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CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-447

1. PROJECT TITLE Basic Health Management Training	2. PROJECT NUMBER 538-0019	3. MISSION/AID/W OFFICE RDO/C 00157
	4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY) <u>538-84-01</u>	
<input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION		

5. KEY PROJECT IMPLEMENTATION DATES			6. ESTIMATED PROJECT FUNDING A. Total \$ <u>2,970,400</u> B. U.S. \$ <u>2,300,000</u>	7. PERIOD COVERED BY EVALUATION	
A. First PRO-AG or Equivalent FY <u>78</u>	B. Final Obligation Expected FY <u>82</u>	C. Final Input Delivery FY <u>83</u>		From (month/yr.) <u>08/78</u>	To (month/yr.) <u>12/82</u>

8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
Clear all accounts, refund remaining funds to AID	CARICOM	9/30/83

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS	10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT
<input type="checkbox"/> Project Paper <input type="checkbox"/> Implementation Plan e.g., CPI Network <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Financial Plan <input type="checkbox"/> PIO/T <input type="checkbox"/> Logical Framework <input type="checkbox"/> PIO/C <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Project Agreement <input type="checkbox"/> PIO/P	A. <input type="checkbox"/> Continue Project Without Change B. <input type="checkbox"/> Change Project Design and/or <input type="checkbox"/> Change Implementation Plan C. <input type="checkbox"/> Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)	12. Mission/AID/W Office Director Approval
Allen Randlov, Regional Health Development Officer Mark Jaskin, Regional Health/Population/Development Officer Terrence Liercke, Program Officer John Tuleja, Controller Ted D. Morse, D/Director	Signature <i>[Signature]</i> Typed Name William B. Wheeler Date <u>10/20/83</u>

PART II
PROJECT EVALUATION SUMMARY

SUMMARY

The Basic Health Management Training Project (538-0019) was initiated on August 30, 1978 when a grant agreement between CARICOM and AID was signed. The project, originally scheduled to run three and one half years and cost \$1.8 million, was subsequently amended, funding was increased to \$2.3 million and the PACD was extended to December 31, 1983.

CARICOM has conducted annual evaluations of the project pursuant to their responsibilities in the grant agreement. The Fourth "Project Evaluation Report" supplements the three previous evaluation reports and provides a summary evaluation of project accomplishments and recommendations for further actions on the part of CARICOM and participating Ministries of Health.

EVALUATION METHODOLOGY

The original project design gave CARICOM, and in turn its member countries, the primary responsibility for developing specific evaluation criteria and methodologies. AID's involvement was to be on a review and participation as necessary basis. This strategy was followed throughout the project. After agreeing with CARICOM on the content of the first, of four, project evaluations CARICOM continued to use the same format/methodologies for the next three evaluations. The other point of AID input into evaluation methods was in the design of the questionnaire for evaluation of the Model District Health Teams (MDHTs). This was done because this particular project element was the one most likely to be built upon in any further AID health sector projects.

Specific evaluation methodologies had to vary among the different project elements. Baseline information on each country's policies, capabilities, management systems and Health Ministry organization was gathered at the beginning of the project. Similar data was reported by each country during the final year of the project so that changes could be assessed.

Some project elements were singled out for separate evaluation. Consultants from the University of the West Indies, Faculty of Medicine, Dept. of Preventive and Social Medicine were charged with evaluating each of the MDHTs one year after these sub-projects were launched. Standardized check lists of information (Appendix N of "Fourth Evaluation") were utilized over an approximately one week visit to each Model District. MDHTs were also evaluated by each country utilizing their own criteria (Appendix B of "Fourth Evaluation"). Health Information Systems were similarly evaluated by the countries utilizing criteria they developed (Appendix C of "Fourth Evaluation").

Management training sponsored by the project was designed to increase individual's management capabilities plus promote organizational improvements. Organizational change was picked up in comparisons of baseline and end-of-project data. An additional evaluative technique was the use of action plans. Each trainee developed a plan of action he or she intended to follow after completing a training session. CARICOM staff subsequently met with trainees to see what had actually been accomplished.

The above constitute measures of project impact. CARICOM's Evaluation Reports also cover process indicators such as months of technical assistance provided, numbers of trainees, etc.

EXTERNAL FACTORS

See pages 9-10 of "Fourth Evaluation".

