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ISN=34454

EVALUATION

OF THE

HAITI RURAL HEALTH DELIVERY SYSTEM PROJECT

(RHDS)

Port-au-Prince, Haiti

March 10, 1983

Prepared by:

Nils M.P. Daulaire, M.D., M.P.H.

Mary E. Taylor, M.H.S.

Robert G. A. Boland, M.D., M.P.H.

M. Kristine Olsen, B.A.

Michael F. Davies, M.A.

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ACKNOWLEDGEMENT

An evaluation such as this, in which a team of five consultants descends on a project for four hectic weeks, puts significant stresses on the recipients of this attention. The evaluation team would like to thank all those whose schedules were disturbed, who were subjected to seemingly endless questions, and who nonetheless provided great assistance during the process of the evaluation.

We would particularly like to thank Paul Hartenberger of the Public Health Office in the AID Haiti Mission. His tireless enthusiasm and interest in the evaluation process provided both information and motivation to the team.

We appreciate the interest and concern expressed by Dr. Ary Bordes, Director General of the DSPP, in the potential of the evaluation process for producing practical recommendations. We hope we have lived up to his wishes.

And finally, we would like to express our gratitude to Dr. Jon Rohde, Chief of Party for the MSH technical assistance team, for unfailingly providing us with any and all information, at virtually any hour that it was requested.

We feel the RHDS project is fortunate in having individuals like this who take such an interest in its success. We hope this report will be both useful for them and able to stimulate further interest in others.

ABBREVIATIONS

RHDS	Rural Health Delivery System
DSPP	Department of Public Health and Population
MSH	Management Sciences for Health
BHPE	Bureau of Health Planning and Evaluation (DSPP)
AGAPOC	Community Pharmacy Drug Supply Agency
CP's	Conditions Precedent
HUEH	Haiti State University Hospital (DSPP)
DON	Directorate of Nutrition (DSPP)
SNEM	National Service for Endemic Diseases Control (Malaria)
PVO	Private Voluntary Organizations
AOPS	Association of Private Health Organizations
PP	Project Paper
UNICEF	United Nations Children's Fund
DFP	Directorate of Family Hygiene (DSPP)
GCH	Government of Haiti
PAHO	Pan American Health Organization
APFUI	Institutional Salary Supplements
IDB	International Development Bank
UNESCO	United Nations Educational Scientific Cultural Organization
DSI	Directorate of Nursing Care (DSPP)
SEMP	Medical and Paramedical Training Section (DSPP)
WHO	World Health Organization
DG	Director General
DEP	Directorate of Public Hygiene
ODVA	Office for the Development of Artibonite Valley
CHREPROF	Haitian Research Center for Feminine Promotion
ONAAC	National Office of Literacy Community Action
DARNDR	Ministry of Agriculture Natural Resources and Rural Development

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HHS PROJECT EVALUATION REPORT

SECTION I

OVERALL PROJECT REVIEW AND EVALUATION

I.A SUMMARY AND MAJOR RECOMMENDATIONS

An evaluation of the Haiti Rural Health Delivery System (RHDS) Project was carried out by a team of five independent public health specialists. This evaluation took place in February 1983, three and a half years after the signing of the Project Agreement between AID and the Department of Public Health and Population (DSPP). It was intended to determine progress toward the project goal of improved health status for rural Haitians, and the project purposes of health services coverage for 70% of the rural populace and reinforcement of DSPP systems needed to support these services.

The RHDS project was found to have been too ambitious and unrealistic in its original design. It presupposed the existence of administrative capacities within the DSPP which did not exist. It also assumed a capacity for expansion and support which was and is beyond the financial and human means of the DSPP.

Viewed in light of these realities, the RHDS project has in fact accomplished substantial progress. More than 550 health agents and 350 auxiliary nurses have been trained and deployed; 51 rural dispensaries have been, or are in the process of being, renovated or built. Principal technical assistance efforts have been directed at policymaking and the development of DSPP management capabilities, with slow but steady progress apparent.

However, it is clear that the goal of improved health status has not yet been measurably realized; that the purpose of 70% rural coverage cannot and should not be achieved within the period of this project because of the certainty of outstripping the support capabilities of the DSPP; and that the strengthening of administrative capabilities needs to be more precisely defined. The goal is appropriate and deserves continued attention, but with a longer time horizon. The 70% coverage should be revised downward to 40%, including private coverage. DSPP administrative strengthening should continue to be the principal focus of activities.

The RHDS project, within recommended revisions, deserves ongoing support from AID. The overall approach to rural services being developed is more likely to

instigation of DSPP leadership, and without the active involvement of the Bureau of Health Planning and Evaluation (BHPE). The DSPP must internally strengthen the BHPE before technical assistance there can be useful.

In management and administration, a major project accomplishment is the creation of AGAPCO, which has begun to supply drugs to community pharmacies. AGAPCO does not yet have the managerial competency necessary for freestanding operations; full-time technical assistance and careful ongoing attention by DSPP and AID are a top priority to keep this important program from going off the track. In other administrative areas, there has been more progress in developing systems on paper than there has been in implementing them. Focus of the next several years of the project must be on applying these systems in support of DSPP health priorities; the nutrition program is an excellent potential test case, and should receive major attention.

In finance, it is clear that the DSPP is not capable of supporting ongoing operating costs of the RHDS project. Consideration must be given to the fact that although the DSPP receives an unusually high proportion of the national budget (15%), its resources are still less than \$3 per capita. While a good deal could be done to improve its efficiency, it must be recognized that the DSPP is underfunded in an absolute sense, and will be forced to rely on external donor assistance for the intermediate term (10 year horizon). The RHDS project, therefore, should halt current expansion of coverage to give time to develop strategies for increasing self-sufficiency. Assistance in the management of project finances should be encouraged to reduce the current serious delays which have hindered progress; computer applications may have substantial benefit.

In information systems, the DSPP is currently collecting an excess of undigestible and unusable information. The focus needs to be on simplification of systems to permit the timely collection of the bare minimum of information necessary for monitoring and decision-making. Priority health information should relate directly to the DSPP's six health priorities. Management information needs to focus on effective activities; while a number of these systems are in place, DSPP leadership must show the political will to

use them and act on them if they are to be of any practical value. Technical assistance in the area of computer application as well as in data needs assessment and analysis are called for.

In the area of training and manpower development, most work in the project to date has been done in curriculum design. The modules developed for health agent training are useful and appropriate. The project called for activities in too many training areas, which has led to dissipated efforts; in the near term the focus should be on evaluation of materials and methodologies already developed to determine their appropriateness to the field situation. Plans should also be developed by the DSPP, possibly with technical assistance, to increasingly involve the Bureau of Nursing in rural training and supervision activities. Manpower planning is an important need, but is unlikely to be accomplished without prior significant strengthening of EHPE; this is a necessary prior condition to useful technical assistance in this area.

I.B BACKGROUND PURPOSE AND PROCESS OF MID-TERM EVALUATION

The RHDS Project Agreement signed on June 29, 1979 called for an independent evaluation to be carried out after 18 months and subsequent evaluations at 12-months intervals thereafter. This first RHDS evaluation comes two years later than originally scheduled, with just over two years left prior to project completion, and less than nine months remaining on the current technical assistance contract.

The purpose of this evaluation was to determine the extent to which the objectives of the RHDS project have been achieved and to provide recommendations for the continued implementation of the project. The emphasis was to be on identifying ways in which the project could be adjusted to achieve optimum health services coverage and health impact, while developing the institutional and financial capacity to sustain these services.

The evaluation team consisted of five public health professionals. The Team Leader was Dr. Nils Daulaire, a public health physician who is Medical Director of Rural Health Associates, an international health consulting firm based in Vermont; he is a Visiting Professor of Community and Family Medicine at Dartmouth Medical School, and specializes in international primary health care. The Public Health Management Specialist was Ms. Mary Taylor, Executive Director of Rural Health Associates and an Instructor of Community and Family Medicine at Dartmouth Medical School; her area of specialty is public health systems planning and management, with special emphasis on health systems in developing countries. The Financial Analysis Specialist was Dr. Robert Boland, a public health physician with extensive training and experience in finance, accounting, and management; he has been active for over ten years in international consulting for government, business and United Nations organizations. The Information Systems Specialist was Ms. Kristine Olsen, a survey statistician working for the International Statistical Programs Center of the U.S. Census Bureau; she has served as an advisor in the design and implementation of AID project monitoring and evaluation activities in Sudan and Indonesia. The Training and Manpower Specialist was Mr. Michael Davies,

an associate of the African Studies Center at UCLA; he has worked in community organization and training of public health personnel for more than five years in West and Central Africa as well as in the Southwestern U.S.

Starting in early February 1983, the evaluation team spent four weeks in Haiti, researching and preparing this report. Interviews were conducted with a wide range of DSPP, AID, MSH and other personnel (See Annex IIIA 1); institutions and project sites were visited in a number of areas around the country (See Annex III A 2); and a substantial quantity of project and related documentation was reviewed (See Annex III A 3). The evaluation team held regular meetings to coordinate their approach and findings, as well as frequently seeking out DSPP, AID and MSH feedback for specific findings and tentative recommendations.

Because of the magnitude and scope of the RHDS project, it was impossible for the team to examine every aspect of project functioning in the short time available. Emphasis was placed on consideration of priority issues, and on the development of practical short and intermediate term recommendations.

This report represents the clear consensus of the five team members. A remarkable degree of unanimity was developed concerning the themes considered most important, as well as the major points of recommendation. The team greatly appreciates the cooperation of all parties involved in making this possible; any errors or omissions are fully accepted as the team's responsibility, and in no way reflects the work of others.

I.C REVIEW OF PROJECT DESIGN, PROGRESS, AND RECOMMENDED CHANGES

The RHDS project was designed as an ambitious, all-inclusive approach to health care services for the rural poor of Haiti. It planned virtually complete health coverage for 70% of the rural population, or 3.5 million people, using a cadre of 1500 newly trained agents de sante, backed up by 550 auxiliary nurses working out of newly constructed or renovated rural dispensaries.

These rural workers were to be supported by an efficient DGPP management structure, integrating all existing vertical health programs, while at the same time decentralizing decisionmaking to anticipated regional and district administrative units. At the end of the project period, the government of Haiti was to be able to support all the operating costs of this system.

This design did not take into consideration the realities and limitations of the Haitian situation. It assumed a capacity for rapid and radical institutional change, the existence of trained, skilled and motivated managers, and the availability of adequate governmental financial resources to pay for the recurring costs of this system. These assumptions were overly optimistic, and the RHDS project must be seen in light of revised expectations.

The long term goal of the project, as defined in the Detailed Project Description of the Project Agreement, is to improve significantly the health status of Haiti's rural poor, as measured by decreased rates of morbidity, mortality and malnutrition, and by reduced birth rates. This is appropriate, and should be maintained as the underlying project goal.

While no detailed nationwide health survey was conducted as part of this evaluation, as would be necessary to document any change in health status, it seemed quite clear to the evaluation team that the RHDS project has not had a significant impact on overall national health status up to this point. It is our opinion that it has the potential for demonstrating such an impact in the intermediate term (5 to 10 years), and that impact may be demonstrated in limited target areas in another two to four years.

In order to reach this improved health status goal, the RHDS project has two primary purposes. The first is to provide access to basic preventive and curative medical services to up to 70% of the rural population by the end of the project. The second is to improve the administrative and support capacities of the DSPP in order to fully supply, maintain, and oversee these rural services. The original project design significantly underestimated the complexity of achieving both these purposes.

In terms of rural access, the project to date in phases I and II has built or renovated 8 rural dispensaries, with another 43 in progress. Approximately 550 health agents have been trained or retrained, and about 350 auxiliary nurses trained and posted to rural areas. Given the rate of progress to date, and the constraints outlined elsewhere in this report, it is doubtful that the 70% coverage target will be achieved by the end of the project.

Were it to be achieved, through the construction of more facilities and the training of more personnel, it is highly likely that the system would rapidly collapse because of a lack of adequate financial and managerial resources needed to support it. It will therefore be necessary to redefine this purpose to provide a more realistic target. A target coverage of 40% of the rural population, including coverage provided by private health institutions in coordination with the government, would better serve the long-term development of health services in Haiti.

The majority of effort under the RHDS project has in fact been directed toward the second purpose, that of improving DSPP administrative and support capacities. The task here has been substantially more difficult than was foreseen in the Project Paper. At the beginning of the project there was virtually no existing capacity in the DSPP to manage and operate a rural health delivery system, and very little understanding of what this would actually require.

In the opinion of the evaluation team, the emphasis which has been given in project implementation to strengthening DSPP structures has been necessary. Progress has been slow, but has clearly taken place. Within the context of

activities aimed at the six major health priorities defined by the DSPP, continued reinforcement of DSPP management and support capabilities should remain a principal project purpose for the remainder of this project, and preferably for the next five to eight years.

In summary, within the terms of the Project Agreement, the project should be revised to reflect more realistic intermediate outputs. The long range goal should remain the improvement of health status among rural Haitians. However, project services expansion should be slowed or halted to permit the necessary support services to catch up to current demands.

Clearer definition of expected DSPP administrative developments (as described in later sections of this report) should be a primary focus of ongoing project activities. All administrative development should be targeted toward anticipated impact on the six DSPP health priorities in order to concentrate on appropriate and effective activities. The strengthening of these targeted administrative systems should be the principal project purpose over the next two years.

The necessary inputs to accomplish this purpose are detailed in Section II. Specific recommendations for necessary ongoing technical assistance are found in Section IE.

I.D STATUS OF CONDITIONS AND COVENANTS

In lieu of detailed project planning and a defined set of graduated intermediate outcomes, the RHDS Project Agreement establishes an extensive list of Conditions Precedent to Disbursement. These CP's are reviewed in detail in Annex III A 4.

In summary, some of the CP's have been met but many have not. Project disbursement has continued notwithstanding. The evaluation team feels that it is appropriate that the CP's have been less than rigorously enforced by AID. The failure to comply with some of the CP's does not reflect an unwillingness of the DSPP to adhere to the conditions as much as it does an inability to meet some of the terms set out. This again reflects the general administrative weakness of the DSPP, which this project has set out to improve rather than punish.

We recommend a full renegotiation of CP's in light of current realities and the experience in the project to date. This would assist the DSPP in defining which conditions are most immediately necessary for accountability, which are of priority for the development of functional administrative systems, and which are desirable for short and long term improvements in operations. Such revisions would also assist AID by reducing the quantity of futile paperwork which policing unachievable CP's entails.

The first Special Covenant in the Project Agreement relates to project evaluation, which this evaluation fulfills. The covenant relating to utilization of equipment and materials is more appropriate for audit consideration, and was not dealt with here. The third covenant, relating to post-project support of ongoing community health services activities by the DSPP is dealt with in the Financial Analysis section of this report, and is at present time clearly unattainable. This covenant will require reconsideration in light of revised output targets and related financial projections.

I B. TECHNICAL ASSISTANCE

In overall terms, the technical assistance provided to the RHDS project by MSH has been of high quality, generally appropriate, and has made a substantial contribution to the progress which has taken place. The evaluation team recommends the continuation of the MSH technical assistance contract.

Backstopping for the TA team by MSH/Boston has been good. Overall management of the MSH contract was not carefully considered in this evaluation, but appears to have been satisfactory.

MSH has had an extremely large long-term technical assistance team in Haiti, with as many as nine full-time consultants here at one time. This was due to the broad scope of the original RHDS project design, and its concomitant requirements for a very wide range of technical assistance. Given the completion of a number of these tasks and the recommendations made elsewhere in this report for focusing the project, the team size can be reduced in the future without jeopardizing project accomplishments. However, the termination of all elements of the technical assistance contract as planned for November 1983 would jeopardize the sustainability of project efforts to date.

Note should be made of the dilemma faced by the MSH team in the RHDS project. During the course of this evaluation, criticism was voiced from individuals in the DSPP because some members of the MSH team were seen as taking too much of an executive rather than advisory role; counterbalancing criticism came from AID, which felt that MSH at times did not accept sufficient responsibility for implementing the activities it was helping to design. This criticism was far outweighed by the generally good working relationship that MSH has established with both the DSPP and AID, but the dilemma remains. To some degree it is unavoidable in the nature of a TA contract, but there are a number of clarifications which might help to minimize it:

1. TA is responsible for maximum effort in carrying through the implementation of recommended activities in close cooperation with DSPP counterparts. This implies that:

a. Recommendations are practical, attainable, and appropriate to the Haitian context;

b. The DSPP assigns capable counterparts who will actually be responsible for implementation, and these counterparts are willing to work with consultants.

2. TA is responsible for accurate and timely transmission of information regarding recommendations and plans to both DSPP and AID.

3. TA is not responsible for policing the terms and conditions of the contract between DSPP and AID.

4. While TA is responsible for adhering to the terms of its own contract, it should involve DSPP to the greatest extent possible in defining ongoing TA needs, and if necessary should request modification of contract terms from AID.

There have been lapses in all of the above areas, but in general TA activities have been carried out with a high degree of sensitivity to host country needs and AID requirements. What is called for is simply refinement of this process.

Specific detailed discussion of technical assistance activities to date and recommendations for the future are found throughout Section II. Major points are summarized below:

1. The role of the Chief-of-Party should be redefined as Senior Health Policy Advisor. This role should be maintained for another two to three years. Increased attention should be paid to coordinating TA activities towards the priority targets defined by the DSPP.

2. There is a serious need in the RHDS project for a full-time Health Planning Advisor to the Bureau of Health Planning and Evaluation of the DSPP; there is no point in adding such a person at this time, however, pending a restructuring and strengthening of the BHPE as discussed in Section II A, and the assignment of a counterpart. It might be appropriate to consider bringing on a Health Planning Advisor in approximately one year. Three to four years of technical assistance would probably be needed.

3. Manpower planning and financial planning are beyond the current capacities of the BHPE. Short-term consultants in this area would be appropriate only for very specifically targeted needs. If the BHPE is strengthened, it would benefit from intermediate-term consultants. This is unlikely for the next year.

4. Technical assistance in management to the DSPP is a top priority for the near term and will continue to require a full-time consultant. However, tasks should be separated between systems development in support of DSPP health priorities and assistance in fulfilling AID requirements. The latter tasks should be carried out by a full-time contractor to AID rather than a member of a technical assistance team. AID should make arrangements for such a PSC within the next twelve months.

5. Continued support of AGAPCO by a full-time technical assistant will also be a top priority over at least the next twelve to eighteen months and should focus on issues of financial solvency and management capacity. Pending periodic reviews of AGAPCO financial and managerial capabilities, it may subsequently be possible to use repeated intermittent consultancies from a single individual.

6. A short-term consultant should be used for two to three months to conduct a crude time-flow analysis of DSPP sections in order to define the percentage of effort devoted to DSPP priority health targets. This consultancy would be desirable within the next six months as a baseline for future planning and resource allocation.

7. A short-term consultant could be used for two months to assist in the implementation of the supply distribution system; if this is done, it should begin prior to the arrival of the next major shipment of supplies.

8. Following an evaluation of the facilities maintenance activities in the South Region, assistance in this area should become the responsibility of the AID engineering section.

9. While the need for continued assistance in the development of a transport system is clear, it would be more appropriate to provide such assistance through a direct contract with AID. The transport advisor's role should be carefully defined to place emphasis on transport services in regions and districts rather than simply in Port-au-Prince.

10. The need for ongoing assistance to the DSPP in the area of finance is clear. Repeated short-term consultancies of a single financial specialist over the next two years would be desirable. Financial planning, as mentioned above, is probably at least a year away as a practical possibility. The use of the computer has great potential value, and will be discussed below. Discussions between DSPP, AID, and MSH should take place within the next two months to define areas where assistance would be feasible.

11. The value of a computer systems specialist in a diverse array of DSPP activities is apparent. Long-term technical assistance in computer systems will be needed for the next two years. This should be focussed on strategic planning and systems design, while actual programming and input should be turned over as rapidly as possible to Haitian counterparts. The need for an ordered and prioritized approach to systems development is of paramount importance for the continued contribution of the TA team, and should be a primary responsibility of this consultant. In addition to assisting with initial data needs assessment, the role of the computer as a financial accountability tool should continue to be expanded. The DSPP should be strongly encouraged to provide these counterparts at higher than a clerical level.

12. In cooperation with the computer specialist, technical assistance should be provided at this point in the design and analysis of information systems. An initial two month consultancy would be appropriate to define the needs and clarify the tasks of a long-term technical assistant in this area, who would optimally begin work before the end of 1983. This individual would initially work with the Statistics Section of the DSPP, but might transfer part of his role to the Evaluation Section of the BHPE if the recommended strengthening takes places.

13. Ongoing long-term technical assistance in training would be desirable for the remainder of 1983. This should be focused on follow-up of training activities and careful evaluation of procedures and materials developed to date; further curriculum development is of lower priority at this time.

14. Short-term technical assistance should be provided to the Bureau of Nursing for an initial one to two month period by a qualified nurse-trainer. Based on the result of this consultancy, decisions should be taken regarding ways to strengthen the Bureau of Nursing with respect to agents de sante and auxiliary nurse training and supervision.

