

This Case Story was submitted to the 2016 CLA Case Competition. The competition was open to individuals and organizations affiliated with USAID and gave participants an opportunity to promote their work and contribute to good practice that advances our understanding of collaborating, learning, and adapting in action.

Improving Access to Health Services by Adapting a Health Systems Strengthening Model to Factory Infirmiries in Haiti

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Credit: Evidence Project/Meridian Group International.

What is the general context in which the story takes place?

Haiti has a fragile health care system with limited infrastructure and resources and a shortage of skilled health workers, many of whom emigrated after the 2010 earthquake. Close to half of the population lacks access to formal health care services.

The apparel industry is one of the largest employers in Haiti, with 30,000 workers, 66 percent of whom are women. Under the Haitian labor code, apparel factories are required to hire a number of nurses and doctors according to the size of their workforce and meet related occupational health and safety regulations. Given the challenges of the Haitian public health system, the existence of factory-based health facilities, services, and programs have the potential to expand access to health services to a sizable proportion of the population. However, compliance with workplace health regulations is poor, as is the performance of factory health care staff. For example, in 2013, only 9 percent of factories had the legally required onsite medical staff.

The pilot project described below took place in an American-owned garment factory in Port au Prince, with 1,600 workers, 60 percent of whom are women. The factory had an onsite infirmary, with services provided by five nurses (Haitian law requires six) and two part-time doctors. The factory was committed to worker health and reproductive health, but faced challenges managing its health functions. It also had three health stations in the production halls, each staffed by a nurse.

What was the main challenge or opportunity you were addressing with this CLA approach or activity?

Health compliance and improvements to health services have been a low priority for factories in Haiti, as in other countries. Yet, these represent a missed opportunity for better business and better health. Formal workplaces in poor and middle-income countries hold great potential for improving the health of workers: Many manufacturers are required to employ health providers and have facilities to address health and safety. The workplace offers a setting to reach all workers, especially women workers, with health information, products, and services. However, worker health and workplace health functions are too often not a priority, and limited to occupational health and safety considerations such as first aid kits, fire exits, and safety equipment. There is little focus on the quality and type of health services and the capacity of health providers to offer more than curative care.

In Haiti and elsewhere, workplaces rarely consider their health facilities and staff as resources that need to be managed. Management tends to view their onsite infirmaries, personnel, and services as costly requirements rather than an integral part of factory operations. Line supervisors take little interest in the health of their workers, and discourage workers from seeking care, onsite or offsite, unless it is an emergency. The health staff lack direction or supervisory support from management. As a result, the quality of services and operations at workplace infirmaries is often poor. They typically do not follow basic clinical standards reflecting public health norms, from hygiene practices and recordkeeping to client-centered treatment and basic confidentiality measures.

Moreover, workplace health providers are underutilized. They sit around waiting to care for injuries when they could do much more to address the unmet health needs of workers, including reproductive health and family planning. In part because their existing nurses are under-occupied during the day, factories in Haiti see it as a waste of money to hire more nurses to meet the minimum number required by labor law.

This pilot project applied a health systems strengthening (HSS) model to demonstrate the value of a new management approach to workplace health services and practices in a Haitian garment factory. Specifically, the pilot looked at how the HSS model could be adapted to the private sector and help build the factory's capacity to manage the health staff and infirmary, institute clinical best practices, and expand the primary care roles for nurses, including the promotion of family planning. It also aimed to show that better management of worker health would benefit the factory through effective use of existing resources, improved human resources processes, and better productivity.



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Describe the CLA approach or activity, explaining how the activity integrated collaborating, learning, adapting culture, processes, and/or resources as applicable.

In 2013, RAISE Health, a major initiative of the Evidence Project, launched a pilot in Haiti to adapt the HSS model to a factory context.

To start, the RAISE Health team conducted a needs assessment of the factory's clinical services, including supplies and equipment, service quality, recordkeeping, and management and supervision, through semi-structured interviews, document reviews, observations, and focus groups. Based on the assessment, the team identified areas for improvement and applied the six core HSS) elements to the factory's health functions:

- 1) **Human Resources for Health:** The nurses had limited knowledge of primary care and reproductive health issues, and there was not a system to develop their knowledge and skills. The nurses did some health education with workers, but needed training on participatory education techniques and interactive outreach strategies.
- 2) **Health Finance:** The factory paid for five nurses, two part-time doctors, and health products, but there was little focus on making full use of these resources. There was a need for more systematic budgeting of these expenditures and linking them to performance and planning goals.
- 3) **Health Governance:** The lines of responsibility and accountability were unclear at the management and infirmary levels. The integration of health services into business functions was limited, including a proactive supervisory structure for the nurses. Furthermore, there was a lack of policies and practices for the recruitment, hiring, and evaluation of nurses and job descriptions and performance goals.
- 4) **Health Information:** The factory did not collect or use health-related data in a way that enabled it to respond to worker health needs, plan education activities, or improve performance. Infirmary recordkeeping, file management, and data collection processes were not standardized.
- 5) **Medical Products, Vaccines, and Technologies:** The workplace infirmary stocked some family planning methods, which were offered free of charge, but lacked a process and clear accountability for managing inventory.
- 6) **Service Delivery:** The infirmary lacked processes, protocols, and basic practices necessary for the provision of high-quality care related to hygiene, confidentiality, patient histories, and health information. Additionally, the layout and location of the infirmary put patient privacy and confidentiality at risk.

The pilot emphasized collaboration, with interventions developed collectively by a project team comprising the RAISE Health team, factory management (particularly the vice president of compliance and the human resources manager), and nurses. The RAISE Health team and the vice president of compliance developed an initial action plan, focused on the six HSS elements, to integrate health into existing management functions.

Over 15 months, RAISE Health conducted five 4-day intensive, participatory trainings with nurses and management (some sessions together, some separate) to build their respective capacities, define responsibilities, and establish practices and processes. Between the onsite trainings, RAISE Health provided ongoing, remote support via email and monthly Skype calls. This structure promoted factory ownership of the process and sustainability of the changes.

Key tools that were adapted and applied to strengthen processes and practices included:

- The Population Council's Family Planning Balanced Counseling Strategy
- John Snow International's contraception inventory and supply chain management tools
- A new health education approach based on the Participatory Rural Appraisal trainings and other tools
- New protocols for medical records, documentation forms, infection control, and privacy and confidentiality, adapted from Joint Commission-approved materials used in Federally Qualified Health Centers in the United States
- A new process for hiring nurses based on job descriptions, qualifications, and formal interviews
- A revised spreadsheet and process for tracking worker absenteeism

Monthly data was collected on health education and reproductive health indicators to monitor project processes, and interviews with workers and staff helped indicate changes over time.

Were there any special considerations during implementation (e.g., necessary resources, implementation challenges or obstacles, and enabling factors)?

A key enabling factor was the vice president of compliance's strong commitment to worker health and reproductive health. However, her full-time job was mostly unrelated to health, which pulled her away from daily management of the infirmary. She was eager to develop a joint project that could help the factory establish new processes to manage its health services and build the capacity of the nurses and management. As the project champion, she saw the larger business benefits of strengthening management capacity for her and her colleagues.

The pilot faced several challenges related to employee behavior and the business culture in attempting to define new responsibilities and accountability. There was a strong belief in hierarchy, reinforced by some senior managers, and the nurses would often not address lower-level problems or take action without "permission" from supervisors. This also led them to view their new responsibilities in narrow terms. For example, the project team instituted a contraceptive inventory supply system to enable the factory to order more oral contraceptives well before supplies ran out. In accordance with the system, the head nurse informed the vice president of compliance in person of the need to order contraceptives. As this was a particularly busy production period, the vice president forgot to place the order. Three weeks passed, the supply ran out, and the nurses did not raise the supply issue again because they had "completed" their task of informing the vice president. A similar situation arose when the Chikungunya virus caused the infirmary waiting area to overflow with workers. The nurses and human resources manager had successfully created a patient management system to limit the waiting time for each worker with non-emergency needs and avoid lost time at work. Yet, when the waiting room filled up, no one took responsibility for the situation



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or viewed the problem as solvable. The clinic triage was easily solved once the nurses and human resources identified the cause (i.e., workers coming to the clinic without reporting to work). Both instances led to changes: clarification of processes and roles, and training on problem-solving for both nurses and the human resources team.

The other challenge related to the factory's business culture is common in factories around the world: Line supervisors and managers felt that worker health was not their concern and was unrelated to their responsibilities for production. They viewed a trip to the infirmary as harmful to production. The establishment of a patient management system in the infirmary responded both to a clinical need for improved operations (fewer people, increased privacy) and a production need for workers (unnecessary waiting to be seen by a doctor). Changes to long-standing behaviors were incremental, and required the oversight of management and adherence to the new policies and processes.

