

Integrating Community Health Program

HAITI COUNTRY SNAPSHOT



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Acronyms

AIDS	Acquired Immunodeficiency Syndrome	
AIP	Multi-skilled Auxiliary Nurse Supervisor	<i>Auxiliaire Infirmière Polyvalente</i>
ASCP	Multi-skilled Community Health Workers	<i>Agent de Santé Communautaire Polyvalent</i>
CDC	Centers for Disease Control and Prevention	
CHW	Community Health Worker	
COVID-19	Coronavirus Disease 2019	
DHIS-2	Digital Health Information System - 2	
ESF	Family Health Team	<i>Equipe de Sante Familiale</i>
GDP	Gross Domestic Product	
GFF	World Bank's Global Financing Facility	
HAART	Highly Active Antiretroviral Therapy	
HIV	Human Immunodeficiency Virus	
ICH	Integrating Community Health	
ICHC	Integrating Community Health Conference	
MSPP	Ministry of Public Health and Population	<i>Ministère de la Santé Publique et de la Population</i>
NGO	Non-governmental Organization	
PAHO	Pan American Health Organization	
PES	Essential Services Package	<i>Paquet Essentiel des Services</i>
PMS	Minimum Services Package	<i>Paquet Minimum des Services</i>
SDGs	Sustainable Development Goals	
TB	Tuberculosis	
THE	Total Health Expenditure	
UHC	Universal Health Coverage	
UN	United Nations	
UNICEF	United Nations International Children's Emergency Fund	
US	United States (of America)	
USAID	United States Agency for International Development	
WHO	World Health Organization	

Preface

Accelerating the Integration of Community Health Worker Programs through Institutional Reform

Approximately half of the world's population do not have access to essential health services. A growing emphasis on the roles of communities recognizes community engagement, including community health workers (CHWs), as a means of realizing the full potential of the primary healthcare (PHC) system.¹ High performing CHW programs at scale are an integral component of responsive, accessible, equitable, and high-quality PHC.

Recognizing the potential for community health to address gaps in coverage, improve financial protection, and support access to quality care, the Declaration of Astana in 2018 committed to strengthening the role of community health in PHC as a means to accelerate progress toward universal health coverage (UHC). Before the Declaration of Astana, the transition from the Millennium Development Goals to the Sustainable Development Goals (SDGs) also helped to reposition communities as resources for health systems strengthening and sources of resilience for individuals and families.

The United States Agency for International Development (USAID) initiated a collaboration with the United Nations Children's Fund (UNICEF) and the Bill & Melinda Gates Foundation in 2016 to advance country commitments toward communities as resources in PHC systems to accelerate progress towards the achievement of the SDGs. The Integrating Community Health (ICH) collaboration fueled a global movement with more than twenty countries to elevate national priorities and progress for institutionalizing community health in primary health care systems. USAID, in collaboration with UNICEF, invested in catalytic partnerships with governments, their trusted NGO partners, and communities across 7 countries (Bangladesh, the Democratic Republic of Congo

(DRC), Haiti, Kenya, Liberia, Mali, and Uganda) to institutionalize reforms and learning, with a focus on CHWs. In alignment with these efforts, the Bill & Melinda Gates Foundation supported the development of new evidence and knowledge regarding performance measurement, advocacy and pathways to scale in the seven focal countries via the Frontline Health Project with Population Council and Last Mile Health as lead partners. Using Last Mile Health's Community Health Reform Cycle framework, the Country Snapshots highlight the ICH collaboration's catalytic partnerships to strengthen national CHW programs as an essential component of PHC and to place these programs within the context of institutional reforms and political commitment needed for national progress in health outcomes.

Re-envisioning health systems to achieve UHC requires leadership and political commitment from within countries. Countries must mobilize the whole society—both public and private sectors as well as communities—as essential resources in this effort. The community component of PHC must be designed to enable the health system to reach the most underserved, respond to pandemics, close the child survival gap, and accelerate the transformation of health systems. Without a major expansion of support for national CHW programs, the measurable acceleration urgently needed to reach the health-related targets of the SDGs by 2030 is unlikely. With a decade remaining to achieve the SDGs and faced with the challenge of the COVID-19 response, building global political momentum with countries and funders is critical to support urgent national priorities, evaluate progress, and develop and share new knowledge to inform bold political choices for a whole of society approach to health systems strengthening.

Community Health Institutionalization as a “Reform Cycle”

The Country Snapshots featured in this series highlight the seven ICH countries’ reform efforts within a framework for institutional reform: the Community Health Systems Reform Cycle (often referred to here as the “reform cycle”).² Countries experience community health systems reform as a process and pathway to institutionalizing community health. The likelihood that any particular reform is successfully institutionalized in an existing policy environment depends on political will and buy-in from key stakeholders, the technical design of the policy, the available capacity and resources to launch and govern the intervention, the ability to learn, and the willingness to adapt and improve the program over time.

The reform cycle framework has guided—and been refined through—a descriptive analysis of the ICH countries’ reform journeys. Country Snapshots, reflecting the ICH investment on community health

systems reform, demonstrate the practical linkages between available literature and specific country experiences. This framework provides health systems leaders with an approach to plan, assess, and strengthen the institutional reforms necessary to prioritize community health worker programs as part of national primary health care strategies to achieve universal health coverage.

The reform cycle traces several stages of institutional reform, which are summarized below. Reforms may encompass an entire community health worker program or target specific systems components, such as health information systems. While reforms may not always follow each stage in sequence and timing can vary depending on the complexity of the program or activity, deliberate and comprehensive planning can strengthen buy-in and overall effectiveness.

THE COMMUNITY HEALTH SYSTEMS REFORM CYCLE





PROBLEM PRIORITIZATION

Actors identify a meaningful and relevant problem. They diagnose pain points and unmet needs, and connect them to priority areas for reform, where possible. Actors acknowledge the need for reform within the community health system and commit to a joint vision for addressing gaps.



COALITION BUILDING

A group is formed around a compelling problem or vision. Members define the coalition's goals, roles, size, and composition. Diverse members fill critical roles in the reform effort (e.g., leaders, connectors, gatekeepers, donors, enablers, change champions, and liaisons to key players outside the coalition).



SOLUTION GATHERING

Potential solutions are gathered, drawing from existing local and international programs. Actors define criteria and metrics to assess solutions, and specific ideas for reform are piloted, where possible. Promising solutions are prioritized for integration into the health system.



DESIGN

Key decision makers, stakeholders, and planners map out different options for program design. Where possible, evidence about the options, expected cost, impact, and feasibility are identified. Through consultations, workshops, and other channels, stakeholders offer feedback on options, and decision makers select a design. This may include operational plans, training materials, job descriptions, management tools, data collection systems, and supply chain processes.



READINESS

Coalition members and champions prepare for launch by getting buy-in from actors instrumental to the launch, rollout, and maintenance of the program. Stakeholders also translate program design into costed operational plans that include clear strategies and tools for launch and rollout. Investment plans for sustainable financing and funding mechanisms are put in place. Stakeholders are prepared for their new roles and responsibilities, and potential areas of policy/protocol conflicts are addressed.



LAUNCH

New policies, processes, and organizational structures are implemented, and key actors execute their new roles. As these shifts progress, learning is gathered to demonstrate momentum and identify challenges to achieving scale. Particular attention is paid to issues around rollout, and timely design and implementation shifts are made as needed.



GOVERNANCE

Stakeholders establish a project governance framework, which includes key leadership and decision-making bodies, clear roles and responsibilities, and explicit decision rights. Processes for risk and issue management, stakeholder engagement, and cross-functional communication are established. Actors monitor program progress to advance clear decision-making and address critical issues or challenges.



MANAGEMENT & LEARNING

Key stakeholders regularly review program data to inform problem-solving at the national or subnational level. Stakeholders engage in continuous learning and improvement, identifying challenges and changes to program design and other systems bottlenecks.

Country Snapshots of Institutional Reform

PURPOSE AND GOALS OF COUNTRY SNAPSHOTS

- Describe the community health landscape within each country
- Present the country's vision for community health reform and situate progress to-date within the framework of the reform cycle
- Articulate the primary community health institutionalization challenges that the country is or was facing at the outset of the ICH investment
- Trace the policy and advocacy process taken by country stakeholders to move reform forward, using the ICH investment as a catalyst
- Identify lessons learned and opportunities for strengthening existing reforms arising out of the ICH investment

The Country Snapshots complement other resources generated within and beyond the ICH investment, such as the countries' Community Health Acceleration Roadmaps, ICH Country Case Studies, and Frontline Health Project Research Studies. The Country Snapshots place a unique emphasis on tracing the process of policy choice, advocacy, and implementation. Together, these complementary initiatives are catalyzing community health systems reform and advancing efforts towards a strong primary health care system and UHC.

APPROACH AND METHODS

The Country Snapshots highlight examples of a country's reform journey through the specific stages of institutionalization outlined in the framework. Country Snapshots both demonstrate the features of each stage within the country context and elevate salient examples of countries' learning and success. The Country Snapshots reflect a process of desk reviews and consultations with country stakeholders. Stakeholders include but are not limited to current and former ministry of health representatives, leaders from non-governmental and technical organizations, and members of multilateral and bilateral institutions. The Country Snapshots elevate both existing

insights captured in policy and strategy documents that are often difficult for those not working within the country to access, as well as novel perspectives gained through methods such as workshops or in-depth interviews with key stakeholders. Where the Country Snapshots draw on existing materials, citations are noted. Insights and country stakeholder recommendations on the reform cycle's application serve not only to validate the framework, but also to highlight ways in which the framework can help trace powerful narratives of reform and accelerate community health systems policy and advocacy efforts.

