# HAITI
## PROFILE OF THE HEALTH SERVICES SYSTEM

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PROGRAM ON ORGANIZATION AND MANAGEMENT OF HEALTH SYSTEMS AND SERVICE
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**PAN AMERICAN HEALTH ORGANIZATION**

## Executive summary

Haiti is a representative democracy with a bicameral national parliament[1] and diverse decentralized institution at local level. The political crisis existing in Haiti since the last decade does not facilitate the improvement of the socio-economical conditions of the population. The government efforts to prepare development plans have been hindered by that situation. This has contributed to paralysis in social policy management and in the approval of foreign investment projects, loans, and donations. This situation is still continuing nowadays.

Due to economic sanctions imposed by the international financial community, the general macroeconomic situation in Haiti further deteriorated in the early 1990s. There was a sharp contraction in GDP, notwithstanding a slight improvement over the past six years with an average growth rate of 2%. The estimated population for 2003 is 8.3 million inhabitants[2] 40% of whom live in rural areas. The illiteracy rate is estimated at 65%;[3] over 70% of the population lives below the extreme poverty line; and 70% of the economically active population is unemployed. This situation places Haiti in 146$^{th}$ place on the Human Development Index, among the 28 poorest countries in the world,[4] and among the five poorest countries of the Americas.

The health system in Haiti is made up of the following: the public sector, which has been significantly downsized due to the ongoing political crisis since 1991: the private nonprofit sector, made up of non-governmental and religious organizations: the mixed nonprofit sector, whose staff is paid by the State but whose management is private; and the private for-profit sector, comprised of physicians, dentists, nurses, and other specialists who work in medical offices or clinics in large cities and the country's capital. The Ministry of Public Health and Population (MSPP) is the second largest national employer. Due to the structural reform the employees' number passed from 8,000 in 1998 to 6,707 in 2002. An estimated 80% of the equipment in public institutions is defective or out of order.

Sectoral management is exercised by the MSPP, which is responsible for guaranteeing the health of population, as well as the delivery of services, policy-marking, and management of the health budget. Overall, the annual per capita health expenditure is estimated at about 93,9 gourdes (US$2,35).[5] Health expenditures account for about 7.10% of total public spending.[6] The external financial cooperation that the country receives for the health sector through loans and grants went from 48.9% (1996-1997) to 56.7% of the sector's total budget in 2003.

The health sector reform process in Haiti began with the adoption of a new health policy in 1996 (revised in 1998), within the framework of an economic program proposing structural reforms such as the restructuring of government functions, financial sector reform, the modernization of nine state entities, and the decentralization program. This health policy is based on two concepts:

[1] Constitution of Haïti, 1987.
[2] IHSI, 2003 in MSPP, OPS/OMS.
[3] UNDP. Haiti. Development Cooperation Report, 1998.
[4] UNDP: World Report on Human Development, 2002.
[5] Ministry of Economy and Finance, *Direction Générale du Budget*, 2002 (rate 40 gourdes for US$1)
[6] Op.cit No 5.

Community Health Units (CHU)[7] and the Basic Package of Services (BPS),[8] which are part of the National Decentralization Policy. The reform process is currently at a standstill, since the external financing designed to support changes in state administration has not been obtained due to the political crisis.

## 1. CONTEXT

**Political Context:** Haiti is an independent democratic republic based on the principle of the separation of three powers: the legislative, the executive, and the judicial. The nation's territory is divided geographically into 9 departments, 135 municipalities and 565 municipal sections.

Planning and development are the responsibility of the executive branch through the Ministry of Planning and External Cooperation, which follows government directives in the preparation of national development policy, enlisting the participation of local and departmental political administrative structures. Input is also provided by all the sectoral ministries, interdepartmental councils, parliamentary commissions, and civil society groups. Government efforts to prepare development plans have been hampered by a lack of consensus and political viability and, especially, by the political crisis. This is reflected in the standstill in managing social policies and approving foreign investment projects, loans, and grants.

The main political and social problems affecting the health situation or the performance of the health services are related to a highly unstable fledgling democracy with frequent conflicts among the branches of government; unresolved human rights situations; high economic risks for both foreign and domestic agents; and poor results from investment projects, among other things.

**Economic Context:** The general macroeconomic situation in Haiti deteriorated further in the early 1990s as a result of the economic sanctions imposed by the international community. There was a sharp contraction in GDP,[9] and the devastating effects of the embargo sent the GDP plunging to negative levels (-13.2% in 1992, -2.4% in 1993), producing a net drop of 25%. After this period, there was a slight but inadequate recovery. Annual inflation rate, in excess of 15% during the period of the embargo (1991-1994) fell to 9.22% in 1999 but has risen in 2000 to 15% and fell down again to stabilize at round 10% in 2002. The average per capita expenditure of the Haitian state is 77,8 gourdes ($US3,26).[10] The donors per capita expenditure for 2001/2002 was 101,3 gourdes (4,23).[11]

[7] Voltaire Henri Claude: Les Unités Communales de Santé: Principes et Orientations Stratégiques, Ministry of Public Health and Population of Haiti, Jun 1999.
[8] Ministry of Public Health and Population of Haiti. Health Policy. Updated Version, May 1998.
[9] Ministry of Economy and Finance. Direction des Etudes Economiques.
[10] Average exchange rate for the year 2001/2002 was 23,9gourdes for US$ 1.
[11] Op.cit no 10.