RHDS PROJECT EVALUATION REPORT

SECTION II

COMPONENT REVIEW

II.A HEALTH POLICY AND PLANNING

1.0 Health Policy

1.1 General

The RHDS Project Paper and Project Agreement based many of the planned activities on the assumption that policy goals had been clearly established and accepted within the DSPP. This was in fact not the case, and much effort not anticipated in early project planning has been devoted to this end. A substantial portion of the technical assistance provided by the MSH Chief of Party has concentrated on the development of coordinated policy as the foundation of a nationwide rural health system. Due in good part to the existence of the RHDS project, the DSPP has recently taken a major stride towards this end with the adoption of "Nouvelle Orientation", and the elements of top-level commitment and a clarified direction hold great promise for progress in health services in the coming years.

1.2 Priority Health Targets

1. Summary of activities and current status

A review of documents put out by the DSPP over the past decade reveal a lack of clear policy coordination and direction. The approach taken was generally that of listing a long series of diseases which deserved attention, with emphasis often on such issues as diabetes, cancer and heart disease. Primary causes of mortality and morbidity in the Haitian milieu were often not accorded great emphasis.

Substantial effort by the RHDS technical assistance team, especially the Chief of Party, over the first two years of their contract was focused on generating information and awareness concerning priority health problems. Interest in these findings by the DSPP varied according to who were presently holding the positions of Secretary of State for Public Health and Director General of the DSPP. Thus, for largely political reasons, progress was slow.

The naming of Dr. Volvick Rémy Joseph as Secretary of State and Dr. Ary Bordes as Director General in the past year has occasioned a major advance in the pursuit of a clear health policy. In the "Nouvelle Orientation", the DSPP defines six major health priorities: family planning, nutrition, diarrheal disease, immunizable diseases, tuberculosis, and malaria. The analysis

underlying the selection of these six priorities is clear and appropriate, and the limitation of attention to a small and manageable number of issues is of critical importance. The DSPP should be applauded for this decision, and the RHDS project is in part responsible for it.

It is noteworthy from AID's standpoint that the choice of these six priorities is in excellent concert with the recently published AID Health Assistance Policy Paper (which, was published after the development of Nouvelle Orientation). An excellent opportunity now exists to see the effect of such policies on a national level.

2. Problems and Constraints

a. Newly established policy, no matter how clear its benefits from an objective standpoint, takes time to become institutionalized. A sudden change of leadership of the DSPP in the near future would threaten the survival of this policy.

b. Lower levels of the DSPP (including various bureau chiefs) have not yet accepted and applied these priorities. Failure to do so, or significant resistance by the DSPP bureaucracy, will threaten the usefulness of this policy.

c. By assigning each of these priority areas to one specific Direction or office, there is risk that DSPP as a whole will fail to assume "ownership" of the set of priorities (e.g., family planning is "just a program that the DHF is carrying out").

d. Current DSPP budgeting priorities are not in any clear way tied to these health priorities.

3. Recommendations

a. For AID: to the extent possible, current DSPP leadership should be supported to provide stability and continuity for the positive steps taken.

b. For DSPP:

i. The leadership must recognize that policy must be vigorously applied throughout the various technical and administrative branches and at all levels, which will require continuous attention and pressure for the near future; the simple statement of policy will not suffice to effect change. The Bureau of Health Planning and Evaluation, if significantly strengthened, has the potential for playing an important role in this coordination of effort. The DSPP should undertake, using the technical assistance available to it from MSH, a section by section study of the DSPP to determine the percentage of effort of each section devoted to the priority health issues. This would serve to inform DSPP leadership of where administrative attention should be focused and where possible cutbacks could be made; it would also underline the seriousness of the DSPP leadership in carrying through these priorities. This study would be most useful and effective if carried out in the next six months, while the Nouvelle Orientation is still fresh.

c. For MSH:

i. The Chief of Party must continue to devote attention to the areas of health policy, but should increasingly provide technical assistance in the area of implementation strategy development under the direction of the Director General. If the DSPP accepts the recommendations listed above, and if they request assistance, MSH should use the short-term assistance available to it from the Management Specialist to carry out the percentage of effort study; this would call for approximately three weeks of home-office preparation time and one to two months in Haiti to conduct the study.

1.3 Health Services Strategy

1. Summary of Activities and Current Status

The overriding design issue of the RHDS project according to the Project Paper and Project Agreement has been the extension of basic preventive and curative health services to 70% of the Haitian population who live in rural areas. The creation of a cadre of agents de santé was intended

as the principal contact point between the rural population and the government health system. The assistance provided to the DSPP centrally was intended to support this system.

Although the extension of rural services has been a stated priority policy of the DSPP for many years, consideration of actual DSPP activities gives a different impression. As discussed in other sections of this report, the great majority of material, personnel and financial resources of the DSPP are expended in Port-au-Prince and other urban centers. Where these resources are expended on health services, most are devoted to hospitals, with the bulk going to the Hôpital de l'Université de l'Etat d'Haiti (HUEH). This use of resources is justified as being necessary for a credible referral system.

What is apparent, then, is a stated centrifugal policy but a strongly centripetal orientation of the health system. The RHDS project was specifically called rural to counteract this reality, but initial project plans were extremely naive in their anticipation of rapid changes within the system. There is no doubt that a substantial portion of project support has benefitted central rather than peripheral interests. However, it is also clear that progress has been made, that there has been a gradually increase in awareness within the DSPP of the importance of rural services, and that the political will now exists at the highest level to bring reality in line with stated policy. This impression is supported by the promulgation of the Nouvelle Orientation as well as by the actual practice which has been initiated by DSPP leadership.

Credit must be given to the RHDS project for its contribution to this gradual shift of orientation. While the emphasis intended in initial project documents has not been realized, it is the strong impression of this evaluation team that a shift is in fact taking place, that this shift will have important long-term ramifications, and that it is as much as could realistically and optimistically be expected, given political counterpressures and the inertia of the system. The need is to reinforce this shift by appropriate incentives and disincentives rather than to criticize its tardiness.

2. Problems and Constraints

a. Significant resistance to these changes in focus continue to be manifest among personnel at all levels of the DSPP. In some cases this is due to a lack of awareness of the issues involved and in others to a conflict with perceived self-interest.

b. At this stage, the single most critical factor in the gradual implementation of this policy is the political will of the DSPP leadership; a change of leadership bringing different priorities before these changes are effectively institutionalized would have a high risk of nullifying progress which has been made.

c. A major internal and external counterforce, with considerable political power, rests with those whose orientation is towards the hospitals. At present, all inpatient services even in the districts, will tend to orient emphasis and resources towards the center - referrals for specialty care, ambulances to bring the sick from the periphery, the need for sophisticated and expensive technology, highly skilled and highly paid urban-dependent personnel. Given the extreme limitation of resources in Haiti, this tendency could rapidly destroy any system of rural outreach.

3. Recommendations

a. For AID:

i. While overly ambitious in terms of expectations, the underlying services strategy of the RHDS project is appropriate and should continue to be supported by AID, within the modifications recommended throughout this report.

ii. Positive reinforcement must be provided to current trends, primarily through support of DSPP leadership.

iii. Ongoing RHDS financial support should be provided in a more carefully targeted manner aimed specifically at providing and supporting rural services. Inpatient services at all levels and their related referral systems should be separated from current project support. Specific

recommendations for appropriate support are found in the following sections. Consideration should be given, as detailed in Section II C, to providing interim separate support for the DSPP functions not clearly related to rural health.

b. For DSPP:

i. Emphasis should be directed to getting a Phase III fully-functioning rural health delivery system implanted in one area (perhaps Cayes Sanitary District) within the next two years to serve as a model.

ii. Clear incentives and disincentives (such as vehicle use) should be provided to DSPP sections as well as district and regional administrations to encourage expanded rural outreach activities.

iii. Salary supplements should be tied specifically to rural activities over a one to two year phase-in period.

c. For MSI/DSPP

i. Technical assistance should be assigned to regional/district counterparts in addition to central DSPP counterparts in order to spend more time assisting in building peripheral level capacities.

ii. All long and short-term technical assistance should be reviewed to determine its potential contribution to a rural outreach system, and priority should be given to assistance most likely to contribute specifically to that system.

1.4. Regionalization

In support of increased rural outreach, the Project Paper called for an acceleration of the regionalization process. This has proceeded with the recent establishment of the West and Transversal Regions in addition to the already existing South and North Regions. A technically useful report on regionalization administrative issues was prepared by MSH consultant Paul Torrens, and a start has been made on providing management and planning assistance to regional district leadership. But the RHDS project has had relatively little impact on the pace of regionalization.

Regionalization does seem to be a reasonable strategy from the standpoint of improving rural services, but the issue was not dealt with at length in this evaluation. Further discussion of its administrative ramifications is found in Section II B, and of training issues in Section II E.

1.5 Integration

1. Current Status

Integration of DHF, SNEM, and DCN into the DSPP is listed as a condition precedent to disbursement subsequent to year two in the Project Agreement (Section 4.8), and is a stated policy of the DSPP. Nonetheless, DHF and SNEM have remained largely separate and pressure for integration, both from the AID and DSPP side, has remained minimal. This delay is reasonable and appropriate, given the slow progress of DSPP administrative systems and the high risk of losing functioning programs through a too-rapid merger.

There has been substantial integration of the DCN with the DSPP, in large part because major funding for the nutrition program now comes through the RHDS project, as amended. This has in fact led to difficulties in execution of nutrition activities called for in the project because of delays in budget provision from the DSPP. These management problems provide cause for concern regarding rapid integration of other services. Further management issues related to integration are discussed in Section II B.

2. Recommendations

In a revised Project Agreement, complete integration should be removed as a CP. An annual review between DSPP and AID should be held concerning progress towards integration in terms of specific administrative capacities of the DSPP, but at this point this should be considered a secondary policy goal.

1.6 Private Sector

1. Summary of activities and current status

At the time that this project was being developed, relatively little consideration was given in project design to the private sector in the provision of rural services. The Project Agreement called only for the compilation of a list of FVO's providing health services in Haiti and

the development of standard guidelines for PVO contributions in this area. Up until this past year, the issue of private sector involvement received little attention from the DSPP in the development of the RHDS project. It should be noted, however, that for many years a substantial number of rural health institutions have been mixed, most usually owned and run by a private group, but employing one or several government health workers.

A number of important developments have occurred in the last year. The Association des Oeuvres Privées en Santé (AOPS) was formed in April 1982 at the behest of the DSPP (see Annex III A 5). This group comprises most of the private non-profit health care providers in Haiti, and its main purpose is to provide coordination of effort between its various members as well as with government health services. Even though still in its early phases, AOPS has established liaison between 214 private organizations, and shows substantial promise for extending rural health services through cooperation between the private and public sectors.

Another important development in the growing awareness of the potential importance of the private sector was the preparation of a set of financial projections concerning DSPP expenditures. This report, prepared by MSH consultant Peter Cross in September 1982, is discussed in detail in Section II C. It makes it clear that the DSPP within its current financial means cannot realistically expect to support the kind of expanded rural health delivery system envisioned in this project.

As a result, consideration is now being given to the possibility of turning over responsibilities for rural health services in selected areas to appropriate groups, under the guidance of the DSPP. This strategy is still in its infancy, but holds promise for being able to approach the kind of coverage discussed in the RHDS.

2. Problems and Constraints

a. Many private groups are uneasy about governmental involvement in their activities, fearing the imposition of a cumbersome bureaucracy or a limitation of their scope of activities.

b. The DSPP, despite responsibilities of the Section of External Assistance and the Bureau of Health Planning and Evaluation, has no clear idea of how or where to utilize private organizations.

c. Dispensaries built under Phase I and Phase II of the RHDS project did not take into consideration the proximity of private institutions, leading in some cases to geographic overlap.

d. AOPS does not have substantial funding of its own, and is therefore at risk of overrunning its resources.

3. Recommendations

a. For AID:

i. Direct support for AOPS in terms of specific rural activities should be a part of a follow-on project, but the remaining period of this project should not be modified to include it.

ii. Discussions between AID and DSPP should begin immediately concerning ways in which AID could provide interim assistance to AOPS in a manner that would not undercut DSPP efforts.

b. For DSPP:

i. Continue regular (quarterly) meetings with AOPS to coordinate services.

ii. Include the Section of External Assistance within Bureau of Health Planning and Evaluation, with primary responsibilities in planning and coordination; supervision of private institutions should rest with other sections of the DSPP as part of their overall responsibilities.

iii. Develop a plan over the next two years to lease or lend rural facilities which cannot be supported by DSPP to selected private organizations, with clear definition of mutual responsibilities.

iv. Do not build or staff any rural dispensaries or health centers within the same geographic area as existing facilities; overlapping facilities built under Phase I and Phase II of RHDS should be top priority for turnover to private hands, as recommended in (iii) above.

2.0 Health Planning

2.1 General

In its original design, the major institutional focus of the RHDS project was to be the Bureau of Health Planning and Evaluation. This was a logical follow-on to the Strengthening Health Services projects, and was reinforced by making the Chief of the BHPE the designated counterpart of the technical assistance Chief of Party. For a variety of reasons, the focus of the actual project has shifted away from the BHPE.

The former Chief of BHPE chose not to make significant use of the available technical assistance, and was himself involved in so many diverse activities that he did not have much time to devote to the project. Partly in response to this and partly because of an interest in policy formulation, the MSH Chief-of-Party became de facto the counterpart of the DSPP Director General. This has led to an appropriate emphasis on policy development, as discussed above, but also a lack of development of the capacities of the BHPE.

The BHPE has not been improved by the RHDS project. It is weak and largely ineffectual. It lacks direction and a sense of purpose, and is understaffed to carry out the functions with which it has been charged. While its potential role is important for the development and oversight of DSPP activities, this role is unlikely to be fulfilled with current personnel and staffing. These changes must be made by the DSPP leadership prior to any major additional inputs to the BHPE by the RHDS Project.

2.2 Program Planning

1. Summary of activities and current status

The general weakness of the BHPE has been outlined above. No significant health planning translatable into action steps has been carried out by the Bureau. The initial project assessment and work plan developed in

December 1980 did not include substantive involvement or contributions from BHPE, and no subsequent DSPP work plans were developed until the past several months.

Program planning has now become an important priority for the DSPP, due in large part to the importance attributed to it by the Secretary of State and the Director General. The first really significant planning activities began late in 1982, and continued into early 1983 with regular presentation by all Regional and District Administrators of the 1982-1983 work plans in conjunction with their budgets. These presentations have taken place at the DSPP with attendance of DSPP leadership and major section heads, and as a result it is becoming clear to DSPP personnel that planning is being taken seriously.

It appears that the involvement of the BHPE in this planning process has been extremely limited. Technical assistance in planning from the MSH team has been provided at the regional and district level in preparing for these presentations, and the quality of presentations has reflected the willingness to make use of this assistance.

This has been an important development in the progressive rationalization of the Haitian health system. It clearly indicates a commitment to the planning process by the DSPP leadership. What is as yet unclear is how these pieces will be appropriately coordinated without an active and capable BHPE whose role should be more than to simply compile the plans prepared by others.

2. Problems and Constraints

a. Current planning activities depend on the continued commitment and interest of DSPP leadership; no steps have yet been taken to institutionalize this process.

b. The BHPE does not currently have the capacity to carry out these activities, or to assist other DSPP entities in carrying them out.

c. Technical assistance available to the BHPE has neither been welcomed nor well utilized up to this point.

d. The MSH Health Planner has, for reasons outlined above, devoted the major part of his effort to activities other than health planning; a great deal of the planning assistance provided has actually come from the MSH Management Specialist, who is no longer a full-time technical assistant in Haiti.

3. Recommendations

a. For AID:

A limited number of priority planning areas (two or three) should be defined by AID through discussions with DSPP leadership; this limited number, rather than the extensive list of yearly CP's now in force, should be used as the basis for reviewing DSPP progress and commitment.

b. For DSPP:

i. Substantially strengthen BHPE. As outlined in other parts of this section, this calls for the appointment of capable and trained personnel to existing positions, and the expansion of the Bureau to include manpower planning, financial planning, facilities planning as well as program planning and evaluation. A substantial portion of the effort of this revised BHPE should be spent in assisting regions and districts with their planning needs.

ii. Utilize technical assistance more appropriately. Short-term consultants could greatly assist recommended new BHPE personnel in defining roles and priorities, conducting needs assessments, and clarifying the planning process.

iii. Continue the excellent progress made in regional and district planning, with a new planning cycle taking place before the summer of 1983 in order to put together the coordinated plan and budget for fiscal year 83-84 well before the end of September 1983.

c. For MSH:

Technical assistance to the BHPE should be a low priority up until the time that the institutional strengthening recommended above takes place; at that time, assistance to clearly defined BHPE counterparts as

requested by the DSPP should become a top priority. When this occurs, consideration should be given to changing the job title of the Chief of Party to Senior Health Policy Advisor, with the appointment of a Health Planning Advisor to work exclusively with the BHPE.

2.3 Facilities planning and construction

1. Summary of activities and current status

A major element of the RHDS project as originally conceived was the construction or renovation of rural dispensaries around the country, as well as the construction of central, regional and district level garages and depots intended to support the rural health system.

The original Project Paper provided estimated funding of \$5.3 million for construction. That amount was subsequently raised to \$6.3 million, which is more than a third of the total project grant.

A site by site review was not conducted as part of this evaluation. Rather, consideration was given to the planning process which resulted in the decision to use RHDS grant funds to build 51 dispensaries, renovate another 28 (down from the 186 proposed in the PP), renovate 2 health centers, and construct 13 garages and 14 warehouses/depots.

Decisions regarding the site selection for the rural dispensaries were made by the former Chief of BHPE; available documentation is lacking regarding criteria for site selection, consideration of other nearby health institutions, priorities for construction versus renovation, and coordination with other planned project activities including personnel training. As a result of this absence of careful planning, it is unlikely that dispensary construction activities to date have made an optimal impact on the distribution and availability of health services. Their political impact was not studied by the evaluation team. It is impossible to estimate coverage from information available at this time (see Annex III A 6 for the most recent map of facilities).

An important change has occurred over the past six months. As part of the increased concern with planning evidenced by the new Director General, a halt was called to new construction in Phase III pending a review of criteria used to select new sites. This has begun the process for establishing a rational basis for planning, and the revised sites in Phase III appear to have been more carefully selected. There is still little coordination, however, with other project elements, especially in terms of agent de santé training and manpower planning.

The construction of DSPP garages and warehouses/depots has proceeded as part of the RHDS project's efforts to reinforce the support structures needed for rural services. Garages were intended as the focal point for the newly designed transport system, while warehouses/depots were to serve as storage and distribution points for supplies and medications intended for distribution to rural facilities. Transport and supply systems are discussed in Section II B.

A major development in the RHDS project which directly affects decisions regarding the supply system is the new AGAPOO drug distribution scheme also detailed in Section II B. With the adoption of AGAPOO, it is unlikely that the DSPP itself will continue to supply significant amounts of medications to the rural areas. This calls for careful consideration of just what items, and in what quantities, are expected to flow through the DSPP system, and whether DSPP warehouses/depots will also be able to serve AGAPOO. The DSPP has not yet formally undertaken consideration of these issues.

2. Problems and Constraints

a. As discussed above, there is a general lack of facilities planning in coordination with health services and manpower planning.

b. There are a great many political considerations inherent in a construction program of this size which are likely to significantly outweigh technical considerations.

c. There is not yet a carefully devised scheme for how the garages and warehouses/depots will be utilized within the DSPP transport and supply operations.

d. There is not yet a DSPP maintenance plan for the buildings constructed under the RHDS program.

3. Recommendations

a. For AID:

i. Given the need to sharpen the focus of this project and limit the DSPP's obligations in terms of stalling and recurrent costs, careful consideration should be given to whether to continue construction as planned. While there are no clear technical reasons to continue construction at this point, there are a number of other considerations which favor continuation. These include the decision by DSPP leadership to use more careful criteria for site selection, the fact that most of the remaining dispensary construction consists of renovation of existing structures, and the considerable political inertia favoring the completion of the construction. This decision will have to be made on a policy basis.

ii. Whatever the decision on continuing the current construction program, no new construction should be scheduled for future projects without extremely careful coordination with financial, manpower, and program planning.

b. For DSPP:

i. Discussions with AID should be initiated within a month to determine the future course of construction activity.

ii. The Bureau of Health Planning and Evaluation should conduct a detailed study over the next year concerning how to adequately staff, support and finance the health institutions already built, including consideration of which might be turned over to private organizations.

iii. As called for in the Project Agreement, a facility maintenance plan should be developed, based on an evaluation of facility maintenance activities in the South Region to be conducted in the next two months.

iv. Transport and supply needs should be realistically reassessed to determine exactly what the needs are for additional garages and depots, and future plans tied to this needs assessment.

v. Arrangements should be made with AGAPCO to share regional and district facilities, even though this may give rise to conflicts within the DSPP administrative structure.

vi. Use should be made of technical assistance in the analysis and planning aspects of the above points, but technical assistance should not be expected to be a decision making role.

2.4. Financial Planning

1. Current Status

This capacity does not currently exist within the DSPP, although an important first step has been taken with the assistance of an MSH consultant in the development of a set of financial projections (see Section II C for details of the Cross Report). This report clearly underlines the value of financial planning for the DSPP if it is to avoid unsupportable obligations. This task fits within the scope of the BHPE, but is currently far beyond its capacities.

2. Recommendations

i. The DSPP should plan for the training and posting of a long-term financial planner who would serve in the BHPE; a reasonable target date for such a posting would be three to five years from now.

ii. In the interim, short-term technical assistance should continue to be used to project financial implications of program decisions.

