HAITI

HUMAN RESOURCES FOR HEALTH SITUATIONAL ANALYSIS

(OCTOBER 2017 - UPDATE)

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The Health Finance and Governance Project

The Health Finance and Governance Project
USAID's Health Finance and Governance (HFG) project will improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, that five-year, $209 million global project will increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG will support countries as they navigate the economic transitions needed to achieve universal health care.

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The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

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LIST OF ACRONYMS

PCHA	: Polyvalent Community Health Agent
WB	: The World Bank
CDC	: Centers for Disease Control and Prevention
CDH	: Center for Development and Health
CMBB	: Catholic Health Mission Board
CRS	: Catholic Relief Services
UHC	: Universal Health Coverage
DFPSS	: Department of Training and Continuing Education in Health Sciences
DPSPE	: Department of Promotion of Health and Environmental Protection
DRH	: Department of Human Resources
DSI	: Department of Nursing Care
FHT	: Family Health Team
ERHIS	: Evaluation of Human Resources of Health Institutions
FONDEFH	: Foundation for Development and Oversight of the Haitian Family
HBC	: Haiti Baptist Convention
HFG	: Health Finance and Governance
HHF	: Haitian Health Foundation
IHSI	: Haitian institute of Statistics and Data Processing
JICA	: Japanese International Cooperation Agency
MSF	: Doctors Without Borders
CBO	: Community-Based Organization
ODD	: Sustainable Development Goal
OHMASS	: Haitian Organization of Social Marketing for Health
OMRH	: Office of Management and Human Resources
PAHO/WHO	: Pan American Health Organization / World Health Organization
PEPFAR	: President Emergency Plan for AIDS Relief
EPS	: Essential Package of Services
PNLT	: National Program to Combat Tuberculosis
PNS	: National Health Policy
PROSAMI	: Maternal and Child Health Project
HRMIS	: Human Resources Management and Information System
SSQH	: Quality Health Services for Haiti
SYSEP	: Performance Evaluation System
UNICEF	: United Nations Children's Fund
USAID	: United States Agency for International Development

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INTRODUCTION

The strategic importance of human resources in an organization is self-evident. They are not part of the company; they are the company itself. The people constitute a competitive advantage for the organization and, all else being equal, human resources are what make the difference between two companies. Therefore, it is extremely a propos that Henry Ford, the father of the automotive industry, was able to say, "My factories can all be burned and that is not the end since I can rebuild them, but the loss of all my employees would be disastrous for me and would leave me with nothing."

In the health sector, the importance of the area of human resources was confirmed by the WHO in describing the six building blocks of the health system. Without human resources, no major initiative in the health sector can have any chance of succeeding.

For Peter Drucker, "The best way to predict the future is to create it," hence the importance of strategic planning. However, one of the crucial steps of that key function of management is situational analysis. It is its foundation, its base, its bedrock. It reveals what is not working, clarifies dysfunctions, draws attention to danger signs, and makes it possible to identify high-priority problems to be addressed in interventions to provide the desired change, and create the desired future.

This situational analysis of the field of human resources for health in Haiti follows that logic. It prepares for formulating a development strategy that is in sync with national and international health priorities so

the country can fit harmoniously into the concert of nations. With a view toward Universal Health Coverage, as the country has chosen a health care organization model based on polyvalent community health agents, the analysis will give special attention to them.

In its organization, the document will use the following structuring:

- Context (1)
- Goals and methodology (2)
- Analysis of the situation (3)
- Summary of opportunities and challenges (4)
- Recommendations (5)

I. CONTEXT

According to the approach adopted for Haiti, the situational analysis is the third milestone on the way to formulating a human resources development strategy. It follows two successive evaluations done in the area of human resources for health with support from the Health Finance and Governance (HFG) project, financed by the USAID. The first, ERHIS 1, done in 2014, concerned the public health sector. The second, ERHIS 2, done in 2016, targeted the private health sector.

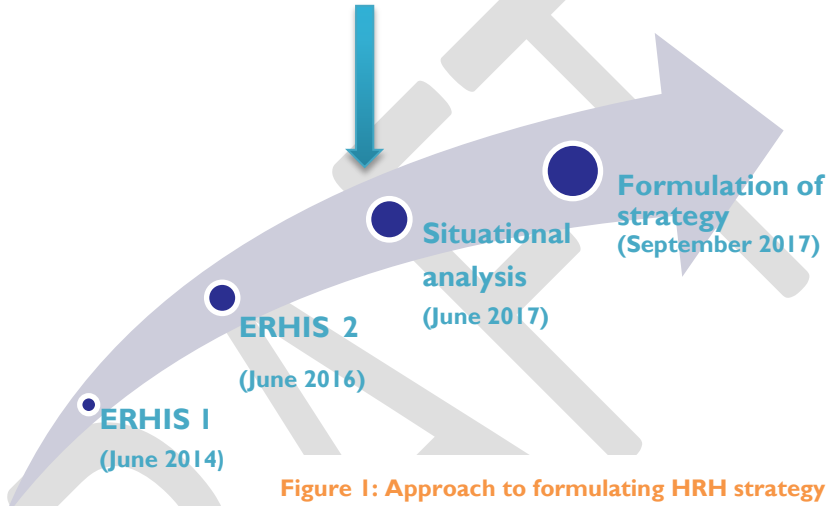


Figure 1: Approach to formulating HRH strategy

ERHIS 1 revealed the human resources for health available in the public sector in Haiti in terms of workforce, profile, distribution, financing, and management at the decentralized level. ERHIS 2 established the landscape of human resources for health in the private sector in Haiti based on the following five variables: workplace or setting of health professionals in the private sector; profile; distribution; financing; work conditions.

Each ERHIS is the product of a broad national consultation process. In fact, for ERHIS 1, the process of data collection and processing took seven months, from November 2013 to June 2014, following a participative approach engaging nearly 300 actors (30 per regional validation workshop, which occurred in each of Haiti's 10 regional health departments) including all HR focal points of the central, regional and operational levels of the MSPP. ERHIS 2 followed the same approach and took 10 months from September 2015 to June 2016 with a work methodology involving the directors of the private health institutions.

In total, more than 500 actors in the public and private sectors were involved in the process of collecting, processing and validating the data of the two reports. Now, this situational analysis summarizes those evaluations by highlighting the key problems identified.

2. GOAL AND METHODOLOGY

Jean Marie Peretti said there are no universal practices in human resources management. The effective practices, he continues, are those that are adapted to the context and make it possible to meet the challenges that a company must face[1].

Based on the lessons of the two ERHIS human resources for health data audits, the document reviews made it possible to define a work methodology for doing the situational analysis.

2.1. Goals

2.1.1. General goal

To present information useful for formulating a national strategy for development of human resources for health.

2.1.2. Specific goals

The situation analysis will provide an overview of:
- the availability of human resources in the health system;
- the production of human resources for health;
- the labor market;
- the distribution of health workers;
- human resources organization and management;
- financing of the area of human resources.

2.2. Methodology

For its realization, this situational analysis of the area of Human Resources for Health in Haiti is based on three (3) frames of reference:
- a general analysis framework provided by the **"Country Health Intelligence Portal CHIP)"** of the WHO;
- an analysis framework specific to the area, the " **House Model**" developed by the JICA;
- a contextual framework specific to the country, established by the orientations given by the National Health Policy document.

[1] Jean Marie Peretti, *Gestion des ressources humaines* [Management of Human Resources], 20th Edition, Vuibert, 2015, Paris, France.

2.2.1. The "Country Health Intelligence Portal" (CHIP)

The CHIP tool was developed in 2010 to provide a guide for Evaluation of the Performance of a National Health System. It considers the six building blocks of the health system. The area of human resources is reviewed based on the following six variables:

- Organization and management of human resources for health
- Methods of remuneration
- Inventory and distribution of human resources for health
- Education and training
- Planning of human resources for health
- Professional path, in which international migration problems play a prominent role, in addition to the career plan.

2.2.2. The "House Model"

Conceived in 2010 as part of a training cycle in Japan for managers of human resources for health in order to strengthen competencies to effectively address the problems of the human resources area, the **"house model"** analysis matrix was developed according to a philosophy borrowed from the field of architecture.

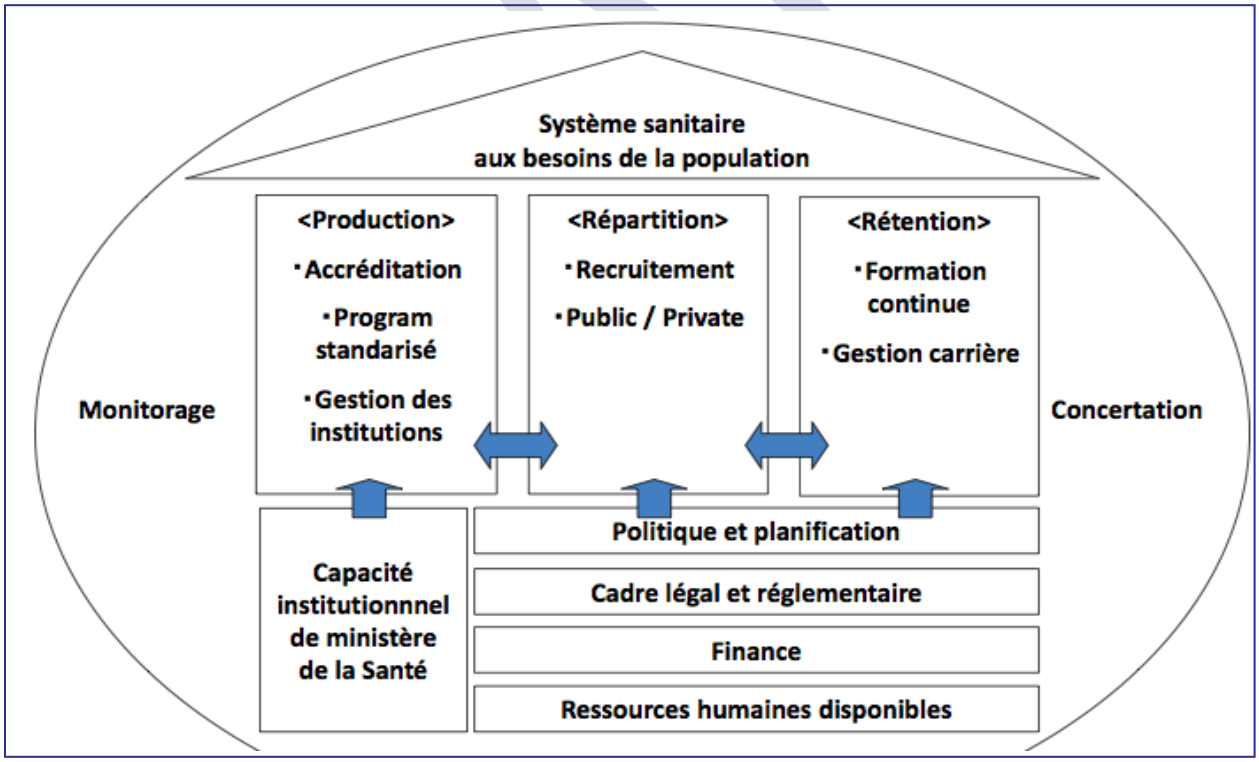


Figure 2: "House model" human resources situation analysis matrix

- The foundation of the house rests on four blocks: (1) available human resources, (2) financing, (3) statutory and regulatory framework, (4) policy and planning
- The front door to the house it is the institutional capacity of the Ministry to manage human resources for health
- The walls of the house are made up of (1) the production of human resources, (2) their geographic distribution and (3) their retention/loyalty in the health system with all related issues
- The roof of the house covering it all is the health system that meets the public's health needs
- A fence made up of two key items surrounds the house: (1) the monitoring of HR data using a HRMIS and (2) the framework for dialogue of stakeholders for keeping track of interventions and decision-making.