**Economic Indicators, 1991 – 2003**

| Indicator | Year | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **1991** | **1992** | **1993** | **1994** | **1995** | **1996** | **1997** | **1998** | **1999** | **2000** | **2001** | **2002** | **2003** |
| GDP per capita in $US | 260.3 | 228.23 | 225.67 | 293 | 325.90 | 371.55 | 413.36 | 459.95 | 507.18 | 357.94[**] | 480[*] | ND | ND |
| Economically active population, | - | - | - | - | 2.77 | 2.83 | 2.88 | 2.93 | 2.99 | 3.04 | 3.10 | 3.16 | 3.22[12] |
| Total public expenditure as a percentage of GDP | 10.00 | 9.57 | 9.84 | 5.93 | 11.58 | 10.77 | 9.86 | 10.47 | 10.70 | 11,2[13] | 11,57 | 13,53 | ND |
| Social public expenditure as a percentage of GDP | ND | ND | ND | ND | 2.74 | 2.67 | 3.14 | 2.86 | 2.93 | ND | 2,7 | ND | ND |
| Annual inflation rate | ND | 18.43 | 37.87 | 51.08 | 17.26 | 17.01 | 17.00 | 8.22 | 9.92 | 15,32 | 12,34 | 10,07 | ND |

The economically active population for the fiscal year 2002/2003 is 3,22 million inhabitants which represent 390 inhabitants/1,000.

The primary sector[14] contributes 25.9% of GDP; the secondary sector, 16.9%; and the tertiary sector 55%. External financial cooperation for the development of Haiti has risen to US$ 265,34 million in the fiscal year 1999/2000.The principal sources[15] of multilateral aid are the World Bank, the IDB and the European Union. The principal donors of bilateral aid are the United States, Canada, France, Japan, and Spain. The disbursement effectuated from 1995 to 2000 by the United States, Canada, France, the World Bank, the IDB and the European Union represents 77% of the external cooperation. For the fiscal year 1999/2000 the IDB, with a disbursement of US$ 44,65 millions was the most important donor, followed by United Nations System (SNU) with US$ 21,27 millions, the European Union with US$ 15,57 millions and the World Bank with US$ 7,88 millions.[16] The expenditure of the external donors for the year 2000/2001 was US$ 34,5 millions[17] which represent a regression comparatively to the previous year.

The social (health, education, gender conditions and the social affairs) public expenditure as a percentage of GDP for the fiscal year 2001/2002 is 2.7%. For health and education only this percentage is 2.4%.

[**] MSPP, PAHO/WHO: *Salle de Situation de Santé*, 2002.
[*] UNICEF: The State of the World's Children, 2003.
[12] Source: IHSI: EBCM (1999/2000). 390 people/1000 inhabitants according to projections by the IHSI in the *Salle de Situation de Santé*.
[13] Source: IHSI, MEF.
[14] Haitian Institute of Statistics and Information (IHSI), 2001/2002.
[15] UNDP, Haiti. Development Cooperation Report, 1998.
[16] UNDAF: United Nations System in Haiti, 2001.
[17] Source: MEF, World Bank external financing report.

**Social Context:** The last population census in Haiti was in 2003 but the data are not available yet. Projections by CELADE and the Haitian Institute for Statistics and Information Technology (IHSI) put the estimated population for the year 2003 at 8,3 million inhabitants. Over one-third of the population lives in the West Department, where the country's capital is located and 40% lives in rural areas.

The estimated illiteracy rate is 65%. Primary school enrollment for the period 1995-1999 is 78% for boys and 83% for girls and for the secondary it is 21% for boys and 20% for girls for the same period. Attendance rate in the primary school for the period 1992-2001 is 52% for boys and 57% for girls.[18] Child labor is the main factor in the dropout rate, affecting three groups in particular: street children, older children in the school system and children hired openly or secretly as domestic servants. These latter are children, who are given to families they may or may not know through a system called "*restavek*," or "stay with," and perform household chores. Estimates put the number of children and adolescents in this situation at 300,000 (UNICEF).
Over 70% of the population lives below the extreme poverty line (65% in urban areas and 80% in rural areas).

The unemployment rate is around 70%. There are no employment statistics[19] in the various sectors of the economy, due to the limited capacity of the institutions mechanisms for collecting and processing data. Statistics from the Ministry of Trade and Industry indicate a 31% jump in factory employment in 1997, with no significant change in 1998. Haiti is among the 28 poorest countries in terms of its ranking on the Human Development Index. In 1990, it ranked 124$^{th}$, falling progressively to 159$^{th}$ in the 1998 report. In recent years, however, its ranking has improved, standing at 146$^{th}$ in the year 2002 report. Haiti currently ranks 123$^{rd}$ on the gender-related Development Index (GDI).

## 2. HEALTH SERVICES SYSTEM

**General Organization:** the health system in Haiti is divided into four sectors: public, private nonprofit, mixed, and private for-profit. The public sector is affected significantly by the political crisis. The private nonprofit sector is made up of nongovernmental organizations and the religious sector. In the mixed nonprofit sector, the staff is paid by the State but management is handled by the private sector. The private for-profit sector is comprised of physicians, dentists, nurses, and other specialists who work in physician's offices or clinics in large cities and the country's capital.

**Public Sector:**
The MSPP is the major public institution in the health sector. It has a central level, a departmental level with nine health departments, health coordinating offices, and a local level, made up of the community health units (CHU).

