HS2004 PROJECT

SENIOR MANAGEMENT REVIEW

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Management Sciences for Health
Haiti Health Systems 2004 Project
USAID Contract Number: 521-C-00-00-00023-00

1) Introduction

The Haiti Santé 2004 project was developed to achieve the USAID Strategic Objective 3 (SO3), "Healthier families of desired size". The Project was designed in two phases. The first phase (1995 – 2000), provided a focus on the creation of a network of service provider organizations, both public and private, to deliver the Ministry of Health's Minimum Package of Services to clearly defined populations throughout Haiti. In addition, through a National focus, technical assistance was provided to both the Ministry of Health (MSPP), and specialist NGOs for the development of national health and population policies, national programs in immunizations, reproductive health, child health, IEC, and institutional development.

Phase II (2000 – 2004), represented a significant change in design, with the HS2004 project no-longer providing direct assistance to the public sector, but focusing exclusively with the private NGO sector with an emphasis on coordination with the Public sector. Assistance to the Public sector was to be provided through a separate Strategic Objective Agreement.

At the end of phase I, work with the NGOs has produced startling improvements in key result areas such as Contraceptive Prevalence Rates, which rose from 16% of all women in 1997, to 25% of all women in 2000. Similarly, full immunization coverage for children under 1 rose from about 50% in 1997, to near 70% in 2000. In addition, coverage of the package of services had been extended and significant improvements in the capacity of many NGOs had led to the introduction of a pilot to fund organizations based on performance in achieving health impact rather than on utilization of resources. However, both the capacity of the Network and its NGO members, and the impact of their activities remained fragile. In Phase II, achievements need to be consolidated for sustained impact. This calls for further expansion of quality services, for interventions that enable people, particularly women, to identify and act on their health needs and demands and for continued strengthening of the NGOs.

This senior review was initiated as a standard part of MSH's management of field projects. Having completed strategic and work planning exercises, and with the first full round of contracts negotiated and being implemented, the Project has requested a validation of the original assumptions in the design, strategies, and implementation plans, to ensure that these continue to lead the Project to achieving the results desired. Because of the security situation in during the fall of 2000 and winter of 2001, TDY travel had been banned, and so this review was delayed from its originally planned date of November 2000. Taking advantage of the lifting of travel restrictions, several other senior staff who were providing technical assistance to the Project were also asked to provide input into this review.

2) Scope of Work

1. To obtain feedback and recommendations from USAID and Partners regarding Project priorities, strategy, work plan and overall HS-2004 Team performance

2. To discuss with USAID potential changes in USAID's SO3 Results Framework and how the Project can best support anticipated changes.

3. To meet with selected Partners, CAs and other international agencies to assess effectiveness of coordination, collaboration and communication through HS2004 and with USAID.

4. To work with the COP and the technical team to review and discuss Project strategies, priorities and plans and jointly determine areas to be strengthened or modified. Particular emphasis will be placed on

(a) Development of a sustainable Network,
(b) STI/HIV/AIDS/TB,
(c) Performance based financing of health services,
(d) Middle income urban service delivery strategy.

5. To assess the effectiveness of MSH/Haiti allocation of roles and responsibility and determine if changes are needed in the management structure and organization of the office.

6. To meet with USAID/Contract and USAID/FM to discuss financial and contractual management issues and ensure that Project is meeting USAID's needs and requirements. (This process will be continued at a later date with a follow-up visit by Kate Griffin, the MSH Chief Financial Officer, to review budgetary implications and any contract requirements related to implementing recommendations of this report that have been accepted).

7. To perform a review of established administrative procedures and practices and ensure that these respond to Project needs while adhering to MSH's standards and regulations.

8. Perform an internal review of established financial and accounting systems as well as internal control mechanisms.

Individual Scopes of Work

Malcolm Bryant
Team leader, responsible for overall SOW and responsiveness. Assignment of roles, Drafting of key recommendations and final report.

Specific tasks: Meet with USAID, Partners, CAs and International organizations as well as HS2004 technical staff to receive feedback and recommendations regarding the project. Assess the current strategies, priorities and plans for validity against the original

design and USAID's evolving strategy for SO3. Evaluation performance of the project to-date in achieving goals and objectives.
Recommend any changes required base on the above observations. Pay specific attention to the development of the network, and the development of a middle income urban service delivery strategy.

John Pollock
Team member, responsible for looking at overall response of HS2004 team to the Project mandates, project's evolution from the original plans, and identify any changes necessary to respond to USAID and changing realities.

Specific tasks: Meet with USAID and Project staff, in administrative, financial and technical units to assess the effectiveness of the allocation of roles and responsibilities to meet existing project priorities, strategy and work plans. With Mark Kripp, review the Project procedure and practices. Recommend changes that may be needed in staffing or administrative procedures to meet the current needs of the project, and if changes in the technical strategy are adopted, recommend accompanying changes for staff and structure. With Jaime Benavente, meet with USAID, CAs and partners to assess the effectiveness of the performance-based financing strategy; make recommendations for continuation or changes in this area; and to determine the degree of coordination, collaboration and cooperation between the Project and these agencies, and recommend changes required.

Douglas Huber
Team member with special focus on the HIV/AIDS/STI/TB strategies, and to review the overall reproductive health component.

Specific tasks: Meet with USAID, Partners, CAs and International organizations as well as HS2004 technical staff to: Assess project's current strategies, priorities and plans for HIV/AIDS/STI/TB. Propose specific responses to better appropriately address these key areas, and strengthen or modify strategies to respond to unmet needs. Recommend new or expanded strategies in HIV/AIDS/STI/TB in order to absorb additional funding. And define how the project can effectively contribute to the international effort in Haiti to reduce the impact of the epidemic.

Jaime Benavente
Team member with specific focus on looking at the results that the project can be expected to achieve and how we need to look at presentation of results given USAID's changing needs and direction.

Specific tasks: Meet with USAID, CAs and International organizations to receive feedback on the project's strategies, policies and workplace to develop a sustainable network (with Malcolm Bryant) and on the performance-based financing of health services. (With John Pollock) and make recommendations for continuation or changes in this area. Assess performance to-date in these areas. Discuss with USAID, potential changes in SO3 and how they may affect the project; meet with key partners, CAs and International organizations to determine the degree of coordination, collaboration and

cooperation between the Project and these agencies, and recommend changes required to improve. Recommend strategies to respond to the above for the Project

Mark Kripp
Team member responsible for review of project financial and contract mechanisms.

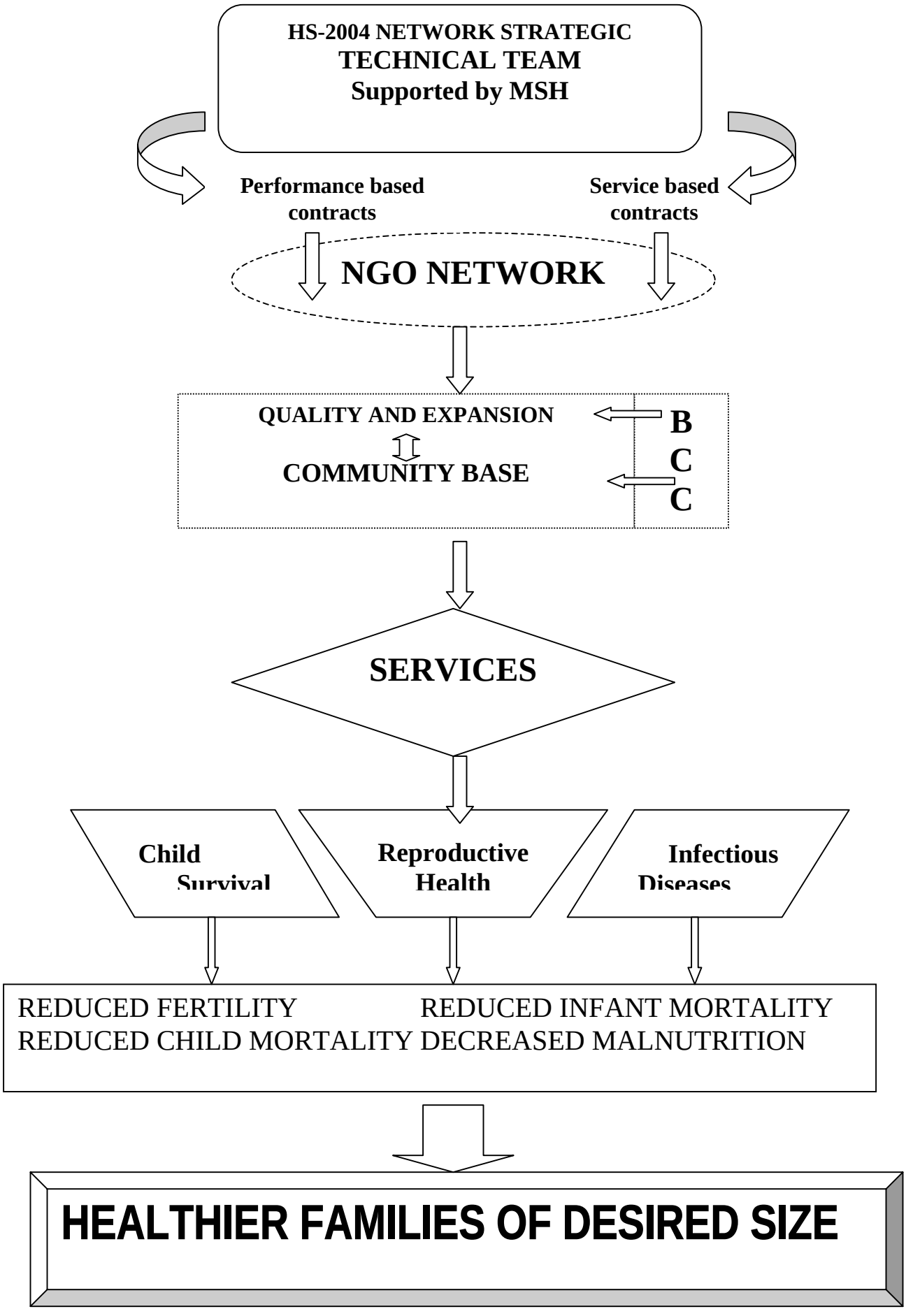
Specific tasks: Meet with USAID financial and contracts staff to discuss management issues and determine the extent to which the Project is currently meeting USAID needs. Recommend any changes necessary to respond to USAID's needs. With John Pollock, review administrative procedures and practices and ensure that these respond to project needs while adhering to MSH's standards. Perform a review of the project's financial and accounting systems, as well as internal control mechanisms. Make recommendations for how these systems can be improved.

3) Original objectives of the project

Observations
The original objectives of the project are well described in Figure 1. This figure has been modified to conform to the changed SO3 Intermediate results. The IR of Women's empowerment has been replaced with the IR of Infectious disease control. As described below, several changes in Project implementation have occurred based on changing priorities within USAID and in the political situation in Haiti.

Conclusions
While there are many important changes that affect the project, there do not seem to be any changes in the environment in Haiti that would specifically require a change in strategy and objectives as laid out in Figure 1. The strategic vision of the HS-2004 Project as laid out in the proposal remains valid when adapted to meet the new Intermediate Results.

Recommendation
Although the overall original project strategy is still applicable. There should be a careful review of targets and indicators in light of the new USAID priorities and, accordingly, revise the objectives Results Tracking Table (Especially in relation to infectious diseases).


HS-2004 NETWORK STRATEGIC
TECHNICAL TEAM
Supported by MSH
Performance based contracts
Service based contracts
NGO NETWORK
QUALITY AND EXPANSION
COMMUNITY BASE
B
C
C
SERVICES
Child Survival
Reproductive Health
Infectious Diseases
REDUCED FERTILITY
REDUCED INFANT MORTALITY
REDUCED CHILD MORTALITY
DECREASED MALNUTRITION
HEALTHIER FAMILIES OF DESIRED SIZE

4) USAID changes of focus

Communication and coordination
In general, communication between USAID and the HS2004 team is good. The team has had good support and communication from USAID, but turnover in the PHN team (turnover which is still in progress) has caused discontinuities in the strategic partnership between the HS2004 team and the PHN team. This partnership has served as one of the main strengths in progress toward targeted impacts, and each change has required stepping back for reorientation and affirmation.

With the evolution of the USAID program in Haiti, the PHN team is going through a rapid process of re-assessment of its priorities and focus. Five main factors are of relevance:

- Within the last three months, the SO3 has been carefully reviewed, and modifications made in the Intermediate Results and sub-results. (This is discussed below).
- The DHS survey results have been made available which suggest that there has been significant progress in key impact indicators in areas served by the project, but this rate has been much lower in areas not served by the Project. Mainly on a rural-urban split.
- The Mission will receive approximately 42% less funding than had been anticipated for the next two years.
- One of the Project CTOs will depart Haiti in June and, therefore, USAID will need to review CTO technical role and confirm the individual who will carry that responsibility.
- USAID has congressional mandate to increase global involvement in TB and HIV/AIDS that requires a review of priorities and a refocusing and rationalization of efforts in relation to impact and cost-effectiveness.

