

EVALUATION

MSF SEXUAL AND REPRODUCTIVE HEALTH PROJECT in Port-à-Piment, Haiti

OCTOBER 2026

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All evaluators contracted by the SEU adhere to the SEU Ethical Guidelines for Evaluations.

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This version is a translation by the SEU of the original French report. Some nuances and wording intended by the evaluation team may be more accurately reflected in the French original, which remains the reference version.

DISCLAIMER

The views expressed by the authors in this publication do not necessarily reflect those of Médecins Sans Frontières or the Stockholm Evaluation Unit.

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LIST OF ACRONYMS

ANC	Antenatal Consultation
ANC1	First Antenatal Consultation
ANFU	Antenatal Follow-Up
AOC	Advanced Obstetric Care
ARO	Annual Review of Operations
ASCP	Polyvalent Community Health Workers (Agents de Santé Communautaire Polyvalents)
BEmONC	Basic Emergency Obstetric and Newborn Care
BTP	Blood Transfusion Post
CAL	Health Centre with Beds (Centre de Santé à Lits)
CAN	National Ambulance Centre (Centre Ambulancier National)
CCS	Community Health Centre (Centre Communautaire de Santé)
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
COC	Combined Oral Contraceptives
ColVols	Volunteer Collaborators (Collaborateurs Volontaires)
COM-B	Capability, Opportunity, and Motivation Behavior
CRHC	Cambridge Reproductive Health Consultants
DHIS2	District Health Information Software 2
DOC	Direct Obstetric Complications
EmONC	Emergency Obstetric and Newborn Care
FGD	Focus Group Discussion
FP	Family Planning
GBV / SGBV	Gender-Based Violence / Sexual and Gender-Based Violence
HC	Health Centre (Centre de Santé – CDS)
HCR	Community Referral Hospital (Hôpital Communautaire de Référence)
HP	Health Promotion
IDI	In-Depth Individual Interview
IMCI	Integrated Management of Childhood Illness
IUD	Intrauterine Device
MIO	Mobile Implementation Officer

MOU	Memorandum of Understanding
MSF	Médecins Sans Frontières
MSPP	Ministry of Public Health and Population (Ministère de la Santé Publique et de la Population)
NGO	Non-Governmental Organisation
NICU	Neonatal Intensive Care Unit
OECD-DAC	Development Assistance Committee of the Organisation for Economic Co-operation and Development
PaPim	Port-à-Piment
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Consultation
PRECEDE	Predisposing, Reinforcing and Enabling Constructs in Educational Diagnosis and Evaluation
PROCEED	Policy, Regulations and Organisational Constructs in Educational and Environmental Development
PSAT	Program Sustainability Assessment Tool
SEU	Stockholm Evaluation Unit
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
ToC	Theory of Change
ToR	Terms of Reference
UNFPA	United Nations Population Fund
WHO	World Health Organization

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EXECUTIVE SUMMARY

Background: Haiti has one of the most fragile health systems in the Western Hemisphere as a result of chronic political instability, widespread insecurity and economic hardship, which have severely reduced access to essential health care. Women and children are disproportionately affected, particularly in rural southern Haiti, where geographic isolation, weak infrastructure, shortages of health personnel and medical supplies, and financial barriers contribute to poor maternal and reproductive health outcomes. In response to these challenges, Médecins Sans Frontières (MSF) established the Port-à-Piment (PaPim) sexual and reproductive health (SRH) project following Hurricane Matthew in 2016. From 2022 onwards, the initial emergency response was progressively expanded into a comprehensive SRH project comprising a network of one comprehensive emergency obstetric and newborn care (CEmONC) facility and four basic emergency obstetric and newborn care (BEmONC) facilities, supported by community-based health promotion and referral systems. Guided by the three delays model, the project aimed to reduce maternal and neonatal morbidity and mortality by improving the timeliness of care-seeking, strengthening referral and transport systems, and ensuring access to high-quality emergency obstetric and newborn care.

Evaluation objective and methodology: This evaluation aimed to assess the progress and impact of the PaPim project from 2022 to 2025, as well as its sustainability prospects after the end of the project cycle, scheduled for the end of 2027¹. We conducted a mixed-methods evaluation using an embedded case study design, combining a document review, secondary analysis of routine health information system data (*DHIS2*), case studies of one CEmONC facility and two BEmONC facilities, patient exit surveys, service mapping, and semi-structured interviews with MSF, the Ministry of Public Health and Population (MSPP), care providers, service users and community stakeholders. Quantitative data were analysed descriptively in Excel to assess service uptake and key SRH indicators, while qualitative data were analysed thematically in NVivo 14 to explore perceptions of service quality, access, referral systems, sustainability and project handover. Findings from all data sources were triangulated to strengthen the evaluation's conclusions. All study procedures were conducted in accordance with the ethical standards applicable to humanitarian research, including informed consent, confidentiality and participant safety.

Findings: Based on the evaluation criteria of the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD-DAC), the findings indicate that the project has been highly relevant in responding to a context marked by geographic isolation, insecurity, poverty, limited availability of health services, transport barriers and restricted access to quality emergency obstetric and newborn care. The project contributed to increased uptake of antenatal consultations (ANC) and facility-based deliveries, strengthened access to emergency care and improved the decentralisation of maternal health services. Despite these achievements, several structural and systemic challenges threaten the sustainability of these gains. The evaluation found mixed coherence between the project and the broader structure of the MSPP health system, particularly regarding the role of PaPim hospital within the emergency obstetric and newborn care (EmONC) network. Continued reliance on PaPim as a high-quality referral centre, combined with persistent barriers related to

¹ Note from the Stockholm Evaluation Unit: the evaluation was conducted on the assumption that the project would end in December 2027. After the evaluation had been completed (mid-2026), the project end date was confirmed as mid-2027 rather than the end of 2027. This naturally has an impact, particularly on the recommendations. This report has not been amended to reflect the new end date, given how late this information arrived relative to the evaluation process.

distance, transport, costs and the limited functionality of peripheral facilities, restricts effectiveness, efficiency and long-term sustainability. Other challenges include delays in emergency referrals, intermittent stock-outs of essential medicines and blood products, weak monitoring and learning systems, low uptake of gender-based violence services, and persistent gaps in sexual and reproductive health services for adolescents.

Conclusion and recommendations: Although the PaPim project has considerably improved access to and use of maternal and newborn health services, sustaining these benefits will require a strategic shift from a donor-supported service delivery model to a health system-strengthening approach that prioritises local ownership, institutional capacity and integration within MSPP structures.

To support this transition, the evaluation recommends the following:

- 1) Develop a financial transition plan combining a targeted cost-effectiveness assessment and a gradual transfer of responsibilities to protect the continuity and sustainability of project activities;
- 2) Redefine sustainability objectives and specific actions in collaboration with the MSPP and other key stakeholders, in particular by developing a joint MSPP–MSF sustainability and transition strategy setting out a gradual handover process, and by establishing a joint MSPP–MSF sustainability assessment framework;
- 3) Involve adolescent peer educators and train them alongside community health workers in adolescent-friendly SRH support;
- 4) Improve data collection and management approaches to incorporate disaggregated data and routine reviews;
- 5) Rethink gender-based violence (GBV) services around a survivor-centred uptake strategy.

INTRODUCTION

THE HUMANITARIAN CRISIS IN HAITI

Haiti has one of the most fragile health systems in the Western Hemisphere (Blot et al., 2018). This fragility is rooted in chronic political instability, fluctuating security, persistent economic hardship, recurrent natural disasters and long-standing structural inequalities. Since 2021, the country has been mired in a humanitarian crisis that has reached critical levels, further weakening already fragile public institutions and limiting the health system's capacity to meet the population's needs. The collapse of basic services due to widespread insecurity has increased vulnerabilities, and armed gang violence has caused tens of thousands of deaths, fuelling an increasingly alarming health crisis (PAHO, 2025).

Gang violence has severely compromised access to health care, with two in five Haitians in urgent need of medical care. Nationally, 49% of health facilities are partially functional, 21% are non-functional and 4% have been destroyed. In Port-au-Prince, the capital, only 37% of health facilities with inpatient care are fully functional, 40% are non-functional and 10% have been destroyed. In addition, security problems have disrupted the humanitarian response, leading to access difficulties, supply shortages and the closure of health facilities (PAHO, 2025). The suspension of international flights to Port-au-Prince further aggravated the crisis by causing a critical shortage of medicines in Haiti (RFI, 2024). Moreover, the current humanitarian crisis in Haiti disproportionately affects women and girls, who account for more than 98% of survivors of sexual and gender-based violence (SGBV) receiving care (MSF, 2017).

The inaccessibility of several roads in major cities, caused by armed groups, has forced the displacement of 1.4 million people, around 12% of the population. More than half of the displaced population are women and children (PAHO, 2025). Most of these people have settled in relatively safer rural areas, such as the south of the country. However, access to health care in the country's rural regions remains extremely limited, and service availability remains insufficient. In southern Haiti, the main barriers to accessing health care include geographic remoteness, weak infrastructure and limited capacity to provide emergency care. With the support of non-governmental organisations (NGOs) such as MSF, interventions have sought to fill critical gaps in the availability, affordability and quality of health services, while contributing to the reconstruction of damaged health facilities and the mitigation of financial barriers that limit access to care.

OVERVIEW OF THE HEALTH SYSTEM STRUCTURE AND ACCESS TO CARE IN HAITI

Haiti's Ministry of Public Health and Population (MSPP) operates within an administrative framework of 10 departments, 146 communes and 571 communal sections (Blot et al., 2018). Within this structure, health care delivery is organised into three levels. The first level provides primary health care services and accounts for around 80% of health institutions, including health centres with beds (CAL). The second level comprises departmental hospitals and specialised medical facilities that provide more advanced care and serve as referral centres. The third level comprises university hospitals and specialised institutions that provide tertiary and highly specialised services. However, despite this formally structured, hierarchical organisation, the health system operates very differently in practice and remains highly fragmented (Dorilien & Sanabria, 2025; MSPP, 2022).

This fragmentation is also reflected in the uneven geographic distribution of health institutions across the country. The Ouest department, which includes the capital, Port-au-Prince, has the largest share of health institutions (36.5%), although it is home to only 15.7% of the population (MSPP, 2022). By contrast, in departments with lower economic activity, where rural areas predominate and poverty is higher, the availability of health institutions is considerably more limited. Because of these structural inequalities, access to health care remains limited for a large part of the population. Only a small proportion of Haitians have access to health services, and most medical staff work in urban areas, with a heavy concentration in the Port-au-Prince metropolitan area. In rural areas the situation is even more critical, as only a small share of health facilities are located there, even though a large share of the population lives there (Blot et al., 2018). Systemic operational difficulties further aggravate these geographic and human resource imbalances. Public hospitals and clinics frequently face management difficulties, strikes, and shortages of staff, medicines, blood, fuel, electricity and medical equipment, further limiting the availability and quality of care.

In addition to these structural and operational barriers, financial constraints further restrict access to health care. The Haitian health system operates on a mixed public–private model under the authority of the MSPP, but public investment in health remains insufficient. As a result, reliance on out-of-pocket payments by households is a major barrier to accessing services (Joseph et al., 2024). Health insurance coverage is extremely limited, with only 2.1% of the rural population and 14.4% of the urban population covered (Alfred, 2012). Consequently, many people delay or forgo seeking care because of financial constraints, further exacerbating health inequalities.

OVERVIEW OF THE HEALTH CONTEXT IN SOUTHERN HAITI

The South department is administratively divided into 5 arrondissements, 18 communes and 69 communal sections, which are themselves subdivided into smaller localities. The departmental capital is Les Cayes, home to the Departmental General Hospital. Remote areas of the department face difficult rural terrain, limited transport infrastructure and restricted access, particularly during the rainy season (Burtscher et al., 2023). Access to health care remains a major challenge in this region, where the quality and availability of health services are insufficient to meet the population’s needs. This situation has been further exacerbated by the instability affecting Port-au-Prince (Burtscher et al., 2023).

In this context, the department’s maternal and reproductive health indicators remain particularly concerning. Official figures put the maternal mortality ratio for facility-based deliveries in the South department at 459 per 100,000 live births ; however, this figure does not account for maternal deaths that occur when women do not manage to reach health facilities. In the same department, only around 56% of pregnant women had access to at least one antenatal care consultation. The South department also has particularly low contraceptive coverage (28%) and is among the departments with the highest rates of adolescent motherhood (13%), after Centre (14%) and Grand’Anse (Blot et al., 2018).

HISTORY AND EVOLUTION OF THE PAPIM PROJECT

Port-à-Piment (PaPim), a coastal commune in Haiti’s South department, is extremely vulnerable to natural disasters and has limited response capacity. This lack of capacity was highlighted during Hurricane Matthew in 2016, which severely damaged health infrastructure throughout southern Haiti, further weakening access to essential health services (Burtscher et al., 2023; MSF, 2024).

Following Hurricane Matthew, MSF deployed emergency interventions at the Port-à-Piment CAL to respond to urgent health needs, in particular cholera management. This emergency engagement gradually evolved into a longer-term programme within the CAL. Over time, MSF strategically refocused its scope on providing basic emergency obstetric and newborn care (BEmONC), while continuing to strengthen the overall functioning of the facility through financial and material support (Burtscher et al., 2023; MSF, 2024).

Following MSF's introduction of free, high-quality services at the Port-à-Piment BEmONC facility, attendance at surrounding health facilities declined, highlighting both unmet needs and disparities in service accessibility and quality. In response, two supported health centres were established in 2019 in the neighbouring communes of Chardonnières and Coteaux to expand access to sexual and reproductive health services. Subsequently, in 2020, the project strengthened the referral system for obstetric and neonatal emergencies by supporting comprehensive emergency obstetric and newborn care (CEmONC) in Port-Salut, thereby strengthening the regional continuum of maternal and newborn care. Unfortunately, the collaboration between MSF and the Port-Salut health facility was not successful (MSF, 2024).

In 2021, a major earthquake severely affected Haiti's southern peninsula, including Port-à-Piment, causing considerable damage to already fragile health infrastructure and further limiting access to essential services (Burtscher et al., 2023; Joseph et al., 2024; MSF, 2024). In response, the PaPim maternity unit was entirely rebuilt and upgraded to provide CEmONC, in partnership with MSF and Haiti's Ministry of Health. It is now one of the few facilities in the region able to provide advanced maternal and newborn care. The Port-à-Piment CEmONC offers comprehensive SRH services, including antenatal and postnatal care, skilled birth attendance, contraceptive care², care for survivors of sexual violence and post-abortion care, supported by operational components such as water and sanitation, sterilisation, hygiene and logistics. The intervention also includes MSF support to 4 peripheral facilities, namely health centres (HC)³ (HC Rendel, HC Chardonnière, HC Tiburon, HC Les Anglais). In total, the project strengthens a network of five facilities (4 BEmONC facilities, i.e. the HCs, and 1 CEmONC at PaPim) with referral pathways supported by dedicated ambulance services to ensure rapid access to comprehensive care (Burtscher et al., 2023; MSF, 2024).

In addition to supporting clinical services, MSF has implemented community-based interventions to strengthen health care delivery and promote community engagement. These activities include sexual and reproductive health (SRH) awareness sessions, including outreach to adolescents through a network of peer educators (due to start in April 2026); dissemination of information on MSF's values and principles; awareness-raising for and co-organisation of blood donation initiatives; engagement with pregnant women and their partners; strengthening and supervision of the network of traditional birth attendants ("matrones"); and the establishment of community health and referral committees. Initially, these community outreach activities were conducted door to door; however, from 2024 this approach gradually evolved towards a more targeted approach aimed at the most vulnerable populations, for example pregnant women and their partners, young people and adolescents, and certain remote areas identified on the basis of the needs assessment (Burtscher et al., 2023).

² Note from the Stockholm Evaluation Unit: This terminology is used because it is recommended by MSF; however, it should be noted that the project documentation refers widely to family planning rather than contraceptive care.

³ Note from the Stockholm Evaluation Unit: This evaluation report refers to health centres (Centre de Santé abbreviated as CDS in the French version and HC in this English version). It should nevertheless be noted that this terminology differs from the Haitian nomenclature for these facilities.

PROJECT HISTORY

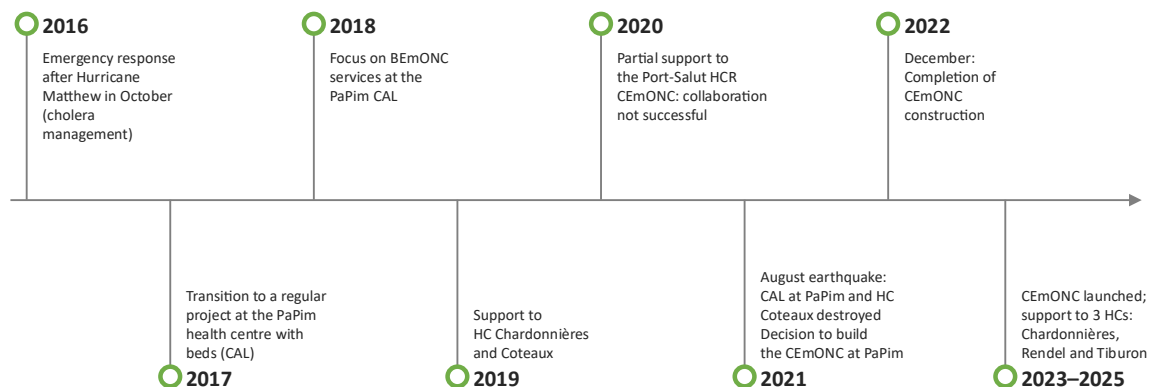


Figure 1: Evolution of the PaPim project (PAPIM ARO, 2026)

Table 1: Health facilities supported by the PaPim project and associated community activities

	HEALTH FACILITY	MAIN ACTIVITIES
CEmONC	Port-à-Piment	- Operating theatre for caesarean sections. - Neonatal intensive care unit (NICU) for newborn care. - Adolescent-friendly SRH care. - Neonatology - Maternity - Outpatient department (OPD) with antenatal consultation, postnatal consultation, sexual violence care and family planning.
BEmONC	HC Tiburon HC Chardonnières HC Rendel HC Les Anglais	- Antenatal follow-up (ANFU). - Family planning (FP). - Postnatal follow-up of mothers and their newborns (up to 7 days after delivery). - Clinical management of survivors of sexual assault. - Referral of direct obstetric complications (DOC) to a comprehensive emergency obstetric and newborn care centre (CEmONC). - Adolescent-friendly SRH care. - Prevention of mother-to-child transmission (PMTCT) (screening only, referral for follow-up).
Community activities	- Schools (ongoing collaboration with two schools, with	- Community education and health promotion sessions for the various local actors in the target area.

	HEALTH FACILITY	MAIN ACTIVITIES
	the aim of reaching five by April 2026) - Youth associations - Local community groups	- Monthly meetings with co-leads, ASCPs and the referral committee. - Group information sessions with pregnant women. - Quarterly meetings with traditional birth attendants. - Health promotion sessions in schools.

NB: HC Les Anglais: new site; support only began in February 2026

GEOGRAPHIC COVERAGE OF THE PROJECT

The PaPim project covers several rural communes in southern Haiti, including Port-à-Piment, Roche-à-Bateau, Tiburon, Chardonnières and surrounding localities, characterised by dispersed populations and difficult geographic conditions. The total population of the area stretching from Tiburon to Roche-à-Bateau is estimated at 154,857. Port-à-Piment covers around 60 km² and has a predominantly rural population of fewer than 20,000 inhabitants. By contrast, Tiburon is both geographically larger and more populous, with more than 20,000 residents living in mountainous, hard-to-reach areas (Burtscher et al., 2023).

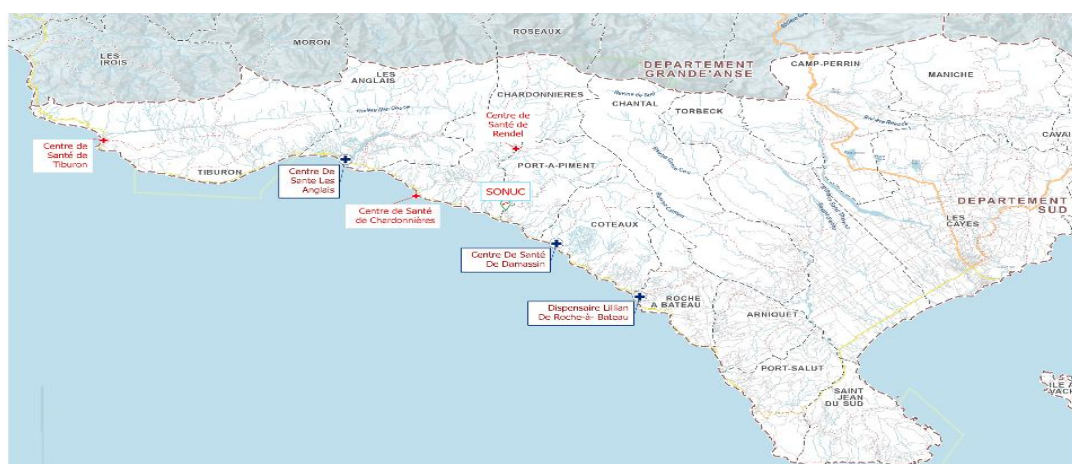


Figure 2: Haiti – South: map showing MSF presence since 2025 (in red) and plans for 2026 (in blue)

Including the surrounding rural localities, the total population probably exceeds 40,000 to 50,000 inhabitants. These populations are widely dispersed, and the distances to be travelled to reach health facilities are often considerable (Burtscher et al., 2023). Many residents live in isolated villages accessible only by footpaths or poorly maintained roads, particularly during the rainy season, which further limits timely access to health services (Sarikhani et al., 2024).

The Port-à-Piment maternity unit operates well beyond its original catchment area, reflecting the severe shortage of operational health services in southern Haiti. Patients frequently travel long distances, including from Les Cayes and surrounding communes, to access its services. Although this dynamic increases demand on limited resources, it also highlights the facility's essential function as a regional referral hub. The PaPim project therefore fulfils a dual mandate: meeting the needs of local communities while serving as an indispensable safety net for underserved populations on the southern peninsula (Burtscher et al., 2023).

PROJECT IMPLEMENTATION APPROACH AND THEORY OF CHANGE

According to the Terms of Reference (ToR) and the project's logical framework, the overall objective is to reduce maternal and neonatal morbidity and mortality in communities in the South, along the Roche-à-Bateau–Tiburon axis. To achieve this objective, the project draws on the “three delays” model (*3-delay model*) of emergency obstetric response (Raymondville et al., 2020), while working closely with the MSPP and other sector partners to ensure the progressive integration and sharing of activities and responsibilities, with a view to a smooth handover by the end of 2027.

The main components of the three delays model are as follows:

Delay 1: Recognising the problem and deciding to seek care

The aim is for women, adolescent girls, families and communities in the project's area of intervention to make timely decisions to seek medical care. To this end, the project focuses on community engagement activities, mainly health promotion sessions (awareness-raising and education) aimed at target groups (adolescents, pregnant women, their partners and certain remote areas).

These activities are also carried out in a variety of settings (schools, community groups such as youth associations and other community-based organisations) to strengthen knowledge of general SRH topics and of the importance of antenatal consultations and of deliveries assisted by skilled health professionals. These community activities are mainly carried out by MSF Colvols (volunteer collaborators) and MSPP-supported ASCPs (polyvalent community health workers), in collaboration with traditional birth attendants (matrones) and community referral committees, under the supervision of MSF health promotion staff (*HP – Health Promotion*).

Delay 2: Access and transport to care

The aim here is to strengthen the quality and timeliness of referral and counter-referral systems in the project's area of intervention. This is mainly achieved through:

- The provision of material resources (ambulances, telephone lines and small items of equipment such as shoes and torches to facilitate travel at night);
- Financial incentives (for MSPP health staff and community partners, including traditional birth attendants, ASCPs and Colvols);
- Capacity building for staff at the three supported peripheral health centres and training of traditional birth attendants (matrones) to recognise obstetric emergencies and refer them from communities and peripheral facilities to PaPim hospital;
- The provision of human resources (health promotion supervisors, drivers and logistics staff).

Delay 3: Access to quality care: The main objectives are as follows:

- To ensure the availability of quality BEmONC services and primary SRH services (FP, antenatal and postnatal consultations, clinical management of sexual violence) at the three supported peripheral health centres, while strengthening the referral and counter-referral system in the project area;
- To guarantee the availability of quality comprehensive CEmONC services at PaPim, and to build the SRH capacity of health staff.

Figure 3 presents the project's overall objectives, activities and outcomes in the form of a schematic theory of change (ToC). Unlike the logical frameworks currently used for the project, the change model offers a simpler, more flexible and more holistic understanding of the mechanisms of change, the assumptions and the roles of each stakeholder in the project. For the purposes of this evaluation, the change model served as a roadmap for verifying whether planned processes had unfolded as intended, identifying where and why implementation had succeeded or failed, and explaining the results observed.

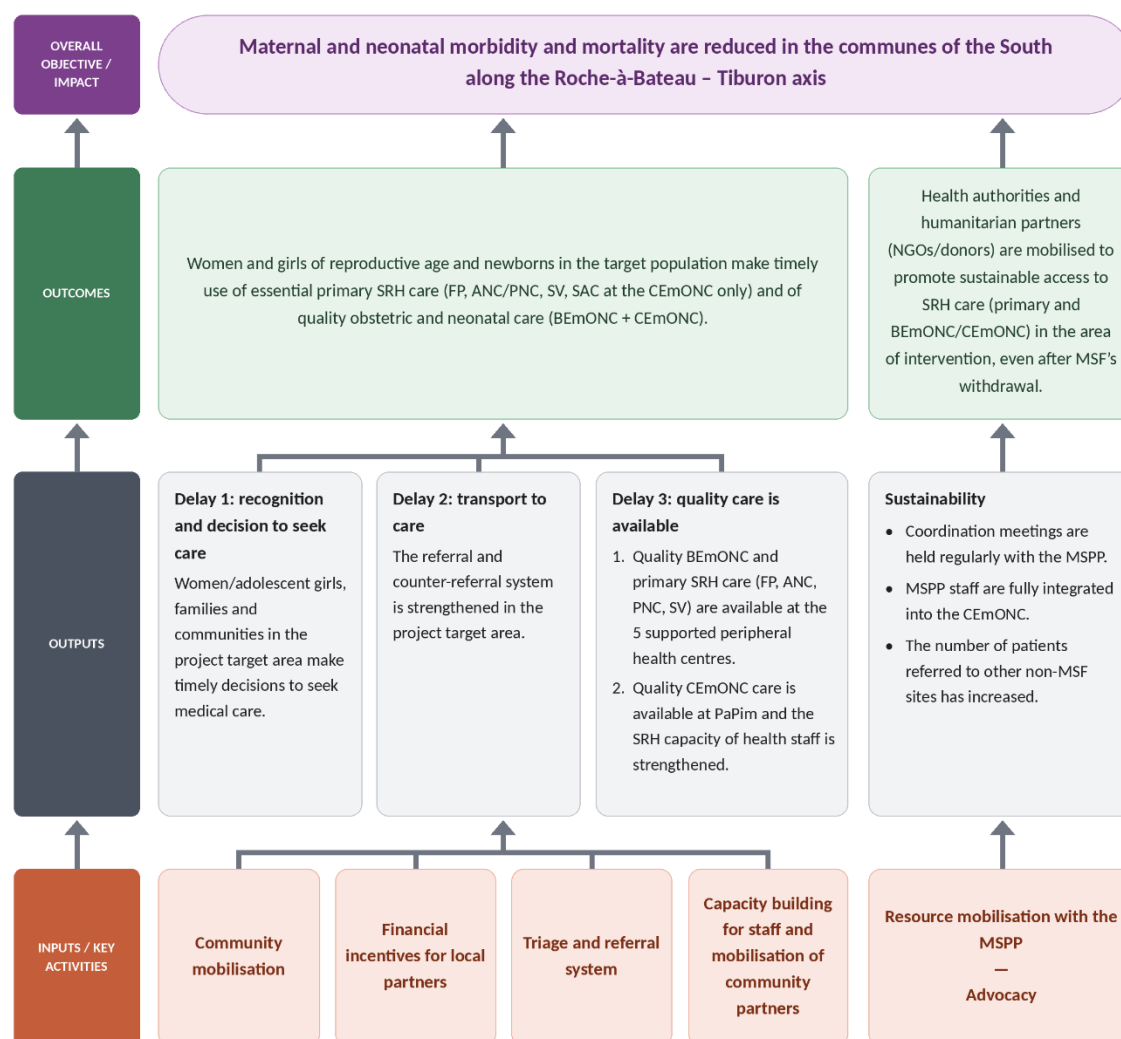


Figure 3: Theory of change (ToC) of the PaPim project

EVALUATION QUESTIONS AND CONCEPTUAL APPROACH

EVALUATION QUESTIONS

According to the ToR, the evaluation questions are as follows:

1. What **changes in care-seeking behaviour** have occurred during the project, and which **conditions or interventions have been most critical** in enabling these changes to persist after MSF support ends?
 - a. What do CEmONC utilisation patterns reveal about **community recognition of complications and care-seeking pathways**, and **what needs to be and remain in place** to ensure that high-risk women receive appropriate care, including after MSF's departure?
 - b. Which **persistent barriers to facility-based care** has the project not yet overcome, and **which of these are likely to intensify** after MSF's departure without specific mitigation strategies?
2. Which **specific capacity improvements in the HCs** (BEmONC) have proved most sustainable and most valued by communities, and what support will these facilities need to maintain service quality and patient trust after the transition?
3. Which foundational investments – such as community engagement approaches and capacity building – have created **self-reinforcing momentum** that will continue independently, and which investments remain **fragile** and dependent on continued external support?
4. **What has proved most and least effective in strengthening emergency and basic obstetric care**, and how can this information guide both MSF's intervention in the final phase of the project and the handover strategy and implementation in order to maximise post-MSF sustainability?
 - a. Which elements of the referral system depend on MSF's presence as opposed to local capacity, and which critical gaps or relationships need to be strengthened now, in particular to avoid any breakdown in referrals after MSF's withdrawal?
 - b. Which capacities can realistically be transferred to the MSPP or other actors given their current capacity and constraints, what will require continued external support, and what gaps does this reveal that need to be filled now or through alternative arrangements?
 - c. Which strategic pivots in MSF's remaining time would best enable the health system to sustain maternal health gains independently, and what would we most regret not having done before leaving?
5. **Which measurable indicators** at community and institutional level could indicate that the conditions for handover are in place, or that withdrawal would be premature, and what should the contingency plan be if these conditions are not met by the planned departure date?
 - a. Which specific services, systems or support mechanisms represent the minimum viable infrastructure for access to SRH, and which early warning signs would indicate that these essential elements are deteriorating after handover?