2.2.3. Orientations of the NHP

The orientations of the NHP were used as a reference in devising the 2012-2022 Health Master Plan. The vision that it lays out cannot be clearer: "*Over the next 25 years, in a context of articulated and dynamic socio-economic development, the Haitian health system evolves and morbidity-mortality decreases significantly. Haitians have fair access to the high-quality services and care defined in the Essential Package of Services, adjusted if need be, considering the changes in the epidemiological and demographic profile*." For the area of human resources, the main goal pursued consists of streamlining the use of labor following the norms and standards of allocation by category of health institutions. More specifically, the strategy will be:

- To plan the health workforce
- To devise the legal framework regulating the health professions
- To establish standards and procedures of accreditation of institutions that train the health professionals
- To standardize the training of the various categories of health professionals and paramedical workers
- To streamline the distribution of human resources over the territory
- To create a work environment and conditions conducive to productivity of human resources
- To see to the continuing education of human resources
- To streamline the management of contractual workers over the long term
- To strengthen institutional capabilities for evaluating the performance of human resources
- To review the system of granting and renewing the licenses for health professionals

The examination of all these general, specific and contextual parameters in light of the information available based on the ERHIS 1, the ERHIS 2 and the other document reviews has made it possible to build an analysis grid following the following logic of intervention:

- Availability of human resources in the health system
- Production of Human Resources for Health in Haiti
- Labor market
- Distribution of HRH
- Organization and management of human resources
- Financing of the area of human resources

Because of its specificity, the topic of PCHAs will be a separate focus.

3. SITUATIONAL ANALYSIS

3.1. Analysis of human resources for health

3.1.1. Preliminary: Definition of human resources for health

Health workers are defined as "people whose job it is to protect and improve the health of their communities"[2]. They include people who provide health services, such as doctors and nurses, as well as people who perform support functions, such as hospital administrators or ambulance drivers. Therefore, Human Resources for Health are all workers who contribute directly (service providers) or indirectly (support) to public care offerings.

It is necessary to make a distinction between **health professionals** and **health workforce**. The term health professional has a narrow meaning and refers to service providers, i.e. professionals in the sector who have a health diploma. The term "health workers" is broader and indicates all those who work in the health sector, whether they be service providers or not.

Figure 3: A doctor sees a patient

Human resources for health save lives. The WHO has established[3], based on three key professional categories, i.e. doctors, nurses and midwives, that the number and the quality of these workers influence vaccine coverage, the extent of primary health care and maternal and child survival. The chances of survival of the mother, the child and the newborn baby increase with the availability of high-quality HRH in those three professional categories, whose workers are used as the basis of calculation in the report on population. For that reason, the situational analysis will place special emphasis on them.

3.1.2. Availability of Human Resources in the Haitian health system

What is the current status of human resources in the Haitian health system? This first point of the situational analysis presents the workforce data and does a quantitative and qualitative evaluation of them.

[2] WHO, World Health Report, 2006.

[3] World Health Report, 2006, op cit

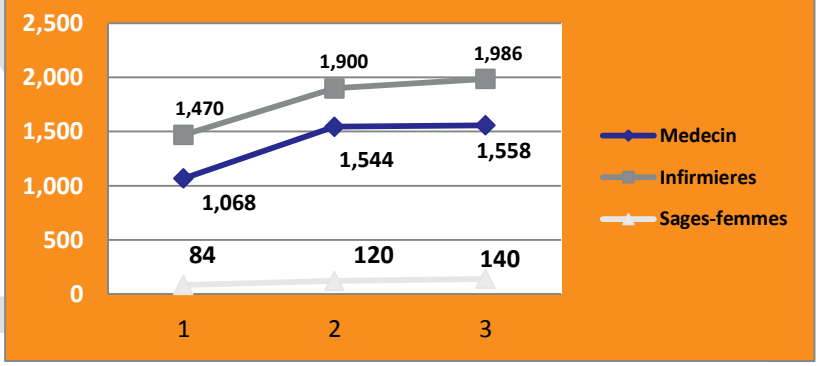
3.1.2.1. Workforce

3.1.2.1.1. Public sector

With a population estimated at 10,579,230 in 2013, of which almost half (49.74%) live in rural areas, The ERHIS 1[4] HRH data audit established that the public health sector in Haiti had a workforce of 13,014 employees as of June 30, 2014. These 13,014 employees included 1,068 doctors, 1,470 nurses and 84 midwives. The general workforce increased to 15,384 employees as of June 30, 2015, then to 15,980[5] as of June 30, 2016: this represents a 2-year increase of 2,966 employees (23%) due to recruitment performed over that period.

The trends in the key professional categories over the same period indicate that the number of doctors in the public sector increased almost by half (46%) from 1,068 as of June 30, 2014 to 1,558 as of June 30, 2016. The number of nurses increased by one third (34%) from 1,470 to 1,986, and the number of midwives increased by 67% from 84 to 140. Of the three, midwives represent the professional category that experienced the largest quantitative increase in employment, due to new interest that the MSPP has shown in expanding direct population access to the midwives career track in order to help reduce poor maternal and child health outcomes.

Figure 4: Change in number of doctors, nurses and midwives in the public sector



3.1.2.1.2. Private sector

The ERHIS 2[6] HRH data audit identified as of June 30, 2016 a total number of 7,191 health professionals active in the private health sector[7], including: 1,048 doctors; 2,241 nurses, 48 midwives and 3,854 workers in the other categories of employment (i.e. pharmacist, dental surgeons, nurse's aides, medical technologists).

In total, as of June 2016, the public and private health sectors had a workforce of 2,606 doctors, 4,227 nurses and 188 midwives, i.e. a total of **7,021** professionals.

[4] ERHIS 1: Evaluation of Human Resources of Health Institutions in the public sector

[5] HRMIS data

[6] ERHIS 2 : Evaluation of Human Resources of Health Institutions in the private sector

[7] All private sector types combined (profit and non-profit)

3.1.2.1.3. Polyvalent Community Health Agents (PCHA)

Since the Declaration of Alma-Ata in 1978, primary health care has become a basic concept in public health, which has given rise to Universal Health Coverage (UHC). The community health strategy means real participation of the community in improving its health[8]. The issue is simple: "to no longer act just at the final stage of care, but far upstream on all determinants of health: environmental, economic, political, social, cultural, to minimize the recourse to increasingly expensive care, in the manner most adapted to everyone's needs"[9].

Conscious of the importance that such an approach has for the effectiveness of the health system, the MSPP developed a Community Health Care organization model formalized by the Document of Essential Package of Services (PES) officially launched on September 1, 2016. That model is based on Polyvalent Community Health Agents (PCHA) deployed in the community and attached to first-level community health institutions. Those are part of a technical and administrative team, entitled **Family Health Team (FHT)**, which provides coordination, planning and supervision of first-level health services. That team is made up doctors, nurses, nurse's aides and community health agents[10].

As of June 2017, the MSPP had 3,036[11] PCHAs working for a total need of 10,920 necessary to cover the entire national territory. All those PCHAs are financed by donors, 51% of them by the SSQH Project alone, which is present in the 10 health regions of the country. Since donors operate by Project cycle, sustaining the financing of the PCHAs is a big problem for the Haitian health system today. In light of that fact, this point of the analysis is discussed at greater length in Section 3.2.

3.1.2.2. Quantitative and qualitative inadequacy of availability of HRH

Do the HRH workforce presented above meet the needs of the health system? In reality, the MSPP is facing a problem of quantitative and qualitative inadequacy of its workforce.

3.1.2.2.1. Quantitative inadequacy: a shortage of service providers

With an average of 0.65 health professionals per 1,000 inhabitants[12] (0.59 doctors or nurses per 1,000 inhabitants) far below the minimum threshold defined by the WHO, which is 2.5 health professionals (doctors, nurses and midwives) per 1,000 inhabitants[13], Haiti is one of the 57 priority countries in the world and one of the five (5) of the America-Caribbean zone which have an acute crisis in the HRH area. Those data merely confirm the diagnosis done one year earlier (2011) by the Global Health Workforce Alliance, which indicated a density of 0.36[14] health professionals per 1,000 inhabitants. Nearly a half-decade later, in June 2016, the data have changed little. Indeed, the report of the combined workforce of the public and private sectors mentioned above on the population estimated in 2015 at

[8] MANCIAUX M. and DESCHAMPS J.P. *La santé de la mère et de l'enfant* [The Health of Mother and Child]. Paris, Flammarion Médecine Sciences, 1978, p. 31

[9] Dr PIERRE LARCHER, communautaire community health

[10] Ideally, a Family Health Team covering a population of 60,000 inhabitants is composed of 60 PCHAs (one agent per 1000 inhabitants), 4 nurse's aides, 2 nurses et 1 doctor. That proportion may be lower or higher depending on demographic dispersion and geographic accessibility.

[11] Administrative data, Community Health Service, DPSPE, MSPP

[12] National Health Policy Document, Haiti, 2012, P. 27

[13] WHO, World Health Report, 2006.

[14] Report on progress made in priority countries in application of the Kampala declaration, GHWA, 2011

10,911,819[15], gives a result of 0.64/1,000 inhabitants. To meet the ratio recommended by WHO, a meaningful coverage of that population would require a workforce of **27,280** key health professionals (doctors, nurses and midwives together for both sectors combined), which naturally means an adequate expansion of the network of health infrastructures to be able to accommodate them. It follows that, in the current situation there is a shortfall of **20,259** professionals. But how can that stagnation of the situation in Haiti be explained?

