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9. ABSTRACT

Reviews and evaluates previous rural health projects in Haiti for the purpose of introducing a rural health delivery system effectively during the next five years. Interviews with health program staff members and others knowledgeable about these programs, as well as written reports and articles, were employed to gain information regarding project goals, methodology, and achievements. Particular attention is given to ecological, social, and cultural factors affecting project implementation. Reviews pilot health programs, which use paraprofessionals to administer primary health care in rural areas and educate rural residents in preventive health care. Compares two such programs regarding 1) selection of health agent candidates, 2) theoretical and practical components of training program, 3) general implementation scheme; and makes recommendations for efficient and effective health delivery system based on previous program experience. Also assesses organization and performance of the Community Health Program of Albert Schweitzer Hospital (Deschapelles) and the Integrated Program for Public Health and Population at Petit Goâve, and lists recommendations based on their specific functions. Appendices include interview schedules used and proposed for use in field survey of the pilot programs and other data-gathering forms.

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RURAL HEALTH DELIVERY SYSTEM PROJECT IN HAITI

Report No. 4

Evaluation of Previous Rural Health Projects in Haiti

Suzanne Smith Saulniers
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This report was based in part by field work undertaken by Mr. Ira Lowenthal. His assistance is greatly appreciated but he bears no responsibility for write-up nor recommendations. The final section on the Integrated Health Project at Petit Goâve was based in part on materials and interview notes which I had gathered and an outline for guidelines on project experiences which I had developed for this report. It was written by Ms. Barbara Ormand because of her greater expertise and familiarity with the project. Mr. Udo Husewinkel, Director of the Community Health Program at the Albert Schweitzer Hospital provided undue assistance in providing information on his programs. His aid is greatly appreciated.

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EVALUATION OF PREVIOUS PROJECTS

A. INTRODUCTION

The purpose of this section is to assess the previous experience in Haiti in rural health programs and determine their relevance toward introducing a RHDS effectively during the next 5 years. Previous projects considered are the community health programs at Deschapelles, Project Integré a Petit Goâve and the two pilot health agent programs in Cap-Haitien and Les Cayes. Greater attention in given to the pilot programs than the others since they have more direct applicability to the implementation and cost-effectiveness of this project.

The following methods were used to assess relevant experience at Deschapelles and Petit Goâve. Interviews were held using a similar set of questions to the current director of the Community Health Programs at Deschapelles and the field staff at Projet Integré. Interviews were also held with Dr. Verley, Division of Family Hygiene who is the Port-au-Prince coordinator of the Projet Integre Program, and Dr. Midy, DSPP, who was active in its development and planning in its early stages. Secondary references were also used. Included were quarterly and annual reports articles written on various project activities, and interviews with persons knowledgeable about these programs but unofficially associated with the projects. Particular attention was paid to the set of articles by the Berggren's on the Deschapelles programs. Since one of the AID staff members had been intimately involved with Projet Integré during her studies at the

Harvard School of Public Health, this section has the added benefit of a more thorough analysis by her.

The pilot programs were investigated in a two week field survey carried out in both regions. Interview schedules were designed to gather information from health agents, auxiliary nurses and community leaders where health agents were located. (See Appendix I). An informal schedule was prepared for interviewing the Regional Bureau staff. Time, topography and unanticipated events constrained the number of interviews completed and altered the design to which all interviews were to be conducted. Community leaders were not interviewed due to lack of field time. Priority was assigned to completing interviews with 4 health agents (one male and one female per region) and the auxiliary nurse (s) in the dispensaries out of which the interviewed health agents are working. All health agent interviews were completed by an anthropologist fluent in Creole. Interviews of Regional Staff and auxiliaries in Cap-Haitien were similarly completed in Creole, while interviews in Les Cayes were conducted in French and Creole. A positive unanticipated consequence of the Les Cayes field trip was that the first meeting of health agents and regional staff was held while the sociologist and anthropologist were engaged in field work. Both were able to do some participant observation at this meeting.

The following analysis includes a general description of the project program(s) with respect to goals, methodology and achievements. Particular attention is given to ecological, social

and cultural factors which may have affected project implementations. The methodology section elaborates on selection of personnel, their training and work load. Additional information is provided on the various systems developed to sustain paraprofessionals -particularly the referral, supervisory, supply and information systems.

It should be pointed out that this is a qualitative evaluation of past health experiences in Haiti and subject to the cultural biases of the three persons involved in the evaluation. However, the experience of these projects has been so rewarding that every attempt has been made to incorporate the most positive aspects of each project into the development of the RHDS. Moreover, the unanticipated consequences or difficulties encountered in administering health care from these project experiences have enabled the RHDS to be designed to minimize similar consequences and anticipate where other difficulties might arise.

B. PILOT HEALTH PROGRAMS

The purpose of the pilot health agent program is to determine the feasibility of using paraprofessionals to administer primary health care in rural areas and educate rural people to preventive health care. Particular emphasis is given in these programs to the following activities:

1) improving health care of infants through increasing vaccinations against neonatal tetanus;

2) teaching proper dietary habits and handling of infant illnesses;

3) increasing the spacing of children through the encouragement and explanation of contraceptive methods;

4) promoting environmental sanitation through such activities as promotion of latrine building, charcoal filter pots for water (or boiling water) and keeping animals at a distance from the house

5) referring patients needing advanced medical help to dispensaries; and

6) servicing those in need of minor care in their respective localities.

The achievements anticipated from these programs are the following:

1) increased awareness and receptivity of the rural population to modern preventive and curative care;

2) more rapid treatment of minor health problems by modern trained personnel;

3) increased access of seriously ill persons to health personnel

4) decrease in infant mortality;

5) decrease in birth rates.

Thus, the one achievement expected from the introduction of the pilot RHDS program is the general improvement in quality of health status of those persons affected by the program. The secondary achievement is an increase in the health infrastructure in rural areas covered by health agent activities.

Success in achieving these goals cannot yet be measured since the goals are immediate, short-term and long term.

Moreover, the programs are only in the initial stages of development. A proper evaluation of their activities and

institutional development is not appropriate at this time. However, an evaluation of the training program and selection process of candidates of the initial program design can provide insights into the actual processes undertaken in the development of a RHDS in Haiti and provide guidelines for effective development of the RHDS on a national scale.

1. General Description

The program design follows the RHDS format. That is, persons desirous of becoming health agents were selected by their communities and the Regional DSPP staff according to an examination and interview and were trained in a three month paraprofessional training program at a regional hospital (Au Cap-Haitien or Aux Cayes). Following the training, the newly formed health agents returned to their localities. They did not receive their diplomas for several months. The health agents in the North worked from January to April without receiving a salary and have worked since April with a salary. The health agents in the South did not begin work until nearly the end of April when they were told they would start to earn a salary.

The pilot program in the North consists of 28 health agents, trained from August 1 - October 31, 1977 at the Cap-Haitien Regional Hospital. The "free labor" from January to April was perceived by some health agents as a "trial period". (That is, they thought that they were being evaluated to determine if they were trained sufficiently to meet their tasks.)

Health agents in the North have not received medicines (as of June 30 1978) and so are still not working at full capacity as health agents.

Twenty-seven health agents were trained at the Les Cayes Regional Hospital from August 8 to November 11, 1977 for the Southern region. They received official notice of employment late in the month of April so they really did not begin work until close to May 1. These health agents received their medical bags and supplies on June 30. Most health agents did not work until they received notification of their employment although one health agent said that he bought medical supplies upon completion of the training program so that he could treat persons. He sold the medicines to those treated in order to cover his costs.

2. Comparison of Program Development

The two pilot projects have marked differences in their implementation scheme. These differences are in their ecological design, support systems and social organization. The following detailed description will explain these differences followed by a list of recommendations of which project components are most appropriate for the national development of the RHDS

a. Ecological Factors:

The Socio-ecological arrangements of the dispensary health agent units differ with respect to proximity to regional center, competition with other dispensaries, and concentration of activities. For example, the proximity to regional center is greater in the North than in the South. In the North, agents are placed in a semi-circle around Cap-Haitien and have relative ease due to regular

transportation facilities in going into Cap-Haitien to attend meetings and returning to their homes that day. In the South, health agents are more spread out in a line bordering the main road; they have considerable difficulty attending a regional meeting and returning to their homes in one day due to the lack of regular and reliable transportation.

A second ecological difference is that the relationship between the private (mixed) and public dispensaries ranges from symbiotic in the South to competitive in the North. In the North, nearly all health agents are assigned to public dispensaries (7 out of 8 dispensaries are public) with the exception of one Catholic dispensary, where both an auxiliary nurse and a Catholic nun are present. In the South, six out of the eight dispensaries are Catholic (i.e., mixed, Catholic-public). Two of these six dispensaries have only a Catholic nun present. The intention in the North is to increase utilization of public dispensaries, whereas the emphasis in the South is to use whichever dispensary the health agent prefers. Private dispensaries are reputed to be better supplied, better equipped and more receptive to poor clients than public dispensaries. (The health agent, however, must remain consistent in his/her attachment to the dispensary selected.)

The third ecological difference lies in the concentration/deconcentration of health activities. In the North, health agents work one day a month at a dispensary and refer clients to that particular dispensary. If their clients are being discouraged by the delay, health agents may accompany them to the dispensary to assure service. In the South, the health agent usually does not work at a dispensary nor does he/she refer clients to any one dispensary.