As these changes are evolving, the range of perceptions within the SO3 team of the relative priority and potential of some key project components and strategies varies significantly. This diversity of views regarding Performance-based contracting, the purpose and appropriate make-up of the HS2004 NGO network, the appropriate structure and function of AOPS, and the most effective strategy for implementing targeted programs for HIV/AIDS and TB control require careful analysis.

Current Priority areas
It was clearly stated that SO3 priorities currently focus on:

- Increased coverage for interventions that are most likely to bring about public health impact and measurable results.
- Exploration of how the Minimum Package can be expanded to groups outside of the current network.
- Exploration of how individual elements of the package can be more effectively used to reach national levels.

- A strong focus on service delivery – Child Survival, Reproductive Health, and Infectious Diseases.

Conclusions

Given the changing focus, the Project must respond appropriately to expand coverage. This expanded coverage should be regarded in two ways:

1. An increased number of service delivery points delivering the full package of interventions and thus increasing the number of people having access to, and using high quality services. This can be done through the network of service providers if the configuration of the network is adjusted in response to the increasing needs and reduced level of resources available, through technical assistance to non-network NGOs, and through coordination with the MSPP. It will be important to identify opportunities to expand network coverage with marginal investments (making efficient use of the fixed costs that are already being financed by HS2004). Significant changes in priorities and network configuration must be considered as a top priority over the next two months. Unless difficult decisions related to targets and network configuration are addressed, many recommendations and strategies outlined in this report will either not be possible or will be ineffective.
2. Establishing mechanisms to increase central level support to the MSPP and organizations for key interventions such as immunization, nutrition, tuberculosis, and HIV/AIDS, and STI programs. Given the significant needs of the MSPP, it needs to be clear that HS2004 "support" must be limited to active collaboration and coordination of efforts and exchange of information. MSPP staff can continue to be included in programmed events and training as they are available, but HS2004 funding and staff resources must be secured for the purposes outlined in the contract.

As directed by USAID, the only way in which such expansion can take place would be through some rationalization of the existing HS-2004 network of service providers. To illustrate the following approach might work:

If the Network were to retain all partners with a target population of 80,000 or more, or who are determined as “high performing” based on the regular performance data collection, and at the same time retain the 4 partners who provide specialized technical services to the whole population, **then** the project would still retain nearly 80% of its current target population and save $1,800,000 per year, while losing a covered population of approximately 600,000 people.

If $500,000 per year of the savings were applied to high needs areas in urban and peri-urban settings, where Phase I demonstrated effective improvements in health indicators, **then** the loss of population would be recovered, so that the original target number of people would be receiving the entire minimum package

If the above savings were made, **then** funding for central programs can be increased to $500,000 per year, and still leave $1,000,000 to be programmed in either service delivery, or in mechanisms to expand coverage.

If USAID should agree with such an approach, MSH should quickly look at the data in depth and present 2 or 3 scenario options for review. Other scenarios could use normative pricing for delivery of the service package a (see recommendation #8) as a means of reducing costs and de-linking NGO budget planning from business-as-usual approaches or combinations of these and other strategies.

Should a course of action be taken that required the discontinuation of support to a group of NGOs, there would be potentially damaging effects on both the morale of Network members, and the working environment for HS-2004 staff members. These shifts would require the development of a detailed transition plan, and there would be need for significant leadership from USAID in communicating the basis for any reductions in the network or major changes in approaches for determining support.

In response to the changed intermediate results, project scope and priorities, and the possible reconfiguration of the network, MSH will review its plans, management, and subcontracts in order to maximize efficiencies.

Recommendations

USAID and MSH should work together to establish sound criteria that include population covered, performance, and political importance to rationalize the current HS-2004 Network. In light of resources available after review of Network, plans and strategies, opportunities for expansion to new areas where higher impact can be reached in a cost-effective fashion should be aggressively sought, and funds also diverted to strengthening national level programs such as immunization, HIV/AIDS and TB.

MSH needs to reexamine its technical needs based on the change in Intermediate Results and rationalization of the network. Specifically, subcontracts with PAGS, IHE, *Konesans Fanmi*, and *Group Croissance* need to be revised based on network rationalization strategies chosen and the changes in expected results.

USAID should develop both a communications and transition plan concerning budget cuts and the need to rationalize activities so that MSH, as the agency responsible for implementation, can remain effective and not be seen as responsible for the cuts. In addition, USAID and MSH should work together to establish an active management of change mechanism which will work to reduce the impact of such cuts on the morale of both the technical assistance team and the Network partners. This transition plan should also mitigate, to the extent possible, the impact on current partners who would be changing status.

The HS-2004 Project work with USAID and Partners to identify potential “lost opportunities”, prioritize these opportunities, and strategize if, and how the Project can take advantage of these opportunities. For example, the use of nutrition and micro-nutrients supplementation as an opportunity for providing MCH services are strategies that have been identified in the past and should be further explored.

5) Assessment of strategies and approaches

Observations
The redefined USAID SO3 changes one of its Intermediate Results from Women's empowerment to Infectious Diseases. New sub-intermediate results focus on Behavior Change and Communication, service availability, quality, and management support.

The MSH approach to implementation of HS2004 is based on six results areas which are described in the work plan and are the basis for reporting on a quarterly basis. These are:

- Increase access and improving quality
- Strengthening support systems
- BCC and women's rights
- Social Marketing
- Development of a sustainable network
- Community Mobilization and participation
- Performance based financing
- Public sector collaboration.

Conclusions
Even a cursory glance at these two sets of results areas shows that they are 100% compatible and supportive. Where there have been significant changes, the project should be able to make easy adjustments. The Women's Empowerment component is at its initial stage, therefore, de-emphasizing this will not create serious problems. HIV/AIDS/STI have already been included in the Minimum Package of Services. With the evolving HIV/AIDS/STI strategy in the country, the MPS will need to be updated anyway. TB has not been in the MPS, and will need to be incorporated and activities operationalized in the project work plans (by Oct.). The need for training, technical assistance, and collaboration should be explored in the context of the TB Team Assessment with USAID.

The one factor that remains unclear at this time is the evolving role of the Public Sector. Following the transition of government, the new MSPP gives signs that it is more willing to collaborate than their predecessor. The Project already has a strategy of collaboration that includes encouraging MSPP staff to attend training activities, participation in policy meetings, adoption of MSPP norms and standards throughout the network, and sharing experience of the Network. It is to be hoped that the opportunities for collaboration will increase.

Recommendations
No major changes need to be made in the Project's result areas as these closely match the USAID results areas. Both Project & USAID results areas, however, should be reviewed to reflect changes in priorities and funding availability (for instance, no specific result has yet been defined for Infectious Diseases - a new IR in SO3).

The Minimum Package of Services needs to be updated to include new initiatives in HIV/AIDS/STI – particularly community based initiatives, and TB.

USAID should continue to work with the MSPP to explore new avenues of collaboration in service delivery, but HS-2004/MSH should continue to promote its current approach of public sector collaboration without direct funding public sector services or activities.

USAID should clarify SOAG role, priorities, and deliverables and communicate with all agencies (including MSH) to present SOAG and work out linkages and other needs for collaboration

6) Assessment of project performance to date

Observations
It was observed by some that the project has lost some visible momentum from Phase I to Phase II. While this observation has not been accompanied with criticism, it is clear that many outside the project are unaware of the level of activity that the project is engaged in, nor the progress that the project has made in making the transition from Phase I to Phase II. It is clear that the Project is now poised to move significantly in producing results.

It is important to remember that Phase I and Phase II are indeed different projects, with a different scope of work, different strategic framework, and different objectives. In addition, because of changes in the team structure mandated by USAID a very different team is now assembled, requiring team building to take place.

The project has also suffered with several externally imposed problems:

a) The late signing of the Phase II contract required that initial efforts focus on avoiding a gap in services (since all service providers funded by USAID were to run out of funds less than a month after Project award) instead of launching the new strategy.
b) Major staffing changes at USAID/PHN at Project start-up initially de-linked some of the essential strategic agreements from the process of implementation
c) Several key staff were not available or left the project in the start-up phase (Logistics, Reproductive Health, and Child Survival advisors).
d) The security situation in the country has meant that travel to areas outside Port au Prince has been curtailed.
e) The travel restriction of the last 5 months has meant that technical assistance to the project has delayed implementation of key technical activities.

Conclusions
However, despite this, the Project has made a remarkable set of achievements:

- 16 new partners have been added to the Network, which has required a doubling of the effort in institutional assessment, monitoring and evaluation, and operational support.

- The new team has been brought together, team orientation taken place, new staff recruited, and at the time of arrival of the review team, a full complement of staff is now present.
- The Minimum Package of Services has been defined and completely bought into;
- The Service Delivery Assessment Protocol has been developed and implementation of assessments has begun with the participation of several institutions.
- The Monitoring and Evaluation framework has been completely revised.
- Performance-based contracting has been extended to now include 7 partners.
- Institutional development activities have been initiated to directly target the two central partners - INHSAC & AOPS. In addition activities have begun with the service delivery NGO partners with the introduction of tools for organizational assessment (MOST), and cost estimation (CORE).
- Compiled a detailed assessment of training needs at all levels
- Achieved continuous support of service delivery in transition from phase I in spite of a late contract award,
- Developed a consensus with NGO network on Project strategies & Priorities;
- Completed assessment of Financial Management capacity of all 16 new partners and provided immediate technical assistance where urgently needed;
- Facilitated successful strategic planning processes with AOPS, INSHAC, and CDS;
- All partners have developed BCC & Training plans that fit within an overall agreed upon strategy
- Developed performance-based contracting arrangements with 7 institutions;
- A new monitoring system of production Services has been finalized and is being launched.
- Clearly defined priorities and targets were developed and negotiated for the first 6 month transition period (immunization and reduction in family planning user dropout rates.
- A clearly articulated strategy was developed for field activities and service delivery. The strategy was revised, negotiated, and finalized with the entire network for the first Partners meeting. This strategy was then used as the reference by all partners for the development of the first two-year work plans.

Technical Components

The integrated minimum package of services

The development of the integrated minimum package of services (the *Paquet de Services Prioritaires* - PSP) represents a significant step in the ability to assure the delivery of consistent quality services throughout the network, which target not only clinical services but also community and preventive services. The organization of the package by level within the system provides great flexibility for adoption by a wide range of provider organizations and service delivery points, and it can easily be adapted as new interventions are identified, or as the state of the art evolves. Most importantly, the package is technically sound, and applicable to both the public, private (for profit) and Private (not for profit) sectors.

During the assessment, it became clear that there are differences of opinion concerning the package. It was designed to be the minimum services necessary to ensure that public health impact is demonstrated in the three IRs in collaboration with representatives of all of the Service Delivery partners, and adapted, finalized, and adopted through the work a broadly attended Partners Meeting. There is some disagreement, however, as to what elements in this package should have priority in relation to the needs for expansion throughout a network of service provider organizations.

During Phase I, the Ministry Package was a comprehensive package intended to be made available to an entire population within a UCS, through a range of service provider organizations which would provide either the whole package, or a portion of the package. In Phase II, the Package has been further defined and clarified to represent the essential services that must be delivered at a service delivery point, but there is a strongly expressed opinion that it would be more cost effective to focus on individual elements of the package at different service delivery points. At this time, it is not possible to resolve whether such a reversion to "vertical" programming of interventions would indeed be more cost-effective than the current "integrated" approach, because the cost analysis of the PSP has not yet been conducted.

It is urgent, given the reduction in budget available to USAID, that a thorough costing of the PSP be conducted before the next round of performance-based contracts. With a good knowledge of the expected cost of service delivery in urban and rural settings, realistic targets can be established for funding of NGOs. By use of the CORE tool at individual institutions a gap analysis between expected and actual costs can be done, and specific targets for financial and management improvements established as a part of the performance-based contracts.

Recommendation
That MSH urgently undertakes a detailed costing exercise for the PSP, determining the expected cost of delivery in urban and rural settings. This exercise should draw on the recent analysis recently completed for the Primary Health Care Package in South Africa and be should, ideally, be completed in time for use during the next round of contracting with partners. Once the costing exercise is completed, there should be a "norms & standards" approach for each component. Collaboration with MSPP will also be important to assure that we are building on what is already in place.

Child Survival.

Child survival was one of the areas of intervention during the Phase I of the project. Important emphasis was placed in supporting the IMCI development at the national level during the period 1999-2000. However, this effort needs to translate into reinforcing child survival activities at the NGO level. It is unfortunate that the originally proposed child survival expert was first rejected at the award stage of the project. It was only after an extensive search that this same candidate was found to be the best qualified child survival expert in Haiti. At this time, therefore, the child survival activities of the project are

getting underway. A detailed, eleven points plan has been proposed to USAID for approval and is strongly supported by this evaluation team as being right on target.

One area of particular concern is that of Nutrition. The lack of integration of the food supplementation program with the service delivery program is clearly one of the "lost opportunities" that have been identified. Also certain changes in the role of food supplementation have been suggested, such as changing the target population for food supplementation to all children between the age of 6 to 24 months.

