.00
Operational Support					
Maternal Mortality Audits	$ 1,000.00		$ 1,000.00		$ 1,000.00
UCS 2 meetings-partners	$ 1,000.00		$ 1,000.00		$ 1,000.00
Meeting/Conference Rooms				$ 6,000.00	$ 6,000.00
Training and Supervision					
Human and Reproductive Rights	$ 500.00		$ 500.00		$ 500.00
Community Mobilization	$ 500.00		$ 500.00		$ 500.00
LQAS	$ 500.00		$ 500.00		$ 500.00
SUBTOTAL OTHER	**$ 4,000.00**	**$ -**	**$ 4,000.00**	**$ 6,000.00**	**$ 10,000.00**

TOTAL	**$ 251,764.38**	**$ 45,301.45**	**$ 297,065.83**	**$ 95,057.80**	**$ 392,123.63**

KOMBIT PROJECT BUDGET
YEAR 4

	HAITI	CONN OFFICE	TOTAL CSHGP	MATCH	TOTAL
PERSONNEL					
KOMBIT Project Director	$ 43,709.00		$ 43,709.00		$ 43,709.00
Has	$ 39,338.17		$ 39,338.17		$ 39,338.17
KOMBIT Grant Administrator	$ 32,781.81		$ 32,781.81		$ 32,781.81
Monitoring and Evaluation Administrator	$ 32,781.81		$ 32,781.81		$ 32,781.81
Field/BBC Coordinator	$ 12,020.00		$ 12,020.00		$ 12,020.00
Medical Director	$ 9,834.54		$ 9,834.54		$ 9,834.54
Field Nurses	$ 8,741.82		$ 8,741.82		$ 8,741.82
Maternal Newborn Care Supervisor	$ 8,741.82		$ 8,741.82		$ 8,741.82
Clinic Nurses Maternal Waiting Home	$ 7,649.09		$ 7,649.09		$ 7,649.09
Breast Feeding-Child Spacing Supervisor	$ 6,556.36		$ 6,556.36		$ 6,556.36
2 Drivers	$ 5,463.64		$ 5,463.64		$ 5,463.64
Accountant	$ 3,278.18		$ 3,278.18		$ 3,278.18
Data Entry Person / Secretary	$ 3,278.18		$ 3,278.18		$ 3,278.18
Statistician	$ 2,731.82		$ 2,731.82		$ 2,731.82
Office Assistant	$ 1,092.73		$ 1,092.73		$ 1,092.73
Technical Backstop (Connecticut) including benefits		$ 27,318.18	$ 27,318.18		$ 27,318.18
Secretary (30%)		$ 9,042.32	$ 9,042.32		$ 9,042.32
STI-HIV nurses			$ -	$ 16,390.91	$ 16,390.91
Physician for Maternal Care			$ -	$ 13,112.72	$ 13,112.72
Nurse Midwife			$ -	$ 8,741.82	$ 8,741.82
Clinic Nurses Maternal Waiting Home			$ -	$ 7,649.09	$ 7,649.09
SUBTOTAL PERSONNEL	**$ 217,998.96**	**$ 36,360.49**	**$ 254,359.45**	**$ 45,894.54**	**$ 300,253.99**
TRAVEL					
Staff in Haiti (Domestic) Per Diem	$ 10,000.00		$ 10,000.00		$ 10,000.00
Vehicle Operating Costs	$ 5,000.00		$ 5,000.00		$ 5,000.00
International Travel	$ 3,000.00	$ 10,000.00	$ 13,000.00		$ 13,000.00
SUBTOTAL TRAVEL	**$ 18,000.00**	**$ 10,000.00**	**$ 28,000.00**	**$ -**	**$ 28,000.00**

	HAITI	CONN OFFICE	TOTAL CSHGP	MATCH	TOTAL
EQUIPMENT					
Office and Medical Equipment	$ 927.88		$ 927.88		$ 927.88
SUBTOTAL EQUIPMENT	**$ 927.88**	**$ -**	**$ 927.88**	**$ -**	**$ 927.88**
SUPPLIES					
Medical Supplies	$ 2,500.00		$ 2,500.00	$ 2,000.00	$ 4,500.00
Office Supplies	$ 1,000.00		$ 1,000.00		$ 1,000.00
SUBTOTAL SUPPLIES	**$ 3,500.00**	**$ -**	**$ 3,500.00**	**$ 2,000.00**	**$ 5,500.00**
SUB CONTRACTORS					
Medical Advisor/Operations Research	$ 4,000.00		$ 4,000.00	$ 7,000.00	$ 11,000.00
SUBTOTAL SUB CONTRACTORS	**$ 4,000.00**	**$ -**	**$ 4,000.00**	**$ 7,000.00**	**$ 11,000.00**
OTHER					
Communications	$ 500.00		$ 500.00		$ 500.00
Opperational Support					
Maternal Mortality Audits	$ 1,000.00		$ 1,000.00		$ 1,000.00
UCS 2 meetings-partners	$ 1,000.00		$ 1,000.00		$ 1,000.00
Meeting/Conference Rooms			$ -	$ 6,000.00	$ 6,000.00
Training and Supervision			$ -		
Human and Reproductive Rights	$ 200.00		$ 200.00		$ 200.00
Community Mobilization	$ 200.00		$ 200.00		$ 200.00
Child Spacing Continuing Education	$ 200.00		$ 200.00		$ 200.00
LQAS	$ 200.00		$ 200.00		$ 200.00
SUBTOTAL OTHER	**$ 3,300.00**	**$ -**	**$ 3,300.00**	**$ 6,000.00**	**$ 9,300.00**

TOTAL	**$ 247,726.84**	**$ 46,360.49**	**$ 294,087.33**	**$ 60,894.54**	**$ 354,981.87**

KOMBIT PROJECT BUDGET
YEAR 5

	HAITI	CONN OFFICE	TOTAL CSHGP	MATCH	TOTAL
PERSONNEL					
KOMBIT Project Director	$ 45,020.00		$ 45,020.00		$ 45,020.00
Has	$ 40,518.32		$ 40,518.32		$ 40,518.32
KOMBIT Grant Administrator	$ 33,765.26		$ 33,765.26		$ 33,765.26
Monitoring and Evaluation Administrator	$ 33,765.26		$ 33,765.26		$ 33,765.26
Field/BBC Coordinator	$ 12,380.60		$ 12,380.60		$ 12,380.60
Medical Director	$ 10,129.58		$ 10,129.58		$ 10,129.58
Field Nurses	$ 9,004.07		$ 9,004.07		$ 9,004.07
Maternal Newborn Care Supervisor	$ 9,004.07		$ 9,004.07		$ 9,004.07
Clinic Nurses Maternal Waiting Home	$ 7,878.56		$ 7,878.56		$ 7,878.56
Breast Feeding-Child Spacing Supervisor	$ 6,753.05		$ 6,753.05		$ 6,753.05
2 Drivers	$ 5,627.54		$ 5,627.54		$ 5,627.54
Accountant	$ 3,376.53		$ 3,376.53		$ 3,376.53
Data Entry Person / Secretary	$ 3,376.53		$ 3,376.53		$ 3,376.53
Statistician	$ 2,813.77		$ 2,813.77		$ 2,813.77
Office Assistant	$ 1,125.51		$ 1,125.51		$ 1,125.51
Technical Backstop (Connecticut) including benefits		$ 28,137.72	$ 28,137.72		$ 28,137.72
Secretary		$ 9,313.59	$ 9,313.59		$ 9,313.59
STI-HIV nurses			$ -	$ 16,882.63	$ 16,882.63
Physician for Maternal Care			$ -	$ 13,506.11	$ 13,506.11
Nurse Midwife			$ -	$ 9,004.07	$ 9,004.07
Clinic Nurses Maternal Waiting Home			$ -	$ 7,878.56	$ 7,878.56
SUBTOTAL PERSONNEL	**$ 224,538.66**	**$ 37,451.31**	**$ 261,989.96**	**$ 47,271.37**	**$ 309,261.33**
TRAVEL					
Staff in Haiti (Domestic) Per Diem	$ 9,797.38		$ 9,797.38		$ 9,797.38
Vehicle Operating Costs	$ 4,000.00		$ 4,000.00		$ 4,000.00
International Travel	$ 3,000.00	$ 8,000.00	$ 11,000.00	$ 10,000.00	$ 21,000.00
SUBTOTAL TRAVEL	**$ 16,797.38**	**$ 8,000.00**	**$ 24,797.38**	**$ 10,000.00**	**$ 34,797.38**

	HAITI	CONN OFFICE	TOTAL CSHGP	MATCH	TOTAL
EQUIPMENT					
Solar Power Inverter System	$ 500.00		$ 500.00		$ 500.00
SUBTOTAL EQUIPMENT	**$ 500.00**	**$ -**	**$ 500.00**	**$ -**	**$ 500.00**
SUPPLIES					
Medical Supplies	$ 2,500.00		$ 2,500.00		$ 2,500.00
Office Supplies	$ 750.00		$ 750.00		$ 750.00
SUBTOTAL SUPPLIES	**$ 3,250.00**	**$ -**	**$ 3,250.00**	**$ -**	**$ 3,250.00**
CONTRACTUAL					
Final Evaluation	$ 14,000.00		$ 14,000.00	$ 2,997.55	$ 16,997.55
Medical Advisor/Operations Research	$ 5,100.00		$ 5,100.00	$ 7,000.00	$ 12,100.00
SUBTOTAL CONTRACTUAL	**$ 19,100.00**	**$ -**	**$ 19,100.00**	**$ 9,997.55**	**$ 29,097.55**
OTHER					
Communications	$ 250.00		$ 250.00		$ 250.00
Operational Support					
Maternal Mortality Audits	$ 500.00		$ 500.00		$ 500.00
UCS 2 meetings-partners	$ 1,000.00		$ 1,000.00		$ 1,000.00
Meeting/Conference Rooms			$ -	$ 6,000.00	$ 6,000.00
Training and Supervision			$ -		$ -
Human and Reproductive Rights	$ 200.00		$ 200.00		$ 200.00
Community Mobilization	$ 200.00		$ 200.00		$ 200.00
SUBTOTAL OTHER	**$ 2,150.00**	**$ -**	**$ 2,150.00**	**$ 6,000.00**	**$ 8,150.00**
TOTAL	**$ 266,336.04**	**$ 45,451.31**	**$ 311,787.34**	**$ 73,268.92**	**$ 385,056.26**

KOMBIT PROJECT BUDGET
FIVE YEAR SUMMARY

	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
PERSONNEL						
Haiti	$ 145,650.00	$ 205,485.00	$ 211,649.55	$ 217,998.96	$ 224,538.66	$ 1,005,322.17
Conn Office	$ 34,000.00	$ 34,273.24	$ 35,301.45	$ 36,360.49	$ 37,451.31	$ 177,386.48
Match	$ 42,000.00	$ 43,260.00	$ 44,557.80	$ 45,894.54	$ 47,271.37	$ 222,983.71
Total	**$ 221,650.00**	**$ 283,018.24**	**$ 291,508.80**	**$ 300,253.99**	**$ 309,261.33**	**$ 1,405,692.36**
TRAVEL						
Haiti	$ 15,000.00	$ 23,800.00	$ 17,000.00	$ 18,000.00	$ 16,797.38	$ 90,597.38
Conn Office	$ 11,000.00	$ 10,000.00	$ 10,000.00	$ 10,000.00	$ 8,000.00	$ 49,000.00
Match	$ 45,000.00	$ 35,000.00	$ 35,000.00	$ -	$ 10,000.00	$ 125,000.00
Total	**$ 71,000.00**	**$ 68,800.00**	**$ 62,000.00**	**$ 28,000.00**	**$ 34,797.38**	**$ 264,597.38**
EQUIPMENT						
Haiti	$ 10,050.00	$ 2,000.00	$ 1,814.83	$ 927.88	$ 500.00	$ 15,292.71
Conn Office	$ 7,500.00	$ -	$ -	$ -	$ -	$ 7,500.00
Match	$ 18,000.00	$ 30,235.00	$ -	$ -	$ -	$ 48,235.00
Total	**$ 35,550.00**	**$ 32,235.00**	**$ 1,814.83**	**$ 927.88**	**$ 500.00**	**$ 71,027.71**
SUPPLIES						
Haiti	$ 3,500.00	$ 4,500.00	$ 4,000.00	$ 3,500.00	$ 3,250.00	$ 18,750.00
Conn Office	$ 7,000.00	$ -	$ -	$ -	$ -	$ 7,000.00
Match	$ -	$ -	$ 2,500.00	$ 2,000.00	$ -	$ 4,500.00
Total	**$ 10,500.00**	**$ 4,500.00**	**$ 6,500.00**	**$ 5,500.00**	**$ 3,250.00**	**$ 30,250.00**

	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
SUB CONTRACTOR						
Haiti	$ 34,200.00	$ 13,590.00	$ 13,300.00	$ 4,000.00	$ 19,100.00	$ 84,190.00
Conn Office	$ -	$ -	$ -	$ -	$ -	$ -
Match	$ 12,000.00	$ 13,555.00	$ 7,000.00	$ 7,000.00	$ 9,997.55	$ 49,552.55
Total	**$ 46,200.00**	**$ 27,145.00**	**$ 20,300.00**	**$ 11,000.00**	**$ 29,097.55**	**$ 133,742.55**
OTHER						
Haiti	$ 21,036.00	$ 14,500.00	$ 4,000.00	$ 3,300.00	$ 2,150.00	$ 44,986.00
Conn Office	$ -	$ -	$ -	$ -	$ -	$ -
Match	$ 33,147.49	$ 13,504.87	$ 6,000.00	$ 6,000.00	$ 6,000.00	$ 64,652.36
Total	**$ 54,183.49**	**$ 28,004.87**	**$ 10,000.00**	**$ 9,300.00**	**$ 8,150.00**	**$ 109,638.36**

ANNUAL TOTALS						
Haiti	$ 229,436.00	$ 263,875.00	$ 251,764.38	$ 247,726.84	$ 266,336.04	$ 1,259,138.26
Conn Office	$ 59,500.00	$ 44,273.24	$ 45,301.45	$ 46,360.49	$ 45,451.31	$ 240,886.48
Match	$ 150,147.49	$ 135,554.87	$ 95,057.80	$ 60,894.54	$ 73,268.92	$ 514,923.62
Total	**$ 439,083.49**	**$ 443,703.11**	**$ 392,123.63**	**$ 354,981.87**	**$ 385,056.26**	**$ 2,014,948.36**

D.4. Budget Narrative

1) All **Salary** costs for Haitian employees are based upon the current wages paid to HHF employees and include employer paid taxes and health benefits. All non-Haitian **Salary** costs are based upon comparable salaries in the United States and include employer paid taxes and health benefits. The Medical Director is included for 35% of his/her salary, the Secretary is included for 30%, and the Technical Backstop is included for 25% of his/her salary.

   In the **Salary** line item, the following positions will be provided by HHF: 1 Physician, 1 Nurse Midwife, approximately 6 Nurses involved with the STI/HIV program, and approximately 3 Nurses with the Maternal Waiting Home program.

   The **Salary** budget also includes a 3% merit increase for each year, vacation time, and a 13th month of salary as required by Haitian Law.

2) Under the **Travel** line item, we are planning 4 trips a year for the Technical Backstop to travel from US to Haiti and 2 trips a year for the Medical Advisor to travel from US to Haiti. Because this is the first child survival grant for HHF, and as it is the only child survival grant HHF currently implements, project staff have determined that to maintain the technical excellence of the program, and to ensure adequate flow of information to and from the project, four trips per year are necessary. These consultants willl provide training to KOMBIT staff as part of their consultations. We are planning two trips from Haiti to Washington DC for the Program Director and Medical Director to attend meetings. Estimated costs for the fuel, repair, and maintenance of the KOMBIT vehicles are included and based upon our 15 years of past experience of using vehicles in Haiti. Additionally, Per Diem expenses are being estimated based upon the current expenses incurred by similar programs run by HHF.

   HHF is also budgeting for the purchase of 3 vehicles and 2 motorcycles over the 5 year project which will be paid entirely by HHF. The Vehicle costs are based upon our experience of the expenses incurred for the purchase and shipment of 4-Wheel Drive vehicles to Haiti, while the motorcycle costs are based upon the current prices of motorcycles in Haiti. A portion of the International Travel Expenses will also be paid for by HHF in the final year of the contract in anticipation of an increased attendance at meetings and seminars where personnel will share information concerning the nearly completed KOMBIT project.

3) The **Medical Equipment** line item includes the purchase of five Dopplers (Fetal Heart Rate Monitors) in Year 1. Office equipment is being budgeted based upon the purchase of chairs, fans, desks, printers, a copy machine, meeting table, cabinets, etc. and are based upon the current market prices of these items in Haiti.HHF's contribution throughout the life of the project will be the provision of 3 Desktop Computers, 5 OBGYN exam tables, a portable sonogram machine, and additional Dopplers. HHF will also contribute a television, VCR, and a small portable generator for rural educational purposes and assist with expenses associated with the Solar Powered Inverter System. Scales and megaphones will also be paid for by HHF.

4) The **Supplies** line item includes two kinds of supplies: Medical Supplies and Office and Educational Supplies. Medical Supplies include blood pressure monitors, stethoscope, specula, gloves, intravenous solution, catheters, and various other educational and miscellaneous medical supplies. Office Supplies include paper, pens, staplers, ink cartridges, and various other office supplies for monthly meetings and the day-to-day operations of the organization. The budgeted amount of these supplies is based upon past budgets and the current prices of these items in Haiti, and HHF will assist with the purchasing of Medical Supplies in years 3 and 4.

5) The **Contractual** line item includes the following personnel for required assessments and evaluations: KPC Consultant, DIP consultant, and HBLSS Consultant in Year 1. Consultants for both mid-term and final evaluations are included in Year 3 and Year 5 respectively. In addition, the grant includes costs for Dr. Frank Anderson, the Medical Advisor, for the Maternal Mortality Audit and all operations research activities. These costs reflect a very conservative estimate of the expenses related to these required activities, and HHF will assist with the costs of the HBLSS consultant in both Years 1 and 2 and with the Medical Advisor through the life of the project.

6) **Other** costs include the following items: Communications, Training and Supervision, and Operational Support. Communications includes the annual cost of the satellite internet service for each year, satellite telephone service, and local telephone service and maintenance. These costs are based upon our current expenses for these items.

   Operational Support includes support for the MSPP UCS 2 meetings with health partners and 10 maternal mortality audits per year. Costs for the MSPP UCS 2 meetings include meeting supplies and refreshments. Maternal mortality audit expenses include per diem and refreshments.

   The rental costs for meetings and conference rooms will be provided by HHF.

   Training and Supervision will occur throughout the life of the program and will be replicated towards the end of the program as we expand into other areas. The Training budget includes the cost of the facilitators, per diem for the participants, training supplies, and follow-up supervision. Periodic continuing education is also included under this line item. Based upon HHF's 15 years of training experience, specific work plans will be developed at the beginning of KOMBIT for the following programs: HBLSS, Human and Reproductive Rights, Child Spacing and Breastfeeding Education, LQAS, Community Mobilization, Neonatal MCI, Maternal Mortality Audit updates, BCC workshops for the creation of new maternal newborn messages, BCC interpersonal communication skills workshops, post-partum care at the level of the institution, post-partum care at the level of the home, and perinatal data management using the PAHO software application.

   HHF will assist with expenses for the HBLSS Training and Community Mobilization in Year 1.

E. DETAILED IMPLEMENTATION PLAN

Description of PVO

General Purpose and Mission Statement: Founded in 1986, HHF is a USAID-registered, 501(c)(3) private voluntary organization (PVO) based in Connecticut. HHF's mission is to "improve the health and well being of the poor, the sick, and the infirm of rural Haiti…with a focus on women and children". HHF has operationalized its mission through an extensive community-oriented primary care system, including community health workers (CHW), health posts, an outpatient clinic, a satellite clinic, a maternal waiting home (MWH), and a nutritional rehabilitation center (NRC). Health care is supplemented by an array of community development programs; humanitarian relief responses to emergencies; and activities to facilitate the exchange of knowledge and expertise among Haitians and the international community of health and development professionals. KOMBIT (K)Communities Organized for Mothers and Babies with Innovation and Technology)) complements HHF's mission by expanding its outreach through a new sector of public health expertise and by facilitating exchange of knowledge and collaboration between public and voluntary Haitian service providers for maternal and newborn health (MNH) and child survival activities. The HHF was authorized to work in Haiti in 1988 (See Attachment A in Appendix).

Annual Budget: HHF has an annual budget of over US $1,250,000, financed by individual and institutional sources including corporations, private foundations, service clubs, and USAID-Haiti. HHF receives substantial in-kind donations of equipment, supplies, and volunteer expertise. HHF's clinic in Jeremie was built and equipped for US $2.7 million with private and in-kind contributions on a donated parcel of land. HHF's most recent facilities in Jeremie are a maternal waiting home (MWH) which was the first in Haiti, a therapeutic feeding and Nutrition Rehabilitation Center, and a new Clinic/Community Center, all constructed and equipped through private donations.

Sectors of Involvement: Over the past 16 years, HHF has moved from an initial health focus to a more comprehensive and, ultimately more effective, multi-sectoral approach. Programs in primary health care outreach provide basic services to a population of over 200,000. HHF provides basic perinatal care in eight rural locations serving a total of 1,000 women each year. HHF operates a modern outpatient clinic in Jeremie with full general medical and dental services, ophthalmology, EKG, sonography, pharmacy, and laboratory. The Clinic provides prenatal services to approximately 2,500 women annually.

The MWH provides prenatal monitoring, nutrition, health education and medical services, in a residential setting, for at-risk pregnant women. The NRC provides food for children and nutrition education for caregivers. Other activities include a family sponsorship program that provides medical and other basic needs to over 500 indigent families, and education support for over 1,450 students and medical and other basic needs to over 500 indigent families. Community development includes construction of latrines, houses, road, and other basic infrastructure improvements as well as animal husbandry and agricultural projects. HHF provides clinical practica to the Grand'Anse's only school of nursing.

HHF works with a number of other organizations in the area and participates in the development and implementation of health and education projects within the entire region.

- Hospital Saint Antoine is the only referral hospital in the region and houses the PEPFAR Counseling, Testing and Treatment Center for HIV Grand Anse (February 2005. HHF coordinates

its HIV clinical, preventive and referral HIV services with the services provided by Hospital Saint Antoine.
- CARE International new programs on insecticide treated bednets and support of people living with AIDS. HHF is providing logistical support for this project.
- Catholic Relief Services, general relief and maternal child nutrition support for the Grand Anse
- Missionaries of Charity hospice facility for families
- Medicin du Monde support Department of Grand Anse health initiatives
- FOSREF provides youth reproductive health services
- Gebeau Methodist programs (microcredit, education, FP, rural development)
- JHPIEGO training in Life Saving Skills (LSS)

Methods of Operation: HHF has made empowerment of local villagers its primary development strategy. HHF has achieved active participation of individuals and communities in its project activities by encouraging and supporting the establishment of over 100 active community-based organizations (CBOs), such as Village Health Committees, Mothers' and Fathers' Clubs, and Youth Groups in its catchment area. CBOs provide village members and their peers with information on family health and community development. This knowledge is used to effectively enhance communication, transfer skills, promote the adoption of new health practices, teach prevention (Sexually transmitted infections (STI), human immunodeficiency virus (HIV), diarrhea, tuberculosis (TB)) and support community participation in the provision of health services. Citizen participation in these volunteer groups has resulted in community ownership of public health interventions as well as the empowerment that comes with membership in democratically constituted organizations.

HHF sponsors an annual meeting of 600 community leaders to discuss progress, share new health information and target activities for the coming year. The village health committees have enthusiastic leaders and are well-organized and recognized by the community. The committees, which include respected indigenous health providers, serve as valuable resources for resident CHWs. These committees have played an essential role in the adoption of preventive interventions, which emphasize person-to-person modeling of positive health behavior to support change among all generations. HHF's successful coverage results have been confirmed through an external evaluation by USAID in 1998.

HHF is committed to community-based education. CBOs and CHWs use a variety of culturally appropriate, non-formal techniques to communicate with the mostly non-literate community members. "Fetes", role-playing, and songs are examples of ways CBOs promote health messages, help raise participants' awareness of issues, and initiate new social norms which support positive behavioral changes. HHF has used an excellent guide for health education developed by CARE (Cooperative for Assistance and Relief Everywhere) which contains approach guidelines and key messages on 15 health topics, with songs and follow up questions. HHF currently uses a 12-lesson program designed by Management Sciences for Health (MSH) in cooperation with CARE, UNICEF (United Nation's Children's Education Fund) and other organizations in Haiti.

HHF has trained over 200 traditional birth attendants (TBAs) in its program area since 1990. This training is recognized by the MSSP. HHF updates a registry of these men and women monthly, provides continuing education and supplies them with simple sterile birthing kits. The experience of HHF in long-term support and supervision of TBAs will be expanded to the entire KOMBIT project area.

HHF is committed to data-based decision-making. In 1988, HHF developed a health information system (HIS) for program monitoring and evaluation. PHACT (Public Health Active Census Tracking) provides a complete, interactive database which is updated by information collected by village CHWs. To make computer-generated reports understandable for persons with little or no literacy, HHF presents the results in pie charts which are called *kassav*, the flatbread staple of the Haitian diet. The concept that it is better to have a whole *kassav* than just a small piece is one that is easily understood by villagers. By providing feedback to nursing staff, CHWs and the populations they serve, everyone participates in program evaluation and planning and all are motivated to achieve better outcomes. PHACT was designed to be used by other programs in developing countries. The system, illustrated with practical HHF field examples, was presented as an invited paper presented at The CORE (Child Survival Collaborations and Resources) Group's 2000 Annual Spring Membership Meeting in Millwood, VA.

HHF's Program Experience: HHF has successfully designed, implemented, and monitored community-level child survival programs since 1987. The main program areas have been in child survival, primary prevention, basic prenatal care, breast feeding (BF), and institutional integrated management of childhood illnesses (IMCI). HHF has documented success in the following areas:

- Reduced pediatric pneumonia-specific death rate of Acute Lower Respiratory Infection (ALRI) program at the community level;
- High rates of exclusive BF;
- STI and HIV prevention, detection, diagnosis and treatment;
- High rates of vitamin A supplementation;
- Increased use of oral rehydration solution (ORS);
- High levels of Tetanus toxoid vaccination for young and pregnant women;
- Significant community participation and behavior change communication (BCC);
- Primary health care program-based, using PHACT;
- Information dissemination through presentations, consultations and onsite teaching of managers from other organizations.
- Perinatal nutrition program and nutrition rehabilitation program
- USAID Mission funded child survival program in 4 counties in western GA (1987-present)
- Prenatal syphilis diagnosis and treatment program(1999- present Hilton Foundation)
- National field trainers for community ARI and family life methods of child spacing
-

HHF's Operations, Current Agreements, and Working Relationships: HHF has formed important working relationships with many organizations in Haiti and the US. HHF has taken the lead with the MSPP (Ministry of Public Health and Population in Haiti) in the implementation of the new policy of decentralization called Unite Communale Sante (UCS) (County Health Unit). The Ministry of Health (MOH) has combined the 12 counties of the Grand'Anse Department into 4 UCS. HHF works in UCS II (the Kombit Project area) which includes the counties of Jeremie, Roseaux, Bonbon, Abricots, and UCS I, which includes the counties of Moron, Chambellan and Anse D'Haunault. In addition, HHF has participated in all Departmental planning meetings since 1987, in national vaccine campaigns since 1989, and in urban health education fairs since 1992, thus developing excellent working contacts with all the public and private service providers active in KOMBIT's catchment area. There is one hospital in the west Grand'Anse, St. Antoine Hospital, to which HHF provides support and capacity building. HHF's medical director has served on the hospital's Advisory Board since 1987. HHF has increased the hospital's capacity to provide maternal and child health (MCH) services by facilitating training and equipment procurement.

HHF has collaborated with the Sisters of the Good Shepherd (SGS) since 1987. The SGS have been working in health and development at three sites in Haiti since 1975. HHF has worked with SGS clinics, providing scheduled staff support and patient education. There is a well-established system of referral from the clinics to the HHF MWH in Jeremie town. As partners, the SGS have provided supervision for HHF CHWs in their clinics, and also serve as referral sites for CHWs and TBAs as the next level of care for medical emergencies.

Summary of Baseline and Other Assessments

During the proposal preparation process, a comprehensive situational analysis had been conducted to direct program priorities. The high rates of maternal mortality and lack of access to maternal care led HHF to expand its mission to include maternal/neonatal care programs and to expand breast feeding and child spacing interventions to the surrounding health areas. Year one activities with program partners culminated in the KPC survey and Facilities Assessment using CSTS+ tools, HBLSS tools from ACNM and other sources.

Baseline data come from 5 major data sources.

1. Facility assessment
2. KPC survey
3. Special surveys
4. Longitudinal study of pregnancy complications
5. Reproductive age mortality survey and verbal autopsy.

The full methodology and results of these strategies are listed below. During December, 2004, KOMBIT launched two surveys. One survey assessed the physical state, resources, range of services and activity levels of eight health facilities that are managed by the three KOMBIT Partners, UCS 2, Sisters of the Good Shepherd and HHF. The other survey assessed prevalence of health-related knowledge frequency of health-related behaviors and coverage rates for selected health services.

The results demonstrate clearly that in the 3 areas of intervention, knowledge, access and quality need to be improved. The results of the KPC survey demonstrate that knowledge of danger signs and care of the newborn are lacking, and that child spacing and breastfeeding interventions are needed. Results from the cohort study demonstrate a high rate of reported pregnancy complications among women in the most rural areas. In addition, the large number of maternal deaths, as determined by the maternal mortality review process, highlights the access and quality issues in the area.

The 3 main program priorities for KOMBIT are Maternal/Newborn care, child spacing and breastfeeding. These priorities were developed from the needs assessment developed for the proposal. The findings from these baseline data collection activities have confirmed the need to develop maternal care capacity in HHF and partners. Facility surveys have confirmed the need to work with project partners to develop a method by which monthly facility reports will serve as a basis to improve areas that are essential for health.

METHODOLOGY

I. Facilities Assessment

The 15-page survey instrument collected information on the condition of buildings, sanitation, furniture, equipment, services, supplies and scheduled activities. The questionnaire also utilized MSPP reports for the previous year.

Representatives from each of KOMBIT's Partners, working in teams of two or three, visited each facility, interviewed the persons responsible for operating the facility and completed the questionnaire. One team-member copied the quantitative information, reported during the previous year, from the MSPP electronic files of monthly reports from each health facility.

Questionnaire results were tabulated in a manner that permitted comparison of facilities by all variables, allowing the partners to realistically assess resources, capacity and needs. It also makes this information more visible to persons responsible for facility management, maintenance and supplies.

II. KPC Survey

KOMBIT staff interviewed 247 mothers of 1-24 month old children in UCS 2, using a 22-page questionnaire. In order to assure geographic specificity of information, the KPC survey used lot quality assurance sampling (LQAS).

Sampling:
The smallest administrative area for which population estimates are available is the Communal District. UCS 2 is made up of 18 communal districts. Their population estimates range in size from 4,796 to 11,975 persons. KOMBIT paired the smaller, geographically contiguous lots to make a total of 13 lots ranging in size from 8,900 to 15,617 persons. The MSPP supplied a list of villages for each lot. From each of those lists, KOMBIT drew, in a random manner, the names of 19 villages.

KOMBIT surveyors engaged local guides to lead them to each village identified in each LOT. Surveyors then selected, in a random manner, the house in which to begin his/her search for a woman to interview. If no qualified interviewee was found in the first house, the surveyor moved from house to house in a systematic manner until he/she encountered a mother of a 0 – 24 month old child who was willing to answer the questions. The surveyors interviewed only one woman per village.

Data Processing:
The questionnaires were field checked due to the maturity and experience of the surveyors. All data in each questionnaire were double entered into the Statistical Package for the Social Sciences (SPSS) V. 12, data errors corrected, recoded, tabulated and analyzed.

Data analysis:
Data analysis has been completed for the general indicators and used for establishing UCS 2 baseline indicators and setting target objectives. LQAS analysis is underway and will be available for the final DIP.

III. Special Surveys. Special surveys were conducted to explore baseline values for program indicators that were not part of the KPC.

IV. Longitudinal Study of pregnancy complications

The longitudinal study of pregnancy complications is being conducted in conjunction with the University of Michigan. This study has 3 specific aims. Every woman who self identifies to the HHF health worker in her village is offered enrollment. Participants are followed at entry, and seen again at 26-28 weeks, 34-36 weeks, within 72 hours of delivery and again at 10-14 days postpartum. Thus far approximately 400 women have been enrolled, and descriptive data from the first 183 participants is described below.

V. KPC General Information

There were no refusals to participate in the KPC. The 247 women in the KPC had an average age of 28.8 (range 16-49). Their educational levels were none (32%), grades 1-6 (47%) and grades 7 and higher (22%). Almost half (47%) worked outside the home, primarily in farming and commerce. Most women lived with the father of the child (66%). The children ranged in age between 2 days and 24 months (average age 9.9 months); 54% of the children were male. In terms of FP, 48% have only one child, 82% do not want another child (at least soon). With only 24% using contraception, there is a high unmet need for FP.

KOMBIT SUMMARY OF BASELINE FINDINGS
13 Lots N=247

KOMBIT Objectives (Percentage of women refers to percentage of women with a child less than 2 unless otherwise specified)	Baseline in UCS2	Baseline in HHF only regions	Method of HHF Data Collection	Target for End of Program
Maternal/Newborn				
Percentage of women with 4 or more prenatal visits	26%	53%	2004 HHF report	50%
Percentage of women who reported that they had received prenatal breastfeeding information and child spacing info	Breastfeeding 56% Child Spacing 50%	100% counseled on Breastfeeding 33% completed 6 months exclusive BF (CS) at Center of Hope	HHF 2004 program statistics	85%
Percentage of women who were immunized to tetanus (2+ doses of tetanus toxoid)	32%	66% HHF non pregnant; 88% pregnant women	PHACT data, 2004	55%
Percent of women who can identify at least 2 danger signs of pregnancy	25%	Data not analyzed yet	2001 census study	50%
Percent of women who can identify at least 2 danger signs of post partum	9%	Data not analyzed yet	2001 census study	40%
Percent of women who can identify at least 2 newborn danger signs	20%	Data not analyzed yet	2001 census study	50%
Percent of villages with written and posted emergency OB and newborn transportation plan	UNK	Not part of HHF current activities	NA	20%
Percent of women adopting a pregnancy delivery/ post partum plan	UNK	45%	% of women who had a signed birth plan stapled to home based woman's card at a series of field and clinic prenatal consultations	40%

KOMBIT Objectives (Percentage of women refers to percentage of women with a child less than 2 unless otherwise specified)	Baseline in UCS2	Baseline in HHF only regions	Method of HHF Data Collection	Target for End of Program
Percent of women who received birth preparedness counseling	49%	45% Same as above	% same method as above used for counseling	75%
Percent of maternity service sites with satellite phones, communication to referral centers for OB emergencies	12%			60%
Percent of women who deliver with a skilled attendant	10%	9% medical	Center of Hope 2004 2004 HHF program statistics (rural)	15%
Percent of patients divided into causes of referral or diagnosis who move to the next level of care	UNK	Not tracked	Performed, but not documented	50%
Percent of completed referrals to the next level of care	UNK	Not documented	NA	50%
Percentage of neonates examined by health personnel within 72 hours of birth	8%	30% infants weighed by HA within 72 hours in rural areas 25% by a nurse	1997-2004 HHF Registration study (HA) HHF 2004 statistics (nurses)	30%
Percentage of post partum women examined by health personnel within 72 hrs of birth	9%	25%	HHF 2004 health statistics	30%
Percentage of women who said they would go to a hospital or health center if they had a danger sign of pregnancy	68%	Not tracked	NA	90%
Percentage of mothers who could describe at least two methods of stopping a post partum hemorrhage	7%	Not tracked	NA	35%
Percentage of women who can name 2 newborn care skills	1%	Not tracked	NA	30%

KOMBIT Objectives (Percentage of women refers to percentage of women with a child less than 2 unless otherwise specified)	Baseline in UCS2	Baseline in HHF only regions	Method of HHF Data Collection	Target for End of Program
BREASTFEEDING				
Percentage of mothers who BF before placenta expulsion	UNK	11%	Small 1 week sample of prenatal and post partum rural and clinic sites March 2005	20%
Percentage of mothers who BF in the first hour of birth	69%	Not tracked	Not tracked	85%
Percentage of mothers with a child 6mo or less who had nothing but breast milk to eat in the last 24 hours	60%	33% breast feed exclusively for 6 months	HHF exclusive breastfeeding- LAM program statistics 2004	85%
CHILD SPACING				
Percentage of mothers who complete LAM	UNK completion 4.5% using currently	22%	HHF program statistics-2004	15%
Percentage of women using NFP methods (CMM)	4%	450 women are followed monthly in the CMM	2004 program statistics-manual	10%
Percentage of women using any method of CS	24%	9%	Computerized HIS for 2004	35%

Health Facility Assessment Survey Results

As discussed in the methodology section, the facility assessment sought to determine the degree to which the health facilities in the KOMBIT region stocked medications and substances that were considered important for the delivery of obstetric care. The results of this assessment are listed in the chart below.

The results of the facility assessment in all 8 KOMBIT facilities are shown in the table below.

HEALTH FACILITIES in the KOMBIT Project Area

ID number	Name	Locality	Type	Managed by
1	Dispensary Saint Pierre	Previlé	Mixed	Sisters of the Good Sheperd/MSPP *Soeurs du Bon Pasteur*
2	Dispensary Bon Samaritain	Roseaux	Mixed	Sisters of the Good Sheperd/MSPP
3	Dispensary Sainte Therese	Marfranc	Government	Ministry of Public Health *Ministère de la Santé Public and Population*
4	Dispensary N.D. de la Perpétuel Secours	Latibolière	Mix	Daughters of Queen Mary Immaculata *Les Filles de Marie Reine Immaculée*
5	Clinic Saint Joseph	Dayère	Private	Haitian Health Foundation
6	Dispensary Sainte Thérèse de l'Enfant Jesus	Carrefour Sano	Mixed	Sisters of the Good Sheperd/MSPP *Soeurs du Bon Pasteur*
7	Clinic Sant Espwa	Jérémie	Private	Haitian Health Foundation
8	Dispensary SILOÉ de Léon	Léon	Mixed	Léon Catholic Church/MSPP *Église Catholique, Léon*

Maternal Care components present in KOMBIT project area facilities

DISPENSARY ID	1	2	3	4	5	6	7	8
ASSESSMENT YEAR	05	05	05	05	05	05	05	05
Medication and Substance								
Women health cards	yes	no	yes	yes	yes	yes	yes	yes
Prenatal consultation room	yes	yes	no	no	yes	yes	yes	no
Anti-tetanus vaccine	yes	yes	yes	yes	yes	yes	yes	yes
Prenatal registry	yes	no	yes	yes	yes	yes	yes	no
Prenatal file	yes	yes	yes	yes	yes	yes	yes	yes
Postnatal file	yes	yes	yes	no	yes	yes	yes	yes
Hospital reference card	yes	yes	no	no	yes	yes	yes	yes
Amoxicilline	yes	yes	yes	yes	yes	yes	yes	yes
Antiacid	yes	yes	yes	no	yes	yes	yes	yes
Chloroquine	yes	yes	yes	yes	yes	yes	yes	yes
Cotrimoxazole - oral	yes	no	yes	yes	yes	yes	yes	yes
Clotrimazole vaginal	yes	no	yes	no	no	no	yes	yes
Dibenzyl Pennicilline 2.500000u.	yes	yes	yes	no	yes	yes	yes	no
Metronidazole	yes	yes	yes	yes	yes	yes	yes	yes
Albendazole	yes	yes	yes	yes	yes	yes	yes	yes
Medication anti-eclampsia	yes	no	yes	no	yes	yes	yes	no
Magnesium Sulfate	no	no	yes	no	yes	no	no	no
Ergometrine vial injectable	no	no	yes	no	yes	yes	yes	no
Pitocin vial injectable	no	no	yes	no	yes	no	yes	no
Tetracycline ophth.	yes	yes	yes	yes	yes	yes	yes	yes
Iron/folic acid	yes	yes	yes	no	yes	yes	yes	yes
Prenatal Vitamines	yes	yes	yes	yes	yes	yes	yes	no
Oral Salts Rehydratation	yes	yes	yes	yes	yes	yes	yes	yes
Stethoscope obstetrical	yes	no	no	yes	yes	yes	yes	no
Speculum vaginal	yes	yes	yes	no	no	yes	yes	no
Pressure bandages	yes	no	yes	no	yes	no	yes	yes
Sterile water (bottled)	yes	no	yes	no	yes	yes	yes	no
Exam table	yes	no	yes	yes	yes	yes	yes	yes
Scale for adult	yes	yes	yes	yes	yes	yes	yes	yes
Measuring tape	yes	yes	yes	yes	yes	yes	yes	yes
Blood pressure equipment	yes	yes	yes	yes	yes	yes	yes	yes
Height gauge	no	yes	yes	no	no	no	yes	no

These results were discussed with partners and lead to a prioritization exercise more fully described in the Monitoring and evaluation section.

Longitudinal Study of Pregnancy Complications Preliminary Results

The following information is based on preliminary analysis of 183 women who have been enrolled in the longitudinal study of pregnancy complications currently being carried out with private funds. Ongoing analysis of these data will provide more comprehensive information about the course of pregnancy in the area.

Demographics

- Age range: 15 to 47, mean 27.53
- Marital status: 10.4% never married, 26.9% married, 61.5% free union, 1.1% widowed
- Education: 35.5% no education, 47.0% partial primary, 8.7% primary school, 8.7% secondary school
- Number living in same house: 2 to 18, mean 6.41
- Floor type: 16.5% cement, 83.5% mud
- Roof type: 59% iron sheets, 0.5% cement, 40.4% thatched
- 79.2% do not have a latrine at the house
- 82.5% used an uncapped spring for drinking water

Health Access

- 24% had ever been to the hospital
- Of the 39 people who answered, 59% got to the hospital by foot, 10.3% by bus, 15.4% by tap tap, 1 person by stretcher.
- Distance to hospital: 0 to 11 hours, mean 4.12

Family Planning

- 18.2% had ever used family planning
- 58.8% of those who ever used family planning were satisfied
- of those who never used contraceptives, 50.7% said it was because “poko” (it is not yet time), 7.4% because it will make them sick,

Birth History

- Gravidity: 0 to 14, mean 4.83
- Parity: 0 to 11, mean 3.93
- 18.1% reported an abortion or miscarriage
- 2 abortions were intentional

Current Pregnancy

5.8% went to an herbalist for help in getting pregnant
3 (1.6%) people are using herbs currently

Prenatal

- 55% currently receiving prenatal care
- 17.5% at dispensary, 12.6% at HHF health post, 20.2% at HHF clinic Jeremie;
- 48.1% with the nurse

41.6% reported some type of pregnancy complications.
Complications

- fever 7.1%
- vaginal bleeding 1.6%
- headaches 29.8%
- swollen face 0.5%
- swollen hand 0%
- abdominal pain 22.7%
- perdition 2.2%
- belly pains 24.3%
- seizures 5%
- convulsions 1.7%
- dizzy spells 8.3%

6 women had been recommended to use the MWH; 1 had used MWH.

Clinical

- Pulse (N=177): 30 to 115, mean 70.91
- Weeks pregnant (N=13) 8 to 42, mean 18.92
- Hemoglobin (N=10) 8.9 to 14.40, mean 11.22

Results of 31 women who have delivered

16.1% (5) had labor problems which were:

- prolonged labor 12.9% (4)
- excessive bleeding 19.4% (6)
- pain (3)

19.4% (6) used herbs during labor
6.5% (2) drank ORS during labor

93.5% (29) delivered at home

9.7% (3) had delivery complications (all excessive bleeding)
1 still birth
1 mother died

5 had post partum problems (16.1%):

- mostly bleeding
- 3 (9.7%) tears
- 9 (29%) tears to vagina (29%)

22 (71%) used herbs postpartum (mostly for reasons having to do with blood: replacing it, making it stronger, get rid of it, etc.)

Pulse ranged from 38 to 93; 4 women had a pulse below 60.

Temperatures ranged from 96.8 to 99.4

Partners Assessment Exercise

An exercise was carried out with the partners in the project to:

a. Compare baseline findings with the current country context and describe any differences.
b. Discuss the constraints to achieving program objectives based upon the local or country context.
c. Give the most up-to-date coverage estimates in the service area relevant to each intervention.
d. Provide the most recent disease surveillance data available for the program area, and discuss the quality of the data, including the completeness of reporting.
e. Discuss MOH policies, strategies and/or case management policies or current services for each intervention.

Partners discussed each of the above points in relation to the original 20 objectives proposed. The following table summarizes the results:

Objectives/Expected Results	Current National Policy/Norm	Baseline Data	National Strategy	Regional Strategy	Current Monitoring Approach	Suggested Monitoring Approach	Constraints to Meeting Objective
Maternal/Newborn							
Increase to 50% of women who can identify at least 2 danger signs of pregnancy, 40% post partum and 50% newborn complications	Educate pregnant women about the complications and danger signs of pregnancy during prenatal clinics. Emphasize where to seek skilled care when complications occur. This education must be simple and include 10 minutes of exposition, followed by 5 minutes of discussion. It can be reinforced by the use of booklets and posters, community meetings and, in homes, by radio if that means is available.[2]	KPC found 25% of women with a child under age 2 could name two pregnancy danger signs, post-partum (9%) and newborn (18%)	Include danger signs education in prenatal clinics. (See first answer, above, and Manual de Normes, pages 22 and23.	Same as national strategy.	Health facilities required to report all their IEC activities in monthly reports to MSPP. Feedback is rarely provided so it is unclear if this activity is monitored.	KOMBIT will monitor training of personnel (how to teach danger signs to women of reproductive age). Training reports will document demonstrated competence in teaching danger signs. Facilities will monitor the community coverage rates by the proportion of women who, during household survey, are able to recite the danger signs and the appropriate action to take if they observe them.	Health facilities personnel are inadequately trained and achievement of the objective will be delayed while the training is accomplished. The health facilities have too few financial resources for community mobilization activities and lack audio-visual materials, educational supports. Some facilities are inaccessible during the rainy season

[2] Translated from "Manuel de Normes de Travail en Planification Familiale et en Soins Maternels" Direction de Promotion et de la Santé Publique et de la population [DPPS] Ministère de la Santé Publique et de la Population [MSPP], Republique d'Haiti (Working Guidelines for Family Planning and Maternal Care)

Objectives/Expected Results	Current National Policy/Norm	Baseline Data	National Strategy	Regional Strategy	Current Monitoring Approach	Suggested Monitoring Approach	Constraints to Meeting Objective
Increase to 20% of villages with written and posted emergency OB and newborn transportation plan	No national policy or norm addresses this objective	No baseline data	Educating people to plan for obstetrical emergencies is a recent concept in Haiti, so no national strategy developed.	No regional strategy addresses this objective	None	1. Register villages that have written and posted their plan. 2. Verbal autopsies of maternal deaths contain questions that identify delays due to lack, or malfunction, of village evacuation plan.	Facilities' lack financial resources to organize community meetings required to accomplish this objective, especially in remote areas most in need of plans.
Increase to 40% of women adopting a pregnancy delivery/ post partum plan	The national policy is to ask pregnant women who attend prenatal care to prepare for delivery in the most hygienic circumstances possible. If a woman decides on home delivery, she should have a trained midwife.*[3]	This objective is a new concept for the region, baseline data are limited. KOMBIT's KPC survey shows that 57% of mothers' made at least one prenatal visit, so these pregnant women are most accessible for birth preparedness education.	The national strategy is to teach mothers and matrones to hygienically prepare the delivery site and layette, or deliver in a Hospital or maternity center. *[4]	Same as national strategy.	None	Prenatal clinics will record pregnant womens' commitment to pregnancy-delivery- postpartum plan during prenatal visits. Health Agent pregnancy reports will include whether or not a plan was made and followed.	Many women do not attend prenatal consultations and therefore are not accessible to personnel who could teach them about pregnancy planning. Women with 1-2 prenatal visits may not receive this education.

[3] * Manuel de Normes de travail en Planification Familiale en Soins Maternels (Working Guidelines for Family Planning and Maternal Care) page 174 #4-5
[3] Ibid page 174 #4-5

Objectives/Expected Results	Current National Policy/Norm	Baseline Date	National Strategy	Regional Strategy	Current Monitoring Approach	Suggested Monitoring Approach	Constraints to Meeting Objective
Increase to 60% of maternity service sites with satellite phones, communication to referral centers for OB emergencies	To create a functional radio-communication system in several UCSs.	1/8 (12%) KOMBIT dispensaries are equipped with radio communication to the KOMBIT office in Jeremie	To identify available resources for a communication network .	Same as national strategy.	No monitoring is currently in place for this objective	KOMBIT monitoring schedule will include equipment purchase, installation, training of personnel, satellite phone system maintenance. KOMBIT's Grant Administrator will report progress semi-annually.	High cost of purchase and maintenance of satellite phones. Calling costs must be paid in US dollars through one of the partners. Sustainable payment options must be identified during the grant.
Increase to 15% of women who deliver with a trained attendant	All deliveries should be conducted by qualified midwives. Unattended deliveries should be discouraged. Ibid. #197	KPC found 10% of deliveries had skilled attendant. 32% of deliveries by matrons were conducted without benefit of a sterile kit. According to DHS2000, 89.7% of Haitian infants were born at home. KOMBIT KPC was similar, 87%.	Recognizes the Haitian custom of delivering at home will not change quickly. Meanwhile women should be urged to choose a trained midwife for delivery. *	Reinforce competence of prenatal care and birthing personnel.	Monthly dispensary reports to MSPP document the number and type of birth attendants followed and reporting, and whether they are supervised, paid, and equipped by the dispensary.	Require further training and supervision of matrons with monthly reporting of matron-training activities and matron prenatal and delivery activities	In UCS 2 only Saint Anthony Hospital and two small maternity centers meet MSPP personnel and delivery standards. Delivery costs at Saint Anthony Hospital are very high for rural Haitians and present a barrier that delays referrals.

Objectives/Expected Results	Current National Policy/Norm	Baseline Data	National Strategy	Regional Strategy	Current Monitoring Approach	Suggested Monitoring Approach	Constraints to Meeting Objective
Increase to 30 % of neonates examined by a CHW within 72 hours of birth	All maternity service providers in the community, midwives, health agents, volunteer collaborators and traditional healers, should always motivate women who have recently given birth to attend post-natal consultations [5]	KPC found that only 15% of women interviewed had attended a post-natal consultation with a skilled health provider within 7 days after their most recent delivery.	To ask maternity service providers in the community, (midwives, health agents, volunteer collaborators and traditional healers) to "motivate" women to attend post-partum consultation soon after delivery. [6]	None.	Health facilities' monthly MSPP reports on post-natal visits.	HAs will register all pregnancies/ report outcomes, including post-natal visit. In areas without HAs, community volunteers will be recruited. Monthly reports will provide information on number of deliveries, post-partum health agent visits, and post-partum dispensary/health center visits.	Consultation for newborns is a new idea for the population, so there is a need for education. Consultation is not available in some facilities due to lack of staff training. Some areas of UCS 2 don't have HAs, especially in areas distant from health facilities.
Increase to 30% of post partum women examined by a CHW or skilled health provider within 72 hrs	All service providers in the community, midwives, health agents, volunteer collaborators and traditional healers, should motivate all post-partum women to attend post natal consultations [7]	KPC found that 20% of women had a post-natal visit within 72 hours of their last delivery. The Facilities' Assessment found 30% of women who attended prenatal clinics also had a post-natal visit	Post-natal visits should be provided by all health facilities and reported monthly. All maternity service providers in the community are asked to motivate recently delivered women to attend a post-natal visit at the nearest health facility.	Support national strategy.	Health facilities' report, monthly on number of women attending post-natal visits. This can be compared to those attending first prenatal visits to calculate the follow-up ratio.	At the community level, health agents and volunteers will report pregnancies and outcomes, including post-natal visits. At the health facility level annual numbers of post-natal visits will be compared to annual numbers of first prenatal visits and their ratio will be calculated.	Post-natal consultation is a new idea for the population. Many post-partum women live at a great distance from their nearest health facility.

[5] opcit. Manuel de Normes p.225
[6] ibid p.225
[7] ibid p.225

Objectives/Expected Results	Current National Policy/Norm	Baseline Data	National Strategy	Regional Strategy	Current Monitoring Approach	Suggested Monitoring Approach	Constraints to Meeting Objective
BREASTFEEDING							
Increase to 20% of mothers who BF before placenta expulsion	To put the infant immediately to the breast by placing the baby face down on the mother'ss chest. Ibid p.214 "Immediate care of newborns to be done in the delivery room"	KPC found that 69% of infants were breastfed within the first hour after birth. 11% of HHF mothers BF before placenta expulsion.	Include recommendation for immediately putting baby to breast in training manual used for all personnel who provide maternity services.	Support the national strategy.	None.	Monthly reports by prenatal clinic personnel on number of pregnant women who began breastfeeding immediately after delivery. Health agents and volunteers will be taught to reinforce this advice at the village level and will report "immediate post-partum breast feeding" as part of their pregnancy outcomes reports.	Resistance to increasing monitoring/ documentation burdens at the health facility and community levels. Too few personnel to permit UCS 2 to teach and monitor the activity directly.

Objectives/Expected Results	Current National Policy/Norm	Baseline Data	National Strategy	Regional Strategy	Current Monitoring Approach	Suggested Monitoring Approach	Constraints to Meeting Objective
Increase to 85% of mothers who exclusively BF for the first 6 months	Educate on the importance and necessity of breast feeding for the health of mother and infant. Emphasize exclusive breast feeding during the first six months.[8]	KPC found 60% exclusive breast feeding in the past 24 hours for infants 6 months and younger. Facilities' Assessment found two dispensaries emphasize exclusive breast feeding in prenatal and post-natal education sessions. Automated MSPP annual summaries for dispensaries did not document this teaching in 2004.	Include recom-mendation in national training manual for personnel in maternal care or family planning.	Support national strategy.	None. Facilities' monthly reports to MSPP on Information, Education, and Communication sessions do not include the topic of Exclusive Breast feeding for six months.	At the health facility level, personnel should be retrained in both the teaching of exclusive breast feeding and in the documentation of that training. Health agents and volunteers should be taught to encourage pregnant women to breast feed exclusively for 6 months and should mark their intentions on the health card. The MSPP should include this in IEC reports, if not, KOMBIT partners should agree to report this teaching in a supplemental report.	Currently monitoring of breast feeding is very weak throughout UCS 2. Facilities do not have the resources or personnel for the community mobilization required to significantly increase the % of mothers who exclusively breast feed for 6 months.

[8] ibid p.174#7

Objectives/Expected Results	Current National Policy/Norm	Baseline Data	National Strategy	Regional Strategy	Current Monitoring Approach	Suggested Monitoring Approach	Constraints to Meeting Objective
CHILD SPACING							
Increase to 15% of mothers who complete LAM.	No national policy. The method is listed in the "Manual de Normes" as one method of family planning that should be available in FP clinics.	KPC found that 4.5% of women were using LAM.	None.	None.	None.	Prenatal-postnatal clinic staff will register women who commit to LAM and mark their intention on the woman's health card. A health agent or volunteer will visit these women to provide support and monitor completion rates.	Insufficient health facility resources to mobilize community support. UCS 2 should require LAM with reporting methods for family planning.
Increase to 10% of women using NFP methods (CMM, SDM)	Natural Family Planning Methods are listed in the Manual de Normes as a category of family planning methods that should be available to family planning clinic clientele.	KPC found 4.5% of women were using LAM. No other NFP methods were reported.	None.	None.	None.	Pre-postnatal clinics will report teaching of NFP methods and register acceptors and utilization as is done for other methods. The woman will be asked to mark her health card with her choice of methods and report outcomes to the health agent or dispensary at 6-months intervals.	Skills for teaching NFP are weak at the facility level, so training must occur. Few teaching supports exist for these methods, and must be created.

Objectives/Expected Results	Current National Policy/Norm	Baseline Data	National Strategy	Regional Strategy	Current Monitoring Approach	Suggested Monitoring Approach	Constraints to Meeting Objective
Increase to 35% of women using any method of CS	Family planning has been part of Reproductive Health since the 1982 MSPP "circulaire" making it policy. FP includes the goal of satisfying the health needs of the couple as well as providing a satisfactory quality of care. [9]	KPC found 24% of women were using some form of family planning.	Encourage public and private health facilities to provide FP services that meet national standards of quality, and to report monthly FP activities	Implement the national strategy	Health facilities provide monthly reports family planning acceptors and users, by service and method. These reports are available from regional MSPP in electronic form.	MSPP monthly reports, with the addition of a monitoring feedback report to each facility.	Some health facilities do not offer all methods. This problem is compounded by the failure to refer clients to facilities that do offer a desired service.
Increase % of villages with active Community Based Organizations (CBO) in partner areas (mothers' clubs, fathers' clubs, care groups, other groups motivating for health)	None.	7/8 (88%) health facilities managed by KOMBIT partners cited one or more CBOs that collaborate with them on a voluntary basis.	None.	None found.	None.	Health facilities will register collaborating CBOs by location, purpose, collaborative activities and leaders. CBOs will provide communication links to communities and help establish KOMBIT activities. Health facilities will report monthly on collaboration results.	Health facilities lack resources for community mobilization. Many also lack audio-visual and other types of educational support.

[9] ibid p.1

Objectives/Expected Results	Current National Policy/Norm	Baseline Data	National Strategy	Regional Strategy	Current Monitoring Approach	Suggested Monitoring Approach	Constraints to Meeting Objective
Increase clinic/dispensary competency in recognition and management of maternal/newborn danger signs/ emergencies	Eight pathological conditions of pregnancy should be recognized, and treated locally or referred to competent care. These are threatened abortion, incomplete abortion, hemorrhage during the third trimester, abruptio placentae, cardiac disease, high blood pressure, toxemia and anemia.[10]	The national Maternal Mortality Rate is 523/100,000, according to DHS2000. There are no cause specific data on maternal mortality in Haiti	None.	None.	None.	All dispensary personnel will be trained and certified to recognize, and to teach women about, danger signs. Dispensaries will document education of pregnant women, community health workers, volunteers, and CBOs. This will be included in monthly MSPP reports on IEC.	Health facilities lack appropriate medicines for emergency care of eclampsia and pre-eclampsia that are required while patients wait for hospital evacuation.
Establish a maternal mortality audit process; increase number of maternal morbidity/mortality reviews in KOMBIT project area	Health workers are required to report deaths on a one-page death declaration form. This information is recorded monthly and in annual reports. (see appendix: Maternal Mortality National Committee-MSPP 2004)	Base line information underway. All deaths of women of child-bearing age are investigated by MSPP/KOMBIT home visits by Verbal autopsy by nurses of all pregnancy related deaths for mortality review.	None.	None.	None.	Regular mortality reviews by KOMBIT staff and community.	Reporting and documentation of maternal deaths is very weak at the community and health facility levels due to the high proportion of home births.

[10] Ibid p.179-181

Objectives/Expected Results	Current National Policy/Norm	Baseline Data	National Strategy	Regional Strategy	Current Monitoring Approach	Suggested Monitoring Approach	Constraints to Meeting Objective
Increase % of CHWs supported by MSPP and private providers	None.	22 HAs paid by one of KOMBIT's partners work in UCS 2. MSPP and private providers do not currently employ health agents.	None.	None.	None.	HA training and skills certification will be documented. Health facilities will perform annual performance evaluations for each HA, using the results in decisions about continued employment, level of responsibility and compensation.	The national health budget is weak and HAs are a lower priority than doctors or nurses.
Assist the MSPP to modify policies to include tested home-based safe motherhood strategies.	Trained personnel in health facilities or hospitals should treat the complications of pregnancy, delivery and post-partum. Manual de Normes, pages 179 - 181	Data analysis incomplete, but preliminary data from verbal autopsies suggests that some deaths from hemorrhage could have been prevented by simple means easily learned by lay persons.	None.	None.	None.	KOMBIT's Director will monitor the quality and relevance of data to support policy change. A KOMBIT committee will write and present policy proposals. It will hold regular meetings and keep minutes. The committee will include and document community participation in the creation of new policies.	Policies are decided at the level of the National MOH. KOMBIT will have to promote and evaluate new policies first at the regional level. If they become part of the Grand Anse Departmental Action Plan, they will be communicated and promoted to the MOH.

Objectives/Expected Results	Current National Policy/Norm	Baseline Data	National Strategy	Regional Strategy	Current Monitoring Approach	Suggested Monitoring Approach	Constraints to Meeting Objective
Strengthen MSPP ability to track peri-natal women	To strengthen national health policy by establishing and supporting Communal Health Units (UCSs)	One UCS is in place but, for lack of money, personnel and transportation, it is not yet functional.	Identify resources to make the UCSs functional.	Support the national strategy.	None.	UCS 2 will create a work plan and calendar. UCS 2 and other KOMBIT partners will monitor progress on scheduled training, reporting and personnel deployment. As the program evolves pregnancies, prenatal care, deliveries, post partum events and pregnancy outcomes, will be monitored for population coverage, quality of services and data, and responsiveness.	A culture of information-based decision making does not exist. It will be developed but it will take time and persistence.

Objectives/Expected Results	Current National Policy/Norm	Baseline Data	National Strategy	Regional Strategy	Current Monitoring Approach	Suggested Monitoring Approach	Constraints to Meeting Objective
Increase % of Mothers' Clubs that meet monthly	None.	1/8 health facilities works with mothers' clubs. 15 HHF HA have mothers clubs	None.	None.	Some non-governmental organizations work with mothers' clubs and include these activities in monthly reports.	The development of Mothers' clubs will be documented. These clubs will provide information to their communities. The KOMBIT partner with the nearest health will be responsible for reporting their monthly with the mothers' club or volunteer workers for Safe Motherhood	Lack of health facilities' personnel to work with mothers' clubs. Currently mothers' clubs focus on maternal child health. To attract busiest and most talented women, it may be necessary to develop micro-credit activities with collaborating NGOs.
Increase community participation in the maintenance of emergency transport systems	None.	Facilities assessment found anecdotal reports of priests and pastors informally providing humanitarian transportation for emergency obstetrical cases.	None.	None.	None.	KOMBIT personnel will organization of village emergency transportation committees. KOMBIT work to document progress for 13 geographic service areas.	UCS 2 lacks sufficient personnel for the training and monitoring required to achieve this objective; and does not have a vehicle to visit the sites.

E.2. PROGRAM DESCRIPTION BY OBJECTIVE, INTERVENTION and ACTIVITIES

The programs and strategies developed for the KOMBIT program reflect the strategic objectives and intermediate results of USAID Global Health Breau, USAID CSGP and the USAID Haiti mission and results as listed below.

KOMBIT supports the strategic objectives (SO) of the Haiti Mission. Strategic Objective 3.0 is and the intermediate results (IR) of the USAID Haiti Mission and the CSHGP.

Haiti Mission SO: Healthier Families of Desired Size

IR #	Haiti Mission Intermediate Results
3.1.1	Improved health reinforcing/care seeking behaviors at the household and community level
3.1.2	Expanded availability of the minimum package of priority services with increased coverage of selected interventions
3.1.4	Improved performance of core management and support systems for the delivery of priority services
3.2.1	Improved quality and effectiveness of reproductive health education and BCC
3.2.3	Improved quality of clinical reproductive health services
3.2.4	Improved policy environment of the provision of FP and reproductive health services

This project supports USAID Global Health Bureau's strategic support objectives SO 1, 2 and 3:

SO #	Strategic Objective
1	Increase use by women and men of voluntary practices that contribute to reduced unintended and mistimed pregnancies
2	Increase use of key maternal health and nutrition interventions
3	Increase use of key child health and nutrition interventions

It also supports the CSHGP intermediate results:

IR #	Intermediate Result
1	Increase use, coverage and quality of child and maternal health and nutrition and infectious disease programs implemented by PVOs and their local partners
2	Increase sustainability of child and maternal nutrition and infectious disease programs/interventions initiated by PVOs and their partners
3	Child and maternal health and nutrition and infectious disease program strategies, common tools and approaches developed/adapted, tested and applied

The selected interventions derive from a careful situational analysis performed at the time of the proposal and further informed by the baseline assessments performed during year one of KOMBIT as seen in the following table.

