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RURAL HEALTH DELIVERY SYSTEM PROJECT IN HAITI

REPORT NO. 2

PROPOSED SUPERVISION SYSTEM FOR
MONITORING HEALTH AGENTS

Suzanne Smith Saulniers
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A. INTRODUCTION

The importance of a supervision system has several social bases. First, previous Haitian development project evaluation reports have indicated that maximum impact of projects was not always effected because there was no structural component to provide immediate feedback of program success or failure. As a result, few modifications in program design were made during the lifetime of projects. Moreover, dissatisfactory project activities were not remedied because program activities were well entrenched before structural problems were systematically observed. A supervision system can thus increase the flexibility of the RHDS program by directing attention more readily to problem areas when encountered on a regular basis. It can also introduce a reporting mechanism by which program officers can determine program needs and demands.

The second basis for a supervision system is that it increases the frequency of observation of health agents and the variety of personnel to whom the health is subordinate. Increased contact with a variety of supervisors can thus reinforce the health agent role as part of the system rather than as the last link in a chain of command. It further provides him with the positive support necessary to build self-confidence and assures continued work through decreasing his/her isolation from other health care personnel paid by the Government.

The third social basis of the supervision system is the increased visibility of the rural health care system to its constituents. Promotion of health activities, the health agent, the state-run dispensary by persons other than the health agent or auxiliary nurse should facilitate the health agent's introduction and effectiveness in administering curative and preventive activities.

Based on the social-cultural aspects of a supervision system, the purposes are to: 1) provide feedback on project performance, 2) reinforce work activities, and 3) increase attention on the national rural health care delivery system from the client population.

Several policy decisions will also be forthcoming from the effective operation of a supervision system. Explicit policy indicators should result from the monitoring of activities and the monitoring of the population served by the rural health care delivery system. These outcomes will be the determination of the: 1) appropriate balance of preventive, curative and environmental activities that the rural health care system can achieve, 2) feasibility of the three-month orientation and formal training period for including all facets of health care, and 3) support and receptivity of the rural population to the health agent service.

B. STRUCTURE

The supervision system consists of three components. Each is based on successfully established supervision mechanisms from the pilot RHDS program and other rural health related delivery programs. They are the following: 1) regional liaison officer, 2) mobile supervision units, and 3) card-based reporting system.

Each reflects different aspects of supervision and provides different methods of monitoring activities. The aspects include the provision and general functioning of the decentralized system (dispensary-health agent relationship), anonymity in reporting personnel difficulties, and tracking of actual program activities. The methods include direct monitoring through personal contacts and indirect monitoring through spotchecking of personnel

and clients assigned to the health agent.

1. Regional Liaison Officer

The first supervision component is the institution of a regional liaison officer. This position need not be full time. It should be a part time position of a physician who primarily has bureau responsibilities and is present most of the time in the office -- perhaps the deputy district administrator. He/she should be trained briefly (perhaps two days) and supervised by the district administrator.

Functions

The liaison officer performs two related functions: 1) to receive oral and written comments from rural persons concerning the performance of the health agents(s), auxiliary nurses and supervision team, and 2) to organize a list of localities where technical and financial assistance is needed to improve environmental sanitary conditions.

The first function is similar to an ombudsman. Its purpose is to enable local feedback at the regional bureau of health activities and problems related to receiving promotional, preventive and curative services. The liaison officer provides a mechanism whereby community members can offer suggestions on community health needs and problems in achieving health improvements. It is also a mechanism whereby community members can offer constructive criticism of the RHDS. Acceptance of the RHDS by the client population may increase if their participation in decision-making is welcomed and active.

The liaison officer must be trained to recognize that this is the primary purpose of this position. He should emphasize the positive aspects of community participation, be conciliatory and receptive to local feedback.

He should be trained to keep comments received anonymous and to insure no negative consequences to the reporter nor to the personnel reported.

The second function of the liaison officer is to tabulate requests for additional assistance on community health projects. These requests could begin a register of habitations or localities where health agents have motivated community members to undertake projects, such as latrine construction or well improvement. These requests could then be coordinated with other development projects funded by AID (or GOH) agencies, whose prime emphasis is community development and/or providing technical and financial assistance to community development projects. This register would not pre-empt the work of L'CNAAC or the Animation Rural programs of the Ministry of Agriculture. On the contrary, it would serve to give additional support to them by coordinating information on areas where community members are organized and motivated to improve themselves in health-related activities. Its prime purpose, however, is to monitor the success of the agent in initiating community activities and provide him/her with followup support.

2. Mobile Supervision Units

The second component is a mobile supervisory unit which will consist of three persons working out of each regional bureau or health center depending on health center location. The personnel will be trained health personnel at the level of public health nurses, sociologists/anthropologists and sanitary officers.¹ They will be carefully selected for their motivation and willingness to travel in rural areas. They will receive refresher training on health issues and special training on motivation and supervisory techniques and rural society. The training will occur before they become a mobile unit and in refresher workshop training sessions during their work experience.

¹See the discussion in the "Evaluation Plan for Health Agents" for the bases of their selection.

The training of supervision teams should be conducted in sessions of no larger than 18 persons per session, or 6 teams at a time. The training should be directed by persons skilled in rural Haitian socio-cultural customs and organization, and persons who use interactive educational techniques (e.g., role-playing, small group sessions). The training program will need technical assistance from community development educators and public health specialists for designing the program and teaching of instructors. The Sanitary Officer of the Cap-Haitien supervision team may be an excellent candidate to either be in charge of the program or provide technical assistance to the formulation of a training team.

Initial training sessions may last 3 weeks per session. Curriculum will include review on environmental sanitation, disease diagnosis, family planning methods, information gathering procedures, counseling, traditional medical beliefs, and educational procedures for communicating these topics in the rural Haitian milieu. Refresher training should be annual and cover no more than 6 days.

Functions

The functions of the team are five:

- 1) visit each health agent and his/her territory at least once but preferably twice a month
- 2) visit each dispensary at least once a month
- 3) give oral reports at dispensary meetings of health agents and general staff meetings at the regional bureau
- 4) file written reports on these visits monthly at the regional bureau
- 5) discuss among themselves problems of supervision and methods for ameliorating their supervisory program.

Activities

The specific activities of the mobile supervision team are divided into those directed towards the auxiliary nurse and dispensary, the health agent and the client population.

- a. Supervision responsibilities at the dispensary level (including the auxiliary nurse)
 1. observe and record availability of medical supplies
 2. observe and record the functioning of medical equipment
 3. review records and referral cards of patients served
 4. observe the quality of primary care delivered
 5. receive complaints of staff regarding workload, supplies, referrals
 6. ascertain and record the number of health instructional meetings held by auxiliaries and topics covered

- b. Supervision responsibilities at the health agent level
 1. observe and record the health agent in his delivery of preventive and curative care
 2. observe and record the adequacy of his/her supplies
 3. observe and record the regularity of his/her salary receipt
 4. give on the spot refresher courses to reinforce agent's capability to treat ailments or identify symptoms
 5. provide role models for teaching health care delivery
 6. check record keeping techniques of health agent

- c. Supervision responsibilities at client population level
 1. observe and record the receptivity of free medical supplies and willingness/capability to purchase medical supplies

2. review and record the frequency of contact and motivation for contact with the health agent by the client population
 3. observe and record the frequency of contact and motivation for contact with the health agent by the client population
 4. ascertain and record the acceptance of family planning and its proper use
- d. Other responsibilities at client population level
1. identify health agent and purpose of health agent
 2. refer clients to dispensary
 3. refer clients to health agent
 4. notify clients of time and place of mobile clinic visit to zone*
 5. promote preventive measures (e.g. latrine construction, planning)
 6. educate on environmental sanitation
 7. recruit persons interested in receiving midwife training
 8. recruit persons to regional office for mothercraft training (or to dispensaries who have the facility for this training)

Coverage

There should be an attempt to have supervisory teams in each region so that each one will be responsible for no more than 50 health agents and 10 dispensaries. This calculates:

1 team per 50 agents, 1500 agents, 30 teams

3 persons/team, thus

90 persons trained as supervisors

The number of health agents supervised by each team will depend on

*The mobile clinic consists of a doctor from the regional hospital/district hospital/health center and auxiliary nurses who set up a medical station in a specific locality to treat the seriously ill, give vaccinations, and other technical medical care.

several factors, mainly the accessibility of communities in the zones, severity of local environmental and health problems, particular difficulties in health delivery encountered by health agents, and population density.

Tentative Operation Schedule

The following table indicates a tentative schedule for allocation of the number of days for specific activities and with which personnel by the supervisory mobile team when the system is in full operation. It is assumed that there are 18 full working days per month and that a supervisory mobile team is responsible for 10 dispensaries and 50 health agents (see Table 1).

The work schedule indicates that the supervisory mobile team will provide feedback every two months to auxiliary nurses and health agents. This may provide sufficient time for the informational system to tabulate statistical information on numbers of highly communicable diseases, recruitment for midwife training, and births and deaths. These data, compiled at the health centers, could then be transmitted to the health agents and auxiliary nurses in instructional exercises during their meetings. The number of visits with auxiliary nurses and health agents in the two types of supervision scheduling assumes that the team has its own means of circulation. It would be extremely difficult to obtain even such minimum coverage unless mobility is assured through the use of a four wheel drive vehicle.

Implementation Schedule

The following schedule indicates the number of supervisory teams required in each project year and the total number of teams employed.

Table 1

Tentative Work Schedule of Supervisory Mobile Team

By Function and Contact with Health Personnel: RHDS, Haiti

<u>Function</u>	<u>work days/month</u>	<u>Number of Contacts</u>	
		<u>with health agent</u>	<u>with auxiliary nurses</u>
<u>Feedback reporting</u>			
to regional/district officials	2	0	0
to auxiliaries and health agents ¹	5	25	10
to themselves	1	0	0
<u>Direct supervision</u>			
dispensary and health agent ²	5	10	10
<u>Health agents and clients³</u>	5	15	0
TOTAL	<u>18</u>	<u>50</u>	<u>20</u>

¹This assumes that the supervision team visits 5 dispensaries when the auxiliary nurses are holding their monthly meeting and at least 5 health agents are present per meeting. It is also assumed that these meetings are held on five different days. On this occasion it is also assumed that the team can carry out its supervisory responsibilities of the dispensary.

²This assumes that a team can visit one dispensary and two health agents per day and these health agents and dispensaries are different from those which receive the supervisory team reports.

³This assumes that a team can visit 3 health agents and their territory per day. It does not take into account greater coverage at market day visits.

Number of Supervisory Mobile Teams by Year of Project

	<u>FY 79</u>	<u>FY 80</u>	<u>FY 81</u>	<u>FY 82</u>	<u>FY 83</u>	<u>TOTAL</u>
No. teams trained	5	4	8	7	6	30
No. teams employed	5	9	17	24	30	30

Based on the scheduled phasing-in of health agents

3. Card-Based Reporting System

Purpose

The last monitoring component is a system of supervising health agent activities by tangible measurement. Two cards are suggested: a home visit card and a referral card. The purpose of these cards is different. The home visit card is designed to supervise the number and frequency of contacts between health agent personnel and community members at the house of the community member. Both the supervisory team or the health agent may hand out the card on the initial home visit. Each time the health agent visits a client's home he must sign the card. The mobile supervisory team should ask to see it whenever they make home visits. These cards purport to identify the coverage of the health agent's territory.

Referral cards are the second form of supervision. They are designed to identify which clients have been seen in the field and referred to dispensaries. They will be given out by both the health agent and the supervisory team. Their purposes are to identify whenever someone needs primary health care, a physical for renewal of birth control pills, vaccinations against tetanus or DPT, physicals for pregnancy, special child attention, or recruitment for midwife training.

The health personnel directly responsible for supervising the card-based reporting system are the auxiliary nurses at the dispensary level.

Figure 3: Referral Card: Cap-Haitien Pilot Project

Referral Card (3" x 5" card made of study paper)

No. de carte: _____	No. de carte: _____
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 ² _____

a) Section kept by Health Agent

b) Section brought to Dispensary
by Client

1)

M: Recruited for matron training program (midwife program)

m: maladie (illness)

E: enceinte (woman is pregnant)

P: pilule (woman is coming for resupply of contraceptive pills or
physical checkup for women on contraceptive pills).

ENF: enfant (child is malnourished or dehydrated-needs special attention)

2)

On the back of this section, the auxiliary nurse must date the referral
card when the patient comes to the dispensary

Functions

The referral cards have three functions. First, they serve as reminders to the clients to go to the dispensary; second, they monitor health agent work in sending persons for further care or training at the dispensary; third, they monitor the receptivity of modern health care and the timing of initial use of modern healers by the client.

C. CONCLUSION

A supervision system at the grass roots level of the RHDS has been demonstrated to be a vital part of the system. It is instrumental in determining the actual performance of the health agent, his/her links with the dispensary and his/her instruction with the rural population. It is a mechanism which primarily monitors the health personnel -- the health agent and the auxiliary nurse and the receptivity of the rural population to the program and personnel. The policy implications of the supervision team, liaison officer, home visit and referral card reporting system are several. They are primarily outputs for matching resources to activities, appropriateness of health personnel training and the balance of preventive and curative care possible, given paraprofessional capabilities.

APPENDIX I: RELATED EXPERIENCE IN LIAISON OFFICERS

The design of an ombudsman system is based on a similar system developed by CARE. It has functioned for them for several years as an effective mechanism for determining local difficulties when conflicts occur between organizational personnel and the community councils. CARE personnel report its use primarily by community leaders and persons on commercial trips to Port-au-Prince. They report its use as frequent enough to warrant a formally identified position.

APPENDIX II: RELATED EXPERIENCE IN MOBILE SUPERVISION UNITS

The regional office in Cap-Haitien has already established a supervision team which performs these activities extremely effectively according to one anthropologist who spent 5 days in the area and a PAHO nurse who has worked in the region for a number of years. The team consists of an officier sanitaire, infirmier diplômée and an auxiliaire hygieniste. Two have worked in health education, training of health personnel, and resolution of rural health problems for nearly 20 years, the other for several years. They carry out all of the above activities now in addition to other health activities. (For example, the head of the team has a special Friday, 2:00 p.m. health program on the local radio station, Radio Citadelle).

Their activities are mainly promotional. They make a considerable number of home visits, going out at least 3-4 days per week to the zones where the dispensary-health agents are in place. In these visits they give instructions on environmental sanitation, nutrition and family planning. Emphasis is also given to referring patients to the dispensary (state run dispensary). In part, this latter emphasis may (and should) be changed when health agents receive medical supplies on a regular basis. Their home visits are made both with and without the health agent present. When the health agent is present, they instruct the health agent through role modeling on how to make effective home visits. Visits made without the health agent present are oriented to finding out where the health agent has visited, and carrying out the same functions as the health agent. In home visits they also recruit persons for the midwife (matron) programs and mothercraft center programs held in Cap-Haitien.

They have no fixed or rigid schedule. The team simply goes into the zone and looks for the health agent; in the process, they carry out the promotional, recruiting, referring and educational activities just as the agent would do.

The team usually stops at the dispensary before going out into the zone to see if the health agent is there. At the dispensary they then perform their supervision of equipment, supplies, referrals and health care delivery by auxiliary nurses.

On the anthropologist's review of team activities several conclusions may be drawn:

1. the health agent perceives his supervisors to be the mobile team more than the auxiliary nurse(s).
2. the health agents respond well to instruction from the team and learn communication skills from them.
3. the team is extremely motivated and so interested in teaching persons about environmental health issues that they sometimes appear overly zealous. That is, in some cases they all speak at once or overwhelm the persons with too much information.

In summary, the primary function of this team has been to supervise the overall functioning of the system: make home visits, directly with the agents and indirectly through spotchecking, and visit the auxiliary nurses at the dispensary. The secondary functions of the team have been to promote preventive care in rural areas and to encourage acceptance of the health agent. At present, the team attempts to supervise, carry out the same functions as a health agent, and perform recruiting for other public health activities in the region. These activities are demanding. As the RHDS grows, emphasis must shift to supervisory activities and away from promotion activities.

APPENDIX III: RELATED EXPERIENCE IN THE USE OF CARD-BASED REPORTING SYSTEM

Home visit cards have had general success in Haiti in the Project Intégré de Santé et de Population Sanitaire du District de Petit Goave, and in the Les Cayes Pilot Health Agent Project. In the former, they have been given out

to each house on a visit by community agents whose purposes are to motivate, educate on preventive health care and identify persons for the mobile health clinic. Any time health-related personnel visit the house, whether the community agent or his supervisor, the card is signed. It has served the purpose effectively by identifying coverage of the community agent through direct and indirect supervision. Through indirect checks by the agent's supervisor, the community agent never knows when he is being observed. The major problem incurred by this system is that the person responsible for the card was frequently not present when the supervisor or community agent made a home visit and others in the house did not know where the card was kept. Hence the card was not always signed on every home visit. A secondary problem was the frequently short duration of the card. Because many persons did not find a safe place to conserve the card, it often was destroyed by children or animals. The doctor in charge of the supervision system, however, stated that the results were generally satisfactory and he would recommend their use. The home visit card in Les Cayes is more complicated and requires identification and the purpose of the visit. It has the same objective and provides additional information. If the latter prove easily manageable, they are the type of home visit cards recommended.

Referral cards also have had mixed success in rural Haiti. The community health program at Deschapelles has used them for a number of years and found them, in general, successful. The basic problems encountered were that 1) persons forgot them, 2) persons saved them in little boxes where they collect and guard their valuable papers, and 3) persons waited too long to use them because they either did not have the 5 gourdes hospital service fee (\$1.00), or they could not take time away from their agricultural

activities to come into the hospital.

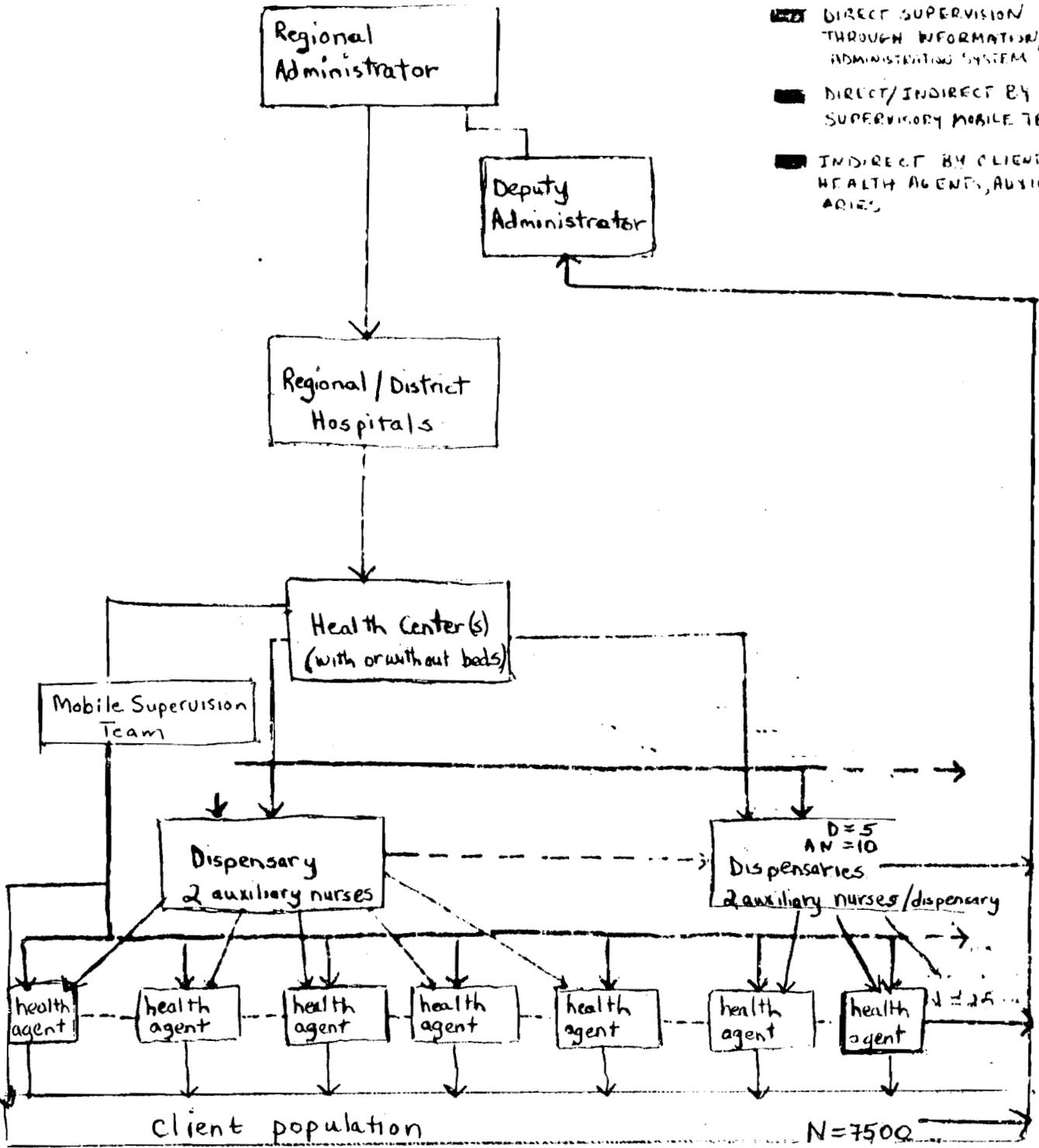
They are currently being used in the pilot project in the North. Their success is noted in the pilot project in three ways: 1) clients are now overloading the dispensary because they have been sent with these cards by the health agent, 2) health agents on their visits to the dispensary are checking the referral cards to see whom among their clients are going to the dispensary, and 3) health agents are using them to identifying where they need to make followup visits.

Although the reporting system such as home visit cards and referral cards may not operate with complete efficiency, their measurable success in these health projects warrants their use in this project.

APPENDIX IV: SCHEMATIC DIAGRAM OF SUPERVISION SYSTEM

KEY 18.

-  DIRECT SUPERVISION THROUGH INFORMATION/ADMINISTRATIVE SYSTEM
-  DIRECT/INDIRECT BY SUPERVISORY MOBILE TEAM
-  INDIRECT BY CLIENTS, HEALTH AGENTS, AUXILIARIES



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