A detailed analysis of the workforce data in the key professional categories show, for example, an acute shortage of midwives (1 per 33,211 women of childbearing age). This shortage can be explained by the fact that, in Haiti, the occupation of midwife is first and foremost a nursing specialty. The low number of midwives is likely to have a negative influence on maternal health indicators. The qualitative inadequacy of the workforce provides other explanations for the insufficient number of service providers. All that said, the production of this professional category has been part of recent MSPP initiatives to improve access to maternal and child health services.

3.1.2.2.2. Qualitative inadequacy: there are almost as many administrative workers as service providers in the system

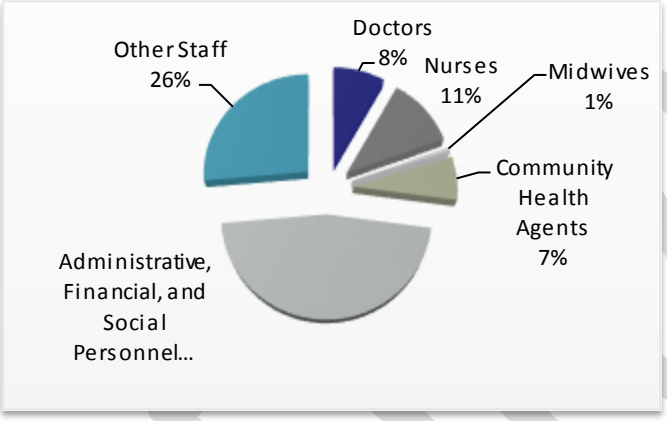


Figure 5: Workforce deployment by professional category

The data in the ERHIS I showed that the public health sector has 53% service providers versus 47% administrative workers. However, for a sector like healthcare whose primary mission is to provide health care to the public, the workforce balance should be tilted far in favor of service providers. As an illustration, a country like Côte d'Ivoire has a percentage of 85%[16] service providers versus 15% administrative workers.

That analysis reveals that one of the reasons for the insufficiency of service providers in the Haitian health system is to be found in recruitments. The system would gain by bringing the balance of its workforce into more reasonable proportions by focusing on the recruitment of service providers.

Those developments lead to a question: Do the training institutions produce sufficient health professionals to supply the health care system? The analysis of the labor market and production in the health sector will illuminate certain elements of response.

[15] IHSI projection

[16] MSHP, *Plan stratégique de développement des ressources Humaines de la sante* [Strategic plan for the development of human resources for health] 2009-2013, Cote d'Ivoire, 2008

3.1.3. Analysis of production of HRH in the system

The area of initial training of health professionals is very liberalized in Haiti. For some time now, the MSPP has made an effort at regulation through the activity of accreditation of Schools that provide training in nursing sciences. That measure will need to be expanded to institutions that train other professionals.

3.1.3.1. Production of doctors

In 2016, the country had five (5) accredited Medical Schools that together have an annual average production capacity of 352 students:

- The School of Medicine and Pharmacy (FMP): 77 students
- The Quisqueya University (UNIQ): 65 students
- The University of Notre Dame of Haiti: 100 students
- The Lumière University (ULUM): 50 students
- The University of the Aristide Foundation (UNIFA): 60 students

Among those schools, only the FMP is public. Specialist training is done through hospital residency established by law in 1982.

3.1.3.2. Production of nurses

According to the administrative data of the DFPSS, in terms of institutions that provide training in nursing sciences, the country has five (5) public schools (four National Nursing Schools-ENI in Port-au-Prince, Cap, Cayes, Jérémie, one School of Nursing Sciences - FASI in Gonaïves) and more than 400 private schools, 89 of which are in the process of accreditation. The ENI and the FASI together produce on average 443 nurses and the private schools in the process of accreditation produce 3,791 nurses; that gives an annual production capacity of 4,234 nurses for the entire country, not counting those graduating from schools that are currently not in the process of accreditation.

On the State examinations in the summer of 2016, the number of candidates (graduates of training schools) were 3,006, among whom 2,800 actually sat for the written examinations. The success rate was 2%. The Bachelor of Nursing, which authorizes one to practice the profession, is awarded only to those who pass the state examinations.

3.1.3.3. Production of midwives

Until 2013, the profession of midwife was a nursing specialty. Considering the problems related to Maternal and Child Health, the career track was opened through direct access at the Institute of Higher Education of Midwives of Haiti (*Institut Supérieur de Formation des Sages-Femmes d'Haïti* - INSFSF), which has produced 75 midwives a year on average since 2015.

3.1.3.4. Production of other professionals

Also according to the administrative data of the DFPSS, the country produces on average 37 dental surgeons, 44 pharmacists and 85 medical technologists.

3.1.3.5. Social service

The institutional framework of the Social Service was established by law in 1981. It is a service to the State (just an emolument is paid) which is mandatory for health professionals who have graduated from private and public institutions of Haiti and abroad on the condition that the diplomas issued by them be accredited. The duration of the Social Service is 12 months. It starts in October and results practically in the issuance of the professional license.

3.1.4. The labor market

3.1.4.1. Recruitment

Even though they do not give a precise account of the recruitments done due to annual attrition, the changes in the workforce of doctors, nurses and midwives enlighten us as to the recruitments done in recent years by the ministry in those key professional categories. We note from 2014 to 2016 an annual average recruitment of 245 doctors, 258 nurses and 23 midwives. In spite of the difficult socio-political and economic climate in recent years, we must recognize here the significant efforts made by the State to meet the new needs.

Year	2014	2016	Change	Annual average
Doctors	1,068	1,558	+490	245
Nurses	1,470	1,986	+516	258
Midwives	84	140	+56	23

Table 1: Change in workforce of doctors, nurses and midwives

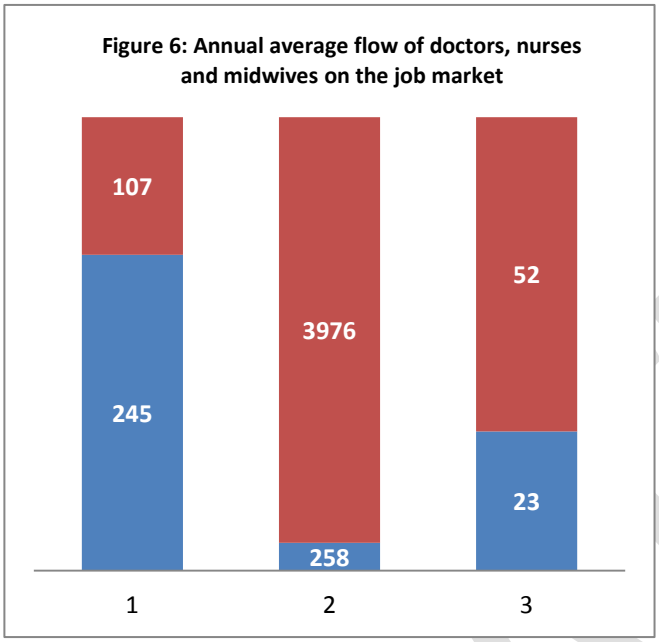
3.1.4.2. Flow of workforce in the labor market

Professional categories	Annual average production	Annual average recruitment	Variation	Percentage of remaining stock
Doctors	352	245	-107	30%
Nurses	4,234	258	-3,976	94%
Midwives	75	23	-52	69%

Table 2: Evaluation of number of health professionals available on the job market

Table 2 and Figure 6 show the number of

health professionals available on the labor market following the recruitment done by the Government.



- ❑ It appears that 30% of doctors, 94% of nurses and 69% of midwives trained are rejected on the labor market if they are not recruited by the private sector

- ❑ Those numerous residual workers are potential candidates for self-employment or international migration.

- ⇨ We can conclude from this phase of the analysis that the needs of the Haitian health system are enormous (shortfall of 20,259 divided between the public and private sectors). It would take several years to fill them, unless the State does extraordinary recruitments en masse to meet that need. In the current situation, only 1/3 of the needs of the system are being met (7,021/20,259). Although significant, the recruitments done by the State are insufficient. The situation is even critical for midwives, for whom, in spite of an increased shortage, the State has not managed to absorb the trained quotas.

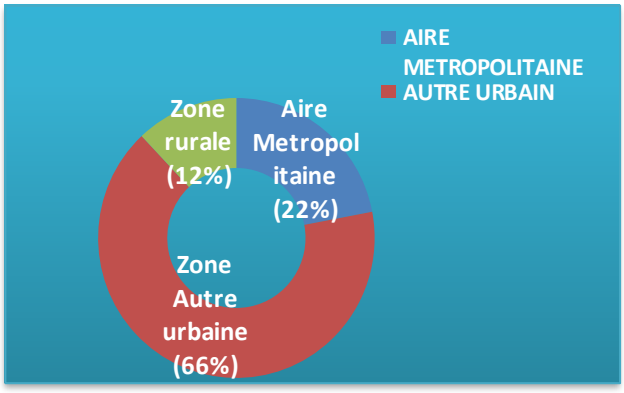
Consequently, another question that one could ask is whether the available workforce is distributed rationally to meet the public health demands. Hence the analysis of the distribution of human resources.

3.1.5. Analysis of distribution of HRH

This analysis will be done on three levels: geographic, sociodemographic and structural.

3.1.5.1. Geographical distribution

Almost all countries in the world suffer from poor workforce distribution characterized by a concentration in cities and a shortage in rural areas. The case of Haiti does not deviate from that pattern, which calls attention to the crisis in human resources for health throughout the world.



This graph (source: ERHIS1) on the residence setting of health workforce indicates in total that 88% of HRH work in urban areas. However, nearly 50%[17] of the country's population lives in rural areas. It seems urgent, under these conditions, to develop strategies in order to attract qualified workers towards rural areas. In that regard, the experiences of the private sector (40% of professional in rural areas; Source: ERHIS 2) could help to provide lessons and improve public sector distribution.

