3. AN INTEGRATED HEALTH CARE DELIVERY SYSTEM.

3.1 Preliminary Considerations.

There are many points on which there is disagreement even within the DSPP as to the desirability of different program strategies. But there appear to be two points on which there is widespread agreement. In the first place, few would disagree with the notion that serious organizational and logistical changes are needed within the DSPP. In addition most decision makers in the DSPP appear to be convinced of the need to extend health care delivery by a more direct penetration of the rural areas than is possible with a traditional dispensary model of health care.

This latter entails the selection and training of local people to become formally involved in the delivery of health services. The desirability of having such local personnel as part of the health team is now rarely questioned; it is the precise nature of their activities which is in question. Whereas some would restrict their activities to a promotional and information-gathering role, others advocate the provision of training which would enable them to provide certain types of minor curative services. In no case is the suggestion being made that the brunt of health care delivery should be turned over to underqualified amateurs. What is being suggested merely is:

1. the promotional and preventive-medicine activities of the village agents will be enhanced to the degree that they themselves can become local "medical figures" by providing certain minor but locally valued curative services;
2. there are in fact simple services that could be provided by paramedics without the need for lengthy travel on the part of a patient to a distant clinic.

The Projet Intégre has developed a sophisticated and to all appearances quite effective structure of village level agents, manned by the Agent Communitaire and his lower level Collaborateur Communitaire. The major activities of these figures have been promotional and information-gathering. The actual delivery of health care services has for the most part been restricted to modern sector personnel based either in stationary health centers or mobile teams.

3.2 Alternative Models.

Though the details have not yet been clarified, higher level decisions have apparently been made to explore other models of health care delivery in which the actual curative role of village agents will be upgraded and enhanced with supplies. Such a strategy was in effect initiated with the training of several midwives in the area of the Projet Intégré (and in other areas of Haiti as well); the role of a traditional healer was formally recognized, and she was to a greater or lesser degree incorporated into the modern delivery system via training and supplies. But now the decision has been made to attempt to go beyond the midwife and train individuals who can perform other types of health care service as well.

This decision will not meet with universal approval; many resist the apparent legitimization thus given to "amateur" healers. But in the context of Haiti and many other developing countries, a convincing case can be made that this is an important waystage tactic which will at least for the present place heretofore isolated groups in more direct contact with public health facilities. The curative activities of the village agent will be less

important in this regard than the referrals which he can make to health centers and the preventive advice which he can dispense to his neighbors. It is unlikely that referrals would be obeyed or advice heeded unless the village agent has some minor "clout" in the form of curative skills and supplies.

There are two basic models which can be distinguished when discussing the penetration of villages with specially trained locals able to administer minor curative services. One model entails the selection and training of an Agent Sanitaire who will provide generalized services in addition to the referrals he makes to the health centers. Another model entails rather the upgrading of the skills of Guerisseurs Traditionnels. Though in theory the Agent Sanitaire could be a traditional healer and in some cases may actually be one, in practice the model of the Agent Sanitaire creates local, village-level competitors to the traditional healers. It would be of great interest to attempt, on a pilot basis, to approach rather these traditional healers themselves, to determine to what degree their skills might be utilized and upgraded, to make them mesh more closely with the services dispensed by modern health establishments. The author was told that a decision has been made to do this on a small pilot basis in the region of the Projet Intégré.

It must be repeated that the two models are not mutually exclusive. On the one hand, traditional healers might be chosen to be Agents Sanitaires. On the other hand, given the fiscal unlikelihood that the entire national territory will be covered by Agent Sanitaires, it is conceivable that in a given region, the central areas might be manned by Agents Sanitaires and the geographically peripheral areas served by trained traditional healers.

Despite the ultimate compatibility of the two models, however, it would be much more profitable at the outset to distinguish them and view them

as possible alternatives. The author tentatively hypothesizes that the Guerisseur Traditionnel model will be a much more cost-effective strategy for reaching out to the rural population and incorporating them into the modern delivery system at least to some degree. The Guerrisseur Traditionnel model has several advantages over the Agent Sanitaire model:

1. Fiscal advantages. One disadvantage of the Agent Sanitaire model is that it creates a new type of employee on the public payroll. The traditional healers would have to be motivated in some manner; but the motivation need not take the form of inclusion on public payrolls as full-time employees. Thus more healers could be involved at only a fraction of the cost entailed by the Agent Sanitaire model.
2. Motivational advantages. The traditional healers are already respected in the community. They become utilized healers, not because someone has trained and chosen them, but because the population itself has benefitted, or believes it has benefitted, from their services. Thus the preventive-medicine and referral activities which are of most interest will be more effectively promoted by these individuals, rather than by individuals assigned by governmental fiat to salaried positions in the community.
3. Sociocultural advantages. The Agent Sanitaire model is more appropriate in societies where there is genuinely a lack of any medical care in the rural areas. Rural Haiti, however, to a much greater degree than most New World societies, is filled with a variety of healers already providing services, some of which--such as injections and bone setting--

would be amenable to simple upgrading via training and the provision of minor supplies. It is not being suggested, for example, that the public sector become involved in the shamanistic elements of healing. It should restrict its intervention, rather, to those elements that could be improved in the repertoire of the traditional healers, and perhaps to those elements which are demonstrably prejudicial to the health of patients. Given the presence of such a variety of healers in Haiti, there seems to be no reason for the creation of yet another village level healer. The Agent Sanitaire model, though ideal for some cultural settings, may have less certain validity in the context of rural Haiti and should perhaps not be mechanically imposed without first experimenting with a Traditional Healer model.

Even within the general rubric of a Traditional Healer model, there are several possible alternatives. The "raw material" of this program will be a series of efforts to reach out to midwives, injectionists, leaf doctors and shamans, the four types whose roles were briefly described above. But there are alternative program tactics.

3.3 The Granny Midwife Program

Before proposing a specific model, it will be useful to examine what has happened with efforts to train and supply granny midwives. This program is a predecessor, and probably to some degree a predictor, with respect to the projected program. The strengths and weaknesses of this program stand a good chance of repeating themselves in any program which will involve other types of folk specialists as well.

3.3.1 General Observations.

The training and supplying of granny midwives has effected at least three types of changes, if the information gleaned in interviews is reliable. The program has affected the midwives by changing their social status, their fees, and their actual delivery behavior.

In terms of their status in the community, misgivings as to possible negative effects were unfounded. The possession of a metal box supplied by léta (the government) has, in the eyes of the midwives involved, enhanced their status in the eyes of the community. Midwives not yet in possession of a box expressed eagerness to obtain one. That is, the government will find neither widespread hostility nor widespread indifference toward its efforts to approach midwives. Enthusiasm and eagerness appear to be the principal initial responses. Problems which the program has do not stem from indifference or hostility on the part of the client midwives.

The fees of the midwives trained have apparently increased, if the comments of community members are to be believed. Though midwives claimed to do some of their work for free, and much of their work for traditional fees, other evidence points to the fact that at least some of the trained and supplied midwives have jacked their prices up to three, four, and even five dollars. The traditional fee in years past was about a dollar, and has more recently moved up closer to two dollars. It is said, however, that the trained matronn tends to charge more.

As for the actual delivery behavior of the midwives, evidence is even more indirect. Very few home births have been systematically observed in rural Haiti; no trained midwife has been observed after her graduation. Nonetheless interview material of midwives and health center personnel attest to the fact that certain practices considered harmful are eliminated by trained midwives, especially as regards the care of the umbilicus and

the care of the neonate's head. The midwives may receive complaints from the parturient who would prefer traditional practice. But one trained midwife informed us that in deliveries she was the boss and no woman would dare insist on imposing her own will. The midwives whom we interviewed, in short, were quite aware of the proper delivery procedures and gave the impression that they carried out most of these procedures.

It is impossible to say at present whether the changes in delivery techniques are leading to decreases in the morbidity or mortality rates among neonates. The virtual elimination of neonatal tetanus in the project region has been the result, not of midwife training, but of inoculation programs. No other measures have been developed to assess systematically the success of the program.

Success, however, may be defined in many ways. Since a major objective of the granny midwife training program is to increase utilization of the health center via midwife referrals, an increase in such referrals could be considered as a sign of program success. But because of certain organizational weaknesses in the implementation of the program, the full programmatic and investigative potential of the granny midwife program is not yet being met. It will be useful to briefly list the main problems that were perceived.

3.3.2 Problems Observed.

In terms of its acceptance by the midwives, its acceptance by the population, and its apparent success at changing certain aspects of delivery behavior, the midwife program must be seen as a valuable experiment which should be continued, expanded, and improved. There are some problems which should be directly confronted.