2.5 Manpower Planning

1. Current Status

This is an area which has received virtually no attention from the DSPP. No careful needs assessment has been done in coordination with services and facilities planning, and there is no clear picture of overall national requirements to support the rural health care system. The number of yearly graduates from the various schools appears to drive the system to respond, rather than the other way around. Nearly all newly graduated health personnel must be hired by the DSPP, whether they are needed or not, and this continues to escalate personnel costs which are already unsupportable within the DSPP functional budget.

A start has been made in considering these problems with the brief MSH consultancy of a manpower planning specialist in early 1983 (Hornby Report, January 1983). However, this is just an initial step, and it appears that the DSPP is not yet ready to internalize functions of manpower planning.

2. Recommendations

a. For AID:

Terminate support for training institutions for which a carefully prepared needs assessment, including necessary skills and numbers of yearly graduates, has not been done; assist the DSPP to develop the means to conduct such an assessment.

b. For DSPP:

Over the next one to two years develop a section of manpower planning within the BEPE which has the authority to determine the number of yearly graduates from the various health training institutions; when an individual has been assigned this responsibility, utilize available technical assistance to conduct initial needs assessment and medium term (5-year) planning.

2.6 Evaluation

1. Current Status

The BHPE currently has neither the necessary information, personnel or skills to carry out evaluation and complete the planning-implementation-evaluation cycle. This appears to be a low priority within the DSPP at this time.

Little has been done to carry out internal evaluation of RHDS project activities to date. This is discussed in some detail in other sections of this report, especially Section II E. There seems to have been little consideration of the potential value of interim process or impact evaluation, and this has been a general weakness throughout the project. Note should be made of a useful survey and evaluation carried out in 1982 in the Cayes District (Arniquet) which gives some insights into the early impact of the agents de santé retrained in nutrition activities; further selective studies, if carefully analyzed, would benefit the DSPP in its ongoing programming.

2. Recommendations

a. For AID:

Process and impact evaluation of the nutrition component of the RHDS project in the South Region should be planned for late 1983 approximately two years after initiation of the Nutrition Amendment to RHDS. Optimally, this would be carried out by the DSPP and MSH jointly, but if this is not possible it should be done by outside consultants; two man-months would probably be appropriate. The value of such an evaluation would be not only to determine the health impact of an important and creative strategy, but also to determine the systems constraints to carrying out this strategy. These constraints are likely to have similar effects on each of the other priority health outreach efforts of the DSPP, and will be useful in any necessary redesign.

b. For DSPP:

i. As a. above.

ii. For strengthening BHPE evaluation capacities, a qualified head of evaluation with appropriate quantitative and analytic skills should be appointed. Details concerning useful information systems needed to contribute to ongoing evaluation of programs are discussed in Section II D.

iii. After appointing the head of evaluation, utilize a long-term technical assistant working jointly with BHPE and the Statistics Section to help in developing the quantitative systems necessary to carry out these tasks. As mentioned in Section II D, the use of a computer in developing these analyses may prove to be a valuable tool.

c. For MSH:

i. As a. and b. above.

ii. More careful and documented internal evaluation of activities supported by technical assistance is called for in all areas, and is discussed elsewhere in this report. This particularly pertains to process and outcome of training activities (Section II E).

iii. Technical assistance to the DSPP in evaluation will be a high priority if the DSPP provides appropriate counterparts; if not, MSH should concentrate only on specific project process and impact evaluation (as in nutrition activities) so that important lessons are not lost.

II. B

MANAGEMENT AND ADMINISTRATION OF THE RURAL HEALTH DELIVERY SYSTEM

Many resources have been applied to creating and upgrading management and administrative systems in the DSPP. According to the Project Agreement the purpose of this is to strengthen the ability of the DSPP to administer a functioning, effective rural health services delivery system nationwide in Haiti. Project implementation was to be planned in such a way as to ensure operational administrative systems prior to increasing support services delivery. For example, supply and transport systems were to be in place before major quantities of drugs and vehicles were procured under project funds.

The Project Agreement sets out several objectives in the area of management. This section will discuss each area separately, in terms of summary of activities, current status, problems and constraints, and recommendations for future activities. Major management/administrative areas include:

1. AGAPCO Drug Supply System
2. DSPP Supply and Logistics System
3. DSPP Transport Management System
4. DSPP Facilities and Technical Maintenance System
5. DSPP Personnel Management
6. Management Training Seminars
7. General Issues
8. Management of a Priority Program: Nutrition Surveillance Project

IIB. 1. AGAPCO

The planning and implementation activities for AGAPCO have been undertaken as steps toward achieving several objectives noted in the Project Agreement. These include:

(1) A plan for strengthening the DSPP supply and logistics system at all levels, as well as providing adequate protection and accountability for commodities.

(2) A schedule for ordering, receiving, and providing all drugs and medical supplies.

(3) Evidence that drugs are being provided by the DSPP to dispensaries and health agents... sufficient to maintain health services delivery at levels foreseen in the Project Agreement.

(4) Conduct a pilot community Pharmacy program to determine whether certain basic drugs can be sold to rural clients at cost on a revolving basis.

In sum, the DSPP and the MSH technical assistance team have made progress towards achieving project agreement objectives. A supply system for medications has been established at all levels with procedures that should ensure protection and accountability. Improvements should be made in scheduling orders and receiving drugs, though distribution mechanisms to regional and district levels have begun working. It is too early to say whether the program will provide adequate amounts of drugs to provide 70% coverage.

AGAPCO does represent a community pharmacy program though it has been instituted on a nationwide level and is not technically "a pilot program". During the evolution of AGAPCO it was decided that experience in similar programs in other countries precluded the need to test the concept in Haiti. AGAPCO is in the process of submitting a management proposal to USAID which will be used to rework and justify this last objective.

1.1 SUMMARY OF ACTIVITIES

The creation of the Agence d'Approvisionnement de Pharmacies Communautaire (AGAPCO) was accomplished in October 1982 after two years of baseline studies, development of drug lists, and design of procedures for accounting,

information and storage systems needed for drug supply and distribution. AGAPOC was established by law as an administratively autonomous agency in order to procure and sell drugs in accordance with three major norms. First AGAPOC will operate on the principle of a self-financing distribution system based on community pharmacies (See Manuel Pour Le Fond De Roulement, 1982). Second, AGAPOC will procure drugs from a generically named formulary in response to priority health needs. (See Annex III B.1.1). Last, AGAPOC will sell drugs in clearly labelled, pre-packaged unit doses.

The basis of the AGAPOC system is community pharmacies which are operated by community management committees through a contract with AGAPOC. Pharmacies are located on the basis of a list of possible places developed by District Administrators and on community response to initial contact with AGAPOC representatives. (See Role of Community Development in the Drug Sales Program, July 1982.) In some localities it has not been feasible to set up community controlled establishments, so institutional pharmacies operating on the same self-financing principle have been started in DSPP health facilities. All pharmacies are supplied with an initial stock of drugs, the value of which provides the capital which serves as the basis of the revolving fund principle.

Community and institutional pharmacies are supplied and supervised by regional depots. These depots may also supply drugs to appropriately authorized DSPP personnel and to non-profit private institutions.

Regional depots are supplied and supervised by the AGAPOC Central office and warehouse in Port-au-Prince. AGAPOC Central tasks also include drug procurement, packaging and storage (See Descriptions de Taches, November 15, 1982.)

Perhaps the most important question that will face AGAPOC and the DSPP is whether financial self-sufficiency can be achieved and if so, in the projected time frame. The AGAPOC central office has the responsibility of rigorously implementing its supply and distribution system in this context. Further, it

is expected to provide timely and adequate financial analysis and evaluation to permit appropriate decision-making at the highest levels of the DSPP. (See Plan Financier de l'AGAPCO, August 31, 1982 and Financial Analysis and Financial Projections, September 1982).

1.2 AGAPCO: CURRENT STATUS

The AGAPCO central office and storage facilities are currently located in the old DSPP depot in Port-au-Prince. The central office is fully staffed and has been operational since October 1982. Drug orders totalling \$1,304,000.00 have been placed from American Companies, UNICEF, and local Haitian companies. To date approximately \$726,000.00 worth of drugs have been received. Procedures for packaging, storage, accounting, and distribution have been established and are reflected in a series of record keeping devices. (See Manuel Pour Le Fond de Roulement, 1982)

Three regional depots have been opened in Cap-Haitien, Gonaives, and Les Cayes. Each depot has been stocked with \$15,000.00 worth of drugs. These depots serve 46 community pharmacies and 7 institutional pharmacies whose initial stock totaled \$1600.00 each. Accounting procedures and record keeping devices have been implemented as part of the overall AGAPCO system. Regional depots are each staffed with one regional director. Community and institutional pharmacies are each staffed with a storekeeper who has received training specific to AGAPCO. (See Regisseurs Training Course, 1982).

Initial data on program implementation have been received from the District of Gonaives for the time period up to January 1983. These data provide information on: a) average price mark for drugs actually sold, b) sales volume of each drug, c) number of unit doses of each product sold, d) volume of drug sales for each pharmacy, e) volume of drugs bought to replace stocks of pharmacies, f) salaries paid to storekeepers, g) other expenses (rent, transport), h) closing balances for each pharmacy for each month.

Analysis of some data has also been done for the first 4 months of AGAPCO central office operation. These data were derived from physical inventory of central warehouse stocks and from drug quantities and values noted in stock control cards and accounts books. Discrepancies in stock value have been noted and AGAPCO central is in the process of reconciling differences, and making system adjustments to assure better financial control.

1.3 PROBLEMS AND CONSTRAINTS

The financial plan for AGAPCO projects self-sufficiency in 1986. This ambitious goal is based on a series of assumptions (losses, operating costs, etc.), which need to be continuously reevaluated. AGAPCO management systems also need to be rigorously implemented and continuously evaluated with clear and timely adjustments made in less than optimum operations. Technical assistance has been provided in the areas of overall financial analysis and management as well as in regard to day to day functioning. AGAPCO central is currently staffed with personnel who have been adequately carrying out daily operations but technical assistance has taken the lead for financial evaluation. This overall task is crucial for AGAPCO to reach self-sufficiency and is not currently being looked after by an appropriately trained AGAPCO counterpart.

The issue of self-sufficiency within 4 years has been discussed in great detail by the DSPP, USAID, and MSH. The attainment of this goal is based on a number of assumptions, some of which are questionable, and others of which are beyond the direct control of AGAPCO itself. For example losses before sales are estimated at 5% and it has also been estimated that an average 28% mark up on drug prices will cover losses, operating costs and stock replacement costs. Given the method for calculating self-sufficiency, higher losses (which would not be unusual) could have a significant effect and would require higher average markups. Also, funds must be made available and spent at annual rates described in the financial plan. AGAPCO depends on the DSPP financial system for both Title I and dollar funds and the problems inherent

in that system have already caused considerable delays. (See Plan Financier pour l'AGAPCO and Annex IIIB 1.2). In light of these problems USAID has already suggested quarterly reviews.

The principle of self-sufficiency raises another issue which needs to be resolved after project development funds are expended. To date approximately 60% of AGAPCO drugs have been purchased locally, while 40% have been procured on the foreign market. There will be significant costs associated with the foreign exchange needed for the purchase of this 40% of stocks. If the costs cannot be met then the array of commodities AGAPCO can provide may be limited.

As an agency receiving drugs from many sources, AGAPCO has reporting requirements beyond those that have been put in place for internal operations. While shipments are controlled and recorded as part of internal bookkeeping, standard reports are not compiled and routinely provided to USAID which has been responsible for the purchasing of a significant amount worth of drugs to date. As a result USAID has not been able to assure that all drugs ordered were received or received within a reasonable amount of time.

A second constraint on controlling receipt of shipments grows out of AGAPCO's dependence on the DSPP for clearing customs. Under this system the customs agent in the Section d'Achats must proceed through several time-consuming steps involving DSPP administration and customs officials. He is hampered in his tasks by lack of transportation, by lack of original documentation from drug suppliers, and by the sheer volume of paperwork required of several key DSPP personnel. As a result drugs are not received and processed in a timely fashion.

Maintaining adequate stock levels in the central warehouse has also been made difficult by extremely long lag times between placing and receiving orders. This has been especially true of drugs ordered from American companies. (average 10.8 months delay.) This makes it necessary to plan orders nearly two years in advance. The capability of AGAPCO to plan such orders, yet alone two years in advance, is questionable since technical assistance and USAID took the lead role in placing earlier orders.

The internal operations of AGAPCO have received the greatest attention in the last several months from both technical assistance and DSPP/AGAPCO personnel. Several problems have recently arisen and while they require quick resolution they should be considered in the context that AGAPCO is a relatively new agency.

AGAPCO is dependent on the DSPP financial system for release of funds to carryout activities. These activities include supervision, participation in training, delivery of initial drug stocks, etc. The funds have either not been provided or not provided quickly enough causing AGAPCO personnel to either advance personal funds or not carry out the activity. While other DSPP activities may suffer from lack of such funds, the impact on AGAPCO will be increased operational costs and/or decapitalization.

Management analysis and evaluation of AGAPCO has begun to concentrate on information gathered in monthly reports and especially on reconciling cash books, stock cards, and inventories. Discussions with pharmacy, depot, and central warehouse personnel indicate that the concept of reconciling these different sources of information is not well understood. This is especially true of performing physical inventories. While training courses do cover these topics, the use of this information is either not acceptable or not considered essential to pharmacy control. (See Section IIC.4.0)

Recordkeeping at several community and institutional pharmacy levels was reviewed for accuracy and completeness. Some discrepancies in sales and stock remaining were noted, and parts of cash books were misunderstood or improperly added. Storekeepers could explain recordkeeping in general but were not always clear about what they actually did. There appeared to be a direct association between the level of accuracy and the amount and kind of supervision received. The only region that has been regularly supervised in Gonaives, where there is an exceptionally motivated regional director for AGAPCO. She has rigorously reviewed requisition and monthly reports before selling replacement drugs and has visited many of the pharmacies to review

storekeeper activity. As a result organized and reasonably complete financial and inventory records for pharmacies are available in this region but not in Cap-Haitien or Les Cayes.

The issue of supervision at all levels has been addressed in this year's work plan and as a task in some job descriptions. To date it has been discussed but little has been done to assure that it is well defined and then implemented. Budget levels for AGAPCO supervision have been inadequate especially for those pharmacies that are newly operational. (This has been partially rectified in the proposed 1982-83 budget). Also it is doubtful that the personnel currently assigned this task actually have or should have the time to perform it. Central level supervision of regional and community levels has been done by AGAPCO's director and administrator. As central operations grow in complexity and size these people will be required to spend more time in Port-au-Prince.

In addition no trip reports of their supervisory activities are available. This is a loss of valuable information, necessary for correcting any problems in program implementation. Some community pharmacists identified the MSH community development specialist as their supervisor. This MSH advisor is primarily responsible for working with communities to start up their pharmacies. He is currently working without an AGAPCO counterpart, and it is clear that many pharmacies may simply end up without a direct link to AGAPCO central. Also, no person at AGAPCO will have been trained in performing his tasks. Since AGAPCO's goal of self-sufficiency depends on reaching a certain level of drug sales, neglect of a major portion of retail outlets could rapidly decapitalize the agency.

Apart from the type of analyses discussed earlier in this section a major problem is the lack of assesement of the impact of AGAPCO. Types of questions that are not yet being considered include:

a. What are the management implications of having different types of pharmacies (institutional and community)?

- b. Are DSPP medical personnel effectively using AGAPOO outlets?
- c. Does the lack of specificity in DSPP drug sales policy result in confusion over selling or giving away drugs?
- d. What are the health and economic impacts of establishing a pharmacy in a community?

One problem that has been presented to AGAPOO for solution is the issue of supplying village health workers with a set of 6 drugs. The current proposal is for community pharmacies to sell drugs to the health workers who will in turn sell them to patients. (See Proposal for Agent de Sante Drug Sales, 1982). This Proposal would have several constraints including:

- a. Increasing operations costs for AGAPOO
- b. Increasing training costs.
- c. Increasing auxiliary supervision tasks.
- d. Changing policy of free drug distribution by Agents de Sante.

However, the only alternative options would be for the DSPP to purchase drugs from AGAPOO adding to the recurrent costs of the DSPP (See Section IIE) or to leave the Agents de Santé without access to their basic pharmacopia.

1.4 RECOMMENDATIONS

AGAPOO represents the DSPP's commitment to a responsible, low cost, drug distribution program. Its creation and subsequent support is a significant departure from earlier DSPP policy, and its accomplishments to date have established a good basis for further growth. In particular the commitment to purchasing generic drugs as a public health strategy is encouraging. As an agency that is managed like a business, it will be more sensitive to the inefficiencies that characterize other DSPP administrative systems on which it depends. Any inefficiencies within its own confines will also be rapidly evident in monetary terms. As such the DSPP should ensure that priority recommendations are well thought out and acted upon quickly.

a. Recruit or provide training for a business/financial analyst whose tasks will include financial evaluation of AGAPCO operations, reviewing and updating of basic assumptions underlying AGAPCO, and implementation of any systems changes required by this evaluation.

b. AGAPCO should provide quarterly and annual reports and recommendations on all assumptions for and progress towards self-sufficiency. AGAPCO, DSPP, and USAID should meet quarterly to review reports and provide ideas for resolving any problems. At the end of each year projections for attaining self-sufficiency should be revised and RHDS (or subsequent projects) support should be programmed to reflect these new projections. See Annex III B1)

c. Use of foreign exchange for purchase of drugs should be quantified and reviewed in 1985 and options for meeting these costs identified.

d. The Director of AGAPCO should ensure that his staff compile drug receiving reports and that they be provided routinely to USAID no later than two weeks after a shipment is received in the central warehouse.

e. The Administrator of AGAPCO should ensure that drug shipments are cleared through customs within three weeks of arriving in Haiti. Since AGAPCO receives large amounts of drugs one of its own administrative staff should immediately be designated customs agent and should be provided with the resources necessary to clear commodities. If the administrative staff does not have sufficient time to carry out these tasks, new staff should be recruited.

f. Drug procurement lag times for American products should be reduced as far as is possible by Chemonics, the new DSPP drug purchasing agents.

g. The procurement specialist of AGAPCO should plan and place orders with appropriate specifications for this year's drugs within the next month if not sooner. The MSH technical assistant should provide any necessary advice needed by his counterpart.

h. The DSPP and USAID should initiate a revolving fund (based on about 3 months of operating costs) on a trial basis for AGAPCO program functions. In order to obtain this fund AGAPCO must provide a detailed prospective budget by activity and must learn to process appropriate vouchers. The AGAPCO Director and Administrator will be responsible for accounting for any such funds expended. Reimbursement of the revolving fund should be dependent on responsible financial management by AGAPCO. MSH technical assistance in financial administration should be provided.

i. Internal audit and reconciliation of books of AGAPCO central, regional, and community pharmacies should be performed regularly. (See Section IIC 4) This activity should be done frequently at first (once monthly) and may be cut back as books are balanced.

j. Supervision, (especially administrative) should be immediately improved throughout the AGAPCO system as follows:

i. One to two additional central staff members should be recruited specifically for supervision and in-service training of regional and community pharmacy personnel.

ii. Supervision norms and tasks should be defined in detail.

iii. Work plans for carrying out supervision this year should be completed with time frames and performance indicators, and rigorous evaluation of these plans carried out by the Director and Administrator of AGAPCO.

iv. Regional directors should be trained to do supervisory tasks and should be given the time (once per week) and resources (means of transport) to carry them out.

v. Each community pharmacy should be actively monitored once per month for the first six months of operation and every 3 months after that. (unless there is personnel turnover)

vi. Each regional depot should be actively monitored once per month.

vii. The central warehouse should be actively monitored in an organized way by the AGAPCO administrator at least once per week.

viii. Per diems and transportation should be provided at levels that will support this expanded activity.

ix. A simple but useful reporting system for supervision should be developed and implemented as soon as possible. This system should include more information than is currently included as monthly report data. For example, qualitative information on topics such as physician willingness to prescribe generic drugs, patients ability to pay, etc would give a more complete background to the numbers that represent sales volumes.

x. MSH technical assistance should concentrate on helping to carry out these supervisory tasks.

k. The DSPP should immediately name a counterpart with appropriate community development training for the MSH community development advisor.

l. The DSPP, AGAPCO, and MSH should consider what operations research questions are important for evaluating AGAPCO impact and see what options are available for carrying the research out. (See Problems and Constraints)

IIB.2. THE DSPP SUPPLY AND LOGISTICS SYSTEM

The objectives that were set out by the Project Agreement for supply have been noted in the previous section on AGAPCO. Since AGAPCO addresses these objectives only in part, they will also be considered here. In addition the following objectives apply:

(a) For regional and district warehouses... evidence that administration has been created officially, and that sufficient counterpart staff and funds have been provided...

(b) A schedule for ordering, receiving, and installing warehouse equipment.

To date the RHDS project has not made much progress towards achieving supply system objectives aside from the AGAPCO example. Proposals for warehouse and system administration exist on paper but have never been officially agreed to by the DSPP or carried further by technical assistance. AGAPCO has required and was justified in receiving major efforts to date but the time has come to define and implement a system to carry out supply functions not covered by AGAPCO.