Figure 7: Geographic distribution of HRH in Haiti

3.1.5.2. Sociodemographic distribution

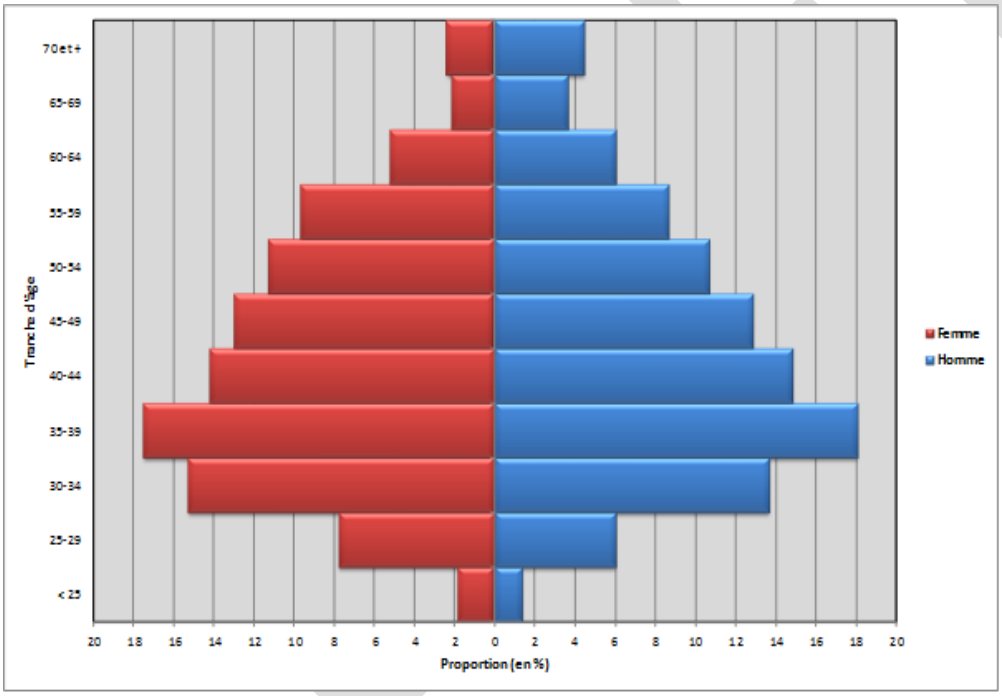


Figure 8: Age pyramid of health workforce

The "spinning top" configuration of the pyramid of the health workforce in the public sector reveals that:

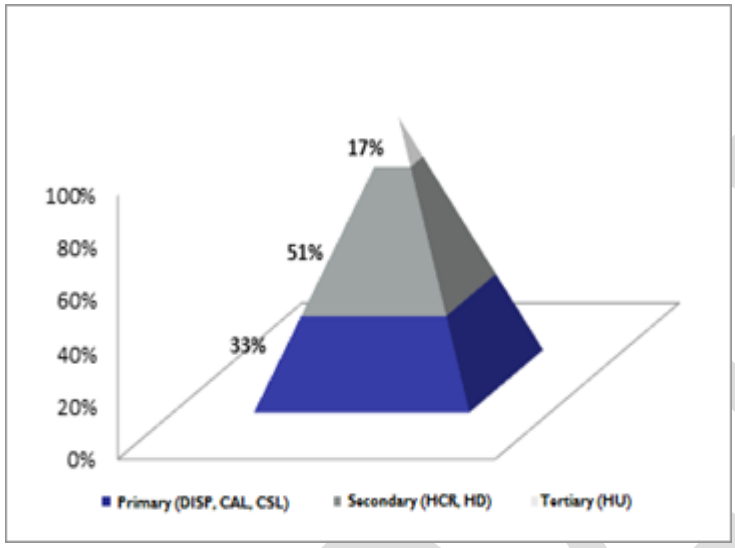
- 1/10th of the current workforce of the MSPP has reached the statutory retirement age, which is 58 years
- In the 10 next years, another fifth of the workforce currently working will have reached retirement age;

[17] 49.74% according to the *l'Annuaire Statistique* 2013 (2013 Statistical Yearbook) of the MSPP

- So the Haitian health system risks losing almost 30% of its current workforce.

Hence, it is urgent to act now in anticipation of the need for replacement, so as not to compromise the sustainability of the system.

3.1.5.3. Structural distribution



- The study of the distribution of the health workforce in the health pyramid shows a strong concentration in the secondary to the detriment of the primary, which, however, constitutes the entryway into the system. Two-thirds (2/3) of health professionals are in hospitals.
- This structuring poses the problem of access to qualified professionals by people living in rural areas (50% of the population).
- There is a quantitative and qualitative imbalance in the distribution of the workforce at the various levels of the care slope of the health pyramid.

Fig … by level on the he… pyramid

At this stage in our analysis, the following finding can be made: not only is the workforce of the health ministry in the key professional categories insufficient, but the little that is available is poorly distributed over the territory and at the various levels of the health pyramid. The analysis of the age pyramid shows the possibility of increased problems. It seems urgent to take measures to redistribute the workforce particularly in favor of the primary level of the health pyramid and in rural areas. Consequently, we could wonder how the HRH are being managed.

3.1.6. Analysis of human resources management framework

3.1.6.1. The organizational framework

The management of human resources for health in Haiti utilizes several bodies external and internal to the MSPP, which must be known for an effective intervention.

3.1.6.1.1. Bodies external to the MSPP

- **The Office of Management and Human Resources (OMRH)**

The Office of Management and Human Resources, a strategic body of the Office of the Prime Minister, is the reference institution in matters of public policies. It sets the standards and procedures for management of human resources. Some time ago, this institution initiated a series of reforms to make the administrative apparatus of the State competitive. We can cite:

- Introduction of a Performance Evaluation System (SYSEP)
- The development of an interministerial system of human resource management (HRMIS)
- Development of a Plan of Action for Training and Continuing Education of ministries and bodies of the State (PAFP/MO)
- Devising a new salary scale based on grades and levels

The validation of the recruitment of civil servants falls within the competence of the OMRH.

- **The Ministry of Economy and Finance (MEF)**

The OMRH is the recruiting body, but the Ministry of Economy and Finance is the body that makes payments on behalf of the State. It manages the payroll and works closely with the MSPP DAB, which authorizes payments. Its correspondent within the MSPP is the Department of Administration and Budget, which authorizes the payments. In Haiti, 90% of the financial resources of the ministries go toward payroll. The introduction of the policy of paying salaries by bank transfer since June 2015 has unquestionable advantages, but it has reduced the possibility of oversight of the recipients of salaries. In principle, the salary should indeed be compensation for the service provided. And the Department of Human Resources should attest to that by the attendance report.

Note: Other external bodies such as the Superior Court of Accounts and Administrative Limitation (*Cour Supérieure des Comptes et du Contentieux Administratif* - CSCCA) and Office of the Prime Minister are involved in validating the contracts and appointment letters because of their financial impact (see Figure 10 below).

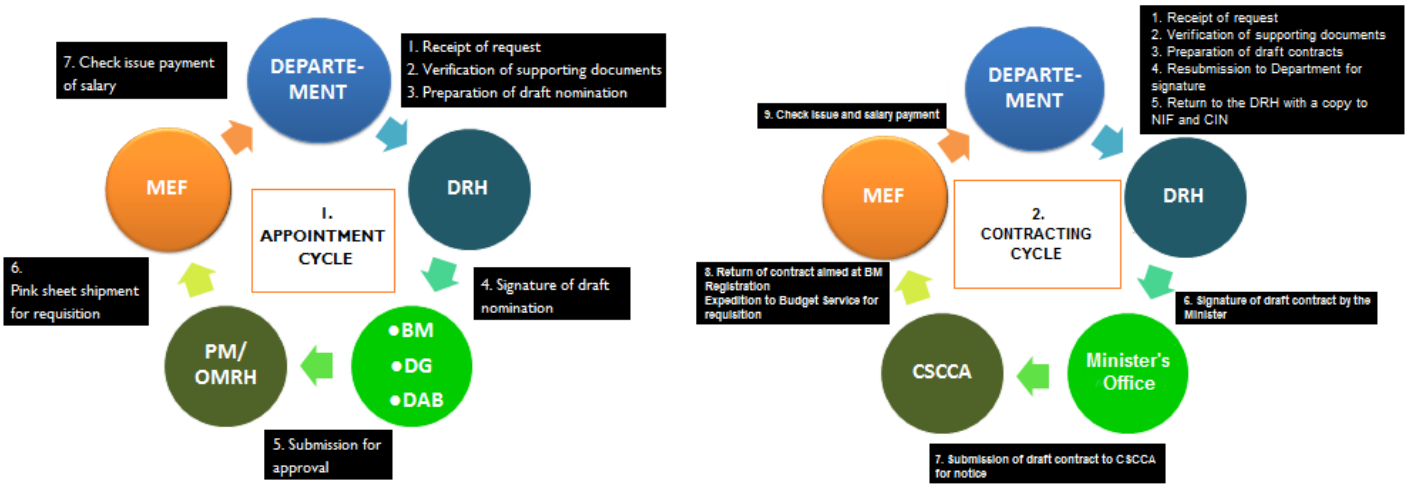


Figure 10: Appointment (1) and Contracting (2) Cycles in the Public Administration

Legend:

DRH = Direction des ressources humaines (Directorate of Human Resources); DAB = Direction de l'Administration et du Budget (Directorate of Administration and Budget); DG = Direction Générale (General Directorate); BM = Bureau Ministre (Minister's Office); PM = Premier Ministre (Prime Minister); OMRH = Office du Management et des Ressources Humaines (Office of Management and Human Resources);

CSCCA = Cour Supérieure des Comptes et du Contentieux Administratif (Superior Court of Accounts and Administrative Litigation); MEF = Ministère de l'Economie et des Finances (Ministry of Economy and Finances)

3.1.6.1.2. Bodies internal to the MSPP

- **The Department of Human Resources (DRH)**

In Haiti, the Human Resources for Health are managed jointly by the Department of Human Resources (*Direction des Ressources Humaines* – DRH) and the Department of Training and Continuing Education in Health Sciences (*Direction de Formation et de Perfectionnement en Sciences de la Santé* - DFPSS).

Under the decree of November 17, 2005, it is the mission of the Department of Human Resources to manage and optimize the workforce of the various categories of the Ministry of Public Health and Population, and promote and track the careers of the government employees and agents of the MSPP.

Thus worded, the institutional mandate of the DRH shows two (2) significant components:

- The typology of the health workforce in Haiti: based on their employability status, a distinction is made between permanent workforce (government employees) and nonpermanent workforce (contractual)
- The content or components of the management of Human Resources for Health in Haiti: it covers needs planning, recruitment, job assignment and career tracking of professionals based on current regulations. Issues of professional development are handled primarily by the Department of Training and Continuing Education in Health Care (*Direction de la Formation et du Perfectionnement en soins de santé* – DFPSS).

As for the DFPSS, it ensures the regulation of initial training and continuing training as well as the practice of the health professions (Article 31 of the Decree cited above).