These narratives reveal opportunities to accelerate the prioritization of community health worker programs and primary health care strategies with the goal of UHC. The Country Snapshots reflect valuable feedback from stakeholders on how the framework can help advance community health systems policy and advocacy.

Key Resources

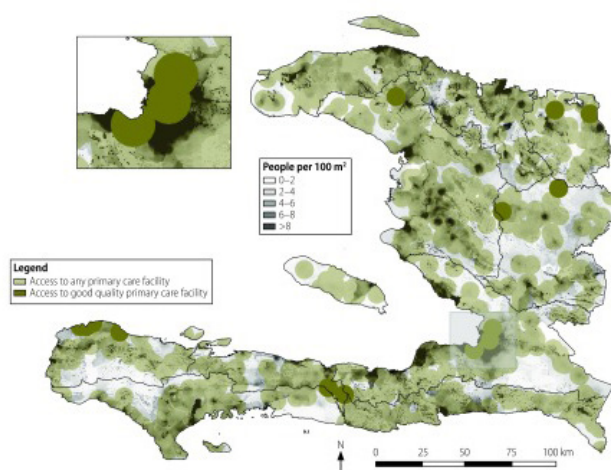
- [USAID Vision for Health Systems Strengthening 2030](#)
- [Astana Declaration](#)
- [CHW Resolution](#)
- [CHW Guidelines](#)
- [Exemplars—Community Health Workers](#)
- [Community Health Roadmap](#)
- [Institutionalizing Community Health Conference 2017](#)
- [Institutionalizing Community Health Conference 2021](#)
- [Community Health Community of Practice](#)
- [Global Health: Science and Practice Supplement 1: March 2021](#)
- [Journal of Global Health: Advancing Community Health Measurement, Policy and Practice](#)

Haiti's Community Health Policy & Advocacy Landscape

The right to health is included in Haiti's Constitution. In 2012, the Ministry of Public Health and Population (*Ministère de la Santé Publique et de la Population* or MSPP) put forth a National Health Strategy committed to UHC. Yet, many challenges stand in the way of realizing these aspirations. Health outcomes in Haiti are poor by many measures, although there have been improvements over the past four decades. In projects and programs since the 1980s, Haiti has served as a model of community health with early programming foundations. The government, implementers, and funders have come together in intensive moments of reform—designing and integrating improvements and adaptations to community health services in Haiti.

Health Access and Outcomes

Today Haiti has a population of 11.4 million people,³ which is similar in population size to Cuba or Belgium, and in population density to India.⁴ Over 6 million Haitians—or almost half the population—live under the national poverty line.⁵ Coverage of basic health services is low in Haiti compared to other low-income countries, despite significant progress made on key health outcomes in the decades since the 1990s. Although about 91% of the population live within five kilometers of a primary care facility, only an estimated 23% of the entire population—including just 5% of the rural population—have access to primary care of good quality.⁶ Wealth disparities also coincide with inequalities in health outcomes. For instance, child birth deliveries in healthcare facilities were eight times more frequent (76%) for the highest wealth quintile than for the



Map of the geographic access to any primary care facility and facilities providing primary care of good quality, Haiti, 2013.

Source: Gage AD, Leslie HH, Bitton A, et al. using Data from the GADM spatial database, Service Provision Assessment Survey and WorldPop population density.

lowest quintile (9%).⁶ The low- and middle-income country average for institutional deliveries is 70.5%, but in Haiti in 2012 the coverage of institutional deliveries was only 37%.⁷ In 2018, the World Bank Human Capital Index Report estimated that children born in Haiti today will be only 45% as productive over the course of their lives as they could be if they benefited from a complete education and optimal health.⁸ Average life expectancy at birth is 63.5 years.⁹ Leading causes of death in Haiti include ischemic heart disease and stroke, lower respiratory infections, neonatal disorders, road injuries, diabetes, HIV/AIDS, and diarrheal diseases.¹⁰ A strong primary health system could meaningfully contribute to the prevention and treatment of almost all of these conditions. Table 1 demonstrates the low coverage of basic health services.

⁶ Good quality was scored in terms of (i) accessible care (financial, geographical, timely); (ii) effective service delivery (safety, trust and respect, competence, motivation); (iii) management and organization (information system use, monitoring and quality improvement.); and (iv) primary care functions (comprehensive, continuity, first-contact accessibility)

TABLE 1: Various Health Indicators for Haiti

INDICATORS	2005-2006 (DHS) ¹¹	2012-2013 (DHS) ¹²	2016-2017 (DHS) ¹³
Infant Mortality Rate (per 1,000 live births)	57	59	32
Under-Five Mortality Rate (per 1,000 live births)	86	88	81
Maternal Mortality Ratio (per 100,000 population)	630	-	532
Children Fully Vaccinated	41.3%	45.2%	41.5%
Children with Diarrhea Treated with ORS	40.3%	52.95%	39.3%
Unmet Need for Family Planning	38%	35%	38%
Skilled Birth Attendance	26%	37%	42%
ANC 4+	54%	67%	67%

The devastating 2010 earthquake, in which 300,000 people lost their lives¹⁴ and 30 hospitals were seriously damaged or destroyed,¹⁵ put a tremendous strain on the nation of Haiti. It is estimated that the earthquake created between 7.8 billion and 8.5 billion USD in damage.¹⁶ An additional 9,000 people died in the cholera outbreak that followed the earthquake, after international responders introduced the disease to Haiti.¹⁷ Given the extent of the damage to the country's infrastructure and health system, it is unsurprising that health indicators were impacted, including an increase in infant mortality and under-five mortality. However, the crowding of emergency response resources also created a concentrated boost to some indicators, such as the number of fully vaccinated children. The cholera epidemic was also concurrent with an increase in children with diarrhea treated with oral rehydration serum. Overall, while there have been improvements over the years, progress was often slow and much remains to be done to improve national health indicators.

HEALTH FINANCING

Haitian governmental financing for healthcare, which is vital to the sustainability and accountability of the health system, still makes up quite a small part of the country's total health expenditure (THE). Many essential services are provided through external funding. However, international financing for healthcare decreased by approximately 45% between 2011 and 2017 (from 48.75 to 26.85 USD per capita).¹⁸ Haiti's health system is grossly

underfunded relative to its neighbors in the Latin American and Caribbean region, which have an average THE per capita of 1,113 USD—compared to just 131 USD in Haiti.⁷

Not only is Haiti's health system underfunded, but resources are also not allocated for greatest impact. As a result, the health system is delivering low value-for-money. Haiti spends more on health than other low-income countries (131 USD THE per capita compared to 93 USD) but achieves the same or poorer results. Countries such as Rwanda and Eritrea spend less on healthcare per capita (125 and 51 USD, respectively) but have achieved similar or lower maternal and infant mortality ratios. In part, this underperformance of the health system is related to a focus on curative rather than preventive care.¹⁹ The impact of poor investment in primary care on the Haitian population is stark, represented in the relatively high maternal mortality, 65-year life expectancy, and other indicators.

Community health worker programs are proven to effectively bridge the gap between people and the health system, even in resource-constrained settings. A 2019 study in Haiti observed that, "households were less likely to incur catastrophic health expenditures when they accessed care from Community Health Workers than when they received care from other types of providers, including public and private healthcare facilities."²⁰ But in a context of non-governmental organization (NGO) and donor fragmentation, and insufficient resource mobilization, the path to national scale for community health has been challenging.

Overview of Community Health Within Haiti's Health System

In all, there are at least 1,033 health institutions in Haiti including university hospitals, specialized centers, district hospitals, community health centers, and dispensaries—34% of which are public, 47% private, and 18% mixed.²¹ Today, the National Health Policy in Haiti (*Politique Nationale de Santé en Haïti*) and the Community Health Strategic Plan provide a unified and standardized vision for health system coordination, and the role of community health workers within it. Community health plays an essential role in extending healthcare services to those hardest to reach so that all people can access the care they need. Thus, community health is essential to achieving the UHC that is aspired to by Haiti and the world.

As displayed in Figure 1, Haiti's health system is divided into three levels: national, health department, and district and community.

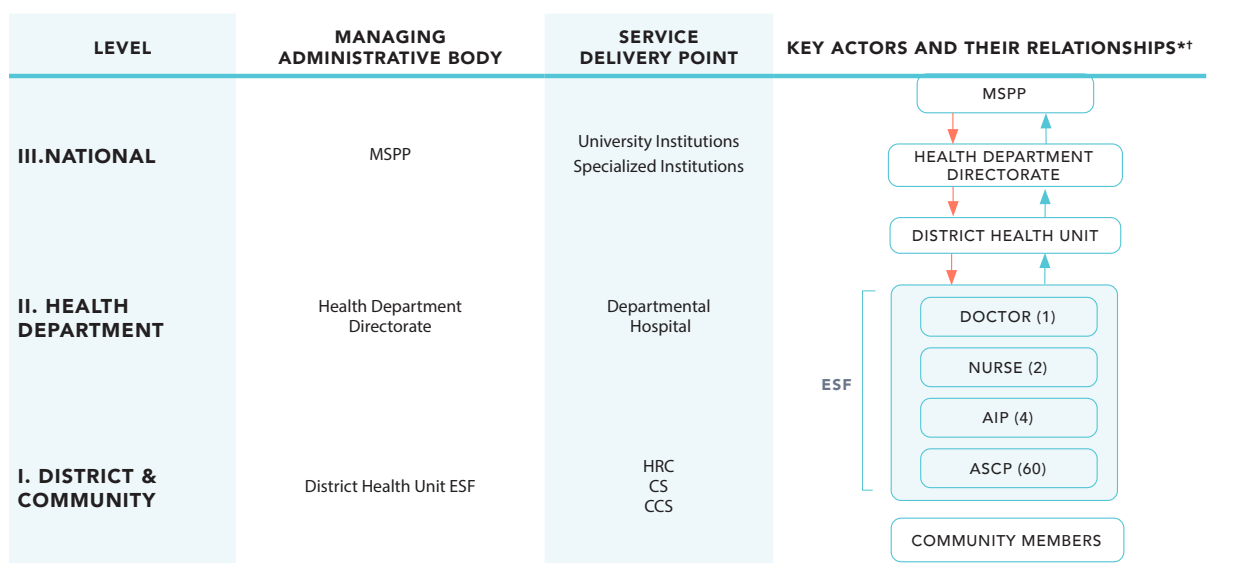
At the national (or highest) level, the national managing administrative body is the Ministry of Public Health and Population (Ministère de la Santé Publique et de la Population or MSPP). Tertiary services are provided by five university hospitals and three specialized centers.²²