Instructions to health agents by the regional staff are that the client has the right to decide which dispensary to seek health care.

b. Activities:

Differences also exist in number and detail of activities expected of health agents. In the North, health agents engage in the following activities: home visits, matron (midwife) recruitment, announcement of mobile clinics, client referrals, health meetings at markets and in other places. Homes visits include basic health instruction in prevention, especially environmental and personal sanitation and family planning. Some emphasis is given to latrine construction but more emphasis is placed on potable water (and boiling water) due to a recent typhoid outbreak. The family planning instruction includes explanation of the use of condoms, contraceptive pills and foam. Condoms are handed out during home visits or on demand.

Contraceptive pills can only be resupplied (up to three months) to women after they have been initially checked by the auxiliary nurse for possible physical difficulties. During home visits, health agents also conduct nutrition and infant child care instruction using a health book supplied by the Division of Family Hygiene. They also hand out referral cards to anyone who is pregnant, being recruited for matron programs, desires birth control pills, has children with signs of malnutrition or diarrhea, or is ill - regardless of severity of the illness. Matron recruitment consists of encouraging persons who are traditional midwives and persons interested in becoming midwives to attend a special midwife training session at

dispensaries. Agents have been encouraged to recruit at least 13. One agent has already recruited 8 persons. The number of home visits per day expected of health agents is 3.

Health agents are urged to go to market days in their areas to promote health activities, engage in consultations and refer clients to dispensaries. They may also perform injections if the client brings the syringe, needle, and medicine. They must do this free of charge. No primary treatment has been administered by health agents in the North since they have not yet received medicines.

The South has a slightly different emphasis on activities. Home visits are similarly the primary activity. However, the emphasis in these visits is more the promotion of environmental sanitation, vaccinations and child care than client referral, matron recruitment and family planning. The emphasis in the environmental sanitation program is latrine construction, since the Sanitary Officer program in the South has been very active in manufacturing latrine pipes and sells them for $6 cash or $7 on time. The latter has been a rather profitable program for these officers and is encouraged by the Regional staff. One of the major purposes of home visits since the beginning of the program has been to count the number of houses in the health agents' zones so that SNEM calculations could be updated to design more workable health zones. The number of home visits per day expected of health agents in the South is 15.

Various methods of family planning have been instructed by health agents--including foam, condoms, contraceptive pills, IUDs. However, at the regional meeting, health agents were urged to limit their instruction to only those methods they could provide (condoms) and

to encourage women interested in the others to visit a doctor. The health agents still do not have condoms to hand out, however. In the South, also, an auxiliary cannot hand out contraceptive pills unless a doctor has checked the woman; she can hand out foam. Since many agents work out of essentially Catholic dispensaries, the only real method of birth control explained to women at dispensaries is the "rhythm method", and catholic nuns refuse to hand out pills or foam. The additional activities urged of health agents are the holding of community health meetings and the treatment of minor illnesses. At the regional meeting, they were reprimanded for holding meetingsat markets because it was said that they encroach on the responsibilities and activities of sanitary officers. Health agents disagreed since they said sanitary officers spend most of their time inspecting food and fining people rather than giving health education, but the instruction remained not to go to market days.

Primary treatment will begin with the eleven medicines and nine medical supplies given to health agents at the June 30, 1978 meeting. The médicines and medical supplies included the following: aspirine, piperazine (Antepar), multivitamines, sulfoguanil, serum buccal, esprit d'ammoniaque, alcool, zephyran, antitussif (Pectoral des Bebes), pommade Ichtyolee, eau saline, thermometre, gaze, coton, tige pour applicateur, seringue, aiguilles, carnet, crayon, lame de gilette, savon lessive, bandage de gaze.

c. System Development

A difference between regions also exists in the various systems developed to support health agent tasks and to measure program

performance. The systems compared are the referral system, data gathering system and supervision system. (See Appendix II for examples of existing system components)

The referral system is well designed and effectively used in the North. It can be used to determine which health problems are referred most often, from which localities, by whom, and when they are referred. It only lacks one factor - the date of arrival of the client at the dispensary. The system has been designed as follows: each health agent receives around 150 referral cards (already numbered) in three booklets of 50 each at a time. The cards are filled out in duplicate with one part kept by health agents, the other given to the client who turns it in to the dispensary when he/she makes the visit. The forms are made of a heavy paper and perforated to facilitate separation. Each card specifies the name and locality of the client, purpose of referral, date handed out to the person, name of health agent and name of dispensary to whom the client is referred. The health agents use these referral cards in several ways:

1) to prepare their monthly reports;

2) to determine which clients have gone to the dispensary; and

3) to prepare a list of revisits to make of clients in order to determine why clients have not yet gone to the dispensary.

It was noted that on monthly workdays at the dispensary, health agents use the referral cards to determine their clients' receptivity; moreover, health agents were reported to frequently accompany clients

to the dispensary with the referral card if they are not certain the client will come on his/her own or that the client will receive immediate service. The degree of sophistication of the referral system and its relative successful use indicate the importance assigned to it by the regional staff for measuring health agent performance and program receptivity.

In the South, by contrast, the referral system is treated differently. Referral cards were designed as green plastic coated cards with only the name of the health agent on it. Each agent receives fifty and is required to re-use them every month after retreiving them from the local dispensaries at the end of each month. Health agents are instructed to give these cards to clients if they need to be referred to a dispensary but to not give them to clients who might use dispensaries considerably distant from the health agent's home in order to minimize difficulties in retreiving the referral cards.

If the health agent runs out of referral cards during the month, it was recommended that he/she make return client visits and pick up referral cards of those clients who have not yet used them. The referral system is not perceived as a means of data gathering nor a central focus of health agent activities in the South. Rather, it is devised as an incentive or reminder mechanism to clients to go to a dispensary for health reasons.

The data gathering system are also different in each region. In the South, data are being gathered using two forms: a monthly report form and a home visit card. The purpose of the monthly

report is to determine size of work zones and coverage capabilitie of health agents. As mentioned earlier, one of the primary activi ties of home visits is to count the number of houses in his/her zo and record the number of visits made per month.

At the regional meeting, it was evident that there was considerable confusion on how to complete these forms. Health agents did not know where to include revisits or whether the number of houses counted should equal the number of visits made or if the number of houses counted should include all houses in the lakou or each lakou meant one house. Various interpretations were made by health agents and use of these data for planning should be limited. The home visit card include the purpose of the visit (education, treatment, reference), the signature of the health agent, and date of visit.

Health agents cited three problems with the home visit card: the paper used to construct them is too light and flimsy and will be easily torn; not every house has a SNEM number so it is difficult to properly identify each house, and the space is insufficient to mark down specifically what assistance is given during the visit. Indeed, it was unclear from the instructions at the meeting whether health agents should simply check which activities were performed or specifically identify what was discussed. Each health agent was given 300 home visit cards and a box of tacks at the regional meeting June 30, 1978.

In the North, only referral cards and a monthly report form have been developed for data-gathering purposes. The health agent is supposed to keep track of daily activities in a notebook and use the notebook and referral cards to complete a monthly report. The report includes number of visits, number of persons recruited for midwife and mothercraft training programs, number of wells and latrines constructed, type of family planning accepted, and number of specific illnesses treated. The latter has yet to be gathered since health agents do not have medicines. The form will be turned in monthly to the assigned dispensary; however the health agents have brought them to the two monthly regional meeting of health agents, auxiliaries, supervision team and regional staff. They exchange the report for their salary receipt. The major problems with the monthly report form is that it does not provide a way to determine the number of revisits made nor does it provide sufficient space to determine what illnesses are being treated by health agents other than those specified on the form. The design of these forms results from the interest of the regional staff in using the data for program planning, determining priority training and retraining needs, and measuring program performance. The regional staff has found no problem in having health agents collect data accurately and is desirous of having health agents collect more.

The third difference in system development is the establishment of a supervisory system in the North and the absence of one in the South.

A mobile team of an auxiliary nurse, registered nurse and a sanitary officer, consists the major supervision component, with other component being the auxiliaries and regional staff. This particular supervision team has long experience in health activities in the North: (The public health nurse and sanitary officer were trained under an American funded Potb-Colè program nearly 15 years ago). The team's approach to rural people, perceptions of difficulties in rural areas and ability to supervise gently, yet firmly, make their contribution to health agent motivation and performance considerable. The anthropologist noted in field survey that the supervision team is highly respected by health agents as role models and highly accepted by rural persons when they make home visits. The regional health advisors further remarked that the effectiveness of the health agents is increased, in part, due to their constant movement in the countryside and their dedication. The team engages in the following activities: visit health agent zones and promote health activities just as the health agent does; make visits with the health agents and observe their effectiveness; perform demonstrations of activities in health promotion when the health agent is present; and visit each dispensary to check on equipment and supplies and fill out a dispensary supervision form for each visit.

The auxiliary staff in the North also supervises health agents. Their supervision occurs in their localities and at their dispensary where health agents work one day a month.

In general, the auxiliary nurses see each health agent about 2-3 times per month in a health context. When the agent is located in close proximity, the contact may be as high as 5-6 times. The auxiliaries provide support to the health agents by giving some training, discussing problem cases, and providing information on the time and location of the mobile clinic. Auxiliaries do not engage- as yet- in any formal evaluation of the health agent's performance. Some auxiliaries have also visited agents at their houses but they have not as yet accompanied them on home visits.