1. Selection of inappropriate trainees. The principal selection criterion should be the status of the midwife as an established healer. Most of the midwives chosen appear to fall into this category. Some individuals, however, were apparently chosen by recommendation of one or another individual in the community, though the woman may never have actually delivered a child. Such artificially created midwives appear to have remained unused by the population. The lesson is that the government cannot really create local healers, but can only upgrade the skills and status of those that have already established themselves. Training should be restricted to those women who have proven themselves in the eyes of the community and who have thus established a reasonably large clientele.
2. Failure to clarify the terms of the relationship. The problem listed above was in part created by the erroneous belief that the midwives selected for training would become public employees and would receive a monthly check from the government. There is an understandably strong desire by individuals in the rural areas to become anplwayé léta (employees of the government), or to touché kòb nan min léta. Information should be given at the outset to prevent the rise of false expectations.
3. Raising of fees by trained midwives. This pattern has been discussed above and should be viewed as problematic. If the trained midwives raise their fees to the point where the poorer households begin using untrained but cheaper midwives, the very objectives of the program will be defeated among that stratum which most needs upgraded services. A type of fee setting should perhaps be considered, and will be discussed below.

4. Refusal of some patients to pay trained midwives. Trained midwives have complained hotly about the refusal of some households to give them anything for their services, believing that, since they had a box with government supplies, the government was paying them a monthly check for their services and the clients consequently did not have to pay anything. This also stems from lack of information in the community. When programs such as this are implemented, it is crucial to disseminate the exact terms of the arrangement in the population at large.

5. Failure of some midwives to come back for supplies. It is reported that some of the midwives have not returned to the health center since the day on which they were given their box. The meaning of this pattern is not clear. It may indicate that the midwife has not used her supplies through lack of clients--a faulty selection procedure. Or it may stem from other reasons not perceived. Highly problematic was the lack of knowledge on the part of health center personnel as to the reasons for this pattern. The personnel at the health center expressed bafflement at this behavior on the part of the midwives; but the bafflement itself is symptomatic of a lack of proper organization vis-a-vis the supervision of the trained midwives.

6. Lack of supervisory arrangements. The midwives interviewed did not even know the name of the auxiliary at the health center to whom they were supposed to report. There are simply no effective mechanisms of supervision, no arrangements by which the midwives can be

led to feel that they are members of an integrated health team. There is a danger of misinterpreting such problems as stemming from indifference on the part of the midwife. Such an assessment would be unwarranted. The midwives appear to be enthused; the drawbacks are not motivational, but organizational.

7. Failure to supply many graduates with boxes. The organizational nature of the problems became manifest when it was discovered that the most recent group of trainees, who had graduated some six months ago, had not yet received their boxes. Several reasons were heard explaining this delay, though apparently the boxes were in the health center at the time this investigation was carried out. As is the case in so many other domains, apparent indifference on the part of health post clients--in this case the midwives--stems primarily from bottlenecks within the system itself, rather than from motivational obstacles on the part of the clients.

3.3.3 Recommended modifications of the midwife program.

There are a number of changes which could be made to enhance the midwife program.

1. Organizational Changes. The current arrangement wherby the midwives haphazardly may or may not come in for resupply and restocking after a delivery is unsatisfactory from an organizational point of view. As the program of traditional healers expands, a full-time role should be created for a supervisor/ombudsman for every hundred or so traditional healers. Thus, despite the rapid turnover in local health center personnel, there would be a more stable contact on whom the midwives and other folk healers working with the government could count.

Furthermore, at the level of the local health center, specific reporting and resupplying procedures should be established, and trained midwives who spend a specified period of time without coming into the health center should be contacted and questioned as to the reason. The current situation, in which apparently nobody feels personally responsible for contacting or monitoring the activities of the trained midwives, should be remedied.

2. Remuneration Arrangements. The following idea was discussed with the project sociologist, with medical personnel in the field, and with several individuals in Port-au-Prince. Current fee-setting and fee-paying arrangements are unsatisfactory. It is recommended that the government establish a fixed fee of ten gourdes ($2.00) per delivery for the trained midwives. Five gourdes will be paid by the client whose child the midwife delivers. After fifteen days, if the child has passed the critical neonatal period alive, the midwife will come to the center and be paid the remaining five gourdes by the state. This plan will have several advantages:
   a. It will foster the heavier utilization of trained midwives, since the price paid by clients will be slightly less than what they are currently paying as a rule even to untrained midwives.
   b. It will create heightened motivation by the midwives to remain in good standing with the health center, since they now touché kòb nan min léta.
   c. It increases motivation and supervision to perform careful deliveries, since careless deliveries resulting in neonatal death would not be paid by the center. This would constitute a new type of control and de-facto supervisory mechanism.