Objectives/Expected Results	IR Haiti AID (SO3) GLOBAL(SO1/2)	Response to Situation Analysis	Response to Baseline Assessment	Strategy	Partnerships
Maternal/Newborn					
Increase to 50% of women who can identify at least 2 danger signs of pregnancy, to 40% post partum and to 50% newborn complications	Mission IR 3.1.1 Global SO2 CSHGP IR 1	Danger signs education limited to pregnancy		Expand danger sign messages to rest of perinatal period through messages to CBOs (Mothers' Clubs/Clinics, Fathers' Clubs, leaders, Mobile Theater Troupes)	SGS MSPP MSH ACNM CBOs
Increase to 20% of villages with written and posted emergency OB and newborn transportation plan	Mission IR 3.1.1 IR 3.2.1 Global SO2 CSHGP IR 1,2,3	Lack of planning for maternal emergency evacuation	Completely lacking in KOMBIT service areas	Community participation (CBOs and providers) in development of emergency evacuation plan using local resources and satellite phones	SGS, MSPP MSH, ACNM MNH BP/CR matrix CBOs
Increase to 40% of women adopting a pregnancy delivery/ post partum plan	Mission IR 3.1.1 IR 3.2.1 Global SO2 CSHGP IR 1, IR 3	Limited documentation of BP/CR	No Activity in KOMBIT areas except HHF- began BP/CR in 2004.	BP/CR activities Village evacuation plan Education on danger signs Increased use of MWH Mobile Theater Troupes	SGS MSPP MSH ACNM MNH CBOs
Increase to 60 % of maternity service sites with satellite phones, communication to referral centers for OB emergencies	Mission IR 3.1.2 IR 3.1.4 IR 3.2.3 Global SO2 CSHGP IR 1, IR 3	Lack of emergency communication and transportation	HHF has one satellite phone in the Dayere clinic 1/8	Provide 6 sites with satellite phones and the hospital maternity unit with a receiving station for 24-hour coverage Establish monitoring system for effective use	SGS MSPP MSH ACNM CBOs

Objectives/Expected Results	IR Haiti AID (SO3) GLOBAL(SO1/2)	Response to Situation Analysis	Response to Baseline Assessment	Strategy	Partnerships
Increase to 15 % of women who deliver with a trained attendant	Mission IR 3.1.1 IR 3.1.2, 3.1.4, 3.1.1, 3.2.3, 3.2.4 Global SO2 CSHGP IR 1, IR 3	Only 11% of deliveries in Haiti are with a trained attendant	10% KPC	Birth preparedness activities Village evacuation plan Education on danger signs Increased use of MWH Mobile Theater Troupes	SGS MSPP MSH CBOs ACNM
Increase to 30% of neonates examined by a HA within 72 hours of birth	Mission IR 3.1.2 and IR 3.1.4 Global SO3 CSHGP IR 1, IR 3	NNMR is 32/1000 live births 90% births at home	92% home births KPC	PAHO training of nurses, then HAs in IMCI Adapt maternal post partum assessment for home setting Advertise new intervention with CBOs, Mobile Theater Troupes	SGS MSPP MSH CBOs ACNM PAHO
Increase to 30% of post partum women examined by a HA within 72 hrs	Mission IR 3.1.2 IR 3.1.4 IR 3.2.3 Global SO2 CSHGP IR 1, IR 3	Estimated MMR: 680/100,000 live births 90% of births at home	92% home births KPC	Establish delivery records so that home visits are emphasized. BCC messages. Relay system for informing HA Mobile Theater Troupes	SGS MSPP MSH ACNM CBOs

Objectives/Expected Results	IR Haiti AID (SO3) GLOBAL(SO1/2)	Response to Situation Analysis	Response to Baseline Assessment	Strategy	Partnerships
BREASTFEEDING					
Increase to 20% of mothers who BF before placenta expulsion	Mission IR 3.1.1, IR 3.2.1 Global SO2, SO3 CSHGP IR 1, IR 3	43% of women in Haiti BF within the first hour	69% of women BF within first hour KPC	Community and clinic BCC activities. Local Theatrical skits on the benefits of BF colostrum	SGS MSH MSPP ACNM CBOs
Increase to 85% of mothers who exclusively BF for the first 6 months	Mission IR 3.1.1 IR 3.2.1 Global SO2, SO3 CSHGP IR 1, IR 3	9.8% BF exclusively for 5 months	60% BF exclusively at 6 months	Mother to mother support from Mothers' Clubs BF BCC in community and clinics	SGS MSPP MSH CBOs ACNM
CHILD SPACING					
Increase to 15 % of mothers who complete LAM	Mission IR 3.1.1 IR 3.2.1, IR 3.1.2 Global SO1 CSHGP IR 1, IR 3	NFP is 4.4% in Haiti	LAM use 4.5% in KPC	BCC in clinics and village sites Mothers' Club volunteers and Mobile Theater Troupes	SGS MSPP MSH ACNM CBOs
Increase to 10% of women using NFP methods (CMM, SDM)	Mission IR 3.1.1 IR 3.2.1, IR 3.1.2 Global SO1 CSHGP IR 1, IR 3	NFP is 4.4% in Haiti	NFP 4% in KPC	HAs will organize classes for women at individual/community level. TOT for new NFP methods. Mobile Theater Troupes. Use of maternal health cards	SGS MSPP MSH ACNM CBOs
Increase to 35 % of women using any method of CS	Mission IR 3.1.1 IR 3.2.1, 3.1.2 Global SO1 CSHGP IR 1, IR 3	FP use is 36% in the Grand'Anse for all methods	FP was 24% for all methods	Acceptors of LAM and NFP have been shown to adopt other methods of FP	SGS MSPP MSH ACNM CBOs

CAPACITY BUILDING	IR Haiti AID (SO3) GLOBAL(SO1/2)	Response to Situation Analysis	Response to Baseline Assessment	Strategy	Partnerships
Increase % of villages with active CBOs and FBO's in partner areas	Mission IR 3.1.1, IR 3.2.1 Global SO 1 2 3 CSHGP IR 1, 2	CBOs are organized in HHF areas - not in rest of KOMBIT area		KOMBIT HAs and village leaders will help organize new clubs in KOMBIT area	SGS MSPP MSH ACNM CBOs
Increase clinic competency in recognition and management of maternal/newborn danger signs/ emergencies	Mission IR 3.1.2, IR 3.1.4, IR 3.2.3, 3.2.4 Global SO 2, 3 CSHGP IR 1, 2, 3	Provider need for continuing education in management of maternal care		Needs assessment of deficiencies, plan for improvements, including training in management of OB emergencies	SGS MSPP MSH ACNM MNH CBOs
Establish audit process, increase number of maternal morbidity/mortality reviews in KOMBIT project area	Mission IR 3.2.4 Global SO 2 CSHGP IR 2, IR 3	Lack of mortality audits/information in the Grand'Anse		Medical Advisor to develop procedures UCS meetings to organize MM reviews	SGS MSPP MSH ACNM CBOs U. Michigan
SUSTAINABILITY					
Increase % of HAs supported by MSPP and private providers	Mission IR 3.2.4 Global SO 2 CSHGP IR 2, IR 3	Certified HAs are recognized by the MSPP		Joint planning for the transition from the private to public sector	SGS, MSPP MSH Gebeau
Assist the MSPP to modify policies to include tested home-based safe motherhood components	Mission IR 3.2.4 Global SO 2 CSHGP IR 2, IR 3	MSPP has encouraged HHF to take a lead role in assessing new maternal activities		Participation in national planning with bilateral and local NGOs. Use of modified HBLSS and neonatal IMCI	SGS MSPP MSH ACNM USAID PAHO CBOs

CAPACITY BUILDING	IR Haiti AID (SO3) GLOBAL(SO1/2)	Response to Situation Analysis	Response to Baseline Assessment	Strategy	Partnerships
Strengthen MSPP ability to track perinatal women	Mission IR 3.1.4 Global SO 2 CSHGP IR 2, IR 3	Lack of coordination among clinical sites		Adapt PAHO computerized perinatal tracking system in KOMBIT area	SGS CBOs MSPP MSH PAHO
Increase % of Mothers' Clubs that meet monthly	Mission IR 3.1.1, IR 3.2.1 Global SO 2 CSHGP IR 2, IR 3	Organized and sustained in HHF area - none in rest of KOMBIT area		Facilitate independent Mothers' Clubs and use modeling strategies to create/ in partner areas	SGS MSPP CBOs FBO
Increase community participation in the maintenance of emergency transport system	Mission IR 3.1.1, IR 3.2.1 Global SO 2 CSHGP IR 2, IR 3	Lack of coordinated emergency communication or transportation		Community motivation for financial contribution System developed to collect community contributions Feedback to villages about progress in achieving goal	SGS MSPP MSH ACNM CBOs

STRATEGIES

KOMBIT will use selected strategies to improve quality of services, implement behavior change communication and improve access.

Strategies
Quality Improvement Strategies Implement the American College of Nurse Midwives Home Based Life Saving Skills program in the KOMBIT region for health agents Implement Georgetown University's SDM program through TOT for HAs and nurses in entire KOMBIT area Conduct Neonatal IMCI training by PAHO for health HAs Conduct training in prenatal, postpartum and newborn care training for personnel at all 8 dispensaries in the KOMBIT project region Training in and implementation of the PAHO perinatal tracking system Training in management of obstetric emergencies for all nurses in the project area Conduct interpersonal communication training for personnel at all 8 dispensaries Workshop to develop danger sign educational messages based on KPC results Continue the reproductive age mortality survey and follow up maternal mortality audit process and facilitate regional Maternal mortality reviews committee meetings and recommendation development Additional training in Child Spacing using Cervical Mucous (CMM) of family planning for KOMBIT partners as well as the Lactation Amenorrhea Method (LAM) PAHO Perinatal software tracking program training with referral and counter referral system training
BCC Strategies Expand danger signs in pregnancy and neonatal period messages, and promote breastfeeding and NFP messages to community based organizations (CBOs) by training HAs to engage Mothers' Clubs, Fathers' Clubs, local leaders and Mobile Theater Troupes Community participation (CBOs and providers) in development of emergency evacuation plan using local resources and satellite phones BP/CR activities, Village evacuation plan, Education on danger signs, Increased use of Maternal Waiting Home (MWH) Mobile Theater Troupes
Access Strategies Provide 6 remote sites and the hospital maternity unit with satellite phones for 24-hour monitoring of pregnancy complications coverage and advice for community based stabilization, care and transport arrangements. Training of nurses and HAs in pregnancy tracking. Establish pregnancy records so that home visits are emphasized and adapt maternal post partum assessments of infection, anemia and breast feeding problems for home setting. Develop an ambulance service.

Timing of Activities

The strategies will be implemented across the spectrum of care and situations from the community level through the clinic and to the hospital levels. The following table was generated during the DIP preparation processes with partners.

Strategy Implementation by Area and Year of Project

	Commune of Jeremie		Roseaux	Bonbon/ Abricots
	HHF zone	Non HHF zone		
Household strategies				
Home based life saving skills (HBLSS) at the level of the home	1	1	2	3
Birth preparedness	1	2	3	4
Community Level				
BCC with Mothers' Clubs, Mobile Theater Troupes, and at clinics and in villages	2	2	3	4
Planning through community meetings of leaders and traditional healers	2	2	3	4
Birth preparedness and village evacuation plan, including satellite phones and emergency transportation	1	2	3	4
Education on danger signs, increased use of MWH	1	2	3	3
Establish a phone receiving station in the hospital maternity unit for emergency coverage	2	2	2	2
Facilitate independent functioning of Mothers' Clubs in all KOMBIT sites	1	2	2	3
Use modeling strategies from HHF sites to create or improve KOMBIT CBOs	1	2	2	3
Community motivation for financial contribution to birth preparedness	2	2	3	4
Discussions of legal rights with Mothers' and Fathers' Clubs	1	2	2	3
Establish a system to document and track women with emergencies or who sought referral for complications	2	2	2	2

	Commune of Jeremie		Roseaux	Bonbon/ Abricots
	HHF zone	Non HHF zone		
Clinic Level				
Establish a monitoring tool for effective delivery of perinatal care	2	2	2	2
Train clinic nurses and HAs in danger sign recognition, triage and referral	2	2	2	3
Train staff in the use of the PAHO perinatal registry system	-	-	-	-
Identify patients referred to the next level of care	1	1	1	2
Determine referral completion through record review and home visits	1	2	3	4
BCC at clinics and villages and individual couple counseling for CS	2	3	3	4
Identify deficiencies and work with KOMBIT members to remedy them	1	1	1	1
Public display of graphic representation of progress on quarterly basis	1	1	1	1
Feedback of progress to service providers of annual statistics	1	1	1	3
Regional Level				
Establish a birth registry at the hospital and at the referring service site	2	2	2	2
TOT for new NFP methods	1	1	1	1
Evaluate circumstances and policies related to maternal death	1	2	3	3
Begin MM reviews with providers and community members	1	1	2	3
Apply facilities assessment tools at baseline	1	1	1	1
Training service providers in ICD-10 (International Mortality and Morbidity) codes and the national death form	2	2	3	4
Joint planning for the transition from the private to public sector	3	3	3	2
Participation in national level symposia with bilateral and local NGOs	1	1	1	1

NB:	1	=	First year	Oct 2004	-	Sept 2005
	2	=	Second year	Oct 2005	-	Sept 2006
	3	=	Third year	Oct 2006	-	Sept 2007
	4	=	Fourth year	Oct 2007	-	Sept 2008
	5	=	Fifth year	Oct 2008	-	Sept 2009

INTERVENTION SPECIFIC APPROACH

KOMBIT has 3 primary areas of intervention: Maternal/Newborn Care (60%), Child Spacing (20%), Breast Feeding (20%).

BCC for KOMBIT

The BCC strategy for KOMBIT includes multiple activities to effect sustainable behavioral change and is detailed in the BCC table. Relying on the extensive history of HHF in achieving long term behavior change in child survival parameters, KOMBIT will allow for the integration of maternal and newborn care BCC into current HHF zones, and introduce maternal/newborn, child spacing and breast feeding concepts and activities to partner zones. KOMBIT will use Mothers' Clubs, Fathers' Groups, Volunteer Mothers for Safe Motherhood groups, and mobile theater troupes as the primary methods of information dissemination.

Mothers' Clubs

Maternal care BCC, and other components of KOMBIT will be implemented through the activities of Mothers' clubs.

Definition of Mothers' Club: The mother'ss club is a structured community group with the mission of addressing their own health and the health of the family and community. They are also mobilize to resolve problems in the community and to improve their lives with internal and external resources.

1. In the beginning, HAs organized and ran the Mothers' Clubs. This took place from 1990 to 1994. HAs taught the mothers and they were the recipients of health education.
2. In 1994-95, HHF began noting women who emerged as leaders and who participated on their own. Women began to bring others into the group and participate more actively in the rally posts even when they had no children receiving services.
3. By 1997, some mothers' groups were organizing themselves into village banks and cooperatives of businesswomen.
4. As women grew in knowledge and confidence, the relationships with other groups and individuals also changed. For example, women helped to organize fathers for child and family health, they sent their children to organize youth groups, and they began organizing children's groups for simple health messages.
5. Some urban women's groups invited other development groups such as FONKOZE or the Gebeau micro credit program to work with them.
6. By 1999, USAID sponsored "Timoun and Sante Kontan," a program that galvanized women and drew in thousands more to witness the dramatic changes that simple technologies can make on the health of a village.
7. The addition of the health and human rights program held in rural villages through Haitian lawyers has brought together people that would never have had the chance to learn and apply their rights. Men AND women attend these day-long seminars.
8. Mothers' Clubs have been an excellent example of learning from the population in community-based Primary Health Care.

KOMBIT will utilize the lessons learned from HHF to begin "Femme Kombit" Mothers Volunteers to Safe Motherhood in all of the KOMBIT zones that presently do not have mothers clubs or HAs .

Fathers' Groups

HHF began working in the Grand Anse Jeremie County in 1987. In the original 25 villages served by the organization, community groups called "gwopman kominote" existed. Nursing staff built on this model in organizing Health Committees in 1988.

In 1994, Robin Devin a doctoral student at the University of Connecticut in the Department of Anthropology, conducted research on women's work and child health. This study was to determine the positive deviant behaviors that spared poor children in rural villages from early death and malnutrition. She compared 120 pairs of mothers in 3 villages – those who had healthy children and those that had malnourished children.

She discovered that the involvement of fathers had a significant relationship with children who were not malnourished. The recommendation based on her rural study in HHF villages was to engage fathers in maternal and child health. And HHF staff began this process in 1995.

Fathers in these associations were originally the partners of women in Mothers' Clubs. There was a subtle rivalry between the mothers' and fathers' groups in the original villages.

Men received health information about their children, their wives and then themselves. They asked for tetanus toxoid vaccine (as they are at risk of tetanus from machete wounds) and HHF complied. They came together to clear roads, build palm frond vaccine stations, build barriers around the village spring and assist with latrine building.

Father's groups expanded to include young men and grandfathers. They also participated in community health fairs and created their own health songs using standard key messages. They participated in skits related to maternal health, childcare, community development and other topics. In 2000 father's groups began hosting community health fairs on their own. Since Fathers' Clubs began, HHF staff nurses and HAs have remarked that more fathers bring children to preventive rally posts, make oral rehydration solution for diarrhea and accompany their wives to pre and post natal care.

Fathers' Clubs activities wax and wane during the year according to the agricultural season and other HHF projects. When there is a need, they are consistently available to plant fruit tree seedlings, prepare for health care, and portage equipment and supplies to the most remote areas served by HHF.

KOMBIT will be incorporating the KOMBIT BCC activities as described in the chart below partly through fathers' groups based on the processes HHF has employed.

HHF Plan for Expanded Use of Theater Groups

Since the HHF staff began working with mothers' groups in 1990 and fathers' groups in 1995, these groups have been evolving from somewhat passive recipients of health education messages to active, engaged, thoughtful and empowered community groups and members. There are now a number of community group gatherings in the HHF service area: Health education (called behavior change communication), problem solving, planning for community events and continuing education.

There is a range of variation among the 100 or so community-based groups. Some are cohesive, have their own community traditional banks, host funeral related activities, activate community response to emergencies and other activities. Others are moderately active and some remain somewhat passive and come together to receive health information.

HHF has worked with the most energetic, motivated mothers and fathers as community advocates for many years. Many have taught others the signs of pneumonia, supported exclusive breast feeding, taught lactation, built latrines, houses, and miles of roads by hand and reported epidemics.

In 1999, with the assistance of USAID Management Sciences for Health, HHF began a 12-subject program for the essential MCH key messages. When women understood and applied these key behaviors, they were tested orally, given a diploma and a public graduation as part of health fairs that often had 500 or more participants. With songs, skits, jokes, contests and demonstration of techniques (for ORS or breast feeding) women not only showed what they learned and applied, but invited others to join their group or form a group of their own.
By 2003, HHF had over 3000 graduates of this practical community based empowerment program. By then, men asked and were included in the training and the graduation ceremonies (youth joined in 2002).

IN 2003, Peace Corps volunteers organized women volunteers to visit those closest to them to refer pregnant women, malnourished children or those with an acute infection to the resident health agent. This was very successful. In the same year PSI supported HHF's plan to expand messages about hygiene, handwashing, and oral rehydration to villages new to the HHF system. Groups of women who had graduated from the "Healthy Happy Family" IEC program traveled to other villages. Using songs, skits, jokes and demonstration, they worked as peer educators for thousands of families in remote rural areas.

KOMBIT will build on the HHF model by organizing groups of 5 women to travel to one of the original 7 KOMBIT clinics (and one mobile team) to spread key messages about safe motherhood. Aspects of the KOMBIT program that are new will be taught to these "certified" mothers first so that they can be effective peer counselors and engaging actresses (and actors). A total of 40 people will be "engaged" as the mobile theater group. In grant years 2-4, others will be chosen from the pool of 3000 community members to be a part of the group.

The goal is to go outside of the HHF service area into clinic sites where there are currently no mothers' groups (and very busy nurses) and provide practical messages for safe motherhood based on their own experiences. They will also help to train "Femme Kombit" for remote areas.

This program will be managed by the Field Coordinator, in collaboration with the KOMBIT supervisors and HAs. Mother and father volunteers will be given food while they are on the road in appreciation of their work.

Topics that they will promote by theater and other non formal adult learning techniques include:

1. Exclusive breastfeeding and initiation of breast feeding before the placenta is expelled
2. LAM (modern method)
3. Cervical Mucus Method of NFP
4. Standard Days Method of modern family planning
5. Danger signs during pregnancy, labor, post partum and for the neonate
6. Oral rehydration during labor and delivery
7. Nutrition
8. Birth Planning
9. Delivery at the hospital and the maternal waiting home
10. Tetanus Toxoid vaccine
11. Vitamin A
12. Other topics as identified.

Plans are underway to film the best theater presentations and obtain outside support for first prizes.

BCC Plan

KOMBIT partners have devised a BCC plan to respond to each of the KOMBIT indicators.
In Haiti BCC primarily means influencing the beneficiaries of care and community-level people, with limited application to providers. Capacity building is customarily used in terms of training professionals and paraprofessional health providers who then execute BCC interventions. However, in KOMBIT, there is BCC for all levels of providers as well as community people. Capacity building through training and support of community members, practitioners and non-health provider collaborators is included.

2. a. BEHAVIOR CHANGE and COMMUNICATION

Maternal and Newborn Care Breast Feeding Child Spacing

Household Level:

Indicator	Use of baseline information to plan strategies	Strategies for improved behaviors	Activities	Training in BCC at this level	How monitored	How will these new behaviors continue after KOMBIT?
Percentage of women with 4 or more prenatal visits	KPC found 26% of women had 4 or more prenatal visits (range 0-12). DHS 2000 found a national median 3.5 prenatal visits	Adult education Engaging community leaders	Community-based education using theater groups. Testing the use of KOMBIT girls health cards in non-health agent areas. Use of songs,messages, Radio spots	HBLSS in July 2005	HBLSS monitoring protocols will be modified and used Monthly reports after training and implementation	Engagement of mothers' groups, fathers' groups, CBOs, FBO's and annual leaders' seminars Engagement of HAs and clinic nurses
Percentage of women who reported that they had received prenatal breastfeeding information and child spacing info	Messages are inconsistently given and received. KPC found 56% of women received prenatal breastfeed counseling and 50% received child spacing counseling	Adult non-formal education Woman to woman support from experienced HHF mothers. Adequate information at the household level.	*Where There Is No Doctor for Women* reading and discussion at the clinic and village levels Theater groups will travel from their home village to KOMBIT care sites beginning in June 2005.	Cervical mucus method (CMM) Standard days method (SDM) Exclusive breast feeding campaign LAM method Training by HAs and disseminated by mothers in community	Home-based mother'ss card review Mid term and final evaluations	By educating the community about KOMBIT's successful impact on exclusive breast feeding and use of family life methods for child spacing and presenting related improvements in maternal and child health. Community support will promote continuation of these practices.
Percentage of women who were immunized to tetanus (minimum of 2 vaccinations)	KPC found 32% of women received Prenatal TT2 DHS 2000 Prenatal TT 2 vaccination rate was 52% nationally.	Antigen availability in all KOMBIT clinics review facilities assessment, rally posts so mothers do not walk > 1 hour	Prioritize maternal vaccination Inspect refrigerators and cold chain monthly Close alliance with MSPP for availability of antigen. Perinatal software tracking system in year 3-4	Vaccination song, distribution of women's health cards Zip lock bags to protect cards Begin with girls	TT rates women's health cards and MSPP reports. Documentation of UCS 2 vaccine procurement/cold chain	Mother to mother education Expanded use of home-based women health cards with coverage in all UCS 2 areas.

Indicator	Use of baseline information to plan strategies	Strategies for improved behaviors	Activities	Training in BCC at this level	How monitored	How will these new behaviors continue?
Percent of women who can identify at least 2 danger signs of pregnancy	KPC found 25% of women could identify at least 2 danger signs of pregnancy (range 0-4 of 5 signs; 43% could not identify any signs); this indicates a lack of consistent messages in rural areas.	Engage CBOs and FBO's to promote understanding of danger signs	Mobile Theater groups. Leaders' seminars. *Where There Is No Doctor for Women* discussions. Meetings with CBOs.	Messages through songs and key phrases exist in Haiti. Obtain radio spots and use in the KOMBIT areas. HBLSS	Direct questioning of pregnant women Periodic exit interviews at prenatal clinics and health posts. Midterm and final evaluations.	Integration into community based education. Positioning of messages in all prenatal care sites in clinics and village-level sites
Percent of women who can identify at least 2 danger signs of post partum	KPC found 9% of women could identify at least 2 post partum danger signs (62% could not identify any signs), indicating a lack of consistent messages in rural areas	Workshop with KOMBIT partners to develop new messages as post partum danger signs are not widely known in Haiti	Follow the same methods of message transfer as with danger signs of pregnancy	Nurse to health agent to CBOs and families in home visits. CBOs and schools in areas without HAs HBLSS	Direct questioning of women at prenatal posts, clinics and homes Surveys. Mini studies or LQAS	Integration into community based education
Percent of women who can identify at least 2 newborn danger signs	KPC found 18% of women could identify at least 2 newborn danger signs (43% did not know any signs).	Workshop with KOMBIT partners to develop new messages as these are not widely known in Haiti	Follow the same methods of message transfer as with danger signs of pregnancy	Nurse to health agent to CBOs and families in home visits. CBO and schools in areas without HAs HBLSS	Direct questioning of women at prenatal posts, clinics and homes Surveys Mini studies or LQAS	Integration into community based education
Percent of villages with written and posted emergency OB and newborn transportation plan	There are no posted plans, but there are selected HHF villages with plans for evacuation.	JHPIEGO Birth preparedness complication readiness matrix will be used as a training tool. Engagement of Leaders	Engage mothers,fathers and families in development of a community plan. Secure litters for remote areas Satellite phones in remote areas	HBLSS	Observation of villages with posted plans	Integration into departmental and UCS 2 yearly action plans Move from expensive satellite phones to cell phones as soon as this technology is available .

Indicator	Use of baseline information to plan strategies	Strategies for improved behaviors	Activities	Training in BCC at this level	How monitored	How will these new behaviors continue?
Percent of women adopting a pregnancy delivery/ post partum plan	0% in UCS 2 45% in a small HHF study	Integrate counseling and development of pregnancy delivery/post partum plan in care of all pregnant women in UCS 2	Nurse training in the written birth plan used by HHF; attaching this plan to each mother'ss health card	JHPIEGO matrix training tool to identify planning for labor and delivery Interpersonal skills training in May 2005	Observation of birth plan stapled to the mother card	Integration into mothers' expectations of prenatal care.
Percent of women who received birth preparedness counseling	KPC found 49% of women had received birth preparedness counseling	Integrate counseling and development of pregnancy delivery/post partum plan in care of all pregnant women in UCS 2	Nurse training in the written birth plan used by HHF ; attaching this plan to each mother'ss health card	JHPIEGO matrix training tool to identify planning for labor and delivery. Interpersonal skills training in May 2005	Observation of birth plan stapled to the mother card	Integration into mothers' expectations of prenatal care.
Percent of women who deliver with a skilled attendant	KPC found only 10% of women had skilled birth attendance	HHF MWH will be promoted more comprehensively as a place to stay close to the hospital Engage community leaders to set a standard of care: birth with a trained attendant. Eventually develop birth centers for mothers to deliver with nurse midwives	Improved reporting of delivery personnel With MSPP support Encourage mothers to deliver at the hospital	HBLSS and referral	MSPP and KOMBIT reporting of delivery site and attendance Mid term and final	Community awareness of benefits of hospital and birth center delivery based on mothers' experiences.
Percentage of women who said they would go to a hospital or health center if they had a danger sign of pregnancy	KPC found that 68% of women reported they would go to a hospital or health center if they experienced a danger sign of pregnancy	Birth kits are too costly for most Haitian families, they need to be available free of charge	Reproductive rights seminars with local lawyers *Where There Is No Doctor for Women* community discussions	Nurse training on facilitation of referrals; work with CBOs	Interview of women periodically Surveys, Group Interviews with CBO-FBOs. Exit interview after counseling for referral completion rates	Referral and counter-referral at clinics and hospital

Indicator	Use of baseline information to plan strategies	Strategies for improved behaviors	Activities	Training in BCC at this level	How monitored	How will these new behaviors continue?
Percentage of mothers who could describe at least two methods of stopping a post partum hemorrhage	KPC found 7% of women could identify at least 2 methods of stopping a post-partum hemorrhage	HBLSS	HBLSS	HBLSS	HBLSS monitoring Mid term process evaluation	Improved community awareness of HBLSS and the transmission of skills from one person to the next.
Percentage of women who received post partum vitamin A	Rapid CATCH found 41% of women received post-partum Vitamin A	Vitamin A health education during prenatal visits	Songs Skits Theater groups CBOs, FBO's Church conventions Health fairs	Training of mothers at prenatal, post natal, youth	Home based cards Monthly facilities' reports	Integrated into UCS 2 action plan
Percentage of women who know 2 newborn care skills	KPC found 18% of women knew 2 or more newborn danger signs.	HBLSS at the level of the home	HBLSS training of nurse managers in July 2005	Transfer of this approach to mothers in community in Jeremie in 2005, and other locations in 2006	Interview with mothers At facilities and reporting from updated MSPP monthly reporting forms	HAs will continue, mother to mother education in areas without HAs Video production
Percentage of mothers who BF before placenta expulsion	KPC found that 69% of women initiated BF within 1 hour of delivery. Small HHF study in Dayere Clinic found that 1 out of 9 mothers (11%) began BF before placenta expulsion	Alter prenatal education to include this message for maternal and newborn health	Song contest Theater presentation	Alert nurses to this new approach as well as community midwives	Mother'ss report at clinics and other post partum sites Surveys Notation on women's health card Midterm and Final Evaluation	Integration in to UCS 2 action plan

Indicator	Use of baseline information to plan strategies	Strategies for improved behaviors	Activities	Training in BCC at this level	How monitored	How will these new behaviors continue?
Increase # of mothers who exclusively BF for the first 6 months	KPC found 60% of infants 6 months or less were exclusively BF for the previous 24 hours	HHF experience in exclusive breast feeding support in the home will be replicated in non HHF villages	Father support Fashion shows Mothers' home card to include exclusive breast feeding	HHF breast feeding and LAM modules in all locations of care and teaching	Mother'ss health card. Monthly MSPP report of enrolled in LAM and completed LAM. # malnourished children under 6 months.	Develop a critical mass of mothers who can maintain mother to mother support for breastfeeding
Increase % of mothers who complete LAM	KPC found that 4.5% of women were using LAM	HHF experience in exclusive breast feeding support in the home will be replicated in non HHF villages	Father support Fashion shows Mothers' home card to include exclusive breast feeding	HHF breast feeding and LAM modules in all locations of care and teaching	Mother'ss health card. Monthly MSPP report of enrolled in LAM and completed LAM. Number of malnourished children under 6 months.	Develop a critical mass of mothers who can maintain mother to mother support for breastfeeding
Increase % of women using NFP methods (CMM, SDM)	LAM was only NFP method reported in KPC (4.5%) SDM does not yet exist in Haiti. HHF only partner that uses CMM	Train nurses, HAs and CBOs in SDM in 2005	Educate mothers, youth and couples in CBOs and other special meetings Theater groups for methods	SDM training in 2005 and again in 2006 CMM and FBO's training by HHF in year 1-5 with nurses and CBOs	Monthly reports of enrolled women and couples Fertility awareness. Home based girls' cards that include CMM, SDM and LAM	Tracking and demonstrating the effectiveness of intergenerational coverage of Family Life Methods
Increase % of women using any method of CS	KPC found 24% of women reported currently using a FP method. HHF database found 9% of women using a FP method	Note on HHF rosters use of any method. Increased use of home based card that includes all methods	Adaptation of HHF home based girls health card as a KOMBIT card	None Documentation of new and continued users on the KOMBIT health card	MSPP statistics Assessment of use of new KOMBIT health cards for girls	Integration of girls cards in to areas with few health services; mother to mother support for family planning

Community Level:

Indicator	Use of baseline information to plan strategies	Strategies for improved behaviors	Activities	Training in BCC at this level	How monitored	How will these new behaviors continue?
Percent of women who deliver with a skilled attendant	KPC found 10 % of women delivered with a skilled attendant HHF found 9% in rural areas	HHF MWH more comprehensively promoted as place to stay close to the hospital. Engage community leaders to set a standard of care: birth with a trained attendant. Eventually develop birth centers for mothers to deliver with nurse midwives	Improved reporting of delivery personnel with MSPP support. Encourage mothers to deliver at the hospital.	HBLSS and referral. Training for CBOs to promote skilled attendance and to use of the KOMBIT girls home based health card that includes delivery information.	MSPP and KOMBIT reporting of delivery site. Mid term and final	Community awareness of benefits of hospital and birth center delivery based on mothers' experiences.
Percentage of post partum women examined by health personnel within 72 hrs of birth	KPC found 20% of women were examined by health personnel within 72 hours of birth 25% in HHF (Center of Hope 2004)	Mandate HA home visits within 3 days. Improve post partum and newborn assessment skills. Encourage mothers to go for postpartum visit. Reward compliance with this protocol.	Neonatal IMCI HBLSS training	Neonatal IMCI HBLSS training	Institutional reporting, notation on mother'ss card Perinatal software program (PAHO) Year 3	Institutional standardization
Percentage of women who received post partum vitamin A	Rapid CATCH found 41% of women received post partum vitamin A	HAs with a stock of vitamin A	Increase demand for vitamin A. Secure stock at village level.	Songs and skits to increase demand for vitamin A in churches and in community organizations.	Monthly reports required by MSPP	In non HA villages – consider non health personnel (TBAs, other moms) for Vitamin A. National policy change.
Percentage of mothers who BF before placenta expulsion	KPC found 69% of women initiated BF within 1 hour of delivery. HHF: 11% before placenta expulsion	Alter prenatal education to include this message for MNC Review this behavior with community TBAs CBO support for behavior	Song contest Theater presentation	Alert nurses to this new approach as well as community midwives	Mother'ss report at clinics and other post partum sites	Integration in to UCS 2 action plan

Indicator	Use of baseline information to plan strategies	Strategies for improved behaviors	Activities	Training in BCC at this level	How monitored	How will these new behaviors continue?
Increase # of mothers who exclusively BF for the first 6 months	KPC found 60% of infants 6 months or less were exclusively BF for the previous 24 hours.	HHF experience in exclusive breast feeding support in the home will be replicated in non HHF villages	Father support Fashion shows Mothers' home card to include exclusive breast feeding	HHF breast feeding and LAM modules in all locations of care and teaching	Mother'ss health card. Monthly MSPP report of LAM enrollment and completion. Number of malnourished children under 6 months.	Develop a critical mass of mothers who can maintain mother to mother support for breastfeeding
Increase % of mothers who complete LAM	KPC found that 4.5% of women were using LAM. HHF data is 22% of all post partum women.	HHF experience in exclusive breast feeding support in the home will be replicated in non HHF villages	Father support Fashion shows Mothers' home card to include exclusive breast feeding	HHF breast feeding and LAM modules in all locations of care and teaching	Mother'ss health card. Monthly MSPP report of LAM enrollment and completion. Number of malnourished children under 6 months.	Develop a critical mass of mothers who can maintain mother to mother support for breastfeeding
Increase % of women using NFP methods (CMM, SDM)	Same as household level					
Increase % of women using any method of CS	Same as household level					

Clinic Level:

Indicator	Use of baseline information to plan strategies	Strategies for improved behaviors	Activities	Training in BCC at this level	How monitored	How will these new behaviors continue?
Percent of maternity service sites with satellite phones, communication to referral centers for OB emergencies	None to date	Satellite phones and an ambulance service will complement the village evacuation plan	Year 2 installation of satellite phones in partner clinics	NA	Phones are only for emergency use. Monitoring	External support until less expensive cell phones are available
Percent of patients divided into causes of referral or diagnosis who move to the next level of care	Limited referral and counter referral documented	Strengthen referral and counter referral in UCS 2 at all monthly meetings (supported by KOMBIT)	Partner and collaborator meetings. Paper copy of all referrals and counter referrals. Daily referral count.	Identification of reasons for referral	Mandated plan will have monthly evaluation of referrals at each level	UCS 2 will make this mandatory and integrated into MSPP supervision
Percent of completed referrals to the next level of care	Limited referral and counter referral documented	Strengthen referral and counter referral in UCS 2 at all monthly meetings (supported by KOMBIT)	Partner and collaborator meetings. Paper copy of all counter referrals. Daily counter referral count	Identification of reasons for referral	Mandated plan will have monthly evaluation of referrals at each level	UCS 2 will make this mandatory and integrated into MSPP supervision.
Percentage of neonates examined by health personnel within 72 hours of birth	KPC found 15%.	Neonatal IMCI or at least neonatal assessment at the facilities by nurses. Training of nursing students in UCS 2.	Communication with PAHO about the translation from Spanish to Creole, use at clinics and then at the home.	Training in Neonatal IMCI or basic newborn assessment until this module is created and approved in year 2.	Reports by KOMBIT partners on monthly basis.	Integration in UCS 2 and Department and training in nursing schools.
Percentage of post partum women examined by a doctor, nurse or a auxiliary nurse within 72 hours of birth	KPC found 20% according to KPC. This is not a priority for clinic operations at this time. HHF data 25%	Begin designated days for post partum care in clinics and rural locations. Improve attendance at post partum clinics. Investigate giving soap or other health-oriented encouragement for attendance.	KOMBIT will engage trainer in post partum assessment. KOMBIT experienced staff will assist others in developing postpartum clinics. Investigate more nurse midwife birthing centers.	Post partum care of the mother and interpersonal communication skills in May 2005 and again in 2006. Grand Anse nursing students included over the life of the project.	Reports Observation Schedule of nurses assisting others in clinics. UCS 2 trimester assessments (none currently).	Advocate for more nurses in clinics in the Grand Anse.

Indicator	Use of baseline information to plan strategies	Strategies for improved behaviors	Activities	Training in BCC at this level	How monitored	How will these new behaviors continue?
Percentage of women who received post partum vitamin A	Rapid CATCH found 41%	Use song about vitamin A post partum in areas with limited health staff and facilities. Investigate administration by teachers, health educators or CBOs in areas with no HAs	Increase the stock Increase the demand through sensitization by mobile theater groups.	Continuing education for nurses. Community mobilization for vitamin A as a part of post partum care through theater groups, CBOs in years 2-5	Reports to MSPP	Establish closer relationship between clinics and CBOs where there is a lack of personnel
Percentage of mothers who BF before placenta expulsion	Small HHF study showed 1/9 (11%) in Dayere clinic.	Improve support for midwives in each clinic area. Create new messages as moms do not keep track of time in minutes. Create and use theater songs about the importance of this behavior for maternal and newborn health	Theater groups at clinic sites on prenatal days in year 1-5. Integration of this message as one of prenatal curriculum key messages	Theater group training Engage nurses in creation of messages for their clinics Integrate with 3rd year nursing students Add this message to the training of traditional birth attendants	Report of mothers at post partum clinic sites	Video tape theater and add to clinic waiting sites in UCS 2. By year 5 will have TVs and small generators for health education in clinics.
Percentage of mothers with a child 6mo or less who had nothing but breast milk to eat in the last 24 hours	60% in KPC	Transfer of HHF experience to clinics using experienced nurses and mothers in nearby areas	Assign KOMBIT nurse to work in partner prenatal and postpartum clinics in years 1-5. Identify mothers with multiple years of experience with exclusive breastfeeding and engage as mother educator. Engage student nurses in lactation education.	Training of nurses in techniques of breast feeding support and identification of problems for improved clinical care. Obtain donated breast pumps to keep in each clinic for mothers with problems. Introduce home based mom card that includes BF patterns (complete, partial or initial).	Documentation of home based cards Interview with mothers at clinics	Engage mothers in KOMBIT areas who have successfully practiced exclusive BF to support other mothers.

Indicator	Use of baseline information to plan strategies	Strategies for improved behaviors	Activities	Training in BCC at this level	How monitored	How will these new behaviors continue?
Increase % of mothers who complete LAM	4.5% currently using in KPC 22% in HHF	Prenatal education in the clinics Theater groups at clinic sites with these key messages	Review prenatal teaching guides used in clinics and standardize for BF and LAM with partner nurses. Train nurses in LAM Teach mothers about importance, mother to mother support.	Interpersonal skill training by KOMBIT national trainer in year 1. Lactation training by HHF year 1 -5. Mother to mother training at clinic sites	Home based health card assessment (BF section) Documentation of teaching sessions at prenatal clinics	Increase in mothers who complete LAM by engaging mother to mother support, link with nearest clinic.
Increase % of women using NFP methods (CMM, SDM)	No promotion of NFP in KOMBIT clinics	Acknowledge that NFP methods are not limited to clinic education and promotion. Engage lay persons to learn and support these methods	Identify couples using NFP couples at clinics. Expand fathers' groups to non health agent areas. Nurse guided support of women and couples. Periodic meetings with CBOs and leaders.	Nurse to community training in LAM, fertility awareness and SDM. Assure availability of cycle beads as IEC material rather than FP commodity. Fertility awareness with youth: begin with 15 year old girls who receive a girls health card enclosed in zip lock bag.	Home based mother'ss card monitoring	Couple to couple and mother to mother support. Engaging youth in responsible sexuality and health and reproductive rights seminars.
Increase % of women using any method of CS	27% in KPC 9% in HHF	Availability of methods in UCS 2 clinics	Note use of all methods on girl's and mother'ss health card	Nurses trained to document use of all methods	Documentation on cards	KOMBIT focuses on family life methods. MSPP as a partner will engage for other methods.

Regional Level:

Indicator	Use of baseline information to plan strategies	Strategies for improved behaviors	Activities	Training in BCC at this level	How monitored	How will these new behaviors continue?
Percent of women who deliver with a skilled attendant	KPC 10%. MSPP reporting is based on TBA assisted deliveries.	Regional reporting needs to expand to include self delivery, TBA delivery, nurse and MD delivery for more accurate reporting.	KOMBIT medical staff will conduct a process to adjust the reporting at the level of the Department of the Grand Anse in conjunction with the National MSPP epidemiologist.	Regional message for hospital delivery. Training on new report form. Initiate a community mobilization program regionally for all MNC messages.	Monitor reporting for accuracy. Interview mothers at post partum sites	By institutionalizing the definition of "skilled attendant" to mean medically trained personnel.
Percentage of post partum women examined by a doctor, nurse or a auxiliary nurse within 72 hours of birth	KPC 20% 25% in HHF zones	Availability of trained staff at clinics and hospital. More nurses must be sent to nurse midwife training. Consistent messages that women should seek postpartum consultation within 3 days of delivery.	Regional health fairs Radio spots Banners Posters Leader meetings to cover UCS 2 remote areas. More rural mobile perinatal "clinics" that are well attended.	CBO promotion. Training and support of nursing staff for enhanced rural perinatal clinics. Engage nursing students and medical residents Possible nursing student practicum	Meetings at the regional level related to staffing retention and motivation.	Number of staff nurses in year 5 compared to baseline for UCS 2
Increase % of mothers who complete LAM	KPC no data (4.5% currently using) HHF 22% MSPP does not report this data routinely.	Engage CBOs in remote areas, this intervention does not require medical expertise.	Meet with Protestant and Catholic pastors and leadership in year 1 Meet representatives of women's religious groups to plan training and support. Fathers' Clubs engagement for family health at representative levels	Training ofCBOs, women's group representatives, school trainees, in family life methods such as this and exclusive breast feeding. Community mobilization regionally	Review mother'ss cards Monitor regional level meetings related to non-commodity based methods of child spacing Final evaluation should include where method learned to identify effectiveness of community mobilization	By setting a community standard and expectation.

Indicator	Use of baseline information to plan strategies	Strategies for improved behaviors	Activities	Training in BCC at this level	How monitored	How will these new behaviors continue?
Increase % of women using NFP methods (CMM, SDM)	See above	Same as above Add these methods to clinic FP mix	Expand Family Life Method training to non-medical personnel and include journalists and radio. Plan training with Georgetown University for the new SDM	Training in interpersonal communication should include non-medical people for expansion of modern methods that are not commodity linked - SDM	UCS 2 report and modified MSPP. Descriptions of training that includes non-medical personnel.	Speed of expansion of methods relative to numbers of non-medical personnel trained. Mass media and religious engagement of methods in rural areas.
Increase % of women using any method of CS	See above	Regional coordination	UCS 2 meetings to discuss medical and non medical methods	Technical training Interpersonal skills training Health fairs and radio spots during the feast day of Jeremie (August)	Descriptive accounts of regional activities	Inncorporate in Departmental Plan

National level:

Indicator	Use of baseline information to plan strategies	Strategies for improved behaviors	Activities	Use of Research to guide policy	How monitored	How will these new behaviors continue?
Percent of women who deliver with a skilled attendant	KPC 10% 11% national (DHS 2000) Problem with national definition of skilled attendance which includes TBAs	Meetings at National level with MSH and the USAID CSHGP liaison to improve understanding of need for common definition and resource development with the Minister of Health and Director of Reproductive Health	National meetings in January hosted by USAID Haiti and MSH Boston. National forum with Ministry of Health (epidemiologist advisor) to discuss this issue.	USAID and other international documents about "skilled attendant" and the impact on maternal mortality reduction. Share international studies	Descriptive accounts of progress. Increased trainings of nurse midwives. Increase number OB doctor in Jeremie referral hospital	Through development of new national policy.
Percentage of post partum women examined by a doctor, nurse or a auxiliary nurse within 72 hours of birth	KPC 20% HHF 25% Not enough staff No nurse midwives Clinics closed on weekends Poor road infrastructure	Maternal death audits to begin regionally in KOMBIT, mortality reviews will identify causes for delays in seeking care. National policy for births in birthing centers or hospitals. National policy reform to recommend 3 day consultation for all post partum women.	Birth Preparedness Complication readiness matrix (JHPIEGO) used as a tool in the pre-KOMBIT phase. Repeat in KOMBIT and move to step 2 of action plan for perinatal care. Promote use of HHF MWH in Jeremie through schools, CBOs, radio spots.	Increased national support for nurse midwives	Number of women examined by a nurse or MD within 72 hours of birth.	Incorporate in Departmental and National Plan

Indicator	Use of baseline information to plan strategies	Strategies for improved behaviors	Activities	Use of Research to guide policy	How monitored	How will these new behaviors continue?
Increase % of mothers who complete LAM	KPC no data (4.5% currently using) HHF 22% MSPP does not report this data routinely.	National policy and norms exist. Publish national norms regionally. Develop curriculum for medical and nursing schools.	Share LAM and BF impact on maternal and child health at national level. Operations research about total fertility rate decline and BF-LAM use. KOMBIT-HHF results will be documented for national use.	Share research findings at national level.	Documentation of results and regional training.	National policy and institutionalization of the BF-LAM
Increase % of women using NFP methods (CMM, SDM)	Not in national policy and norms	SDM at national level through USAID and Georgetown University CMM experience at HHF will be better documented and implemented in KOMBIT	Share KOMBIT experience in HHF and KOMBIT with national level decision makers.	Share research findings at national level.	Documentation of results and regional training.	National policy and institutionalization for inclusion of NFP

E.2.b. Maternal and Newborn Care Quality

Increase to 50% of patients divided into causes of referral or diagnosis to the next level of care
Increase to 50% of completed referrals to the next level of care
Increase to 30% of neonates examined by a HA within 72 hours of birth
Increase to 40% of post partum women examined by a HA within 72 hrs

Improvement in the quality of the maternal care environment at the community and clinic levels will lead to improvement in the referral system and the postpartum evaluation of women and neonates to identify early problems. The project has chosen several training topics that will contribute to the improvement in the quality of services provided by workers at all levels.

HOME BASED LIFE SAVING SKILLS (HBLSS)

KOMBIT will adopt HBLSS as one of the major maternal/newborn care interventions. The American College of Nurse Midwives (ACNM) will train KOMBIT staff in the implementation of HBLSS, establish a monitoring and supervision plan and participate in an evaluation of the training.

ACNM has provided detailed information about the HBLSS program:

Background: In a recent editorial in the British Medical Journal Costello, Orsin and Manandhar emphasized, "Most maternal and newborn deaths take place at home, beyond the reach of health facilities. Current international policy emphasizes the provision of skilled birth attendants and improved health facilities as key interventions to reduce maternal and neonatal morality. Such policies are essential to achieve what should be a basic right for every woman. But skilled attendance and institutional delivery alone is not a credible strategy to reducing mortality in populations where most mothers deliver at home." Promising programs, such as HBLSS and similar home and community-based maternal and newborn care interventions, provide access to the most basic care for poor, underserved, rural populations who carry the greatest burden of maternal and newborn morbidity and mortality. As Costello et. al. recommended, "large-scale community effectiveness trials are both necessary and feasible if we are to make further progress with reducing maternal and newborn mortality such trials are important: they measure the true scale of a problem, accurately assess community and cost-effectiveness, and avoid investment in ineffective strategies."

With the implementation of HBLSS training, HBLSS "Guides" will be trained to function in the community. Their performance is measured pre training, post training and at one year ex-post training using skills checklists. [For example in Ethiopia, the post training performance score for HBLSS Guides for "First Actions – Immediate Postpartum Care" was 87% (a 78% increase over the pre training baseline) and 79% at one year (a 9% decrease).]

The training will allow case management to be performed by HBLSS Guides. The experience of ACNM is that, compared to other unskilled attendants, guides are more likely to use the "first actions" as defined in the program. This was determined using in depth interviews and audit forms. [For example in Ethiopia, the case management score for "First Actions" was 89% for HBLSS Guides, compared with 32% for other unskilled attendants.]

HBLSS teaches skills using a checklist to observe performance. The HBLSS Guides teach women and families in the community as they were taught, using pictorial Take Action Cards, role-play and demonstration and using a variety of venues. [For example in Ethiopia, the post-exposure performance score for women for "First Actions" was 55%.]

Determination of population coverage will be ascertained using interviews and record review, including community log books and facility records. [For example in Ethiopia, HBLSS guides attended an estimated 24%-26% of births, while an estimated 54% of women were exposed to HBLSS training. Other findings show that the HBLSS program is well organized and integrated by the HBLSS team into existing health promotion activities. Importantly, the program is well accepted and supported by community members who appreciate its practical action oriented approach. The HBLSS lifesaving practices become part of household behaviors and will remain far beyond the life of the project.]

Quality of care at referral sites is determined by follow-up monthly support visits by the HBLSS coordinator to discuss HBLSS referrals, review patient care records, and document woman and newborn care units for infection prevention and equipment/ medications for life-threatening problems.

The implementation of HBLSS will be throughout the KOMBIT area, thus improving skills in partner and collaborating organizations and all communities.

HBLSS Cascade Training Plan

HBLSS training utilizes a cascade approach to increase capacity in the recognition of complications and ability to take action at all levels. Four levels are defined:

First Level = ACNM consultants. These 2 consultants will train 24 Master Facilitators.

Second Level = Master Facilitators (24 nurses and health agents trained as master facilitators). These facilitators will initially train 24 Village Guides. However, they will have the capability to train many more village guides in the future, as needed, as the knowledge and skill remains with them. This is a means to make the activity sustainable into the future. They also become responsible for follow-up and support of the Village Guides, as a support and supervision activity to maintain the village guide's knowledge and skills. They also are able then to identify problems (system or other problems) and find solutions to strengthen the activities.

Third Level = Village Guides (24 Health agents and TBAs trained as village guides). These village guides actually educate women, families and birth attendants. They may conduct the participatory learning in a family's home, or they may bring a number of families together to share information and skills. They may also work closely with community organizations to support what the community and health organizations have jointly agreed to be their activities, objectives, goal.

Fourth Level = Home birth team (pregnant woman, family member, birth attendant) This is the group that is targeted for learning about how to deal with the delays, emergency first aid, referrals, and preventive and safe care.

SCOPE OF WORK: HHF – ACNM 2005-2006

Schedule of Activities:

1 day	Finalize preparation
2 days	Plan HBLSS training with leaders
2 days	Facility orientation for practitioners
12 days	Learning with Learners (24 master facilitators)
6 days	The 24 master facilitators teach 24 village guides
1-2 days	Wrap-up and plan for follow-up trip

Note: This training was originally planned for July 2005. It was necessary to postpone it until after the elections in Haiti due to travel restrictions of USAID. The training will most likely take place in January 2006. The schedule below is an example, the dates no longer coincide with a specific month.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
4	5	6	7	8	9	10
					Diana Arrive	Kelly Arrive
11	12	13	14	15	16	17
Finalize Prep	**Plan HBLSS Training with Leaders**		**Facility/Practitioner Orientation**		M & E	Prepare for HBLSS
18	19	20	21	22	23	24
	Week 1 Trainina of Master Facilitators					
25	26	27	28	29	30	31
	Week 2 Trainina of Master Facilitators					
1 Aug	2	3	4	5	6	7
	Master Facilitators Teach Villaae Guides					
8	9	10				
Wrap-up and Plan Next Trip						

Consultant Days:

Diana Beck = 32 Days	1 prep 2 travel 28 in-country 1 post
Kathryn (Kelly) McNatt = 22 Days	1 prep 2 travel 18 in-country 1 post

Products:

1. Leaders (number = 4) oriented to HBLSS and how to support the nurses and health agents trained as master facilitators
2. 24 Nurses and health agents trained as master facilitators
3. 24 Health agents and TBAs trained as village guides
4. Collaborate with master facilitators and village guides to develop action plans for subsequent trainings
5. Review existing M & E system, integrate key HBLSS information needs and plan future monitoring and evaluation.

An ACNM consultant conducts one monitoring and follow-up trip; this includes developing a monitoring and supervision system with the assistance of the HBLSS coordinator, conducting post test and observational assessment of the HBLSS trainers to certify trainers, conducting 5-day Supervision workshop for the HBLSS trainers, and beginning monitoring and supervision activities. ACNM long distance support provides assistance with monitoring data and analysis. [For example in Ethiopia, an ACNM consultant conducted three monitoring and follow-up trips to: 1. draft monitoring and supervision system, certify trainers and conduct Supervision Workshop, 2. conduct supportive supervision activities and ensure data accurately recorded in the community logbook and facility records, begin audit interviews, and, 3. complete audit interviews and develop long-term HBLSS plan. The impact of the HBLSS training on maternal and newborn mortality was not evaluated because of the requirement of very large statistical denominators. Any inference concerning potential impact is based on the assumption that appropriate case management of complications and referral will increase the chance of survival.]

Supportive supervision in HBLSS is required for the success of HBLSS. The HBLSS philosophy and supervision system respects local customs and uses (as possible) the local supervisory mechanisms. The ideal support comes from:

- An HBLSS community. This group varies by locality and is made up of those trained in HBLSS such as: Guides, families, other health agents, and community organizations
- HBLSS trained Guides from other communities
- HBLSS trainers and supervisors who were involved in the HBLSS training
- Referral site staff who provide feedback and clinical information updates.

Supportive Supervision System

The supportive supervision system in HBLSS is an ongoing system of follow-up visits and monitoring. This system will fit within the existing system of supervision for KOMBIT; by incorporating follow up and monitoring visits are integrated into the existing system a sustainable HBLSS program will be ensured. [For example in Ethiopia, HBLSS trainers provide supportive supervision for HBLSS Guides when the

Guides participate in the community health organization monthly meetings. If possible, the HBLSS Guides are visited twice a year in their communities. This arrangement is consistent with the existing NGO system of supervision. Complication audits are conducted on reported complications every three months by HBLSS trainers. To strengthen HBLSS supervision, supportive supervision training is necessary for those responsible (not HBLSS trained) for supervision.]

Integration of Monitoring and Evaluation Records and Forms
Documentation of HBLSS indicators and HMIS for MandE will reflect the needs of the HBLSS program, KOMBIT and MSPP to avoid duplication of reporting and forms. [For example in Ethiopia, the HBLSS indicator tracking. HMIS and MandE system was drafted to integrate with NGO/MOH MandE monthly report system.]

Plan for Sustainability
As described above, the system will fit within the existing system of supervision for KOMBIT/MSPP. Follow up and monitoring visits will be integrated into the existing system to ensure a sustainable HBLSS program. Reporting records and training materials are simplified and easily reproducible. The training resources (demonstration dolls, apron, gloves/plastic bags, soap/water, basin, etc) will be locally made or locally available and/or come from the home. Support for the guides and families will be incorporated ingoing community mobilization and health education programs. Progress will be monitored, discussed by program staff and community representatives and procedures will be modified to improve HBLSS implementation and effectiveness. Because KOMBIT is working in partnership with MSPP, SGS and so many other collaborating agencies, the likelihood of long term impact and sustainability is high.

Perinatal Tracking System

KOMBIT will adapt the Perinatal Information System(SIP) in conjunction with MSPP in the area. The Pan-American Health Organization created the Latin American Center for Perinatology and Human Development as a Regional Technical Center to cooperate with the governments and the institutions in the improvement of their services to women and children. One of the key aspects of this improvement is the adequate management of relevant information at the local level of the health services, clinics and maternity hospitals**.**

The Center has developed original tools to foster perinatal health and to disseminate the best available practices. One such tool is the Perinatal Information System (SIP), which consists of a standard clinical record and software to manage the information. The software developed in 2000, and available in French, features health indicators for the health provider and manager as well as the availability of statistical references on the web. The reference data and its indicators are derived from clinical databases automatically merged by users from their hospital desktop computers. SIP forms and methods have been a standard for registration of basic clinical perinatal care in most countries of the region for the last 15 years. There is a barrier to the full exploitation of SIP due to lack of sustained actions in training and dissemination.

The main advantage of SIP is that it includes a *de facto* regional standard of clinical data based on its relevance for the care of each mother and infant. This primary information, collected in a specially designed first page of the clinical record, is copied onto a card that the mother carries to each prenatal visit and when admitted to the hospital during pregnancy or for delivery. This card is called Maternal or Obstetric passport. Carrying this complete information with her is often the only practical alternative to data transmission between different levels of care in the health services, from the clinics to the hospital.

The SIP system provides the workers immediate feedback on their actions, as well as suggesting the best actions to take at that specific point of care. Supervision and quality assurance at all levels is easy to perform with SIP, as has been documented in small countries such as Uruguay, provinces of Argentina, areas of Peru, Bolivia, Honduras, Nicaragua, and islands such as the Bahamas.

The data collected with SIP can also be filed, transmitted, retrieved and analyzed by EPI Info compatible software developed by the Center in collaboration with the US Centers for Disease Control (CDC).
KOMBIT will facilitate the use and integration of the SIP system into the entire KOMBIT region, adopting the QA methods that have been developed by the Center.

Both the SIP and Mothers' Clubs will be used in the referral system to be adopted the project. Details of the referral system are provided in the monitoring and evaluation section.

E.2.c. Maternal and Newborn Care Access

Increase from 12 to 60% of maternity service sites with satellite phones, communication to referral centers for OB emergencies Improve health facilities to improve maternal care

Access to maternal/newborn care will be accomplished through three main interventions.
Satellite phones and satellite phone service will be provided by KOMBIT to improve communications between dispensaries and the hospital for the provision of emergency care and for the dispatch of ambulances when available. In addition, KOMBIT activities will work to improve the commodities available at facilities for maternal care.

As described in the summary of baseline findings, health facility assessments were conducted to determine the presence or absence of key maternal care materials. During the DIP preparation workshop, partners were asked to prioritize the materials as listed. The following table reflects the results of this prioritization.

Priority #1 indicates items which every dispensary needs urgently, every day, or are so important that they must be always available in the dispensary. If they are not available in the dispensary they must be supplied within a week after they are out of stock.

Priority # 2 indicates items which are essential to the dispensary but their replacement is not an emergency, and can be restocked within a month or a quarter.

Priority #3 indicates those items necessary to the dispensary but when they are not available, the dispensary can wait up to a year for their replacement.

PRIORITIZATION of MATERIALS, MEDICINES and EQUIPMENT for MATERNAL HEALTH in the 8 KOMBIT Dispensaries

Medicines, Supplies, Resources	Priority	Medicines, Supplies, Resources	Priority
Women's health cards	1	**Poubelles dans chaque service:**	
		Contaminated materials	1
		Non-contaminated materials	1
Prenatal consulting room	1	De-contamination solution	1
Tetanus toxoid	1	Sterilization materials	1
Prenatal registry	1	Encapsulating materials	1
Prenatal patient record	1	Household gloves	1
Postnatal patient record	1	Clean latex gloves	1
Referral forms	2	Sterile latex gloves	1
Amoxicillin	1	Incinerator	3
Antiacide	2	Garbage pit	1
Chloroquine	1	Other methods of disposal	1
Cotrimoxazol	2	**Protective clothing**:	
Cotrimoxazol vaginal	2	Aprons	2
Dibenzyl penicillin	1	Goggles	2
Anti-eclampsia medications	1	Gloves	1
Magnesium sulfate	1	Slippers	2
Ergometrine	1	Special care with sharp objects	1
Pitocin	1	Avoid contact with body fluids	1
Tetracycline ophthalmic	1	**Equipment decontamination by**:	
Iron/folic acid	1	Chlorox solution	1
Prenatal vitamins	2	Wash in soapy water	1
Oral rehydration salts	2	Disinfect or sterilize	1
Obstetrical stethoscope	1	I. Clean rooms and furniture	
Vaginal speculum	2	With disinfecting solution	1
Lighting system	1	**Appropriate destruction of waste:**	
Compressive dressings	2	Burn or bury placenta and Needles	1
Gallons of sterile water	2		
Examination table	1	**Personnel Skills:**	
Adult weighing scale	1	Catheterizing the bladder	1
Tape measure	1	Stimulating the nipples by:	
Sphygmomanometer	1	Putting baby to breast	1
Standard for measuring height	3	Rolling the nipples	1
Metronidazol	2	Intravenous rehydration	1
Albendazol	3	Intra rectal rehydration	3
		Stopping uterine bleeding by	
		Bimanual, external compression	1
		Bimanual,internal compression	1
		Pitocin	1

BREASTFEEDING
Increase to 20% mothers who BF before placenta expulsion
Increase from 60% to 85% of mothers who exclusively BF for the first 6 months

HHF added exclusive breast feeding to its community-based primary health care program in 1993 and will expand this intervention into KOMBIT. HHF began a program to promote the Lactation Amenorrhea Method (LAM), in collaboration with Georgetown University by training all of the nursing staff in lactation support, rapid care for women with BF problems, supporting fathers and obtaining breast pumps. In 1995, the year HHF joined the UNICEF-sponsored national breast feeding campaign; HHF reached a critical mass of over 1000 women who breast fed exclusively for six months. During the campaign UNICEF provided funding for educators to make home visits to promote breast feeding; later this was phased out as HHF recruited women who exclusively breast fed to work as volunteers in counseling ten other women. HHF began to document and computerize each mother'ss breastfeeding pattern (complete, partial or initial). This program continues today.

In 1995 HHF also re-introduced and supported the practice of "wet nursing" for babies of mothers who had died in childbirth (MMR is approximately 700/100,000 in this area of Haiti). Mothers with babies of the same age receive a thorough physical examination (including HIV testing), and if healthy, are supported with food, vitamins and public support for this life saving gift. Since 1995, 25 babies have been nursed successfully in this program, most by women who were not family members.

In addition, HHF encouraged the shift from the common practice of giving newborns an unhealthy purgative called lok (castor oil, nutmeg and other ingredients). HHF adopted the approach used by CARE/Haiti, teaching "the first milk is the best purgative." An evaluation in 1998 found that the practice of giving lok had been nearly discontinued in the HHF service area. In addition, using the LQAS methodology, it was found that 66% of women in HHF areas breast fed exclusively to 6 months compared to a national rate at that time of 0.6% (2000 DHS)

In 1999, HHF designed a girls' home-based health card that included information on pre-pregnancy care, youth group membership, tetanus toxoid vaccination and other variables. It also includes information about the experience and outcomes of 4 pregnancies including delivery information and space for tracking infant feeding. By 2005, over 30,000 of these cards will be distributed and in use in a population of 200,000 people.

Lessons learned about the introduction of exclusive breast feeding include:

1. Support of nurses and doctors is critical as they often introduce bottle feeding. This includes the use of Medela breast pumps and a 3 month maternity leave from work at HHF and support of pumping at work;
2. Develop a variety of activities for social mobilization of breast feeding - support of dads, breast feeding clothing fashion shows, distribution of cups and spoons for expressed breast milk, obtain baby spoons to replace bottles.
3. Strong and consistent messages about using colostrum rather than a foreign substance (lok) with grandmothers took hold over a period of 5 years;
4. Support of fathers with tee shirts when their wives reached 6 months of exclusive breast feeding was an important aspect of the program;
5. Engaging "mother graduates" to provide mother to mother support was very successful and accounts for the continued success of the program since 1995;

6. the UNICEF program for Baby Friendly Hospital came at a good time to reinforce exclusive BF promotion in hospitals
7. The use of a home based health card that includes tracking BF enhanced reporting;
8. Use of the LAM method of family planning in a place as remote as Jeremie was very successful. The 1998 program evaluation suggested that the TFR in HHF was 3.5 compared to the national average of 5.2 at that time. Further study was recommended.

Child Spacing/Family Planning

CHILD SPACING
Increase to 15% of mothers who complete LAM
Increase from 4% to 10% of women using NFP methods (CMM, SDM)
Increase from 24% to 35% of women using any method of CS

KOMBIT will implement the standard methods of NFP, and introduce "cycle beads" to increase fertility awareness. This activity will constitute the main child spacing activity of HHF but and will occur in the context of the comprehensive child spacing services that are provided by the MSPP Kombit partner. It is estimated that 27 million couples worldwide (21 million of these live in developing countries) use periodic abstinence to avoid pregnancy. Thus, 2.6% of all couples in the reproductive age span are using periodic abstinence. Moreover, analysis of data from 15 low and middle-income countries found that about 28% of contraceptive failure is attributable to incorrect use of periodic abstinence. The majority of these couples do not know when they are most likely to get pregnant. Additionally, millions of women who do not want to get pregnant are not using any method of family planning. Others are using a method inconsistently, switching methods frequently or discontinuing a method after just a few months of use. In Haiti, only 28.1% of married women reported using contraception in the most recent DHS, with only 22.8% using modern, effective methods. Many of these women could benefit from simple, accurate information about their fertility so they would know when to avoid unprotected intercourse to prevent pregnancy.

Research shows that when people can choose among several different contraceptive methods they are more likely to find – and use – a method that appeals to them. The addition of one new method throughout a country increases the contraceptive prevalence rate by an average of 12 points

The Standard Day Method (SDM), developed by the Institute for Reproductive Health (IRH) at Georgetown University, may help meet the needs of many Haitian couples. SDM is a safe, easy-to-use and effective method of family planning, based on fertility awareness. Women with menstrual cycles between 26 and 32 days can use the SDM to prevent pregnancy by abstaining or using a condom on days 8-19 of their cycles. SCM has been studied in a rigorous international efficacy trial that conformed to internationally recognized criteria; this showed that the method is more than 95% effective when used correctly.

Results from the efficacy study [6] confirmed that women are able to use Cycle Beads and find them a useful tracking and communication tool. Cycle beads are part of SDM in most settings. These beads represent each day of a woman's menstrual cycle; she moves a rubber ring over one bead every day to visibly track where she is in her cycle, and she marks the first day of menstrual bleeding on a calendar. The beads are color coded to indicate whether the woman is on a fertile or an infertile day. A red bead represents Day 1 of the cycle, which is the first day of menstrual bleeding; 6 brown beads follow (indicating that the first 7 days of the cycle are not fertile). Days 8-19 of the cycle are represented by white beads, which represent the fertile window. Women are counseled to avoid unprotected intercourse when the rubber ring is located on the white beads. Days 20-32 are represented by brown beads, and are days on which pregnancy is very

unlikely. To assist a woman in tracking her cycle, the bead for day 27 is darker brown in color. Women are counseled that if menses returns before the black band is on the dark brown bead she has had a short cycle, and she is advised to visit her service provider. The same advice is given if the woman completes the 32 day cycle and her menses has not returned. The SDM can be used by a wide variety of women—as long as their menstrual cycles usually last between 26 and 32 days (according to WHO, 80% of cycles are in this range). If a woman has more than one cycle outside of the 26-32 day range, although the SDM will still offer her some protection, she is advised to consider another method, since the efficacy figure of 95% is for women with a maximum of one cycle out of range in the 13 monthS period of the study. Like all FP methods other than condoms, the SDM does not protect against STIs or HIV/AIDS.

SDM can be taught by a trained provider or community health/outreach worker to women, men, or couples in either individual or group sessions; this usually takes about 20 minutes. SDM is a modern, scientific method which provides two couple years of protection (CYP) per user

Although it is a relatively new method, it has already been incorporated into guidance documents for contraceptive use published by the World Health Organization. These documents explain that the SDM, like other fertility awareness-based methods of family planning, does not have any negative effects on the health of people who choose it.

An example of findings from a recent IRH assessment of a one year pilot program (2003-4) of 13 sites (12 rural) in Rwanda is included below. Based on these results, plans are underway to increase the number of sites to 48.

Key Preliminary Findings from Rwanda Assessment

- During year one of SDM introduction in Rwanda, 818 clients chose to use SDM, and only 12 pregnancies were reported. Interviews with women who became pregnant using the SDM showed that all but one (knowingly) had unprotected intercourse on days of their cycles identified as fertile
- Less than 5% of SDM users had previously used FP.
- Intent to continue using the method is almost universal;
- Over 90% of women and their partners find management of the 12 day fertile period easy;
- Over 20% of couples combine SDM and condom use, which suggests increased use compared to 2000 DHS findings that less than 4% of men had ever used a condom;
- Many clients have discussed the SDM with others;
- Providers find the method easy to teach and learn;
- Clients find the method easy to learn and use;
- Knowledge of the fertile period among SDM users was over 90%, compared to 9% in the 2000 DHS.

While the SDM is not difficult to provide and does not require any special procedures or equipment, the accuracy of the information provided to the client and the quality of the counseling are critical to successful method use. Thus, the KOMBIT program will employ Georgetown to carefully train providers. The length and content of the training depend on the providers' existing skills. International experience suggests that high level providers with family planning experience can be trained to offer the SDM in less than two hours. Community-level workers may need up to two days of training.

Providers may need refresher training and support during the first months of service delivery to make sure they have mastered the key elements of SDM counseling. This will also provide them an opportunity to discuss questions that arise while offering the method.

To ensure quality, the following activities will be conducted:

1. Adaptation, implementation, and monitoring of training and supervision tools, aids, BCC materials, and implementation guides for SDM service delivery;
2. Integration of SDM data collection, into existing data collection/monitoring and evaluation systems;
3. Training SDM trainers and service providers to correctly offer the method and record statistics.
4. Technical assistance on SDM work-planning, monitoring and evaluation, and research design to implementing partners.
5. Provision of sample supervision guides for local adaptation and use;
6. Technical assistance on how to monitor providers' and supervisors' willingness to continue offering the method (for example, provide sample focus group discussion guides);
7. Assistance on how to profile clients who choose SDM and estimating user acceptance, satisfaction, and continuation by providing sample instruments and designs for focus group discussions, key informant interviews, and other qualitative research techniques;
8. Technical assistance on collection of service statistics of new users, number of active providers, and number of sites offering the method;
9. Sharing information and experience on how the SDM can be integrated into national RH norms and policies;
10. Technical assistance in the development of pre-service and in-service curricula to integrate the SDM;
11. Assist in design of a study to test the feasibility of offering SDM through alternative channels, such as social marketing.

