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Maternal and Child Survival Program

SSQH SERVICES DE SANTÉ DE QUALITÉ POUR HAITI

# Establishing Model Referral Networks in Haiti

## MCSP Case Study

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## Background

The USAID Maternal and Child Survival Program (MCSP)'s *Services de Santé de Qualité pour Haiti* (SSQH) project worked closely with the Ministry of Health (*Ministère de la Santé Publique et de la Population* or MSPP) and all 10 of Haiti's departmental health directorates (*Direction Départementale de la Santé* or DDS) to support the development of a high quality, sustainable health system. MCSP provided technical, financial, and material support to the DDSs and 164 MSPP and non-governmental organization (NGO) supported health facility and health post sites to strengthen health provider capacity, increase utilization, improve the quality of health services and referral networks, develop managerial capacity, and support the formulation and implementation of national and departmental health policies.

A doctor fills out a referral form at the Providence Departmental Hospital in Gonaives. Photo credit: MCSP

One of the major health care issues that MCSP addressed with the MSPP was the lack of strong referral and counter-referral systems in the country. Formal health care referral networks establish the protocols and provide the necessary tools for providers at the community and institutional levels to refer patients to receive appropriate and timely care. Under such systems, community health workers refer patients to either the local health center or the community referral hospital, clinicians at the health centers refer patients with complications to the community or departmental referral hospitals, and specialists at the community referral hospitals receive and treat complicated cases or refer them to the departmental referral hospitals. The cycle closes with the counter-referral process, in which local health centers and community health workers receive patient files post-care and continue to provide follow-up care as relevant.

The Haitian government developed a national manual on referrals and counter-referrals in 2008 but never introduced the manual at the site level. Some private clinics and hospitals developed their own referral systems and tools, but there were no standardized, government-approved referral tools or protocols. If a patient required a higher level of care, the clinician on call provided a verbal recommendation to the patient and/or wrote the name of the hospital on a piece of paper. It was the patient's responsibility to get to the departmental hospital, which was not notified of the incoming referral. A pregnant woman suffering complications or postpartum hemorrhage, for example, had to find her own way to the next hospital, where the process of seeking care started all over again—and where she might be referred to yet another hospital. Within the framework of a pilot project, MCSP with the MSPP introduced a referral and counter-referral tool in 36 sites organized under three Model Referral Networks (MRNs). MCSP further supported the operationalization of these MRNs by developing communication and transportation protocols and by training staff at the 36 participating MRN sites in their use. At the end of the project, MCSP assessed, through operational research, the feasibility, acceptability, and accessibility for the health care providers to use of the referral and counter-referral tools and protocols.

## Methodology

The MRN pilot project operated for 17 months, from the introduction of the referral and counter-referral forms in May 2016 through the end of MCSP's third year in September 2017. The purpose of the project was to establish a formal referral system in Haiti that would serve as a model for national scale-up. To this end, USAID and the MSPP identified three regional districts with informal referral networks to serve as model MRNs in the pilot: Mattheux in the West Department (17 sites), St. Michel de L'Attalaye in the Artibonite Department (9 sites), and Ouanaminthe in Northeast Department (10 sites).

In March 2015, MCSP coordinated with the MSPP and the USAID-funded Leadership, Management, and Governance (LMG) Project to test referral and counter-referral forms in Mattheux, the first of the three MRNs established. Once the initial phase was complete and the referral form was validated by the MSPP, MCSP collaborated with partners to print and distribute them to all 36 MRN sites in the three intervention departments. MCSP trained staff at the sites to use the form through ongoing trainings starting in the spring of 2016, and the project provided regular supportive supervision to ensure proper use and referral tracking.

To ensure that referrals were effectively carried out, MCSP also developed communication and transportation protocols with job aids and tools. These protocols were finalized in March 2016 in close collaboration with the MSPP, local health departments, and partners. The protocols established the steps that must be taken, starting with the provider making a referral, including completing the appropriate form; calling the referral hospital to provide information about the incoming patient; and having a patient-paid ambulance service safely transport the patient to the referral hospital. They also required site administrators to record referrals in referral registers. MCSP trained health providers, administrators, community health workers, and ambulance drivers on the use of these protocols in the spring of 2016. MCSP also equipped the ambulances with basic materials and provided visual tools for many of the MRN sites that included a map of the area with the best transport routes, a list of the services provided at the closest referral hospital, and the phone numbers of key contacts at the referral hospital to support protocol implementation.