[18] UNICEF: The State of the World's Children, 2003.
[19] Bank of the Republic of Haiti: Annual Report, 1998.

Since 1990, the budget of the MSPP[20] has gradually increased from 148 million gourdes to 1,415 million in 1999. It dropped to 1,178,548.262 gourdes in 2002. However, due to inflation and the depreciation of the national currency against the U.S. dollar, the budget has decreased in real terms.

Roughly 36% of health facilities are in the public sector.[21] Within this sector, most institutions function with extreme autonomy, without state control or a vision of a network of services. A system has been designed for patient referral among institutions, but it is not operational.

**Private Sector:**
The exact number of actors in the private sector is unknown, although it may be as high as 400 institutions, most of which are NGOs and institutions affiliated with churches of different denominations. During the embargo, these institutions were the beneficiaries of almost all foreign assistance in the form of humanitarian aid. Today, although some donors directly finance the Ministry of Health, this entity subcontracts companies or NGOs to prepare proposals, since its capacity is very limited in this regard.

In terms of service coverage, these organizations are responsible for an estimated one-third of the medical care provided to the population. Their distribution is not known for sure, but nearly half the services are concentrated in the capital and its poor neighborhoods and the rest in rural areas. Some of these institutions have national coverage, but most are more local in scope. In sum, 33% of health facilities belong to this sector.

**Systems Resources:**

**Human resources in the Health Sector[22]**

| Indicator | Year | |
|---|---|---|
| | 1993 | 1998 |
| Ratio of physicians per 10,000 pop. | 1.6 | 2.5 |
| Ratio of professional nurses per 10,000 pop. | 1.3 | ND |
| Ratio of dentists per 10,000 pop. | ND | ND |
| Ratio of mid-level laboratory technicians per 10,000 pop. | ND | ND |
| Ratio of pharmacists per 10,000 pop. | 1.6 | 2.5 |
| Ratio of radiologists per 10,000 pop. | ND | 0.05 |
| No, of public health personnel with graduate studies | ND | ND |

In 1998, the number of physicians in Haiti was estimated at 1,848,[23] which represented 2.7 physicians per 10,000 inhabitants. In 2001, the number increased to 2,500,[24] or 3.01 physicians per 10,000 inhabitants. Of the 2,500 physicians, 550 are general practitioners. Some 88% of physicians work in the West Department, where the country's capital is located. The development of specialties has been linked to the country's technological capabilities.

[20] UNDP, Haiti. Development Cooperation Report, 1998.
[21] PAHO/WHO. Health Situation Analysis. Haiti, June 1998
[22] Source: Dr Ary Bordes : Les cinquante Ans de l'Association Médicale Haïtienne. March 1998. MSPP-OPS/OMS. Health Situation Analysis, Haiti, June 1998.. UNDP: Human Development Report 1998.
[23] Dr Ary Bordes : Les cinquante Ans de l'Association Médicale Haïtienne. March 1998.
[24] AMH, G Lerebours.

**Human Resources in Public Institutions, 1998**[25]

| Institutions | Type of Resource | | | | | |
|---|---|---|---|---|---|---|
| | Physician | Nurses | Nursing Auxiliaries | Other workers | Administrative Personnel | General Services |
| HUEH* | 120 | 221 | 102 | 139 | 131 | 212 |
| Central Offices | 2 | 14 | 2 | 26 | 338 | 132 |
| Metropolitan Area | 43 | 14 | 76 | 113 | 150 | 225 |
| Artibonite | 37 | 47 | 126 | 97 | 86 | 184 |
| Centre | 7 | 6 | 78 | 92 | 39 | 73 |
| Grande-Anse | 12 | 30 | 114 | 73 | 79 | 153 |
| West | 192 | 165 | 249 | 194 | 212 | 337 |
| North | 47 | 133 | 221 | 176 | 80 | 232 |
| North East | 5 | 25 | 65 | 59 | 41 | 64 |
| North West | 8 | 10 | 53 | 79 | 30 | 80 |
| South | 20 | 56 | 224 | 111 | 83 | 131 |
| South East | 20 | 20 | 65 | 107 | 51 | 104 |
| **Total** | **513** | **798** | **1,375** | **1,266** | **1,320** | **1,927** |

The Ministry of Health is the second largest national employer, with a staff that went from 8,000 in 1998 to 6,707 in 2002 after the structural reform. Of this number, 55% are physicians and paramedical personnel and 45% are support staff and administrative personnel. There are no statistics on the total number of health workers in the country.

**Human Resources in Public Institutions, 2003**[26]

| Type of Personnel | Category | | |
|---|---|---|---|
| | Administrative | Medical | Grand Total |
| Administrator | 75 | | **75** |
| Financial Analysis | 1 | | **1** |
| Medical support personnel | | 209 | **209** |
| Auxiliary | | 1.449 | **1.449** |
| Bureau | 177 | | **177** |
| Cadre mid-level | 35 | | **35** |
| Accountant | 45 | | **45** |
| Dactylographer | 61 | | **61** |
| Dentist | | 16 | **16** |
| Nurse | | 1,013 | **1,013** |
| Physician | | 730 | **730** |
| Pharmacist | | 25 | **25** |
| Secretary | 103 | | **103** |
| Maintenance personnel | 2,328 | | **2,328** |
| Technician | 187 | | **187** |
| Medical technician | | 253 | **253** |
| **Grand total** | **3,012** | **3,695** | **6,707** |

[25] Source: Ministry of Public Health and Population of Haiti., Personnel Services, Number of workers by category* Hospital of the State University of Haiti.
[26] Ministry of Public Health and Population of Haiti. Summary Table with personnel by category (partial list).