New Birth Spacing Interval Recommendations

The USAID fundeed Catalyst program has determined that a 3-5 year birth interval is optimal for both infant and maternal outcomes. The current messages and currriculum incorporated into the HHF natural famillly planning program and child spacing activites provide guidelines for the progam participants to guide their child spacing decisions. This new recommendation of a 3-5 year birth interval will be examined during the Kombit child spacing program implementation. The Kombit staff and the child spacing coordinator will be presented with and discuss the data which demonstrates improved outcomes with the 3-5 year birth interval. Using established methods employed by HHF for the development of curriculum and messages, the Kombit staff will explore and test mechanisms to provide Kombit program beneficiaries the most up to date and accurate information for optimal health

Referral for child spacing and HIV prevetion

HHF promotes responsible sexuality and provides education on behavior changes to avoid transmittal. HHF is an ecumenical organization that incorporates Catholic philosophy in its programming. To provide comprehensive services, women who request expanded options are referred to the HHF partner organizations. In the UCS2 intervention zone, open communication exists among all health providers in terms of family planning and HIV testing and counseling. Different methods are promoted depending on Institution's mission. HHF , reinforces Abstinence & Fidelity through community informative sessions at mothers clubs, fathers clubs and youths clubs. The adults are referred to St-Antoine Hospital for counseling on various preventive methods or modern methods of family plannin. The sexually active youths are referred to youth's centers in the vicinity of Jeremie such as: FORSEF and VDH (Volunteer for the Development of Haiti).

Kombit does not have a formal HIV component as one of the planned interventions, however, HHF is actively involved in HIV prevention activites in the area as described in the description of the PVO. The clinical services of HHF have established a formal system for referral of women and adolescents with the MSPP to the St-Antoine Departmental hospital:

HHF conducts prenatal HIV testing on all patients who are seen at the HHF clinic. Comprehensive HIV testing is not avaialabe in the entire Kombit project area at this time. HHF prepares list of HIV infected mothers and date of birth with needed medication then sends list to the Hospital's Gynecologist. If the patient fails to come on the estimated date of birth, HHF is notified for follow-up with health agents.

HHF also refers patients to St-Antoine Hospital for free ARV treatment. Geskio provides material to both centers to support institutional visits and monthly meetings. Counter-reference is tracked and cases discussed to agree on intervention and treatment.

E.3. PROGRAM MONITORING AND EVALUATION PLAN

Program Monitoring and Evaluation Plan:

The KOMBIT monitoring system will be based on the existing MSPP and HHF information systems, as well as incorporate a new system to track all pregnancies and monitor referrals. This approach will provide quality information for decision-making and improvement of maternal/newborn care. The general HHF and MSPP data systems will be described and then discussed in terms of areas of monitoring and evaluation relevant to KOMBIT. Then specific maternal/newborn monitoring and evaluation methodologies used by MSSP and HHF will be presented, followed by the new pregnancy tracking and referral monitoring systems.

HHF Health Information System

HHF has developed a comprehensive health information system that is based on a census of the 150,000 people in the service area; it is continuously updated with health information such as weights, immunizations, pregnancies and deaths. HHF's HIS is called PHACT (Public Health Active Census Tracking) and is a visual Fox Pro data base. PHACT replaced the census program that was used from 1988 to 2000. It is a repository of all health and social data for households, families and individuals who live in villages and neighborhoods in the Counties of Jeremie, Roseaux, Moron and Bonbon in the Department of the Grand Anse. Family health is tracked through the mother and data is primarily focused on maternal and child health.

The Census was originally conducted in 1988, shortly after HHF was established, and has been updated monthly when new families or persons enter the registered areas. Additional Censuses were conducted in 1991, 1995 and 2000. This allows for validation of information collected previously as well as the routine updates.

Health agents (about 1:2000 population) known as "Agents de Sante" (HAs), under HHF staff supervision, make regular visits to homes and utilize rosters of all women in the reproductive age group in their villages ("Suivi femmes" registers). Health agents help collect and update all PHACT information, and receive monthly reports categorized by age (in 5-year age groups), services (immunizations and coverage rates) and vital events. This information is used to for program monitoring and planning, health agent performance and community level indicators. HAs carry rosters printed out from the information system and update these during home visits and at rally posts. In 1998, a 10 year program evaluation was completed by external reviewers. Using LQAS, they found the concurrence between HIS data and home based mother and child health cards was 98%. The HIS database has been used by the CDC and NIH for population-based studies. HHF is able to locate over 85% of all people who were in the original census in 1988 (base population 28,000).

MSPP Health Information System

MSPP requires monthly report forms from all private and public facilities that provide prenatal and newborn care. These data are automated, using a software system that allows for compilation of monthly reports annual reports from each health facility. Selected data from are compiled into an annual report for each facility that is sent as "feedback." The local district office receives monthly reports from outlying health centers and dispensaries, and these are tabulated to provide feedback to outlying dispensaries and health centers, whether public, private, or mixed. Information collected during the month includes maternal and newborn services, immunizations, and IEC delivered. MSPP reports will need to include new information to document some KOMBIT interventions. See discussion of new section of MSPP reporting below.

The HHF TBA ("matronne") birth reporting system.
HHF has trained and is supervising 300 TBAs who provide monthly reports on all their pregnancy outcomes/births. They do not deliver all women and therefore cannot report on the 5% births that are unattended. TBAs report live/still birth, immediate survival status of mother and child, and whether the child was put immediately to breast. They are instructed to alert the local health agent who registers the birth and completes a birth declaration form. TBAs also note the geographic area of the birth (births within the registered population by locality, births in the same locality but in an unregistered zone and births that they attend from outside the HHF reporting system area). This system complements the above HAs reporting system and can act as a "double check" on it.

The RAMOS Questionnaire and Maternal Mortality Review
The purpose of this activity is to document the number and proportion of deaths to women 14-49, and investigate those that may be maternal mortalities (WHO definition: death while pregnant or within 42 days of a pregnancy termination due to pregnancy related causes). The KOMBIT partners have already met and been trained on the use of the RAMOS questionnaire for deaths of women in the reproductive age group. HAs have been trained, and as of January 1, 2005, these questionnaires have been submitted to the HHF nurse supervisor who works with the KOMBIT nurses on a regular basis. All maternal deaths are followed up with a Verbal autopsy that is performed by a nurse.

The Verbal Autopsy System investigates deaths of women in the reproductive age group since nurses and others have been trained to apply the verbal autopsy form, the entire team of health personnel will be able to conduct monthly "maternal morbidity/mortality" reviews to consider whether any maternal deaths might have been preventable. These reviews will provide information to support new approaches to project implementation and policy at every level. For example, the MSPP approved the use of death investigations for all women 15-49 in defined populations (RAMOS), and authorized the use of "verbal autopsy" for those deaths related to maternal causes. A volunteer board in UCS 2 will review the data for their area, and determine what can be done to reduce delays in care that led to maternal deaths. The conclusions and recommendations of the review board will also affect and improve maternal and child health care in Grand Anse.

New Monitoring Tools in KOMBIT
KOMBIT will use the HHF and MSPP tools currently in place for much of the project monitoring. In addition, KOMBIT will employ 2 new data systems to enhance program monitoring—Mothers' Clubs reporting and the PAHO perinatal tracking system. By utilizing and enhancing all of these systems, KOMBIT will ultimately develop a system to track all pregnancies and monitor referrals.

Reporting by Mothers' Clubs
HHF has been working with mothers clubs since 1988 as described in Annex II. Volunteer Mothers for Safe Motherhood (VMSM) will be initiated in areas without Mothers' Clubs (in areas with Mothers' Clubs they will develop a more representational structure). These will be locally chosen representatives (one woman will represent 20 families in her neighborhood) and will report on pregnancies/pregnancy outcomes in each village. Where there are HAs, this becomes a "double check" on the reporting system. The purpose is to see that no pregnancy is missed, that every pregnancy is registered as early as possible, and that the women's group representative can educate and support pregnant women. It is based on the fact that women know who is pregnant in their neighborhoods even before the health agent does. In villages where there are no HAs, the women's group representative will substitute for HAs in reporting all pregnancies to the MSPP. Initially, in villages with the two pregnancy registration methods, this will be used as a validation of the reporting system. Where there are HAs, the women's group representative will assist the HAs in identifying all pregnant women as early as possible. They will notify the HAs, and the nearest prenatal

facility or post, of new pregnancies. The women's group will retain a record of their pregnancy register, follow it, and record simple outcomes for both mother and neonate.
Women's groups can represent and report on pregnancies/pregnancy outcomes in each neighborhood, providing whole village coverage. This will be the main reporting system in KOMBIT villages of the UCS 2 where there are no HAs. It has been shown elsewhere that rural village women can represent 15 – 20 families in their area. Each women's group will register in pregnant women in triplicate: one copy to be given to the HA, one copy to the nearest heath facility or post. The one kept by the group becomes their permanent pregnancy/pregnancy outcome register. (*N.B. This approach has been field tested by volunteers in Petite Goave in 1974 –78. Dr. Carl Taylor of Johns Hopkins currently has a team in Mozambique working with World Relief to verify the reported results of mothers group reporting on all births and deaths and analyzing them for future preventive action. The women's groups there essentially do what the HAs do for families in HHF villages).*

Just as a "double entry system" is used in automated data collection in order to clean and verify data quickly, so a "double reporting system" in every village has been used by many demographers to ensure there are no missed vital events (ref: Nathan Keyfitz, Harvard Center for Population Studies, 1978). Women in a given neighborhood know about and can register all pregnancies, even if they are illiterate. HHF's system gives each woman a single unique identification number and therefore would prevent an event being registered twice.

Faith based organizations (FBOs) in the area will be invited to help develop Volunteer Mothers for Safe Motherhood (VMSM). For example, local Baptist churches have women's groups in 66 villages and have already expressed an interest in health. Last year representatives from each group came to Jeremie to be educated about breast self-examination. The Faith Mission also has many churches in the UCS 2 region. KOMBIT will assist these FBOs in developing women representatives. By organizing a pregnancy reporting system that includes all women, KOMBIT would make an important contribution.

PAHO Perinatal Tracking System
PAHO has developed a system for tracking pregnant women. It is available in French, Spanish and English and is being considered for adoption by the national Ministry of Health. The PAHO system is used extensively in Latin America to record pregnancies and outcomes. (Appendix VIII). Since the KOMBIT area has providers that speak and write all three languages, it will be a useful tool to standardize perinatal care. The software also produces reports automatically and this feature will allow each service site to evaluate its own work and follow up of women and neonates.

Referral Monitoring
Referral from the dispensary or health center to the next level is practiced but is poorly documented; counter-referral does not exist. Therefore, the MSPP representatives have asked KOMBIT to develop and implement a referral/counter-referral form. This form will have two parts, one that is kept at the referring facility and second part that the woman will take to the referral dispensary or hospital for documentation of care. The woman or her family will take this form to the referring facility when they return for care. The referring facility will attach the completed counter-referral form to the original referral form and file the referral/counter-referral document. This will provide information about numbers of patients referred, cause for referral and referral completion rate. It will also improve the quality of follow-up by the referral facility. HAs, mothers' clubs and VMSM will help facilitate this process.

Referral monitoring will also be managed using the home-based KOMBIT girls/women's health cards. (Appendix VIII) This card contains information on pre-pregnancy, pregnancy and family planning information. Referral for each pregnancy will be noted on this card and evaluated at the level of the home.

Improved MSPP Reporting

KOMBIT will assist MSPP in providing additional information in its monthly reporting. An additional data collection sheet will added to the monthly facility report (see draft format in (Appendix VIII) to document facility-based education of women about NFP methods, acceptance rates and knowledge of home based life saving skills (HBLSS). This will ensure that the facility reports only document modern methods such as depo-provera, condoms and pills.

Facility Improvement

Table 6 form the Facilities Assessment lists the items with which dispensaries are ordinarily equipped. During the Facilities Assessment, KOMBIT staff found dispensaries were working without some items they felt were necessary for proper operation of dispensary services. Knowing that several of the items needed re-supply immediately and that others were less urgent, KOMBIT partners ranked needs. After the facilities assessment, staff from each partner organization, working individually, ascribed one of three levels of priority to each item. Individual work was then compared and consensus reached on the priority ascribed to each item.

Selected maternal care services, vaccinations and other MCH activities are already monitored by the MSPP. Therefore the KOMBIT partners are already familiar with expectations of monitoring. The use of information for decision making and feedback will be emphasized through this project. KOMBIT will introduce feedback strategies and public display of progress in clinics for maternal and newborn care. Also, based on the experience of HHF, the use of a computerized data management system (such as the PAHO perinatal software) might be the key tool for improved reporting and use of computer generated summaries for each clinic. HHF has already mandated computerized reporting by all nurse supervisors.

Operations Research

HHF has been engaged in operations and field research since 1987. KOMBIT will continue this tradition by working with its collaborating universities in the US to develop operations research. HHF partners with faculty from the University of Connecticut, University of Michigan and others, and will continue to foster relationships to host public health and doctoral students to assist in small studies and data collection. One example of operations research that is planned, is that KOMBIT will test the innovative indicator: *Increase the % of women who breastfeed before expulsion of the placenta* through focus groups and post partum interviews to determine if this indicator can be measured more accurately than using a measure of time (30 minutes or 1 hour) which is not easily measured for women who do not use clock time. This practice has the dual benefit of increasing uterine contractions for the prevention of post partum hemorrhage and the encouragement of early BF. KOMBIT has also identified 2 major areas of operations research, MWH and NFP. Some ideas include effective protocols for MWH; qualitative research on the acceptance of the MWH; qualitative research on the acceptance of NFP methods; and quantitative research on the effects of NFP methods on unmet contraceptive needs and total fertility rates.

Maternal/Newborn Care

Overall responsibility for MandE is the Administrator who will work in collaboration with the partners:

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
1) Increase number of women that can name at least 2 danger signs during pregnancy	Hold seminar to decide: - On best messages based on KPC and results of maternal mortality studies - About danger signs during pregnancy HAs will take responsibility for their villages educating mothers about danger signs; in villages without HAs, CBOs will do same. Facility education sessions will include danger signs during pregnancy	Seminar to develop messages; develop brochure(s) that includes role of Center of Hope (MWH) for high risk rural women Train medical personnel (MDs, nurses), distribution of appropriate reference materials Train supervisors of HAs to train Has in new health messages Train the women leaders of CBOs to train women representatives for their entire communities (contact church leaders in Jeremie area : - Faith Mission - Baptists - Methodists -Catholic Formation of Theater Troupes for health messages; roving theatre troupe at key market places and other sites KOMBIT work calendar for these activities	**MSPP**: UCS 2 Nurse **SGS**: SGS Nurse Manager **HHF**: KOMBIT Nurse Midwife	Written results of seminar; Field test of sample brochure; Pregnancy/pregnancy outcome planning tool Outline of curriculum for training professionals; record of materials distributed. Outline of curriculum for TOT. Report on sessions and materials (HHF has model report) Outline of curriculum for women leaders and report on TOT session record of distribution of materials Outline of theater troupe's curriculum; results; dates approved Written work calendar	Reports on contacts with Women's Groups Baptists Faith Mission Methodists Catholics Exit interviews from prenatal clinics and health posts Focus group	**Midterm Evaluation**: process evaluation by interviewing women. **Final Evaluation:** KPC study

Maternal/Newborn Care

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
2) Increase number of women that can name at least 2 danger signs during labor and delivery	Hold seminar to decide best messages based on KPC and maternal mortality reviews HA s will take responsibility for their villages educating mothers about danger signs; in villages without HAs, CBOs and FBOs will do same.	Seminar to develop messages; develop brochure Train or retrain medical personnel (MDs, nurses), distribution of materials Train supervisors of HAs to train or retrain their HAs to get messages out Train the women leaders of CBOs to train women representatives for their entire communities (contact church leaders in Jeremie area : - Faith Mission - Baptists - Methodists -Catholic Formation of Theater Troupes for health messages; roving theatre troupe at key market places and other sites KOMBIT work calendar for these activities Create a KOMBIT work calendar for these activities	**MSPP**: UCS 2 Nurse **SGS**: SGS Nurse Manager **HHF**: KOMBIT Nurse Midwife KOMBIT health agents	Written result of seminar; sample brochure Outline of curriculum for retraining professionals; record of materials distributed. Outline of curriculum for TOT Report on training session and materials (HHF has model report) Outline of curriculum for women leaders and report on TOT session record of distribution of materials Outline of theater troupe's curriculum; results (in brief); dates approved Written work calendar	Reports on contacts with Women's Groups Baptists Faith Mission Methodists Catholics Exit interviews from prenatal clinics and health posts Focus group	**Midterm Evaluation**: focus group process evaluations. **Final Evaluation:** KPC study

Maternal/Newborn Care

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
3) Increase number of women that can name at least 2 post partum danger signs	Hold seminar to decide: - On best messages based on KPC and results of maternal mortality studies - About danger signs immediately after delivery and for 72 hours thereafter HAs will take responsibility for their villages educating mothers about danger signs; in villages with no HAs CBOs will do same. Facility education sessions will include danger signs during pregnancy.	Seminar to develop messages; develop brochure(s) Train medical personnel (MDs, nurses), distribution of appropriate reference materials Train supervisors of HAs to train Has in new health messages Train the women leaders of CBOs to train women representatives for their entire communities (contact church leaders in Jeremie area : - Faith Mission - Baptists - Methodists -Catholic Formation of Theater Troupes for health messages; roving theatre troupe at key market places and other sites KOMBIT work calendar for these activities Create a KOMBIT work calendar for these activities	**MSPP**: UCS 2 Nurse **SGS**: SGS Nurse Manager **HHF**: KOMBIT Nurse Midwife **MSPP:** UCS 2 Nurse **SGS:** SGS Nurse Manager **HHF:** KOMBIT Nurse Midwife **MSPP:** UCS 2 Nurse **SGS:** SGS Nurse. Manager **HHF:** KOMBIT Nurse Midwife	Written result of seminar; sample brochure Outline of curriculum for training professionals; record of materials distributed. Outline of curriculum for TOT Report on training session and materials (HHF has model report) Outline of curriculum for women leaders, TOT session report, distribution of materials Possible tool: Brochure slipped into women's health card and danger signs Outline of theater troupe's curriculum; results dates approved Written work calendar	Reports on contacts with Women's Groups Baptists Faith Mission Methodists Catholics Exit interviews from prenatal clinics and health posts Focus group	**Midterm Evaluation:** Process evaluation of CBO and FBOs **Final Evaluation:** KPC study

Maternal/Newborn Care

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
5) Increase the number of villages with a posted emergency OB and transportation plan	Develop model for plan Identify recruit and train village leadership in every village to carry out task (HAs and CBOs in villages without HAs) Identify central local in village where plan can be posted	*Update list of all villages in UCS 2 information on total population, name of HA or key CBO in village to assist in community mobilization.* Develop TOT seminar for CBOs to train their leaders (for example pastors' association that has monthly meetings in Jeremie) Identify, recruit and train at least one village leader or organization in every village to carry out task Provide materials (poster board, and permanent marker)	**SGS:** SGS Nurse Manager **HHF:** Field BCC coordinator **MSPP:** Medical Director UCS 2 HA s CBOs FBOs Leaders	Model plan Curriculum for model plan Written work calendar	Review list of villages that have written plan every 3 months Visit sample of villages that have been provided training and materials to see if plan is posted	**Midterm evaluation:** Visits to village with and without posted plans to assess process and constraints **Final evaluation:** Documentation of posted plans

Maternal/Newborn Care

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
6) Increase % of women adopting a standard pregnancy/delivery/ postpartum plan	Forum for NGOs and MSPP to present results of HHF experience with the pregnancy plan instrument and develop modifications for KOMBIT. Reach consensus with partners on use of adapted pregnancy plan to be used at all KOMBIT prenatal clinics.	Plan and schedule forum on improving methods for mothers to understand how to protect themselves and their newborns; include use of standard pregnancy plan; Develop agenda for forum and include presentations by all partners and collaborators to understand each other's innovations as well as HHF instrument Develop corresponding curriculum and TOT Include use of birth plan as part of MSPP insert sheet for monthly reporting Include information on girl's Health card about receiving educational session on birth planning.	**SGS:** SGS Nurse Manager **HHF:** Field BCC Coordinator **MSPP:** UCS 2 Nurse	Planning agenda for forum Training plan and curriculum for TOT in use of instrument Standard pregnancy/delivery/postpartum plan adapted and adopted by partners	Review list of villages that have written plan every 3 months Visit sample of villages that have been provided training and materials to see if plan is posted	Periodic exit interviews of post partum women to see if plan has been accomplished **Midterm Evaluation:** Document inclusion of plan in monthly reports **Final Evaluation:** Program reports; women reporting pregnancy plan.

Maternal/Newborn Care

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
7) Increase % of maternity service sites with satellite phones/transmission to referral centers	Participate in seminar for partners and collaborators to discuss transmission and implementation. District MSPP officers and hospital director will be included (N.B. transmission to referral center implies that center will receive transmission and act on it; consensus must be reached). Reach consensus with partners on sites, use of satellite phones and upkeep of system (N.B. This seminar could be combined with discussion of use of vehicles such as the Red Cross ambulance to evacuate pregnant women in emergency situations)	Develop protocol for nurses and drivers at dispensaries/clinics for use of phone and referral to the Hospital for OB emergencies.	**SGS:** SGS Nurse Manager **HHF:** KOMBIT grant Administrator **MSPP:** Director Medical UCS 2	Planning agenda for seminar Training plan and curriculum for TOT in use of instrument Satellite phones	Number of service sites with satellite telephone	**Midterm evaluation:** to see if satellite phone are in place and functioning **Final Evaluation:** Documentation of phone operation, utilization and outcomes

Maternal/Newborn Care

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
8) Increase the number of women who deliver with a professional doctor, nurse midwife, or especially trained auxiliary nurse midwife	↑ Proportion of pregnancies that are registered, followed, and where the mother has pregnancy and delivery plan that includes choice; ↑ Number of delivery sites with trained professionals; ↑ Villages with written evacuation plan to nearest delivery facility; ↑ Education about danger signs of pregnancy and motivate women's groups to engage to seek help for high risk women to get to HC (health center) Theatrical troops illustrating the importance of going to the hospital	Create seminar to work with partners to identify and improve delivery sites where women could deliver with professionals; Work with MSPP to assure adequate material resources for these sites ✓ Training of trainers for HA supervisors and for trainers of women's groups to engage pregnant women with a written plan for their delivery that includes referral to hospital; Advertise the use of the Birth Plan through churches and all CBOs; Distribute these and train in their use to help plan for delivery and referral ✓ Work with theater troupe to design appropriate dramatic plays that shows advantages of delivery in safe place ✓ Create plan and agenda for theater troupes to present educational piece about use of Birth Plan and importance of planning to deliver in a safe place; plan to cover key marketplaces and other sites in UCS 2.	**MSPP:** MSPP statistician and Medical Director UCS 2 **HHF:** BCC Team **SGS:** SGS Nurse Manager	Written reports on seminar and delivery sites Birth Planning form developed and tested by KOMBIT; number distributed/utilized Annual report by MSPP on number of deliveries by site of delivery KOMBIT report on progress made with partners on planning and funding additional delivery sites Tabulation from MSPP monthly report form on place of delivery Written work calendar	Reports on contacts with possible donors Results of donor contacts; facilities assessment survey results Posted bar graph presentation showing # Deliveries by site by year	**Midterm Evaluation:** Process of documentation of delivery attendant in place or not in UCS 2. **Final Evaluation:** KPC

Maternal/Newborn Care

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
9) Increase % of women pre, intra, or post partum referred divided into causes of referral or diagnosis to next level of care	Participate in seminar for partners and collaborators to discuss experience with referrals and possible instruments. District MSPP officers and hospital director to be included . Presentation of KOMBIT's modified referral/counter-referral form and plan (based HHF form)	Interviews with key players to present referral-counter referral form prior to seminar. Schedule and plan agenda for seminar Invite key players well in advance, including archivists who will have to handle and file the forms and clinic and dispensary personnel who will initiate referrals using the forms and completing counter-referrals. N.B.: Seminar must reach consensus on extent of referral-counter-referral problem, instruments needed and process to be followed. MSPP St. Antoine Hospital and HHF's Center of Hope are major players and must be in accord with this plan.	**SGS:** Clinic nurses **HHF:** Clinic nurses **MSPP:** Clinic nurses	Planning agenda for seminar Training plan and curriculum for TOT in use of instrument Standard referral/counter referral form Provision of file box for same in sites where there is no designated space for these files	Periodic and midterm site visits and midterm site visits to interview of persons in charge in dispensaries and clinics to see if form is being used and files are in order. Tabulation of referrals by cause at end of each year	**Midterm Evaluation** MSPP annual report of referrals by type and cause **Final Evaluation** Facilities Assessment

Maternal/Newborn Care

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
10) Increase % of completed referrals to the next level of care	Participate in seminar for partners and collaborators to discuss experience with referrals and the possible instruments. (see # 9 above) District MSPP officers and hospital director to be included (N.B. Transmission to referral center implies that center will receive referral and act on it; consensus must be reached). Reach consensus with partners on sites and use of forms	Plan and schedule seminar on improving methods for referring mothers to care, especially Emergency care, including referral/counter-referral forms that can be maintained, used for quality assurance and archived. Develop corresponding curriculum and TOT for nurses in charge of dispensaries/clinics in use and Management of referral process and forms. Reach agreement with partners on periodicity of site visits/tabulation of completed forms	**SGS:** Clinic nurses **HHF:** Clinic nurses **MSPP:** Clinic nurses	Plan for agenda of seminar Training plan and curriculum for TOT in use of instrument Referral/counter-referral form developed by HHF and modified by KOMBIT, with "tear off front sheet to allow for counter-referral	Periodic and midterm site visits and midterm site visits to interview of persons in charge in dispensaries and clinics to see if form is being used and files are in order. Tabulation of referral completion rate at end of each year	**Midterm Evaluation:** MSPP annual report of referral completion rates **Final Evaluation:** Facilities Assessment MSPP reports

Maternal/Newborn Care

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
11) Increase the # of post partum mothers visited by HA or women's group representative and who have newborn examined by a health agent or other trained person within 72 hours of delivery;	ACNM training of all nurses (TOT) followed by, training of HA supervisors who in turn will reinforce training of HAs in use of use of tool for examining newborn and questioning mother about her post-partum status; and to motivate mothers to get post-partum exam by nurse; Educate mothers in new intervention through CBOs, churches, theater troupes Train CBO leaders in villages to use method	-Plan and implement training of nurses in newborn assessment and post-partum exam/assessment (HHF nurses already adapted instrument for HA to use in home based assessment); - Implement TOT of supervisors for periodic training of HAs in use of tool; Implement similar training for selected leaders of CBOs that have shown they can register/follow most pregnancies; plan and implement supervision by traveling nurse - Plan with leaders of CBO women's groups for similar activity using tool developed by HHF -Develop theater pieces appropriate to this intervention -Schedule roving theater troupes to introduce the idea and the instrument in all geographic areas, region by region to cover UCS 2.	**MSPP:** UCS 2 Nurse **HHF:** Field Nurse Supervisor **SGS:** SGS Nurse Manager	Documentation of curriculum, training plan and report of trainings Main tool is Postpartum form. Do annual sample of same for assessing adequacy of tool Written report of theater troupe training Written work calendar	Monthly report of activities. Calculate number and proportion of newborns who have had tool applied according to HHF records turned in the declaration de naissance;	**Mid Term**: Process evaluation of KOMBIT partners protocols. Interviews with community providers Evaluation tool of ACNM **Final Evaluation**: KPC and facilities assessments

Breastfeeding

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
1) Increase the number of mothers who breastfeed before expulsion of the placenta; increase the number of mothers who practice other HBLSS skills such as uterine massage (N.B.: See HBLSS curriculum; this is only one of the HBLSS skills)	BCC education and demonstration in clinics and in communities using pelvic model and doll, especially with the personnel who will deliver the baby: doctors, nurses, auxiliaries and "matronnes" to insure their willingness to comply with these strategies; Integrate this training with that on value and use of colostrums: putting baby to breast immediately benefits both mother and baby Develop women's theater pieces to illustrate how to do these skills; use of teaching aids that are hands on for women to do apprenticeship through role play (N.B. Rural Haitian women learn with their hands; they need to "do it" not just see a picture of it –Note from 20 years experience by G Berggren in Haiti)	-Plan/implement annual training for all doctors and nurses who deliver babies in UCS 2. - Plan/implement training for the matrons. -Plan/ implement training for CBO and FBOs. -Develop formative supervisory plan -Develop appropriate theater piece to illustrate how to do this. -Develop agenda for how to do this across the whole UCS 2	**SGS**: SGS Nurse Manager **HHF:** KOMBIT Nurse Midwife **MSPP**: UCS 2 Nurse	Written report on training of doctors and nurses with follow-up report on observation in hospital Written report on training of matrons, HA s supervisors and women's groups on this subject Written report on theater play and its use Documentation or schedule for implementation of all the above Plan for consistent "Role plays" of putting baby to breast before expulsion of placenta, and other HBLSS skills	Documentation of institutions who say they put baby to breast before expulsion of placenta and observation of same Documentation of other life saving skills Monthly report of assisted delivery Formative supervisory report on matrons using pelvic model	**Mid Term Evaluation:** Questionnaire to mothers, evaluation of reports. **Final Evaluation**: KPC Focus groups

Breastfeeding

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
2) Increase in % of mothers who adopt exclusive breastfeeding for 6 months	Strategy planned by KOMBIT: Breastfeeding training in clinics and at community level through women's groups; Mother'ss Clubs and CBO women's groups, especially setting up support groups of successful breastfeeding mothers.	✓ TOT: Seminar: Preparation and implementation of seminars for clinical staff on: definition, advantages of, and barriers to breastfeeding. Arrange demonstration by having groups of exemplary mothers describe to staff their experience/problems with exclusive breastfeeding (like leaving baby with others while they go to market), ✓ Identification and training of CBO/church women's groups for exclusive breastfeeding ✓ Design and implement a training plan that will go beyond area where HHF villages are already trained so that all geographic regions of UCS 2 will be covered N.B.: This training can be combined with training in NFP since it is essentially the same as the LAM Method	**SGS**: SGS Nurse Manager **HHF**: Community health workers CBOs **MSPP**: UCS 2 Nurse	Outline of training curriculum and report on training session HA s reports on exclusive breastfeeding; reports on LAM method at postpartum sessions Adaptation and design of reports for CBOs on same (they can send reports to nearest center) Monthly report of MSPP from centers using insertion sheet (Report on education sessions already asks for subject, and lists community meetings as a possible average) Written agenda and schedule for accomplishing trainings across the UCS 2	Tabulation of HA s records of exclusive breastfeeding for one month/year as point prevalence survey Tabulation of reports from CBOs With MSPP statistician, develop a data entry method for reported LAM method on the special cards Community health workers reports Focus group	**Mid term Evaluation:** Process evaluation Focus groups with mothers **Final Evaluation**: KPC

Child Spacing

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
1) Increase the number of mothers who complete LAM;	Training at clinics, of HA supervisors (TOT) and at key sites (such as leaders of women's groups identified through churches and trained as trainers) who will then train women's groups in villages without HAs Prerequisite: they should have given evidence first that they are registering most pregnancies in their communities	Train staff for LAM and SDM; Train staff to use insertion sheet for monthly report form of MSPP in order to document LAM or SDM as family planning methods. Develop training plan and method of documentation of acceptors for women's groups where there is no HA. Develop training plan and schedule to move across UCS 2 with training in these Methods.	**SGS**: SGS Nurse Manager **HHF**: Community health workers **MSPP**: UCS 2 Nurse	Outline of curriculum; report on training Insertion sheet in MSPP monthly report form so that these two methods are included Modified method for HA to track in register: must add SDM to Routine reports Creation of a report form for new tool: Women's group report on acceptors of these two methods	Date and documentation of Software modified for using/reporting from MSPP monthly report form to show monthly training and adoption on the two methods as having been introduced. (With MSPP statistician) To adapt software to include all methods on the monthly reports) Written report on theater group's introduction of method	**Mid Term Evaluation**: Process evaluation of MSPP tracking added to monthly form; Review of annual reports of completed LAM **Final Evaluation**: KPC

Child Spacing

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
2) Increase number of women who opt for natural family planning methods, proportion of women who opt for NFP for child spacing. Increase the number who adopt SDM or LAM (*N.B. Since two methods dovetail, it is logical to train in the two methods at the same time*)	KOMBIT partners adopt a standardized curriculum for all methods, (NFP): ➢ LAM ➢ SDM ➢ CMM TOT for supervisors, leaders of Mother'ss Clubs, and Women's groups in NFP methods Devise and pretest theater pieces for ambulant theater troupe Add method codes implemented to Women's home-based health record and to MSPP monthly report.	✓ Plan and implement a training of trainers curriculum for each level ➢ Nursing school and nurses ➢ HAs ➢ Leaders of women's groups and fathers groups ➢ Women Leaders in churches ✓ Adapt and print the women's health cards to include NFP; especially completion of LAM and adoption of SDM ✓ Adapt HHF register to reflect NFP methods ✓ Formation of theater troupes to explain methods	**SGS**: SGS Nurse Manager **HHF**: Field Nurse **MSPP**: Statistician Departmental	Curriculum outline and report on TOT and review training curricula for each method and at each level Adapt Girls home-based health card to reflect each NFP method Adapted HHF register to reflect each of these methods Monthly report form of MSPP special insert sheet that displays methods accepted and methods taught.	Date health redesigned and printed; dates distribute to various groups Special tabulation from MSPP Monthly report to monitor facility trainings/acceptors for NFP (all methods) Monitor codes implemented to Women's home-based health record and to MSPP monthly report.	**Mid term Evaluation**: Exit interviews yearly at facility sites for pregnant women in order to detect what they perceived as their options in these methods Special tabulation of HA registers to detect # and proportions using NFP methods, by method **Final Evaluation:** KPC

Child Spacing

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
3) Increase number of women who choose any family planning method; proportion who opt for NFP for child spacing	KOMBIT partners add to MSPP standardized curriculum for all methods, including NFP methods NFP: ➢ LAM ➢ SDM ➢ CMM TOT for HHF supervisors, leaders of Mother'ss Clubs, and Women's groups in NFP methods since these need to be added Devise and pretest theater pieces for ambulant theater troupe Add method codes implemented to Women's home-based health record and to MSPP monthly report	Plan and implement a training of trainers curriculum for each level -Nursing school and nurses -HAs, Leaders of women's groups and fathers groups Women Leaders in churches Adapt and print the women's health cards to include NFP; especially completion of LAM and adoption of SDM or CMM Suggested: ✓ Mama (already adopted as symbol for LAM method) ✓ CMM. ✓ SDM Adapt HHF register for codes, Adapt MSPP monthly report to reflect NFP methods that can be inserted into monthly report form; Formation of theater troupes to explain methods	**SGS**: SGS Nurse Manager **HHF**: Field Nurse Supervisor **MSPP**: Medical Director UCS 2	Curriculum outline and report on TOT and review training curricula for each method and at each level Adapt Girls home-based health card to reflect each NFP method Adapted HHF register to reflect each of these methods Monthly report form of MSPP special insert sheet that displays methods accepted and methods taught	Date health redesigned and printed; dates distribute to various groups Special tabulation from MSPP Monthly report to monitor facility trainings/acceptors for NFP (all methods)	**Mid Term Evaluation**: Exit interviews yearly at facility sites for pregnant women in order to detect what they perceived as their options in these methods Special tabulation of HA registers to detect # and proportions using NFP methods, by method **Final Evaluation**: KPC Facilities Assessment

Capacity Building

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
Increase % of villages with an active identified CBO (church based or other) willing to be active in maternal health, especially in those regions without an Health Agent	Training of Trainers strategy: The HAs already active in KOMBIT will act as teacher-trainers in outlying areas where there is no health agent to identify, recruit, and train leaders in women's groups' to develop women's groups that are truly representative of their village and that can keep a pregnancy register and train their members in aspects of maternal and newborn care	--Training of trainers for village leaders and women to map their villages in order to choose one representative woman for every 20 families and thus form women's groups that are truly representative. --Contact associations of pastors and teachers to endorse training for families., especially in localities where there is no HA; - Work with pastors to promote women's groups to register all pregnancies -Train women's groups for universal pregnancy registration, follow-up of all pregnancies, in HBLSS, NFP, exclusive breastfeeding, Birth Plan and the like	**SGS**: SGS Nurse Manager **HHF:** Field BCC coordinator **MSPP**: UCS 2 Nurse	Reprorts on pastors contacted and committed, women's meetings, church conventions, etc/ -Report on training session for women about pregnancy registration in triplicate, communicating with HA and the nearest health post/clinic. Triplicate pregnancy registration forms and reports from women's groups for all pregnancies completed.	Number of groups formed according to training officer(s) for women's groups; Number trained for pregnancy registration; number of pregnancies registered/followed	**Mid Term Evaluation**: Process of engaging CBOs and FBOs well documented. Number active by mid term. **Final Evaluation**: Focus groups in communities, KPC

Capacity Building

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
2) Increase clinic competency in early detection and referral of maternal/neonatal cases with prenatal; intrapartum, post-partum and neonatal danger signs	Documentation of assessment of facility and capability to accomplish appropriate action; materials and resources to detect and refer KOMBIT partners encouraged to find resources to upgrade institutions and update training of staff in use of equipment to facilitate early detection and referral of cases with danger signs	Tabulate/ interpret results of facilities assessment questionnaire to identify deficiencies in training, equipment. -Design and implement seminar to share results with all partners about the extent of the problem and adopt new referral-counter referral form. -Plan/ adopt methods for better detection, referral and transport of cases with assurance of appropriate forms for reference and counter-reference Develop referral/counter referral form; train in its use Plan with partners to be trained in and acquire appropriate materials Plan and implement training seminar corresponding to the above Train at outpatient and community level for referral.	**SGS**: SGS Nurse Manager **HHF**: Medical director **MSPP**: UCS 2 Nurse	Facility assessment form Use of previous studies (Médecin du Monde; work of Yale students at HHF archive**)** HHF modified referral/counter referral form	Written work plan/calendar include how to cover facilities in each geographic area (each section communal): who will train centrally, and then who will do follow up formative supervision: revisit each facility to train	**Mid Term Evaluation**: Number of staff trained with post test scores acceptable Record review of counter referral **Final Evaluation**: KPC Facilities Assessment

Capacity Building

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
3)Maternal Mortalitydetection, documentation, and Review	• Introduce and propagate maternal mortality reviews by review board that includes all partners and hospital staff through use of RAMOS investigation of every death in women 15 – 49 in registered areas and review of Verbal autopsy investigations of every maternal death, beginning in HHF villages and pushing beyond • Motivate staff and organize meeting of review board and key UCS 2 members to review all cases of maternal mortality and make policy decisions based on lessons learned	Develop Method and procedures for investigating women's deaths to be defined and propagated by KOMBIT partners. -Applied 1st in HHF villages and then across KOMBIT UCS-Adapt to Creole and train HAs and others in use of RAMOS investigations for all deaths of women 15- 49; field test and apply "autopsy verbal" first in HHF villages and then in rest of UCS 2 - Applied in all UCS 2 with scheduled meeting of professional staff to review lessons learned and derive results. -Introduced as a similar procedure in areas not covered by HHF through use of women's KOMBIT groups; accomplish training of trainers for sameness trainers. -Develop agenda and schedules by year to spread methodology across UCS 2	**SGS:** SGS Nurse Manager **HHF**: Medical Director **MSPP**: Medical Director UCS 2 **Advisory Board**: Epidemiologist MSPP Community	Modified death declaration from HAs (MSPP form) RAMOS form and Verbal Autopsy Form Training curricula for above: Mortality Register for all deaths in women 15 – 49 at HHF for HHF villages, distinguishing clearly those that are maternal deaths with cause and ICD 10 code For calculating age and cause specific death rates for women in the reproductive age group	Maternal mortality meetings to discuss verbal autopsy findings; Activity report of HHF and KOMBIT partners use of the RAMOS form and follow up with Verbal Autopsy quarterly	**Mid Term Evaluation:** Assessment of overall process of introduction of RAMOS and Verbal Autopsy in UCS 2 noting success and constraints, modify process as necessary **Final Evaluation** Annual Age specific, cause specific death rates calculated for all women age 15 – 49 by year; Combine date for 5 year period to calculate maternal mortality rate for 5 year period.

Capacity Building

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
4) Increase # of villages with identified CBOs willing to implement Volunteer Mothers for Safe Motherhood groups	Identify CBOs with women's groups in each locality or group of localities; increase capacity of groups to register every pregnancy support pregnant women	Identify leaders and CBOS to make crude map of village, divide village into areas of 10 – 20 families and help them to choose a representative woman to join Volunteer Mothers for Safe Motherhood or Mothers' Club.	MSPP: UCS 2 Nurse HHF-Field BCC Coordinator SGS: SGS Nurse Manager	Village map (method for same) Documented Method of finding areas of 10 – 20 families each and choosing a representative mother from each Mothers' Clubs and Volunteer Mothers for Safe Motherhood groups meeting schedule Pregnancy register by women's groups	Number of villages who registered pregnancies monthly.	# and % of villages that have active Mothers' Clubs or Volunteer Mothers for Safe Motherhood groups that register pregnancies monthly; Totals for each year of the project

Capacity Building

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
5) Increase # and % of pregnancies registered at village level	HAs registers every pregnancy in roster Mothers' Clubs and Volunteer Mothers for Safe Motherhood equitably distributed across villages meet monthly to register pregnancies	Recycle HAs supervisors to hold HAs responsible to register pregnant mothers. Develop "Femmes KOMBIT": a Train Village to map and section village into neighborhood within 10-20 families each neighborhood b Each neighborhood chooses one representative c Mothers' Clubs and Volunteer Mothers for Safe Motherhood meet monthly to register pregnancies in triplicate - One copy to health agent - One copy to Health Center - One copy for herself	**MSPP:** UCS 2 Nurse **SGS:** SGS Nurse Manager **HHF**-Field BCC Coordinator	a) HAs' women's registry b) Pregnancy register in triplicate for "femmes KOMBIT"; c) Training plan for Mothers' Clubs and Volunteer Mothers for Safe Motherhood leaders.	Number of villages who registered pregnancies monthly :	**Mid term Evaluation:** Annual # of villages with women volunteers for safe motherhood that meet monthly # and % of pregnancies registered (using expected numbers) **Final Evaluation**: KPC, facilities assessment

Capacity Building

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
6) Increase community participation in evacuation plan at all levels	Motivate community to contribute to evacuation emergency fund; Create running account of progress.	TOT for community leaders, representatives of churches, women groups, to reach consensus on implementation of evacuation plan.	**SGS**: SGS Nurse Manager **HHF**-Field BCC Coordinator **MSPP:** UCS 2 Director	Outline form for plan Calendar Agenda for meeting at key locales across UCS 2	Number of villages that have a written evacuation plan	**Mid term Evaluation**: # and % of villages that have written evacuation plan at end of year of the project. Process assessment of success and constraints. **Final Evaluation**: Focus groups, KPC. Provider experience with this process.

Sustainability

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
1) Increase # of HAs supported by MSPP and private donors	Joint planning by partners to shift to MSPP responsibilities for support of HAs	Organize seminar to decide ideal ratio of HA/1000 population; study distribution of HA s across UCS 2; MSPP agreement to increase # of HA s List of localities with population of each and name of HAs accompanied by map that shows all localities	**MSPP**: Director Medical UCS 2 **HHF**: Medical Director and Board of Directors.	Create Curriculum Seminar report Map updated and accompanied by Government list localities add name of HHF (MSPP or otherwise) written in; update map across UCS 2, where HAs can be found Report from each organization on number of HAs	Document new health Agent supported by MSPP and private donors.	**Mid Term Evaluation**: # of HA supported by MSPP in UCS 2 compared to 2004; repeat same info for all partners. **Final Evaluation:** Completed document of process of MSPP support of community based HA s in rural Haiti.

Sustainability

Objective	Strategy	Activities implied	Responsible	Tools	Monitoring	Evaluation
3) Assist MSPP to adopt innovations, especially home based "maternity sans risk" (HBLSS, IMCI neonatal)	Develop and utilize modified HBLSS and neonatal assessment at institutional level; Participate in forum for NGO's where MSPP is present with results of KOMBIT experience	Training on HBLSS and neonatal assessment followed by Seminar for partners to reach consensus on modified HBLSS and home base neonatal assess. Tool that will be applied in homes by HA s or done by "femmes KOMBIT "	**HHF:** Medical Director, Advisory board, medical advisor	HBLSS and Neonatal assess tool (modified by partners)	Documentation of activities related to innovative maternal and newborn care and support in UCS 2.	Mid Term Evaluation: Written report of implementation or constraints to implementation of facility and community activities. Modification of DIP based on this, **Final Evaluation**: Assessment of evidence of plan to spread KOMBIT interventions to other UCS areas.

E.4. MANAGEMENT TABLE

Human Resource Management
KOMBIT 2005-2009

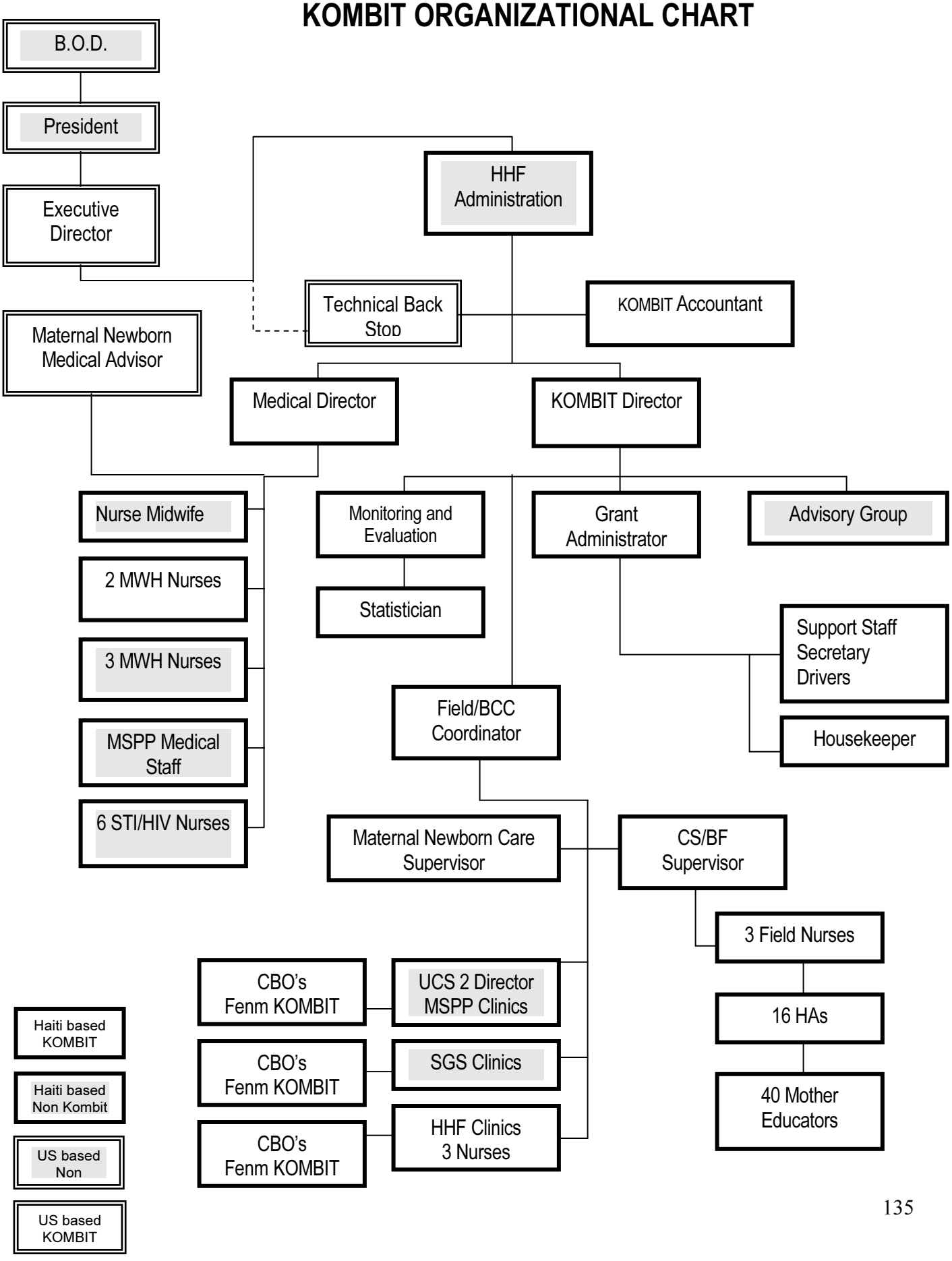
Job Title	FTE	Affiliation	Role	Supervisor- Lines of Authority	% Effort	Support
FIELD ADMINISTRATION AND SUPPORT						
HHF Administrator/KOMBIT Project Director	1	HHF	Administration of all HHF operations in Haiti and management of KOMBIT program	HHF Board of Directors	100%	CSHGP
KOMBIT Grant Administrator	1	HHF	Coordinate daily operations of the KOMBIT project including collation of work of partners	KOMBIT Project Director	50%	CSHGP
Data Entry/Secretary	1	HHF	Routine secretarial and data entry of baseline data and other studies	KOMBIT Grant Administrator	100%	CSHGP
UCS 2 Medical Director	1	MSPP	Coordinate all health agencies, programs and studies conducted in the 4 county region of Jeremie	Director of the MSPP Department of the Grand Anse	25%	MSPP
Sisters of the Good Shepherd Nurse Manager	1	SGS	Coordinate SGS partner activities in Jeremie and in rural clinic sites for all KOMBIT interventions, studies, and presentations.	Regional Director of the Sisters of the Good Shepherd and the KOMBIT Project Director	25%	SGS
Department of Administration and Finance	1	HHF	All financial administration in collaboration with the HHF HQ	HHF administrator	As needed	HHF
Drivers	2	HHF	Coordinate field to clinic transport and communication. Procurement	KOMBIT Grant Administrator	100%	CSHGP
Accountant	1	HHF	Disbursements	Director of Administration and Finance	16%	CSHGP
Housekeeper	1	HHF	Maintain KOMBIT office on HHF campus	KOMBIT Grant Administrator	100%	CSHGP
HEADQUARTERS ADMINISTRATION AND SUPPORT						
Technical Back stop	1	HHF	Headquarters representative for all KOMBIT activities. Coordinates KOMBIT field reports required by CSHGP. Collaborates with KOMBIT consultants (KPC, DIP, HBLSS)	KOMBIT Program Director and HHF Executive Director (HQ)	15%	CSHGP

Job Title	FTE	Affiliation	Role	Supervisor- Lines of Authority	% Effort	Support
Executive Director	1	HHF	Support for periodic required documents for the CSHGP reports	HHF President	15%	CSHGP
Medical Advisor	1	University of Michigan	Guides protocols- policy related to maternal-newborn care. Designs operations research. Collaborates with Technical Backstop, Medical Director and KOMBIT partners. Advises at national level when requested.	Joint collaboration rather than supervision with Technical Backstop, Medical and HHF Public Health Directors and KOMBIT Project Director	5%	CSHGP and University of Michigan
CLINICIANS						
Medical Director	1	HHF	Sets medical protocols with MSPP and Medical Advisor. Manages maternal mortality audit process. Liaison with MSPP for HHF. Coordinates KOMBIT and HHF health programs	HHF Administrator/KOMBIT Project Director	50%	CSHGP
Nurse Midwife	1	HHF	Clinic and field service delivery	Medical Director	100%	HHF
Clinical physician	1	MSPP	Maternal and newborn clinical care	Medical Director	100%	MSPP
Clinic nurses	3	HHF	Perinatal Care at the Maternal Waiting Home	Nurse Midwife	100%	HHF
Clinic Nurses	2	HHF	Perinatal Care at the Maternal Waiting Home	Nurse Midwife	100%	CSHGP
Clinic Nurses	8	MSPP SGS	Perinatal Care in rural clinics in KOMBIT areas	UCS 2 nursing supervision	100%	MSPP
STI –HIV nurses	6	HHF	Pre and post test counseling and testing for HIV and syphilis in the clinic and field site settings	Medical Director	100%	HHF
COMMUNITY CARE AND EDUCATION						
Field/BCC Coordinator	1	HHF	KOMBIT field management and BCC master trainer. Liaison with partner clinics and staff. Coordinator of all field operations	KOMBIT Project Director	58%	CSHGP

Job Title	FTE	Affiliation	Role	Supervisor- Lines of Authority	% Effort	Support
Maternal Newborn Care Supervisor (nurse midwife)	1	HHF	Coordinates perinatal service delivery at KOMBIT care sites. Principal role in training and implementation of HBLSS with the College of Nurse Midwives (ACNM)	Field/BCC Coordinator	100%	CSHGP
Breast feeding/Child Spacing Supervisor	1	HHF	Family Life Methods manager Exclusive Breast feeding trainer and manager. LAM trainer	Field/BCC Coordinator	100%	CSHGP
Field Nurse Supervisor	1	HHF	Supervise HAs, Participate in Perinatal Care in partner clinics, BCC message training, Training of mobile theater groups. Assist with monitoring and evaluations.	Field/BCC Coordinator	100%	CSHGP
Field Nurse Supervisor	1	MSPP Departmental Staff	Supervise HAs, Participate in Perinatal Care in partner clinics, BCC message training, Training of mobile theater groups. Assist with monitoring and evaluations.	Field/BCC Coordinator	80%	CSHGP
Nursing Supervision	1	UCS 2 KOMBIT	Supervise HAs, Participate in Perinatal Care in partner clinics, BCC message training, Training of mobile theater groups. Assist with monitoring and evaluations.	Field/BCC Coordinator collaboration	50%	CSHGP
Health agents	11 Yr 1 15.5 yrs 2-5	HHF	HBLSS activities, management of CBOs, support of mobile theater groups in KOMBIT areas with no health agents, newborn IMCI, liaison with KOMBIT clinics and Faith based community groups.	Field nurse supervisors	100%	CSHGP

Job Title	FTE	Affiliation	Role	Supervisor- Lines of Authority	% Effort	Support
Mother Educators	40	KOMBIT	Participate in mobile theater troupe for education on safe motherhood and child spacing strategies	Health Agents	25%	Volunteers with CSHGP support for community mobilization
MONITORING EVALUATION and OPERATIONS RESEARCH						
Monitoring and Evaluation Administrator	1	HHF and MSPP	Design M and E plan with partners, design public displays of progress at KOMBIT sites, present progress at UCS 2 meetings, validate data, plan and participate in Mid term and final evaluations.	KOMBIT Project Director	100%	CSHGP
Statistician	1	MSPP	Collects, collates, validates and presents progress toward meeting KOMBIT objectives. Bridges departmental reports and KOMBIT new reports	Monitoring and Evaluation Administrator	25%	CSHGP
Midterm Evaluator	1	consultant	Coordinate and document the process evaluation of the KOMBIT program in year 3	Technical Backstop, KOMBIT Program Director, Executive Director, KOMBIT leadership	Limited consultancy	CSHGP
Final Program Evaluator	1	consultant	Coordinate and document the formative evaluation of the KOMBIT program in year 4	Technical Backstop, KOMBIT Program Director, Executive Director, KOMBIT leadership	Limited consultancy in year 4	CSHGP
ADVISORY GROUP						
Field Technical Advisor	1	HHF	Support programmatic directions with the HHF/Administrator-KOMBIT Project Director	Advisory role only	20%	HHF
USAID Haiti CSHGP Medical Liaison	1	USAID Haiti Mission	Participate in KOMBIT activities and provide USAID support and over sight to the KOMBIT Program Director	Advisory role only	3%	USAID
Epidemiologist	1	MSPP	Assist maternal –newborn audit process in UCS 2. Advise about expanded use of strategies	Advisory to KOMBIT and Advocacy in the Ministry of Health in Port-au-Prince	10%	MSPP CSHGP for travel

KOMBIT ORGANIZATIONAL CHART



E.5. WORK PLAN

KOMBIT WORK PLANS

	Yr 1	Y 2	Yr 3	Yr 4	Yr 5
Hire key staff	X				
Establish project office	X				
Orient Project team and evaluate yearly	X	X	X	X	X
Key informant and structured group interviews	X				
KPC survey and feedback	X				
Modification of clinic registries	X	X			
DIP workshop and presentation	X				
Training: maternal and newborn care IMCI-clinics	X				
Training/upgrading nurses in BCC /communication	X	X	X	X	
NFP and breast feeding LAM training	X	X	X	X	
Mother to Mother health education and theater		X	X	X	X
Monthly "Where there is no doctor for women" Reading and discussion sessions with mothers and father's groups	X	X	X	X	X
Annual Reports		X	X	X	X
Mid term Evaluation			X		
Operations Research		X	X	X	X
Participation in CORE technical meetings	X	X	X	X	X
Participation in Haiti national MNH provider Meetings	X	X	X	X	X
Expansion of interventions to other UCS Communes			X	X	X
Verbal autopsy/maternal death review: continuing ed	X				
Verbal Autopsy/maternal death reviews	X	X	X	X	X
Referral of high-risk pregnancies- Maternal Waiting Home	X	X	X	X	X
Training and implementation of home IMCI	X	X	X	X	X
Perinatal health information system (PAHO)	X	X	X	X	X
Feedback of progress with communities and partners		X	X	X	X
Final Evaluation					X

KOMBIT project developed the Work plan with the local partners. Each year as the annual report is being prepared, lessons learned and constraints encountered will guide the participatory creation of the upcoming year's work plan. Each quarter, the CSHGP director, medical director and field staff will evaluate progress toward achievement of the planned activities and modify assignments as necessary. HHF has used a similar system based on the computerized health information system and routine staff meetings over the past 16 years.

OCTOBER 2004-SEPTEMBER 2005	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Hire key staff	X	X										
Establish project office	X	X	X									
Orient Project team	X	X										
Participate in Haiti MNH meetings								X				
Technical Backstop to Haiti		X		X		X				X		
KPC survey design	X	X	X									
KPC survey data collection			X	X	X							
KPC survey data analysis/feedback				X	X	X	X					
Participatory Capacity assessments				X	X							
Capacity assessments analysis/feedback				X	X							
Assessment of clinics- EOC and Health Systems data analysis/feedback					X	X						
DIP workshop/writing					X	X	X					
DIP submission							X					
Verbal autopsy/maternal death review training			X									
Verbal autopsy/maternal death activities				X	X	X	X	X	X	X	X	X
Modification of HHF and selected HIS or maternal-newborn care											X	
Annual PVC/PVO meeting							X					
DIP presentation									X			
Continuing education of HHF and partner clinics staff in maternal and newborn health care								X	X	X	X	X
Continuing education of clinic and service site nursing staff on interpersonal communication and maternal and newborn health care								X	X	X	X	X
Training of staff in NFP, LAM and Breast feeding							X	X	X	X	X	X
II. HBLSS training and document translation								X	X	X	X	
III. CORE Group annual meeting							X					X
Referral of problem pregnancies to Maternal Waiting Home	X	X	X	X	X	X	X	X	X	X	X	X
IV. KOMBIT meetings, UCS 2 meetings	X		X		X		X		X		X	

OCTOBER 2004-SEPTEMBER 2005	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**
KOMBIT alliance Meeting (MSPP, HHF, SGP)				X	X	X	X	X	X	X	X	X
Analyses OF questionnaire ON Dangers Signs								X	X	X		
Ramos process				X	X	X	X	X	X	X	X	X
Monthly "Where there is no doctor for women" Reading and discussion sessions with mothers and father's groups								X	X	X	X	X
Create new BCC messages								X				
Training of KOMBIT Partners onBCC								X				
Community mobilization and theater popular									X		X	X
Creation of organizes clubs in Partners												X
Leader meetings (N=1000)										X	X	X
Training of leaders on human and reproductive rights							X		X	X		
Purchase of medical supply to improve prenatal and postpartum care							X	X	X	X		
Mother's day Activities for Safe Motherhood								X				

OCTOBER 2005 – SEPTEMBER 2006	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Team and project Evaluation	X											
Modification of clinic registries						X						
Training: maternal and newborn care IMCI-clinics							X	X				
Training/upgrading nurses in BCC /communication							X	X	X			
NFP and breast feeding LAM Continuing education		X	X	X								
Mother to Mother health education and theater				X	X	X	X	X	X	X	X	X
Monthly "Where there is no doctor for women" Reading and discussion sessions with mothers and father's groups	X	X	X	X	X	X	X	X	X	X	X	X
V. Training in Neonatal IMCI			X	X								
Annual Reports											X	X
Operations Research								X	X	X	X	
Participation in CORE technical meetings							X					X
Participation in Haiti national MNH provider Meetings								X				
Verbal autopsy/maternal death review: continuing ed	X	X	X	X	X	X	X	X	X	X	X	X
Verbal Autopsy/maternal death	X	X	X	X	X	X	X	X	X	X	X	X
Referral of high-risk pregnancies- Maternal Waiting Home	X	X	X	X	X	X	X	X	X	X	X	X
Training and implementation of HBLSS	X	X	X	X	X	X	X	X	X	X	X	X
Perinatal health information system (PAHO)						X						
Feedback of progress with communities and partners	X	X	X	X	X	X	X	X	X	X	X	X
VI. KOMBIT meetings, UCS 2 meetings	X		X		X		X		X		X	

OCTOBER 2005-SEPTEMBER 2006	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
KOMBIT alliance Meeting (MSPP, HHF, SGP)	X	X	X	X	X	X	X	X	X	X	X	X
Ramos process	X	X	X	X	X	X	X	X	X	X	X	X
Create new BCC messages										X	X	
Continuing education on BCC/CM	X	X	X	X	X	X	X	X	X	X	X	X
Community Mobilization and theater popular for vulgarization of new health message.	X	X	X	X	X	X	X	X	X	X	X	X
Creation of new organizes clubs in the Partners clinics	X	X	X	X	X	X	X	X	X	X	X	X
Meeting of community Leaders to share KOMBIT progress										X	X	X
Training of leaders on human and reproductive rights			X			X				X		
Installation of 2 Satellites telephones in remote areas								X	X			
Purchase of ambulance for the evacuation of obstetrical emergency and newborn						X						
Implantation and training of local committee for evacuation obstetrical emergency and newborn				X	X	X	X	X	X	X	X	X
Purchase of medical supplies to improve prenatal and postpartum care	X											
Mother's day Safe Motherhood Program								X				
Training of nurse on the written birth plan	X	X	X									
CMM-SDM training for additional nurses											X	
Meeting and Continuing education for trained midwifes	X	X	X	X	X	X	X	X	X	X	X	X
Assign KOMBIT nurse\to work in partners clinic on prenatal and post-partum days	X	X	X	X	X	X	X	X	X	X	X	X

OCTOBER 2006- SEPTEMBER 2007	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Team and project evaluation	X	X										
Upgrading nurses in BCC /communication								X	X			
NFP and breast feeding LAM continuing education	X	X	X	X	X	X	X	X	X	X	X	X
Mother to Mother health education and theater	X	X	X	X	X	X	X	X	X	X	X	X
Monthly "Where there is no doctor for women" Reading and discussion sessions with mothers and father's groups	X	X	X	X	X	X	X	X	X	X	X	X
Annual Reports												X
Mid term Evaluation					X	X	X	X				
Operations Research	X	X	X	X								
Participation in CORE technical meetings							X					X
Participation in Haiti national MNH provider Meetings							X					
Expansion of interventions to other UCS Communes									X	X	X	X
Verbal autopsy/maternal death review: continuing ed	X	X	X	X	X	X	X	X	X	X	X	X
Verbal Autopsy/maternal death reviews	X	X	X	X	X	X	X	X	X	X	X	X
Referral of high-risk pregnancies - Maternal Waiting Home	X	X	X	X	X	X	X	X	X	X	X	X
Activities of HBLSS	X	X	X	X	X	X	X	X	X	X	X	X
Perinatal health information system (PAHO)		X			X			X				
Feedback of progress with communities and partners	X	X	X	X	X	X	X	X	X	X	X	X

OCTOBER 2006-SEPTEMBER 2007	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
KOMBIT alliance Meeting (MSPP, HHF, SGP)	X	X	X	X	X	X	X	X	X	X	X	X
Ramos process	X	X	X	X	X	X	X	X	X	X	X	X
Create new BCC messages				X	X	X	X					
Continuing education on BCC/CM	X	X	X	X	X	X	X	X	X	X	X	X
Community Mobilization and theater popular for vulgarization of new health message.	X	X	X	X	X	X	X	X	X	X	X	X
Creation of new organizes clubs in the Partners clinics	X	X	X	X	X	X	X	X	X	X	X	X
Meeting of community Leaders to share KOMBIT progress						X	X	X				
Training of leaders on human and reproductive rights	X	X	X	X	X	X	X	X	X	X	X	X
Installation of 2 Satellites telephones in remote areas	X											
Implantation and training of local committee for evacuation obstetrical emergency and newborn	X	X	X	X	X	X	X	X	X	X	X	X
Purchase of medical supply to improve prenatal and postpartum care	X	X										
Mother's day Safe Motherhood Activities								X				
CMM-SDM updating for additional nurses						X	X					
Meeting and Continuing education for trained midwives	X	X	X	X	X	X	X	X	X	X	X	X
Assign KOMBIT nurse\to work in partners clinics on prenatal and post-partum days	X	X	X	X	X	X	X	X	X	X	X	X

OCTOBER 2007 – SEPTEMBER 2008	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Team and project evaluation	X	X										
Training/upgrading nurses in BCC /communication	X	X	X	X	X	X	X	X	X	X	X	X
NFP and breast feeding LAM Continuing education	X	X	X	X	X	X	X	X	X	X	X	X
Mother to Mother health education and theater	X	X	X	X	X	X	X	X	X	X	X	X
Monthly "Where there is no doctor for women" Reading and discussion sessions with mothers and father's groups	X	X	X	X	X	X	X	X	X	X	X	X
Annual Reports												X
Operations Research												
Participation in CORE technical meetings						X						X
Participation in Haiti national MNH provider Meetings						X						
Expansion of interventions to other UCS Communes	X	X	X	X	X	X	X	X	X	X	X	X
Verbal autopsy/maternal death review: continuing ed	X	X	X	X	X	X	X	X	X	X	X	
Verbal Autopsy/maternal death reviews	X	X	X	X	X	X	X	X	X	X	X	
Referral of high-risk pregnancies - Maternal Waiting Home	X	X	X	X	X	X	X	X	X	X	X	
Activities of HBLSS	X	X	X	X	X	X	X	X	X	X	X	X
Prenatal health information system (PAHO) expansion to other clinics	X	X	X									
Feedback of progress with communities and partners				X	X	X						

OCTOBER 2007-SEPTEMBER 2008	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
KOMBIT alliance Meeting (MSPP, HHF, SGP)	X	X	X	X	X	X	X	X	X	X	X	X
Ramos process	X	X	X	X	X	X	X	X	X	X	X	X
Continuing education on BCC/CM	X	X	X	X	X	X	X	X	X	X	X	X
Community Mobilization and theater popular for vulgarization of new health message.	X	X	X	X	X	X	X	X	X	X	X	X
Creation of new organizes clubs in the Partners clinics	X	X	X	X	X	X	X	X	X	X	X	X
Meeting of community Leaders to share KOPMBIT progress						X	X	X				
Training of leaders on human and reproductive rights	X	X	X	X	X	X	X	X	X	X	X	X
Implantation and training of local committee for evacuation obstetrical emergency and newborn	X	X	X	X	X	X	X	X	X	X	X	X
Purchase of medical supply to improve prenatal and postpartum care	X											
Mother's day Activities								X				
CMM-SDM continuing education for providers (FBO-teachers)	X	X	X	X	X	X	X	X	X	X	X	X
Meeting and Continuing education for trained midwifes	X	X	X	X	X	X	X	X	X	X	X	X
Assign KOMBIT nurse to work in partners clinic on prenatal and post-partum days	X	X	X	X	X	X	X	X	X	X	X	X
MOST(Management organizational Sustainability stool) exercise								X				

OCTOBER 2008-SEPTEMBER 2009	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Team and project evaluation	X	X										
Upgrading nurses in BCC /communication	X	X	X	X	X	X	X	X	X	X	X	X
Mother to Mother health education and theater	X	X	X	X	X	X	X	X	X	X	X	X
Monthly "Where there is no doctor for women" Reading and discussion sessions with mothers and father's groups	X	X	X	X	X	X	X	X	X	X	X	X
Operations Research	X	X	X	X	X							
Participation in CORE technical meetings							X					X
Participation in Haiti national MNH provider Meetings							X					
Expansion of interventions to other UCS Communes	X	X	X	X	X	X	X	X	X	X	X	X
Verbal autopsy/maternal death review: continuing ed	X	X	X	X	X	X	X	X	X	X	X	X
Verbal Autopsy/maternal death reviews	X	X	X	X	X	X	X	X	X	X	X	X
Referral of high-risk pregnancies - Maternal Waiting Home	X	X	X	X	X	X	X	X	X	X	X	X
Activities of HBLSS	X	X	X	X	X	X	X	X	X	X	X	X
Perinatal health information system (PAHO)	X	X	X	X	X	X	X	X	X	X	X	X
Feedback of progress with communities and partners	X	X	X							X	X	X
Final Evaluation										X	X	X

OCTOBER 2008-SEPTEMBER 2009	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
KOMBIT alliance Meeting (MSPP, HHF, SGP)	X	X	X	X	X	X	X	X	X	X	X	X
Ramos process	X	X	X	X	X	X	X	X	X	X	X	X
Continuing education on BCC/CM	X	X	X	X	X	X	X	X	X	X	X	X
Community Mobilization and theater popular for vulgarization of new health message.	X	X	X	X	X	X	X	X	X	X	X	X
Creation of new organizes clubs in the Partners clinics	X	X	X	X	X	X	X	X	X	X	X	X
Meeting of community Leaders to share KOMBIT progress						X	X	X				
Training of leaders on human and reproductive rights	X	X	X	X	X	X	X	X	X	X	X	X
Implantation and training of local committee for evacuation obstetrical emergency and newborn	X	X	X	X	X	X	X	X	X	X	X	X
Purchase of medical supply to improve prenatal and postpartum care	X											
Mother's day Activities for Safe Motherhood								X				
Meeting and Continuing education for trained midwives	X	X	X	X	X	X	X	X	X	X	X	X
Assign KOMBIT nurse to work in partners clinic on prenatal and post-partum days	X	X	X	X	X	X	X	X	X	X	X	X

Performance Monitoring and Evaluation

KOMBIT will develop a monitoring and evaluation system that will be used by the partners in collaboration with ongoing MSPP reporting requirements. A series of expected results has been developed and is listed in the evaluation matrix that follows. The program matrix in Section 3 describes how each of the expected results emanates from the Situational Analysis. The following table describes how these results-based objectives will be monitored and evaluated. The table contains a notation of selected publicly monitored results. These results will be monitored quarterly and displayed in each clinic and at the KOMBIT office and used to give feedback to the community and the staff and to make modifications that respond to newly identified needs.