At the health department (or middle) level, the Health Department Directorate is the managing administrative body. Each of the 10 geographic divisions, known as departments, has a dedicated hospital. Nearly half of the health facilities in Haiti are concentrated around the greater Port-Au-Prince area, yet 65% of the population live outside of that region.²² Ensuring that every department has at least one hospital is essential because Haiti's insufficient road infrastructure can critically inhibit travel and access to care. The hospitals are strategically distributed by the MSPP across departments in order to counteract the consolidation of health services in the capital.²³

In addition to the hospitals in each of the 10 health departments, in 2012 the MSPP created district health units (*Unités d'Arrondissement de Santé*)—one for each of the country's 42 districts. While this new subdivision does help promote more equitable dissemination of healthcare throughout the country, the district health units have varying capacity to carry out their mandate, mainly due to lack of human resources.²²

At the district and community (or primary) level of the health system, according to the Community Health Strategic Plan, the district health units coordinate family health teams (*équipes de sante familiale* or ESFs). Each is comprised of a doctor, two managing nurses, four supervising nurses (auxiliaires-infirmières polyvalents or AIPs), and

FIGURE 1: Health System Structure



* The exact flow of community-level data and supervision structure beyond the community / district levels are not specified in policy. However, policy implies that data flows up the health system and supervision is top-down. The dotted arrows indicate this.

30 community health workers (*agents de santé communautaire polyvalents* or ASCPs). Together, each family health team covers a population of 60,000 people. The ESF exemplifies the coordination of services in order to provide essential health services to as many people as possible, and to effectively diagnose and refer patients up and down the health system in accordance with their needs. Various programs in Haiti have deployed community health workers to provide health services, and they have been effective in improving health outcomes.^{7,24,25,26} Now, as the government is working to systematically extend primary healthcare services to the entire population in order to achieve UHC, the MSPP has incorporated ASCPs into the family health team system. The design of the family health team not only leverages the ability of ASCPs to provide community-based care, but also connects ASCPs to supervisors and integrates them into the broader health system, strengthening the continuum of care.

The service delivery points for the primary level of care in Haiti are community health centers (*les centres communautaire de santé* or CCS) and dispensaries. These delivery points serve as the center for the family health team. At this level, we also have a Community Health Committee (*Comité Communal de Santé*), consisting of influential volunteer community members who help ensure that the health system factors in local determinants of health.

At present, reality does not completely match the plan for community health set forth by the MSPP. According to a recent census of all community health workers (CHWs) in the country, there are around 5,210 nationally; of these, 1,000 are financed by the MSPP.²⁷ Fifty different agencies in the country—mostly different donor/NGO programs—are financing community health worker programs in Haiti. This division follows the combination of public, private, and mixed health services in the rest of the health system. Out of all the CHWs in the country, three-quarters are ASCPs, as defined by the MSPP. The remaining 1,343 CHWs are financed by international organizations to specialize in particular conditions like malaria, tuberculosis, or HIV. All community health programs

in Haiti are supposed to follow the Community Health Strategic Plan defined by the MSPP. However, in practice, not all implementing agencies agree with the MSPP on certain tasks or protocols, leading to fragmentation in operational modalities of different community health programs. Often, the community health programs that do not follow the Community Health Strategic Plan are financially tied to verticalized interventions for specific diseases or conditions. Some major donors are interested in pursuing a blended approach where a percentage of a community health worker's time would be spent on the activities described in the Community Health Strategic Plan. However, the percentage of time has yet to be specified, raising questions about the effectiveness of this approach.²⁷ Presently, fragmentation and differences of implementation persist. By reinforcing the collaboration between the different levels of the health system, Haiti can reduce fragmentation and improve the cost-effectiveness of its health system investments, supporting effort towards achieving UHC.

Overall, curative care accounts for 54% of Haiti's total health expenditure, with only 19% spent on preventative care. The number of hospitals exceeds the norms of the MSPP, while the number of dispensaries at the district and community level remains below the norms set by the MSPP.²⁷ However, tertiary services still need to be strengthened. Throughout the hospitals and health centers nationwide, there is a need for increased ICU beds, capacity to mechanically ventilate a patient, and emergency and critical care training for doctors and nurses.²⁸ It is important to learn from percentages of allocation, while remembering that the whole pie is too small and ineffectively implemented to meet the needs of Haitian people.

The power of the UHC vision is that it takes a whole-system approach to health system strengthening, from the national level to the district and community level. Community health is an under-leveraged and powerful mechanism for improving health outcomes, especially amongst the most marginalized, but it must be considered in a holistic way—with tertiary, secondary, and primary care integrated with and complementing each other for greatest impact.

Community Health Reform Foundations

To understand the foundations of community health reform in Haiti, it is helpful to review the much-overlooked foundations of the nation itself. In 1804, enslaved Africans and people of African descent overthrew French colonial rule thus winning Haitians the freedom to self-govern, the right to health and becoming the second republic in the Western Hemisphere. Theirs was the only slave revolution to result in a sovereign nation. However, the fight for recognition amongst world powers was far from over. Many founding fathers of the United States (US), including Presidents Thomas Jefferson, James Madison, and James Monroe, refused to acknowledge Haiti's independence. During debates in the US Senate in the 1820s, Senator Robert Haynes said, "Our policy with regards to Haiti is plain. We never can acknowledge her independence."²⁹ In order to have its sovereignty recognized in the eyes of France and other world powers—and for the sake of trade relations—the nascent nation agreed to pay France the equivalent of today's 21 billion USD to compensate former plantation owners for their loss of property (namely, land and enslaved people). The nation of Haiti paid that debt over the next 100 years.²⁹ It is left to speculation what that sum of money—had it been invested domestically from the nation's founding—could have done for Haiti. Political stability has often been in jeopardy in the two centuries that followed. What is more, lacking the maritime climate enjoyed by the Dominican Republic on the other side of the island, suffering significant deforestation, and positioned both in a hurricane belt and on an earthquake fault line, Haiti has faced exceptional obstacles.

Despite these significant challenges, Haiti has never lost its sense of identity as a birthplace of freedom for all people, won by Haitians themselves. The spirit of independence, true perseverance, fraternity with fellow citizens, and belief in the right to healthcare for all can be powerfully seen in the fact that Haiti was one of the first countries in the world to implement community health programs.

FOUNDATIONS OF COMMUNITY HEALTH IN HAITI

In the 1980s, tuberculosis (TB) was a leading killer in Haiti, as it was in many countries. That threat was compounded by the new human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) epidemic. Both diseases required complex and consistent treatment to achieve any decrease in morbidity and mortality. Innovative implementers like Zanmi Lasante discovered that community members enabled with basic health education and employed to bridge the continuity of care could very effectively improve patient outcomes, even among poor people in remote locations with weak infrastructure.³⁰

The sister organization to Partners in Health (PIH) in Haiti, Zanmi Lasante was founded in the early 1980s to serve the rural community of Cange. Today, Zanmi Lasante provides health services throughout the Central Plateau and lower Artibonite. After the national government, Zanmi Lasante is the largest healthcare provider in Haiti³¹ and has worked closely with the MSPP for decades. Serving more than 1.3 million people, the organization provides primary care, maternal and child healthcare, HIV and tuberculosis services, and more advanced secondary and tertiary care.³¹

In 1991, Zanmi Lasante conducted a project exploring the efficacy of a TB treatment that was effective in countries with more infrastructure. They relied heavily on daily visits with community health workers called *accompagnateurs* for close follow up found on patients using directly observed therapy with highly active antiretroviral therapy. The outcomes of the *accompagnateur* project were as encouraging as a contemporary treatment that included a two-month hospital stay. The results suggested that in settings of extreme poverty, when hospital-based care is unavailable even for the critically ill, quality treatment is possible. The study also recognized the compounding relationship between TB and HIV.

By 2000, AIDS had overtaken TB as the world's leading infectious cause of adult death. Incorporating lessons from TB control, Zanmi

Lasante piloted a program to provide patients with highly active antiretroviral therapy (HAART). The model involved support from community health workers known as *accompagnateurs*, because they accompanied their patients every day with directly observed therapy. HAART had been effective in sharply dropping mortality in affluent countries, but until then the cost of the medications and the lack of necessary infrastructure meant that HAART was not widely used in poor countries. Zanmi Lasante's pilot study found a favorable clinical response to therapy in 59 out of 60 patients. The pilot also decreased AIDS-related stigma, improved staff morale, and increased voluntary participation in HIV testing and counseling utilization by 300%.²⁴ When people felt confident that they could receive effective treatment, they were more likely to seek care that helped to prevent, detect, and respond to HIV/AIDS.