It is important to note however, that these are both areas that have been addressed in the past with less success than hoped for. In 1997, during Phase I, USAID strongly supported the development of a new National nutrition policy for Haiti, and sponsored an international workshop to initiate this process, and later sponsored the actual production of the national policy (including food supplementation) by the Ministry of Health. Changed strategic focus within USAID then moved away from the field of nutrition. This past investment should be the starting point for any further exploration of nutrition and food supplementation.

In terms of closer integration of MCH services and food supplementation, the review team strongly supports this idea. Again, there are have been past attempts within Haiti to establish such an integration at the clinic level that have failed. These should be examined carefully, and strong consideration be given to community-based programs, which rely on the mobilization of community members to participate in models such as the *Foyer de Demonstration Nutritionnelle*. However, these must be combined with a broader community development approach such as providing for community and demonstration gardens and protein production projects, while at the same time focusing on issues such as water and sanitation to reduce the incidence of diarrhea. This would lend itself to working with micro-enterprise projects and community banks.

Recommendations
The eleven-point child survival plan developed by Drs. Grand Pierre and LaForce must be implemented as the Project's strategy in Child Survival.

That USAID lead a review of USAID's past contribution in the development of Haiti's national nutrition program, and consider reconvening the panel of international experts that initiated moving towards a unified strategy for nutrition and food supplementation in 1997.

That food supplementation at the community level be integrated with the delivery of community-based health services, and community-development activities such as nutrition, water, and sanitation projects that can be funded through micro-credits.

Reproductive Health

Reproductive health, and particularly family planning, constituted one of the most successful components of Phase I. The project was able to provide direct training to

over sixty percent of the providers; to train TOT for all the NGOs in the network; and to develop an aggressive program to train community workers. At the impact level, the programmatic areas under the HS-2004 project passed from a modern contraceptive prevalence rate of 16% in 1997 to 25% in the year 2000.

At this point in time, hormonal methods are the main methods used by the family planning clients in the network. Most of the CPR increase between 1997 and 2000 is associated to the increase of these methods use. The key priorities in the area of family planning continue to be:

- To reinforce a better use of injectables and orals by developing intervention that emphasizes the needs of the client and reduces the tendency to discontinue the use of methods because of the occurrence of side effects that have not been adequately explained and discussed with the client.

- To expand the method mix in order to cover populations that are currently under served (e.g. youth). This effort for expanding method mix may also include exploration to re-introduce IUD use in the country in collaboration with other CAs such as FHI.

- To make the improvement of quality of services the primary goal of the family planning program throughout the network.

The evaluation team notes that the project and its partners made, and can continue to make, a big difference in the national rates of family planning use.

Contraceptive Prevalence Rates- Modern Methods

	All Women		Women in Union	
	Base Line 2000	2004	B/L 2000	2004
National	16	23	22	26
Non-HS2004	**13**	**17**	**18**	**21**
HS2004	**25**	**33**	**29**	**37**

The table above shows that at the time of the baseline for Phase II, the areas served by the Project network were significantly ahead in contraceptive prevalence for women ages 15 – 49 (25%) when compared to the non-HS2004 areas (13%). This contribution makes a significant difference to the national Contraceptive Prevalence Rate (16%).

If we consider that the areas under the project presented a relatively similar level of CPR to the rest of the country at the beginning of Phase I (1995 – 19996), then we can estimate the extent of the changes in the project area and their impact on the national level. The same table also indicates the role of the project and its partners in further increasing contraceptive prevalence during the period 2000 – 2004. (We note here that the progress achieved includes a high proportion of use of hormonal methods and, therefore, progress requires both an increasingly reliable system for pharmaceutical distribution and effective programs to minimize drop-outs).

REPRODUCTIVE HEALTH (RH)

Several priorities for HS2004 and the program emerged during our discussions. Efforts have continued to support community and clinical services for family planning. A RH advisor is needed, and the project has nominated a person to be hired for this position in the near future.

Maternal Mortality and Safe Motherhood

To reduce Haiti's very high maternal mortality rate, additional emphasis on training TBAs (who perform 80% of deliveries) is needed. Public sector midwifery training is also needed, although not in the realm of this project. Improved community responses can reduce mortality by addressing the first two "delays"—delay in recognizing an obstetrical problem, and the delay in transporting the woman to a facility. The third "delay" is in receiving care at the facility, and this may be addressed by the JHPIEGO efforts to upgrade public facilities in emergency obstetrics in 8 departments. JHPIEGO is also working with U.S. and Japan funds to improve infection prevention, and to strengthen post-abortion care (PAC). Early recognition and referral for complications of incomplete and septic abortions should be part of the community services that deal with OB complications. The HS2004 project can develop the links between community and hospital to reduce mortality from obstetrical problems and unsafe abortions.

Hospital Albert Schweitzer covers 280,000 population with 6000-7000 births per year. The year. HAS supports an active community program that addresses the major factors contributing to maternal mortality (see above notes with USAID). This program may be a good example of how to link community actions with facilities to reduce maternal mortality. The hospital has a Gates grant for maternal health. This support may help them to share experience with our HS2004 NGO partners. CDS/Pignon also has a similar project.

Postnatal care deserves improvement, which could benefit mother and child. Provision of family planning, especially IUDs can be suitable at a 4-6 weeks postpartum visit. This would improve family planning services and avoid unwanted pregnancies and the high rate of illegal abortions,

Recommendations for Safe Motherhood and PAC

- Strengthen community initiatives for early problem recognition and prompt transportation for women with obstetrical or post-abortion complications
    1. Train TBAs and community health workers to use partograms and recognize other complications
    2. Develop networks for prompt transportation for women with pregnancy related complications
- Establish links with facilities providing emergency OB and PAC services
    1. Contact JHPIEGO and the hospitals where upgraded OB services are available
    2. Identify facilities in close proximity to communities served by HS2004 NGOs and collaborate to provide access for emergency care for pregnant women
    3. Strengthen prenatal and postnatal counseling and services, including clinical family planing methods.

Family Planning

Increased use of injectables has led the substantial increase in contraceptive practice, including areas of the MSH supported NGO partners. An effort to re-introduce IUDs would increase the method mix and the choice of long term methods.

The HS2004 project needs to introduce the family planning norms and standards in a more systematic manner for the NGO partners. This will improve the quality of services, especially for injectables, Norplant and IUDs, where there is general agreement that more needs to be done to reduce dropouts and to ensure that clients are well informed about their methods, side effects and removal (for Norplant).

Reducing the dropout rate for injectables and orals will improve coverage and improve method mix. Reintroduction of the IUD will be a long-term effort, and will not substantially affect contraceptive practice rates in the short term. Many women complete their desired family size at an early age (22-30), and therefore want long-term effective methods. The forthcoming FHI report on the feasibility of IUDs in Haiti may be useful for guiding HS2004 IUD efforts.

The national guidelines for injectables, Norplant and IUDs are consistent with good international standards (e.g., *The Essentials of Contraceptive Technology, R. Hatcher et al)* and the WHO contraceptive eligibility criteria. These can form the basis for HS2004 expanded information to clients and providers to strengthen management of contraceptive side effects for injectables, Norplant and IUDs.

The PSI client information brochure on injectable contraceptives was reviewed. It gives clear and important information for women regarding the major side effects. It might be revised to emphasize the almost universal experience of irregular and/or prolonged menstrual bleeding early in use, with gradual reduction in bleeding followed by the absence of menses. Amenorrhea will occur for slightly over half of all women using

DMPA by one year. The box contains information for the provider to shake the vial, use a sterile needle and syringe, and to destroy the vial, needle and syringe after use.

In the social marketed injectable package, there is no information for providers (the person who gives the injection) on how to manage side effects. This may be a problem, since the woman purchases the kit and then takes it to a provider who gives the injection. We did not explore how well this works for women; however, one would expect that many clinicians who actually give the injection are not familiar with side effect management. It is unclear whether women return to the pharmacist (or informal drug seller) when they experience side effects.

For the social marketing project, one approach might be to prepare a separate brochure for the clinician who gives the injection. The brochure would reinforce the counseling messages and instruct providers how to manage side effects if the woman returns with problems. Without this, some clinicians may not support the continued use of DMPA, especially if the woman returns with complaints that they do not know how to manage. Interaction of HS2004 with PSI to discuss this or other options, including updated training for the pharmacists and other drug sellers may be appropriate. (See above notes on meeting with PSI)

PSI provides about 1 million condoms per month and sells injectable contraceptives (DMPA) and oral contraceptives through 300 formal pharmacies and 100 non-commercial drug outlets. PSI sales for DMPA, 92,000 injections/year, have been about 10% of the total injectables provided in Haiti. PSI also sells about 110,000 cycles of pills per year.

PSI/Haiti staff share the concerns of MSH HS2004 staff about improving the continuation rates for injectables, recognizing that DMPA use has been growing, in spite of less-than-optimal counseling and management of side effects. They were aware of the MSH focus group study of DMPA discontinuers and that better management of side effects is important. The main side effects that need to be addressed are irregular, prolonged, and heavy bleeding, plus concerns about amenorrhea.

Recommendations for Family Planning
HS2004 should continue its focus on high quality services in the network NGOs. These have raised the contraceptive practice rate among all women of reproductive age from 16% in 1997 to 25% in 2000, in a population of about 2.5 million (perhaps closer to 3 million by 2000). There is every reason to believe that these impressive gains can continue to 33%, the actual FP objective of the project during the life of HS2004. This achievement will substantially increase the national contraceptive prevalence rate.

Injectables:

- HS2004 can strengthen quality of injectable contraceptive services through the NGO partners (and social marketing programs where applicable) to meet the growing demand by women
    1. Improve counseling in NGO and social marketing sectors (responding to the results of the focus group study of injectable dropouts)
    2. Provide clear written, as well as oral instructions to injectable clients regarding use of the method and common side effects. Inexpensive materials, similar tot he PSI social marketing package brochure would be helpful, with a little more on management of side effects. Possibly these could be made available in the public system as well.
    3. Provide simple to follow guidelines for appropriate management of common side effects by providers in the NGO and social marketing sectors. Collaborate to help public sector provide similar guidelines. Consistent guidelines across all sectors will have a positive effect on the community response to injectable side effects. Many women get information from other women.
    4. Employ Haiti's appropriate service delivery guidelines, Manual de Normes de Travail in Planification Familiale , MOH, July 1999, in these efforts to improve quality
    5. Strengthen community participation to support women's understanding of expected normal patterns of irregular and prolonged bleeding, and amenorrhea which follows for the majority, during the first year.
- Work with pharmaceutical management efforts to meet the need for increased injectable demand.
- Orient providers and clients to consider injectables as an appropriate option for moderately long term use, while improving provision of other L-T methods

Norplant:

- Support quality Norplant services through HS2004 NGO partners, especially for timely removal when the woman wants to discontinue, or at the end of five years, whichever is first.
    1. Identify current sites with staff trained in removal, and inform NGO network providers of sites for referring women needing removal (consider developing a map locating removal sites)
    2. Encourage skilled providers at current removal sites to continue training staff in Norplant removal to maintain availability of removal capacity at these sites, even if some skilled staff move
    3. Notify Norplant users through the NGO network of the importance of removing Norplant at five years and the availability of removal at any time she desires.
    4. Provide card with the specified removal date and other follow-up information for women who have lost their cards.
    5. Strengthen management of Norplant side effects using the national service delivery guidelines, similar to efforts with injectables

IUDs:

- Assess the feasibility of strengthening IUD services (a long-term process), if resources permit. It may be most practical to participate in a pilot effort with an NGO such as FOSREF. If it is feasible to provide greater support to IUD services, the following elements may be useful in a new approach.

1. Support increased use of IUDs (the TCu380A), based on new international assessments of IUD use in relation to STD prevalence and considerations of quality services
2. Consider holding a workshop that will assess the barriers to IUD use in Haiti and the new assessment of low attributable risk of pelvic infection with IUDs in settings with relatively high STI rates.
3. Identify NGOs willing to reintroduce IUDs in a quality manner and which can document the experience.
4. Support the provision of IUDs in the early postpartum (PP) period (at 4-6 weeks PP), utilizing good prenatal counseling, PP care for the mother and child, and careful assessment of risks using the national guidelines. [Do not provide IUDs in the immediate PP period, right after delivery, as the insertion skill and counseling challenges are much greater at this time. Quality, effectiveness and voluntarism are more complicated at this time.]
5. Provide refresher training for selected NGOs in IUD counseling, insertion, follow-up, and management of side effects and complications.
6. Provide IUD acceptors with simple, low-cost written and oral instructions on use of IUDs, side effects and health conditions for which continued use is inadvisable.
7. Document safe and acceptable use of IUDs in a high quality IUD services that emphasize good counseling, screening, management of side effects and complications in a setting with good client-provider interaction

Recommendation

The project can make significant impacts on family planning practices through the NGOs in the network which have been proven to be effective in delivering services. The project should continue to focus in improving the quality of services delivered throughout the network. It should reinforce a better use of injectable and oral methods by improving counseling and reducing discontinuation of methods used. It should encourage the expansion of the methods mix to better reach the target population.

Other areas of Reproductive Health

Considering other areas of reproductive health, the project has played a significant role facilitating the interaction between network's NGOs and community traditional birth attendants (TBAs), by supporting intensive training and assisting in the setting in place mechanism for coordination and supervision of TBAs by the providers. This has increased safe deliveries and appropriate referral, and has probably contributed to efforts to reduce maternal mortality.