Supervision is also undertaken at the monthly regional meeting of the supervision team, auxiliaries, health agents, and regional staff. At this time, problems are discussed and the supervision team gives refresher training. The monthly reports are exchanged for salary receipt (agents receive cash; auxiliaries receive checks) These meetings are particularly useful for handling administrative detail, providing closer supervision of the interaction between health presonnel-especially between auxiliary nurses and health agents where competition has been observed -and reviewing the data gathering forms.

The South is only in the early stages of developing the supervision system. The Les Cayes office does not seem to have the funds nor the highly trained health personnel readily available to construct a supervision team. Moreover, auxiliary nurses, have not received supervision training. In the dispensary-health agent unit visited, for example, the auxiliary had not visited one of the health agents and had visited the other only because the agent helps her at her mobile clinic. She had not given any supervision on forms nor health care at the dispensary. It was apparent that the regional meeting

was the first time for most health agents that any monitoring had taken place except perhaps when the Regional Staff encountered health agents in non-supervisory field trips. Fairly open discussions took place at this meeting. Problems aired by health agents were the following: low salaries, too large a zone, needed improvement in transportation, mixed receptivity by rural people, policing activities of sanitary officers and uncooperative staff in Catholic dispensaries. Problems aired by Regional Staff were errors in filling out monthly report forms, not meeting work standards, and interfering with sanitary officer responsibilities.

3. Comparison of Training Program

Both regions have followed the DSPP guidelines for health agent training. Topics covered, hours per topic, and personnel involved in training met all DSPP standards. The training programs differed, however, in type of practical training and background of personnel inv ved in the training program. The factors may contribute to the quality of performance of health agents in each region.

The following format was followed in the training of health agents in the North:

Theoretical Training: 2 lectures per day; one-two persons lecturing on each topic. Mimeographed notes were handed out in French.

Practical Training: practice in family planning demonstrations and injections at training center: visits together to the communities of each health agent (28 communities); visits to the seven dispensaries out of which agents would work; home visits with the public

health instructors; meetings with community members to practice giving a health meetings.

Instructors in the training program were varied, but the greater proportion of instruction was carried out by three persons. These persons later became the supervision team for the health agents. As mentioned earlier these persons had worked in rural health for nearly 15 years and know well how to effectively communicate ideas and knowledge about health promotion and prevention. The fact that these instructors later became health agent supervisors probably adds to the health agent receptivity of their decisions and advice when in the field.

The community visits by all student health agents were found to be especially effective. Everyone wanted to see where everyone lived after being together for 2-3 months. Moreover, each wanted to compare his/her community problems with those of the other health agents. The visits also became extremely relevant for future work activities of agents. On the visits, local problems were discussed and advice was given on what work needs to be carried out by both the instructors and other health agents.

In the South, most all training activities occurred at the Les Cayes Regional Hospital or in nearby localities. The instructors included: 2 registered nurses, an auxiliary nurse, 1 educator (on community development), 1 member of the Red Cross, 1 auxiliary nutritionist, and 1 doctor. Since treatments were not sophisticated, it was not considered appropriate to have many doctors involved in the program. Both health agents mentioned the community development instructor as particularly good.

Theoretical training: daily lectures and demonstrations in French with Mimeographed notes of the lectures in Creole. The method of instruction on treatment was memorization.

Practical Training: practicing injections and personal hygiene with a baby doll at the training center; visits to nutrition centers in the Les Cayes area; and visits to homes with community agents near Cayes in groups of 4-6 student health agents. No practical training was given in the local areas of the health agents.

For example, an instructor uses a blackboard or other visual aids to demonstrate illness and treatment; he/she repeats several times what is being treated and the amount of doses of medicine. Health agents repeat back in unison the illness and the proper number of doses for treatment. When the instructor assesses that the health agents understand the treatment and all have repeated back the instruction correctly, the lesson is over.

A short quiz on health knowledge revealed that basic health knowledge has been retained after nearly nine months out of the training. Moreover, the method used to identify illnesses is the "symptom method". It was evident by the type of responses that special emphasis was given to providing contradictory knowledge to traditional causes of illnesses. Illnesses identified easily by all agents were childhood diarrhea, fever with diarrhea, and fever. Malnutrition was also identified but responses varied in the number of signs or severity of nutrition that could be identified. The two questions most frequently missed were childhood tuberculosis (except by the health agent who said tuberculosis was present in her zone) and vitamin A deficiency.

Everyone knew correctly and without hesitation answers to family planning questions. The questions that had insufficient information to determine an illness received mixed answers--most did not know how to handle the question.

There is considerable interest in the North in improving the training program, especially the methodology used for treatment and illness identification. In the South, the agents have not been in place long enough to note whether training modifications are needed. The Cap-Haitien regional staff is currently discussing the possibility of collecting baseline data as a task of the training program. These data would be used throughout the program to teach about illnesses, causes of illnesses, childcare and family planning. Their thoughts are that discussing technical aspects by drawing analogies and cases from areas familiar to the health agents would increase their retention and motivation to learn about technical aspects. The regional staff also notes that group discussions rather than lectures are more effective in teaching health agents and that more training can be given in field practicals than in a classroom situation.

Interviews with health agents about their training program further supports these modifications. There was relatively little excitement expressed about their technical training and much more recall of practical training. The major areas of training recalled where those on community development methods and family planning. Indeed, in the North, when agents were asked what they remembered from their training program, responses were the discussions on

communication skills by the supervisory team, discussion by an ONAAC official on community development, and a presentation by a nutritionist on new sources of food. The sessions given by doctors on anatomy and adult illnesses were not well recalled nor did they seem very relevant to health agents.

In summary, training guidelines set out by the DSPP are adequate for allocation of hours and content of training program. The weakest part of the training manual seems to be the methodology used to impart health knowledge. The training program needs further structure so that technical aspects are not memorized but understood. Training also needs to include more practical sessions in areas of the health agent's zones so that the training has more direct relevance to his/her future work.

4. Comparison of Selection of Candidates

The DSPP guidelines were followed both in the North and South for health agent selection. The better candidates were found not to be those recommended by the local community councils but those recommended by auxiliaries or local priests. The DSPP selection exam was performed in both regions with only those candidates who received a passing score entering the program. The process of candidate selection varied by region. Because the difference may be a factor that contributes to regional program performance, the processes will be briefly elaborated followed by a summary of social characteristics of health agents in the South. Similar data were not retreived in the North to make a comparison on candidate selection. Of the total number of agents in the North, there are 11 males

& 17 females.

a. Process of Selection

In the North the process of selection was the following: first, announcements were made on the local Health Program held by the Sanitary Officer every Friday afternoon about the institution of a rural health program and the concept, health agent. Next, the DSPP (Regional Staff) team went into different areas and talked to local leaders, nurses and community councils about the program and asked them for recommendations of candidates. Any candidate interested in the program was then asked (via the radio program) to go to Cap-Haitien for further program explanation. When the candidates arrived in Cap-Haitien they were given an oral test separately then asked to speak in front of a group of candidates. They were also not immediately told of their selection. Instead on the following week's health program an announcement was made of which candidates were selected and from which communities. Those selected were asked to go to Cap-Haitien to attend the training program. Candidates were not told that there was a salary attached to the work during the whole process.

In the South an announcement of the health agent program was also made on the local radio station; however, the announcement mentioned that it was a salaried position. When the regional director and nurse visited various dispensaries and community leader to further elaborate on the program, they also reaffirmed this.

Interested candidates were asked to go to Aux Cayes for a meeting with the Regional Director. Some came with and without letters from their community councils, local auxiliaries and local priests. The DSPP exam was administered in the Regional director's office, graded on its completion, and the candidate was noted of his acceptance of rejection immediately. Sometimes several candidates were interviewed and tested together in the director's office with only one candidate being selected. There was no radio announcement of which candidates were selected nor from which places, as in Cap-Haitien. In fact, it was only this past June that a more detailed explanation of the program was given on the local radio station by the Regional Director and Nurse since they considered the program as really only beginning when health agents received medicines. During the radio program, both carefully identified program activities, the names and locations of health agents, and their scope of work. It was emphasized on the program that all treatment, including injections, were to be performed free by health agents.

Hence, the process of selection of health agents differed in terms of emphasis of the program stressed to both candidates and clients and the recognition or reward system used to motivate health health agent performance. In Cap-Haitien, the emphasis was on community involvement, with gradual introduction of the health agent program to the region. The key motivation techniques were to identify persons and program on the radio, and inspire dedication to community development.

In Les Cayes, the emphasis was on treatment with a rapid introduction of the program to the local peop e. The key motivation techniques used in the South were salary and direct links with the DSPP.

b. Characteristics of Candidates

The following table provides a summary of general characteristics of health agents selected for the Les Cayes region.

The candidates are nearly equal in number of males and females selected (14 and 13, respectively). Females who are on the average 5 years younger, are almost exclusively residents of their place of birth and single. Nearly half of the females identified their previous occupation as seamstress although two had previous medical experience either as an auxiliary aide or a qualified midwife. Male candidates have a slightly lower educational status than the females, with fewer of them receiving the CEP (primary school certificate). About half of the males are farmers with only one of them receiving previous medical training. Like female candidates, most are single and live in their locality of birth.