The results of this study present a forceful counterargument to skeptics of community health, who often cite lack of health workforce motivation, poor workforce retention, the power of cultural stigma towards epidemics, and lack of behavior change as arguments that a community is not yet ready for investment. The study demonstrated, however, that people are discerning about the options available to them. When quality care is available, for instance through community health workers, it can generate real hope in under-served communities that can motivate action and behavior change.

Over the past several decades, Zanmi Lasante and other organizations in Haiti developed different groups of community health workers, including health agents, women's health agents, *accompagnateurs*, youth monitors, traditional birth attendants, and agricultural agents.³² These different cadres have contributed to diverse projects to improve health outcomes throughout the country. As early as 1984, community health workers were contributing to healthcare access in Haiti.³³ Recruitment of community health workers was initially driven by the need for TB and then HIV treatment that required daily, long term adherence to medication. Over time, community health implementers piloted community provision

of additional healthcare services, progressively adding new community health cadres or expanding the service package for existing community health workers. Ultimately, community health workers have come to represent an important part of primary healthcare services.

Given the flourishing of successful community health programs, it is perhaps surprising that Haiti did not immediately succeed in developing a national, standardized community health system. However, the feasibility of doing so has been severely limited by a relentless onslaught of political unrest and natural disasters. In addition, ongoing challenges like deforestation and the high cost of imported goods, like food staples, have continued to erode health gains and compound short-term crises. With the Haitian government constantly in response mode in the face of these ruptures, the MSPP has faced major challenges to invest in the upfront work of building and strengthening its health system for the long term.

ADVANCES IN COMMUNITY HEALTH THROUGH THE 2000s

In 2002, the success of HIV treatment programs in Haiti was recognized by the Global Fund to Fight AIDS, TB, and Malaria. The Global Fund's 24.7 million USD grant to Haiti was the first one given to a Caribbean or Latin American country, and specifically applauded "a pioneering approach using community members to promote adherence to treatment."³⁴ This was a historic collaboration and an early recognition of the beneficial value of community health workers in Haiti and globally.

In an effort to decentralize services in 2004, the MSPP launched the Strategic Plan for Health Sector Reform (*Plan Stratégique du Secteur de la Santé pour la Réforme*). While the plan did not formally recognize community health workers in the national health system, it took steps to extend the national healthcare structure to the community level by introducing Community Health Units. As a precursor to the District Health Units, Community Health Units had the mandate of ensuring the provision of basic health services by managing primary level facilities.³⁵ Unfortunately, the Community Health Unit model was not applied uniformly throughout

the country, with some areas facing challenges, including lack of political will and resources to establish and maintain the facilities.

A packet of basic services was first defined in the 2004 Strategic Plan for Health Sector Reform and revised in 2006. By 2010, Haiti had laid out a packet of essential services (*paquet essential de services* or PES) along with an accompanying list of secondary level services.³⁵ The Government of Haiti was taking steps to strategically clarify role that the national health system either provides or aspires to provide in the pursuit of more effective care. Community health workers were not formally delivering the PES in 2010, but it would not be long before they were incorporated into the national system strategic plan. Appendix 1 includes a table of key policy documents and resources relevant to community health in Haiti.

THE 2010 EARTHQUAKE

On January 10, 2010 Haiti's capital, where a quarter of the population lived,³⁶ was struck by a major earthquake, which killed over 300,000 people and displaced 10% of the population. More than half (61%) of the nation's hospitals were destroyed or seriously damaged.ⁱⁱ Key buildings, such as the Presidential Palace, the Parliament, the Ministry of Health, and other government ministries, collapsed. Many civil servants, medical professionals, and students were killed when these buildings fell. Public records were lost. The economic damage and losses are estimated at 8 billion USD (at least 120% of the 2009 Gross Domestic Product). A cholera outbreak followed—spreading through poor sewage drainage from a base where UN peacekeepers were stationed, responding to the earthquake.¹⁷ The cholera epidemic killed more than 9,000 people and sickened over 340,000. Together, the earthquake and outbreak had a devastating effect on the entire health system. Community health proved to be an important part of both the emergency and long-term healthcare response.

Several community health worker projects were launched in the immediate aftermath of the

earthquake. Community health workers already comprised close to half of Zanmi Lasante's employees, and the organization hired dozens more to provide care in the tent communities where people were living after the earthquake.³⁷ The MSPP began to develop the framework for a national model of ASCPs integrated into family health teams. The Pan American Health Organization (PAHO) took a leading role in piloting this model in the municipality of Carrefour, which had been particularly hard hit due to its proximity to the epicenter of the earthquake.²² As part of its response to the cholera epidemic, the US Centers for Disease Control and Prevention (CDC) strategically distributed cholera training materials to 1,000 community health workers.³⁸

The earthquake prompted many to talk about “building Haiti back better,” and indeed some major reforms followed. In 2011, the MSPP instituted community health workers as a national cadre, and updated national policies would follow over the next few years. While these policies, in addition to physical reconstruction projects, represented important progress for Haiti, the earthquake also greatly exacerbated existing coordination burdens among stakeholders and actors. Before the eyes of the world turned to Haiti in the aftermath of the earthquake, the country already had more NGOs per capita than any other nation—more than 10,000 organizations for a population of 10 million.³⁹ After the earthquake, hundreds of actors—including an influx of newly arrived organizations—engaged to support Haiti's recovery. Coordination between international NGOs and local Haitian NGOs has always been fraught, and these problems were exacerbated during recovery efforts. Earthquake response coordination meetings hosted by the UN were held in English, not French or Haitian Creole (Haiti's two national languages). When a steering committee was created for NGO coordination, sixty international organizations cast their votes. However, because no local NGOs were present, Haitians were not represented in the vote or on the steering committee.⁴⁰ Structural exclusion from the coordinating meetings meant that local NGOs were

ii Eight hospitals were destroyed and 22 were seriously damaged.¹⁶ According to PAHO, there were 49 hospitals nationwide before the earthquake.¹⁷

not able to participate equally in the earthquake response. It also meant that they were prevented from contributing to the design of post-earthquake “build back better” systems, discussed in these meetings. The challenges of coordination and collaboration have continued to impede community health reform.

With time, disaster response subsided, and major rebuilding efforts kicked off, including the physical reconstruction of the MSPP⁴¹ and the construction of a new teaching hospital outside of Port-Au-Prince. Stakeholders recognized the importance of the moment to prioritize the institutionalization of community health into the national healthcare system.

POLICY ADVANCES FROM 2011 THROUGH 2016

In the five years immediately following the earthquake, Haiti would see unprecedented community health reform during the push to nationalize a unified cadre of community health workers. In 2011, the MSPP revised the basic service package in the Minimum Services Package (*Paquet Minimum des Services* or PMS) providing Haiti’s most complete essential package of health services to date. The same year, the MSPP published the Training of the Polyvalent Community Health Worker: Student Workbook (*Formation de l’Agent de Santé Communautaire Polyvalent: Cahier d’Elève*), which was followed by an accompanying textbook and instructor’s manual in 2012.⁴² These texts defined the role and work of an ASCP, as

compared to any other regional or programmatic community health workers who had come before them. The ASCP student workbook, textbook, and instructor’s manual were created in collaboration with the Ministries of Health of Cuba and Brazil as part of earthquake recovery commitments from the two countries.

In continued momentum to reform the national health system, the MSPP also published the National Health Policy (*Politique Nationale de Santé*) in 2012 and the Healthcare Master Plan 2012-2022 (*Plan Directeur de Sante 2012-2022*) in 2013. Both of these documents include ASCPs and position them in their ESFs within the structure of the national healthcare system. These resources and policies defined the role of the ASCPs and their position within the greater health system. However, these resources and policies did not include costed operational plans and implementation guidance.

Stakeholders soon recognized the problems around implementation and financing of the national ASCP cadre in Haiti, and in 2015 the MSPP published The Organization of Community Healthcare (*Organisation des Soins de Santé Communautaire*). This was the first national community health policy to include a costed plan for the ASCP program. In 2015, the MSPP also updated the basic service package in the Essential Services Package Manual (*Manuel du Paquet Essentiel de Services*). Please see Appendix 1 for a table of key policy documents and resources relevant to community health in Haiti.

Institutionalization Challenges in Haiti

The cycle of community health reform that launched in the wake of the 2010 earthquake generated landmark results, including the creation of one unified community health cadre in 2011 as well as policy reform in 2012, 2013, and 2015. These steps represented major achievements in advancing community health in Haiti, but by 2016 progress had stalled. The MSPP's community health plan has yet to be implemented at scale across the country.

The reform cycle is a useful framework to analyze the progress and challenges in Haiti's journey towards community health institutionalization from 2010 to the present.



PROBLEM PRIORITIZATION AND COALITION BUILDING

As Haiti was rebuilding and strengthening the health system after the devastation of the 2010 earthquake, the government recognized that weak health system infrastructure, an insufficient health workforce, and lack of primary healthcare of good quality were leading to some of the worst health outcomes in the Western Hemisphere.³³ The MSPP and its partners, therefore, prioritized these

problems and committed to creating a unified, national cadre to extend essential health services across Haiti.

Coalition building is recognized as a core step in community health systems reform, and it also connects with Goal 17 in the Sustainable Development Goals (SDGs): to strengthen the means of implementation and revitalize the partnership for sustainable development.⁴³ When problem prioritization and coalition building are at their best, the shared identification of a compelling problem at the right moment galvanizes something special—a winning coalition. If such a powerfully aligned group is carefully constructed and maintained by its members, they connect the priority problem with the right actors to influence the health system to change. This positive force can be engaged throughout all stages of reform. Haiti has many committed international and local implementers, funders, and civil servants but there have been challenges in creating strong coalitions in community health.