Expected Results	Indicator	Monitoring Strategy * indicates a publicly monitored result	Evaluation Methods
Maternal/Newborn Care			
Increase to 50 % women who can identify at least 2 danger signs of pregnancy	Numerator: # women with a child less than 2 who can identify at least 2 danger signs Denominator: # women with a child less than 2	Report of educational sessions held Number of participants in training sessions	Baseline Survey Final Survey
Increase 40% women who can identify at least 2 danger signs during labor and delivery	Numerator: # women with a child less than 2 who can identify at least 2 danger signs Denominator: #women with a child less than 2	Report of educational sessions held Number of participants in training sessions	Baseline Survey Final Survey
Increase to 40% women who can identify at least 2 danger signs of the post partum period	Numerator: # women with a child less than 2 who can identify at least 2 danger signs Denominator: # women with a child less than 2	Report of educational sessions held Number of participants in training sessions	Baseline Survey Final Survey
Increase to 50 % women who can identify at least 2 danger signs of the newborn	Numerator: # women with a child less than 2 who can identify at least 2 danger signs Denominator: # women with a child less than 2	Report of educational sessions held Number of participants in training sessions	Baseline Survey Final Survey
Increase 20% villages with a written and posted emergency OB and newborn transportation plan	Numerator: The number of villages with a plan Denominator: 100 villages with resident HAs	*Number of villages with written plan every 3 months	Final evaluation % of villages with a written plan
Increase 40% women adopting a standard pregnancy delivery/post partum plan	Numerator: # women who report a plan of action Denominator: # women with a child less than 2	*Periodic follow up of post partum women (check list)	Baseline Survey Final Survey
Increase to 60% maternity service sites with satellite phones/ transmission communication to referral centers for OB emergencies	Numerator: # Village and clinic sites with a functioning emergency satellite phones system Denominator: Number of service sites	*Program Administration documents	Mid term evaluation

Expected Results	Indicator	Monitoring Strategy * indicates a publicly monitored result	Evaluation Methods
Increase to 15% women who deliver with a trained attendant	Numerator: # women with a child less than 2 who report that a doctor or nurse midwife cut the umbilical cord Denominator: # women with a child less than 2	Referral system PAHO perinatal software program *Post partum visit interview results	Baseline Survey Final Survey
Increase to 50% of patients divided into causes of referral or diagnosis to the next level of care	Numerator: # women referred from the service sites for each diagnosis Denominator: All pregnant women consulted at the service sites	Referral system Clinic/MWH/Hospital registries PAHO perinatal software program Post partum visits	Mid term evaluation of systems Final evaluation of systems
Increase to 50% completed referrals to the next level of care	Numerator: # women who were tracked through the system from the first level service site to the highest level of care Denominator: All referrals	Referral system/registries PAHO perinatal software program *Post partum visit interview result LQAS	Mid term evaluation of systems Final evaluation of systems
Increase to 30% births in which infant is examined/visited HA within 72 hours	Numerator: # of visits within 72 hours Denominator: All births	*Percent of women and newborns assessed every 3 months (IMCI and post partum assessment) LQAS	Mid term evaluation review of monitoring data, Final evaluation
BREAST FEEDING			
Increase to 20% mothers who BF before the expulsion of the placenta	Numerator: # women with a child less than 2 who report putting the child to breast before expulsion of the placenta Denominator: # women with a child less than 2	*Periodic interviews with women in the post partum period LQAS post partum assessment forms	Baseline survey Final survey
Increase to 85% mothers who report exclusively BF in the last 24 hours	Numerator: # women with a child less than 6 months who report exclusive BF Denominator: # Women with a child less than 6 months	*Periodic interviews with women estimated to have an infant less than 6 months old	Baseline survey Subset analysis Final survey Subset analysis
CHILD SPACING			
Increase to 15% mothers who complete LAM	Numerator: # women with child less than 2 who complete LAM Denominator: # women with child less than 2 who began LAM	*Report of women enrolled and mothers who complete LAM	Baseline survey Final survey

Expected Results	Indicator	Monitoring Strategy * indicates a publicly monitored result	Evaluation Methods
Increase to 10% women using NFP methods (CMM, SDM)	Numerator: # women with a child less than 2 using NFP for CS Denominator: # Women with a child less than 2	*Report of women enrolled in NFP methods LQAS	Baseline survey Final survey
Increase to 35% women using any methods of CS	Numerator: # women with a child less than 2 using any method for CS Denominator: # Women with a child less than 2		Baseline survey Final survey
CAPACITY BUILDING			
Increase the number of villages with active CBOs	Numerator: number of villages with CBOs Denominator: number of eligible villages	* Meeting reports of active CBOs	Final evaluation
Increase clinic/service site competency in recognition/ management of maternal/newborn danger signs/ emergencies	Numerator: # staff scoring greater than 85% on OB knowledge test Denominator: Number of staff in clinic and service sites	Pre and post test scores	Final evaluation findings
Increase # of maternal morbidity and mortality reviews in KOMBIT project area	Numerator: # meetings held to discuss maternal morbidity and mortality Denominator: 12 meetings planned per year	Meeting reports	Midterm and final evaluation findings
SUSTAINABILITY			
Increase the number of village health workers supported by the MSPP and private providers	Numerator: # HAs employed by the MSPP/ providers Denominator: # HAs	Financial management reports	Final evaluation findings
Improve the MSPP policies to include tested home-based effective safe motherhood components	Refined national policy in place	Written policy Conference reports Results of MM reviews	Final evaluation

E.6. ORGANIZATIONAL DEVELOPMENT

The CSHGP is interested in documenting not only the technical results of the projects it funds, but also the capacity development that new partners experience from participating as grantees. CSHGP grantees not only contribute to population-level health outcomes and development of local capacities in country, but also to the capacities of their primary implementing partners (e.g., grantees) to carry out similar programs for other donors and in other settings. For grantee organizations new to the CSHGP, please use the questions below to guide a discussion of how the project will track changes in the grantee organization's capacity over the life of the g rant.

Discuss the PVOs present capacity to both implement and provide backstop support for this project. Consider capacity to include such areas as technical knowledge and skills, human resource management, organizational learning, financial resource management, administrative infrastructure and procedures, and management practices and governance.

As noted in the proposal (page 23), HHF staff have participated at the field level in the MOST exercise prior to the KOMBIT proposal submission. This experience highlighted deficiencies in the management and operations of HHF in the area of maternal and child health service delivery.

In 2005, HHF has been placed in the "A" category by USAID Haiti (through Management Sciences for Health management). This means that HHF has the financial, technical, human resources and organizational maturity to be considered an excellent, functional health PVO in Haiti, and to be a resource for other less highly functional health organizations.

HHF has the benefit of low attrition. 80% of the original management and field supervisors are still working in HHF and many in expanded roles.

HHF technical advisors have advanced medical, nursing, public health and anthropology degrees and experience.

HHF's community based primary health care program has proven impact on the pediatric death rate (CDC evaluation 1998)

HHF's level of ownership at the village level has been noted by others in Haiti to be one of the reasons for its continued successes in an otherwise unstable country.

Describe any plans the grantee organization has for strengthening its capacity in any of these areas over the life of the grant. What tools/measures will be used to demonstrate that the organization's capacity has increased as a result of implementing this grant.

HHF will continue to strengthen its organizational, clinical and operational programs through KOMBIT by testing new and innovative strategies for maternal and newborn health. With the MSPP and SGS partners, approaches that HHF has experience with will be shared, and together we will all learn new approaches to improved MNC e.g. HBLSS, neonatal IMCI.

The biggest challenge to improved organizational management will be the attempt to standardize maternal perinatal care through the introduction of the PAHO SIP perinatal software in all the clinics and hospital in the KOMBIT area by year 5. This will be a giant step in building the capacity of all providers in this area.

ANNEX I

RESPONSE TO APPLICATION DEBRIEFING

Name of PVO Applicant: Haitian Health Foundation
Name of Country: HAITI
Application Category: Standard

BUDGET INFORMATION

Strengths

It appears that all required forms are provided as requested. Narrative is clear and concise, and gives a good description of the way resources will be used in the headquarters and at the field level. Costs are reasonable and evidenced by historical data. Clear and logical allocation of the cost share proportion of the total budget. It appears that the project can be accomplished with the funding levels represented in the budget, and give very good value for investment.

The PVO match is documented at slightly above the 25% match requirement with apparently well thought out contributions needed for project operations (vehicle, motorcycles, and equipment such as medical supplies).

Weaknesses

It would be useful to understand the percentage of time that will be charged to the project, numbers of staff (e.g. HAs), and clearer breakdowns between HQ and field staff.

The technical backstop in CT is shown at 25% with 4 trips to the field planned in the first year which will mean much of the position's support time will be taken up in field travel. The only other HQ/US support is 30% time of a CT-based secretary. It may need to be re-evaluated as to whether or not this HQ support is adequate to support field operations, both technically and managerially, especially since this would be HHF's first centrally funded USAID grant. There is no HQ finance/admin staff budget to support field operations, which might be important for field mentoring/monitoring purposes.

EXECUTIVE SUMMARY

Strengths

The executive summary is well written, concise, and covers all recommended areas outlined in the RFA.

Strong description summarizing all significant components of the proposed program. Description provides for a clear understanding of this organization's past work, the various programs elements, and the strategies that will be implemented.

The project name, "KOMBIT" communicates a community-oriented, integrated approach with a "catchy" name that seems culturally appropriate and meaningful.

Weaknesses

None noted.

DESCRIPTION OF THE PVO APPLICANT OR PROGRAM

Strengths

Applicant provides a good, overall explanation of their mission, purpose and general approach.

Clear description of the organization's goals and activities. It is extremely clear that this organization is well founded and deeply rooted in the Haitian community, and has more than sufficient evidence of the past successes. They have experience implementing the PHACT system, which evidences their strong commitment to evidence-based decision-making. Strong collaborative efforts are already evidenced, and plans are in place to strengthen these links.

HHF appears to have a positive, longstanding presence in Haiti (Granddames), and in both community and facility-based MCH programming that provides an excellent basis for Child Survival (CS) Program. Experience with HAs, Mother/Father's Clubs and youth groups demonstrate a strong commitment to working within existing community structures, which is an important strategy for this proposed project. Involvement in primary health care (health posts, MWH, etc.) could provide HHF with facility level understanding and credibility to carry out provider/systems improvements during the life of the project.

HHF appears to have a good working relationship with the MSSP, as illustrated in the new decentralization efforts (UCSs), which is important for a successful CS Program where the MSSP is operating.

HHF developed PHACT, and innovative HIS (with good potential for community-based decision making/use) that could be built or expanded for this proposed project. Additionally, this PVO appears to have a good track in leveraging diverse funding sources.

Weaknesses

It was unclear whether HHF has been a US-based PVO since 1986. It was not explicitly stated whether or not HHF was first a Haiti-based organization, that more recently obtained a US-based in Connecticut (this information would be helpful to better understand the PVO and its context for implementation).

SITUATIONAL ANALYSIS

Strengths

Parameters are adequately addressed. It is clear that this organization has been operational in the area for a long period, and knows the situation intimately. It is also clear that relationships have been developed over this period, which will contribute significantly to this project's success over the short- and long-term.

There is a good understanding of the resources that are available in the community, and the challenges that will be encountered in the implementation of this program. This leads to very realistic timelines, budgets, goals, etc. The planning to this point has clearly been community-based and participatory, and there is every indication that the implementation would be equally rooted in the community.

The USAID-Haiti mission, as well as other governmental and non-governmental organizations indicates very strong support for this organization. This is due to the fact that HHF is the main PVO working at the Grand Anse department and Jeremie area for more than fifteen years. HHF is the leader in Haiti for CS activities such as immunization and IMCI services, breastfeeding promotion, and natural FP.

HHF demonstrates good knowledge of target population. The applicant appears to have an excellent understanding of other health providers, PVO/community efforts in the proposed project area (PSI, St. Antoine Hospital, FOSREF, etc).

The proposal presents important key household characteristics and behaviors, socioeconomic elements, local human resources (use of lok, significance of traditional healer practices, etc.) that indicates HHF's knowledge of the proposed project's target population.

Statistics on lack of trained providers, unattended home births, and limited access to quality health care for mother/newborns provides a good basis for the MNC focus of the proposed project.

Weaknesses

Although health status data is difficult to obtain in Haiti, the proposal would have been further strengthened if HHF would offer local indicators/data regarding the extent of MCH issues (through PHACT, past census information, or facility-based records indicating maternal or child mortality/morbidity trends). Given the organization's longstanding experience working in the proposed project area, this localized data (even if informal) would be helpful.

The processes used by HHF to select the project site were not explained and it would be helpful to learn more about how the Grand Anse was prioritized/targeted (outside of obvious operational realities).

An explanation of how the St. Helene Clinic, the Leon Clinic, and FOSREF will work with the proposed program—or at least an indication that there will not be any overlap or duplication would have been useful.

The HIV/AIDS situation was not mentioned. It is the project's prerogative not to address the issue, but it should be mentioned in the situational analysis to set the scene.

PROGRAM STRATEGY AND INTERVENTIONS

Strengths

The applicant provided very detailed and clearly documented strategy and interventions – all components included and related to each other clearly and concisely in the table. Clear work plans were included in annex, showing a strong understanding of the necessary pre-implementation activities and the time required to accomplish them in an effective manner.

The overall strategy was coherent and realistic for the setting. Especially realistic is the proposed timeframe – adequate time and resources are given to the collection of baseline data and the initial planning and consensus building.

The initiative to reinforce the communication/referral system by installing sat-phones in selected locations is important. It will be equally important to reinforce the emergency transport system to maximize the impact of this initiative.

The proposed linkages within the region, as well as the initiation of Maternal Mortality reviews, should maximize the potential for broad usage of "lessons learned".

The applicant makes a good presentation of how the proposed project relates and complements USAID's IR's and SO's (both mission level and CSHGP).

The proposed interventions of MNC, Child Spacing, and BF appear well thought out in light of background data previously noted in the proposal, and present and strong "package" of complementary interventions for mothers, infants/children and families. Breastfeeding appears to be a well-chosen intervention that is highly complementary to the proposed child spacing NFP approaches.

Innovative BCG strategies that are culturally appropriate are proposed and present an opportunity to reach both fathers and mothers with important health messages. The applicant mentions the importance of male involvement in MNC (relevant for CS and BF as well), especially in light of the fact that 77% of fathers participate in facility-based birth. This presents and opportunity for HHF to further involve fathers to play a stronger role in mobilizing resources for safer births that take place at home (since this represents the majority of births).

It seems that SGS, HHF, and MSSP provide strong clinic resources/context for improving facility level care in the proposed project area.

Weaknesses

As mentioned above, the proposed interventions are logical given the background information presented in the proposal. It would have also been helpful to know why other interventions such as HIV/AIDS were not selected, and how other gaps such as HIV/AIDS prevention and FP (modern contraceptive utilization and access, especially since modern methods such as a Depo are favored) are being addressed if HHF will not focus on them.

The BF section does not ape fully developed and the link between BF and NFP is not explained. Since only 9.8% of women report exclusive BF to the fifth month, it would seem that more intensive community-level support (through HAs, mother'ss clubs/peers, TBAs) could be important for BF mothers in the early post-partum period and beyond.

It is not clear how community entities (HAs,TBAs, Mother/Fathers' groups, etc.) will be supported to maintain sustainable community-level services for mothers and their families.

PERFORMANCE MONITORING AND EVALUATION

Strengths

Objectives under MNC (#8, #11) regarding increasing the number of women delivering with a trained attendant (does this include TBAs?), and infants visited/examined by CHW within 72 hours post partum are important. Are high-risk mothers also visited post partum by TBA or CHW?

It is very positive that HHF conducted a MOST previously and that HHF will repeat one in year 4 to explore further organizational capacity/sustainability issues.

HHF seems to have a good base with maternal care census-based information collected previously and relates strong HIS experience in general. Proposed OR efforts to be explored with Univ. Michigan, Univ. Connecticut, and other universities are excellent.

MandE plans clearly linked to strategy and implementation. One person budgeted for FT MandE work within the project—this is especially important given the fact that the plans are to toll-out successful program elements on a larger scale. The proposed MandE Director appears to be well qualified and his background with MSSP should be an asset to the project to promote collaboration/integration between HHF and MSSP efforts.

Excellent proposal to include publicly monitored elements, along with feedback to the community which will enhance community ownership.

Data collection and monitoring will build on work already initiated in earlier programs. The chances for a sensitive and accurate monitoring system will be enhanced by the extensive relationships already built within the community.

The applicant provides a good combination of qualitative and quantitative measurements. Plans are made for recording and disseminating lessons learned—especially in regards to operational research.

Efforts made to reduce or eliminate parallel reporting systems. And instead strengthen existing systems.

Weaknesses

The PME matrix on pages 20-21 includes MNC knowledge-based objectives, process-oriented (written emergency OB/transport plans, sites with satellite phones), and a few strong behavior change-oriented objectives (women adopting pregnancy/delivery/postpartum plan, women delivering with a trained attendant). It might be helpful to re-evaluate some of the objectives (and related indicators) to target (behavior change orientation as possible); as well as clarify objectives/indicators to ensure that they are measurable.

Under "Evaluation Methods" in PME matrix, most measures are noted to be the baseline survey, MT or final evaluations; and monitoring strategies focus on number of educational sessions, interviews, etc. It would strengthen this proposed project to utilize other continuous, more community-based HIS methods (PHACT or other) to establish ongoing community-level ownership and use the data gathered for decision-making purposes. Previously mentioned PHACT (or other community-based HIS system managed by HAs, other community resource persons) was not mentioned in this section.

MANAGEMENT PLAN

Strengths

The staff planned and budgeted for appears sufficient to support the planned programs.

The hierarchical structure and ultimate accountability within the organization are clear and easy to track. The supervisory ratios appear appropriate in the areas where numbers are indicated; however, the numbers that are ultimately being supervised towards the bottom of the matrix are not always clear.

The Project Work Plans cover general project work areas to communicate a general sense of project activities. The five-year detailed 1-year work plan is useful to envision management tasks that will be necessary.

It appears that the HHF Haiti office has established financial management roles and systems.

A security plan is in place and HHF Haiti staff has extensive experience in the area on managing ongoing security issues for staff, property.

Weaknesses

Attachment J (KOMBT Organizational Chart) is not clear in regards to which staff is US vs. Haiti-based, the percentage of time dedicated to the project, and which positions have proposed or existing staff. A few abbreviated job descriptions of key program level staff would have made it easier to understand the proposed organizational chart.

The proposed HQ backstop staff, Judy Lewis, appears to have a strong academic and research background, but limited PVO and program management experience. Given that she is the main US-based contact (besides a secretary) for the project, this is of concern. Technical as well as program management backstop support is important to the success of CS field operations.

The Maternal Newborn Advisor (Frank Anderson) is noted in the organizational chart (HQ staff) but is listed in the contractual section of the budget, indicating that he is a consultant for HHF on an “as needed” basis. Will there be an agreement between HHF and Univ. Michigan regarding his support to the project? His role needs to be clarified as the organizational chart notes he is HHF HQ staff.

COLLABORATION WITH USAID FIELD MISSION

Strengths

HHF appears to have an excellent relationship with the Haiti USAID mission, and has made various contacts with key health staff there. A strong letter of support from Polly Dunford, Acting Chief of PHN is included in the attachments.

Weaknesses

None noted.

OVERVIEW COMMENTS

The proposed application is strong and offers a good context for a successful Child Survival project. Throughout this proposal, HHF articulated their experience in Haiti, MCH, ability to develop local partnerships, and well established field presence in the proposed project area. All of these elements should make it feasible for the PVO to implement the proposed project successfully, making necessary modifications at DIP time.

GH/HIDN
Debriefing Summary Sheet
FY 2004

PVO: HHF
Country: Haiti
Category: Standard

Categories	Entry	Mentoring	Standard	Cost Ext	Expanded
Number Reviewed	12	0	34	8	13
Number funded	3	NA	8	2	5
Highest score	86.61	NA	97.83	94.73	98.81
Lowest score	43.42	NA	78.87	80.26	77.10
Funded upward	80.0	NA	94.00	94.0	95.00
PVO App. Rank	NA	NA	2	NA	NA
PVO App. Score	NA	NA	95.82	NA	NA

Individual Category Scores: (Maximum Points in Parentheses)

Budget	Executive Summary	PVO Applicant	Situational Analysis	Program Strategy and Interventions	Performance M & E	Management Plan	Collaboration with USAID	Total Points
(3)	(2)	(5)	(25)	(30)	(25)	(5)	(5)	(100)
2.80	1.85	4.91	24.20	28.59	23.88	4.67	5.0	95.82

ANNEX II

BASELINE ASSESSMENTS

a. COHORT Longitudinal Pregnancy Study

KESTYONE KI DERAPE PWOGRAM SOU ETA SANTE FANM YO
[WOMEN HEALTH INITIAL QUESTIONNAIRE]

A. Enskripsyon
(***Enrollment Interview)***

Date of Interview (dd/mm/yyyy) :_____
Dat enskripsyon (jj/mm/aaaa):_____
Location: _____
Ki lokalite:_____
Interviewer's name: _____
Ki non moun kap poze kesyon yo: _____
Interviewee's Name:_____
Ki non moun kap reponn kesyon yo : _____
Relationship of the interviewee with the mother:_____
Ki relasyon'l avek manman an:_____
Interviewee's HHF #:_____
Ki nimewo HHF li: _____
Identification number**:** _____
Nimewo idantifikasyon: _____

Enfomasyon sou lantouraj ou ***(Demographic Information)***

1. Laj: *(Age)* _____

2. Lane ou fèt: *(Year of birth)*_____

3 Matrimonial status *(Marital Status)*:
1 Pa janm marye *(Never married)* 2 Marye *(Married)*

3 Plase *[Living as married cohabitation (free union)]* 4 Vèv *(Widowed)*

5 Divose *(Divorced)*

3. Nivo edikasyon (Education level)
1 pa konn li *[no education (Can not read)]*
2 nan alfabetizasyon *(literacy training)*
3 primè *(primary school)*
4 secondè *(secondary school)*
5 mòso inivèsite *(partial university)*

6 diplome nan inivèsite *(completed university)*
7 lekol pwofesyonel (ki metye) *[technical or professional training (specify)]*_____

4. Ki travay ou fè? *(What is your employment status?)*
   1 en chomaj *(not employed)* 2 travay pou lajan *(working for cash)*
   3 pa travay pou lajan *(not working for cash)*
   4 ki lot djob (precize) *[other (specify)]* _____

5. Kombyen moun ki gen nan fanmi'w (menm san avè'w tankou mari'w, pitit ou yo, avek ou menm) ***[How many people are in your family (of the same blood i.e. your husband and children and yourself)?]*** _____

6. Nou kombyen kap viv ansnm nan kay la? *(How many are living in the same house?)*
   _____

7. Nan ki zonn wap viv? *[Where do you live (which village/county)]* _____

8. ***Kombyen tan li ye pou kite kay ou pou rive jiska Jeremi?***
   How far is your home from the city of Jereme (walking time) _____

9. Eske ou konsydere ke wap viv *(Do you consider your self to be)*
   1 Lavil *(Urban residence)* 2 andeyò *(Rural residence)*
   3 ou byen toulède (both)

10. Eske gen limyè elektrik lakay ou ? *(Do you use electricity at your house?)*
    1 Wi *(Yes)* 2 Non *(No)*

11. Avek kisa atè andedan kay la fèt? *(What is the floor of your house made of?)*
    1 siman *(cement)* 2 mozayik *(tiles)* 3 tè *(mud)*
    4 ki lot bagay (precize) *[other (specify)]*_____

12. Avek kisa tèt kay la kouvri? *(What is the roof of your house made of?)*
    1 fèy tòl *(iron sheets)* 2 beton *(cement)* 3 pay *(thatched)*
    4 ki lot bagay (precize) *[other(specify)]*_____

13. ***Eske you gen latrinn nan kay ou?*** *(Do you have a latrine at your house?)*
    1 Wi *(Yes)* 2 Non *(No)*

14. Ki kote ou jwen dlo pou bwè? *(What is the source of your drinking water?)*

    1 Pipe *(tap)* 2 pi kouvri *(protected well)*

    3 pi ki pa kouvri *(unprotected well)* 4 rivyè *(stream/river)*

    5 sous ki pa kapte *(uncapped spring)*

    6 ki lòt dlo (precize) *[other (specify)]* _____

III. II. Kounye a nou ta renmen poze'w kestyon sou zafè sante'w depi'w fèt kive jodi a
IV. (Now we would like to ask you some questions regarding your medical history)

15. Eske you janm al lopital? *(Have you ever been to the hospital?)*

1 Wi / Yes — 2 Non / No → ale nan kestyon 23 / Go to question 23

16. Ki lopital? *(Which one?)*

1 Sen Tantwann (Saint-Antoine) — 2 Pòtoprens (Port-au-prince) — 3 Okay (Cayes)

4 ki lòt (precize) _____ / Other (specify)

17. Ki dènye fwa outal lopital? *(When was the last time you went to hospital?)*

1 gen de semèn desa *(Two weeks ago)* — 2 mwa pase *(Last month)*

3 gen twa moi desa *(Three months ago)* — 4 gen plis pase twa mwa *(More than three months)*

18. Ki rezon ki fè ou tal lopital? *(What was the reason you went to the hospital for?)*

1 verifye ki jan'w ye an general *(Check your health status in general)* — 2 doulè *(Pain)*

3 lafièb *(Fever)* — 4 tap pèdi san *(Bleeding)*

5 ki lòt (precize) _____ *[Other (Specify)]*

19. Pa ki moayin ou tale lopital la? *(How did you get to the hospital?)*

1 a piye *(By foot)* — 2 sou bèt *(on animal)* — 3 lan bis *(by bus)*

4 lan tap-tap *(On tap-tap)* — 5 sou branka *(on stretcher)*

6 ki lòt fason? (precize) _____ *[Other way? (specify)]*

20. Si se lopital Sen Tantwann, kombien tan sa pran pou te rive? (*If you have been to St Antoine, how long does it take you to get to the St. Antoine hospital?)*

(an kolomèt) _____ *(In kilometers)* tan (kombyen èdtan) _____ *(Hours)*

21. Ki rezon ki ta fè ou pa vle ale lopital la? (W*hat are the reasons you would not have wanted to go to hospital?)*

_____

III. An'n koze jounye a sou istwa planig ou
Now I would like to ask you about your contraceptive history

22. Eske'w konn fè metod planig ? *(Have you ever used a birth spacing method?)*

1 Wi / Yes — 2 Non / No → ale nan kestyon 31 *(Go to question 31)*

23. Kijan de metòd *(Which method?)*

1 bwe grenn Pills
2 piki injection
3 gle Cervical mucus method
4 voye deyo Withdrawl
5 MAMA lactation amenorrhea
6 pa fe bagay Abstinance
7 kapot condom
8 ti baguette nan bra Norplant
9 piki 3 mwa Depo provera
10 rete net tubal ligation
11 retire bowl grenn yo vasectomy
12 realite fanm condom for women

24. Dpi kilè? *(Since when or when did you start?)* _____

25. K moun ki konseye w/montre w metòd sila? *(Who recommended/taught you this birth spacing method?)*

1 matwòn *(Midwife)*
2 dokè *(Doctor)*
3 fanmi *(family)*
4 employe HHF *(HHF Employee)*
5 ki lòt moun? (precize) _____ *[Other people? (specify)]*

26. Eske ou te satisfè ak metod sila ? *(Were you satisfied using this method?)*

1.- Wi *(yes)* 2.- Non *(No)*

27. Si'w satisèe, di nou pou kisa? *(If yes, what are the reasons for being satisfied or tell us why?)*_____

28. Sinon, pouki rezon ou decide pou pa janm itilize anyin ki pou ridew kontrole pouvwa fè piti ou ? *(If no, what is the reason(s) you decide **never** to use contraceptive to control birth spacing?)*

1 ***Paske se bondye ki bay pitit*** God give babies
2 ***Potestan*** Protestant
3 ***venn ki gen san*** Varicose veins
4 ***li fe ou malad*** will make me sick
5 ***poko*** not yet
6 ***pa gen neg*** no stable partner
7 ***pa ka jwenn andeyo*** no chance to get methods
8 Si m fe plannin, yo di, m ka pa fe pitit People say if I use FP I will not have children
9 m pa janm gen reg - I have never had a period
10 plannin' kon fe yo pedi twop san FP makes women hemorrhage
11 lap bay'm opresyon It gives me asthma
12 Kon fe san pa vini It makes you not have your menstrual period
13 ***pa konnen*** I do not know)
14 ki lòt rezon? (precize) *[Other reason (specify)]*_____

IV. Kounye a nap poze'w kèk kesyon sou zafè pitit ou
II. Now we would like to ask you some questions regarding your reproductive and obstetrical history

29. Eske ou janm te ansent deja? *(Have you been pregnant before?)*

1 Wi / Yes 2 Non / No → ale nan kestyon 41 / *Go to question 41*

30. Kombyen fwa ou deja tombe ansent (kitou te fè pitit la, kit ou fè avòtman/foskouch)
[How many times have you been pregnant (including live births, abortions/miscarriages)?]

_____

31. Kombyen pitit ou fè? (*How many children did you give birth to?)*_____

32. Kombyen ki *(How many are)*

1 Anvi _____ alive 2 Mouri _____ (dead

33. Invantè timoun yo Delivery Information

Nimewo gwosès **Pregnancy number**	**Laj ou lè ou tap akouche** Age at the delivery	**Dat akouchman** Mwa/an Delivery date Month/ year	**Ki kote** Where 1-lakay Home 2-klinik Clinic 3-lopital Hospital	**Rezilta gwosès** Pregancy result 1-avòtman Abortion 2-fòskouch Miscarriage 3-anvi alive 4-fèt mouri Born dead	Moun ki ride Person who help you 1-mis Nurse 2-doktè Doctor 3-matròn (TBA)	**Ki jan ou *TE* delivre** **How do *DID* you diliver** 1-NVD vaginal 2-C/S sezeryan 3-C/S sezeryan ak pye devann 4-NDV vaginal ak pye devann 5-Lòt Other	**Sou kombye mwa ou akouche** How many month did you have when you delivered	**Sex** sex 1-gaso boy 2-fi girl	**Kipwa ti bebe a te peze** What was the weight of the baby at birth	**Kisa timoun sa devni** What does the baby become 1 Anvi Alive 2 Mouri dead
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

34. Eske'w deja fè avòtman/foskouch *(Have you ever had an abortion/miscarriage?)*

1 Wi Yes — 2 Non No → ale nan kestyon 41 *go to question 41*

35. Siw te fè avòtman oubyen foscouch, combyen *(If you had an abortion/s or miscarriage, how many)*_____

36. Eske avòtman oubyen foskouch sayo te volontè ousinon yon aksidan?
(Were the abortion(s)/miscarriages intentional or an accident?)
1 volontè *(Voluntary /intentional abortion)* 2 aksidan *(Accident)*

Kesyon sou avòtman volontè 37-38 *(Questions on voluntary/intentional abortion 37-38)*

37. Siw te deside fè avòtman oubyen foskouch volontèman, konbyen? *(If the abortion(s)/miscarriages were intentional how many?)* _____

38. Souple bay infòmasyon pou chak avòtman volontè
(**Please fill in for each intentional abortion in the table below)**

Avotman volontè Voluntary abortion	**Sou konbyen mwa gwosès** How many month of pregnancy	**Ki moun ki ede'w fè avòtman an** Who help you doing the abortion 1-doktè doctor 2-mis nurse 3-matwòn Midwife 4-fanmi Family 5-vwazin Neighbor 6-pèsonn moun None 7-kidòt; eksplike Who else(specify	**Ki sa yo itilize pou fè avòtman an ?** What do they use to do the abortion 1-fey Traditional medicine 2-manyin Touching it 3-zouti Tools 4-te Tea 5-maji-vodou Vodou magic 6-lòt bagay; eksplike Other thing (specify)	**Eske'w te gen pwoblèm aprè avòtman an, osinon foskouch nan?** Did you have problem after the abortion, or the miscarriage 1-wi yes 2-non no	**Ki jan de konplikasyon?** What kind of complication 1-oken'n No complication 2-lafièv Fever 3-senyen Bleeding 4-etoudisman Dizzy spell 5-pa sonje Don't remember 6- lòt bagay; eksplike Other complication (specify)	**Eske'w te oblije al lopital pou konplikasyon?** Did you have to go to hospital for the complication 1-wi yes 2-non no
1						
2						
3						
4						
5						
6						
7						
8						

Kesyon sou avòtman pa aksidan 39-40
(Questions on accidental abortion 39-40)

39 ***Kombyen fwa ou fe fos kouche*** Siw te deside fè avòtman oubyen foskouch pa aksidan, konbyen ? *(If the abortion(s)/miscarriages were accidental how many?)*_____

40. Souple bay infòmasyon pou chak avòtman pa aksidan
Please fill in for each accidental abortion in the table below

Avòtman pa aksidan Abortion By accident	**Sou konbyen mwa gwosès** How many month of pregnancy	**Ki moun ki ede'w trete avòtman sa** Who help you treating the abortion 1-doktè doctor 2-mis nurse 3-matwòn Midwife 4-fanmi Family 5-vwazin Neighbor 6-pèsonn moun None 7-kidòt; eksplike Who else(specify)	**Eske ou te sèvi ak fèy aprè avòtman an ?** Do you use traditionl medicine after the abortion 1-wi yes 2-non no	**Eske'w te gen pwoblèm aprè avòtman an, osinon foskouch nan?** Did you have problem after the abortion, or the miscarriage 1-wi yes 2-non no	**Ki jan de konplikasyon?** What kind of complication 1-oken'n No complication 2-lafièv Fever 3-senyen Bleeding 4-etoudisman Dizzy spell 5-pa sonje Don't remember 6- lòt bagay; eksplike Other complication (specify)	**Eske'w te oblije al lopital pou konplikasyon?** Did you have to go to hospital for the complication 1-wi yes 2-non no
1						
3						
4						
5						
6						
7						
8						

41. Eske'w ansent kounye an? *(Are you currently pregnant?)*

1.- Wi *(yes)* 2.- Non *(No)*

42. Ki jou ki te premie jou dènie fwa ou gen periòd ou? *(What was the first day of your last menstrual period)* _____

43. Ki dat ou sipoze akouche: (kalkile) *[What is the expected date of delivery (please calculate)]* _____

44. Eske'w talwè yon koktè oubyen yon ajent sante pou ede'w tonbe ansent?
(Did you go see a doctor or a health worker to receive help in getting pregnant?)

1.- Wi *(yes)* 2.- Non *(No)*

45. Si wi ki metòd li amplwaye? *(If yes, what procedure did he/she do?)* _____

46. Eske'w talwè yon medsin fèy pou ede'w tombe ansent:
(Did you go see a herbalist or traditional doctor to get pregnant?)

1.- Wi *(yes)* 2.- Non *(No)*

47. Si wi ki fèy li itilize? *(If yes, what herb tea or infusion did he/she do to help you?)* _____

48. Eske ou te itilize kèk té fèy? *(Are you currently taking herbs?)*

1 Wi ( ) yes 2 Non ( ) no Si non ale nan 37 (*if no, go to 37)*

49. Ou te pran kèk fèy? Kijan yo rele?: ***(****If you took some leaves (or herbs)? What are they called?)* _____

50. Poukisa ou te pran fèy sa yo? *(If yes, why did you take these leaves (or herbs)?)* _____

IV. **Kounie a nou ta renmen poze'w kèk kesyon sou gwosès aktyèl ou**
I. (Now we would like to ask you some questions regarding your current pregnancy)

51. Eske wap swiv la swenyaj yon kote pou gwosès sila? *(Are you getting prenatal care at a particular place?)*

1.- Wi *(yes)* 2.- Non *(No)*

52. Si wi, ki kote wap swiv? *(If yes where do you are you going for prenatal care?)*

1	lopital Hospital	2	klinik Clinic	3	dispensè dispensairy
4	post sante HHF HHF health post	5	Klinik HHF nan Jeremi HHF clinic in jeremie		
6	pa swiv oken kote No where	7	ki lòt kote? (precize) _____ Other? (Specify)		

53. Eske ou te al lot kote pou swen pandan ou te ansent? *(Besides to this place you went to, did you go to another place for prenatal care as well?)*

1.- Wi *(yes)* 2.- Non *(No)*

54. Si wi, ki lot kote? *(If yes, where did you go?)* _____

55. Kilè oute fè prenmie vizit pou gwosès ou? *(When did you make your first prenatal care visit?)*

1	jodia Today	2	semèn pase last week	3	de semèn pase two weeks ago
4	mwa pase Last month	5	pat gen redevou no appointment		
6	ki lòt lè? (precize) _____ Other time (specify)				

56. A pati de konbyen tan gwosès ou te fè premiè vizit sila (sou konbyen mwa osinon sou konbyen semèn*) [At what stage of pregnancy did you make your first prenatal care visit (in months or weeks) How many months or weeks did you have when you did your first visit?]*

_____

57. Ki moun ki te pren ka'w nan premie vizit la? *(Who was your provider at the first visit?)*

1	doktè Doctor	2	mis nurse	3	ajen de sante health agent
4	doktè fèy Traditonal doctor	5	TBA Midwife	6	pat gen redevou no appointment
7	ki lòt moun? (presize) _____ Other people (specify)				

58. ***Apres moun sa, ki lot moun te konsilte ou pandan ou te ansent?***
(Besides seeing this provider, did you see another provider for prenatal care as well?)

1.- Wi *(yes)* 2.- Non *(No)*

59. Se wi, ki moun? *(If yes, who did you see?)* _____

60. Ki laj dènye pitit ou lè ou tombe ansent fwa sa a (ki entèval depi dènye akouchman)
[How old was your last child when you got pregnant this time (interval since last birth)]

1	***mwes ke12 mwa***	2	12-18 mwa	3	***ant 18-24 mwa***
	<12 months		12-18 months		18-24 months
4	>24 mwa				
	plis ke 24 mwa				

61. Eske tibebe a ap bouge byen? *(Is the baby kicking/moving well?)*

1.- Wi *(yes)* 2.- Non *(No)*

62. Eske'w gen pwoblem sante kounie a? *(Do you have any health problems now?)*

1.- Wi *(yes)* 2.- Non *(No)*

63. Eske'w gen konplikasyon kounie a ak gwosès sila: *(Are you having any pregnancy complications?)*
1.- Wi *(yes)* 2.- Non *(No)*

64. Eske'w gen :
Do you have :

lafièv	1	wi	2	non
Fever		yes		no
senyen	1	wi	2	non
Bleeding		yes		no
maltèt	1	wi	2	non
Headaches		yes		no
figi'w enfle	1	wi	2	non
Swollen face		yes		yes
men enfle	1	wi	2	non
Swollen hand		yes		no
vant fèmal	1	wi	2	non
Addominal pain		yes		no
wè twoubl	1	wi	2	non
Trouble vision		yes	no	
pèdisyon	1	wi	2	non
Perdition		yes	no	
vant tranche	1	wi	2	non
Belly pain Like labor pain		yes	no	
Frison	1	wi	2	non
Seizures(fit epilespy)		yes	no	
Krize	1	wi	2	non
Convulsions(chills, fever)		yes	no	

lòt pwoblèm? (presize) _____
Other problem (specify)

65. Si'w te gen youn nan komplikasyon nou sot pale la, ki epòk sa te rive'w ?
(If you had any one of the complications above, when did you have them?)

_____

66**.** Eske ou kon gen maladie tombe ou fe yon kriz le ou pat ansent?
(Have you ever had a fit (seizure) when you were not pregnant?)

1.- Wi *(yes)* 2.- Non *(No)*

67. Eske'w janm pèdi san pa ba**? (***Did you experience any vaginal bleeding?)*

1.- Wi *(yes)* 2.- Non *(No)*

68. Si wi, kilè ou te pèdi san pa ba? ***(****If yes when did you experience vaginal bleeding?)*
_____

69 Eske'w janm gen pèdisyon paba ? (*Did your baby ever stop growing inside you for a long period of time?)*
1.- Wi *(yes)* 2.- Non *(No)*

70. Kombyen tan? **(***How long?)* _____

71. Eske'w janm gen pèdisyon ***dlo paba***? *(Did you experience any leakage of fluid into the vagina?)*
1.- Wi *(yes)* 2.- Non *(No)*

72. Si'w kon n gen ***dlo paba***, kilè sa te rive'w ? (*If yes when did you experience leakage of fluid into the vagina?)*
_____

73 ***Eske'w te gen vant tranche pandan ou ansent fwa sa?***
Did you have labor pains during this pregnancy?

1.- Wi *(yes)* 2.- Non *(No)*

74 Si wi, kilè ou kon gen vant tranche ? *(If yes when did you experience abdominal contractions?)*

1	jodia Today	2	yè yesterday	3	avantyè the day before yesterday
4	semèn pase Last week	5	de semèn pase two weeks ago	6	mwa pase last month
7	de mwa pase Two months ago	8	ki lòt lè? (precize) _____ Other time? (specify)		

75 Konbyen tan vant tranche a dire sou ou? *(How long did the contractions last?)*
How long did you have the belly pain?
_____

76 Eske te gen mon ki te konseye'w wè yon koktè? (*Has someone recommended you to see a doctor?)* Did you have someone who advised you to see a doctor?

1.- Wi *(yes)* 2.- Non *(No)*

77 Si te gen yon moun ki te di'w pou w`doktè, ki yès mon sa a te ye ? *(If someone recommended you to see a doctor, who recommended you to see a doctor)*
If there is someone who advised you to see a doctor, who was it ?

1	penson moun Anyone (no one)	2	mis/matwon nurse/midwife	3	oksilyè auxiliary
4	agen de sante Health agent	5	doktè fèy Traditional doctor	6	TBA TBA
7	ki lòt moun? (precize) _____ Other people (specify)				

78 Eske ou tal wè yon doktè ? *(Did you see/visit a doctor?)*

1.- Wi *(yes)* 2.- Non *(No)*

79 Ki dènye fwa ou te wè yon doktè ? *(When was the last time you saw a doctor?)*

1	jodia Today	2	yè yesterday	3	avantyè the day before yesterday
4	semèn pase Last week	5	de semèn pase two weeks ago	6	mwa pase last month
7	de mwa pase two months ago	8	ki lòt lè? (precize) _____ other time (specify)		

80 Pouki rezon kifè'w tal wè yon doktè ? *(What was the reason you saw a doctor for?)*

1	lafièv Fever	2	senyen bleeding	3	toudisman dizzy spell
4	tèt fè mal Headaches	5	figi enfle swollen face	6	men enfle swollen hand
7	doulè nan lestomak Abdominal pain	8	wè twoubl trouble vision	9	ekoulman pa ba discharge
10	vant tranche Belly pain	11	ki lòt rezon? (precize) _____ other reason (specify)		

81 Eske'w chache laswenyaj lan men lòt mou ki pat doktè? *(Have you sought help from someone who is not doctor?)* Did you look for health care from someone who is not a doctor?

1.- Wi *(yes)* 2.- Non *(No)*

82 Si wi, kilòt moun sa a ? *(If yes, from whom?)* _____

83 Eske'w konn fimen sigarèt? *(Have you ever smoked cigarettes?)*
Do you use to smoke cigarettes?

1	Wi Yes	2	Non no	→ ale nan kestyon 86 go to question 86

84 Si wi, eske'w fimen sigarèt pandan'w ansent la a ? *(If yes did you smoke cigarettes during current pregnancy?)* If yes, do you smoke cigarettes while you are pregnant?

1.- Wi *(yes)* 2.- Non *(No)*

85 Konbyen sigarèt ou fimen pajou pandan'w ansent la a ? *(How many cigarettes did you smoke per day during this pregnancy?)* How many cigarettes do you smoke while you are pregnant?

_____

86 Eske'w pa janm bwè tafia ? *(Do you ever drink alcohol?)*
Have you ever drunk CLAIRIN?

1 Wi / Yes — 2 Non / no → ale nan kestyon 91 / go to question 91

87 Eske'w pat bwè tafia ditou pandan'w ansent lan ? *(Did you drink any alcohol during this current pregnancy?)* Have you ever drunk CLAIRIN while you are pregnant?

1.- Wi *(yes)* 2.- Non *(No)*

88 Kijan de bweson ou bwè pandan'w ansent la a ? (*What is the type of alcohol you drank with this current pregnancy?)* What kind of drinks do you take during your pregnancy?

1 byè nan boutèy / Beers — 2 klerin / CLAIRIN (spirits) — 3 diven / wine
4 pa konnbwè / Don't drink — 5 ki lòt bweson? (precize) _____ / other drinks (specify)

89 Konbyen fwa pa semèn ou bwè tafia pandan'w ansent la a? *(How many times did you drink alcohol per week with this current pregnancy?)*
How many times a week do you drink CLAIRIN during your pregnancy?

1 nan fèt / At party — 2 1-3 fwa pa semen / 1-3 times a week — 3 4-6 fwa pa semen / 4-6 times a week
4 chak jou / every day — 5 pa konn bwè / don't drink

90 Ki kantite tafa ou kadi ou kon bwè lè konsa ? *(What was the amount of alcohol you can say you drank per occasion?)* What is the quantity of CLAIRIN you can say you drink?

1 yon vè / One cup — 2 2-3 vè / 2-3 cups — 3 4 vè ou plis / 4 cups or more
4 pa konnbwè Don't drink

V. Kounye a mwen pral wè konesans ou na zafè sant matènite
(Now I would like to ask you about your knowledge of Maternity homes)

91 Eske'w konen si gen yon sant matènite nan zon lakay ou ? *(Are you aware of a presence of maternity home in your area?)* Do you know if there is a maternity center in your area?

1.- Wi *(yes)* 2.- Non *(No)*

92 Si wi, eske'w konn al nan sant matènite sa a? *(If yes, have you utilized the service offered at the maternity home?)* If yes, do you use to go to that maternity center?

1 Wi Yes 2 Non no → ale nan kestyon 101 go to question 101

93 Kilè ou tal nan sant matènite sa a? *(When did you use the maternity home)* When did you go to that maternity center?

_____

94 Si'w te rete nan sant matènite sa, pendan ki èsk nan gwosès ou yo *(If you used the maternity waiting home, with which pregnancy?)* If you stayed in that maternity center, during which pregnancy? _____

95 Kombyen fwa'w tal nan sent espoir nan Jeremi? *(How many times did you visit the maternity home?)*

1 yon sèl fwa Once
2 2-3 fwa 2-3 times
3 4-5 fwa 4-5 times
4 plis pase 5 fwa more than 5 times

96 Eske se yon moun kite di'w ale nan sant matènite a pandan gwosès sa a ? (*Did someone recommend you to visit/use the maternity home with this pregnancy?)* Did someone tell you to go to the maternity center during this pregnancy?

1.- Wi *(yes)* 2.- Non *(No)*

97 Si wi, kiyès moun kite di ou pou al nan sant matènite a ? *(If yes, who recommended you to visit the maternity home?)* If yes, who tell you to go to the maternity center?

1 pwop desizyon'm My decision
2 emplòaye HHF HHF employee
3 matròn Midwife (TBA)
4 fanmi family
5 lòt moun (precize) _____ Someone else (specify)

98 Eske'w te rete nan sant matènite sa a pandan gwosès sa a *? (Did you use the maternity waiting home with this pregnancy?)* Did you stay at the maternity center during this pregnancy?

1 Wi 2 Non → ale nan kestyon 101

Yes no go to question 101

99 Si'w te rete nan sant matènite sa a pandan w'ansent la a, kilè sa a ? *(If you used the maternity waiting home with this pregnancy when did use it)* If you stayed at the maternity center while you are pregnant, when exactly? _____

100 Konbyen mwa gowsès ou te ye, lè ou te rete nan sant matènite a ? (*How many months pregnant were you when you used the maternity waiting home with this pregnancy?)* How many months did you have, when you stayed at the maternity center? _____

101 Si yo rekòmande'w pou tal nan sant matènite a, e pi ou pat ale, pouki rezon ? *(If you were recommended and **did not** to use the maternity waiting home, what is the reason(s) you did not visit the maternity waiting home?)*

If someone recommand you to go to the maternity center, then you didn't go, what is the reason?

_____

_____

_____

VI. Kounye a mwen ta renmen fè yon egzamen general sou fanm nan e sou gwosès li
(At this time I would like to perform a general and obstetrical examination)

102

Otè (cm) : _____ Pwa (kg) : _____
Height Weight

Ki gwosè rondèl bra'l (cm): _____
Upper arms circumference?

Tansyon (Systolic) : _____ Tansyon (Diastolyc): _____
Blood pressure

Pou: _____
Pulse

Otè vant fanm: _____ batman kè tibebe nan vant: _____
Size of her abdomen heartbeat of her baby

Apeprè konbyen semen li ansant: _____
About how many weeks she gets pregnant

Laj devlopman tibebe pa iltrason : _____ Dat : _____
Development age of the baby date

Nan ti dialog nou sot gen la-a eske'w gen lòt bagay ou ta renmen ajoute?
Is there anything else you would like to tell us concerning the survey or any of your answers?
After our quit conversation do you have other thing that you would like to know?

MESI POU TAN OU AK KOLABORASYON'W
THANK YOU FOR YOUR TIME AND COOPERATION!
Thank you for your time and collaboration

MEDICAL CHART ABSTRACTION
Selman pou manman ki te we medsen *(Only for mothers who saw a doctor/nurse)*

Kikote manman te we medsen ou miss? *[Where did the mother see a health professional (doctor/nurse)]*

1 ***Klinic ou dispanse*** clinic
2 ***Lopital*** hospital
3 ***pos de resambleman*** health post
4 ***foye matenel nan sant espoir Jeremi*** maternity waiting home
5 _***Lot*** (precize) other (specify) _____

Rezilta Emoglobin Hemoglobin result _____

Rezilta Sifilis Syphilis result _____

Rezilta Malaria Malaria test result _____

Diagnostik Diagnosis _____

Tretman yo te bay Treatment given _____

_____

Pou sèvis biwo sèlman
For office use only

Dat li rive : _____
Joined date

Dat Premye kod yo mete : _____ Inisyal _____
First code date Initials

KPC 2000+

Knowledge, Practices, and Coverage Survey 2000+

KESYONÈ KPC

Developed by Donna Espeut,
The Child Survival Technical Support Project

Tradiksyon nan lang kreyol
KOMBIT [HHF/MSPP/SGS]
Desanm 2004

AGREEMENT FORM

Hello, My name is._____,I am working with Kombit. We are doing research and we would like you to participate in it. I'm going to ask you some questions about your health and your family's health, especially about your last child under two years of age. Kombit will use this information in order to plan some health services and to control if they work with the objectives to improve child services. The research normally takes _____ minutes. Whatever information you give us will remain a secret and nobody else will know it.

Your participation in this research is voluntary, and you can decide whether or not to respond to any question regarding yourself or any other question we ask. But we hope that you will participate in the research because what you think has a lot of importance.

Do you have any question that you like to ask me regarding the research?

Signature of interviewer _____ Date _____

Signature of interviewee.....1

Interviewee doesn't Accept.....2 ─End

POU KISA

She's Busy .....A

Going out.....B

She's doesn't know C

Not willing to speak to strangers.....D

Says to come back another time.....E

Other reason .....F

.....

.....

Cover page for Research To Test knowledge and practice with Cover (CPC)

Identification	
Number Group	
House Number	
Registration Number	

These questions should be asked to a mother who has a child older than 24 months

Sit and Speak with reporter

Day

Month

Year

Date Sit and speak (Date of Conversation)
_____/_____/_____
(dd/mm/yy)

Name of the person posing the questions
_____

Name of Supervisor _____

Locality _____

Commune _____

Name of woman

_____

Name of the child who is older than 24 months
_____

Mother's Age (Year of Birth)) .....

Sex of Child 1=Male 2=Female) .....

Date of birth

Day

Month

Year

Child's Age (Month Of Birth)

General Characteristics of the research

Nº	Question and Response	CODE	GO TO
1	How many years have you gone to school (If never, Mark 00)	Years in school..... ☐☐	
2	What languages do you speak [2]?	_____ _____ _____	
3	What language are you most comfortable speaking?		
4	Does the father (Name) of the child live in this house?	yes..... 1 NO..... 2 Don't know 8	
5	Who is boss of the house ?	Mother)..... 1 Father/Man..... 2 Parent (who is the Woman: _____ 3 (PRECISE) Parent who is the Man _____ 4 (PRECISE) OTHER _____ 7 (PRECISE)	
6	Do you work outside the house to make money? If no, circle A (don't work outside the house) If yes, what kind of work do you do	Don't work outside the house ..... A ARTIST..... B FAMER..... C SELL FOOD..... D SELL ON STREETI..... E HOUSEKEEPER..... F JOB PAID BY MONTH..... G OTHER _____ X (PRECISE)	✱FIN
7	Who cares for the house when you are not there (Name_____)?	MOTHER..... A FATHER..... B OLDEST CHILD..... C OTHER PARENTE _____ ..... D (PRECISE) NEIGHBOOR/FRIEND..... E HOUSEKEEPER..... F KINDERGARTEN..... G OTHER_____ X (PRECIZSE)	

BREASTFEEDING & NUTRITION

Nº	Question and Response	CODE	GO TO
1	**Are you breastfeeding?**	**Yes .....1** **NO 2**	**—— 8**
2	**After the child was born, how much time passed Before you started breastfeeding?[1]**	**Immediately after birth/** **During the first time .....1** **After the first hour 2**	
3	During the first 3 days after childbirth, did you give ? _____the baby(Name) colostrums(Yellow milk) or water from the breast	YES.....1 NO .....2 DON'T KNOW 8	
4	During the first 3 days after childbirth, did you give. ? _____the baby (Name) food or some other thing drink before you breast feed.	YES 1 NO ..... DON'T KNOW 8	 6 6
5	What did you give _____(Baby 's name)? What other thing ? Write everything the person says to you	MILK (OTHER THAN BREAST-MILK) A SIMPLE WATHER B SWEET WATHER ..... C WATHER FOR ABDOMINAL PAIN ..... D SALTY WATHER/SUGAR WATHE .....E NATURAL JUCE .....F PODERED MILK ..... G TEA/INFUSION ..... H HONEY.....I OTHER _____ X (SAY WHAT)	
6	Now, are you breastfeeding _____ ?	YES.....1 NO 2	8
7	How long will you breastfeeding _____? If the child is older than 1 month, write <<00>	MONTHS ..... ☐☐	
8	Now, I would like to ask you questions about the quality of liquid(Water) that (name of baby) drinks during the day and night. Did (Name of baby) drink liquid or one of the following yesterday during the day or last evening during the night Mark an x if the child drank one of the liquids . Mother's milk ? A Simply water ? B Bottled Milk, powdered milk, or cow's milk ? C Powder milk purchases at the Market D Natural juice ? E Other liquid (like sugar water, tea, coffee cola or stew F	A ..... ☐ B ..... ☐ C ..... ☐ D ..... ☐ E ..... ☐ F ..... ☐	

Nº	QUESTION AND RESPONSE	CODE	GO TO
	Now, I would like to ask you some questions about the quality of food (baby's name) that the child ate yesterday and evening Did(baby's name) eat these foods yesterday during the day or evening Mark an x if the child ate one of the following foods .		
G	Food that was made with grain (like flour, sorghum, corn, rice, white flour, porridge, or other local grains?	G ..... ☐	
H	Yams yellow yams, carrots or red potatoes or sweet potatoes?	H ..... ☐	
I	All other food made with roots or potatoes, white yams, manioc or other local roots	I ..... ☐	
J	Green leafy vegetables?	J ..... ☐	
	Mango papaya. Other fruit in the area near your house that are rich Vitamin A		
K	Other fruits or vegetables (plantains, apples, avocados, or tomatoes)?	K ..... ☐	
L	Meat, poultry, fish, seafood or eggs?	L ..... ☐	
M	Food made with vegetables (like lentils, beans, oil, vegetables whit?	M ..... ☐	
N	Cheese or yogurt?	N ..... ☐	
O	Food made with oil, grease or butter?	O ..... ☐	
P		P ..... ☐	
9	How many times (baby's name) did the baby eat during the day	How many times ..... ☐☐ Don't know. 8	
10	Can I see the salt you use in the kitchen ? (Look to see if the salt has iodine)	WITH YODINE ..... 1 WITHOUT YODINE 2	
11	Did _____(baby's name) take a dose of Vitamin A at sis (6) months -??	YES ..... 1 NO ..... 2 DON'T KNOW 8	

CARE AFTER DELIVERY

Nº	QUESTION AND RESPONSE	CODE	GO TO
1	WHILE YOU WERE PREGNANT (NAME), DID YOU SEE A PERSON TO FIND CARE BEFORE CHILDBIRT? IF YES, WHO DID YOU SEE ASK IN ORDER TO WRITE ALL THE PEOPLE THE MOTHER NAMEA	PROFESSIONAL IN THE HEALTH BUSINESS DOCTOR ..... A NURSE MIDWIFE ..... B AUXILIARY ..... C OTHE PERSON MIDWIFERESPONSABLE WOMAN ..... D COMMUNITY HEALTH AGENT ..... E OTHERT _____ X (PRECISER NO OTHER PERSON ..... Z	→ 6
2	How many times did you see a person in order to find care while you were pregnant ?	HOW MANY TIMES..... ☐☐	
3	During the visit (prenatal) before childbirth did they give you advice on:	**YES NO** Preparation for childbirth Breastfeeding Birth spacing PEV Danger sings while you are pregnant	
4	**Before you gave birth to (name), did you receive an injection in your arm to prevent the baby from having???,** **That is to say seizures after he was born**	**YES ..... 1** **NO ..... 2** **DON'T KNOW 8**	
5	Did you gave a maternal health card for pregnancy of (Name)	YES, I SEE IT ..... 1 DON'T FIND IT ..... 2 NEVER HAD CARD 3	→ 6
5A	Look at the card and count how many prenatal visits the mother made while she was pregnant with (name).	Number of visit..... ☐☐	
5B	Look at the card and mark all the dates for each injection that appear on the card	day Month Year 1er.... ☐☐ ☐☐ ☐☐ 2 eme. ☐☐ ☐☐ ☐☐ 3 eme. ☐☐ ☐☐ ☐☐ 4 eme. ☐☐ ☐☐ ☐☐ 5 eme. ☐☐ ☐☐ ☐☐ 6eme. ☐☐ ☐☐ ☐☐	
6	How much distance separates you from the hospital	DISTANCE(km) ..... ☐☐☐	

Nº	QUESTION AND RESPONSE	CODE	GO TO
7	What means of transportation do you use to go there? WRITE ALL RESPONSES	ON FOOT.....A CAR .....B MOTOCYCLE.....C CHARET .....D ROWBOAT .....E OTHER _____ X (PRECISES)	
8	How much times does it take you to arrive at the center	LESS THAN 1 HOUR ..... 1 1 - 3 HOURS..... 2 MORE THAN 3 HOURS ..... 3 DON'T'KNOW..... 8	
9	Who was it decided to send you there Write everyone that in mentioned	PERSON WHO RESPONDS TO THE QUESTION .A HUSBAND .....B HERE MOTHER .....C MOTHER IN LAW.....D FRIEND/ NEIGHBOR .....E OTHER PERSON _____? (PRECISER)	
10	What sign did you see while pregnant showed you that you have to look for health care ? .	FIVER .....A HEAVY BREATHING .....B BLEEDING/HEMORRHAGE .....C BODY/HAND/ FACESWOLLEN …..... D OTHER_____ X (PRECISER) DON'T KNOW.....Z	— END
11	What the first place you would go to find care if you would notice these signs	WHERE THEY GIVE HEALTH CARE OSPITAL..... 01 HEALTH CENTER..... 02 HEALTH POST..... 03 HEALTH ORGANISATION..... 04 CLINIC ..... 05 HEALTH AGENT OF THE LAND IN THE COMUNITY.....06 OTHER PLACE THEY GIVE HEALTH CARE _____ 07 (PRECISER) OTHER SOURCE HERB DOCTOR ..... 08 SHOP..... 09 PHARMACY ..... 10 DISTRIBUTE IN THE COMMUNITY..... 11 FRIEND/FAMILY ..... 12 OTHER_____ 88 (PRECISER)	

SUB-MODULE IRON SUPPLEMENT RECEIVED DURING PREGNANCY

Nº	QUESTION AND RESPONSE	CODE	GO TO
1	When you were pregnant whit (Name), did you receive or buy iron pills or syrup which had iron in it Show the pills or syrup	YES ..... 1 NO ..... 2 DON'T KNOW 8	┐ └ END
2	For how many days did you take the syrup if she doesn't give you an exact number, try to find out Approximately how many days	HOW MANY DAYS ..... | | | DON'T KNOW 998	

DELIVERY AND CARE FOR THE CHILD JUST BORN

Nº	QUESTION AND RESPONSE	CODE	GO TO
1	Where did you give birth to _____(name of child) ? IF THE PLACE WAS IN A HOSPITAL, A CENTER OF HEALTH, OR A CLINIC, WRITE THE NAME OF THE PLACE . _____ (NON KOTE YA)	MY HOUSE 11 OTHER HOUSE ..... 12 **SANITARY ESTABLISHMENT** HOSPITAL ..... 21 CLINIC ..... 22 HEALTH CENTER ..... 23 HEALTH ORGANIZATION ..... 24 HEALTH POST ..... 25 OTHER _____ 26 (say what place) OTHER_____ 96 (Say what place)	
2	**WHO WAS TOGETHER WITH YOU WHEN YOU GAVE BIRTH TO (SAY CHILD NAME)?** **WRITE THE NAMES OF EVERYONE THEY MENTION**	**PERSON WITH HEALTH KNOWLEDGE** **DOCTOR ..... A** **NURSE/MIDWIFE ..... B** **MIDWIFE/AUXILIARY ..... C** **OTHER PERSON** **HERB DOCTOR ..... D** **COMMUNITY HEALTH AGENT ..... E** **A PERSON IN YOUR FAMILY ..... F** _____ **(SAY NAME)** **OTHER ..... G** _____ **(SAY NAME)** **NOBODY ..... Y**	

SUB-MODULE ON CHILDBIRTH METHODS

Nº	QUESTION & RESPONSES	CODE	GO TO
1	TOOLBOX FOR CHILDBIRTH CLEAN AND AVAILABLE IN YOU ZONE CLEAN & AVAILABLE IN YOUR ZONE ☐ NOT AVAILABLE ☐		→ 3
2	Did you use a a clean toolbox?	YES....1 NO....2 DON'T KNOW....8	→ 4
3	What did they use to cut the umbilical cord ?	NEW RAZOR BLADE....1 OTHER INSTRUMENT....2	
4	Who cut the umbilical cord?	**PERSON KNOWLEDGE IN HEALTH** DOCTOR....1 NURSE/MIDWIFE....2 AUXLIARY/MIDWIFE....3 **OTHER PERSON** HERB DOCTOR....4 COMMUNITY HEALTH AGENT....5 SOMEONE IN THE FAMILY....6 _____ (SAY WHO) OTHER....7 _____ (SAY WHO) NOBODY....8	
5	Where did you place _____ (child name) as soon as he was born ?	WITH MOTHER....1 IN CRADDLE....2 ON THE GROUD....3 WASH BASIN....4 OTHER_____ 6 (SAY WHERE) DON'T KNOW....8	
6	What did you do with _____ (child name) as soon as he was born ?[1,2]	PUT TO BREAST....1 WASH....2 LET SLEEP....3 OTHER _____ 6 SAY WHAT DON'T KNOW....8	