With a workforce of 27 employees, the Department of Human Resources in its current configuration is essentially focused on administrative management. The department receives technical assistance from an embedded advisor from the HFG Project of the USAID.

- **HR Focal points**

The HR focal points are the extensions of the DRH in the services of the Ministry. They provide routine management of the workforce in their area of jurisdiction (institutions, health region). The appointment and contracting procedures are initiated by the latter in conjunction with the Departmental Directors as shown in Figure 10 on page 21.

- **The network of HR managers**

For effective tracking of human resources management data, the DRH and its subdivisions in the decentralized and operational services of the Ministry, which are the health regions and the university hospitals, have come together as part of the Network of Managers of Human Resources for Health of Haiti (RES-GRH). The members of this network meet at the end of every quarter as part of a Quarterly Review of human resources management activities.

Here also, other internal bodies such as the Office of the Minister, the Department of Administration and Budget, and Directors of health institutions are involved in management of human resources either in recruitment (appointment, contracting), or in career management (promotion, movements, disciplinary actions, etc.).

In sum, the human resources management function is a shared function. For effective management of human resources, it is important that the DRH be able to develop leadership strong enough to provide coordination of activities.

3.1.6.2. The management framework

The management of human resources in the health sector essentially consists of acquiring, maintaining and developing the workforce that the health system needs to meet the public's demand for care.

If we consider workforce recruitment as a benchmark, the management of human resources can be construed in three ways depending on the key concepts of the field:

- before recruitment: prospective management;
- when the recruitment has taken place: routine management or daily management or administrative management;
- after recruitment: strategic management.

When these various concepts of human resource management are made effectively operational, it can result in products or deliverables through mechanisms and management tools. To visualize the support provided to the Department of Human Resources / MSPP of Haiti as part of strengthening its management capabilities through the HFG project, a modeling of the support framework has been formalized in the following schema:

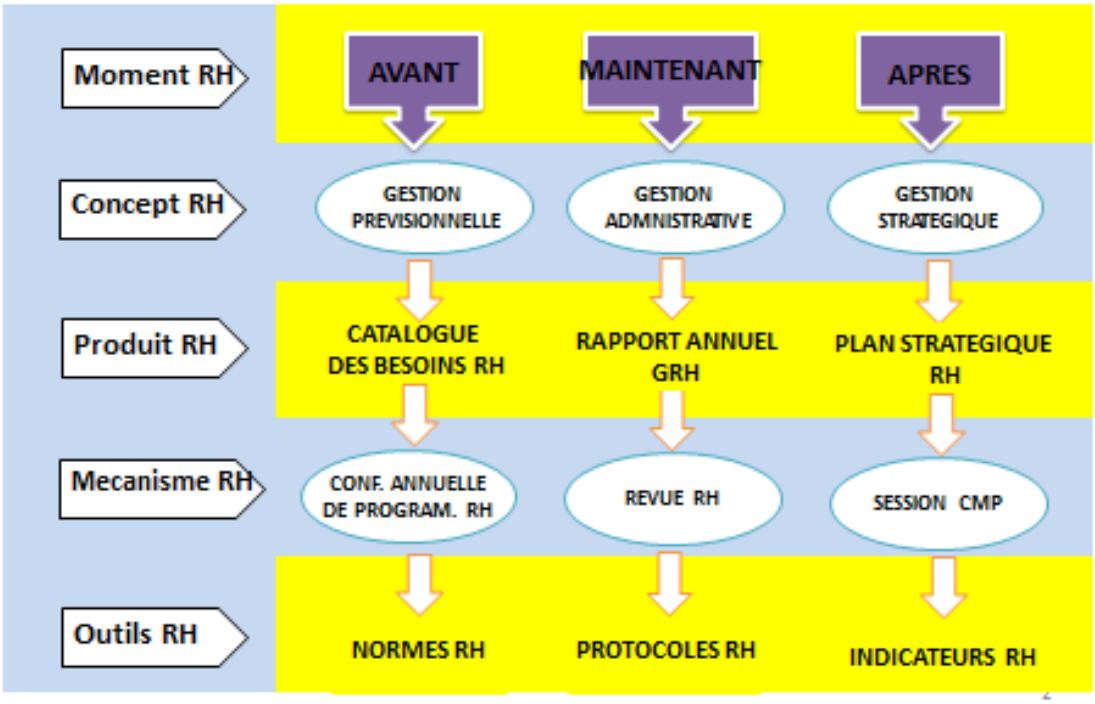


Figure 11: Modeling of management framework of human resources for health in Haiti

3.1.6.2.1. Prospective management

This precedes recruitment. It comprises all the operations that are for the purpose of precise identification of workforce needs. Considering the context of scarcity of resources, the needs expressed by the health institutions are the subject of arbitrage at an annual workforce programming conference. The needs adopted are set forth in the catalogue of needs, which serves as a reference for advocacy and recruitment.

3.1.6.2.2. Routine management or administrative management

Once the workforce has been recruited, it undergoes routine management or administrative management (transfer, promotion, attendance status, etc.) according to the established standards and protocols. The routine management data are tracked through periodic publications (quarterly). The data collected are processed and analyzed in the Annual Report on Human Resources Management (RAN-GRH), which gives an account of the management activities during a fiscal year.

3.1.6.2.3. Strategic management

Strategic management enables us to look toward the future by doing prospective management of HR to be in sync with institutional goals. Beyond the strategy document, it gives practical consideration to operations such as professional development and performance evaluation. It mobilizes all stakeholders around HR problems through a Multisector Steering Committee (*Comité Multisectoriel de Pilotage* - CMP) whose work results in the drafting of a strategic plan.

That theoretical management model specifically guided the implementation of the following key activities as part of support for the DRH/MSPP:

- Development of HR allocation standards
- Development of an HR procedures manual
- Setting up the network of HR managers and conducting quarterly Reviews
- Drafting an Annual HR Management Report
- Setting up a multisector meeting framework for formulating HR strategy

3.1.6.3. Tools for management of human resources for health

The management of human resources for health at the MSPP is based essentially on statutory and regulatory texts that the Department of Human Resources is in charge of applying, and on the HRMIS.

3.1.6.3.1. Statutory and regulatory framework

There are two fundamental texts of the Department of Human Resources.

- **The general charter of the Civil Service**

This is the reference text for the management of government employees. It specifies the methods of recruitment (through competitive process), career management and retirement of government employees.

- **The Labor Code**

This is the equivalent to the general charter of the civil service for non-governmental workers.

3.1.6.3.2. The HRMIS

The Human Resources Management Information System (HRMIS) makes it possible to record individual data on workers. It is accessible over the Internet in real time. The biggest challenge of the HRMIS is to perform regular updating because HR data are dynamic.

3.1.7. Financing of human resources

3.1.7.1. Legal status based on the employment contract

In Haiti, out of a total volume of 13,014 employees in the public health sector, there are five types of workers (table 7) when we consider the nature of their contracts. Among those workers, only the budgeted ones (64.19%) have permanent status. Conversely, this means that the care offerings in the public sector rely on 35% nonpermanent workers. When contracts do not get renewed, that can pose a problem of sustainability of the system and compromise the progress that has been made towards achieving the Sustainable Development Goals.

Type of contract	Workers	Proportion	Employability status
Budgeted	8,354	64.19%	Permanent
Contractual with MSPP	1,036	7.96%	Nonpermanent
Contractual with Donor	2,784	21.39%	Nonpermanent
By piece work	616	4.73%	Nonpermanent
By internship	224	1.72%	Nonpermanent
Total	13,014	100%	

Table 3: Volume of HR of the MSPP by type of contract

- Nearly 2/3 of workers on the job are budgeted (64.19%).
- All contract workers taken together represent just less than 30% of the workforce and are essentially financed by donors (21% of cases).
- 6% of the remaining workforce consists of piece workers and social service workers, all of whom also have nonpermanent status.

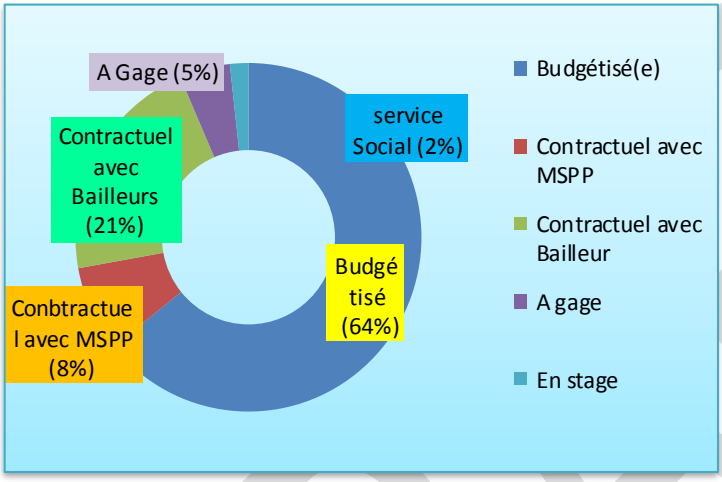


Figure 12: Representation of HRH workforce of the public sector in Haiti by type of contract

3.1.7.2. Phenomenon of double-employment

The ERHIS 2 revealed a phenomenon of double employment for 9% of the workforce in the private sub-sector; or even triple employment for 0.5% of them. The real extent of this phenomenon still remains to be determined.

3.1.7.3. Financial loss due to the phenomenon of "phantom" employees

The ERHIS 1 established that 6% of the employees of the MSPP (788 agents) were not on the job for various reasons, particularly: abandonment of job (15% of cases), academic leave[18] (9% of cases), death (8% of cases) or work disability (8% of cases). That job desertion by employees represented an annual financial loss for the State estimated at more than 130 million gourds (nearly $US 3 million). Since then, the MSPP has made significant efforts (notably, the special operation of payment by check, the

[18] These are unauthorized academic leaves.

introduction of attendance sheets) to clean up its workforce. As of September 30, 2016, the rate of "ghost" employees had dropped by 85% to around 118 employees.

3.1.7.4. International migration

One of the major problems in the area of human resources for health (HRH) of low-income countries where the health systems are already very fragile is international migration of health professionals. It creates shortages of skilled workers and serves to disorganize public care offerings. But what is driving it? In some cases, health workers leave their country of origin in search of better work conditions and career opportunities abroad. In some respects, that gives health workers an opportunity to improve their competencies, their work conditions and their economic prospects. But concurrently, it can cause increasing inequalities in terms of access to health care, within countries and among countries. That is why, to limit the problem, a Global Code of Practice for international recruitment of health workers has been devised under the leadership of the WHO and submitted for adoption by all Member States at the 63rd World Health Assembly in May 2010.