Table I. General Characteristics of Health Agents: Les Cayes 1978

Social Characteristics General	Males	Females	Total
Average age	30.6	25.4	27.9
Ave. No. yrs. education	5.2	5.6	5.4
Ave. No. dependents	5.5	7.4	6.5
Ave No. children	2.2	1.1	1.6

Table I. General Characteristics of Health Agents: Les Cayes, 19

Social Characteristics General	Males	Females	Total
Avegage age	30.6	25.4	27.9
Ave. No. yrs. education	5.2	5.6	5.4
Ave. No. dependents	5.5	7.4	6.5
Ave. No. children	2.2	1.1	1.6
Residence			
Place of birth	9	13	22
Other	4	1	5
Marital Status			
Married	5	3	8
Place	1	1	2
Single	7	9	16
Separated	0	1	1
Former Occupation			
Agriculture	10	2	12
Trades person	0	6	6
Medical Work	1	2	3
None	2	4	6
Total	13	14	27

Source: Regional Bureau files of Health Agent Candidate Interview Schedules.

The number of dependents mentioned by males and females tends to be high but difficult to interpret. It is unclear if persons identifies dependents as members of the family that they would support or supplied the number of persons in their household.

Data from the interview schedules also indicate that more than half of the candidates had previous experience in bandaging and nearly half had performed injections. One male, for example had extensive medical experience helping his wife who is an auxiliary. It may be that candidates interested in health agent work were those who formerly performed health services as a secondary occupation(e.g. as charlatans) and were particularly desirous of improving the quality of their services.

5. Conclusion

There are several marked differences between regions in the ecological and social organizational development of the pilot proramss. The types of activities performed are similar and in accord with the guidelines established by the DSPP. Indeed, in both regions the concentration of activities is on the following: 1) education and promotion of modern health care, environmental sanitation, vaccinations for pregnant women: 2) home visits and community meetings; 3) client referrals; and 4) family planning. The methods of carrying out these activities differ, nevertheless, in their emphasis, logistical support, and regional planning of short term and long term gains. It is evident that regional differences in geography, infrastructure and past experience in health problems by personnel have contributed to the difference in institutional development.

6. Summary Recommendations

Based on the initial pilot health agent programs, the following recommendations are made for the development of the RHDS.

a) With respect to Program identification, it is recommended that extensive use of the local radio programs be used to promote and explain the health agent program before, during, and after training of health agents.

b) With respect to Candidate selection, it is recommended that candidates not be told initially that a salary is attached to the health agent position; moreover, that candidates be selected primarily for their interest in preventive health rather than curative health care.

c) With respect to training health agents, it is recommended that more practical training be emphasized and the practical training take place in the zones of the health agents rather that an area not relevant to any health agent experience. Furthermore, it is recommended that the methodology used for identifying diseases, human anatomy and adult disorders be based on group discussions, role playing and other exercises which would make theoretical training more relevant to student health agents.

4. With respect to data gathering, it is recommended that forms be uniform for the whole country and not left to regional direction. Furthermore, that careful instruction be given to health agents on how to complete them with frequent refresher training. Moreover, it is recommended that the data be used to instruct health agents so that their concern is not collecting statistics to get paid but to help them understand their local health problems. It is recommended that home visit cards as developed in the South be used nationally as a means to identify home visits made and purpose of visit.

An improvement in their construction is necessary as well as a special number given for each card. These cards should prove useful to health agents in identifying when and what topics were covered in previous visits and provide them with guidance on coverage of their zones.

5. With respect to referral objectives, it is recommended that the type of referral card booklets designed by the Northern regional staff be used nationally. It is further recommended that the referral cards be dated when they are turned into the dispensary. These cards are an excellent source of data on client receptivity to modern health card and cultural timing of initial health treatment It is recommended these characteristics be studied using the referral system.

6. With respect to supervision, it is recommended that supervisior teams be formed using the Northern pilot program as the model. Supervisory responsibilities for health prevention and promotion are recommended as the responsibilities of the supervision team with supervisory responsibilities on data gathering, reporting and technical, curative care be the responsibilities of the auxiliaries. It is recommended that a well developed supervision system be developed to insure nonessential data gathering, proper treatment, motivation and temporary refresher training, whenever necessary.

7. With respect to relationships between public and private dispensaries, it is recommended that the DSPP take stronger control measures of activities carried out in dispensaries to which health agents are attached.

In whichever dispensary, health agents should be allowed to resupply clients with contraceptive pills and condoms and auxiliaries should be allowed to instruct on birth control measures other than the rhythm method. It is recommended that a non-religious auxiliary nurse be assigned to each of religious dispensaries to insure total services to clients. Furthermore, it is recommended that public dispensaries be developed not in competition with private (mixed) dispensaries but as a viable alternative to private dispensaries.

8. With respect to activities performed, it is recommended that health agents be assured a regular supply of medicines and medical supplies so that one of their primary activities can be carried out. Moreover, it is recommended that health agents receive some technical assistance or financial assistance for encouraging preventive health care investments, such as latrine construction.

9. With respect to family planning, it is recommended that they continue to promote various family methods and explain carefully the relative merits of each.

10. With respect to coverage, it is recommended that more careful construction of health agent zones be achieved, that zones not be based on SNEM estimates, but on estimates bases also on initial data collection. Moreover, it is recommended that the number of houses covered per day be no less than three unless exceptional circumstances prevail. However, it is recommended that the number of houses covered should depend on local conditions and the discretion of the health agent rather than standardized estimates.

C. Community Health Program of Albert Schweitzer Hospital

Five community Health programs have been established at the Albert Schweitzer Hospital at Deschapelles. They are Immunization Clinics, Tuberculosis Rest Centers, Demography and Family Planning Register, Nutritional Centers and Sanitary Agents. The Nutritional Centers have been closed for about nine months due to problems of food distribution and high cost-benefit ratios. The sanitary agent program to work out of a dispensary was initiated in June 1978. The following brief description of the existing programs should provide insight into the viability of introducing community health programs to increase rural health delivery in Haiti.

1. Immunization Clinics

Immunization clinics consist of 2 teams: a large team of 14 persons who go out nearly every day to perform immunizations at markets and a small census track team, of 2 hospital personnel (one a nurse) and 2 or more volunteers who perform local immunizations, the purposes of these clinics are four: immunize all women (whether pregnant or not) against tetanus and DPT,

2. Weigh babies and check their "Road to Health" Cards
3. take blood pressure, and
4. educate on health prevention

The best volunteers have been found to be selected from their local communities for their interest and willingness to work. Volunteers are paid $1 per day.

Their work activities vary, depending on their previous clinic experience. Initially volunteers spread information on day, time and place of the clinic; then gradually they work up to checking vaccination cards, weighing children (by weighing mother and child and substracting mother's weight), rescheduling visits or even giving immunizations. Volunteers are evaluated informally. If they are found to work well, they are encouraged to work again for the team, some are then selected to be regulars on the team. These regulars have never earned more than $40 per month. Merit Salary increases are given every October.

Three observations about program effectiveness were noted by the community health director:

1) literate men between 20-40 years are better workers in running about the countryside announcing the time and place of the clinic than women. Literate women tend to walk less and work more effectively at "sit-down" jobs.

2) Volunteers need to know how to read and write creole (all forms are in Creole, French is not expected nor encouraged to be used by advisors) Acceptance and increased understanding on the part of volunteers and persons served seem to result from the exclusive use of Creole.

3) teams never go out unless they have sufficient serum to meet the demand. From experience, it was found that if there were an inadequate supply, clients unable to be served became disappointed with the service and were more resistant to receiving aid on next contact.

2. Tuberculosis Rest Centers

The tuberculosis case finding and treatment program consists of two activities. The first is supervised therapy at village centers or isolated areas; the second is volunteer case finding through gathering sputum in boxes and bringing it to the hospital for testing or performing PPD skin tests.

The usage of rest centers is very low (around 3%) and said to be due to the family or agricultural responsibilities of persons needing extended rest periods. Furthermore, those who receive referral slips go infrequently to the rest areas. The major reasons for low referral are the client cannot read the slip, does not understand its meaning, or simply stores the slips in his/her box of "important" papers. It was found that only when volunteers explain the referral slips or remind persons to go the center that increased participation results.

The effectiveness of this program also has been found to lie with the hiring of volunteers to go out to the rural areas and look for persons who have not come in for medical attention and give them skin tests or sputum box service. It is bringing the service to the client rather than waiting for the client to come for the service that has decreased the number of tuberculosis cases in the area, according to the community health director.

3. The Demography Register and Family Planning Program

The Demography register reports vital rates and basic demographic data.

Three registers were developed (birth, death and migration) in the community health office, and data were obtained from 1968-1978. The household register forms included the following data.

- Name
- birth month and year based on birth certificate or events calendar
- sex
- marital status and order of union determination
- role in the household, giving attention to relationship of individual to head of the household
- occupation
- number of years/complete schooling
- Hospital number
- Service Santé number (an identification number assigned to each child under the age of six linking him to his mother)

These data were gathered by voluntary collaborators who were assigned to approximately 500 persons (or 100 families). They were recruited locally and had previous experience in community development programs. The field-workers had a supervisior for every two workers to assign houses and be available to answer questions. The selection criteria for the field workers were:

- able to read and write
- capable of completing a simple questionnaire
- known and respected in the community
- interested in collaborating with the health outreach program
- chosen or at least mentioned by local community leaders

It was found that these selection criteria were adequate. Indeed, field workers, in less than one week's training were not only capable of filling out the register but were able to give more information on each family than was required. Moreover, the more the field worker worked in his own area, the more accurate the register, Berggren, Berggren and Ewbank, Ibid., section II, p. 13. An older woman familiar with the history of the region was also hired to help with age determination problems Op. Cit., section II, p. 14

While this register has become an important part of analyzing the fertility and infant mortality rates and sex differentials in mortality, the data have little utility for community health planning, according to the director. Indeed, no questions were asked on nutrition or illnesses - information which could be used for measuring program performance (other than neo-natal tetanus vaccinations) and planning of future health care programs.