However, according to the inception report, question 1 was reformulated as follows: “*What **changes in care-seeking behaviour appear to have occurred during the project**, and which **conditions or interventions have been most critical** in enabling these changes to persist after MSF support ends?*”

KEY CONCEPTS AND DEFINITIONS

When reviewing the initial project documents shared with the evaluation team (including the logical frameworks and project documents), we identified certain concepts relating to project implementation, handover and sustainability. These concepts were explored further in the initial interviews with members of the steering group and are presented here to ensure clarity and a shared understanding between the evaluation team and the steering group. They are as follows:

- i. **Pooling/Integration:** In the PaPim project, the terms “pooling” (mutualisation) and “integration” are used interchangeably to describe the sharing of staff, financial and other resources between the MSPP and MSF. This approach progressively involves MSPP staff in project activities and enables the MSPP to take on certain responsibilities (financial and material) previously borne exclusively by the project. It thus serves as a strategy for initiating or approaching handover to the MSPP, ensuring a gradual transfer of responsibilities. Since its launch in early 2025, progress has been slow and, up to early 2026, only planning and coordination activities with the MSPP, and the pooling of certain support staff and their roles between the Port-à-Piment HC and the MSF CEmONC (cleaners, security staff), had been achieved. The project hopes to continue advocating for this transition, including the pooling/integration of medical staff at the CEmONC and of community activities in 2026, with full handover by the end of 2027.
- ii. **Mobilisation:** this term refers to mobilising other actors (mainly the MSPP and the United Nations Population Fund – UNFPA) and humanitarian funding to fill existing gaps in the health system in the South, particularly in sexual and reproductive health. It covers the advocacy efforts that MSF is making or plans to make with the MSPP and other partners supporting SRH activities in the area, with the aim of securing their recognition of, and interest in, taking over MSF’s activities at CEmONC, BEmONC and community level before and especially after the 2027 handover. As we understand it, mobilisation activities started slowly in 2025 and are expected to form a significant part of project activities in 2026, with target activities including:
 - Advocacy for the deployment of qualified staff in the South
 - Advocacy for the decentralisation of blood testing and improved availability of blood in the South
 - Improved comprehensive management of sexual violence and other neglected SRH priorities
 - Promotion of the importance of an adolescent SRH approach (PaPim Log frame 2024 & 2025)
- iii. **Decentralisation:** Although “decentralisation” is often understood in general terms as the transfer of powers from a higher to a lower level of decision-making (OECD, 2019), in the PaPim project the term has a more strategic dimension. It represents an operational paradigm shift for the project, from a parallel/vertical approach (in which the project was located solely at PaPim hospital and involved only MSF staff) to a more horizontal/integrated approach (supporting three peripheral health facilities – HC Tiburon, HC Chardonnières and Rendel – all run by MSPP staff), with the aim of building the capacity of these health facilities to function effectively as BEmONC sites (operating 24 hours a day, 7 days a week, managing less complex

obstetric cases and referring only complex cases to the CEmONC). The decentralisation initiative was also implemented as a strategy to better align the project with the Haitian health system, make the BEmONC sites the first point of contact for patients, decongest the CEmONC and make it more efficient by managing only cases requiring specialised attention.

CONCEPTUAL APPROACH

We used three theoretical frameworks: the PRECEDE-PROCEED model, the COM-B model and the socio-ecological model.

- i. **The PRECEDE-PROCEED model (Green & Kreuter, 2005):** The PRECEDE (*Predisposing, Reinforcing and Enabling Constructs in Educational Diagnosis and Evaluation*) and PROCEED (*Policy, Regulatory, and Organisational Constructs in Educational and Environmental Development*) model is a health promotion model suited to interventions that target a community and work with it to foster change. This framework serves as the overarching framework and guides the evaluation as a whole. It makes it possible to examine the level of community and stakeholder engagement in programme planning and implementation, its relevance and impact, and the barriers and opportunities for improvement, which will inform handover plans.
- ii. **The COM-B model (Michie et al., 2011):** The COM-B model (*Capability, Opportunity, Motivation – Behaviour*) is a behavioural model that seeks to understand how individuals' characteristics in terms of capability (psychological and physical, knowledge and skills), motivation and opportunity (the situations in which they find themselves) influence their behaviour. It also guides how behaviour change interventions can be implemented and the policy options needed to support them. This model is used to assess the behaviour change aspects brought about by the project, the interventions and activities put in place to foster this change within the population, and what can be done to improve and facilitate the transition.
- iii. **The socio-ecological model:** This model explores the interactive processes between a person and the different layers of their environment (McLeroy et al., 1988). This framework guides our understanding of how the different levels of society – individual, interpersonal, community and societal factors – influence behaviour change, adoption and the subsequent handover of the project.

METHODS

EVALUATION DESIGN

We used a mixed-methods approach incorporating a case study to carry out this evaluation. It comprised the following components:

1. **Document review:** Analysis of project-specific documents and relevant national and international policies to contextualise and situate the project (e.g. memorandum of understanding with the MSPP or other partners, the project's theory of change and logic model, national SRH reports).
2. **Secondary data analysis:** We carried out a secondary analysis of routinely collected monitoring data to examine trends in health services and health outcomes over time. Data were extracted from the national health information system (DHIS2) and cover the period 2022 to 2025. Where possible, data from 2019 to January 2026 were used to establish trends before and after the evaluation period. We did not obtain authorisation to access the DHIS2 portal; a member of the project team extracted the relevant datasets and sent them to us by email.
The data included indicators on maternal and newborn health, service use, family planning, GBV and other key SRH indicators, from MSF-supported and non-MSF-supported health facilities. The analysis used both facility-level aggregate data and individual-level data where available. Individual-level data included information on age, reason for consultation and place of residence, but did not include full patient medical records. Aggregate data included routinely reported facility-level indicators on services and health outcomes.
3. Similarly, secondary data for the South department were extracted from the national statistical reports for 2022, 2023 and 2024 (MSPP 2022, 2023 & 2024). Data on contraception, maternal mortality, home deliveries, sexual violence and other relevant aspects of sexual and reproductive health were extracted and analysed and, where possible, trends were established. In the absence of data from other non-MSF-supported sites, South department data were used as proxies to visualise trends at non-MSF-supported sites. Throughout the Findings section, we refer to the results of this analysis as South department data.
Case study: The case study focused on PaPim hospital (CEmONC) and HC Rendel and Tiburon (BEmONC) and their respective communes (Port-à-Piment, Chardonnières and Tiburon), in order to gain an in-depth, holistic understanding of programme activities, including patient referrals from the BEmONC facilities and communities. The decision to use these sites as case studies was taken in consultation with the project team. Activities at the selected sites included: a document review of existing guidelines and documents, a client exit survey, service mapping, in-depth individual interviews (IDIs) with care providers and community partners, and a secondary analysis of key performance indicators.
4. **Semi-structured key informant interviews:** Interviews with strategic stakeholders from MSF, the MSPP and the community.

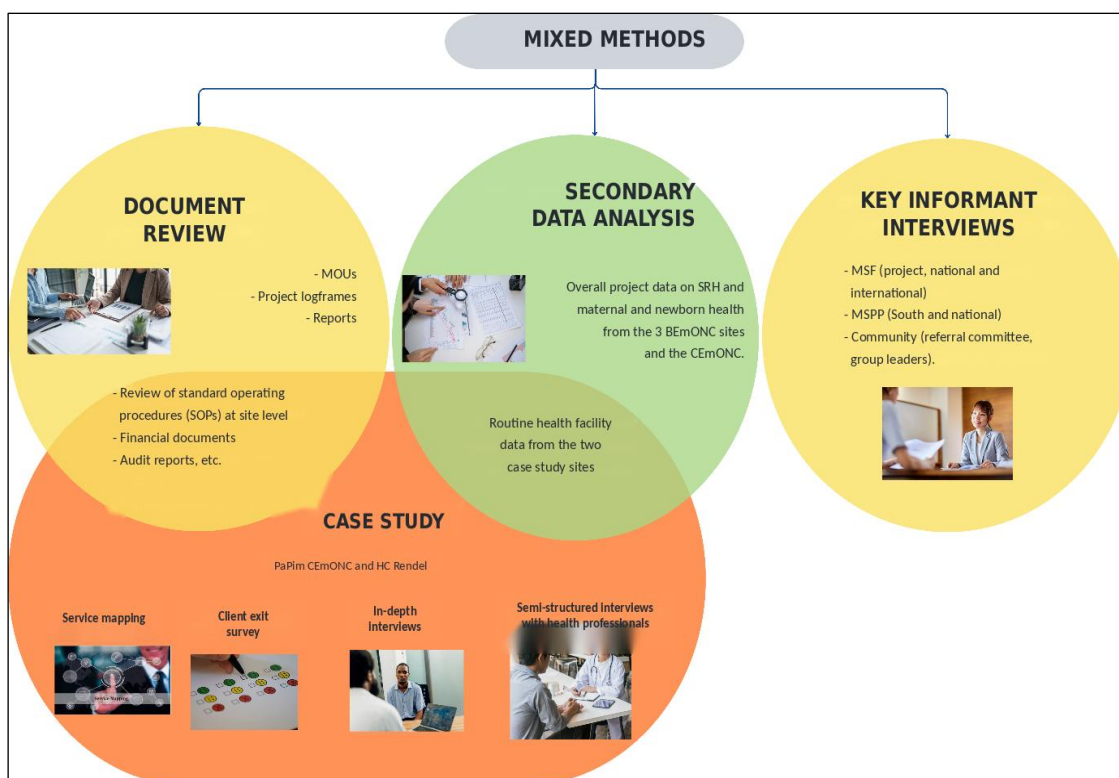


Figure 4: Evaluation design

STUDY POPULATION AND PARTICIPANT SELECTION

The evaluation team used convenience sampling to identify participants for the different components of the evaluation.

1. **MSF key informants:** Strategic MSF staff at global/international, national and project level were selected and invited to take part in semi-structured interviews. Targeted staff categories included regional/national project coordinators, medical referents and support staff, and community activity coordinators, including communications staff.
2. **MSPP key informants:** Potential MSPP key informants included the national SRH representative, the health director of the South department, SRH and human resources managers, and supervisors of community activities.
3. **Health facility staff:** We sampled health facility staff at the case study sites according to their level of involvement in SRH programme activities, whether they were MSF staff, MSPP staff or recruited by other partners. Potential participants included hospital directors, nurses, midwives, doctors and community staff involved in the referral pathway. We also identified patients attending the case study sites during the data collection week, at the various entry points (outpatient department, delivery room, NICU), together with their companions and partners, to take part in the exit survey. A subsample of survey participants who had actually used the services was invited to take part in in-depth interviews. Purposive sampling was used to ensure diversity in terms of age, sex and reasons for consultation.
4. **Community level:** At community level, we recruited and surveyed service users taking part in community outreach activities (pupils, and men and women attending mobile service points,

including pregnant and postpartum women and their partners). A subsample of these participants was also selected for in-depth interviews.

DATA ANALYSIS

We analysed quantitative data using descriptive statistics in Excel to explore service uptake and selected SRH and obstetric care indicators. This analysis aimed to inform our understanding of care-seeking behaviour, uptake of CEmONC and BEmONC services, facilitators of and barriers to accessing care, and potential gaps affecting continuity of care.

We analysed qualitative interview data thematically using NVivo version 14. Our analysis explored perceptions of service quality and user experience, barriers to and facilitators of access to care and referral, and perspectives on sustainability, local priorities and handover following MSF's withdrawal. We triangulated the results of the quantitative and qualitative analyses to strengthen interpretation and support practical conclusions and recommendations.

We entered data from the document review and service mapping into Excel sheets and summarised them using narrative and tabular approaches. We integrated this information with the other evaluation components to support a holistic understanding of the project, the local context, available services and existing gaps.

ETHICAL CONSIDERATIONS

We conducted the evaluation in accordance with the ethical standards applicable to research and evaluation in humanitarian settings and complied with the requirements of the Canadian Tri-Council Policy on research ethics (Government of Canada, 2013). Participation was voluntary and based on informed consent, with procedures adapted to participants' language preferences.

Adolescents were deliberately included in the evaluation, as they are among the users of SRH services, and their direct views and experiences were considered important for the evaluation of services. With regard to consent, where adolescents sought services independently, their consent to take part in interviews was obtained directly from them. Where adolescents were accompanied by a parent or guardian, the parent's or guardian's consent was obtained, together with the adolescent's assent. Participation was voluntary and participants were informed that they could decline to answer any question or stop the interview at any time. The same core data collection tools and questions were used with adolescents and adults to ensure consistency and comparability of responses. However, in interviews with adolescents, language, tone and explanations were adapted to their age and level of understanding, with questions worded clearly, simply and non-judgementally.

Given the sensitivity of SRH topics, the evaluation team applied a "do no harm" and trauma-informed approach throughout data collection. Interviewers avoided unnecessarily probing experiences likely to cause distress and respected participants' boundaries and choices, including their option not to answer certain questions or to stop the interview without any consequences. Where relevant, participants were informed of available support services should they need further assistance after the interview.

All data were treated confidentially, and information was anonymised during analysis and report writing. Interviews were conducted in private settings, and no private or identifiable information was included in the findings. Data collection approaches prioritised the safety and dignity of both participants and researchers.

FINDINGS

To answer the evaluation questions appropriately, we first present the scope of the PaPim project through a detailed analysis of the service mapping carried out at the case study sites (Port-à-Piment CEmONC, HC Rendel and HC Tiburon). We then present the other findings according to the OECD criteria: relevance, coherence, effectiveness, efficiency, impact and sustainability (OECD, 2019). We cross-reference and present findings from all data collection methods (quantitative findings complementing the qualitative and document review findings, and vice versa) where relevant when examining each evaluation criterion, and we answer the evaluation questions as set out in the evaluation matrix (Appendix 4).

SCOPE OF INTERVENTIONS IMPLEMENTED UNDER THE PAPIM PROJECT

As part of the implementation of the PaPim sexual and reproductive health (SRH) project, MSF exclusively runs the PaPim CEmONC and supports the maternity units of four other health facilities along the Roche-à-Bateau–Tiburon axis: HC Rendel, Chardonnières, Les Anglais and Tiburon. To provide details of MSF's support in the target area, this subsection presents the results of the service mapping exercise carried out at the case study sites: the PaPim CEmONC, HC Rendel and HC Tiburon.

Table 2: Service mapping

SERVICES	PAPIM	HC RENDEL	HC TIBURON	COMMENTS
Section 1: Facility identification and classification				
Facility level	CEmONC	BEmONC	BEmONC	
Managing authority	Private (MSF)	Mission & MSPP	Mission & MSPP	
Location (commune)	Coteaux	Rendel	Tiburon	
Years since start of MSF support	2016	2023	2023	
Section 2: Facility operations				
Opening days per week	7/7	5/7	5/7	Rendel and Tiburon are open Monday to Friday only.
Opening hours per day	24/24	8h/24	8h/24	8 a.m. to 4 p.m. for Rendel and Tiburon.
Emergency care outside opening hours	Yes	No	No	At Rendel and Tiburon, nurses can be reached at home in emergencies after working hours, at weekends and on public holidays.
Seasonal schedules (e.g. public holidays)	Yes	No	No	
Section 3: Staff profile				
Clinical staff				
Obstetricians/Gynaecologists	1	0	0	

SERVICES	PAPIM	HC RENDEL	HC TIBURON	COMMENTS
General practitioners	5	0	1	Family doctors
Midwives	8+2*+1 [§]	1*	1	
Nurses	22+4*	1	4	
Nursing assistants	13+2*	1	2	
Anaesthetists	4+2*	0	0	1 anaesthetist and 5 nurse anaesthetists
Paediatricians	1 [§]	0	0	Travel from Port-au-Prince (flying)
Laboratory technicians	4+1 [§]	0	1	At Rendel, the nurse performs laboratory tests for antenatal consultations
Pharmacists/dispensers	2+1 [§]	1	1	1 pharmacist at PaPim; the others are dispensers
Psychologist	1 + 1*	0	0	
Community staff				
Mobile midwives	2+1 [§]	0	0	Coaching for BEmONC sites
Health promotion staff	10	-	-	10 staff in total, deployed in pairs in the communities
Community partners / relays				
Matrones (traditional birth attendants)	6	13	20	Referral and active orientation of pregnant women
Colvols	10	5	0	
ASCP	0	0	17	
Community action groups	7	4	5	
Referral committee	Yes	Yes	No	
Peer educators/mentors	0	0	0	Project to identify and train youth ambassadors from June 2026
<i>Section 4: Infrastructure and capacity</i>				
Total bed capacity	27	5	2	The bed at Tiburon is reserved for immediate postpartum observation
Labour ward beds	3	2	0	
Delivery tables/beds	3	1	1	
Postnatal beds	17	2	1	Includes 4 post-operative beds, 1 isolation room and 4 pathology beds at PaPim

SERVICES	PAPIM	HC RENDEL	HC TIBURON	COMMENTS
Post-operative recovery room	3	0	0	
Neonatal beds	11	0	0	Includes 4 neonatal intensive care beds and 1 isolation room at PaPim
Kangaroo unit	Yes	No	No	
Operating theatre available?	Yes	No	No	
Blood transfusion?	Yes	No	No	
Functional delivery room?	Yes	Yes	Yes	One delivery room per facility
Electricity (grid/generator/solar/none)	Yes	Yes	Yes	Solar + generator at PaPim; solar only at Rendel and Tiburon
Water supply (source)	Yes	Yes	Yes	Filtration system at PaPim hospital
Functional sanitation facilities	Yes	Yes	Yes	MSF provides WASH (water, sanitation and hygiene) supplies to Rendel and Tiburon
Maternal health services				
Antenatal care	Yes	Yes	Yes	Monday to Friday; full package
Skilled birth attendance	Yes	Yes	Yes	
Postnatal consultation (PNC)	Yes	Yes	Yes	Up to 45 days after delivery
Management of obstetric complications	Yes	No	No	
PMTCT	No	No	No	The PaPim maternity unit provides antiretroviral treatment before referral
Family planning	Yes	Yes	Yes	Short- and long-acting methods available; tubal ligation at PaPim only
Post-abortion care	Yes	No	No	
Newborn and child health services				
Neonatal resuscitation	Yes	Yes	No	PaPim and Rendel have oxygen.
Management of neonatal infections	Yes	No	No	

SERVICES	PAPIM	HC RENDEL	HC TIBURON	COMMENTS
Immunisation	Yes	Yes	Yes	MSF support ends 45 days after delivery.
Growth monitoring	Yes	Yes	Yes	MSF support ends 45 days after delivery.
Integrated Management of Childhood Illness (IMCI)	Yes	No	No	MSF support ends 45 days after delivery.
Adolescent sexual and reproductive health services				No specialised services for adolescents are currently available; however, a project to establish them is planned at PaPim.
Antenatal consultation for adolescent girls	No	No	No	
STI management services	No	No	No	
Contraceptive counselling	No	No	No	
Community outreach	Yes	Yes	Yes	In schools
Other sexual and reproductive health services				
Management of gender-based violence	Yes	No	No	No legal assistance or psychosocial services
Psychosocial support	Yes	No	No	
STI/HIV management	No	No	No	Only syphilis screening is carried out at the first antenatal consultation (ANC1), with treatment if positive
Gynaecological care (infertility, cancer screening)	No	No	No	
<i>Section 5: Service availability</i>				
Essential equipment				
Blood pressure monitor	Yes	Yes	Yes	
Foetal Doppler	Yes	Yes	Yes	
Delivery kits	Yes	Yes	Yes	
Neonatal resuscitation bag and mask	Yes	Yes	No	
Sterilisation equipment	Yes	Yes	Yes	PaPim's high-capacity sterilisation unit also supports the BEmONC sites.
Essential laboratory supplies				

SERVICES	PAPIM	HC RENDEL	HC TIBURON	COMMENTS
Routine basic antenatal tests (haemoglobin, urinalysis, screening for sexually transmitted infections)	Yes	Yes	Yes	
HIV testing	Yes	Yes	Yes	At the first antenatal consultation (ANC1), then every three months.
Hepatitis B screening	No	No	No	
Essential medicines and commodities				Health commodities were marked "Yes" only if they were in stock on the day of the assessment.
Oxytocin	Yes	Yes	No	Temporarily out of stock at Tiburon.
Magnesium sulphate	Yes	Yes	Yes	
Misoprostol	Yes	Yes	Yes	
Injectable antibiotics	Yes	Yes	Yes	
Antiretrovirals	No	No	No	
Contraceptive methods (by type)	Yes	Yes	Yes	Short- and long-acting methods.
Iron / folic acid	Yes	Yes	Yes	
Antiretroviral therapy (ART) / prophylaxis	Yes	No	No	Up to 45 days after delivery.
<i>Section 6: Referral pathways and logistics</i>				
Referral pathways and logistics				
Is a written referral protocol available?	Yes	Yes	Yes	
Are standardised referral forms used?	Yes	Yes	Sometimes	
Are emergency referral criteria defined?	Yes	Yes	Yes	
Is there a feedback mechanism from the receiving facility?	Yes	Yes	Yes	By telephone or radio for Rendel, and by telephone only for Tiburon.
Referral destinations				

SERVICES	PAPIM	HC RENDEL	HC TIBURON	COMMENTS
Obstetric emergency	Incoming	Outgoing	Outgoing	To PaPim
Neonatal emergency	Outgoing and incoming	Outgoing	Outgoing	To PaPim
Surgical referral	Outgoing	Outgoing	Outgoing	At PaPim, patients are referred to other facilities for non-obstetric surgical cases
Blood transfusion	Incoming	Outgoing	Outgoing	To PaPim or Les Cayes
Emergency transport and logistics				
Is an ambulance available on site?	2	0	1	Tiburon's ambulance is provided by the CAN; it was out of service but was recently repaired by MSF.
# Number of functional ambulances	2	0	1	
Shared ambulance?	1	1	0	PaPim's ambulances are shared with the MSPP and Rendel
Community transport?	Yes	Yes	Yes	Branka
Fuel availability constraints	No			Fuel provided by MSF for the ambulances at all three sites
Average ambulance response time	Immediate	45 min to 1 hr	0 to 2 hours	Up to 2 hours if the Tiburon ambulance is out of service
Alternative means of transport used (motorbike, bicycle, taxi)	Car	No	No	
Communication system				
Mobile network coverage	Yes	Yes	Yes	Sometimes irregular owing to poor network coverage
Institutional telephone line	Yes	No	No	24/24, 7/7
Radio communication	Yes	Yes	No	
WhatsApp groups / Teleconsultation	Yes			Unreliable owing to poor internet connection
Digital reporting system (DHIS2, etc.)	Yes	No	No	Paper-based data reporting system only at Rendel and Tiburon
Other (word of mouth)	Yes	Yes	Yes	

SERVICES	PAPIM	HC RENDEL	HC TIBURON	COMMENTS
Partners and support networks				
MSP	Yes	Yes	Yes	Care > 45 days after delivery
NGO	AVSI	No	UNICEF, DELR & UNFPA	
Faith-based organisations	No	Yes	Yes	The Catholic mission supports Rendel and Tiburon with staff and equipment.
Community leaders' group	No	No	Yes	

¹Branka: traditional method of manually carrying people with disabilities and sick people on a stretcher. It usually requires 4 physically fit people (preferably men) to carry the person

*Relief staff (part-time employees called upon to replace full-time staff during absences)

[§]Supervisor

[&]Part-time staff

DETAILS OF FACILITY OPERATIONS AND STAFFING

The Port-à-Piment health centre houses the CEmONC, a “two-in-one” facility run jointly by the MSPP and MSF. The MSPP runs the outpatient department (OPD), while MSF runs the CEmONC. Formerly a BEmONC facility, the centre began receiving MSF support in 2016 and was converted into a CEmONC by MSF after the 2021 earthquake. The centre operates 24 hours a day, 7 days a week, and provides on-call, fully equipped emergency obstetric care for populations along the Roche-à-Bateau–Tiburon axis and beyond. In terms of staffing, the centre has 1 full-time obstetrician-gynaecologist, 1 full-time anaesthetist, 5 nurse anaesthetists, 5 full-time general practitioners, 11 midwives, 24 nurses and 1 pharmacist, as well as a wide range of other support and part-time staff, as shown in Table 2. From time to time, a paediatrician travels specially from Port-au-Prince, Haiti’s capital, to support the team. As for community staff attached to the PaPim CEmONC, 2 mobile midwives visit nearby maternity units at least once a week to provide support and mentoring. They are also assisted by 10 CoVols and 6 traditional birth attendants who facilitate patient referrals from the community, and by 7 community groups that support health promotion staff in their community awareness-raising activities.

HC Rendel and HC Tiburon are both para-public health centres run by the Catholic mission and supported by the MSPP. MSPP support mainly takes the form of staff deployment. Under Haiti’s national health structure, these facilities are classified as community health centres (CCS). However, because of their geographic location and the support they have received from MSF since 2023, they now function as health centres with BEmONC (Centre de Santé – CDS). Both centres are open 8 hours a day, 5 days a week (Monday to Friday). In the evenings and at weekends the facilities are closed; however, nurses can be reached by telephone or by word of mouth at home to attend to any woman in labour. HC Rendel has 1 full-time nurse, 1 nursing assistant, 1 part-time midwife and 1 pharmacy assistant. The full-time nurse is recruited by and registered with the MSPP, while the others are contract staff paid from the hospital’s own funds. The centre also has 5 CoVols, 13 traditional birth attendants, 4 community associations and a referral committee affiliated with the health centre. Similarly, Tiburon

has a full-time family doctor, a full-time midwife, four nurses, two nursing assistants, a laboratory technician and a pharmacy assistant. Of these staff, only two nurses are recruited and registered by the MSPP, while UNFPA covers the midwife's salary and the community funds the other nurses and the doctor. At community level, Tiburon has 17 trained community representatives (polyvalent community health workers – ASCPs), unlike the ColVols at PaPim and Rendel. These ASCPs have received comprehensive training from the MSPP and, beyond awareness-raising, can perform other specialised functions in the community, such as immunisation and identifying danger signs. The community also has 20 traditional birth attendants and 5 associations; however, it does not have a referral committee.

INFRASTRUCTURE, CAPACITY AND UTILITIES

The PaPim CEmONC has a total capacity of 27 beds across the maternity, postnatal and neonatology wards, as shown in Table 2. The neonatology and premature care units have 6 and 4 beds respectively; however, this capacity is often exceeded owing to high demand, with a single bed sometimes accommodating more than one patient. There is no dedicated kangaroo care unit; however, mothers whose babies need such care are often admitted to the neonatology and maternity wards. HC Rendel and HC Tiburon have a total capacity of 5 and 2 beds respectively, serving only the delivery room and the postpartum ward, with no neonatal services. At all three case study sites, the project provides postnatal care for mother and baby for up to 45 days after birth. Postnatal services include breastfeeding counselling and support, family planning, hygiene and infection prevention, and immunisation (polio and BCG provided by the MSPP, hepatitis B provided by MSF). Beyond 45 days after delivery, the MSPP continues to provide support, mainly through immunisation.

With regard to blood transfusion services, the MSPP has a centralised system in which all blood collected is sent to the capital (Port-au-Prince) for testing before distribution. However, the PaPim CEmONC has a temporary blood bank able to store more than 50 pints of blood and supply the CEmONC for about a month. It should be noted that this centre has the largest blood storage capacity in the South. To support this unit, MSF coordinates and funds monthly community blood donation drives and facilitates and funds the transport of blood bags to Port-au-Prince for testing and back.

The CEmONC's power supply is also provided and funded by the project. Electricity is supplied by solar panels and a back-up generator and also powers the PaPim outpatient department. With regard to water, sanitation and hygiene (WASH), the CEmONC has a water treatment unit that collects and treats all water used in the hospital. Filtered drinking water is also available at all access points and is accessible to patients and staff. The project also provides HC Rendel and HC Tiburon with WASH supplies and drinking water, and helped restore the water supply in Tiburon. The CEmONC also has a waste management unit, including an incinerator, and a sterilisation unit that serves the entire hospital, including the outpatient department, and supports HC Rendel and HC Tiburon when their services are interrupted.

MATERNAL, NEWBORN AND CHILD HEALTH SERVICES

All three case study sites provide antenatal care (ANC) and skilled birth attendance. During antenatal consultations, women receive a full package of care at all three sites (at least four antenatal consultations including HIV and syphilis screening, haemoglobin measurement, urinalysis and foetal heart rate monitoring with a Doppler device). MSF supports these services by providing the test kits and Doppler devices. With regard to HIV, only the MSPP facility in Port-Salut provides comprehensive care. When a woman is diagnosed HIV-positive, she is referred to Port-Salut hospital for follow-up, as

none of the case study sites holds ART stocks. However, at the PaPim maternity unit, MSF maintains a safety stock of ARVs for post-exposure prophylaxis for staff and GBV cases, which is also used for HIV-positive mothers and makes it possible to provide prophylaxis for exposed babies before their transfer to Port-Salut. This safety stock is available for up to 45 days postpartum, during the follow-up period at PaPim.

With regard to family planning, all three health facilities offered short- and long-acting contraceptive methods (progestogen-only injectables, e.g. medroxyprogesterone acetate – Depo-Provera and medroxyprogesterone acetate – Sayana Press; combined pills; implants, e.g. levonorgestrel – Jadelle; and IUDs). However, the PaPim maternity unit also offers surgical contraceptive methods, including tubal ligation and vasectomy

REFERRAL SYSTEM

A well-structured referral system is in place at all three case study sites, with established protocols for identifying and referring obstetric emergencies. These protocols are available in the delivery rooms of HC Rendel and HC Tiburon. PaPim hospital (CEmONC) serves as the main receiving centre for obstetric emergencies, including cases requiring blood transfusion. PaPim hospital also refers low-risk pregnant women to the BEmONC sites, including HC Rendel and HC Tiburon. Pregnant women who present at their first antenatal consultation (ANC1) with minimal risk and who come from distant communes are referred to the health centre in their commune for subsequent antenatal consultations and delivery; this strategy aims to encourage the use of nearby health facilities and to decongest the PaPim maternity unit. Women are also referred out of PaPim when they present with non-obstetric complications requiring a general surgeon. In these situations, they are referred to Les Cayes (OFATMA, a para-public hospital, or HIC, a public hospital).

The maternity units at HC Rendel and HC Tiburon both have documents setting out the criteria for identifying and referring obstetric emergencies, as well as referral forms. As soon as a potential complication is identified, the PaPim maternity unit is contacted to arrange the referral. This system works particularly well during the opening hours of the HC Rendel and Tiburon maternity units; in the evenings, at weekends and on public holidays, however, the Rendel and Tiburon nurses can be reached at home to facilitate transfers or to attend to the woman in labour if there is no indication for transfer. For all transfers from the BEmONC sites to PaPim, a feedback notice is sent to the referring facility once the patient has been discharged.

Most referred patients were transported by ambulance; however, some transfers were occasionally made by car (when all ambulances were in use) or by “branka¹”, particularly for patients from hard-to-reach communities inaccessible by car. In these cases, the branka is used until the patient can be transferred to an ambulance. PaPim hospital has two operational ambulances on site, shared with HC Port-à-Piment and HC Rendel; it also supports Tiburon when the latter’s ambulance is out of service. Partners supporting the referral system include community actors (Colvols, traditional birth attendants and ASCPs), who actively identify potential obstetric emergencies and refer them to the three case study sites. The MSPP provides health staff at HC Rendel and Tiburon, as well as ambulances through the CAN and other NGOs such as the United Nations Population Fund (UNFPA), which supports Tiburon by providing delivery supplies and paying its midwife, and UNICEF, which provides vaccines.

With regard to the communication system for referrals to specialised care, the PaPim maternity unit has a stable telephone line that facilities in the BEmONC network, including HC Tiburon, and

communities can use in emergencies. This line is managed by the nurse on duty and is available 24 hours a day, 7 days a week. Other means of communication include a radio link at PaPim and Rendel, and mobile phones and WhatsApp at all three case study sites. However, these are unreliable owing to frequent connection instability. Information about women in the community needing specialised care sometimes reaches the three case study sites by word of mouth, through community partners (ColVols and traditional birth attendants), or directly from carers and neighbours.