In Haiti, there is a real loss of health workers, which constitutes a true source of concern. Indeed, the ERHIS 1 highlighted job defection of at least 6% of the total number of employees in the public sector for various reasons, including job abandonments. International migration of health workers is strongly indicated as one of the reasons for that situation. But what is the real scope of that phenomenon? What are its decisive factors? What are the professional categories affected and why? What are the impacts on health coverage and what are the financial losses for the State? Those are questions that need to be elucidated as part of a study.

3.2. Analysis of the Area of Polyvalent Community Health Agents

3.2.1. A original community health care organization model

The MSPP has developed a model of organization of Community Health Care formalized by the Document of Essential Package of Services (PES) officially launched on September 1, 2016. That model is based on Polyvalent Community Health Agents (PCHAs) deployed in their communities and attached to first-level community health institutions. Those are part of a technical and administrative team, entitled **Family Health Team (FHT),** which provides coordination, planning and supervision of primary health services. That team is made up of a doctor, nurses, nurse's aides and community health agents[19].

The health model is graphically represented in the following figure:

Figure 12:

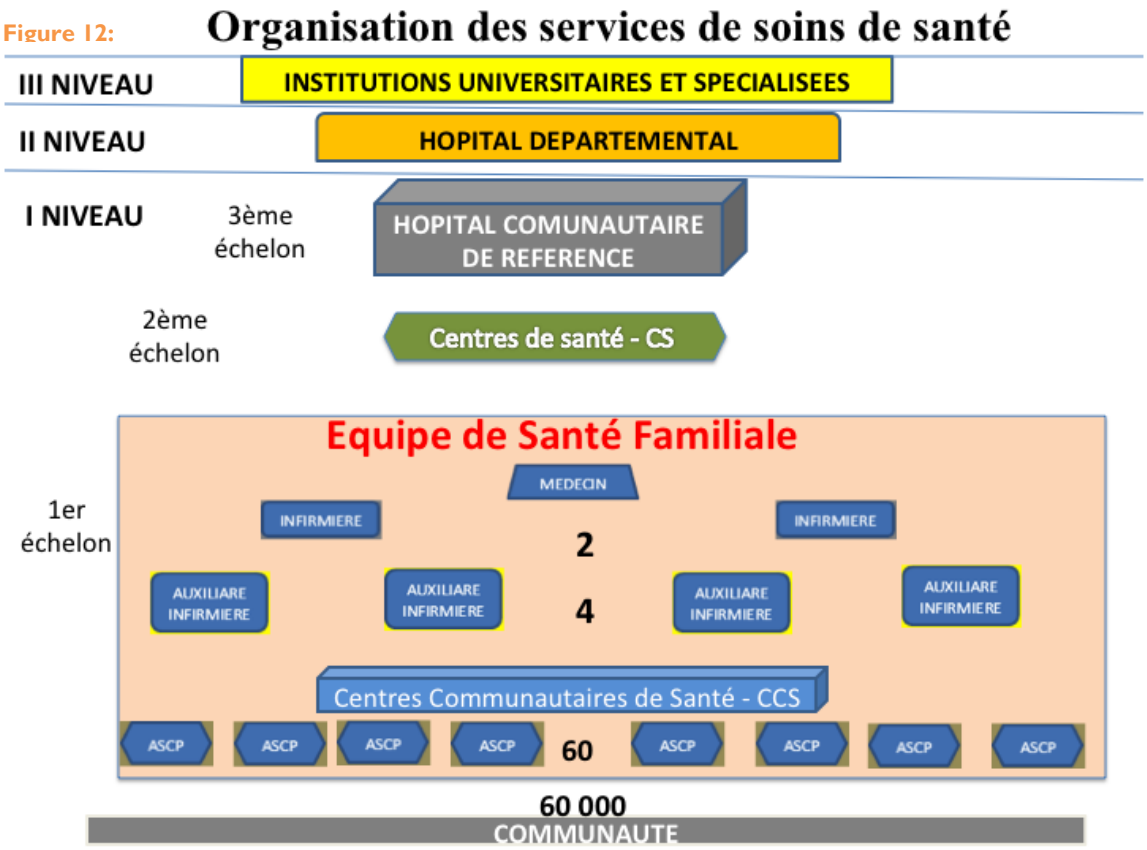


Figure 13: Health care organization model

[19] Ideally, a Family Health Team covering a population of 60,000 inhabitants is composed of 60 PCHAs (one agent per 1,000 inhabitants), 4 nurse's aides, 2 nurses and 1 doctor. That proportion may be lower or higher depending on demographic dispersion and geographic accessibility.

According to the demographic, geographic and socio-economic conditions and the availability of health services in the Districts and Municipalities, and considering that a Family Health Team covers a population of approximately 60,000 inhabitants, we estimate for national coverage, a projection of 182 Family Health Teams which, in total, must enlist:

- Doctors 182
- Nurses 364
- Nurse's aides 728
- PCHA s 10,920

The model will be implemented gradually, for its geographic expansion and for the conditions to be created in the network of services participating in the care continuum. The availability of human, material and financial resources, as well as the organization to be created in the network, will define the pace of that process.

3.2.2. Definition of the PCHA, role and responsibilities

3.2.2.1. Definition

The Polyvalent Community Health Agent is a member of the community, man or woman, chosen by the community and that, after special training, is part of the workforce of the Ministry of Public Health and Population.[20]

3.2.2.2. Profile

The profile of the PCHAs to be recruited must meet the following selection criteria:

- Be 18 to 35 years old

- Live in the municipality of intervention

- Have an academic level equivalent to or higher than the 9th year of fundamental schooling (not exceeding secondary school)

- Have the backing of the community (a reference from a notable person or a person known in the zone)

The candidate will also undergo a written examination based on general knowledge and an interview.

3.2.2.3. Role and responsibilities

- **Mission:** to help the community to solve its curative and preventive primary health problems, while working under the supervision of the medical and nursing staff of the institution to which he/she is attached.

- **Tasks:** the responsibilities for the PCHA cover the following aspects of health services
  - Promotion of child health
  - Promotion of family planning
  - Control of communicable diseases (typhoid, malaria, tuberculosis, filariasis) venereal disease and diarrheal diseases

[20] MSPP, DSI, *Responsabilités et tâches du personnel Infirmier, Auxiliaire Prestataire de Soins et Agent de Santé Communautaire Polyvalent* [Responsibilities and tasks of Nurses, Nurse's Aides and Polyvalent Community Health Agents], January 2015

- Environmental sanitation and hygiene
- Community development
- Health education

Therefore, the functional specifications of Haitian PCHAs consider the promotional, preventive and curative aspects of health.

3.2.3. A management framework in progress

PCHAs are managed at the MSPP by the Community Health Service (*Service de Santé Communautaire* SSC) of the Department of Health Promotion and Environmental Protection (*Direction de la Promotion de la Santé et de la Protection de l'Environnement* - DPSPE) created in 2016. That service is currently led by two very motivated community health nursing executives receiving technical assistance from the PAHO/WHO. The service collaborates with the Task Force for expanding the community health model set up by the MSPP and grouping together the internal Stakeholders and the technical and financial partners (*partenaires techniques et financiers* - PTF).

The SSC also has the support of the HFG project financed by USAID for developing its organic framework and devising strategic planning in the area of the PCHAs. The goal of that intervention, which, at the programming level, has been was attached to the SYSEP[21], is to make the service operational. That support is materialized by three (3) major outputs:

- defining the role and allocations of the service;
- developing an organizational flow chart;
- writing the job descriptions of the service.

There is an urgent need for a computer scientist to collect, process, and analyze data from community health activities.

Ultimately, strengthening the SSC's intervention capabilities by providing it with sufficient human, material and logistical resources to enable it to meet its mission is a necessity.

3.2.4. A problem of integration into the workforce of the MSPP

The employee's integration has an emotional dimension, which is defined with respect to his/her feeling of belonging to a staff, to a work team, to help to achieve organizational goals. It cannot be achieved by decree. It is the product of the recruitment process, which does not stop with the signing of an employment contract.

Indeed, how many cohorts of PCHAs have actually been received after their recruitment for an orientation session at the regional office in order to be briefed on the organizational culture of the MSPP and their work conditions within the institutions that they represent at the community level?

[21] Performance Evaluation System

Actually, the fact that the PCHAs are right at the end of the chain offering service to the public and to the community highlights the risk that they may be marginalized in the management of the regional staff of which they are an integral part. However here, it is plain to see that, in the current situation, there is true confusion in the administrative and technical management of the PCHAs such that, in many cases, they feel beholden only to the donor who pays them, under the principle according to which the salary is the compensation for the service provided!

3.2.5. Need to establish a distinction between the administrative and technical tasks of management of PCHAs

Something that confirms the problem of integration of PCHAs is the fact that they are not entered in the HRMIS of the MSPP even though it has a section "Donor contract worker" or "MSPP contract worker." That situation is reportedly due primarily to the fact that they are unknown to the local HR manager, who most of the time is not involved in the process of their recruitment. So, the community health nurse seems to be the main contact person to have individual information on the PCHAs within a health area while the PCHAs belong to the health system. In the final review[22] of HR management activities for fiscal year 2015/2016 done in December 2016 by the Department of Human Resources with HFG support, the community health nurses were invited to take part in the work of conducting a quick review of the PCHAs: the finding was unequivocal: in none of the 10 health regions was it possible to find a staffing agreement between the community health nurse and the HR department head, who feels that the management of them is done between the nurse and the technical and financial partner.

So we should clarify the fact that the administrative management (contract, work conditions) of the PCHAs should be handled by the regional HR manager and its technical management (activities, supervision) should be handled by the community health nurse. And that division of managerial tasks should extend up to the central level between the Department of Human Resources and the Community Health Service.

Figure 14: The PCHA management triangle

[22] The HR review is a quarterly exercise in monitoring and evaluation of HR management activities done by the Network of Managers of Human Resources for Health (RES-GRH) grouping together the HR Department and its divisions in the operational and decentralized services of the Ministry represented by HR focal points. The aim is to monitor the efforts to make optimal use of the workforce of the MSPP in order to guarantee health care to the public. The purpose of the quarterly reviews is to produce an Annual Report on Management of Human Resources (RAN-GRH).

In total, the analysis of the local management of the PCHAs shows three management functions:

- administrative management provided by the human resources manager
- technical management provided by the community health nurse
- financial management provided by the Project Administrator

3.2.6. Is the availability of HRH in SSH assured to meet the demand for the formation of Family Health Teams?

The theoretical framework of the community health care organization model provides for complete coverage of the country **182 Family Health Teams** with **182 doctors, 364 nurses and 723 nurse's aides** for supervision of 10,920 PCHAs. Does the Haitian system have, on first level of its health pyramid, enough health professionals to meet that need?