The family planning program is limited to discussions by an obstetrician and two aides at the Albert Schweitzer Hospital. They provide information on different birth control methods and their relative costs. These discussions are held under the big tree in the hospital court yard, and have not been part of a community outreach program. The methods mostly discussed are IUD's, condoms and contraceptive pills. The hospital has found that none of these methods has been readily accepted. One explanation given as to why women have not been accepting the pill is that women must return to the hospital every month to be resupplied. Each hospital visit regardless of service costs $1 (5 Gourdes), which is expensive to many.

The hospital is experimenting with handing out free pills to determine if the hospital fee is the major reason for non-acceptance.

4. Sanitary Agent-Dispensary Program

The health agent program is just beginning. It is being developed on a small scale (one dispensary only) in order to test out the concept and work out potential problems.

The program was initiated with the following methodology. First a visit was made by a medical team and some hospital workers to a village which has a functioning community council. In the visit, the residents were asked:

a) what they wanted

b) how they could attain it

c) what they (the team) could do to help.

The response was that they wanted a dispensary, were willing to supply labor, materials (wood, stones, roofing material) and would provide a central location for its construction. The hospital team returned with support of cement, nails and materials that needed purchase in Port-au-Prince. It took four months to construct the dispensary from the date the medical team approached the community.

The location of the dispensary is part of an overall regional design to build dispensaries around the hospital in a walking or riding path toward the hospital. The dispensary plan is also designed to be geographically spaced so that it is grouped around villages and in a downward focal point from mountainous localities (villages).

Four sanitary agents work out of the dispensary. They are males who have previously worked as volunteers in immunization clinics and have been trained up to performing injections. They were trained mostly by watching doctors and nurses perform tasks, but they also received considerable training in their previous hospital experience. The characteristics used to select agents were that they are

1) from the local area
2) respected for their work effort and competency by community members and
3) trusted by both the auxiliary nurse in the dispensary, the community health director, and the local people.

The work assignment of the Sanitary agents is the following:

- promote health education, especially environmental sanitation
- improve nutritional status by talking about dietary habits and handling out beans from hospital harvests
- refer cases to the dispensary and hospital and identify what problems are being referred

  screen cases to determine those who are homebound (i.e., so sick they cannot come to the dispensary or hospital) or who need more immediate treatment
- provide confidence in the modern health care services provided in the area

The sanitary agents will not be allowed to deliver medicines nor provide primary treatment initially. The director felt these tasks could be gradually achieved without any problems.

The Sanitary agent program will begin slowly because of limited funds and recalcitrance by the grant foundations to fund such a project. Hence, in the beginning, Sanitary agents will work only one day a week and gradually work up to a full six day week. Their salary will be anywhere from $5-10/week depending on their previous experiences in health work, and number of work days. The agents will be closely supervised. A supervision plan is not totally completed since the number of work days is not fixed. A suggested schedule was that if a sanitary agent works one day a week, he will be supervised every two weeks; if he works six days a week, he will supervised once a week. Supervision as frequently as possible was recommended by the Community Health Director.

The further training of health agents and construction of another dispensary will not begin until probably September, 1978, or when some reliable evaluation of the new program takes place.

5. Conclusion

The community health program of the Albert Schweitzer Hospital has several program components applicable to the development of the RHDS. The first is that local persons can and have been demonstrated to be used effectively in delivering health promotion, achieving referral tasks, administering health duties, and collecting baseline data. Secondly, the health programs have demonstrated the need to perform outreach tasks in order to improve health status and servicing of rural people

Finally, the health programs note the movement in Haiti to use paraprofessional dispensary units as a means to improve health activities and as an alternative to establishing health programs directly associated with hospitals or with highly trained medical personnel.

6. Summary Recommendations

a. It is recommended that literate women be more carefully interviewed than literate males for the position as health agent since they may be less likely than males to walk around daily to promote health care without some form of transportation.

b. It is recommended that all forms and training notes be written in Creole (not necessarily exclusively) to facilitate direct communication between health personnel and client population.

c. It is recommended that continual resupply of medicines be available to health agents so that seldom a health agent will not be able to treat a person for lack of insufficient medicines.

d. It is recommended that referral cards be explained clearly to clients and emphasized as a ticket for improved health care rather than as valuable paper to be stored.

e. It is recommended that baseline data collection include data which can improve health programming and not data whose primary benefits are statistical reporting of population characteristics and vital events.

f. It is recommended that close field supervision be undertaken when baseline data are obtained and local persons be hired to go around on surveys to facilitate recall of vital events and improve age reporting.

It is also recommended to use local persons in data collection to increase its accurancy.

g. It is recommended that contraceptive pill acceptors be resupplied at a woman's house rather than at the dispensary every month in order to decrease transportation and other costs which may be incurred for resupply at a dispensary.

h. It is recommended that careful geographical planning of health centers and dispensaries be undertaken to facilitate the assessibility of care to the local population and increase the focal point of dispensary health agent units.

i. It is recommended that health agents be selected more for their previous community development experience and ability to gain trust from local persons and dispensary staff than for their age and marital status characteristics.

j. It is recommended that close supervision be developed in the initial stages of program development in order to evaluate wich activities health agents are capable of doing and which activities they can be taught "on the job".

D. Integrated Project for Public Health and Population at Petit Goave (written by Barbara Ormand).

The Integrated Project for Public Health and Population at Petit Goave is a program of the Division of Family Hygiene (A Bureau in the Department of Public Health and Population). It is designed to provide health services to a rural population in southern Haiti. The service area is divided into three district regions each with a population of approximately 10,000 and each receiving a different level of health services (as described below).

The three levels of service were designed to provide the DHF with a basis for comparing the relative effectiveness of different intensities of service delivery.

The project is not scheduled for completion until December 1978 so the final analysis of the data has not been made. However, in terms of the acceptability to the rural population, the feasibility of administration, and the cost-effectiveness of each of the approaches much has already been learned. The lessons learned in Petit Goave by the Division of Family Hygiene have been applied in the design of this system.

1. Project Design

The low service area has one resident "community collaborator" per 500 population serving on a part-time voluntary basis. His function is one of animateur, assistant to the "community agent" (described below). For each 2,000 population there is a community agent who is a full-time, health worker with a salary of $40 month. His training consisted of a 4-week training seminar at the Division of Family Hygiene. Regular supervisory meetings with other community agents throughout the project life provide continuing on-the-job training. His duties include health information and education, motivation and recruitment for the mobile team, health surveillance, participation in community development activities, and registration of vital events. Each five community agents have one supervisor. The supervision was indirect and direct methods of supervision through checks on home visit cards and the itinerant monthly schedule filled out by community agents. The community agent and the

community collaborators are responsible for personally inviting each member of the population to come to the "ralley station" (a location provided by the community) for the tri-monthly visit of the mobile team which is composed of one doctor and five medical aides. Each three months every child under five is weighed and measured and his progress registered on a growth chart. Each member of the population is immunized with immunizations recorded on a card which the person keeps. A system of "chits" allows a duplicate of this card to be maintained at the central office in Petit Goave. The doctor with the mobile team gives pre-natal check-ups to pregnant woman and worm treatment to children who need it.

The medium service area has all of the above and also a dispensary (one per 10,000 population). The community agents' job expands to include referrals to the dispensary. In the high service area the services are the same except that the dispensary is equipped to provide some in-patient care as well. Family planning activities in the low service area are limited to the community agents' handing out condoms to couples who want them. The agents are resupplied at their regular supervisory meetings. In the other two areas, the agents refer interested couples to the dispensaries.

Coverage figures for the project area indication that the program has been well accepted by the population. As of 31 December 1976, 76% of the population under four had received the full series of DPT immunization, 88% of the under six year olds had received BCG,

and 45% of the under-fourteen year olds had received polio immunization. Although the time period covered is too short to establish a trend, mortality rates appear to have responded favorably to the increased availability of health services. Infant mortality rates have been substantially affected by the virtual elimination of neo-natal tetanus.

2. Summary

The lessons learned by the DHF from the Petit Goave project have aided in the design of the RHDS. The experience gained in administration will be invaluable in the successful implementation of the current project.

Appendix I
Interview Schedules Used/Proposed for
Field Survey of Health Pilot Projects

Summary

Basic areas questions are to cover

1. Selection criteria of agent.
2. Training in health and communication and primary health skills of agent.
3. Personal hygiene of agent and family.
4. Work Schedule of health agent.
5. Referal Practices of agent.
6. Supervision System by auxiliary nurse and community.
7. Community receptivity of health agent.

Persons to be contacted for information

1. Regional health official.
2. Auxiliary nurses.
3. Health agent.
4. Clients (patients) in their homes and at health agent's home with health agent present.
5. Clients (patients)in their homes or around area without the health agent present.
6. Community leaders.