Notes for social marketing of injectables, Haiti, 1 May, 2001 (HS2004 Review)

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Recommendation
The project should build on initial efforts at safe motherhood, for instance by fast-tracking some of the strategies outlined in the proposal, like building on Phase I efforts to introduce and expand throughout the network a focus on the community and (with Pathfinder) enhance capacity at first provider levels for early recognition of complications, rapid referral, and active management of obstetric emergencies (including Post-Abortion Care).

Cross cutting issues:
Training.

Observations:
Implementation of the training component plan for year 2001 is moving according to schedule. The goal of the current training plan is to complete the overall training strategy defined during the Phase I, aiming to reinforce knowledge and skills and identify weaknesses and gaps in productivity. Thus, a key task in the development of this plan has been the training need assessment that has allowed the project to set priorities both by technical topic and by specific NGO. The project staff are directly involved in curriculum development, and the actual training activities are implemented with the assistance of INHSAC and GHESKIO. A key aspect that should not be over looked is the need for the building of a comprehensive evaluation component that could help in making appropriate adjustments to the strategy and plans. Training is also well coordinated with the behavioral change and communication activities. There is a need to strengthen the integration the involvement of the project training component in other technical efforts of the project (service delivery, institutional development, etc.) in order to assure that the training programs are targeted to meet their needs in the field.

In Phase I, the Project worked with local partners to develop a national trainers' network which has departmental levels. A good capacity for training program design, organization, implementation and evaluation now exists in most of the departments at the local level. HS-2004 started to work with the trainers' network on issues related to longer-term sustainability: how to organize itself, keep technically current, organize the supply of services, etc. The Network continues to be a useful and cost-effective complement to MSH technical resources in the organization of local members from both private and public sectors as well as from the national and the training programs. In several cases, Network members from one institution have been seconded to help Network members of other institutions in the organization of their training programs. Some partners (for example, GHESKIO) have switched their training methodology to the andragogic approach and have reported great satisfaction on the part of both their staff and the participants with the quality of the program.

Some of the results:

- Planning and implementation of training interventions are no longer limited to a few specialized institutions.
- The capacity to manage training programs has significantly increased. For example, an MOH staff member reported that she was better prepared to evaluate the training programs being proposed by donors and to have more balanced and effective technical negotiations with them. She believed her new-found skill increased the quality of consultants' work.
- More than 700 persons were trained in 1999 in areas related to service delivery, IEC, and management. More than 95% of the partners ranked the Training Program as very good to excellent.
- For the first time, follow-up of training in the field was implemented

Given the success of Phase I training strategy and the continuity during the first year of Phase II, the project should continue with the strategies outlined in the proposal. Other approaches, such as the introduction of a self-learning approach, should also be considered where impact can be increased or, under some circumstances, costs might be lowered. Self-learning, for example, could imply expanded effect by using a strategy of training providers in the work place without disturbing the normal delivery of services. This approach builds on the development of topic oriented modules that are specifically prepared to be used by groups; the modules frames the training on a programmatic topic in both the need for evaluating progress in the working of the program as well as planning future steps.

Recommendations

The Project should continue with proven training strategies. Particular attention should be given to follow up. It includes observation and measurement of providers' improvement in delivering services to clients as well as on-the-job training to improve the quality of services, and promotion of facilitative supervision to ensure that training investments result not only in improved knowledge but also in positive behavior change.

Consideration should be given to the potential benefit of channeling training activities towards a distance and self-learning approach to increase the cost-effectiveness of training, to strengthen the processes of human resource development within NGOs, and also to minimize disruption to service provision by the need to upgrade skills.

The training program should follow the already successful model for coordination with behavioral change and communication activities be more actively integrated into strategies and program efforts related to community mobilization, service delivery, institutional development, etc. to assure that the training programs are targeted to meet their needs in the field. Support to the public sector members of the trainers network should be limited to collaboration (including collaboration in planning) and inclusion of public sector participants in events where MSPP can support their participation.

<u>Human Resource Development</u>

This sub-component of training is ready to start in October 2001. In its first phase, HRD will conduct a diagnostic exercise with five of the more mature partners. As a result of this exercise, joint efforts will be implemented to develop plans for HRD strengthening. It is planned that INHSAC will take the overall implementation of this component. However, caution should be exercised in the implementation of this plan given the institutional and management weakness of INHSAC. Furthermore, INHSAC has little experience in the area of human resource development …which is more properly considered as an essential component of institutional capacity and development than as an offshoot of training. For any organization, human resource development (HRD) must be connected to the goals of the organization. It should also be linked with the strategic planning that should be done to coordinate the diverse activities and processes undertaken by the units within the organization in pursuit of those goals. This linkage will assure that HRD efforts will be effective and cost-efficient within the organization=s resource constraints. Elements relating to HRD should be built into most aspects of the human resource management (HRM) function of the organization.

The primary goals of the HRM unit are to assess and meet the changing human resource requirements of an organization and to maintain a positive and constructive staff environment. Essential elements of the HRM program are: participation in strategic planning and staffing needs assessment; participation in resource allocation decisions; role definition and clarification, classification and documentation; recruitment; orientation; training; performance planning, monitoring, and review; staff development and; completing the cycle, back to planning. A serious question is if INSHAC will be able to provide both quality training and technical assistance in the area of HRD without significant assistance from MSH.

Recommendations
MSH should provide technical assistance to INHSAC in Human Resource Development to establish a clear capacity function as a technical resource in this critical area.

To ensure that the HRD element of the project succeeds, MSH should include HRD (and support in the use of the HRD tool) as a part of its own technical assistance to network partners. An introductory seminar on the structure and utility of the HRD tool could be included as a component of the next major partners meeting.

Human Resource Development and Institutional Development work plans should be carefully integrated to ensure that current gaps are filled and that the natural synergy of these two components is realized.

<u>Behavior Change and Communication.</u>

Implementation of BCC component plan is on track. There is good coordination with the training component, but coordination with the other technical areas of the project should be expanded to reinforce understanding of this component among the network partners. Heightened awareness of the value of communication and information exchange in

reaching program goals will be an advantage to network NGOs in establishing sustainable community based programs.

The MSPP National plan for IEC (the national and departmental plans were developed with HS2004 assistance during Phase I) is the main guide for the developing the Project's BCC strategy for Phase II, while the review of NGO's technical proposals has provided the basis for the phase II operational plans. These proposals have been key in guiding the preparation of training workshops and the research plan for BCC. An independent company will implement these research studies and the project is in the process of developing an RFP for this.

A key accomplishment has been the establishment of the Technical Group for Communication. This Group has representatives from key NGOs and institutions such as - SADA, CDS, FOSREF, USAID, PSI, CARE, POZ, IMPACT & Konesans Fanmi, all of whom have been actively involved in the whole process. The experience and expertise in communication and field experience (work in specific areas - youth, STI, HIV, etc.) of this group will be essential to the success of this BCC effort. Through this group the project will have the opportunity to increase our collaboration with PSI, and expand their experience with brand promotion materials to a wider communication community.

The project is currently implementing all the field activities of the plan and systematically working to overcome the identified shortage of IEC materials. Posters, radio spots, radio soap opera, and a distance learning program are being developed, in addition to support materials for the client, with key reminders for the community health agents. A set of five fliers is being developed which includes material on maternal health, child health, the sick child, family planning, and STIs. These will contain key behaviors for specific situations, e.g. in pregnancy - go to clinic if you are pregnant, eat good food, how to prepare at home for delivery, and how to deal with the post-partum period. In addition, the Project has been conducting intensive training in interpersonal communication.

Recommendations
The BCC staff should continue to provide leadership in this area and to collaborate closely with UNICEF and MSPP to make sure that the Project is tied into what they are doing.

The BCC staff should work with each technical component of the project to assure that the concept of strategic communication and exchange of information is used to promote local program impact. This aspect of the work related to community mobilization is of particular importance because of the range of interests and activities extending beyond 'health' of community-based organizations.

<u>Community Services & Community Mobilization</u>.

The project's overall Community Approach has yet to be clearly articulated as a project-wide strategy. This could have been anticipated at the design stage given the complexity

of both components and the need to bring them together into truly community-based services. In order to have the maximum impact, it is going to be important for both areas to establish a clear and integrated conceptual framework for project implementation , identify areas of synergy, and use these to establish a comprehensive plan for community approaches.

Based on the inventory of community organizations and services that has already been done, it seems likely that the community approach should focus on strengthening of community based services and mechanisms to reinforce them with the participation of the community. This will require ensuring that NGO's remain committed to improving community-based services. The manual for community health workers will then need to be framed more broadly in community development terms rather than on a single worker or institutional base.

Given the complexity of shifting from an institution-based to a community-based service delivery modality, and the variation in organizations and approaches in Haiti, it must be expected that the community approaches become gradually effective within the network areas. However, the Project can expect that as the two areas come together community-based programming will become central to the overall technical agenda of the project.

Recommendation
The community services and community mobilization groups should come together through the mechanism of a Community Approaches Focus Group. This group will develop a comprehensive community approach for the project, which will guide both community-based approaches and community participation in service delivery.

Institutional Development

The implementation of the component for institutional development has a clear scope and framework outlined in the proposal that identifies the end stage of development and the stages in getting there. The project's Institutional Development strategy focuses on the 'Fully Functional Service delivery Point' concept. This concept of being "fully functional" will be determined by partners' capacity (1) provide the package of services at an expected level of quality (measured by the SDAP) and 2) implement and operate the minimum requirements of the management package. The strategy contemplated by the project builds on the progressive development of these components and not from a global abstract plan that institutions must adhere to. This indeed was a key conceptual point in the proposal. In implementation, this component has not yet fully implemented this framework and there is now some urgency in directing the MOST and CORE tools and other assessments to relate more specifically to facilitating the processes specific to each network partner in progressing though the stages of institutional development outlined in the original proposal.

A simple review of the interventions to date, the design of a comprehensive diagnostic process, and re-introduction of the organizational stages of development concept will be the first step. This step should then be supplemented by using the performance

improvement analytical methods and integrating the findings with performance based financing, other institutional development interventions and human resource development. Together, these interventions are likely to ensure that we will succeed in strengthening organizations to produce more and better health services, better prepare to manage their resources and become more capable to adapt to a changing environment.

Recommendation
The institutional development team should review planned activities and strategies to more closely follow the originally proposed process for institutional development and make use of performance improvement analytical methodology to target interventions at the factors that are impeding individual institutional progress toward articulated goals.

Monitoring and Evaluation.

M&E component has shown good responsiveness vis-à-vis USAID's changes. Strategy for further developing Service Statistics component needs some attention; particularly regarding the role of IHE. Starting in January 2001, IHE is co-reponsible for processing and reporting the service statistical information coming from the partners.

The sequence for data processing and reporting is:

1) Currently, the partners sent original data to HS-2004 in hard copies (forms).
2) The HS-2004 M&E team sends the forms to IHE.
3) IHE proceeds to enter the data into the database, produces the defined tables and prepares quarterly reports.
4) Finally, these reports are sent to HS-2004.

There is a clear need for streamlining the overall process to assure that the production of services reports are timely produced and sent to HS-2004 offices. A key issue is the time allowed for each of these steps to happen as the project requires to prepare timely feedback to the partners regarding production of services. This constitutes a challenge. For example, to date, although the data have been timely sent from HS-2004 to IHE, the project does not have yet the reports for January and February 2001.

Impact Survey
A particular area of concern is the subject of impact monitoring. Given the sudden reduction in the overall funding level available for the implementation of HS 2004, MSH agrees with USAID that a review of the scope for the planned impact survey makes sense. Upcoming budget reallocation decisions may require limiting the ambition of the scope of the survey, however, a timely and appropriately targeted impact survey is essential to assess the progress of HS2004 toward its goals in order to effectively report impacts and target future efforts to build on Project results.

Recommendations
To streamline the production of service reports, IHE should assure assignment of qualified staff to focus as a first priority on the processing of data into the agreed report format upon receipt of data.

Funding shortages should not be allowed to prevent the project from measuring health impacts brought about by project interventions. While much of this can be done through routine collection, periodic impact surveys must take place to obtain specific population-based information.

Essential Drug Logistics

This component is in its inception. Three temporary specialists have been hired and trained. Thus the project is ready, in collaboration with other agencies (AOPS, JSI/MEASURE, JSI/DELIVER, MSH/RPM+) to begin activities in support of the network partners in the field. (Please see April 2001 Report submitted by MSH/Center for Pharmaceuticals Management consultants)

7) HIV/AIDS

Haiti's AIDS epidemic has stabilized, with a modest decline in HIV+ prevalence among pregnant women, from 6.2% in 1993, to 4.5% in 2000. However, in young women, aged 20-24, the HIV+ rate has increased. In addition, in some sex worker populations the HIV+ rate has increased.

Expanded voluntary counseling and testing (VCT) for HIV was urged by several organizations in order to support new interventions, including care for people living with AIDS (PLWA), preventing mother-to-child-transmission (MTCT), and identifying persons at high risk for TB and other opportunistic infections (OI). The number of centers and the availability of VCT services would appear to be relatively low, about 35 (current and planned in near future) with a demand that is increasing. Rapid tests that give results on one visit (along with pre- and post-test counseling) can help meet the need. The accuracy of rapid tests has been studied and confirmed at GHESKIO. They can also provide training.

At some sites currently doing traditional HIV tests and requiring 3 separate visits, about 30% of clients fail to return for their test results. Problems of stigma and lack of care and support for PLWA was identified as a major problem. The deficiencies include lack of basic nutrition, psychological and spiritual support, drugs to treat simple OI and TB, and end-of-life care at the community and home level. Only INH for TB prophylactic treatment (PT) is available free.

Some organizations in the HS2004 network specialize in care for PLWA and these could serve as examples for others. Materials could be shared among NGOs in the network, including brochures from the Dominican Republic currently being translated into Creole (by POZ). A handbook for home based care (HBC) is available from GHESKIO. Other HBC materials are available from MSH projects in South Africa and from other agencies. Health experts in Haiti believe that HIV+ people will have better quality of life and be

less likely to infect others if they stay in their nuclear family. Supporting families with food and the training to give HBC is seen as a sound alternative to hospital care.

There is a special need to help HIV+ women prevent MTCT, although this is a complicated area. UNICEF will support pilot activities. Marc Laforce with Jules Grand-Pierre had explored this new effort. Rapid tests to screen prenatal women will be part of this effort, which may include 1-2 institutions in the HS2004 network. HS2004 staff will be participating on the April 2001 USAID HIV/AIDS assessment team (in particular, Dr. Elke Konings will participate as a member of the team), and more details should be forthcoming about those institutions best suited to participate in this new initiative. The USAID team may also obtain the screening and treatment protocols to prevent MTCT, guidance on the use of triple anti-retroviral (ARV) therapy for mothers, and guidelines on preventing HIV transmission through breast feeding.

Helping HIV+ women avoid MTCT through family planning is another important component. At GHESKIO, the percent of HIV+ women who become pregnant dropped from 24% to 4% with improved family planning (FP) services. Women were previously referred elsewhere for FP, and many did not get served. Now FP services are offered on site and successful contraceptive practices have increased. This may be a good model to develop in other NGOs that can offer VCT to non-pregnant, as well as pregnant women.

The Albert Schwietzer Hospital provides VCT using rapid tests and is interested in expanding this service. The hospital and the community outreach efforts may be a good early site to provide AZT or nevirapine for prevention of MTCT.

Additional mechanism for MTCT is through breast feeding. Given that milk or artificial feedings will not be feasible for most HIV+ women in Haiti. The cost of BF substitutes will be very high for the average family, perhaps 20-30 times as much as the nevirapine treatment. Some Haitian experts believe breast feeding may be a better option, in spite of the risk of HIV transmission. The WHO guidelines, give breast feeding as an option when breast milk substitutes are not affordable, or cannot be safely prepared. Women will need good information to make informed choices. There are other interventions to control HIV/AIDS that are more likely to receive support through other organizations, rather than MSH.

- Given the apparent contribution of condoms to stabilizing the HIV epidemic, continuing to promote condoms through social marketing seems reasonable. PSI is continuing this work with funds outside HS2004.
- New initiatives to reach the poorest street sex workers, might include offering male and female condoms through a social marketing effort that would permit SWs to keep profits from selling male condoms. Social marketing has addressed the needs of sex workers in more organized settings, and might consider serving this group.
- Educating school children about AIDS may become a higher priority, and is being addressed by a few organizations.
- Additional effort may be needed with other high-risk groups, truck drivers, taxi drivers, and police. Some agencies have worked with these populations and are prepared to do additional work.

Conclusions and Recommendations

In order to strengthen HIV/AIDS prevention and care, MSH can initiate selected interventions from the following recommendations. HS2004 staff, working with the USAID HIV assessment team, should refine and revise what is feasible, and in what magnitude during the life of the project. Assuring the human resource capacity and expertise within the team and through project partners will be critical to the success and sustainability of selected strategies and interventions.

- Expand HIV voluntary counseling and testing (VCT) with rapid tests for HIV as the basis for strengthening other initiatives:
  1. Providing HBC and community support for PLWA,
  2. Preventing MTCT among pregnant women,
  3. Offering contraceptive services to HIV+ women to reduce MTCT by reducing pregnancy rate.
  4. Screening HIV+ people for TB to assess whether INH prophylactic treatment (PT) may be appropriate,
  5. Increasing involvement of PLWA in their own care an in developing capacity at the community level
  6. Identifying the large number of HIV- people who will benefit from BCC efforts to change behavior, relate with partners and remain negative
- Provision of HIV rapid test kits assumes that USAID, other donors, or MSH will procure and distribute sufficient kits to meet the needs of pregnant and non-pregnant women, as well as men who want to be tested.
- Increase capacity for VCT first at well established centers to increase access and streamline VCT for one visit testing. As test kits become available, plan to extend VCT to all health centers with qualified staff and where community care and support can be provided.
- Develop a map of all VCT testing sites, during the USAID HIV assessment that can be used by HS2004 network and other providers (action for entire team)
- Work with NGO partners who provide VCT training to introduce new rapid tests for network NGOs.
- Through the NGO network (and potential new partners) MSH should support training and community mobilization for care of PLWA, including, where possible, treatment or prevention of OI, TB management, improved nutrition, and links to clinical services.
- MSH and the NGOs should collaborate other partner agencies working with logistics and pharmaceutical management efforts to provide supplies of rapid tests, drugs for OI, TB screening, PT, treatment of active TB, and prevention of MTCT.
- MSH should work with UNICEF as a partner to initiate prenatal HIV screening and provision on AZT and nevirapine for MTCT in two network centers, along with guidance on breast feeding, supplemental feeding, ARV drugs for mothers and treatment of OIs as is feasible (Marc LaForce trip report, 30 March 2001)

8) Sexually Transmitted Infections (STIs)

During the Phase I project, training was conduced, in collaboration with GHESKIO, for the dissemination of the syndromic approach throughout the network. Providers from all NGOs were trained in its use. With the start of Phase II, syndromic management is expected to become more widely used among HS2004 partners, as reflected in the workplan.

In Haiti the diagnosis and treatment of STDs has generally been weak. Availability of STI drugs is a problem in many locations. Using syndromic diagnosis is appropriate for some STD syndromes. However, GHESKIO is no longer using the vaginal discharge syndromic management protocol, because it is neither sensitive nor specific for gonorrhea (GC) and chlamydia (CT). This seems reasonable, since the international experience with this syndrome has been disappointing. HS2004 should advise the network partners about the problems of syndromic management for vaginal discharge and encourage greater emphasis on syndromic management of male urethritis with treatment for men and their sexual partners. MSH technical staff reviewed some of the initiatives and materials that can be used to revise the approach to syndromic management. USAID technical staff also agree with this shift

One priority from a health perspective is the prenatal syphilis screening and treatment. This is a cost-effective intervention, even when syphilis rates are relatively low, due to the low cost of testing, the accuracy of the test and the major benefit of simple antibiotic treatment to prevent pediatric syphilis. This will require making syphilis testing available at sites with prenatal services.

The dissemination of national norms for syndromic management of STDs have been limited. The approach to syndromic management of vaginal discharge still provides for the treatment of GC and CT and partner notification. Most experts now agree that this is not a good use of resources and can social problems, when men are informed they have an STD based on weak accuracy for diagnosing GC and CT. MSH and the HS2004 project should work with the MSPP regarding future revisions; samples of alternative treatment algorithms (presented at APHA) were reviewed with MSH staff and the new reproductive health consultant.

Recommendations

- Assess components of syndromic management of STIs to maximize effectiveness and acceptability of interventions
    1. MSH/Haiti should collaborate with GHESKIO, FHI, and MSH/Boston technical staff to refine the syndromic management of male urethritis in order to increase accuracy of treatment for gonorrhea (GC) and chlamydia (CT) and improve treatment of female partners
    2. MSH staff, working with the NGO network should provide clear written, as well as verbal instructions to enhance compliance with treatment regimen, give condoms, educate, and provide partner notification materials (NGO sector could adapt the four STI kit components for male urethritis as successfully used in Uganda)

3. Educate men, women and youth in the community about need for STD treatment of men with urethritis as well as their partners through community health workers and other mediums for health communication.
4. Provide convenient services in the community for reaching and treating men with urethritis, using existing community health centers and community workers.
5. Work with NGO partners on revised syndromic management protocol for vaginal discharge—in most cases to treat only for simple vaginitis, without partner notification

- Collaborate with pharmaceutical management efforts to ensure availability of common STI drugs and condoms.
- Continue to provide condoms and STI prevention messages in the NGO network.
- Assess the current level of syphilis testing at network NGOs and establish norms for universal testing and treatment of positives.

9) Tuberculosis (TB)

Haiti has 180 new cases of documented pulmonary TB per 100,000 population per year (about 15,000 per year), according to staff at the National TB Control Program. From 15-25% of new cases are in children under 10 years of age. There are about 180 centers in Haiti with trained staff and equipment. At present there are 54 suspect and confirmed cases of MDR TB. Of these 35 are under treatment. Assistance from Partners for Health in Boston helps with the culture and drug sensitivity testing, as well as providing the expensive drugs to treat these patients.

Improved national surveillance for TB drug resistance is needed to better establish the best drug regimens for Haiti. Drug resistance is high in the Dominican Republic and roughly 500,000 people pass the border each year. Therefore, some common resistance patterns may exist. A priority for TB is to review the current national TB treatment protocols at a national workshop in light of relatively high recurrence rates. The idea was offered to hold a Haitian workshop inviting a few international experts. Clinicians at GHESKIO are concerned about the new 4 drug, 8 month directly observed therapy (DOT) protocol that provides only 2 months of Rifampin. GHESKIO studies showed a high recurrence (late, at 2-4 years) with a 4 drug, 6 month protocol that included 6 months of Rifampin.) The workshop could review the evidence on effectiveness current TB treatments, along with other considerations of expanding DOT availability and other topics related to national TB control. Additional topics may be the approach to HIV+ patients in Haiti--whether to provide prophylactic treatment (PT) with INH, and for how long--and the need for all institutions dealing with AIDS or TB to deal with both diseases. Providers working in HIV need to also work with TB and vice versa. At GHESKIO, 30% of patients coming with a cough have active TB, the same for both HIV+ and HIV-.

Assistance is needed in conducting cost analysis for TB prophylactic therapy for HIV+ patients in Haiti. Costs need to be compared for various alternatives for providing PT for HIV+ patients who do not have active TB. Considerations of which drug will be best, the levels of resistance to INH, and the consequences of not using INH correctly could be

included. The Albert Schwietzer hospital has an active TB diagnostic and treatment program with good lab facilities. They use a TB treatment protocol that they believe is better than the national protocol. HAS will be a good institution to include in a Haitian TB workshop.

Recommendations

These recommendations should be reviewed in light of findings by the USAID TB assessment team visiting Haiti, 16-30 April, 2001.

- Evaluate current TB interventions for efficiency and impact in network areas to guide technical assistance to network partners as TB control is introduced into the minimum package of services.
- MSH should expand efforts to identify and treat active TB cases within the HS2004 network using the national protocols for diagnosis and treatment in Haiti
    1. Use national TB control program facilities for identifying suspect TB in adults and children and record efforts using the standard forms
    2. Identify sources of supplies (from the national TB program?) for TB skin testing, and for referral to examine sputum (primarily in adults)
    3. Identify centers where chest X-ray can be performed
    4. Establish norms and guidelines for NGOs to link TB and HIV control efforts and follow TB prophylaxis protocols for HIV+ people
    5. Link with higher centers for occasional MDR TB, when identified
- Introduce DOT management in NGOs where this is not yet established. MSH may need to conduct a quick review of the sites where DOT is provided and the number of people being treatment.
    1. Follow national reporting systems
    2. Consider community and home efforts to improve DOTS performance using the South Africa Equity examples and other innovations specific to Haiti
- Establish revised TB treatment protocols to the extent that there is lack of consistency
    1. Work with AOPS or another organization to hold a national workshop on TB treatment protocols for HIV- and HIV+ patients with Haitian and a few international TB experts
    2. Collaborate and meet with selected Dominican Republic TB experts who work with Haitian counterparts to address common problems with treatment and surveillance efforts
    3. Collaborate with efforts at national level to culture sputum of suspect treatment failures to provide earlier detection of drug resistant strains
- Establish increased emphasis on childhood TB—children constitute 15-25% of the 15-20,000 new TB cases each year
    1. Help with diagnosis and testing to detect active cases (sputum is difficult to obtain from children), using skin testing (with interpretation appropriate to Haitian setting where BCG is widely used) and chest films
    2. Review whether there is a Haitian consensus about treating only active childhood TB, and not providing prophylactic treatment for children under 5 who are household contacts of an active case—this could be on the agenda of a national workshop

3. Introduce new pediatric treatment protocols that are nearing approval (ethamutol is deleted)

- Support community efforts to link child health, TB, HIV, nutrition and supportive care for children and adults with single or double infections—efforts to improve TB control should link with HIV efforts and vice versa.
- Consider coordinating with ICC/CAT as well as with MSPP to extend TB program impacts to non-network areas.