2.1 SUMMARY OF ACTIVITIES

The DSPP supply and logistics system involves three sections in the central administration office: Approvisionnement, Inventaire, and Achats. At regional and district levels it involves warehouses and the staff needed to run them. Since the inception of the RHDS project, the chiefs of the Achats and Approvisionnement sections and the MSH supply consultant have carried out several activities in an intermittent fashion. A baseline survey of the DSPP supply system (including commodities handled, facilities and equipment) was carried out. A supply information system was proposed (primarily for drugs) and District Administrators were oriented to the new system. Descriptions of tasks for warehouse/depot personnel were written and equipment was ordered for the new storage facilities. The Inventaire section has been involved with updating and computerizing some of their records with the MSH computer and administrative consultants.

2.2 CURRENT STATUS

The development of supply systems for the DSPP has taken two distinct paths. AGAPCO has become the only functional mechanism for drug supply. The DSPP has not had functional budget funds available for purchasing commodities since last fall, hence the role of its internal supply system has essentially been

narrowed. The three supply sections do process and store purchases, but the volume is low and related only to funds available through foreign donors. The distribution system does not function effectively due to lack of means of transportation and other funds.

Under the RHDS Project 8 warehouse/depots have been constructed or renovated. Six are either under construction or in Phase III plans. They have not been opened since equipment has not arrived or been purchased locally.

Plans for reorganization of the new warehouses, strengthening the supply pipeline, instituting a new information system have been proposed by the MSH technical assistant but have not been acted upon by the DSPP.

Several regional, district, and health center depots were inspected in the course of this evaluation. In general, depots were illkept and disorganized, and recordkeeping practices not well carried out. There was considerable variation in how supplies were stored and controlled for different health divisions. For example, DHF material was often separated out and records were kept up to date. Not much concern was expressed about the status of the DSPP supply system since it was clear that resources were not available to supply anything.

The Inventaire section has entered a small percentage of its items on the RHDS computer, and initial lists have been printed with information on location, donor, and value of each item.

2.3 PROBLEMS AND CONSTRAINTS

The development of AGAPOO and the RHDS resources required for this development have caused the DSPP internal supply system to be relegated for later consideration. This has probably been justified to date but several events require remedial action quickly.

a. USAID/RHDS purchased equipment for health establishments is expected from UNICEF in the next two months. The equipment is valued at \$145,000 and will need to be efficiently delivered to the appropriate facilities throughout Haiti.

b. The DSPP is required by USAID to provide inventory control reports on equipment purchased with project funds. The USAID audit is scheduled for April.

c. The new warehouses are scheduled to open in the next three months (as soon as equipment valued at \$181,000 arrives) and no official DSPP agreement has been given to proposed management systems. The new warehouses will require both improved system design and retraining of personnel to operate them at all DSPP levels.

The role of the DSPP supply system has been tacitly redefined but has not been officially recognized. Norms and tasks still relate largely to drug and medical supply distribution which were formerly the principal commodities in the system. Handling essentially non expendable equipment will require different kinds of procedures.

Shared use of the new warehouses by the agencies involved in supply of health materials (AGAPCO, DSPP Approvisionnement, DHF, DON, and possibly SNEM has not been resolved). AGAPCO central is in the old DSPP warehouse in Port-au-Prince. Approvisionnement intends to move into the new warehouse in the old SNEM compound. No one has yet tried to define space requirements for either group, nor plan the most efficient use of facilities available. This problem extends to the regional and district levels.

The purchasing and supply system is a cumbersome and time consuming bureaucracy. Decisionmaking authority is concentrated in the hands of a few, whether purchases are significant or not. The development of regional budgets to provide some of these commodities has helped but lack of sufficient funds force the problem back to the central level.

One notable time problem in the Achats section relates to clearing commodities through customs. Items stay on Port-au-Prince docks for extended periods of time largely due to problems with documents and lack of transportation for the customs agent.

The information links between the sections of Achats, Inventaire, and Approvisionnement are weak. While forms and receipts in theory pass through all three sections, compiling of data and updating of master lists is not done. This is especially evident with the computer list being developed for inventory control. When an item is purchased, Achats should send a receipt to Inventaire but no one knew how this information was to end up in the computer.

Information links with health establishments are also poorly defined. Regional or district Chiefs de Bureau are supposed to report on items received or equipment that is beyond repair but no effective method of supervision of this type of reporting exists. The entire data system depends on the requisition process which has been set up on the basis of central office financial procedures rather than on the need for supplies to run a health system.

Warehouses and depots are currently poorly controlled and storage and control procedures are not followed. Personnel should now have more than enough time to carry out these tasks since drugs are not being handled in any significant volume.

Some equipment that is needed for the daily operations of health establishments is not being supplied by the DSPP or AGAPCO. This includes items such as cotton, gauze, syringes, X-ray film, etc. Regional and district personnel have been purchasing this type of equipment with facility receipts but at high retail prices.

The Approvisionnement section is charged with the distribution of supplies but has not been actually delivering many of its commodities. The burden for procuring an item at the district level rests with the district administrator,

i.e. he goes to Port-au-Prince to pick it up. Lack of means of transportation (vehicles, fuel, perdiems) has created a system that is expensive in terms of personnel time lost.

MSH technical assistance for supply has been applied largely to AGAPCO. DSPP supply has not actively called upon the supply consultants, nor have intensive efforts been made to push Approvisionnement to improve its operations more quickly.

2.4 RECOMMENDATIONS

a. The DSPP should immediately clarify its policy on the relative responsibilities of its internal supply system vis a vis AGAPCO, especially with respect to which commodities are to be carried by which system. The purposes of the internal supply system and its major tasks should be redefined accordingly as soon as possible.

b. MSH should provide a short term technical consultant (2-4 months) to DSPP supply as soon as possible, to organize and implement a simplified central system; this task should not be added on to the current responsibilities of the long-term advisor.

c. The MSH short term supply consultant should concentrate his efforts on the Approvisionnement section. Along with the chief of the section of Approvisionnement he should redesign forms and procedures (using those already submitted to the DSPP as a basis) for supply management in the central warehouse and regional depots.

d. The consultant and the chief of section should retrain all personnel at central and regional levels in the new procedures before the new warehouses open.

e. A plan for and norms of supervision for the center, regions and districts should be made as part of the development of the new system.

Supervision should include: Recruitment, naming and training of supervisors and provision of resources (transport, perdiems) for them. Supplies should not be delivered to regions and districts if supply norms are not met.

f. The simple modified supply system should be installed and tested with the arrival of the USAID purchased dispensary equipment (expected in April-May 1983). The Chief of Approvisionnement and the MSH short-term supply consultant should fully evaluate this test operation and implement systems adjustments as necessary

g. A plan for the supply of medical materials (cotton, gauze) utilizing AGAPCO should be developed and implemented in the next year by the Director of AGAPCO and the long-term MSH technical assistant.

h. Space requirements for DSPP supply (including DHF and DON) and AGAPCO should be analyzed. Use of the new warehouses should be delegated accordingly though this should be done after the DSPP supply system is well established. Sharing of space in depots at regional levels should be started within 6 months.

i. MSH computer technical assistance should continue to enter inventory information but efforts should concentrate on: establishing systems for updating the information and on accurately entering equipment that is arriving for RHDS.

j. Information requirements for inventory control with health establishments should be clarified and simple reporting mechanisms established.

k. The customs agent should be provided with transportation from the central motor pool and should be required to clear items within 3 weeks of arrival in Port-au-Prince. (Consideration should be given to putting a motorcycle in the pool. - 3 are currently in storage in the old DSPP warehouse). Each delay beyond that should be investigated and the appropriate bottleneck eliminated with the help of the Direction General.

1. Options for delivery of materials to the regions and districts by Approvisionnement should be listed and costed out in the next year. One option might be to schedule weekly delivery vehicle visits to each regional capital, and twice monthly visits to district capitals. These deliveries could include checks and mail as well as supplies. A decision should then be taken to follow the most cost-effective mechanism.

3. DSPP TRANSPORT MANAGEMENT SYSTEM

Objectives found in the Project Agreement for transport management include:

a. For Transport facilities at regional and district levels: evidence that administration, staff, and funds have been provided to supervise and administer the facility.

b. A schedule for ordering, receiving, and installing all vehicles and garage equipment.

c. Evidence that a vehicle maintenance plan has been approved for the central DSPP Garage and multi-regional garages.

d. Merge all health transportation systems under DSPP control, provide transport to the nationwide health system, develop new operating procedures for the integrated unit and train personnel to operate the new system.

To date, the REDS project has primarily made paper and not active progress towards these objectives. Procedures and systems as designed on paper appear to be sound, and in those areas that are starting to function they should provide the basis for good control. The major problem is a lack of political will to enforce the system; without that kind of support the system will never be comprehensive and effective. The integration objective is not currently realistic and all parties including foreign donors should resolve the financial issues that impede it.

3.1 SUMMARY OF ACTIVITIES

During the first year of RHDS the old DSPP garage was closed down, cleaned up, repaired, and reopened under stricter supervision. Security measures were instituted and employee absenteeism reduced. The MSH advisor, the Chief of transport, the dispatcher and an MSH short term consultant completed a transport system status report including an inventory of vehicles. Based on this report activities to improve the transport system were identified. (See Fielden report, 1980). The goal of all activities was to develop a motor pool system and a vehicle/spare part procurement plan for RHDS.

The long-term advisor went on to develop norms for preventive maintenance, allocation of fuel and vehicles, and maintenance of inventory. Job descriptions for transport personnel were written and supervisory responsibilities identified. An extensive information and control system including 12 forms was developed, tested, and is currently being implemented. A system of weekly, monthly, and annual reports has been proposed and partially implemented. Vehicles are being registered and entered into the central garage system and procedures for utilization of these "pool" vehicles have been established.

Training courses were held for central, regional, and district level mechanics under the direction of the MSH vehicle maintenance advisor. One of the management training seminars for district administrators included a transport presentation (See IIB6).

An initial plan for procurement of vehicles was set forth and orders for these vehicles and spare parts placed. Equipment for vehicle repair has been ordered to outfit the new garages (one central, 3 regional) that have been built with RHDS funds. A committee has been set up to study and plan for the integration of the DSPP, SNEM, and other DSPP division transport systems.

3.2 CURRENT STATUS

The DSPP central garage has been physically upgraded so that minimal repair work is being done . For example 65 preventive maintenance and repair orders were carried out in September 1982. The dispatcher has been keeping vehicle use and repair records for those vehicles under his control. The January 1983 report covered all pool vehicles. No regional or district reports are available and many assigned-vehicle records are not being kept. A fuel allocation report for January was also made by the transport section though control of fuel distribution still rests at higher DSPP levels and vehicle users often add it without noting in the records. Attendance lists have been kept and reviewed for garage employees by the chief of the transport section.

Thirty four vehicles have been procured through USAID, 20 of these have been assigned to Port-au-Prince, 14 to the districts and regions. There is one outstanding request for 7 new vehicles for the DON. Initial shipments of \$69,000 worth of spare parts have been received. \$74,000 worth of spare parts are on order. Garage equipment totalling \$186,000 is expected to be received in the next three months.

The number of vehicles actually assigned to the central pool was impossible to verify. At least 7 or 8 of the 20 vehicles in Port-au-Prince have been provisionally assigned to DSPP personnel and are not available for the pool. No information was available as to how many activities were not carried out because personnel were not provided with means of transportation.

Two of the three norms packages for control of the transport system (Preventive Maintenance and Maintenance of Inventory) have been officially approved. Allocation of fuel and vehicles is currently agreed to "in principle". 60 central mechanics have been trained in Port-au-Prince and 30 mechanics and chauffeurs have been trained for regional and district bureaus. A diesel mechanics course is scheduled to start in March for about 38 participants. The management training seminar in transport was carried out

and resulted in making district administrators aware of the new control system and it also provided information for transport system managers (See Annex IIIB3).

The transport integration committee (DSPP Administrator, Chief of the DSPP transport section, Chief of the SNEM Transport Section, MSH transport consultant) has met 3 times and has raised several key issues. The SNEM system does work relatively well, while the DSPP system has not been widely implemented or in existence long enough to predict its outcome. The difficulties in releasing DSPP funds for procuring fuel, spare parts, and vehicles are far greater than those faced by SNEM. In addition the source of funding for SNEM and DSPP activities require separate mechanisms for accountability.

3.3 PROBLEMS AND CONSTRAINTS

While norms for preventive maintenance, etc., have been officially established there is no authority in the transport section to enforce them. This lack of authority extends to ensuring the use of reporting forms for vehicle utilization. As is evident from the January 1983 report the section is capable of identifying central level problems but must look toward higher levels for making any systems adjustments. Since transport is only one of many priorities at this level, it is questionable whether rapid effective action will take place.

The lack of regional and district reports and the fact that many have not been actively initiated in the system is another indicator of how slowly implementation is proceeding. To some extent there seems to be confusion over who must provide detailed supervision. The amount of time that is required to implement the new system seems to exceed that available to district administrators.

Fuel allocation has essentially not been turned over to the transport system. There is a serious shortage of funds to purchase fuel and given that these

funds are released on a monthly basis, activities requiring transport have been severely curtailed. Vehicle assignment to the regions has been straightforward though decisions regarding utilization do not necessarily follow priorities. Vehicle assignment to the central pool has been problematical since some personnel have vehicles on a "provisional" basis. Thus far, provisional has meant permanent assignment and this undermines the pool concept as well as removing the vehicles from transport section supervision. An inventory control system for spare parts and lubricants has been instituted and with the small stock on hand seems to be working. However careful supervision has been carried out primarily by the MSH consultant and in the new garage will require much time on the part of a transport section supervisor.

The imminent opening of the new garage, along with the arrival of expensive equipment will pose a problem for the DSPP. Administrative systems are not yet operational in many cases and not enough central personnel will have been trained to carry them out. In particular the chief of the section has defined his role as technical supervisor. An administrative director has not yet been named. The lack of authority to enforce the new system in the new garage makes it nearly impossible at this time to provide accountability for items received.

The information system that has been designed for transport appears complicated. This seems to be especially true in the compilation of information and its presentation to help make management decisions. Some policies necessary for a transport system have not yet been established. In particular there is no replacement plan for vehicles either in terms of what to do with old ones or what kind of new ones should be bought.

Integration of DSPP, SNEM, and DSPP divisions will continue to be a problem until financing issues are resolved. It is unlikely that they can be resolved solely by the work of the committee.

3.4 RECOMMENDATIONS

a. All transport reforms that have been officially accepted should be fully supported and strictly enforced by the highest levels of DSPP starting immediately. In those instances when procedures are not followed (information available from vehicle records) action to revoke the privilege of vehicle/gasoline use should be taken.

b. Central level personnel should receive intensive training from the MSH transport consultant to operate the new garage management system and should actively participate in installing the system before equipment and parts arrive.

c. An experienced administrative director should be named and oriented to the new system before the new garage opens. (Estimated for May 1983).

d. The highest levels of the DSPP should require rigorous accountability of all systems installed in the new garage.

e. Audits of equipment, spare parts, and vehicle use should be performed by an outside auditor every month in the first year of new garage operation.

f. Any new vehicles purchased should be assigned to regions and districts for priority activities as identified in other sections of this report. No new vehicles should be assigned to the central garage/bureau until administrative systems are functioning adequately.

g. The supervision system of the new transport section should be clarified and strengthened as follows:

i. Central level personnel should be given more authority and time to supervise administrative tasks.

ii. One or two central level personnel should be named as trainers and supervisors (especially administrative) for the regions and districts and should be given the means to spend more than 50% of their time in the field. Their first task should be to implement the new system in each area.

h. The MSH computer consultant should assist the transport section in simplifying summaries of records so that they may be used for management decisions.

i. The DSPP should develop and officially recognize any policies still outstanding, i.e. fuel allocation, replacement plans before any new vehicles are ordered.

j. Integration of SNEM, DHF, and DSPP transport systems should wait until financial issues are resolved. These issues need to be resolved by USAID and the highest levels of SNEM and the DSPP.

4. DSPP FACILITIES AND TECHNICAL MAINTENANCE SYSTEM

The Project Agreement is very specific about its facilities maintenance objective: Create an institutional capability at the DSPP for maintenance of all health facilities serving the rural health delivery system. While some baseline work has been performed this objective has not been met nor is there currently a plan for meeting it.

4.1 SUMMARY OF ACTIVITIES

A baseline assessment of all DSPP health facilities in the North and South regions was conducted by the Chief of the maintenance section with the help of the MSH facilities consultant. The consultant also developed maintenance checklists, workplans, simple training courses, and job descriptions. Regional maintenance was to be accomplished by properly equipped teams, funded centrally, and with strong central level supervision in the form of inspectors. Tools and supplies were provided along with at least one vehicle for one regional team. Some initial repair work was done in the South region. Long term training of personnel for technical equipment repairs was also undertaken.

4.2 CURRENT STATUS

The southern region has one facilities maintenance team consisting of one inspector, 3 technicians, and one chauffeur. No information was available as to how many repairs had been carried out, but no resources from central or regional levels have been available for the greater part of a year. The team was equipped with tools totalling \$8,800 and a vehicle worth \$12,000.

The responsibility for ensuring facility maintenance is not clearly assigned to any one section or person at the DSPP and no operating resources from the center have been allocated. No planning for ongoing maintenance has been done. Eight monovalent technicians for repair of equipment have been trained at Canidot with project funds. As of February 1982, 7 had been named to the DSPP but they have not had resources to do any repairs outside of Port-au-Prince.

4.3 PROBLEMS AND CONSTRAINTS

The lack of resources made available for facilities maintenance has hampered any activity in this area. The lack of even one person at the central level of DSPP whose responsibility is facilities maintenance indicates the low level priority assigned to the concept.

The cost effectiveness of the Southern region team has not been evaluated, though agreement was reached by USAID, DSPP, and MSH to do so. This evaluation should be an important basis for establishing maintenance plans and a program for all of the health facilities built with RHDS funds. The 7 or 8 technical repair personnel are not provided with the ability to do repairs outside of Port-au-Prince. This represents a heavy investment in training with no benefit.

4.4 RECOMMENDATIONS

a. The DSPP with the assistance of an MSH consultant should carryout an evaluation of the costs, activities, and effectiveness of the southern region team within 60 days of the submission of this report. Failure by the DSPP to

plan this evaluation within 30 days and carry it out within 60 days should result in the immediate cessation of RHDS construction activities to the extent possible by law. (See Section II A.) until such an evaluation has been conducted and findings reported to AID.

b. This evaluation team should also review one sample district's records to determine what repairs were done and at what cost, where a team was not present. If this information could be matched with the MSH facilities consultant's initial assessment, some basis for comparing maintenance options might be obtained.

c. The DSPP with the assistance of MSH should consider and formulate a maintenance program on the basis of several options such as:

- i. Regional maintenance teams.
- ii. Regional-level inspector who defines maintenance needs and contracts for local labor to do repairs.

Any option chosen should include a central section with adequate support for frequent and rigorous supervision of facilities.

d. Technical repair needs at regional and district levels should be defined and prioritized. Based on the assessment the technical repair personnel should be provided with the transport, equipment, and per diems necessary to carry out priority repairs.

IIB 5 DSPP PERSONNEL MANAGEMENT

Objectives pertaining to personnel management include:

a. The DSPP will develop an active personnel management system including standardized criteria for employment and performance evaluation, identification of health sector manpower and training requirements, and for specifications of the functions and appropriate staffing of each section of the DSPP at all levels.

b. Further USAID will be provided with approved functional statements and staffing patterns for the central DSPP.

c. A list of positions within the national health system to receive project salary support

Some progress has been made towards these objectives though the time taken to make this progress seems excessive. In addition the outputs (personnel lists, job descriptions, etc) that would allow evaluation of this progress are available only in draft form.

5.1 SUMMARY OF ACTIVITIES

Personnel management activities have focused on defining and describing DSPP jobs and personnel. A survey of existing personnel was carried out for all levels and in combination with payroll verification has resulted in a computerized listing of those paid through the functional budget. (See Section IID). This activity has been carried out by the DSPP administrator, the Personnel Section, all regional/district administrators, the MSH personnel consultant, and most recently the MSH administrative consultant.

The Chief of personnel and the MSH personnel consultant began to implement a manual of norms for personnel operations at regional and district levels. Also a system of recording employee attendance was instituted at all levels. About this time the administrative reform commission began to review the Haitian government personnel system and the DSPP personnel section participated. After some time standard salary scales and professional categories were officially defined, and are now being implemented under a policy called "regularisation".

To gain more information on personnel than was available from the computer listing a system of personnel dossiers was instituted for all levels. These dossiers were to be part of a system of supervision and performance evaluation. Other parts of this system included development of job descriptions for each personnel category, and development of objective supervision reporting forms.

MSH short term consultants also provided recommendations for staffing needs with respect to regionalization and the growth of DSPP administrative systems. (See Torrens Report, 1982). A manpower consultant was provided to assess the DSPP's current capabilities and recommend initial steps for building on personnel information available to undertake effective manpower planning (See Hornby report, 1983; Section IIA). One of the district administrator management training seminars focused on personnel management.

5.2 CURRENT STATUS

A computerized list of personnel paid by the functional budget exists although it is not known how accurate and current it may be. Monthly reports of personnel changes are given to MSH consultants and SISA for inclusion (personnel section employees are being trained to enter data). At district and regional levels, lists are being updated for 1983. USAID has also been provided with partial listings of those receiving salary supplements through AID projects. This list tends to be more accurate for district than for central level personnel. Personnel dossiers have been completed for the central bureau. The personnel section is in the process of collecting dossiers from the Port-au-Prince metropolitan area. Regional and district level administrators have begun to collect some of the information.