CARE AFTER DELIVERY

Nº.	QUESTION AND RESPONSE	CODE	GO TO
1	When (baby's name) was born, did a person consult with you ?	YES.....1 NO.....2	✱END go to sub-module A ignore sub-module B
2	After how many days or weeks after delivery did you have your first consultation? WITH WHO WAS THE MOST QUALIFIED PERSON?	DAY AFTER DELIVERY...1 ☐☐ WEEK AFTER DELIVERY 2 ☐☐ DON'T KNOW.....998	
3	Whith whom did you have your consultation ? Ask who was most qualified person.-.	VII. PROFESSIONAL HEALTH WOKER DOCTOR .....1 NURSE/ MIDWIFE .....2 AUXILIARY MIDWIFE .....3 OTHER PERSON MIDWIFE WITHOUT TRAINING 4 OTHER _____ 5 (PRECISE)	
4	During this time, did these people consult you too _____?	YES.....1 NO.....2	
5	Did you have another exam after childbirth?	YESI.....1 NO.....2	✱END go to sub-module A & B
6	Who did the second exam for you? Ask who was the most qualified person	***PROFESSIONAL HEALT WORKER*** DOCTOR .....1 NURSE/MIDWIFE.....2 AUXILIARY MIDWIFE .....3 VIII. OTHER PERSON MIDWIFE WITHOUT TRAINING 4 .....5 OTHER_____ 6 PRECISE	
7	DURING THIS TIME, DID THESE PEOPLE CONSULT YOU TOO?	YES.....1 NO.....2	

SUB-MODULE A : KNOW DANGER SIGNS FOR PERIOD FOLLOWING CHILDBIRTH

Nº.	QUESTION AND RESPONSE	CODE	GO TO
1	What are the danger sings after childbirth which would make you think you needed to look for health care or go to see a doctor ? [1] Write everything they say	FEVER.....A BLEADING.....B PASS WATHER IN VAGINAL OR BAD ORDOR.....C OTHER_____ X (PRECISE) DON'T KNOW.....Z	
2	What are the sings you need to look for that would show you that the baby is sick? Writhe everything they say)	NOT BREAST-FEED.....A LOSS APPETITE.....B BREATHING SLOWLY.....C RED UMBILICAL CORD .....D RED EYES/CONJUNCTIVITIS.....E OTHER_____ X (PRECISE) DON'T KNOW.....Z	

SUB-MODULE B : CARE AFTER CHILDBRITH

Nº.	QUESTION AND RESPONSES	CODE	GO TO
1	When you had your consultation after childbirth did they give you advice on the following problems space between birth of children	YES NO	
	Space between births of children?	Family Planning 1 2	
	Food for child?	Food for child 1 2	
	Vaccination for child?	Vaccination for child 1 2	
	When child has diarrhea?	When child has diarrhea..... 1 2	
	First sign of pneumonia?	First pneumonia..... 1 2	
2	In the first month after childbirth, did you receive a dose of Vitamin A, the same as this (Show Vitamin A)?	YES..... 1 NO..... 2	

SUB-MODULE C: ABILITY TO PROVIDE CARE IN HOUSEHOLD

Nº.	QUESTION AND RESPONSE	CODE	GO TO
1	How many pregnancies lasted six (6) months or more you had ?	Total pregnancies ☐☐	
2	How many of your children were born alive?	Total live birth ☐☐	
3	When a woman is bleeding a lot after childbirth and after placenta expulsion what action should you take immediately to stop the bleeding? DON'T READ OUT THE POSSIBLE ANSWERS TO THE INTERVIEWEE	HELP HER KNEEL TO URINATE....A MAKE HER BREASTFEED....B MASSAGE HER NIPPLE....C PRESS BOTH HAND ON WOMB....D BLOCK BLEEDING WITH TISSUE....E GIVE A LOT OF LIQUID....F LAY HER DOWN....G COVER HER UP....H OTHER_____ X (WAY WHAT) DON'T KNOW....Z	
4	When of child of less than one month old is ill, what are you suppose to do right away to help that child?	KEEP HIM WARM....A BACK MASSAGE FOR BREATHING....B DRAIN LIQUID IN HIS MOUTH....C BREASTFEED OR SPOONFEED BREASTMIL OFTEN....D BRING BABY TO HEALTH PERSONNEL FOR TREATMENT....E OTHER_____ X (SAY WHAT) DON'T KNOW....Z	

IX. BIRTH SPACING

Nº	QUESTION & RESPONSE	CODE	GO TO
1a	How many children living in this house are more than 5 years old??	ONE (1) CHILD.....1 TWO (2) CHILDREN .....2 THREE (3) CHILDREN OR MORE 3	
1b	How many of these children are your children?	ONE (1) CHILD.....1 TWO (2)CHILDREN .....2 THREE (3) CHILDREN OR MORE 3	
2	What is the sex of your two youngest children, their age and date of birth? (ASK TO SEE THE CHILD'S VACCINE CARD)	**CHILD #1** **SEX** **MALE.....1** **FEMALE.....2** **BIRTH DATE.** DAY ..... MONTH..... YEAR..... **CHILD #1** **SEX** **MALE.....1** **FEMALE.....2** **BIRTH DATE.** JOUR..... MWA..... ANÉ	-
3	Now, I would like to ask you a question on the way you control the space of time which passes between each time you make a child? Do you know a place they can show you a mothod in order to control the space between each child/or to do family planning? IF NO, CIRCLE "Z" (DON'T KNOW) IF YES, ASK "WHERE" WRITE ALL WHICH IS SAID IF THE SOURCE IS IN A HOSPITAL, A HEALTH CENTER OR CLINIC, WRITE THE NAME OF THE PLACE _____ (NAME OF THE PLACE)	WHERE THEY GIVE HEALTH CARE HOSPITAL.....A HEALTH CENTER.....B HEALTH INSTITUTION..... C HEALTH POST..... D FAMILY PLANNING CLINIC .....E COMMUNITY HEALTH AGENT.....F PHARMACY ..... G OTHER HEALTH PLACE..... H _____ (WHERE) OTHER SOURCE SHOP.....I CHURCH .....J FRIEND/FAMILY .....K OTHER .....X _____ (WHERE) DON'T KNOW .....Z	
4	Are you pregnant now?	YES.....1 NO .....2 DON'T THINK SO.....8	➔ END
5	Would you like to have another child?	YES.....1 NO .....2 DON'T KNOW 8	} ➔7
6	When would you like to have another child?	AFTER TWO YEARS.....1 AFTER MORE THAN 2 YEARS .....2 DON'T KNOW WHEN 8	

7	Now, do you do something or use a method in order that you don't become pregnant? IF NO CIRCLE "01 (DON'T HAVE A MEHTOHD) IF YES, ASK WHAT TYPE OF METHOD DO YOU, YOUR HUSBAND OR YOUR BOYFRIEND USE TO PREVENT YOU FROM BECOMING PRENANT? CIRCLE THE NUMBER THAT MORE RESEMBLE THE ANSWER GIVEN	DON'T HAVE METHOD ..... 01 NORPLAN ..... 02 INJECTION ..... 03 PILLS ..... 04 DIU ..... 05 BLOCKING METHOD/DIAPHRAGM ..... 06 CONDOM ..... 07 GEL ..... 08 TUBAL LIGATION ..... 09 VASECTOMY ..... 10 LAM ..... 11 RYTHM ..... 12 ABSTINENCE ..... 13 REMOVE YOUR BODY ..... 14 OTHER _____ 96 (SAY WHAT)	

SUB-MODULE A : INFORMATION TO CONTROL SPACING OF CHILDREN DURING THE PERIOD AFTER CHILDBIRTH

Nº	QUESTION & RESPONSE	CODE	GO TO
1	After the mie you had the child (name of child), did you have a person who examined the state of your health? IF YES: ask "where did you find information on how to control child spacing during this exam"? CIRCLE THE NUMBER THAT MORE RESEMBLE THE ANSWER GIVEN	NO POSTNATAL CONSULTATION ..... 1 EXAM NO INFORMATION ..... 2 RECEIVED INFORMATION 3	

CONTACT AND INFORMATION SOURCE IN HEALTH BUSINESS

Nº	QUESTION & RESPONSE	CODE			GO TO
1	In the month which just passed, how many times did you have contact with one of these people?	ALL THE TIME (4 times or more)	NOT OFTEN (1-3 times)	NEVER (0 time)	
	DOCTOR	1	2	3	
	NURSE/MIDWIFE	1	2	3	
	COMMUNITY HEALTH AGENT	1	2	3	
	HEALT EDUCATOR	1	2	3	
	WEIGHT PERSON	1	2	3	
	TRAINNED MIDWIFE	1	2	3	
	HERB DOCTOR	1	2	3	
2	WHERE DO YOU FIND INFORMATION WHICH IS GOOD? RECORD EVERY ANSWER GIVEN	X. OFFICIAL WAYS DOCTORA NURSE/MIDWIFE B AUXILIARY/MIDWIFE C TRAINNED DELIVERY MIDWIFE D COMMUNITY HEALTH AGENT E HEALT EDUCATOR F WEIGHT PERSON G **UNOFFICIAL WAYS** HUSBAND/BOYFREIND H MOTHER/MOTHER IN LAW I SISTER J GRANDFATHER K AUNT L FRIEND NEIGHBOR M HERB DOCTOR N WISE PERSON IN THE AREA O OTHER_____ X (WHO)			
3	In the month which just passed, did you receive a message from the following ways?	YES	NO		
	RADIO ?	1	2		
	JOURNAL?	1	2		
	TÉLÉVISION ?	1	2		
	HEALTH EDUCATOR?	1	2		
	COMMUNITY HEALTH AGENT?	1	2		

c. Facilities Assessment

Facilities Assessment Data Collection Questionnaire

ENQUÊTE 2005 SUR LES FACILITÉS GERÉES PAR LES PARTENAIRES DE KOMBIT

ENQUETEURS

Nom : _____ Représentant de l'UCS 2 – MSPP

Nom : _____ Représentant des Sœurs du Bon Pasteur

Nom : _____ Représentant de HHF

IDENTIFICATION de l'INSTITUTION

Nom : _____

Adresse : _____ Localité _____ Commune

Catégorie:

- ❑ MSPP
- ❑ Prive: Organisation: _____
- ❑ Mixte: Organisation: _____
- ❑ Autre : Organisation : _____

LES PERSONNES INTERVIEWÉES

Nom : _____

Titre : _____

Nombre d'années de service au sein de l'Institution : _____

Nom : _____

Titre : _____

Nombre d'années de service au sein de l'Institution : _____

Distance par rapport à l'hôpital St-Antoine de Jérémie:

En voiture ou camion: _____ heures _____ minutes

A pieds ou à dos d'âne: _____ heures _____ minutes

L'Institution dispose-t-elle d'un personnel qui peut fournir des soins d'urgence en dehors des heures de travail ? oui/non

HORAIRE de FONCTIONMENT de l'INSTITUTION

JOURS	HEURES D'OUVERTURE	ACTIVITÉS
Lundi		
Mardi		
Mercredi		
Jeudi		
Vendredi		
Samedi		
Dimanche		

CHARACTÉRISTIQUES du BATIMENT

1	ETAT du BATIMENT	Bon état	Mauvais état
2	ETAT du PROPRETE	Oui	Non
3	EAU COURANTE ?	Disponible	Non-disponible
4	LATRINES ?	Oui	Non
5	EAU POTABLE ?	Oui	Non
6	W.C. MODERNE ?	Oui	Non
7	LAVABO LAVAGE MAINS ?	Oui	Non
8	SAVON LAVAGE MAINS ?	Oui	Non
9	SYSTEME d'ECLAIRAGE ?	Génératrice	Lampe à kérosène
		Autre (à préciser) :	
10	REFRIGERATEUR	Solaire Gaz propane	Non-disponible
		Autre (à préciser) :	
11	CONDITION du REFRIGERATEUR	Fonctionnel	Non-fonctionnel
12	CIRCULATION des CLIENTS	Bonne Régulière	Mauvaise
13	SALLE d'EDUCATION	oui	Non
14	SALLE d'ATTENTE	oui	Non

PRÉVENTION des INFECTIONS and GESTION des DÉCHETS

1	DISPONIBILITE DES POUBELLES Dans CHAQUE SERVICE	MATÉRIELS CONTAMINÉS	Oui	Non
		MATÉRIELS NON-CONTAMINÉS	Oui	Non
2	SOLUTION de DECONTAMINATION		Disponible	Non-disponible
3	MATERIELS de STERILISATION		Disponibles	Non-disponibles
4	MATERIELS d'ENCAPSULATION		Disponibles	Non-disponibles
5	GANTS de MENAGE		Oui	Non
6	GANTS, LATEX PROPRES		Oui	Non
7	GANTS, LATEX STERILES		Oui	Non
8	INCINERATEUR		Oui	Non
9	FOSSES à DECHETS		Oui	Non

HBLSS

10	AUTRES MÉTHODES POUR ÉLIMINER les DÉCHETS		à préciser :	
11	Vêtements Protecteurs	Tablier	Disponible	Non-disponible
		Lunettes	Disponible	Non-disponible
		Gants	Disponible	Non-disponible
		Pantoufles	Disponible	Non-disponible
12	Précautions dans la manipulation des objets pointus et coupants		Oui	Non
13	Éviter tout contact avec les fluides corporels		Oui	Non
14	Équipement	Décontamination dans la solution de chlorox pendant 10 minutes	Oui	Non
		Laver dans l'eau savonneuse	Oui	Non
		Désinfecter ou Stériliser	Oui	Non
15	Nettoyer les chambres/meubles avec la solution de désinfection		Oui	Non
16	Destruction appropriée des déchets: brûler ou enterrer le placenta et les aiguilles		Oui	Non

EXAMENS de LABORATOIRE

TYPE d'EXAMEN	DISPONIBLES	**NON-DISPONIBLES**
MALARIA TEST		
BACILLOSCOPIE		
VIH		
RPR		
URINES ALBUMINE		
URINES, MICROSCOPIE		
HEMOGLOBINE		

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1	Vérification et diagnostique des infections	Seins	Oui	Non
		Utérus	Oui	Non
2	Antibiotiques disponibles		Oui	Non
3	Injection intraveineuse (IV) disponibles		Oui	Non
4	Anti-protéases données Énumérez(quand/quoi) à utiliser		Oui	Non
5	Examen des réflexes		Oui	Non
6	Examen sensitivité des reins (CVA)		Oui	Non
7	Débuter perfusion intraveineuse - femme		Oui	Non
8	Donner perfusion intraveineuse - nouveau-né		Oui	Non
9	Donner perfusion rectale		Oui	Non
10	Donner perfusion intra-péritonéale		Oui	Non
11	Donner transfusion sanguine	laboratoire identifie le type sanguin et correspondant	Oui	Non
		Équipement and accessoire pour prise de sang	Oui	Non
		Banque de sang où banque ambulante de sang	Oui	Non

12	Hémoglobine vérifiée Si oui, qu'elle méthode est utilisée	Oui	Non
	Examen Spéculum exécuté	Oui	Non
	Examen Bi-manuel Exécuté	Oui	Non

SURVIE de l'ENFANT

1	VACCINS DISPONIBLES ?	TT	Oui	Non
		DTC	Oui	Non
		BCG	Oui	Non
		POLIO	Oui	Non
		ROUGEOLE	Oui	Non
2	VITAMINE « A » DISPONIBLE ?		Oui	Non
3	BALANCES DISPONIBLES ?		Oui	Non
4	CARTES CHEMIN de la SANTE ?		Oui	Non
5	REGISTRE de la VACCINATION ?		Oui	Non
6	FORMULAIRE de PCIME ?		Oui	Non
7	FORMULAIRE de REFERENCE ?		Oui	Non
8	COIN de la REHYDRATATION ORALE ?		Oui	Non
9	SELS de SERUM ORALE ?		Oui	Non
10	PROGRAMME de RECUPERATION NUTRITIONELLE ?		Oui	Non
11	DISTRIBUTION des ALIMENTS SECHES ?		Oui	Non
12	MINUTEURS ?		Oui	Non
13	ACETAMINOPHENE ?		Oui	Non
14	COTRIMOXAZOLE PEDIATRIQUE ?		Oui	Non
15	AMOXICILLIN SP ?		Oui	Non
16	MALAQUIN SP ou CHLOROQUINE SP ?		Oui	Non
17	MEDICAMENTS ANTI-PARASITAIRES ?	PIPERAZINE	Oui	Non
		ALBENDAZOLE	Oui	Non
		MEBENDAZOLE	Oui	Non
18	ALGORHYTHME de P en CHARGE	des MALNUTRIS ?	Oui	Non
		RATIONS SECHES ?	Oui	Non
19	EQUIPEMENT POUR l'EXAMEN CLINIQUE de l'ENFANT	ABAISSE-LANGUE	Oui	Non
		STETHOSCOPE OTOSCOPE	Oui	Non
		FLASH	Oui	Non
20	EDUCATION sur les SOINS de l'ENFANT :	SALLE POUR l'EDUCATION	Oui	Non
		PERSONNEL ENSEIGNANT FORME	Oui	Non
		CURRICULUM sur la NUTRITION des NOURISSONS	Oui	Non
21	Outils pour allaitement maternel et capacités		Disponibles	Non-disponible
22	Tubes et seringues d'alimentation		Disponibles	Non-disponible
23	Peau pour peau : méthode de réchauffement		Oui	Non

SANTE MATERNELLE

CARTE SANTE de la FEMME		Disponibles	Non-disponible
SALLE de CONSULTATION PRENATALE		Adéquate	Inadéquate
VACCIN ANTI-TETANIQUE		Disponible	Non-disponible
REGISTRE PRENATALE		Disponible	Non-disponible
DOSSIER PRENATALE		Disponible	Non-disponible
DOSSIER POST NATALE		Disponible	Non-disponible
FICHE de REFERENCE VERS l'HOPITAL		Disponible	Non-disponible
AMOXICILLINE		Disponible	Non-disponible
ANTIACIDE		Disponible	Non-disponible
CHLOROQUINE ce 250mg		Disponible	Non-disponible
COTRIMOXAZOLE ce		Disponible	Non-disponible
CLOTRIMAZOLE VAGINALE		Disponible	Non-disponible
DIBENZYL PENNICILLINE inj. 2.400.000 u.		Disponible	Non-disponible
METRONIDAZOLE ce 250 mg		Disponible	Non-disponible
ALBENDAZOLE ce 200 mg		Disponible	Non-disponible
MEDICAMENTS ANTIECLAMPSI		Disponible	Non-disponible
SULFATE de MAGNESEUM		Disponible	Non-disponible
Dresser la liste des anti-hypertensives couramment disponibles :			
ERGOTAMINE inj amp 0.2mg		Disponible	Non-disponible
PITOCIN inj (ainsi que son Protocole écrit)		Disponible	Non-disponible
TETRACYCLINE ophth		Disponible	Non-disponible
FER / ACIDE FOLIQUE ce		Disponible	Non-disponible
VITAMINES PRENATALES		Disponible	Non-disponible
SELS de REHYDRATATION ORALE		Disponible	Non-disponible
EQUIPMENT pour l'EXAMEN CLINIQUE :	STETHOSCOPE OBSTETRICAL	Disponible	Non-disponible
	SPECULUM VAGINAL	Disponible	Non-disponible
	SYSTEME d'ECLAIRAGE	Disponible	Non-disponible
	PANSEMENTS COMPRESSE	Disponible	Non-disponible
	EAU STERILE (en gallon)	Disponible	Non-disponible
	TABLE d'EXAMEN	Disponible	Non-disponible
	BALANCE ADULTE	Disponible	Non-disponible
	RUBAN METRIQUE	Disponible	Non-disponible
	TENSIOMETRE	Disponible	Non-disponible
	TOISE	Disponible	Non-disponible

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CAPACITÉ		**OUI**	**NON**	**Commentaires**
1	Personnel habileté à gérer les cas d'hémorragies en post-partum			
a	Vessie vidée avec un cathéter			
b	Stimulation des mamelons			
	- bébé aux seins			
	- Rouler les mamelons			
c	Hydratation disponible			
	- fluide intraveineux et raccords			
	- fluide rectal et tube rectal			
d	Faire la compression bi-manuelle			
	- Externe			
	-Interne			
2	2. Ocytocine correctement emmagasinée			
3	3. La thérapie de réhydrations comprenant l'infusion intraveineuse pour la mère et le nouveau-né			

FORMATION

EDUCATION des FEMMES ENCEINTES :	PLAN pour l'ACCOUCHEMENT et la PUERPERUM	Disponible	Non-disponible
	PERSONNEL ENSEIGNANT FORME	Disponible	Non-disponible
	CURRICULUM sur NUTRITION	Disponible	Non-disponible
	Les SIGNES des DANGERS de la GROSSESSE	Disponible	Non-disponible

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Anémie : prévention et traitement		Disponible	Non-disponible
Prévention : Infection Sexuellement Transmise, Virus Immunodéficience Humaine (VIH), Infection de l'Appareil Reproductif		Disponible	Non-disponible
Quand est-ce que les conseils sur la planification familiale sont donnés?	En Prénatal	Disponible	Non-disponible
	Après la naissance	Disponible	Non-disponible
	Après un avortement	Disponible	Non-disponible
	Pendant les soins post-avortement	Disponible	Non-disponible

Liste des Localités desservies par cet établissement:

DÉMOGRAPHIE

	Population totale année	Dont groupes-cibles: Femmes (15 à 49 ans)	Femmes Enceintes	**Enfants** (0 à 1 an)
Population de l'aire de Responsabilité				
Pop. Habitant à moins d'un kilomètre				
Pop. habitant de 1 à 5 kilomètres	±			

TRANSPORTATION

Plan de transport pour les cas d'urgence à l'hôpital

- Ambulance disponible
- Autre véhicule disponible
- Formation des comités locaux pour qu'ils aient un plan pour transporter la femme en cas d'urgence
- Téléphone ou communication par radio

Lieu de Référence	Nom du Lieu de Référence le Plus près	Distance à parcourir
A. Hôpital		
B. Clinique		

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Méthodes de transport (Encerclez la méthode la plus utilisée)	Combien d'Heure jusqu'au Lieu de référence ?	Coût du parcours
A. Voiture		
B. Autobus		
C. Moto		
D. Bateau/canot		
E. Cheval		
F. à pied		
G. Autre**s** Méthodes		

Est-ce que cet établissement fait le suivi des activités des matrones ? oui/non

Si Oui, combien de matrones sont affectées à l'institution? _____

Est-ce que les matrones sont :

- Supervisées ? oui/non ;
- Equipées ? oui/non ;
  Avec quoi ?

_____

_____

PERSONNEL

CATEGORIE de PERSONNEL	FONCTION SOIGNANT	FONCTION NON-SOIGNANT
MEDECIN		
INFIRMIERE SAGE FEMME		
INFIRMIER		
AUXILIAIRE		
RECEPTIONIST		
ARCHIVISTE		
REGISSEUR de PHARMACIE		
BACILLOSCOPIST		
AGENT de SANTE		
GUARDIEN		
MANŒUVRE		
PERSONNEL de SOUTIEN		
MATRONE		
TOTAL PERSONNEL REMUNERE		
PERSONNEL BENEVOLE (Indiquer leur qualification)		
CLUB des MERES		
CLUB des PERES		
CLUB des JEUNES		
COMITE de SANTE		
COVOL		
ANIMATRICE		
AUTRES		
TOTAL PERSONNEL BENEVOLE		

RAPPORTS des ACTIVITES de l'ETABLISSEMENT

Source : RAPPORTS MENSUELS de l'ETABLISSMENT PENDANT l'ANNEE 2004

MOIS RAPPORTES en 2004

CATEGORIE d'ACTIVITE		1	2	3	4	5	6	7	8	9	10	11	12	TOTAL
1	FREQUENTATION de l'ETABLISSEMENT													
2	ETAT FINANCIER													
3	COMMUNICATION et EDUCATION en SANTE													
4	SOINS BUCCO-DENTAIRES													
5	EXAMENS de LABORATOIRE													
6	URGENCES													
7	MEDICAMENTS ESSENTIELS													
8	CONSULTATIONS PRE- et POST-NATALE													
9	CONSULATION PLANNING FAMILIALE													
10	ACCOUCHEMENTS													
11	PRISE EN CHARGE DE L'ENFANT													
12	NOUVEAUX EPISODES de MALADIE													

FREQUENTATION de l'ETABLISSEMENT

(Rapporté _____ fois pendant 2004)

VISITES/NOMBRE

XI. VISITES	NOUVELLES	SUBSEQUENTES	**TOTALS**
INSTITUTIONELLES			
NON-INSTITUTIONELLES			

CONSULTATIONS GENERALES

CATEGORIES	**TOTAL des CONSULTATIONS**
ENFANTS (<1 an)	
ENFANTS (1 a`4 ans)	
ENFANTS (5 a`14ans)	
FEMMES ENCEINTES	
CLIENTES de PLANNING FAMILIAL	
AUTRES ADULTES	

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Nombre de Références	L'année dernière	Par Mois
A. PRÉNATAL		
1. Du Poste de Santé à L'hôpital		
2. Du TBA au Poste de Santé		
3. Du TBA à L'hôpital		
B. TRAVAIL et ACCOUCHEMENT		
1. Du Poste de Santé à L'hôpital		
2. Du TBA au Poste de Santé		
3. Du TBA à L'hôpital		
C. APRÈS la NAISSANCE		
1. Du Poste de Santé à L'hôpital		
2. Du TBA au Poste de Santé		
3. Du TBA à L'hôpital		
D. PLANIFICATION FAMILIALE		
1. Du Poste de Santé à L'hôpital		
2. Du TBA au Poste de Santé		
3. Du TBA à L'hôpital		

COMMUNICATION et EDUCATION POUR la SANTE

	DISCUSSION de GROUPE	CAUSERIES	ASSISTANCE CONSEIL	FORUM	REUNIONS COMMUNAUTAIRES	AUTRES
PRISE en CHARGE de l'ENFANT						
SANTE REPRODUCTIVE						
HYGIENE PERSONNEL						
HYGIENE de l'ENVIRONMENT						
MALADIES TRANSMISSIBLES						
ALLAITEMENT MATERNEL						
DANGERS du BIBERON						
ALLAITEMENT EXCLUSIF, 6 mois						
ALIMENTATION COMPLEMENTAIRE, ENFANT 6-9 mois						
L'UTILISATION de l'AKAMIL						
L'UTILISATION du SERUM ORALE						
EDUCATION en NUTRITION						
AUTRES						

EXAMENS de LABORATOIRE

(Rapporté _____fois pendant 2004)

TYPE d'EXAMEN	TOTALE	POSITIFS
MALARIA TEST		
BACILLOSCOPIE		
VIH		
RPR		
URINES ALBUMINE		
URINES MICROSCOPIE		
HEMOGLOBINE		

MEDICAMENTS ESSENTIELS

(Rapporte _____fois pendant 2004)

TYPE de MEDICAMENT ESSENTIEL	DISPONIBLE ____mois SUR 12	QUANTITE UTILISE
AMOXICILLINE		
COTRIMOXAZOLE		
FER/ACIDE FOLIQUE		
PARACETAMOL		
SELS DE REHYDRATATION ORALE		
COTRIMOXAZOLE VAGINALE		
CHLOROQUINE Cie 250mg		
DIBENZYL PENICILLIN inj 2.4OO.OOO u.		

ANTIHYPERTENSIVES		
ERGOMETRINE inj. Amp 0,2 mg		
PITOCIN inj.		
METRONIDAZOLE cap 250 mg		
VITAMINES, PRENATALES		
ANTI-ACIDES		

PRISE en CHARGE de la FEMME

(Rapporté _____ fois pendant 2004)

NOMBRE de GROSSESSES ATTENDUES _____

XII. CONSULTATIONS PRE- POST- NATALES

Consultations prénatales

Premiers Visites

<3 mois	3 mois et plus	2 ème visites	3ème visites et plus	Total visites

GROSSESSES à RISQUE : _____

CAS d'ANEMIE_____

VACCINATION ANTI-TETANIQUE	**TT 2**	**TT R**
FEMMES ENCEINTES		
AUTRES FEMMES 15 a` 49 ans		
AUTRES		

Consultations postnatales : _____

Distribution de Vitamine A et de Fer

FEMMES RECEVANT de la VITAMINE A	
FEMMES RECEVANT du FER	

ACCOUCHEMENTS

AGE DES MERES	**INSTITUTIONNELS**	**DOMICILIAIRES**
<15 ans		
15 a` 19 ans		
20 a` 34 ans		
35 ans et plus		
Inconnu		

NAISSANCES VIVANTES	INSTITUTIONNELS	DOMICILIAIRES
<2,5 kg		
2,5 kg et plus		
Non-pesees		
Mises au sein immédiatement		

DECES	INSTITUTIONNELS	DOMICILIAIRES
Mort-nés		
Décès maternels		
SOINS POST-AVORTEMENT		

MATRONES	INSTITUTIONNELS	DOMICILIAIRES
Certifiées		
Supervisées		

HBLSS

Travail et Accouchement	OUI	NON	Commentaires
Partographe Utiliser pour contrôler le travail			
Version externe exécutée			
Version interne exécutée			
Exécuter extraction par ventouse ou utiliser les forceps bas			
Exécuter Symphysiotomie			
Couper l'épisiotomie			
Donner l'anesthésie locale pour suturer			
Examiner pour:			
lacérations du vagin/périnéum			
lacérations du col de l'utérus			
Intégralité du placenta			
Suture / Réparation:			
Épisiotomie			
Lacérations du col de l'utérus			
Lacérations du vagin			
3ème et 4ème degré de lacérations			
Compression bi-manuel de l'utérus :			
XIII. Externe			
Interne			
Extraction manuelle du placenta :			
Ocytocine donnée			
Intramusculaire			
Intraveineux			

CONSULTATIONS en PLANNING FAMILIAL

Utilisation et acceptation de contraception

FEMMES	UTILISATEURS	ACCEPTANTS
Lofemenal		
Ovrette		
Depo-provera		
Noristat		
Norplan		
DIU (sterilet)		
Tablettes vaginales		
Condom		
CCV		
TOTAL FEMMES		

HOMMES	UTILISATEURS	ACCEPTANTS
Condom		
CCV		

CONTRACEPTIFS DISTRIBUÉS	UNITE	QUANTITE
LoFeminal	Cycle	
ovrette	Cycle	
Depo-provera	Vial	
noristerat	Vial	
Norplan	Implant	
Sterilets	Pièces	
Tablettes vaginales	Tab	
Condom	Pièces	

PRISE en CHARGE de l'ENFANT

Population <1an : _____

Population 1 a` 4 ans : _____

ENFANTS / AGE

SERVICES FOURNIS/ CHARACTERISTIQUE	<1 an	1 à 4 ans
TOTAL VU		
PESES		
POIDS TRES FAIBLE POUR AGE		
PRISES en CHARGE		

ENFANTS / AGE

VACCINATION	<1 an	1 à 4 ans
BCG dose unique		
DPT 3		
DPT Rappel		
Polio 3		
Polio Rappel		

ENFANTS / AGE

VACCINATION (suite)	< 1 an	1 à 4 ans	5 ans et plus
Rougeole dose unique			
Vaccination complète			

VITAMINE « A »	<1an	1 – 4ans	5 – 7 ans
Dose 1			
Dose 2 and +			

FORMATION En PCIME	MEDECINS	INFIRMIERES	AUXILIAIRES
Certifiés			
Supervisés			

d. Facilities Assessment Results:

ASSESSMENT on HEALTH FACILITIES managed by KOMBIT PARTNERS

ID number	Name	Locality	Type	Managed by
1	Dispensary Saint Pierre	Previlé	Mix	Sisters of the Good Sheperd/MSPP Soeurs du Bon Pasteur
2	Dispensary Bon Samaritain	Roseaux	Mix	Sisters of the Good Sheperd/MSPP Soeurs du Bon Pasteur
3	Dispensary Sainte Therese	Marfranc	Government	Ministry of Public Health Ministère de la Santé Public & Population
4	Dispensary N.D. de la Perpétuel Secours	Latibolière	Mix	Daughters of Queen Mary Immaculata Les Filles de Marie Reine Immaculée
5	Clinic Saint Joseph	Dayère	Private	Haitian Health Foundation
6	Dispensary Sainte Thérèse de l'Enfant Jesus	Carrefour Sano	Mix	Sisters of the Good Sheperd/MSPP Soeurs du Bon Pasteur
7	Clinic Sant Espwa	Jérémie	Private	Haitian Health Foundation
8	Dispensary SILOÉ de Léon	Léon	Mix	Léon Catholic Church/MSPP Église Catholique, Léon

Table 1: CONDITION of the BUILDING

DISPENSARY ID		**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**	
ASSESSMENT YEAR		05	06	05	06	05	06	05	06	05	06	05	06	05	06	05	06
Building condition		good		good		bad		bad		"+/-"		good		good		bad	
Cleaning condition		yes		yes		yes		yes		yes		yes		yes		no	
Running water		available		notavailable		available		available		available		available		available		notavailable	
Latrine condition		yes		no		yes		no		yes		yes		yes		yes	
Potable water		yes		no		yes		no		yes		yes		yes		yes	
Modern toilette		yes		no		yes		no		no		no		yes		yes	
hand washing bassin		yes		yes		yes		yes		no		yes		yes		yes	
hand washing soap		yes		yes		yes		yes		no		yes		yes		yes	
Lightning System																	
	Generator	no		no		yes		no		yes		no		yes		no	
	Kerosene lamp	no		no		yes		no		no		no		no		no	
	Solar system	yes		yes		no		no		yes		no		yes		yes	
	Flash light	no		no		no		yes		no		yes				yes	
	candles	no		no		yes		no		yes		no				yes	
2nd available lighting system		no		no		yes		no		yes		no		yes		yes	
Refrigerator																	
	Solar	yes														yes	
	gaz	yes		yes		yes		yes		yes							
	other													electric			
	available	yes		yes		yes		yes		yes				yes		yes	
	functionnal	yes		yes		yes		yes		yes				yes		yes	
Clients circulation		good		good		good		good		good		good		good		good	
Education room		yes		yes		no		no		yes		yes		yes		yes	
Waiting room		yes		yes		no		yes		yes		yes		yes		yes	

Table 2. : INFECTION PREVENTION & WASTE MANAGEMENT

DISPENSARY ID		**1**	**2**		**3**		**4**		**5**		**6**		**7**		**8**	
ASSESSMENT YEAR		05	06	05	06	05	06	05	06	05	06	05	06	05	06	05	06
Waste disposal in each service																	
	contaminated material	yes		no		yes		yes		no		yes		no		yes	
	non-contaminated material	yes		yes		yes		yes		yes		yes		yes		yes	
Decontamination solution		yes		yes		yes		yes		yes		yes		yes		no	
Sterilized material		yes		no		yes		no		yes		no		yes		yes	
Container for material		no		yes		no		no		yes		no		yes		no	
Cleaning gloves		no		yes		no		yes		yes		no		yes		no	
Gloves, latex, clean		yes		yes		yes		yes		yes		yes		yes		yes	
Gloves, latex, sterilized		yes		yes		yes		yes		yes		yes		yes		yes	
Incinerateur		no		yes		no		no		yes		yes		yes		no	
Waste dump		yes		no		yes		no		no		yes		yes		yes	
Other elimation methods		no		no		no		no		no		no		no		no	
Protective clothing																	
	apron	yes		no		yes		yes		yes		yes		no		no	
	eye covering	no		no		no		no		yes		no		no		no	
	gloves	yes		yes		yes		yes		yes		yes		yes		yes	
	feet covering	no		no		no		no		no		no		no		no	
Care with sharp objects		yes		yes		yes		yes		yes		yes		yes		yes	
Avoid contact with body fluids		yes		yes		yes		yes		yes		yes		yes		yes	
Equipment																	
decontaminate in chlorine solution		yes		yes		yes		yes		yes		yes		yes		yes	
clean in soap & water		yes		yes		yes		yes		yes		yes		yes		yes	
disinfect or sterilize		yes		no		yes		yes		no		yes		yes		yes	
Clean rooms/furniture																	
with disinfection solution		yes		yes		yes		no		yes		no		yes		yes	
Proper disposal of waste																	
to burn or bury placenta & needles		NA		yes		yes		yes		no		yes		yes		yes	

Table 3: LABORATORY EXAMS

TEST AVAILABILITY

DISPENSARY ID	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**	
ASSESSMENT YEAR	05	06	05	06	05	06	05	06	05	06	05	06	05	06	05	06
Type of exams																
Malaria test	no		no		no		no		no		no		yes		no	
Bacilloscopy	yes		no		no		yes		no		yes		no		yes	
XIV. HIV	yes		no		no		no		no		no		yes		yes	
RPR	no		no		no		no		yes		no		yes		no	
Urines Albumin	no		no		no		no		no		no		yes		no	
Urines microscopy	no		no		no		no		no		no		yes		no	
Hemoglobin	no		yes		no		no		yes		no		yes		no	

Table 4: ACTIONS & USUAL SERVICE PRATICES at the FACILITIES

SERVICES AVAILBLE or NOT per FACILITY

DISPENSARY ID	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**	
ASSESSMENT YEAR	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**	**05**	**06**
Infections diagnostic & verification																
breasts	no		no		yes		yes		yes		yes		yes		yes	
uterus	no		yes		yes		yes		no		yes		yes		yes	
Antibiotics available	yes		yes		yes		yes		yes		yes		yes		yes	
Available intraveneous solutions	yes		yes		yes		yes		yes		yes		yes		yes	
Give anti-proteasis																
knowledge of indications	no		no		no		no		no		no		no		no	
knowledge of directions	no		no		no		no		no		no		no		no	
Reflex testing	yes		no		no		yes		no		yes		no		no	
Test for kidney tenderness	yes		no		no		no		yes		no		yes		yes	
Intravenous infusion - women	no		yes		yes		no		yes		yes		yes		yes	
Intravenous infusion - newborn	no		yes		yes		no		no		no		yes		no	
Intravenous infusion - rectal	no		no		no		no		no		no		no		no	
Give intraperitoneal infusion	no		no		no		no		no		no		no		no	
Give blood transfusion																
Blood type idenfication	no		no		no		no		no		no		no		no	
cross match	no		no		no		no		no		no		no		no	
blood transfusion sets	no		no		no		no		no		no		no		no	
blood bank & ambulant blood bank	no		no		no		no		no		no		no		no	
Check Hemoglobin	no		yes		no		no		yes		no		yes		no	
Hema Cube Method	no		no		no		no		yes		no		yes		no	
Perform Speculum Exam	no		no		yes		no		no		no		yes		no	
Perform Bimanual Exam	no		yes		no		no		no		no		yes		no	

Tableau 5: CHILD SURVIVAL

ITEM AVAILABILITY

DISPENSARY		**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**	
ASSESSMENT YEAR		05	06	05	06	05	06	05	06	05	06	05	06	05	06	05	06
VACCINES	tt	yes		yes		yes		yes		yes		yes		yes		yes	
	dpt	yes		yes		no		yes		no		yes		yes		yes	
	bcg	yes		yes		yes		yes		no		yes		yes		no	
	polio	yes		yes		no		yes		no		yes		yes		yes	
	measles	yes		yes		yes		yes		yes		yes		yes		yes	
Vitamine "A" available?		yes		yes		yes		yes		yes		yes		yes		yes	
Scales available?		yes		yes		yes		yes		yes		yes		yes		yes	
Health Card?		yes		yes		yes		yes		yes		yes		yes		yes	
Vaccine registry?		yes		yes		yes		yes		yes		yes		yes		yes	
PCIME form?		yes		yes		yes		yes		yes		yes		yes		yes	
Reference form?		no		yes		yes		no		yes		yes		yes		no	
Oral rehydratation corner		yes		yes		yes		no		yes		no		no		no	
Oral rehydratation salt?		yes		yes		yes		yes		yes		yes		no		yes	
Nutritional recuperation Prog		no		no		yes		no		yes		no		yes		no	
Dry food distribution?		no		no		yes		no		yes		no		yes		no	
Timers?		no		no		no		no		yes		no		no		no	
Acetaminophene?		yes		yes		yes		yes		yes		yes		yes		yes	
Cotrimoxazole pediatric?		yes		yes		yes		no		yes		yes		yes		yes	
Amoxicilline solution pediatric		yes		yes		yes		yes		yes		yes		yes		yes	
Malaquin or Chloroquine s.p.?		yes		yes		yes		yes		yes		yes		yes		yes	
Piperazine?		yes		yes		no		yes		yes		yes		yes		yes	
Albendazole?		yes		yes		no		yes		yes		yes		yes		yes	
Mebendazole?		no		no		yes		no		no		no		yes		yes	
Algorithm of malnutrion?		yes		no		no		no		yes		yes		yes		no	
Dry ration?		no		no		yes		no		yes		no		yes		no	
Tongue depressor?		yes		yes		yes		yes		yes		yes		yes		yes	
Stethoscope, Otoscope?		yes		no		yes		yes		yes		yes		yes		yes	
Education Room?		yes		yes		no		no		yes		yes		yes		no	
Trained personnel		yes		no		yes		yes		yes		yes		yes		yes	
Curriculum, newborn nutrition		yes		yes		yes		no		yes		no		yes		yes	
Tools/trainer: breastfeeding		no		no		no		no		yes		no		yes		no	
Feeding Tubes and syringes		no		yes		no		no		yes		no		yes		no	

Table 6: MATERNAL HEALTH

DISPENSARY ID	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**	
ASSESSMENT YEAR	05	06	05	06	05	06	05	06	05	06	05	06	05	06	05	07
Medication & Substance																
Women health cards	yes		no		yes		yes		yes		yes		yes		yes	
Prenatal consultation room	yes		yes		no		no		yes		yes		yes		no	
Anti-tetanus vaccine	yes		yes		yes		yes		yes		yes		yes		yes	
Prenatal registry	yes		no		yes		yes		yes		yes		yes		no	
Prenatal file	yes		yes		yes		yes		yes		yes		yes		yes	
Postnatal file	yes		yes		yes		no		yes		yes		yes		yes	
Hospital reference card	yes		yes		no		no		yes		yes		yes		yes	
Amoxicilline	yes		yes		yes		yes		yes		yes		yes		yes	
Antiacid	yes		yes		yes		no		yes		yes		yes		yes	
Chloroquine	yes		yes		yes		yes		yes		yes		yes		yes	
Cotrimoxazole - oral	yes		no		yes		yes		yes		yes		yes		yes	
Clotrimazole vaginal	yes		no		yes		no		no		no		yes		yes	
Dibenzyl Pennicilline 2.500000u.	yes		yes		yes		no		yes		yes		yes		no	
Metronidazole	yes		yes		yes		yes		yes		yes		yes		yes	
Albendazole	yes		yes		yes		yes		yes		yes		yes		yes	
Medication anti-eclampsia	yes		no		yes		no		yes		yes		yes		no	
Magnesium Sulfate	no		no		yes		no		yes		no		no		no	
Ergometrine vial injectable	no		no		yes		no		yes		yes		yes		no	
Pitocin vial injectable	no		no		yes		no		yes		no		yes		no	
Tetracycline ophth.	yes		yes		yes		yes		yes		yes		yes		yes	
Iron/folic acid	yes		yes		yes		no		yes		yes		yes		yes	
Prenatal Vitamines	yes		yes		yes		yes		yes		yes		yes		no	
Oral Salts Rehydratation	yes		yes		yes		yes		yes		yes		yes		yes	
Stethoscope obstetrical	yes		no		no		yes		yes		yes		yes		no	
Speculum vaginal	yes		yes		yes		no		no		yes		yes		no	
Pressure bandages	yes		no		yes		no		yes		no		yes		yes	
Sterile water (bottled)	yes		no		yes		no		yes		yes		yes		no	
Exam table	yes		no		yes		yes		yes		yes		yes		yes	
Scale for adult	yes		yes		yes		yes		yes		yes		yes		yes	
Measuring tape	yes		yes		yes		yes		yes		yes		yes		yes	
Blood pressure equipment	yes		yes		yes		yes		yes		yes		yes		yes	
Height gauge	no		yes		yes		no		no		no		yes		no	

Table 7: OBSTETRICAL HEMORRHAGE CARE CAPACITY

DISPENSARY ID	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**	
	05	06	05	06	05	06	05	06	05	06	05	06	05	06	05	06
PERSONNEL ABLE TO:																
Empty bladder with catheter	no		no		yes		no		yes		yes		yes		yes	
Nipple stimulation																
Put Baby to breast	no		no		yes		no		yes		yes		yes		yes	
Rolls nipples	no		no		yes		no		no		yes		yes		yes	
Hydration available																
Intravenous fluids & infusion sets	yes		no		yes		yes		yes		yes		yes		yes	
Rectal fluids & rectal tubes	no		no		no		no		no		no		no		no	
Uterine compression																
Bimanual external	no		no		yes		no		yes		yes		yes		no	
Bimanual internal	no		no		yes		no		no		yes		yes		no	
PITOCIN, correctly stored	no		no		yes		no		yes		no		yes		no	
XV. REHYDRATION intravenous infusion																
mother	yes		no		yes		yes		yes		yes		yes		no	
newborn	yes		no		yes		yes		yes		no		yes		no	

Table 8: EDUCATION PLAN for PREGNANT WOMEN

DISPENSARY ID	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**	
ASSESSMENT YEAR	05	06	05	06	05	06	05	06	05	06	05	06	05	06	05	06
Perinatal plan	no		no		yes		yes		yes		yes		yes		no	
Training of qualified educator	yes		yes		yes		yes		yes		yes		yes		yes	
Curriculum written for:																
nutrition education	yes		yes		yes		yes		yes		no		yes		no	
pregnancy danger signs	no		no		yes		no		yes		no		yes		yes	
prevent & treat anemia	no		yes		yes		yes		yes		yes		yes		yes	
prevent HIV, MST, and reproduction system infection	yes		yes		yes		yes		yes		yes		yes		yes	
When does family planning counselling occur?																
prenatal	no		yes		yes		yes		yes		yes		yes		no	
after birth	yes		yes		yes		no		yes		yes		yes		yes	
after abortion	no		no		yes		no		yes		no		no		no	
during post abortion care	no		no		yes		no		yes		no		no		no	

Table 9: DEMOGRAPHY

DISPENSARY ID	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Number of localities serviced	18	unknown	unknown	unknown	24	10	unknown	16
Serviced population								
Total	50,000	31.196	unknown	13,102	26,214	11,571	unknown	unknown
Women 15 to 49	unknown	7.799	unknown	3,276	6,076		unknown	unknown
Pregnant women	unknown	unknown	unknown	unknown	unknown	116	unknown	unknown
Children 0 to 11 months	unknown	1.092	459	459	584	405	unknown	unknown

Table 10: MENTHODS OF TRANSPORTATION

DISPENSARY ID	1	2	3	4	5	6	7	8
Ambulance	no	no	no	no	no	no	no	no
Other vehicle	yes	no	yes	yes	yes	no	no	no
Organized local committee for emergency evacuation cases	yes	no	no	yes	yes	no	no	no
Telephone or radio communication	radio	yes	no	no	no	radio	telephone	no

Table 11: TRANSPORTATION to SAINT ANTOINE HOSPITAL, or CENTER OF HOPE

DISTANCE, TIME and COST of TRAVEL

DISPENSARY ID		1	2	3	4	5	6	7	8
Travel distance						2 hr.	8 km	200 m.	12 km
Travel duration	car	1 hr.	45 min	1 hr.	0.5 hr.	2 hr.	45 min.	5 min.	1 hr.
	bus		1 hr.						1 hr.
	motorcycle	1 hr.	1 hr.				45 min		1 hr.
	boat/canoe								
	horse back								
	on foot	4 hr.			1.5 hr	12 hr.	2 hr.	5 min.	3 hr.
Travel cost	car	unknown	unknown	20 gourdes					unknown
	bus	unknown	unknown						unknown
	motorcycle	unknown	unknown						unknown
	boat/canoe	unknown	unknown						unknown
	horse back	unknown	unknown						unknown
	on foot	unknown	unknown						unknown

Table 12: TRADITIONAL TRAINED BIRTH ATTENDANTS ACTIVITY REPORT

DISPENSARY ID	1	2	3	4	5	6	7	8
Number of reported birth attendants	20	0	31	2	64	10	n/a	0
Number affiliated to an establishment	20	0	0	0	0	0	n/a	0
Number supervised	0	0	0	0	64	10	n/a	0
Number equiped	20	0	31	0	64	10	n/a	0
Items/equipment distributed	1, 2, 3	n/a	1, 2, 8	0	1 to 8	1, 2, 3	n/a	0

Numbered equipment list

1. Razor blade sterilized
2. String to tie umbilical cord
3. Sterilized gauze for dressing
4. Birth attendant tool box/kit
5. Gloves
6. Soap
7. Apron
8. Gentian Violet

NB: Roseaux's Bon Samaritain clinic distributes equipment # 1, 2 & 3 to pregnant women

Table 13: PERSONNEL POSTED IN EACH ESTABLISMENT

DISPENSARY ID	1	2	3	4	5	6	7	8
Doctor	0	0	0	0	0	0	1	0
Nurse/midwife	0	0	0	0	0	1	0	0
Nurse	1	2	0	0	3	1	4	1
Auxiliary nurse	2	1	1	2	0	1	4	0
Receptionist	1	1	0	0		2	1	0
Archivist	0	0	0	0	1	1	1	1
Pharmacy manager	1	1	0	1	0	1	1	1
Bacilloscopist	1	0	0	1	0	1	0	1
Health Agent & Animator	0	0	0	0	12	2	1	2
Guardian	0	1	0	1	0	0	4	1
Labour	0	2	0	1	1	1	1	1
Support staff	1	1	0	0	0	0	1	0
Traditional birth attendant	0	0	0	0	0	0	0	0
Total paid personnel	7	9	1	6	17	11	18	6
Mothers Club	0		0	0	many	0	0	0
Fathers Club	0		0	0	1	0	0	0
Youth Club	0		0	0	many	1	0	0
Health Committee	1		0	1	1	0	0	1
Weight Personnel	30		31	8	many	0	0	0
Voluntary Animators	0		0	0	0	0	2	0
RVC (CARE), fathers	1		0	1	0	1		1
RVC (CARE), youths	1		0	1	0	1		1
Other	0		0	0	0	0	6	0

NB #1:
5 doctors work full time

Table 14: YEAR 2004 MONTHLY REPORTS

NUMBER OF MONTHS FOR WHICH ACTIVITY WAS REPORTED

DISPENSARY ID	1	2	3	4	5	6	7	8
Visits reported	12	12	12	12	12	12	12	11
Financial reports	0	0	12	11	0	0	0	0
Communication & Education	12	3	12	9	12	8	12	11
Oral & dental care	0	0	0	1	13	1	0	0
Laboratory exams	9	3	0	0	13	12	12	0
Emergencies	12	11	10	12	0	10	12	11
Essential medications	12	3	9	10	12	3	12	3
Pre and post natal consultations	12	12	12	11	12	10	12	9
Family planning consultations	4	10	12	12	12	11	0	9
Childbirth	4	5	0	4	12	6	0	0
Child care	12	12	12	12	12	12	12	11
Other illnesses seen	0	0	0	0	12	0	0	0

Table 15: YEAR 2004 VISITS TO THE FACILITIES

NUMBER OF PATIENTS BY VISIT CATEGORY

DISPENSARY ID	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Institutional Visits								
New	6,010	2,785	2,063	2,700	2830	6,265	3,378	1.271
Subsequent	3,276	4,011	8,701	1,663	7,904	3,306	9,555	914
Total	9,286	6,796	10,764	4,363	10,734	9,571	12,930	2,085
Non-Institutional Visits								
New	36	70	2,054	0	111	0	0	0
Subsequent	15	789	10,291	0	0	94	0	0
Total	51	859	12,345	0	111	94	0	0
Children Visits								
< 1 year	882	1,103	534	260	492	677	1,058	248
1 to 4 years	1,165	1,428	1,053	418	662	1,153	14	271
5 to 14 years	787	1,016	971	437	299	1,089	0	346
Visits Pregnant women	278	74	2,651	66	1,618	116	9,079	78
Family Planing clients	15	476	1,777	449	0	105	0	79
Other Adults	5,145	3,889	2,280	2,680	2653	6,314	993	1,663

REFERENCE

All facilities referred clients to the Center of Hope & to Saint Antoine Hospital. None of the facilities kept a copy of the referral letter sent. Therefore no documented reference or counter-reference can be reported.

Table 16: HEALTH COMMUNICATION & EDUCATION

A: NUMBER OF GROUP DISCUSSIONS HELD & TOPICS

DISPENSARY ID	1	2	3	4	5	6	7	8
Child care	8	1	3	0	41	0	18	0
Reproductive Health	2	0	0	0	5	0	27	0
Personnal Hygiene	22	2	0	0	3	0	15	0
Environmental hygiene	16	0	0	0	1	0	15	0
Transmissible diseases	39	6	0	0	2	0	52	0
Breastfeeding	0	0	0	0	0	0	0	0
Bottle-feeding danger	0	0	0	0	0	0	0	0
Exclusive breastfeeding - 6 months	0	0	0	0	0	0	0	0
Nutrition supplement - children 6 to 9 months	0	0	0	0	0	0	0	0
Usage of Oral rehydration salts	0	0	0	0	0	0	0	0
Nutrition Education	0	0	0	0	0	0	0	0
Other	0	3	0	0	28	0	28	0

Table 16: HEALTH COMMUNICATION & EDUCATION

B: NUMBER OF TALKS HELD & TOPICS

DISPENSARY ID	1	2	3	4	5	6	7	8
Child care	22	0	48	25	0	13	0	18
Reproductive Health	7	1	55	82	0	23	0	12
Personnal Hygiene	41	2	68	20	0	4	0	24
Environmental hygiene	38	1	51	62	0	2	0	17
Transmissible diseases	77	5	80	68	0	66	0	47
Breastfeeding	0	0	0	0	0	0	0	0
Bottle-feeding danger	0	0	0	0	0	0	0	0
Exclusive breastfeeding - 6 months	0	0	0	0	0	0	0	0
Nutrition supplement - children 6 to 9 months	0	0	0	0	0	0	0	0
Usage of Oral rehydration salts	0	0	0	0	0	0	0	0
Nutrition Education	0	0	0	0	0	0	0	0
Other	0	5	2	26	0	46	0	18

Table 16: HEALTH COMMUNICATION & EDUCATION

C: NUMBER of PARTICIPANTS to COUNSELLING SESSIONS GIVEN by TOPICS

DISPENSARY ID	1	2	3	4	5	6	7	8
Child care	0	2	223	0	0	0	0	83
Reproductive Health	0	3	251	0	0	33	0	49
Personnal Hygiene	19	2	225	0	0	0	0	83
Environmental hygiene	7	0	210	0	0	0	0	33
Transmissible diseases	64	4	342	0	0	0	0	53
Breastfeeding	0	0	0	0	0	0	0	0
Bottle-feeding danger	0	0	0	0	0	0	0	0
Exclusive breastfeeding - 6 months	0	0	0	0	0	0	0	0
Nutrition supplement - children 6 to 9 months	0	0	0	0	0	0	0	0
Usage of Oral rehydration salts	0	0	0	0	0	0	0	0
Nutrition Education	0	0	0	0	0	0	0	0
Other	0	6	19	0	0	51	0	0

Table 16: HEALTH COMMUNICATION & EDUCATION

D: NUMBER OF FORUMS HELD BY TOPICS

DISPENSARY ID	1	2	3	4	5	6	7	8
Child care	4	0	0	0	0	0	0	0
Reproductive Health	0	0	0	0	0	1	0	0
Personnal Hygiene	2	0	0	0	0	0	0	0
Environmental hygiene	8	0	0	0	0	0	0	0
Transmissible diseases	11	0	0	0	0	0	0	0
Breastfeeding	0	0	0	0	0	0	0	0
Bottle-feeding danger	0	0	0	0	0	0	0	0
Exclusive breastfeeding - 6 months	0	0	0	0	0	0	0	0
Nutrition supplement - children 6 to 9 years	0	0	0	0	0	0	0	0
Usage of Oral serum	0	0	0	0	0	0	0	0
Nutrition Education	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0

Table 16: HEALTH COMMUNICATION & EDUCATION

E: NUMBER OF COMMUNITY MEETINGS HELD BY TOPICS

DISPENSARY ID	1	2	3	4	5	6	7	8
Child care	0	6	2	0	0	1	0	0
Reproductive Health	0	8	0	0	0	3	0	0
Personnal Hygiene	4	3	0	1	0	0	0	0
Environmental hygiene	2	1	0	0	0	0	0	0
Transmissible diseases	13	11	0	5	0	0	0	8
Breastfeeding	0	0	0	0	0	0	0	0
Bottle-feeding danger	0	0	0	0	0	0	0	0
Exclusive breastfeeding - 6 months	0	0	0	0	0	0	0	0
Nutrition supplement - children 6 to 9 years	0	0	0	0	0	0	0	0
Usage of Oral serum	0	0	0	0	0	0	0	0
Nutrition Education	0	0	0	0	0	0	0	0
Other	0	16	0	0	0	2	0	1

F: OTHER COMMUNICATION & EDUCATION

DISPENSARY ID	1	2	3	4	5	6	7	8
Child care	14	0	0	0	0	1	0	0
Reproductive Health	0	0	0	0	0	3	0	0
Personnal Hygiene	11	0	0	0	0	0	0	0
Environmental hygiene	15	0	0	0	0	0	0	0
Transmissible diseases	24	0	0	0	0	1	0	0
Breastfeeding	0	0	0	0	0	0	0	0
Bottle-feeding danger	0	0	0	0	0	0	0	0
Exclusive breastfeeding - 6 months	0	0	0	0	0	0	0	0
Nutrition supplement - children 6 to 9 years	0	0	0	0	0	0	0	0
Usage of Oral serum	0	0	0	0	0	0	0	0
Nutrition Education	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	2	0	0

Table 17: YEAR 2004 LABORATORY EXAMS

A: NUMBER OF EXAMS GIVEN BY TYPES

DISPENSARY ID	1	2	3	4	5	6	7	8
Malaria test	0	0	0	0	0	504	897	0
Bacilloscopy	31	0	0	6	0	148	0	0
HIV	3	11	0	0	0	5	2,397	0
RPR	0	0	0	0	429	0	2,418	0
Urines, Albumin	0	0	0	0	0	0	0	0
Urines, Microscopy	0	0	0	0	0	0	0	0
Hemoglobin	0	0	0	0	0	0		0

B: NUMBER & PERCENTAGE OF POSITIVE RESULT EXAMS BY TYPES

DISPENSARY ID	1		2		3		4		5		6		7		8	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Malaria test											227	45	190	22		
Bacilloscopy	20	65					0	0			15	10				
HIV	0	0	7	64									187	7.8		
RPR									26	6.1			143	5.9		
Urines, Albumin																
Urines, Microscopy																
Hemoglobin																

Hemoglobin positive: <10 grams %

Total rpr done: 2,847
Total rpr positive: 169
Percentage of positive: 6%
Percentage treated: ?

Table 18: YEAR 2004 AVAILABLE ESSENTIAL MEDICATIONS

A: NUMBER OF MONTHS AVAILABLE MEDICATION FOR 2004

DISPENSARY ID	1	2	3	4	5	6	7	8
Amoxicillin	11	2	8	9	12	3	12	3
Cotrimoxazole	11	0	9	8	12	3	12	3
Iron/Folic Acid	8	2	5	2	12	3	12	2
Paracetamol	11	2	9	11	12	3	12	3
Oral Rehydratation Salt	12	3	6	6	12	3	12	1
Vaginal Cotrimoxazole	0	0	0	0	6	0	6	0
Chloroquine	0	0	0	12	12	12	12	0
Dibenzyl Penicillin 2,500,000u	0	0	0	0	12	12	12	0
Antihypertensives	0	0	0	12	12	12	12	0
Ergometrin	0	0	0	0	12	0	12	0
Pitocin	0	0	0	0	12	0	12	0
Metronidazole	0	0	0	12	12	12	12	0
Prenatal Vitamines	0	0	0	12	0	12	12	0
Antiacides	0	0	0	12	12	12	12	0

B: QUANTITY OF ESSENTIAL MEDICATIONS USED

DISPENSARY ID	units	1	2	3	4	5	6	7	8
Amoxicillin	cies	21,250	qnr	5,840	3,018	qnr	6,100	qnr	372
Cotrimoxazole	cies	30,800	qnr	5,600	3,563	qnr	6,500	qnr	240
Iron/Folic Acid	cies	4,980	qnr	35,500	100	qnr	4,700	qnr	0
Paracetamol	cies	20,668	qnr	5,800	4,894	qnr	12,200	qnr	510
Oral Rehydratation Salt	package	12	qnr	915	266	qnr	67	qnr	0
Vaginal Cotrimoxazole	tubes	614	qnr	0	0	qnr	0	qnr	0
Chloroquine	cies	0	qnr	0	0	qnr	0	qnr	0
Dibenzyl Penicillin 2,500,000u	vials	0	qnr	0	0	qnr	0	qnr	0
Antihypertensives	cies	0	qnr	0	0	qnr	0	qnr	0
Ergometrin	capsules	0	qnr	0	0	qnr	0	qnr	0
Pitocin	capsules	0	qnr	0	0	qnr	0	qnr	0
Metronidazole	cies	0	qnr	0	0	qnr	0	qnr	0
Prenatal Vitamines	capsules	0	qnr	0	0	qnr	0	qnr	0
Antiacides	cies	0	qnr	0	0	qnr	0	qnr	0

qnr: quantity non reported

Table 19: CONSULTATIONS PRE- & POST-NATAL for 2004
NUMBER OF WOMEN BY TYPE OF VISITS

DISPENSARY ID	1	2	3	4	5	6	7	8
Number of pregnancies	0	1,248			584	463		
Prenatal consultation 1st visit								
Pregnancies <3 mois	16	5	50	0	79	0	185	2
Pregnancies 3 months +	212	50	592	26	432	48	2,108	58
Second Visit	48	16	1,099	8	475	28	1,769	20
Third Visit or more	0	9	948	11	717	29	5,017	2
Total Visits	276	80	2,689	45	1,703	105	9,079	82
Pregnancy at risk	0	40	129	2	254	23	192	15
Cases of anemia	0	0	0	0	64	0	1,340	0
Post-natal Consultations	10	3	851	17	210	23	18	26

Table 20: WOMEN WHO RECEIVED VACCINES, VITAMINES or IRON for 2004
NUMBER OF WOMEN BY SERVICE CATEGORY

DISPENSARY ID		1	2	3	4	5	6	7	8
Vaccination anti-tetanous									
Pregnant women	TT2	71	13	1,031	3	251	27	788	17
Pregnant women	TTR	61	5	502	3	310	6	361	58
Other women	TT2	22	0	0	1	608	0	27	9
Other women	TTR	18	25	0	11	1,080	1	52	0
Other	TT2	0	3	0	0	3	2	0	0
Other	TTR	0	0	0	0	0	0	0	0
Women received vitamine A		21	44	1,614	26	280	12	789	8
Women received iron		17	43	2,167	35	3,248	90	8,696	51

B: NUMBER of CHILDBIRTH & BIRTHS by TYPE

DISPENSARY ID	1		2		3		4		5		6		7		8	
Mothers age group	in	non	in	non	in	non	in	non	in	non	in	non	in	non	in	non
<15 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15 to 19 years	0	4	0	0	0	0	0	0	0	25	0	0	0	0	0	0
20 to 34 years	0	13	1	18	0	0	3	6	0	249	0	0	0	0	0	0
35 years & more	0	7	0	1	0	0	0	0	0	86	2	6	0	0	0	0
unknown	0	0	0	53	0	0	0	0	0	0	0	37	0	0	0	0
Live births																
<2.5 kg.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.5 kg. & more	0	0	0	0	0	0	0	1	0	0	2	6	0	0	0	0
not weighted	0	24	0	54	0	0	0	6	0	353	0	31	0	0	0	0
Immediate breastfeeding	0	19	0	0	0	0	0	0	0	0	0	37	0	0	0	0

in: institutionnal
non: non-institutional (home)

Table 22: FAMILY PLANNING CONSULTATIONS for 2004

A: WOMEN NUMBER of CONSULTATIONS by CATEGORY by METHODS

DISPENSARY ID	1	2	3	4	5	6	7	8
Lofeminal								
users	16	26	131	224	0	133	0	20
brand new users	15	16	35	9	0	5	0	8
Ovrette								
users	1	3	98	9	0	44	0	1
brand new users	0	3	41	0	0	4	0	0
Depo-provera								
users	5	620	1,813	1,226	0	919	0	242
brand new users	4	250	249	52	0	79	0	26
Noristerat								
users	0	0	0	0	0	0	0	0
brand new users	0	0	0	0	0	0	0	0
Norplan								
users	0	0	0	0	0	0	0	0
brand new users	0	0	0	0	0	0	0	0
IUD Inter Uterine Device								
users	0	0	0	0	0	0	0	0
brand new users	0	0	0	0	0	0	0	0
Vaginal tablets								
users	0	0	0	0	0	0	0	0
brand new users	0	0	0	0	0	0	0	0
Condom								
users	5	0	0	0	0	4	0	22
brand new users	5	0	0	0	0	0	0	8
CCV (Hormonal combination)								
users	0	0	0	0	0	0	0	0
brand new users	0	0	0	0	0	0	0	0
TOTAL WOMEN								
users	27	649	2,042	1,449	0	1,100	0	263
brand new users	24	269	325	69	0	88	0	34

Table 22: FAMILY PLANNING CONSULTATIONS for 2004

B: MEN **NOMBRE de CONSULTATIONS par CATÉGORIE, MÉTHODE et ÉTABLISSEMENT**

DISPENSARY ID	1	2	3	4	5	6	7	8
Condom								
users	3	458	483	79	0	168	0	22
brand new users	3	68	146	20	0	137	0	8
CCV (Hormonal combination)								
users	0	0	0	0	0	0	0	0
brand new users	0	0	0	0	0	0	0	0

Table 23: CONTRACEPTIVES DISTRIBUTED for 2004
TYPE & QUANTITY OF CONTRACEPTIVE DISTRIBUTED

DISPENSARY ID	unit	1	2	3	4	5	6	7	8
Lofeminol	cycle	192	33	362	484	0	141	0	36
Ovrette	cycle	30	0	127	12	0	37	0	0
Depo-provera	vial	5	620	847	406	0	263	0	76
Noristerat	vial	0	0	0	52	0	0	0	0
Norplan	implant	0	0	0	0	0	0	0	0
Sterilets	pieces	0	0	0	0	0	0	0	0
Vaginal tablets	tablets	0	0	0	0	0	0	0	0
Condoms	pieces	36	649	5,703	2,690	0	736	0	436

Table 24: CHILD CARE for 2004
NUMBER of CHILDREN & TYPE of SERVICES PROVIDED

DISPENSARY ID	1	2	3	4	5	6	7	8
Population								
<1 year	unknown	1,092			unknown	405	unknown	
1 to 4 years	unknwon	1740			unknown	1,331	unknown	
Total seen								
<1 year	814	1310	1,599	378	5,724	1034	10,702	283
1 to 4 years	1,036	1,740	3,508	355	19,564	1093	8,501	257
Weighted								
<1 year	739	1,255	1,599	378	5,724	855	10,702	283
1 to 4 years	961	1,670	3,508	355	19,564	1062	8,501	257
Weight too low for age								
<1 year	8	72	380	3	265	25	175	21
1 to 4 years	21	186	996	7	2,166	99	4,106	64
Care								
<1 year	180	105	504	46	unknown	78	53	30
1 to 4 years	1	14	199	17	unknown	4	27	8
TOTAL	181	119	703	63	880	82	80	38

Table 25: VACCINES & VITAMINE A GIVEN to CHILDREN for 2004

NUMBER OF CHILDREN per VACCINE & VITAMINE A DOSES

DISPENSARY ID		1	2	3	4	5	6	7	8
BCG unique dose	<1 year	180	105	504	46	512	78	1,050	30
	1 to 4 years	1	14	115	17	64	4	14	8
DPT 3	<1 year	144	66	469	36	540	67	614	11
	1 to 4 years	0	44	403	10	189	8	26	3
DPT Booster	<1 year	0	0	0	0	0	0	0	0
	1 to 4 years	83	70	339	36	515	23	108	19
Polio 3	<1 year	175	69	469	42	612	57	721	16
	1 to 4 years	0	29	403	7	210	16	24	3
Polio Booster	<1 year	0	0	0	0	0	0	0	0
	1 to 4 years	83	61	339	27	627	29	105	16
Measle unique dosage	<1 year	153	25	407	20	526	24	437	10
	1 to 4 years	88	45	0	0	689	1	24	8
	5 years & +	4	0	0	0	49	0	0	0
Completed vaccination	<1 year	247	11	111	14	495	61	437	2
	1 to 4 years	156	55	37	9	455	37	24	0
	5 years & +	12	0	0	1	0	0	0	0
Vitamine A dosage 1	<1 year	123	190	251	36	130	175	437	24
	1 to 4 years	55	20	79	0	28	124	58	21
	5 to 7 ans	83	363	250	128	10	266	0	2
Vit. A dose 2 or more	<1 year	97	139	165	25	0	395	163	31
	1 to 4 years	72	28	66	13	618	33	52	0
	5 to 7 ans	35	100	99	55	264	88	1	1

Table 26: IMCI TRAINING

CATEGORY of CERTIFIED & SUPERVISED PERSONNEL IN IMCI

DISPENSARY ID	1	2	3	4	5	6	7	8
Doctors								
certified	0	0	0	0	0	0	1	0
supervised	0	0	0	0	0	0	0	0
Nurses								
certified	0	0	0	0	3	0	1	0
supervised	0	0	0	0	0	0	0	0
Auxiliaries								
certified	0	0	0	0	0	0	1	0
supervised	0	0	0	0	0	0	0	0

ANNEX III

AGREEMENT AND LETTERS

a. WHO

ORGANISATION PANAMERICAINE DE LA SANTE
Bureau sanitaire panaméricain, Bureau régional de
L'ORGANISATION MONDIALE DE LA SANTE

BOITE POSTALE 1330 | BUREAU SANITAIRE PANAMERICAIN | 295, Ave. John Brown PORT-AU-PRINCE, HAITI | Tel. : 45-07 45-86 45-86 FAX : 45-17

REFERENCE:

Port-au-Prince, 16th 2001

Mrs. Betty Magloire
Haitian Health Foundation
Jérémie, Haïti

Dear Mrs. Magloire:

We are pleased to confirm our best disposition to collaborate with your institution in the implementation of Community IMCI and Neonate IMCI. We are working at the present time with MOH, HS-2004 and UNICEF to adapt the modules of Community IMCI. During the IMCI evaluation meeting in Honduras last March, PAHO informed that the document on Neonate IMCI will be available this coming December. As soon as the documents will become available, we will contact you to discuss about the implementation process. It is clear that MOH, UNICEF and HS-2004 will be associated in all steps.