If this strategy is utilized, it should be promulgated in the project area, in order that both clients and midwives are clear as to expectations. This type of shared fee paying by client and health center would be inexpensive for both and would be a compromise solution between the impractical extremes of having the government give midwives a monthly check on the one hand, and expecting midwives to change their behavior without any sort of tangible reward from the government on the other. If necessary, this remuneration strategy could be considered as a temporary measure, until such time as all deliveries in a region are being made by trained midwives. When untrained midwives are no longer functioning and in competition, it might be possible to have clients pay for the entire delivery. But as a waystage tactic, partial remuneration by the state would be an effective way of encouraging midwives to conform to modern expectations and at the same time encourage clients to utilize those midwives who are so trained.

3.4 The Integration of Other Traditional Healers.

Mutatis mutandis, similar arrangements can be devised for the training, supplying, motivation, and supervision of other traditional healers as well: the chalatan, the mèdsin fèy, and the gangan.

There are two alternatives which were discussed in the follow-up meeting in the Division D'Hygiène Familiale. It had originally been assumed that the traditional healers would be treated as a homogeneous group, and that all selected would be given identical instruction and training. But on the basis of preliminary field investigation, and particularly in light of the strong patterns of specialization which exist among different healer types, the author

and the project sociologist propose a model which would take as its starting point the healing specializations which exist in rural Haiti. To create generalized healers would constitute a departure from what actually occurs in the rural areas. Such a departure would inevitably slow down the acceptance of the new program, since both healers and clients will continue, whenever possible, to follow traditional guidelines in these matters. The proposed project should, it is recommended, accept these pre-existing specializations as programmatic givens. All of the healers chosen for collaboration with the program should be given a basic corpus of training. But in addition each group should be given more specific instructions in carrying out those activities which they already perform. In practical terms, this means that the chalatan would be taught and supplied to dress wounds and give injections in a more competent fashion. The mèdsin fèy, on the other hand, would be taught more effective techniques for setting bones.

Because of the publicly supported anti-voodoo stance which has come to prevail in most of the area served by the Projet Intégré, the author and the project sociologist feel it would be unwise at present to approach gangan qua gangan. However, many gangan simultaneously double as mèdsin fèy (cf. p. 12). Half of the mèdsin fèy contacted should be individuals who are also known to be gangan. In this way, spirit healers will be brought into the project without the public health system in any way formally legitimizing a ritual and theological system toward which many people have come to express at least public antipathy.

3.4.1 <u>Selection of Traditional Healers.</u>

It is important that the selection of healers for collaboration be made on the basis of their possessing a clientele. There will be three possible sources of data. In the first place the death register of the Projet Intégré contains the names of healers who were utilized in the case of many deaths. Secondly, the project sociologist has prepared a report entitled "Enquête sur

l'identification des guerisseurs les plus sollicités" (December 1976). Thirdly the research to be carried out in the coming months should give fairly precise quantitative data on the healers who are used with greatest frequency. These sources can be compared with each other to make a credible choice of the healers that are contacted by patients with greatest frequency.

The author recommends that in each of the three regions served by the Projet Intégré four chalatan and six mèdsin fèy be selected and invited to participate. As was mentioned above, about half of the mèdsin fèy should, if possible, be individuals known to do spirit healing as well (gangan). These individuals should be told discreetly that they are being chosen because of their skills with herbs, but that there is no prohibition being made against their performing spirit healing rituals. That is, the gangan should not be forced into pretending that they are not gangan. They should simply be made aware that the state is here interacting with them qua mèdsin fèy.

3.4.2 Training of the Traditional Healers.

Several recommendations can be made concerning the training of the traditional healers approached for collaboration.

1. A manual should be prepared beforehand containing the necessary information.
2. A common core of basic information should be taught to all of the healers, be they chalatan, mèdsin fèy, or gangan.
3. Research should have been carried out to identify more precisely those healing specializations--such as injections, wound dressing, bone setting, massaging--which are "objective" enough as to provide a handle for training and supplying on the part of the state. Instruction should be given to healers in their areas of specialization.
4. Particular attention should be given to the recognition of symptoms

which should motivate immediate referral to the clinic, without any attempt on the part of the healer to diagnose or treat.