MCSP engaged local health departments and other key stakeholders in each participating locale. MCSP hosted monthly meetings at the local health department offices to troubleshoot problems and identify solutions that considered the needs of all stakeholders. Prior to MCSP's close at the end of 2017, the referral/counter-referral at the three MRNs continued with systematic use.

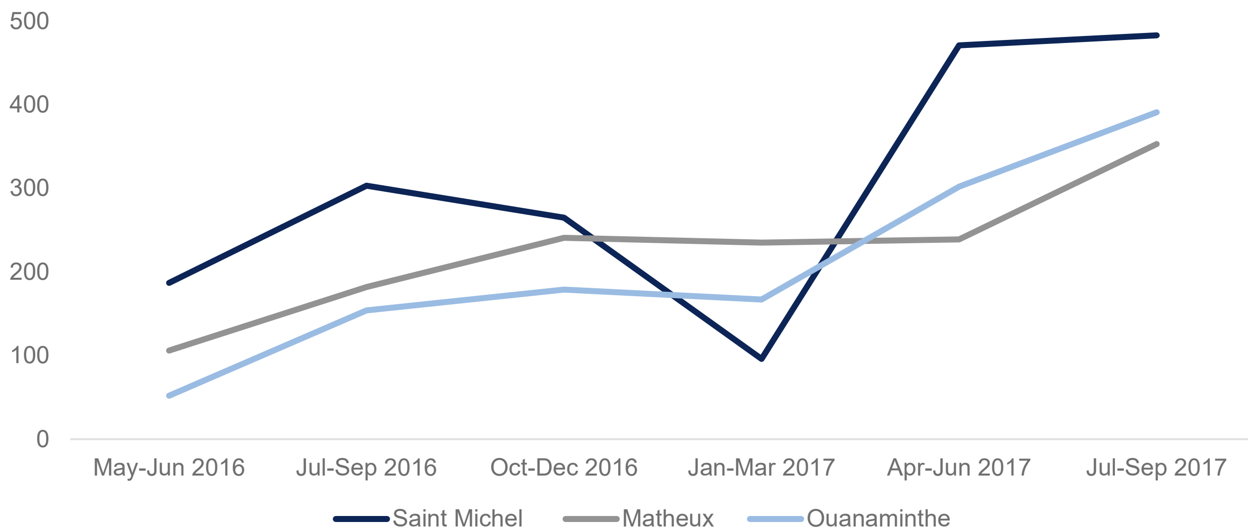
## Achievements

During MRN pilot project implementation, MCSP in collaboration with the MSPP and partners:

- **Introduced a nationally approved referral system with tools and protocols:** Haiti now has an established model upon which to scale-up a national referral system tested in the three MRNs. The existing tools and protocols will support the formalization of patient referrals to adequate levels of care. A number of hospitals and local health departments outside the MRNs have submitted requests to the MSPP for permission to use the nationally-approved and standardized referral system in their departments.
- **Trained health providers, administrators, community health workers and ambulance drivers**: During the course of the project, MCSP trained participating staff at the 36 sites in the three MRNs to implement the referral/counter-referral tools and protocols. These providers continue to operate and perform referrals/counter-referrals at the sites after the end of the pilot project.
- **Conducted 4,406 referrals and 1,104 counter-referrals**: The three MRNs referred 4,406 patients, 2,558 at the institutional level (health center to referral hospital) and 1,848 at the community level (community to health center), to appropriate levels of care. Patients received 1,104 counter-referrals, 83 at the institutional level and 1,021 at the community level. These numbers represent a modest proportion of the total population who received care within the three networks; however, prior to the MRN study, there was no systematic referral system, so these results demonstrate true progress. Figure 1 below shows the number of institutional and community referrals conducted in each quarter by each of the three MRNs. The number of referrals showed a steady increase over time, despite a

temporary drop partway through the project due to the nationwide hospital strike in 2016. St. Michel de L'Attalaye had a much higher number of referrals due to active community health worker participation.