HHF will be our first partner for this initiative. We are very grateful that you accept to offer your time and your experience.

We look forward to talking in depth about this matter at your next stay in Port au Prince.

Best regards,

Dr. Julio Desormeaux
Child Adviser Consultant
PAHO/WHO-Haïti

b. Grand'Anse Health Department - Ministry of Health & Population

REPUBLIQUE D'HAITI

MINISTERE DE LA SANTE PUBLIQUE ET DE LA POPULATION

DEPARTEMENT SANITAIRE DE LA GRAND'ANSE

No. 063

Jérémie, le 6 Novembre 2003 20 .....

DU : Dr Jean Marie MONTINOR
Directeur du Département Sanitaire de la Grand'Anse

AU : Dr Jeremiah LOWNEY
Président de la Haitian Health Foundation

OBJET : **Appui à HHF JEREMIE**

Monsieur le Président,

Compte tenu de la très bonne collaboration qui a toujours existé entre la Haitian Health Foundation (HHF) et la Direction Départementale Sanitaire de la Grand'Anse (DSGA) dans leurs différentes activités conjuguées au profit de leurs frères Grand'Anselais, cette instance départementale donne sans réserve son appui au profit du projet K.O.M.B.I.T de la HHF qui vise à réduire la mortalité maternelle et Néonatale au niveau de l'UCS2.

Persuadée que vous êtes édifié, la DSGA vous prie de recevoir, Monsieur le Président, ses salutations distinguées.

DIRECTION D.P.T SANIT. M.S.P.P GRAND'ANSE

Jean Marie MONTINOR, MD, MPH
Directeur du Département
Sanitaire Grand'Anse

c. Sisters of Good Shepherd

The Sisters of Good Shepherd
Regional Center
24 rue Bordes
Jérémie, Haïti

October, 20, 2003

Jeremiah Lowney DDS MPH, President
Bette Gebrian Ph.D. director of Public Health
Haitian Healt Foundation
Jeremie, Haïti

Dears Drs. Lowney and Gebrian,

The Haitian Health Foundation (HHF) is a key partner in the provision of health care to thousands of rural inhabitants the Jeremie area. We fully support a close technical partnership and support their quest to obtain additional funding through the Child Survival and Health Grants Program (USAID). We agree to participate in the assessment of needs, joint planning between the communities and rural clinics, training for our nursing staff and the new approaches for care of the neonate under the proposed Project ``**KOMBIT.** We are looking forward to learning more about the **JHPIEGO** Matrix for maternal care and White Ribbon Alliance in November 2003.

The Sisters of Good Shepherd have been providing health care, education and development with the people of Haiti for more than 30 years, We manage and participate in the operation of clinics in the western Grand Anse region in the areas of Roseaux, Carrefour Sanon, Previle and Latiboliere.

The Haitian Health foundation came to Jeremie in 1987 and asked us and about how they could contribute to the health of the people in these poor villages. They established a public health program and, after three years, opened a clinic in Jeremie. The HHF American and Haitian staff have worked closely with us in the following ways:

1. Village health workers were assigned to participate in our clinics closest to their villages for the first 2 years of the HHF public health program (1988-1990);

2. Nurse auxiliaries were assigned as additional health workers and educators in our clinics on a periodic basis;

3. HHF provided training in the new bacterial pneumonia protocol from the WHO for our nursing staff in 1994;

4. HHF has included our clinics in special **clinics** staffed by visiting professionals such as dental clinics, pediatric and adult asthma clinics, medical care clinics, and special services by oral surgeons;

5. HHF has been a regular partner with our sisters in the education and employment of auxiliary and registred nursing students and new graduates;

6. HHF has provided an excellent public health clinical practicum for senior nursing students and nutritional care sessions for freshmen nursing students in the Ministry of Health nursing school that we operate in Jeremie;

7. HHF has shared supplies and medication with our staff in the clinics for many years.

We, the nurses of the sisters of Good Shepherd, have witnessed the deaths of women in labor and from infections afterwards for many years. This joint effort between the Sisters, the Haitian Ministry of Health and HHF is necessary and should be completely supported by the government of the United States and by private donors as well.

Respectfully,

Sister Lise Gagné, s.c.i.m.
Regional superior of the
Good Shepherd Sisters

d. USAID

UNITED STATES
AGENCY FOR INTERNATIONAL DEVELOPMENT
MISSION TO HAITI

October 8, 2003

To Whom It May Concern

The Population, Health and Nutrition office of USAID/Haiti (PHN) is pleased to support Haitian Health Foundation's (HHF) application to the Child Survival and Health Grant Program (CSHP).

For more than fifteen years, HHF has been a remarkable and excellent partner of USAID/Haïti, working in very remote areas in the department of Grand'Anse of Haiti. It has implemented one of the most successful integrated maternal and child health projects in the country serving as a good model for training and cross fertilization among other Non Governmental Organizations. Two years ago, due to its great success in child health, the Ministry of Health and PAHO selected HHF as a pilot site for community IMCI (Integrated Management of Childhood Illness).

USAID believes that HHF has built a strong technical and financial capacity to fulfill CSHP requirements and to expand its activities.

Should you need more information regarding HHF's performance, please feel free to contact Dr Yves Marie Bernard or me at USAID/Haiti PHN office.

Polly Dunford
Acting Chief of Population,
Health and Nutrition Office
USAID/Haïti

USAID/HAITI
P.O. Box 1634
Port-au-Prince, Haïti, W.I.

Phone: 222-5500
Phone: 229-3084
Fax : 223-9603

e. UNICEF

United Nations Children's Fund
Fonds des Nations Unies pour l'enfance
Fondo de las Naciones Unidas para la Infancia

Port-au-Prince, 24 April 2000
PH45/00/0258

To Whom It May Concern

SUBJECT: Relationship between UNICEF-Haiti and Haitian Health Foundation (HHF)

This letter is to attest to the working relationship between the UNICEF representation in Port-au-Prince, Haiti and the Haitian Health Foundation, located in the rural area of Jeremie, Haiti. The HHF has had official recognition to work in Haiti since 1988. It is a US-based non-governmental organization. Since 1989, senior public health medical and nursing staffs have worked together in the following areas:

Acute Respiratory Infection
Global Care of the Sick Child
Breast feeding Promotion
Measles eradication campaigns
Rural pediatric vaccination programs
Malaria treatment
Documentation of primary health care services

The UNICEF office has supplied the HHF with over $25,000 dollars in program assistance, medical supplies, including cold chain equipment for vaccination, medicine, micronutrients, equipment, motorcycles and educational promotional items over the past 11 years. The HHF staff have executed superior care in the provision of maternal and child health programs for over 200,000 people in four remote, mountainous counties in Haiti. In addition, Dr. Bette Gebrian and Dr Royneld Bourdeau have provided critical field documentation and research in the areas of Acute Respiratory Infection (ARI) and the growth of babies that were exclusively breast fed.

UNICEF has been impressed with the commitment of the HHF staff and encouraged by the positive health impact that has been made during years of political unrest and economic instability. The HHF has received financial assistance from USAID as well as from academic and philanthropic organizations.

Sincerely,

Thomas Haettenschwiller
Officer in Charge

RM/mo

ANNEX IV

KEY PERSONNEL

a. Kombit Project Director

b. M & E Administrator

c. Headquarters Technical Consultant

Sister Maryann Berard OSF

St. Francis Convent#10 Rue Rochasse
La Verna Rd.
Jeremie, Haiti Springfield IL
509 284-5216
(217)522-3386

EDUCATION:

Bachelor of Science in Nursing. Marillac College St. Louis MO 1970.

Management of patient services internship in Taiwan. 1979

Nursing internship in Leprosy 1985. India.

Personnel Management Seminars 1994. VACS project. Haiti

Computerization for Health Management. Seminars in Jeremie 1990-2000

CURRENT EMPLOYMENT: **Administrator Haitian Health Foundation. Jeremie, Haiti 1992 - present.**

Administrative Responsibilities

- Represents the Haitian Health Foundation in matters of health and development, training, and management at national and international fora;
- Coordinates all construction, maintenance and upgrade of all buildings on the HHF campuses in urban Jeremie and in other locations in the Jeremie area;
- Provides administrative oversight in all personnel issues and embodies the spiritual dimension of all of the services given with the people of Haiti through the staff and volunteers;
- Coordinates all professional consultants and volunteers with medical and public health directors;
- Advises the HHF Board of Directors and President concerning urgent needs and future directions of the organization in Haiti;
- Directs operations research as an advisor to the Medical and Public Health Directors.

Clinical Responsibilities:

- Designs, updates and implements clinical protocol with the assistance of the Medical Director and other clinical experts;
- Spearheaded the opening of the maternal waiting home in Haiti for pregnant women at high risk;
- Facilitates on site consultation by international experts in the areas of malnutrition, anemia, pediatrics and newborn health;
- Assures clinical quality of care through continuing education by advising the Medical and Public Health Directors.

Financial Responsibilities

- Financial oversight of all federal and non federal grants in Haiti;
- Decisions made concerning special projects, construction, development projects, disaster relief and special donations.

Grant Writing Responsibilities

- Uses aggregate data summaries for the Ministry of Health and other related health and development foundations and institutions;
- Assists in the completion of all federal and non-federal proposals written in Haiti and at the headquarters level;
- Co Author of the USAID grant KOMBIT that was approved by USAID Washington with a score of 96/100
- Provides oversight to the Public Health Director concerning programmatic fit of more than 10 successful grants awarded to HHF for field work.

Charitable Responsibilities

- Raises funds for a variety of relief efforts from individuals, foundations, institutions and churches
- Manages a comprehensive family support program called "Save a Family" for over 500 families in urban Jeremie.
- Administers a school program for 1550 children including primary, secondary schools and universities

Assistant Administrator. Haitian Health Foundation Clinic of the People of God. Jeremie Haiti. 1989 – 1992.

Responsiblities: Constuction oversight and clinical protocols for the HHF clinic. Provided clinical consultation as a tropical disease nurse specialist. Designed personnel policies, management strategies and public-private partnership with the MSPP. Engaged corporate connections for health in Jeremie. Assumed management of the family sponsorship program.

Clinical Manager and Construction Chief. Bihar India. 1985-1989.

Responsibilities: Designed and built leprosy and polio clinic. Managed clinical cases and performed administrative and supervisory duties in an area of 30,000 thousand people.

Clinical Coordinator. Kaohsiug, Taiwan. 1979-1982

Responsibilities: Clinical protocol development, patient management, staff supervision, IEC message development. Public-private partnership strengthening.

Hospital Nurse Clinician and Supervisor 1970-1979 Hospital Sisters Health System in Illinois and Wisconsin.

LANGUAGES: English, Mandarin, Creole, French, Hindi

RESEARCH OVERSIGHT Investigation of children with multiple episodes of bacterial pneumonia in rural Haiti. HHF and Centers for Disease Control. July 1998.

An investigation of childhood diarrhea episodes in children who have access to latrines in rural Haiti. 1995. Unpublished.

Factors Associated with Birth Spacing: 1,000 women in rural Haiti. 1992. In association with the University of Connecticut Department of Community Medicine. Unpublished.

The explanatory model of Acute Respiratory Infection in rural Haiti. 1990. A Focused Ethnographic Study. WHO, Geneva.

GRANTS CO-AUTHORED

Lactation Amenorrhea Method and Natural Family Planning. HHF Pilot project. 1994 - 1996. $9,000.00 Georgetown University and PROFAMIL, Haiti.

Education and Screening: Sexually Transmitted Diseases and AIDS. $5,000.00 CARE International. Port-au-Prince, Haiti for HHF. 1995 - 1996.

National Breastfeeding Campaign. Jeremie Project. $6500.00. UNICEF. Port-au-Prince, Haiti. 1995.

Explanatory model of Acute Respiratory Infection in rural Haiti. $2,000.00 World Health Organization, Geneva.

PUBLIC TALKS

1995-2004 Health Care and Development in rural Haiti. Progress and needs. Springfield IL Numerous talks to groups.

AWARDS AND DISTINCTIONS:

2003 Paul Harris Fellow for outstanding contribution to service and development. Rotary International.

SUJATA NAIK

sujatanaik@hotmail.com
3815 Maple Drive
Ypsilanti, Michigan 48197
Home: (734) 434-5796

EDUCATION

Tulane University School of Public Health and Tropical Medicine **New Orleans, Louisiana**
May 2004

Masters of Public Health in International Health and Development Courses include: Communications Research, Hands on Demographic Analyses, Health Economics, International Health Policy, Biostatistics, Intermediate Research, Issues in adolescent Health, Monitoring and Evaluation, Population and Environment Theory and Evidence, Survey Measurement.

University of Michigan Population Fellows Program Ann Arbor Michigan
Summer Certificate Course in International Population August 2003

University of Michigan College of Engineering Ann Arbor Michigan
Bachelor of Science and Engineering in chemical Engineering December 1998
Courses included: Biochemistry, Chemistry, Fluid Mechanics, Heat and Mass Transfer, Immunology, Physiology, Reaction Engineering, Separation Processes, Thermodynamics.
Awards: Dean's Honor list
Leadership: Founding Chair of Professional Development for Society of Indian American Engineers, Member of Indian American Students Association.

HEALTH RELATED EXPERIENCE

University of Michigan Department of Obstetrics and Gynecology Ann Arbor, Michigan
Research Associate Sept 2004 to present

- Assists the Director of Global Initiatives with research and programs related to meternal health in developing countries.
- Assists in the development and administration of data collection instruments and tools.
- Assists in data collection and analysis

National Network of Public Health Institutes New Orleans, Louisiana
Student Intern March 2004
to May 2004

- Created, wrote, compiled, and edited a manual on forming a Not for Profit Organization for emerging public health institutes.
- Designed brochure cover, CD label, and pamphlets.

Johns Hopkins Center for Communication Programs Baltimore,
Maryland
Research Assistant May 2003 to Dec. 2003

- Created a manual on monitoring and evaluating birth preparedness and complications readiness (BP/CR manual)
- Wrote, compiled, and edited pieces for the BP/CR manual
- Searched literature on BP/CR
- Created tabulation plan for Nicaraguan Youth Survey
- Analyzed data for Nicaraguan Youth Survey using SPSS and Stata.

Peace Corps Manandona,
Madagascar
Health Communications Volunteer Feb. 1999 to Apr. 2001

- Worked in finding health communication methods at the village level for better child survival. Themes included immunization, hygiene, nutrition, disease prevention and treatment, reproductive health, English, vocational skills, and empowerment.
- Performed needs assessment and evaluated existing health problems.
- Participated in Rapid Rural Appraisal intensive training and subsequently applied knowledge in village.
- Trained and supervised Non-Governmental Organizations' use of focus groups. Aided in synthesis, analysis, and translation of focus group data.
- Worked with Population Services International on various family planning animations including showing an AIDS related film that led to an AIDS exposition at the high school.
- Developed and taught basic health lessons inn local languages at 13 primary schools, a junior high, a health clinic, meetings fot he youth, women's, and church groups, and Seecaline (a world bank nutrition project).
- Planned Girls' Camp in collaboration with other volunteers.
- Organized a women's professional development cooperative with 40 members.
- Planned, procured funding, and planted vegetable and fruit gardens with nine schools and two women's groups. Educated students, teachers, parents, and agriculture extension workers on methods that improve soil fertility such as composting, natural pesticides and fertilizers, and crop rotation.
- Designed and supervised building of water purification system for 28 households.
- Developed and supervised building of water purification system for 28 households.
- Developed and successfully marketed protein enriched bread to 30 merchants leading to planting of more soybean crops and thus replenishment of soil nutrients.
- Helped in campaigns for Polio Eradication, Vitamin A, iron and deworming medication.
- Ran dance club of 30 girls to do health songs, skits, and dances for festivals. Helped organize and participated in those health festivals.

SKILLS

Computer: Access, ASPEN, Authorware, BASIC, DOS, Excel, FORTRAN, Foxpro, HTML, Illustrator JMP, Macintosh, Matlab, Netscape, Painter, Pascal, Photoshop, Printshop, Powerpoint, Ray Dream Studios, SAS, SPSS, Stata, UNIX, Windows, Word.
Languages: French, Gujurati, Malagasy, English
Certifications: First-aid, CPR
Cross Cultural: Living in India and Madagascar. Travel in England, France, Haiti, Mexico, and Southern Africa.

VITA

Judy Lewis

Department of Community Medicine
University of Connecticut School of Medicine
Farmington, CT 06030-1925
(860) 679-3458
lewisj@nso.uchc.edu

3 Old Mill Lane
West Hartford, CT 06107
(860) 521-8265

AREAS OF SPECIALIZATION:

Medical Education
Maternal and Child Health
Medical Sociology
International Health

EDUCATION:

M. Phil., Yale University, 1973 – (ABD) Met all requirements except dissertation for Ph.D.

Graduate Study, Department of Sociology, University of Illinois, Urbana, 1968-1969

B.S. with Honors in Sociology and with High Distinction, University of Iowa, (February) 1968 Thesis: "Self Disclosure and Self Concept."

PRESENT EMPLOYMENT:

Director of Community Based Education, 1984 - present
Professor, Department of Community Medicine 2003 – present
Professor, Department of Pediatrics 2003 - present

PREVIOUS FACULTY POSITIONS:

Associate Professor:

Department of Community Medicine, 1992 – present

Department of Pediatrics, (secondary appointment) 2002 - 2003

Assistant Professor:

Department of Community Medicine, 1983 – 1992
Department of Pediatrics, 1980-2002

Instructor: Department of Pediatrics, and Department of Behavioral Sciences and Community Health, University of Connecticut, 1973 - 1979

TEACHING EXPERIENCE:

DIRECTOR, COMMUNITY-BASED MEDICAL EDUCATION PROGRAM:

Course Director:

SELECTIVES: 4th year 2 month required independent project in research, education or intervention based in laboratory, curriculum development, clinical or community settings. Chair course committee, develop opportunities for students, evaluate proposals, presentations and papers, 1994-present

Curriculum Chair/Director CBE (current responsibilities):

Developed and implemented an integrated 4-year curriculum for medical students in medical school curriculum. Community Based Education activities related to course themes of health promotion and wellness in Year 1; chronic illness in Year 2; community resources for patient care and an oral and written project for the Multidisciplinary Ambulatory 8 month Experience in Year 3; research and intervention in Year 4; and learning about community health and resources and participating in community service programs throughout all 4 years. Linkages have been established with more than 350 community programs in Connecticut. Chair of Community Curriculum Planning Committee, which sets policy for these required educational activities. Also, includes working with students in local and international community health electives, 1994–present

CBE Director, responsibilities for the period of 1984-1996

Course Director:

PRINCIPLES OF CLINICAL MEDICINE (First year didactic component of Clinical Medicine Curriculum). Required course in new integrated medical school curriculum; administrative and shared curriculum responsibility for 22 faculty in 10 groups providing clinical skills education in communication, history, physical examination, health promotion, and community health, 1995-1996

Course Director:

INTRODUCTION TO CLINICAL MEDICINE **A** (Subject Committee for first year students): "Introduction to Health and Illness from the Patient Perspective". Required course for first year medical students fall semester (September-December). Developed the course in 1984, administrative responsibility included working with 12-15 clinical programs and 80 patients living in the community (students individually matched with patients), curriculum development, course evaluation and direct teaching responsibility for 24 students in three classes of 8 medical students each, 1984 - 1994

Co-Chair: PRIMARY CARE CLERKSHIP. Required 8-week clinical clerkship in community-oriented primary care. Primary administrative and curriculum responsibility for multi-site, multi-track clerkship. Forty percent of clerkship curriculum was community-based including a community experience and project. Developed community experience and base of over 60 agencies in the greater Hartford area: bimonthly newsletter established fall, 1990. On going curriculum and faculty development, course evaluation and direct teaching responsibility for several core seminars, as well as individual student precepting for Primary Care Project requirement, 1982-1995

Director, MPH Practicum:

Directed 30-35 MPH students per year in Practicum, an independent community-based applied learning experience. Major supervision provided to each student and evaluation based on written analysis, 1991-1995. Directed approximately 25% of practicum students as member of Practicum Advisory Committee, 1996-2000. Continue to advise 5-7 practicum students a year.

MPH Faculty Advisor:

Advise entering students as well as theses, 1987-present

Chair: Community Service Oversight Committee (faculty, student, community representatives) developed guidelines for community service graduation requirement, created service opportunities, and evaluated completion of requirement, 1991 – 1996

Faculty: Exploring the Experience of People with Disabilities (with J. Delucia and A. Ardolino); 2003-present

Faculty: Global Literature and Women's Health Elective (with Sawsan Abdel-Razig); 2003-present

Faculty: HDH Special Topics Sessions "Race, Ethnicity and Health," with S. Lindsay; 2001-present

Faculty: 1st Year Medical Elective in International and Community Health Research Methods I (with S. Schensul) 1996-present

Faculty: 2nd Year Medical Elective in International and Community Health Research Methods II (with S. Schensul) 1997-present

Faculty: 2nd Year Medical Elective in International Health with S. Schensul, 1990-1994

Faculty: Center for International Health Studies (CICHS) International Training Program; sessions on community-based education and community health in Hartford, maternal and child health, health education and promotion; as well as providing consultation on individual participant projects, 1988–2001

Faculty: 1st Year Social and Behavioral Science Course Family and Health Seminar with C. Pfeiffer, 1990

Faculty: Maternal and Child Health, 3 credit course in MPH Program (20 students per class), 1987 and 1991

Advisor: 2nd year medical student research projects and 4th year electives; MPH essays and theses, 1974-present

Chairperson: School Health Component of Child Development Rotation (3rd yr. Pediatric residents) University of Connecticut, 1981-1982

Lecturer/Curriculum Committee:
Social and Behavioral Science Subject Committee (1st year medical and dental students), lecturer and seminar faculty, University of Connecticut, 1974 - 1978

Teaching Assistant:
Race and Ethnic Relations, Yale University, 1971

Teaching Assistant:
Sociology of Leisure, Sociology of Family, University of Illinois, 1968-1969

Teaching Assistant:
Social Psychology, University of Iowa, 1967-1968

RESEARCH, TRAINING GRANTS AND CONSULTATION:

GRANTS AND RESEARCH PROJECTS:

PI: Kaiser-Permanente Teaching Fund Grant Award to develop a Collaborative Community Based Cross Cultural Education Event, University of Connecticut Medical School ($1000), 2000-2001

Co-PI: Community Health Education for Local Initiative Groups, (with S. Schensul) USAID Counterparts Organization, Ashgabat, Turkmenistan ($32,000), April 2001

PI: PRISMS, Medical Student Personal and Professional Development Workshop Grant, Gold Foundation ($4915), 1999-2000

PI: Health Professions Schools in Service to the Nation Program, phase 2 Mentor-Mentee Grant with University of Puerto Rico, service–learning and community based education development ($5000), 1998-1999

PI: Health Professions Schools in Service to the Nation Program, 3-year multidisciplinary service-learning curriculum development grant ($70,000), funded by The Pew Charitable Trusts, the Corporation for National Service and the Health Resources and Services Administration, 1995-1998

Co-PI: Youth and Sexual Risk in Sri Lanka (with S. Schensul et. al.), International Center for Research on Women, Phase II: Women and AIDS Program ($95,000), 1994-1997

PI: Connecticare Fund, support for medical student health education project in sixth grade classrooms in Hartford Public Schools ($4200), 1995

Co-PI: Join-In! Grant from CADAC, Connecticut Department of Public Health Addiction Services, to design a curriculum model for medical student education about alcohol and substance abuse prevention, treatment, and community resources ($5,000), 1993

Director: Evaluation of Medical Home Program - A 3 year pilot program to link low income children with primary care providers, funded by the Hartford Foundation for Public Giving as part of a grant to the Hartford Primary Care Consortium, 1991-1995

Co-PI: Triangle Program (with R. Peeters and T. Silva), collaboration between the Universities of Connecticut, Antwerp (Belgium), and Peradeniya (Sri Lanka); funded by the Belgian ABOS and the European Community to provide training in health social science research to faculty from the University of Peradeniya. Responsibilities included grant development, participant selection, curriculum design, lecturing, and individual consultations for two month-long training workshops and during the intervening year of project implementation (11 projects conducted by 12 University of Peradeniya faculty), 1989-1992

Co-PI: University of Connecticut-University of Haiti, Medical Student Education in Community Health Project (with S. Schensul), sponsored by USAID ($25,000). Responsibilities included curriculum development, teaching, field precepting, and data analysis supervision, 1988-1989

Participant: Faculty Exchange Program between the University of Connecticut and the University of Peradeniya, Sri Lanka, sponsored by USIA. Worked with Peradeniya faculty in Connecticut and made two site visits to Sri Lanka to work on various research proposals; conducted a family planning study with Peradeniya faculty; 6 month sabbatical leave, 1986-1988

PI, Director: Model School Health Project, funded by the Robert Wood Johnson Foundation ($1,055,137) to the Department of Pediatrics, University of Connecticut Health Center. Responsibilities included grant development, model program design, supervision of clinical and evaluation staff, and liaison with state and federal agencies. Developed primary pediatric and dental care service delivery model for two elementary schools in Hartford serving approximately 2000 children. Created organizational and financial foundation for school based health clinics in Hartford Public School System that has supported services up to the present time; grant funding, 1975-1982

Project Director:

A Method for Monitoring the Quality of Care of Pediatric Nurse Associates, research project, funded by the Nursing Research Branch of U.S. Department of HEW to the Department of Behavioral Sciences, University of Connecticut Health Center. Responsible for sample recruitment, data collection, project management, and data analysis, 1973-1975

Research Director:

Program and staff evaluation for community mental health agency, Adolf Meyer Zone Center, Illinois Department of Mental Health, 1968-1969

Research Associate:

Community Health Care Center Plan, New Haven, Connecticut, November 1971-February 1972

Research Assistant:

Career of Mental Patient Study, University of Iowa, 1967

CONSULTATION/TRAINING:

Consensus Building Group to Develop Cultural Competency Curricular Modules, Office of Minority Health, Department of Health and Human Services, and American Institute of Research, Washington, D.C. March 18-19, 2002

Faculty and Mentor for Community Campus Partnerships for Health (CCPH) Advanced Service Learning Institute in Soquel, CA, January 26-29, 2002.

Community Campus Partnerships for Health (CCPH) consultant for Fan Fox and Leslie R. Samuels Foundation, Evaluation of the Urban Health Initiative of the New York Academy of Medicine, 2001-2002.

World Health Organization, Western Pacific Region, Short-Term Consultant on Child Health and Rehabilitation, Malaysia, March, 1999

Robert Wood Johnson Foundation, National School Health Program, 1978-1982

Community Life Association, Neighborhood Life Center Evaluation Project Hartford, Connecticut, 1974-1976

United Newhallville Mental Health Referral Service, New Haven, Connecticut, 1970

FELLOWSHIPS AND SCHOLARSHIPS:

Public Health Traineeship (Medical Sociology), Yale University, 1969 - 1973

Rosenfield Memorial Scholarship, full-support, four years of undergraduate study, University of Iowa, 1964 - 1968

University Honors Scholarships, University of Iowa, 1965, 1966, 1967

Iowa Elks Club Scholarship, University of Iowa, 1964

ACADEMIC HONORS:

Phi Beta Kappa, University of Iowa, 1967

President of Senior Class, University of Iowa, 1967 - 1968

Mortar Board, University of Iowa, 1967

Hancher Award, awarded each year to the outstanding junior at the University of Iowa, 1967

Alpha Lambda Delta, freshman women's honorary society, University of Iowa, 1965

AWARDS:

Winner of first Faculty Poster Award for "International Health Education: The Evolution of a Program," International Health Medical Education Conference, Vancouver, BC, "International Health Education: The Evolution of a Program," poster session, International Health Medical Education Conference, Vancouver, BC, 2000

Winner of the Health Resources and Services Administration, U.S. Department of Health and Human Services' "Measuring the Effectiveness of Academic/Community Partnerships" Program, presented at the Third National Primary Care Conference, Washington, D.C., 1997

Selected as a Model Program for "Prevention in Medical Education for the Year 2000" by the Association of Teachers of Preventive Medicine and The Association of American Medical Colleges, 1995

Community Based Education Program, Connecticut Department of Higher Education Award for Leadership in Community Service, 1994

Community Based Education Program, Connecticut Traumatic Brain Injury Association, For Outstanding Contributions to the Welfare of People with Traumatic Brain Injury, 1994

MEMBERSHIPS:

American Public Health Association

Connecticut Public Health Association

International Health Medical Education Consortium

Community Campus Partnerships for Health

MEDICAL SCHOOL AND HEALTH CENTER SERVICE:

DEPARTMENTAL AND MEDICAL SCHOOL:

Member, Curriculum Operating Committee, 1996 – present

Member Principles of Clinical Medicine Committee, 1994 - present

Multi-Disciplinary Ambulatory Experience Committee, 1996 – present

Member, LCME Committees on Diversity and Educational Program Leading to the M.D. Degree, 2001-2002

Member, SCP Journal Award Committee 2000 - present

Member Steering Committee of MPH Program, 1990 -1999

Member, LCME Committees on Objectives and Educational Program Leading to the M.D. Degree, 1994 – 1996

Member, Executive Committee, Department of Community Medicine and Health Care, 1993 - 1997

Member, CUME Committee on Undergraduate Medical Education, 1991 - 1996

Member, Implementation Chairs Committee 1994 - 1996

Chair, Incentives Committee of the Clinical Sites Group for the New Curriculum, 1993 - 1995

Member, Clinical Curriculum Planning Committee, 1992 - 1993

Co-Chair, Department of Community Medicine Kellogg Community-Based Public Health Initiative, 1991

CUME Committee on Evaluation of ICM Curriculum, 1989

Clinical Operating Committee for Required Clerkships, 1986 - 1996

Department of Community Medicine Faculty Appointments Committee, 1985 - 1991

Medical School Admissions Committee, 1984 - 1991

Co-Chairperson, Milton Markowitz Day Program and Mark's Park Development, 1983

HEALTH CENTER:

International Health Education Committee (Dean's Office Committee responsible for identifying funds and reviewing student applications for international community health educational experiences) 1985 - present; Co-chair, 1992 - present

Faculty Advisor to Student World Health Interest Group, 1988 - present

Convocation Committee, 1986 - present; Convocation organizer, 1993, 1995

ARTSOUNDS (fundraising event for student scholarships) Faculty Planning Committee, 1988 - 1989

Program Coordinator International Child Health Conference – Spring, 1983

Member, Institutional Review Board (Human Experimentation Committee), 1976 - 1984

<u>COMMUNITY SERVICE:</u>

HARTFORD:

Advisory Board, Health Committee, New Britain Head Start, 1998 - present

Advisory Board, Building Parent Power, community parent group organized to improve child health in Hartford, 1997 – present

Passport to Success Committee, Breaking the Cycle (campaign to reduce teen pregnancy), Hartford Action Plan, 1996 – 1999

Race for the Cure Grant Review Committee (women’s breast cancer outreach and screening program), 1995 - 1998

Member, CHILD Council, City-wide planning group for child health in Hartford (initiated in response to the Lewin Report on the proposed Newington-Hartford Children's Hospital with the purpose of examining and planning for pediatric and adolescent primary care needs), 1991-1997

President, Adolescent Health Council, Inc. (community-based collaborative to promote adolescent health and school-based clinics) 1993 - 1997; Vice-President and Chair, Quality Assurance Committee for Quirk Middle and Hartford Public High School Clinics, 1987 - 1993

Chair, Adverse Consequences of Teenage Sexual Activity Task Force (collaboration of UCHC, City of Hartford Health Department, Hartford Board of Education, Hispanic Health Council and other community agencies to provide a needs assessment of services) 1989- 1991

Greater Hartford Ambulatory Pediatrics Association, pediatric primary care clinic physicians serving Hartford with purpose of improving service delivery, 1974 - 1995

Hartford Board of Education School Health Advisory Committee, 1983 - 1988

CONNECTICUT:

Member Preventive Services Block Grant Advisory Committee, Connecticut Department of Public Health, 2001 - present

President, Connecticut Public Health Association, 2000-2002

President Elect, Connecticut Public Health Association, 1998-2000

Governing Board, Connecticut Public Health Association, 1997- present

Member, National Health Service Corps Fellowship Advisory Committee, Department of Public Health and Addiction Services, 1993 - 1997

Member Advisory Committee Robert Wood Johnson "Making the Grade in Connecticut" School Based Health Center Project, 1994-1998

Review Committee for State Loan Repayment Program for Connecticut Community Health Centers, Connecticut Department of Public Health, 1990

Program Chair, "Identifying Children at Risk: The Collaboration Between Health and Education", Academy of Pediatrics School Health Committee Annual Program, Spring 1981

Connecticut State Department of Education Advisory Committee to develop "A Guide for Curriculum Development in Health and Safety," 1980

Member of Governor's Coordinating Committee for the International Year of the Child, State of Connecticut, 1980

Appointed by Governor to 30 member School Health Task Force--mandated to review all Connecticut laws pertaining to school health and education and make recommendations to Connecticut State Legislature, 1978- 1980

REGIONAL, NATIONAL AND INTERNATIONAL LEADERSHIP:

Board Member, International Health Central American Institute, 2002 – present

Co-Chair, International Health Committee, Maternal and Child Health Section, American Public Health Association 2000 – present

Governing Councilor, American Public Health Association, 2003 - present

Board Member, Buguruka Orphan and Community Economic Development (BOCED, Inc), 2000 – 2002

Board Member, BOCED Trust, Tanzania, 2000 - 2002

State Affiliate Team Leader, Maternal and Child Health Community Health Leadership Institute, program to meet the Healthy People 2010 Goals, American Public Health Association, March 9-10, 2000 and September 26-29, 2000

"Population Health Coordinating Committee Planning Meeting," AAMC (American Association of Medical Colleges), Washington, D.C., September 3, 1998

"Opening Doors to Health: Learning From Each Other," Executive Committee Member and Program Chair, 7th Annual IHMEC (International Health Medical Education Consortium) Conference, San Jose, Costa Rica, March 4-8, 1998

Organizer and Chair of Cross Cultural Learning Special Interest Group (section of the Group on Education Affairs of Association of American Medical Colleges), 1995-2000

Governing Council of International Health Medical Education Consortium (IHMEC), 1993- present; Member Program Committee, 1994; President, 1996; President Elect, 1994; Chair, Program Committee, 1995-1996

Chair of Special Interest Group on Introduction to Clinical Medicine Courses, 1991 - 1992 (section of the Group on Education Affairs of Association of American Medical Colleges); Member of Governing Committee, 1991-1997

Medical Education Task Force on the Teaching of "Introduction to Clinical Medicine,' of the Association of American Medical Colleges; task force created to review course structure, content, teaching and evaluation methods, faculty recruitment and promotion, and budget issues and to make recommendations about future directions for these courses; Member 1987 -1989; Chair 1989-1992

Steering Committee for Region I, U.S. Health and Human Services Administration, Meeting on EPSDT, held in Boston, Massachusetts, November 5-6, 1980

Committee on Disability of the Medical Sociology Section of the American Sociological Association, 1973-1979

JOURNAL REVIEWER

"Really Good Stuff: new ideas in medical education" for Medical Education, 2002 - present

Medical Education Online, 2002 - present

Journal of General Internal Medicine, 2001- present

Education for Health, 2000 – present

"In Progress" for Academic Medicine, 1998-2001

PUBLICATIONS AND PRESENTATIONS

BOOKS and MONOGRAPHS:

Seifer, S., Lewis, J. and Hermanns, K. Eds. Creating Community-Responsive Physicians: Concepts and Models for Service-Learning in Medical Education, American Association of Higher Education, 2000

Silva, K.T., Schensul, S, Schensul, J., Nastasi, B., de Silva, A.M.W., Sivayoganathan, C., Ratnayake, P., Wedisinghe, P., Lewis, J., Eisenberg, M. and Aponso, H, Youth and Sexual Risk in Sri Lanka, Women and AIDS Research Program, Phase II Research Report Series, No. 3, International Center for Research on Women, 1997

*Lewis, J., and members of the ICM Task Force, Report of the Introduction to Clinical Medicine Task Force, AAMC, 1993

Lewis, J., and Wilms, J., Eds. Introduction to Clinical Medicine, NMS Series, Harwal Publishing, 1991

Aponso, H.A., deSilva, A.S.W., and *Lewis, J. A Socio-Anthropological Study of Family Planning, With Special Reference to Voluntary Surgical Contraception, in a Rural Setting in Sri Lanka, University of Peradeniya Monograph, Department of Paediatrics, 1988

Hochheiser, L., Lewis, J., and Bailit, H., Eds. Proceedings of the Nurse Practitioner Research Conference, University of Connecticut Health Center Monograph, 1974

BOOK CHAPTERS:

*Lewis, J. "University of Connecticut School of Medicine: An Urban Partnership" in Seifer S., Lewis, J. and Hermanns, K. Eds. Creating Community-Responsive Physicians: Concepts and Models for Service-Learning in Medical Education, American Association of Higher Education, 2000

*Lewis, J., Greenstein, R. "A First Year Medical Student Curriculum about Family Views of Chronic and Disabling Conditions" in Families, Physicians, and Children With Special Health Needs: Collaborative Medical Education Models, edited by R. Darling and M. Peter Greenwood Publishing Group, Inc., 1994

ARTICLES:

De Silva, M.W.A., Pelto P.J., and Lewis, J., "Social Support, Food Gifts and Wight Gain during Pregnancy in Rural Sri Lanka", The Sri Lanka Journal of the Humanities (volumes XXVII & XXVIII (Numbers 1 & 2): 38-58. 2001-2002

*Lewis, J., Unger, J., Fichtner, L., delGaudio, M., Hurley, M., Plessy, B., Gordon, N. and Acosta, R., "Twenty-five Years of Collaboration Between the University of Connecticut Health Center and the Hartford Public Schools, " invited article for Metropolitan Universities, Fall (Vol 11, Number 2) 2000

*Lewis, J., "The Rewards of Faculty Engagement", invited essay in the Journal of Public Service and Outreach, 5 (1):12-16, 2000

Beatty, M. and Lewis, J., "Inaccurate Medical Student Introductions: Frequency and Motivation," Connecticut Medicine 58 (9): 455-460, 1995

Peeters, R., Silva, K.T., and Lewis, J. "Health and Social Sciences in Sri Lanka. An Overview of the Triangle Programme," Social Science and Medicine 40 (4): 425-429, 1995

Sivayoganathan, C., Gnanachandran, S., Lewis, J., and Fernando, M. "Protective Measure Use and Symptoms Among Agropesticide Applicators in Sri Lanka," Social Science and Medicine 40 (4): 431-436, 1995

Silva, K.T., Peeters, R., and Lewis, J. "The Triangle Programme: Lessons in Interdisciplinary Collaboration," ACTA TROPICA, 57 (2/3): 175-184, August 1994

Beatty, M. and Lewis, J. "Adolescent Contraceptive Counseling and Gynecology: A Deficiency in Pediatric Office-Based Care," Connecticut Medicine, 58 (2): 71-78, February 1994

Lewis, J. "Linking Medical Education and the Community" UCONN Physician, Fall, 1993

*Lewis, J., Peeters, R., and Fernando, M. "The Triangle Program: A Collaboration for Training in Health Social Science Research," Bridge, 7: 6, 12, 1991

Silva, K. and Lewis, J. "Some Thoughts on How to Operationalize Socio-Economic Status in Health Social Science Research in Sri Lanka," CICHS-P Newsletter, 1 (1): 1, 3, 6, 1991

Bailit, H., Lewis, J., Hochheiser, L., and Bush, N. "Assessing the Quality of Nurse Practitioner Care," Nursing Outlook, 23 (3): 153-159, 1975

*Lewis, J., "The Structural Aspects of the Delivery Setting and Nurse Practitioner Performance," The Nurse Practitioner, 1 (1): 16-20, 1975

*Lewis, J. and Burns, J., invited editors. Yale Sociology Journal, Vol. 1, No. 1, Spring, 1971

PUBLISHED LETTERS:

*Response to "Should medical students be required to participate in community service activities?" in AAMC Reporter, Volume 9, Number 1, October 1999

Beatty, M. and Lewis J., "When Students Introduce Themselves as Doctors to Patients," Academic Medicine 70 (3): 175-176, 1995

VIDEOS:

"University of Connecticut School of Medicine Community Based Education in Hartford" with the University of Connecticut Health Center Department of Biomedical Communication Services, 1996

"Glaucoma: Are You at Risk?" developed with Frank Falck from a Primary Care Clerkship Project, distributed by Health Sciences Consortium, Chapel Hill, NC, 1990

ABSTRACTS AND PRESENTATIONS:

Invited Lecture, "Community Based Medical Education at the University of Connecticut," University of Gezira Medical Faculty, Wad Medani, Sudan, November 30, 2003

"How to Develop International Health Medical Education," Small Group Discussion, co-facilitator with S. Rosenthal, S. Saferty, D. Hunt, K. Chang, J. May, AAMC, Washington, D.C., November 12, 2003

Organizer and Panel Moderator, "Innovations in International Maternal Care and Program Evaluation," American Public Health Association, November, 2003

With A. Safari, Poster presentation "Learning How to Improve Breastfeeding and Infant Nutrition from the Community: Developing A Local Resource and Culturally Appropriate Intervention," American Public Health Association, November, 2003

Organizer and Panel Moderator "Reaching the Hard to Reach," Connecticut Public Health Association Annual Meeting, Rocky Hill, CT, October 24, 2003

Presentation and Panel Discussion of *The Spirit Catches You and You Fall Down* with author Anne Fadiman at Smith College School of Social Work, August 4, 2003

"Developing a Cross Cultural Curriculum with the Community" Plenary Session, International Health Medical Education Consortium Annual Meeting, New York, NY, March 5-8, 2003

"Community Health Development: Healing a Nation," invited speaker, Afghanistan: Reconstruction and Reconciliation, Rebuilding a Nation, sponsored by University of Connecticut, University of Rhode Island and Afghans 4 Tomorrow, October 29, 2002

1) "Student Research in Community Based Education" invited Workshop
2) "Partnering for Health in a Tanzanian Community"

Sustaining Innovative Health Services, Education and Research against Declining Resources,
The Network 2002 Conference, Eldoret, Kenya, September 9-12, 2002

"Community Connections for Education, Service and Research," CT Health Forum, UCHC, June 17, 2002

"Building Community Partnerships," invited Workshop, Association of Teachers of Preventive Medicine Annual Meeting, Washington, DC, March 21-23, 2002

"International Health Cooperation: An Example from Haiti," Organizer and Presenter, Plenary Session, International Health Medical Education Consortium Annual Meeting, Havana, Cuba, March 13-15, 2002

"Creating Community Responsive Physicians," invited Speaker and Faculty, Minnesota Campus Compact and Community-Campus Partnerships for Health, Minneapolis, MN, March 8-9, 2002

"Institutionalizing Service Learning," Invited Speaker and Faculty, Advanced Service Learning Institute, Community-Campus Partnerships for Health, Soquel, CA, January 26-29, 2002

1) "International Maternal and Child Health Innovations in Community Care"
2) "Global Lessons to Assure Safe Motherhood" Martha May Eliot Leadership Forum, Session Organizer and moderator

American Public Health Association, Atlanta, GA, October 2001

1) " Developing a Cross Cultural Curriculum with the Community"
2) "Teaching the Good Death: Integrating End of Life Issues in Medical Education,"

Moderator and Presenter, AAMC, Chicago, IL November 1, 2000

1) "Silver Anniversary of a Community-Campus Partnership for Health: Twenty-five Years of Collaboration between the Hartford Public Schools and the University of Connecticut Health Center to Improve the Health and Educational Opportunities of Hartford's Children" discussion session with L. Fichtner, M. Hurley, M. delGaudio, J. Unger, R. Acosta, N. Gordon
2) "Community Based Clinical Practice Sites as Role Models for Partnership and Health Promotion" poster session

Community Campus Partnerships for Health, Washington, DC April 29-May 2, 2000

"International Health Education: The Evolution of a Program," poster session, International Health Medical Education Conference, Vancouver, BC, March 22-25, 2000

"Expanding the Scope of Cross-Cultural Curricula," moderator and presenter, AAMC, Washington, DC, October 22-28, 1999

1) "Assessment of Students in Non-Hospital Settings" invited workshop with Mohi Magzoub,
2) "Do Community Based Clinical Practice Sites Provide Role Modeling for Health Promotion and Community Health Education?"
3) "Community Based Education" Session Moderator

Training Professionals for Further Health Care, the Network of Community-Oriented Educational Institutions for Health Sciences, Linköping, Sweden, September 5-9, 1999

"Models of Care and Intersectoral Collaboration for Children With Special Needs in Malaysia: Planning Issues," Workshop on Intersectoral Strategic Planning for Rehabilitation and Care of Children with Special Needs, sponsored by the Ministry of Health, Malaysia and the World Health Organization, Kuala Lumpur, Malaysia, March 25, 1999

"Cultural Competence Education: Developing and Implementing Effective Programs," organizer and presenter at a Mini-Workshop at the AAMC, New Orleans, LA, October 29- November 3,1998

1) "Expansion of Community Based Education: Pitfalls and Opportunities"
2) "A First Year Medical Student Curriculum in Community Health Education: Assessing Program Effectiveness Through Student and Community Feedback"
3) "Applying Clinical Skills Assessment Approaches to Community Skills" Mini-Workshop

Partnerships for Community Health, the Network of Community-Oriented Educational Institutions for Health Sciences, Albuquerque, NM, October 17-22, 1998

1) "Developing Assessment Methods for Community Health Skills" with C. Pfieffer, M. Sousa
2) "Health Education Project: Assessing Program Effectiveness through Student and Community Feedback"

Primary Care Education for the 21st Century, Lessons from National Initiatives Conference, Baltimore, MD, September 26, 1998

"Methods of Research in Cross-Cultural Sexuality, The Sri Lanka Projects," co-authored with H. Aponso, P. Wedisinghe, presented at the Society for Applied Anthropology Annual Meeting, San Juan, Puerto Rico, April 21-26, 1998

"Developing Assessment Methods for Community Health Skills," with C. Pfeiffer, Northeastern Group on Educational Affairs of AAMC, Boston, MA, April 16-18, 1998

"Serving the Underserved, How to Develop and Maintain a Career Incorporating International Health Opportunities," faculty panel, Northeast International Health Medical Education Consortium Meeting, Harvard Medical School, Boston, MA, November 15, 1997

1) "Three Models of Cross Cultural Education"
2) "Developing Assessment Methods for Community Health Skills"

Moderator and presenter of Small Group Discussion and Mini-Workshop at the 109th Annual AAMC Meetings, Washington, DC, October 31-November 6, 1997

1) "Evaluating a New Curriculum on Health Promotion in Community Settings"
2) "Developing Assessment Methods for Community Health Skills"
3) "Community Based Education" invited workshop with M. Magzoub and Z. Nooman

20th Network Anniversary Conference, "Involvement of Communities in Health Professions Education: Challenges, Opportunities and Pitfalls," Mexico City, October 19-24, 1997

1) "Developing University-Community Service Partnerships"
2) "Integration of Community Experiences into Clinical Rotations"

Community Campus Partnerships for Health: Conference, San Francisco, CA, April 26-29, 1997

"Incorporating Research into Community Based Education for Medical Students," the Third Annual National Primary Care Conference, sponsored by the Health Resources and Services Administration, Washington, DC, February 26-28, 1997

1) "Teaching and Learning in the Community"
2) "Combining Community Service and Critical Skills Development in Medical Education"
3) "Integrating Curricula: Teaching Introductory Clinical Medicine Skills in Parallel with Basic Science Content"

Small Group Discussions and Mini-Workshop, AAMC, San Francisco, CA, November 6-12, 1996

1) "The Community Voice in Service Learning: The University of Connecticut School of Medicine Curriculum and the Hartford Community"
2) "Evaluating Outcomes of Service Learning"
3) "Community-Based Curricula: Three Schools' Experiences"

4) "Community Partnerships"
Plenary session, panel discussions and poster session at the "Community Partnerships in Health Professions Education Conference: A National Conference on Service Learning," Boston, MA, March 28-31, 1996

ATPM Teaching Rounds, Part II, "Putting Prevention into the Teaching of Clinical Prevention," panelist/presenter, PREVENTION '96, Dallas, TX, March 23-26, 1996

"Working with Underserved Communities in the US and Abroad," panel presentation, IHMEC Annual Meeting, El Paso, TX, February 29-March 3, 1996

"Research Basis for Development and Evaluating a New Longitudinal Clinical Curriculum," presented at "Research in Medical Education: Policies for the Future," sponsored by the American Association of Medical Colleges and the U.S. Health Resources and Services Administration, Herndon, VA, September 17-19, 1995

Model Program presented at "Prevention in Medical Education for the Year 2000" by The Association of Teachers of Preventive Medicine and The Association of American Medical Colleges, July 26-July 28, 1995
1) "Maintaining the Community as a Priority in Curriculum Change"
2) "Determinants of Contraceptive Use in a Rural Sri Lankan Population"
"The Role of the University in Health Research for Development," Network of Community-Oriented Educational Institutions for Health Sciences, Madras, India, February 5-9, 1995

"Impact of International Programs on Generalist Medical Education," "International Health and Primary Care at the University of Connecticut School of Medicine," 4th Annual IHMEC Meeting, Boston, MA, October 27-28, 1994

1) "Training Physicians for Multi-Cultural Health Care--International Health Medical Education Consortium"
2) "Cross-Cultural Training in U.S. Medical Schools: Lessons from International Health: The Connecticut Experience"
Poster and Small Group Discussion at the105th Annual Meeting of the AAMC, Boston, MA, October 28-November 3, 1994

1) "Determinants of Contraceptive Use in a Rural Sri Lankan Population"
2) "Women in Traditional Cultures"
Presenter and plenary chair, Sixth International Congress "Women as Careers, Health Care Providers, & Health Care Recipients," International Congress on Women's Health Issues, Gaborone, Botswana, June 29-July 2, 1994

"Creating Family-Professional Partnerships: Educating Physicians and Other Health Professionals to Care for Children with Chronic and Disabling Conditions," sponsored by Beginnings: Early Intervention Services of Cambria County, Inc., Pennsylvania Chapter of the American Academy of Pediatrics, Pittsburgh, PA, May 21-22, 1992

Organized National Conference for policy-makers and health providers on results of Triangle Programme Research Projects and presented "Women's Employment and Family Planning,"
Colombo, Sri Lanka, June 6, 1992

Convener of a Special Interest Group to report on "Results of the Task Force on Introduction to Clinical Medicine," AAMC Annual Meeting, "Health Care Reform: Academic Mission and Public Need," New Orleans, LA, November 9, 1992

1) "Community-Based Medical Education Curriculum"
2) "The Triangle Program: Collaboration in Health Social Science Research"
"Community and University Partnerships: A Challenge for Health Development," sponsored by the 7th Biennial Network of Community-Oriented Educational Institutions for Health Sciences, Illorin, Nigeria, September 22-27, 1991

"Organizational and Curriculum Issues for Introduction to Clinical Medicine Courses," Group on Educational Affairs Small Group Discussion AAMC Annual Meetings, San Francisco, CA, October 23, 1990

"Working in the Field: Challenges and Opportunities," presented at the "Cross-Cultural Nursing Second Annual Conference," University of Connecticut, School of Medicine, Farmington, CT, April 13, 1990

1) "Community Health Education in a Primary Care Clerkship"
2) "A Method for Evaluating Community-Based Medical Education in an Introduction to Clinical Medicine Course"
"International Symposium on the Role of the Student in the Health Professions and Community Health Education" sponsored by the Network of Community-Oriented Educational Institutions for Health Sciences at Ben Gurion University of the Negev, Beer-Sheva, Israel, October 10-13, 1988

1) "Teaching Interpersonal Skills to Medical Students"
2) "ICM-A: Introduction to the Doctor-Patient Relationship"
First Annual Conference on Teaching Introduction to Clinical Medicine, Springfield, IL, March 20-21, 1987

"Health Problems of School-Aged Children", with Dr. Samuel Perrera, Health Education Director, Ministry of Health, Sri Lanka: workshop presented at "Children in the Cities: Health Needs and Strategies," the Northeast Regional Conference of the National Council on International Health, Hartford, CT, October 16-17, 1986

"The Connecticut School Health Model," workshop at the Region 1 Meeting on EPSDT and the Schools, Boston, MA, November 5-6, 1980

"Comprehensive Health Care - A Model Program," Faculty, Advances in Pediatric Nursing, University of California, San Francisco, CA, March 1980

"The Role of the Schools in Primary Care," panel participant, American School Health Association Meetings, San Diego, CA, October 1979

"Child Participation in Health Care: A Model School Health Program," presented as part of a small invitational WHO conference, Self Care and Mutual Aid Societies, Yugoslavian Centre for Intercultural Studies, Dubrovnik, Yugoslavia, September 1979

"Introduction to Epidemiological Methods in Ambulatory Pediatrics" workshop presented at the Ambulatory Pediatric Meetings, Atlanta, GA, April 1979

"Child Participation in Service Delivery," presented at the International Association for Dental Research Meetings, New Orleans, LA, March 1979

"A Model Program for School-Based Health Care Delivery," workshop presentation at the Ambulatory Pediatric Association Meetings, New York City, NY, April 1978

"Toward Comprehensive Child Health Care: The School-Based Delivery Model," presented at the American Public Health Association Convention, Washington, DC, October 1977

Research Participation: "Consequences and Implications for Pediatric Nurse Practitioners," presented at the American Nurses Association Biennial Convention, Atlantic City, NJ, June 1976

"Three Methods of Assessing Quality of Ambulatory Pediatric Care: A Comparison," presented at the Ambulatory Pediatric Association Meetings, St. Louis, MO, April 1976

"Videotape as a Method of Social Research," Proceedings Midwest Sociological Society, April 1975

"Student Views of Training in Medical Sociology and Disability" (with Carole Tokarczyk), Proceedings American Sociological Association, New York, NY August 1973

ANNEX V

HUMAN RESOURCES

Health Providers in KOMBIT PROJECT AREA Grand Anse Department UPDATED 2005

County	Health Professionals					Institutions	Dispensary Health Center			without beds Health Center			with beds Hospital		
	MD	TBA	Nurses	Aux	ADS		public	mixed	private	pub	mix	private	pub	mix	public
Jeremie	0		1	1	2	St. Therese Carrfour Sanon		X							
	0	63	1	2	20	Gebeau Methodist					X				
	0	60	3	0	10	St. Joseph Clinic (HHF rural)			X						
	0	68	0	2	0	Notre Dame PS Latiboliere Latiboliere		X							
	0	30	1	1	2	Siloe de Leon		X							
	0	0	1	1	0	Makandal Urban Jeremie Urban Jeremie	X								
	0	0	0	1	0	Notre Dame Assomtion Numero II		X							
	0	12	1	1	0	Bon Pasteur Previle Previle		X							
	3	138	13	15	54	HHF clinic(s) Jeremie Urban Jeremie urban						X			
	0	58	3	2	18	Imaculee St. Helene (urban)					X				
	0	32	0	2	2	Marfranc	X								
	10	0	37	33	0	ST ANTOINE HOSPITAL									X
Roseaux	0	25	1	1	1	Bon Samaritan de Roseaux Bon pasteur Sisters									
	0	17	1	1	1	Carrfour Charles	X								
	0	0	0	0	0	St. Antoine de Padoue Lopino		X							
Bonbon	0	30	0	2	0	Chemen de lavi	X								
Abricots	0	27	1	3	2	St. Joseph des Abricots/maternity	X								
	0	30	3	3	10	Leon Coicou Anse de Clerc						X			

Human Resource Management
KOMBIT 2005-2009

DRAFT

Job Title	FTE	Affiliation	Role	Supervisor- Lines of Authority	% Effort	Support
FIELD ADMINISTRATION AND SUPPORT						
HHF Administrator/KOMBIT Project Director **Sister Maryann Berard**	1	HHF	Administration of all HHF operations in Haiti and management of KOMBIT program	HHF Board of Directors	100%	CSHGP
KOMBIT Grant Administrator **Roxane Dimanche**	1	HHF	Coordinate daily operations of the KOMBIT project including collation of work of partners	KOMBIT project Director	50%	CSHGP
Data Entry/Secretary **Guerline Josma**	1	HHF	Routine secretarial and data entry of baseline data and other studies	KOMBIT Grant Administrator	100%	CSHGP
UCSII Medical Director **Dady Monitnor MD**	1	MSPP	Coordinate all health agencies, programs and studies conducted in the 4 county region of Jeremie	Director of the MSPP Department of the Grand Anse	25%	MSPP
Sisters of the Good Shepherd Nurse Manager **Sister Ninoche**	1	SGS	Coordinate SGS partner activities in Jeremie and rural clinics for KOMBIT interventions.	Regional Director of the Sisters of the Good Shepherd and the KOMBIT Project Director	25%	SGS
Department of Administration and Finance **Nicole Quinlan**	1	HHF	All financial administration in collaboration with the HHF HQ	HHF administrator	As needed	HHF
Drivers **Marc Elie Forture** **Barthelemey Pascal** **Gerald Lundy**	2	HHF	Coordinate field to clinic transport and communication. Procurement	KOMBIT Grant Administrator	100%	CSHGP
Accountant **Jn Frenel Vincent**	1	HHF	Disbursements	Director of Administration and Finance	16%	CSHGP

Job Title	FTE	Affiliation	Role	Supervisor- Lines of Authority	% Effort	Support
Housekeeper **Monique Denis**	1	HHF	Maintain KOMBIT office on HHF campus	KOMBIT Grant Administrator	100%	CSHGP
Job Title	**FTE**	**Affiliation**	**Role**	**Supervisor- Lines of Authority**	**% Effort**	**Support**
HEADQUARTES ADMINISTRATION AND SUPPORT						
Technical Back stop **Judy Lewis**	1	HHF	Headquarters representative for all KOMBIT activities. Coordinates KOMBIT field reports required by CSHGP. Collaborates with KOMBIT consultants (KPC, DIP, HBLSS, etc)	KOMBIT project director (field) and HHF executive director (HQ)	15%	CSHGP
Executive Director **Marilyn Lowney**	1	HHF	Support for periodic required documents for the CSHGP reports	KOMBIT program director	15%	CSHGP
Medical Advisor **Frank Anderson MD MPH**	1	University of Michigan	Guides protocols- policy related to maternal-newborn care. Designs operations research. Collaborates with Technical Backstop, Medical Director and KOMBIT partners. Advises at national level when requested.	Joint collaboration rather than supervision with Technical Backstop, Medical and HHF Public Health Directors and KOMBIT Project Director	5%	CSHGP and University of Michigan
CLINICIANS						
Medical Director **Royneld Bourdeau MD**	1	HHF	Sets medical protocols with MSPP and Medical Advisor. Manages maternal mortality audit process. Liaison with MSPP for HHF. Coordinates KOMBIT and HHF health programs	HHF Administrator/KOMBIT Project Director	50%	CSHGP
Nurse Midwife **Sr. Sophia RN**	1	HHF	Clinic and field service delivery	Medical Director	100%	HHF
Clinical physician **Perla Barbe MD** **Israel Lobez MD**	1	MSPP	Maternal and newborn clinical care	Medical Director	100%	MSPP
Clinic nurses **Miglaine Gesner** **Juna Maurency** **Irma Revange**	3	HHF	Perinatal Care at the Maternal Waiting Home	Nurse Midwife	100%	HHF

Job Title	FTE	Affiliation	Role	Supervisor- Lines of Authority	% Effort	Support
Clinic Nurses **Marie Reine Louis** **Dolores Charles**	2	HHF	Perinatal Care at the Maternal Waiting Home	Nurse Midwife	100%	CSHGP
Job Title	**FTE**	**Affiliation**	**Role**	**Supervisor- Lines of Authority**	**% Effort**	**Support**
Clinic Nurses Marfranc Clinic Leon Clinic Latiboliere Clinic	6	MSPP	Perinatal Care in rural clinics in KOMBIT areas	UCS II nursing supervision	100%	MSPP
STI –HIV nurses **Charlemage Alexis** **Bertony Cenal** **Esmond Anderson** **Elysee Fortune** **Jacqueline Jean** **Pierre E. Moise**	6	HHF	Pre and post test counseling and testing for HIV and syphilis in the clinic and field site settings	Medical Director	100%	HHF
Clinic Nurses Dayere **Margaret Pierre** **Urope Laguerre** **Michelene Toussaint**	3	HHF	Perinatal Care in rural clinics in KOMBIT areas	UCS II nursing supervision	100%	HHF
Clinic Nurses Roseaux Clinic Previle Clinic	4	SGS	Perinatal Care in rural clinics in KOMBIT areas	UCS II nursing supervision	100%	MSPP
COMMUNITY CARE AND EDUCATION						
Field/BCC Coordinator **Casimir Alfred**	1	HHF	KOMBIT field management and BCC master trainer. Liaison with partner clinics and staff. Coordinator of all field operations	KOMBIT Project Director	58%	CSHGP

Job Title	FTE	Affiliation	Role	Supervisor- Lines of Authority	% Effort	Support
Maternal Newborn Care Supervisor (nurse midwife) **Nadege Pierre**	1	HHF	Coordinates perinatal service delivery at KOMBIT care sites. Principal role in training and implementation of HBLSS with the College of Nurse Midwives (ACNM)	Field/BCC Coordinator	100%	CSHGP
Job Title	**FTE**	**Affiliation**	**Role**	**Supervisor- Lines of Authority**	**% Effort**	**Support**
Breast feeding/Child Spacing Supervisor **Serge Juste**	1	HHF	Family Life Methods manager Exclusive Breast feeding trainer and manager. LAM trainer	Field/BCC Coordinator	100%	CSHGP
Field Nurse Supervisor **Islande Francois**	1	HHF	Supervise Health Agents, Participate in Perinatal Care in partner clinics, BCC message training, Training of mobile theater groups. Assist with monitoring and evaluations.	Field/BCC Coordinator	100%	CSHGP
Field Nurse Supervisor **Adeline Lagrenade**	1	MSPP	Supervise Health Agents, Participate in Perinatal Care in partner clinics, BCC message training, Training of mobile theater groups. Assist with monitoring and evaluations.	Field/BCC Coordinator	80%	CSHGP
Nursing Supervision **UCS II nurse**	1	UCSII	Supervise Health Agents, Participate in Perinatal Care in partner clinics, BCC message training, Training of mobile theater groups. Assist with monitoring and evaluations.	Field/BCC Coordinator collaboration	50%	CSHGP
Mother Educators **Leon Region -8** **Previle Region-8** **Marfranc Region-8** **Latiboliere Region-8** **Roseaux Region-8**	40	HHF	Participate in mobile theater troupe for education on safe motherhood and child spacing strategies	Field Nurse Supervisors	25%	Volunteers with CSHGP support for community mobilization

Job Title	FTE	Affiliation	Role	Supervisor- Lines of Authority	% Effort	Support
Community Health Workers **Jean Wilner Antoine** **Benise Belfleur** **Phado Bellot,** **Amos Pierre** **Boussuet Demoulin** **PR Dorismond** **Philogene Etienne** **Gerant Antoine** **Phito Innocent** **P. Marie Lizaire** **Ifiginie Louis** **Jn Louis Numa** **Louis Sinor,** **Anel Luc** **Canceuse Moise** **Jowel Romulus** **Gerald Theolein** **Wilson Vital**	11 Yr 1 15.5 yrs 2-5	HHF	HBLSS activities, management of CBOs, support of mobile theater groups in KOMBIT areas with no community health workers, newborn IMCI, liaison with KOMBIT clinics and Faith based community groups.	Field nurse supervisors	100%	CSHGP
MONITORING EVALUATION and OPERATIONS RESEARCH						
Monitoring and Evaluation Administrator **Sujata Naik** **Charliene Hecdivert**	1	HHF and MSPP	Design M& E plan with partners, design public displays of progress at KOMBIT sites, present progress at UCS II meetings, validate data, plan and participate in Mid term and final evaluations.	KOMBIT Project Director	100%	CSHGP

Job Title	FTE	Affiliation	Role	Supervisor- Lines of Authority	% Effort	Support
Statistician **Jn Luc Philippe**	1	MSPP	Collects, collates, validates and presents progress toward meeting KOMBIT objectives. Bridges departmental reports and KOMBIT new reports	Monitoring and Evaluation Administrator	25%	CSHGP
Job Title	**FTE**	**Affiliation**	**Role**	**Supervisor- Lines of Authority**	**% Effort**	**Support**
Mid term Evaluator **TBN**	1	consultant	Coordinate and document the process evaluation of the KOMBIT program in year 3	Technical Backstop, KOMBIT Program Director, Executive Director, KOMBIT leadership	Limited consulta ncy	CSHGP
Final Program Evaluator **TBN**	1	consultant	Coordinate and document the formative evaluation of the KOMBIT program in year 4	Technical Backstop, KOMBIT Program Director, Executive Director, KOMBIT leadership	Limited consulta ncy in year 4	CSHGP
ADVISORY GROUP						
Field Technical Advisor **Bette Gebrian PhD**	1	HHF	Support programmatic directions with the HHF/Administrator-KOMBIT Project Director	Advisory role only	20%	HHF
USAID Haiti CSHGP medical liaison **Dr. Desinor**	1	USAID Haiti Mission	Participate in KOMBIT activities and provide USAID support and over sight to the KOMBIT Program Director	Advisory role only	3%	USAID
Epidemiologist **Dr. Roc Magloire**	1	MSPP	Assist maternal –newborn audit process in UCSII. Advise about expanded use of strategies	Advisory to KOMBIT and Advocacy in the Ministry of Health in Port-au-Prince	10%	MSPP CSHGP for travel

ANNEX VI

RAPID CATCH

Rapid CATCH: Rapid Core Assessment Tool on Child Health

Questionnaire is for mothers who have children less than 24 months old

Weight

1. Can I weigh_____(name of child) ?
    1. Yes
    2. No if no - go to question 8

2. *Write the weight of the child* ___ ___ . ___ kilograms

Childhood vaccines

3. Does _____(name of child) have 4 vaccinations ?
   Can you show me the vaccine card ?

    1. Yes, we can let the person doing the investigation see it.
    2. It is not available (lost it or it is not in the house) Ia) →**Go to AQ5**
    3. Never had a card→**Go to AQ5**
    4 Do not know→**Go to AQ5**

4. Write the information from _____(name of child) card on this chart..

	DAY		MONTH		YEAR	
BCG						
POLIO 0						
POLIO 1						
POLIO 2						
POLIO 3						
DPT 1						
DPT 2						
DPT 3						
MEASLES						
VITAMIN A (last dose)						

5. Did_____(name of child) already have a shot to prevent measles ?

    1. YES
    2. NO
    3. DO NOT KNOW

Prevention of malaria

6. Do you have mosquito nets in your house ?

    1. YES
    2. NO→**GO TO AQ.9**
    3. DO NOT KNOW→**GO TO A Q.9**

7. Who slept under the mosquito net last night? WRITE EVERYTHING THEY SAY.

    A. CHILDREN _____(name of children)
    B. PERSON WHO IS RESPONDING TO THE QUESTION
    C. OTHER PEOPLE_____
    (SAY WHO)
    Y. OTHER PEOPLE

8. Was the mosquito net already dipped into a solution that repels mosquitos or any other bugs ?
    1. YES
    2. NO
    3. DO NOT KNOW

Integrated Care of the Sick Child (PCIME)

9. Did _____(name of child) have a problem with one of the illnesses listed below in the past week ?

IT IS GOOD TO SAY THESE ALOUD AND WRITE ALL THE RESPONSES TO THE QUESTION.