With your initial challenge/opportunity in mind, what have been the most significant outcomes, results, or impacts of the activity or approach to date?

The pilot showed that adapting an HSS model to a factory setting led to sustainable, systemic improvements to the factory's health care services, including family planning, clinical care practices and standards, the capacity of its nursing staff and management team, and the use of data. Specifically:

- **Factory management developed a stronger, more integrated approach to managing health services.** The project established new management roles and lines of responsibility for health services. A designated middle manager, the head of human resources, now provides supportive supervision to health staff and oversees infirmary practices and educational activities. A supervisory structure of weekly and monthly meetings, data collection, and action planning is still in use. A formal hiring process was established for nurses and other positions, and a human resources process was established to follow up with absent workers to see if their absences were health-related and required an infirmary visit.
- **Introducing high-quality clinical practices and standard operating procedures improved operations and care.** The factory rebuilt its infirmary to ensure patient privacy, and new protocols were instituted for recordkeeping, data management, and handling hazardous medical waste. The inventory management system improved the supply of contraceptives at the infirmary. The factory also established a new process in which nurses prepared worker charts and took vital signs to more efficiently use doctors' time.
- **Nurses have greater capacity for education and worker outreach, resulting in increased use of services.** The nurses are responsible for developing education activities and worker outreach. This includes weekly "walkabouts" to share basic health messages with workers on the production lines, distributing condoms, and holding health education sessions at lunchtime. Nurses reported that they enjoyed this new active role, and data suggests that more workers were accessing family planning at the end of the project than when it began.



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What were the most important lessons learned?

1. **Focus on personnel and processes.** Hiring qualified people and defining responsibilities are very important. The new hiring process helped factory management avoid nepotism (previously common) and find qualified, committed employees. It was necessary to establish management processes (e.g., regular meetings, action planning, checklists, and job descriptions) to improve accountability and enable capable staff to do more. These processes helped management to assess performance of nurses and staff, as well as identify whom to hire and to promote.

A key management change was making the human resources manager responsible for the infirmary and for ensuring all related policies and processes were followed. The defined roles and clear supervisory functions enabled the vice president of compliance to manage the process rather than perform all the tasks.

2. **Buy-in of middle management/line supervisors is critical.** The vice president of compliance and the human resources manager handled the engagement of middle managers and line supervisors, who have the most direct contact with workers. This was more effective than if engagement had been led by the RAISE Health team. However, RAISE Health should have provided the vice president more support in briefing middle management and line supervisors on the project goals and the connection between worker health and productivity from the start.
3. **Build on existing processes and structures.** A key principle for the pilot project was to build on existing structures. Although RAISE Health did create some new processes, they were done in the context of existing processes and systems. For example, the factory and health facility already collected some data; the project mainly added to or improved existing systems. The team formalized and defined reporting relationships to enable greater accountability and greater autonomy at all levels.

Any other critical information you'd like to share?

The factory pilot was initiated under the USAID-funded Evidence to Action Project and later transitioned to the Evidence Project, USAID's flagship project for strengthening family planning and reproductive health through implementation science. Additional funding from the HRA Pharma Foundation provided critical support for the site visits and consultant technical assistance.

Through the pilot, RAISE Health achieved important results and broader impact, beyond the results at the factory, including:

- Replication of this model by Levi Strauss & Co. as part of its Worker Well-being initiative at a factory in Egypt. The Levi Strauss Foundation with RAISE Health is developing a publicly available toolkit using the tools, processes, and practices developed under the Haiti pilot to assist its supplier factories in adopting better management practices for worker health.
- The development and testing of *Workplace Health Facility Guidelines and Management Benchmarks*, produced by RAISE Health in partnership with Business for Social Responsibility. These were tested in Business for Social Responsibility's HERproject factories in Bangladesh and made

publicly available in 2015. These guidelines are being used in other HERproject locations and are expected to be tested and adapted in other contexts, such as the Philippines in partnership with Merck.

In addition, through the Evidence Project, these products and the experience gained in Haiti are being used to influence the global corporate standards and policies for supply chain factories and farms. This work is also informing a USAID project in Cambodia, the Cambodia Worker Health Coalition, led by the Evidence Project and Marie Stopes International Cambodia.

The CLA Case Competition is managed by USAID LEARN, a Bureau for Policy, Planning and Learning (PPL) mechanism implemented by Dexis Consulting Group and its partner, Engility Corporation.



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