

EVALUATION

MSF SEXUAL AND REPRODUCTIVE HEALTH PROJECT

in Port-à-Piment, Haiti

SUMMARY REPORT

OCTOBER 2026

This publication was commissioned by Médecins Sans Frontières (MSF) – Operational Centre Brussels (OCB) under the management of the Stockholm Evaluation Unit (SEU).

It presents a summary based on the full evaluation report. Readers are invited to refer to that report for further details and a more accurate reflection of the nuances and wording intended by the evaluation team.

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All evaluators engaged by the SEU are required to adhere to the SEU's ethical guidelines.

DISCLAIMER

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

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.

The overall objective of the project 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 Ministry of Public Health and Population (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 polyvalent community health workers, in collaboration with traditional birth attendants (matrones) and community referral committees, under the supervision of MSF health promotion staff.

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, polyvalent community health workers 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 (family planning, 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.

The schematic theory of change (TOC) in the annex sets out the project's overall objectives, activities and outcomes. For the purposes of this evaluation, this model served as a roadmap for verifying whether processes had unfolded as planned, identifying where and why implementation had succeeded or failed, and explaining the results observed.

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. The consultants 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.

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.

FINDINGS AND DISCUSSION

RELEVANCE AND CONTRIBUTION TO ACCESS TO SERVICES

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. The reported increase in attendance at antenatal consultations 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. These findings are in line with international standards aimed at improving access and coverage, which are fundamental to both effectiveness and long-term sustainability.

ALIGNMENT WITH THE MSPP HEALTH SYSTEM ARCHITECTURE

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. 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.

CARE-SEEKING BEHAVIOUR

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 antenatal consultations reflects persistent gaps in risk perception, community awareness, trust and understanding of the value of preventive care. WHO recommends early and repeated antenatal contacts, with the first contact taking place in the first trimester, because early antenatal consultations provide opportunities to identify risks, provide counselling, prevent complications and direct women to appropriate care.

PERCEIVED QUALITY AND GEOGRAPHIC DISTRIBUTION OF DEMAND

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. This pattern suggests that PaPim functions de facto as a regional referral hub, whether or not this was formally intended in the initial planning.

BARRIERS TO ACCESSING CARE

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, 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.

REFERRAL SYSTEM AND TRANSPORT

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. 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.

MATERNAL AND NEONATAL MORTALITY AND DATA AVAILABILITY

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. Standardised data collection and audit systems, such as maternal and perinatal death surveillance and response, are essential for identifying preventable factors and improving quality of care.

GENDER-BASED VIOLENCE (GBV) SERVICES

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. **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. WHO guidelines emphasise the importance of standardised, survivor-centred clinical care and clear referral pathways for improving access to and quality of GBV services.

SUPPLY CHAIN

Supply chain weaknesses also undermine the project's effectiveness and efficiency. **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. Under the WHO health system building blocks, reliable access to essential medicines is fundamental to system performance. Standardised procurement, stock management and forecasting systems are essential for sustainability, particularly in fragile settings where supply disruptions are frequent. Strengthening these systems within MSPP structures is essential to reduce dependence on external support.

COSTS AND DEPENDENCE ON MSF

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.

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

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. Addressing these gaps requires standardised, adolescent-friendly service delivery models that ensure confidentiality and accessibility and respond adequately to gender and power dynamics.

SUMMARY: READINESS FOR HANDOVER

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. 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.

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.

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.

RECOMMENDATIONS

The full set of recommendations is detailed in the evaluation report. A summary is presented below:

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. **Improve and strengthen community activities** to integrate treatment services and adolescent-friendly approaches, in particular by involving adolescent peer educators and training 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.

> 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.

ANNEX 1

PAPIM PROJECT THEORY OF CHANGE