General Characteristics of the Community of Health Agent

1. Presence/absence of a school
2. Water source
3. Religious facilities.
4. Conseil communautaire presence and activities.
5. General state of housing.
6. Prevalence of SNBM No. on houses.
7. Road conditions to get in and out of community
8. Distance in hours of walking from dispensary (proximity of dispensary).
9. Proximity to other privately-run health facilitie

10. Awareness of presence of health agent by community members.

a. How many persons did you ask if there was health agent in the area?

_____

b. How many had hear that there was one?_____

c. How many definitely know there was one?_____

11. Receptivity of community to health agent

a. How many persons know what a health agent was?_____

b. For those who know what one was, what was the general reaction?

_____

c. For those who did not know what one was, what was the gernal reaction after you explained "health agent"?

II. Interview Schedule for Health Agent

A. Background

1. Sex

   1 Male

   2 Female

2. What year were you born?

3. What is your marital status?

a.) How many current mates do you have? _____

b.) How many mates have you ever had? _____

4. How many children have you ever had? _____

a.) How many children are still living? _____

5. Were you born in this "habitation"? Yes: _____ - No: _____

a.) If not, were you born in the zone? Yes: _____ - No: _____

6. Have you lived in this "habitation" during the last 5 years? Yes: ___ No: _____

7. Does your mother live in the zone? Yes: _____ - No: _____

8. Do you have an older sister who lives in the area? Yes: _____ - No: ____

9. How many years of school have you completed? _____

10. What is your current religion?

    1- Catholic - loa (sèvi loa)

    2- Catholic - franc

    3- Protestant

11. Before you became a health agent, what did you do? _____

12. Do you still work in this (Give occupation)? Yes: _____ - No: ___

a.) Are you happy about your new occupation? Yes: ____ - No: _____ Why: _____

_____

13. Are you or have you ever been known as a:

		Yes, Now	Yes, Before,	No
a.	Docteur feuille			
b.	Bone Setter			
c.	Injectionist			
d.	Femme Sage (without training)			
e.	Femme-Sage (with training)			
f.	Hougan			

14. How are you related to the following persons?

		Not related	Don't know	Relationship
a.	Chef Section			
b.	President de Conseil Communautaire			
c.	V. Pres. de Conseil Communautaire			
d.	Treas (Sec) de Conseil Communautaire			
e.	Maître (maîtresse) d'ecole			
f.	Magistrat Communal			
g.	Travailleur de SNEM			

B. Motivation and Attitudes towards Role

1. How were you chosen a health agent? _____
2. Why do you think you were chosen? _____
3. Why did you want to become a health agent? _____
4. When you first heard of the programs, what did you think? _____
5. What do you think is the work of the Health Agent? _____

_____

6. Why is this work important? _____
7. If, the Government were to stop this program, what would you do? _____

_____

a.) How would you feel about this change? _____

8. Do you think your own life has changed since you received your diploma as a health agent? _____

_____

9. How do people around here feel about having a Health Agent in the area? _____

10. Have you had any problems with people accepting you as a Health Agent?
a). If yes, which type of persons gives you the most problems? _____
b). What was the most common problem you had? _____
11. Who do you talk with mostly about health problems? _____

_____

12. What health problem is the most common one you have treated? _____
13. Who do you think is more important to teach about health care? _____
Women: _____ Men: _____
14. How important do you think are the following persons to work with?

Local healers	Very Important	Important	Not Important
Women	_____	_____	_____
Men	_____	_____	_____
Children	_____	_____	_____

C. Educational Training

1. What did you do during your training program? _____

2. Were there any problems which you wished you had learned to solve but did not during your training problem.? _____

3. What do you think is the most important work you can perform?

_____

4. How important do you think it is to do the following activities:

	Very Impt.	Important	Not very Impt
a. To work with Dr. Feuille:	_____	_____	_____
b. To work against Dr. " :	_____	_____	_____
c. To work with hougan :	_____	_____	_____
d. To work against " :	_____	_____	_____
e. To work with Femme-Sage :	_____	_____	_____
f. To work against Femme-Sage :	_____	_____	_____
g. To deliver babies :	_____	_____	_____
h. To hold local community health meetings. :	_____	_____	_____
i. To give out contraceptives :	_____	_____	_____
j. To treat infections :	_____	_____	_____
k. To bandage persons :	_____	_____	_____
l. To hand out pills against worms :	_____	_____	_____
m. To hand out pills against diarrhea :	_____	_____	_____
n. To teach water sanitation :	_____	_____	_____
o. To teach food preparation	_____	_____	_____
p. To teach personal hygiene toilet - soap) :	_____	_____	_____

	Very Impt.	Impt.	Not very Impt.
q. To refer patients to the dispensary :	_____	_____	_____
r. To make reports to auxiliary nurses on health problem. :	_____	_____	_____

5. What are the major health problems you see frequently in your area? _____

6. What are the most frequently treated diseases in the area:
Tuberculosis - Veneral disease - Malaria - Worms - Diarrhea
Eye infections - Tetanous?

7. What medicine is the most frequently used in the area? _____

8. What did your teachers emphasize were the most important services you should do. _____

_____

9. How many hours by walking is your furthest client? _____

_____

a. Did you know (him) them before you started working as an health agent? _____

b. How well did you know him? _____

10. Can you tell me what you usually do during a 24 hour period?

_____

E. Ideology (completed, but only in Creole, by Mr. Ira Lowenthal)

1. General about diseases, etiology, diagnosis, treatment
2. Traditional/modern system
3. Birth control, planning
4. Referral to whom
5. If a client refuses to go the dispensary, what would you do?
6. If a client refuses to see you, what would you do?

F. Knowledge/Health Beliefs

Hypothesis: The greater the knowledge of preventive and curative modern (western) health practices by the health agent, the greater his effectiveness in delivering modern health care.

1. If a woman comes to you with a small baby who is just beginning to get teeth, and she says the baby has diarhea frequently, what do you think might cause the diarrhea? _____

a). What advice would you give to her? _____

2. If a woman has just received contraceptive pills from the dispensary and she comes to you to ask how many times a day she has to take the pill, what would you tell her? _____

3. Another woman has also received contraceptive pills but she has just begun to menstruate and doesn't know when she should take the pill, she comes to you with the pills and asks you when to start, what would you tell her? _____

4. Sometimes at the dispensary, the nurses give out jelly for family planning. One day, a woman with three children comes to you with the jelly and asks you how to use it. What advice would you give her? _____

5. The other day, I was talking with an older man about preventing pregnancies and he gave me a condom. How many times can I use it before I have to throw it away? _____

a.) Should I use it with my wife? _____

6. If a mother came to you and said her child seemed very afraid at night and would cry during his sleep, what would you tell the mother to do? _____

7. I have an eight-month old child (show picture), he frequently has diarrhea and cries a lot, do you have any suggestions on what my wife and I can do? _____

8. My wife's sister's child frequently has diarrhea too. But when the little girl has diarrhea she has a fever too. Can you give me some advice that I could bring back to her? _____

9. Does a pregnant woman have to be vaccinated? _____

a). If yes, what is she vaccinated against? _____

b). If yes, how many times? _____

10. If a woman were going to make some porridge and give it to her infant to eat, what should she do with the water? _____

11. Are there many children in the area that do not seem to play, eat or are happy? _____

a.) If answer is yes, why do you think this is so? _____

b.) If no, why do you think not _____

12. If a woman brings you a child with a big (swollen) belly, what might be wrong with the child ?

13. If a child has difficulty breathing, eats food but doesn't seem to grow, and he seems to have the "grippe", what do you think might be wrong with the child? _____

14. If a child doesn't play, his eyes are not shiny or bright and he doesn't seem to see very well at night, what do you think might be wrong with the child? _____

_____

a. What would you suggest that the person do? _____

_____

G. Infrastructure - Support System

Hypothesis: Greater the access to supplies, the greater his effectiveness in delivering care.

Hypothesis: The more regularly he is rewarded, the more motivated is the health agent.

Access to Supplies

1. What do you think is the best way to be supplied with medicine? _____

2. Which supplies have you received since you have been working as a health agent? _____
3. Which ones do you need more often? _____
4. Where do get your medical supplies? _____
5. Do you have to pay for any of the supplies when you receive them? _____

a). If so, for which ones? _____
6. How do you get the supplies? _____
7. How often do you receive your supplies? _____
8. When you receive your supplies, how do you indicate that you have received them? _____

Salary Receipts

9. Have you received a salary every month? _____
10. How often do you receive your salary? _____
11. Who pays you? _____
12. Where do you get paid? _____
13. Is your salary the amount you were told you would receive when you earned your diploma? _____

a). If your salary is not what you thought you would receive, why do you think you have not received all of it? _____

14. If you do not receive your salary this month, what will you do? _____

15. Who is your supervisor? _____

16. What does she (he) do when he (she) meets with you? _____

_____

17. How often in the last three months have you talked with her (him)

_____

Supervision Observations

18. If the supervisor is not the auxiliary nurse, has the auxiliary nurse from the dispensary visited you?

Yes: _____ No: _____

a) If so, how often has she visited you? _____

19. Has any DSPP person visited you? Yes: _____ No: _____

a) Who? _____

20. Has any officer of the Conseil Communautaire asked what you were doing? _____

a) Did she ask what kinds of problems you might be having while working as a health agent? Yes: _____ No: _____

21. Has the "docteur feuille" visited you and asked about what you were doing? _____

22. Has the Chef Section visited you? _____

23. Has the Magistrat Communal visited you? _____

24. How do you feel about an auxiliary's work? _____

_____

25. What is the salary of an auxiliary? _____

26. How do auxiliaries react toward health agents? _____

_____

H. Work-Related Activities

Hypothesis: The greater the role playing(contact), the greater the effectiveness.