The supervision/performance evaluation system now rests with the office of regionalisation. A simplified form and guide for its use are scheduled to be introduced to district administrators in March 1983. (See Annex IIB5). The job descriptions for all positions are in the final revision stage at the central bureau. The manual needs to be retyped and edited and processed through official channels for approval. Staffing needs for the regions have not been redefined by the DSPP since regionalisation. The basis for manpower planning and proceeding with a manpower situational analysis have not been extensively discussed with the DSPP. This seems to have been largely a consultant activity. In addition to the informal training provided to regional and district administrators in the area of personnel management, the management seminar at Petit Goave was noted as an informative exercise.

5.3 PROBLEMS AND CONSTRAINTS

Personnel management has been a difficult and sensitive area to work with at the DSPP since much information was not available and since people were unsure as to why it should become available. Since personnel do account for up to 85% of the DSPP budget this information could be invaluable to the DSPP for planning and resource allocation purposes.

The computerized list of personnel is useful but with its accuracy in question and the lack of an effective updating system it is not clear whether it will even be usable. In addition DSPP personnel section employees do not seem to have established ownership of it. This includes a general lack of understanding about why they are doing it. (Beyond the fact that they have been ordered to do so). District and regional level administrators seem to have a better understanding of their particular list's utility and it has provided them with an overall personnel picture.

The current list only includes the functional budget. USAID and other foreign donor salaries are not included leaving the specification of all personnel incomplete.

The personnel dossiers are kept at the personnel section but there has been no link between them and an intended supervision system. For the regions and districts the response rate has been low and administrators repeat that those forms that are filled out are not done well. There has not been any pressure from the central level to improve the situation.

The job descriptions have not been officially recognized so it is difficult to see how the supervision forms can be instituted as quickly as March. In addition it is not clear what actions can, may, or should be taken given "poor" performance evaluations.

With the development of the personnel management system to date consideration of the issues of manpower analysis, planning, and development seem premature. As noted in the Hornby report several information steps need to be taken

before any manpower seminars are planned. It is essential to begin with transmitting an understanding of the uses of simple personnel information. To some extent this lack of understanding is caused by no communication links between the different sections involved with manpower.

5.4 RECOMMENDATIONS

a. The DSPP with the assistance of MSH and USAID should identify either a point in time or an estimated level of accuracy to designate the computerized personnel list as a complete baseline (See Section IIID1 for recommendations regarding updating procedures).

b. The DSPP should officially identify and provide personnel information from other budgets for the computerized list to complete the inventory of its personnel.

c. The DSPP planning and personnel sections, with the assistance of MSH should clearly define the uses of the personnel information they are collecting and should widely disseminate an explanation of the uses to those involved with its collection..

d. The job description manual should be completed and officially recognized by the DSPP in the next two months.

e. The proposed supervision/performance evaluation system should be field-tested with documented results in one district before general application.

6 MANAGEMENT TRAINING SEMINARS

The Project Agreement notes that the DSPP will provide basic and refresher training to all personnel responsible for... the administration of the rural health system. Several management seminars and much informal training were provided to district administrators to fulfill this objective. The educational quality of these seminars is discussed in section IIE.

Four seminars were offered concurrent with district administrator meetings.

They were:

General Management	March 1981
Financial Planning	December 1981
Personnel Management	March 1982
Supply and Transport Management	June 1982

The chiefs of relevant DSPP sections and MSH consultants in each one of these specialty areas planned and presented the seminars with support from the MSH Boston office. In general, when asked in the course of this evaluation, regional and district participants reported that the seminars served the purpose of informing them about the RHDS project and its component systems. They did not find the seminars particularly useful in day-to-day work, nor did they feel that they had developed any new skills. Based on this response and the evaluation discussed later in IIE the recommendation is to:

Use management/administrative training resources to provide informal training to build skills when and where (regions and districts) it is needed rather than using scarce resources to provide large group seminars as was previously done.

IIB7 GENERAL ISSUES

Several issues have presented themselves during the course of this evaluation that pose important problems for management and administrative systems. They are the new DSPP policy of regionalization and the policy of integrating DSPP systems with those of the DHF, DON, and SNEM.

7.1. Regionalization

By decentralizing the health system to the regions and districts it will be necessary to strengthen and reorient the administrative tasks in those offices. The administrators and bureau chiefs will be called upon to do more decisionmaking. They will also have increased responsibility for supervising new DSPP systems (transport, personnel management, etc.) This might require

additional personnel but most certainly will require the time and effort of those at the center to help district administrators develop new skills. The Torrens Report is an initial attempt to identify some of the needs for regionalizing a health system.

Recommendations

a. For those management systems being implemented in the DSPP, more effort should be aimed at installing these systems at the regional or district level. For example, the transport section should adequately train and supervise regional/district mechanics, drivers, and administrators in new vehicle control procedures.

b. A management/administrative task analysis should be done in one region or district to determine what type of strengthening needs to be done and to determine if staffing patterns are appropriate and adequate.

7.2 Integration

The question of integration has been ongoing and is dealt with extensively in other consultant reports. In principle it is appropriate to integrate the normative function of the divisions in question. In reality most of the administrative systems being put in place do not yet have the capacity to take in these other functions. However, at some levels integration can take place. For example, the computerized personnel list should include staff from all health related bureaus even though they may be paid from a different budget. This would allow for more national manpower planning. The time and scope of work for this evaluation did not allow for an extensive listing of such possibilities, but with the planning of each major step in the development of management/administrative systems the possibility of limited integration should be explored. It is likely that at the very least in many cases information can be brought together for analysis from the DSPP, the DHF, the DON, and SNEM.

8. MANAGEMENT OF A PRIORITY PROGRAM: NUTRITION SURVEILLANCE PROJECT

There is a need to focus the efforts that should be made in management/administrative systems for the RHDS. Given the "Nouvelle Orientation" for the DSPP, these systems should be developed to give the greatest support to programs in the six priority areas. Nutrition is one of these priority areas and the project currently being implemented in the South Region provides an excellent test case for evaluating and improving DSPP management and administration. With a well defined framework, the RHDS Project should assess the management needs of the nutrition program, ensure that all DSPP systems designed to date are implemented, and evaluate what happens. By concentrating on one discrete program, bottlenecks and problems can be resolved more quickly, and appropriate systems adjustments made. This information can be fed back to the central level to help them reorient systems to be more responsive to priority programs.

II C FINANCIAL ANALYSIS

1.0 OVERALL PROJECT FINANCING ACTIVITIES

1.1 EVALUATION OBJECTIVES

This mid-project financial evaluation in February 1983 seeks to:

a) Examine the financial management of the project related activities: in budgeting accounting, disbursement and financial control with special attention to the problems of GOH in obtaining timely funding of its relevant activities.

b) Analyze the financing procedures of GOH and:

1. Recommend specific remedial actions to alleviate its immediate financial constraints in relation to this project, and

2. Suggest possible long term financial reforms and potential resources for future study.

The evaluation involved discussions with staff members from: GOH, DSPP, MSH and AID and examination of the relevant financial documents and reports available. Financial data was reviewed for internal consistency without audit, which is scheduled for 1983 by AID auditors.

The evaluation concentrated on the RHDS project and did not attempt an in-depth study of DSPP long term sources and uses of funds, started in the Cross Report of September 1982. However, such a study for the period 1983/93 should be completed before the decisions are made for possible Title III funding and possible extension of the RHDS project 1984/9

1.2 PROJECT AGREEMENT

The RHDS Project Agreement was signed on June 29, 1979 based on the Project Paper No. 521-0091 dated December 14, 1978, which scheduled activities for the five year horizon of February 1979 to June 1983. Original budgeted funds were: AID \$16.0M (Millions) and GOH Title I funds \$17.3M.

The project objective was to provide low cost, preventive and curative medical services for about 70% of the Haitian rural population by 1990 and to strengthen the DSPP sufficiently to support the RHDS after termination of the AID Project.

Subsequent to the signing of the Project Agreement, certain changes were made, with financial implications, either formally or informally as follows:

a) The project horizon was extended (two years) to June 1985 since a nutrition component was added and the project work started effectively one year late (Aug. 1980)

b) The CP (Condition Precedent) for a Title III agreement which would provide high priority continuous funding, was informally waived in favor of Title I funding (Aug. 1980)

c) The total funding was increased by the Nutrition Component to: AID \$17.5M and GOH \$18.4M (Sept. 1981).

d) A revolving fund of \$0.3M was allocated from Title I GOH funding as working capital for the AID Dollar Reimbursable costs (Sept. 1981).

e) Annual DSPP central staff salary supplements were paid from the RHDS Title I budget. Similar salary supplements for DSPP rural staff were paid by a special additional Title I project (Total annual cost exceeded \$1.0M) (Sept. 1981).

f) Another special Title I project was authorized to pay salaries of auxiliary nurses (Sept. 1981).

g) The target number of trainees was reduced as follows:

	<u>PROJECT PAPER TARGET</u>	<u>PROJECT AGREEMENT TARGET</u>	<u>INFORMAL LIMITED TARGET (1983)</u>
Auxiliary Nurses	550	550	300
Health Agents	1500	1500	550*
Sanitary Officers	220	0	0

* 375 already existed before the project. (Nov. 1982)

Notes: The Project Paper estimated no difficulty in DSPP being able to support RHDS annual costs from internal funding after project termination. However, it failed to consider:

1) DSPP chronic shortage of funds to pay current operating expenses from 1979 onwards

2) The combined effects of multiple concurrent health projects which had to be supported as well as the RHDS project.

h) Phase III construction (\$1.0M) was held pending investigation (Nov. 1982).

i) GOH (Title I funds) was subject to strict CP enforcement for FY 83 (Jan. 1983).

1.3 FINANCING AGAINST TARGET

The RHDS inputs outlined in the project agreement (as amended) were as follows:

<u>ITEM</u>	<u>FUNDING AID \$M</u>	<u>FUNDING GOH \$M</u>
1. Construction and renovation of dispensaries, warehouses, garages, vehicle maintenance facilities etc.	6.3	—
2. Drugs and Vaccines	1.0	2.5
3. Equipment and Supplies	1.8	0.8
4. Vehicles and Spares	1.2	1.5
5. Personnel	1.8	12.3
6. Training	2.0	1.3
7. Technical Assistance	3.2	*
8. Evaluation and Research	0.2	*
TOTAL \$M	17.5	18.4

* Indicates less than \$.1M (less than \$100,000)

Up to December 31, 1982, about 30% of the project funds were actually disbursed in cash as follows:

<u>SOURCE</u>	<u>TOTAL PROJECT \$M</u>	<u>DISBURSED IN CASH \$M</u>	<u>NOT YET DISBURSED \$M</u>
- AID (ANNEX III C3)	17.5	6.5	11.0
- GOH (ANNEX III C3)	18.4	3.4	15.0
TOTAL \$M	35.9	9.9	26.0

Expenditure procedures involved several stages, and the status at December 31, 1982 may be summarized as follows:

	<u>AID</u> <u>\$M</u>	<u>GOH</u> <u>\$M</u>	<u>TOTAL</u> <u>\$M</u>
TOTAL PROJECT:			
- Earmarked	12.8	5.0	17.8
- Not Earmarked	<u>4.7</u>	<u>13.4</u>	<u>18.1</u>
TOTAL \$M	17.5	18.4	35.9
TOTAL EARMARKED:			
- Earmarked and disbursed	6.5	5.0	11.5
- Earmarked, not disbursed	<u>6.3</u>	<u>-</u>	<u>6.3</u>
TOTAL \$M	12.8	5.0	17.8
DISBURSED AGAINST TARGET:			
- Target (Year III)	9.2	6.0	15.2
- Actual	<u>6.5</u>	<u>3.4</u>	<u>9.9</u>
UNDER DISBURSED \$M	2.7	2.6	5.3

The actual disbursements to December 31, 1982 (\$9.9M) compared with the target for Year III of the Project Paper (\$15.2M) substantiate the reported delay in disbursements (\$5.3M) discussed later in this report. Special efforts are in progress to accelerate disbursements in 1983.

1.4 FINANCIAL PRIORITIES

For the GOH funding contribution (\$18.4M) there appears to be some contrast in financial priorities:

a) The Project Agreement implies concentration of new funds on mainly rural rather than central health care systems and strengthening of central DSPP to support the RHDS after termination of the project.

b) The DSPP appears to use such funds as general operating expenses for the whole DSPP because such expenses are not provided for in the Functional Budget. This directly relates to the critical shortage of DSPP resources and its overall financial strategy.

However, until regular reports of actual expenditure by geographical location and organizational unit become available (perhaps from FY 83 onwards with the computer) this contrast can not be well documented, but it must be clearly recognized.

2.0 FINANCIAL MANAGEMENT

2.1 MANAGEMENT OF PROJECT BUDGETING, ACCOUNTING, DISBURSEMENTS AND CONTROL

a) Generally

The project budgets were divided as follows:

1. AID (\$17.5M)

-Direct Dollar Funds (\$13.6M)

-Reimbursable Dollar Funds to GOH (\$3.9M)

2. GOH Title I Fund (\$18.4M) (PL 480). The key stages in funding are briefly illustrated in the Annex IIIC4.

b) AID Direct Dollar Funds (\$13.6M)

This budget is for Direct Dollar payments to U.S. and Haitian suppliers for: construction: (\$6.2M), drugs (\$1.0M), vehicles and parts (\$1.2M), equipment and supplies (\$1.8M), technical assistance (handled by direct Federal Disbursement Contract) (\$3.2M) and evaluation (\$.2M). The usual AID procedures for authorization, earmarking, obligating, sub-obligating and expenditure were observed.

The AID Dollar Direct funds were well managed. Difficulties arose in: annual availability of AID monies, suitability of certain limited expenditures for construction and vehicles, and long lead-time in providing drugs for AGAPCO.

Appropriate solutions to these problems are being resolved by AID/DSPP/MSH staff.

c) AID Reimbursable Dollar Funds (\$3.9M)

This budget is mainly for personnel costs (\$1.9M) and training (\$2.0M) and may be reimbursed to the DSPP only after: a) compliance with appropriate CP's,

b) authorization by PIL, c) disbursement by DSPP in cash, e) submission of appropriate verification vouchers.

The AID Dollar Reimbursement Funds were well managed. Difficulties arose in:

1. Annual availability of AID's monies.
2. Lack of an adequate DSPP Dollar Advance from this budget (Title I \$0.3M funds were supposed to be used instead)
3. Difficulties of satisfying CP's quickly without extensive training of all DSPP managers in AID requirements.
4. Failure of DSPP staff to submit the necessary plans, budgets, vouchers etc. for timely reimbursements.
5. Significant reimbursement delays directly related to the need to maintain rigorous AID financial control.

d) GOH (Title I) Budget Funds (\$18.4M)

Since the Title III agreement CP was informally waived, Title I monies were budgeted as follows: drugs (\$2.5M), vehicles spares including gasoline and maintenance (\$1.5M), equipment and supplies (\$.8M), personnel (\$12.3M), training (\$1.3M).

However, only \$3.4M was disbursed up to December 31, 1982 of which \$0.3M was used as a revolving fund for the AID Dollar Reimbursable Fund. Thus, DSPP had only \$3.1M against a target in the Project Paper for Year III of \$6.0M.

The GOH funding for RHDS was subject to uncertainties including:

1. Annual availability of total Title I food commodities to Haiti and the ability of GOH to sell the food without delay.
2. Agreement by AID that appropriate CP's had been satisfied with budgets, plans etc., so that the Ministry of Plan could transfer the money to DSPP.
3. Agreement by the Ministry of Plan, after due review, to actually request the transfer of the money to DSPP.
4. Subsequent normal DSPP control of expenditures with the Ministry of Plan and the Ministry of Finance.

Thus, GOH Title I funds were not well managed. Difficulties arose from: the annual uncertainties of funds actually available, the usual four months delay in payment after the start of each financial year, failure of DSPP to provide annual budgets for new funds and reports of past expenditures which could be clearly associated with the inputs specified by the Project Agreement, and finally complex GOH disbursement procedures.

2.2 DELAY IN FUNDS AVAILABLE TO DSPP

From the preceding discussions it will be apparent that the reasons for delay in timely availability of funds to DSPP are complex. They are briefly summarized below:

1. Failure of DSPP to satisfy the Project Agreement requirements in terms of: CP's, PIL's, Plans, Budgets, etc.
2. Failure to negotiate a Title III agreement and delay in the availability of Title I funds.
3. Failure to provide a Dollar Reimbursement Fund cash advance separate from Title I monies.
4. Failure to train DSPP accounting and managerial staff on the requirements for reimbursement in the Project Agreement.
5. Staff changes in DSPP central administration and allocation of responsibilities.
6. Difficulty for the DSPP legal accounting system to provide routine financial reporting in a form which could be related to specific project inputs.
7. Complexity of DSPP multiple external financing sources.
8. DSPP chronic cash shortage.

Note: No satisfactory GOH Title I budget was actually received until FY 83 and concessions had to be made in earlier years.

2.3 RECOMMENDATIONS

1. Review the AID Direct Dollar fund problem areas in construction, vehicles and drugs.
2. Negotiate an AID Dollar Reimbursable cash advance of \$.8M against a total budget of \$3.9M to assist DSPP with immediate cash problems.
3. Consider a Title III agreement for more secure and timely long term funding.
4. Renegotiate modifications of CP's in relation to the critical management problems of DSPP.
5. Train DSPP staff at all levels in the need for cooperative efforts to meet CP requirements by timely submission of plans, budgets, schedules and vouchers.
6. Accelerate development of computer based "Supportive Accounting" to provide the necessary budgets and reports which directly relate to specified project inputs.
7. Consider appointment of a Financial Advisor as part of Technical Assistance (or French Ministry of Cooperation) with responsibility to assist DSPP administration in more rapid reimbursement of funds.
8. Negotiate separate Title I funding for the DSPP general operating expenses not provided for in the annual Functional Budget.
9. Avoid severe central rationing of gasoline and travel expenses for rural managers when it reduces their ability to maintain proper supervision of outreach personnel as required by CP's.

3.0 DSPP FINANCIAL CONSTRAINTS

3.1 FINANCIAL STRATEGY

The DSPP has a chronic shortage of internal resources and its financial strategy is to: a) use internal funds (FY 82 Functional Budget \$16M) for immediate priorities, and b) use multiple external funds (FY 82 Development Budget \$18M) for major supplies of: construction, vehicles, equipment, drugs, general DSPP operating expenses, etc.

The Functional Budget expresses the traditional, political and organizational DSPP priorities. It provides for personnel costs (partly), supportive medical institutions (partly), and the absolute minimum of operating costs (but no salary supplements).

The Development Budget (\$18M) supports the health system with external aid from: AID (RHDS, SNEM, DHP, APPUI etc.), PAHO, IDB, Japan etc., with priority for salary supplements (50 to 80% of basic salary) and central rather than rural needs.

This financial strategy has led to some interesting DSPP practices:

1. Some resources allocated to central rather than rural priorities
2. Central institutions maintained at high cost for clinical rather than public health objectives.
3. Priority to pay salaries and salary supplements to preserve the structure. Acceptance of multiple checks for special staff members as a normal practice.
4. Expansion of health services on external funding to provide immediate cash benefits even though this may put an intolerable burden on future operating costs.
5. Financial administration of multiple programs, donors and requirements, which makes the accounting complex, and the computation of total health service delivery costs very difficult.
6. Political and organizational rigidities as a response to changes in the general administration of the DSPP each year.
7. Acceptance of uncertainty in future specific funding, with the general expectation that somehow, total funding will become available because of the multitude of international donors. No effective difference between "donations" and "loans".
8. Acceptance of relative financial crises from natural disasters or inflation, since resources are extended to the limit without reserves. However, no technical criticism of the personnel who have to "make do" with minimal operating expenses until adequate supplies are available from external sources.

Note: Field visits by the evaluation staff to Hinche District revealed 108 out 140 DSPP District staff either in the District hospital or closely associated with it.

Thus, the DSPP financial strategy is to expand its health care structure towards H/2000, but it is not planning a "self-sufficient" health system, due to the absolutely low level of internal resources available.

3.2 FUTURE CONSTRAINTS

The Cross Report, initiated by MSH in September 1982, attempted long term projections on the effect of externally funded health development projects on DSPP recurring annual costs. For the RHDS project, at full capacity, it forecasts extra recurrent annual costs of about \$5M by 1985. (Annex III C5).

Similarly, for all projects and for the chronic DSPP shortage of central operating costs, the Cross Report forecasts extra total recurring annual costs for the DSPP about \$14M by 1985. Annex III C5).

Since the Functional Budget (\$16M) cannot reasonably increase to support these costs (plus inflation), some immediate and longer term financial constraints are appropriate.

For proper understanding, however, of the DSPP long term financial problems, the Cross Report forecasts must be reworked with a variety of alternative specific assumptions for the ten year period 1983/93, to test out alternative financial strategies.

3.3 RECOMMENDATIONS FOR SHORT TERM RELIEF

1. Accelerate reimbursement of Project Funding by timely compliance with the CP's required by the Project Agreement.

2. Continue the RHDS project for 1983/4 with emphasis on consolidation without further expansion, with retraining of existing DSPP personnel for improved health manpower productivity.