RELEVANCE OF THE PAPIM SRH PROJECT

This section examines the extent to which the project's interventions and activities meet the needs of the target population (residents of the Roche-à-Bateau–Tiburon axis and the South department of Haiti). It also examines the extent to which these interventions and activities are in line with Haiti's national health strategy and policy, as well as the institutional policies and priorities of MSF and other international organisations. We also consider whether the context has changed over the years and how the project has adapted to remain relevant. Finally, we assess whether project activities respect the principles of equity (leaving no one behind) and take gender power dynamics into account.

Given the social, economic and geographic context of the South, particularly the Roche-à-Bateau–Tiburon axis, **the PaPim project has demonstrated both contextual relevance and adaptability over time in meeting the sexual and reproductive health (SRH) needs of the South, including those of the Roche-à-Bateau–Tiburon axis.**

This section, like the rest of the findings, integrates results from all other components of the evaluation (document review, secondary data analysis, survey and quantitative results).

Table 3 presents the characteristics of survey participants. In total, 68 participants responded to the survey; their mean age was 27 years, ranging from 17 to 43 years. More than 94% of participants (N = 64) identified as women. Only one person (1.47%) was from PaPim. Most had completed either primary education (N = 34; 50.0%) or secondary education (N = 26; 38.24%), and 39 (57.35%) were unemployed. Although only 5 participants (7.35%) reported being married, the majority, 45 (66.18%), were cohabiting.

Table 3: Profile of survey participants

CHARACTERISTIC	VALUE (N=68)
Sex, n (%)	
Female	64 (94.12%)
Male	4 (5.88%)
Age, mean (SD)	27.82 (6.66)
Age group, n (%)	
17–24	24 (35.29%)
25–34	34 (50.00%)
35–43	10 (14.71%)
Marital status, n (%)	
Single	17 (25.00%)

CHARACTERISTIC	VALUE (N=68)
Cohabiting	45 (66.18%)
Married	5 (7.35%)
Widowed	1 (1.47%)
Place of residence, n (%)	
Port-à-Piment	1 (1.47%)
Other	67 (98.53%)
Level of education, n (%)	
No schooling	5 (7.35%)
Vocational school	1 (1.47%)
Primary	34 (50.00%)
Secondary	26 (38.24%)
Higher / university	2 (2.94%)
Household size, mean (SD)	
Number of adults	3.04 (1.71)
Number of children	2.84 (1.68)
Main occupation, n (%)	
Casual work	1 (1.47%)
Salaried employee / service sector	1 (1.47%)
Unemployed	39 (57.35%)
Self-employed	6 (8.82%)
Other	21 (30.88%)

CONTEXTUAL RELEVANCE

Haiti's South department remains among the departments with poor sexual and reproductive health outcomes, including high maternal mortality (459 per 100,000 live births), low family planning uptake (22%) and low antenatal care uptake (67%) . The department also has high rates of gender-based violence (160 cases of sexual violence reported in 2024, more than 94% of which involved women and girls), and more than 10% of deliveries still take place without the assistance of skilled health professionals (MSPP, 2025). The Roche-à-Bateau–Tiburón area, where the PaPim project is located, is particularly affected by difficult terrain and limited access to functioning health facilities, exposing women and girls in this region to poorer sexual and reproductive health outcomes. Moreover, as a rural area, it has a low-income population that lacks the financial means to access care when needed (Burtscher et al., 2023).

The relevance of the PaPim project was further underlined by the survey and the interviews with patients, health professionals and key informants. One community stakeholder stressed the need for the project's activities in the community and expressed this view as follows:

“MSF plays an essential role in our community. MSF helps our women give birth free of charge.....Before they arrived, women faced many difficulties in accessing care, and there were many maternal deaths, but today, thanks to MSF, women can receive quality care” (Community key informant)

“The MSF project responds enormously to the needs of the target population. For example, when I started working here [at the health centre], very few patients came to the centre because services were not really provided, even though the hospital was there. So it was thanks to MSF’s support (providing medicines and sending qualified staff) and its approach to patients that we began to see a gradual increase in attendance at the centre. What’s more, most, if not all, services are free.” (Health professional)

We asked survey participants for their perception of the most pressing sexual and reproductive health problem in their community. Most respondents (50%) cited unwanted pregnancies, while 18% highlighted maternal mortality. Other problems, such as the cost of services, lack of services, poor service quality and transport difficulties, were reported by fewer than 10% of participants (Figure 5). This underlines the relevance of the project’s family planning and community mobilisation initiatives.

These findings were also confirmed in interviews with participants, most of whom indicated that the PaPim project was relevant because it helped to solve concrete problems in the community, such as reducing maternal and infant mortality and providing free services for all. Some participants put it this way:

“We used to have a lot of unwanted pregnancies, but since family planning became free with MSF’s arrival, this has decreased. I would say that around 70 to 80% of the women I see come for family planning; most are young girls, but we also have older women who already have children and simply want to space their pregnancies” (Health professional)

“MSF plays a very important role in our community, because the organisation helps raise women’s awareness about coming to give birth at the hospital and preventing complications that can lead to death when they give birth at home. For example, if a woman has eclampsia at home or with a traditional birth attendant, she will die. What’s more, everything is free; even those who have no money can access essential care” (Community informant)

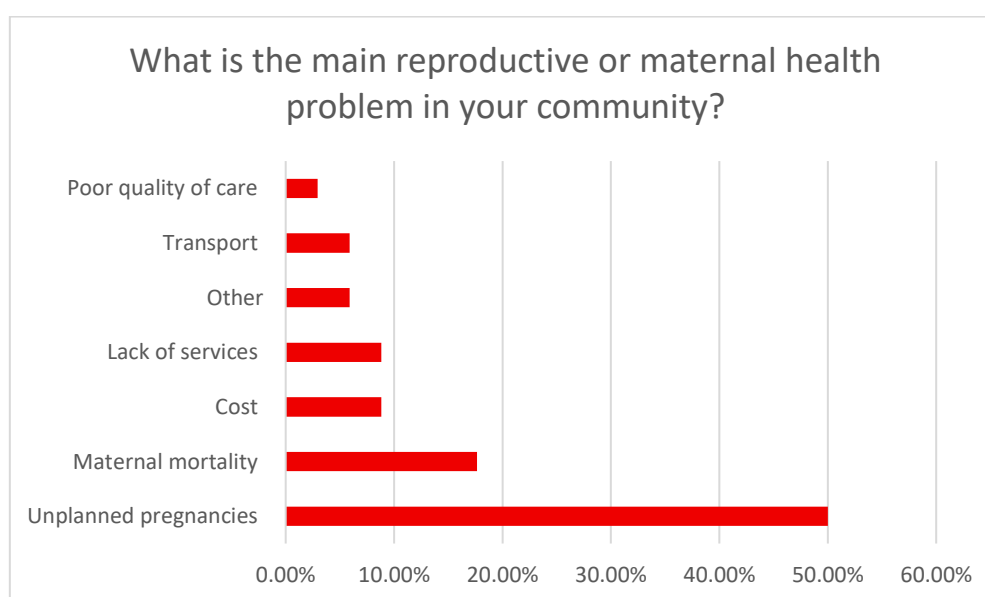


Figure 5: Participants’ perceptions of reproductive or maternal health problems in the community

We also asked participants which services they considered most important in their community. Around 90% of respondents cited maternal health and skilled birth attendance as the most important services, while around 80% mentioned family planning and infant services such as immunisation and nutrition as relevant (Figure 6).

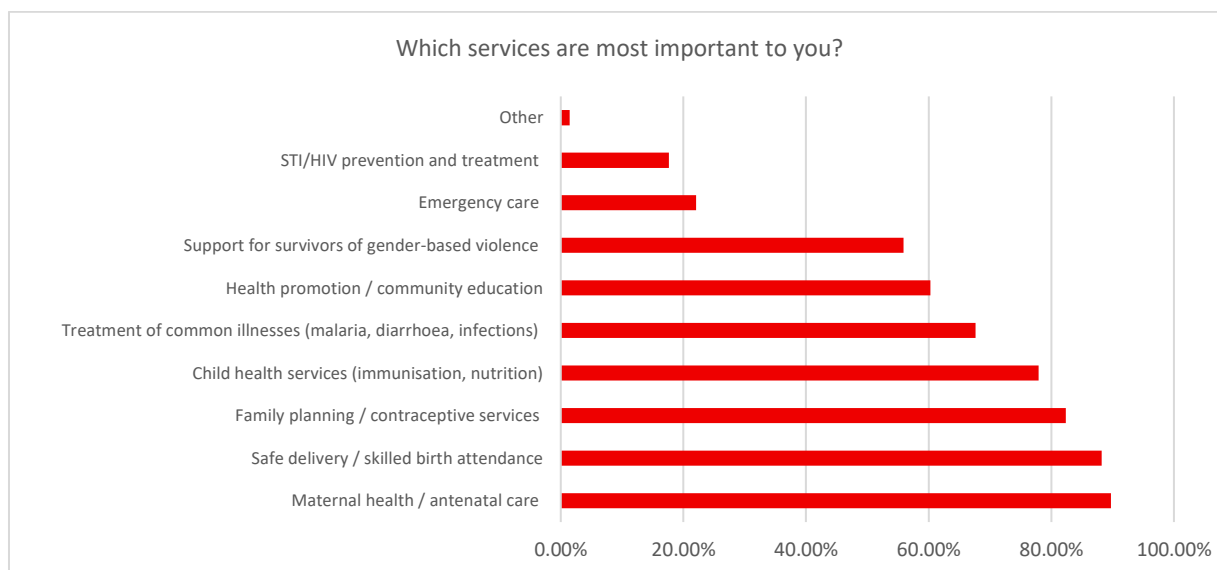


Figure 6: Participants' perceptions of the relevance of services

Similarly, we asked participants which intervention was most important for improving maternal and reproductive health outcomes in the population. Most of them – around 87% – cited the provision of free services; around 68% mentioned health education; 65% the availability of medicines; 57% improved transport to health facilities; and 56% the use of community relays. The fact that every response option was selected by more than 50% of participants underlines the relevance of all these interventions for improving maternal health outcomes in the community (Figure 7).

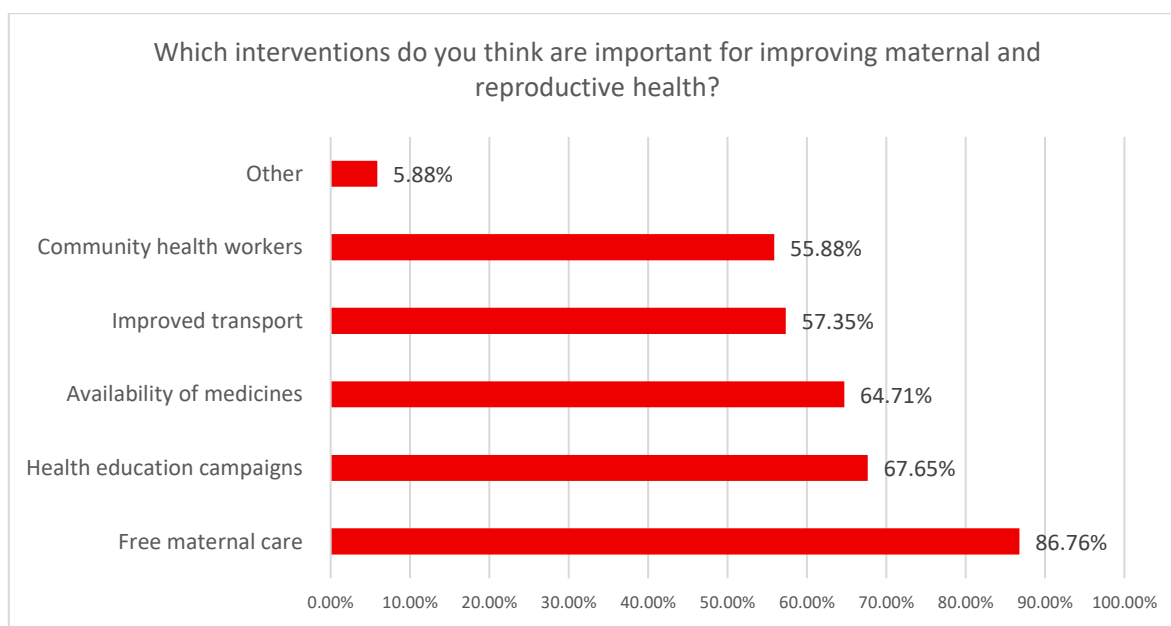


Figure 7: Participants' perceptions of important reproductive and maternal health interventions in their community

We also heard similar accounts in the interviews: many participants said that before MSF arrived, many people did not go to health facilities because they could not afford medical fees. Since MSF's arrival, people have been able to access care more easily because it is free. One participant said:

"Before, people didn't go to the hospital because it cost money; ... Now MSF is here and has made care free for everyone. That's the most important thing I've seen them [MSF] do." (Service user)

Another participant said:

"I can say that MSF plays an essential role in our community; the organisation provides quality care that is very accessible to everyone, because its services are free." (Community key informant)

Other services offered under the project, such as the blood bank at PaPim, were also considered highly relevant by most interview participants. They stressed that PaPim was the only facility in the project's target area, all the way to Les Cayes, able to store blood. Without it, only the Blood Transfusion Post (BTP) in Les Cayes can supply blood for transfusions to health facilities. One participant went on to explain how this service had saved the lives of many people needing blood transfusions in the area.

"These services are truly indispensable. For example, PaPim is the only facility able to store blood ready for transfusion. There is no other such centre between Tiburon and the BTP in Les Cayes. Thanks to this service, many lives are saved... For example, we had the case of a woman who was transfused 5 pints of blood, the first three on the same day. Imagine if there had been no blood and they had had to go to Les Cayes to get it. That woman would have died." (Health professional)

Participants recognised that maternal and child health care was the main specialty in the region, while acknowledging that this care would not have been accessible to part of the population without additional services. In this regard, one of the most important aspects of the PaPim project highlighted by participants was the availability of ambulances to facilitate the transfer of pregnant women with obstetric complications from BEmONC facilities to the CEmONC facility.

"The strength of this project, I think everyone knows, lies in the pregnancy and delivery components. When women go to the hospital, they benefit and receive free care, and they have access to an ambulance put at their disposal. That last point, I can tell you, is 100% true." (Community key informant)

Beyond the health services provided by MSF, the centre's geographic location proved to have a significant impact on the lives of community members. Participants stressed that establishing the CEmONC centre as a referral hub for remote areas meant that patients no longer had to travel to Les Cayes, a journey that in the past had led to preventable deaths among patients unable to withstand the distance.

ADAPTATION OVER TIME

Over time, as circumstances have changed, the project has adapted its interventions to better meet current needs.

a. Evolution of the community outreach approach

Interviews with key informants and community staff clearly showed that the approach used for community outreach activities has evolved. Initially, in the first years of the project, outreach was carried out through door-to-door campaigns. This approach quickly proved very costly and did not meet the needs of certain population groups, for example young people and some people living in remote areas.

“The approach changed; at first we ran door-to-door campaigns in which health promotion (HP) staff went into the field every day and tried to visit every household.” (MSF respondent)

There were also issues of trust in the people delivering these messages, since previously it was MSF health promotion staff who went into the field to run the health information sessions.

“We [MSF] also found that people didn’t really trust the health promotion staff carrying out this outreach, because they were all from MSF... Some people even refused to let them into their homes.” (MSF respondent)

As the health promotion activities did not deliver the expected results, focus group discussions were held in the community and the findings were used to revise the strategy in 2025. A new strategy was introduced from 2026. Under this new strategy, health information sessions were organised in collaboration with community-based organisations and by local volunteers (CoVols), with traditional birth attendants (“matrones”) on the front line and MSF staff in a purely supporting role. Outreach activities were also carried out to reach the general population in public places such as churches and markets, as well as specific groups such as women, men and adolescents, with the help of community-based organisations. Messages were also adapted to the target population.

“We now regularly carry out outreach in public places such as churches and markets, in collaboration with local associations. We also work with the ‘Colvols’ and the ‘matrones’, who are on the front line of this outreach, and we simply support them... For adolescents, we also go into schools to run health education sessions on sexual and reproductive health and, with the help of local associations, we go to remote areas to reach adolescents who are not in school.” (MSF respondent)

Another strategy was to set up referral committees in each commune of the target area to facilitate the referral of women living very far from health centres, where ambulances cannot reach. The members of these committees are all volunteers from these communities; they help carry women by hand to the health centres using a “branka”.

“Another initiative was the creation of a ‘referral committee’ in each commune. The focus group discussions helped us understand that transport was a major barrier for pregnant women living in hard-to-reach areas; so this referral committee helps identify and transport women who need to go to health facilities. The committee members are all volunteers, and MSF simply provides them with the necessary equipment and training on how to identify and approach these women..... To date, four communes in the project’s target area (Roche-à-Bateau, Coteaux, Rendel and PaPim) have been able to set one up, and the goal by the end of the year is for every commune to have one” (MSF respondent).

b. Evolution of the support approach for BEmONC sites

The approach to mentoring and supporting the supported BEmONC sites has also evolved since the project began. In the first one to two years of support, the approach consisted mainly of bedside coaching: MSF sent midwives to spend time – usually three days to a week – at these health facilities to support their midwives by managing clinical cases together. During this period, BEmONC staff had the opportunity to learn directly at the bedside. This approach was complemented by off-site training sessions on the comprehensive management of basic obstetric cases.

“MSF usually sends us midwives who stay a few days, sometimes a week, to help us and show us how to identify and manage certain complex cases. It was very useful for me. I learned a lot” (Health professional)

However, from late 2025 this approach evolved towards a more technical assistance model to enable BEmONC site staff to take charge of case management. MSF midwives visited the BEmONC sites only once a week to review the week's activities and answer any questions or concerns raised. MSF respondents indicated that this change was intended to reduce the sites' dependence on MSF support and enable BEmONC midwives to become self-reliant.

"We no longer send our midwives to stay overnight at the Tiburon and Rendel health centres; they only go once a week to collect data and support them if they have questions or need additional supplies. We now only do this for Les Anglais, because we have only just started supporting them. After a while, we noticed that they were becoming very dependent on our staff. For example, they no longer want to manage deliveries as soon as they see our staff, even when it isn't a complicated case... But we continue to provide the necessary off-site training when needed." (MSF respondent)

COHERENCE OF THE PAPIM SRH PROJECT

This section examines the extent to which the project's activities and interventions are consistent with the policies and decisions of the wider Haitian health system, and with those of other local and international organisations present in the region. It also assesses whether project activities duplicate or complement those of the MSPP and other organisations, and how coordination and collaboration between partners are managed.

Based on the findings, **the PaPim project has demonstrated partial coherence: it is aligned with MSF's internal policies and practices, but not with the broader policies and practices of the MSPP.**

INTERNAL COHERENCE

The PaPim project was launched by MSF after the 2021 earthquake in response to high maternal and infant mortality rates in the region; it is an emergency intervention consistent with MSF's overall mission. In addition, the project's target area is a crisis-prone region (earthquakes, hurricanes and other epidemics such as cholera) that had already received MSF support in the past. One stakeholder confirmed this coherence by stressing the importance of MSF's mission to intervene in emergencies, including in sexual and reproductive health.

"MSF's mission is to intervene in emergencies; so yes, this project is in line with MSF's mission. What's more, MSF had already been present in the region since 2016, after Hurricane Matthew, to respond to certain epidemics. It was then that the organisation identified a gap: on the one hand, it realised that there was no equipped hospital in the region to manage obstetric emergencies and, on the other, that technical expertise was lacking. That's when MSF decided to provide support through the PaPim project." (MSF respondent)

The project had also been designed to run for five years, in line with MSF's institutional action plan. Moreover, the initial memorandum of understanding between the project and the MSPP was very general and did not provide for specific activities, allowing some flexibility to adapt to possible changes in resource allocation within MSF.

"MSF's mandate must not exceed ten years in the same area; so whatever support MSF provides, the organisation makes sure it does not exceed that period. That's why the project was designed to last five years, as MSF had already been in the area for four years." (MSF respondent)

"At MSF we can only draw up an annual plan; that's when we (MSF) define the activities that will be carried out during the year, according to the available budget. We can't plan beyond one year,

because the plan could be interrupted by other emergencies elsewhere that would need our support.”
(MSF respondent)

EXTERNAL COHERENCE

a. Coherence with the Haitian health system

Although the project fits well with MSF's policies and practices, it is not aligned with the wider Haitian health structure or with the country's institutional coordination arrangements; it therefore lacks external coherence.

The Haitian health system has three levels: primary, secondary and tertiary. The primary level comprises the Community Health Centre (CCS) – 1st tier, the Health Centre (CS/CDS) – 2nd tier (BEmONC) and the Community Referral Hospital (HCR) – 3rd tier (CEmONC) (Table 4). Under this structure, PaPim hospital is classified at the 2nd tier of the primary level (BEmONC), like the other supported sites. The referral hospital for the target area is Port-Salut hospital, which was the only CEmONC before MSF's arrival. In this context, PaPim hospital, which currently operates as a CEmONC, does not conform to the national structure, exposing the project to a high risk of strategic failure and reducing its chances of sustainability.

Table 4: Structure of the health system in Haiti (PES)

LEVEL	TIER	POPULATION SERVED	MAIN SERVICES
Primary level	Community Health Centre (CCS) – 1st tier	5,000 to 6,000 inhabitants	Essential curative, preventive and promotional care, rapid screening, community activities, health promotion, prevention
	Health Centre (CS) – 2nd tier	25,000 to 30,000 inhabitants	Curative, preventive and promotional care, basic emergency obstetric and newborn care (BEmONC), primary laboratory, short-stay hospitalisation (10–15 beds), 24-hour service
	Community Referral Hospital (HCR) – 3rd tier	250,000 to 300,000 inhabitants	Complex first-line care, emergencies, comprehensive emergency obstetric and newborn care (CEmONC), secondary laboratory, hospitalisation, 24-hour service
Secondary level	Departmental Hospital (HD)	450,000 to 550,000 inhabitants	Specialised and sub-specialised care: traumatology, orthopaedics, ophthalmology, urology, dermatology, physiotherapy, intensive care, infectious diseases, neonatology, cardiology, dialysis; 100 to 150 beds
Tertiary level	University and specialised hospitals	National population	Highly specialised care, teaching, research, national referral

(MSPP, PES Manual, 2016)

Some key informants also highlighted this in interviews, adding that the PaPim project's non-conformity makes it difficult for them to monitor project activities and performance during their routine supervision visits.

"According to the organisational chart, PaPim is a BEmONC facility. No official document states that it is a CEmONC; that's why sometimes, even when we go into the field for supervision visits, we face this difficulty: how do we assess their performance?" (MSPP respondent)

Other local actors also remarked that the hospital's current location was not their preferred one, making it difficult for them to mobilise support from local partners, who to this day would like the hospital to be moved back to its former location.

"We wanted MSF to renovate the old site, because it could have served the whole population, but MSF decided otherwise and only built a delivery unit for pregnant women. The old space was bigger and better suited to the whole population... Today it is difficult for us (the community) to lobby for support if it is not in the area of sexual and reproductive health. A petition has now been launched to have the hospital moved back to its original site so that it can serve the whole population, as initially planned." (Community key informant)

However, some key informants explained the reasons for choosing the new site, linking them to the earthquake that destroyed the old building and made its renovation more difficult and costly. They also specified that the decision to change sites had been taken by mutual agreement with the MSPP.

"Before the earthquake, when we [PaPim] were still a BEmONC facility and MSF was already planning to leave the area, they [MSF] felt that a CEmONC was needed along the south coast (Roche-à-Bateau–Tiburón axis) because Port-Salut was very far away. Then, after the earthquake, when MSF decided to rethink the project and convert the site into a CEmONC, the building could no longer be used because it too had been destroyed. At the time, the government had proposed refurbishing Les Anglais because it planned to convert that site into a CEmONC later, but that did not happen, and MSF decided to build the CEmONC here [on the current site]. What's more, the space in the old building they proposed using for the operating theatre was not suitable in terms of size and patient flow." (MSF respondent)

Stakeholders from remote communities such as Tiburón were in favour of locating the CEmONC at PaPim, stressing that Port-Salut and Les Cayes were very far from Tiburón and other hard-to-reach areas, making referrals to those places very complicated, unlike a CEmONC at PaPim.

"If you think about the journey, going from here (Tiburón) to Les Cayes, or from here to Port-Salut, is a long trip. With MSF in Port-à-Piment, though, it's only halfway. That means that when we leave here (Tiburón) for Les Cayes, if the patient is in distress, going to Les Cayes, which is the longest route, can even lead to their death. But now, with MSF at PaPim, the journey is shorter, which reduces the risk of death." (Community respondent)

Other informants who were there when PaPim was a BEmONC facility added that they faced many difficulties whenever they had to transfer a patient to Port-Salut or Les Cayes, because many health facilities were far away and transporting critically ill patients was risky. Moreover, most referral hospitals in Port-Salut and Les Cayes refused very critically ill patients because they did not have the capacity to manage these cases, even though they were in theory the referral hospitals. One participant said:

"It was a difficult time to work when PaPim was still a BEmONC facility, because most of the time we (PaPim staff) had to transfer patients a long way, all the way to Les Cayes; for example, it took about two hours to transfer a bleeding patient. It was both stressful and difficult... What's more, some

facilities refused to admit the patient after such a long journey, because they were not able to manage the case. It's a situation that still makes me uncomfortable when I think back on it today."
(Health professional)

The internal policy of drawing up only one-year activity plans is not compatible with the MSPP's institutional coordination arrangements, which require more time (usually more than two years) to implement measures such as staff deployment and policy development to strengthen the project's actions. One key informant put it this way:

"We (the MSPP) knew the project would run for five years, but we didn't know exactly how MSF wanted to manage the transition or what it expected from the government each year to support it. We all know there is a major human resources problem and that these things take time; it can even take the government two years or more to send staff after receiving the request... Only now are we planning to address their departure in 2027 in concrete terms, which in my view could happen sooner." (MSPP respondent)

b. Collaboration with other stakeholders and the MSPP

Throughout the project, MSF has collaborated with other actors such as UNFPA, which also supports certain aspects of SRH in the project area, as well as with the community and the MSPP. Participants indicated that before 2024 there were other non-governmental partners; however, because of funding cuts, particularly by USAID, many other actors are no longer present in the area. Since 2026, UNFPA and UNICEF have been among the main partners; they also support certain SRH-related activities in the project's target area. MSF works with these partners to complement their activities; for example, UNFPA covers midwives' salaries while MSF provides medicines and training.

"...I [a midwife] am paid by UNFPA, but it's MSF that provides the medicines we need, and it's also MSF that facilitates the referral of women with complications to PaPim by sending an ambulance... MSF also sends its midwives to work with us and train us in managing certain cases." (Health professional)

MSF's support also complements the actions of the MSPP and the community, particularly at the satellite sites (BEmONC sites). MSF provides a buffer stock of essential medicines to supplement the MSPP's supplies; it also pays incentives to top up the salaries of staff recruited by the MSPP and the community, especially as these salaries are sometimes paid late or are insufficient to allow them to work full time. In addition to medicines and staffing support, MSF also provides supplies and equipment to these facilities and helps with repairs and fuel for the ambulances provided by the CAN (National Ambulance Centre).

"MSF supports us by providing medicines and supplies; when we contact the South department and they tell us they are out of stock, we call MSF, which then sends us medicines." (Health professional)

"MSF supports us by providing fuel and by maintaining and repairing our ambulances, to ensure continuity of care for the population." (MSPP respondent)

Although the project appears to complement these other partners' activities well, there are some gaps and areas of overlap. For example, providers complained that laboratory tests for pregnant women and consultation fees are not covered by any partner, while some items, such as medicines and supplies, are provided by both UNFPA and MSF. Some health professionals put it this way:

"MSF provides us with medicines, but where we still have difficulties is with laboratory tests; here (at the health centre), women have to pay consultation fees at every antenatal follow-up visit. Neither MSF nor UNFPA covers these, and it really is a challenge." (Health professional).

“... MSF provides us with supplies and medicines, as does UNFPA; sometimes we receive supplies of the same product from both organisations. For example, when there is a stock-out, we usually call on UNFPA and MSF, and we may end up receiving the same supplies twice.” (Health professional)

At community level, the project appears to take a good approach to collaboration and communication, actively involving the community in its activities and thereby giving it a sense of belonging and ownership. MSF works with community leaders to develop action strategies and enables them to lead awareness-raising activities in the community. For example, MSF holds quarterly meetings with community actors to gather feedback and plan activities. The organisation also works with actors such as the “colvols” and the “matrones” to raise community awareness, an approach that communities appreciate and accept. MSF also works with the MSPP to train the “colvols” and pay them a monthly allowance

“The colvols are volunteers chosen by the community and recognised by the MSPP; they are generally MSPP staff at community level, while the matrones are traditional birth attendants. We [MSF] work with them [the colvols and matrones] during awareness-raising activities in the communities; the colvols take the lead because they have been trained for this, while the matrones help identify women in the community who need support and referral. They [the matrones] also help raise the awareness of other traditional birth attendants who still assist home births... MSF pays the colvols a monthly allowance, while the matrones are only paid if they refer a pregnant woman to a health facility.” (MSF respondent)

“We [the colvols] are very grateful to MSF because they support us in the work we do. Before MSF arrived, other partners supported us, but since they left, the government has not been able to keep paying us. That period was very frustrating... Thank God MSF stepped in and started paying us a monthly allowance, which helps us a lot and motivates us to continue our work.” (Community key informant)

With regard to collaboration with the MSPP, from the start of the project MSF took part in drawing up a memorandum of understanding between the two parties and defined the tasks each would take on for each health facility. However, during project implementation, certain difficulties put a strain on the collaboration between the two parties. For example, under the PaPim memorandum of understanding, the MSPP was responsible for providing human resources while MSF provided technical expertise. Over the course of the project, the MSPP was to gradually assign qualified staff to PaPim, and MSF was to train them and gradually transfer activities to them as part of the pooling plan. This did not go as planned. Key informant interviews revealed that this was partly due to the country’s political situation, which affected hierarchical stability and available resources, preventing the MSPP from meeting its contractual commitments.

“The plan was that by early 2026 we [MSF] would start to have MSPP staff deployed at PaPim, but that hasn’t happened so far, and we don’t even know whether it will be possible.” (MSF respondent)

“The crisis the country is going through has really affected us [the MSPP]; the situation is not stable, and even the leadership keeps changing, which makes it difficult to follow things up. What’s more, there is no money; the government cannot pay health workers, which causes many difficulties on the ground.” (MSPP respondent)

Another key informant added that MSF’s staff rotation system was another factor that had a negative impact on collaboration and the coordination of activities between the MSPP and MSF. He put it this way:

“For us [the MSPP], another challenge has always been the change of leadership due to MSF staff rotation, and sometimes it depends on the personality and the person in post... It feels like starting from scratch every time there is a new coordinator, which also slows down the follow-up and coordination of activities. For example, you discuss with the team in place and make recommendations, everything seems to be going well, and then suddenly their assignment ends and they have to be replaced... When the new team or coordinator arrives, it takes some time to get to grips with the context and pick up where you left off with the previous person. So yes, that’s another drawback.” (MSPP respondent)

Although the MSPP was not able to deploy staff to PaPim as initially planned, it sent final-year medical students and other trainee professionals, such as midwives, to PaPim so that they could benefit from the technical expertise of MSF staff. However, PaPim health staff were not sure what the intention behind this strategy was, or whether it was meant to make up for the original plan. One person explained:

“...We [PaPim] do, however, host final-year medical students and a few student midwives who have been sent to PaPim to gain experience. We hope this is another way the government is considering to send MSPP staff here, but we’re not yet sure.” (MSF respondent)

EFFECTIVENESS

This criterion assesses the extent to which the project has achieved its overall objective of reducing maternal and infant mortality rates in the target area, through improvements in the “three delays” (ensuring that women and families decide to seek medical care in a timely manner, ensuring the availability of quality, responsive referral and counter-referral systems, and strengthening access to quality care at BEmONC and CEmONC facilities) and through stronger coordination and integration of activities with the Ministry of Health. We also examine whether differences are observed between population groups and geographic settings.