5. The training should be carried out uniformly by a special team which will travel to the three project area. That is the trainees will consist of three teams, each composed of four chalatan, three mèdsin fèy, and three combined mèdsin fèy and gangan. The utilization of an itinerant team will ensure uniformity of instruction and avoid the haphazard and unsystematic "regionalization" that was reported to have occurred in the training of the midwives.
6. A supervisor should be appointed whose future responsibility will be the supervision and monitoring of the traditional healers, including the midwives (cf. pp. 22-3). If the training of traditional healers is to proceed and expand, there is a danger of creating a mass of unsupervised and uncoordinated healers. The creation of a full-time supervisory role--not necessarily involving a physician--will be useful. The supervisor should participate in the training.
7. Personnel in each of the health centers should also participate in the training.
8. Trainees should be remunerated for the days on which they come to receive instruction.
9. Instruction should last some three months, each group coming in for a full day once a week. This would entail twelve sessions for each group.
10. At the end of training, candidates should be examined. Some practical demonstrations of skill should also be included as part of the examination.

3.4.3 Supplying the Traditional Healers.

More research and discussion is needed on this matter. But the author envisions that the healers can be supplied with some basic materials--syringes, bandages, scissors, alcohol, ointments, pain relievers, and other materials--to permit the performance of their healing functions. In discussing this matter, it should be kept in mind that we will not be training new healers to perform new activities. We are merely identifying certain individuals who are performing, and will continue to perform, certain healing roles, and helping them to perform these functions in a more efficient, or at least less harmful, manner.

3.4.4 Motivating the Traditional Healers.

The specific tactic being recommended here entails recognizing, legitimizing, and upgrading certain healing activities on the part of the traditional healers. But the overall strategy is to motivate these locally important individuals to send patients to the modern health care facilities near their communities. It would be ingenous to think that a period of training would suffice to ensure this collaboration. A reward structure must be established and maintained to elicit continued cooperation on the part of the healers, in such a manner that they will encourage patients to go to the local health center for any problem that appears to fall outside of their limited, specialized domain.

To facilitate this, a number of symbolic devices could be used. The provision of some type of uniform, or at least cap; the supplying of a sign or plaque to hang up on the healer's house--these and other devices might be used to create the feeling of being a member of a health team and the concomitant sense of responsibility which such membership implies.

But there must be tangible rewards as well. The matter bears further discussion. But one type of payment could be the provision of a certain number

of supplies, which the healer would be able to sell at fixed rates. At all costs, however, the healers should not be given a regular check from the government,no matter how small. The entire purpose of this model is to avoid the creation of regular public employees. Whatever reward structure is established should entail payoffs strictly on the basis of services provided. And the clients themselves should bear the brunt of those payments.

The specifics of how to reward the traditional healers will have to be hashed out in more detail, to find a formula that is effective on the one hand, but financially reasonable and philosophically acceptable to the DSPP on the other hand. And when such a formula is proposed, it should reward not only services provided directly to patients, but also--and perhaps especially--those instances where the traditional healer succeeds in having a patient make use of modern health facilities. I.e. referral successes should be rewarded as much as actual healing services.

3.4.5 Supervising the Traditional Healers.

Once a healer is a member of the local health team, it will be his responsibility systematically to record all cases that come to him and all treatments, no matter how minor, which he dispenses. If the healer is illiterate, as many of them are, a procedure must be instituted in which the healer communicates his activities to the Collaborateur Communitaire or some analagous community agent. A system of random checking of patients thus treated can be instituted, utilizing perhaps the Agent Communitaire, or some other analogous figure. This will enhance the likelihood of veracity by the healer and create a de facto structure of supervision. Rewards should be allocated in a manner that benefits healers with more clients, fewer post-treatment infections and the like, and more referrals to modern health centers.

The preceding pages have outlined a proposed pilot project for training and to some degree integrating traditional healers into the modern delivery system. This scheme has been presented as an alternative to the Agent Sanitaire model currently being considered and implemented in other parts of Haiti. Though the two schemes can eventually be integrated, the author recommends that the Guerisseur Traditionell model be examined independently as a more cost effective strategy for achieving the same objectives assigned to the Agent Sanitaire. More patients will be reached by traditional healers at a substantially smaller per-patient (and per healer) cost. The quality of the curative services provided will probably be higher--since we are dealing with experienced healers rather than recently trained novices. And the credibility of the promotional and referral messages will also be higher, since they will be coming from already respected figures in the community. It is the author's opinion that this model is more closely attuned to the contemporary rural Haitian reality.

Such a scheme will not be feasible unless certain misconceptions are cleared up concerning traditional healers. The scheme presented here entails no legitimization by public authorities of folk religion; it merely entails a cessation of any public criticism. It does not require that physicians believe naively in the curative power of untrained healers. It merely requests recognition that such healers are being used and will continue to be used, and that such healers can, if properly trained and motivated, become important allies of the physician, and to some degree useful extensions.