3. Negotiate possible modifications of CP's required by the Project Agreement which seem unreasonable to the DSPP management problems. (Annex IIIC9).

4. Consider sub-contracting dispensaries and health centers to groups of FVO's or the Private Sector under DSPP overall control.

5. Continue user charges for services and drugs, with local authority to use these funds for local rural priorities.

6. Strict manpower planning to take up the existing health agents and auxiliary nurses on to the regular payroll, but without increase in the total overall number of personnel in the years 1983/84.

7. Charge AGAPCO with all of its operating and development costs and maintain strict financial control to prevent unforeseen substantial losses.

8. Early payment of salary supplements or increase in petrol or travel advances to reward performance in terms of: immunization, supervision etc. Thus, try to find "motivators" towards improved health systems performance which do not require additional funds.

9. Negotiate a Dollar Reimbursement cash advance of \$.8M (total budget \$3.9M) to assist the DSPP critical cash shortage.

10. Accelerate computerized "Supportive Accounting" to provide: a) data for external funding reimbursement and b) health service delivery cost data for "cost effective" decisions-making.

3.4 RECOMMENDATIONS FOR LONG TERM STUDY

1. Negotiate extension of the RHDS Project for the period 1984/9, including: consolidation without expansion, concentration on cost effectiveness and focus on the key priority areas, development of one region as a model of "ideal RHDS" with high standards of technical and financial management.

2. Develop annually a ten year financial forecast of DSPP health sources and uses of funds for proper long term financial planning of internal and external funding.

Notes: AID policy requirements for financing recurring costs include: a) An acceptable policy framework or a clear movement toward such a policy; b) assurance that recurring costs support has a higher development impact than new investments; c) inability of the host country to undertake recurring cost financing; d) a carefully phased plan for shifting the entire burden to the host government.

Notes: With the DSPP chronic shortage of internal resources, health decisions become directly related to financing and cost effective alternatives. The World Bank could possibly be approached to evaluate and finance a School of Public Health (associated with the University Medical School) to train physicians as managers with financial skills appropriate for the DSPP.

3. Negotiate a GOH/AID Title III Agreement including provisions for: external auditing, a Financial Advisor and special funding of continuing DSPP central operating expenses with planned phase-out over ten years in accordance with AID policies.

4. Simplify external financing by consolidation of multiple projects.

5. Consider use of international volunteer staff (French Ministry of Cooperation, Peace Corps, etc.) in accounting, computers and finance.

6. Develop special planning for improved manpower productivity (with assistance of WHO) to achieve a 20% personnel reduction over 1984/9. Thus, be able to develop a balanced "Functional Budget" as a step toward self-sufficient DSPP health systems in the future.

4.0 FINANCIAL CONTROL OF AGAPOO

4.1 STRUCTURE

The AGAPOO community pharmacy system was set up as a legal entity in September 1982 with a capitalization of over \$1.0M from AID and GOH Project Funding, to provide drugs for resale in 100 pharmacies. The pharmacies were not designed to provide free vaccines or drugs to health agents.

Operations began rapidly in September 1982 and by December 31, 1982, AGAPOO capitalization was \$1.0M, consisting of: drugs received \$0.7M and in the pipeline \$.3M. Three regional warehouses had been stocked (\$.1M) and about 60 community pharmacies (\$.1M).

Notes: If all the relevant set-up costs for AGAPOO could be accumulated from the multiple funding sources, they might well exceed \$.2M.

A mark-up of 28% on costs was taken by AGAPCO to cover its overheads and potential losses. However although AGAPCO salaries and expenses are charged to the DSPP Development Budget, substantial losses (\$.2M) are anticipated from operation of the first three years until break even is achieved.

A mark-up of 100% on cost was provided to community pharmacies to pay for their own personnel and overheads; they were expected to be self-supporting immediately.

4.2 PROBLEMS

Financial problems to date include: a) only 11 out of 60 pharmacies have achieved timely adequate reporting of sales, costs, cash flow, inventory etc. b) losses of central warehouse inventory, c) accounting errors, d) failure to establish monthly financial reporting procedures, e) internal audit procedures not fully operational, and finally, f) failure by DSPP to provide adequate petrol and travel costs for supervision of the 60 community pharmacies.

4.3 RECOMMENDATIONS

1. Charge all AGAPCO costs (salaries, training, expenses etc) to AGAPCO and not to the DSPP Development Budget to show the total financial costs and viability of AGAPCO.

2. Quarterly review as to whether margins are adequate to cover expenses and potential losses of: cash, inventory, shipments, accounting errors etc. Maintain an original capital for each pharmacy clearly in the accounting system to distinguish initial capitalization from subsequent profits or losses.

3. Enforce monthly reporting by the 10th of each month for each community pharmacy.

4. Immediately hire two internal auditors to audit each community pharmacy monthly, until monthly reports are satisfactory, and thereafter quarterly. The audit program should include: verification of shipments from the regional warehouse, physical inventory compared with inventory records, accounting records, cash counts, profit/loss computation, reconciliation of inter-unit accounts and verification of monthly reports. Similarly, do internal auditing for the central warehouse and the three regional warehouses. (Estimated total cost \$20,000 per annum for salary and travel expenses).

5. External auditing of AGAPOO for the purpose of published certified annual financial statements, by a firm of public accounts accredited by the World Bank. (Estimated cost \$10,000 per annum).

6. Since AGAPOO is by design a "commercial business entity" one of the senior management must be an experienced businessman/financial controller to ensure its financial viability and continuity. He should be responsible for preparation of monthly income statements and balance sheets and financial forecasts.

7. Develop five key operating ratios as simple indices of performance (gross profit to sales, stock turnover, inventory losses to total inventory etc.) to encourage good financial management at each pharmacy. Arrange meetings of the pharmacy staff in groups to discuss mutual problems.

Since this is a very important part of the RHDS project, it is vital that it should not sustain significant financial losses.

5.0 TECHNICAL ASSISTANCE IN FINANCE

5.1 OBJECTIVES AND ORIGINAL WORK PLANS

Previous technical assistance in finance by AID projects to the DSPP has resulted in analysis, manuals and reports but little effective change in the financial system. This was probably due to multiple factors including: well established DSPP financial practices and priorities, organizational rigidities and legal requirements, high priority for "cash budgeting of scarce resources" and low priority for health service delivery cost data.

The major outputs of the Project Agreement for administrative/management systems required: improvement of the Financial System and preparation of Annual Budgets.

Note: The cost of such internal and external financial controls is probably immaterial compared with the potential for significant financial losses in the future. (Peat Marwick and Mitchell & Co. have experience in this field and are available in Haiti).

The first MSH Technical Assistance Finance Work Plan set out a program for study and change in budgeting, accounting, disbursement, financial reports, internal audit and development of regional accounting. The problems were well documented and a chart of accounts developed but little change in procedures could be achieved. This process was repeated with the second Technical Finance Work Plan in 1981 which terminated in 1982. (Annex IIIC8). It was extremely difficult to achieve change in DSPP financial systems before change could be achieved in DSPP organization.

5.2 NEW DEVELOPMENTS SINCE 1982

In 1982, MSH introduced three very significant and creative contributions to the finance area:

- a) The Cross Report on the long term financial implications of the multiple externally funded health development projects.
- b) Introduction of computers, initially for personnel analysis to satisfy a CP, and subsequently for budgeting and supportive accounting.
- c) Close and acceptable assistance to DSPP in satisfying CP's for more rapid reimbursement of project funding.

The new Technical Assistance Finance Work Plan (Annex IIIC8) appears to have good potential but it should be recognized that it takes several years for new budget and accounting systems to become institutionalized and effective. To date, a budget has been prepared using the computer facility, and programs are being written for financial accounting and reporting. The value of these systems is not yet proven but they could be associated with appropriate DSPP long term financial reforms.

5.3 RECOMMENDATIONS

1. Recognize the rigidity of the DSPP legal accounting systems and develop computer based "Supportive Accounting" to provide:
 - a) Health service delivery cost data for "cost effective" decision making i.e., analysis and reporting of actual cost expenditures.
 - b) Supportive data for external funding.

2. Expand computer applications as a "Psychological Entry Point" to motivate change in organization. This is not obvious or purely "technical". It involves strategic planning of the use of computers to determine "appropriate systems and objectives" especially in finance. It is essential to recognize realities of DSPP management problems and thus to choose applications of the computer that are "simple and low risk", at least initially e.g. analysis of actual expenditures etc.
3. Continue assistance to DSPP in long term financial planning using the computer (SuperCalc and other packages).
4. Support training of DSPP managers at all levels in:
 - a) AID funding requirements.
 - b) Practical use of computer outputs.
5. Consider concentration of Technical Assistance 1983/84 to the limited fields of: computers, finance and health planning support.

Notes: Special mention must be made of:

- a. The high level of MSE professional competence in the areas of finance, accounting and computers.
- b. The helpful cooperation provided by DSPP, MSE, and AID staff members.

II D. INFORMATION SYSTEMS

In the course of this evaluation the information systems used and developed in relation to the RHDS Project by the DSPP and by the technical assistance contractor, MSH, were reviewed. The focus of this review is on determining how the information systems could be improved to provide useful and timely health and management information.

Developing information systems to enhance and support DSPP operations such as planning, evaluation and administration has been a high priority AID concern since the project paper was approved in August 1978. This document emphasized the need for the technical assistance of a statistical advisor to the DSPP Statistics Section (36 person-months), to ensure that the RHDS project got necessary epidemiological baseline and follow-up data. This data would be used to evaluate project health impact and monitor national health status.

Systems emphasized were national health information, program budgeting, and active personnel management. Major developments in the area of information systems have centered on the need to prepare detailed budgets and respond to AID Conditions Precedent, such as providing information on staffing patterns for the central DSPP, and a list of positions to receive project funded salary support. Substantial time and effort has been required to obtain and organize the information required by these conditions, and the MSH team has taken the lead role in organizing and computerizing the data. Although some work has been done in the health information area, management information systems have received greater attention as the project has unfolded. These two systems are discussed separately below.

II D MANAGEMENT INFORMATION SYSTEMS

1.1 Current Status

Some major accomplishments have been made in development of information systems, especially during the six months preceding this evaluation. These

accomplishments include substantial progress in developing computerized systems for:

a) producing a file of health establishments (including public and private "mixed" health care establishments, DSPP regional and district offices) and creating a unique identification system for each establishment which is to be used to link other information files (such as the inventory, vehicles, personnel, budget files);

b) producing a file of DSPP personnel (as required by 4.6 of the Conditions Precedent in the original Project Agreement), storing and developing a system for updating this personnel information;

c) recording yearly DSPP budget information for three budget sources (the functional budget, the Title I budget and the reimbursable project budget) with details about amounts budgeted to each rubrique (category) of each budget;

d) recording the amount for and the recipient of each DSPP check written and the exact budget rubrique appropriate to the check;

e) recording information about inventories of equipment such as desks, refrigerators, scales, sterilization equipment available at each health establishments;

f) recording information about the location and status of vehicles available by each DSPP section or regional/district bureau.

g) processing reports submitted to the central AGAPCO drug supply office concerning sales, receipts, requisitions.

Additional details about each of these computerized data files are contained in Annex III-D.

MSH staff have taken the lead role in development of management information systems due in part to a lack of DSPP counterparts assigned to work full-time on compiling, verifying and organizing the data required for these systems. Compiling and verifying information for the financial/accounting, personnel, inventory, and vehicles files has been an extremely time-consuming effort for technical assistance staff, since adequately documented operational manual systems were not in place.

An approach has been developed using Radio Shack TRS 80 microcomputers to store and process the data for some of the files, and DSPP staff are being trained to enter data as prescribed by specifically programmed menus. These staff are also being trained in production of computer-generated reports using available data.

The addition of two systems analysts to the MSH team in the past six months has added significantly to their ability to develop user oriented systems and to take on new tasks. These tasks include training some staff selected by DSPP in data entry and production of the keyed data. Staff from the DSPP inventory office have been trained to enter data on the inventory file, and AGAPCO staff have been trained to enter data to produce monthly AGAPCO accounting reports.

1.2 PROBLEMS AND CONSTRAINTS FOR MANAGEMENT INFORMATION SYSTEMS

The major problem discovered during this review has to do with the lack of DSPP involvement in and ownership of the management information systems developed.

When computerized systems have been developed in the course of this project (e.g., personnel, establishment, budget, expenditure, and property control), it has been MSH staff who took the major role. Adequate planning for technology transfer and the institutionalization necessary for DSPP's long-term maintenance and use of the systems in the DSPP at various levels (central, district/regional, health care establishment) has been lacking.

Creating in the DSPP the capacity to: a) update the information in these systems, b) tailor the systems to fit their needs, c) use the information to its full potential for planning, monitoring, and evaluation activities and, d) add additional components to the system (especially health services statistics) will require continuing technical assistance. It will also require a change in the current relationship between DSPP and MSH to drastically increase DSPP participation in the development, maintenance and use of these systems. DSPP has virtually no institutional experience in computerized data processing activities or use of computer outputs, and has no trained programmers or systems analyst on its staff.

Thus, if the technical assistance did not continue and if the available machinery, data files and software were turned over to DSPP today, none of the 7 existing computerized systems would survive. Of course, the technical assistance contract is not scheduled to end for seven months, but it is unlikely that the situation will be dramatically different at that time. Continuing technical assistance in the area of management information systems will be essential if the work done thus far is to have any impact beyond the life of this project. However, the technical assistance must be accompanied by substantial, full-time counterpart involvement.

The two Radio Shack TRS-80 Model II Microcomputers which MSH staff have used in developing the data sets now available are both located at MSH offices (only a short walk from DSPP but still physically separate). One of these machines was purchased and the other was rented. Some major planning decisions will be made about the use of the computer soon which may result in the purchased microcomputer being relocated within a DSPP office (although which particular office and which activities will be undertaken there are not clear).

Other problems include:

a) Some information required for budget/personnel data systems has been extremely difficult to obtain and verify because of resistance within the DSPP.

b) Manual information systems containing required data are often unavailable, incomplete, or not clearly documented, and therefore difficult to computerize in a satisfactory fashion.

c) Target populations are not identified and indicators of success in reaching target populations or improving health care services, are not determined. Thus, the data collected are not focused and the reports are not generally useful.

1.3 RECOMMENDATIONS FOR MANAGEMENT INFORMATION SYSTEMS

a. FOR DSPP/MSH

1. Focus on the most important data needs only and define how data are to be used. Which systems are top priority, what decisions require accurate and timely data, what outputs would be most useful, and how often are these outputs needed?

2. Determine a long-term plan for computerization of DSPP information systems and determine project equipment, software, staffing and training needs at DSPP.

3. Focus on institutionalizing maintenance of priority systems within DSPP and provide assistance in turning over systems to DSPP. Locate equipment within the DSPP.

4. Develop clear documentation of computerized and manual systems. Define uses and outputs.

5. Train DSPP staff in use of equipment, systems, and computer-generated reports.

6. Involve regions and districts in feedback about results of using computer systems, and train them to use outputs. Consider possibilities of locating computer terminals in regions/districts in the future.

7. Computer-generated data does not necessarily represent good data. Build in quality control procedures for data collection, data entry, data editing and data manipulation such as use of test data and crosschecks with manual records.

b. AID/DSPP

1. Support development of automated management information systems at DSPP and improvement of manual systems.

2. Increase technical assistance in the area of information systems development, documentation and training activities.

3. Focus on training needs of DSPP staff and train more than enough people to take on needed work at each level (e.g., data entry, programmer, systems developers).

4. Consider hiring a full-time computer expert consultant for DSPP to assist in above activities for 2-3 years with short-term consultants thereafter.

II D 2 HEALTH INFORMATION SYSTEM

2.1 SUMMARY OF ACTIVITIES AND CURRENT STATUS

Currently regular reports are supposed to be filled out at every level of health care delivery—agent de sante, dispensary, centre de sante, hospital. These reports include monthly records of activities and types of patients seen. (See Annex III-D-2).

Hospitals and centres de sante are also supposed to submit weekly communicable disease reports to the districts or regions which are to supervise them. (See Annex III-D-3). These regular reports are supposed to move in roughly the manner illustrated in Table 4.

TABLE 4

To be provided by Kristine Olsen

Regions are becoming more active in the area of summary reporting. Report from the North Region for 1982 was recently released as its first annual report; the South Region has been publishing annual reports for the past several years.

Some district heads are required to write reports concerning the health establishments in their areas, although the contents and period to be covered for these reports are not yet well defined. Some administrators say that the Bureau of Health Planning and Evaluation dictates the subject, while others say the local district or regional administrator decides.

The central Statistics Section has the responsibility of preparing a composite national report for the first six months of a fiscal year and again for the entire year. The Epidemiology Section is charged with preparing reports every three months using weekly (and very incomplete) transmissible disease data.

The DHF prepares reports primarily concerned with data related to family planning. Data sources are often the same as those used for the DSPP Statistics Section Reports.

It is estimated that at least half of the rural population receiving primary health care services receive them through private establishments. These establishments are requested to provide regular reports to the district or region in which they are located. Cooperation is highly variable according to regional statisticians who tabulate this data.

2.2 PROBLEMS AND CONSTRAINTS

In order to provide information about budgets and personnel, the health statistics information system was given relatively little attention by the technical assistance team. The detailed analysis of the problems of the DSPP Section Centrale de Statistiques by the technical assistance team in January of 1981 reflects problems still found in the health information system. These problems include: incomplete data (generally 40% response to monthly required

reports from health units), inconsistent/inaccurate data (due to varying perceptions of definitions or simply filling the report in order to receive one's paycheck); unused data; unavailable required data; and no feedback to lower levels concerning the use and interpretation of the data. Peripheral levels do not see the data as meaningful or useful and often do not report. These problems continue to cause major limitations in the usefulness of the reports generated through the Section Centrale de Statistiques.

Additional problems of lack of supplies (especially reporting forms), lack of organization, lack of trained staff at many establishments, and delays in receiving funds for purchasing forms and equipment are often cited by the Chief of the Section, who realizes many of the limitations in the data now collected and used in reports.

Currently there is no central source of information concerning what data are needed, what data are available from whom, how the data flow, how the data are disseminated, and how they are used. Such a central source is necessary so that efforts are not duplicated, staff know what sources of data can be used for their work, lessons learned from previous data collection efforts are incorporated in future data collection, and the combinations of available information are known. This centralization of information concerning data sources (and knowledge of who can gain access to data sources) will become increasingly important and useful as the various systems are computerized. For example, under current plans it is likely that files will be able to be linked by use of unique coding systems so that manpower available at each health establishment could be compared to service statistics to evaluate manpower needs and evaluate establishment performance.

The central source of information about previous, current and planned data collection activities could provide a useful demonstration of the benefits of integration of various DSPP organizational units. This source could itself be well-suited to computerized filing so that changes, additions and corrections could be easily made and the status of each output (e.g. report) easily

determined. The central source could include descriptions of data resources, what is to be produced from those resources, scheduled outputs and how to tap those resources if additional information were required from or about them.

There is a major problem in the reporting system which contributes to the underreporting and unreliability of the data obtained. The data are not seen as useful to those who are to collect and transfer the data to higher levels. For example, the reports are not analyzed for examining health trends in one's own area, measuring performance of subordinates or for the health team or for examining retraining needs.

Part of this problem has to do with lack of training and experience in analyzing the meaning of reports, and part has to do with the fact that targets are not set. Thus the data collected have no context and no standard by which to be judged. There are no set sanctions for non-reporting, although in some areas requirements have been established for report submission before paychecks are distributed.

Target populations are not identified and indicators of success in reaching target populations or improving health care services, are not determined. Thus, data collected are not focused.

2.3 RECOMMENDATIONS

a. General

The DSFP central, regional, and district office administrative staff are aware of many of the deficiencies in the current health information system operations as are MSH staff.

1) The problems require a concerted effort to define the priority data needs for each level of the system (central, regional, district, establishment, health worker, client) and to develop a workable system to provide valid, reliable data on a timely and affordable basis. (See Figure III D-2 for an example of the product of such a systematic assessment.)

2) Rather than simply adding to the problems of the current system by creating new forms, a very focused approach which considers the specific needs of different levels, the technical emphasis of the various actors and the array of data sources which could provide the necessary information should be taken (e.g. from DHF data sets, from Bureau of Nutrition surveys, from Institut Haitien de Statistiques data sets, from studies done by international organizations such as PAHO and UNESCO). Before adding any additional form or even any item to the information already required from health establishments, the data already available should be reviewed, the specific data use should be well defined and documented, the level of precision necessary and time frame for usefulness should be determined (i.e., Could the information be obtained once a year rather than once a month, every month? Could it be obtained by examining a sample of records or by a sample survey rather than through constant reporting?).

3). Any new or revised data collection instrument should be pretested in the actual type of situation and by the actual type of staff who would be using the instrument. Procedures and written instructions which document definitions of terms should also be tested.

4) Training and supervision needs should also be planned, and the actual performance of the data collection effort should be evaluated and documented.

5) Reports from central district and regional levels should be reviewed for analysis and meaningful interpretations and uses should dictate their contents.

b. Recommendations for GOH/MSH

1. Concentrate on defining priority data needs for each level of DSPP staff and best ways to obtain and use data. Have administrators at each level meet with the information systems technical assistant to define jointly what is used from the current system, what is not used, and what is not available but necessary. Emphasize the use of data at each level rather than just satisfying requirements for those at higher levels.