To address the effectiveness criterion, we present aspects of the secondary analysis of the project’s routine data to identify patterns and trends in access to services at both MSF-supported and non-MSF-supported sites, as well as the main maternal health outcomes at the supported health facilities. We cross-check and complement these results with those from the survey and interviews.

The findings show that **the project has contributed to increasing antenatal consultation and institutional delivery rates, strengthening access to emergency care and improving the decentralisation of maternal health services to BEmONC facilities. However, the continued reliance on the PaPim CEmONC as a high-quality referral centre, together with persistent barriers related to distance, transport, costs and the limited capacity of other peripheral facilities not supported by MSF, limits the project’s effectiveness.**

HEALTH-PROMOTING BEHAVIOUR AND ACCESS TO HEALTH CARE (TOC OUTCOME 1: RECOGNITION AND DECISION TO SEEK CARE)

To assess whether there had been a change in care-seeking behaviour during the project, we asked survey participants what their first point of contact was when they had a health problem. Most participants (89.7%) said they would first go to a public health facility, followed by 25% who preferred a private health facility. Only a small proportion of participants – fewer than 5% – said they would start

with home remedies (Figure 6). This suggests that most participants, and probably most residents, are aware of the importance of seeking medical care in a timely manner. Similarly, in the IDIs, participants said they had been made aware of the services available at MSF-supported sites and were willing to seek care as soon as they or a family member needed it. One participant put it this way:

“Whatever means they have today, women go to the hospital; things have changed. Before, there was no hospital like MSF’s; normal deliveries took place at home. Today, thanks to MSF, as soon as you’re ill or feel the slightest pain, you’re supposed to go to the hospital.” (Service user)

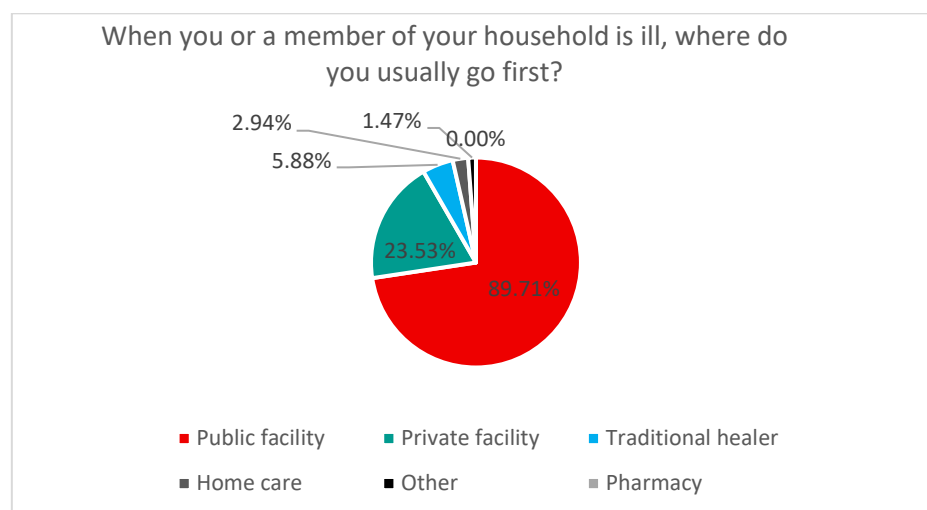


Figure 8: Participants’ first point of contact when unwell

a. Non-institutional deliveries

We also examined trends in facility-based and non-facility-based deliveries using secondary data from both the project and the South department, in order to estimate patterns of health service use during childbirth, which can indirectly indicate changes in care-seeking behaviour in the population. Figure 9 below presents the results for women who received postnatal consultations at PaPim in 2025 and shows that 7.1% of women who came to the clinic reported having given birth at home without skilled personnel. Although the available data were not sufficient to establish a trend, this proportion at PaPim is lower than that reported by the South department in 2023 and 2024 (Table 5), suggesting that the proportion of non-facility deliveries in the communities around PaPim is lower than in the rest of the South.

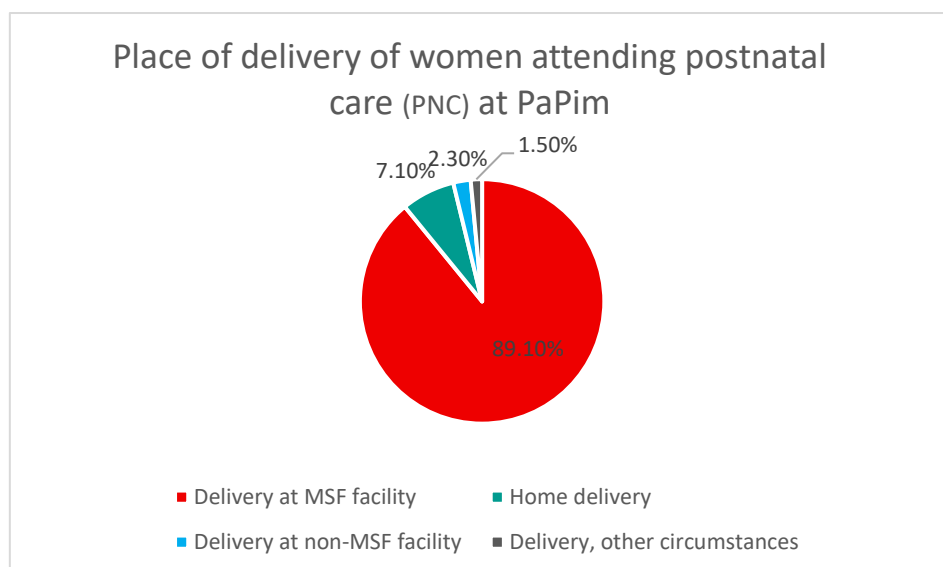


Figure 9: Place of delivery of women attending postnatal care (PNC) at PaPim

Table 5: Place of delivery – South department data

	SOUTH DEPARTMENT DATA		
	Total deliveries	% non-institutional deliveries	% institutional deliveries
2022	15,381	7.0	73.6
2023	13,819	9.5	90.5
2024	10,726	10.8	89.2

Although the proportion of women giving birth without the assistance of skilled health personnel may appear lower in the project's target area, a larger share of the women presenting for postpartum care at PaPim came from within the project's target area than from outside it (Figure 10). On the one hand, this could indicate a still high rate of unassisted deliveries in the project's target area; on the other, it could mean that women in this area are more aware of the importance of seeking skilled care at health facilities and that, even if they were unable to access care before delivery, they are motivated and willing to seek care even after giving birth.

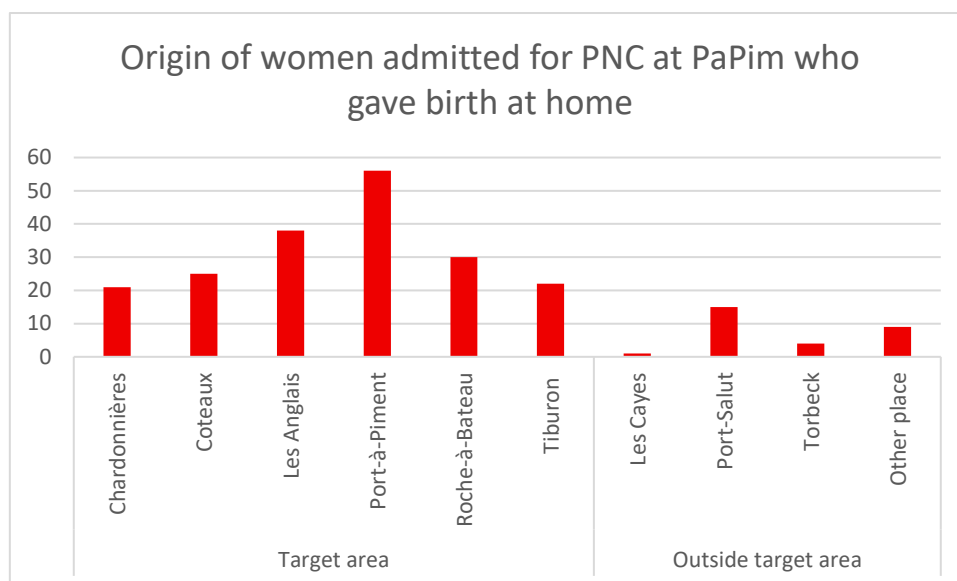


Figure 10: Origin of women coming to PaPim for PNC after giving birth at home

We also examined the proportion of non-facility deliveries in this survey. We asked participants – mainly women receiving antenatal and postnatal care at the facilities where they had given birth in their last pregnancy – to estimate the proportion of women who give birth without the assistance of skilled health personnel, and the proportion of those who had previously given birth at home and are now willing to give birth in a health facility. In contrast to the secondary data analysis, a larger proportion of participants (33.9%) reported having given birth at home without the assistance of skilled health personnel in their previous pregnancy (Figure 11). This disparity could indicate gaps in the health system’s monitoring and reporting of deliveries without skilled assistance, but it could also reflect a change in women’s care-seeking behaviour, with women now more motivated and better able to seek the assistance of skilled health personnel.

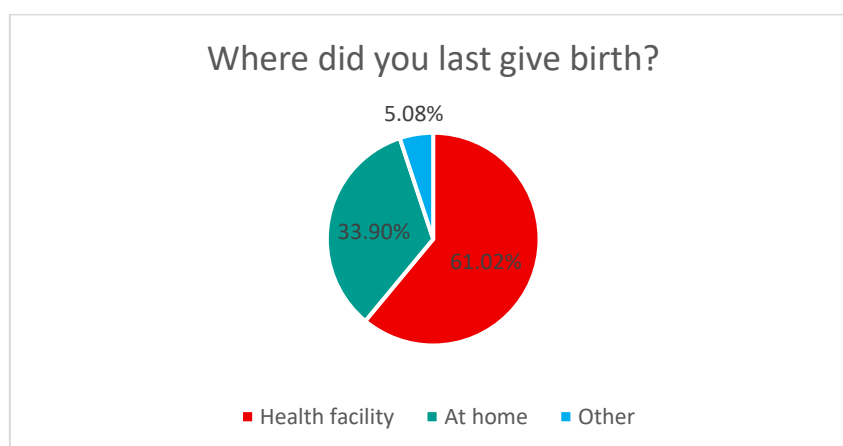


Figure 11: Place of last delivery of survey respondents

We also explored potential aspects of behaviour change during the interviews. Most IDI participants said they had received extensive education through community outreach activities, which had enabled them to make the informed decision to seek care from a skilled health professional.

“MSF’s community workers are always in the field explaining how the hospital works. They keep repeating that as soon as you have a problem, you mustn’t stay at home. You’re supposed to come to the hospital so they can examine what you have... It’s because I knew this that I came to the hospital immediately when I started having contractions.” (Service user)

Others also stressed that the quality of care they receive at MSF-supported health facilities is the main reason they go there.

“Before MSF arrived, the hospital didn’t always work well: some days it was open, other days not. You could have a problem, come here and find the hospital closed. But since MSF has been here, that kind of problem no longer exists. It’s open every day, and now people are more inclined to seek care.” (Service user)

Community key informants, particularly those who previously worked as traditional birth attendants, also spoke of the impact of the project’s community outreach, which helped them become aware of the dangers of their former practices and encouraged them to act as relays to raise awareness among colleagues who still encourage women to give birth at home, and to support women who need help getting to health facilities.

“A woman was in labour, it was midnight; they sent someone to fetch me... The person came to get me, and I said: ‘I have to take her to the hospital.’ Because I don’t know what the nurse knows. The child could have been born there and died, but if she gives birth at the hospital, she can’t die.” (Community key informant)

“MSF helped us become aware of the dangers of our old practices. They gave us lots of training to identify women who need help in the community and refer them to the hospital; now, in the community, whenever a pregnant woman needs help, people come and call us.” (Community key informant)

Health staff also stressed that the project’s direct support to health facilities encouraged women to seek care. For example, one participant highlighted the provision of free services, medicines and support for specialist referral, which enables them to offer quality care to patients and encourages women to seek care, unlike when these services were lacking.

“Before MSF’s intervention, many women did not give birth at the hospital because services were not free and the quality of care left much to be desired. Today, MSF provides us with medicines and trains us, so the patient pays very little or nothing at all... So when a pregnant woman goes to the hospital, if she needs medicines, they are provided free of charge; even if she needs surgery, it is performed free of charge, which really encourages women to come and give birth at the hospital” (Health professional)

b. Gestational age of women at ANC1

The gestational age of women attending ANC1, calculated from secondary data on women receiving antenatal care at PaPim, was also analysed to assess pregnant women’s care-seeking behaviour. Between August 2024 and the first quarter of 2026 at PaPim, we observed a slight increase in the proportion of women attending their first antenatal consultation in the first trimester (Figure 12). In 2024, most women (> 60%) attended ANC1 in the third trimester, whereas in 2025 and the first quarter of 2026 a clear improvement was observed, with only around 30% attending this consultation in the third trimester.

These results were compared with secondary data from the South department for the period 2022–2024 (Figure 12). The South data show a similar trend over time for the first trimester; however, the

increase is less marked than at PaPim, with fewer than 30% of women attending their first antenatal consultation in the first trimester at the end of 2024 and a larger proportion (> 50%) doing so in the second trimester. By contrast, the proportion of women attending ANC1 in the third trimester is lower in the South department than at PaPim. This could indicate a slight change in care-seeking behaviour and access to care among women at PaPim compared with the South department as a whole.

Interviews with participants revealed that, despite women's late attendance at ANC1, this represented a major change, as many women were coming to the hospital for the first time after six or seven pregnancies. One participant said:

"There are women who come for their seventh, eighth, ninth pregnancy, but it's the first time they've come to the hospital. And they believe in their heads that they can carry a pregnancy to term without going to the hospital even once. She'll often say, 'I've already had four children, five children, I've never been to the hospital'" (Health professional)

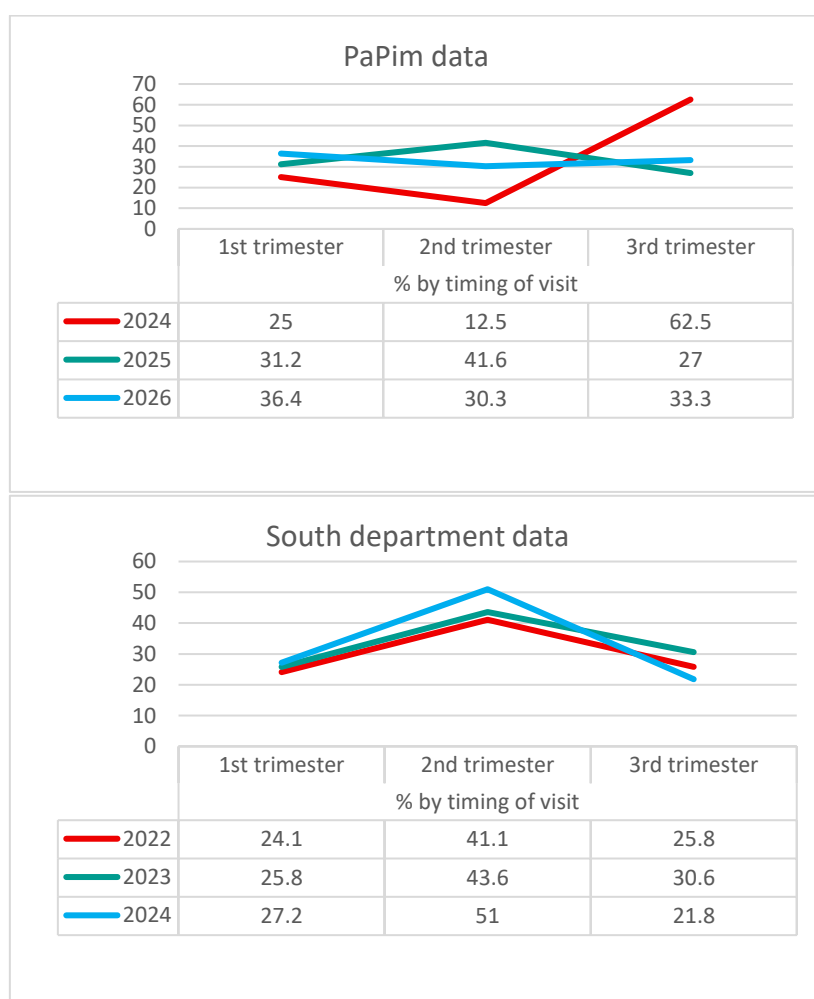


Figure 12: Gestational age at ANC1 at PaPim compared with the South department

SERVICE USE AND PATTERNS OF USE OF EMERGENCY OBSTETRIC AND NEWBORN CARE (CEMONC) AT PAPIM (TOC DELAY 3)

As part of the assessment of the project's effectiveness, we assessed the rate and trend of service uptake at PaPim using the project's secondary data, and triangulated these results with primary data from the survey and interviews.

a. Trends in maternal health service use

Figure 13 shows the trend in uptake of maternal health services (ANC1, ANC follow-up visits and normal vaginal deliveries) at PaPim between 2019 and 2025. From 2019 to 2021, uptake of all three maternal health services at PaPim gradually declined. This decline was probably due to the transfer of MSF support from CAL PaPim to the HCR in Port-Salut in 2020, and to the destruction of CAL PaPim in the 2021 earthquake. However, from 2021 to 2024, uptake of all three services increased, and in 2024 it exceeded 2019 levels. In 2025, uptake of ANC1 and ANC follow-up visits continued to increase; however, the number of normal deliveries declined slightly, probably because of the decentralisation of deliveries to other HCs, with the referral system launched in 2025 to direct women presenting at PaPim for ANC to continue their care and give birth at their nearest HC. This increase in service uptake after the launch of the PaPim SRH project in 2023 could indicate that the target population is aware of, is accessing and is using the services available at PaPim.

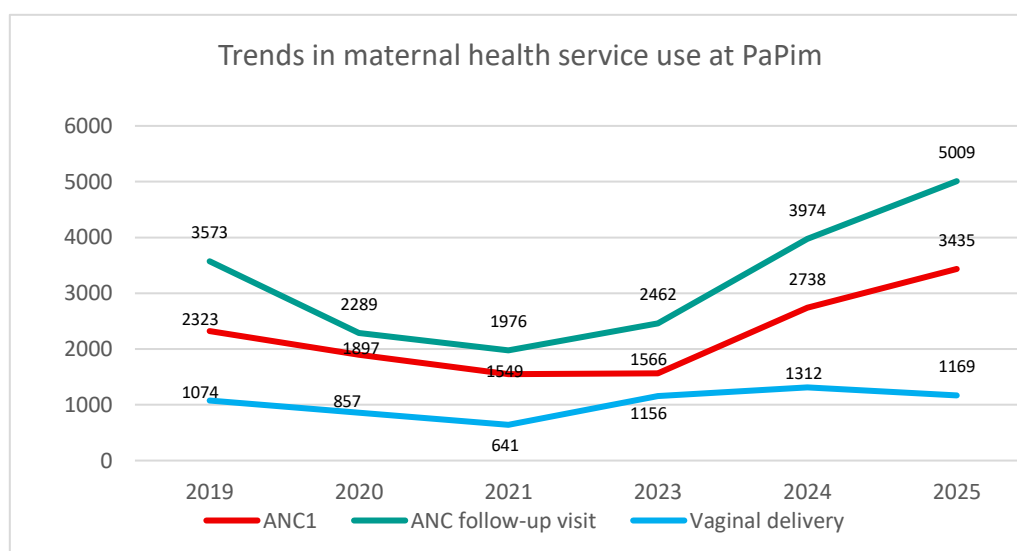


Figure 13: Trends in maternal health service use at PaPim, 2019–2025

Similarly, in the IDIs, service users expressed a desire to use the services of the PaPim CEmONC because they knew these services existed, and most also expressed a desire to go there because of the good quality of care.

"I prefer to give birth at this hospital [PaPim]. After the delivery, the doctors look after you, and if there's a complication, they're able to deal with it. For example, if the baby is in distress, the doctor can intervene and perform a caesarean if necessary." (Service user)

b. Origin of ANC attendees at PaPim

We also analysed where patients attending antenatal care services at PaPim came from and found that around 26% of women receiving this care at PaPim came from outside the project's target area (Figure 14). Of these, a large share came from Les Cayes and Port-Salut (Table 6), which are not only distant but are also among the largest towns in the department, with other CEmONC facilities and referral facilities. This large influx of women from outside the area, particularly from the larger towns, could be explained by the free services offered at PaPim.

Interviews with participants confirmed that this preference for bypassing nearby health facilities was due to the free services at PaPim. However, most of them revealed that it was more about the quality and level of care available at PaPim compared with other facilities in the towns they came from. One participant put it this way:

"I live near (name of a health facility outside the target area), but... there are no good doctors there. I've noticed that most of the time, when people are sent there, they always end up being referred here anyway. A lot of people also told me not to waste time and to come here straight away." (Service user)

For others, it was also because of the dignity and humanity with which care was provided at PaPim, which made them feel valued and gave them a sense of belonging, and not necessarily because services were free.

"Here (PaPim), I like the way they talk to us; they treat us with respect" (Service user)

"Once I'm getting good care, money doesn't matter" (Service user)

Health care providers also echoed these reasons why women leave the towns to use maternal health services at PaPim. One provider said:

"For most of those who come from Les Cayes, it's not so much the free services that count, because I think most of them can afford the care offered by the health facilities there. In my view, what counts is the assurance that by coming here [to PaPim], they will be treated well and with respect" (Health professional)

Table 6: Origin of patients attending ANC at the PaPim CEmONC

	COMMUNES	NUMBER	%
Outside target area	Aquin	2	0.03
	Arniquet	88	1.3
	Other places	114	1.6
	Camp Perrin	45	0.6
	Cavaillon	5	0.07
	Les Cayes	401	5.7
	Chantal	52	0.7
	Maniche	4	0.06
	Port-Salut	830	11.8
	Saint-Jean du Sud	64	0.9
	Saint-Louis du Sud	6	0.08

	COMMUNES	NUMBER	%
	Torbeck	249	3.5
	Total outside target area	1860	26.4
Target area	Chardonnières	811	11.5
	Coteaux	1104	15.7
	Les Anglais	1046	14.9
	Port-à-Piment	1026	14.6
	Roche-à-Bateau	716	10.2
	Tiburón	476	6.7
	Total target area	5179	73.6
	Total	7039	

In addition to women from the larger towns outside the target area who came to PaPim for care, some came from smaller, remote, hard-to-reach towns such as Torbeck (3.5%) and Camp Perrin (0.6%). Like the women from the larger towns, they cited the quality of services at PaPim as one of the factors that prompted them to seek care there.

“It’s better here than in Les Irois... Whatever you need done at the Les Irois hospital, you have to have money on you. And the care isn’t very good there either. Here they treat you, and some things are even free. You don’t... you don’t have to spend money. Here they don’t hold you back over money. They look after you; they look after your baby.” (Service user)

In addition to service quality, for these women from hard-to-reach areas, dignified care and free access to services were major motivating factors. Some of them decided to come well before their expected delivery date and stay at the hospital to avoid the risk of going home and not being able to return in time to be admitted once labour had started.

“I live in Les Cayes... I came here because I have family living in this area. I’ve been here since last Saturday because I’m in pain... The nurses advised me to walk. I walked and walked, but they told me I wasn’t ready to give birth yet...” (Service user)

We also analysed the origin of newborns referred to the PaPim neonatal intensive care unit (NICU) and found that more than 80% of newborns admitted to PaPim came from outside the target area, including cases referred by the HCR in Port-Salut, a second-level referral hospital that should in theory take PaPim’s cases requiring specialised care. This paradox is partly explained by the level of care offered by the PaPim NICU, but it also highlights the weakness of the Haitian health system in maintaining specialised services at second- and third-level health facilities in the department.

These findings were also reflected in interviews with health care providers, who reported receiving more referrals from facilities outside the target area and attributed this to the quality of services provided at PaPim and the quality of equipment available in the PaPim NICU. One provider said:

“As far as I know, the PaPim neonatal intensive care unit is one of the best equipped in the South department... That’s why even larger health facilities with specialists send us their patients, even though they know we don’t have a paediatrician. Our incubators are fully operational most of the time, and we can take more patients than many NICUs in the South” (Health professional)

Other providers mentioned free services, which could be a very attractive factor, even if the patient gave birth at the referral hospital. Another provider said:

“... What’s more, the fact that we offer free services is an advantage most patients will appreciate. Admitting a newborn to a neonatal intensive care unit at other health facilities is very expensive, because the patient bears the costs. The bills are sometimes so high that many people prefer to use our services, precisely because they are free.” (Health professional)

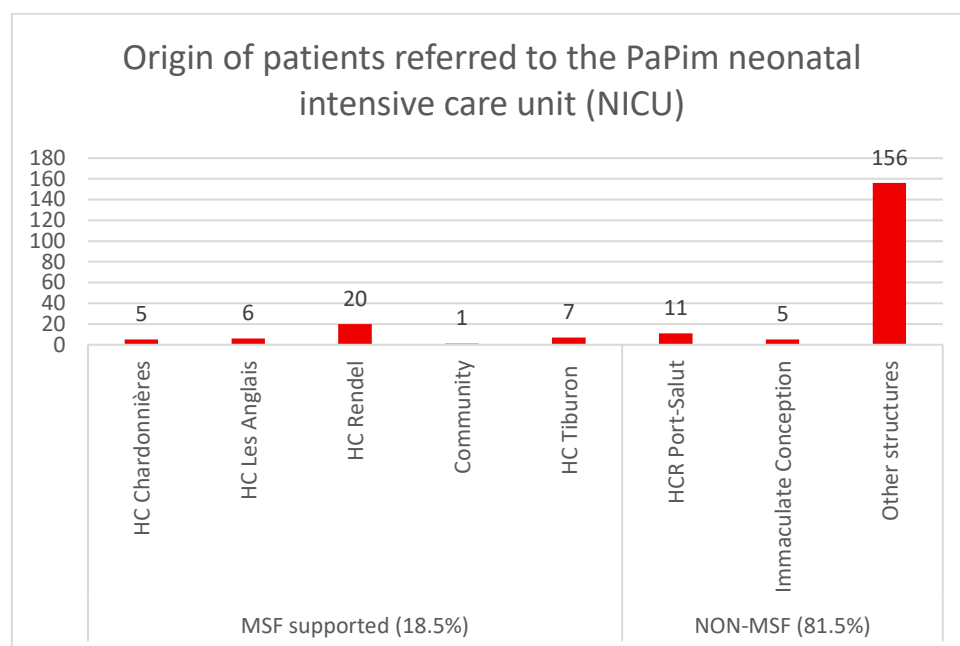


Figure 14: Origin of patients referred to the neonatal intensive care unit (NICU) at PaPim

BARRIERS TO AND FACILITATORS OF ACCESS TO CARE

As part of the effectiveness assessment (understanding what worked), the survey asked participants to identify factors that could be barriers to or facilitators of access to services at MSF-supported health facilities. Figures 14 and 15 present the results for barriers and facilitators respectively. These factors were proposed in order to identify the full range of possible facilitators and barriers across the different levels of society (personal, interpersonal, institutional and policy). Overall, more than 50% of participants cited distance to the health facility as a major barrier to accessing services. This was followed very closely by the cost of services (45%), the cost of transport (39.7%) and the lack of services (39.7%). Most of these barriers are institutional and systemic.

Interviews with participants, health workers and community members also confirmed most of these barriers. Most participants said they sometimes could not afford transport to the health facility. One adolescent participant mentioned that her partner had paid for the motorbike taxi for her, as she did not have that sum of money.

“To be able to come to the hospital, my husband had to pay 1,500 gourdes for a motorbike taxi... He’s a builder, he also sells peanuts; it was the money he made from the peanuts that he gave me to come to the hospital.” (Service user)

Another participant also had to spend a considerable sum of money to get to the centre, having spent an entire day on the road, travelling for 9 hours.

“It’s better here than in Les Irois... whatever you need done at the Les Irois hospital, you have to have cash in hand. And the care isn’t very good there either... I left home at 6 in the morning to get here at 3 in the afternoon, and I even had to take a boat to reach Tiburon before continuing my journey, because the roads are in bad condition.” (Service user)

Although only 4.4% of survey participants cited the influence of family and friends as a barrier, many IDI participants described these barriers as having a significant impact, particularly when they came from influential family or community members. This was often combined with other barriers, such as lack of money and autonomy. One participant recounted sadly how a community figure had persuaded her to give birth at home rather than go to the hospital

“When I started feeling unwell, I thought about going to the hospital, but because I didn’t have money on me to cover the necessary costs... because I didn’t have money, I hesitated a bit. There was a woman in the neighbourhood who helped women give birth (a matrone), and she told me it was my feet that needed putting back in place.” (Service user)

Most participants (51%) said that distance to health facilities was a barrier to accessing services. Similarly, in the interviews, most participants cited long distances and poor road conditions as the main barriers to accessing services. One participant explained that road conditions and transport difficulties had prevented her from having a skilled birth attendant in her previous pregnancies, even though that had been her preference

“Yes, I trust health facilities because, after God, there are the doctors. I’m not afraid of going to the hospital, because that’s where you go to save your life. ... I prefer to give birth at the hospital. After the delivery, the doctors look after you, and if there’s a complication, they can deal with it... However, our roads are in very bad condition, so I gave birth at home, which wasn’t my choice.” (Service user)

Health care providers also confirmed that distance to health facilities and poor road conditions were the main barriers to care for patients, particularly for those living in remote areas inaccessible by car or bicycle. One provider said

“For me, the biggest concern is distance, because the patients who come here come from very far away. And the road is not accessible at all. Sometimes patients make a great deal of effort, really a great deal of effort, to get to the hospital. The distance is considerable, and you can’t get there by car or motorbike. So they sometimes have to arrive on foot or be carried on a kind of device called a stretcher. So it’s the men who have to carry this woman over the hills for a long distance – 1 hour, 1.5 hours, 2 hours – to reach an area from which the patient can be evacuated, by motorbike or by car, to get to the hospital.” (Health professional)

Although the services provided by MSF are free, other indirect costs at most BEmONC sites, in particular transport, continue to be a barrier to accessing services for service users. During the service mapping exercise, we found that at some BEmONC sites, such as Tiburon, patients pay consultation fees and fees for other services not covered by MSF. They must also buy medicines not supplied by MSF when these are prescribed for them. One health professional described it as follows:

“At this health facility, every patient has to pay a consultation fee of 100 gourdes before they can be seen. Normally it’s not a very large sum, but some patients struggle to pay it. What’s more, MSF doesn’t cover everything; the organisation has its own care programme, which mainly covers delivery and maternal health services... So if the patient needs another service, they have to pay for it

themselves. Sometimes they also have to buy medicines that aren't covered by MSF." (Health professional)

To address this situation, one key informant suggested that MSF further strengthen its support to the Tiburon health centre. In his view, offering entirely free or reduced-cost services would help ease the financial burden on the population in this area.