The SIGRH[23] of the MSPP showed at June 30, 2016 a total workforce of 15,980 employees, including 1,558 doctors, 1,986 nurses and 1,874 nurse's aides. The ERHIS[24] 1 showed a quantitative and qualitative imbalance in the distribution of workers on the various levels of the care slope of the health pyramid: only 1/3 of health workers work on the first level. That means an available workforce of **519 doctors, 662 nurses and 621 nurse's aides.**

A comparison of those data and the data of the organization model indicates that the MSPP has sufficient doctors and nurses to implement its policy. Moreover, the ERHIS 2 showed that there are more than 1,200 Aides working in the private sector with 40% working in rural areas. Consequently, the country reportedly has sufficient nurse's aides to implement the policy of the MSPP.

Only as the ERHIS 1 indicated, 88% of the country's health professionals are in urban areas. That means that making the care model operational should be accompanied by an HR retention strategy to attract qualified workers to rural areas.

Ultimately, the analysis of HRH availability in the Haitian health system shows that the two public and private sub-sectors combined have enough doctors, nurses and nurse's aides to form the Family Health Teams necessary for making the community health services organization model operational. Only it should be accompanied by a redeployment of workforce based on a retention strategy in rural areas.

3.2.7. The area of PCHAs receives much attention from donors in Haiti

A quick mapping of donors in the area of PCHAs shows a large number of participants covering the entire national territory, even though ultimately no health region is covered 100%.

[23] Human Resources Information and Management System

[24] Evaluation of Human Resources of Health Institutions in the public sector (ERHIS 1)

No.	Technical and Financial Partners	Areas of intervention (health regions)									Total
		DSA	DSC	DSGA	DSNi	DSN	DSNE	DSNO	DSO	DSS	DSSE	
1	Tripartite (Brazil-Cuba-Haiti)	X			X				X	X	X	5
2	Action against Hunger (ACF)	X	X					X				3
3	SSQH	X	X	X	X	X	X	X	X	X	X	10
4	Prisma	X										1
5	Zanmi Lasanté	X	X									2
6	Norway-Cuba-Haiti			X	X							2
7	National Plan to Combat Malaria (PNCM)			X								1
8	Haitian Health Foundation			X								1
9	CRS			X						X		2
10	CDS			X				X				2
11	Colorado project				X							1
12	PEPFAR					X						1
13	HCB					X						1
14	Haiti plan						X					1
15	OHMASS							X				1
16	PAHO/WHO							X		X		2
17	UGP/PEPFAR							X				1
18	GESKIO								X			1
19	St. Marguerite Foundation								X			1
20	ITECA								X			1
21	JOHANNITER								X			1
22	PROSAMI								X			1
23	Doctors of the World								X			1
24	Canada/WHO								X			1
25	Food for the Hungry (FFH)								X			1
26	CMMB										X	1
27	UNICEF										X	1
	TOTAL	5	3	6	4	3	2	6	10	4	4	

Table 4: Mapping of donors involved in financing of PCHAs

The analysis of the data in Table 4 shows several significant things.

- More than twenty donors are involved in financing the PCHAs. Although at first this situation appears to be a strength for the system by diversifying the financing sources, it carries within itself the seeds of its weakness when we know that each donor has its own specific mechanisms set by its funders.
- In spite of that diversity, there is unequal coverage of the territory owing to the fact that each donor has its area of intervention.
- So only an effective framework of coordination at the central level could guarantee synergy of action in the area.
- The SSQH project financed by USAID is the only project to be implemented at the same time in all 10 health regions of the country.

In sum, the analysis of the mapping of donors involved in financing the PCHAs shows that:

- strengthening the framework of coordination of the stakeholders is needed to orient coverage of the territory according to the health priorities and standardize interventions according to the standards defined by the Essential Packages of Services;
- the State could benefit from the experience of the SSQH project, which is the only one present throughout the country, in its strategy of expanding the community health care organization model.

3.2.8. Low appropriation of financing by the national party

One of the striking features regarding PCHAs in Haiti is the near-absence of the national party through the State or community in financing sources. Figure 15 shows the number of PCHAs covered by financing source.

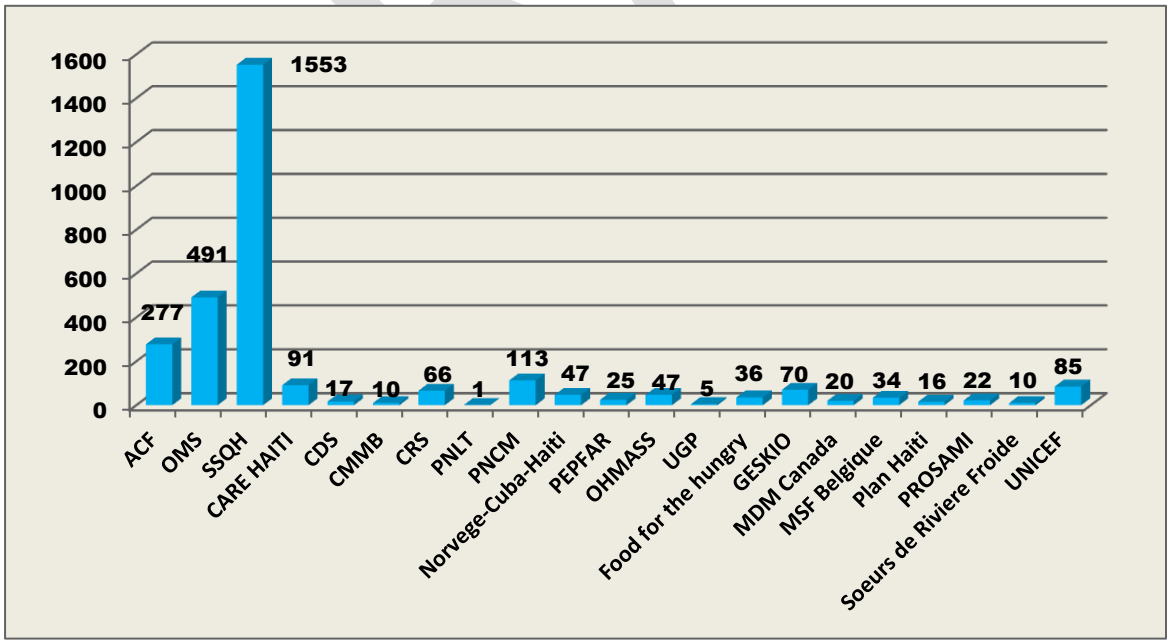


Figure 15: Distribution of PCHAs by financing source

The total number of PCHAs working is 3,036. The SSQH Project seems by far the largest employer. It covers more than half (51%) of the agents working. Three (3) other donors (WHO, ACF, PNCM) cumulatively provide financing for 29% of the workers. Hence those four donors alone cover 80% of the payroll of the PCHAs. The remaining 20% are covered by all the other donors combined.

While the political will has been affirmed in the choice of the health care model formalized by the Essential Package of Services document edited in October 2015 and published in September 2016. How under these conditions can one guarantee the continuity of interventions when we know that a project has a finite lifespan? In fact, despite the strong presence of donors, the area of financing of PCHAs in Haiti still remains quite precarious.

Ultimately, the analysis of PCHA financing sources presents the problem of low appropriation of coverage of those workers by the national party, which is a threat for sustainability. It seems urgent for the MSPP to initiate a review to assure the gradual transfer of salaries to the national budget or to develop new financing mechanisms.

3.2.9. Difficult work conditions

According to whether or not they are integrated into the workforce of the MSPP after their training, the table of PCHAs in Haiti is marked by a diversity of status. There are three of them:

- those that are trained and integrated;
- those that are trained, but not integrated;
- those that were trained, were integrated in the past and no longer are because their contracts have ended.

Table 5 shows the workers related to each one of these cases.

Items	Workers	Percentage
Number of PCHAs planned	10,920	100
Number of PCHAs trained	4,131	38
Number of PCHAs working	3,036	28
Number of PCHAs not integrated	1,095	10
Need for PCHAs	6,789	62

Table 5: PCHA activity status in the country

This table indicates that the total number of PCHAs planned for total coverage of the country is 10,920 (100%). To meet that need, 4,131 PCHAs (38%) have already been trained; of those, 3,036 have been integrated (28%) and 1,095 have not yet been integrated (10%). The quota of agents integrated in the past (whose volume remains to be determined by a complete mapping) can be found in the quota of the agents not integrated.

Those last two categories of agents carry the seeds of potential problems:

- whether they are waiting for a first job or to be called back, it is plain to see that those trained agents are like free electrons in the community. Consequently, the risk that they may operate on their own account by setting up shop as health professionals cannot be ruled out;

- that standby situation is also the source of some wastage, while there was a large investment for the training (the complete training of a PCHA costs on average 55,000 HTG i.e. approximately US$850);
- in addition, these unintegrated agents constantly put pressure on the State through more or less violent demonstrations to demand their integration;
- lastly, expirations of contracts are the source of interruptions in services, resulting in breaks in continuity or the care continuum.

Lastly, the analysis of PCHA activity status indicates instability in employment resulting in breaks in continuity of service, once again showing the need to guarantee a sustainable financing source.

3.2.10. Can a PCHA really do everything?

This point of the analysis leads us to question the PCHA's activity package in the context of integrating priority programs at the community level

According to the Revised Manual of Norms in Maternal Health, attendance at childbirth, including non-institutional deliveries, remains the primary allocation of trained matrons. But for all other areas, the Ministry's vision is to remove all vertical agents by transferring their responsibilities to the PCHAs.

However, such a change requires a considerable level of effort on the part of the latter given all of the tasks to be performed in compliance with quality standards; mainly with regard to HIV/AIDS prevention and care services.

This situation therefore requires more in-depth thinking before arriving at a final decision.

3.2.11. An adaptation/streamlining of standards is required

The ratio of 1 PCHA per 1,000 inhabitants was prescribed by the PES. The pilot project carried out in the commune of Carrefour, where 95% of the population live in an urban area, has shown that this ratio is suitable for the urban area where there is a high concentration of population in a small area. On the other hand, for the rural area, an adjustment is necessary considering the topography (high mountainous cover) and the spacing between residential areas. In the country, it takes sometimes 8 hours on foot in the mountains to reach two areas.