The previous data show that the total number of employees of the health sector is 6,707. The table presents the human resources of the public institutions in the health sector by sites.

**Human Resources in Public Institutions in the health sector 2003**[27]

| | Personnel | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Department** | **Medical support personnel** | **Auxiliaries** | **Dentists** | **Nurses** | **Doctors** | **Pharmacists** | **Medical Technician** | **Grand total** |
| **Central offices** | | 2 | | 14 | 44 | 1 | 3 | 64 |
| **ETM** | | | | | | | 3 | 3 |
| **HUEH** | 43 | 98 | | 282 | 128 | 9 | 37 | 597 |
| **MIJ** | 6 | 27 | | 36 | 36 | 1 | 12 | 118 |
| **ENIP** | | | | 9 | | | | 9 |
| **ENISFP** | | | | 9 | 1 | | | 10 |
| **North West** | 31 | 55 | 1 | 23 | 31 | | 7 | 148 |
| **South East** | 13 | 60 | | 32 | 18 | | 13 | 136 |
| **South** | 5 | 228 | 1 | 76 | 32 | 1 | 17 | 360 |
| **North** | 20 | 217 | | 162 | 50 | 1 | 35 | 485 |
| **North East** | 9 | 56 | | 22 | 7 | | 4 | 98 |
| **Artibonite** | 19 | 144 | 1 | 43 | 42 | 2 | 18 | 269 |
| **Population Secretariat** | 10 | 2 | | 12 | 3 | | | 27 |
| **Sanatorium** | 1 | 35 | | 25 | 22 | | 5 | 88 |
| **Psychiatric** | | 16 | | 9 | 10 | 1 | 2 | 38 |
| **West** | 23 | 294 | 2 | 167 | 250 | 5 | 64 | 805 |
| **Centre** | 24 | 77 | | 19 | 12 | 1 | 5 | 138 |
| **Grand Anse** | 5 | 133 | | 62 | 22 | 1 | 12 | 235 |
| **Red Cross** | | 3 | | 9 | 4 | | 16 | 32 |
| **Total** | **209** | **1,147** | **5** | **1,011** | **712** | **23** | **253** | **3,660** |

There is no information on the ratio of specialists to general practitioners, the average remuneration of general practitioners versus specialists, or the average productivity of health workers in the principal public institutions.

***Drugs and Other Health Products**:* The country has three private pharmaceutical laboratories, and local production covers 30% - 40% of the market.[28] As of March 1998, the MSPP had identified 58 drug importers. However, there is no data on the total number of pharmaceutical products sold, the percentage of brand-name drugs, the percentage of generic drugs, total drug expenditure, per capita drug expenditure, or the percentage of expenditure made by the MSPP for drug purchases. The five largest selling products in the national market are: appetite stimulants, antacids, antibiotics, vitamins, and analgesics.

Based on the epidemiological profile, the country elaborated a drug formulary, which has not yet been approved. This is disaggregated at the institutional level. Treatment algorithms have been designed, and health workers have been trained in their use. The distribution of drugs is the responsibility of a central facility, a PAHO/WHO project implemented in 1991. This facility

[27] Ministry of Public Health and Population of Haiti. Summary table with personnel by category (partial list).
[28] Source: Ministry of Public Health and Population of Haiti., Personnel Services, Number of workers by category.

distributes products to public and private nonprofit institutions and to warehouses that supply the health institutions. For pharmacies to obtain authorization to operate they must have a pharmacist on the premises. However, the majority does not follow this norm, and there is no oversight of the private sector. Since 1996 the Blood Transfusion Center[29] of the Haitian Red Cross has been responsible for all activities related to blood transfusion. A total of only 8 of the 9 existing centers are operational, collecting around 8,000 units of blood a year. Blood donations are screened for hepatitis B and C, HIV, syphilis, and occasionally, malaria. One hundred percent of donors are screened, in both the public and private sectors of Port-au-Prince, the country's capital.

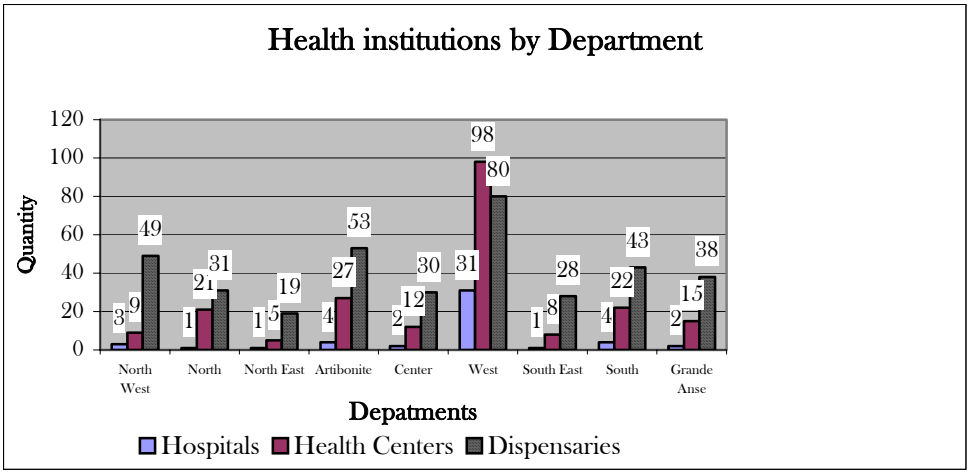
***Equipment and Technology**:*

**Availability of Equipment in the Health Sector, 1997**

| Sector | Type of Resource | | | |
|---|---|---|---|---|
| | **Beds Per 1,000 pop.** | **Diagnostic Imaging Equipment** | **No. Clinical Laboratories** | **No. Blood Banks** |
| Public Sector | 0.51 | 23 | ND | 4 |
| Private Sector | 0.39 | ND | ND | 5 |
| **Total** | **6473*** | **ND** | **205** | **9**** |