Frequency of contact at Health Agent's Home

1. How many times has a person from far away come to your house for aid? _____

2. How many times do persons from your community come to you? _____

3. At what time of the day do they come? _____

(observation-Are there people going to the house for aid?

Who: males - females - old - young)

Frequency of contacts at home in areas

4. How many home visits did you make last month? _____

5 How many home visits did you make last week? _____

6. Who do you usually find at home, when you make a home visit? _____

7. With whom do you usually talk about health care the most?

Young males _____ Young females _____

Older males _____ Older females _____

8. How often do you go to a patient's house more than once?

Very often Sometimes Seldom

Community Recognition and Involvement

9. Have you conducted a health meeting?

a). If yes, how many meetings have you conducted ? _____

b). If yes, how many persons attended the meeting? _____

c). If yes what did you talk about? _____

10. Where do you keep your diploma? _____

a) Has anyone asked to see it? Yes_____ No_____

b). Who has asked to see it?_____

11. When you returned from training, was there any special meeting called of the community? Yes_____ No_____

a. If yes, what was it like?_____

_____

b. If yes, did you like that? Yes_____ No_____

12. Are (Is) there any privately run dispensaries (dispensary) near you? Yes_____ No_____ How many?_____

a. If yes, do you contact persons in this dispensary when you have health problems to solve? Yes_____ No_____

b. If yes, who are the persons who work in the dispensary?_____

_____

13 Are there other health agents in the area? Yes_____ No_____

a. If yes, who trained them?_____

III. Interview Schedule for the Auxiliary Nurses at the Dispensary

Length of Service

1. How long have you worked in this dispensary? _____

Supplies

2 a). How do you receive your medical supplies? _____

b.) How frequently do they arrive? _____

Salary

3. a). Do you receive your salary? Yes: No:

b. If yes, how do you receive your salary? _____

_____

c. If yes, do you receive your salary every month? _____

Yes: No:

d. How adequate do you think your salary is?

Very adequate: Adequate: Inadequate:

4. Referrals

Do you receive referrals from health agents in your district?

Yes: No:

a: If no, why do you think no one has come? _____

_____

b. If yes, are they referred from all of the health agents in your district? Yes: No:

c) If yes, how many referrals have you received in the last three months? _____

d) If yes, what kinds of ailments did the referral clients suffer?

1 _____ 2 _____ 3 _____ 4 _____

5. Were there persons referred to you by the health agent that did not come to the dispensary? Yes: No: Don't Know:

a) If yes, about how many _____

b) If yes, what were the reported illnesses of these persons?

1 _____ 2 _____ 3 _____ 4 _____

Supervision

Have you visited the health agent under your supervision at their home or in their communities?

Yes: No:

a. If yes, what was the major purpose of your visit ?

	Yes	No
1. to give training	___	___
2. to evaluate his performance	___	___
3. to distribute medical supplies	___	___
4. to visit a sick person	___	___
5. other (specify) _____	___	___

7. Have you accompanied any health agents on their home visits?

Yes: No:

8. About how many health agents do you supervise? _____

Frequency of Contact

9. About how often do you see a health agent per month?

a) at the dispensary?_____ b)at their house?____ c)in their district?____

10. Have there been any meetings among all the health agents (together) and the auxiliary nurses? _____

Yes: No:

a. If yes, who suggested that a meeting be held? _____

b. If yes, what did you discuss most at the meeting _____

c. If no, why have you not held a meeting? _____

Agent Performance

11. Among the health agents working out of your dispensary, are there some who are more successful than others?

Yes_____ No _____ Don't Know_____

a. If yes, why do you think they are more successful? _____

_____

_____

System Performance/Awareness

12. From your point of view, what is the purpose of training health agents?

_____ _____

_____

13. Do you think the program is meeting its goal of improving health care service?

Yes: _____ No: _____ Don't Know: _____

14. Do you think there are any problems with this program?

Yes: _____ No: _____ Don't Know: _____

a. If yes, what suggestions can you make for possible improvements?

_____

Attitude towards Training

15. Would you like to receive more training?

Yes _____ No: _____ Don't Know: _____

a. If yes, what king of training would you like to receive?

	Yes	No
preventive health care	___	___
curative health care	___	___
family planning	___	___
record keeping	___	___
supervision	___	___
other (specify)	___	___

Attitude towards Dispensary

16. How adequate do you think the dispensary is with respect to

	very adequate	Adequate	Inadequate
sanitary conditions	_____	_____	_____
storage of supplies	_____	_____	_____
number of supplies	_____	_____	_____
chairs	_____	_____	_____
tables	_____	_____	_____
number of patients attending	_____	_____	_____
record book (s)	_____	_____	_____
living quarters	_____	_____	_____

17. Do you have any suggestions on how to improve the dispensary?

Yes: No:

a. If yes, what are they? _____

_____

18. Has anyone from the regional bureau visited you in the last three months?

Yes___ No_____

a. If yes, who was it?_____

b. If Yes, what did he (they) do ?_____

_____

19. Has anyone else visited you to see if you were having problems?

yes_____ No_____

a. If yes, who was it?_____

b. If yes, what did he(they) do?_____

_____

Observation of interviewer:

How adequate are the following conditions of the dispensary?

	Very adequate	Adequate	Inadequate
Sanitation			
Supply storage			
No. of supplies			
Chairs			
Tables			
No. of patients attending			
Record/book (s)			
living quarters			

IV. Interview Schedule for Community Leaders (officers of conseil communautaire, priests or ministers, school teachers, patrons, local merchants).

1. Have you been visited last month by the health agent for health reasons?
   Yes: No:
2. Has the health agent asked you to organize a community health meeting?
   Yes: No:
   a. If yes, where was it held? _____
   b. If yes, about how many people came? _____
   c. If yes, what was the discussion about? _____
   d. If yes, what were the points the health agent emphasized? _____
   _____
3. About how often does the auxiliary nurse visit the health agent?
   Very often - Sometimes - Seldom - Never - Don't know
4. About how often does the health agent received supplies?
   Very often Sometimes Seldom Never Don't know
5. Was the health agent known in the community for her/his "medical prowess" before his/her selection for health training?
   Yes No Don't know
   a. If yes, what was it that he/she was especially good at curing? _____
   _____
6. Has anybody gone to the health agent if they have had a high fever?
   Yes No Don't know
7. Has anybody gone to the health agent if their children have had diarrhea for a long time? Yes No Don't know
8. How often last week did you see the health agent giving medical aid at his/her house? _____
9. How often last week did you see the health agent giving aid at some one else's house? _____
   a. How do you know he was giving health care? _____
   _____
10. Does the health agent travel very far from his/her house during the week to give health instruction or aid? Yes No Don't know

11. What does the health agent do on market days? _____

12. Do you think your community members go more [illegible] to the dispensary that you have a health agent?

much more slightly more about the same less much less

13. Do you think your community members go more [illegible] to the "docteur feuille" now that you have a health agent?

Much more Slightly more about the same less much less

14. Have the "docteur feuille" and the health agent worked together to try to help someone who was ill? Yes No Don't know

15. Have the sage femme (Farm Sage) and the health agent worked together to deliver a baby? Yes No Don't know

16. Have the sage femme (farm sage) and the health agent worked together to help a sick baby? Yes No Don't know

17. Now that you have a health agent, do community members seek medical help faster for:

	Yes	No	Don't know
Fever :	____	____	_____
Cuts :	____	____	_____
Infections :	____	____	_____
Diarrhea :	____	____	_____
Grippe :	____	____	_____
Eye problem :	____	____	_____

18. What do you think are the best things the health agent does? _____

19. What do you think are the worst things the health agent does _____

20. What else would you like to see the health agent do? _____

V. Indirect Observation of Health Agent

A. Communication Skills/Educational Practic

Hypothesis: The greater the use of primary health care skills, the greater is the effectiveness in delivery of modern health care.