"What should change is that MSF should remove the consultation fees in Tiburon; that would allow everyone who needs a consultation to come and be seen in Tiburon without any problem... And pregnant women or those who have just given birth should also be able to get medicines at a reduced price." (Community stakeholder)

Another institutional barrier was mistreatment by health care providers, alluded to by 30% of survey participants. In the interviews, although many participants appreciated the quality of care, a smaller proportion, particularly those who had been hospitalised, expressed dissatisfaction with the attitude of care providers.

"For my part, I felt they didn't handle my case well because... when I arrived that Saturday, I was having contractions, and they told me I was 3 cm dilated and to go and walk. I went and walked. When I came back, I was bleeding, and they told me again to go and walk. Every time I was in pain, they told me to go and walk. They didn't take care of me. After that, they told me the baby was breech. That means, I think, that they could still have done something about it... I think if it's a breech, there's an answer they could have given me... After that, I met two nurses who spoke to me strangely... One of them told me I was disturbing her. It was time for her to sleep and rest. She really spoke strangely." (Service user)

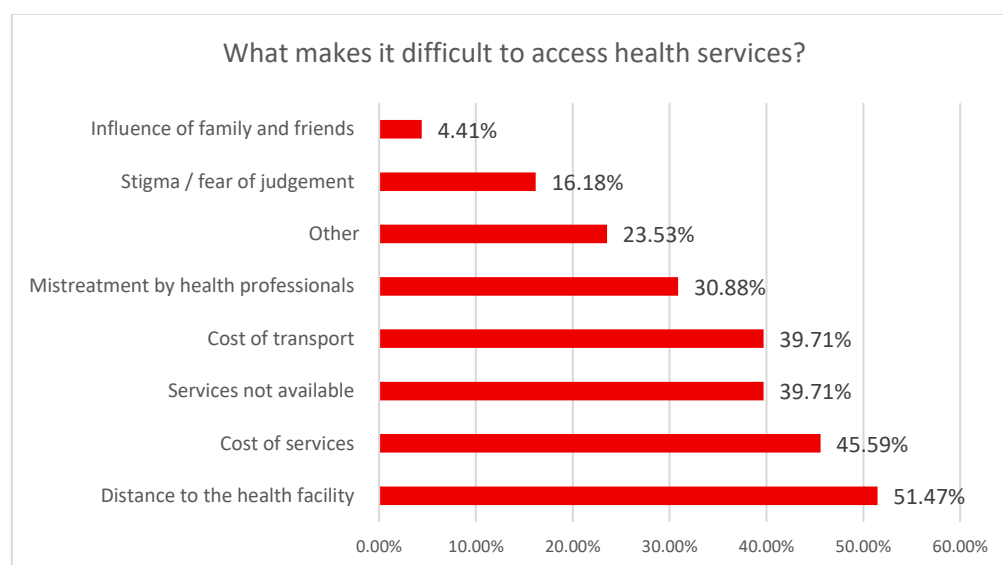


Figure 15: Barriers to accessing care

With regard to factors facilitating access to care, more than 70% of survey participants cited free services, service availability and the quality of the welcome received from health professionals. A smaller proportion (< 40%) mentioned transport to health facilities, and 16% cited family support as factors facilitating access to care.

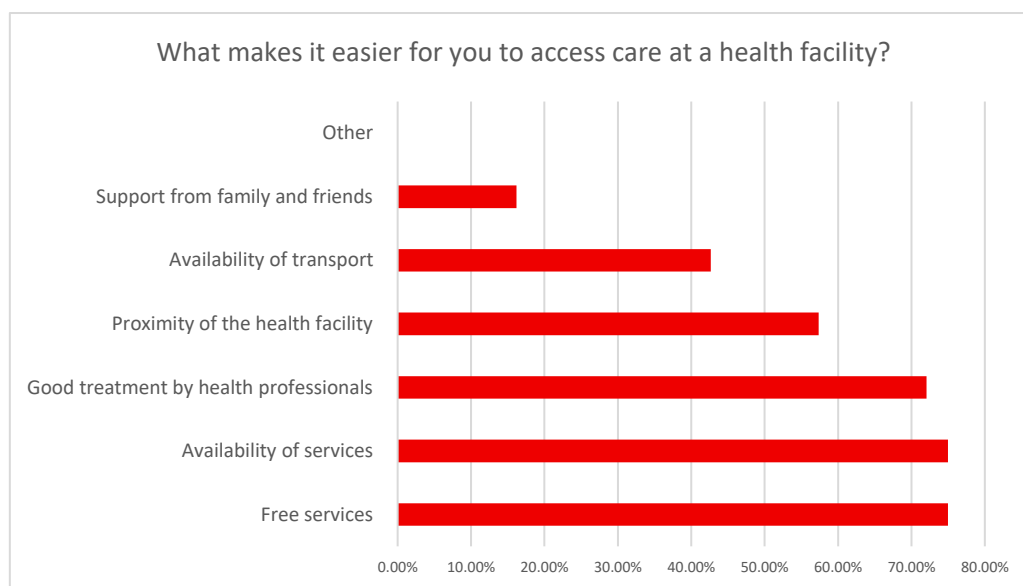


Figure 16: Facilitators of access to care

RESULTS OF SUPPORT TO BEMONC SITES (TOC OUTCOME 3, DELAY 3: QUALITY CARE IS AVAILABLE)

Table 7 presents trends in the use of health facilities in the project's target area, whether or not they are supported by MSF. Among MSF-supported sites, particularly HC Rendel and HC Tiburon, service uptake (first antenatal consultation, follow-up visits and deliveries) increased exponentially between 2023 and 2025. The annual number of ANC1 visits at Chardonnières rose from 38 in 2023 to 115 in 2025; at Rendel, from 98 in 2023 to 260 in 2025; and at Tiburon, from 43 in 2023 to 293 in 2025. A similar trend was observed for ANFU consultations and deliveries at the three supported health facilities, with the increases at Rendel and Tiburon more marked than at Chardonnières. This increase in service uptake, particularly at Rendel and Tiburon, could be explained by the fact that these sites serve larger geographic communities than HC Chardonnières, which is very close to PaPim and part of the same commune.

Although we observed an increase in uptake of ANC and delivery services at the supported sites, the delivery rate at these sites remains relatively low compared with the number of women attending ANC. This could indicate a weakness in the delivery services of these health facilities, or a persistent preference among women for giving birth outside health facilities. Community health workers confirmed in interviews that many women still prefer to give birth with traditional birth attendants rather than go to health facilities, because they believe that traditional birth attendants have supernatural powers to manage complications if they arise.

"It takes a great deal of effort to convince women to come and give birth at the hospital, because they tend to trust traditional birth attendants more. They think they have a special intuition and mystical powers that can help them if there are difficulties during delivery. They also trust herbalists and Vodou priests. Sometimes a woman may think that someone in her community is the cause of her problem; she then turns to a Vodou priest for help during the delivery. Even when we call them, they often don't come." (Community stakeholder)

The interviews revealed that most women, although they attend ANC at the supported BEmONC sites, prefer to give birth at PaPim. One health professional said:

“We see many pregnant women for antenatal consultations, but when the time for delivery approaches, most of them prefer to go to PaPim to give birth, ... no doubt because they can easily access specialised services there if there are complications, but also because they receive free food and delivery kits for their babies there, which isn’t the case here.” (Health professional)

A woman who developed a heart condition during pregnancy was transferred from the Les Anglais health centre to the PaPim health centre, where she subsequently gave birth to twins. She highlighted the limitations of the Les Anglais health centre from which she had been referred.

“There are lots of differences between here (Port-à-Piment) and Les Anglais. The difference is that here there are more doctors, and you can get medicines 24 hours a day. It’s not the same... In Les Anglais there are medicines too... but it’s mainly doctors that are lacking... I usually go to Les Anglais because it’s closer to home. But sometimes, when I go to Les Anglais, I don’t like the way things are done there, whereas when I come here (to Port-à-Piment), I find it works better.” (Service user)

However, she acknowledged the efforts made by the Les Anglais health centre staff at the time of her transfer.

“When I went there, they couldn’t give me the care I needed, so they did what they could. They gave me the transfer documents, called the ambulance and sent me here. It was they who referred me to this facility. I don’t have a preference between the two. They (Les Anglais and PaPim) are both competent.” (Service user)

Table 7: Trends in BEmONC service use between 2023 and 2025 (MSF-supported sites in green)

	ANC1			FOLLOW-UP VISIT			DELIVERY		
	2023	2024	2025	2023	2024	2025	2023	2024	2025
Chardonnière HC	38	-	115	25	-	146	9	-	33
Coteaux HC	18	-	-	25	-	-	-	-	-
Rendel HC	98	248	260	218	419	495	23	27	72
Tiburón HC	43	84	293	45	99	356	4	19	59
Roche-à-Bateau	75	-	-	17	-	-	-	-	-

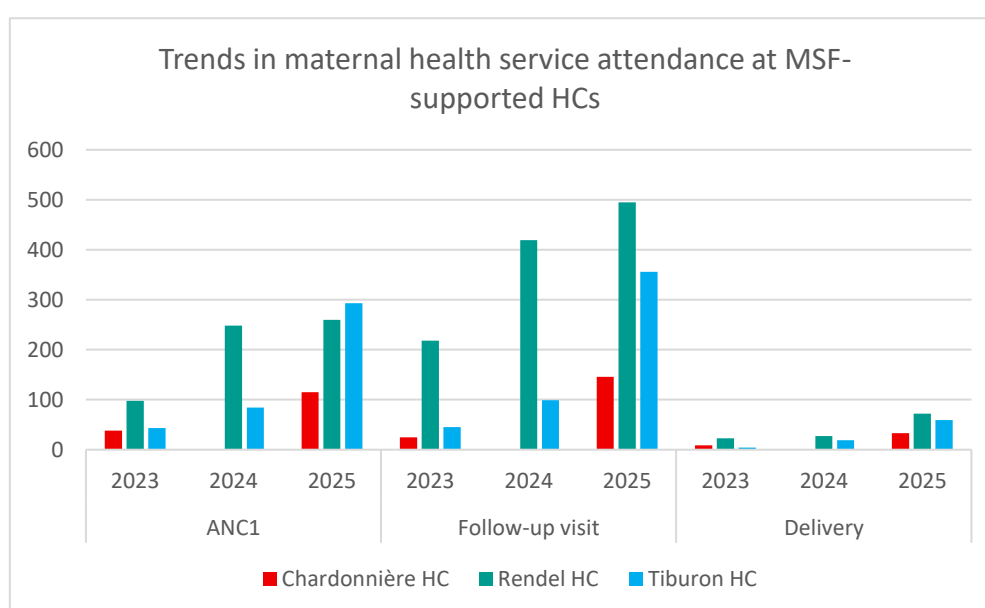


Figure 17: Trends in maternal health service attendance rates at MSF-supported HCs

In interviews with key informants and health staff, we explored possible reasons for the increase in service uptake at the MSF-supported BEmONC facilities. The main reason cited by almost all staff was the presence of skilled care providers. One key informant put it this way:

“Patients can’t go to a health facility if there’s no one there to receive them. One of the main problems MSF has helped health facilities in our region solve is human resources. In Haiti, and particularly in remote areas like the one where the project is located, it is very difficult to find and retain health staff; most of them don’t want to come to these remote areas... There are many reasons, but I think the main one is that the [government] system doesn’t pay them enough; so most of them prefer to stay where they can also access jobs in the private sector, and the South is not that kind of place. So because MSF offers them incentives, that’s a great motivation for them to be available.” (Community key informant)

Another participant added that in addition to financial incentives, MSF also provides health staff with the training they need, strengthening their capacity and confidence in performing their duties.

“The training provided by MSF has also enabled us [health professionals] to do our work better. We are now able to manage certain cases with confidence, and patients see this and now trust us more.” (Health professional)

Other factors cited to explain the increase in service uptake included improved material resources, availability of medicines, infrastructure, and the community outreach activities MSF carries out in the target area.

In addition, one health educator stressed that MSF provides him with the resources he needs to do his work, particularly when travelling to very remote areas to carry out community outreach activities. This support highlights the essential role of community health actors in extending the reach of health services beyond formal facilities and reducing the geographic barriers that limit access to care for hard-to-reach populations.

“In terms of collaboration, I can say that cooperation is good... When we ask for supplies or equipment, even if it takes a little time, we usually receive them... They offer us lots of training. Sometimes nurses and midwives run training sessions with us. It helps us build our capacity and improve our skills... It enables us to deliver our services better thanks to the training we receive.” (Community key informant)

EFFECTIVENESS OF REFERRAL SERVICES (TOC OUTCOME 2, DELAY 2: TRANSPORT TO CARE)

As part of the project’s strategies to facilitate access to care for all, particularly for cases requiring emergency or specialised care, the project supports the referral system by working with the CAN to provide 24/7 ambulance services to all supported sites, as well as other resources to facilitate care, as explained in section 4.1. Health staff at these sites have also been trained on danger signs in pregnancy, and referral criteria are displayed in their maternity units. Thanks to this support, MSF-supported sites saw a steady increase in the number of pregnant women referred to PaPim between 2023 and 2025, compared with non-MSF-supported sites (Figure 18).

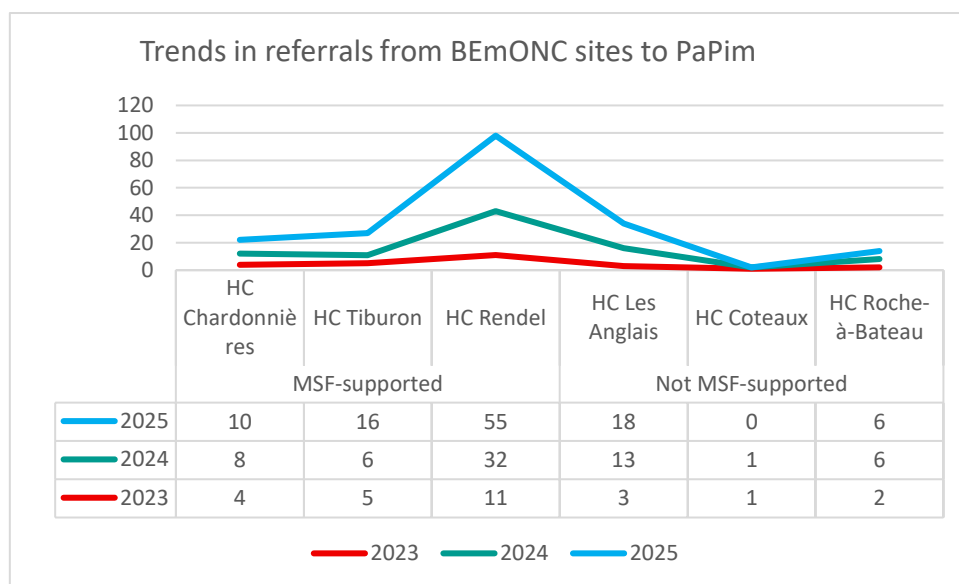


Figure 18: Trends in referrals from BEmONC sites to PaPim

Participants also spoke about the effectiveness of referral services in the interviews and described them as an essential component of the project that has saved many lives. One care provider said:

“MSF has also made an ambulance available to us to transfer critically ill patients to PaPim. We have a radio link; if we need to transfer a patient, we contact PaPim by radio, and they send an ambulance to transport them. These services are very fast and have enabled us to save many lives” (Health professional)

Patients also spoke about the quality of services and appreciated the care they received throughout the process. One patient said:

“When I got there (to HC Les Anglais), they couldn’t give me the care I needed, so they did what they could. They gave me the transfer documents, called the ambulance and sent me here. Everything went very well.” (Service user)

Some participants noted that services are more effective because they are free, and that MSF provides fuel for the ambulances supplied by the CAN and sometimes helps repair them when they break down, in order to keep ambulances available and reduce delays caused by financial constraints.

“Thanks to the support MSF provides to the community, particularly in the form of ambulances, fuel and free transport for patients, the situation has improved considerably. Patients no longer have to bear these costs, which has made a huge difference.” (Community key informant)

“At one point, the ambulance assigned to us (in Tiburon) was in poor condition, and MSF sent an ambulance from PaPim every time we had a case to transfer. Recently, they helped the CAN repair the ambulance, and I’ve heard that it now works.” (Health professional)

Although MSF supports most aspects of referrals, including fuel and ambulances for health facilities, gaps remain in the prompt availability of drivers at health facilities with ambulances supplied by the CAN. Some participants reported that the lack of available drivers delayed patient referrals, even when the ambulance was present and in good condition. One participant suggested that MSF provide financial support to overcome this barrier.

“As for ambulance service staff, I don’t know whether the government pays them, but financial support of any kind would help create a better working environment and motivate them in their work. If they are called out to an emergency, they should be able to respond without difficulty.” (Community key informant)

When we asked about the CAN’s role in patient referrals and how the CAN pays ambulance drivers, one key informant replied as follows:

“At the CAN, we make ambulances available to health facilities to facilitate patient transfers. Ambulances are allocated according to population size and type of health facility. We sometimes also take into account the distance between the facility and the nearest referral hospital, even when population density is low... CAN services are normally free, and each ambulance has a dedicated driver, a nurse and a third person to assist the nurse. Recently we have had difficulties with ambulance operations: some have broken down and we can’t repair them in time, while others have run out of fuel. What’s more, drivers’ salaries have been irregular and paid late recently... I attribute these difficulties to the country’s socio-political situation and government instability, which prevent us from continuing to provide our services normally. That’s why we really appreciate MSF’s support, and we work with them to make sure all transfer-related problems are resolved.” (MSPP respondent)

Health care providers also described difficulties related to the transport team available to move the patient. In most cases, the ambulance had only one nurse or midwife and the driver, making it difficult to stabilise the patient during the journey. One participant said:

“So sometimes you get called, it’s a complicated case and you’re on your own. If it were at the hospital, we would manage it. All the staff would be there – the doctor, the midwife, the auxiliaries, the nurses. But once you’re at the facility or in the ambulance, you’re alone with the patient. So that was difficult.” (Health professional)

Part of the referral system relies on referrals made by community health workers (Colvols, traditional birth attendants and ASCPs). These community health workers are trained by MSF to identify pregnant women in the community who need medical care and refer them to the nearest health facility. They also facilitate the transport of women from hard-to-reach communities, together with members of the “referral committee”, to the point where they can be picked up by the ambulance. From 2023 to 2025, we also observed an increase in the number of referrals made by community health workers affiliated with PaPim (Figure 19).

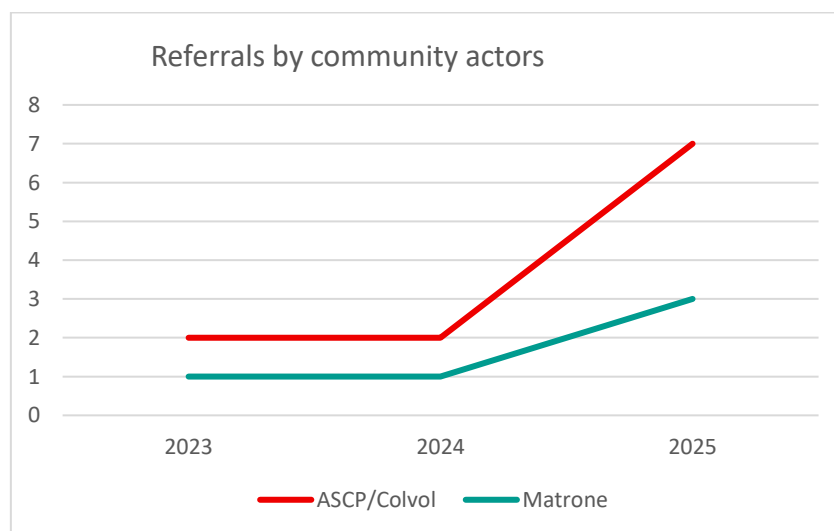


Figure 19: Referrals by community workers

Although the referral system appears effective, the diagnoses of cases referred to PaPim reveal gaps in the referral process. For example, some women reportedly gave birth en route before arriving at PaPim (Table 8). All these cases were recorded at HC Rendel and could indicate a delay in the referral process at that site, or difficulties in the early identification of danger signs by health staff. Although it was not possible to determine whether these deliveries were uncomplicated (in which case these women would not have been eligible for referral), health staff confirmed in interviews that some referred cases arrive late with complications that sometimes cost the infant's life. One participant said:

"... Some patients arrive too late and already have complications, even though they were transported by ambulance. For example, some patients were in obstructed labour for a long time before arriving and developed chorioamnionitis; even when we perform a caesarean immediately, it's too late and the baby has died" (Health professional)

Table 8: Discharge diagnoses of women referred to PaPim from MSF-supported sites

	2023	2024	2025
Anaemia	1	0	5
Antepartum haemorrhage after the 2nd trimester	0	0	1
Chronic hypertension	0	0	1
Delivery before arrival	1	3	4
Uncomplicated delivery	11	17	30
Eclampsia	1	0	1
Postpartum haemorrhage	1	2	4
Severe pre-eclampsia	3	0	4
Preterm delivery	0	1	1
Prolonged labour	0	0	2

Although there is a well-established referral system between the satellite sites and PaPim, referrals from PaPim to tertiary health facilities are rare, particularly for advanced obstetric complications requiring more intensive management, such as intensive care. Participants explained that this is because there are no competent facilities to receive cases that cannot be managed at PaPim. They added that in theory the departmental hospital should have such intensive care services, but it does not, and the only option is to refer patients to the capital region, Port-au-Prince, which is not feasible given the country's socio-political context.

"When you look at the South region, there is no hospital to which we can refer patients with obstetric complications more serious than those we (PaPim) are able to manage. For example, if a patient needs intensive care or has a complication such as HELLP syndrome, we should normally refer her to another facility, but we don't, because there is no health facility in the South with an intensive care unit, apart from the capital region. So we have to keep these cases and manage them as best we can." (Health professional)

ANALYSIS OF KEY MATERNAL AND CHILD HEALTH INDICATORS

To assess effectiveness in terms of key maternal and child health outcomes, we analysed secondary data on indicators of pregnancy-related comorbidities, maternal and infant mortality, family planning uptake and uptake of GBV services.

a. Maternal and infant mortality

Table 9 presents the frequency of comorbidities among women presenting at PaPim during pregnancy. Among pregnant women who received antenatal care at PaPim between December 2024 and January 2026, around half (49.4%) were diagnosed with comorbidities. Of these, most (21.3%) had urinary tract infections (red), followed by STIs (2.2%), syphilis (1.7%) and malaria in pregnancy (1.8%) (orange). Although chronic hypertension, gestational hypertension and pre-eclampsia (purple) accounted for only a small proportion (< 2%), interviews with health professionals revealed that they were among the main pregnancy-related complications for which women were referred to PaPim. One key informant said:

“Here (at PaPim), I’ve noticed that many women have hypertension-related complications during pregnancy: pre-eclampsia, eclampsia. For example, last year (2025) we recorded four maternal deaths, all related to pre-eclampsia. What’s more, more than half of hospitalised patients are admitted for complications related to pre-eclampsia.” (Health professional)

Table 9: Prevalence of comorbidities diagnosed during pregnancy at the CEmONC, December 2024 to January 2026

COMORBIDITIES	NO.	FREQUENCY (%)
Anaemia	26	0.37
Other morbidity	1324	18.81
Other STIs	157	2.23
APH – 1st half of pregnancy	2	0.03
APH – 2nd half of pregnancy	1	0.01
Chronic hypertension	49	0.70
Gestational hypertension and pre-eclampsia without severe features	44	0.63
Pre-eclampsia with severe features or eclampsia	8	0.12
Urinary tract infection	1501	21.32
Not reported	57	0.81
Malaria in pregnancy	129	1.83
Syphilis	120	1.70
HIV (confirmed)	59	0.84
Subtotal with comorbidities	3477	49.4

COMORBIDITIES	NO.	FREQUENCY (%)
No health problem	3562	50.60
Grand total	7039	

We also examined maternal outcomes between 2023 and 2025. Although around half of the pregnant women attending ANC had comorbidities, the vast majority (96.3%) were able to leave the facility after delivery (Table 10). Only 0.17% died, and 1.5% were referred to other health facilities for further care. Of those referred, interviews with health staff revealed that most were women who had had hypertension during pregnancy and were referred to see a cardiologist, while a few others had non-obstetric complications.

“The few cases we (PaPim) refer to other facilities are those that require a specialist, for example a cardiologist, an internist or other specialists we don’t have at PaPim. Once we have stabilised the patient, we refer them to the referral facilities in Les Cayes for further care” (Health professional)

A smaller proportion (2.04%) also left the facility against medical advice. Interviews revealed that these were mainly women who do not yet understand the importance of standard care and who think that once they have given birth there is nothing more to be done at the hospital, even when health staff advise them otherwise. One participant said:

“So in their heads, they believe it can work like that (leaving the hospital right after giving birth). And that’s why, when the person develops something, they don’t really know, or it’s difficult to make that person understand that she needs to stay in hospital because she’s in danger, ... So these are taboos, and it’s for the same reason that they think going to a traditional healer or a matrone will be fine, that’s it” (Health professional)

Table 10: Maternal/obstetric outcomes at PaPim

MATERNAL OUTCOMES	2023	2024	2025	TOTAL	%
Death	2	3	4	9	0.17
Referred to another health facility	10	58	13	81	1.51
Left against medical advice	22	38	49	109	2.04
Discharged from hospital	1093	1782	2271	5146	96.3
Total	1127	1881	2337	5345	

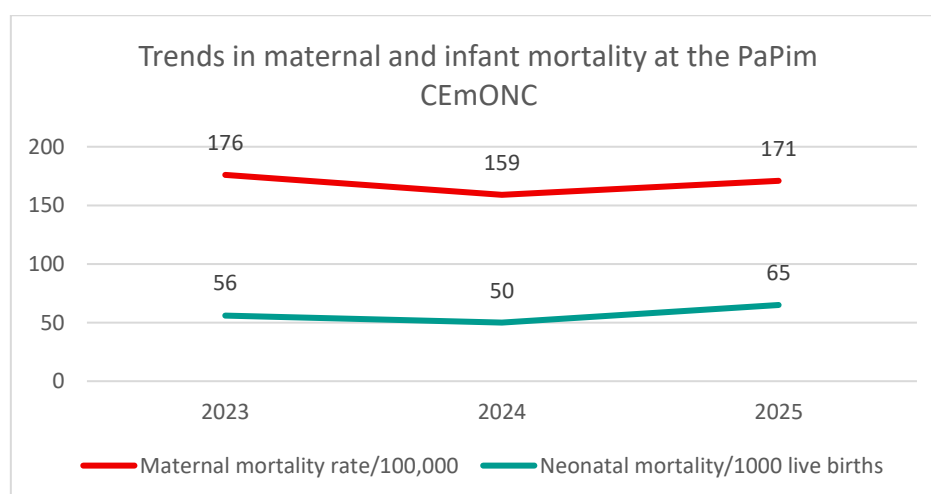
Similarly, among newborns admitted to the PaPim NICU, the vast majority were discharged cured (88.5%), 5.6% died, 4.3% left against medical advice and 1.2% were transferred out of PaPim to another health facility (Table 11).

Table 11: Outcomes of newborns admitted to the NICU at PaPim

NEONATAL OUTCOME	2023	2024	2025	TOTAL	%
Death	14	23	34	77	5.6
- Discharged from hospital - treated	221	412	459	1221	88.5
External referral (transfer to another facility)	7	9		16	1.2
Left against medical advice	9	14	33	60	4.3
Grand total	252	458	526	1380	

Although the maternal mortality rate recorded at PaPim throughout the project is considerably lower than that observed in the South (Figure 20 and Table 12), it has remained virtually unchanged. Between 2023 and 2024, the rate fell from 176 deaths per 100,000 to 159 per 100,000. In 2025, however, it rose again to 171, without returning to the baseline level observed in 2023.

Similarly, the infant mortality rate among newborns admitted to the PaPim neonatology unit fell slightly, from 56 deaths per 1,000 live births in 2023 to 50 deaths per 1,000 live births in 2024. In 2025, the rate rose again to 65 deaths per 1,000 live births, exceeding the 2023 level.

**Figure 20:** Trends in maternal and infant mortality rates at the PaPim CEmONC, 2023–2025**Table 12:** South department data – Institutional maternal mortality

	INSTITUTIONAL MATERNAL DEATHS	INSTITUTIONAL DELIVERIES	HOSPITAL MATERNAL MORTALITY RATIO PER 100,000 DELIVERIES
2022	37	11,327	326.7
2023	43	12,505	343.9
2024	44	9,569	459.8

b. *Family planning*

The project also provides family planning services at PaPim and at all other health facilities in the area supported by the project. Uptake of family planning services and the methods provided were analysed to assess the effectiveness of these services.

Table 13 presents the results for the methods and number of family planning services provided at PaPim from December 2024 to December 2025. During this period, a total of 840 FP services were provided, the majority being injectable methods (651), followed by implants (104). Fewer clients used combined oral contraceptives (COCs) (62), condoms (19) and the intrauterine device (IUD) (4). This pattern was similar to that observed in the South department data (Table 14), where the most widely used family planning methods were injectables, followed by implants.

Table 13: FP methods used at PaPim, December 2024 to December 2025

ROW LABELS	2024	2025	GRAND TOTAL
FP – COC	0	62	62
FP – IUD	0	4	4
FP – Implant	1	103	104
FP – Injectable	18	633	651
FP – Condom	0	19	19
Grand total	19	821	840

Table 14: FP methods and uptake in the South department

	SOUTH DEPARTMENT DATA		
	2022	2023	2,024
Expected women aged 15–49	209,390	211,965	214,572
Pill	2,581	2,707	2,707
Injectable	15,890	18,292	18,292
IUD (intrauterine device)	1,217	822	822
Implant	13,745	15,219	15,219
Condom	6,212	7,533	7,533
Lactational Amenorrhoea Method (LAM)	112	191	191
CycleBeads	271	293	293
Tubal ligation	1,605	2,156	2,156
Vasectomy	21	5	5
Total	41,654	47,218	47,218

(MSPP 2022, 2023 & 2024)

In the interviews, health staff noted that most of the family planning methods recommended by the MSPP were available at the health facilities supported by the project, except vasectomy and other

invasive methods such as tubal ligation, which are performed only at PaPim. However, to date the project has not received any requests for vasectomy.