**Source:** PAHO/WHO* Estimated total data, not divided by sub-sector** More blood banks are registered, but only these are in operation.

Around 70% of the country's laboratories do not meet the internationally accepted minimal standards. Nevertheless, there has been progress. For example, thanks to the bilateral cooperation with Cuba, there is a microbiology laboratory at the University Hospital, as well as improvements in HIV diagnosis. Unfortunately, there is no quality control program for these services. There is no information available on delivery rooms, clinical laboratories, or diagnostic imaging equipment by level of care.




This graphic illustrates the predominance of health institution in the West department.

[29]Communication by Dr. Elsie Métélus Chalumeau, Director of the Blood Transfusion Center.

Nearly 80% of the equipment in public institutions is defective or out of order. An operating budget for preservation and maintenance has not been available for the last 12 years, but in 1990-1991 it was around 2% of the sector's budget. For the past seven years training has been provided to build a cadre of maintenance personnel. However, they are located in the capital and often unutilized.

Haiti has very few resources in terms of high tech equipment: renal dialysis and computerized axial tomography services are found only in the capital and are limited to the private sector. The same holds true for radiology and radiation therapy services, although they have become slightly more available since 1995.

***Functions of Health System:***

***Steering role*:** The Ministry of Public Health and Population is responsible for guaranteeing the health of the population, as well as for service delivery, policy-making, and the health budget. The essential public health functions measurement instrument has been applied. The Office of the Controller oversees public financing of the sector. The MSPP is responsible for supervising, evaluating, and monitoring the delivery of health services by the different public and private providers.

Intersectoral efforts have been limited to the education sector, in the health program for school children. MSPP information systems are neither reliable nor up-to-date. The mechanism with the best performance was disease surveillance through sentinel posts, nearly 50 in the country, which provide information on reportable diseases with a certain periodicity and acceptable reliability. Nowadays, the mechanism for diseases surveillance through sentinel posts is effective with a certain periodicity and acceptable reliability only for the following diseases: Neonatal tetanus, measles and acute flaccid paralysis. But all the institutions must provide positive information on reportable conditions such as hemorrhagic dengue, maternal mortality, tuberculosis with positive microscopy, HIV/AIDS, death by malaria, typhoid fevers, confirmed by hemo-culture, cholera, carbon, dog and cat bites.

There is no human resources planning in the MSPP. The procedures for accrediting training centers are neither clear nor uniform; therefore many are producing health professionals without the corresponding authorization to do so. In order to be accredited as a health facility, the institution, through its director, must submit a request to the corresponding departmental office, which issues a decision; however, the procedures are not in writing and vary from sector to sector. There is no public or private agency in charge of health technology assessment, nor are there policies in that area.

***Financing and Expenditure**:* Information on financing health expenditure is not reliable. A few studies by the World Bank provide some information, albeit incomplete.

**Structure of Health Sector Financing, 1994-1997**

| Agent | Year | | | | | |
|---|---|---|---|---|---|---|
| | 1994-1995 | | 1995-1996 | | 1996-1997 | |
| | Million gourdes | % | Million gourdes | % | Million gourdes | % |
| Internal financing | 293 | 10.4 | 417 | 15.4 | 464 | 15.4 |
| External financing | 896 | 31.8 | 587 | 22.1 | 857 | 28.4 |
| NGOs | 592 | 21.0 | 604 | 22.7 | 616 | 20.5 |
| Household financing of private health services | 1,034 | 36.7 | 1,054 | 39.6 | 1,076 | 35.7 |
| **Total health expenditure** | **2,815** | **100.0** | **2,263** | **100.0** | **3,013** | **100.0** |
| **Source:** Study on the financing of health services in Haiti - World Bank - Nov. 1997 | | | | | | |

**Household Average expenditure for health 1999-2000**[30]

| | Country | Urban | Rural r |
|---|---|---|---|
| Expenditure/household | 1,660 | 2,443 | 1,242 |
| % expenditure | 3.3% | 3.4% | 3.2% |

External financial cooperation for the health sector through loans, grants, plus the support that NGOs receive, accounts for 56.7% [31]of total sectoral financing. According to European Union studies, over 70% of this cooperation is in the form of grants or non-reimbursable loans. The principal sources of grants are the European Union, USAID, Japan, France, Spain, and other countries, as well as the United Nations system.

The Office of Administration and Finance is responsible for preparing the budget and issuing periodic reports on expenditures. The health expenditure data are not timely.