A. Diarrhea
B. Blood in the stool
C. Cough
D. Difficulty breathing
E. Breath rapidly
F. Fever
G. Malaria
H. Convulsion
I. Other _____
(SAY WHAT)

J. Other_____
(SAY WHAT)

K. If there were any illnesses given→ **GO TO AQ 12**

10. When_____(name of child) had _____ (name of illness) how did he/she drink?

1. LESS THAN NORMALLY DRINKS
2. SAME AMOUNT AS USUALLY DRINKS
3. MORE THAN NORMALLY DRINKS

11. When_____(name of child) had _____(name of illness) how did it eat?
1. LESS THAN IT USUALLY EATS
2. SAME AMOUNT AS NORMALY EATS
3. MORE THAN NORMALLY EATS

HIV/AIDS

12. Are you accostomed to hearing talk about an illness called AIDS?
1. YES
2. NO→ **GO TO A Q.20**

13. How does a person avoid catching AIDS ?

WRITE ALL THE RESPONSES MENTIONED

A. NOTHING
B. ABSTINANCE (DO NOT HAVE SEX)
C. USE A CONDOM
D. ONE WOMAN AND ONE MAN WHO ARE FAITHFUL TO EACH OTHER
E. LIMIT THE NUMBER OF PARTNERS YOU HAVE
F. AVOID ALL SEXUAL RELATIONS WITH PROSTITUTES
G. AVOID ALL SEXUAL RELATIONS WITH PEOPLE WHO HAVE SEVERAL PARTNERS
H. AVOID HOMOSEXUAL CONTACTS
I. AVOID SEX WITH PEOPLE WHO INJECT DRUGS
J. AVOID BLOOD TRANSFUSIONS
K. AVOID INJECTIONS
L. AVOID KISSING ON LIPS
M. AVOID MOSQUITOE BITES
N. LOOK FOR PROTECTION AT THE HOUSE OF THE VOODOO PRIEST
O. DO NOT USE SOMEONE ELSE'S RAZOR
W. OTHER_____
(WHAT)
X. OTHER_____
(WHAT)
Z. DO NOT KNOW

Practice of handwashing

14. Before we finish we want to ask a final question.
Can you say when you wash your hands with soap or with ashes ?

(TAKE TIME TO INCLUDE ALL THAT THE PERSON RESPONDS TO THE QUESTIONS ASKED.

A. NEVER
B. BEFORE I COOK FOOD
C. BEFORE I GIVE THE CHILDREN FOOD
D. AFTER USING THE TOILET
E. AFTER I FINISH CLEANING THE CHILDREN WHEN THEY FINISH USING THE TOILET

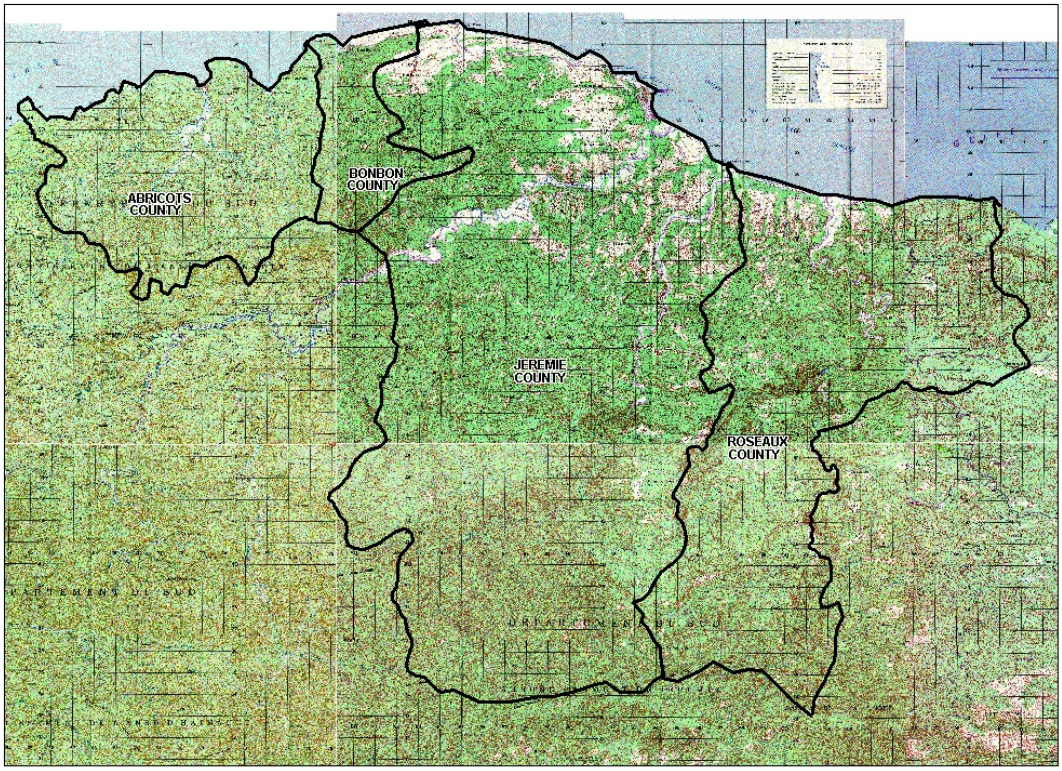
X. OTHER _____
(SAY WHAT)

ANNEX VII

a. UCS 2 Map

b. Mothers' Clubs Description

UCS II GRAND ANSE DEPARTMENT



Haitian Health Foundation
Mother's Clubs
1990-2004

The Haitian Health Foundation (HHF) community-based primary health care (PHC) program is based on a philosophy of community participation. There are a number of facets to this philosophy including the village selection of health worker, initial involvement of health committees and the use of health information for decision-making. One key feature is the development and advancement of women's groups for family health. This paper documents the evolution of mother's clubs from 1990 to the current mature status in 2002.

Definition of Mother's Club: The mother's club is a structured community group whose mission it is to ameliorate their own health and the health of the family and community. They are also charged to mobilize to resolve problems in the community and to improve their lives with internal and external resources.

1990
The first steps in the evolution of the HHF PHC program included the selection and training of village health workers and the formation and facilitation of health committees in 25 villages(28,000 people) in the County of Jeremie. Health interventions were then added in a step-wise fashion to the work of the MSPP-trained village health workers (agents de sante) moving from census and feedback to vaccination of children through oral rehydration to the addition of prenatal care. By 1990, most of the health agents had mastered the simplest interventions due in part to the intense supervision by field nurse auxiliaries and non-technical oversight of health committees.

It became clear that one health agent was unable to manage the health education needs and preventive health care interventions without the support of a wider group of community members. Even though health committee members were asked to participate in rally posts and other community-wide gatherings, these 15 or so individuals were inadequate to "spread the health news" and help move to healthy behaviors for the 1000-1500 people covered by each agent. Through the excellent training of the nurses and health agents by CARE International using the *CARE GID RICHES* health messages and songs, staff became energized to apply known messages and techniques in the HHF areas.

Mother's with children under the age of 5 years who attended monthly rally posts were invited to attend a weekly educational meeting with the health agent to learn more about the maternal and child health care services and messages. Since the villagers themselves selected the health agent and members were a part of the census effort, gathering women together was not difficult. On non-market days and often on Sundays after church, health agents (and frequently the nurse supervisor) would pass along health messages using catchy songs, jokes and other non-formal techniques. Demonstrations of oral rehydration solution for diarrhea were conducted with the women and they, in turn, replicated the message and recipe and explained to others the purpose of the solution.

Initially, 15-20 women were gathered together and the women elected one as the president. The health agent was responsible for completing a report of the meeting. Information included the number of women present, the issues discussed or educational message, materials used, items distributed (as with ORS packets) and decisions made. The date of the next meetings was also included. This report was brought to the HHF office at the end of each month and given to the supervisor. The number of meetings and number of participants was recorded on a QUATTRO spreadsheet as it had been done for health committee meetings since 1989. These data on all meetings in all villages is still maintained on and ACCESS file to monitor community participation.

1991

Each village and urban neighborhood in the HHF program in Jeremie County had a mother's group. In the summer of 1991 all of the presidents of the clubs came together in Jeremie for a celebration lunch and a meetings for the day. During this meeting, some of the topics discussed included:

- ✓ The objectives of the HHF and the referral policy
- ✓ The progress of each village to day in the form of "kassav dous" or pie diagrams
- ✓ Certificates were awarded to women who showed the most outstanding leadership during the year
- ✓ Plans for expansion of groups and addition of new topics and members
- ✓ Mothers were thanked for participating in the 1991 census verification process that was based on the 1988 census.

A training of additional health agents was completed.

1992-1993

The groups continued to flourish and many women participated in the rally posts by assisting in the growth monitoring activities, spreading the message about the preparation of ORS, advertising the date of the rally posts and participating in the protein-carbohydrate gruel (a complementary food for children) demonstration posts sponsored by HHF with UNICEF support. The staff noticed that many children that were attending the rally posts were suffering from respiratory infection and that some died during the posts. This finding stimulated HHF to request assistance to pilot the WHO acute lower respiratory infection community-based detection and treatment program (HHF later demonstrated a 50% reduction in the pneumonia death rate because of this program).

Children that had severe kwashiorkor were referred to one of Mother Teresa's Missionaries of Charity Hospice for long term rehabiliataion. The referral system with the HHF clinic and missionary clinics was strengthened. Children that recovered from malnutrition were returned to the village and followed up by the resident health agent. Medical and dental posts were held in the villages that demonstrated the highest level of community participation. A latrine project was completed in a selected number of HHF villages through the health committees and mother's clubs.

Women members began to work together for broader development. In some villages, women put money together every week and saved the amount for community emergencies. Others pooled money and bought animals or beans and resold for a profit that was divided among the members. Other groups combined resources for assistance of the village after a death by washing the clothes

of the deceased and assisting with the wake. HHF observed these internal advancements but did not participate in village banking or group economic enterprises.

1994
When the HHF expanded the PHC program to include detection and treatment of bacterial pneumonia, members of mother's clubs were included in the initial "leader training" so that they too could identify rapid breathing and refer neighbors to the health agent for rapid treatment at the village level.

An assessment of mother's competence was completed in the area of ORT preparation, vaccination of themselves with 2 doses of tetanus toxoid vaccine and other health information. A list was made at the central level of the names of the president of the mother's club and the number of active members. A notation was made on the computerized database of women who were members of the group. An anthropological study of positive deviance was completed on matched pairs of mothers in 2 villages related to mother's work and child health. From this in depth study came the realization that involvement of father's for family health was important. Father's associations were begun during this year.

In one case, the health agent left the area and another training was not planned, the mother's club members continued to meet and share health messages and advertise for the mobile vaccine and health posts. Vaccine coverage rates did not decline.

1995
As with the pneumonia intervention, the new breast-feeding campaign was centered on the involvement of women in the mother's clubs. With the assistance of UNICEF promotional items and support for community education, over 1000 women successfully completed 6-months of exclusive breast-feeding. Women who completed 6 months of complete breast feeding received a shopping bag, their partners a tee shirt and moms and babies a photo of themselves with a certificate of completion. Each mother was charged with assisting another mother to attain 6 months of complete breast-feeding for 6 months. Since that time, there are few bottles seen in HHF villages and a report of 60% of mothers of exclusive breast-feeding in the absence of food aid. Women proudly display their photo with their baby and have become "breast feeding agents". Because grandmothers are encouraged to become members of mother's clubs, we have noticed a decline in the use of a traditional purgative called *LOK*, an increase in the use of colostrums and the transmission of "new ideas" by grandmothers.

Feedback of the health impact on children under the age of one year was discussed with the health committees and mother's clubs.

Due to severe financial cutbacks in 1995, only 10 health agents remained employed for the year 1995. Village mother's clubs did not disband and health care was delivered in a mobile fashion until the majority of the health agents were hired back after a number of months.

1996
The population of the HHF PHC program reached 100,000. Each health agent covered at least 2000 people. Many had more than one mother's club and some had four. The involvement of the women in the delivery of health education messages became stronger and consistent. They were

present at all rally posts. Home visits declined in favor of specialized meetings—breast-feeding mothers, weighing posts before vaccine posts, etc.

Feedback of progress to community-based organizations was institutionalized and health agents, rather than nurses, conducted problem-solving meetings. Road maintenance became integrated into the community's participation in health. Mother and father's clubs had joint meetings in many villages and celebration of the progress of the community was celebrated through "village health days". These public health extravaganza drew thousands of parents and youth to see health 'theater", applaud father's knowledge in health and participate in one of the many health "stations" set up around the area (breast feeding, ORS, vitamin A, education, fingernail cutting, counseling, etc)

1997
HHF expanded the base population from 100,000 to 200,000 and was given three additional communes (counties) to cover including Moron, Roseaux and Bonbon. CARE International left the rural areas in the Commune of Moron and HHF inherited 48 community volunteers of which 14 passed the training as health agents.

Mother's clubs that were started by CARE were continued by HHF in Moron County. The plan was to phase-in the implementation of PHC in the other 2 communes (and this was accomplished in 2003-2004)

Mother's clubs did have the opportunity to participate in a well-funded program to reward their knowledge and application of basic health strategies in the home and community. The "Healthy, Happy Family" program supported by USAID through Management Sciences for Health (MSH HS2004) created culturally and epidemiologically appropriate 12 key messages. These messages focused on maternal and child health and included flannel graph and playing cards to enhance capture of the messages, audio cassettes and printed diplomas for the mother's who completed the program and financial assistance for community diploma ceremonies. Staff were trained in 1997 for this program.

1998
The mother's clubs embraced the new program with its concrete and practical messages and support with gusto. Each health agent learned the messages and received additional training in group education and interpersonal communication. The program graduated over 500 women in the first year. Each graduate received a diploma and a photo of herself with the diploma on the day of graduation. The community ceremony highlighted the groups' knowledge as they presented skits of their own making, new songs including the key messages. Food was shared and the festive mood and positive changes helped to stimulate an increase in the number of members of mother's clubs. Women also became obviously stronger and more outspoken. For many, this was the first diploma that they had received in their lives.

1999
The healthy, happy family program expanded rapidly with the addition some new strategies. Diplomas for fathers had to be created because they too wanted to be a part of the program. We had not planned on this and were thrilled that they themselves asked to be included.

Mothers in the clubs began to create health songs and women's group songs on their own. And they were better than the ones that we had brought to them 9 years earlier!
HHF and Rotary Club decided to give 1000 female goats to graduates of the program. One male goat was to be returned to HHF to feed the poor and one other female goat was to be given to another graduate mother or father in the village.

St. Bridget Church in Manchester Connecticut copied the logo of the program onto a tee shirt. Each graduate also received a tee shirt at the same time they get a diploma (we are a bit behind with this).

2000-2002
HHF field staff no longer bring in the presidents of the mother's clubs to Jeremie once a year. For the past 5 years, the areas have been split into 5 central zones. Once a year a leader seminar is held for general information about health in the Grand Anse, feedback, plans for the future and discussion of progress by area. There are now 700 leaders of health committees, mother's clubs, father's associations and trained midwives!

Youth have organized themselves and asked to be recognized by HHF. Many of these groups have also asked for education in anatomy- physiology and sexuality. Hundreds have formed into groups and HHF has added youth groups to the cadre of thousands of community volunteers.

The MSH HS2004 health education program has nearly 3000 graduates. Many are mothers but about as many are young girls, boys and fathers. Health fairs are held in each village once a year. PSI provided support for a woman to woman diarrhea awareness program that will be completed in 2002 including a distribution of a free packet of serom sel lavi ORS.

The Happy House project (Rotary Club) has also had a continuing impact on some members of community-based organizations. For the very poor or for families that have lost their homes due to fire, HHF works with the family and the community to rebuild houses. In an open community meeting, a family is selected as long as they own the land. (It is common in the Grand Anse for rural people to own the piece of land that their house is built on) Over 100 houses have been built with community support.

Mother's clubs and the other community-based organizations have worked together to build roads to 5 villages and to maintain access to all others. Latrines have been built and maintained – some better than others.

Most importantly, thousands of community members have begun to find their voice. In 2002, HHF began simple educational sessions with mothers' groups about the legal rights of women through volunteer lawyers.

HHF has undertaken the next step in community development and that is the practical application of community diagnosis and mobilization for action. Steps in the process include assessment of need and resources and then establish a plan of action and execute the plan.

This has been tested in 2 areas and the results have been dramatic. One village built a 1.5 km road by hand with no external assistance. They identified a place for rally posts to be held in order

to reach more families. They wrote a project to CRS for a water cistern. The other village understood that youth groups were a viable way to teach the young responsible sexuality and the health agent and school director with the help of the nurse supervisor are educating 72 teenagers. This village decided with the leadership of the mother's club to identify a location for a community center.

Summary of Important points:

9. In the beginning, health agents organized and ran the mother's clubs. This endured from 1990 to 1994. Health agents taught the mothers and they were the recipients of health education.
10. In 1994-95 HHF began noting women who emerged as leaders and who participated on their own. Women began to bring others into the group, participate more actively in the rally posts even when they had no children receiving services.
11. By 1997 some mother's groups were organizing themselves into village banks and cooperatives of businesswomen.
12. As women grew in knowledge and confidence, the relationships with other groups and individuals changed also. For example, women helped to organize fathers for child and family health, they sent their children to organize youth groups, and they began organizing children groups for simple health messages.
13. Some urban women's groups invited other development groups such as FONKOZE or the Gebeau micro credit program to work with them.
14. By 1999 the USAID sponsored "Timoun and Sante Kontan" program galvanized women and drew in thousands more to witness the dramatic changes that simple technologies can make on the health of a village.
15. The addition of the health and human rights program held in rural villages through Haitian lawyers has brought together people that would never have had the chance to learn and apply their rights. Men AND women attend these day-long seminars.
16. We are continuing to learn from the people and adapt the community-based Primary Health Care Program (CBPHC) to the needs of the people.

A more complete accounting of the roles of women for HIV- AIDS and STIs is to be added to this historical overview but has not yet been written!

To truly understand the integrated nature and impact of the mother's clubs on community-based PHC, one has to visit Jeremie and talk to the women themselves.

Bette Gebrian RN MPH Ph.D. Director of Public Health Haitian Health Foundation
University of Connecticut Schools of Nursing and Community Medicine

ANNEX VIII

Selected Monitoring Tables

Page

Haitian Health Foundation
Birth Reporting form

Village: _____ #Village Number: _____

Identification of the Mother

Complete Name: _____

Age: _____ # HHF: _____

Did you give the mother vitamin A? _____ _____
yes No

Identification of the Infant

Complete name: _____

Birth Date: _____ Sex: _____

Weight at birth: _____ # HHF: _____
Infant

Weight before the 9th day: _____

Location of Delivery:

By Whom ?:

Tetanus Vaccine:
Date

1e Dose 2e Dose Rappel

Prenatal Care ?:

Oui Non

By Whom? _____

Key to Location and Personnel

1) At Home
2) At at Clinic
3) Hospital

Par:

1) Midwife (not nurse)
2) Health Agent
3) LPN
4) Medical doctor or Nurse

_____
Name of Person completing the form

REGISTER OF PREGNANCIES IN THE VILLAGE

Club :_____

No	Morther's Name	Age of mother's	EDC	Delivery Date	Sex of child	Pregnancie result Mother / Child L / D / L / D			
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

AREA : _____

REPORTER'S NAME :_____

Pregnancie Result: L=Living after delivery
D=Died during labor and delivery

REGISTER OF PREGNANCIES IN THE VILLAGE

Club :_____

No	Mother's Name	Age of mother's	EDC	Delivery Date	Sex of child	Pregnancie Result Mother / Child L/D / L/D			
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

AREA : _____

REPORTER'S NAME :_____

Pregnancie Result : L=Living after delivery
D=Died during labor and delivery

REGISTER OF PREGNANCIES IN THE VILLAGE

Club _____

No	Mother's Name	Age of mother's	EDC	Delivery Date	Sex of child	Pregnancie Result Mother / Child L / D / L / D			
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

AREA : _____

REPORTER'S NAME :_____

Pregnancie Result: L=Living after delivery
D=Died during labor and delivery

BIRTH PLAN

Safe Motherhood

Card Number :	Age :		
Village :	Address:	Name:	
How many months pregnant are you now?			
Do you have birth layette ready ?		Yes No	
Where will you go for delivery?			
Who will assist you during your delivery?		Does the birth attendant have materials? Don't no	Yes No
Do you have money set aside to go to hospital & buy medicine or pay the midwife ?		yes No	almost
If you need transportation to go to hospital, who will carry or transport you?			
If you are going to delivery at hospital in Jeremie, do yo have a house where you can stay beforehand?			
Do you have any person who will take care of your children during your absence?		Yes No	Not yet
Do you have anyone to help you in town after delivery?		Yes No	Not Yet

HOAPITAL DELIVERY

- Home-based mother perinatal card
- Clothes for the newborn and kotex
- Personal hygiene articles and a towel for the baby and basin, dish for eating, silver ware, cup for mom and food for mom.
- Sandles to wear, underwear, tooth brush, moumou to wear, brus hand comb, night dress

XVI. 250Goud for hospital bed

500Goud for medicine and normal birth

700Goud for medicine for Caeserian

1500Goud for Caeserian operation

HOME DELIVERY

- Clean water, soap and bath towel
- New razor blade, alcohol or moonshine
- Potassium permangenate, plastic sheet for bed
- Matches and kerosene for a lamp, or candle
- Infant clothing, gauze pad and clean cord-tie
- Plastic pan and drinking glass, oral rehydration mix.

Do not forget to pay a birth attendant who is trained and who has an MSPP supply box.

Mother's signature Date :

(on the reverse side of the above form)

Record of Education and Counseling given

- danger signs during pregnancy	date :	signature :
- danger signs during delivery	date :	signature :
- importance of immediate breastfeeding	date :	signature :
- importance of hydration	date :	signature :
- necessity of notifying the HA of the birth	date :	signature :
- other subjects	date :	signature :

HHF Referral Form (To Be Adapted for KOMBIT)

Identification of the Person referring the person :

First and Last Name: _____

Position:_____ Date: _____

Village: _____ Village Number :: _____

Identification of the person being referred :

First and Last Name: _____ Village:_____ #HHF:_____

Age: _____ Sex: _____ Weight: _____

1e: _____ BP : _____ Heart Rate:_____

Medication given

_____

_____

Clinical History

_____

_____

Reason for Referral :

_____

_____

_____

Special MSPP Insert Sheet for KOMBIT

K – 1 Communication and Education

Subject Method	Discussion Group	Dialogue, counselling	Forum	Community Meetings	Other
Prenatal women's health					
Preparation for delivery Choices regarding the delivery					
How to preserve the live of a pregnant woman					
PF: Standard Days Method					
PF: Exclusive breastfeeding					

K – 2 Laboratory

	Total			Number of positive results		
	Women	Men	Total	Women	Men	Total
HIV						
Syphilis						
Gonorrhea						

K – 3 Obstetrical Emergencies seen or referred

Cause	Numbre	Referred to
Hemorrhage		
Pre-eclampsia		
Éclampsia		
Distocia		
Results for women referred	**Commentary**	
Number of women healed		
Number of women who died		
Number of women with results unknown		
Results fpor their children		
Number of infants born dead		
Number of infants born alive		
Numbre of infants with results unknown		

K – 4 Care of the woman

Total number of pregnancies at risk	
Having anemia	
Having pre-eclampsia (hypertension)	
Having twins/multiple births	
Having more than 5 previous pregnancies	

K – 5 Consultations postnatales (numbres)

< 1 month	commentary	> 1 month	Commentary	Total

K – 6. Consultations PF:

Natural Methods:

Method	Users	New Users
MAMA Method		
Periodic abstenence – Standard Day Method		
Cervical Mucus Method		
Total		

K – 7. Distribution of beads for SDM:

Number distributed: _____

K – 8.Care of the newborn:

Age < 1 week: _____

Age 1 – 2 weeks:_____

Services	< 2.5 K	> 2.5 K		
# Weights:				
# Examinations:				
# referred:				

K – 9 Formation in Newborn IMCI (includes breastfeeding, First Aid, Natural FamilyPlanning)

Formation	**By a Physician**		**By a Nurse**		**By an Auxillary**	
	Certified	Supervised	Certified	Supervised	Certified	Supervised
Neonatal IMCI						
Breastfeeding						
First Aid						
Natural Family Planning						
Other						

K – 10. New cases of gynecological illnesses in non-pregnant women

Illnesses or conditions	Women Age 15 – 49	Total number of cases	Deaths
Hemorrhage			
Hypertension			
Vaginal infections			
Arrested fetal growth (traditional)			
Others			
HIV +			
Syphilis			

VERBAL AUTOPSY QUESTIONNAIRE
KESYONE OTOPSI VEBAL

Bonjou. Mwen konnen ke-w sot pèdi yon moun ki chè anpil pou ou. Mwen prezante-w bon jan kondoleyans ki soti nan fon kè-m. Mwen ta renmen pose-w de twa ti keksyon sou maladi ak lanmò moun ou sot pèdi-a. Mwen pa konnen si sa ap deranje-w. Eske ou ka rakonte-m nan ki sikonstans li mouri ?

1) INFOMASYON JENERAL

1- Non moun ki mouri a: _____

2- Non moun ka reponn kesyon yo : _____

3- Dat ke li mouri : _____

4- Sa li ye pou moun ki mouri a : _____

5- Adrès kote li abite : _____

6- Depatman _____

7- Dat li te fèt: | | | | | | | (jou Mwa Ane)

8- Komin _____

9 Date chita pale a : | | | | | | | (jou Mwa Ane)

10-Seksyon Kominal _____

11- Lokalite: _____

2) ENFOMASYON PESONEL SOU MOUN KI MOURI-AN

12- Ki pi gwo klas li te fè _____

13- Ki travay li tap fè poul viv _____

14- Eske li te : Marye Pa marye Divose Vèv Plase

15- Eske li te gen pwoblèm anemi ? Oui No Pa konen

16- Ki kote li mouri : Lopital Lakay Lòt kote .....

17- Li mouri : anvan pandan apre akouchman

18- Konbyen timoun vivan manmzèl te fè ? …….....

19- Konbyen timoun tou mouri li te fè ? …….....

20- Konbyen fos kouch li te fè ? …….....

21- Konbyen avòtman li te fè ? …….....

22- Konbyen pitit vivan li te fè ? …….....

23- Nan pitit li yo kap viv ki laj pi piti-a ? …….....

24- Lè li te fin fè timoun sila eske li te ansent ankò ? wi non

25- Konbyen fwa li te ansent antou ? …….....

26- ki dat dènye akouchman avan timoun sa –a ...../...../.....

27- Eske li te guin pwoblem sante avan li te ansent ? wi non

28- Si wi ki pwoblem ? _____

29- ki sa ou panse ki fè-l mouri (ou ki tye-l)? _____

3) SWEN PANDAN GWOSES

30- Eske-l te ale konsilte pandan gwosès-la? Wi Non Pa Konen 31- Ou ka montre-m kat sante-l ? Wi Non Pa Konen

32- Si wi: Ki kote li te ale? kay doktè sant lopital matronn dokte fèy lot kote: .....

33- Konbyen fwa li te al konsilte kote sa-a pandan gwosès li? Yon sel fwa 2-4 fwa 5-7 fwa plis ke 7 fwa pa konnen

34- Sou konbyen mwa gwosès li te ale konsilte premye fwa-a ? .....mwa nan kosmanman nan mitan pa konnen

35- Sou konbyen mwa gwosès li te ale konsilte dènye fwa-a ? .....mwa nan kosmanman nan mitan pa konnen

36- Lè li te ale konsilte, konbyen lajan li te depanse pou? Konsiltasyon .....Gdes medikaman.....Gdes laboratwa.....Gdes
transpò.....Gdes lòt depans.....Gdes **Total lajan.....Gdes** Pa konnen konbyen li te peye

37- Si li pat ale consilte, eske ou ka di nou pou ki rezon : Neglijans Distans pwoblem lajan transpò lòt .....(kisa)

4) PWOBLEM PANDAN GWOSES-LA

Eske _____(non moun ki mouri-a) te prezante pwoblèm ke nou pwal site la yo avan li mouri :

38- Eske yo te di-l ke li fè tansyon?
non, wi, mwen pa konnen
a- Kiyès ki te di-l sa ?
doktè, Miss, lòt moun .....(kiyès)
b- Depi konbyen tan ? .....

39- Eske li tap senyen pa ba ? non, wi, pa konnen
a- Konbyen tan li te fè ap senyen anvan li mouri ? .....
b- Lè li te mouri-a eske li tap senyen toujou ?
non, wi, pa konnen
c- Eske san-an te tache rad li ? non, wi, pa konnen

40- Eske-l te gen kote lan ko-l ki te anfle ? non, wi, pa konnen
a- Ki kote? vant, Figui, janm pye, men
lòt kote :.....

41- Eske-w te wè souf li kout avan li mouri non, wi
a- Eske-w ka di'n kile-w te remake sa premye fwa ? .....
b- Konbyen tan sa te dire sou li ? .....

42- Eske-w te wè po-l bay you ti koulè pal ?
non, wi, pa konnen

43- Eske li te guin Gwo tèt fè mal avan li mouri ?
non, wi, pa konnen

44- Eske-l te kon pipi souvan e anpil? non, wi, mwen pa konnen
a- Eske-w ka di'n kile-w te remake sa premye fwa ? .....
b- Konbyen tan sa te dire sou li ? .....

45- Eske li te gen lafyèv avan li mouri ? non, wi, pa konnen
a- Eske-w ka di'n kile-w te remake sa premye fwa ? .....
b- Konbyen tan sa te dire sou li ? .....

46- Eske li te kon bay dlo pa ba ? non, wi
a- Si Wi depi kombyen temps :. .....

47- Eske li te kon fè kriz avan li mouri?
non, wi, pa konnen

48- Eske gen lòt bagay ki gen rapò ak Gwosses li te genyen-an ke nou pa di ? non, wi
a- Se kisa ?

49- Eske pwoblèm sa yo te:
grav anpil se grav pa tèlman grav pa konnen

50- Kilès ki te wè pwoblèm sa yo anvan?
.....

51- Eske li te resevwa konsèy sou pwoblèm sa-yo? Wi Non

52- Kilès ki te bali konsèy yo? .....

53- Eske _____(non moun ki mouri-a) te fè yon bagay pou rezoud pwoblèm-nan? wi non pa konin

54- Ki kote li te ale : kay doktè sant lopital matronn
doktè fèy lot kot: .....

55- Konbyen li te depanse pou regle pwoblèm sa-a pou: Swen .....Gdes medikaman.....Gdes laboratwa.....Gdes
transpò.....Gdes lòt depans.....Gdes **Total lajan.....Gdes** Pa konnen konbyen li te peye

56- Si li pat ale consilte, eske ou ka di nou pou ki rezon : Neglijans Distans pwoblem lajan transpò lòt .....(kisa)

5) PWOBLEM PANDAN AKOUCHMAN

57- Tranche-a te komanse ? avan lè a lè apre lè pa konin

58- Ki kote tranche-a te komanse

59- Konbyen tan tranche-a dire avan timoun-nan fèt ? .....

60- Apre kombyen tan kompanie an tombe

61- Ki moun ki te okipe li lè timoun-nan fèt la? Manman matant matronn infimyè doktè lot moun: .....

62- ki moun ki te okipe-l pandan tranche-a ? manman sè mari matant matronn infimyè Doktè lot.....

63- Ki kote timoun-nan fèt? .....

Sityasyon ti moun nan

64- Li fèt anvi oswa li fèt mouri

65- Li fèt : prezantasyon nomal Nan move prezantasyon

66- Si ti bebe-a ap viv ki laj li genyen ? .....

67- Si li mouri, depi konbyen tan ke li mouri ? .....

68- Si ti bebe-a te mouri ki kote sa rive ? La kay li Nan dispansè Nan lopital Lakay matronn
Nan wout pou ale nan dispansè ou lopital Doktè fey/ougan Lòt :.....(presize)

Eske _____(non moun ki mouri-a) te prezante pwoblèm sa yo pandan akouchman :

69- Eske yo te di-l ke li fè tansyon?
non, wi, mwen pa konnen
a- Kiyès ki te di-l sa ?
doktè, Miss, lòt moun .....(kiyès)
b- Depi konbyen tan ? .....

70- Eske li tap senyen pa ba ? non, wi, pa konnen
a- Konbyen tan li te fè ap senyen anvan li mouri ? .....
b- Lè li te mouri-a eske li tap senyen toujou ?
non, wi, pa konnen
c- Eske san-an te tache rad li ? non, wi, pa konnen

71- Eske-l te gen kote lan ko-l ki te anfle ? non, wi, pa konnen
a- Ki kote? vant, Figui, janm pye, men
lòt kote :.....

72- Eske-w te wè souf li kout avan li mouri non, wi
a- Eske-w ka di'n kile-w te remake sa premye fwa ? .....
b- Konbyen tan sa te dire sou li ? .....

73- Eske-w te wè po-l bay you ti koulè pal ?
non, wi, pa konnen

74- Eske li te gen Gwo tèt fè mal avan li mouri ?
non, wi, pa konnen

75- Eske-l te kon pipi souvan et anpil? non, wi, mwen pa konnen
a- Eske-w ka di'n kile-w te remake sa premye fwa ? .....
b- Konbyen tan sa te dire sou li ? .....

76- Eske li te gen lafyèv avan li mouri ? non, wi, pa konnen
a- Eske-w ka di'n kile-w te remake sa premye fwa ? .....
b- Konbyen tan sa te dire sou li ? .....

77- Eske li te kon bay dlo pa ba ? non, wi
a- Si Wi depi kombyen temps :. .....

78- Eske li te kon fè kriz avan li mouri?
non, wi, pa konnen

79- Eske gen lòt bagay ki gen rapò ak akouchman li te fè-a ke nou pa di ? non, wi
a- Se kisa ?

80- Eske pwoblèm sa yo te:
grav anpil se grav pa tèlman grav pa konnen

81- Kilès ki te wè pwoblèm sa yo anvan?
.....

82- Eske li te resevwa konsèy sou pwoblèm sa-yo? Wi Non

83- Kilès ki te bali konsèy-yo? .....

84- Eske _____(non moun ki mouri-a) te fè yon bagay pou rezoud pwoblèm-nan? wi non pa konin

85- Ki kote li te ale : kay doktè sant lopital matronn doktè fèy lot kot: .....

86- Konbyen li te depanse pou regle pwoblèm sa-a pou: Swen .....Gdes medikaman.....Gdes laboratwa.....Gdes
transpò.....Gdes lòt depans.....Gdes **Total lajan.....Gdes** Pa konnen konbyen li te peye

87- Si li pat ale consilte, eske ou ka di nou pou ki rezon : Neglijans Distans pwoblem lajan transpò lòt .....(kisa)

6). PWOBLEM APRE AKOUCHMAN

Eske _____(non moun ki mouri-a) te prezante pwoblèm ke nou pwal site la yo pandan 42 jou ki swiv akouchman-l :

88- Eske yo te di-l ke li fè tansyon?
non, wi, mwen pa konnen
a- Kiyès ki te di-l sa ?
doktè, Miss, lòt moun .....(kiyès)
b- Depi konbyen tan ? .....

89- Eske li tap senyen pa ba ? non, wi, pa konnen
a- Konbyen tan li te fè ap senyen anvan li mouri ? .....
b- Lè li te mouri-a eske li tap senyen toujou ?
non, wi, pa konnen
c- Eske san-an te tache rad li ? non, wi, pa konnen

90- Eske-l te gen kote lan ko-l ki te anfle ? non, wi, pa konnen
a- Ki kote? vant, Figui, janm pye, men
lòt kote :.....

91- Eske-w te wè souf li kout avan li mouri non, wi
a- Eske-w ka di'n kile-w te remake sa premye fwa ? .....
b- Konbyen tan sa te dire sou li ? .....

92- Eske-w te wè po-l bay you ti koulè pal ?
non, wi, pa konnen

93- Eske li te guin Gwo tèt fè mal avan li mouri ?
non, wi, pa konnen

94- Eske-l te kon pipi souvan e anpil? non, wi, mwen pa konnen
a- Eske-w ka di'n kile-w te remake sa premye fwa ? .....
b- Konbyen tan sa te dire sou li ? .....

95- Eske li te gen lafyèv avan li mouri ? non, wi, pa konnen
a- Eske-w ka di'n kile-w te remake sa premye fwa ? .....
b- Konbyen tan sa te dire sou li ? .....

96- Eske li te kon bay dlo pa ba ? non, wi
a- Si Wi depi kombyen tan :. .....

97- Eske li te kon fè kriz avan li mouri?
non, wi, pa konnen

98- Eske li te kon bay dlo pa ba ki guinyen movèz odè ? non, wi
Si Wi depi kombyen tan sa te dire: .....

99- Konbyen jou apre akouchman an pwoblèm-nan te kòmanse ?
.....jou

100- Eske gen lòt bagay ki gen rapò ak lèl fin akouche-a ke nou pa di ? non, wi
a- Se kisa ?

101- Eske pwoblèm sa yo te:
grav anpil se grav pa tèlman grav pa konnen

102- Kilès ki te wè pwoblèm sa yo anvan?
.....

103- Eske li te resevwa konsèy sou pwoblèm sa-yo? Wi Non

104- Kilès ki te bali konsèy yo? .....

105- Eske _____(non moun ki mouri-a) te fè yon bagay pou rezoud pwoblèm-nan? wi non pa konin

108- Ki kote li te ale : kay doktè sant lopital matronn
doktè fèy lòt kote: .....

109- Konbyen li te depanse pou regle pwoblèm sa-a pou: Swen .....Gdes medikaman.....Gdes laboratwa.....Gdes
transpò.....Gdes lòt depans.....Gdes **Total lajan.....Gdes** Pa konnen konbyen li te peye

110- Si li pat ale consilte, eske ou ka di nou pou ki rezon : Neglijans Distans pwoblem lajan transpò lòt .....(kisa)

111- Eske gen diferans ant gwosès sa-a ak lot fwa ke fam sa-a te konn ansent deja ke nou poko pale jodi-a? Oui Non

112- Eske fam-nan te gen pwoblem lakay li ki ba-l tèt chaje, lè li te ansent fwa sa-a? Oui Non

113- Eske ou ka di nou ki pwoblèm li te genyen?

114- Eske _____(non moun ki mouri-a) te kon malad pandan lòt gwosès avan sa? Oui Non

115- Eske ou ka di nou ki sa li te kon genyen?

116. Ki kote li te akouche avan fwa sa-a? lakay sant lopital lot kote .....(di ki kote)

KOMBIT CARD

RECORD # _____

HOSPITAL #_____

CLINIC # _____

HHF-PHC #_____

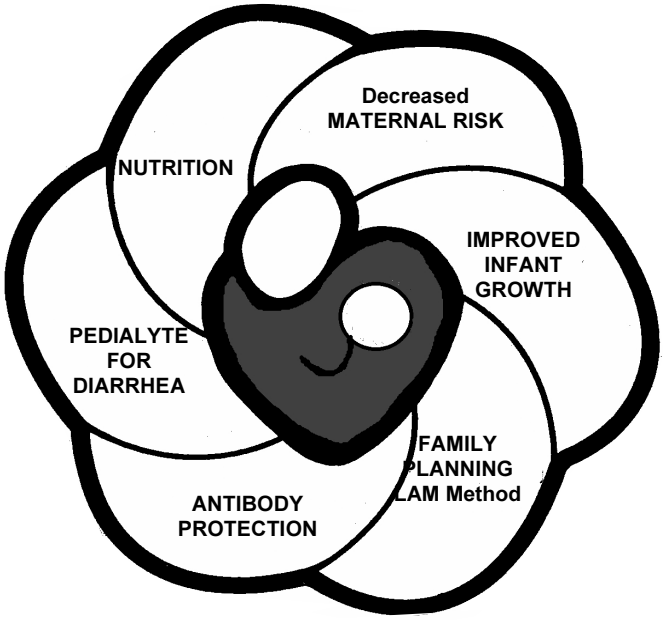
First Name_____ LAST_____

Address_____

Mother's group? Yes ____ No ____ Date _____

TETANOS	1e_____ date
TOXOID ANTIGEN	2e _____
	3e _____
(15-49 years)	4e _____
	5e _____

Date of birth _____



NAME OF CHILD	DELIVERY DATE	BORN ALIVE STILLBORN
1.		
2.		
3.		
4.		
5.		
6.		

PREGNANCY

TB____ _____ No _____ Yes _____

Number of Pregnancies? _____ Miscarriages _____

Number of Stillbirths _____

Number of babies who died before 1 month of age _____

Age of the last child _____ Less than 24 months _____

Ceserean? _____ No _____ Yes _____

Other health problems (cardiac, liver...) No __ Yes _____

Problem List_____

Height_____ Less than 150 cm _____

BP ____Systolic >140mm Hg _____Systolic < 90mm _____

DATE														
Month	1	2	3	4	5	6	7	8		9				
								1	2	1	2	3	4
Weight														
BP														
Edema f-p-m														
Urine Protein														
STI-														
Fetal Heart														
Uterine Ht														
Syphilis lab														
HGb														
Iron														
Danger Signs														

Reference _____ Date_____ Reason_____

Date of Childbirth _____Weight (boy/girl)_____kg

Place of Childbirth _____Type of deliver _____Birth attendant?_____

POST-PARTUM VISITS

DATE	Breast Feeding C-P-T	Vitamine A	Problem Referral	Food Aid For Mother

Date of first menstruation_____

Months

AGE	JAN	FEV	MAR	AVP	MAY	JUN	JUL	AOG	SEP	OKT	NOV	DES	**WEIGHT**	**HEIGHT**	**BP**	**HGB**	**YOUTH GP**
14																	
15																	
16																	
17																	
18																	
19																	
20																	
21																	
22																	
23																	
24																	
25																	
26																	
27																	
28																	
29																	
30																	
31																	
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34																	
35																	
36																	
37																	
38																	
39																	
40																	
41																	
42																	
43																	
44																	
45																	
46																	
47																	
48																	
49																	

KEY:

Menstruatin:	yes *
	No x
Breastfeeding	C-P-T
Menopause	R
Lofeminol	L
Ovrette	O
Depo-provera	D
Noristerat	N
Norplan	NO
Sterilets	S
Vaginal tablets	TAB
Condoms	K
Foam	MO
SDM	MC
Cervical Mucus	Glè
Tubal ligation	ES

REPUBLIQUE D'HAITI

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

RAPPORT MENSUEL DES SERVICES DE SANTE

Page

Institution	Niveau	Commune	Département

Mois / Année _____

Population desservie: _____

1) FREQUENTATION DE L'INSTITUTION

Visites	Visites/Nombre	
	Nouvelles	Subséquentes
Institutionnelles		
Non institutionnelles		

Consultations générales

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

2) ETAT FINANCIER

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

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

3) COMMUNICATION ET EDUCATION POUR LA SANTE

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

4) SOINS BUCCO-DENTAIRES

	Nombre
Patients vus	
Extractions	
Prophylaxies	
Amalgames	

5) EXAMENS DE LABORATOIRE

Type d'examen	Total	Positifs
Malaria Test		
Bacilloscopie		
VIH		
RPR		

6) URGENCES

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

7) MEDICAMENTS ESSENTIELS

Type de médicaments essentiels	Disponible tout le mois (oui, non)	Quantité utilisée (Unité)
Amoxicilline		
Cotrimoxazole		
Fer/acide folique		
Paracétamol		
SRO		

MSPP Rap. Mens. SSPE/SSDE

8) PRISE EN CHARGE DE LA FEMME

Nombre de grossesses attendues: _____

8.1) Consultations pré/postnatales

Consultations prénatales

1ères Visites		2èmes Visites	3èmes Visites et plus	Total Visites
< 3 mois	3 mois et plus			

Grossesses à risque :	
Cas d'anémie :	

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

Consultations postnatales	

Distribution de Vitamine A et de Fer

Femmes recevant Vitamine A	
Femmes recevant du Fer	

8.2) Accouchements

	Institutionnels	Domiciliaires
Age des mères		
< 15 ans		
15 - 19 ans		
20 - 34 ans		
35 ans et plus		
Inconnu		
Naissances Vivantes		
< 2,5 kg		
2,5 kg et plus		
Non pesés		
Mises au sein immédiatement		
Décès		
Mort-nés		
Décès maternels		
Matrones		
Certifiées		
Supervisées		

8.3) Consultations PF: _____

Utilisation et Acceptation Contraception

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

Hommes		
Condom		
CCV		

Contraceptifs distribués

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

Opérations de CCV

Ligature	
Vasectomie	

9) PRISE EN CHARGE DE L'ENFA

Population < 1 an : _____

Population 1 - 4 ans : _____

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

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

Vaccination (suite)	Enfants / Age		
	< 1 an	1 - 4 ans	5 ans
Rougeole dose unique			
Vaccination complète			

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

Formation PCIME	Méd.	Inf.	Aux
Certifiés			
Supervisés			

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10) NOUVEAUX EPISODES DE MALADIE

Maladies / Symptômes	Nouveaux épisodes/Age						Total Décè
	< 1 an	1 - 4	5 - 14	15 - 49	50 +	Total Cas	
Anémie							
Asthme							
Bubon Inguinal							
Problèmes bucco-dentaires							
Charbon							
Conjonctivite néonatale							
Coqueluche							
Dengue							
Dengue hémorragique							
Diabète							
Diarrhée							
Diphtérie							
Douleurs abdominales basses							
Douleurs, brulûres d'estomac							
Ecoulement urétral							
Filariose							
Goître							
Hémorragie							
HTA (minimum > 9,5 et âgé de + de 20 ans)							
Ictère fébrile							
Intoxication alimentaire							
Infections Respiratires Aigues (IRA)							
Kwashiorkor/ marasme							
Lèpre							
Leptospirose							
Malaria (Rx chloroquine)							
Malaria (cas confirmés)							
Malaria (cas résistants)							
Méningite (autres)							
Méningite Méningococcique							
Morsures par chien/chat							
Oreillons							
Paralysie flasque aigue							
Parasitose intestinale							

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10) NOUVEAUX EPISODES DE MALADIE (suite)

Page

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

CAPACITE INSTALLEE / UTILISATION

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

ACCOUCHEMENTS ET NAISSANCES

AGE DE LA MERE	Nb.
< 15 ans	
15 - 19 ans	
20 ans et +	
Age inconnu	

MODE	Nb.
Normal	
Césariennes	
Autres	

NAISSANCES VIVANTES / POIDS	
< 2,5 Kg	
2,5 Kg et +	

Morts-nés	
Décès maternels	
Nouveau-nés mis au sein immédiatement	

Préparé par: _____ Date : _____

Signature _____ Approuvé par : _____

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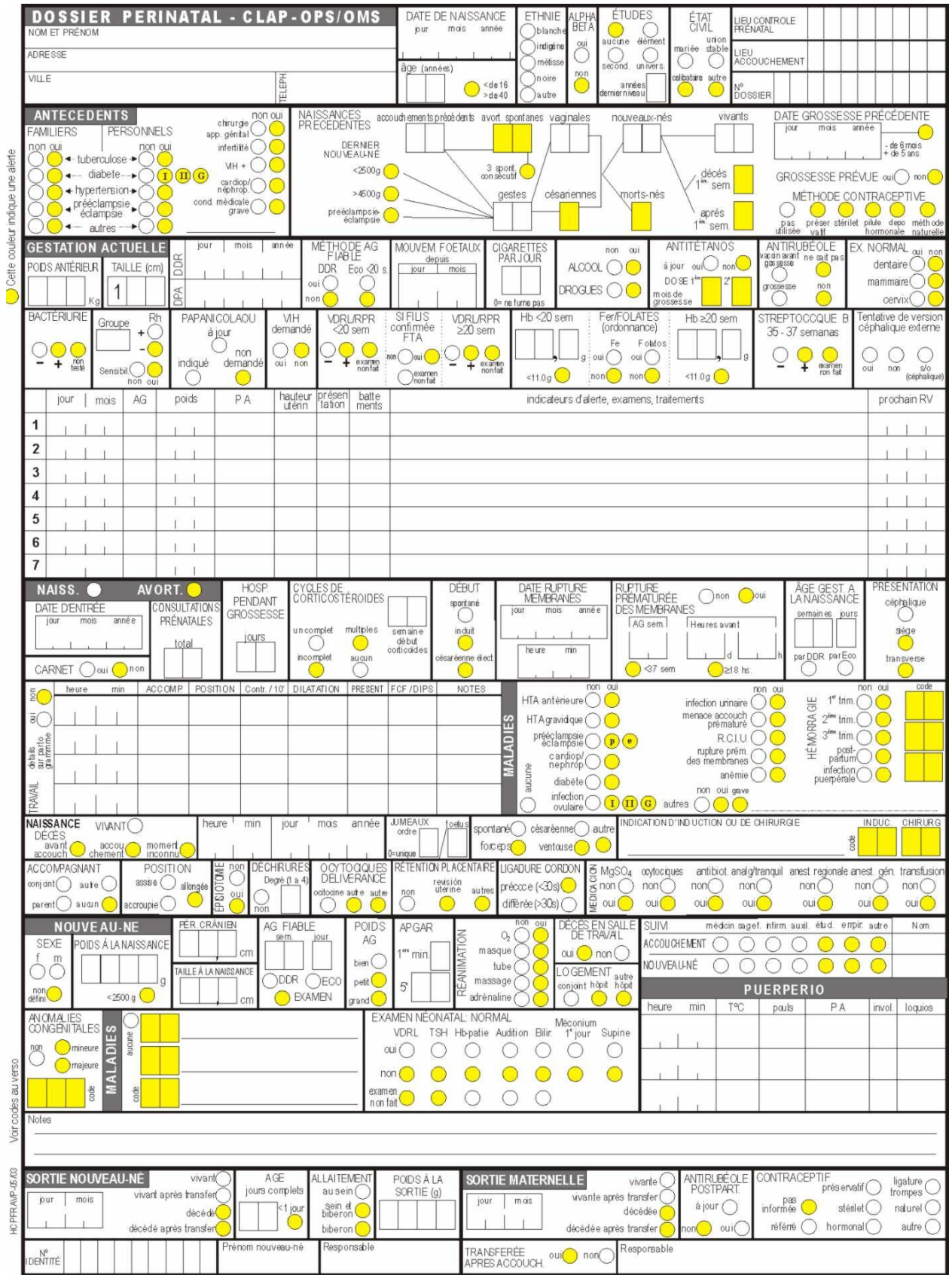

DOSSIER PERINATAL - CLAP-OPS/OMS
NOM ET PRÉNOM
ADRESSE
VILLE
TELEPH.
DATE DE NAISSANCE
jour mois année
âge (années)
<de 16
>de 40
ETHNIE
blanche
indigène
métisse
noire
autre
ALPHA BETA
oui
non
ÉTUDES
aucune élément
second. univers.
années dernier niveau
ÉTAT CIVIL
mariée union stable
célibataire autre
LIEU CONTROLE PRÉNATAL
LIEU ACCOUCHEMENT
N° DOSSIER
ANTECEDENTS
FAMILIERS
PERSONNELS
non oui
tuberculose
diabete
I II G
hypertension
prééclampsie éclampsie
autres
chirurgie
app. génital
infertilité
VIH +
cardiop/ néphrop.
cond. médicale grave
NAISSANCES PRECEDENTES
accouchements précédents
avort. spontanes
vaginales
nouveaux-nés
vivants
DERNIER NOUVEAU-NÉ
<2500g
>4500g
prééclampsie éclampsie
3 sport. consécutif
gestes
césariennes
morts-nés
décès 1ère sem
après 1ère sem
DATE GROSSESSE PRÉCÉDENTE
jour mois année
- de 6 mois
+ de 5 ans
GROSSESSE PRÉVUE oui non
MÉTHODE CONTRACEPTIVE
pas utilisée préser vatif stérilet pilule hormonale depo méthode naturelle
Cette couleur indique une alerte
GESTATION ACTUELLE
POIDS ANTÉRIEUR
Kg
TAILLE (cm)
1
DDR
DPA
jour mois année
MÉTHODE AG FIABLE
DDR Eco <20 s.
oui
non
MOUVEM FOETAUX
depuis
jour mois
CIGARETTES PAR JOUR
0= ne fume pas
non oui
ALCOOL
DROGUES
ANTITÉTANOS
à jour oui non
DOSE 1ère 2e
mois de grossesse
ANTIRUBÉOLE
vaccin avant grossesse
ne sait pas
grossesse
non
EX. NORMAL oui non
dentaire
mammaire
cervix
BACTÉRIURIE
non testé
Groupe
Rh
Sensibil.
non oui
PAPANICOLAOU
à jour
indiqué
non demandé
VIH demandé
oui non
VDRL/RPR <20 sem
examen non fait
SIFILIS confirmée FTA
non oui
examen non fait
VDRL/RPR ≥20 sem
Hb <20 sem
<11.0 g
Fer/FOLATES (ordonnance)
Fe
Folates
oui non
Hb ≥20 sem
STREPTOCOQUE B 35 - 37 semanas
examen non fait
Tentative de version céphalique externe
oui non s/o (céphalique)
jour mois AG poids P.A hauteur utérin présen tation batte ments indicateurs d'alerte, examens, traitements prochain RV
1
2
3
4
5
6
7
NAISS.
AVORT.
DATE D'ENTRÉE
jour mois année
CARNET oui non
CONSULTATIONS PRÉNATALES
total
HOSP. PENDANT GROSSESSE
jours
CYCLES DE CORTICOSTÉROIDES
un complet multiples
incomplet aucun
semaine début corticoides
DÉBUT
spontané
induit
césarienne élect.
DATE RUPTURE MEMBRANES
jour mois année
heure min
RUPTURE PRÉMATURÉE DES MEMBRANES
non oui
AG sem.
Heures avant
d h
<37 sem
≥18 hs.
ÂGE GEST. A LA NAISSANCE
semaines jours
par DDR par Eco
PRÉSENTATION
céphalique
siège
transverse
non
oui
détails sur partogramme
TRAVAIL
heure min ACCOMP. POSITION Contr. /10' DILATATION PRESENT FCF /DIPS NOTES
MALADIES
aucune
HTA antérieure
HTA gravidique
prééclampsie éclampsie
p e
cardiop/ néphrop
diabète
infection ovulaire
I II G autres
infection urinaire
menace accouch prématuré
R.C.I.U.
rupture prém. des membranes
anémie
non oui grave
HÉMORRAGIE
1er trim.
2ème trim.
3ème trim.
post-partum
infection puerpérale
code
NAISSANCE
VIVANT
DÉCÈS
avant accouch
accou chement
moment inconnu
heure min jour mois année
JUMEAUX
ordre
0=unique
jumeau
spontané césarienne autre
forceps ventouse
INDICATION D'INDUCTION OU DE CHIRURGIE
INDUC.
CHIRURG.
code
ACCOMPAGNANT
conjoint autre
parent aucun
POSITION
assise allongée
accroupie
EPISIOTOMIE
non oui
DÉCHIRURES
Degré (1 à 4)
non
OCYTOCIQUES DÉLIVERANCE
ocitocine autre autre
RÉTENTION PLACENTAIRE
non
révision utérine
autres
LIGADURE CORDON
précoce (<30s)
différée (>30s)
MEDICATION
MgSO4
oui
oxytociques
antibiot.
analg/tranquil
anest regionale
anest. gén.
transfusion
NOUVEAU-NÉ
SEXE
f m
non défini
POIDS À LA NAISSANCE
g
<2500 g
PÉR. CRÂNIEN
cm
TAILLE À LA NAISSANCE
cm
AG FIABLE
sem. jour
DDR ECO
EXAMEN
POIDS AG
bien
petit
grand
APGAR
1ère min.
5'
RÉANIMATION
non oui
O2
masque
tube
massage
adrénaline
DÉCÈS EN SALLE DE TRAVAIL
oui non
LOGEMENT
conjoint hôpit autre hôpit
SUIVI
médecin sage-f. infirm. auxil. étud. empir. autre
Nom
ACCOUCHEMENT
NOUVEAU-NÉ
PUERPERIO
heure min T°C pouls P.A invol. loquios
ANOMALIES CONGENITALES
non
mineure
majeure
code
MALADIES
aucune
code
EXAMEN NÉONATAL: NORMAL
VDRL TSH Hb-patie Audition Bilir. Méconium 1er jour Supine
oui
non
examen non fait
Notes
Voir codes au verso
SORTIE NOUVEAU-NÉ
jour mois
vivant
vivant après transfert
décédé
décédé après transfert
AGE
jours complets
<1 jour
ALLAITEMENT
au sein
sein et biberon
biberon
POIDS À LA SORTIE (g)
SORTIE MATERNELLE
jour mois
vivante
vivante après transfert
décédée
décédée après transfert
ANTIRUBÉOLE POSTPART.
à jour
non oui
CONTRACEPTIF
préservatif
pas informée
stérilet
référé
hormonal
ligature trompes
naturel
autre
N° IDENTITÉ
Prénom nouveau-né
Responsable
TRANSFERÉE APRES ACCOUCH.
oui non
Responsable
HCPFRAVP-05/03

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

CERTIFICAT / CONSTAT DE DECES

CARACTERISTIQUES DU DEFUNT

Nom _____ Prénom _____

Sexe : F ☐ M ☐ Age Ans ☐☐ Mois ☐☐ Jours ☐☐ Date de naissance Jour ☐☐ Mois ☐☐ Année ☐☐☐☐

Résidence: Département _____ Commune _____

Habitat : urbain ☐ rural ☐

Etat matrimonial _____ Occupation _____ Décès maternel: OUI ☐ NON ☐

LIEU DU DECES

Extra-institutionnel ☐ Institutionnel ☐

Si extra-institutionnel : Domicile ☐ Autre ☐ Préciser _____

Si institutionnel: Institution _____ Service _____

Durée d'hospitalisation (en jours) _____ Dossier No ☐☐☐☐☐

Le défunt a-t-il été vu par un personnel de santé au cours de cette maladie?

OUI ☐ NON ☐

Si OUI, remplissez le certificat ou constat

Si NON, remplissez la case ci-dessous

CERTIFICAT ☐ CONSTAT ☐ DE DECES

Prénom NOM

Je soussigné, _____

Médecin ☐ Infirmière ☐ Autre ☐ _____

certifie par la présente que la personne identifiée ci-dessus

est décédée

le ☐☐ ☐☐ ☐☐ (Jour Mois Année) à ☐☐ . ☐☐ AM ☐ PM ☐ (Heure)

CAUSE DU DECES

I Maladie ou affection morbide ayant directement provoqué le décès — a) _____

due à (ou consécutive à)

Antécédents — b) _____

Affections morbides ayant éventuellement conduit à l'état précité, l'affection initiale étant indiquée en dernier lieu — due à (ou consécutive à) c) _____

II Autre état morbide important ayant contribué au décès mais sans rapport avec la maladie ou l'état morbide qui l'a provoqué _____

Signature _____

Adresse _____

Téléphone _____

MSPP, DECEMBRE 1998

Source d'information

Famille ☐

Police ☐

Pompes funèbres ☐

Autre ☐

Circonstances du décès:

Moyen(s) de confirmation du diagnostic:

Examens paracliniques ☐

Chirurgie ☐

Autopsie ☐

PERMIS D'INHUMER: N° ☐☐☐☐☐

CODE CIM-10 ☐☐☐☐

RAMOS

KARAKTERISTIK JENERAL

Bonjou. Mwen konnen ke-w sot pèdi yon moun ki chè anpil pou ou. Mwen prezante-w bon jan kondoleyans ki soti nan fon kè-m. Mwen ta renmen pose-w de twa ti keksyon sou maladi ak lanmò moun ou sot pèdi-a. Mwen pa konnen si sa ap deranje-w. Eske ou ka rakonte-m nan ki sikonstans li mouri ?

Non moun ki mouri a _____

Dat ke li mouri : _____

Non moun ka reponn kesyon yo : _____

Sa li ye pou moun ki mouri a : 1-mari, 2-manman, 3-papa, 4-frè, 5-sè, 6-matant, 7-tonton, 8, vwazen, 9-lòt _____

Adrès kote li abite : _____

1. Depatman : ☐ 1
1 Grand'Anse 2 Centre 3 Artibonite 4 Ouest 5 Nord 6 Nord-Est 7 Nord-Ouest 8 Sud 9 Sud-Est 10 Nippes

2 a Komin : ☐ 2
1-Jeremie, 2-Moron, 3-Roseaux

b Seksyon Kominal ☐ 3
1ere , 2ème, 3ème, 4ème, 5ème 6ème, 7ème, 8ème, 9ème

3. Nimero dosie-l : ☐☐☐☐ 4-7

4. Dat ke li mouri : ☐☐☐☐☐☐ 8-13

5 Date chita pale a : ☐☐☐☐☐☐ 14-19
jou Mwa Ane

6 Ki laj li te genyen? ☐☐ 20-21

7. Ki dènye klass li te fè lekol? ☐☐ 22-23

8. Ki dènye klass mari-l te fè lekol? ☐☐ 24-25

9. Eske ou marye? ☐ 26
1 pa janm marye 2 mary 3 plase 4 vev 5 divose

10. Ki travy ou fe? ☐ 27
1 en chomaj 2 travay pou lajan 3 pa travay pou lajan 4 ki lot djob

11. Avek kisa atè andedan kay la fèt? ☐ 28
1 siman 2 mozayik 3 tè 4 ki lot bagay

12. Avek kisa tèt kay la kouvri? ☐ 29
1 fèy tòl 2 beton 3 pay 4 ki lot bagay

13. Eske you gen latrinn nan kay ou? ☐ 30
0-non, 1-wi

14. Ki kote ou jwen dlo pou bwè ☐ 31
1 pi 2 pi kouvri 3 pi kip a kouvri 4 rivyè 5 sous kip a kapte 6 sous kapte 7 ki lòt

15. Eske li te kon fimen? ☐ 32
0-non, 1-wi, 2-pa konin

16. Eske-l kon chike tabak? ☐ 33
0-non, 1-wi, 2-pa konin

17. Ki kote li mouri? ☐ 34
1 lopital 2 lakay li 3 lòt kote

18. Si li pat mouri lopital, eske lit e we yon moun ki gen konesans sou zafe lasante le li te malad la? ☐ 35
1 doktè 2 enfimyè 3 oksilyè 4 ajan sante 5 yon lòt

19. Kombyen timoun vivan li kite? ☐☐ 36

20. Ki laj dènye piti li genyen? 00-pi ba ke yon ane, 99-pa konin ☐☐ 37-38

21. Eske li te tombe ensent depi dènye pitit sa te fèt? 0-non, 1-wi, 2-pa konin/ dat gwosès _____ ☐ 39

22. Konbyen pitit vivan li te fè? ☐☐ 40-41

23. Konbyen timoun tou mouri li te fè? ☐ 42

24. Konbyen fos kouch li te fè? ☐ 43

25. Konbyen avòtman li te fè? ☐ 44

26. Total gwosès *(byen komte konbyen)* ☐☐ 44-45

27. Eske li te kon swiv yon metòd planin? ☐ 46

28. Apre dènye fwa li te ansent la eske limenm oswa mari'l te kon swiv yon metòd planin? ☐ 47
0-non, 1-wi, 2-pa konin

29. Si se vre, ki metòd : ☐☐ 48
1-ligati tronp, 2-esterilè, 3-grenn, 4-piki, 5-kapòt, 6-krèm, 7-dyafrag, 8-grenn nan vajen, 9-enplan, 10-MAMA, 11-glè 12-colier, 13-lot bagay _____

30. Eske li sispan metòd la depi li tonbe ensant? ☐ 49
0-non, 1-oui, 2-pa konin

31. Ki lè li sispan itilize metòd planin ☐☐☐☐ 50-51
Mwa Ane

32. Depi konbyen mwa li pat swiv metòd sa ankò? 98-li pat sispan, 99-pa konin ☐☐ 52-53

International Fertility Research * Research Triangle Park, North Carolina 27709 USA
Badan Koordinasi Keluarga Berencana Nasional * Jalan Raya Puputan-Denpasar, Bali
Translated into Haitian Creole by HHF jul 04

KEKSYONÈ SOU SIY YO

6 a. Eske-w konnen ki maladi ki tye _____ ? 0-non, 1-wi
Se te kisa ? _____

7 a. Konbyen tan maladi sa te fè sou li anvan-l mouri ? *
b. Eske li te pote li byen anvan sa ? 0-non, 1-wi, 2-mwen pa konnen

8. Depi kilè li pa te ka fè okenn travay ? *
9. Pandan maladi (oubyen aksidan) ki reskonsab lan mò li-a, èske gen doktè, enfimyè oubyen ajan sante ki te konsilte-l ? 0-non, 1-wi, 2-mwen pa konnen
Kiyès ? 0-ajen sante, 1-doktè, 2-infimyè, 3-matron, 4-medsen fèy, 5-oksilyè, 6-lot moun, 7-pakonin
Ki Kote ? 0-dispensè, 2-post sante, 3-klinik, 4-lopital, 5-lakay, 6-lot kote, 7-pa konin

Kounye-a mwen pral poze-w keksyon sou tout sentom ke li ta sipoze genyen anvan li te mouri. Dim ki senton ke li te genyen nan dènye bout maladi li-a.