2. Limit what is collected to what is to be used
3. Plan ahead for analysis in the design of forms and concentrate on priority health areas.
4. Review data needs and data collection efforts regularly (e.g. once a year) to determine their relationship to quality of data provided and use of data.
5. Always pretest forms in the actual field setting, with the appropriate field staff using the proposed form, before institutionalizing it. This will allow early discovery of many weaknesses, sources of confusion and error.
6. Provide a long-term data analyst (1-2 years) as a technical assistant to work full-time with the Statistical Section on needs assessment, target population, indicators of progress in priority health areas, planning and reviewing all DSPP reports which use health data.
7. Plan for eventual computerization of processing in all forms designed. Have all forms reviewed by a programmer before pretesting. Determine priorities for automation (See Annex III D4, A discussion of death certificate information which is currently under study).
8. Create one single system for flow of data.
9. Consider the information needs of private institutions and feed back results to them to encourage use of information and continued reporting. Avoid having two separate reporting systems developed; if private institutions find the DSPP system unresponsive to their information needs, they will develop a parallel system.

II D 3 OTHER SYSTEMS BRIEFLY REVIEWED: SUPERVISORY REPORTS

3.11 Current Status

The Bureau de Service de Sante Regionalise has worked with MSH on a system for rating each establishment based on objective criteria such as presence of filed monthly reports, job description information on file for each employee, status of equipment and drug supplies.

The purpose of the form will be for use in periodic supervisory visits to health establishments by regional and district level teams. The forms are to provide an objective basis for performance evaluation and for detecting establishments requiring a more frequent supervision.

3.12 Problems and Constraints

Uses and outputs from the reports have not been defined. Who will receive the data? In what form? What decisions will be made based on the data? Do the responses require additional explanation rather than just a point system grade?

3.13 Recommendations

Pretest the system thoroughly in one district using the type of staff who will conduct the supervision visits and also using the staff who developed this system. Plan how the data would be presented and used. Refine the plans and data collection form before using it in additional areas.

3.2 VITAL EVENTS REGISTRATION

3.21 Current Status

Very little work has gone into improvement of the vital events registration system under this project. There have been efforts to locate, register, and train traditional birth attendants (matrones) to report all births to agents de sante and dispensaries. A preliminary reporting system (monthly form using

pictures) denotes the number of births assisted by the matrone. This form is brought to the dispensary during the matrones meeting with the auxiliary (to receive supplies such as soap and discuss activities).

Registered deaths constitute only an estimated 15-20 percent of all deaths in Haiti and these are almost exclusively deaths occurring in hospitals.

The RHDS Administrator indicated that this was an area known to require technical assistance.

3.22 Problems and Constraints

There is very little incentive to register births or deaths. Developing a working registration system would require technical assistance and coordination among several agencies—DSPP, Institut Haitien de Statistiques et d'Informatique and the Registrar's Office in the Ministry of Health.

3.23 Recommendations

Development of a working vital events registration system is not a high priority within the goals of the RHDS project. Improving the health information system and building relations among matrones and dispensary auxiliaries could be expected to result in better information about births. The Director of the Institut Haitien de Statistiques and D'Informatique indicated that a national mortality survey was planned for 1983. Results from this survey, if it is carried out, plus improved mortality data from the health information survey could provide needed information about deaths.

Thus, although building the vital events registration system may be a very important activity the resources required to focus additional specific attention on developing this system may be beyond the focus of the RHDS project.

3.3 TRAINING REPORTS -AGENTS DE SANTE

3.31 Current Status

Very little information is available centrally concerning training carried out under this project. For agents de sante, district supervisory teams are supposed to keep information about who has been trained, those in training and plans to train in the future. Generally it appears that this is done. Training teams do not systematically provide information about their evaluations of the training sessions. Although a form was developed and sent out, no responses were received, virtually no followup was done and there is no formal mechanism for obtaining participant evaluations for the training or determining the relationship of the training to actual performance or day-to-day activities in the field.

3.32 Problems and Constraints

Needs for data have not been defined. It has not yet been considered important to evaluate the training in light of performance and actual activities required on the job, or to have information at the central level about number of persons trained (See Section II E for details)

3.33 Recommendations

Supervisory training teams should determine a simple, systematic way to obtain, use and retain information for easy reference. Data likely to be required include:

	Available
Number of Agents de sante trained; New vs. recyclage and their location	Yes
Number of agent de sante in training; new and recyclage and their proposed locations.	Yes

Simple report concerning problems identified in each training which could be used to feedback to those who write/review trainings and for making local training adaptations as necessary	Yes
Problems identified in supervisory visits, from auxiliaries comments requiring special attention in training and in supervision.	No
Feedback from agents de sante about training after the session and after a period of work	No
Information from observing agents de sante in action which indicate where training was weak, inappropriate or not available.	No

This list is just for example purposes. Specific data needs should be defined carefully and only information that would be profitably used should be collected.

II E TRAINING AND MANPOWER DEVELOPMENT

There is wide acknowledgement of the primordial role of training and manpower development in primary health care projects such as the (RHDS). An ambitious purpose, such as "the implementation of a nation-wide, low-cost rural health delivery system concurrent with the strengthening of the DSPP to manage that system... "(Project Agreement, GOH/USAID)", depends on a strong, department-wide training component for any degree of success; weakness or gaps in that component make chances for long-term upgrading of service delivery and management slim.

To this end, \$2.009 million in aid was budgeted through the Project Agreement (with an additional \$1.296 million in GOH contribution) for training activities for medical and para-medical personnel, including long and short term training in the United States. Technical assistance to the DSPP in training and manpower development has been provided by MSH through 24 person/months of long-term technical assistance (a training specialist fielded in February 1981), as well as through short-term consultancies in training and manpower development (well over 8 person/months to date).

In addition, the other principal areas of technical assistance--health systems planning and management, transport, supply, information, nutrition--have included training activities to varying degrees. The situational analysis set out in the MSH "Initial Analysis and Work Plan" of December 1980 described several key problem areas in training among them:

"There has been little effort to base any... training activities on clear job descriptions or ... task analyses".

"Basic training at all levels occurs in relative isolation from other personnel comprising the health team".

The analysis noted DHF training programs in MCH/FP and DON training in nutrition for doctors, nurses, auxiliaries and health agents while further

noting a certain lack of coordination between DSPP technical services. Some allusion was made to the responsibilities of the Division of Nursing and the Section of Medical and Para-Medical Training. It concluded that "a coordinated training, continuing education and on-going supervision strategy is vital to improve the efficiency of the health and administrative manpower." This strategy was to be developed through-priority setting as a way to make training task-oriented so that it "result(s) in specific job activities which can be objectively supervised by selected indicators."

1. SUMMARY OF ACTIVITIES

Health Agent Training

By late 1980, as a result of previous pilot projects and FVO activities, as many as 376 health agents had been trained and fielded in the North, South, and Artibonite regions; of these perhaps 330 were active. This corps of health agents was far from homogeneous in term of training received, work patterns, and responsibilities. Style and regularity of supervision also varied widely from zone to zone and from project to project.

On the basis of an MSH consultancy (Sept-Oct 1980) the initial point of intervention chosen was that of curriculum review and development, and the chosen agency, was the DSPP section of Medical and Para-medical training (SEMP) (which, it appeared, would be transformed into a full-fledged training and continuing education service). The DSPP had already produced a training document in 1977 for health agents—Guideline for the Training and Utilization of Health Agents—prepared by SEMP, DHF, DSI and a WHO consultant.

The choice was made by SEMP in late 1980 to develop a new set of training documents, with a module format, based on health agent task analysis. In January 1981 a central committee was organized through SEMP to define health agent tasks and coordinate the development of training modules. Representatives from DHF, DON, DSI, SNEH and the Tuberculosis Monitoring

Office made up this central committee, along with MSH consultants. Initially ten modules were foreseen (see Annex IIEI), corresponding to ten tasks or task areas, and work groups for the development of each module were organized and worked through February, March and April of 1981 to produce the modules. It is worthy of note that MSH consultants (Drs. Rohde and Genece, Ms. Pryor-Jones) formed the majority of five of the ten groups, forming half of three others. (At least one MSH consultant was present in all ten groups).

Before the completion of all ten modules in April, two of the draft modules (Community Diagnosis and Diarrhea) were briefly field tested in health agent training in March in Jacmel. These were the only modules to be pre-tested. In 1981 the draft modules were presented to regional and district personnel involved in health agent training at a 4-day Seminar-Workshop in Cap-Haitien. Training teams from the North, South, and Artibonite region were present, as were representative from the Districts of Croix-des-Bouquets, Jacmel, and Petit-Goave. After some re-editing, the modules were printed in August 1981 for use in training of health agents, and their supervisors (auxiliary nurses). Companion documents (aide-memoire) were also published in French and Creole for health agents. In addition, eight forms were developed and printed for health agent work—census, daily activities, monthly reports, supervision check lists—to complement the training documents.

These modules have been used in health agent and auxiliary/supervision training sessions, since that time. Health agent training is carried out in three-month sessions at regional or district headquarters; auxiliary/supervision retraining is done either during or subsequent to health agent training sessions in the same sites, but these sessions are generally no longer than a week in duration. The DSPP accepted recommendations from MSH to redefine the training strategy set out in the Project Paper. Rather than rely on centrally-based mobile training teams, regional and district training/supervision teams were to be established, with SEMP responsible for the training of these teams.

Training teams already existed at the regional level in the North, South and Artibonite; district teams were established in Petit-Goave, Port-de-Paix, Hinche and Jacmel as staffing of the District office permitted. A district-level team at Croix-des-Bouquets was already operative. Training of trainers—the training and supervision teams—will be discussed in detail below.

Some retraining of fielded health agents in the North and South Regions took place in 1981; 35 new agents were also trained in 1981 but not with the entire ten-module program. From April 1982 to February 1983 there were seven health agent training sessions which trained a total of 178 new health agents. Perhaps half of these agents have actually been fielded; the others await official assignment and supplies. Some further in-service training was given in short session, to health agents, in the North and South also in 1982. While the training modules describe means of verifying participant comprehension, and while all sessions seem to have included some form of post-testing (after each module or at the close of the three-month period), there is no standard competency test in use at this time.

AUXILIARY NURSES/SUPERVISORS: RETRAINING

The fielding of health agents creates a new area of supervision, and since health agents are tied to a dispensary or health center, the responsibility for local supervision, falls on the auxiliary nurses. This change in the role of the auxiliary would necessitate a review of the present curriculum of the auxiliary nurses training schools as well as the retraining of auxiliaries staffing the facilities with health agents in their zones. To this end, workshops have been organized to inform auxiliaries of the health agent program and of their role as supervisors. During 1982 this retraining became more systematic, as the district training teams moved into action and new groups of health agents were trained.

SEMP has developed a supervision form for auxiliary supervisors which is accompanied by a pamphlet, "A Guide to Health Agent Supervision. This guide

was not ready for distribution while most of the above retraining was carried out and it is not clear how many auxiliaries actually have this guide in hand, or how many regularly use the SEMP supervision form.

These workshops for auxiliary supervisors have generally been limited to 5 to 6 day sessions. SEMP has developed guidelines for these sessions in a guide for District training teams. While in some areas (South Region for example) there have been follow-up sessions, this remains a very weak pillar of the health agent program. The proposed supervision schedule--a minimum of one field visit per month per health agent (by the auxiliary or auxiliaries) plus a monthly meeting of health agents at the base dispensary or health center--has been difficult to implement, and few auxiliaries in the field seem to have a very clear understanding of the role of supervision i.e. in what way they are to supervise health agents.

TRAINING OF TRAINERS

As stated earlier, the initially proposed strategy of creating mobile training teams for health agent/auxiliary supervisor training was modified to one of building up Regional and District training and supervision teams. This strategy recognizes the intimate relationship between training (especially in-service training) and supervision at the field level, but this requires a great deal more investment in training of trainers. That is, rather than train three national mobile teams, it would be necessary to train fourteen or more.

Activities in this area began in May 1981 with the Cap-Haitien seminar during which the draft health agent training modules were presented to the functioning training teams of North, South and Artibonite Region. Late in the same year, with the printing of the compiled modules in a trainer's guide (September), SEMP (assisted by the MSH training consultant) began to work directly with District offices to organize training and supervision teams. In the course of this work SEMP has developed a guide to the preparation of

District training and supervision teams ("Preparation des Equipes de Formation et de Supervision au niveau des District Sanitaires") which outline the steps involved. District teams established through this process are now in place in Petit-Goave, Port-de-Paix, Hinche, and Jacmel.

According to the SEMP document ("Preparation des Equipes..") the preparation of training and supervision teams is a matter of 5 to 7 days intensive work in five stages:

- The structure of the District
- Community motivation and health agent recruitment
- Budgeting (for activities)
- Retraining of auxiliary supervisors
- Health agent training

This 5 to 7 day preparation sets out very ambitious training objectives (see annex IIIE2), and it is not yet clear how effective it has been. Once again, no systematic evaluation took place at the time of this training at District level, either of trainer or of participant reaction and performance. Close monitoring and follow-up of District teams at least during the initial year or two of operation, seems essential. However, SEMP has not been able to do this, primarily because of severe personnel constraints.

RHDS SUPPORT SYSTEM

Support for the community-based activities of RHDS must exist at all levels, from District up to central level, and this normally would mean organization of training activities—not only for management personnel, but also for key technical services such as transport and logistics. Four management training seminars were organized through MSH for District administrators, chefs de bureaux, and central level (DSPP) administrators: Health Planning and Budgeting for Regions and Districts (8-11 December 1981 at Kyona Beach); Personnel management (25-26 March 1982 Petit-Goave); Drug Supply Management (15-18 April 1982 in Port-au-Prince); and Transportation System Management (15-18 June 1982 in Port-au-Prince).

While reports from these seminars are surprisingly incomplete, it is fairly certain that the great majority of District level participants attended all four seminars, with central level DSPP participation varying from seminar to seminar. Once again, no systematic evaluation of these seminars, or need assessments for participants were carried out.

Beyond these more formalized sessions, there are now weekly meetings within the administrative division of DSPP involving the five service chiefs—Transport, Personnel, Archives, Inventory, Supply. Beginning in late 1982, a planning exercise was instituted wherein District administrators, normally two per week, present their annual work plans and budgets to the Secretary of State, DG, and divisional and service chiefs. With the introduction of computer technology as a management tool (by MSH) in 1982, new areas of training will be opened up.

Transport and vehicle maintenance has kept a strong training component in RHDS. While the Transport Seminar (June 1982) focused on presenting and explaining the new systems of vehicle use plans, motor pool strategy, and vehicle maintenance plan, the bulk of training has actually been focused on mechanics: 67 DSPP and SNEM mechanics have been trained in preventive maintenance, with the SNEM mechanics also trained in diesel engine mechanics. Administration and organization of a garage are included in the courses. At the regional and district levels, 25 mechanics and drivers have received training in simple repair and maintenance. The success in this particular area of training is largely attributable, to not just the excellent technical assistance, but particularly the fact that it clearly responds to the professional needs of its target group. There is no lack of motivation to attend, and to actively participate, in training activities. A maintenance training manual has been produced and is in use.

Training in logistics and supply systems has been almost exclusively focused on the drug supply system, AGAPOD in particular. The creation of community pharmacies through AGAPOD requires training of clerks (proposed by their

respective communities) to operate them. Training methods and practice have evolved since the earliest session in 1982, due to a backlog of communities ready to open pharmacies, 40 clerks in South Region were trained at one 5-day session. At the present time, the training of clerks closely follows the community organization procedure. Once a community takes the steps to create a pharmacy and propose clerks (AGAPCO suggests 2 per pharmacy), the training is immediately carried out, with the AGAPCO community organization specialist training no more than 4 clerks in one session. Of the five days of training, fully two are focused on AGAPCO bookkeeping and pharmacy operation. This initial training is then reinforced by a full-day of review timed to correspond with the actual opening of the pharmacy. Supervision schedules have, however, not been completely worked out, and follow-up of trainees is quite weak. A check-list type supervision form has been developed but has not yet been approved for regular use. The form would be the only available means of evaluating pharmacy clerk training. The document produced in this area--the AGAPCO accounting manual--was not designed to be a training manual, yet neither can it serve as much of a guide. Several clerks admitted freely that the manual did not seem to be adapted to their educational background. Observations during field tours raised serious doubts about competency (but not level of enthusiasm) to operate pharmacies without decapitalization and/or resupply problems. Prospects are dimmed further by the fact that the close, regular supervision necessary for the success of the program has not yet been fully planned, much less implemented.

TRAINING INSTITUTIONS

The reorientation of the national health delivery system through RHDS would almost inevitably generate the need for some reorientation of basic training provided by the medical and paramedical training institutions. There are a number of possible points of intervention here--curriculum review/development and field practicums being two of the primary ones.

Technical assistance in this area began in December 1980 with a review by Dr. R. Northrup of the auxiliary nurse, hospital nurse, and medical school curricula. Review of the nursing and sanitation officer training programs was continued by the long-term MSH training advisor in early 1981 with a view toward establishing learning objectives for the various field practicums. A 2 1/2 day seminar - "Journées d'Etudes"-on field practicums was organized in April 1981 in Port-au-Prince which brought together representatives of SEMP, DSI, DHF, DHP, and Bureau of Nutrition along with directors and teachers from the auxiliary nursing school, nurse-hygienist school, and sanitation officer training schools of Port-au-Prince. Objectives, methods, and organization of field practicums were discussed, as were necessary resources. Work in groups produced individual plans for each program--auxiliary, nurse hygienist, and sanitation officer--consisting of objectives, methods, and resources required. These workshops were to lead to the establishment of a permanent committee on field practicums chaired by SEMP. It is not clear whether this committee has remained functional. Of the seven problem/action areas cited in the concluding statement of the seminar, material needs (financing, lodging, vehicles) account for three; two are specific to individual schools; and but two are clearly technical--lack of sufficiently trained supervisors and of effective orientation sessions to precede practicums. These expressed needs should not be ignored in future discussions of assistance to these institutions in terms of the material/technical mix.

For a number of reasons, some of which will be discussed below, in the Problems and Constraints section, activities have been quite limited in the wake of that seminar. A review follows by institution:

AUXILIARY NURSING SCHOOL

One of the results of the April 1981 seminar was the organization of work groups to produce eight community health practicum modules for the month-long rural stage in the auxiliary program. This work process met with much less success than did the health agent modules. The Division of Nursing (DSI)

remained unconvinced of the need for revision of the curriculum and SEMP's role (and mandate) was thus brought into question. Thus resistance to general curriculum reform (as proposed by Dr. Northrup and SEMP) carried over to reform of the field practicum. Work has therefore been slow and acceptance of the modules questionable. It should be noted that DSI, aided by a WHO/PAHO consultant, had revised the auxiliary curriculum in 1979; Bureau of Nutrition and DHP had also revised the nutrition and family planning components of the program, working with teachers in the schools, in the intervening period. In any case, after extensive re-editing, the eight Community Health practicum modules are now in press (February 83). The title of the modules are listed in annex IIIIE 1

HOSPITAL NURSES

It was thought by SEMP that the eight modules could also be used by these nursing schools as well. This also remains to be seen. Presently this category of personnel is not seen as a priority, given its hospital orientation, in terms of the RHDS project.

SANITATION OFFICERS

Interest has been renewed very recently in revision of the sanitation officer curriculum, due in large part to the scheduling of an MSH consultancy in this area of technical assistance. Meetings within the DHP (Public Hygiene Division) are now being held to discuss curriculum reform and learning objectives in light of the role of sanitation officers in RHDS and a revised job description. As overextended as SEMP is at this time, it is difficult to see who will follow-up this consultancy and participate in work groups during the process of curriculum review and revision.

MEDICAL SCHOOL

The Faculty of Medicine has remained remarkably closed to DSPP attempts to bring about a review of curriculum. The situation has been further

complicated by the inauguration of the year of Social Service for physicians. While this Social Service year created the need for sound pre-field orientation sessions, attempts by RHDS to develop such sessions proved to be abortive. However, a very useful study was carried out by DSPP through RHDS which evaluated, with full Social Service physician participation, the experience of the first class (1975-81) to be fielded under the Social Service decree. This evaluation and the laudatory initiative of the Director General (DSPP) in associating the Haitian Public Health Association in further study of the matter, give some new hope for new directions in the community health orientation of physician training in Port-au-Prince.

PILOT/DEMONSTRATION HEALTH CENTER (Petit-Goave)

The Project Agreement (Version Francaise, annexe 1, p. 3) speaks of a pilot health center to be built in Petit-Goave to serve as a rural health training center. Little interest in this component is apparent, and very little action has been taken, by any party, to pursue it.

OVERSEAS TRAINING

The Project Agreement also speaks of establishing an exchange program with an accredited university for public health training. No preliminary agreement with such a university has yet been established. Some steps have been taken to develop an overall DSPP manpower assessment and staffing plan, but this task is far from complete. None of this training has taken place through RHDS.