Health expenditure represents 7.10% of total public spending.[32] Per capita public expenditure is about US$33, total public expenditure was 10,978 million gourds for the fiscal year 2001/2002.[33] Overall, the estimated per capita health expenditure is about 93,91 gourdes (US$2.35; US$1 = 40 gdes).[34] No information is available on the ratio between the external debt in health and the total external debt. The anticipated trend is toward stabilization, since no major changes in the health system are expected in the coming years.

[30] Source: IHSI; Enquête budget consommation des ménages, 1999/2000
[31] Source: MEF
[32]Sources: Ministry of Economy and Finance, Bank of the Republic of Haiti, International Monetary Fund.
[33] Sources: Ministry of Economy and Finance, Bank of the Republic of Haiti, International Monetary Fund.
[34] Source: Ministry of Economy and Finance.

**Distribution of National Health Expenditure by Agent, 1994-1997**[35]

| Agent | Year | | |
|---|---|---|---|
| | 1994-1995 | 1995-1996 | 1996-1997 |
| General Management | 5.8% | 7.1% | 5.1% |
| Programs | 8.5% | 6.6% | 6.7% |
| Central-capital district | 23.2% | 26.3% | 21.0% |
| Training | 3.5% | 3.3% | 3.1% |
| Outskirts | 58.9% | 56.8% | 64% |
| Total | 100% | 100% | 100% |

Information on health expenditure by item of expenditure and by level of care is not available, nor is information on private health expenditure.

***Health Insurance**:* Haiti has no private health insurance providers. Thus, the MSPP is responsible for insuring the entire population against risks and damage to health. There is a Social Security system under the Ministry of Social Affairs. This system is made up of the Insurance Agency for Occupational Accidents, Illness, and Maternity (OFATMA) and the Old Age Insurance Agency (ONA) but coverage is inadequate and the beneficiaries are limited to a small number of urban workers. In 2003, the ONA has about 300,000 members and between 150,000 to 200,000 active members.[36]

Since 1999, all state employees, some 45,000 in all, have accident and medical insurance. Work has begun on a basic health benefits plan called the "Basic Package of Health Services," which the MSPP has defined as “a basic set of essential integrated interventions, selected from among those that are most effective, to which the State is committed to ensuring access to the majority of the population, as resources permit, to improve health status." The package includes the following elements: maternal health, including family planning, comprehensive care for children, the control of certain communicable diseases, medical emergencies, health education, essential drugs, and common curative interventions.

***Service Delivery:***

Population-based Health Services: The delivery of public health services is the responsibility of the MSPP, NGOs, and the private for-profit sector, located mainly in the cities. Services are based on the demand and delivered through specific programs.

The principal programs for specific prevention have been: immunization, integrated management of childhood illness, prevention of maternal mortality, malaria, dengue, AIDS and sexually transmitted diseases, and tuberculosis. The coverage of these programs varies with the availability of trained human resources and access to specific tests and treatment. There are no programs for early detection of chronic pathologies, such as diabetes mellitus or hypertension.

On average, coverage of the Expanded Program on Immunization does not exceed 40% nationally, reaching only 18% of the target population in some departments in the country. Mass

[35] Source: Study prepared by F. André and J. Buttari - French Cooperation
[36] Source: ONA

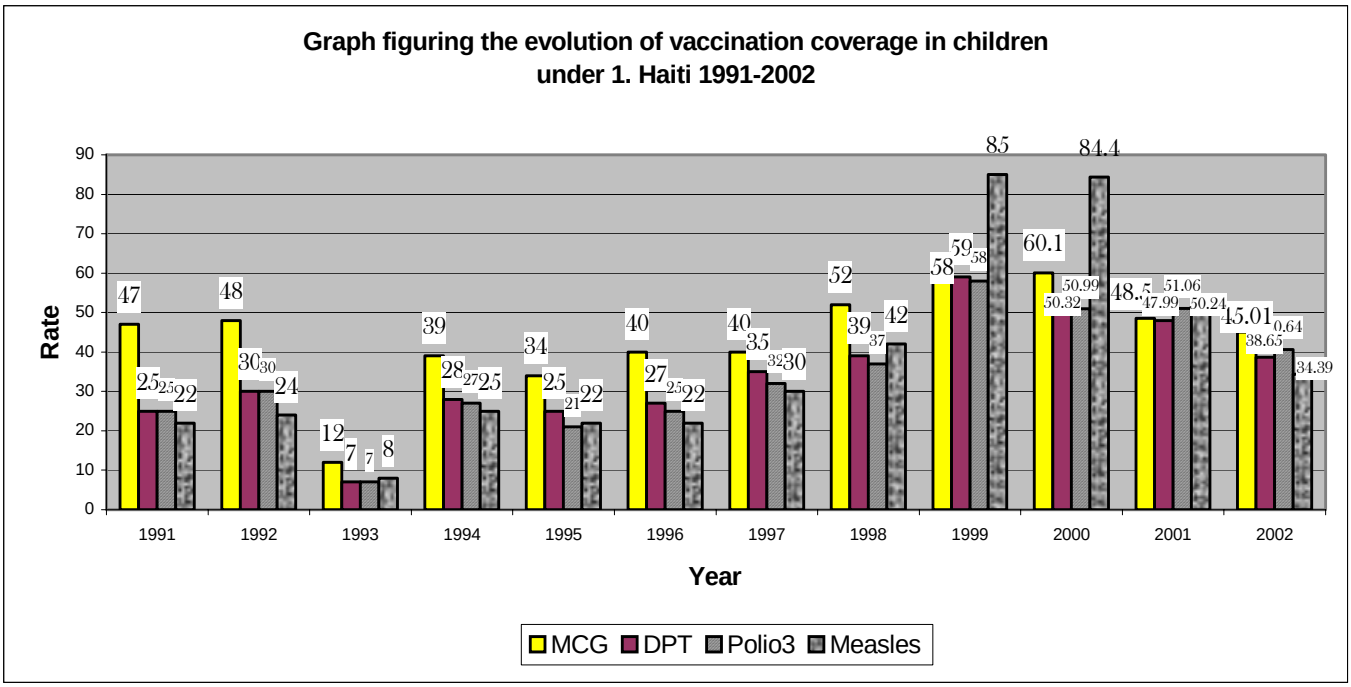
vaccination campaigns resumed in 1999, still with inadequate results, after an absence of five years.