FRAGMENTATION

Coalition building in Haiti has faced major challenges, with low levels of engagement between NGOs. Mixed methods research on rural and maternal child health NGOs in 2017¹⁰ revealed that while there was some level of cooperation occurring between them, it was quite low. Participants were aware that increasing collaboration would enable better information and resource sharing, learning from other organizations, patient care provision, and efficiency. However, they noted barriers to achieving these gains, such as competition amongst NGOs, egos, physical infrastructure limitations, time constraints, rogue groups, and lack of resources.

These challenges persist. While some NGOs share information and a small number share resources and materials, there is very little in the way of joint effort among them.⁴⁴ Without effective networks between community health implementers that enable collective action for policy reform, it is deeply challenging for Haiti to reduce fragmentation or advance institutionalization of community health.

Perhaps even more concerning, there is a noted scarcity of meaningful collaboration between NGOs and the Haitian government. At the same time that the MSPP worked with partners from the governments of Cuba and Brazil to develop ASCPs as a national community health cadre, other stakeholders were conducting research for a national curriculum on community health in Haiti. The results of this parallel workstream were not always shared and incorporated effectively. As the disconnect was recognized, implementer and donor collaboration and trust were weakened.

The Haitian government has often been outside the sphere of key financial and programmatic decision making carried out by donors and implementers. Two years after the earthquake, the Haitian government had been allocated just 1% of the humanitarian aid provided for the earthquake response, and between 15% and 21% of long-term relief aid. The rest went directly to NGOs and private contractors.⁴⁵ Most NGOs (80-90%) do not submit their annual reports to the government even though it is a requirement, according to staff at the Minister of Planning and Foreign Cooperation.³⁹

Many other NGOs remain unregistered.⁴⁴ The lack of meaningful government inclusion has blurred lines of accountability, strengthening vertical relations between NGOs and civil society mostly to the exclusion of the Haitian government. This dynamic threatens the legitimacy of the government in the eyes of the people.⁴⁶

HISTORICAL INFLUENCE

Recalling the historical stance of American leaders at Haiti's founding—to "never...acknowledge her independence"²⁹—it is worth questioning whether modern aid implementers and funders who are not from Haiti have inherited this spirit of non-collaboration and supremacy. In a 2010 Progressio report, an anonymous displaced person living in Belladere, Haiti commented: "These international organisations should talk to us and learn about what we need. They will save a lot of money by doing that. Development should be led by grassroots organisations supported by the international community, not the other way round." Colette Lespinasse of the *Groupe d'Appui aux Rapatriés & Réfugiés* in Haiti shared complementary insights: "If the reconstruction process is carried out in the same exclusionary manner, and without consensus and respect, we will not be eliminating poverty in Haiti. On the contrary, we will be building more fragmentation and divisions in a process that requires building consensus."⁴⁷ A culture of supremacy leads to inefficient resource allocation and fragmentation, as local knowledge is overlooked and accountability to the people is bypassed. The pursuit of UHC is about every person getting affordable, timely, quality healthcare. Without dismantling such structural inequalities, systemic change towards UHC may prove impossible.

CALL TO ACTION

The need to strengthen coordination in practice—and government leadership of coordination—is critical. Further progress in coalition building and institutionalizing community health may be achieved by stakeholders in Haiti by leveraging the challenges and lessons learned to date. A renewed and ardent commitment to come together could have large sustainable impacts on saving lives.



SOLUTION GATHERING

Successfully reforming community health requires gathering solutions to the prioritized problems from existing capabilities, practices, partners, and resources within a health system. In endeavoring to create a unified national community health worker cadre in 2011, Haiti had several decades of community health programs to draw from.

The MSPP and other stakeholders recognized the successful role of community health worker programs—ranging from HIV *accompagnateurs* to women’s health agents (*agents de femmes*)—in providing quality essential care services.^{32, 24} Despite the success of these programs, there was no standardization across programs or implementing organizations.

Elements that were incorporated from smaller scale programs into the national strategy included supportive supervision, competency-based training, and salaries for community health workers and their supervisors. In 2010 Zanmi Lasante’s *accompagnateurs*, for example, were already part of a supervision hierarchy in the districts where they worked. The supervision hierarchy included the head of the commune (or district), public health nurses, HIV program nurses or social workers, and *accompagnateurs*.³² Supervision included monthly meetings and continued training sessions, as well as field supervision.

All of Zanmi Lasante’s different groups of community health workers received initial training specific to the work of their cadre.³² Women’s health agents were trained on reproductive health and HIV/AIDS; youth monitors learned about sexuality and good practices concerning sexuality and STDs; and traditional birth attendants were trained to recognize danger signs and refer mothers. Health Agents (*Agents Santé*) received the broadest training in order to provide basic health services, vaccinations, family planning, and hygiene education, along with activities specific to the regions where they worked.

Zanmi Lasante also paid all of their community health worker groups in addition to providing other social benefits, before a national, paid cadre existed.³² Health Agents and Women’s

Health Agents, were paid as full-time employees. *Accompagnateurs* were classified as part-time employees with a pay scale based on their number of patients. Traditional birth attendants were paid per case, and youth monitors were paid per diem, in addition to having their school fees paid for them.

Supervision, training, and compensation were among the interventions that solved problems in quality of care and employee motivation—challenges that had been recognized elsewhere in community health and in other parts of the health system in Haiti.⁶ Zanmi Lasante’s projects demonstrated the effectiveness of these interventions in the regions where they worked.^{24,32} Based on these outcomes, community health stakeholders advocated for supervision, training, and compensation to be incorporated into the national policy for ASCPs.

At the same time, the diversity of community health worker engagements needed to be streamlined so that one multi-skilled (or polyvalent) cadre could provide an essential package of health services. In a national system that already struggled with fragmentation and coordination challenges, it would be too difficult to implement all the different community health interventions, however effective they might be. As a solution, community health stakeholders prioritized the package of services already defined by the MSPP and identified ways to deliver those services to more people using community health workers. Deprioritized groups included youth monitors and agricultural agents (*agents agrikol*). These and other groups—considered less central to the basic package of services—were not scaled to the national level.

In the aftermath of the 2010 earthquake, community health worker programs responding to the cholera epidemic piloted the MSPP’s emerging ASCP model. The CDC created cholera treatment training manuals in French, Haitian Creole, and English for community health workers, calling them “the backbone of the health system in rural Haiti.”³⁸ The manuals were shared at departmental training sessions, with NGOs, and in trainings with community health workers. One thousand community health workers used the

training manuals as they staffed local clinics, taught health education, and led prevention activities in communities. The community health workers using CDC's manuals included the newly recruited and trained ASCPs in Carrefour, a district especially close to the epicenter of the earthquake. With technical support from PAHO, the ASCP pilot that the MSPP deployed made a measurable positive impact. From 2011 to 2015 the immunization coverage of infants increased from 37% to 87%, family planning consultations increased by 20%, and institutional deliveries increased by 16%.²² When oral cholera vaccines became available in 2013, community health workers participated in community education and their distribution.⁴⁸ These new community health interventions were developed or started contemporaneously with the MSPP's ASCP curriculum and policy development. These projects piloted the vision led by the MSPP of multi-skilled community health workers that could not only respond to epidemics and crises, but also extend quality primary healthcare in the long term.



POLICY AND PROGRAM DESIGN

As the MSPP and other community health stakeholders were designing the national ASCP program, they needed to consider how a national community health cadre would function within the existing health system. On the one hand, Haiti's health needs were great: The health system needed to address both acute crises like the cholera epidemic and systemic challenges like the lack of high-quality primary healthcare. On the other hand, caution was merited: Loading too many responsibilities onto a nascent cadre of new health workers could be setting them up to fail.

In 2012, the MSPP published two key policy documents: the National Health Policy (*Politique Nationale de Santé*) and the Healthcare Master Plan 2012-2022 (*Plan Directeur de Santé 2012-2022*). They presented the national health system with ASCPs incorporated into the design.^{42,49} At the national level, the ASCP cadre would be housed within the Department of Health Promotion and Environmental Protection (*La Direction*

de Promotion de la Santé et de Protection de l'Environnement). This department had engaged community health workers for health education through its different structural iterations since the early 1980s.⁵⁰ At the community level, the ASCPs would be part of a family health team (*Equipe de Sante Familiale* or ESF). ESFs were designed to provide the supervision, as well as the interconnectivity with other levels of the health system.

A formal national community health program design was an important and exciting step in Haiti's community health reform journey. However, success of the program design has been undermined by lack of coalition collaboration. For example, four years after the MSPP published the Organization of Community Healthcare, a 2019 World Bank report stated that there is "lack of agreement on a common model" for community health in Haiti.²⁷ The report suggested that community health workers who address specialized diseases or conditions—instead of following the MSPP's model—be termed non-polyvalent community health workers (*agents de santé communautaires non-polyvalents* or NCHWs). Some 50 different agencies finance community health programs in Haiti. Almost a quarter of those programs confine their financing to certain diseases or conditions, and do not follow the program designed by the MSPP. However well intended, these programs complicate the delivery of care. If a national community health program is to succeed at reaching scale in Haiti, funders as well as implementers and the government must be able to work together to agree to follow a common strategy. Otherwise, fragmented programs will continue and lines of accountability to the government will remain broken.