“All family planning methods are available; MSF provides us with supplies whenever we need to restock. Women come to see us and choose the method they want; our role is limited to informing them of side effects and, if it’s pills, explaining how to take them.” (Health professional)

We also explored the reasons for the choice of FP method. Some participants put it as follows:

“All family planning methods are available; MSF provides us with supplies whenever we need to restock. Women come to see us and choose the method they want; our role is limited to informing them of side effects and, if it’s pills, explaining how to take them.” (Health professional)

The family planning uptake rate among survey participants (Figure 21) was higher (36.4%) than the highest rate observed in the South department between 2022 and 2024 (21% in 2023) (Figure 22). This difference could reflect the effectiveness of the community-based outreach services provided in the target area around PaPim. These findings were also confirmed in interviews with participants. One of them said:

“Since the project was launched, we have seen an increase in the number of women seeking family planning services. Many women, and especially young girls, come every day to ask for family planning services. As a midwife, I would say that apart from deliveries, that is my main daily activity: offering family planning methods to women and girls.” (Health professional)

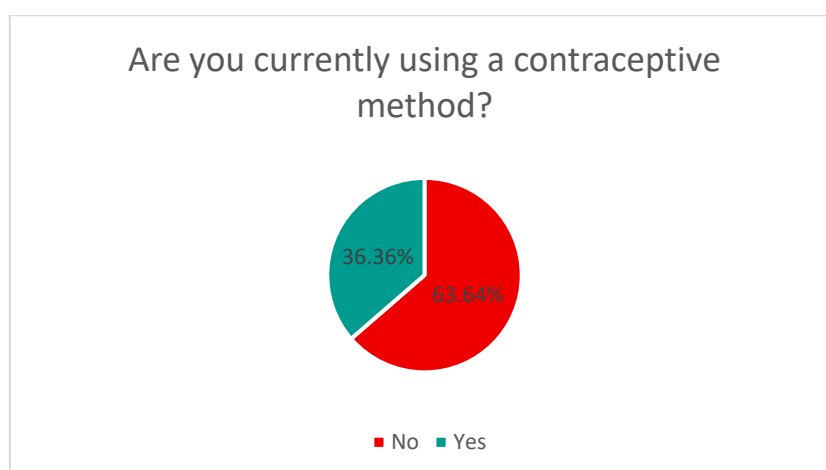


Figure 21: Proportion of survey participants using an FP method

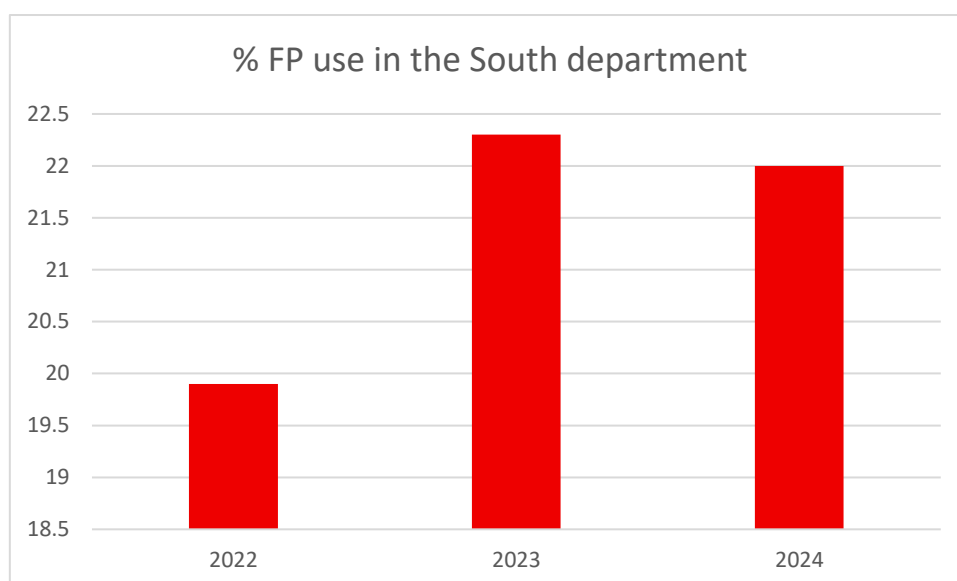


Figure 22: Percentage of FP uptake in the South department

c. GBV

We also examined rates of violence (physical, sexual and emotional) and the uptake of GBV services at PaPim, as part of the project's key outcomes. Unfortunately, the data were insufficient to calculate the service uptake rate, as the denominator (number of people at risk or referred to use these services) was missing. We therefore used the number of people reporting violence to estimate the effectiveness of post-violence services

Table 15 presents the number of people who used GBV services at PaPim. From 2024 to the first quarter of 2026, we observed an increase in the number of survivors using services, from 20 in 2024 to 55 in 2025, and 11 in the first quarter of 2026. Moreover, compared with the number reported in the South for 2024, the number of sexual violence cases received at PaPim represented 12.5% (20 of 160) of all cases reported in the South. This could indicate a higher reporting rate for GBV cases at PaPim than in the rest of the South department.

Table 15: Number of GBV cases reported at PaPim, July 2024 to April 2026

	2024	2025	2026	GRAND TOTAL
Female	20	54	11	85
Male	0	1	0	1
Grand total	20	55	11	86

In the survey, around 9% of participants reported having experienced at least one form of violence (physical, sexual or emotional) from a family or community member. Of these, 3% occurred in the last 12 months and 6% more than 12 months ago (Figure 23). We also asked participants whether they knew a community member who had experienced violence, and found a much higher proportion. Around 24% of participants answered yes, indicating that they knew a community member who had experienced physical, sexual or emotional violence (Figure 24). This higher proportion of known victims

in the community could indicate that a larger proportion of people who experience violence do not present at health facilities.

In the IDIs, participants confirmed that they knew they should report cases of violence at health facilities. However, this is rarely done, as many victims of violence in the community go unreported, particularly cases involving children. One participant put it this way:

“I know many people in my community who are victims of sexual assault but who don’t go to the hospital. For example, not long ago, my neighbour’s daughter was raped by another neighbour, but because she’s a child, they didn’t take her to the hospital... MSF is always in the community encouraging us to report this kind of case, but sometimes you can’t understand why people don’t want to go” (Service user)

Health staff and community workers also noted that using community workers (ColVols and traditional birth attendants) to identify survivors of violence and facilitate their referral had helped increase the service uptake rate at PaPim. They attributed this to the fact that violence, particularly sexual violence, remains a taboo subject in the community, and that these community workers enjoy the population’s trust, enabling them to facilitate referrals. They also highlighted the element of active referral, which makes it even easier for survivors to access services.

“I now see many more survivors of sexual violence than before, and most of them arrive with a referral slip, which means a community worker has helped them access care... .. When they arrive, they are very shy and traumatised, and it’s not easy to get information from them. They prefer to withdraw and talk only to the community worker, because they trust them. In our community, it’s still a very difficult subject for survivors to talk about freely.” (Health professional)

Another participant added that most victims do not know they should go to the hospital, while others prioritise legal action.

“... rape is still a taboo subject here. Most of the time, people think the first thing to do after an act of sexual violence is to go to the court. Through our awareness-raising, they have learned that they must first go to the hospital, and then to the court, in order to prevent the consequences of rape.” (Community stakeholder)

However, most participants appreciated the GBV services provided at MSF-supported sites and said they were effective. One participant said:

“There are cases of sexual violence: it’s MSF that handles all these situations for us... Within two days, you can already go to the hospital to have them check that you haven’t caught any dangerous germs (infections)... MSF provides all these services for us. It makes us proud; it makes us happy.” (Community stakeholder)

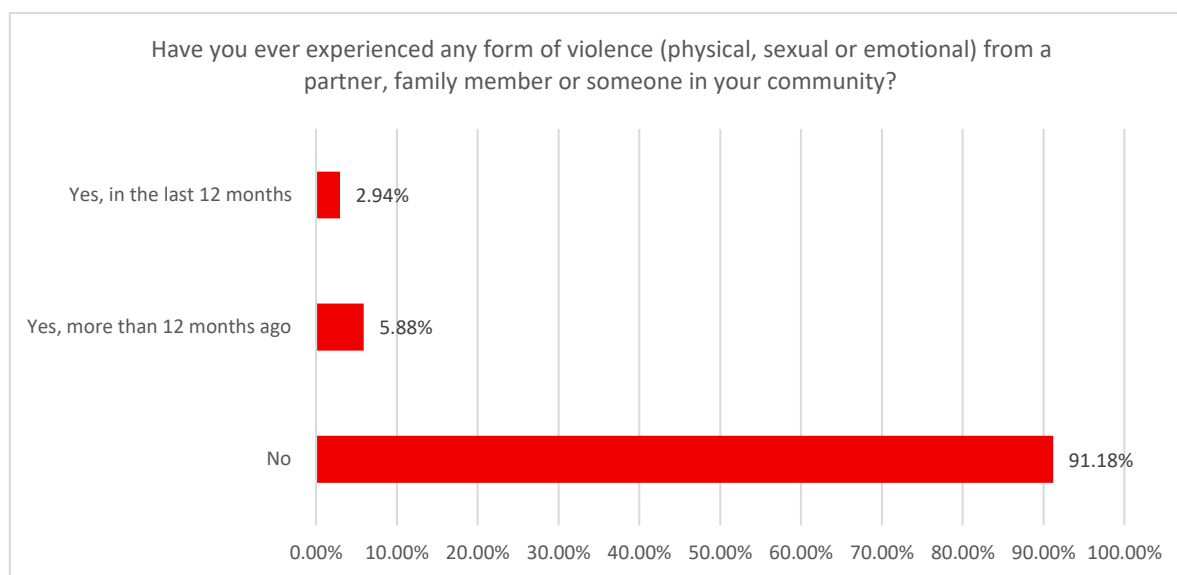


Figure 23: Experiences of violence among survey participants

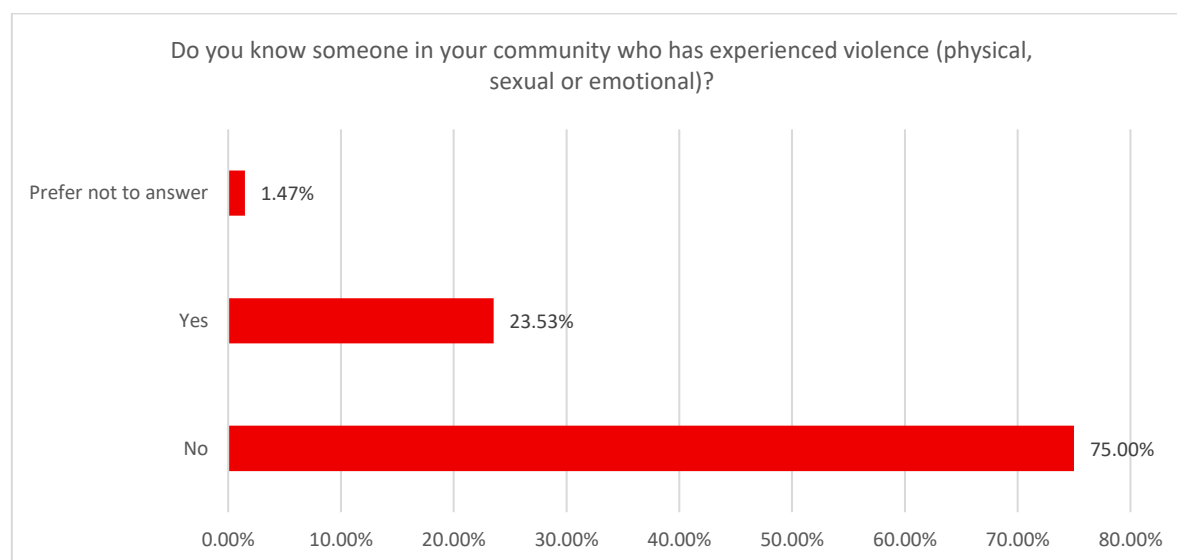


Figure 24: Participants' knowledge of community members who have experienced violence

EFFECTIVENESS

This criterion examines the extent to which the project's available resources (time, human and material resources) are used to achieve the project's objectives. It also assesses how these inputs are converted into outputs, outcomes and overall impact in terms of strengthening the health system and reducing maternal and infant mortality in the target area. To illustrate this, we present a programmatic cost assessment analysing resource allocation and budget use, the timeliness of activities and interventions, and other findings relating to human, material and time resources.

According to the findings, **the project has helped ensure the availability of essential medicines and supplies and has facilitated the referral of emergency cases. However, certain difficulties, including delays in emergency referrals and intermittent stock-outs of essential medicines and blood products,**

undermine the efficiency of these services. In addition, the length and high cost of the supply chain, and the gradual increase in project implementation costs, particularly human resource costs, raise further concerns about cost-effectiveness.

RESOURCE MANAGEMENT AND SUPPLY CHAIN

a. Availability of essential maternal and child health commodities

Essential equipment and commodities – such as oxygen and appropriate oxygen masks, foetal heart rate monitors, blood pressure monitors, sterile delivery kits and supplies for essential tests, for example HIV and hepatitis B screening, haemoglobin measurement and urinalysis – are indispensable for the effective management of maternal and child health. Service mapping data showed oxygen cylinders at only one of the two BEmONC case study sites, and the neonatal oxygen mask was also present at only one of the two sites. The lack of oxygen and an appropriate oxygen mask could seriously compromise the resuscitation and stabilisation of mother and newborn before referral, if needed.

Some essential supplies and reagents for blood tests were also out of stock, and providers expressed frustration at how these shortages were managed. One provider said:

“We’ve been waiting more than two weeks for the new stock to arrive. It’s a large number of medicines and supplies, and we don’t know when we’ll receive them. For example, right now, pregnancy tests are out of stock, along with many other products.” (Health professional)

b. Availability of essential SRH medicines

Essential medicines, including oxytocin, magnesium sulphate and others needed for the effective management of complications of labour and delivery, such as postpartum haemorrhage, are supplied to all sites supported by the project. Timely availability of these medicines is crucial for optimal obstetric care. Interviews with health staff revealed intermittent stock-outs of certain essential medicines, which slowed service delivery and, in some cases, prevented patients from receiving the care they needed.

“Recently we’ve had delays in receiving some of the medicines supplied by MSF. For example, it was only yesterday that we received the order we had placed a few weeks ago, which makes the situation difficult to manage. Fortunately, we had some stock in our hospital pharmacy, but patients had to buy their own medicines, which isn’t easy because they’re already used to receiving free care.” (Health professional)

“We sometimes run out of essential medicines; for example, right now we have no medicines to treat hypertension in pregnancy, no furosemide and no certain other essential medicines, which is a real challenge.” (Health professional)

This stock-out also affected certain family planning methods and other essential medicines, and patients had to be sent home to return at a later date, which could increase the risk of unwanted pregnancies and unsafe abortions.

“Recently we’ve had stock-outs of many medicines, which has complicated client care. For example, last week we didn’t have many other products... We tried to use alternative family planning methods, but that isn’t possible in every case, and unfortunately we had to send some clients away without providing a service, asking them to come back at a later date, which was very disruptive” (Health professional)

We explored the possible reason for this stock-out and determined that it was related to the supply chain. The supply of medicines and certain essential supplies to PaPim involves a complex and lengthy

supply chain, in which every essential medicine and item is imported from Europe. Because of the current socio-political situation in Haiti, arrival in and transport from Port-au-Prince are very costly and time-consuming, as everything has to be flown in, the roads being blocked.

“All the medicines MSF uses are imported, which makes them very expensive... What’s more, given the current instability in the country, the cost is even higher, because all medicines have to be flown in, the roads being blocked, and local flights are sometimes cancelled, which delays the supply process even further. That’s why we have recently started having medicine stock-outs, which had never happened before.” (MSF respondent)

OPERATIONAL EFFICIENCY AND TIMELINESS

a. Efficiency of transporting blood samples and blood products

In addition to transporting medicines, certain blood samples and blood products have to be transported between the central pharmacy and PaPim. During the service mapping and interviews, we learned that the PaPim blood bank is only a storage centre, and that all blood testing is carried out at the Blood Transfusion Post (BTP) in Les Cayes and in the central system in Port-au-Prince, requiring considerable time, logistics and supplies. This long and costly supply chain is not very efficient in terms of time, supplies and finances.

“The system for collecting blood for transfusion in Haiti is highly centralised. For the South department, it is normally the BTP in Les Cayes that is responsible for collecting blood from the population and sending it to Port-au-Prince for testing. As its resources are sometimes limited, MSF steps in to help organise blood donation drives, and then we (MSF) send the blood to the BTP in Les Cayes, which then sends it on to Port-au-Prince for testing, and the final blood products are sent back by the same route... Getting blood is very difficult and expensive.” (MSF respondent)

Because of this long supply chain, the storage unit at PaPim sometimes runs out of blood. Although this does not usually last long, the situation is not safe for a CEmONC.

“Sometimes there’s no blood in the blood bank (at PaPim), even though it’s not very frequent, and it’s very stressful. Even though we haven’t had any deaths due to lack of blood recently, the situation is sometimes very difficult” (Health professional)

b. Efficiency of support to BEmONC sites and the referral system

Although referral services between the BEmONC sites and PaPim proved highly relevant and effective in improving the quality of care received by patients, particularly pregnant women, they were not very efficient in terms of time and resources at some sites. For example, some interviews revealed that the Tiburon ambulance could not be used because there was no driver, and that at one point it was temporarily out of service. Similarly, at Les Anglais, although an ambulance was present, it could not be used because it had not been properly registered administratively. As a result, referrals took longer than usual, as another ambulance had to be sent from PaPim to these sites to transport the patient, doubling the fuel, time and other logistical resources involved.

“The ambulance here (in Tiburon) wasn’t working, and every time MSF had to send an ambulance from PaPim to pick up the patient; it wasn’t easy and it took a lot of time.” (MSF respondent)

“Normally there is an ambulance in Rendel, but at central level this ambulance isn’t registered; so we can’t include it in our schedule and assign a driver or nurse to it as we do for all the other ambulances, so for the time being this ambulance isn’t operational.” (MSPP respondent)

On PaPim's side, health staff also expressed difficulties when they had to be reassigned to other health facilities to respond to emergencies or transport patients, particularly because this added an extra workload that had not originally been planned. One participant said:

"Sometimes we went to fetch patients from health centres that don't have the capacity to manage or refer certain cases. ...it's also up to us to go and fetch these patients. When you arrive with the patient, you may have other patients to look after." (Health professional)

In addition to referring emergency cases to PaPim, some BEmONC sites do not have a functioning laboratory or a doctor, and have to refer all women who need even a basic laboratory test, as well as medical problems that could be managed by a family doctor. This is not efficient in terms of time and finances and may increase the risk of complications because of delays in care.

"A doctor used to come twice a week to see those who had problems, and that helped us a lot. But that doctor left, and it's now been about a year since we've had any doctor, and our patients are suffering... We also have a laboratory with all the necessary equipment, but it isn't operational because we don't have a laboratory technician. So for any patient needing laboratory tests or with a problem requiring a doctor, MSF sends a car so that the patient can be transferred to PaPim, which is very stressful for patients, but it's the best we can do." (Community key informant)

COST EFFICIENCY

We carried out a programmatic cost assessment to explore the costs of supplies, staff and the services provided, and to identify potential areas where costs were inefficient or could be optimised.

Figure 25 presents the project's gross annual expenditure from 2022 to 2025. 2023 recorded the highest expenditure, probably because it was the initial phase of the project, during which material resources and equipment had to be purchased and installed. After 2023, expenditure fell slightly in 2024 before rising again in 2025.

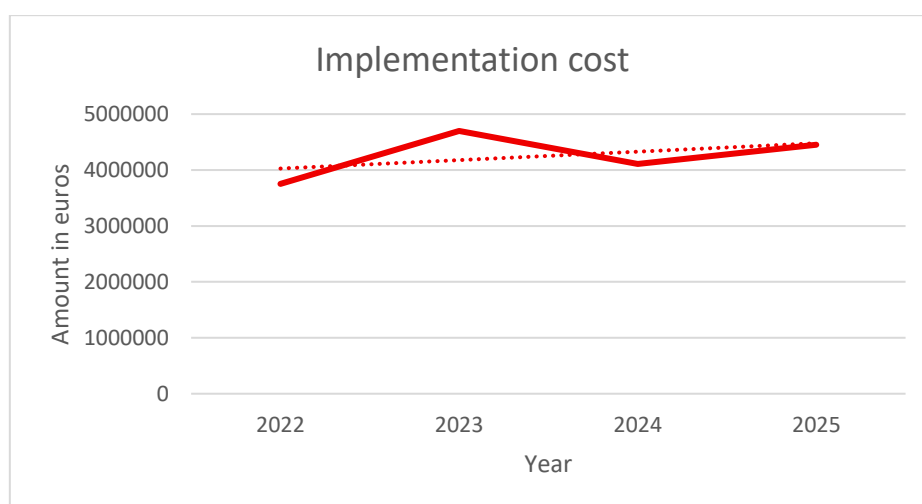


Figure 25: Annual implementation cost

Similarly, Appendix 5 provides details of the cost of services by project year, from 2022 to 2025. We present the percentage of the total budget spent on staff time, travel, space and utilities, consumables and equipment, and capital assets. Overall, staff time was the most expensive item, accounting for more than 50% of the project budget across all years (in red). This proportion increased steadily, from

55.2% in 2022 to 65.5% in 2023, 69.7% in 2024 and 71.6% in 2025. Within this item, paramedical staff salaries were the highest and increased over the years. In 2025 they accounted for 31.13% of total costs, almost double their share in 2022. This shows that service delivery has become increasingly labour-intensive, in response to the increase in service volume observed in section 4.3. Logistics support staff salaries, meanwhile, remained relatively stable over the years and accounted for more than 10% of the annual budget throughout this period. Daily rates also accounted for % of the total budget over the years; however, this proportion fell from 15.6% in 2022 to 11.5% in 2025, suggesting reduced reliance on rate-based or externally funded arrangements, potentially owing to greater use of in-house staff or more stable service delivery models.

Unlike staff costs, the costs of other services, such as travel, space, utilities, and supplies, materials and equipment, decreased over the years (Figure 26). In the absence of denominators linking these costs to outputs, this cost assessment shows how costs vary across services, highlights the main cost drivers and identifies potential areas where costs could be optimised.

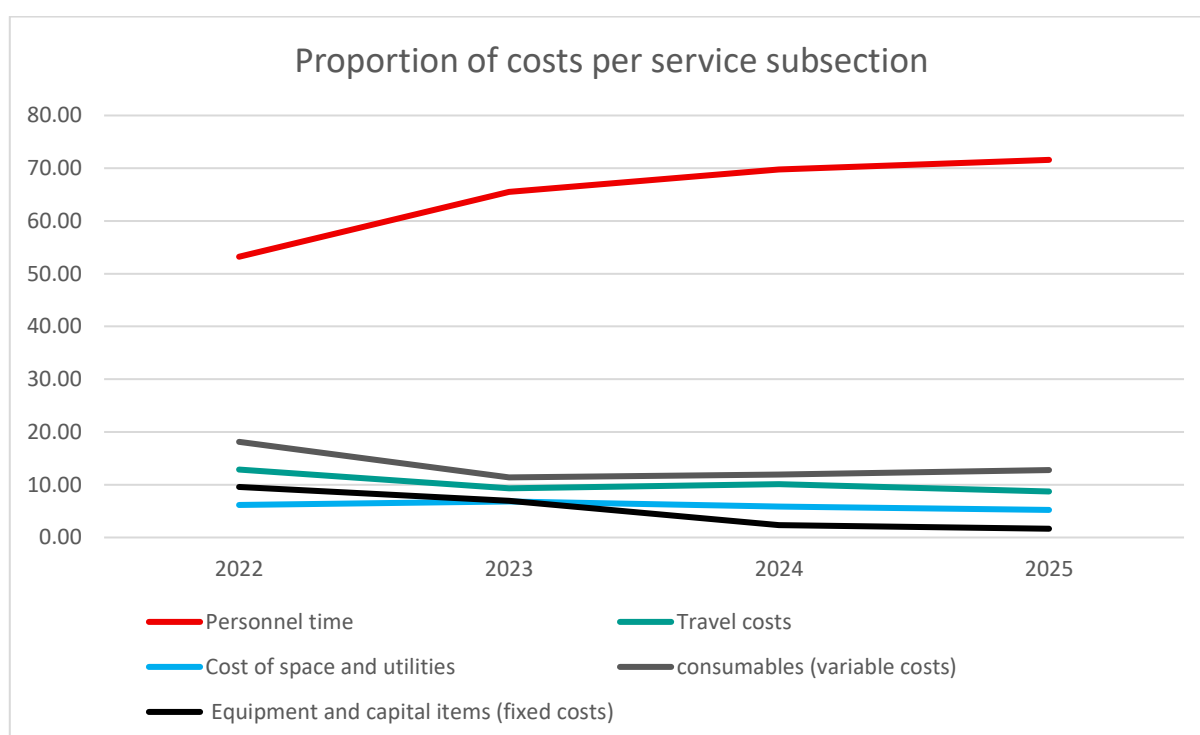


Figure 26: Proportion of costs by service subsection

IMPACT

Here we present the positive and negative, intended and unintended, local and higher-level effects the project has had, in terms of broader long-term impacts at individual, community and system level. We examine these effects critically with regard to people's well-being, human rights and gender equality.

In summary, the project has had a **positive impact on care-seeking behaviour and on service quality at MSF-supported facilities through capacity building and support with equipment and medical supplies. However, persistent gaps in sexual and reproductive health services for adolescents, heavy dependence on MSF support and weak monitoring systems limit its long-term impact and sustainability.**

IMPACT ON INDIVIDUALS AND THE COMMUNITY

a. Impact on care-seeking behaviour

Interviews with participants revealed that the project's presence and its awareness-raising activities may have brought about a change in care-seeking behaviour in the community. Participants said that before MSF arrived, people, including pregnant women, were not motivated to use health facilities. However, thanks to MSF's presence and its awareness-raising activities, a much larger number of pregnant women and other members of the population now have the capability and motivation to seek care at health facilities when needed. One participant put it this way:

"In the past, before MSF (Médecins Sans Frontières) was on the ground, a woman could be pregnant without even thinking of going to the hospital. Likewise, someone in pain who needed transport to Les Cayes might not be able to afford it... and so that person could die... Someone could be ill – suffering from anaemia, an infection or other conditions preventing their body from functioning properly – come for a consultation but not be able to afford medicines, and end up dying, losing their life. MSF has brought many changes to the communities, particularly in Port-à-Piment." (Community key informant)

Another participant described her experience: although her family and friends advised her otherwise, she decided on her own initiative to seek care, because she knew about the available services and wanted to go to the hospital rather than give birth with a traditional birth attendant ("matrone").

"I decided to come to the hospital on my own. You see, when I started having contractions, they told me they were going to call a 'matrone' for me. I said: 'What matrone? ... No.' I packed my bag myself and came on my own... It's thanks to MSF. MSF does good work." (Service user)

b. Impact on adolescent girls and other key populations

Although many participants said they knew about the services offered and could access care, this was not the case for many adolescents. Most adolescents said they did not know that services such as FP were available at the hospital, and some thought they had to pay for them. The few adolescents who had used these services said they had obtained the information from family members rather than community workers. This shows that the current community mobilisation approach is not adapted to adolescents and does not specifically target them.

"It was my mother who told me that here (PaPim) was where I should come if I needed family planning services." (Service user)

Adolescent girls also raised issues related to parental consent, which sometimes delayed access to services, particularly for family planning. One participant said:

"I was supposed to go and get contraception before, but by the time I was going to go, I was already pregnant. ... But for me to go and get contraception, my mother had to come with me, because on my own they wouldn't have given it to me. We hadn't gone yet, because the month when she (my mother) was due to renew her own contraception hadn't come yet." (Service user)

Among adolescents, we also identified other barriers related to gender power dynamics, particularly among young girls, indicating a persistent gap in health promotion interventions to overcome these barriers. One adolescent girl described her experience as follows:

"I don't use condoms... because the young man I'm with says it makes him ill when he uses them." (Service user)

As an SRH project with many activities focused on improving maternal and child health, some men expressed in interviews a feeling of exclusion and a wish for the project to also take some of their needs into account. With frustration, one participant said:

“I feel that we (men) are left out of the help provided by MSF; we too have difficulties, but when we come to the hospital, we have to pay... I know they (MSF) already do a lot, but I would have appreciated it if MSF also covered some services for us (men)” (Service user)

c. Impact on quality of care

To assess the impact of the quality of care provided, we asked survey participants about their level of satisfaction with the services offered at MSF-supported sites. Around 87% of respondents said they were very satisfied, 9% said they were satisfied, and < 5% were either neutral or dissatisfied (Figure 27). This indicates a positive impact of the project’s interventions on service users and probably on the community as a whole.

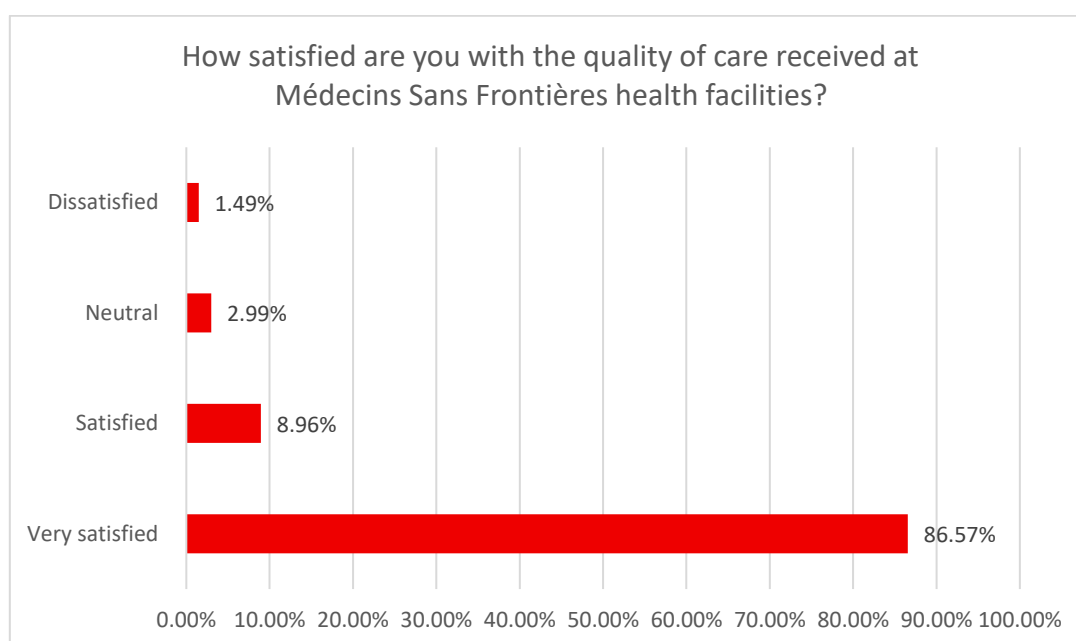


Figure 27: Satisfaction levels of survey participants

Similarly, interviews with participants revealed a positive impact on the quality of care provided at PaPim and at other MSF-supported sites. One participant described her experience of being cared for by a large medical team.

“The doctors took care of me. They monitored me 24/7 – they checked my blood pressure, monitored my condition and made sure everything was all right for me. You understand? They came with all their equipment for me and quickly identified everything that was wrong. And the nurses even slept on two chairs; all night long they were up caring for me and watching over us. If anything could harm us, they gave us medicine and water to drink. They helped us.” (Service user)

SYSTEM-LEVEL EFFECTS AND BROADER LONG-TERM EFFECTS

a. Impact on project outcomes

The rising rate of service uptake at PaPim and at other MSF-supported sites for ANC, delivery and other services such as family planning (Section 4.3 – Effectiveness) could indicate a positive impact of project activities at these health facilities. In addition, the lower maternal mortality rates at PaPim compared with the rest of the South department could indicate a positive trend towards reducing maternal and infant mortality in the area, although the available data were not sufficient to establish trends at PaPim before and after project implementation.

In the interviews, we also asked participants which project activities or services they felt had had the greatest impact. For the vast majority, it was maternal services, including the management of obstetric complications and the NICU. Some participants expressed their views as follows:

“Well, in my view, MSF’s most effective service in the commune of Port-à-Piment is the maternity service.” (Community key informant)

“I think all the services have an impact, but for me it’s the neonatal intensive care unit and the maternity service, including the operating theatre, that have had a considerable impact because, on the one hand, our neonatal intensive care unit is the only one in working order in the whole area, and on the other, the maternity operating theatre has saved many lives, and we’re grateful for that.” (Health professional)

In addition to the quality of care provided in these units and the lives they save, another participant highlighted the economic impact of these services, since they are offered free of charge, particularly the NICU, where newborns can sometimes stay for more than a month. One health educator said:

“... In neonatal care too, some mothers stayed in hospital for up to a month and a half with their baby, and many of them don’t have the financial means. Today, if a mother had to stay a month and a half in a facility with her newborn while paying for medicines – especially when the baby is on oxygen or in an incubator – it would be impossible for many of them. Even food isn’t at their expense, because MSF provides three meals a day.” (Community stakeholder)

b. Impact on health staff and the health system

Throughout the project, MSF has trained community and health staff to better equip them to perform the required tasks, even after MSF leaves. This has had a positive impact on staff and on the health system. Interviews with participants confirmed the impact of this training on their individual capacity and on the team as a whole.