THE NUTRITIONAL SURVEILLANCE PROGRAM

By Project Agreement amendment No. 3 (25 August 1981) an expanded nutrition component was added to RHDS. The operational expression of this component has been a pilot nutritional surveillance program established in Cayes District of South Region. In its first year of operation (Sept. 81 - Sept. 82) the component included a number of training activities: 1) Revision of curricula

for health agents (this was accomplished in the nutrition module), auxiliaries, and nutrition monitors. 2) In-service training for field personnel in the pilot zone on a regular basis. 3) In-service training for agricultural agents (15) to help them assist health agents and monitors at rally points and demonstration center.

In all, 24 health agents, 14 auxiliaries, 15 doctors and nurses, and 12 nutrition monitors received training. Rally posts—organized gathering points—were set up in over 50 locations for regular nutritional surveillance, with associated nutrition demonstration centers. At these centers, monitors present demonstration of food preparation and conservation, provide nutrition and health education, and food distribution. This amounts to a short course for mothers of children referred through the rally point nutritional surveillance. Training with agriculture extension agents has focussed on home gardens, food storage, and goat breeding. The impact of this training is not yet clear, nor has the training been formally evaluated.

There is good indication that this pilot program can effectively demonstrate the viability of rally points and demonstration centers as an approach to rapid extension of nutrition education and surveillance. A listing of training materials produced can be found in annex III.E.

II CURRENT STATUS

In order to discuss current status, moving from the preceding summary of activities, it is necessary to have some gauge, a guide to measure progress in implementation. Normally, the logical framework found in USAID Project Papers would serve the purpose. Unfortunately, the logical framework found in the RHDS Project Paper is not reflected in the RHDS Project Agreement, the only binding document relative to all parties to the Project. The Project Paper not only differs from the Project Agreement, project description (annex I of ProAg) in significant terms, it also seems to have been little influenced by

the realities of the present Haitian health service delivery system and its capacity for rapid transformation and for absorption of new structures. This raises questions as to the degree of DSPP Haitian participation in the formulation of the PP.

While Project Papers and Project Agreements never correspond exactly (they are indeed documents of very different natures) normally the goal-purpose-output-input structure is nevertheless shared and consistent i.e. the goal and purpose, end of project status, quantifiable outputs, etc. are the same in both. This is not the case for RHDS. Thus, to measure current status, one is obliged to select one or the other as a measure--necessarily, the Project Agreement can be the only acceptable measure despite its shortcomings as an evaluation tool.

CONDITIONS PRECEDENT (TRAINING)

Satisfaction of Conditions Precedent for disbursement of funds would not normally be a measure of Project achievement; the degree to which Conditions Precedent have been met, however, has greatly influenced the progress made in different areas of training and therefore current status.

The Project Agreement describes five Conditions Precedent for disbursement of training funds (ProAg Article 4 Section 4.5 a-e) corresponding to the following categories of training: health agent training, auxiliary nurse training, sanitary officer training, other in-country training, overseas training. As of 30 December 1982, in the opinion of USAID/H, conditions precedent have been at least partially satisfied for health agent, auxiliary nurse, and other in-country training. This reflects rather faithfully the priorities chosen by SEMP during the first 30 months of the Project. Since that date, some further action has been taken in the areas of sanitary officer and overseas training. The USAID document stating its view on conditions precedent as of 30 December 1982 should serve as a basis for discussion with DSPP for an update and for further negotiation of disbursements.

A summary of current status, by ProAg category, follows:

HEALTH AGENT PROGRAM (ProAg Target Number: 1500 by Project end)

Presently there are approximately 550 trained or retrained health agents, most of whom continue or have taken up service. A goodly number well over 100—of recently trained agents still await an official prise de service and necessary supplies. With the exception of Artibonite Region, particularly O.D.V.A, these agents are assigned on the order of three to four by health facility

Auxiliary nurses working in those facilities have with few exceptions, received some degree of retraining relative to their new role as supervisors of health agents. The effectiveness of this retraining, and actual supervision carried out, varies widely from district to district, both in regularity and in quality. An estimate would be that 150 auxiliaries have received re-training.

District or Regional training teams presently exist in two regions and five districts, with expansion possible into 3-4 more districts (Jeremie, Miragoane, Belladere, Gonaives). The quality of work provided by these teams also varies, and remains to be systematically evaluated.

The support system for the program descends from the RHDS Project Administration Office at DSPP through DSI and SEMP and other technical services of the DSPP (personnel, transport, supply). At this time this support system is being put to a severe test, given the dramatically increased need for health agent supplies and salaries, for supervision (personnel, vehicle, per diem), and for health information collection and analysis.

TRAINING INSTITUTIONS

Intervention in the area of training institutions has been limited by a number of factors. The chosen point of intervention—field practicum—seems technically (and politically) most promising. A set of field practicum

modules has been produced which remain to be introduced into the auxiliary nursing schools. There is a matter of interpretation here of the ProAg target output - 550 auxiliary nurses trained for service in health agent program areas (275 facilities x 2 auxiliaries.) The auxiliary schools continue to train auxiliaries at a rate of approximately 200 per year (Port-au-Prince :100, Cayes: 50, Cap Haitien: 50). Indeed since 1968 these schools have trained over 1,400 auxiliary nurses (DSI figures, 1968-1982). It is thus arguable (by DSI and the District training teams) that the intent of this output is being satisfied in that the target number will be reached before Project end. The real problems are 1) assuring that basic training responds to service needs (cf. role as supervisor of health agents) and 2) that auxiliaries are posted on the basis of priorities of the RHDS program when possible. Improvement in basic training, especially the field practicum is both desirable and feasible.

Sanitation officer training has not seen any real RHDS influence up to this time. Present efforts at curriculum review and development will be plagued by personnel constraints at SEMP. The ProAg does not specify a target output; however the school in Port-au-Prince turns out approximately 50 sanitation officers per year who are being assigned at commune level in rural areas.

Intervention in other medical training institutions is not clearly defined in the ProAg, but in any case these remain in an embryonic stage. Intervention in the field practicums of nursing schools and orientation for Social Service is possible. Overseas training as foreseen in the ProAg is tied to a preliminary agreement with an accredited school; this agreement has not been established and will remain an obstacle until such time as the component is redefined and some of the conditions precedent renegotiated.

MANPOWER DEVELOPMENT AND PLANNING

Manpower development requires close coordination of planning, training, personnel and field operational units—and thus, normally, a plan. Such a plan in turn requires precise goals and information about current staff as

well as future staff needs. Certain elements of this information are now available--personnel lists, job descriptions, qualifications of staff, curricula of training institutions. These remain to be centralized and analyzed. A recent MSH consultancy, the Hornby Report (Jan 31, 1983) is useful here in analysis of the present situation.

NUTRITIONAL SURVEILLANCE PROGRAM

The pilot program in Cayes District has been established in the zones of seven facilities. Health agents have been supplied with "chemin de sante" charts in sufficient numbers, scales, and Shakir strips. Auxiliary nurses have been retrained in supervision of health agents, rally post activities, and nutrition education. A nutritionist has been detached from the Direction of Nutrition to serve at the regional level. Planned expansion into another ten sectors of Cayes District, and supervision of present activities, have suffered greatly from lack of Direction of Nutrition participation. DCN has been without funding and without road-worthy vehicles for a number of months. Thus while the effectiveness of the pilot program in seven sectors of Cayes District is beginning to be clearly demonstrated, its efficiency (costs of demonstration centers, food distribution) needs further study, and the possibilities of diffusion of the pilot to other sectors and district therefore greatly compromised. The program has closely followed the description of activities contained in the ProAg amendment except in the areas of nutrition research and national nutrition policy and planning. Preliminary steps have been taken in those areas, specifically in the development of a statistical base for nutrition research. No quantifiable outputs are defined in the ProAg Amendment

A NOTE ON FVO ACTIVITIES

With the notable exception of Deschepelles District (where a health agent program among other community-based programs has been in operation since the early 1970's), FVO activities and participation in RHDS have been extremely

limited. The DSPP has taken action to encourage PVO participation, beginning with a conference in April 1982 to discuss RHDS and possible PVO roles. This in turn led to the establishment of AOCS (Association des Oeuvres Privées de Santé) by PVO's as a coordinating body. The exact role of PVO's and the coordination/integration of efforts remain to be negotiated. AOCS would seem to prefer to work on a facility-by-facility basis to develop community health services. PVO's tend to focus more on volunteer/collaborator rather than salaried health agents; RHDS is also moving in this direction through the health agent program, and this presents a good opportunity to share experience. Very basic questions--training, supervision, degree of integration, levels of coordination--remain to be negotiated. There is a constant risk here of duplication of effort in field services and health information collection and analysis and thus inefficient use of resources. But the possibilities for improved coverage and expansion of RHDS are equally rich.

II.E TRAINING/MANPOWER

3. PROBLEMS AND CONSTRAINTS/RECOMMENDATIONS

Discussions here will be confined to problems and constraints which affect future growth and/or consolidation of gains. Categories used in the preceding discussion are collapsed into the primary foci of the training component of RHDS.

HEALTH AGENT PROGRAM

a. RECRUITMENT, TRAINING, PERFORMANCE

Any further expansion in the health agent program will be severely hampered by unresolved questions of support. The decision was made at Project inception by DSPP that health agents be salaried employees; and yet to date not a single health agent salary is paid from the DSPP budget...and nearly 100 new health

agents will soon enter the payroll list. It would be exceedingly difficult for DSPP to absorb the present number of health agents, even in a phased manner over a period of two to three years. The target of 1500 health agents added to the DSPP payroll is simply out of the question. Fortunately, to date this salary situation has not been harmful to health agent field performance, as salaries have been regularly paid from outside the functional budget (See Section II C) Serious problems in supply, however, have affected health agent morals and performance in some cases. Health agent supply systems suffer from confused lines of responsibility and high costs/low availability of supplies. Confusion of responsibility is a direct result of the lack of DSI integration in the health agent program. The lack of coordination/information flow between SEMP and DSI is evident.

Beyond this, and due to the fact that health agents dispense free health care and free drugs, the program is creating a heavy burden on DSPP stocks of drugs and supplies without a compensating generation of funds. The vast majority of health agents in the field soon depleted their initial allotments of drugs and have at present, and at best, incomplete stocks. It is not at all certain how and to what extent newly trained health agents will be supplied with medicine.

Thus, in the overall picture, the curative services provided by health agents could become severely limited. What this will mean in terms of community perceptions of health agents, in terms of their own self-perceptions, and in terms of health agent/charlatan conflicts is not clear, and deserves urgent study.

Support at a number of levels of the health service hierarchy for the curative aspect of health agent work is less than whole-hearted. This has been manifest in reactions to a recent proposal that AGAPCO supply health agents through community pharmacies (with the health agent selling an initial consignment of drugs at cost to clients and replenishing his stock with revenues from these sales). Leaving aside the resistance to this proposal based on financial questions (added burden to AGAPCO, a high risk of

decapitalization), it has become clear that AGAPCO itself has serious questions about the role of the health agents, and whether curative services and the provision of medications should be a part of that role.

Health agent recruitment, training and performance are not being systematically monitored—indeed at present no consistent means exist to evaluate them. This is a critical flaw present throughout the RHDS training systems. Eight different teams have trained health agents, and while they have all used the same basic training document since late 1981 the (modules) evaluation of the modules and of the actual training has been either anecdotal or left to the individual teams. A proliferation of forms has certainly not resolved the problem. One of these forms now available to District teams (since Sept. 1982) "Evaluation de la Formation des Agents par les Modules" (SEMP; see annex IIIIE 4) is a case in point. A large volume of training had already taken place before the form was made available and thus trainer responses to many of the questions may not be very accurate. Beyond this, the questionnaire only indirectly addresses the training needs of trainers. It focuses almost exclusively on the modules. Granted that the modules will need periodic revision, the major focus of evaluation at this point must be how effectively the modules are used by trainers.

The training and supervision teams, and not the modules, have become the critical element in the training component of the health agent program. Many of the current obstacles to systematic evaluation could have been avoided with clearer guidelines written into the modules for pre and post-testing of participants and for evaluation of training by both participants and trainers. Technical flaws here mirror the generalized problems encountered in the development of a health information system for RHDS. Without sound evaluation tools neither the effectiveness of training nor health agent competency and performance can be measured.

The level of motivation of health agents following basic training seems quite high; a number of health agents would seem to be performing in excellent fashion--these are no small accomplishments. But what documentation will show this?

b. SUPERVISION AND SUPPORT SYSTEMS

As health agents and community pharmacies have come into action, the crucial role of supervision and support systems has become obvious. Supervision suffers at two levels--one logistical, the other technical. Logistical problems are numerous and form a familiar litany: shortage of road-worthy vehicles; shortage of fuel, lack of funds for per diems. Indeed, 1982-83 budgeting was such that the bulk of this funding for supervision and training was to come from dollar reimbursable sources. This is equally true for Direction of Nutrition training and supervision--with an equally disastrous result. Delays in turn-around time in this form of financing generate even longer delays in availability of funds and materials locally. And some Districts do lack vehicles for direct supervision.

Beyond these material problems loom technical ones. Even where supervision both by auxiliary nurse and by Regional/District teams seems fairly regular (eg. Cayes District) there is a clearly incomplete understanding of the role of supervision and what it entails. Supervision visits to health agents generally mean sharing his or her work for the day or scheduling vaccinations to coincide with the visit. These supervision activities must be completed by advising, by professional development activities. This requires trainer skills, the ability to analyze monthly report and census data, problem-solving skills, and observation skills. Such skills can only be developed through regular in-service training sessions and training contacts. SEMP training documents--modules, "aide-memoire", guides--are full of guidelines and exhortations. They are at best a base from which field experience and regular training contacts can build.

Because of this incomplete supervision activity, the practice of auxiliary nurse supervision of health agents has not really been tested. Questions of auxiliary authority and professional competency raised a priori cannot yet be answered. No doubt experience will vary from District to District, and even from facility to facility. It is necessary to study the reasons for that variation, and these findings should be very useful to discussion of the "medecin de commune" concept.

Programs should develop through these overlapping learning stages:

1) learning to be effective, 2) learning to be efficient; 3) learning to expand. RHDS cannot fully learn from its first 30 months of experience without sound evaluation tools built into its training and supervision activities. Until RHDS can learn how effective it has been, it cannot learn how efficient it can be nor can it meaningfully study program options. The entire package of RHDS components—health agents, community pharmacies, District training and supervision teams, nutritional surveillance must be fully in place and closely monitored in the present Districts before any serious thought be given to gradual diffusion elsewhere.

c. RECOMMENDATIONS

1. Freeze health agent training; concentrate effort and resources on improving the supply and support system of the 550 health agents already trained and in the field. This would mean:

- SEMP must devote itself to monitoring and assisting the District Training and Supervision Teams. Each team should be visited at least once per year (2 day sessions at District) during 1983 and 1984.

- SEMP should integrate DSI into this monitoring activity; for example the assistant to the Director could join the SEMP team for this purpose.

- A seminar for District Teams should be organized, focussing on the development of needs assessment, training, and supervision skills. This would include elements of statistical analysis of reports.

- A concerted effort within DSPP must be made to assure timely provision of inputs for supervision activities, beginning with a streamlining of the dollar reimbursable process and a precise inventory of materials (vehicles included) available at District level. Detailed supervision plans and budget are to be required from each District (these could be expanded from District annual work plan).

- SEMP, DSI and the Regionalization Office work with deliberate haste to develop and field test a standardized evaluation form for health agent performance based on selected indicators.

2. Studies of community perceptions of health agents and community willingness to pay for health care services and/or drugs are urgently needed. Haitian rural sociologists and medical students could carry out the studies with limited technical assistance.

3. The Nutritional Surveillance program should continue in two clear directions:

- Expand the rally post concept to other health agent zones in the South, gradually introducing the activity, as supplies and training resources permit, to other Districts where health agents operate.

- Explore the possibility of staffing nutrition demonstration centers with personnel in place locally from under-utilized services—CHREPROF, ONAAC, DARNDR, as well as with volunteers; this to study the extent to which these personnel can replace present monitors.

4. Quarterly evaluation meetings at District level should be institutionalized. The meetings would be chaired by the District team and attended by auxiliary nurse supervisors and health agents. (Not all health agents would attend each quarterly meeting ; of the four operating in a given dispensary catchment area, one health agent would represent the others, on a rotation basis.) This provides opportunities to discuss problems and local solutions, share successes and experience, discuss reports (feedback) and assess training needs.

5. The new Health Education Section, in order to develop effective articulation of efforts in RHDS with SEMP and DSI, should orient itself toward training activities for DSPP field personnel. Development of health education methods and training skills among field personnel is crucial to any subsequent mass campaigns, and must accompany any production of health education materials.

6. FVO role in RHDS: Every possible measure should be taken to avoid duplication of effort between public and private facilities: Therefore:

- Coordination functions, questions of territorial coverage, and collaboration in training efforts must be thoroughly negotiated before launching a wave of FVO activity.

- In the essential area of information systems, standardized information collection and analysis protocols must be negotiated, again, before any expanded activity.

ii. TRAINING INSTITUTIONS

Problems and constraints in this area of RHDS training interventions grow out of the chosen agency for intervention - SEMP. In attempting to transform SEMP into a continuing education service, while retaining its traditional function as initiator of institutional curriculum review and development, RHDS has severely overextended the material and human resource of the Section. This

overextension would not be so dramatic if there were close collaboration between SEMP, DSI, other DSPP technical services, and the training schools. But this is not the case. Inability to invest the time and resources in cultivating that collaboration (due to pressures to reach unrealistic target outputs as well as to quickly produce materials and due to lack of personnel) has produced the current situation: training materials have been developed—but commitment to the use of those materials is limited in the most crucial quarters: DSI and the field. As right as the concept may be, i.e. that field practicums must be adapted to better meet training needs, implementation requires active support from all parties to the changes in program. This applies equally across proposed reforms in nurse and sanitation officer training.

Another factor linked to the acceptance of reform is that of an appropriate mix of assistance between technical and material. Judging from the final report of the "Journées d'Etudes" on field practicums there was a general consensus that under present material conditions, technically sound field practicums simply were not feasible. Proffering of technical assistance to tighten up field practicum programs with new documents does not respond to the problem. The excellent field training opportunities offered by active RHDS zones (especially Cayes District) cannot be exploited if necessary material resources for schools are lacking.

In sum, as the acting Chief of SEMP has so rightly observed, SEMP cannot operate effectively without the active support and collaboration of DSI, the training institutions, and the other technical services (DHF, DHP, Direction of Nutrition) who train health personnel. This unity of effort, and coordination of activities, has not yet been achieved.

RECOMMENDATIONS

1. It is desirable that a public health nurse consultant be contracted to work with SEMP and DSI to effectively develop the practical training (and field practicums) done in the various nursing schools. Thus:

- Possibilities for exploiting the use of field training sites in Cayes District should be fully explored (both for nursing schools in Cayes and for nurse hygienist field training)

- Seminars to introduce the eight field practicum modules could be organized at each of the auxiliary nursing schools as starting point for renewed analysis of field practicum improvement.

2. Any further effort in reform of Sanitation Officer training curriculum should be the object of appropriate technical assistance to SEMP and DHP ; if the present long-term assistance cannot be augmented in this way, or if SEMP does not receive additional personnel, it is recommended that work be postponed until such time as it can be effectively done.

3. It is essential that adequate material for field practicums—at the very least, camping equipment for stageaires and one vehicle (CJ8) per school for supervision—be provided. Camping equipment (beds, lamps, kerosene cookers) would be stored at all Regional (or Central for Port-au-Prince) warehouses, thus also being available for other field training sessions. Provision of this equipment (and vehicles) can be made contingent upon detailed programs for field practicums: site selection, check lists for supervision, learning objectives, supervision schedules, orientation and debriefing sessions, budget, etc.

4. USAID and DSPP should renegotiate the Condition Precedent for Overseas Training assigning the primary responsibility (to DSPP or USAID or MSH) in establishing an agreement with an accredited school of public health. Account should be taken of the SEMP (Dr. Bonhomme) effort of matching projected posting needs at regional and district levels with training requests.

iii. MANPOWER DEVELOPMENT AND PLANNING

The framework for manpower management from which the DSPP could more systematically train and appoint personnel remains to be developed. Hornby cites two major problems:

"... absence of a comprehensive picture for all staff training needs related to ... jobs" and

"...absence of a detailed development plan which would permit a meaningful schedule of priorities for training".

He goes on to describe the type of information needed to fill in this picture and develop such a plan. He also points out the absence of a post within DSPP's Planning Office with the specific responsibility for manpower planning.

Thus, lack of relevant information in a centralized, accessible format, and lack of a DSPP post with full-time responsibility in the area constitute the principal obstacles to further progress. Degree of DSPP commitment to progress in this domain is not yet clear.

RECOMMENDATIONS (From Hornby)

1) Create a separate unit for manpower within the planning office at DSPP, beginning with at least one full time senior staff member with secretarial support. This is an essential first step, and a necessary condition for any subsequent technical assistance.

2. The DSPP manpower planner would then lead an assessment of the total post-basic training needs of DSPP beginning with professional grade staff. This would include collection of all available manpower data in view of a

manpower situation analysis, which would show types of DSPP personnel by geographic distribution. Incomplete data could be improved through quick sample surveys (guidelines available from WEO).

3. A seminar could then be organized (manpower planning workshop) around this situational analysis, inviting relevant DSPP, AOPS, and GOE officials. WEO, again, has developed a workshop framework for this purpose. The product of the Workshop—the framework for an annual manpower plan—would be a step toward incorporation of a manpower plan in the 1983/84 DSPP annual plan.