**Vaccination Coverage in Children under 1, Haiti, 1991-2002**[37]

| | Year | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Vaccine** | **1991** | **1992** | **1993** | **1994** | **1995** | **1996** | **1997** | **1998** | **1999** | **2000** | **2001** | **2002** |
| MCG | 47 | 48 | 12 | 39 | 34 | 40 | 40 | 52 | 58 | 60,1 | 48,5 | 45,01 |
| DPT | 25 | 30 | 7 | 28 | 25 | 27 | 35 | 39 | 59 | 50,32 | 47,99 | 38,65 |
| Polio3 | 25 | 30 | 7 | 27 | 21 | 25 | 32 | 37 | 58 | 50,99 | 51,06 | 40,64 |
| Measles | 22 | 24 | 8 | 25 | 22 | 22 | 30 | 42 | 85 | 84,4 | 50,24 | 34,39 |

Prenatal care coverage is low; there are no quantitative evaluations in this respect. Around 75% of births take place at home, especially in rural areas. It is estimated that no more than 30% of births are attended by trained personnel.

The following graphic shows the evolution of vaccination coverage in children under 1 in Haiti from 1991 to 2001.




Personal Health Services: The data provided by the health information system are not adequate for managing services at the different levels and go virtually unused.

[37] Source: Ministry of Public Health and Population of Haiti, (DPEV), 2003.

Since the start of the decade, the public's ability to choose from among different providers of single type of service has not increased, but rather has decreased with the serious socioeconomic crisis.

Primary care: Global information on the degree of coverage provided by public services is based on the legal classification of the facility. Thus, the MSPP is responsible for 36%; the private sector, for 33%; and the mixed sector, for 31%. An estimated 40% of the population does not have effective coverage, especially in rural areas. The MSPP has begun to reach the localities through an agreement with health professionals from Cuba. Some 500 Cuban professionals are currently working throughout Haiti.[38]

The percentage of primary care centers that have computerized information systems is unknown. Only a few NGOs that provide services have this technology.

**Production of Services**

| | Number | Rate per 1,000 pop |
|---|---|---|
| Consultations and check-ups with physicians | ND | ND |
| Consultations and check-ups with non-physicians | ND | ND |
| Consultations and check-ups with dentists | ND | ND |
| Emergency consultations | ND | ND |
| Laboratory test | ND | ND |
| X-rays | ND | ND |

There is no reliable information on the production of services. However, it is estimated that the five most frequent causes of consultation are acute respiratory infections, diarrhea diseases, fever generally associated with malaria, parasitic diseases, and skin diseases. There are no modalities for house calls by trained personnel.

Secondary care: No information was available on the percentage of coverage provided by the various public and private health service networks.

Less than 20% of hospitals with more than 50 beds have computerized information systems for administrative and clinical management. They are concentrated in the capital and the private sector. The degree of use of that information is limited to administrative management, particularly human resources management.

**Capacity at HUEH in 2003**

| Indicator | |
|---|---|
| Total discharges | ND |
| Occupancy rate | 100% |
| Average length of stay | ND |

[38] Source: Cuban Cooperation.

The information about the coverage of services is not available. The number of beds at HUEH is 730. The occupancy rate is 100% for the three last months. This occupancy rate is never less than 80%.

In 1997, the World Bank financed a survey by AEDES/CIDEF. It showed that occupancy was, on average, 42% in the public sector and 74% in the private, nonprofit sector. The lower percentages were in public obstetrics and pediatrics wards (36 and 37% respectively). No data are available on the most frequent causes of discharge.

***Quality:***
Technical Quality: There is no available information on the percentage of facilities with established and operational quality insurance programs, or on facilities with ethics committees. Caesarian sections account for 10% of total deliveries.

Data on hospital infection rates are not available. Nevertheless, a 1998 PAHO/WHO study on pediatrics and intensive care at the University Hospital found that over 50% of the children had contracted hospital infections. An examination of 40 staff who had handled these children found fecal coliforms on the hands of 39.

Information on the percentage of facilities with hospital infection committees is not available. There are no data on the percentage of autopsies performed, statistics of maternal and child deaths, or the percentage of patients given a discharge report or instructions when they leave the facility.

Perceived Quality: There are no available data on facilities with programs to improve sensitivity and treatment, user orientation, satisfaction studies or surveys, or arbitration commissions.

## 3. MONITORING AND EVALUATION OF SECTORAL REFORM

### *Monitoring of the Process*

**Monitoring of the Dynamics:** The reform process in Haiti began with the adoption of a new health policy in 1996 (revised in 1998), within the framework of an economic program proposing structural reforms, such as the restructuring of government functions, financial sector reform, the modernization of nine state entities, and the decentralization program. This health policy is based on two concepts: Community Health Units (CHU) and the basic package of services (BPS), which are part of the National Decentralization Policy.