Another disagreement is about scale of the cadre. In the ASCP program designed by the MSPP, each ASCP should cover no more than 1,000 people. To scale the plan nationally this would require around 10,000 ASCPs.ⁱⁱⁱ The Community Health Roadmap,⁴⁹ lists a goal of 5,000 ASCPs nationally

ⁱⁱⁱ One ASCP to no more than 1,000 people is a common scale in other countries in the region, like Brazil. Some partners, such as the World Bank, argue that the designed scale of the ASCP cadre is too ambitious for Haiti.²⁷ They suggest that Haiti follow the examples of countries like Ethiopia and Nepal, where CHWs cover many more than 1,000 people each (2,400 and 6,900 respectively).

by 2021–2022. The discrepancy in these numbers points to persisting challenges in alignment around the design of the program and disagreement on what is feasible and necessary for quality care. As the reform cycle continued, there would be opportunities to address these challenges and refine the program design.



PROGRAM READINESS

Complementing the urgent need for stronger coalition building, the program readiness stage may be the one that has the most to offer community health stakeholders in Haiti, as they strive to advance community health reform through the cycle.

When it came to the policies and resources for the national ASCP cadre developed from 2011 to 2013, key parts of the program readiness stage were not realized. Buy-in from many key stakeholders was inadequate. Costed operational plans and implementation guidance were not included in the policies. In fact, community health stakeholders in Haiti would learn from this experience and include costed operational plans in the policies they published in 2015, and in community health policy revision started in 2019.



LAUNCH

Launching a reform is not simply a question of implementing a new plan; actors in the system are transitioning from one reality or identity to a new one. In 2011, the MSPP set forth a vision for a national-scale community health cadre to extend quality primary healthcare services to all in Haiti with pilot projects and national policies developed over the following years.

By 2014, there were 3,161 ASCPs in Haiti.⁴² When the MSPP established ASCPs as a cadre in 2011, there were 1,609 community health workers in Zanmi Lasante-managed networks³³ and 1,000 community health workers were trained in cholera interventions by the CDC.³⁸ These groups may have overlap, and Zanmi Lasante's community health workers were not yet certified as official ASCPs by the MSPP, but these insights begin to shed some

light on baseline numbers for the cadre. By 2016, ASCPs were included in many projects, including those with the Red Cross,⁴² The US President's Emergency Plan for AIDS Relief,⁵¹ and USAID.⁵² Community Health implementers adhered to the MSPP's ASCP policies and resources based on their funding and organizational capacity, but coverage of ASCPs across the country did not reach the scale that the MSPP intended.



GOVERNANCE

Collective action and decision making define the governance stage. A set of formal and informal rules and relationships among actors allows for the setting of strategic direction, creation of an enabling environment, and execution oversight.

The challenges in previous steps of the reform cycle, specifically coalition building, and resource mobilization in the readiness and launch stages led to difficulties in governance. Indeed, implementers identified competition over resources, and lack of information and resource sharing—a symptom of siloed implementation—as challenges.⁴⁴

Until a survey was conducted in 2019 with support from the World Bank,²⁷ the MSPP lacked systematic and up-to-date information about the different CHW programs in the country, hindering its ability to anticipate funding or service delivery gaps and inefficiencies. For instance, the government did not systematically track the number and geographic distribution of ASCPs and other community health cadres, or the expected duration of program funding.

In the governance stage, community health stakeholders in Haiti also recognized the shortage of successful referrals up and down the health system. One USAID report in 2016 stated, "The referral system is widely considered by facility managers, staff, and ASCPs to be non-functional or even non-existent in peripheral areas."⁵³ The report recommended that USAID and other community health implementers be intentional about strengthening the referral system at and through the community level in future projects and programs.



MANAGEMENT AND LEARNING

During the management and learning stage, actors implement reformed policies and programs and utilize learning and data to improve performance of the system. ASCPs were involved in much of the progress in public health from 2011 to 2016. There were advances in TB case notification and detection, HIV clinical surveillance efforts, the national immunization program, and cholera control (as the country moved toward eradication).⁵⁴

Nevertheless, community health stakeholders acknowledge that the ASCP cadre did not scale nationally from 2011 to 2013, as designed in the MSPP policy. They recognized the lack of sustainable financing and the problems in the referral system, among other challenges. Based on this learning, in 2015 the MSPP published the Organization of Community Health Care (*Organisation des Soins de Santé Communautaire*).⁴² This policy included a five-year operational cost of 257 million USD for the program. Although the policy did not include plans to achieve the needed funding, nor identify funding gaps, it did spark renewed conversation around financing for community health.

The same year Dr. Georges Dubuche, the Director General of the MSPP, gave a presentation⁵⁵ on financing the health system, including community

health. He acknowledged that the implementation of the ASCP service package would be progressive and would be increased as funding permitted. He outlined a plan to have ASCPs scaled across the whole country by 2025. He noted that the Haitian government did not invest enough in health (compared to countries with a similar or lower GDP) and that Haitian households were the source of almost a third of the financing for health in Haiti.

By 2016, Haiti had moved through a reform cycle—from problem prioritization through to management and learning—to establish a unified national community health worker cadre, the ASCPs. However, some stages of reform were more completely realized than others, specifically coalition building and resource mobilization within the readiness stage. Concurrent with the 2016 presidential elections, Haiti's community health system was at a critical juncture. While the foundations for the national community health system had been laid, Haiti needed further investment, coalition building, and institutionalization of community health to bring the ASCP cadre to a national scale.

Haiti's ICH Investment as a Catalyst for Reform

Haiti's community health reform journey reached a critical moment in 2015 when the MSPP published The Organization of Community Healthcare (*Organisation des Soins de Santé Communautaire*).

In 2016, most people concerned with Haiti's prosperity and development were focused on the presidential election—the first since President Michel Martelly was elected the year after the 2010 earthquake. No one knew how the country might change through this transition in leadership. Just as the country was poised to scale the ASCP cadre nationwide and thereby increase health access for underserved populations, there was significant risk that these opportunities could be lost in the shuffle of new leadership.

It is within this context that Zanmi Lasante, the MSPP, and USAID came together to launch the ICH Investment in Haiti.

Introduction to the ICH Investment

Zanmi Lasante has a history of trusted partnership with the MSPP and quality health program implementation in Haiti spanning back to 1983. In the years leading up to the 2010 earthquake, Zanmi Lasante created jobs for more than 4,000 Haitian people, constructed 12 hospitals and health centers, developed a strong working relationship with the MSPP,³⁷ and developed and led many community health programs.³² A core part of Zanmi Lasante's approach is not to focus on the capital, Port-Au-Prince, where both public and private services tend to cluster, but rather to continually strive for better health services for all by providing services in rural and remote areas. As a trusted partner of the MSPP and a quality implementer with a long history of community health innovation

ICH IN HAITI AT A GLANCE

PROJECT: Scaling Up Agent de Santé Communautaire Polyvalent in Haiti

IMPLEMENTING PARTNER: Zanmi Lasante

DATES: March 18, 2016 – December 2020 Amount: 750,000 USD (USAID), 250,000 USD (Cost Share)

OBJECTIVES:

- Align Zanmi Lasante's network of CHWs with the MSPP's new requirements and standards for ASCPs
- Strengthen the continuum of care by developing linkages between communities and health facilities in Mirebalais
- Strengthen health information systems and data management capacity in order to improve data for decision making within the ASCP network

GEOGRAPHIC FOCUS:

- The commune of Mirebalais in the Central Plateau department of Haiti

SCALE: Complete coverage of community health workers (ASCPs) at a ratio of 1 ASCP per 1,000 habitants, working within family health teams (ESFs) across the commune of Mirebalais

in Haiti, Zanmi Lasante was an ideal implementing partner to advance the expansion of the MSPP's community health strategy at this critical moment.

Through the ICH investment, Zanmi Lasante would scale the ASCP cadre throughout the Mirebalais commune, where the organization had just completed construction of the new University Hospital at Mirebalais. UHC requires all levels of the health system to work together, from the national level to the primary level. The University Hospital at Mirebalais actualized a major step forward in providing tertiary care. In its first year of operation, the hospital's emergency department electronically registered nearly 17,000 patient visits, and the number of visits continued to grow.⁵⁶ The moment was opportune to foster a strong referral and counter referral system between the new hospital in that commune, from emergency care services through to the most fundamental primary care services. The learning from this project had the potential to benefit the MSPP and the whole country.

In order to reach full coverage of ASCPs in the commune of Mirebalais, as alignment with the 2015 *Organisation des Soins de Santé Communautaire* and serve as a model for national scale-up, Zanmi Lasante was supported by USAID and collaborated with the MSPP in the ICH collaboration.

While the project served a greater purpose of advancing community health reform, it also addressed key barriers to community health within the project's area of implementation. The ICH project was designed to address critical shortcomings in Haiti's community health system, including funding, availability of human resources for health, referral, and supervision.

The vision for the project was for ASCPs in Mirebalais to be directly linked to the greater health system through:

1. A systematic training and certification process
2. A coordinated referral system
3. A supportive supervision system
4. An improved information system⁵⁷

The international research NGO Population Council collaborated with Zanmi Lasante, the MSPP, USAID, and UNICEF to study the effectiveness of existing referral mechanisms as a measure of the strength of community-to-facility health system linkages.

The ICH investment brought together, in one commune, the vision for community health in Haiti nationally. The project followed the national community health strategy put forth by the MSPP and was led by a collaborative and effective implementing partner. International funders provided the needed financial support to bring the program to scale. The ICH investment itself was in service of a greater, ultimate goal of "the MSPP [possessing] the appropriate tools to coordinate all implementing partners and begin harmonizing existing fragmented CHW programs into one unified ASCP structure, fully integrated within the larger health system and fully aligned to national policies and implementation plans."⁵⁷

Throughout implementation of the ICH project, Haiti experienced several political shocks. Jovenel Moïse became the new president of Haiti early in 2017 and the change led to many transitions in government, including at the MSPP. This resulted in the loss of nearly all relationships developed between Zanmi Lasante and the MSPP leadership.⁵⁸ As members of Zanmi Lasante described, "Zanmi Lasante continues to collaborate with the MSPP despite political transitions and instability, which often times encumbers our robust working relationship. This has, as stated in the past, affected the project's integration and progression, as if starting over entirely. [Zanmi Lasante] has worked to re-engage the MSPP representatives, as their collaboration is essential, not only for scale-up of the model, but also for the official certification of the trained ASCPs in Mirebalais."⁵⁸

In addition to the collaboration challenges, the project also faced operationalization challenges. Months into his presidency, a major report implicated President Moïse in embezzling funds, just as gas prices and inflation were climbing. Protests periodically shut down roadways and businesses nationwide, which impeded travel and

safety across the country. Because Mirebalais is a political epicenter, it also became, at times, a focal point for turmoil. At the national level, the highest levels of government were not fully functioning, with frequent turnover and legislative positions left open for extended periods of time.

Despite and throughout this turmoil, all 100 ASCPs and their 10 ASCP supervisors in Mirebalais continued their work. Zanmi Lasante reported that the ASCPs and their supervisors “travers[ed] burning roadblocks” to access needed supplies, complete home visits, provide family planning services, and administer vaccines. While the protests and unrest complicated fieldwork for the ASCPs, who were expected to maintain their neutrality, they developed strategies to perform most of the duties expected of them. In the words of Zanmi Lasante, the field team “should be commended for their loyalty, their sense of duty and their bravery,” as their actions during these times of upheaval “are a testament to [the field team’s] renewed motivation and fervor in the face of grim odds.”

Yolette Toussaint, a community leader and mother of five shared her personal perspective on the project: “In the past, children in the community would get sick with diarrhea, furthermore, they had to go very far for vaccination services. But they are now able to receive help at home or near with the ASCPs. The ASCPs talk often to the members of the community, giving counsel, information, showing us how to protect ourselves, our health, and our children’s health from disease. They talk to us about family planning, hygiene, hand washing in relation to diarrhea and other disease that are water borne... Truly the work the ASCPs are doing is great.”⁵⁸ Especially amidst such extraordinary circumstances, the positive results reflect the power of community health workers to provide sustainable, quality care when they are well supported and integrated into the health system.

Even as Zanmi Lasante rolled out these ASCP services to provide needed primary healthcare to community members, the organization was also working to address national community health priorities. Returning to the community

health reform cycle provides a useful framework for understanding how the learnings from the ICH investment are advancing community health institutionalization.



MANAGEMENT AND LEARNING

Throughout project implementation, Zanmi Lasante developed key questions and lessons learned, including: whether the ASCP selection criteria impeded sufficient recruitment, how to best deploy ASCPs in relation to community needs, and how to optimize a joint training, certification and supervision model.⁵⁷ During implementation, Zanmi Lasante observed the effectiveness of the training curriculum and the MSPP instructors in building the capacity of the ASCPS in Mirebalais. Zanmi Lasante was so encouraged by the early results of the project that, despite financial barriers outside the ICH project, they began to plan the MSPP trainings and certification of ASCPs in additional regions where Zanmi Lasante operated.

Zanmi Lasante faced substantial challenges in operationalization of a new referral and counter-referral system between the community and health facility. The existing weak referral system reflected the fragmented nature of the health system. However, the referral and counter-referral system is essential to integrating ASCPs into the health system meaningfully. The Population Council subsequently focused its research project on the barriers and pitfalls of the referral system in Mirebalais with the goal of developing an approach that would eventually be scalable throughout the region.^{59, 58}

The management and learning phase of the ICH project produced lessons that can help improve the community health system nationally—regarding the referral process, the selection criteria for ASCPs, and the process of their training and certification. The project also generated lessons that could be immediately applied. Managers observed that together the Zanmi Lasante team and the MSPP instructors learned how they could improve, schedule, and present the ASCP curriculum. These lessons are being applied as the MSPP certifies community health workers beyond Mirebalais.

However, opportunities remain for the many lessons learned in the ICH project to be incorporated into national reform.

ICH Investment as Part of Continued Momentum of Community Health in Haiti

Over the course of the ICH investment, other community health activities were also happening. In 2016, representatives from the Government of Haiti as well as nonprofit organizations in Haiti attended the Integrating Community Health Conference (IHC) in South Africa, fueling continued momentum for community health reform amongst all parties.

The 2017-2018 national budget included salaries for 1,200 ASCPs and 200 AIPs. This was the first time ASCP and AIP salaries were included in the national budget. This was a major step in government ownership and national integration of community health into the national health system. In 2019 in his statement at the World Health Assembly, the MSPP Director General Dr. Lauré Adrien specifically recognized the essential contribution of ASCPs and their supervisors in the fight against cholera.⁶⁰

Contemporaneously with the ICH investment, the MSPP is leading reform of the strategic plan for community health. Utilizing funding from the World Bank, UNICEF, and USAID, the MSPP led important assessments to inform a new strategic plan for community health in Haiti. This includes a situational analysis, field studies, cartography, and consultations with different stakeholders at all levels. The reformed community health strategic plan includes a synthesis guide, a revised ASCP curriculum, and costing of the strategy. During a window of political stability before COVID-19 arrived in Haiti, the MSPP led a workshop sharing the new strategic plan with stakeholders. The final step is to have the plan formally approved by Haiti's Senate.

Applying the reform cycle to the community health strategic plan reform process, the reform went

through some degree of problem prioritization and coalition building. Solution Gathering is clear in the analyses and studies that inform the policy reform. Policy and program design is demonstrated in the synthesis guide, revised ASCP curriculum, and costing of the strategy. According to the reform cycle, the community health policy reform had arrived at new and important stages: readiness and launch.

PROBLEM PRIORITIZATION

The Community Health Roadmap⁴⁹ brought together the Bill & Melinda Gates Foundation, The Rockefeller Foundation, UNICEF, The World Bank Group, USAID, and the Community Health Acceleration Partnership to identify investment priorities to scale primary care at the community level in Haiti and other priority countries. In 2019, they published their summary of priorities for Haiti, which connect with the reform cycle stages of design, program readiness, and governance.

In program design, the Community Health Roadmap prioritized the need for clearer policy guidance for the ASCP program, including a more developed national community health strategy; updated synthesis guide, manuals, and training tools; and finalized protocols and field guides for HIV. As a first step towards harmonizing training performance management, and incentives, the MSPP and partners would need to map different cadres/partners in community health. Using lessons from partners like Zanmi Lasante, the Community Health Roadmap recommends that the MSPP and partners revise the recruitment process and develop certifications and standards of care for community health workers of different cadres – not just the ASCPs. Historically, Zanmi Lasante and other implementing partners have used different cadres of community health workers focused on different interventions. Those focused community health cadres have not always become integrated into the MSPP's ASCP cadre, especially when funding priorities from donors focus on key interventions and don't align with the ASCP cadre's mandate. Diversifying the type of nationally recognized community health workers could help broaden services provided and create compromises with donor that prioritize verticalized interventions.

Finally, the Roadmap recommends that supervisory structures be included in the new design. While supervisory structure already exists on paper (ASCPs are supervised AIPs) a stronger design, perhaps with stronger partner alignment, could increase the effectiveness of ASCP supervision—a necessary component of quality care.

To strengthen program readiness, the Community Health Roadmap prioritized hiring more ASCPs. The Roadmap set a goal of 5,000 ASCPs—only half the scale recommended by the MSPP but more than the existing 3,915 ASCPs working at the time the Roadmap was published. Further scale up could be planned iteratively. The Roadmap recommended deploying and reassigning ASCPs and their AIP supervisors, which aligned with plans for better mapping of the different community health partners across Haiti. Program readiness also included training and refresher training for ASCPs and their AIP supervisors. The Roadmap also recommended resource mapping and exploring more sustainable and innovative funding mechanisms to close the resource gap. This was in line with the presentation made by the MSPP Director General in 2015, calling for more innovation and strategy to increase health financing.

In terms of program governance, the Community Health Roadmap prioritized moving to DHIS-2 (Digital Health Information System 2). This move would complement prioritized efforts to strengthen governance, coordination, and monitoring at the national, departmental, and community levels. The Roadmap prioritized developing an integrated performance management system that is harmonized across data systems for CHWs. Overarching all other reforms is the priority to build capacity for leadership and governance.



COALITION BUILDING

In 2018, the MSPP established a Principal Financial Partners Group (*Groupe Principaux Partenaires Financiers* or GPPF) to increase collaboration and harmonization among technical partners and donors. Under the leadership of the MSPP, the

group's members include USAID, the Global Fund, PAHO, the EU, CDC, the World Bank, the Canadian government, and the French Development Agency (*Agence Française de Développement*). This group supports the planning, monitoring, and troubleshooting of key areas of interest, based on the Minister of Health's priorities.⁶¹



DESIGN

In 2019, the MSPP released the Process for the Development of the Strategic Plan for Community Health 2019-2023 (*Processus d'Élaboration du Plan Stratégique de la Santé Communautaire 2019-2023*), which outlined the path towards a national community health strategy.⁴⁹ At the same time, the World Bank and key donors are collaborating with the MSPP on the development of a reformed and more robust community health strategy and implementation plan.²⁷ These would include a finalized community health worker Operational Manual with clearly defined tasks and task time allocations for both the ASCPs and disease-specific community health workers who can dedicate a meaningful percentage of their time to the ASCP mandate.²⁷ This may be a functional way of reaching the compromise prioritized in the Community Health Roadmap and help with the alignment of implementing partners to the MSPP strategy.

Through the Roadmap, Haiti identified the development of the national strategy; updated a synthesis guide, manuals, and training tools for ASCPs; and finalized protocols and field guides for community-based HIV services as a priority.⁴⁹ This created a real opportunity for reform. For example, the MSPP is exploring the value of a "risk stratification" approach, in which ASCPs would identify more at-risk households for a closer follow-up to use their time most efficiently.²⁷ In addition, optimizing the distribution and allocation of ASCPs was identified as a priority in the Community Health Roadmap.⁴⁹ By allotting ASCPs based on population density, household vulnerability, and other factors, the MSPP can explore coverage ratios that would ensure equitable access to healthcare while potentially reducing program costs.²⁷



PROGRAM READINESS

In November 2017, Haiti joined the World Bank's Global Financing Facility (GFF), a partnership of funders that collaborate with country governments to align major global investment to the government's own priorities and strategies for reproductive, maternal, neonatal, child, and adolescent health. The GFF process entails defining country priorities, estimating the costs of delivering the prioritized interventions, mapping existing resources and funding gaps, and developing long-term strategies to address major health system and financial management challenges. The GFF strongly emphasizes the value of investing in community health and has played a critical role in strengthening community health systems in other countries. In Haiti, the GFF process began in April 2019 with a resource mapping exercise. The overall planned approach in Haiti will include the prioritization and costing of the Health Sector Development Plan to align donors and implementing partners. The GFF also intends to work with the Haitian government to develop mechanisms to track donor financing for efficiency and identify opportunities to reallocate both government and donor funding to align with priorities and cover funding gaps.⁶²

Opportunities and Next Steps

From being one of the earliest implementers and sources of learning in community health in the 1980s through the present moment, community health workers in Haiti and the national ASCP cadre, in particular, have the potential to lift up communities and improve health outcomes throughout Haiti. As the MSPP rolls out the new strategic plan for community health, it is imperative that there be sustainable financing to scale the ASCP implementation nationally. Scaled and supported ASCPs within their ESFs will strengthen primary care, by connecting communities to the national health system with regular visits, education, and counseling. Investing in ASCPs will increase the effectiveness of the health system overall, focusing investment where the health system has been particularly underresourced.⁶

While helping to extend basic primary healthcare services, community health workers in Haiti have responded to many crises over the decades, including TB, HIV/AIDS, and cholera. They have worked through the aftermath of the 2010 earthquake and recent political instability. Today, as the world responds to the Coronavirus Disease 2019 (COVID-19) pandemic, and decision makers design approaches to contact tracing, health information sharing, and vaccine distribution, ASCPs are an important investment for pandemic response and future preparedness.^{63, 64}

The GFF work will advance in connection with a World Bank project, that has so far mobilized 55 million USD to increase utilization of primary healthcare services in selected geographic areas—through the deployment of ASCPs to improve surveillance capacity. One goal of the project is to strengthen the design and implementation of the national community health strategy and implementation plan, in part, by filling gaps in implementation tools. Building on lessons from countries with strong community health systems,

including Ethiopia and Rwanda, the project recognizes the importance of a harmonized national approach using common protocols, strong linkages between ASCPs and the health system, effective supervision and data collection, and design choices that enhance sustainability (e.g., regarding coverage ratios). To meet the surveillance capacity-building objectives, a notable goal of the project will be to “de-verticalize” infectious disease interventions, particularly for cholera treatment and community interventions to support disease control.²⁷ If successful, such de-verticalization would mean more existing community health workers and community health programs in Haiti would become aligned with the government-led national health system. This shift would lead to stronger integration of health services and a stronger health system. De-verticalization of interventions could address significant ongoing challenges in partner coordination, as more and more partners join in supporting a unified community health program that covers the country.

The MSPP recently completed a census of all CHW programs, including ASCPs and other community health workers operating in Haiti. This initial census is intended to be a springboard for a longer-term system of continually tracking the number, location, tasks, and funding for all community health workers.²⁷ The initial census is also designed to support the harmonization of training, performance management, incentives, and other implementation features across the wide array of NGO partners and donors in Haiti.⁴⁹



COALITION BUILDING

For community health to progress in Haiti, implementing and funding partners need to align more faithfully with the MSPP. While there are continuing capacity needs in the MSPP, it is essential that the Ministry be the central,

convening, in-country public health leader, if community health is to become sustainable in Haiti. The MSPP must also be accountable to the Haitian people.

Historically, from independence through the 2010 earthquake and up to the present day, many partners have failed to align with—or meaningfully include—the Haitian government in community health efforts, thus undermining sustainability. Applying a racial lens so important in today’s world, one must remember when neighboring nations and global industries acted out racist intentions to ignore, exploit, and delegitimize the nation of Haiti and its independence. The world is at a critical turning point in reckoning with colonialism and racism. It is essential that partnership with the nation of Haiti, its people, and its government, be viewed with respect, humility, and reconciliation in mind.

There is unmet potential for a stronger coalition of the MSPP, implementing partners, and funders to realize the goals of nationally scaled and supported ASCPs who could strengthen primary care and advance UHC. Community health in Haiti would benefit tremendously from a strong and active coalition comprised of the most relevant and critical stakeholders. Such a coalition would help identify the problems, functional gaps, and their causal relationships and ensure continued alignment via ongoing mechanisms for coordination, communication, and partnership.

ASCP CADRE SCALE-UP

More ASCPs and their AIP supervisors need to be hired and trained to provide national scale coverage. The Community Health Roadmap sets the near-term goal of scaling the ASCP cadre from 3,915 to 5,000—and possibly to scale further to meet the MSPP’s prescribed ratios. The mapping and modeling exercises that the MSPP has recently undertaken with partners^{27,49}—as well as innovations about how to incorporate previously verticalized community health programs—will help make an investment in ASCP scale up highly effective.



READINESS: RESOURCE MOBILIZATION

Despite successes in implementing the basic package of services through ASCPs within their ESFs, it is unclear whether there will be sufficient funding for the ASCPs’ work to continue. Over the decades, community health worker programs in Haiti have proven their effectiveness and have made a significant impact on primary care services, even in low-resource and challenging settings.²⁴ There is a clear impetus to integrate ASCPs into the health system in practice as well as policy. Stakeholders on all sides have increased their stated support of community health. This includes the CDC report calling community health workers “the backbone of the health system in rural Haiti,”³⁸ to the recent World Bank project appraisal in Haiti stating that “CHWs play a critical role in PHC delivery in different settings worldwide.”²⁷ Yet, resource mobilization currently remains insufficient to ensure that these services continue and ultimately scale nationwide.

Conclusion

Reform suffers if stakeholders are not able to connect program learning—such as lessons coming out of the ICH investment—with national policy reform. Reform also suffers when multiple parties do duplicative research on curriculum development or other aspects of health system strengthening. In the long run, the hard work of meaningful coalition collaboration will save time and money for all parties involved and lead to greater sustainability.

The advances in community health over the decades in Haiti have reached a critical moment. The ICH investment has achieved the scaling up of community health in the commune of Mirebalais and gathered important lessons along the way. As the MSPP rolls out the new strategic plan for community health, the momentum from the ICH investment could lead to continued investment in coordinated efforts to further scale ASCPs within ESFs across the country. Seizing this moment will accelerate sustainable progress towards achieving universal health coverage in Haiti.

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Appendix 1

Key Policy Documents and Resources Relevant to Community Health in Haiti

YEAR PUBLISHED	OFFICIAL TITLE (IN FRENCH)	ENGLISH TRANSLATION OF TITLE	NOTES
EARLY POLICIES			
2004	<i>Plan Stratégique du Secteur de la Santé pour la Réforme</i>	Strategic Plan for Health Sector Reform	Extended the national healthcare structure to the community level by introducing Community Health Units
2006	<i>Paquet Minimum des Services (PMS) in the in the Plan Stratégique du Secteur de la Santé pour la Réforme 2003-2008</i>	Minimum Package of Services	The first primary care service package
FOLLOWING THE 2010 EARTHQUAKE			
2011	<i>Paquet Essentiel de Services (PES)</i>	Essential Package of Services	Revision a more complete version than in 2006
2011	<i>Formation de l'agent de santé communautaire polyvalent: cahier d'élève</i>	Training of the Multipurpose Community Health Worker: Student Workbook	With Brazil and Cuba
2011	<i>Formation de l'agent de santé communautaire polyvalent: cahier de texte</i>	Training of the Multipurpose Community Health Worker: Textbook	
MAJOR NATIONAL HEALTH POLICIES INCLUDE COMMUNITY HEALTH			
2013	<i>Plan Directeur de Santé 2012-2022</i>	Healthcare Master Plan	Includes ASCPs
2012	<i>Politique National de Santé 2012</i>	National Health Policy	Includes ASCPs
COMMUNITY HEALTH POLICIES BECOME MORE DETAILED			
2015	<i>Organisation des soins de santé Communautaire</i>	The Organization of Community Healthcare	
2015	<i>Manuel du paquet essentiel de services</i>	The Essential Services Package Manual	
PARTNERS AND GOVERNMENT WORK TOGETHER FOR A NEW ITERATION ON COMMUNITY HEALTH POLICY			
2019	<i>Processus d'Élaboration du plan stratégique de la santé communautaire 2019-2023</i>	Processes for the Development of the Strategic Plan for Community Health	