Initial Contact:

1. How does the health agent approach a person in a home visit?

	Yes	No	Did not observe
a. with authority	___	___	___
b. offensively	___	___	___
c. directly in identification of purpose of visit	___	___	___
d. indirectly in identification of purpose of visit	___	___	___
e. confidently	___	___	___
f. brusquely	___	___	___

Deductions

	Yes	No	Did not observe
2. Does he ask questions by symptoms?	___	___	___
3. Does he give a diagnosis before asking the person for his?	___	___	___
4. Does he ask if the person has diagnosed his problem?	___	___	___
a. If yes, does he only accept the person's diagnosis?	___	___	___
b. If yes, does he act critically against the person for diagnosis?	___	___	___
5. Does he ask if the person has already tried a teatment?	___	___	___

a. If yes, how does he act towards that treatment? _____

_____

	Yes	No	Did not observe
6. Does he look around for:			
a. dirty bottles	___	___	_____
b. food storage procedures	___	___	_____
c. bar of soap	___	___	_____
d. SNEM no.	___	___	_____
e. floor swept	___	___	_____
f. latrine/place of defecation	___	___	_____
7. Does he volunteer information about preventive care from observation	___	___	_____
Method of instruction			
8. Does he repeat verbatim or as though instructions were memorized?	___	___	_____
9. Does he instruct indirectly through proverbs?	___	___	_____
10. Does he instruct person in words only?	___	___	_____
11. Does he show/make illustrations?	___	___	_____
12. Does he demonstrate by action or role playing?	___	___	_____

Instruction with service on curative health practices

13. Does he adequately give instruction on how to use specific medicines?
    Yes: No: Did not observe:

14. Does he ask the person to repeat instructions?
    Yes: No: Did not observe:

15. Does he ask this at different times to insure that the person will remember instructions?
    Yes: No: Did not observe:

16. Does he offer instruction in such a way that the person will be able to recall that he should use that sort of medicine of health care if the symptoms appears again?
    Yes: No: Did not observe:

17. Does he encourage persons to apply modern medicine treatment if the same symptoms appear?
    Yes: No: Did not observe:

Referral

18. Does he admit to not knowing how to help?
    Yes No: Did not observe:

19. Does he suggest another person can help the person feel better or give him medical advice?
    -- auxiliary nurse
    -- medical doctor
    -- docteur feuille
    -- sage fame (farm sage)
    -- one of health agent's relatives
    -- one of client's relatives

20. Does he recommend that the person go to the dispensary?
    Yes: No: Did not observe:

21. Does he say he will tell the auxiliary nurse about the illness or ask her advice?
    Yes No: Did not observe:

22. Does he give any evidence that he is going to refer to the person to the health center or dispensary?
Yes: No: Did not observe:

Follow up visit

23. Does the agent give any evidence that he will follow-up his visit?
Yes: No: Did not observe:

24. Is the follow up to determine if a person saw an auxiliary nurse?
Yes: No: Did not observe:

25. Does he set up a time for the person to visit him at his house?
Yes: No: Did not observe:

26. Does he set up a time when he will come back to visit the person?
Yes: No: Did not observe:

27. Does he suggest that the person send someone to get him if the person doesn't become better?
Yes: No: Did not observe:

28. Does he suggest that he will send someone to check on him in a few days?
Yes: No: Did not observe:

Socio-emotional mannerism

29. Does the agent seem generally concerned about the patient rather than showing off to you
Yes: No: Did not observe:

30. In what ways does he demonstrate his psychological support for getting well? _____

_____

31. In what ways does he minimize stress? _____

_____

Positive last contact

32. Does he leave the person with positive support that he will get well?
Yes: No: Did not observe:

33. Does he leave too abruptly or when the perceived needs are not met:
Yes: No: Did not observe:

34. Was the person ready for him to leave?
Yes: No: Did not observe:

35. Does he demand anything for his services which might deter the agent's reception (e.g. ask for coffee, food, money)?
a. If yes, was the health agent's response? _____

_____

Emphasis of actual activity (during your visit)

38. Does the agent give primarily preventive attention?
Yes: No: Did not observe:

39. Does the agent emphasis birth control?
Yes: No: Did not observe:

40. Does the agent give primarily environmental sanitation instruction?
Yes: No: Did not observe:

41. Does the agent emphasize child care?
Yes: No: Did not observe:

42. Does the agent teach more than lecture?
Yes: No: Did not observe:

B. Personal Hygiene

Hypothesis: The greater the adoption of preventative health practices by agent, the greater his effectiveness in diffusing information.

Hypothesis: If the primary group [illegible] adopt [illegible] preventive health practices, then the effectiveness of the agent increases (role modeling and behavior adaption and training of primary family members).

Agent

	Yes	No	Don't know
1. Uses soap			
2. urinates ways from house (Use latrine)			
3. defecates away from house (Use latrine)			
4. covers defecation			
5. has diarrhea --			
a. has he had diarrhea for a long time?			
Household Sanitation			
1. SNEV/card/number			
2. Boiling water for food preparation			
3. Boiling water for drinking			
4. House floor swept			
5. Animals in house			
6. Children playing nude on floor			
7. Water storage			
a. covered			
b. non contaminated container			
8. Food storage units			
a. protected from rats			
b. protected from insects			
9. Kitchen (foyer)			
a. use of sanitary measures			
b. projected from animals			
c. other (specify)			

Appendix II. DATA GATHERING FORMS USED IN PILOT HEALTH AGENT PROGRAMS: CAP-HAITIEN & LES CAYES, 1978

Figure 1. Referral Cards: Cap-Haitien Pilot Project

Dispensaire _____	Dispensaire _____
M M E P ENF 1/	M M E P ENF
Nom, Prénom _____	Nom, Prénom _____
Localité _____	Localité _____
Nom de l'Agent de Santé _____	Nom de l'Agent de Santé _____
_____	_____
Date donnée _____	Date donnée _____

M : recruited for matron traini

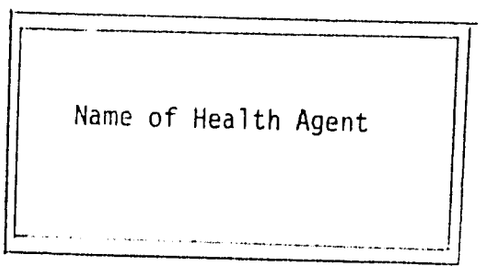
M : maladie

E : enceinte

P : pilulle

ENF: enfant

Figure 2. Referral Cards: Les Cayes Pilot Project



Paper with name of health agent sewn into a green plastic covering

Figure 3. Monthly Report System: Les Cayes Pilot Project

FORMULAIRE DES AGENTS DE SANTE

Région Sanitaire	: Sud
District Sanitaire	: Cayes
Communauté	:
Nom & Prénom de l'Agent	: _____
No. de foyers	:
No. de visites	:
Type d'activités	- Premiers soins
	- Séances éducatives
	- Références de cas
	- Autres

_____
Responsable du dispensaire

REGION SANITAIRE DU NORD

RAPPORT MENSUEL DES ACTIVITES DES AGENTS SANITAIRES

PERSONNEL: _____ NOM DE L'AGENT _____ ZONE _____

ACTIVITES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
Visites																										
Réunions																										
Puits forés																										
Source captée																										
Latrines construites																										
Barrieres-Nomb enf.presentn																										
Matrones recrutées																										
Cliniques mobiles préparées																										
Clients référés																										
Mariculture-pers. référées																										
Fractures																										
Hémorragie																										
Autres Accidents																										
[illegible]																										
[illegible]																										
[illegible]																										
Mal aux yeux																										
Fievre																										
Autres																										
Condoms N																										
A																										
Pilule N																										
A																										
Crème N																										
A																										
Sterilits(référence)																										

Pour [illegible] toutes les activités réalisées et [illegible]

Figure 4: Monthly Report System: Cap-Haitien Pilot Program

Figure 5. Home visit card: Les Cayes Pilot Project

LOCALITE: _____ No. SNEM _____

NOM DU CHEF DE FAMILLE _____

DATES	EDUCA-TION	TRAITE-MENT	REFE-RENCE	SI NON TRI

Figure 6. Supervision schedule for Dispensaries: Cap-Haitien

DEPARTEMENT DE LA SANTE PUBLIQUE ET DE LA POPULATION

REGION SANITAIRE DU NORD

RAPPORT DE SUPERVISION DES CENTRES DE SANTE

ET DES DISPENSAIRES

Date:_____ Localité:_____ Nom du Centre:_____

Nom du Superviseur:_____: _____:_____

1. Balance adulte ? oui ( ) non ( ) ; Balance enfant? oui ( ) non( )

   Bon état oui ( ) non ( ) Bon état oui ( ) non ( )

   technique pesée bonne oui ( ) non ( )

2. Revisez deux fiches "cliniques prénatales" au hazard:

   Bien remplies oui ( ) non ( )

   Commentaires:

3. Revisez deux fiches "infantiles et d'immunisation"

   graphique poids-age bien rempli oui ( ) non ( )

4. Rapport journalier pédiatrie bien rempli oui ( ) non ( )

   Commentaires:

5. Rapports précédemment préparés ont été expédiés au siège de la Région ? oui ( ) non ( )

6. Vitamine A en stock oui ( ) non ( )

   distribution faite oui ( ) non ( ) rapports er)

7. Capsules de fer en stock oui ( ) non ( )

   distrubution faite oui ( ) non ( ) rapports expédiés oui ( )

   non ( )

8. Production et distribution de AK 1000 bien organisées oui ( )

   non ( )

AK 1000 en stock oui ( ) non ( )
distribution faite selon normes oui( ) non( )
rapport production et vente à jour oui( ) non( )

9. Autres distributions d'aliments ? oui ( ) non ( )
distribution faite selon normes? oui ( ) non ( )

10. Existe-t-il un CERN desservant l'établissement de santé ? oui ( )
non ( )
" " une Garderie " " " " ? oui ( )
non ( )

11. Education individuelle oui ( ) non ( )
" collective oui ( ) non( )
technique adéquate oui ( ) non( )

12. Activités de Planification Familiale oui ( ) non ( )
Distribution de contraceptifs faite selon normes oui ( ) non ( )

13. Travail des Agents de Santé:

Agent _____ bon oui ( ) non ( ) Agent_____ bon
oui ( ) non( )
Agent _____ bon oui( ) non( ) Agent_____ bon oui()
non()

14. Rapports finances bon oui( ) non( )

15. Etat général du local Bon oui ( ) non ( )
Etat du mobilier Bon oui ( ) non ( )

COMMENTAIRE: