REPORT OF PACIFIC CONSULTANTS CONTRACT TEAM VISIT TO HAITI
March 13-April 13, 1979
REPORT OF PACIFIC CONSULTANTS CONTRACT TEAM

VISIT TO HAITI, MARCH 18-APRIL 13, 1979

EVALUATION OF "STRENGTHENING HEALTH SERVICES II" (PROJECT 0086)

AND

RECOMMENDATIONS RE IMPLEMENTATION OF

RURAL HEALTH DELIVERY SERVICES (0091)

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A. **Summary, Conclusions and Recommendations**

Health projects, including integrated maternal child health, family planning activities and malaria control have been underway in Haiti for a number of years. However, it was not until 1972 that the concept of developing a system of decentralized generalized health services for the country was undertaken in earnest. This resulted in increased assistance from a number of donors, including UNICEF, PAHO, the Inter-American Development Bank (IDB), and AID. The first AID project in this area was called "Strengthening of Health Services I" (070) and was followed in 1975 by "Strengthening of Health Services II" (086) and in 1978 by a plan to develop a project entitled "Rural Health Delivery Systems." The Project Paper for this undertaking has now been approved (091), funds have been allotted, and the Project Agreement is awaiting signature.

Projects 070 and 086 were contracted to Westinghouse Health Systems, Inc. However, until the present time there have been no formal external evaluations of either 070 or 086. Consequently, and in view of the imminent possibility of proceeding with 091, the GOH and the Mission together have requested a visit by a consultant team to look into the adequacy of both 070 and 086 in meeting project objectives and appropriate levels of contractor performance, as well as to identify a relationship between 086 and 091, and as appropriate, make recommendations for possible changes/improvements in the latter project (See Annexes 3 and 4 for detailed terms of reference for both the Westinghouse contracts and the consultant contract with Pacific Consultants.)
The consultant team has studied the situation carefully, met with appropriate officials in the GOH Department of Public Health and Population (DSPP), the Faculty of Medicine in the University of Haiti, and with other assisting agencies, especially PAHO and UNICEF. In addition, the team has participated in a seminar held for regional health department staff by the Bureau of Planning and Evaluation of the DSPP and has visited Regional Health Departments in the North (Cap Haitien), in the South (Les Cayes), and the community medicine and health teaching facilities at Croix des Bouquets and Thomazeau.

As a result of the above activities, the team has arrived at certain conclusions and recommendations which, based primarily upon Section E "Discussion and Analysis of Findings" of this Report may be summarized as follows--:

I. Projects 070 and 086

The contractor met basic output requirements but use of project outputs in strengthening DSPP health services was inhibited among other things by inadequacies of project design, including especially failure to appreciate the length of time required to achieve project objectives.

II. Project 091

The project, at least in concept, is an excellent one. However, the team has the following recommendations to make regarding the way in which this project might be re-timed and concerning various items in the project and activities in the DSPP which seem to need strengthening or perhaps some degree of re-orientation if 091 is to
have a reasonable chance of success--:

1.) The project time frame of five years strikes us as being unrealistic for a project of this size and complexity. It is recommended that advantage therefore be taken of the flexibility in the way the project was written to consider making plans perhaps after several years have passed, for one or more follow-on projects. These could provide for the necessary improvement in management information, training, and organization in the DSPP which the consultant team feels, from previous AID, other donor and other country experiences, might be necessary before implementation of such an ambitious comprehensive health program in Haiti could be successfully undertaken.

2.) Along somewhat the same lines, it is noted that the project presently provides for only one person-year of full-time technical assistance in the management training area. Likewise, the project paper does not place sufficient emphasis, in the team's opinion, on the development of a Haitian institution capable of carrying on training for DSPP and other GOH personnel in modern concepts of management, including the motivational areas of management. The team therefore recommends extension of the period of full-time technical assistance in management training to at least 2 years and strengthening of Haitian institutional capacity to teach this subject in its full dimension.
3.) The team likewise noted difficulties throughout the rural elements of the system in delegation of authority along with responsibility. It concludes that this requirement needs further emphasis in the training component of 091 as well as in its implementation.

4.) It is felt that the Bureau of Planning and Evaluation staff in the DSPP could profit from strengthening in terms of number of personnel as well as in areas of substantive expertise and increased authority. Additional short-term consultation and long-term training in certain disciplines is therefore recommended for members of the staff of this extremely important unit of the DSPP.

5.) In order more effectively to implement the concept of "regionalization" the concept should be translated to something like "decentralized generalized health services" and the administrative units might therefore be somewhat different than: "Regions" and "Districts" as they are presently envisioned. In fact, the need for more than one administrative/management "tier" between DSPP headquarters and the point of delivery of health services is questioned.

6.) Implementation of the concept of a model rural health delivery system on a national scale without phasing this process geographically and in time may not be successful. The team recommends that a unit by unit approach should be emphasized and that efforts to begin in new units (for the moment outside
of the Northern and Southern Regions) should be deferred at least to some extent until the work in existing units is progressing satisfactorily. This phasing process needs also to take into account, of course, GOH financial, managerial, administrative and logistical capacity to undertake this degree of expansion.

7.) Project 091 includes the concept of integration of various vertically organized parts of the DSPP into the general rural delivery system. Organizations so included are the Division of Family Hygiene (DHF), the Bureau of Nutrition (BON), and the National Malaria Eradication Service (SNEM). It is already recognized that, primarily for technical reasons at the moment, integration of SNEM will probably have to be postponed indefinitely (another consultant team is evaluating this particular problem in much more depth. Consequently, the present report does not deal with it except tangentially.)

The team feels that, in general, the word on integration should be to "go slow" and that it should be looked at on a unit by unit basis as suggested above for the whole RHDS.

8.) The team was concerned about the reliance, from a motivational point of view, on salary supplements for DSPP staff working on certain projects, in rural areas, etc. The team recommends, instead, that although salary levels for all personnel may need adjustment, reconsideration, or other study by GOH, the DSPP might consider other types of motivational mechanisms. These
could include management training in the already scheduled regional seminars, further decentralization of these seminars to the Districts, and, the general strengthening of positive employee motivation through such mechanisms as job enrichment. This will improve the ability of the DSPP to attract and keep the well-qualified rural health workers necessary if the DSPP's efforts to improve rural health services are to be successful.

9.) In the manpower development area the biggest need, as the consultant team sees it, is more emphasis on the "training of trainers" side of the scale. This seems particularly important in the need for developing a program to train the trainers of auxiliary nurses. The latter in turn will be responsible for supervising the agents de santé, who, at the base of the health "pyramid", are in fact the people at the most important point in the entire system, namely direct delivery of health services to the rural population.

As a corollary to this recommendation it is felt that the section on medical and paramedical education in the DSPP should be strengthened to include a full-time executive assistant. Likewise, there is an urgent need for development of a program in continuing education for all the DSPP staff involved in the RHDS (over and above Regional seminars already going on as scheduled.)

10.) The team had difficulty finding evidence that the provision
of potable water for people living in small communities (for example, with less than 200 population) was being addressed with sufficient intensity and detail. Accordingly, the team recommends that the AID-assisted hydro-geologic survey in the near future be linked with efforts of other donor agencies to utilize the results of this survey making a beginning at least on the development of small rural water supplies. Obviously, this will require consideration of dug wells, drilled wells, protected springs, infiltration galleries, cisterns, and the mechanics of developing and maintaining such supplies.

11.) a. "Cold chain" problems are pronounced in Haiti as in most developing nations. The team recommends that, if this has not already been done, GOH seek assistance in this area from PAHO through the WHO "Expanded Immunization Program."

b. The team's limited field survey indicates need for much improvement in equipment, training, and perhaps, motivation of laboratory staff and record keeping. Accordingly, it is recommended that, development of training programs, for example, for assistant laboratory technicians to work in health centers and dispensaries be considered along with the provision of necessary equipment and supplies on a reliable basis. This could incidentally, be one of the items to be considered in a possible follow-on project to 091.

c. Sanitary officers in the rural areas appear to be spending a lot of time on excreta disposal problems and insufficient time
dealing with small water supplies as described above. It is recommended that this possible program deficiency be considered in re-thinking the use of these DSPP staff at both the regional and district levels.

d. Sample surveys and functional analyses do not appear to be widely used in obtaining better quality management information. Development of such surveys possibly including functional analyses might be another area that could be considered in one of the follow-on projects proposed.

e. One of the areas in which activities going on through SNEM can be used to help strengthen the rural health delivery system is by providing chloroquine tablets routinely to agents de santé. It would appear, at least from the team's observations that, at present, the agents have to request this medicament from the nearest dispensary before prescribing it for one of their patients. Likewise, some SNEM field workers in under-utilized areas could perhaps be trained as agents de santé and it is recommended that this be looked into as a possibility either under 091 or some follow-on project.

f. Integration of presently "mixed" clinics into the DSPP needs to be carefully examined since at least one of the clinics observed by the team was carrying out a program which exceeded in quality any which were observed in purely DSPP-supported clinics. Experience elsewhere has shown that this can, in fact, be accomplished but it does require careful consideration and
coordination between the official government organization responsible and the private voluntary organizations providing such a large part of the services in these installations.

g. There is a need for strengthening training, facilities and materials for health education of the public. It is recommended that this element be given greater emphasis than it now receives and that this include participant and observational training in elements and locations appropriate to Haitian needs.

h. Observational experiences in the area of improved management and management training might be included in the overall participant training program. For example, visits for high level DSPP/BPE officials, to countries where rural health service management has become an important area of concentration might prove profitable not only within the health substantive area but in the conceptualization of the holistic approach to development.

12.) There seems room for even further collaboration between the various assisting organizations and DSPP. The team recommends that, in order to develop this positive element more thoroughly, the BPE be given more authority by the DSPP to oversee and organize in a practical way the needed collaboration and coordination toward improvement of health services for the benefit of the people of Haiti.
B. Background

It is not felt necessary to include the usual "Sanitary Survey" (in the complete sense of the term) because the matter is dealt with quite exhaustively in the Health Sector Statement of 1975\(^1\), the Syncrisis report\(^2\) and background statements for the two consecutive Strengthening Health Services Projects (070 and 086) for the two consecutive MCH/FP Projects (071 and 087), and in the background portion of the PP for a "Rural Health Delivery System", (RHDS), (091). However, it might be well to review certain aspects of the history of U.S.G., other donor and PVO assistance to Haiti in the health area since some understanding of this is absolutely necessary in order to appreciate the extraordinarily complex and intertwined relationships between the different projects, the assisting organizations and their relationships with Government of Haiti implementation Agencies. All of these relationships, as it turns out, played a major part both in strengthening Haiti's efforts to improve health services and paradoxically in creating some big problems, both actual and potential in the conception and implementation of the projects with which this report is primarily concerned, namely, 086 and 091.

Early assistance in Health planning to Haiti involved the Pan American Sanitary Bureau and among other things, this led to adoption of the Pan American Sanitary Code by Haiti on June 25, 1926.

In addition, the U.S. Military presence in Haiti in the 1920's included a group of commissioned officers and enlisted men of the U.S. Navy Medical Corps and a number of American Red Cross nurses and other personnel. This early assistance resulted in
conception and implementation of a system of decentralized health services based on creation of 10 "P.H. Districts", along with some considerable generalization of the services provided. Also, during the same period, the Rockefeller Foundation gave material assistance to the University of Haiti Medical School and implementation of the overall health system program and there were many opportunities provided for training of Haitian doctors, nurses and others in the United States and in Haiti. Finally, during this period there was the now-famous, successful effort to eradicate yaws.

The next USG-assisted program in the health field in Haiti commenced operations in 1961 in the form of assistance to the "Association National Pour l'Eradication de Malaria"* (SNEM) through the use of intradomiciliary spraying and appeared to have come within reach of its goal in 1968 when the slide positivity rate dropped to .2%. Unfortunately, although USG assistance to Haiti in this area has continued ever since, the original objective of eradicating malaria was never achieved, and, in fact, due to factors which will be detailed in the SNEM project review, the slide positivity rate has increased greatly in the past few years.

Family planning services began to be offered to the population of Haiti by several private organizations from 1962 onwards. By 1968, an awareness had been created not only in a sector of the population but more so at the policy-making levels in the country, of the need for MCH/FP services and of organized means for the delivery of such services to the population. During 1968-1972, a legal framework was established and an institutional mechanism for the delivery of services was considered.

*Now "Service National des Endémies Majeures"
In May 1972 a PAHO/WHO-assisted Maternal and Child Health and Family Planning Project (4900), was initiated based on an agreement signed between the government of Haiti and the Executing Agency (PAHO/WHO) in March of the same year.  

This pilot project largely to be confined to the Port-au-Prince metropolitan area, was funded entirely by UNFPA and was considered "a groundwork" for the extension of the program into the rural areas. Additional assistance for this latter purpose was requested by the government of Haiti at a meeting in Port-au-Prince in April 1973 and, subsequently, was provided from UNFPA, PAHO (Executing agency for UNFPA) USAID (Project 071) and Pathfinder Fund. At that point, also, an Inter-American Development Bank (IDB) 6.3 million dollar loan was signed for the construction and renovation of facilities in two health districts, Cap Haitien and Les Cayes. However, these funds were to be used primarily for strengthening the activities of the Division of Family Hygiene, a semiautonomous unit of the DSPP whose main function was conceived as providing integrated maternal and child health and family planning services to the country and, under this project, to the particular health districts mentioned above. In fact, it is clear that, as stated in the 086 Project Paper, "population and family planning are central considerations in dealing with Haiti's health problems--It is expected that family planning services will therefore, be part of the repertoire of services offered by the basic health worker (agent de sante*) under a nationwide rural health delivery system".

*The term "agent sanitaire" was also used in earlier phases of development of the DSPP "lexicon" for rural health personnel.
The highly significant part being played by PAHO in conceptualization, advisory services and implementation of the overall scheme for improving integrated health services in Haiti is exemplified by the fact that the regionalization plan of the GOH for the Cap Haitien and Les Cayes regions is already being implemented by the DSPP, Division of Family Health with technical assistance from PAHO. In fact, PAHO is not only helping in establishing the complete administrative structure for health services in the two regions, but is also serving as IDB's implementing agency for facilities construction.

Further, with respect to PAHO assistance in the health area in Haiti, it is important to note that this international agency is assisting with such projects as latrine construction and improving water supply systems in both rural and urban areas, in manpower development, particularly in improving the curriculum of the School of Medicine, teaching in nursing schools, training of sanitary engineers and of auxiliary nurses. PAHO is also providing the major technical input to the SNEM Malaria Control Program in which AID has invested roughly $20,000,000 over the past 14 years.

The Haitian/American Community Help Organization (HACHO) includes in its program, a regional project for the operation of nutrition centers, MCH services and water systems projects. AID is providing some of the funding for this organization.

In the rural as well as the urban parts of the country, private voluntary organizations (PVO's) are an important source of material resources and technical assistance in the form of medical care,
public health education and community development. Apparently, about 35% of dispensaries in the country are operated by PVO's; and of total medical establishments in the country PVO's operate almost 40%. Some of the organizations accounting for this assistance are CARE, Ford Foundation, Direct Relief Foundation, FOCUS, Inc. and the International Eye Foundation, not to mention a number of organizations with religious affiliations.

In the area of nutrition various agencies have assisted the Bureau of Nutrition (another semiautonomous unit of the DSPP); and the private voluntary agencies, CARE, Catholic Relief Service and Church World Services are the distributors of PL480 Title II food in schools, food-for-work projects and MCH centers. CARE is just completing a three-year project providing nutrition education to a number of primary school teachers in some 82 schools around the country, coupled with school-feeding and the establishment of 65 "home economics" centers to be coordinated with a World Bank Project for the construction of 65 new rural schools. There are also integrated rural health/nutrition delivery projects in the Petit Goave area which are being carried out under supervision of the DSSP's Division of Family Hygiene (DHF), and there appears to be a USAID/Haiti plan to introduce a FY79 project intended to expand the scope of nutrition activities in Haiti.

As pointed out above in paragraph 1 there are two consecutive projects entitled "Strengthening of Health Services" namely 070 and 086. To paraphrase from the approved project paper for Project 086, AID strategy was to assist the GOH to "provide basic preventive and curative services to the rural poor through the use of an integrated Rural Health Delivery System (RHDS)".
The strategy to realize that objective was to incorporate three elements. Namely, "(1) improve the DSPP's personnel system; (2) establish DSPP communications, financial and logistic links with rural health posts; and (3) create a more reliable and effective information and data collection system". The project also provided funding for "(a) continued operations of the SNEM Malaria Control Program, while the incidence of malaria was to be reduced sufficiently to incorporate the control program into the RHDS, and while the phase-over to complete GOH financing for that activity was to be accomplished; and (b) support of activities determined in the DSPP/Westinghouse (WHS) planning exercise to be necessary for the strengthening of the DSPP and design of the RHDS". These latter activities were to fall into three categories, namely; "(1) administrative strengthening at the central level, including manpower development and training, technical equipment to support an information system, operational costs of the Bureau of Planning; (2) the design of a functioning logistics system; and (3) the design of a model rural health delivery system."

The project "Rural Health Delivery System (091) supposedly to follow and build upon 086 was to "provide the necessary assistance to implement the model rural health delivery system (developed by Project 086) on a national scale."*

Further, details about the two projects of primary concern namely, 086 and 091, are contained in the following section of the report. However, it might be well to point out here that study of the background events leading to the development of these projects and of activities of other donors and the government of Haiti in the

*underlining by team
The same general areas, leads the team to the inescapable conclusion that it would have been necessary for the host government to provide strong coordinating leadership in order to avoid the development of considerable overlap, duplication and even, albeit accidentally, working at cross purposes that may have occurred between the various external technical assistance agencies. The latter types of problems were generated both by the host country's needs, and willingness, even eagerness, of the various donor agencies to assist in solving some of the health/family planning/nutrition problems which were seen seriously to impede overall development, and improvement in the quality of life of the people of Haiti.

As a result, it would seem at least to a considerable extent, due to partial lack of this coordinating leadership and because planning within the DSPP was still to a great extent "crisis planning", the DSPP developed organizationally in too great a degree as a response to donor interests. The Divisions of Family Hygiene (DHF) and Nutrition (BON), and the Malaria Eradication effort (SNEM), have been funded directly by population, nutrition, and endemic disease control monies and are relatively strong, essentially vertical programs. Thus the donors have encouraged a multipartite system that creates a difficult problem for the DSPP planners trying to rationalize a unified health delivery system. In fact, to be perfectly frank, the system as it is appears indeed to be uncoordinated and inefficient. Moreover, moving from categorical programs to an integrated system will create enormous problems—possibly leading to a reduction in the efforts of the individual programs and a diffusion of administrative and service
activities. This situation, combined with the problem of highly centralized administrative control, will make the work of the BHP/E very difficult as new projects come "on stream" with large financial, personnel and organizational demands. Further details regarding the concerned projects and related other donor and DSPP actions are taken up in the following sections.
C. Summary, Project Descriptions and Prior Evaluations--086, 091 and related projects.

I. General Statement

From what has been said above, it appears clear that there has been a constant and intensifying effort on the part of a number of donors to assist the government of Haiti in dealing with its major rural health problems. The five USAID-supported projects MCH/FP (071, 087), SHS (070, 086) and RHDS (091) certainly fit into this general term of reference. However, it may be well to draw attention to several factors related to these projects which have been given serious consideration by the consultant team because analysis of interactions between the projects and between donors may affect future projects and, specifically, technical assistance in these areas.

II. Relationship between PAHO and USAID-supported WHS inputs

Because of the importance of this and the following sections in the project paper for 086, they are quoted in entirety as follows:

"Plan for Application of Project Inputs and Role of Other Organizations"

The major inputs to the project are technical assistance, training, and budget support including operating and personnel costs. Technical assistance to the DSPP will be supplied primarily through the Westinghouse Health Systems (WHS), contract. This contract was funded in FY75, began in January of 1977*, ** and runs for two years. A technical assistance contract will be continued for an additional two years beginning in January, 1979 (under the Strengthening Health Services II project). Under the WHS contract, technical assistance will be provided for the development of the transport and supply systems starting in Year One of the FY77 project, and will continue throughout the life of the project. WHS will act in an advisory capacity and assist the DSPP in deciding

* Note approximate two year delay in implementation
** Underlining added by consultant team
the other types and levels of technical assistance needed under this project and the follow-on RHDS project.

PAHO, as technical advisor for the IDB health project, is also furnishing technical assistance to the DSPP on administrative matters involved in "regionalization." The exact division of effort and responsibility between WHS and PAHO is now being discussed with the DSPP.* As a consequence, technical assistance is included to augment the WHS contract for Year One. Precise subsequent levels will be determined as a result of the decisions made on PAHO's potential inputs to the FY77 project within the DSPP."

Role of Other Organizations

"The Pan American Health Organization (PAHO) plays important direct and indirect roles in this project. First, PAHO is responsible for providing all technical guidance to SNEM. An important assumption underlying this project is that PAHO's support to SNEM will continue.**

"PAHO's work with the central DSPP is also of significance to this project. PAHO is providing the technical assistance which will enable the DSPP to carry out the "regionalization" (administrative decentralization) called for in the 1975 National Health Plan. To date, the regionalization process has begun in both a northern (Cap Haitien) and southern (Cayes) health district.*** Administrative responsibility is being transferred to these two districts. The next step will be to bring all health services in these districts under the purview of the respective district chiefs;+ and to install a system under which planning for health needs commences at the lowest field levels and moves up the administrative chain to the district chief who will obtain those needs from the central DSPP. In reality, this "bottom-up" type of planning has yet to be installed.+"

"The Cap Haitien and Cayes districts (Regions now++) were selected to lead off the regionalization, in part, because their existing human and infrastructure resources are at a higher level than the other districts, making implementation and testing easier.

* Underlining added by consultant team
** For details see SNEM Evaluation Team Report
*** Now called "Regions."
+ Underlining added by consultant team. The statement is somewhat confusing in the light of present plans unless one assumes that the "district chiefs" referred to are in fact the present "Regional Directors"—a probably valid assumption.
++ Inserted for clarification.
What is accomplished in these districts will undoubtedly take considerably longer in the remaining health districts. However, in the long run, it would appear more desirable for the rural health delivery system to be administered by, and most responsive to the needs of, the health districts, rather than the central Ministry. It is also self-evident that the quality of district-level administration will greatly affect the quality of the RHDS (i.e. ability to deliver services) in any given region. Therefore, the efforts of the Westinghouse Health System (WHS) contract team under this project will be closely coordinated with PAHO's assistance to the DSPP's regionalization program. The working out of that coordination has a high priority on WHS' agenda of tasks to be performed in the initial stages of the project.*

"The IDB-financed project to construct over 60 new health facilities* will not have a direct bearing on this project, but will create infrastructure useful for the rural health delivery system. However, AID's analysis of the health sector does not indicate that construction of physical facilities is of prime importance in meeting the most urgent health needs of the rural areas. AID is looking to the World Bank - PAHO effort to strengthen the institutional capabilities of the rural water service in order to begin bringing improved water supplies to rural areas. Once the rural water authority has been sufficiently strengthened, it may be possible to incorporate some of its services in the established RHDS*." (end quote from 086 PP)

III. GOH Commitment

There seems to be little doubt about GOH commitment to the concept of "regionalization" of health services in principle and to a considerable degree in practice.** As pointed out in the 086 Project Paper, the "National Health Plan of July, 1975" required the DSPP to bring about a fundamental reorganization aimed at gradual extension of health services to rural Haitians. Soon thereafter, a law for regionalization of health services was enacted on (October 23, 1975.)

* Underlining added by consultant team.
** The inferred limitation to "in practice" will be discussed in more detail under the "Analysis" section of this report.
As a result of this legislative authority, DSPP has taken steps to re-group the eleven previous health districts into six Regions and is in the process (with PAHO technical assistance) of issuing rules and regulations defining the DSPP's organizational structure and operating procedures. The new procedures are being worked out for the regional levels in two test "regionalized" areas (Cap Haitien and Cayes.)

Furthermore, in October, 1976, the GOH (Conseil de Development et Planning, CONADEP) issued the 5-year (1976-1981) Development Plan, Volume II - Sectoral Plans. The section dealing with health set as GOH 5-year objectives, "(a) to raise national life expectancy levels to 50 years of age; and (b) assure total health services coverage for all the population." The basic strategy to attain these objectives would be to extend and strengthen the health facilities network within the framework of regionalization of health services. The regionalization concept was described as administratively and operationally "pyramidal." Each region is to be composed of health districts, and will have a regional hospital, district-level hospitals, dispensaries, and local Health Centers (both with and without beds.) The administrative structure is to be organized at 3 levels: central, regional and local. Six basic health programs were to be carried out in the period of the 5-year Plan:

"(1) Regionalization of Health Services

- To install the necessary administrative and operational structures in accordance with the Government's priority in the North and the South;"
- To prepare technical personnel (both medical and paramedical);
- To construct and equip medical facilities in the North and South regions.

(2) Maternal-Child Protection & Family Planning
- To lower the maternal, infant, and early childhood mortality rate.
- To integrate maternal/child health services and family planning.

(3) Campaign Against Endemic Diseases
- To progressively reduce the incidence of malaria.
- To extend vaccination programs to the rural areas.

(4) Campaign Against Malnutrition
- To diminish the malnutrition mortality rate among children 5 years of age or under.

(5) Strengthening of Health Services
- To improve technical and administrative capabilities within the health sector.

(6) Medicines and Supplies
- To furnish the best medicines and medical supplies to the people."

Although the quoted material seems to indicate a clear intention of very sound priorities in the GOH approach to regionalized health services, the Development Plan points out that in the financial analysis of comparative health sector contributions to this plan, there are
obviously some inconsistencies within it, such as the low ranking, from a financial point of view, of the MCH-Family Planning Component, which although high in CONADEP's prioritization is at the lower end of the scale in terms of projected GOH financial support. In any case, the GOH contribution to the health account as a portion of the national budget is high (14%). It is also projected to increase by at least 122%, the project paper states, between 1976-1981.

IV. Evaluations

Search of the Mission's files and documents fails to reveal any formal prior external evaluations specific either to Project 070 or 086. Thus, the present team effort seems to be the first full-scale external evaluation of either project 070 or 086 under AID auspices and certainly is the first external effort to relate them to the RHDS Project 091. In any event it appears that the decision to proceed in the latter way was timely and perhaps even an urgent necessity. These matters are discussed in more detail in the following sections.
D. **Review of Westinghouse Health Systems Activities**

I. **Objectives of the WHS Project**

The objectives of the Westinghouse Health Systems Project as outlined in the contractor's terms of reference were:

(1) To provide assistance to the Ministry of Public Health and Population in its actions to:
   a. create a functioning bureau of national health planning
   b. conduct a study to reorganize the Ministry to manage more efficiently a regionalized health care delivery system
   c. provide advice and on-the-job training for Haitian Bureau of Health Planning officials in Port-au-Prince, and in the regional offices (to be established)
   d. determine manpower requirements for the Bureau of Health Planning
   e. examine the nature and quality of data now being received by the Evaluation Unit, and the manner in which these data are used, and identify improvements in the data system and the categories and the types of personnel necessary to make the improvements and implement a revised system
   f. develop and analyze statistical information needed to plan an integrated national health service
   g. design and elaborate a national health plan
   h. integrate the above components (a-g) in the specification of appropriate rural health service system(s)
   i. improve the overall administrative machinery of the Ministry
   j. design and implement an improved financing system
   k. conduct manpower task analyses, including an analysis of present staffing patterns

(2) To produce the following reports:
   a. a plan for the reorganization of the Bureau of Health Planning and Evaluation (BHP/E)
   b. training requirements for personnel of the BHP/E
   c. a report summarizing the results from the baseline survey
   d. an outline for a National Health Plan
   e. a specific plan for the improvement of the administrative system of the Ministry
   f. component reports for the development of the administrative system improvement plan as follows:
      1. financing
      2. manpower and task analysis
      3. drug inventory and supply
      4. analysis of physical facilities
      5. transportation systems
   g. a final report summarizing contract accomplishments
II. Overview

The Westinghouse Health Systems team contracted to assist the DSPP to strengthen its capability in the areas of planning and administration. The contract provided for one technical assistant to work in Haiti with the DSPP for two years, and for technically specialized short term consultants to assist with the preparation of the specified reports.

WHS appears to have fulfilled all of its concrete contractual obligations and to have produced the requisite reports. However, it would appear that the project was designed so that the specialized consultants were not in Haiti long enough to build productive working relationships with their collaborators in the DSPP. Although the project was intended as an institution building effort, in fact, the time was too short. The pressures to complete the "deliverables" (read "reports") diverted attention from the longer term process of providing real technical education and assistance. The reports seem to have been end projects in themselves and because of the tight contractual schedule, did not all coincide with the immediate planning and administrative needs of the DSPP.

In addition, several of the short term consultants, though well qualified in their areas of expertise, were not able to speak French. The long term consultant was apparently neither a management specialist nor experienced in international health planning. In addition, his French was not adequate to enable him to communicate freely with his Haitian colleagues, and to provide the necessary advice to them on the implementation of the concepts recommended by the specialized advisors. Apparently, field visits by contract staff were also somewhat less frequent or extended, especially in the case of the long-term adviser, than would have been considered ideal by the DSPP and other
health related agency staffs with whom they worked.

The goal of the project was to build-in the capability for planning and administration within the DSPP. However, the project outputs were manuals. The development of those manuals should have been an educational process for the DSPP. But, because the project was timed to meet a tight schedule, and because of the paucity of local staff, it would appear that most of the reports were prepared without the ideally full substantive involvement of the people who will have the responsibility for implementation. A manual is not likely to be well used unless the users participate most actively in its development.

Unfortunately, therefore, this appears to be another example where the design of a project was faulty. There was neither adequate time in the project to achieve the real project objective--institution building--nor was the concept appropriately built into the design. Since it is clear, in this case, that a strengthened management capability had to be developed, in order for the pending AID project to support a national health delivery system to have the desired chance of success, the apparent failure to do this adequately may have serious implications for the implementation of RHDS Project 091.

Although most of the WHS reports were not adopted verbatim, they are now being used by DSFP staff and PAHO advisors as background documents. The Administrative Norms report, developed by a DSPP Commission on which the WHS Chief of Party sat, and published by WHS, is being greatly simplified and tightened. The new manual, prepared with the collaboration of a PAHO management consultant, is under discussion by the DSPP. The transport and logistics reports are being used as the basis for streamlined guidelines that are being written in cooperation with PAHO and will be discussed by the DSPP.
The Financial Management report provided a useful analysis of the line item costs that can be ascertained from published budgetary figures. However, it must be emphasized, there is not much interest in implementing program budgeting,* the recommendation that formed the major portion of the report.

The development of a National Health Plan is still in abeyance and therefore it is premature to determine whether or not the Outline for a Revised National Health Plan, that was developed by the Bureau of Health Planning and Evaluation, with the assistance of WHS staff, will be used. The one report that is being implemented is the Report on Statistical Norms. Furthermore, the WHS Haitian consultant who prepared it is now working under an AID Personal Services contract as a consultant to the DSPP.

In the following sections we will discuss each of the major areas of the WHS consultancy.

III. Planning

The Bureau of Health Planning and Evaluation (BHP/E) was at a very incipient stage when the WHS project began. The BHP/E was only 6 years old and had been very understaffed. A great deal of progress was made during the two years that WHS had advisors in Haiti. AID supported staff salaries and the renovation of offices for the Bureau, most of the staff positions were filled, a lot of constructive planning activities were

* Nor does the team feel that, considering all the other high priority problems, program budgeting, with the detail and time requirements it implies is particularly appropriate in the DSPP at the present time.
carried out, and the Bureau began to play an important role within the DSPP. Although the director of the Bureau (Dr. E. Midy) is very competent and strong, it seems clear that the WHS Chief of Party and his team, as well as the PAHO advisors, provided important support to the Unit. The momentum that was established during that time has continued to gather strength and the BHP/E is evolving into a major force within the Ministry, although in the Team's opinion, it still requires strengthening in certain substantive areas and should have more control over the planning and coordination of donor assistance (See Discussion and Analysis section of this report.)

Although a lot of constructive planning efforts were made during the WHS consultancy, there does seem to have been an orientation toward process rather than outcome. A great deal of effort went into the development of administrative and operational "norms" in the absence of a revised National Health Plan specifying program objectives and priorities. In the opinion of the Team, the selection of activities and the definition of functions should have been more directly related to pre-defined targets (objectives.) Furthermore, even though the teaching and adoption by DSPP of modern concepts of management, in the inclusive sense of the term, was not very strongly emphasized in the terms of reference for the Westinghouse team, one wonders if more imaginative leadership of the team might not have identified this requirement and proposed some measures towards meeting it.

A National Health Plan had been written in 1975, in preparation for the IDB financed Regionalization Project. The AID project, of which the WHS contract was a part, prescribed the development of a revised National Health
Plan that would include guidelines for the integration of SNEM and the other technical services, in preparation for the introduction of an AID-supported national program for the delivery of integrated primary care. The contract was modified to require only that an outline be produced, under the WHS project. While this delay was probably unavoidable because of the crowded agenda of the BHP/E (and perhaps because of an inadequate data base), it is unfortunate that the design of the new AID project (091) preceded the completion of the revised plan, because the national delivery system clearly should reflect the national health development plan, not anticipate it.

In the opinion of the Team, the outline for a revised National Health Plan is confusing and repetitive. It should be simplified and better organized. A tightened outline for Sections II and III might follow these guidelines:

Section II, The Existing System:

(1) the goals and objectives of the DSPP
(2) a description of health activities
   a. DSPP activities - including those funded or given technical assistance by outside sources
   b. privately operated health activities
   c. related activities operated by other ministeries
(3) existing facilities and utilization or service data
(4) manpower
(5) budget
Section III, Future Plans

(1) plans for the expansion of facilities and services
(2) a manpower plan (a projection of need and availability)
(3) the projected annual operating and capital budgets during the Plan period (anticipating sources of funding, e.g. DSPP and other)

IV. Budgeting

Although the terms of reference for the WHS project required expertise in program budgeting, the Team's view is that the recommendation to move forward with program budgeting is premature and probably unrealistic at this stage for the following reasons:

1) given the inadequate capability and paucity of the staff currently in the financial management and budgetary section of the DSPP, the first priority should be to develop a functioning system of financial control with the capability for preparing and analyzing a line item budget, and for providing the necessary financial information to the Planning Unit,

2) more time needs to be devoted to projecting the future budgetary implications of current capital investments,

3) program budgeting would necessitate a duplication of effort as a line item budget is still required by Haitian law,

4) a line item budget will still be required for each Division's forward planning and future budgetary requests, and to identify the allocations of individual donor contributions,
5) program budgeting would require either extensive functional analysis to determine the programmatic breakdown of health resources (e.g. the proportions of time a health worker spends on each of the identified programmatic areas), or arbitrary decisions.

6) even given the introduction of program budgeting, it is estimated that results could not be expected for 3 to 5 years.

In recommending program budgeting, the report clearly articulates the arguments in favor of the concept, and systematically outlines the necessary steps for implementation. However, the report is weak in describing how to set up a program budget. The guidelines for identifying programmatic areas are very abstract and the only specific examples given come from the United States, rather than Haiti.

V. Logistics and Transportation

The transportation report including training requirements, is thorough and detailed. However, the recommendation for decentralizing maintenance facilities suggests that, in addition to the main depot in Port-au-Prince, garages be established in Les Cayes and Gonaives with mobile units attached. However, if regionalization is going to be successful, there has to be a dispatch and basic maintenance center in each of the regional headquarters. It would seem more cost effective to have only one central garage (in Port-au-Prince) in which all major servicing would be done, and to develop the capability for minor and emergency maintenance in each of the regions.

The logistics report clearly and succinctly outlines a plan for
organizing the supply network. However, the report deals only with organization and procedures. It does not discuss the substantive issues of how to effectively operate the system, e.g. forward planning and budgeting, inventory control, bulk purchasing, etc. It is not clear to the Team from the terms of reference whether or not these issues should have been considered by the logistics advisor.

VI. Statistics

Although there is a recognition throughout the WHS reports of the value of statistics for planning, it does not appear that the information needs of the DSPP were defined prior to developing the health information system. The manual of Statistical Norms describes the process but not the outcomes or objectives of the health information system. The Team believes that the information system could be simplified if the objectives were carefully defined in terms of (1) the information that is absolutely necessary for planning and administrative purposes, and (2) the data that it is realistic to anticipate can be collected with acceptable veracity.

Available information is inadequate for current planning and administrative purposes, and it is unlikely that reliable data will be available for some time. The planned health information system is very ambitious. It is estimated by the DSPP that it will take at least five years to prepare the requisite number of statistical technicians. Therefore, the Team believes that sample surveys should be conducted to obtain information that is needed now by the DSPP, and in order to provide baseline data for future evaluation of the health delivery system.
The information system could be greatly simplified and provide more regular, reliable and uniform data if: (1) patient-retained records were introduced; (2) the daily register (maintained in duplicate) replaced all other clinic records (e.g. under-five registers, family planning registers, etc.) and doubled as (a) the record of consultations and (b) the statistical reporting form to be submitted from the outpatient unit; and (3) the nosological code form were shortened and included codes for presenting symptom by system and those few diseases which can be diagnosed with the meager laboratory facilities found in most outpatient units.

Some of the advantages of patient retained records are: (1) the time that is necessary to retrieve records in the clinic can be used instead for service, (2) the patient has a personal health data base that he can present if he goes to other units for service, (3) the "agents de santé" can determine the patients' followup health needs (immunizations, family planning, etc.) during home visits -- without having to keep cumbersome records themselves, (4) certain community based health surveys are more easily conducted, (5) patients retained records can be used for patient education and stimulate patient responsibility for their own health care, (6) over time, especially in large outpatient units (such as hospital out-patient services), it has been found that more records are lost by the clinic than by the patients, (7) hospital discharge information can be integrated into the patient retained card, thus providing a data base for followup outpatient care.

It should be noted that the Team found little evidence of conscientious maintenance of the Under Five weight-for-age chart in the peripheral health units which were visited. In view of the high priority that is given to reducing malnutrition and improving child health, this would seem to be a
serious lapse. The Team felt that one minor change in the design of the Under Five records would probably increase the use of the chart: if there were no place to write the weight in numerals, then the health workers would be forced to record it on the growth chart. This adjustment has had a positive effect in other countries.

VII. Health Manpower

With respect to manpower development the Evaluation Team looked specifically at indicators of those activities conducted under 086 that were intended to determine manpower requirements of the DSPP and to provide a background on the health manpower situation relevant to the proposed RHDS project.

During the period the Team was in Haiti, one of the two annual Seminars of District Administrators was held in Gonaive on March 26-30, 1979 and the Team was privileged to attend the final two days of the meeting and to observe the officials of the BHP/E, the Director General, regional and district medical and health administrators, and technical consultants in action. On the basis of this observation, the Team feels convinced that definite progress has been made by the BHP/E, first of all in establishing itself as a "team" in the words of the Bureau Chief, and second in creating esprit de corps among the top administrators of the rural health services and a flow of communication between them and the Central Bureau.

Although there is still a gap between the making of recommendations and the taking of action as a result, the bi-annual meetings are a positive step in identifying organizational problems and in seeking solutions. The
participants conducted a planning exercise with much energy and attention; the seminar was an exciting learning experience as well for both participants and leaders. It eventuated in a set of recommendations derived from the open-floor discussions and the review of the past six months of experience in the field. Officials from the Central Bureau exhibited obvious skill in "interpersonal relations" and a remarkable ability to conduct a participatory meeting. Certainly this event is a striking example of managerial strength in the BHP/E, and of a knowledge of modern management and training techniques. Whether or not the recommendations will result in political or executive action is another issue.

In interviews with separate officials in the Central Bureau, the Team heard a confirmation of the fact that the presence of the technical consultants provided by WHS provided "encouragement" and "support" as the Bureau worked to reorganize itself more effectively in the effort to develop a National Health Plan and to devise a Rural Health Delivery Plan.

WHS Documents

The documents relating to manpower development within the DSPP and at the central level, and for manpower development for the RHDS consist of reports entitled: "Health Manpower Component for the Development of the Administrative Systems Improvement Plan" (April 1977); and "Institutional Analysis: Finance System Component (June 1978); and part of the "Outline for the National Health Plan." In addition manpower task analyses were developed in conjunction with PAHO technical advisors in public administration.

The first of these three reports and the one most directly addressed
to health manpower development for Haiti is the "Health Manpower Component." This report is introduced as "a memorandum," "observations," and a "crucial direction setting analysis." The terms of reference did not require surveys, nor were they undertaken, and the Report warns that data presented are inadequate and imprecise because of the general difficulty of obtaining complete or reliable figures on health manpower stock and supply, distribution, utilization, or even training in Haiti. The Report relies heavily on previous analyses of the health manpower situation made in the Syncrisis and made by the DSPP itself. It promises that inventories of training institutions and of PVO programs will be compiled by WHS. The Evaluation Team has however not been able to locate copies of these nor to determine if they were actually prepared.

A deficiency of the Health Manpower Report in the eyes of the Team is the fact that it does not clearly identify what are basic human resources data requirements for planning purposes although a possible specification of these is "buried" in the Outline for a National Health Plan. Dummy tables in the Outline call for a listing of (1) existing types of health facilities, (2) a health manpower personnel inventory, (3) a list of all types of training institutions, and (4) a list of all types of students and dates of their promotions. It is proposed in the Report that these tables would be accompanied by "A narrative which will discuss the interaction between the existing personnel system and those persons in training including: rate of retirement, rate of school drop out, rate of persons leaving service, independently funded positions." This is standard information requirement for human resources planning. It would have been useful, therefore, if an
analysis had been made of precisely what statistics were needed with respect to health planning and how they would be used, e.g. in an analysis of recurrent manpower costs vs. budget allocations. This is an important issue which is not given adequate discussion. Will the GOH be able to absorb expanded manpower supply once 091 support is terminated?

Scattered throughout the Report are recommendations impinging on policy decisions with respect to health manpower development. These recommendations include (and without any special emphasis or discussion):

a. in the fiscal component, manpower training support is justified for strengthening existing formal health manpower training institutes
b. in-service training of nursing instructors in community nursing
c. continuing education and in-service training for auxiliary nurses who will be responsible for training and supervision of agents (in addition to acquiring skills and knowledge requisite to community nursing)
d. additional staff (Executive Assistant) for the Section on Medical and Paramedical Education

In addition it is recommended that the intake of medical students be reduced.

In the view of the Evaluation Team, however, an important priority not dealt with adequately in the Report is the additional staffing of the Section on Medical and Paramedical Education. This section could be an important link between the Medical School with its strengthened Community Medicine Department (affiliated with Harvard School of Public Health through Project 086); the Bureau of Nursing which, with technical assistance
from a PAHO nurse-educator, has just finished definition of standards of care, norms for auxiliary nurses, and a curriculum revision to include expanded supervisory and community nursing duties; and training activities conducted with relation to RHDS.

An obvious requirement for the success of 091 activities is continuous training and supervisory efforts. These could be coordinated and planned through the Section referred to above.

The person appointed to the position of Executive Assistant would have the responsibility for: planning, organizing, assisting in the implementation of continuing education courses for various levels of personnel involved with 091, with special emphasis on middle level and supervisory workers, and evaluating these activities. The Assistant could also work with the Planning Bureau in the conduct of in-service training which has already been initiated in that Bureau. The Section, like other Bureaus and Departments and the training institutions, needs support in order to carry out its training activities successfully.

Finance Component

This document contains recommendations with respect to strengthening training of personnel in the DSPP who have assumed planning responsibilities and who will have critical operational responsibilities with respect to 091.

It recommends that the following selected personnel receive (additional) training in management sciences:

- Bureau of Health Planning
  - 1 Staff trained at M.A. level, Applied Economics
  - 1 Staff trained at M.A. level, Quantitative Analysis
Statistics Section
1 Section Chief - Supplementary Training (6 months), Management
1 Senior Staff - Master's level training, biostatistics
4 Junior Staff - 1 year or less, Data Management

Personnel
1 Section Chief trained to MBA level, Business Administration
1 Staff Member - trained in Information Systems

Budget
1 Section Chief - supplementary in Management Sciences

Transport
1 Section Chief - training in Management Sciences

The recommendations emphasize the importance of such analytic skills as are necessary to perform such planning exercises as cost effectiveness and benefit analyses. In addition, the Evaluation Team would like to emphasize the importance of skills in health program evaluation. A list of suggested schools and universities in the U.S. is included. It is remarked that this list is incomplete (it does not include Johns Hopkins, for instance.)*

In addition it should be noted that the emphasis in the recommendations of WHS is on the acquisition of quantitative skills essential to management in its planning and evaluation of responsibilities. There are other management skills crucial to the leadership of organizations, skills in: decision-making/problem solving; leadership styles; change techniques; group dynamics; conflict management; supervision and motivation; team building; work and time management. These must not be overlooked in the effort to strengthen:

* A useful activity which AID/W might consider supporting would be the compiling of catalogues from the institutions mentioned, and others, so that specific courses and programs suitable for use by students from developing nations could be identified. A clearing house for information about training seminars and conferences on management subjects would provide information necessary to arranging for useful and appropriate out-of-country study by recipients of AID-supported grants.
the quantitative skills of DSPP leadership.

The Finance Component also makes unflinching recommendations that training is not enough to bring the DSPP to an effective operating capability. It prescribes institutional reforms that include: Civil Service reform with hiring and firing procedures standardized and executed by Personnel Section; the institution of a performance evaluation system and a promotion ladder; reorganization of the DSPP with delegation of responsibilities and dismissal of superfluous personnel; institution of effective management systems providing for deployment of resources, collection and use of statistics, and the evaluation of DSPP activities.

At the moment these recommendations are being reviewed by the Director General and the Minister of Health. Should they be approved, then a sequencing plan must be developed to schedule their implementation.

Until further strengthening of the capability of the DSPP to manage, administer and implement its activities has occurred, the question remains: can 091 be established under less than ideal conditions? The Evaluation Team is of the conviction that further technical assistance is a pre-condition of successful implementation of 091.

VIII. Conclusion

It is the Team's view that there were faults in the design of the WHS project. In the first place, the time period was too short, especially for the long-term advisor, to accomplish the fundamental project objective of strengthening the planning and management capability of the DSPP. Thus the production of the reports and manuals became the project objective. Secondly,
there was considerable duplication with the technical assistance provided by PAHO under the IDB contract, implying that there had been inadequate coordination between AID, PAHO, and the Government of Haiti, during the design phase. PAHO was providing technical assistance to the DSPP in planning and administration all during the WHS project, and is continuing to do so. The terms of PAHO's contract also commit them to assist the DSPP with the preparation of manuals—a function more or less duplicating that assigned to WHS.

It was anticipated that during the WHS project, the DSPP would develop an effective health planning unit and introduce administrative reform. It is clear that the WHS team provided assistance to the DSPP in these areas and that major progress was made, particularly in the Bureau of Health Planning and Evaluation. However, the long-term advisor, (Chief of Party), was not as effectual as he might have been if he had been more innovative and more experienced in international health planning and management, and if he had had better communication with DSPP officials. Although considerable progress in health planning was made during the WHS consultancy, it is impossible to determine the relative importance of the WHS, PAHO, and GOH contributions.

The WHS team produced some useful procedural manuals, particularly in the areas of transportation, logistics, and statistics. However, because (excepting in the area of statistics), the timing of the WHS efforts did not coincide with the DSPP's readiness for implementation, those reports are simply being used as background documents for the continuing work that is being carried out with the assistance of PAHO.
The Team believes that the central administration of the DSPP is neither organizationally nor functionally at the point that was originally anticipated for the end of project status. The project design was unrealistic in assuming that in two years an entire structure could be renovated, and people trained and given adequate on-the-job experience to undertake a major new health services program.

The Team feels that the DSPP is still very weak in the areas of health administration and management. It seems likely that the DSPP will be reorganized over the next few months to reflect the more rational management structure that has been proposed. However, there is still an inadequate number of personnel trained in the necessary management and administrative operations. The expanded health program will require enormous growth and rapid sophistication of this administrative structure. There is far too little experience in operations to ensure adequate program and project management over the next few years. Strengthening the DSPP capability to meet this requirement will take more time and additional external financial and technical support.

The Team believes that the DSPP is better prepared in the area of health planning for the implementation of O91. The BHP/E still requires considerable strengthening in data collection and management, and economic analysis. The unit also needs to acquire greater authority for planning and coordinating funds. However, the BHP/E does have a strong capability in planning that has been well utilized in designing O91.

In sum, the Team found that WHS consultants completed the tasks
that were agreed to but were unable to fulfill the underlying objectives of laying much of the groundwork in the DSPP for the implementation of 091. This is largely attributable to the short time frame of the entire project and the even shorter period that most of the consultants spent in Haiti.
E. Analysis of Findings

I. Projects 070 and 086 "Strengthening Health Services I and II --" Westinghouse Health Systems Contract

Westinghouse met the basic output requirements. Reports and manuals were prepared as required by the terms of the contract. However, it appears that the "connections" that could have been made between the preparation of the reports and their utilization by the DSPP were not fully developed. It seems that one of the problems was that the leader of the team and some of his WHS colleagues had difficulty with the French language and did not get around the country as much as might have been desirable. Consequently, officials of DSPP, both in the Headquarters Office and in the field, did not have fullest contact with the WHS team leader or with other members of the team. Therefore, as indicated above, the use of the reports and of the WHS team expertise was not up to the standards which might have been expected. It is only just to point out, however, that a considerable portion of the difficulties experienced by WHS, as described above, in implementing this project were due to inadequacies of project design including especially failure to appreciate the length of time required to achieve project objectives, particularly those related to building administrative and management capability within the DSPP.

Fuller details re this aspect of the analysis of our findings are contained in the section of the report immediately preceding.

II. Project 091 - "Rural Health Delivery System"

The project, in concept at least, is an excellent one. However,
after carefully taking into consideration all the information we could lay our hands on, including the numerous meetings, conferences, field trips, etc. listed and discussed briefly in Annexes 1 and 2, study of the Project Paper, of the Project Agreement (about to be signed we presume), and the Information Memorandum for the Assistant Administrator (LAC) dated September 21, 1978, concerning the DAEC review, we have come to the conclusion that there are a number of potential and/or existing issues which should at least be discussed in order that everyone be aware of the fact that they might lead to serious problems in the implementation of this project at some point along the way. These are as follows--:

1.) The project time frame of five years strikes us as being unrealistic for a project of this size and complexity. Among some of the reasons for this conclusion are the following: (a) the project will be attempting to "turn around" an entire system of delivering health services from a centralized more or less curatively-oriented approach to the concept of delivery of decentralized generalized health services and (b) even though Haiti is a small country, there are still many administrative units involved, there is much substantive new information required, and very few trained people to do the work. Consequently, even the time needed to train the necessary personnel so that the forward movement can be institutionalized as a Haitian continuing project, could very well be more than the time proposed.*

* As Lippit and Watson said years ago, 6 "If the efforts of the 'change agent' with the 'client system' are not of sufficient duration to produce the needed client system institutions, then the end result may be no progress at all!"
Fortunately, there are two aspects of the project, as wisely written, that give it considerable flexibility, namely:

(a) There is a good deal of flexibility in the funding provisions (e.g. a quite large "contingency element.""

(b) Formal annual evaluations are provided for.

Presumably, to take advantage of this flexibility and as the project progresses and, for several years, as new requirements become apparent and project performance justifies it, plans can be made for one or more follow-on projects.* Such projects could take the form used in Ghana or elsewhere in which step by step development of the necessary management information, training and implementation programs are carried out on a planned basis over a more realistic period of time, e.g. 10 years+ or whatever period seems appropriate.

2.) The project provides only for one person-year of full-time technical assistance in the management training area, although the concept is mentioned here and there in the paper and the possibility is obvious that some of the short-term TA consultants can be used for this purpose. In view of experience which AID has had in other countries (e.g. Ghana) it seems likely that the time it takes to institutionalize a whole new approach to management from top to bottom of the organization and with the development of a new philosophy which changes from a more

* There are probably numerous precedents for this approach to similar situations in the history of AID's technical assistance projects (vide for example projects in Ghana, 055 Danfa Rural Health Program, 068 Management of Rural Health Services and 071 Community Health Team Support.)
or less "autocratic" type of management style gradually to the "developer" approach, is probably a long-term effort, and one which we think, in any event, will require much more than one person-year of technical assistance.

Furthermore, without this change in management style and resulting improved motivation and productivity on the part of all performers in the Ministry, including the Agents de Santé, the whole project could flounder. We, therefore, believe that there should be an increase in the period of time of long-term technical assistance in management training and that additional short-term consultant services need to be provided in this area; that an effort should be made to look into the possibility of management training capacity in an existing Haitian institution (we understand there is one) or building that institution to the point where it can take on this responsibility. Training in modern concepts of management, including the motivational areas and not just limited to budgeting and planning, etc. should also be included as appropriate at all levels in all of the curricula being developed for the training of the personnel who will have to be put in place in order for this project to be successful. In addition, attention should be directed time and again to the need to decentralize authority with responsibility and the need for training people to exercise this authority in a wise and productive manner.
3.) The Bureau of Planning and Evaluation staff may not be wholly adequate either in terms of number of personnel, areas of substantive expertise or terms of reference. Short-term consultation and long-term training may be needed in several disciplines additional to those already available and planned to be included in Project 091. Additional training might be in areas such as planning aspects of public health nursing program development, health education, socio/cultural and economic aspects of the development process as these relate to required health inputs, epidemiology, public health engineering, etc. All these substantive areas and, no doubt, others, should be included if a Health Planning Unit is to have a sufficiently broad information base to be able to deal with all of the planning issues which will arise in the elaboration of a properly organized long range plan for comprehensive health services in any situation.

4.) The concept of "regionalization" is often cited to justify the creation of different kinds of organizational setups when, in reality, what the concept means is simply the establishment of decentralized, generalized health services; and the question of whether or not these services should be administered through a Region or District or some other geographic or governmental unit, is quite beside the point. Any one of these kinds of units could work if the health program were properly decentralized. Thus, in the present instance, it seems that one might be more concerned with the question of whether, for example, a District health unit is divided by a mountain range which prevents the people in one part of the unit from being referred to a hospital in another part. In addition, of course, there is always the question of a Region's being
divided into Districts, some of which are so far from the Regional headquarters or so difficult to reach, that, in effect, the Districts may be dealing directly with Headquarters in Port-au-Prince simply as a matter of necessity.

Many years ago, Dr. Haven Emerson wrote a paper called "Local Health Services for the Nation" in which he pointed out all of these things and said that the important issue was to establish Local Health Units of reasonable size from a population point of view and of reasonable accessibility to health services, whether or not they fitted in with governmental entities. For the most part, in Haiti, it appears that a District is a good unit from both the substantive-logistic and governmental points of view. In any case, however, we think the issue should be an open one and that the Ministry of Health (DSPP) should not necessarily be "wedded" to the concept eventually of setting up six Health Regions and seventeen Districts in the country when perhaps the fundamental issue is the need to limit the administrative/management "tiers" between DSPP headquarters and the point of delivery of rural health services to those which are essential for the job. Thus, an appropriate grouping of Districts (with their attached Health Centers, etc.), or some other workable unit, might provide a more efficient and satisfactory way for covering the entire country with the desired health services than the present proposed system of Regional and District offices.

5.) The implication in O86 and O91 that implementation of the model rural health delivery system would be planned from the outset on a national scale also seems unrealistic. It has not, as far as the Team knows, worked
this way in any place where AID has been successful before. Instead, the approach is usually to assist in building the system by discrete units (geographic and functional) over a period of time but definitely not all at once. In fact, the approach in Haiti already seems, in some respects at least, to have followed this general incremental plan since efforts have been concentrated in the North and the South Regions, and in a few smaller subdivisions for special projects such as Petit Goave and Croix des Bouquets. The Team feels that this unit by unit approach should be continued and that efforts to begin in new units should be deferred at least to some extent until the work in existing units is progressing satisfactorily. This probably should include the health center and dispensary construction program as well, although economies of scale and the need to have physical facilities in place for staff to work in, once they have been trained, means that a compromise of some kind may have to be worked out.

In other words, for example, a dispensary may have to be built somewhat in advance of its occupation and use by trained staff in order to avoid the problem that was faced in the early days of health program development in countries like Ethiopia where relatively large numbers of well-trained health personnel were coming out of the training institutions and yet there were no health centers or other rural health facilities ready for their use. A makeshift and comparatively expensive plan involving rental of the needed facilities had to be worked out in a hurry!

The argument here is that the whole process of developing and extending the rural health delivery system needs to be very carefully
planned in advance so that the rate of expansion is phased not only
into the GOH financial capacity but also into the training, management,
administrative, logistic and physical facility construction capacity for
such an expansion. In short, the emphasis here is on an approach to
planning based on a realistic assessment of needs, and on the capacity, over
time, to meet these needs. Of course, the approach suggested may increase the
time needed to cover the entire country but, in the end, it is likely to be
the most cost/effective way of getting the job done.

6.) A complication of similar type to that just discussed arises
when one considers that stated intentions in 091 of "integration" of
various "vertically organized" parts of the rural health delivery system
into the desired "horizontal" format, e.g. Division of Family Hygiene
(DHF), Bureau of Nutrition (BON), and most difficult of all, SNEM.*

Indeed, it is already recognized that, primarily for technical reasons
at the moment, (excessive malaria transmission in many parts of the
country), integration of SNEM will probably have to be postponed
indefinitely.** But integration of the other two elements is important
and yet will be very difficult and perhaps counter-productive if the
supporting systems in DSPP are not adequately developed to handle the
work. Consequently, the Team feels that the word on integration should
be to "go slow" and to consider doing it on the unit by unit basis suggested

* Integration of certain aspects of SNEM, e.g. the vehicle maintenance
facilities, are not included in this caveat, since such integration
might be relatively simple and worthwhile early on.

** However, it might be that certain SNEM field staff in low transmission
areas could, with re-training, serve as agents de santé quite soon
(suggestion from one of the SNEM project evaluation team members.)
above for the whole RHDS.

7.) The salaries of all the newly trained personnel at the auxiliary nurse and health agent level, in addition to considerable other DSPP staff for the 5 year life of the project, will be paid for from funds to be generated from Title 1 food sales (about $8 m) and this is in part a "Condition Precedent" for the rest of the grant. However, even if this condition is met (as seems probable) the GOH will still be faced with the long-term need to absorb these salaries into its regular budgetary process after the project ends. The Team questions whether this issue has been adequately addressed in the Project Paper.

Furthermore, a related question needs to be addressed, namely, salary supplementation as a motivation for health workers to accept rural assignments. The Team feels that these supplementations will prove very expensive and, in the long run, perhaps less important in meeting project goals than would concentration on the human, social-psychologic aspects of motivation, e.g. job enrichment, a career ladder, peer group professional status, etc.

DSPP apparently recognizes the importance of the latter since the regional seminars are an obvious step in that direction. However, the Team believes that Project 091 could perhaps benefit from a more intensive and direct approach to the need for improved motivational objectives and increased clarity of their definition. There could also be consideration of mechanisms, e.g. Regional management training seminars, visits to health management projects like the ones in Ghana, for appropriate DSPP officials, and the like, to help DSPP in its efforts to improve its
management capability as a means of strengthening positive employee motivation rather than relying to such an extent on the monetary (or, as Drucker\textsuperscript{8} says, "hygienic") motivational elements needed to attract and keep well qualified rural health workers.

8.) Further to what has been said above, the whole question of continuing education and professional development needs further attention in 091. This issue could be considered along the following lines--:

The experience of pilot and demonstration projects in Haiti in the training of basic community health workers has provided a useful prototype for the training of agents de santé for the implementation of 091. The curriculum for agents de santé has been written in detail, and teams of physicians, public health nurses, auxiliary nurses, and sanitary engineers have been formed and trained to teach successive cadres of agents to be attached to the communities, dispensaries, and health centers that make up the expanded system for the delivery of health services in currently under-served rural areas.

At the central level, provision is made in 091 for technical assistance to continue to strengthen the capability of the DSPP with respect to managing and administering the RHDS. And, for community medicine faculty and students, an exchange program with the Harvard School of Public Health will strengthen the Department of Community Medicine at the Medical School in Port-au-Prince.

What has emerged, however, from the growing international experience in trying to provide health services to rural areas is that at the heart of developing peripheral health services is mid-level management. This
includes the regional and district medical officers and their staffs; but it also includes the auxiliary nurses who will staff the health centers and dispensaries, and who will be the trainers and supervisors of agents de santé, the first point of contact for many with the primary care services to be provided by RHDS.

The curriculum for auxiliary nurses is in the final stages of revision, and will be adopted in a matter of days. This process was begun by a task force which first defined standards of care for auxiliary nurses, and then performance norms for them. A detailed curriculum with strengthened content in community nursing has been developed and it includes some instruction in methods of supervision. Once adopted, the curriculum will be taught by the instructors in the three nursing schools in Haiti. These instructors are typically recent graduates of the nursing schools, some of whom have completed the post graduate course in public health nursing. However, their instruction in pedagogical methods is not strong, and their familiarity with the community nursing curriculum content is somewhat limited. Their responsibility for teaching important members of the health team, on the other hand, is great; consequently, their preparation to assume this responsibility is considered by the team as likely to prove inadequate.

The task force which revised the curriculum for auxiliary nurses made an effort to reduce the didactic content from the 70% previously typical of it to less than 30% in order to concentrate on practical skills rather than theoretical knowledge. To make such a change in the planning of the curriculum requires a change in methods of teaching.
What the instructors of auxiliary nurses need to learn is ways of teaching that provide practice in those skills essential to the work which the student will be expected to perform on completion of training. Such practical teaching approaches include effective methods of: conducting a demonstration; planning for role playing; preparing materials for demonstrations; designing practical examinations; asking questions; planning simulations of on-the-job situations; teaching trainees how to plan their time and their work; teaching them how to supervise the work of others.

The team therefore feels that what is needed is some training of the trainers, in this case the school-based instructors of auxiliary nurses. There are excellent resources for this activity in Haiti. PAHO provided the curriculum task-force with a nurse-educator technical assistant. The head of the section on Medical and Paramedical Education is keenly interested in educational and training issues. (And skilled in health education. He writes a weekly column on family planning in the Port-au-Prince daily newspaper.) There are senior nurses already in community health service with talent and dedication. What is lacking are the kinds of administrative and technical support necessary for planning, organizing, implementing and evaluating a program to train trainers of auxiliary nurses. And the money.

To the Evaluation Team it would seem advisable that AID support a workshop in practical teaching methods for instructors of auxiliary nurses. This is an immediate need, since the newly revised curriculum will go into effect at the beginning of the next term in the nursing schools.
It would also seem advisable that AID provide technical assistance to the Section on Medical and Paramedical Education for the establishment of a continuing education and professional development program for all levels of personnel involved in the RHDS.

Follow-up education on a regular basis is a requirement of continued professional growth of health workers. The content of continuing education programs should be based on an analysis of the frequency of health problems treated and the most frequent "mis-diagnoses" or errors in "treatment" that occur.

Too often the training of health workers has not been reinforced by a consequent course of further instruction and reinforcement. To a certain extent the training activities in 091 are of the nature of a "campaign." The training has not been institutionalized to the extent that the training itself will continue to be responsive to immediate needs of the health workers and of the health problems of the communities they serve. The experience after most campaigns, whether they teach literacy or preventive and promotive skills, is that unless they are followed up by other activities the effects are soon extinguished.

At present the Section on Medical and Paramedical Education consists of only one physician appointment. At a minimum the section should include a full time executive assistant with the responsibility for planning, organizing, implementing, and evaluating the workshops, seminars, conferences, and lectures sponsored by the section. The head of the section has expressed interest in learning more about the principles of adult and continuing education program development. He would welcome both
technical assistance and the chance to communicate with his peers in other countries who have similar interests and responsibilities. Another of his responsibilities is the coordination of a committee composed of membership from the Nursing Bureau, the Medical School, and the Bureau of Planning in meeting the professional training needs of all involved in the health team, and in the management and administration of RHDS.

There already exists the mechanism for further future professional development of personnel for RHDS, but the mechanism needs broadening and strengthening and the section needs additional staff and financial support. For at this point provision has been made for strengthening and developing the bottom and the top, but not the middle levels of personnel for RHDS. And the training needs of the trainers of auxiliary nurses have been entirely neglected in O91.

9.) It can be stated quite without qualification that a generalized health program cannot succeed in areas where an adequate source of potable water is not available to the majority of the population to be reached by the other health services. The subject is not dealt with in detail in the PP for O91 as it is expected that an AID-assisted hydro-geologic survey in the near future plus the efforts of the other donor agencies, especially UNICEF, IDB, and World Bank will lead to gradual solution of the problem. However, the absence of detailed attention to this problem either in PP's for 070, 086, or O91 and therefore little consideration of it in WHS work with the DSPP Bureau of Planning and Evaluation or in development of the RHDS project, could lead to a situation in which everything except the water supply problem is taken care of. As a result,
it could occur that in spite of all other efforts, little headway would be made in dealing with infantile diarrhea and other water-related major causes of death and disability in small rural villages throughout Haiti! "Incroyable!"

10.) Miscellaneous problems observed on field trips

a. The "cold chain" problem showed up in both the Northern and Southern Regions. Difficulties were being experienced either with availability of kerosene for "electrolux" type refrigerators or with availability of electricity. For example, in Quartier Morin electricity was available only for 2 hours each evening. In Les Cayes the power went off on the morning we were there and, as a result, vaccines in the refrigerator were on the verge of being rendered useless.

Cold chain problem solutions have been studied by WHO in their "Expanded Immunization Program" in many countries. One recommendation given us by the RMOH in Northern Region was to switch to propane refrigerators. However, the problem is more complex than that and perhaps requires a comprehensive study if not already undertaken.

b. The level of laboratory technologic "back-up" for an improved health information system was poor to non-existent except in the one "mixed" clinic we saw in Les Cayes (See below for additional details re this clinic.) There is a need for much improvement in equipment, training, and, it would
appear, motivation, of laboratory staff and record keeping.

c. The work schedules and general approach of the sanitary officers (officiers de santé) in the Southern Region seemed somewhat stereotyped. In addition, much effort and considerable expense was being allocated to privy construction, prefabrication of concrete slabs, etc. It is the team's opinion that the portion of program time of these personnel devoted to improving water supplies in small villages and communities might profitably be increased at the expense of time devoted to solving problems related to excreta disposal.

d. We saw or read of few if any sample surveys and/or functional analyses going on in rural areas outside the training locations such as Croix des Bouquets and Petit Goaves. These methods of getting important operating information for improved management can be very useful and, by use of sampling technics, can be kept within reasonable bounds of staff and finances required.

e. Although it would appear that SNEM cannot be integrated into DSPP for the moment there are some things that can perhaps be done. One, in the training area, has already been referred to. Another might be to make chloroquine tablets available routinely to agents de santé instead of requiring this medicament to be obtained "on request" from the nearest dispensary.
f. The "mixed" Sacré Coeur Clinic in Les Cayes, sponsored by the Oblate Fathers and DSPP together, is far and away the best rural comprehensive program in Haiti observed by the Team. The facility was staffed by well-qualified highly motivated and dedicated staff, it was very clean, both equipment and supplies were extensive and comprehensive and above all, utilization of the Clinic appeared excellent. The Clinic also appeared, in reality, to be functioning as a health center without beds. Complete integration into the DSPP of such clinics, if this example is at all generalizeable, might have uncertain consequences at the present time.

g. Throughout our field visits and in study of the various training programs including participant training under any of the AID-assisted projects, we found little concentration on needs in the area of health education of the public.* In installations in the North and in Les Cayes, emphasis on and facilities (e.g. health education media) for this substantive area were, in our opinion, inadequate. True, none of these requirements can be met all at once and 091 has not even started yet. However, a gradual strengthening of this element in the plans for the

* Indeed in some of the GOH materials we have seen, there seems a possibility that there may be some confusion between "education of health personnel" and "health education of the public."
training and implementation parts of 091, at the very least, seems indicated beyond the presently included courses for training of auxiliary nurses and agents de santé as described on pp. 48, 51, and 52 (para 4) of the Project Paper. For example, health education materials in Creole, especially for the agents de santé, and illustrated messages (slides, using a sunlight projector, silk screen or other similar device) could help a lot to liven up the whole attitude towards and range of possibilities for improved health education of the public throughout the system. Finally, introduction of specific emphasis on methodology for health education of the public, especially in situations like those in Haiti, might be increased in the participant training and observational training components of the program.

11.) Finally, coordination and cooperation with other donors has of course been given important consideration throughout development and implementation of all the health projects assisted by AID which the Team studied. However, perhaps this could be increased even over that collaboration which has already been undertaken with PAHO and UNICEF in preparation of the Project Paper for 091. For example, the work of PAHO in health service management and organization, and in the health personnel training area, and of UNICEF in the area of rural water supplies, could bulwark our assistance to the GOH in the health service area and vice versa. The same could be said perhaps for other assisting organizations' activities for example, in health training, administration, operational research,
or project implementation. One obvious requirement for this improvement would be delegation to the DSPP/BPE by the GOH of more authority to oversee and organize in a practical way the needed collaboration and coordination between donor agencies in this field. Finally, perhaps even greater efforts can be made by AID to develop fully the potential of cooperation and coordination with our sister donor agencies working in this country on the improvement of health services for the benefit of the people of Haiti.
Synopsis of Meetings, Conferences, Field Trips

The Team arrived on schedule, Sunday, March 18, 1979, and had been able to brief itself en route with considerable background documentation obtained through courtesy of the Office of Development Information, AID/W. Subsequent meetings, etc. may be summarized as follows--:

1.) Meeting with Ms. Sylvie Kulkin, Health Projects Manager for USAID/Haiti, Monday, March 19, 1979

Ms. Kulkin briefed us in considerable detail about the various inter-acting projects in the H/P/N areas and asked us particularly to address the question of the capability of the DSPP at the present time, what they have accomplished during the past few years in using the assistance of the various agencies and what we thought the chances are for successful implementation of Project 091. If difficulties are foreseen, she said she would like us to indicate what additional or different kinds of technical assistance might be appropriate. This fitted quite well with the terms of reference already given the Team in Block 19 of the PIOT (See covering memorandum to Dr. Boynton and Annex 3.)

2.) Meeting with Mr. Joel Cotton, USAID/Haiti Evaluation Officer, March 19, 1979

Following the meeting with Ms. Kulkin, we met with Mr. Cotton who explained to us how our evaluation procedure should fit in with the required Mission "Performance Evaluation Statement." He also asked us to address the question, given the magnitude of Project 091, of what our judgment would be concerning the DSPP's ability to plan the necessary actions under this Project and then implement them. As in the case of our meeting with Ms. Kulkin, Mr. Cotton asked us to identify problems
we might foresee and suggest recommendations for dealing with them.

Finally, he asked us to keep in touch with him more or less on a weekly basis.

3.) **Meeting with Dr. Boynton and Ms. Kulkin, March 20, 1979**

This meeting was simply a briefing and a discussion meeting to get our ideas together prior to the meeting scheduled shortly thereafter with the Secretary of State for Health.

4.) **Meeting with Secretary of State for Health, Dr. Willy Verrier and Director General, Dr. Gaston Des Louches**

The meeting lasted only a short time and involved only a general discussion of our terms of reference. Dr. Verrier then gave us permission to visit any health installation, and meet with any health or health-related staff as considered desirable during the course of our consultation.

5.) **Meeting with Dr. Evariste Midy, Director, Bureau of Planning and Evaluation, (BPE) DSPP (with the Team, Dr. Boynton, and Ms. Kulkin)**

Dr. Boynton explained the purpose of our visit, emphasizing the need for us to pursue the question of administration and planning in the DSPP and in the BPE and how these related to the implementation of Project 091. Dr. Midy agreed and asked the Team to feel free to proceed as it saw fit.

6.) **Meeting with Dr. Boynton**

Following the meeting with Dr. Midy, we returned to Dr. Boynton's office and discussed, in some detail, the plans for our time during the consultant visit and the possibility of several field trips. He suggested that we might visit a combined service and training health center at Croix des Bouquets and the health center at Thomazeau to be followed later by attendance at the Regional meeting of the DSPP with Headquarters and
Regional staff at Gonaives beginning March 20.

7.) Meeting with Mr. Jacques Saint-Surin, Statistician, BPE
Following the meeting with Dr. Midy, we met with Mr. Saint-Surin and discussed with him his training in the area of health information and biostatistics as well as the use he would make of this information in implementing the various projects now underway or being contemplated. Mr. Saint-Surin said that the government is training the statisticians needed to staff the BPE by sending them on WHO fellowships to schools in Latin America and Canada. However, there are only ten statisticians receiving this training at the moment and he thought that it would take three to five years to train a sufficient number at the graduate level to be able to provide staff required adequately to meet the needs of all the Regions and the Central office as well.

8.) Semi-annual meeting of District Administrators, March 20-21, 1979
This meeting was attended by top administrative/management officials from the DSPP Headquarters, and, in fact was organized by Dr. Evariste Midy, Director, BPE/DSPP. In addition, appropriate staff from the DSPP Regions and Districts, especially the Northern Region and Southern Region were well represented. The meeting was also attended by representatives of the different agencies assisting the DSPP, as well as by the Harvard University School of Public Health Project Chief of the "Integrated Health Program" at Petit Goaves and both U.S. and Haitian members of this year's class.

The consultant team members participated as observers but they also used the time between meetings, in informal "corridor discussions" to obtain
additional information about the Projects in question and points of view, etc. of the various DSPP and other agency officials in attendance.

This was a fascinating meeting indeed and gave us the clear impression that the DSPP does indeed place great emphasis on the importance of modern concepts of management in the organization and in the development of the necessary esprit de corps among the staffs of the different administrative levels and organizations within the DSPP, especially at the Regional and District level. There's no need to go into more detail here since a copy of the conclusions of the Regional Seminar is attached as Annex IV of this report. However, to sum it up as stated in paragraph XXII of the mentioned paper (free translation), "The theoretical review of the methodology of planning in public health as well as the development of a practical model and the working efforts of the groups have shown the interest of the participants in the Seminar and have created a real identification of interest between the administrators of the Districts and Regions, and an understanding of the importance of their effective participation in the process of planning for the health sector in Haiti."

9.) Regional visit – Northern Region (Cap Haitien), March 23–24, 1979
On this visit the Team was accompanied by Ms. Kulkin and was provided transportation courtesy of the AID Mission.

We arrived in Cap Haitien early on the afternoon of March 23, went immediately to the Regional Health Department Headquarters and met Ms. Debbie Leroy, PAHO Public Health Nurse assigned to assist the Director of the Northern Region Health Department, Dr. Marc Angrand.

Since Dr. Angrand was not available at the moment, we had quite a
lengthy discussion with Ms. Leroy and received the following information—
(1) concerning location of dispensaries in the Region, Ms. Leroy said that the facilities are often in rented locations, fixed up with funds and labor from the communities in which the dispensaries may be located.
(2) Concerning supplies and equipment, much reliance is still placed on UNICEF which is providing this kind of assistance to the MCH/FP program in the Region. The new UNICEF Director, Mr. James Akre in Port-au-Prince has apparently been very helpful in this process.

Later on Dr. Angrand came in and made the interesting comment that he had been a pediatrician but "after 20 years of practice" he found that he wasn't really dealing with the problem of repeated illnesses, preventable mortality, and the like. So, in 1973, he went to the University of California in Berkeley and took a one-year program leading towards a M.P.H. degree with his major in MCH/FP. The Director of the program at U.C.B. at that time, Dr. Helen Wallace, arranged follow-on field visits for Dr. Angrand during the next 18 months in various locations in the United States, Latin America, and Puerto Rico. He was also given three months experience at the "Center for Population Activities" in Washington. Thus, his background and training have equipped him superbly for his present job.

Dr. Angrand said that he thought the Regional Plan was a good one but that it was impossible to carry this out over the entire country at the same time and that it would have to be "serially." He thought that given the rapid flow of new resources, it might, however, be possible to complete the Regionalization of health services for the entire country
in the five-year life of project envisioned in 091 (see however the Team's comments concerning this matter in the body of the Report and in the Section on Analysis.)

Concerning management Dr. Angrand said that the Division of Family Health in the Ministry excelled in this area and certainly so in comparison with other Divisions in the organization. There are good channels of authority and excellent communication in both directions. He noted, however, that when the supplementary salaries paid family planning workers were "thinned out" and given to all of the staff in the Region, motivation diminished greatly.*

Dr. Angrand then emphasized the fact that he had been responsible for creating the supervisory teams (to supervise dispensaries in the Region) and that teams of this type have not been envisioned by the DSPP-- instead, the idea was for individuals, perhaps, to do the supervision of dispensaries and for individual auxiliary nurses from the dispensaries to supervise agents de santé. However, Dr. Angrand doesn't think that this would work very well and that it's necessary to have a number of well-organized teams for the purpose. Consequently, he has established seven such teams. They are reasonably mobile, although, apparently there has been considerable problem with transport. In any case, one presumes from this innovative approach to supervision, results are yet to be determined.

Concerning the ever-present "cold chain" problem Dr. Angrand said

* See comments about this in the Section on "Analysis."
that there are nine refrigerators in the Region (4 from DFH and 5 from Bureau of Nutrition.) He needs 27, that is, one for each dispensary. Furthermore, he said they should be propane refrigerators—not kerosene since kerosene is hard to come by in the area. In short, in any case, the "cold chain" is not working very well in the Region. Neither is it working very well in getting the vaccines from Port-au-Prince as it is necessary to dispatch someone to that city to pick them up and bring them down immediately since, if they rely on normal transportation facilities, the vaccines are often spoiled en route.*

Concerning the supply system in general, it doesn't seem to work very well. Requisitions are sent and, as the Team has seen in many other places, something altogether different is often received and has little relation to the requirement for which the original requisition was forwarded.

Concerning the epidemiologic situation in the Region Dr. Angrand said that many of the disease problems are related to "bad water." The UNICEF program for improving local water supplies is "not adequate" and "only for tourists." River water is polluted, a well is often nothing more than a "hole" and if springs are used, they are not protected.

Needless to say, numerous other matters were discussed with Dr. Angrand but the Team Leader, Dr. Prince, will provide these for interested parties on request rather than lengthen the Report too much with added details.

After the meeting with Dr. Angrand we visited a Dispensary at a

* None of these problems are unusual to Haiti—in fact, they are the rule rather than the exception in most of the developing nations.
place called Quartier Morin and then a place where an Agent de Santé worked.

The auxiliary nurse at the Dispensary seemed very keen and said that her biggest need was a manual for diagnosis and treatment of various diseases.* Next to that in importance is some sort of laboratory facility for doing limited tests like malaria smears to improve their diagnostic capability. Third on the list are visual aids for health education of the public.

The agent de santé's community numbered 347 houses and they are now doing a census. One interesting observation was that the agent had an excellent map of the community very similar to the ones which are usually prepared when communities of this type are to be sampled for one purpose or another. In other words, the houses are all located and numbered so that they can be found again by the agent de santé in going about her duties.

The agent de santé was equipped with a "sac de travail." It contained, besides the usual supply of contraceptive pills and condoms, aspirin, multi-vitamins, iron, pipearizine, and some bandages. Noticeably, there was no chloroquine. Apparently, the chloroquine is kept at the dispensary level and if the agent de santé needs it she requests it for special prescriptions.

* Such a Manual is currently being prepared by a task force of physicians and nurses and with technical assistance from PAHO.
10.) Visit to Training Health Center and other facilities at Croix des Bouquets and Thomazeau Health Center, March 26, 1979

Main points brought out by this visit were as follows:

1. The Medical Director of the Center, Dr. Antonio Narcisse, has been there 8 years, so continuity is excellent.

2. The Center is a very important source of training in community medicine for the medical students—idea conceived in 1973 by Dr. Ary Borde, Director of DHF of the DSPP.

3. The Center works with Community Councils in the area to train workers called "Community Agents." These are not the same as the Agents de Santé but instead these workers are chosen from among students in the schools in the area who receive a short course in environmental health, community health education, etc. At the conclusion of the course, the students receive a certificate signed by Dr. Borde. Their motto is "we work with and for the community."

4. The Center also has established a school for traditional birth attendants (TBA).

5. Concerning water supplies, people in the community use water from the rivers in the area and from rather large farms which are provided with irrigation pumps. The water from these pumps is also used for drinking purposes. Other than these two sources there is very little else and no real program for developing additional sources or supplies of potable water.

6. The medical school program runs from 10:00 a.m. until 2:00 p.m.
on Tuesdays and Thursdays for two to three months for the juniors at the school. The Center takes thirty of these students at a time. The Director of the curriculum is Dr. Raymond Derosena. He was trained at Rennes School of Public Health, France in 1974 and has been working at the Center in charge of the mentioned program for about three years.*

7. Concerning the training of auxiliary nurses to work in dispensaries around the area the Center provided training programs in the past but due to the expense of dormitory facilities, the program was discontinued last year.

8. The Center runs on a very slim budget—said to be no more than total (!) $30 a month over and above salaries and other fixed costs which are defrayed from the DHF budget. The Center has a laboratory in which they carry out a fair range of the usual tests (hemoglobin, urine, stool, VDRL, blood slides for malaria, Widal, etc.) The four laboratory technicians are all trained at Port-au-Prince as there does not seem to be a laboratory training center outside that city.

9. In the visit to Thomazeau it was determined that the physician assigned there, Dr. Louis Jacques Eden, is one of the doctors who is discharging his two-year service obligation to the

* Dr. Derosena discussed the heavy demands made on staff at the Center to perform their dual responsibilities, the first to deliver service, the second to train the medical students and resident nurses who are assigned there.
Government. Besides the doctor, the Center is staffed by a Public Health Nurse, three auxiliary nurses, one statistician, six community agents, one agent de santé, and one sanitary officer. This is obviously a well diversified and adequate staff for a truly rural health center. However, it does serve a population of about 40,000 people scattered over a wide area so the size of staff may not be out of line. Attendance at the clinics is usually no bigger than 50 in one day and there's no transport and therefore no real way for the Center staff to be able to work in supervising the agents de santé in the surrounding communities. The Center only has electricity for two hours at night, but has a well-functioning propane refrigerator.

10. Community agents trained as indicated above at Croix des Bouquets work in five or six communities in the area but each agent has four to five communities of his own to look after. The agents provide very limited medications and contraceptives, and concentrate on health promotion. Some villages have springs, but, in most cases, potable water is very hard to come by. The result is that diarrheal disease and malnutrition are very common.

11. Other meetings with ES, DSPP and other related officials

The Team met again with Dr. Midy, Mr. Theodore, with Dr. Rochemont, (all of DSPP, Bureau of Planning and Evaluation) and with Dr. La Roche, Director of the Department of Community Health of the Medical School and with Dr. Ary Borde, Director of the Division of Family Health and some members of his staff. Results of these meetings are not detailed here
but, where it seemed appropriate, have been included in the relevant sections of the Team's Report.

12. The Team also met with the Directors of both the PAHO and UNICEF offices and various members of their staffs. The same comments as made above apply in this case also.

13. **Field visit to Southern Region Health Department, Les Cayes, April 8-9, 1979**

This field trip was again arranged with the cooperation and assistance of Dr. Midy and Dr. Boynton so that our visit was expected, transport was arranged, etc. We met with the Regional Health Department Director, Dr. Bijou and with the Regional Public Health Nurse, Miss Salomon. Again, results of this visit cannot be detailed here but, where appropriate are included in our analysis of the situation as we see it and in our recommendations.
ANNEX 2

List of Individuals, Documents/Reports Consulted

I. Partial list of individuals and/or organizations consulted, together with geographic locations

USAID—Haiti

a.) Mr. Lawrence Harrison, Mission Director
b.) Mr. Al Furman, Deputy Mission Director
c.) Dr. Willard Boynton, Chief, H/P/N
d.) Ms. Sylvia Kulkin, Project Manager, Projects 086 and 091
e.) Mr. Winn McKeithan, Population Officer
f.) Mr. Joel Cotton, Mission Evaluation Officer

Departement de la Sante Publique et de la Population (DSPP), Port-au-Prince

a.) Dr. Willy Verrier, Secretary of State for Public Health
b.) Dr. Gaston Deslouches, Secretary General for Public Health
c.) Dr. Evariste Midy, Director of Bureau of Planning and Evaluation (BPE)
d.) Mr. J. Theodore, Demonstrator, BPE, Port-au-Prince
e.) Mr. Jacques Saint-Surin, Chief, Statistics Office, BPE, Port-au-Prince
f.) Dr. Serge Rochemont, Director, Training and Manpower
g.) Dr. Ary Borde, Director of Division of Family Hygiene (DHF)

University of Haiti, Medical Faculty

a.) Dr. Victor La Roche, Director, Department of Community Health

DSPP Northern Region (Cap Haitien)

a.) Dr. Marc Angrand, Regional Medical Officer, Director Northern Regional Office
b.) Ms. Debbie Leroy, WHO Advisor, Northern Regional Office
c.) other Regional staff including staffs of dispensary in Quartier Morin and the agent de santé at de Sablé
Training Health Center, Croix des Bouquets, and Health Center at Thomazeau

a.) Dr. Raymond Derosena, Training Director
b.) Dr. Antonio Narcisse, Medical Director
c.) other staff at the other two health centers

Southern Region, DSPP--Les Cayes

a.) Dr. Bijou, Director and Regional Medical Officer of Health
b.) Ms. Adrienne Salomon, Chief, Public Health Nursing
c.) Dr. Silvère Simeant, WHO Advisor
d.) Ms. Janet Sylvain, Public Health Nurse
e.) Hospital Administrator, Les Cayes Hospital
f.) staff at Les Cayes Health Center and Sacré Coeur dispensary ("mixed type")

PAHO Office--Port-au-Prince

a.) Dr. Vladimir Ratthauser, W.R.
b.) Mr. Peter Railley, Planning Officer (on contract)
c.) Dr. Careos Pettigianni, Deputy Director
d.) Ms. Helen McDowell, Technical Assistant in Community Nursing

UNICEF

a.) Mr. James Akre, Country Director
II. Documents consulted

Westinghouse Health Systems reports, 1978:

"Report on Administrative Norms for the DSPP"

"Report on Progress of the Bureau of Health Planning and Evaluation"

"Revised National Health Plan: Outline and Process"

"A Manual of Statistical Norms, Procedures and Forms for DSPP"

"Transportation Component"

"Logistics Component"

"Health Manpower Component"

"Finance Component"

"Final Consultants' Activities Report"

"Final Project Report"


"International Workshop on Caribbean Experience in MCH/FP and Community Development," Dr. A. Verly, Assistance Assistant Chief, Division of Family Hygiene, Haiti, 1976.
ANNEX 3

Pacific Consultants, Inc. Contract Team Terms of Reference

Strengthening Health Services II (521-0086) was designed with a two-fold purpose: a) to establish within the DSPP the planning and administrative structure to expand health services in rural Haiti; b) to reduce the incidence of malaria.

The proposed evaluation would only be concerned with the first purpose, i.e. the DSPP capability, since the malaria program will be the focus of a separate evaluation.

The evaluation team should be prepared to assess the following:

1) the degree of progress achieved in meeting project outputs pertaining to the DSPP, as stated in the PP log frame, and their impact on the overall DSPP capability;

2) the effectiveness of the planning and statistics sections in a) collecting data; b) using them for health planning purposes;

3) the capability of the DSPP to plan, implement and evaluate health activities;

4) the effectiveness of the contract technical assistance provided by WHS;

5) the contribution of SHS II to the planning of RHDS-091 and the National Health Plan.

The team in its final report should also make recommendations for improvements in rural health delivery and for future technical assistance particularly in light of RHDS, the final phase of the present health program.
Westinghouse Health Systems Contract Team Terms of Reference

The contractor is to provide technical assistance to the Government of Haiti in its program of "Strengthening of Health Services." Specifically the assistance is to include that required by the Ministry of Public Health and Population in its actions to:

a. create a functioning bureau of national health planning

b. conduct a study to reorganize the Ministry to manage more efficiently a regionalized health care delivery system

c. provide advice and on-the-job training for Haitian Bureau of Health Planning officials in Port-au-Prince, and in the regional offices (to be established)

d. determine manpower requirements for the Bureau of Health Planning

e. examine the nature and quality of data now being received by the Evaluation Unit, and the manner in which this data is used, and identify improvements in the data system and the categories and types of personnel necessary to make the improvements and implement the revised system

f. design baseline survey instruments, conduct baseline surveys, and organize the manipulation of data obtained

g. design and elaborate a national health plan

h. integrate the above components (a-g) in the specification of appropriate rural health service system(s)

i. improve the overall administrative machinery of the Ministry

j. design and implement an improved financing system

k. conduct manpower task analyses, including an analysis of present staffing patterns
C. Reports: The reports listed below are expected to be prepared with the assistance of the contractor. A schedule for the completion of these products is expected as a portion of the proposal. That schedule will be reviewed at six month intervals by AID, and revised as necessary by mutual agreement between the contractor and AID during the course of the contract. Documents will be prepared in French, with an English translation also to be provided by the contractor.

a. a plan for the reorganization of the Bureau of Health Planning (BHP)
b. training requirements for personnel of the BHP
c. a report summarizing the results from the baseline survey
d. a specific plan for the improvement of the administrative system of the Ministry
e. component reports for the development of the administrative system improvement plan as follows:
   1. financing
   2. manpower and task analysis
   3. drug inventory and supply systems
   4. analysis of physical facilities
   5. transportation systems
f. a final report summarizing contract accomplishments.
   (This report will be prepared by the contractor.)
ANNEX 5

RECOMMANDATIONS ET CONCLUSIONS DU VIIIe SEMINAIRE DES ADMINISTRATEURS DE DISTRICTS

Gonaives 27 - 30 mars 1979

Le VIIIe Séminaire des Directeurs régionaux et des Administrateurs de Districts sur "LE ROLE DES RESPONSABLES LOCAUX DANS LA PLANIFICATION EN SANTE PUBLIQUE" tenu aux Gonaives du 27 au 30 mars 1979 a adopté les conclusions suivantes :

- I -

Le Séminaire considère que la Planification est une démarche essentielle au Développement et la méthodologie de la Planification en santé devra être adoptée par le Département de la Santé Publique et de la Population.

- II -

Pour permettre la participation des niveaux périphériques à cette planification, le DSPP devra continuer les dispositions déjà entreprises en vue de doter les institutions locales de personnel qualifié.

- III -

Il a été reconnu que certaines contraintes peuvent empêcher la réalisation immédiate des objectifs visés, mais il importe surtout que le niveau local "pense Planification" et adopte des attitudes en conséquence.

- IV -

Etant donné qu'il n'y a pas de Plan sans Budget, il a été admis que les responsables régionaux en envoyant leur plan au Bureau Central doivent aussi le faire accompagner du Budget correspondant.

- V -

La voie de la Planification devra constituer le meilleur moyen de faire admettre par le niveau central les recommandations ou suggestions en provenance des niveaux périphériques.
Pour faciliter le travail des responsables régionaux, le Bureau Central fera de son mieux pour les tenir au courant des ressources disponibles.

A la suite de l'Exposé du Dr Francis Johnson ROMUALD, Consultant de l'OPS/OMS, les participants du Séminaire ont reconnu d'une part, l'importance des médicaments dans la plupart des programmes de santé et d'autre part, l'impossibilité pour n'importe quel pays au monde de donner gratuitement tous les médicaments à la population. Le système de Pharmacie communautaire a été envisagé comme solution à expérimenter en vue de mettre les médicaments à la disposition de la Population à un prix abordable. L'expérience pourra varier suivant qu'il s'agit d'une zone urbaine ou d'une zone rurale.

Si les conjonctures actuelles nous obligent à recourir à une certaine assistance extérieure (bilatérale ou internationale) pour atteindre certains de nos objectifs, celle-ci pourra être considérée comme provisoire. Nous devons profiter de l'assistance extérieure pour nous organiser et voler ensuite de nos propres ailes.

A la suite de l'Exposé du programme de la Division d'Hygiène Familiale, les participants du Séminaire ont renouvelé la nécessité de la participation régionale dans toute programmation réalisée au niveau central.

L'Organisation et la motivation des communautés en vue de leur participation effective dans les programmes de santé ont été reconnus comme des conditions très importantes de succès surtout dans les pays comme le nôtre en voie de développement. Mais dans cette participation communautaire, on devra autant que faire se peut, éviter toute duplication - chevauchement entre le système institutionnel et le système communautaire. Les deux doivent se compléter.
Au sujet de l'utilisation des cliniques mobiles et des cliniques satellites programmée par la Division d'Hygiène Familiale, il a été admis que ces cliniques devraient constituer autant de ressources mises à la disposition des responsables régionaux et des Administrateurs de District. Ces derniers devraient pouvoir les utiliser suivant les nécessités de l'extension de la couverture sanitaire par exemple : dans les programmes "pénétration rurale" au niveau des zones d'accès difficile ou de population dispersée pour lesquelles un programme institutionnel n'a pas pu être encore établi.

XII

A la suite de l'Exposé du Projet d'Assistance alimentaire dans les établissements hospitaliers, il a été souligné la nécessité pour les Administrateurs de District de choisir parmi le personnel existant des éléments capables et sérieux en vue de suivre un entraînement pour servir comme interdant au niveau de l'établissement. Les Administrateurs eux-mêmes pourront étudier l'opportunité d'utiliser l'Auxiliaire nutritionniste à cette fin ou un autre employé.

XIII

Il est recommandé qu'au moment de l'exécution du Projet, le Département utilise l'assistance alimentaire jusqu'ici reçue du CARE ou des autres institutions similaires pour les établissements hospitaliers compris dans ce Projet au bénéfice des nouveaux Centres de santé avec lits devant être construits dans les régions Nord et Sud suivant le programme BID, étant donné qu'on n'a pas tenu compte de ces nouveaux établissements dans l'accord signé avec le PAM.

XIV

Les contacts devont se maintenir entre le Bureau Central et surtout la Division d'Assistance Publique et les Directeurs régionaux et Administrateurs de district en vue des modalités d'application de l'accord d'Assistance alimentaire signé avec le PAM.
L'Exposé de la Division d'Hygiène Publique a permis de considérer la situation des Inspecteurs sanitaires dont certains sont réellement inaptes à remplir leurs fonctions au niveau des régions et des Districts. Il ne s'agit même pas suivre un cours de recyclage. Le DSPP devrait envisager sérieusement leur cas.

Les Divisions, de plus en plus, avec le développement des régions, devraient tendre à se confiner à leur rôle normatif et laisser l'exécution des programmes aux niveaux périphériques.

Les commissions de réforme technico-administratives et d'élaboration de normes qui, actuellement travaillent au niveau central devraient nous permettre de corriger les nombreuses déficiences tant techniques qu'administratives constatées même au Bureau Central et d'arriver à un changement, étant donné que cette volonté de changement existe même au plus haut niveau du DSPP.

Les discussions qui ont suivi l'exposé du Bureau de Nutrition ont permis d'attirer l'attention des responsables du niveau central et des niveaux périphériques sur l'importance de la supervision et de sa normalisation. Devant la tendance de chaque Division technique à présenter ses normes propres de supervision, il s'est avéré urgent d'uniformiser le système de supervision et de former une équipe unique de supervision pour les diverses activités s'exécutant au niveau de la région ou du dit district sanitaire tout en dotant ces niveaux périphériques de l'équipement et du matériel nécessaire pour régulariser de façon régulière ou systématique cette importante activité.

Les demandes en vue de l'établissement de nouveaux centres d'éducation et de récupération nutritionnelle (CERN) devraient, en principe, partir de l'initiative des Administrateurs de district. Ceux-ci en feraient la demande à la Direction Générale qui chargerait le Bureau de Nutrition de faire
Les enquêtes nécessaires en vue de l'établissement éventuel du CERN au niveau de l'aire considérée.

- XX -

L'Exposé du programme du SNEM a été l'occasion pour les Directeurs régionaux et les Administrateurs de district de se rendre compte de la gravité du problème de la Malaria dans le pays et du fait qu'ils doivent se sentir de plus en plus impliqués dans le développement de diverses activités entreprises par le SNEM en vue de lutter contre ce fléau. Leurs responsabilités seront précisées et spécifiées ultérieurement.

- XXI -

Le Séminaire a permis aussi à tous les participants de bien se pénétrer du rôle fondamental des Statistiques en Santé Publique en vue de la planification. On a émis le vœu que les Hauts Responsables du DSPPP continuent d'efforts déjà entrepris en vue du développement de l'amélioration des services statistiques au niveau de toutes les institutions; d'un autre côté les administrateurs de district tâcheront aussi d'améliorer à leur niveau la collection et le traitement des données en vue de disposer de statistiques réellement fiables qu'ils pourront exploiter au maximum dans l'établissement de leurs plans et programmes.

- XXII -

Le rappel théorique de la méthodologie de la Planification en Santé publique ainsi que le développement du modèle pratique et les travaux de groupes réalisés avec intérêt par les participants du Séminaire ont crée une réelle prise de conscience chez les régionaux et les Administrateurs de District de l'importance de leur participation effective dans le processus de la Planification du secteur santé en Haïti. Tout en souhaitant ardemment que les hauts responsables du Département les mettent en mesure de bien exécuter cet aspect de leurs fonctions, les Directeurs régionaux et les Administrateurs de District adressent leurs sincères remerciements aux organisateurs du Séminaire ainsi qu'à Son Excellence Emmanuel CO TANT, Evêque des Gonaïves qui a gracieusement mis à leur disposition un local approprié pour le déroulement de leurs travaux et délibérations. Ils remercient aussi bien sincèrement toutes les autorités et la population.
gonaiwienne de leur aimable hospitalité et de l'accueil chaleureux dont ils ont été l'objet.

- XXIII -

Le prochain Séminaire des Directeurs régionaux et des Administrateurs de district devant avoir lieu à Port-au-Prince en Septembre 1979, la Ville de ................. Chef-lieu du District sanitaire de ........ a été choisi pour la tenue du Xe Séminaire de Mars 1980.
ANNEX 6

Bibliography


3 Summary of Reports of Public-Health Service Dec. 31, 1922-Dec.31, 1924 (separate reports otherwise unidentified), and Annual Report of American High Commissioner, Dec. 31, 1925, with Appendix IV, Public H. Service and same Appendices (separate reports) through Dec. 31, 1929.


6 Watson, Jeanne; Lippit, Ronald; "The Dynamics of Planned Change", Harper Bros., N.Y., 1951.

7 Emerson, Haven; "Local Health Services for the Nation", Monograph, American P.H. Assoc., N.Y., 1946.