Note: when the Alliance TB report is finalized, these recommendations will be reviewed in relation to their findings to provide additional guidance on 'next steps'.

10) HS2004 Teamwork

Observations
There is some need for reviewing the current project structure and reporting relationships. While the team has developed and each member has a defined work plan, the complexity of the project and its context require that new focus be made in regard to effective team work. The work plan is good in that the scope of the project is covered by the individual roles, but there is not an adequate overarching mechanism that draws things to work together.

Each team member is effectively implementing his or her work plan, mechanisms must be found to assure that essential communications are made in a timely fashion and that individual team members are able to draw on the capacities of the others in carrying out the goals of their jobs.

In the technical area, the Deputy Director should assess priorities and identify areas of activity that she can redesign or further delegate to others in order to allow for a stronger focus on overall coordination across the broad range of technical staff efforts. Many administrative and technical delegations have been appropriately achieved; however, overall systems for communication and coordination need to be strengthened. It may be reasonable to explore the utility of a technical committee. This technical committee could include, perhaps on a rotating basis, individual technical advisors from each of the key project areas. The primary function will be to help assure that technical strategies and interventions are regularly adjusted to reinforce each other for efficiency and impact. Additionally, it would be appropriate in relation to the key technical areas of the project to establish focus teams to facilitate effective technical exchange and support of closely related project specialty areas.

Additionally, there a few direct reporting relationships that should be altered to achieve better coordination and clarity among related functions. The drug management effort and the work that needs to be focused on linking performance based contracting with performance improvement and organizational development implies that the technical advisors in those roles shift to the Finance & Organizational Development Unit.

Recommendations

Cadres of staff work in *Focus Teams* to assure effective communication and implementation in their areas and to facilitate effective technical exchange, communication and integration with other HS-2004 units and efforts. The formation of these focus teams will not change existing reporting or supervisory relationships. In each major technical area, backstop expertise has been identified to assure essential quality and institutional support from MSH and its partners. Focus areas should be:

- Institutional Development
- Community Approaches
- Technical Delivery of Services

Each of these groups includes three or four technical staff and/or partners.

Additionally, there are several Crosscutting areas that operate in relation to all three of these groups:

- Direction
- Training
- Behavior Change & Communication
- Monitoring & Evaluation
- Drug Management
- Finance/Contracts/&Management

Recommendation
In order to assure appropriate planning, support, and analysis to the performance-based contracting initiative, the role of the Policy Advisor, Mr. Chevalier, be redefined to include responsibility for coordinating efforts with partners around the implementation of performance-based financing (PBF) program efforts.

His work plan should include technical assistance and planning activities to facilitate NGO partner performance with particular attention to using Performance Improvement methodologies to enable partners to identify the causes of problems before targeting their efforts. Areas of activity will include: working with partners and participating with other HS2004 team members on appropriate design of indicators and incentives for meeting them; understanding need for and uses of strategic and operational planning; data collection and use; monitoring & evaluation; improvement of efficiency; enhancement of institutional focus and staff morale; and achievement of impact. Because of the need to integrate this activity with the overall institutional development work of the project, his reporting relationship should shift to the Finance & Organizational Development Unit.

Recommendation
As noted under 'Network Development,' with the shift in Mr. Chevalier's role, the direct responsibility for supporting and coordinating with AOPS and for network development should become a primary responsibility of the Chief of Party, Mr. Auxila.

11) Network development

Observations

Historically, a reduced number of partners have produced the bulk of services and served the majority of the target population. In 1997, five of the total number of partners in the network covered 60% of the entire population assigned to the project. Considering service production, this percentage is even higher. This phenomenon would justify a review of the permanency of all the partners in the network. The HS-2004 project should at this point (as specified in the proposal and contract for the project) review both the performance and the estimate impact of each NGO and remove from the network of supported institutions those that have marginal impact in relation to the size of their target population and those that have a systematic unsatisfactory performance. If HS-2004 continues working with as few as 12-15 of the best-performing partners it will still have the expected impact and covering a significant portion of the current target population.

In order to maintain the closeness with the partners, the project should intensify contacts with NGOs directors and technical-medical coordinators and other technical people. This was a key element in the successful network development during the first phase. The existence of a field operation unit was very instrumental in the intense HS-2004 – partners interaction. The project structure has integrated this function with technical coordination for Phase II and it is possible that some clarity for prioritization in field operations coordination has been lost.

Regarding productivity, most partners maintain a level of production of services more or less at the same level as in Phase I, while some struggle with low or very low production. Given this variance, another area that could help to strengthen the network is a more effective and better planned technical assistance to the partners. Discussions with team members have indicated that currently direct technical assistance to partners occurs in a responsive rather planned sequence. Planning technical assistance is a priority task that is directly connected to the improvement of field operations.

The management and operational capacities of the Central Partners – INHSAC, IHE and AOPS, need further strengthening. It will be important to get a realistic agreement with with each and with USAID regarding the forward scope of activity with HS 2004 in light of the changed resource environment.

INHSAC: Needs to continue reinforce management and planning systems. Technical expectations should be reviewed carefully to assure that they are realistic in relation to the resources available (See notes related to Human Resources Development)

IHE: Still requires significant technical assistance and, while actively working to build its own capacity to provide technical assistance to partners in the area of service statistics improvement, should review with HS2004 the reasonable scope and expectations for its work given the changed circumstance of the project.

AOPS: In MSH's technical proposal it was noted:

"Currently MSH is the "home of the Network." MSH will work with its members to develop a secretariat and a home that will have the capacity of coordinating Network activity at the end of the Project. We will explore with the

members the possibility of re-engineering AOPS and developing its capacity for it to move away from the conflict-of-interest role that it is now playing to its initial mandate as an association….

…The existence of AOPS represents a good opportunity to address the issue of sustainability of the Network. The AOPS board has expressed its desire to assume this role and its secretariat has confirmed its desire to collaborate with MSH in re-orienting the organization to its original mission. This appears to be a sound strategy, since AOPS includes not only HS-2004 members but also institutions outside the Network, and AOPS could also be strengthened to attract others."

The Project has worked very effectively with the board and executive of AOPS to develop a long-range strategic plan. Since that plan was developed, several events have taken place that have created some disagreement between the executive and the board about the way forward. The original basis for collaboration with AOPS remains valid. There is an overwhelming need for an organization within Haiti that can be responsible for the role of coordinating NGOs, maintaining quality standards of practice, (possible extending to accreditation), representing members in broader forums, and advocating with the public sector on behalf of the members. By assuming these roles for the HS2004 network members, AOPS would then be able to apply their skills and expertise through the several hundred members of the association, thus extending the reach of the original HS2004 network to all NGOs in the health sector.

Recommendations
AOPS's board of directors finalize agreement on their strategic plan, and work with MSH and USAID to develop a clear operational plan to bring this strategic plan to completion by the end of 2004.

The Project Chief of Party should take over the role of key link with AOPS and for network development.

The project should work with USAID and AOPS to review the strategic goal of the *Haiti Sante'* Network in relation to the current AOPS strategic plan and the practical reality of what the functions of the network will be after the end of the HS2004 Project (some examples include …technical forum for exchange, coordinator of standards and certification processes, mechanism for organized discussions with MSPP).

12) Performance Based Approach

The HS2004 Project began a pilot with three Partner organizations on a performance basis for financing (PBF), as a shift from pure cost reimbursement, during the latter part of Phase I (CDS, Save the Children, and CPB). This beginning produced some positive results and enthusiasm from those partner organizations to continue. Evaluation of the pilot indicates the extent of the positive results. The most striking result comes from the increase in immunization coverage shown in Figure 2. Members of the assessment team met with six of the seven NGO partners working through the performance based financing mechanism (CBP, Ste Croix, CDS, SADA, MARCH, and Save the Children). It was not possible to arrange a meeting with HAS in the available time frame.

PBF partners responses have been positive. The PBF approach has enabled better financial agility and has altered behavior and procedures within the NGOs in a way that helps them focus t more on reaching goals than on the simple tracking expenses. They report that they are thinking strategically in terms of results, impacts and, because of the incentive mechanism, consequences.

The table below presents baseline measures, targets, and actual results for each participating NGO. The most striking results came from the increase in immunization coverage. Each participating NGO exceeded the performance targets for immunization coverage substantially. By 80%, 28% and 82% respectively. This represents an increase of 6,143 children in Haiti that have been immunized as a result of the performance based payment pilot program. In two of the three NGO service areas, the proportion of mothers who reported using ORT increased, similarly, and in two out of three NGO areas the proportion of mothers who reported using ORT did so correctly also increased significantly. Other indicators such as prenatal visits and reducing the discontinuation rate of modern contraceptives, however, indicate a show a weak performance.

Results from Performance Based Reimbursement Pilot in Haiti

Indicator	NGO 1			NGO 2			NGO 3		
	Baseline 9/99	Target	Results 4/00	Baseline 9/99	Target	Results 4/00	Baseline 9/99	Target	Results 4/00
Immunization coverage	40	44	79	49	54	69	35	38	73
3+ prenatal	32	38	36	49	59	44	18	21	16
FP discontinuation	32	24	43	43	32	30	26	20	12
Utilization of ORT	43	50	47	56	64	50	56	64	86
Correct utilization of ORT	71	80	81	53	59	26	61	67	74

Changes introduced by performance based reimbursement motivated NGOs to request assistance in a number of key areas that would strengthen and improve the sustainability of their institutions. Requests for technical assistance included areas such as strategic planning, strategic pricing, cost and revenue analysis, determining client perceptions of the quality of service, models of staff organization and utilization, and human resources management.

Specific points made by "PBF partners"in discussions (these points can be taken as guides to management and organization development elements that should be pursued):

- Targeting activities to specific objectives has lead directly to improved achievement of results.

- Higher level of financial autonomy (95% of the budget for the contract period is advanced) improved ability for planning & financing longer-range events (earlier funding cycle of 45 days was a constraint) This lead to greater participation of staff in planning and efficiency in implementing programs.
- Considering the latest set of indicators, the some partners indicated that, the indicator relating to coordination with MSPP does not really measure performance and, as a purely administrative matter requiring signatures, can sometimes be a nuisance in the managing of the PBF program at the NGO level.
- Several partners noted that their staff have been motivated to better evaluate own systems and that their organizations have now internalized the need for and utility of good service and financial efficiency data.
- Several groups noted that the introduction PBF had signified a significant increase in the motivation and morale among the personnel (these organizations distribute part or all of the 5% performance award as staff incentives)
- Decisions have been facilitated to create internal mechanisms for meeting targets. Several partners reported a general impression of changed behavior.
- Internal use of incentives has generated staff commitment & improved use of the registers (particularly immunization) and positively impacted vaccination coverage
- One partner noted that the PBF mechanism had resulted in improved community involvement as a direct out come of their strategizing on how to achieve service delivery goals.

At the project level, it has always been clear that the Chief of Party has overall responsibility. It has also been clear (and has already been communicated to the team) that there is need for another arrangement because the initiative requires more time than can be committed by the Chief of Party. In discussions, it was hard to identify who was operationally in charge of the implementation of this initiative on a daily basis. The team was able to identify three technical staff with responsibility for parts of the initiative. Uder Antoine is responsible for the preliminary assessment of institutional capacity of the NGOs invited into the program; Laurence Pierre is responsible for contract negotiation and documentation; and Pasquale Farese manages the performance indicators and monitoring of results.

The PBF program has had a strong focus on indicator definition, information collection and processing. That is, in the management of evaluation tools and material. These efforts have been effective and should, a the next stages in contracting are reached, be carried out in full collaboration with the PBF partners to assure understanding and acceptance of the indicators chosen. Stronger focus should be placed on the processes for strengthening NGO management and work and to clearly identify interventions that can help these organizations to improve their organization to perform (see notes on Performance Improvement under 'Institutional Development').

Another noticeable factor with PBF is the recent change in the bases for measuring results. Performance indicators had been measured through the fielding of population based surveys, providing the bases for a NGO-bias free evaluation. It became necessary to shift the bases of these evaluations to service statistics data (causing the empirical basis

of the experience to lose some of its comparability force) because the cost of the population-based evaluation efforts had become excessive in relation to the benefit (e.g. the cost of the evaluation was sometimes close to the value of the total awards). A cautionary note, therefore, is needed to assure the extra effort required to secure service statistics data that are free of bias and manipulation.

Of all these partners interviewed, CDS seems to be the most truly mature in relation to the PBF program. CDS has clear vision for participating in this initiative and long term ideas (objectives) regarding where they want to arrive.

Recommendations
The project should continue with further development of Performance Based Financing but should be careful about the selection of additional partners to be included. It has had the impact of motivating NGO's around setting and meeting performance goals that are in line with strategic initiatives. It has resulted in progress with elements of institutional development that are both improving organizational capacities and establishing with those organizations an understanding of the real value of strategic planning, performance improvement and management, and organizational and staff incentives that are linked to productivity. There should be careful review and development of contracting mechnisms, audit and financial verification standards, equipment needs, performance improvement, in addition to motivation and incentive programs. An early visit (in time to be useful in the next contracting round) by Rena Eichler, Kate Griffin, and John Pollock should be scheduled to work with the team and partners on next steps in development of this program element.