Discussion of the reform proposal focused on two actors: the government and donors. At no time the population or other public or private institutions were involved in the discussions.

The reform process has not been spelled out through an explicit agenda. As mentioned earlier, sectoral reform is part of the framework of a state structural reform policy. It was designed by health authorities at the Ministry of Health, which assumed leadership in negotiating its objectives and content. The negotiations have been carried out within the government, among the

sectors, without the participation of other actors. At present, the MSPP is on the process of elaborating a 5 year plan of action.

Various studies have focused chiefly on financing for the development of the Community Health Units (CHU) and the BPS. Donors finance the studies jointly with the Ministry of Health.

At present, the reform process is at a standstill, since the external financing designed to support the changes in state administration could not be obtained due to the political crisis. In addition, the political crisis has prevented the changes needed to promote the decentralization process. The same is happening with the legal instruments underpinning the financial support for implementation of the Community Health Units (CHU). The Ministry of Health in collaboration with PAHO/WHO and donors has been undertaking a new process of elaboration of the Health National Strategic Plan. This plan, elaborated in order to reinforce the health sector, will be finished by October or November 2003.

The initial objectives and strategies proposed still have not been modified, and evaluation criteria have focused mostly en economic results, not sectoral ones. There are no evaluations of the execution or impact of the reforms, but there are documents that analyze the degree of decentralization and the financing for implementation of the Community Health Units (CHU) and BPS.

***Monitoring of the Contents***

Legal Framework: The legislative amendments to support the reform process could not be enacted, due to the political crisis. Laws such as the Drug Act and the Health Act are still pending approval. The national Health Policy is grounded on equity, social justice, and community participation.

Right to Health Care and Insurance: The right to health care is guaranteed by the country's constitution, although it has not been disseminated adequately to the population.

The strategy to increase coverage focuses on the formation of Community Health Units (CHU), which incorporate community participation in local health facilities.

The Basic Package of Services (BPS) was designed by the Ministry of Health and international cooperation experts. It includes basic health actions for women and children, but its financing has not been analyzed.

Steering role and separation of functions: Exercise of the steering role in health has not been reviewed. However, changes are being made in the structure of the health authority, especially at the central level. New offices have been created, such as the Health Service Organization Office (DOSS), which will be replicated at the departmental level. The object is to improve the decentralized response capacity to health problems. There have been no organizational changes to adapt the functions of steering role, nor have public institutions been created with responsibility for policy making, financing, insurance or the delivery of personal care services by the public sector.

Health coordinating offices are created in order to improve the services provided to the population.

Actions to guarantee that information systems produced relevant reports on a periodic basis were limited. Only sentinel sites -some 50 in the country- had the responsibility to report rapidly and accurately on reportable diseases. This strategy was handled for several years by an NGO financed by PAHO/WHO. Toward the end of 1999, full operating capacity was transferred to the Ministry of Health. Since the beginning of the year 2003 all the health institutions must provide information on the reportable conditions.

Decentralization Modalities: The administrative levels of the Health Services System, its functions, and its relations are being reviewed with a view to implementing the CHU and delivering the BPS. These proposals are directly related to the decentralization of the health sector.

Some responsibilities, such as financing, are being transferred to the departmental level, but the degree of deconcentration within health institutions remains insufficient.

Social Participation and Control: Social participation has been proposed as one of the pivotal points of the National Health Policy. Thus, the CHU are considered the foundation for executing joint efforts and social control at the local level.

The entities being created to promote social participation are the Management Cells and Municipal Health Councils. They are situated at the departmental and the local or municipal level. They will be used to carry out the annual programming of health services activities and adopt mechanisms to control those activities. The members of the Municipal Councils should be elected by the community. The legal mechanisms for their operation have not yet been developed.

Financing and Expenditure: The financing and expenditure mechanisms have not varied substantially due to the political crisis.

Services and Models of Care: The redefinition of the model of care is linked to how the strategies for implementing the BPS are executed in the future, although the activities that this package envisages are already determined.

No changes have been introduced into the health care modalities, and the referral system has not been modified.

No decisions have been made to modify the supply of public health services at either the primary or secondary levels.

Although more vulnerable groups have been identified, there has been little direct action targeting them.

Management Model: The Ministry of Health is gradually assuming its role in a more visible way, after the damage caused by the economic embargo.

Management contracts or commitments have not yet been introduced. Nevertheless, the management of the CHU envisages three types of contracts: the management contract, the concession contract, and the service contract, depending on the actor. Legal capacity has not yet been developed, due to the country's political problems.

Few public health facilities operate on the basis of business criteria. It is expected that upon implementing the CHU, public facilities can be turned over to private management, when warranted, in accordance with the aforementioned contract modalities.

Human Resources: No changes have been made in the human resources education process.
The participation of health workers and their representatives in the reforms has been almost nonexistent.

There are still no changes in human resources planning and management or in the incentives systems, forms of professional practice, health worker training, and mechanisms for certifying health workers.

Quality and Health Technology Assessment: No changes have been made in the accreditation procedures for facilities and programs or in the areas of technical quality and the assessment of technologies to be introduced.

**Evaluation of the Results**
The political difficulties and short time elapsed since implementation of the reform process began make it too early to evaluate the results.

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