“They (MSF) have given us a lot of training. Sometimes it’s nurses and midwives who run training sessions with us. It helps us build our capacity and improve our skills, which enables us to deliver our services better thanks to the training we receive.” (Community stakeholder)

“We receive training all the time; at the beginning it was more frequent, but today we mainly put into practice what we’ve been taught... I’m very grateful to MSF because even if I go somewhere else, I feel comfortable working. What’s more, we (PaPim) now host students who come to do their practical placements in the final years of their medical studies, and I think that’s a good thing, because even when MSF leaves, this knowledge will remain in the community and with the few staff who will stay at the HC.” (Health professional)

In addition to training health staff, the service mapping and interviews with participants revealed that MSF has also provided equipment to the health facilities it supports and upgraded their infrastructure to include aspects such as access to safe drinking water, a reliable power supply and other services, including the construction of sterilisation units and incinerators at these hospitals.

*“MSF has set up a water point to make access to water easier. People now drink safe water.”
(Community key informant)*

MSF also regularly provides hygiene and sanitation products to all the sites it supports and has trained hygiene staff in their use to effectively prevent contamination in the hospital setting.

“MSF also provides us with hygiene and sanitation products, and our cleaning staff have been trained in their correct use. Thanks to them (MSF), the hospital is always clean” (Health professional)

Alongside the many positive impacts of MSF’s presence on health staff and the health system, a probably unintended consequence of the project may be these health facilities’ heavy dependence on MSF. Since most staff, particularly at PaPim, are recruited and retained by the project, it almost single-handedly provides essential SRH services, including ANC, deliveries, emergency neonatal care and the referral system. It is highly likely that these systems would be absent or extremely limited without MSF. Interviews with participants also confirmed this, with several expressing doubts about whether these services would exist if MSF were to withdraw.

“I wonder what will happen to pregnant women when MSF leaves; they (MSF) help us by providing medicines. If a woman has a difficult delivery, they send an ambulance to take her to a specialised centre, and MSF does many other things for us too; I don’t know what we would do without them. There will be lots of problems.” (Health professional)

“The project is going to end, which will cause enormous difficulties for the community and for pregnant women, but also for those who work in the project.” (Community key informant)

SUSTAINABILITY

Under this criterion, we present the extent to which the benefits of the intervention are likely to continue after MSF’s departure. We examined the economic, social, environmental and institutional capacities of the MSPP and other local partners to sustain the project’s activities and benefits over time.

Broadly speaking, **despite the progress made in SRH, the sustainability and handover of the project to the MSPP remain constrained by several systemic factors, including: heavy dependence on MSF, weak stakeholder ownership, the misalignment of certain project activities with the health system, gaps in certain key SRH services, and high implementation costs.**

STAKEHOLDER ENGAGEMENT, OWNERSHIP AND ORGANISATIONAL CAPACITY

Throughout the project, contributions from other stakeholders – including the MSPP and other local and non-governmental organisations in the community – to supporting project activities, particularly at the PaPim CEmONC, have been minimal. This limited engagement and contribution increases the risk of dependence on MSF and reduces the prospects for sustainability.

In terms of human resources, the PaPim CEmONC is run exclusively by MSF staff, with pooling only for hygiene and sanitation staff. At the other supported sites, MSF pays financial incentives to maternity staff recruited by the MSPP or the community, as neither the MSPP nor the community alone can consistently pay these workers’ salaries. Without these incentives, these staff would not be able to work full time.

“The MSPP made us many promises, saying it would provide trained staff during the project who would gradually replace MSF staff. But in reality that hasn’t happened; so far we have only been able to pool hygiene and sanitation staff, and all PaPim staff are still exclusively MSF... We (MSF) also give incentives to MSPP staff and others recruited by the community to encourage them to work full time.”
(MSF respondent)

Similarly, community workers (traditional birth attendants) are paid exclusively by the project; moreover, although ASCPs and Colvols are recruited by the MSPP, they receive financial incentives from the project, without which their involvement in SRH services would be minimal, since they are also responsible for other activities such as immunisation and awareness-raising on other infectious diseases. In the interviews, participants also expressed doubts about whether awareness-raising activities would continue without MSF. One participant said:

“If MSF were to leave, it would affect my role in the community, because we are already used to carrying out health education with the population, and we work with MSF. If MSF were to leave, I don’t think we would be able to continue our awareness-raising activities.” (Community key informant)

In addition, in the interviews, participants expressed serious doubts about the ability of health facilities and the government to sustain the project’s current activities. They feared serious consequences if MSF were to end its support, particularly if it were withdrawn abruptly. One participant said:

“If MSF were to leave, the maternity service would have to be maintained because, despite all the efforts made, some people would continue to be negligent. We also know that our government does not provide certain services. That would mean that if MSF were to leave, the situation of the past would return. Many women would die in childbirth, and many newborns would die after birth... We don’t really have a government that looks after us, so MSF has been like a saviour for our community. If everything were suddenly to stop, it would have serious repercussions both for employment and for the community’s access to health services.” (Community stakeholder)

PERSISTENT GAPS AND SUSTAINABILITY PROSPECTS

a. Sustainability plan

Although the project was designed to last 5 years, no clear exit and sustainability plan existed before the third year. This is inconsistent with the MSPP’s coordination style and could therefore affect the prospects for sustainability. Many interview participants acknowledged that the transition and sustainability plan had yet to be developed, particularly with the MSPP, even though the end of the project in December 2027 was already certain. This lack of coherence and the delay in developing sustainability plans weaken the project’s ability to implement long-term policies and secure MSPP support.

“It was clear that MSF would leave the area after five years, but only now, a year and a half before the departure, are we trying to sit down at the negotiating table with the Ministry of Health to plan and finalise our departure.” (MSF respondent)

“We (the MSPP and MSF) haven’t had any concrete discussions about MSF’s departure... It’s true that at the beginning we knew it was a five-year project, but they should have confirmed to us that they would actually leave at that date. Just as when they arrived, they always intended to leave but didn’t; so this discussion needs to take place so that we (the MSPP) know what their plans are.” (MSPP respondent)

b. Persistent gaps

Despite the overall effectiveness and impact of project activities, gaps persist in data management, adolescent SRH, policy (government buy-in) and partner support, which could have a negative impact on sustainability.

The routine data collected by the project are limited and do not reflect patients' needs; they do not include enough demographic information, such as participants' age or other factors related to the social determinants of health. Moreover, the available data are not disaggregated, are mainly clinical and contain no information on the demographic and social determinants of health, making it difficult to monitor progress. We also identified gaps at policy level: insufficient legal frameworks for certain services and limited political support for the actions taken, which increases the fragility of these services and reduces their chances of sustainability. For example, measures such as converting PaPim into a CEmONC and integrating traditional birth attendants ("matrones") as community workers have not been endorsed by any policy. In addition, most health professionals at the health facilities are either recruited by the community or on temporary contracts, and have not been fully recognised by the government. This lack of recognition or buy-in increases the fragility of these services and limits their chances of sustainability. In the interviews, participants reiterated the fragility of many services and linked it to government instability, leading them to think that this was not the right time for the project to stop providing services, as they feared the situation would worsen if support were to end. One participant expressed this view as follows:

"Why is MSF leaving when the problems it set out to solve are still there? ... I don't think this is the right time for them to leave; the country isn't doing well, we have no leader, which is why everything is at a standstill... It's true that at the start of the project the government made a lot of promises, but nothing is happening because of political instability. Their departure will only make things worse, and the situation will be even worse than before they arrived" (Community key informant)

Gaps also persist in adolescent SRH, particularly in pregnancy prevention, leaving young girls increasingly exposed to unwanted pregnancies. Participants confirmed this both in the survey (Figure 5) and in the interviews, noting that unwanted pregnancy remained one of the most pressing and unresolved problems in their community. One participant estimated its prevalence at around 60 to 70% and proposed targeted education for young girls.

"In terms of needs, training should be set up for young girls, that is, those aged 12 to 18, so that they can receive support to help them avoid early pregnancies. I can say that this phenomenon accounts for around 65 to 70% of cases in the region..." (Community key informant)

c. Sustainability prospects (leverage points)

To assess sustainability prospects among service users, we asked participants whether they would continue to use the services if MSF support were to end. 85% answered yes, indicating that they would continue to use the services, while 10% answered no and around 4% were unsure. This demonstrates a positive impact of the interventions on the community and indicates promising prospects for sustainability, as participants' motivation to keep using the services can be leveraged to strengthen local ownership and improve sustainability.

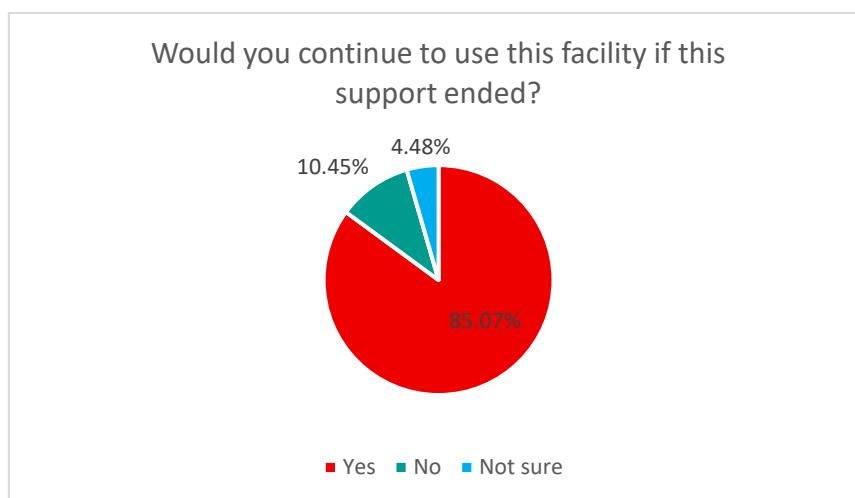


Figure 28: Participants' responses to the question: "Would you continue to use this facility if MSF support ended?"

Similarly, in the interviews, many participants said they would continue to use the services at MSF-supported sites even if MSF were to end its support, provided the services remained available, including for a fee. One participant said:

"If MSF wasn't here any more, well... For me, as long as the care I need is still available here, I would keep coming... even if I had to pay... but as long as I can get the care I need, I would still come here."
(Service user)

For others, however, concern was expressed about being unable to cover the cost of services, which would no longer be free without MSF.

"Here (at the Port-à-Piment CEmONC), we get good care, and that care is free... I don't think I would come here if MSF were to leave, because I could no longer get it for free." (Service user)

SUSTAINABILITY RISKS AND POTENTIAL TRADE-OFFS

Persistent supply chain difficulties, the country's socio-political instability, the government's limited capacity and buy-in, and heavy dependence on MSF, particularly for human resources, increase the risk to the project's sustainability in its current form. Continuing the project as it stands, with full MSF support, further increases MSF's operating costs, dependence and sustainability risks. Trade-offs between achieving immediate impact and long-term effects must therefore be assessed, including decisions on funding/expenditure, the supply chain (e.g. source of supply, brand, etc.), the nature of support (e.g. more coaching and technical assistance rather than direct service delivery), handover options (e.g. to the MSPP or another NGO), policy integration, and the consideration of the population's different needs and priorities (OECD, 2019).

DISCUSSION

The evaluation findings suggest that the PaPim project has played an important role in improving access to sexual, reproductive, maternal and newborn health services in the South, particularly along the Roche-à-Bateau–Tiburon axis. In line with the OECD-DAC evaluation criteria, the project demonstrates strong contextual relevance: it operates in a context marked by geographic isolation, insecurity, poverty, limited service availability, transport barriers and restricted access to quality emergency obstetric and newborn care (OECD, 2019). The reported increase in ANC attendance and deliveries at the supported BEmONC sites indicates that the project has contributed to improving service uptake and decentralising access to care, consistent with evidence showing that expanding first-level maternal services improves coverage and equity (WHO, 2015, 2016a). These findings are in line with international standards aimed at improving access and coverage, which are fundamental to both effectiveness and long-term sustainability (WHO, 2016a).

However, the findings also highlight persistent systemic constraints that limit effectiveness, efficiency, coherence and sustainability. Although the project appears aligned with internal organisational standards and practices, it is not coherent with the broader structure of the MSPP health system or with its response approach. Classifying and operating PaPim hospital as a CEmONC rather than a BEmONC facility may have enhanced its capacity to manage complex maternal and neonatal complications, but it also creates a misalignment with the formal public health architecture. This misalignment risks undermining system integration and long-term sustainability, since sustainable interventions require fit and alignment with national structures, the policy environment and the care delivery system (Bodkin & Hakimi, 2020). This matters because CEmONC systems depend not only on the availability of individual facilities but also on a coherent referral network in which BEmONC and CEmONC functions are clearly defined, standardised and linked by rapid referral and transport systems (Bailey et al., 2009).

Care-seeking behaviour remains a major determinant of maternal and neonatal outcomes. The finding that more than 10% of women in the South department were still giving birth at home in 2024, despite subsequently seeking postnatal care, suggests that contact with the health system does not consistently occur at the most critical moment (labour and delivery). Similarly, the late initiation of ANC reflects persistent gaps in risk perception, community awareness, trust and understanding of the value of preventive care (Tunçalp et al., 2017). WHO recommends early and repeated antenatal contacts, with the first contact taking place in the first trimester, because early ANC provides opportunities to identify risks, provide counselling, prevent complications and direct women to appropriate care (WHO, 2016b, 2022; Wojcieszek et al., 2023).

The findings also reveal a tension between service quality and geographic distribution. Patients travel from outside the target area and bypass nearby facilities because PaPim's services are free and perceived to be of higher quality. Moreover, the fact that 80% of newborns admitted to PaPim come from outside the target area is a strong indicator of perceived quality and of unmet needs beyond the project's catchment area. However, it also raises a potential efficiency and equity concern. When a facility becomes the preferred point of care for populations beyond its intended area, it can become overloaded, distort referral pathways and weaken the role of peripheral facilities (WHO, 2018b). This pattern suggests that PaPim functions de facto as a regional referral hub, whether or not this was formally intended in the initial planning.

In addition, more than half of participants cited distance as a major barrier, while 45% cited the cost of services, 39.7% the cost of transport and 39.7% the lack of services. These barriers correspond closely to the “three delays” model of maternal mortality: delays in deciding to seek care, delays in reaching appropriate care, and delays in receiving adequate care once at the facility (Thaddeus & Maine, 1994), indicating persistent gaps in achieving the project’s objectives of overcoming these three delays. These findings also indicate that the remaining barriers stem not primarily from knowledge gaps at the individual level but from institutional and systemic constraints. Solutions must therefore go beyond health education to include transport, referral, financing, service availability and quality improvement (cf. socio-ecological model). According to OECD standards, interventions that fail to address systemic constraints risk limited effectiveness and sustainability (OECD, 2019).

Although referral services were perceived as relevant and effective, delays persist owing to ambulance shortages and logistical constraints. Reported cases of women giving birth in ambulances also indicate that referral occurs too late, that transport is not sufficiently reliable, or that facilities are unable to stabilise and transfer patients quickly. Furthermore, there is heavy reliance on PaPim for referral support, with PaPim having to send ambulances to some BEmONC sites to carry out referrals. This continued reliance on PaPim for emergency referrals indicates that further investment is needed to ensure that BEmONC sites are reliable, functional, adequately staffed, equipped and connected to referral pathways. The effectiveness of decentralisation depends on facilities’ ability to consistently perform the expected signal functions, maintain essential supplies and refer complications promptly (Bailey et al., 2009). Since obstetric complications can arise quickly and unpredictably, referral delays are a critical concern for quality of care and patient safety. Standardising clinical competencies, supervision and quality assurance mechanisms is therefore essential to ensure consistent performance across facilities (WHO et al., 2017).

Furthermore, the finding that maternal and infant mortality rates have not declined, although they remain below departmental rates, may reflect better case detection, increased referral of more severe cases to PaPim, greater service uptake by high-risk patients, or persistent gaps in the quality and timeliness of care. The lack of disaggregated data and the limited consideration of the social determinants of health currently restrict the project’s ability to explain why mortality is not declining and which groups remain most at risk (Luke et al., 2014). Standardised data collection and audit systems, such as maternal and perinatal death surveillance and response (MPDSR), are essential for identifying preventable factors and improving quality of care (WHO, 2013a).

Similarly, the low uptake of GBV services is another significant concern. However, limited data on prevalence and on those eligible for services restrict the ability to explain this trend. In fragile and crisis-affected settings, GBV services often remain underused because of stigma, fear of disclosure, lack of confidentiality, limited awareness, safety concerns and weak referral pathways (UNFPA, n.d.). Low uptake should not simply be interpreted as low need. Rather, it may indicate that services are insufficiently visible, trusted, confidential, youth-friendly, survivor-centred or integrated into broader SRH and community platforms (Heron & Eisma, 2021; WHO, 2013b). WHO guidelines emphasise the importance of standardised, survivor-centred clinical care and clear referral pathways for improving access to and quality of GBV services (WHO, 2013b).

Supply chain weaknesses also undermine the project’s effectiveness and efficiency (WHO, 2007). Intermittent stock-outs of essential medicines, combined with the long and complex supply chain for blood products, directly affect the quality of care for obstetric emergencies, neonatal complications,

infections and transfusion needs. These bottlenecks are particularly concerning in a CEmONC setting, where rapid access to medicines, commodities and blood can determine survival (Olaniran et al., 2022). Under the WHO health system building blocks, reliable access to essential medicines is fundamental to system performance (WHO, 2010). Standardised procurement, stock management and forecasting systems are essential for sustainability, particularly in fragile settings where supply disruptions are frequent (WHO, 2007). Strengthening these systems within MSPP structures is essential to reduce dependence on external support.

The cost findings suggest that the project is becoming increasingly resource-intensive, with staff time accounting for around half of the budget across all years. This gradual increase in implementation costs, combined with dependence on MSF for staffing, material and financial support, raises sustainability concerns. This is particularly important given the low level of stakeholder involvement and limited local ownership (OECD, 2019). Finally, despite some observed impact on service users and the health system, the findings highlight persistent gaps in adolescent SRH, particularly regarding pregnancy prevention, power dynamics and safer sexual practices. This is a significant gap, since adolescent pregnancy is influenced by access to contraception, education, gender norms, coercion, confidentiality and the ability to negotiate safe sex (WHO, 2024). Addressing these gaps requires standardised, adolescent-friendly service delivery models that ensure confidentiality and accessibility and respond adequately to gender and power dynamics (WHO, 2025).

Overall, the PaPim project appears highly relevant, has contributed to increased service uptake, particularly at the supported BEmONC sites, and shows strengths in terms of public health impact. However, the project's sustainability and readiness for handover to the MSPP remain constrained by several interdependent systemic factors: insufficient alignment with the MSPP health structure, persistent bypassing of peripheral facilities, heavy reliance on MSF support for staffing and supplies, referral and ambulance constraints, intermittent stock-outs, limited disaggregated data, limited stakeholder ownership, and persistent gaps in services for adolescents and GBV survivors. These findings suggest that PaPim has not yet reached a stage at which a full handover to the MSPP would be low-risk (Bodkin & Hakimi, 2020; Luke et al., 2014; Wiltsey Stirman et al., 2012). Furthermore, the high share of costs allocated to staff time also suggests that workforce sustainability will be a central element of any handover strategy. Likewise, stock-outs and blood bank constraints indicate that clinical handover cannot be separated from supply chain handover.

CONCLUSION

This evaluation analysed the progress, impact and sustainability of the MSF sexual and reproductive health project in Port-à-Piment, Haiti, using a mixed-methods approach. The findings show that the PaPim project has contributed substantially to improving access to sexual, reproductive, maternal and newborn health services in Haiti's South department, particularly in geographically isolated and underserved areas. The increased uptake of antenatal care and facility-based deliveries at supported sites, strengthened referral pathways and improved access to emergency obstetric and newborn services suggest that the project has been highly relevant and has generated significant progress in service utilisation and health system responsiveness. However, the findings also reveal persistent structural and health system challenges that threaten the long-term sustainability of these gains, including insufficient alignment with MSPP structures, heavy dependence on donor resources, referral and transport constraints, supply chain weaknesses, and limited institutional capacity for monitoring, financing and service delivery.

Sustaining the project's benefits will require a deliberate transition from a donor-supported service delivery model towards a system-strengthening approach that prioritises local ownership, institutional capacity and integration into national systems. The recommendations in this evaluation highlight the need for a formal roadmap for the transition from the MSF programme to the MSPP programme, strengthened BEmONC facilities, resilient referral and supply systems, improved data collection and learning mechanisms, and the protection of services for vulnerable populations, such as adolescent sexual and reproductive health and the management of gender-based violence. In addition, developing a joint MSF–MSPP sustainability assessment toolkit offers a practical mechanism for assessing readiness, identifying gaps and guiding adaptive handover decisions. Ultimately, the sustainability of the project's gains will depend not only on maintaining services but also on building a coherent, resilient and locally owned health system capable of continuing to deliver equitable, high-quality maternal and newborn care long after external support has ended.

LIMITATIONS

- Some existing secondary quantitative data were not shared with the evaluation team during the evaluation, although this does not call into question the overall validity of the findings. It does, however, reinforce the recommendations on data collection and use. Disaggregated data were insufficient for comparative and trend analysis.
- The case study was conducted in only 3 of the 5 beneficiary health facilities, and its findings were used to formulate recommendations for the project as a whole. This may be a limitation, given that each health facility is unique and faces different realities. However, to mitigate this, we cross-checked the case study findings against the project's routine data in order to examine differences between beneficiary health facilities and complement the case study findings.
- The data collected represent a snapshot and may not represent or reflect participants' perceptions over the full duration of the project.
- Potential selection bias, as we used a purposive sampling strategy to select evaluation participants.
- Potential bias in stakeholder responses: qualitative findings, particularly those from interviews and focus group discussions, may be subject to social desirability bias or confirmation bias. Some respondents may have emphasised successes or downplayed operational difficulties because of their affiliation with the programme or their expectations of the evaluation.
- The low participation of MSPP key informants restricted the diversity of perspectives gathered and limited the development of recommendations fully grounded in the views of key government stakeholders.

RECOMMENDATIONS

The recommendations have been prioritised in light of the project's current context

Recommendation 1: Develop a financial transition plan combining a targeted cost-effectiveness assessment and a gradual transfer of responsibilities to protect the continuity and sustainability of project activities

Background: A financial transition plan is needed to ensure that essential SRH services do not weaken when the project's external funding decreases or ends. Without a clear transition plan, facilities risk service interruptions, stock-outs, reduced outreach, unpaid community workers, weakened supervision and lower service uptake, among other things. A realistic plan helps the project determine what needs to be maintained, what it costs, who will fund it, what the local health system can absorb and what requires gradual support. It also protects equity by ensuring that the financial transition does not shift costs onto clients who already face barriers to accessing care.

Proposed actions:

1. Use economic analysis in a targeted way for major service delivery decisions

Rationale: A full cost-effectiveness analysis may not be necessary for every activity, but it is useful in helping the project choose between different models that may have different costs and outcomes, for example community outreach activities and maternity services. A cost-minimisation analysis would help the project opt for the least costly approach when two options are expected to produce the same results.

- Carry out cost-effectiveness analyses for choices such as outreach versus facility-only services, peer support for adolescents versus standard health talks, or full support versus technical assistance.
- Carry out cost-minimisation analyses to identify the most efficient options in areas such as staff training, medicine supply options and staff recruitment (e.g. local versus international staff).
- Summarise the findings in simple decision notes for project and district managers.

2. Integrate transition costs into local planning, monitoring and accountability systems

Rationale: The financial transition will only be sustainable if priority costs are integrated into the routine planning systems of facilities, districts and partners, rather than remaining project-specific expenditure.

- Work with district and facility managers to integrate priority SRH costs into annual operational plans and facility budgets.
- Align medicines, supplies and reporting tools with existing government systems wherever possible.
- Create a simple financial readiness dashboard showing funded activities, funding gaps, risks and corrective actions.
- Review financial readiness at routine quarterly project, facility and district meetings.

Recommendation 2: Redefine sustainability objectives and specific actions in collaboration with the MSPP and other key stakeholders

Background: Sustainability is defined as the ability to maintain health benefits, institutionalise essential activities within existing organisational structures and develop sufficient local capacity to continue essential functions after external support is reduced or withdrawn (Shediach-Rizkallah & Bone, 1998; Bodkin & Hakimi, 2020). The sustainability of the PaPim project will require strong community and stakeholder ownership. Handover to the MSPP should therefore include not only an institutional transfer to government actors but also a broader governance model involving communities, local leaders, women's groups, youth representatives, other key stakeholders, referral/transport actors and the supported health facilities. Moreover, the handover process should not be designed as a rapid exit strategy but as a gradual process of institutionalisation. A handover to the MSPP will therefore only be feasible if there is a clear plan specifying which staff functions will be absorbed, co-funded, transferred or redefined.

Proposed actions:

1. Develop a formal MSPP–PaPim transition roadmap 12 to 24 months before the end of the project

Rationale: Sustainability planning should begin before external support ends in order to ensure programme continuity and minimise the waste of human, financial and technical investments (Stirman et al., 2012).

- Create a 12- to 24-month handover plan with clear milestones, responsible actors, timelines, risks and decision points.
- Divide activities into those to be handed over immediately, those to be handed over after capacity building or resource allocation, those to be maintained temporarily with donor support, and those that cannot be handed over until certain systemic conditions are met.
- Also include precise timelines and describe how each component will be handed over.

2. Define, jointly with the MSPP, a minimum package of sustainable services

Rationale: Sustainability does not mean continuing every project activity. Not all project activities are necessarily financially or operationally transferable at the same time. This requires defining what must be maintained, what can be adapted and what should be institutionalised through a clear plan (Bodkin & Hakimi, 2020).

- Design and agree with the MSPP a minimum package of services to be preserved after MSF's departure: ANC, facility-based delivery, newborn stabilisation, emergency obstetric referral, postnatal care, contraception, GBV response, etc.
- Identify the SRH/maternal and newborn health services to be maintained at PaPim, and those that will continue to be provided at the other supported BEmONC facilities.
- For each service, define in detail the activities to be maintained, for example community services for adolescents only, or the types of contraception offered.

3. Clarify PaPim's position within the MSPP health structure

Rationale: The evaluation found mixed coherence, with PaPim operating as a CEmONC while being classified, at best, as a BEmONC under the MSPP health structure. Sustainability depends on fit/alignment with the host system; this “alignment” is identified as a key sustainability factor in the literature on the sustainability of health promotion programmes (Stirman et al., 2012).

- Bring together the MSPP at national level, the departmental health authorities, PaPim management and the supported facilities to decide whether PaPim should formally operate as a CEmONC hub or be reclassified/operationalised in line with the structure set out by the MSPP.
- Then map the referral roles of PaPim and the other surrounding facilities: Chardonnières, Rendel, Les Anglais and Tiburon.

4. Move from direct substitution to co-management before full handover

Rationale: Programme sustainability is influenced by organisational context, capacity, processes, workforce stability, stakeholder participation and funding. A co-management phase makes it possible to build these capacities before full handover (Stirman et al., 2012).

- Move gradually from donor-led delivery to joint MSPP–MSF management.
- For each service area, create a co-leadership model pairing an MSF technical lead with an MSPP counterpart, with a gradual transfer of responsibility for decision-making, supervision, procurement, reporting and budgeting.

5. Strengthen and equip BEmONC sites so that they can manage the increased workload

Rationale: The increase in service uptake at the supported BEmONC sites provides a solid basis to build on for sustainability.

- Prioritise BEmONC sites, particularly Chardonnières, Rendel and Tiburon, for upgrades in facility readiness, staffing, supervision and supplies, in order to increase their capacity to absorb the growing workload.
- Carry out supportive supervision at these sites and monitor whether the increase in service uptake is matched by adequate quality and sustainability readiness.

6. Create a joint MSPP–PaPim sustainability assessment toolkit, using or adapting the domains of the Program Sustainability Assessment Tool (PSAT), to assess sustainability readiness every 4 to 6 months

Rationale: The PSAT is a reliable instrument for measuring the sustainability capacity and handover of public health programmes. It establishes the degree of stakeholder commitment to continuing project activities and the availability of the financial and material resources needed to sustain the programme.

- Establish a joint MSPP–PaPim sustainability working group involving departmental, facility and community members, with focal points at national and departmental level.
- Develop assessment components specific to each domain. The proposed adapted domains are:
 - Political and environmental support
 - Financial sustainability

- Partnerships and coordination
 - Organisational and human resource capacity
 - Monitoring, evaluation and learning
 - Service adaptation and integration
 - Communication and community ownership
 - Strategic planning
 - Draft actions and timelines, and assess readiness every 4 to 6 months.
7. **Develop a realistic financial transition plan with the MSPP**
- Rationale:** Funding stability is consistently identified as central to sustainability, but the literature also stresses that sustainability is more complex than simply replacement funding. Stable funding must be accompanied by adequate organisational capacity, partnerships, strategic planning and alignment.
- Estimate the recurrent costs the MSPP would need to absorb: staff, essential medicines, transport, blood supply, supervision, data systems, facility maintenance and emergency referrals.
 - Develop scenarios: full absorption by the MSPP, mixed funding, pooled donor bridge funding, and gradual absorption by cost category.
8. **Develop a workforce absorption and capacity transfer plan**
- Rationale:** Staff time is the main cost driver, and dependence on donors for staffing is a major risk to sustainability. The sustainability literature identifies workforce stability, staff competencies and organisational capacity as important factors influencing sustained implementation (Stirman et al., 2012).
- For each staff category, determine whether staff will be absorbed by the MSPP, retained through donor bridge funding, converted into MSPP-supported posts, or gradually phased out.
 - Identify realistic timelines for each decision.
 - Link the workforce transfer to training and mentoring materials, supervision tools and competency checklists for MSPP staff.

Recommendation 3: Improve and strengthen community activities to integrate treatment services and adolescent-friendly approaches

Background: Community activities help bring SRH services closer to young people, who may face barriers such as stigma, transport costs, limited confidentiality or fear of judgement (Ninsiima et al., 2021). Adding treatment services and adolescent-friendly approaches would improve continuity of care, encourage early care-seeking and strengthen trust between communities and health facilities (WHO et al., 2025). It also supports sustainability by building on local structures such as community health workers, peer educators, youth groups and community leaders to maintain this support beyond the project period (WHO, 2018a).

Proposed actions:

1. **Involve adolescent peer educators and train them alongside community health workers in adolescent-friendly SRH support:**

Rationale: To build a community workforce able to offer respectful, confidential and practical support to adolescents and other vulnerable groups.

- Develop a short competency-based training module covering adolescent-friendly communication, confidentiality, respectful counselling, non-judgemental care, STI prevention, family planning services and gender-based violence response.
- Include role-play exercises in the training.
- Clarify what community health workers and peer educators can provide directly at community level and what must be referred to a health facility.