PBF indicators must be reviewed with the NGO partners prior to or during the upcoming contract round to assure that they are appropriate, challenging, understood and agreed upon. Some thought should be given to how the indicators should be expected to evolve as time goes by (they are not static).

Focus should be brought to the processes for strengthening NGO management and work. An HS2004 team member should be designated to provide operational leadership, assure feedback, identify technical assistance needs, and assure coordinated attention to this program. A particularly important function will be to identify interventions that can help these organizations in their efforts to improve performance. It is suggested that Mr. Chevalier be assigned to this role under the supervision of the Chief of Finance and Organizational Development.

The project should continue to document the PBF experience.

13) **A complementary service delivery strategy for middle-income urban areas.**

Observation
The following section of MSH's original proposal addresses the challenge of expanding coverage of the Project's interventions in a cost-effective fashion.

> "There is a growing segment of the Haitian population in urban areas, with some ability to pay. This population tends to seek health care from young, private doctors, who generally provide immunization services but rarely offer adequate family planning services, child survival services, or case management of TB, STIs, and other common illnesses. In most cases, preventive care is not available and the national MSPP Norms and Standards for reproductive and child health are not systematically applied.
>
> As a complementary strategy to the HS-2004 NGO Network, this private practitioners' network will evolve into a self-financing franchise with a name and logo to be chosen by its initial members. It is anticipated that the Project's financial assistance to this initiative will be limited to the first two years, although technical assistance will continue for the entire second phase. The rationale for this effort is that clients and potential clients will associate the urban network of private practitioners with a distinct level of quality of services. Thus this mark will help private providers attract and keep clients, while encouraging them to both maintain high-quality services and facilitate expansion of access to under-served populations. Medical services offered by the HS-2004 NGO Network and by the urban network will be streamlined, following national standards and encouraging referrals, continuity, and follow-up among different types of health providers."

In speaking with network members, private physicians, Dr. Reginald Boulos of CDS, and the Haitian Medical Association, it is clear that this situation is unchanged and there is strong potential for the Project to expand its coverage through this mechanism. There are approximately 800 private physicians working in urban areas throughout Haiti, with a catchment population of 1,500,000 to 2,000,000 people. This "middle income" will not use NGO services, and cannot afford to access the expensive Private specialists. At the same time, the quality of services offered by these generalist private practitioners is extremely variable, and does not have any specific orientation towards achieving public health impact. There have been several small networks of physicians established in Port au Prince around small clinics, and these have proven to be extremely successful. The founders of these groups and the Haitian Medical Association (AMH) have expressed a willingness to collaborate with HS2004 in establishing a Physician's Network.

Based on a small concept paper, the AMH would provide the umbrella certification & accreditation of members of this Physician's Network, while HS2004, through one or more of the current NGO partners would provide technical assistance, and make available a revolving fund to finance the first cohort of physicians to join. The technical assistance represents the investment of HS2004 in reaching and providing sustainable services to 1.5 to 2 million people. The revolving fund would secure the capacity of each physician to have essential equipment and supplies to support the minimum package of services. The Network would recover costs through a "franchise fee" or subscription, which will then be used to provide on-going monitoring of standards and quality of service.

Conclusion

This initiative represents a significant opportunity for the Project. It will allow the Project to reach small populations (2,000 – 3,000), with very low fixed costs, and an already established mechanism of full cost recovery. The investment of technical assistance to the AMH in adapting the Minimum Package of Services to the private physician's office, training of individual physicians, and provision of basic equipment would be very cost-effective in terms of likely outcome in terms of measurable health

impact. It should not be assumed that the population that can be reached in this way already has access and, therefore, should not be given special attention. It is clearly established that members of the group in question do not access the services available for reasons that are compelling to them as individuals. It is also know that they will, however, seek services and can pay some amount. In terms of what the project can accomplish within its limited resource base, this group is a major target of opportunity.

Although this is still at the conceptual stage, there is already experience in Haiti that suggests that such an initiative could be rapidly successful. There is also the availability of significant amounts of funding that can be accessed through private sector loans once the concept is shown to be effective (it might then become possible to explore the involvement of such a network in delivering services to marginal or peri-urban zones).

Recommendation
That HS2004 should work with the drafters of the original concept paper and establish a small task force consisting of MSH, CDS, AMH & IHNSAC to develop a clearly articulated proposal for the establishment of an urban private physician's network. This network can serve to significantly increase coverage beyond the range of the current NGO network.

- MSH conduct a careful review of experience with similar initiatives around the world and share this with the task force.
- A small survey of private physicians be conducted to confirm catchment areas and baseline population health statistics in these populations.
- The Minimum Package of Services be adapted to the private physician's office, with clear standards of practice established
- A package of equipment and materials be developed to support the initiative
- A careful costing exercise be carried out, standard fees established and "franchise" royalty levels be established
- Criteria for the selection of the first 20 members of the network be established, with a goal of enrolling these and starting the initiative in practice by March 2002.

14) Financial and Operational review

Reviews were made of the Finance, Contract, and Administration policies and practices for the project. Mark Kripp, the MSH Director of Finance, conducted a review according to the protocol of the standard MSH Internal Audit Program and applying the standards and provisions of federal regulations (E591.5.3, 4) "Audits of Foreign Non-Profit and For-Profit Organizations and Host Government Entities.) The full review included the 12 local subcontracts with the highest financial value plus two others (total 14). A finance-only review was conducted in regard to 8 other local subcontracts. The result of these reviews was an overall commendation of the financial and contracting procedures of HS2004 (which are well-documented). There were also a number of observations and findings related to divergences from normal procedures (with specific instructions for correction or adjustment), and a small number of recommendations (Please see the separate report filed by Mark Kripp for specific recommendations.)

A full review of the ***Projet HS-2004 Manuel de Procedures Administratives*** was conducted. This manual is an excellent resource for the staff and management for the project. Except to note that a revision is about to be made to update and adapt the documented procedures to match the revisions required to meet the identified needs of this Phase of HS2004, no other observations or recommendations are needed.

15) Summary of Recommendations

1) Although the overall original project strategy is still applicable. There should be a careful review of targets and indicators in light of the new USAID priorities and, accordingly, revise the objectives Results Tracking Table (Especially in relation to infectious diseases).

2) USAID and MSH should work together to establish sound criteria that include population covered, performance, and political importance to rationalize the current HS-2004 Network. In light of resources available after review of Network, plans and strategies, opportunities for expansion to new areas where higher impact can be reached in a cost-effective fashion should be aggressively sought, and funds also diverted to strengthening national level programs such as immunization, HIV/AIDS and TB.

3) MSH needs to reexamine its technical needs based on the change in Intermediate Results and rationalization of the network. Specifically, subcontracts with PAGS, IHE, *Konesans Fanmi*, and *Group Croissance* need to be revised based on network rationalization strategies chosen and the changes in expected results.

4) USAID should develop both a communications and transition plan concerning budget cuts and the need to rationalize activities so that MSH, as the agency responsible for implementation, can remain effective and not be seen as responsible for the cuts. In addition, USAID and MSH should work together to establish an active management of change mechanism which will work to reduce the impact of such cuts on the morale of both the technical assistance team and the Network partners. This transition plan should also mitigate, to the extent possible, the impact on current partners who would be changing status.

5) The HS-2004 Project work with USAID and Partners to identify potential "lost opportunities", prioritize these opportunities, and strategize if, and how the Project can take advantage of these opportunities. For example, the use of nutrition and micro-nutrients supplementation as an opportunity for providing MCH services are strategies that have been identified in the past and should be further explored.

6) No major changes need to be made in the Project's result areas as these closely match the USAID results areas. Both Project & USAID results areas, however, should be reviewed to reflect changes in priorities and funding availability (for instance, no specific result has yet been defined for Infectious Diseases - a new IR in SO3).

7) The Minimum Package of Services needs to be updated to include new initiatives in HIV/AIDS/STI – particularly community based initiatives, and TB.

8) USAID should continue to work with the MSPP to explore new avenues of collaboration in service delivery, but HS-2004/MSH should continue to promote its

current approach of public sector collaboration without direct funding public sector services or activities.

9) USAID should clarify SOAG role, priorities, and deliverables and communicate with all agencies (including MSH) to present SOAG and work out linkages and other needs for collaboration

10) MSH urgently undertakes a detailed costing exercise for the PSP, determining the expected cost of delivery in urban and rural settings. This exercise should draw on the recent analysis recently completed for the Primary Health Care Package in South Africa and be should, ideally, be completed in time for use during the next round of contracting with partners. Once the costing exercise is completed, there should be a "norms & standards" approach for each component. Collaboration with MSPP will also be important to assure that we are building on what is already in place.

11) The eleven-point child survival plan developed by Drs. Grand Pierre and LaForce must be implemented as the Project's strategy in Child Survival.

12) USAID lead a review of USAID's past contribution in the development of Haiti's national nutrition program, and consider reconvening the panel of international experts that initiated moving towards a unified strategy for nutrition and food supplementation in 1997.

13) Food supplementation at the community level be integrated with the delivery of community-based health services, and community-development activities such as nutrition, water, and sanitation projects that can be funded through micro-credits.

14) FOR SAFE MOTHERHOOD AND PAC

- Strengthen community initiatives for early problem recognition and prompt transportation for women with obstetrical or post-abortion complications
- Train TBAs and community health workers to use partograms and recognize other complications
- Develop networks for prompt transportation for women with pregnancy related complications
- Establish links with facilities providing emergency OB and PAC services
- Contact JHPIEGO and the hospitals where upgraded OB services are available
- Identify facilities in close proximity to communities served by HS2004 NGOs and collaborate to provide access for emergency care for pregnant women
- Strengthen prenatal and postnatal counseling and services, including clinical family planing methods.

15) HS2004 should continue its focus on high quality services in the network NGOs. These have raised the contraceptive practice rate among all women of reproductive age from 16% in 1997 to 25% in 2000, in a population of about 2.5 million (perhaps closer to 3 million by 2000). There is every reason to believe that these impressive gains can

continue to 33%, the actual FP objective of the project during the life of HS2004. This achievement will substantially increase the national contraceptive prevalence rate.

16) The project can make significant impacts on family planning practices through the NGOs in the network which have been proven to be effective in delivering services. The project should continue to focus in improving the quality of services delivered throughout the network. It should reinforce a better use of injectable and oral methods by improving counseling and reducing discontinuation of methods used. It should encourage the expansion of the methods mix to better reach the target population.

17) The project should build on initial efforts at safe motherhood, for instance by fast-tracking some of the strategies outlined in the proposal, like building on Phase I efforts to introduce and expand throughout the network a focus on the community and (with Pathfinder) enhance capacity at first provider levels for early recognition of complications, rapid referral, and active management of obstetric emergencies (including Post-Abortion Care).

18) The Project should continue with proven training strategies. Particular attention should be given to follow up. It includes observation and measurement of providers' improvement in delivering services to clients as well as on-the-job training to improve the quality of services, and promotion of facilitative supervision to ensure that training investments result not only in improved knowledge but also in positive behavior change.

19) Consideration should be given to the potential benefit of channeling training activities towards a distance and self-learning approach to increase the cost-effectiveness of training, to strengthen the processes of human resource development within NGOs, and also to minimize disruption to service provision by the need to upgrade skills.

20) The training program should follow the already successful model for coordination with behavioral change and communication activities be more actively integrated into strategies and program efforts related to community mobilization, service delivery, institutional development, etc. to assure that the training programs are targeted to meet their needs in the field. Support to the public sector members of the trainers network should be limited to collaboration (including collaboration in planning) and inclusion of public sector participants in events where MSPP can support their participation.

21) MSH should provide technical assistance to INHSAC in Human Resource Development to establish a clear capacity function as a technical resource in this critical area.

22) To ensure that the HRD element of the project succeeds, MSH should include HRD (and support in the use of the HRD tool) as a part of its own technical assistance to network partners. An introductory seminar on the structure and utility of the HRD tool could be included as a component of the next major partners meeting.

23) Human Resource Development and Institutional Development work plans should be carefully integrated to ensure that current gaps are filled and that the natural synergy of these two components is realized.

24) The BCC staff should continue to provide leadership in this area and to collaborate closely with UNICEF and MSPP to make sure that the Project is tied into what they are doing.

25) The BCC staff should work with each technical component of the project to assure that the concept of strategic communication and exchange of information is used to promote local program impact. This aspect of the work related to community mobilization is of particular importance because of the range of interests and activities extending beyond 'health' of community-based organizations.

26) The community services and community mobilization groups should come together through the mechanism of a Community Approaches Focus Group. This group will develop a comprehensive community approach for the project, which will guide both community-based approaches and community participation in service delivery.

27) The institutional development team should review planned activities and strategies to more closely follow the originally proposed process for institutional development and make use of performance improvement analytical methodology to target interventions at the factors that are impeding individual institutional progress toward articulated goals.

28) To streamline the production of service reports, IHE should assure assignment of qualified staff to focus as a first priority on the processing of data into the agreed report format upon receipt of data.