INPUTS

In general inputs were provided in a timely manner. A contract between Westinghouse Health Systems and CARICOM for technical assistance took longer to negotiate than was anticipated. Under this contract services were not always satisfactory and were more expensive than anticipated. The result was cancellation of the contract with CARICOM taking over provision of technical assistance. This required a P.P. amendment extending the life of the project and making additional funds available to CARICOM.

OUTPUTS

See pages 41-50 of "Fourth Evaluation".

More individuals than were originally anticipated were trained (1,342 vs 700). Due to financial and time constraints only three of the four originally planned training packages were actually conducted. The deletion of the final training package was anticipated in the P.P. amendment.

PURPOSE

See pages 10-30 of "Fourth Evaluation".

GOAL/SUB-GOAL

The goal stated in the original P.P. and the measures of goal achievement are at too general a level for there to be any meaningful assessment of this project's impact. It is true, however, that during the period of the project the trends in the measures chosen; decreased infant mortality, decreased incidence of gastroenteritis, decreased malnutrition, and increased immunization coverage, have been in the directions predicted.

BENEFICIARIES

See page 41 of "Fourth Evaluation".

UNPLANNED EFFECTS

There are no known unplanned effects of this project.

LESSONS LEARNED

See pages 30-40 of "Fourth Evaluation"

SPECIAL COMMENTS

Are as follows:

Organizational Change in the Public Sector

The project assumed that organizational change and management improvement could be accomplished through (1) short-term training of managers at all levels within Ministries of Health and (2) limited technical assistance. In hind sight it seems that one, the other, or both of these inputs must be substantially increased if major administrative changes are anticipated. In addition inputs must have a broader focus. Although some management and organizational problems are specific to Ministries of Health, many relate back to broader governmental and/or civil service policies, others relate to socially and culturally defined roles of individuals, both as persons and in their work roles. A deeper understanding of these factors is required if the time and inputs required for major institutional change is to be estimated.

On the other hand, more micro-level changes, such as the re-organization and re-vitalization of district level health services (MDHTs) can be accomplished with surprizing rapidty. In these cases there appear to be two important predisposing factors. First, the managerial and organizational changes expected were within the authority of the Ministry to implement. Second, the people to be affected by the changes, the district health staff plus the communities they serve, were actively involved in the planning and implementation of the re-organization.

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CARICOM/AID BASIC HEALTH MANAGEMENT
DEVELOPMENT PROJECT 1979-1982

FOURTH PROJECT EVALUATION REPORT

By

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Project No. 538-0019

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Issues to be Addressed in Relation to the Development of the Primary Health Care Approach

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PREFACE

This final Internal Evaluation Report on the Health Management Training (Development) Project spans its entire duration. It both updates developments since the Project Manager's last Annual Report and endeavours to provide a qualitative analysis of the extent to which the Project, from the perspective of four and a quarter years' experience, has met its stated objectives and the undertakings of the Caribbean Community Secretariat in executing the Grant Agreement which brought the Project into existence.

The Report is divided into five major sections. The first section provides an introduction and overview of the Project.

The second section provides a summary of the achievements of the Project in meeting its stated objectives and the undertakings of the Caribbean Community as party to the Grant Agreement.

Section 3 embodies recommendations emanating from the 4 $\frac{1}{4}$ -year experience of the Project staff and the Participating Countries.

Section 4 focusses on the beneficiaries under the Project and Section 5 deals with the Project's financial management.

The Appendices are immediately followed by an Addendum which deals with issues to be addressed in relation to the Primary Health Care Approach in the Participating Countries. It closes with a summary of the strengths presently in the Region and the countries which can be used to further develop and implement the PHC approach in the Region.

Every effort has been made to bring together in this Report all information relevant to the Project so that as a single document it can be useful to anyone wishing to build on the Project's achievements or to secure resource material on particular aspects of the Project.

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The staff of the Basic Health Management Project wishes to thank all those persons within the Secretariat; in the Ministries of Health of each of the Participating Countries; the Department of Social and Preventive Medicine, UWI; PAHO/WHO; CARICAD and the Caribbean Development Bank for their cooperation and assistance towards meeting of Project objectives. We would also like to thank the management and staff of the two Regional consulting firms: SINCOS in Barbados for the excellent job done with the Training of Organisation Development Officers/Management Trainers, LURIJOS of Antigua for the high level of training done in Packages A and C.

We are, of course, also deeply indebted to the Project Coordinators and USAID without whose help there could not have been a successful conclusion to this Project.

The Project Manager apologises for the limited comments on Belize, due to the fact that Belize's Project Coordinator left the Service in June just when necessary information was to be collected.