10.a Eske li te gen doulè? 0-ale nan keksyon # 12 , 1-wi, 2-mwen pa konnen
b. Ki kote li te gen doulè-a? 1-tèt, 2-vant, 3-lestomak, 4-sen, 5-jamb, 6-amba ti vant, 7-lot, 8-pa konin
c. Konbyen tan doulè sa te dire ? *
Jouk lè li mouri ? 0-non, 1- wi, 2-mwen pa konnen
d. Depi kilè li te kòmanse gen doulè-a ? *

11.a Eske li te gen doulè lot kote? 0-ale nan keksyon # 12 , 1-wi, 2-mwen pa konnen
b. Kote li te gen doulè-a ? 1-tèt, 2-vant, 3-lestomak, 4-sen, 5-jamb, 6-amba ti vant, 7-lot, 8-pa konin
c. Konbyen tan doulè sa te dire ? *
Jouk lè li mouri ? 0-non, 1- wi, 2-mwen pa konnen
d. Depi kilè li te kòmanse gen doulè-a ? *

12a. Eske li tap senyen pa ba ? 0-non, 1-wi, 2-mwen pa konnen
b. Konbyen tan li te fè ap senyen anvan li mouri ? *
c. Lè li te mouri-a eske li tap senyen toujou ? 0-non, 1-wi, 2-mwen pa konnen
d. Eske san-an te tache rad li ? 0-non, 1-wi, 2-mwen pa konnen

13a. Eske li tap senyen yon lòt kote tou ? 0-non, 1-wi, 2-mwen pa konnen
b. Nan ki pati nan kò'l ? 1- bouch, 2- nin, 3-lot kote _____
c. Konbyen tan li te fè ap senyen la-a anvan li mouri ? *

èd tan	minit

d. Konbyen tan sa te dire ? *
Jouk lè li te mouri-a ? 0-non, 1-wi, 2-mwen pa konnen

14a. Eske li tap touse ? 0-non, 1-wi, 2-mwen pa konnen
b. De pi ki lè li te komanse touse anvan-l te mouri ?*
c. konbyen tan sa te dire ? *
Jouk lè li te mouri-a ? 0-non, 1-wi, 2-mwen pa konnen
d. Eske li tap krache ? 0-non, 1-wi, 2-mwen pa konnen
e. Eske te gen san nan krache li-a ? 0-non, 1-wi, 2-mwen pa konnen

* 0-mwens ke yon èd tan 1-mwens ke yon jou 2-1 a 7 jou 3-7 jou a 1 mwa 4-1 a 6 mwa 5-6 a 12 mwa 6-plis ke 1 an 7-mwen pa konnen

15a. Eske li te gen lafyèv ? 0-non, 1-wi, 2-mwen pa konnen
b. Eske-w ka di'n kile-w te remake sa premye fwa ? 0-non, 1-wi, 2-mwen pa konnen
c. Konbyen tan sa te dire ? *
Jouk lè li te mouri-a ? 0-non, 1-wi, 2-mwen pa konnen
d. Eske li te gen frison ? 0-non, 1-wi, 2-mwen pa konnen

16a. Eske-w te wè po-l bay yon ti Koulè dròl ? 0-non, 1-wi, 2-mwen pa konnen
b. Eske-l te pal? 0-non, 1-wi, 2-mwen pa konnen

c. Eske-l ta vle yon ti jan jòn? 0-non, 1-wi, 2-mwen pa konnen
d. Eske-l ta vle bay yon ti coulè ble? 0-non, 1-wi, 2-mwen pa konnen

17a. Eske-l te vomi ? 0-non, 1-wi, 2-mwen pa konnen
b. Depi konbyen tan sa te rive-l anvan-l te mouri ? *
c. Konbyen tan sa te dire ? *
Jouk lè li te mouri-a ? 0-non, 1-wi, 2-mwen pa konnen
d. Eske-l te bwe yon bagay dròl ? 0-non, 1-wi, 2-mwen pa konnen
e. Eske-l te vomi bon jan san ? 0-non, 1-wi, 2-mwen pa konnen

18a. Eske-l te gen dyare ? 0-non, 1-wi, 2-mwen pa konnen
b. Depi konbyen tan sa te rive-l anvan-l te mouri ? *
c. Konbyen tan sa te dire ? *
Jouk lè li te mouri-a ? 0-non, 1-wi, 2-mwen pa konnen

19a. Eske watè-l te nwa ? 0-non, 1-wi, 2-mwen pa konnen
b. Depi konbyen tan sa te rive-l anvan-l te mouri ? *
c. Konbyen tan sa te dire ? *
Jouk lè li te mouri-a ? 0-non, 1-wi, 2-mwen pa konnen
d. Eske-w te wè lòt bagay dròl nan watè-l ? 1-san, 2-mikis / glè, 3-pi, 4-likid fonse, 5-lòt bagay (di kisa) _____

20 Eske li te mal pou pipi ? 0-non (al nan keksyon #25), 1-wi, 2-mwen pa konnen,

21a. Li pa-t ka pipi menm ? 0-non, 1-wi, 2-mwen pa konnen
b. Depi konbyen tan sa te rive-l anvan li te mouri ? *
c. Konbyen tan sa te dire ? *
Jouk lè li te mouri-a ? 0-non, 1-wi, 2-mwen pa konnen

22.a Eske-l te pipi souvan ? 0-non, 1-wi, 2-mwen pa konnen
b. Depi konbyen tan sa te rive-l anvan-l te mouri ? *
c. Konbyen tan sa te dire ?*
Jouk lè li te mouri-a ? 0-non, 1-wi, 2-mwen pa konnen

* 0-mwens ke yon èd tan 1-mwens ke yon jou 2-1 a 7 jou 3-7 jou a 1 mwa 4-1 a 6 mwa 5-6 a 12 mwa 6-plis ke 1 an 7-mwen pa konnen

23a. Eske-l te konn soufri lè l'ap pipi ? 0-non, 1-wi, 2-mwen pa konnen
b. Depi konbyen tan sa te rive-l anvan-l te mouri ? *
c. Konbyen tan sa te dire ? *
Jouk lè li te mouri-a ? 0-non, 1-wi, 2-mwen pa konnen

24a. Eske-l te konn pipi san ? 0-non, 1-wi, 2-mwen pa konnen
b. Depi konbyen tan sa te rive-l anvan-l te mouri ? *
c. Konbyen tan sa te dire ? *
Jouk lè li te mouri-a ? 0-non, 1-wi, 2-mwen pa konnen

25a. Eske-l te konn santi-l fatige souvan ? 0-non, 1-wi, 2-mwen pa konnen
b. Eske-w ka di nou kile-w te remake sa premye fwa? *
c. Konbyen tan sa te dire ? *
Jouk lè li te mouri-a ? 0-non, 1-wi, 2-mwen pa konnen

26a. Eske-l te pèdi pwa ? 0-non, 1-wi, 2-mwen pa konnen
b. Eske-w ka di nou kile-w te remake sa premye fwa ? *

c. Eske-l te pèdi anpil pwa ? 0-non, 1-wi, 2-mwen pa konnen

27a. Eske-l te gen kote lan ko-l ki te anfle ? 0-non, 1-wi, 2-mwen pa konnen
b. Ki kote ? 1-vant, 2-fas, 3-janm/pye, 4-fas/janm/pye, 5-lòt kote (di kibò) _____
c.. Eske-w ka di nou kile-w te remake sa premye fwa ? *
d. Konbyen tan sa te dire ? *
Jouk lè li te mouri-a ? 0-non, 1-wi, 2-mwen pa konnen

28a. Eske-w te wè souf li kout ? 0-non, 1-wi, 2-mwen pa konnen
b. Eske-w ka di nou kile-w te remake sa premye fwa ? *
c. Konbyen tan sa te dire ? *
Jouk lè li te mouri-a ? 0-non, 1-wi, 2-mwen pa konnen

29 Eske-l te soufri maladi opresyon ? 0-non, 1-wi, 2-mwen pa konnen

30a. Eske-l te gen yon men oswa yon pye ki te mòlòlòs ? 0-non, 1-wi, 2-mwen pa konnen
b. ki kalite ? Janm dwat ? 0-non, 1-wi, 2-mwen pa konnen
Janm goch ? 0-non, 1-wi, 2-mwen pa konnen
Bra dwat ? 0-non, 1-wi, 2-mwen pa konnen
Bra goch ? 0-non, 1-wi, 2-mwen pa konnen

c. Depi konbyen tan sa te rive-l anvan-l te mouri ? *
d. Konbyen tan sa te dire ? *
Jouk lè li te mouri-a ? 0-non, 1-wi, 2-mwen pa konnen

* 0-mwens ke yon èd tan 1-mwens ke yon jou 2-1 a 7 jou 3-7 jou a 1 mwa 4-1 a 6 mwa 5-6 a 12 mwa 6-plis ke 1 an 7-mwen pa konnen

31a. Pandan maladi-l la, eske-l konn endispoze ? 0-non, 1-wi, 2-mwen pa konnen
b. Konbyen fwa ? (bay yon chif) _____, 96-ampil fwa, 97-okin fwa, 98-pa konen
c. Eske-l konn pèdi konsyans ? 0-non, 1-wi, 2-mwen pa konnen
d. Eske-l konn gen kriz oubyen latranblay ? 1-latranblay, 2-kriz, 3-anyen menm

32 Eske-l konn gen maladi tonbe ? 0-non, 1-wi, 2-mwen pa konnen

33a. Eske yo te konn di-l ke li fè tansyon? 0-non, 1-wi, 2-mwen pa konnen
b. Kiyès ki te konn di-l sa ? 1-doktè, 2-moun ki fòme pou sa, 3-lòt moun (di kiyès)
c. Depi konbyen tan ? *

34a. Eske-l te ansent lè li mouri-a ? 0-non, 1-wi, 2-mwen pa konnen
b. Konbyen mwa li te genyen ? (bay yon chif) _____, (al nan keksyon # 37)

35a. Eske li te fenk ansent ? (6 semèn ou pi piti) 0-non, 1-wi, 2-mwen pa konnen
b. Kouman gwosès la te fini ? 1-li te akouche timoun vivan, 2-li te akouche timoun tou mouri, 3-li te fè fos couch, 4-yo te fè-l fè avòtman
c. Eske-l te pèdi anpil san ? 0-non, 1-wi, 2-mwen pa konnen
d. Konbyen tan li fè ap viv aprè ke li pa te ansent ankò-a pou yon rezon oubyen pou yon lòt ? 1-mwens ke 6 semèn 2-6 semèn a yon ane 3-plis ke yon ane

36. Ki dènye fwa li te gen règ li ? (semèn)_____, 96-menopoz, 97-pa jan te rete, 98-pa kon gen règ li, 99-pa konen

37 Eske-l te fè operasyon deja ? 0-non, 1-wi, 2-mwen pa konnen

Ki operasyon	Nan ki lopital	Depi kilè ?*

38a. Eske gen lòt bagay ki gen rapò ak maladi li te genyen-an ke nou pa di ? 0-non, 1-wi

b. Se kisa ? _____

39. Kouman moun kap poze keksyon-an wè kalite enfòmasyon yo : 1-bon, 2-pasab, 3-move, 4-li pa konn sa pou-l di

40. Non moun ki tap poze keksyon yo : _____

* 0-mwens ke yon èd tan 1-mwens ke yon jou 2-1 a 7 jou 3-7 jou a 1 mwa 4-1 a 6 mwa 5-6 a 12 mwa 6-plis ke 1 an 7-mwen pa konnen

SAMPLE
Format for Summary of Maternal Death Investigation

Summary----Case Number (year - ##)

Date of Death: _____

Location of Death: (Inpatient in hospital, at home, on the road) _____

Marital Status: _____

Gestation Age: _____

Religion: _____

Death Occurred: (pre-delivery, post delivery, number of days, etc) _____

Past Medical History: _____

Prenatal Care: _____

Clinical Course and Management: _____

Final Diagnosis: _____

Autopsy Findings: _____

Maternal Mortality Study Medical Review Committee Findings page 1

Case Number _____

XVII. Classification

Pregnancy Related The death of a woman while pregnant or within 365 days of termination of pregnancy irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by her pregnancy or its management but not from accidental or incidental causes.

Pregnancy Associated The death of a woman while pregnant or within 365 days of termination of pregnancy irrespective of causes.

Undetermined

XVIII.

XIX.

XX. Responsibility and Preventability

To what degree was death preventable (If preventable, describe prevention activities on back of page)

Definitely Probably Probably not Not at all Unsure Insufficient Information

Attending Physician 1. Error in Judgment 2.Error in technique 3.Undetermined 4.None 5. N/A

Describe: _____
_____

Consulting Physician 1. Error in Judgment 2.Error in technique 3.Undetermined 4. None 5. N/A

Describe: _____
_____

Patient 1. Yes 2. No
Describe: _____
_____

Hospital 1. Yes 2. No
Describe: _____
_____

Community 1. Yes 2. No
Describe: _____
_____

Maternal Mortality Study Medical Review Committee Findings page 2

Committee Cause of Death

_____
_____
_____
_____
_____
_____

Committee Findings – Recommendation for Prevention

_____
_____
_____
_____
_____
_____
_____

MATERNAL MORTALITY STUDY PREVENTION SUMMARY

PROPOSED PREVENTION ACTIVITIES

1.Advocacy: Describe:

2. Legislation, Law or ordianance: Describe:

3. Community Safety Project: Describe

4. Product Safety Action: Describe:

5.Professional Education: Describe:

6. Educational Activity in Schools: Describe:

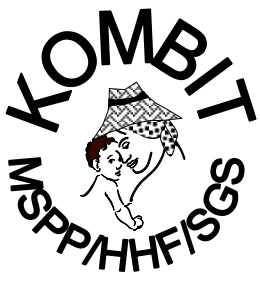
7. Educational Activities in the Media: Describe:

8. Public Forums: Describe:

9. New Services: Describe:

10.Changes In Agency Practice: Describe:

11. Other Programs or Activities: Describe:



EXIT INTERVIEW

HHF Villages from post or Center –qty month's intervals

Date	

Mother name & ID	

Interviewer name	

Ask post-partum client:

Did Health Agent visit you after baby was born? O yes O no

How many days after child was born? _____ of days

Did he/she examine baby? O yes O no

Did he/she examine you? O yes O no

Did he/she give you advice? O yes O no

If yes, what advice: _____

_____

_____

_____

Do you understand the LAM method? O yes O no

If yes, explain: _____

_____

_____

_____

NEWBORN ASSESSMENT
EVALYASYON TI BEBE KI FENK FET

Siy Vital Batman kè _____ Tanperati _____ Vitès respirasyon _____	Aparans jeneral Li eveye/actif O wi O non Li gen kò lage O wi O non Lap dòmi O wi O non Lap fè degoutan O wi O non Li kontan O wi O non
Po li : bon kondisyon O wi O non Koulè ya (bon, pal, jòn) O wi O non Tanperati (tiyèd, fre) O wi O non Imidite (sèch, soupl) O wi O non Gratèl (wi, non) O wi O non Ki bò gratèl leve sou li _____	Tèt Zo tèt li: plat, gonfle, fè twou Zorey li: kanal louvri/li pa louvri Je li: klè, drenaj Blan je ya (blan, jòn)
XXI. Bouch Rele: (fò, piti, vwa pike) po bouch: (imid, sèk) lang: (bouje facil, pa ka deplase) Plafon bouch: (bon kondisyon, defòme)	Pwatrin Aspè: Byen proposyone, yon bò pi gwo Zo na zèpol: byen aliyin, leve Tete li: nòmal, gonfle, ap bay pi
Vant Aparance: ron, retonbe, di, mou Lombrit kòd la tache, kòd tombe, pwop, imid, sèch, by odè, irite, koule	
Aparey jenital ti gason Kanal: twou a nan mitan, pa nòmal Gren: byen desann (sa a dwat, sa a gòch) Pipi: wi, non Twalèt: wi, non XXII.	Aparey jenital ti fi Lèv: gonfle, ap fè pi Pipi: O wi O non Twalèt: O wi O non
Extremite Bouje bra ak jamb: O wi O non Men: tout dwèt la, manke dwèt Pie: tout zòtey la, manke zòtey Bouje ranch: O wi O non Pliye jamb: mem longè, pa mem longè Batman kè nan ranch (artè femoral): presan, absan	
Kolòn vètebral **rèl dò:** O**drèt,** O**koube,** O**louvri,** O**fèmen**	**Reflèx.** Sezi: O wi O non Souse: O wi O non Pouse: O wi O non Fèmen men: O wi O non Pliye pie: O wi O non

Alètman matènèl	Satisfè	Pa satisfè
Rale lèt la byen		
Manman genyen lèt		
Kombyen fwa bebe tete – q 4 hrs		
Komantè:		

MATERNITÉ SANS RISQUE

SDM QUARTERLY REPORTING

Reporting Period: _____

The purpose of this part of the report is to track the types and numbers of providers [employed in your organization or your partner organization(s)] that implementing organizations have trained to provide the SDM.

Column 1	Partners			Collaborators			Column 2	Column 3
Types of Providers	MSPP	HHF	SGS	MDM			Number of trained provider by category	Number of active providers
Physician								
Nurses/Auxiliary nurses								
Midwives (trained)								
Family planning counselors/Health promoters								
Community Health workers/CBD								
Community Health mobilizers								
Non health NGO								
Other								

ANNEX VX- KPC Narrative Report

KOMBIT KPC SURVEY METHODS AND RESULTS

During December, 2004, KOMBIT launched two surveys. One survey assessed the physical state, resources, range of services and activity levels of eight health facilities that are managed by the three KOMBIT Partners: UCS 2, Sisters of the Good Shepherd and HHF. The other survey assessed prevalence of health-related knowledge, frequency of health-related behaviors and coverage rates for selected health services.

KPC Survey

KOMBIT interviewed mothers using a 22-page questionnaire; sampling 247 mothers of children aged 0-23 months living in UCS 2. In order to assure the geographic specificity of the survey results, the sample was drawn by lot quality assurance sampling (LQAS).

Questionnaire

The questionnaire used in this survey was the *Knowledge, Practices and Coverage Survey 2000+*, developed by Donna Espeut of the Child Survival Technical support Project. The questionnaire was translated into French and Creole and administered in the Creole language. It included:

1. An informed consent form
2. Identity and address of the interviewee
3. General characteristics of the interviewee's family
4. Breast feeding and other nutritional care of the interviewee's youngest child
5. Care and medication received by the mother before, during and after delivery, including place of delivery and identity of care-givers in attendance
6. Care received by the new-born child at delivery and during the weeks following delivery, including puerperal care and post-partum education of the mother.
7. Birth history of the mother, mother's knowledge of birth spacing and of how to care for her baby
8. Mother's knowledge and current use of family planning methods
9. Mother's sources of Health Information
10. All the "Rapid CATCH" questions which included actually weighing the interviewee's child, recording its weight and:
    - Copying the child's vaccination history from the "road to health" card
    - Asking whether or not the family uses a mosquito net
    - Recording the child's history of recent illnesses and of care he/she received during his/her illness
    - Asking about the mother's knowledge of AIDS
    - Asking the interviewee when she washes her hands

A field test of the questionnaire's first Creole version, performed by three experienced Haitian surveyors, found that several questions were not understood by the interviewees and that some of the skip instructions were not understood by the surveyors. Senior staff members from each of KOMBIT's three Partner organizations then reviewed and commented on the questionnaire. A final Creole version was then created in a meeting of five senior Haitian surveyors and one Haitian physician.

Training

Eleven Haitian surveyors were trained in the use of the questionnaire. All trainees spoke Creole as their first language. Some were nurses and some were senior Health Auxiliaries or Health Agent Supervisors. All had many years of experience and all had worked as interviewers in previous surveys. Training was conducted during one day, using adult education methods, by a Haitian Physician with 16 years of experience in Community Health with the Haitian Health Foundation.

Population size and geographic distribution

MSPP's Grand'Anse District Office of Statistics provided the only information available concerning the size and distribution of UCS 2's population. UCS 2 includes the *communes* (counties) of Jeremie, Roseaux. Trou Bonbon and Abricots. Three of the counties are subdivided into 17 county sections. Trou Bonbon County, on the contrary, has a small population and is not subdivided. The Office of Statistics supplied county-section specific lists of all villages in the UCS 2, estimated population sizes for each county section, and an estimated population size for County Trou Bonbon. No information was available on the estimated population sizes or geographic positions of any of the villages on the lists provided by the Statistics Office.

Sampling design

As geographic positions and population sizes are unknown for UCS 2 villages, a clear method for selecting clusters of households at geographic intervals, based on probability proportional to population size was not possible. The Interim KOMBIT Director, who also served as the onsite KPC consultant, therefore chose to use Lot Quality Assurance (LQAS) as the survey sampling method. The method facilitates the acquisition of geographically specific information. It is especially helpful in identifying geographic areas where vaccine coverage, health knowledge or access to health services is especially deficient.

As the lots and sample sizes are ordinarily of very manageable sizes, repeated monitoring of the same lot in the future is feasible from the standpoint of time and expenses. Most of UCS 2 is characterized by sparse distribution of health facilities and a topography that presents many barriers between villages and health facilities. Thus, there is great diversity in coverage rates, etc. between the lots. LQAS makes this geographic diversity immediately and quantitatively accessible to project planners, priority setters, monitors and evaluators.

The Interim KOMBIT Director chose to designate existing administrative and geographic divisions, i.e., county sections, as lots; and individual villages as sampling units. Only one woman-child pair was interviewed in each village, thus assuring that the interviewees would be geographically dispersed within their lots. The Interim KOMBIT Director then chose a sample size of 19 villages to be randomly chosen from each lot.

UCS 2's county sections vary in population size from 4,796 to 11,975 persons. KOMBIT paired ten small, contiguous county sections to create five large lots. Thus seventeen county sections and Trou Bonbon County were consolidated into 13 geographically distinct lots with population sizes varying from 8,900 to 15,617 persons. Although UCS 2 includes the town of Jeremie, KOMBIT does not include the population of Jeremie in its projected activities to improve women's geographic access to health care. Jeremie already contains the District and Reference Hospital and most other health facilities that are available in Grand'Anse.

Randomization and selection of villages

The village names, from one lot-specific list provided by the Statistics Office, were placed in a hat, mixed well, and 19 village names were drawn, randomly, from the hat. This procedure was repeated for each of the lots, in turn. Counties Abricots and Trou Bonbon each contained a town with a population size equal to 10% of its population size. Accordingly, these two villages were each entered twice in the drawing. Trou Bonbon was drawn twice, Abricots was drawn only once.

After the drawing, each of the villages was assigned to a specific surveyor among the 11 trained surveyors. The surveyors were transported by vehicle to the county section of their village of destination, where they found guides whom they could pay to lead them to their designated village. Upon arrival in the designated village, the surveyor selected, in a random manner, the first house to approach. If no woman with a child aged 0-23 months was present in that house, the surveyor chose (an) alternative, neighboring house (s) in a systematic manner until an appropriate interviewee was found.

Conduct of the Survey

Only one mother of a 0-23 month old child was interviewed in each of the 19 villages in each of the 13 lots, making a total of 247 interviews. The interviews were completed over a nine week period as the conduct of the survey was interrupted by a year-end vacation period of two weeks, two national holidays, and several days of rain. Questionnaires were field-checked by a senior Haitian Supervisor and then given to the Interim Director of KOMBIT for review before being filed for the data-entry process.

Quality control procedures

The Supervisor and the Director detected several errors in the completed questionnaires and required each surveyor who committed an error to correct it. A few of the surveyors were required to return to the village to correct or complete the information on their questionnaires. The most frequent error was failure to skip questions that should have been skipped, failure to specify the distances from the village to the nearest health facility and errors in filling in the child-spacing tables. One of the surveyors had to find another interviewee in a village where she had first chosen a mother whose child was already 24 months old. Another surveyor was inadvertently assigned to the same village in which another surveyor had completed an interview three weeks earlier. Another surveyor found the right village, but was in the wrong lot: two lots had villages of the same name.

All data was entered in SPSS V. 12 (Statistical Package for the Social Sciences). It was entered twice by two separate people and checked for inconsistencies. These were corrected by returning to the original questionnaires. In a couple of instances, an interviewer had to be sent to the village to correct the data.

Results

There were no refusals to participate in the KPC. The 247 women in the KPC had an average age of 28.8 (range 16-49). Their educational levels were none (32%), grades 1-6 (47%) and grades 7 and higher (22%). Almost half (47%) worked outside the home, primarily in farming and commerce. Most women lived with the father of the child (66%). The children ranged in age between 2 days and 24 months (average age 9.9 months); 54% of the children were male. In terms of FP, 48% have only one child, 82% do not want another child (at least soon). With only 24% using contraception, there is a high unmet need for FP.

The table on the next page shows the overall KPC baseline and the range of variation by LOT for each of the primary KOMBIT Objectives. There was no significant difference in age of mother or child, education of mother, presence of father in the home, mother working outside the home or designated head of household between Lots so these are unlikely to be factors in Lot differences for objectives.

KOMBIT Objectives (Percentage of women refers to percentage of women with a child less than 2)	Baseline in UCS2	Range Between LOTS
Maternal/Newborn		
Percentage of women with 4 or more prenatal visits	26% Mean 2.1	11% - 37% Mean 1.2-3.5
Percentage of women who reported that they had received prenatal breastfeeding information and child spacing info	Breastfeeding 56% Child Spacing 50%	26-80% 31-63%
Percentage of women who were immunized to tetanus (2+ doses of tetanus toxoid)	32%	5-68%
Percent of women who can identify at least 2 danger signs of pregnancy	25% Mean .88	5-58% Mean .72-1.37
Percent of women who can identify at least 2 danger signs of post partum	9% Mean 1	0-16% Mean .7-1.5
Percent of women who can identify at least 2 newborn danger signs	20% Mean .8	0 - 37% Mean .26-1.4
Percent of women who received birth preparedness counseling	49%	26 - 68%
Percent of women who deliver with a skilled attendant	10%	0 – 32%
Percentage of neonates examined by health personnel within 72 hours of birth	8%	0-21%
Percentage of post partum women examined by health personnel within 72 hrs of birth	9%	0-21%
Percentage of women who said they would go to a hospital or health center if they had a danger sign of pregnancy	68%	37 - 95%
Percentage of mothers who could describe at least two methods of stopping a post partum hemorrhage	7% Mean .26	0-16% Mean .11 - .47
Breastfeeding		
Percentage of mothers who BF in the first hour of birth	69%	42-84%
Percentage of mothers with a child 6mo or less who had nothing but breast milk to eat in the last 24 hours	60%	25-88%
Child Spacing		
Percentage of mothers who complete LAM	UNK completion 4.5% using currently	0-16% currently using
Percentage of women using NFP methods	4.5%	0-16%
Percentage of women using any method of CS	24%	5-37%

The Rapid CATCH demonstrated similar variation between Lots. The percentage of women with a Mother's health card ranged from 42% to 95%, completed child vaccination ranged from 5% to 68%. The percent of children who were severely malnourished (Zscore 2 or more SD) ranged from 5% to 32%. There was only 1 ITN identified in

the KPC survey. The average child spacing between the last two children for those with two children or more was almost 30 months, this ranged from 20 to 35 months among Lots. Total number of appropriate hand washing practices ranged from .88 to 2.2 (1.6 overall). Total HIV prevention methods knowledge ranged from 1 to 2.6 methods (1.6 overall).

Discussion

As can be seen from the results presented above, there is considerable variation among Lots in this sample. This will provide useful information for planning, determination of selective interventions and monitoring progress towards meeting KOMBIT's objectives. KOMBIT is in the process of developing GPS mapping for the intervention area. The KPC data and supplemental surveys will mapped using GPS. This will provide systematic and valuable information for KOMBIT staff and partners to use in planning.

The KPC further demonstrated the need for the proposed interventions. While mothers report that they receive counseling, there is evidence that much work needs to be done to ensure that they understand the danger signs of various stages of pregnancy and for the newborn so that they can seek appropriate help. There is clearly a need to improve access and services for mothers and infants.

ANNEX IIIX
Responses to DIP reviewers comments

Comments		Responses
	Sustainability and Financial Matters	
1	How will the project be able to increase the % of HAs who are paid by MSPP, (given the MSPP's poor infrastructure)?	We are working with MSPP to help them work with the National MOH to increase funding for this activity. Based on the partners meeting, this seems to be a possibility
2	How the UCS 2 will integrate the mandated plan for referrals into the MSPP: is this reverse hierarchical order possible?	Yes, this process is possible. There have been several examples of ideas developed locally and then utilized nationally: RAMOS (Reproductive Age Mortality Survey) is being refined in KOMBIT for national application by the government epidemiologist; HHF has been asked to be national field training site for LAM, BF, SDM and community based treatment of ARI. A system of referral and counter-referral is officially in place, but is not fully functional. The development of the KOMBIT referral/counter-referral forms will make this a viable process. An innovative proposal for places that do not have village health agents is also included in KOMBIT, this will incorporate a village level birth report form.
3	Is all the staff of KOMBIT paid a 100% by the project?	The Human Resources table addresses KOMBIT paid staff and KOMBIT related staff (not paid by KOMBIT) and describes the amount of time and responsibilities.
4	Mother and father volunteers will be given food while they are on the road in appreciation of their work. Where will they stay?	These are day trips and the volunteers will receive food while in locations outside their home villages.
5	How are HAs mobilized? What incentives are there for them to do this work? How will skilled attendants and HAs travel to homes/villages?	HHF currently has resident, paid community health workers in Jeremie County. Many have been highly productive for over 15 years. They currently visit women in the post partum period within 9 days. This time frame will be shortened in the KOMBIT program. In areas where there are no village health workers, or where they are not resident in the villages of the KOMBIT work area, women's representatives will be engaged to refer them to the nearest clinic for care. Nurses do not make home visits.
6	It is unclear what is meant by "Standard Grant" on p. 8, second paragraph. This is a "new/entry" project. Likewise, the reference to "its mission funded child survival project" is not clear in the third	This is a New Child Survival Grant, the wording was incorrect. HHF has had a USAID Mission funded child survival project since September 1987. This covers 30% of the cost of maternal child development projects at HHF. Programs that receive some support from mission funding include basic perinatal care, EPI

	paragraph. This is a centrally-funded project. Does HHF have a mission-funded child survival project? If so, this is not described elsewhere in the document.	for women and children, Vitamin A and multi-vitamins, IMCI and ARI, BF staffing support and ORS, supervision and support of TBAs, STIs, FP and BCC and a small PTMCT counseling and treatment program. Private funding supports the rest of MCH and many other health and development programs.
7	The DIP is missing an estimate of person/days spent preparing the DIP, although a detailed timeline is provided.	1647 total person were devoted to planning, data collection, writing, workshops and meetings related to the DIP.
8	The total number of international trips seems high, as the number remains the same through all five years of the project.	This is what the project has determined necessary.
9	Regarding sustainability, HHF might consider conducting a more systematic assessment, like the approach recommended by the CSSA (http://www.childsurvival.com/documents/CSTS/Sustainability.cfm)	Will adapt process from MOST and CSSA.
10	Organizational assessments of HHF and partners are missing, and there are no plans described to conduct these. Likewise, organizational capacity building indicators for HHF are missing from the M&E plan. The OD plan could be strengthened. This should focus on HHF. Tools for monitoring are not mentioned.	HHF has used the Management Sciences for Health MOST organizational assessment and will use the same model for the SGS and MSPP. Page 144 As noted in the proposal (page 23), HHF staff have participated at the field level in the MOST exercise prior to the KOMBIT proposal submission. This experience highlighted deficiencies in the management and operations of HHF in the area of maternal and child health service delivery. Page 150 comments on KOMBIT proposal: It is very positive that HHF conducted a MOST previously and that HHF will repeat one in year 4 to explore further organizational capacity and sustainability issues. Work plan May 2008 MOST Management organizational Sustainability tool exercise page 138 in DIP
11	Supportive supervision is mentioned, but the plan for system development and implementation is not described. Supervision is critical to the success of the interventions. Discuss this in terms of HA and HF provider supervision.	HHF has a model of monthly supervision at all levels based on direct and indirect supervision. Once a monthly activity schedule is determined in a participatory fashion, the supervision plan is then established. Direct supervision ins performed using quality check lists. The supervisors are evaluated by the field coordinator. Outside experts are also called in for objective technical assessments (as with IMCI).

		The same process will be used in KOMBIT with new interventions. Training using pre and post tests of technical knowledge, direct supervision with quality checklists, and indirect supervision will be used for skills assessment. Spot checks and home interviews have been used for many years by HHF to verify the quality of care and completeness of documentation.
12	The organigram provided seems top heavy on upper and mid-level management.	There are a large number health agents and nurses involved in the project that may not be clearly labeled on the organigram. The project relies on the community based component.
13	Boxes are cut off so cannot determine the title of person. The role of Maternal and Newborn Advisor and lines of authority are not shown in relation to medical director. In addition, there is another maternal and newborn position listed under the Field/BCC coordinator and the respective roles are unclear. The legend with respect to Haiti based, US and non-US is not legible.	The Maternal Newborn Medical Advisor is Frank Anderson, who advises all HHF programs, and works with KOMBIT. The MN Medical Advisor works closely with the medical director of HHF, hence the horizontal line. The Maternal and Newborn position listed under Field/BCC is specific to KOMBIT field operations and reports within that structure. We will make sure that the Final DIP organigram is clearer.
14	The extent to which the FBO community will be involved in implementation was unclear, as it was mentioned only briefly. Strengthened partnerships are recommended, given the value lent by the FBOs.	One of the partners, The Sisters of the Good Shepherd, is a FBO. Gebeau, one of the major collaborators is a Methodist FBO. The Pastor's Association of the Grand Anse has been part of the planning and implementation of KOMBIT. Preliminary activities have already been conducted with FB women's groups where there are no CHWs.
15	What is the potential for scaling up successes of KOMBIT beyond the Grande Anse region? How could HHF expand its scope to other parts of Haiti? Perhaps involvement as a partner in HS-2007 will provide a vehicle for knowledge sharing.	Selected interventions will be incorporated into the Departmental Plan as they are demonstrated to be effective. A formal expansion plan will be delineated for UCS 1 and 3 in the follow-on grant application. Currently, HHF has been identified as a national site for field training for Family Life Methods and community based ARI. KOMBIT will also provide training for national implementation for demonstrated maternal newborn interventions for incorporation by MOH and NGOs in other parts of Haiti.
16	What is the relationship to the departmental hospital in Jeremie? In particular, how will KOMBIT relate to the PMTCT program? This may be an opportunity for collaboration to demonstrate community mobilization and follow-up of mothers and infants enrolled	The Hospital Saint Antoine and HHF have a long standing relationship. As part of the MOH partner services, it will be an integral part of KOMBIT. The government hospital, Saint Antoine, was named one of the PEPFAR sites for counseling, testing and medication so PMTCT is available as part of the referral network of KOMBIT.

	in the PMTCT program.	
Monitoring and Evaluation		
1	While the monitoring and evaluation of the program is strength of the proposal, in many ways it may also be considered a weakness. There needs to be a careful balance between program implementation and collection of data and result documentation. We would not want program staff to be overwhelmed by the information that will need to be collected. It sometimes appears that there is a heavy domination of the evaluation components and not enough emphasis on the program implementation.	All HHF field staff have monitoring responsibilities already, it is not a separate function. KOMBIT will work with the partners, SGS and MOH, to develop this same integrated capacity for service delivery and documentation. One of the goals is to pilot selected parts of the PAHO perinatal software program to standardize and simplify maternal newborn care and documentation.
2	The plan does not address the requirement of explaining how the M&E skills of local staff and partners will be assessed and strengthened	See above.
3	How sustainable is the PHACT system in the Haiti context. Is that an approach that can realistically be scaled up?	A family registration system has been in continuous operation in HHF since 1988 and has been a major source of program information for feedback and resource allocation. It is sustainable in Haiti. This census based system was replicated by another program in urban Port au Prince.
4	Despite HHF's many years in the Grand Anse region of Haiti and its presumed familiarity with the population, the DIP does not clearly exhibit an understanding of the existing health problems, specific reasons for these problems and where to target interventions There is little use of demographic or other data. The baseline survey findings are not elaborated on to further refine the intervention. With such a long and close relationship with these communities one would expect more detailed information about the population and their practices and how best to tailor health education messages.	The DIP focuses on the data that pertains to the currently described project. HHF has great familiarity with health problems in the area, and has multiple other programs and sources of information to address them. HHF has demonstrated success in dissemination of health messages and behavior change in breastfeeding, vitamin A, ARI, vaccination, engagement of youth, community participation, consistent use of home based mother and child health cards. The Haitian government has recognized these effective programs through awards and invitations to present at national meetings. Other programs in Haiti have come to HHF to learn about program implementation. HHF has been named the site for community level training for Haiti for public and private providers in FP, BF and community pneumonia treatment.

5	It would be useful to have the Percentage information for additional indicators collected during the KPC. An analysis of the KPC results would be useful.	Descriptive data (frequencies, age distributions etc.) will be available in the final DIP. Detailed analysis of all the questions (cross tabs and other relational analysis was not conducted for all variables). Data relevant to specific KOMBIT was included in all the tables in the DIP.
6	To what extent is one woman per village representative of that population's conditions for the KPC?	This is standard LQAS methodology—1 household randomly selected from 13 randomly selected Lots.
7	Under Breastfeeding, the data for Response to Situation Analysis, states 9.8% BF exclusively for 0-5 months. The KPC result on page 13 indicates this was 65.1%	The Response to Situational Analysis was based on national data, according to DHS 2000, 9.8% was the rate for exclusive BF. The KPC result is based on local data.
8	What is the meaning of "Special surveys" and how did they take place?	HHF internal program studies which include exit interviews, analysis of trends in monthly technical data, a random survey of 800 households on pregnancy danger signs (being analyzed currently), small qualitative study of BF before expulsion of placenta, as well as standard HHF census and program monitoring data.
9	There is a clear presentation of data for the Longitudinal Study of Pregnancy Complications (Preliminary Results). Will this data be analyzed for the final DIP?	No, it is an ongoing study and data collection and monitoring will continue.
10	Under "How monitored" for the National Level, indicator: percentage of post partum women examined by a doctor, nurse or an auxiliary nurse within 72 hours of birth. Given the rural context would you consider including HAs as part of the monitoring? How realistic (and sustainable) is it for a nurse or MD to examine a woman within 72 hours?	As indicated on page 9, the expectation is that HAs will be conducting 72 hour visits, it was never intended for doctors or nurses to do this.
11	A +/- at the confidence figure would make the rapid catch indicators easier to read.	This was on the electronic form for data submission, but did not print properly. If the electronic version cannot be corrected, the final DIP will be edited to more clearly show this.
12	The BCC table does not indicate how often indicators will be monitored.	This table is available but is quite large. It provides much more detailed time lines and will be posted for program management and monitoring. If reviewers wish to see it, an electronic version will be provided.
	The M&E plan nicely indicates which indicators will be shared	We will include these as publicly shared indicators

	publicly. Why will the project not share the child spacing (any method) indicator? Why only the natural family planning indicators?	
13	An English translation of questionnaires would be helpful.	They will be provided.
14	The monitoring and evaluation systems as well as the HIS seem overly burdensome and redundant. The DIP gives the impressions that excessive data collection through census, forms, facility-based reports and special studies will take up a large percentage of the overall project level of effort. There is a need to simplify the data being collected paring it down to essential information that is needed for project monitoring and evaluation and to limit data collection to only that which can be used. A census is a time consuming data collection process. Is a census really necessary or can a survey which takes less effort and is quicker producing some of the same data? The document suggests that data will be fed back to stakeholders on an annual basis. Is there not a process that could feedback some of the data to stakeholders with more frequency? The data collection processes described seems almost vertical for each intervention. As much as possible data for the HIS should be integrated into one system for ease of collection, inputting and use.	The monitoring and evaluation system for KOMBIT has been developed through the many years of program activity by HHF, has been informed by it and is integrated into it. New systems are not being developed, rather, existing systems are being brought together and HHF systems are being adapted to the KOMBIT project. HHF work has monitoring and evaluation integrated at every level – this is the fashion of work and will continue that way. The census is a central component of HHF's HIS in the area. The census is not funded by the KOMBIT grant, but will benefit from the infrastructure it creates. In terms of data feedback, a list of publicly displayed indicators had been indicated in the DIP that will provide monthly feedback to the community
15	More information about the implementation of the PAHO perinatal monitoring system would be useful. It was mentioned that it will be a challenge to install this at all of the clinic sites, but the process was not detailed.	The PAHO perinatal tracking program is not available yet and is the final development phase. It is currently being adapted into French. Meetings have been held and HHF has been approved as a pilot implementer of this program. Details of the implementation will be worked out further with PAHO the later years of the project.
16	The Level of effort to support such an extensive monitoring and evaluation plan seems inadequate.	M and E is integrated into the project at all levels and occurs through existing HHF and partner data collection mechanisms. The 1.5 FTE will coordinate

	Page 140 lists only1 M&E administrator and 0.25 FTE of a Statistician. In addition, it seems it is the same staff that is listed for the operations research (OR). If OR is to be done by other groups, then their LOE will still have to be mentioned.	monitoring and analyze the data from various levels of supervision and evaluation. HHF believes that through its long standing method of operation, the proposed M and E staffing will be adequate.
Objectives		
1	The project has 20 objectives to achieve and we asked ourselves to what extent this is feasible.	Details through out the DIP explain the feasibility of achieving these objectives
2	Not sufficiently oriented toward Child Survival activities. Training for Birth Attendants, Health Agents to counsel the Mothers for referring child for vaccination, to counsel mothers on steps to be taken in cases of Acute Respiratory Infections (ARI) or in cases of diarrhea besides promotion of Breastfeeding.	The project is responsive the CSHGP as a child survival project with the major interventions in Maternal Newborn Care, Breastfeeding and child spacing.
3	HHF should justify why it is not addressing poor indicators like hand washing, full immunization, bed nets, continued feeding during illness, and HIV/AIDS. In an area of high HIV prevalence, what about promoting risk reduction and PMTCT as part of MNC intervention mix? Risk reduction is an important topic, considering the project's emphasis on NFP.	KOMBIT is addressing indictors as they relate to the program described. HHF conducts parallel programming that addresses many of the mentioned issues. HHF holds to the principle that by creating a strong maternal care infrastructure, essential components like HIV, PMCT, Syphilis, bed nets and other programs can be added with additional funding, instead of the other way around.
4	With HIV prevalence rates among antenatal patients in this region well above the national average it is unclear why no mention is made about referral to VCT services and access to short-course prophylaxis for MTCT and perhaps even HAART for those who test positive. This was raised in the proposal review but has not been addressed, The DIP mentions that the Haitian NGO FOSREF works in this region but fails to discuss how the program could refer women and children for HIV and other RH	KOMBIT is not directly managing HIV. HHF has a parallel program with the MSPP. The main (and only) government hospital is the regional center for PEPFAR. HHF tests all pregnant women for HIV. HHF is the official site for MTCT testing. Counseling, social support, protection from transmission, medication and follow up lab testing are managed by the GHESKIO program at the hospital. Food aide is also provided by this program. An urban and rural syphilis detection and treatment program is already underway and HHF reduced the prenatal syphilis rate from 14% to 7% by 2003 according the CDC national seroprevalence survey.

	services. Haiti is one of the PEPFAR countries for USAID and it is therefore important to strengthen the referral system. Also with the high rates of HIV among antenatal patients it seems very appropriate to be distributing condoms as part of the package of services while promoting dual methods for pregnancy prevention and HIV/STI prevention as appropriate. This also raises the issue of breastfeeding and HIV positive women and appropriate referrals for counseling for these women as well as HIV positive women and their family planning needs. Please elaborate on existing services for these populations. The DIP mentions that there is some syphilis testing and a study is planned. What are the rates of syphilis among antenatal populations in this region? Is there any data? Please strengthen the DIP with respect to syphilis detection and treatment and HIV prevention, detection and treatment.	For breastfeeding, since June 2003 has been promoting exclusive breastfeeding for 3 months and for 6 months exclusively since June 2005. Other liquids are used with abrupt weaning at 6 months.
5	In the table (pp. 50-67), it is not clear how some constraints will be addressed, e.g. p. 57 first constraint box states that there are too few personnel to permit UCS 2 to teach and monitor the activity directly. How will the project overcome this?	Most of these are already addressed in the DIP. The exercise to determine the constraints was to assist in programming and implementation and to engage the partners in the process. These constraints have been identified before implementation of the project. Most of the project activities will addresses these constraints in one way or another,
6	For each expected result, a constraint was identified. Some of these constraints are beyond the control of KOBMIT and may delay or obstruct achievement of program results. Do any of these constraints suggest that the objective should be altered? For example, if the program objective is to increase to 40% the percentage of women who adopt a delivery plan but many women do	The constraints identified will inform program implementation. At no time have the partners considered the identification of constraints as a reason to alter the program objectives.

	not attend prenatal consultations at all or often enough to develop the plan, is this a realistic target? Further, this constraint suggests that one program objective should be to increase the percentage of women attending 3-4 or more prenatal visits (noted that this is an additional indicator listed on page 18).	
7	There are three large tables with objectives presented; some information seems to overlap—it may be possible to combine at least two of these tables.	Although there is overlap, for program management purposes and for ease of understanding, we chose to maintain this format.
8	Messages about the importance of prenatal vitamins, iron supplementation and folic acid could be packaged with the antenatal and health education interventions. The DIP does not mention malaria as a problem for pregnant women. Is there any information about the rates of malaria in this population?	These issues will be covered in the BCC message project. There are problems with procurement at this time due to instability in the country. Malaria is present in the area. Clinical services in the area address this, but the KOMBIT program is not addressing Malaria. This is covered in parallel programming.
9	There is little or no emphasis on newborn interventions that would improve survival outcomes. Interventions such as clean cutting of the umbilical cord, use of eye drops for infants and detecting and addressing infections could be integrated with the existing health education and facility level interventions.	HBLSS has, as a vital component, neonatal care and these modules will be implemented in the project region. HHF and KOMBIT have been selected as a pilot site for PAHO to conduct neonatal IMCI. This activity is still being developed and will be implemented when the details are available from PAHO.
10	Having not read the original proposal, it was unclear how end program targets were established. In some cases, a dramatic increase is expected, which may be unrealistic. For example, the baseline assessment showed that 9% of women interviewed could identify at least 2 postpartum danger signs, and the target is 40% (a 4-fold increase). Would it be possible to modify these targets based on a mid-term evaluation?	We can consider this – targets were chosen with partners during the DIP preparation process and if changes are needed, we will consult with them.

11	The five-year work plan provides an exhaustive list of activities. It might be useful to organize these in a particular way, either by intervention, indicator, or program area (management, M&E, etc…). How will this be used to show progress or status of the program?	We will adopt this suggestion
Prenatal, delivery, and postnatal care		
1	The expected increase (5%) for women who deliver with a trained attendant seems low and it is not clear whether this is the total expectation for the 5 years of the project.	Access to skilled attendance will be limited to emergency cases and in instances when resources for a hospital birth are available
2	To increase to 30% of neonates examined by a HA within 72 hours of birth: which new interventions would HHF implement along with CBOs?	Health agents currently see post partum patients within 9 (usually 5-7days) will work to see postpartum patients within 72 hours. A modified plan will be developed for non-HHF areas without health agents, including mother representatives trained in HBLSS.
3	The logic behind encouraging mothers to deliver at the hospital, especially given the costs involved, the distances between homes and hospitals as well as transportation issues.	Distance and cost are factors that will be addressed in several ways: the Maternal Waiting Home provides housing, food and clinical care for high risk women from distant areas; some dispensary nurses have received EOC training and more has been requested—this will provide skilled attendance in rural areas; HHF has sent one nurse for the nurse midwife training in Port au Prince and plans to send one nurse each year to increase the availability of skilled attendance.
4	Has the Home-based life saving skills (HBLSS) program has been tested in Haiti and if so, what obstacles have been found in its implementation? Examples provided come from a country (Ethiopia) that has a better infrastructure than Haiti. Does HHF consider that this could make a meaningful difference in its success? And yet it is great that the Ethiopian Midwifery Association has already expressed interest in partnering with the project. (p. 101)	It has not been tested in Haiti, KOMBIT will be a pilot site and hopes to become a national field training site for Haiti as HHF has been for other interventions. We have been meeting with ACNM since 1988 to explore this option, and most recently to plan the training. They are excited to have the opportunity to work with such a well established program as HHF.
5	The idea of a designed girls' home-based health card that includes information on pre-pregnancy care	This is being pilot tested as part of an expanded M and E system so that information beyond what is present on the national card can be collected.

	sounds very interesting but we would like to know if it has worked and, if so, how the HHF has measured this success. Given that there is little awareness about the importance of prenatal care, it may be difficult to develop interest amongst young girls to take care of themselves before pregnancy.	
6	We would like to better understand why, if HHF has trained 300 TBAs who provide monthly reports on all their pregnancy outcomes/births, there are only 10% attended births (p.83). Maybe skilled attendant is only defined as auxiliary nurse, nurse and doctor?	We follow internationally accepted definition of skilled attendant and do not consider a TBA a skilled attendant
7	In this table (p. 83), for 'percent of women who deliver with a skilled attendant', what about a strategy to get skilled attendants to homes and/or to develop birth plans at the household level? Fewer mothers dying will contribute to the continuation of new behaviors in this regard.	There will be no program to get skilled attendants to the home this is not feasible.
8	Improve support for midwives in each clinic area' (p. 91) – how will this be done? No details provided.	We meant nurse midwives, not TBAs. Support will include training (EOC, referral and counter-referral, HBLSS, maternal mortality audit process), HHF staff assistance and facility improvements.
9	Similarly, the only intervention discussed for improving the quality of maternal and newborn care is HBLSS. While it is understood that this will be the focus of the program, have you considered using performance and quality improvement approaches as well which are being used in other programs in Haiti?	The monitoring system is set up to ensure QA in project through supervision, performance checklists, follow-up on referrals, continuing education and implementing new appropriate technologies. If other strategies are being used in Haiti, we would be happy to incorporate them in our DIP.
Birth and evacuation plans		
1	One of the objectives is to increase to 20% the number of villages with written and posted emergency OB and newborn transportation plans, when there is no national policy addressing this objective. How will HHF manage to implement this	We have detailed a plan to use satellite phones and ambulance service to increase access. Often, women must be carried out by teams of community members. There is a long history of this in the region. The BP CR matrix has been taught to 1000 community members whose heighten awareness of pregnancy complications will hopefully lead to

	given the lack of roads and transportation? What level of community participation has been foreseen in order to maintain the emergency transportation system: which methods of transportation will be used, given that there are neither cars nor money for transportation? Has a specific fund, such as a community bank, been considered to secure money for transportation?	increase in transports. This will be monitored by the project. We acknowledge the challenges and will implant these activities with the expectation of documenting some success.
2	How will women adopt a pregnancy delivery plan since we consider this to be a very new idea in the Haitian context and as a result, very difficult to implement.	HHF has piloted this activity and has been very successful. Although a new activity, it has been actively adopted in HHF regions and will be implemented throughout the entire KOMBIT zone. Please see Annex VIII of the DIP for an example.
3	Some innovative ways should be looked at to reduce the financial barriers that prevent pregnant women in Foyer Lespwa in Jeremie (HHF) to attend the Saint Antoine Hospital for high risk pregnancies or OB/GYN emergencies.	Community funds have been described for emergencies. This is the only current fund raising activity at this time.
4	It is not clear how the ambulance service will be developed.	KOMBIT has a multi level approach to transport women to higher levels of care during the perinatal period. • Women will identify an evacuation strategy as part of the written birth plan process • Traditional birth attendants will have signs of danger reviewed and reasons for evacuation • the Home Based Life Saving Skills (HBLSS) includes more intense attention to evacuation in the perinatal period • Satellite telephones will be installed in remote, vehicle accessible areas. Regional advertisement of this fact will be expanded. The HHF has secured a Toyota vehicle that will be used as the transport vehicle • A driver with a telephone will be “on call” to respond to needs during the evening or week end periods • Women in crisis will be brought to the Jeremie St. Antoine hospital for emergency treatment • The vehicle will be housed and maintained by the HHF
Breastfeeding		

1	It is important to promote exclusive breastfeeding. More information is needed on why mothers are not exclusively breastfeeding between 6 to 9 months old or otherwise what complementary foods are being given. Have HHF studies been able to find whether women are feeding children too early? And if so, what complimentary foods are being given? Changing the mentality to doing Breastfeeding before the placenta expulsion can be difficult since in some cultures milk is not considered good while the placenta is still inside. Have other alternatives been considered such as training the TBAs to massage. the nipples so it will increase uterine contractions? This may help in quickening the expulsion of the placenta.	HHF uses the international standard of 6 months exclusive breast feeding. HHF has been implementing breast feeding programs in the HHF zones for some time and will be implementing them into the KOMBIT zones. HHF is the national trainer in breast feeding programs for both public and private providers. TBA training is not a part of the KOMBIT program, but is part of HHF and the MSPP.
2	We would like to better understand how “wet nursing” for babies will continue to be promoted so it can increase, given that in 10 years (since 1995) only 25 babies have been successfully nursed.	HHF is documenting its best practices and more information will be available. There have been many babies nursed in this way, but complete information has not been obtained on all of them. This is an HHF function and not KOMBIT
3	P. 85 – Mothers placing baby to breast before expulsion of placenta – training and activities around creating baby-friendly hospitals and health centers, with rooming in, could help to improve this indicator.	The currently describe project is a community based one as more than 95% of all deliveries occur at home. The creation of baby friendly hospitals and health centers is a good idea and perhaps can be addressed in a follow on program or with other funding.
4	The Breastfeeding section has not addressed the issue of duration of breastfeeding as an intervention beyond the message of 6 months exclusive. It is not clear from the DIP if this is an omission or if a two year or more duration of breastfeeding is traditionally practiced. The DIP also does not mention health education messages about optimal infant feeding including appropriate and available weaning foods at 6 months of age. As mothers will be	HHF utilizes the international standards and terminology for breastfeeding. We promote exclusive breast feeding for the first 6 months, and use the term “complimentary” instead of weaning during the period of breastfeeding from 6 – 24 months. HHF has established programs for Breastfeeding that will be implemented to the KOMBIT zones

	asked to not feed their children anything but breast milk until 6 months this may raise issues about what foods are the best foods to first introduce. It would be logical to have health education messages on this topic to ensure that appropriate calorie-dense locally available foods are recommended. The DIP mentions that kwashiorkor is a problem among some children within the population and also mentions a past intervention that included a feeding program yet no other mention is made of other nutritional issues or interventions that might be easily packaged with the chosen interventions.	
5	The breastfeeding section does not mention what messages will be given to the 47% of mothers that are engaged in work outside the home. There is also little focus on what information will be imparted to new mothers so that they will learn to help newborns latch on effectively as well as learning proper and comfortable breastfeeding positions.	These messages will be included.
Family Planning		
1	Child spacing-increase to 35% of women using any method of CS. However, it is currently at 36% in the region of Grand Anse: is there a contradiction?	CS 27% in our figures 28% nationally DHS 2000 ? grand anse data BUT KPC is 27%
2	Has intensive training of providers been foreseen for SDM? This is a very good method for strongly religious countries and we wonder to what extent this may work in Haiti.	60 trainers of trainers were trained in April 2005.
3	Is LAM a reliable FP method? Does HFF consider this could be one of the reasons for which only 4.5% of women use it?	The KPC was performed in areas where LAM has not been promoted. In HHF areas where LAM has been promoted, HHF has documented LAM completion rates of 30-50% and has found it a very reliable and attractive method
4	Why is HHF promoting CMM?	CMM is related to fertility awareness and is a

	There is no rationale or background information provided.	prerequisite to understanding a woman's eligibility for SDM.
5	The Standard Days Method (SDM) was the only intervention described in detail for child spacing, while the other proposed methods are LAM, other NFP, and modern methods. It would be interesting to see more detail about the other interventions.	These will be translated and added to the final DIP. LAM and CMM are currently in use in HHF and in other locations in Haiti.
6	While the proposal mentions the reason for focusing only on NFP, we believe that it is only fair to offer women a full choice of methods available to prevent unwanted pregnancy. At the least, the counseling should include other FP methods like pills, condoms, IUD etc. A greater effort should be made to engage other groups responsible for contraceptive security so that the women in your target areas have an option of the full range of methods.	LAM and SDM are considered by USAID to be modern methods. Women in the project area will have other methods available to them though the Ministry of Health and KOMBIT collaborating organizations. Sisters of the Good Shepherd is a Catholic FBO, and while HHF is not a FBO (i.e., does not require participation in religious activities or that clients or staff be Catholic), it is grounded in Catholic philosophy and follows the teachings of the Catholic Church regarding services provided.
7	Objectives 2 and 3 under Child Spacing seem to be the same. Why are there slightly different activities listed?	This is already explained
8	The child spacing section is extremely weak because of its emphasis on NFP while omitting any discussion or information on referral for other modern contraceptive methods. Family planning and optimal child spacing –up to 3 year birth intervals-- have a strong positive effect on maternal and newborn health. Family planning is a key intervention for preventing maternal deaths. With the high rates of fertility cited in this population and the short birth intervals, a strong family planning component would be essential to avert maternal deaths and improve newborn outcomes. The key to an effective and high quality family planning or child spacing intervention is to provide a choice	This project is promoting 2 modern methods of family planning LAM and SDM. We can include the methodology for training in an appendix. Please note that in an evaluation of the HHF project region in 1997, when the national TFR was 5.2, the HHF region TFR was 3.5.

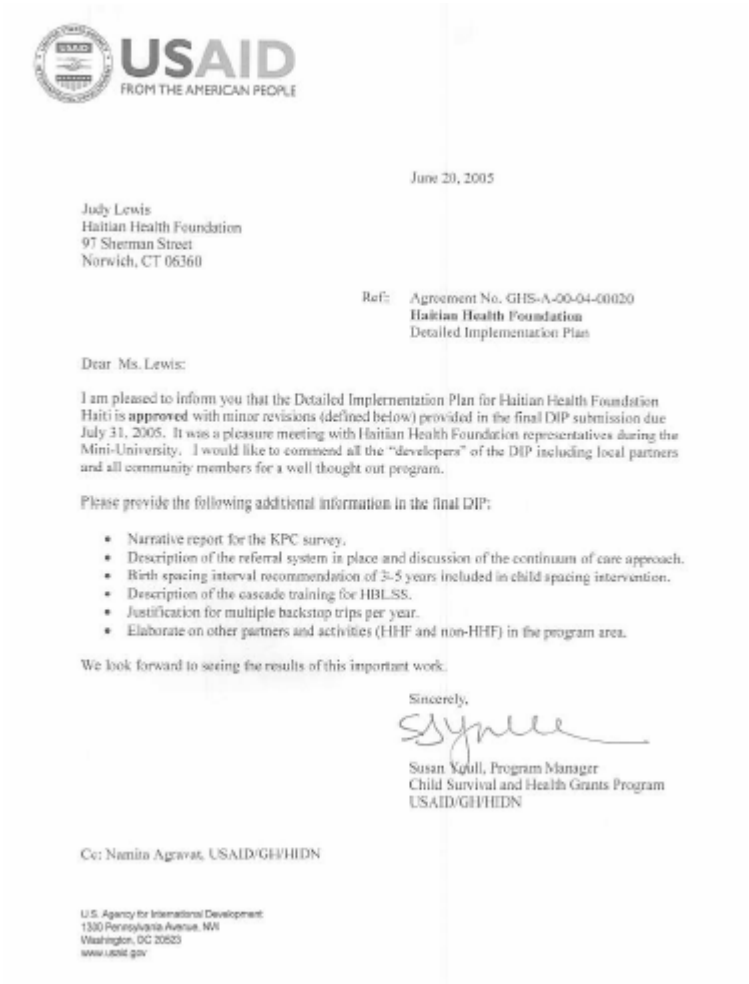
	of methods with information and education about the benefits and considerations for each of the methods. The client can then choose a method based on their own needs and desires. Standard Days Method is dependent upon spousal cooperation. Many poor women do not have decision-making power around the timing of sexual intercourse. Without agreement about periodic abstinence or use of condoms during the fertile period this method can have high failure rates. The use of LAM is limited to only those who are in the six month post-partum period whose menses has not returned and who are fully or nearly fully breastfeeding. For these reasons this method is very limited in who can choose it. There is no mention about how individuals will be trained in the LAM algorithm for those who choose the method. This is also true for SDM.	
9	Of even more concern is the DIP's proposed promotion of the Cervical Mucous Method. It is unclear if the Cervical Mucous Method that will be used in the DIP is the two day method or the Billings method. USAID does not support the Billings method and there are concerns about the appropriateness of this method in general and for use with low and non-literate populations. It is very complicated and requires more training than the DIP has indicated and its effectiveness has not been as clearly established as the SDM.	HHF considerers CMM as a prerequisite to SDM.
10	The document mentions that pills, condoms and Depo Provera are used in the region although at very low levels. It would be appropriate to integrate information about all of the methods and even allow	The UCS 2 concept of the MOH is that the minimum package of services be available is being respected in this regard. Because HHF provides services based on a Catholic philosophy and Sisters of the Good Shepherd is a Catholic organization, KOMBIT has chosen and been funded to promote 2 modern

	community based distribution of condoms and oral contraceptives by the Health Assistants and volunteers with referral for DMPA. This has successfully been done in many community-based programs including child survival programs. If this is not feasible it would be important to ensure that a strong education and referral system is in place for these methods and services either with public sector clinics or NGOs.	natural methods of child spacing LAM and SDM. Since other methods are actively promoted and distributed by the MOH and other collaborators such as FOSREF, and Gebeau, it was felt that the practical and economical features of NFP would be an excellent addition to the package of services available in the KOMBIT service area.
Access		
1	For Quality Improvement work, please refer to resources published by the Quality Improvement Project (www.qaproject.org) and Maximizing Access and Quality (www.maqweb.org). There are four steps to QI and there are resources documenting recommendations. Consider using the BEHAVE Framework to systematize barrier analysis, message selection, and testing (www.coregroup.org). JHPIEGO has materials on EMOC and danger sign recognition. Review CORE's compendium of Safe Motherhood Standards and Indicators.	HHF has a strong history of supervision and quality assurance based on ethnographic and participatory strategies. HHF will emphasize these steps in program implementation and introduce them to KOMBIT partners so that they too can incorporation QA strategies in their programs.
2	Priority #1 indicates items which every dispensary needs urgently, every day, or are so important that they must be always available in the dispensary...if they are not available in the dispensary they must be supplied within a week after they are out of stock. How will this be managed? Given the continuous shortages from the Ministry of Health?	HHF chose to conduct facility assessments priority setting exercise during the DIP process but is not actively involved in facility improvement projects. Some resources are available to purchase supplies and medications, but a full scale facility improvement and sustainability plan for facilities is not in the scope of KOMBIT..
3	The facility assessment data were interesting. It is a good tool to prioritize supplies and commodities and identify the needs at the facility level. However, how will this tool	See above

	be used to monitor facilities and reduce stock outs? There are no indicators related to this process.	
4	While it may be beyond the scope of work of this project to strengthen facilities, it is clear from the assessment that some are weaker than others. Particular efforts should be made in those in need of assistance to identify gaps and propose improvement plans, even if this requires external support.	Some resources are available and will be distributed after meeting with the KOMBIT partners as part of program implementation.
5	On the table which prioritizes materials, medicines and equipment, it would be useful to have a column that indicates where the supplies come from and any possible obstacles the official supplier may have in providing those supplies in a timely manner.	We will develop this with our partners
6	Will the KOMBIT dispensaries not carry HIV testing kits or ARVs?	This is being implemented by the PEPFAR program at the hospital, and expansion to the dispensaries is under consideration.
7	Past abortion care services referrals would be another appropriate package of referrals/services for this population to prevent maternal mortality. Are there any organizations that are currently providing PAC services? Is there any data or anecdotal evidence about PAC needs?	This is being provided by the OB GYN at the main hospital who has been trained by JHPIEGO
8	Are Maternal Waiting Homes already being used?	Only one exists in the Jeremie area. It is the first in Haiti and was developed by HHF. It has been operating since 2002; it will be part of the referral network of KOMBIT
9	What is the current quality of provider – client interaction? This and client satisfaction seem to be missing from the HFA.	There was an exit interview monitoring strategy implemented MSH in HHF in the mid 90s. HHF client satisfaction was rated above 85% in all areas. HHF did not continue with this approach because exit interviews are not a reliable source of client satisfaction. KOMBIT will develop field based strategies for client satisfaction as part of the work with HBLSS.
10	It is also unclear if the public and private clinics in the catchment area would also benefit from	JHPIEGO came for EOC training in 2003 during the pre-KOMBIT phase and HHF has requested further training which would include KOMBIT partners and

	having their essential and emergency obstetric skills refreshed and upgraded. The American College of Nurse midwives could also consult on strengthening these services if needed. What is the quality of birth attendance at these facilities for normal and high-risk births?	collaborators in the coming year.
BCC		
1	There is a sense that many of the health interventions will be done in groups through talks, theater and songs. While this is a good introductory strategy for behavior change communication it is only a first step. Training mothers groups and other community leaders as well as health agents is not enough. Facilitative supervision of these lower level cadres of health communicators needs to be done periodically to ensure that health education is effective. The literature shows that Health workers and volunteers learn best through on the job strategies while mothers learn best through interpersonal communication that addresses their individual issues and concerns. Also as some 47% of the mothers report working outside of the home how will the mothers' groups be structured and timed to ensure participation? More facilitative supervision and observation of the health talks and communications needs to be structured in the DIP and work plan.	Supervision checklists for community based activities have been developed by project staff. HHF has multiple strategies in place for supervision of community BCC. These are integrated into project activities.
2	More information is needed about the design and development of appropriate materials for health education—flipcharts, felt boards, brochures etc. It seems that the majority of the population to be served is low or non literate. What materials will be developed and field-tested to use with women in	HHF has demonstrated behavior change with its current strategies that support people who are unable to read brochures, flip charts and felt boards. HHF has a proven strategy of community engagement and trust that is expressed through the proposed strategies and in promoted by community leaders. KOMBIT will adopt these proven strategies. HBLSS has developed an extensive BCC package of field tested pictures to convey the bulk of maternal and

	addition to songs and theater when giving talks, group education and one on one interpersonal communication?	newborn care messages as well.



USAID
FROM THE AMERICAN PEOPLE

June 20, 2005

Judy Lewis
Haitian Health Foundation
97 Sherman Street
Norwich, CT 06360

Ref: Agreement No. GHS-A-00-04-00020
Haitian Health Foundation
Detailed Implementation Plan

Dear Ms. Lewis:

I am pleased to inform you that the Detailed Implementation Plan for Haitian Health Foundation Haiti is **approved** with minor revisions (defined below) provided in the final DIP submission due July 31, 2005. It was a pleasure meeting with Haitian Health Foundation representatives during the Mini-University. I would like to commend all the "developers" of the DIP including local partners and all community members for a well thought out program.

Please provide the following additional information in the final DIP:

- Narrative report for the KPC survey.
- Description of the referral system in place and discussion of the continuum of care approach.
- Birth spacing interval recommendation of 3-5 years included in child spacing intervention.
- Description of the cascade training for HBLSS.
- Justification for multiple backstop trips per year.
- Elaborate on other partners and activities (HHF and non-HHF) in the program area.

We look forward to seeing the results of this important work.

Sincerely,

Susan Youll, Program Manager
Child Survival and Health Grants Program
USAID/GH/HIDN

Cc: Namita Agrawal, USAID/GH/HIDN

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The following changes have been made in response to the above :

1. The KPC narrative can be found in Appendix VX
2. The description of the referral system can be found in the child spacing section page 101.
3. A discussion of the birth spacing interval can be found in the child spacing section page 101.
4. A description of the cascade training for HBLSS can be found in the Maternal newborn care section page 91.
5. Justification for 4 backstop trips can be found in the budget narrative page 35.
6. A description of the PVO and partners is found in a new section page 37.