29) Funding shortages should not be allowed to prevent the project from measuring health impacts brought about by project interventions. While much of this can be done through routine collection, periodic impact surveys must take place to obtain specific population-based information.

30) In order to strengthen HIV/AIDS prevention and care, MSH can initiate selected interventions from the following recommendations. HS2004 staff, working with the USAID HIV assessment team, should refine and revise what is feasible, and in what magnitude during the life of the project. Assuring the human resource capacity and expertise within the team and through project partners will be critical to the success and sustainability of selected strategies and interventions.

- Expand HIV voluntary counseling and testing (VCT) with rapid tests for HIV as the basis for strengthening other initiatives:
- Providing HBC and community support for PLWA,
- Preventing MTCT among pregnant women,
- Offering contraceptive services to HIV+ women to reduce MTCT by reducing pregnancy rate.

- Screening HIV+ people for TB to assess whether INH prophylactic treatment (PT) may be appropriate,
- Increasing involvement of PLWA in their own care an in developing capacity at the community level
- Identifying the large number of HIV- people who will benefit from BCC efforts to change behavior, relate with partners and remain negative
- Provision of HIV rapid test kits assumes that USAID, other donors, or MSH will procure and distribute sufficient kits to meet the needs of pregnant and non-pregnant women, as well as men who want to be tested.
- Increase capacity for VCT first at well established centers to increase access and streamline VCT for one visit testing. As test kits become available, plan to extend VCT to all health centers with qualified staff and where community care and support can be provided.
- Develop a map of all VCT testing sites, during the USAID HIV assessment that can be used by HS2004 network and other providers (action for entire team)
- Work with NGO partners who provide VCT training to introduce new rapid tests for network NGOs.
- Through the NGO network (and potential new partners) MSH should support training and community mobilization for care of PLWA, including, where possible, treatment or prevention of OI, TB management, improved nutrition, and links to clinical services.
- MSH and the NGOs should collaborate other partner agencies working with logistics and pharmaceutical management efforts to provide supplies of rapid tests, drugs for OI, TB screening, PT, treatment of active TB, and prevention of MTCT.
- MSH should work with UNICEF as a partner to initiate prenatal HIV screening and provision on AZT and nevirapine for MTCT in two network centers, along with guidance on breast feeding, supplemental feeding, ARV drugs for mothers and treatment of OIs as is feasible (Marc LaForce trip report, 30 March 2001)

31) Recommendations related to STI's

- Assess components of syndromic management of STIs to maximize effectiveness and acceptability of interventions
- MSH/Haiti should collaborate with GHESKIO, FHI, and MSH/Boston technical staff to refine the syndromic management of male urethritis in order to increase accuracy of treatment for gonorrhea (GC) and chlamydia (CT) and improve treatment of female partners
- MSH staff, working with the NGO network should provide clear written, as well as verbal instructions to enhance compliance with treatment regimen, give condoms, educate, and provide partner notification materials (NGO sector could adapt the four STI kit components for male urethritis as successfully used in Uganda)
- Educate men, women and youth in the community about need for STD treatment of men with urethritis as well as their partners through community health workers and other mediums for health communication.
- Provide convenient services in the community for reaching and treating men with urethritis, using existing community health centers and community workers.

- Work with NGO partners on revised syndromic management protocol for vaginal discharge—in most cases to treat only for simple vaginitis, without partner notification
- Collaborate with pharmaceutical management efforts to ensure availability of common STI drugs and condoms.
- Continue to provide condoms and STI prevention messages in the NGO network.
- Assess the current level of syphilis testing at network NGOs and establish norms for universal testing and treatment of positives.

32) These recommendations related to TB control should be reviewed in light of findings by the USAID TB assessment team visiting Haiti, 16-30 April, 2001.

- Evaluate current TB interventions for efficiency and impact in network areas to guide technical assistance to network partners as TB control is introduced into the minimum package of services.
- MSH should expand efforts to identify and treat active TB cases within the HS2004 network using the national protocols for diagnosis and treatment in Haiti
- Use national TB control program facilities for identifying suspect TB in adults and children and record efforts using the standard forms
- Identify sources of supplies (from the national TB program?) for TB skin testing, and for referral to examine sputum (primarily in adults)
- Identify centers where chest X-ray can be performed
- Establish norms and guidelines for NGOs to link TB and HIV control efforts and follow TB prophylaxis protocols for HIV+ people
- Link with higher centers for occasional MDR TB, when identified
- Introduce DOT management in NGOs where this is not yet established. MSH may need to conduct a quick review of the sites where DOT is provided and the number of people being treatment.
- Follow national reporting systems
- Consider community and home efforts to improve DOTS performance using the South Africa Equity examples and other innovations specific to Haiti
- Establish revised TB treatment protocols to the extent that there is lack of consistency
- Work with AOPS or another organization to hold a national workshop on TB treatment protocols for HIV- and HIV+ patients with Haitian and a few international TB experts
- Collaborate and meet with selected Dominican Republic TB experts who work with Haitian counterparts to address common problems with treatment and surveillance efforts
- Collaborate with efforts at national level to culture sputum of suspect treatment failures to provide earlier detection of drug resistant strains
- Establish increased emphasis on childhood TB—children constitute 15-25% of the 15-20,000 new TB cases each year
- Help with diagnosis and testing to detect active cases (sputum is difficult to obtain from children), using skin testing (with interpretation appropriate to Haitian setting where BCG is widely used) and chest films

- Review whether there is a Haitian consensus about treating only active childhood TB, and not providing prophylactic treatment for children under 5 who are household contacts of an active case—this could be on the agenda of a national workshop
- Introduce new pediatric treatment protocols that are nearing approval (ethamutol is deleted)
- Support community efforts to link child health, TB, HIV, nutrition and supportive care for children and adults with single or double infections—efforts to improve TB control should link with HIV efforts and vice versa.
- Consider coordinating with ICC/CAT as well as with MSPP to extend TB program impacts to non-network areas.

Note: when the Alliance TB report is finalized, these recommendations will be reviewed in relation to their findings to provide additional guidance on 'next steps'.

33) Cadres of staff work in *Focus Teams* to assure effective communication and implementation in their areas and to facilitate effective technical exchange, communication and integration with other HS-2004 units and efforts. The formation of these focus teams will not change existing reporting or supervisory relationships. In each major technical area, backstop expertise has been identified to assure essential quality and institutional support from MSH and its partners. Focus areas should be:

- Institutional Development
- Community Approaches
- Technical Delivery of Services

Each of these groups includes three or four technical staff and/or partners.

Additionally, there are several Crosscutting areas that operate in relation to all three of these groups:

- Direction
- Training
- Behavior Change & Communication
- Monitoring & Evaluation
- Drug Management
- Finance/Contracts/&Management

34) In order to assure appropriate planning, support, and analysis to the performance-based contracting initiative, the role of the Policy Advisor, Mr. Chevalier, be redefined to include responsibility for coordinating efforts with partners around the implementation of performance-based financing (PBF) program efforts.

His work plan should include technical assistance and planning activities to facilitate NGO partner performance with particular attention to using Performance Improvement methodologies to enable partners to identify the causes of problems before targeting their efforts. Areas of activity will include: working with partners and participating with other HS2004 team members on appropriate design of indicators and incentives for meeting them; understanding need for and uses of strategic and operational planning; data

collection and use; monitoring & evaluation; improvement of efficiency; enhancement of institutional focus and staff morale; and achievement of impact. Because of the need to integrate this activity with the overall institutional development work of the project, his reporting relationship should shift to the Finance & Organizational Development Unit.

35) As noted under 'Network Development,' with the shift in Mr. Chevalier's role, the direct responsibility for supporting and coordinating with AOPS and for network development should become a primary responsibility of the Chief of Party, Mr. Auxila.

36) AOPS's board of directors finalize agreement on their strategic plan, and work with MSH and USAID to develop a clear operational plan to bring this strategic plan to completion by the end of 2004.

37) The Project Chief of Party should take over the role of key link with AOPS and for network development.

38) The project should work with USAID and AOPS to review the strategic goal of the *Haiti Sante'* Network in relation to the current AOPS strategic plan and the practical reality of what the functions of the network will be after the end of the HS2004 Project (some examples include …technical forum for exchange, coordinator of standards and certification processes, mechanism for organized discussions with MSPP).

39) The project should continue with further development of Performance Based Financing but should be careful about the selection of additional partners to be included. It has had the impact of motivating NGO's around setting and meeting performance goals that are in line with strategic initiatives. It has resulted in progress with elements of institutional development that are both improving organizational capacities and establishing with those organizations an understanding of the real value of strategic planning, performance improvement and management, and organizational and staff incentives that are linked to productivity. There should be careful review and development of contracting mechnisms, audit and financial verification standards, equipment needs, performance improvement, in addition to motivation and incentive programs. An early visit (in time to be useful in the next contracting round) by Rena Eichler, Kate Griffin, and John Pollock should be scheduled to work with the team and partners on next steps in development of this program element.

40) PBF indicators must be reviewed with the NGO partners prior to or during the upcoming contract round to assure that they are appropriate, challenging, understood and agreed upon. Some thought should be given to how the indicators should be expected to evolve as time goes by (they are not static).

41) Focus should be brought to the processes for strengthening NGO management and work. An HS2004 team member should be designated to provide operational leadership, assure feedback, identify technical assistance needs, and assure coordinated attention to this program. A particularly important function will be to identify interventions that can help these organizations in their efforts to improve performance. It is suggested that Mr.

Chevalier be assigned to this role under the supervision of the Chief of Finance and Organizational Development.

42) The project should continue to document the PBF experience

43) HS2004 should work with the drafters of the original concept paper and establish a small task force consisting of MSH, CDS, AMH & IHNSAC to develop a clearly articulated proposal for the establishment of an urban private physician's network. This network can serve to significantly increase coverage beyond the range of the current NGO network.

- MSH conduct a careful review of experience with similar initiatives around the world and share this with the task force.
- A small survey of private physicians be conducted to confirm catchment areas and baseline population health statistics in these populations.
- The Minimum Package of Services be adapted to the private physician's office, with clear standards of practice established
- A package of equipment and materials be developed to support the initiative
- A careful costing exercise be carried out, standard fees established and "franchise" royalty levels be established
- Criteria for the selection of the first 20 members of the network be established, with a goal of enrolling these and starting the initiative in practice by March 2002.

16) Annexes

Meetings Held:

MSH HS2004 team
Paul Auxila
Florence Guillaume
Pasquale Farese
Marie Christine Brisson
Laurence Pierre
Uder Antoine
Raymond Chevalier
Ednel St Jean
Patrick Schutt
Bernateu Demangle
Staff Meetings

USAID SO3 Team
Carl Abdou Rahmann
Lynn Adrian
Pierre Mercier
Marlene Charlotin
Yves Marie Bernard

JSI-Deliver - Rudolph Magloire
SADA Dr Frantz Champagne
AOPS Dr. Lucito Jeannis
Dr Lionel Yamite

CDS (Centres pour le Developpment et la Sante
Dr. Reginald Boulos
Dr Pierre P. Despagne
Dr Lionel Barthelemy

CPB (Pignon)
Dr. Louis

Ste. Croix
Dr. Lafontant

Population Services International:
Moussa Abbo, Project Director
Douglas Call, Deputy Director

Policy Project, Futures Group:
Dr. George Debuche

FHI/IMPACT:
Dr. Roberte Eveillard, Country Representative

Hopital Petits Freres & Soers:
Dr. Gauthier

National Tuberculosis Control Program:
Dr. Lunel Delannay

UNDP:
Diane Keita, Representant Resident Adjoint

MSPP:
Dr. Joelle Deas, Hopital Militaire

Fondation Promoteurs Objectif Serosida (POZ):
Dr. Eddy Genece

GHESKIO:
Dr. William Pape, Directeur des Centres GHESKIO

UNICEF:
Dr. Dominique Robez-Masson, Responsible Section Sate
Ralph Midy, Charge Adjoint de Project Sante

International Child Care:
Dr. Marie Renee Lubin, Directeur Grace Children's Hospital

Hatian Medical Association representatives

Documents Reviewed:

"Resume Proposition Strategique" Projet HS-2004 Phase II
"Taches de l'Agent de sante,"Project HS2004, Volet Service Communitaires
"Contract Procedures," HS2004 Phase II
Subcontract between MSH and Hospital Albert Schweitzer-HAS, Subcontract No. 521-023-0056, and amendment, October , 2000
"Manuel de Procedures Administratives," Projet HS-2004
"Resultats Attendus Phase II," Projet HS2004
"Reseau Haiti-Sante: Projet pilote de mise en reseau des intstutions hatiennes du secteur prive de sante," AOPS, Jan. 2001
"Document elabore par le comite de pilotage du reseau Haiti Sante," AOPS, April, 2001
"Augmentation de la representativite de l'AOPS a travers les institutions privees de sant," AOPS, Avril 2001
"Association des Ouvres Privees de Sante, Statuts," AOPS
"Association des Ouvres Privees de Sante, Statuts Revises," AOPS, Mars 2001
"Plan Strategique (2000-2005), AOPS, Aout, 2000
"Plan Annuel (Octobre2000-Septembre 2001), AOPS, Octobre , 2000