2. Integrate family planning and basic SRH services into community outreach activities

Rationale: To bring key SRH services closer to clients who cannot easily access them because of distance, cost, stigma, lack of privacy or childcare responsibilities.

- Define a minimum package of community SRH services including SRH education, voluntary family planning counselling, condom distribution, pregnancy and postpartum counselling, HIV/STI information, danger-sign screening and referral to clinical services.
- Offer community-based distribution or resupply of approved short-acting methods, such as condoms and contraceptive pills, in line with national guidelines.
- Organise periodic outreach led by trained nurses or midwives for services requiring clinical assessment, such as injectable contraception or postpartum family planning, in accordance with local policy.
- Establish clear referral pathways for facility-based methods and services, including implants, IUDs, antenatal care, STI treatment, HIV care, postnatal care and management of complications.

3. Create safe, youth-friendly community outreach spaces

Rationale: To offer trusted spaces where adolescents and young people can receive SRH information, counselling, referrals and certain services without fear of stigma or loss of confidentiality. Identify safe, discreet community venues, such as youth centres, schools, community halls, women's group spaces, mobile outreach points or designated private rooms for youth-friendly gatherings.

- Schedule outreach sessions at times suited to adolescents, young people and their carers, for example after school, at weekends or on market days, depending on the context.
- Provide opportunities for confidential one-to-one counselling so that clients can raise sensitive issues such as contraception, pregnancy, HIV care, violence or relationship concerns.
- Use peer educators and community champions to make the space more welcoming and reduce fear of judgement.

4. Link community activities directly to health facilities and local structures

Rationale: To ensure that community work is not isolated but connected to formal services and sustained through local ownership.

- Introduce referral slips, feedback forms, referral registers or telephone confirmation of referrals between community health workers, peer educators, outreach teams and health facilities.

- Designate a focal person for adolescent SRH services at both facility and community level to ensure that clients referred from the community are received respectfully and followed up.
- Involve community leaders, schools, youth groups, women's associations and local authorities in planning outreach activities, while protecting client confidentiality.
- Gradually transfer certain responsibilities – such as outreach planning, coordination of peer support, family planning follow-up and referral tracking – to local health committees and joint facility–community teams.

Recommendation 4: Improve data collection and management approaches to incorporate disaggregated data and routine reviews

Background: Data management strengthens the project's ability to identify who is being reached, who is being left behind, where the service gaps are, and whether interventions are improving access, quality, continuity of care and equity. A better data system will support timely decision-making, accountability and sustainability.

Proposed actions:

1. Define a minimum SRH dataset with the required disaggregation

Rationale: To ensure that all facilities and community teams collect the same priority data consistently.

- Develop a simple minimum dataset for all services – for example maternal, neonatal, adolescent and community services – across all supported sites.
- Disaggregate data by age, sex/gender where relevant, place of residence, facility and other key determinants of health.
- Align indicators with national DHIS2 tools wherever possible, to avoid creating a parallel system.

2. Update data collection tools at facility and community level

Rationale: To ensure that registers, forms and reporting templates accurately capture disaggregated SRH data.

- Review existing facility registers, community outreach forms, referral slips, appointment tracking tools and monthly reporting templates, and add fields for disaggregated data where needed.
- Integrate and harmonise community-level indicators.
- Use client codes rather than names where possible, keep registers under lock and key, and restrict access to sensitive data to ensure confidentiality.
- Use simple paper-based or existing digital tools that local staff can maintain after project support ends.

3. Train staff and community teams in data quality and confidentiality

Rationale: To improve the accuracy, completeness and secure handling of data.

- Organise practical training on the revised tools for facility staff, data entry clerks, community health workers, peer educators and supervisors.
- Introduce monthly checks to review all project data.

- Designate one data focal person at facility level and another at community level for each site to provide ongoing support.

Recommendation 5: Rethink GBV services around a survivor-centred uptake strategy

Background: A survivor-centred approach places the survivor's safety, confidentiality, dignity, preferences, agency and well-being at the heart of service design and delivery. It reduces barriers to accessing care, avoids exposing survivors to further risk, and ensures non-judgemental, respectful and accessible support.

Proposed actions:

1. Map barriers to the uptake of GBV services and redesign entry points within existing SRH and community services

Rationale: To integrate GBV response into existing services in order to increase participation and create a routine that is easier to sustain.

- Carry out a rapid community assessment to understand why survivors may hesitate to seek care.
- Integrate confidential GBV support into existing services such as family planning, ANC, postnatal care, HIV/STI services, adolescent-friendly services and community outreach, in order to reduce stigma and encourage service uptake.
- Ensure confidential spaces at every service point to encourage participation.

2. Strengthen local capacity for survivor-centred first-line support

Rationale: To build a network of trusted people, including peer mentors, able to continue training new staff and community health workers even after the project ends.

- Train facility staff, community health workers, peer educators and supervisors in survivor-centred communication, confidentiality, informed consent, adolescent-friendly care and safe referral.
- Designate GBV/SRH focal persons at each facility and community site.
- Build a small pool of local trainers or peer mentors able to continue training new staff and community health workers after the project ends.

3. Use survivor feedback and community engagement to build trust and service uptake

- Create safe feedback channels, such as anonymous forms, private client interviews, or feedback through trusted women's or youth groups.
- Use community dialogues to address stigma, confidentiality concerns, harmful norms and misinformation about available services.
- Involve adolescents and young women in designing outreach messages and service approaches.

PROPOSED HANDOVER SEQUENCE

Phase 1: Joint diagnosis and transition design, 0–3 months

Carry out a sustainability readiness assessment, map all MSF-supported functions, cost recurrent activities, identify MSPP counterparts, and agree on the minimum package of services.

Phase 2: Co-management and capacity transfer, 3–12 months

Move to joint supervision, joint stock monitoring, joint referral audits, joint data review, and paired leadership for each major service area.

Phase 3: Gradual handover, 6–12 months

Hand over low-risk, stable functions first, such as routine ANC reporting, community outreach activities, standard supervision meetings and routine facility-level data review. Hand over higher-risk functions later, such as emergency referral and maternity, blood supply, neonatal emergency care and procurement.

Phase 4: Post-handover support, minimum 12 months

Maintain light-touch technical assistance, quarterly review meetings, targeted support for weak indicators, and contingency funds to address supply chain or security-related disruptions.

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Contributors

This report was written by Rosemary Tazinya Asong, Lisa Dona Bonhomme, Andrew Aoun, Priscilla Bokele and Angel M. Foster. All worked as external consultants affiliated with Cambridge Reproductive Health Consultants and the University of Ottawa.

This report was reviewed before finalisation by the evaluation reference group and the Stockholm Evaluation Unit (SEU).

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APPENDICES

APPENDIX 1 – TERMS OF REFERENCE

BACKGROUND AND EVALUATION

This section is based on a 2025 project document⁴. All sections in italics are direct extracts from that document.

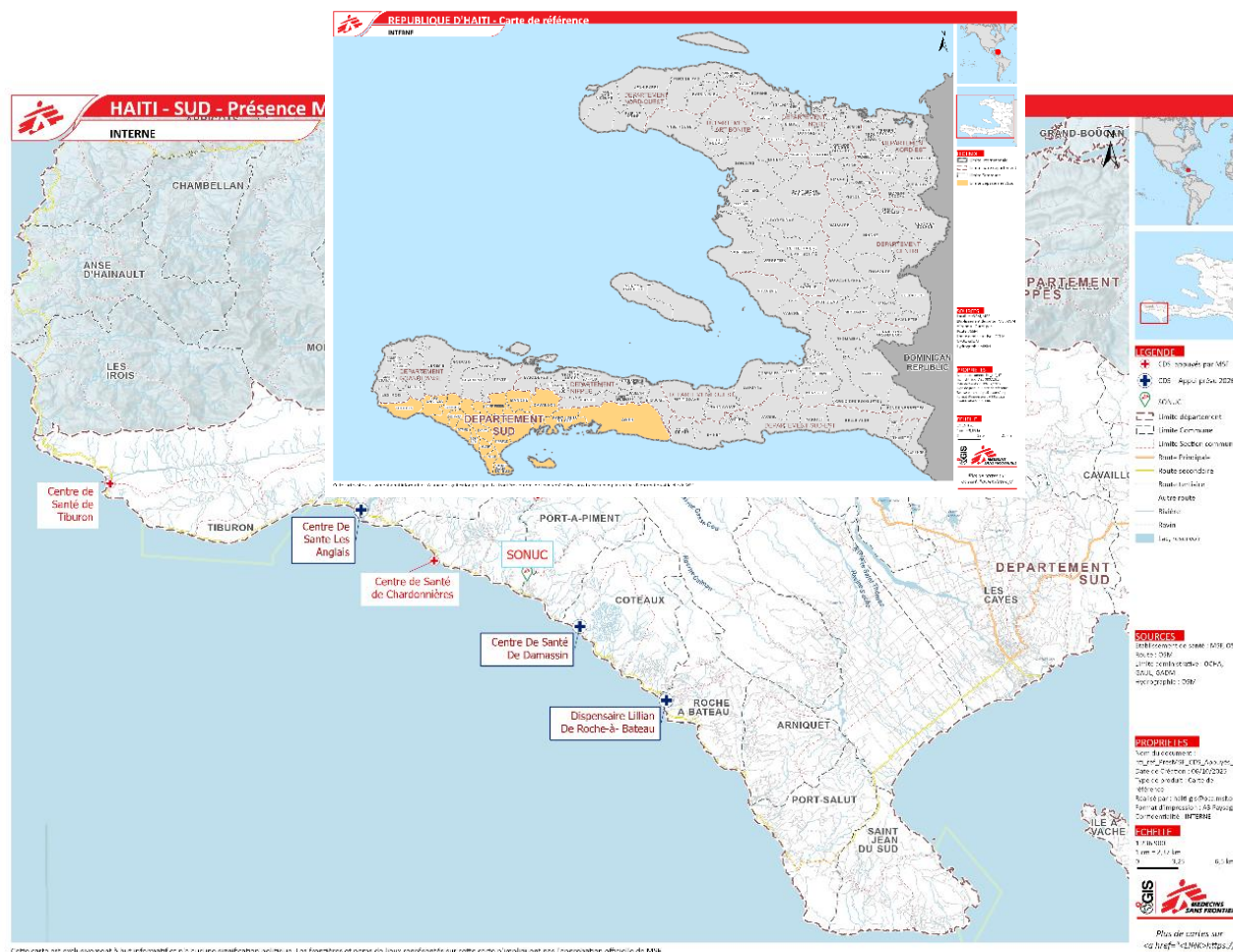
MSF-OCB began supporting the Port-à-Piment health centre in October 2016, following Hurricane Matthew, which severely affected the southern parts of Haiti. In February 2017, once the emergency was over, the regular Haiti mission took over the Port-à-Piment project, which included primary health care and water and sanitation activities in the community. Between 2018 and 2021, MSF supported three maternity units (basic emergency obstetric and newborn care (BEmONC)) as well as the maternity unit of Port-Salut hospital (comprehensive emergency obstetric and newborn care (CEmONC)). The August 2021 earthquake damaged the Port-à-Piment maternity unit, which had to be relocated. Construction of the new site was completed at the end of 2022, and MSF has run the CEmONC there since December 2022 (100% MSF).

The CEmONC has an operating theatre (OT) to manage caesarean sections and the capacity to respond to direct obstetric complications. The maternity unit also provides neonatal care and has an intensive care unit, the only one in the South department. In addition, MSF provides [...] decentralised support to three rural health centres (Rendel, Chardonnières, Tiburon) and will begin supporting a fourth centre (Les Anglais) and potentially even a fifth (to be confirmed) in 2026 with a full package to ensure that they can function as 24/7 BEmONC maternity units, identify complications and refer to the MSF CEmONC. MSF's support includes financial, human (capacity building) and logistical resources, including the rehabilitation of facilities for better access to water and improved infection prevention and control.

In terms of human resources, the project is implemented by around 10 MSF international mobile staff, 191 MSF local staff and 45 Ministry of Health employees receiving incentives paid by MSF. The budget for 2026 is around EUR 4.5 million.

The project is planned to run until 2027, after which it will be handed over to the Ministry of Health or other interested actors.

⁴ The information in this section is a translation of material presented in English in the project document "Project ID Card_Port-a-Piment_Haiti_HT159_OCB_Final_2025_EN"



The overall objective of the project is for women and girls of reproductive age and newborns in the target population to make timely use of quality essential primary sexual and reproductive health (SRH) services, and of obstetric and neonatal care, at the supported CEmONC and BEmONC facilities. To achieve this, the project has defined the following expected results (ER):

ER 1: Women/adolescent girls, families and communities in the project target area make timely decisions to seek medical care

ER 2: Quality basic emergency obstetric and newborn care (BEmONC) and primary SRH services (family planning, antenatal and postnatal consultations, CMR) are available at the four supported peripheral health centres, and the referral and counter-referral system is strengthened in the project target area

ER 3: Quality comprehensive emergency obstetric and newborn care (CEmONC) is available in Port-à-Piment, and the SRH capacity of health staff is strengthened

ER 4: Health authorities and humanitarian partners (NGOs, donors) are mobilised to ensure continued access to SRH care in the project target area, even after MSF's departure.⁵

⁵ This ER 4 appears only in the project's logical framework. (20251007_Logical Framework_PAPIM_2026_V2)

OVERALL OBJECTIVE AND INTENDED USE OF THE EVALUATION

The project team wishes to evaluate the results of the MSF SRH project in Port-à-Piment as of the end of 2025.

A second major element of the evaluation is to explore the prospects for the continuity of these results. MSF plans to leave the area at the end of 2027: in light of the handover to the MSPP or other partners, which activities can and should be maintained, and what adjustments should be made in the final phase of the project to prepare for an effective and responsible MSF exit?

The evaluation will be used by the project to optimise the final months of implementation and guide the handover to the MSPP. Beyond that, the evaluation will be useful to MSF and the MSPP in understanding the project's results and what did or did not work.

This evaluation could be followed by a second one in 2027, focusing on the final phase of the project. This will be discussed and confirmed later, also depending on the results of this evaluation.

EVALUATION QUESTIONS

1. What **changes in care-seeking behaviour** have occurred during the project, and which **conditions or interventions have been most critical** in enabling these changes to persist after MSF support ends?
 - What do CEmONC utilisation patterns reveal about **community recognition of complications and care-seeking pathways**, and **what needs to be and remain in place** to ensure that high-risk women receive appropriate care, including after MSF's departure?
 - Which **persistent barriers to facility-based care** has the project not yet overcome, and **which of these are likely to intensify** after MSF's departure without specific mitigation strategies?
2. Which **specific capacity improvements in the HCs** have proved most sustainable and most valued by communities, and what support will these facilities need to maintain service quality and patient trust after the transition?
3. Which foundational investments – such as community engagement approaches and capacity building – have created **self-reinforcing momentum** that will continue independently, and which investments remain **fragile** and dependent on continued external support?
4. **What has proved most and least effective in strengthening emergency and basic obstetric care**, and how can this information guide both MSF's intervention in the final phase of the project and the handover strategy and implementation in order to maximise post-MSF sustainability?
 - Which elements of the referral system depend on MSF's presence as opposed to local capacity, and which critical gaps or relationships need to be strengthened now, in particular to avoid any breakdown in referrals after MSF's withdrawal?
 - Which capacities can realistically be transferred to the MSPP or other actors given their current capacity and constraints, what will require continued external support, and what gaps does this reveal that need to be filled now or through alternative arrangements?
 - Which strategic pivots in MSF's remaining time would best enable the health system to sustain maternal health gains independently, and what would we most regret not having done before leaving?

5. **Which measurable indicators** at community and institutional level could indicate that the conditions for handover are in place, or that withdrawal is premature, and what should the contingency plan be if these conditions are not met by the planned departure date?
 - Which specific services, systems or support mechanisms represent the minimum viable infrastructure for access to SRH, and which early warning signs would indicate that these essential elements are deteriorating after handover?

EXPECTED OUTPUTS

1. Inception report in French

In line with SEU standards, following a preliminary review of documents and initial interviews with the reference group in particular. It will include a detailed evaluation proposal, including methodology and timeline.

2. Ongoing feedback

Ongoing feedback (arrangements to be proposed) to share observations with the project team and the reference group in real time. This is intended in particular to inform ongoing processes and make any adjustments deemed necessary, without waiting for the final evaluation report.

3. Working session

With the participation of the commissioner and members of the reference group. This session is an integral part of the process of writing the final report: the evaluator(s) will present the findings in order to gather participants' initial feedback and begin a discussion on them, the lessons learned and the recommendations (where applicable, and ideally generated collaboratively).

4. Final report in French (the SEU will arrange the English translation, checked by the evaluation team)

In line with SEU standards, it will answer the evaluation questions and include conclusions, lessons learned and any recommendations (where applicable, and ideally generated collaboratively; see Working session).

Finalisation of the report after addressing the feedback received during the working session and the written comments of the evaluation manager (SEU) and the reference group.

5. Presentation at a debriefing session with stakeholders at project level (MSF and MSPP at a minimum).

6. Webinar presenting the evaluation, followed by questions/answers and discussion

(audience: all MSF OCB staff, and beyond if deemed relevant). *Other dissemination activities may be suggested during the evaluation, including by the evaluation team.*

TOOLS AND METHODOLOGY

In addition to the proposal submitted during the selection process (see the Evaluator(s) profile section below), a detailed evaluation protocol must be prepared by the evaluators during the inception phase of the evaluation and presented in an inception report. It will include an explanation of the proposed methods and a justification based on validated theory or theories. This protocol will be reviewed and approved at the end of the inception phase, under the coordination of the SEU.

RECOMMENDED DOCUMENTATION

- Project documents (narratives, logframe, monthly and annual reports, organisational charts, presentations, visit reports, decision-making, etc.)
- Medical databases
- MSF sources (strategic orientations, operational priorities, protocols and policies, operational research, etc.)
- External literature, similar experiences, other actors, standards, etc.

APPENDIX 2 – LIST OF PARTICIPANTS INTERVIEWED

PARTICIPANT CATEGORY	NUMBER
Key informants – MSF	5
Key informants – MSPP	3
Key informants – Community	13
Health staff	15
Service users – in-depth interviews (3 adolescents, 1 man and 8 women)	12
Total	48

APPENDIX 3 – LIST OF DOCUMENTS REVIEWED

TITLE	YEAR
Memorandum of understanding on CEmONC/BEmONC activities at HC Port-à-Piment between the MSPP and MSF	2024
MOU MSF MSPP CDS Tiburon	2025
Collaboration protocol_MSf - MSPP_HC Chardonnières	2025
Collaboration protocol_MSf - MSPP_HC Rendel	2025
LogFrame_Haiti_Papim_VF_février 2025	2024 & 2025
PapimLogFrame_2024	2024
PaPim ARO 2025 presentation_17 October 2024	2024
PROJECT_DOCUMENT_PAPIM_ARO2024_FR	2024
Anthropo report Haiti Port a Piment 2023	2023
EVL_2026_PAPIM_PRE_ToR	2026
Visit report_MIO SRH_June 2025	2025
PROJECT DOCUMENT SRH Port-à-Piment	2026
Medical Strategy Narrative 2026	2026
PAPIM Actor Mapping 2025	2025
Evaluation of HCs South SRH	
Presentation _Haiti_Papim ARO 2026	2026
Project ID card_Port-a-Piment_Haiti	2025
MSPP Statistical Report	2022, 2023 & 2024

APPENDIX 4 – EVALUATION MATRIX

	EVALUATION QUESTION OR SUB-QUESTION	INDICATIVE OECD CRITERIA FOR JUDGING PERFORMANCE	THEORETICAL FRAMEWORK	SOURCE(S) OF EVIDENCE	ANALYTICAL APPROACH(ES)
1	What changes in care-seeking behaviour “appear” to have occurred during the project, and which conditions or interventions have been most critical in enabling these changes to persist after MSF support ends?	Effectiveness	COM-B model and PRECEDE – phase 3 (educational and ecological diagnosis)	- Routine project data on interventions and their use - Client exit survey - In-depth interviews with clients	- Trend analysis - Thematic analysis of qualitative data
1a	What do CEmONC utilisation patterns reveal about community recognition of complications and care-seeking pathways, and what needs to be and remain in place to ensure that high-risk women receive appropriate care, including after MSF’s departure?	Effectiveness and impact	COM-B model and PROCEED phase 7 – impact evaluation	- Routine project data on referrals (pathways, indications and timing) - Key informant interviews (community staff and BEmONC sites) - Exit survey and in-depth interviews	- Descriptive and comparative analysis of quantitative data - Thematic analysis of qualitative data
1b	Which persistent barriers to facility-based care has the project not yet overcome, and which of these are likely to intensify after MSF’s departure without specific mitigation strategies?	Effectiveness and sustainability	Socio-ecological model and PROCEED phase 8 – outcome and sustainability evaluation	- Client exit survey and in-depth interviews - Interviews with key MSF and MSPP stakeholders	- Descriptive statistics – Thematic analysis
2	Which specific improvements in HC capacity have proved most sustainable and most valued by communities, and what support will these facilities need to maintain service	Relevance, coherence and sustainability	COM-B model, PRECEDE phase 1 (social and epidemiologic al diagnosis) and phase 8 (outcome and	- Routine project data on trends in service use - Exit survey and in-depth interviews	- Descriptive statistics and comparative analysis - Thematic analysis

	EVALUATION QUESTION OR SUB-QUESTION	INDICATIVE OECD CRITERIA FOR JUDGING PERFORMANCE	THEORETICAL FRAMEWORK	SOURCE(S) OF EVIDENCE	ANALYTICAL APPROACH(ES)
	quality and patient trust after the transition?		sustainability evaluation)	- Interviews with HC-level stakeholders	
3	Which foundational investments – such as community engagement approaches and capacity building – have created self-reinforcing momentum that will continue independently, and which investments remain fragile and dependent on continued external support?	Impact and sustainability	PROCEED phase 8 – outcome and sustainability evaluation	- Mapping of project services and resources (inputs vs outputs), including human resources, costs and services provided (transport, training, etc.) - Secondary data analysis - Stakeholder interviews - In-depth interviews with users	- Descriptive statistics and trend analysis - Gap analysis - Analysis of dependencies and linkages between services - Thematic analysis
4	What has proved most and least effective in strengthening emergency and basic obstetric care, and how can this information guide both MSF's intervention in the final phase of the project and the handover strategy and implementation in order to maximise post-MSF sustainability?	Effectiveness and sustainability	SEM and PROCEED phases 6, 7 and 8 (process, impact and outcome evaluation)	- Routine project data to assess outcomes over time - Document review of audits (e.g. maternal death audits), clinical records, medicine stock registers, etc. - Stakeholder interviews	- Descriptive statistics and comparative analysis - Thematic analysis
4a	Which elements of the referral system depend on MSF's presence as opposed to local capacity, and which critical gaps or relationships need to be strengthened now, in particular to avoid any breakdown in	Effectiveness and sustainability	PROCEED phases 5 and 6 – implementation and process evaluation	- Service mapping to identify all resources involved in referrals (human, economic and material) - Key informant interviews to	- Service gap analysis - Analysis of dependencies and linkages between services – Thematic analysis

	EVALUATION QUESTION OR SUB-QUESTION	INDICATIVE OECD CRITERIA FOR JUDGING PERFORMANCE	THEORETICAL FRAMEWORK	SOURCE(S) OF EVIDENCE	ANALYTICAL APPROACH(ES)
	referrals after MSF's withdrawal?			identify MSF-dependent or sustainable resources	
4b	Which capacities can realistically be transferred to the MSPP or other actors given their current capacity and constraints, what will require continued external support, and what gaps does this reveal that need to be filled now or through alternative arrangements?	Sustainability	PROCEED phase 8 – outcome and sustainability evaluation	- Routine project data – Stakeholder interviews	- Descriptive statistics and comparative analysis - Thematic analysis
4c	Which strategic pivots in MSF's remaining time would best enable the health system to sustain maternal health gains independently, and what would we most regret not having done before leaving?	Effectiveness and sustainability	PRECEDE phase 4 – administrative and policy diagnosis and intervention alignment	- Routine project data to assess outcomes over time - Exit survey and in-depth interviews - Stakeholder interviews	- Descriptive statistics and comparative analysis - Thematic analysis
5	Which measurable indicators at community and institutional level could indicate that the conditions for handover are in place, or that withdrawal is premature, and what should the contingency plan be if these conditions are not met by the planned departure date?	Efficiency, coherence and sustainability	COM-B model and PRECEDE phase 4 – administrative and policy diagnosis	- Routine project data to assess outcomes over time - Exit survey and in-depth interviews - Stakeholder interviews	- Comparative analysis – Thematic analysis
5a	Which specific services, systems or support mechanisms represent the minimum viable infrastructure	Coherence and sustainability	PRECEDE phases 1 and 2 (social and ecological diagnosis) and	- Document review of relevant project documents (including the	- Gap analysis - Cross-checking of information from the document

	EVALUATION QUESTION OR SUB-QUESTION	INDICATIVE OECD CRITERIA FOR JUDGING PERFORMANCE	THEORETICAL FRAMEWORK	SOURCE(S) OF EVIDENCE	ANALYTICAL APPROACH(ES)
	for access to SRH, and which early warning signs would indicate that these essential elements are deteriorating after handover?		phase 8 (outcome and sustainability evaluation)	memorandum of understanding on task transfer, cost of services, etc.) – Interviews with MSF and MSPP stakeholders	review and interviews

APPENDIX 5 – PROGRAMMATIC COST ASSESSMENT

SERVICES	2022 (%)	2023 (%)	2024 (%)	2025 (%)
1. Personnel time				
Salaries of Domestic Staff	1.38	4.08	4.99	4.56
Sal. Coord/Admin Staff	1.45	1.01	1.34	1.50
Salaries Medical Staff	1.20	2.77	3.31	3.75
Salaries of Paramedical Staff	16.28	28.39	30.66	31.13
Salaries Supply Staff	1.03	1.71	1.52	1.51
Salaries Logistic Support Staff	10.91	10.85	11.61	11.79
Daily Workers (Non Moh, Non-Incentive)	0.23	0.29	0.82	1.26
Professional independent Services	0.00	0.00	0.00	0.03
Other Professional Services	0.01	0.03	0.03	0.00
Daily Tariff (Rac)	15.61	12.68	11.80	11.52
Per Diem	1.85	1.50	0.91	0.00
Per diem for Expats	0.00	0.00	0.40	1.32
Other Non-Taxable Allowances & Benefits	0.12	0.05	0.06	0.00
Other non-taxable allowances and benefits for national staff	0.00	0.00	0.06	0.28
Other Expat Benefits	0.00	0.00	0.00	0.01
Health Costs	0.00	0.00	0.24	0.70
Health Costs	0.73	0.64	0.47	0.00
Insurance medical cost	0.00	0.00	0.00	0.06
Training Costs For Msf Staff (External, Tuition, Trainer...)	0.07	0.00	0.00	0.01
Severance Pay	0.00	0.00	0.04	0.43
Severance Pay	0.14	0.09	0.04	0.00
Incentives To Moh	2.22	1.40	1.04	0.00
Incentives to partner agencies	0.00	0.00	0.39	1.74
Subtotal	53.22	65.49	69.74	71.59
2. Travel costs				
International Travel	3.30	2.32	3.01	2.53
Domestic Flight (Capital/Project)	0.35	0.76	0.66	0.79
National travel	0.00	0.00	0.16	0.58
International Flight By Air	2.75	2.02	2.26	0.94
International freight by Sea or by Road	0.00	0.00	0.04	0.37

SERVICES	2022 (%)	2023 (%)	2024 (%)	2025 (%)
Other International Freight	0.98	0.32	0.02	0.00
Local Customs & Clearance Costs	1.75	0.56	0.40	0.25
Vehicles Or Other Means Of Transport	0.00	0.66	0.00	0.00
Vehicles Or Other Means Of Transport	0.00	0.00	0.00	0.00
Fuel	2.30	2.01	3.06	2.95
Spare Parts Vehicles	1.43	0.63	0.44	0.14
Maintenance and reparation of vehicles	0.00	0.00	0.01	0.17
Maintenance Of Vehicles	0.03	0.03	0.01	0.00
Subtotal	12.88	9.32	10.08	8.72
3. Cost of space and utilities				
Premises, Land Rentals, and Hotels	5.01	4.25	3.61	0.00
Rental of land, premises and hotels	0.00	0.30	0.96	3.73
Maintenance Of Premises	0.48	0.13	0.00	0.36
Utilities & Other Energy Consumables	0.25	0.17	0.22	0.13
Satellite & Internet	0.40	0.99	0.26	0.31
Mobile, Land Lines & Postage	0.44	0.80	0.73	0.66
Rental Equipment	0.02	0.16	0.01	0.00
Rental Vehicle	0.02	0.03	0.05	0.00
Insurance Of Vehicles	0.01	0.01	0.01	0.02
Subtotal	6.19	6.83	5.86	5.22
4. Supply, material and equipment				
A. consumables (variable costs)				
Medicines	4.08	1.62	2.77	2.28
Vaccines	0.09	0.08	0.09	0.10
Medical Kits	0.30	0.09	0.03	0.00
Therapeutic Food	0.08	0.02	0.03	0.07
Laboratory: Consumables And Small Material	1.87	0.59	0.84	0.00
Laboratory: Consumables And Small Material And Tests	0.00	0.00	0.15	1.14
Other Medical: Consumables And Small Material	0.97	1.47	1.16	1.54
Medical Consultation & Referrals	2.22	0.43	1.10	0.16
Medical External Diagnostic Tests	0.12	0.01	0.00	0.00

SERVICES	2022 (%)	2023 (%)	2024 (%)	2025 (%)
Water Hygiene And Sanitation Material (Wash)	1.14	0.74	1.09	1.44
Food & Drinks (All kinds of food, other than therapeutic)	0.00	0.00	0.43	1.72
Food Non Therapeutic	1.27	1.60	0.89	0.00
Non-Food Relief Items (Nfi)	0.24	0.17	0.23	0.00
Relief items for beneficiaries	0.00	0.00	0.00	0.03
Temporary Shelter	0.00	0.02	0.02	0.02
Other supplies: durable & consumables	0.00	0.00	0.65	2.06
Supplies, Stationary And Other Consumables	3.72	2.08	0.98	0.00
Hygiene & cleaning products	0.00	0.00	0.33	1.62
Hygiene & cleaning products, Linen, mosquito & bed nets	1.63	1.42	0.28	0.00
Construction And Rehabilitation Material	0.39	1.05	0.86	0.65
Subtotal	18.13	11.39	11.96	12.81
B. Equipment and capital items (fixed costs)				
Medical Equipment (Incl Spare Parts)	3.69	1.48	0.31	0.58
Laboratory Equipment (Incl Spare Parts)	0.62	0.29	0.21	0.02
Cold Chain Equipment (Incl Spare Parts)	0.05	0.39	0.31	0.00
Water Hygiene And Sanitation Equipment (Wash) (Incl Spare Parts)	0.40	0.36	0.14	0.09
Construction Equipment And Tools (Incl Spare Parts)	0.17	0.51	0.04	0.00
Construction Tools (Incl Spare Parts)	0.00	0.00	0.04	0.11
It, Office Equipment (Including Spare Parts)	0.29	0.83	0.22	0.27
Telecom Equipment (Including Spare Parts)	0.94	2.30	0.11	0.15
Furniture And Small Household Equipment	1.99	0.18	0.54	0.29
Spare Parts Vehicles	1.43	0.63	0.44	0.14
Subtotal	9.58	6.98	2.36	1.66

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