**Figure 1**. Number of referrals by MRN, May 2016-September 2017




## Analysis and Recommendations

At the end of the pilot project, MCSP conducted operational research using a mixed methods study to assess the overall MRN operations from the perspective of health providers, administrators, and patients, with a special focus on the communication and transportation protocols and tools. Evaluators used primary data collection tools (site logbooks and registers) to collect quantitative data and interviewed stakeholders to obtain qualitative data. As the MSPP moves forward with scaling up the referral system into other regions and eventually at the national level, the results of this assessment provide insight into the next steps and important considerations.

- **Health providers readily adopted the referral systems and protocols; however, counter-referral systems need reinforcement.** Nearly all (93%) of network health providers said they made a referral in the past six months. The majority (70%) of providers followed the guidelines by recording the referral in the patient chart and referral register. Most patients (87%) reported being satisfied with the care they received. In total, 73% of health providers said they used the communication protocol, with 56% reporting that they followed all elements of the protocol (inform the patient of the referral, log the referral in the register, call the referral institution, inform the driver of the severity of the disease). About half (51%) of health providers said they applied the transportation protocol, following all requisite steps (inform the patient the best route to get there, comfortably secure the patient in the ambulance, accompany the patient to the referral institution). When communication and transportation protocols were displayed next to a map of preferred transport routes, providers reported greater ease and frequency in informing patients of the best route to reach their next point of care.

  Healthcare workers are cognizant of the importance of providing effective referrals, but it is harder to motivate them to close the loop with counter-referrals. If a patient has been seen and treated, many clinicians and hospital staff at busy referral hospitals do not prioritize the time to complete the counter-referral form that sends a patient back to their local health center. The majority of providers (51%) said that they never received counter-referral slips after referral of patients. In addition, 38% of them say that they rarely receive counter-referral slips. A very small percentage of providers reported receiving these cards often (8%) or always (3%). Working with providers to identify ways of reducing the burden associated with counter-referrals will be important for strengthening the referral system.

- **Referral protocols should include alternatives outside the referral network sites.** Of all referrals, 65% were sent to the referral hospital inside the MRN, while 30% were sent to an out-of-MRN hospital. For the out-of-MRN sites, often private or NGO hospitals, providers reported that they believed patients with particularly complicated cases would receive better care. The study found that establishing relationships with hospitals that are commonly used but are not formally part of the referral system is important to strengthening the network plan. These relationships are especially important during hospital strikes, when services may be lacking or nonexistent at certain public hospitals.

- **The National Ambulance System needs reinforcement, and alternative sources of transport should be part of the referral plan.** Ambulances served as the mode of transport for only 26% of referrals, as nearly half (41%) of the time ambulances were unavailable when requested. Reasons that ambulances were not available included mechanical problems (32%), planning problems (28%), fuel shortages (18%) and no available driver (10%). When ambulances were not available, public transport was used 40% of the time, a private car 24% of the time, and other means of transport (foot, stretchers, donkey, bike) 10% of the time. The National Ambulance Center had several ambulances in populated communities, but many of these ambulances were not accessible to people living in hard-to-reach areas. For the few ambulances that were available, many lacked the basic equipment to ensure adequate transport of a patient in critical condition. Even after MCSP equipped the ambulances with basic materials, often the ambulances were out of commission due to a lack of funds to pay for fuel or maintenance. For patients who did take an ambulance, 77% reported a good experience. However, parents/guardians of minors were less likely to report a good experience (56%).

  As an alternative to ambulance transportation, MCSP found that many communities have transport committees. These committees are designed to provide assistance to patients that require transportation to a next-level facility when ambulances are not available. Community-level transport solutions included stretchers and motorcycle taxis. The pilot project made use of these committees for community referrals but focused on the ambulance network for facility-to-facility referrals. Expansion of the national referral system should support and collaborate with these existing community transport committees to leverage existing resources.

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