Another factor in favor of readjusting the standards is cost. The number of PCHAs is growing proportionally in reverse correlation to the number of inhabitants, which only further places a burden on salary expenses. The estimated cost of setting up a Family Health Team by the PAHO/WHO[25] considering three parameters (degree of expansion of the model, composition of the Family Health Team and ratio of population coverage of PCHAs) made it possible to distinguish between 64 different scenarios.

[25] PAHO/WHO, Organization of Community Health Services in Haiti, pilot project in the municipality of Carrefour [*Organisation of des services de santé communautaire en Haïti, projet pilote dans la commune de Carrefour*] 2011-2015, October 2016, pages 48-49

If the current standard were to remain unchanged, it would take more than $36 million to cover the 183 Family Health Teams to be formed, i.e., ¼ of the total current MSPP budget. In no country in the world with per capita income close to Haiti's is there such a ratio: according to the World Bank, the ratio is 1 per 2,435 in Ethiopia and 1 per 6,936 in Nepal. And even in Haiti, a study conducted by the World Bank including five organizations shows that all except for the Municipal Health Office of Carrefour have a ratio of more than 1,000 inhabitants per agent:

- HHF: 1,500 to 2,000
- FONDEFH: 8,600
- Mission Baptist and HAS: 2,400
- Zanmi Lasante: 3,000

In total, a fair balance that takes into account all of the data around this problem, is to be found for the redefinition of a PCHA/ Population ratio reference standard. In any case, an adaptation/ rationalization of this standard will be essential depending on the living environment to ensure the viability of the community health services organization model in Haiti.

3.2.12. Insufficient involvement of the community in solving its public health problems

One of the fundamental principles of primary health care is that *all human beings have the right and the duty to participate individually and collectively in planning and implementing their health care*[26]. This principle which supports community participation includes a sharing of cost that the community and the country can assume at all stages of their development in a spirit of self-responsibility and self-determination. That means that the community in its smallest unit should take charge of its public health problems.

In Haiti, the involvement of the community in solving health problems is a reality. This fact is the result of efforts undertaken over several years by the MSPP, particularly in the context of USAID-funded projects such as HS[27] 2004, HS 2007, or SDSH[28] which have integrated a community component into their interventions. These approaches have led to improved community participation in all health departments in the country through the development of support groups for health activities that are attached to health institutions. Among these could be mothers' clubs, groups of satisfied family planning clients, and community groups for emergency transport, especially in areas covered by HHF[29] and HBP / CBP[30]. All of these initiatives need to be supported for greater community mobilization in solving health problems.

According to the 2012/13 NHA[31] published in August 2015, households contributed to 32% of public health expenditures.

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[26] WHO, Declaration of Alma Atta, 1978

[27] Health System

[28] Santé pour le Développement et la Stabilité d'Haïti [Health for Development and Stability of Haiti]

[29] See Table 4, page 33

[30] Hôpital Bienfaisance de Pignon/Comité Bienfaisance de Pignon [Charity Hospital of Pignon / Charity Committee of Pignon]

[31] National Health Accounts

In such a context, community-based organizations (CBOs), which are part of a process whereby people living in close proximity to one another organize to promote their common interests, should be encouraged.

Associations of Community Health (ACH), through which populations organize themselves by pooling their efforts to take charge of their problems including the motivation of their health workers, made community health a success in Mali, a country with limited income. Such an approach could redirect donor funding by helping CBOs to identify income-generating activities that would be supported. By solving the problem of people's financial autonomy, the question of the perpetuation of the funding of the PCHAs is being solved at the same time while empowering the communities around their health problem.

4. SUMMARY OF OPPORTUNITIES AND CHALLENGES

The situational analysis of the field of human resources has revealed the following opportunities and challenges:

OPPORTUNITIES

- Existence of a national health policy document and a Health Master Plan 2012-2022
- Existence of a high-level authority (*Office de Management des Ressources Humaines* - OMRH) under the Office of the Prime Minister in charge of defining public policies for State human resources management
- Initiation of major reforms to make the administrative machinery of the State more effective
- MSPP, pioneer in making public reforms
- Existence of a functional website of the MSPP and an entity providing training in health administration
- Rich and flourishing pool of donors financing the field of human resources
- The country has enormous potential HRH with various competencies in the public sector and in the private sector
- Regular annual recruitment of HRH done by the State in spite of the economic and socio-political crisis
- Development of ERHIS 1 and 2, which have mapped HRH available in the country
- Sector of production of Human Resources for Health very liberalized
- Experience of a pilot project of Result-Based Financing in progress in an underprivileged area
- A Performance Evaluation System (SYSEP) is operational in accordance with the institutional framework layout by the Office of Management of Human Resources
- Existence of a Human Resources Management System and an updating mechanism instituted by quarterly HR Reviews
- Interconnection of the Department of Human Resources with the HR focal points of decentralized and operational structures through the Network of Managers of Human Resources for Health (RES-GRH)
- The Department of Human Resources participates in meetings of the global forum on human resources for health organized by the Global Health Workforce Alliance
- Haiti's acceptance as a member of the Réseau Vision Tokyo 2010 of managers of human resources for health of the French-speaking countries

CHALLENGES

- There is no framework of Coordination and Facilitation of stakeholders in the area of Human Resources for Health
- There is no national Strategic Plan for Development of Human Resources in the health sector: the process of developing that plan is constantly thwarted by institutional changes at the MSPP
- Low appropriation by the national party (State, community) of the coverage of PCHAs hence the problems of sustainability of their financing
- Disparities in the technical resources of health institutions of the same level such that it is not easily possible to implement a standard of the Human Resources for Health
- An increased need for medical and paramedical workers
- Unequal geographic and structural distribution of health workers
- Irregular distribution of electrical current and fluctuation in Internet connection speeds hinders the functionality of the Computerized System of Management in Human Resources for Health and consequently the real-time updating of the database
- Difficult geographical accessibility of rural areas because of topography
- There is no plan for retention of RHS in the rural areas that are hard to access
- Legal framework for regulation of health professions not yet adopted: nonexistence of professional associations; problem of ethics in the practice of the health professions
- Weak regulation of health institutions in the private sector
- The nomenclature of Civil Service jobs does not include certain types of staff important for the health care system, such as specialist physicians, who are placed on the same level as general practice physicians
- No career profile of health workers
- Small proportion of Human Resources for Health currently on the job area affected by continuing education
- Workers have high expectations for salary increases and there is a large disparity in salaries of workers in the same job and at the same level

Particularly for PCHAs, the following items are to be taken into consideration:

With regard to the opportunities

- Definition of a community health services organization model based on PCHAs
- Existence of the Essential Package of Services
- Definition of PCHA profile and a training curriculum
- Mobilization of donors around the problems of PCHAs
- Creation of a Community Health Service within the Department of Health Promotion and Environmental Protection
- Existence of focal points in the health regions (community health nurse)
- Existence of a network of PCHAs in all health regions even though no region is covered 100%
- Experience of a pilot project in the municipality of Carrefour in the Western health region
- Experience of organizations that have been offering community services for more than the past 25 years

With regard to the challenges

- Insufficient framework of coordination of the Stakeholders
- Weakness of the organizational and administrative framework of the area of PCHAs
- No control of workforce
- Central and decentralized actors have overlapping authorities in the management of PCHAs
- PCHAs are poorly integrated into the workforce of the Ministry
- Instability and precariousness in work conditions
- Inadequacy of regulatory framework
- The model is not financially viable in its current configuration
- National party does not participate in PCHA financing
- Package essential of services to be reviewed
- Low appropriation/sense of responsibility for the public health problems by the community

The analysis of all these strengths and weaknesses as part of a dialogue including all stakeholders based on criteria such as their acuteness and their impact on the health care system will make it possible to determine the high-priority problems that will be addressed in formulating the strategy. But some recommendations can be made right now.

5. RECOMMENDATIONS

The strengths and weaknesses indicated above provide a basis for making recommendations. In general, the recommendations are as follows:

- Accelerate setting up the Multi-Sector Steering Committee (framework of dialogue of stakeholders) in order to develop—in a participative and inclusive process—the strategic plan of Development of HRH and proper management of the sector
- Move toward setting up a National Authority for Oversight of Health Workforce in order to have a site specific to the field that assembles the information of the public and private health sectors,
- Develop the PPP by making a network of health institutions in the public and private sectors
- Continue to decentralize the Health HR management and information system (SIGRHS) to extend it to HR managers of health institutions and even to employees
- Improve the technical resources of health education institutions
- Revitalize the system of continuing education of HRH
- Strengthen the infrastructure, material and human capacities of the structures in charge of HR management at all levels of the health pyramid
- Develop the performance-based financing (PBF) approach to assure better loyalty and motivation of the workforce
- Develop a plan for retention/loyalty of staff in rural areas
- Regulate workforce mobility
- Regionalize workforce recruitment by opening the branches of health institutions as needed
- Extend the Performance Evaluation System (SYSEP) to the entire Ministry
- Advocate for the adoption of the legal framework of professional associations

The following recommendations are more specifically for the area of PCHAs:

- Make the Community Health Service more operational
- Do mapping of PCHAs
- Prepare the policy document and the national strategy of community health
- Provide initial training and continuing education of community health professionals
- Advocate for integrating the PCHAs into the national budget
- Review the Package of Essential Services of PCHAs
- Improve the PCHA/population ratios
- Organize the network of health centers
- Conduct an inquiry into vertical agents
- Support community pooling efforts to address its health problems
- Revise the framework and tools of the community health information system
- Define the indicators of performance of community health professionals

6. CONCLUSION

The analysis of the situation of human resources for health in Haiti shows various complex problems. They concern all aspects of the field;

- governance and leadership
- regulation and oversight framework, and tools and mechanisms of management;
- production, acquisition, maintenance/loyalty, professional development, motivation;
- financing;
- the framework of follow-up-evaluation.

These problems cannot be solved within the health sector alone, hence the orientation toward a much more comprehensive multisector solution involving all stakeholders. The creation of the Multisector Steering Committee (*Comité Multisectoriel de Pilotage* - CMP) for the process of devising and implementing the national policy of Human Resources for Health in Haiti fits within that perspective.

It makes it possible to give a comprehensive and inclusive response to the challenges identified in HRH. The Kampala Declaration[32], in its first section, invites government leaders to provide the stewardship to resolve the health worker crisis, involving all relevant stakeholders and providing steady political support for the process. This point constitutes the next ultimate stage of the process which should enable Haiti to obtain this important tool, which is the Strategic Plan for Development of Human Resources for Health (SPHRH).

[32] Declaration issued by the First Global Forum on Human Resources for Health held in Kampala in Uganda on March 2-7, 2008

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