1. INTRODUCTION AND OVERVIEW

On August 30, 1978, a formal Grant Agreement was signed between the Caribbean Community Secretariat (CARICOM), and the United States Government, through its Agency for International Development, USAID, at the Regional Development Office for the Caribbean (RDO/C), Barbados. Under the terms of this Agreement CARICOM agreed to "develop and implement a management training programme to service the health needs appropriate to the needs of the Caribbean Region, through the upgrading and expansion of the skills in the Ministries of Health employees and community health aides of the Eligible Countries."¹ The eligible countries are Antigua, Barbados, Belize, Dominica, Grenada, St Kitts-Nevis, Saint Lucia, Montserrat and St Vincent and the Grenadines.

The Project, originally scheduled over three years, was to be modified a total of five times, finally extending the project life to 4½ years. The initial funding arrangement wherein the United States contributed US\$1.8 million, the Participating Countries \$468.2 thousand and CARICOM \$56.3 thousand of in-kind support was modified to take into account inflation and other variables such as increased air fares and accommodation costs. The final amendment to the Grant Agreement signed on February 12, 1982, increased the United States Government contribution to US\$2.3 million.

These funds enabled the Participating Countries to initiate the implementation of one of the major objectives adopted in their "Declaration on Health for the Caribbean Community"² which the Regional Health Ministers of CARICOM had adopted in 1978, viz. to develop "The more dynamic and creative management of the Health Services", through a programme designed to strengthen and enhance the managerial capacity of personnel at all levels of Health Ministries, especially those involved in the delivery of Primary Health Care to the most vulnerable and underserved: the poor; rural communities; young children and mothers.

¹ Project Grant Agreement No. 538-0019

² Declaration on Health for the Caribbean Community. CCS 1978

The undertakings of the US Government and CARICOM were clearly set out in the Agreement.

The Project had as its objectives the:

1. Increased knowledge and use of management concepts and skills by personnel at all levels of the health system;
2. Improved teamwork, both vertically and horizontally, throughout the health organizations of the countries, particularly in relation to multi-disciplinary district health teams;
3. Improved use of operational tools of management by mid-level personnel in the Ministries of Health;
4. Enhanced ability of top and mid-level managers to plan, design, implement and evaluate health sector programmes;
5. Implementation of a sector-wide planning process in at least six countries;
6. Operation of effective information systems in all of the Participating Countries, and reinstitutionalization of annual reporting;
7. Improved coordination of internal and external resources within the countries; and
8. The establishment of an ongoing operational programme within CARICOM to coordinate and support health management activities and resources of the Region.

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In order to fulfil these expectations:

a. The Project provided:

- Training
- Technical Assistance
- Material Resources
- Special Activities

b. The Participating Countries provided:

- Participants
- Coordinators who would give 50% time to the Project towards fulfilling the objectives
- Facilities/office space, classrooms
- Some supplies
- Secretarial support
- Customs clearance and tax exemptions of contractor personnel

The Caribbean Community Secretariat in accepting responsibility for the implementation of this Project, undertook to:

- (a) Identify and define problems in the area of health management;
- (b) Ensure the timely implementation of the Project's work plan;
- (c) Design curricula for the various training modules;
- (d) Determine the appropriate mode of response to specialized technical assistance requests from the Participating Countries and provide positive reinforcements to the Participating Countries by ensuring the rapid deployment of technical assistance;

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- (e) Integrate project activities with other health activities, in the Participating Countries;
- (f) Assemble basic materials for the "Management Development Resource Centres", and collect and disseminate supplementary materials to establish a Centre in each country;
- (g) Develop and maintain a system to identify the personnel who would receive training under the Project;
- (h) Conduct periodic evaluation of Project activities;
- (i) Maintain an active system of communication with the Participating Countries and coordinate logistic activities;
- (j) Ensure that timing, roles and duties of technical assistance are clearly understood by all parties.

The Project was operated with a core staff of seven persons - one Project Manager, one Administrative Officer, one Management Trainer, One Clerk, two Stenographers and one Messenger. A full-time*Health Planner and Associate Management Trainer joined the staff in its final year as a cost saving measure. All other services were provided by consultants or other contracted personnel. The core staff operated within the Health Section of the Caribbean Community Secretariat.

Training was carried out mainly in each Participating Country, with a basic Curriculum for each training module being modified to meet country-specific needs and the level or prior knowledge and skills of the

* designated Management Development Officer

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participants. Any training not done in-Country was nevertheless carried out in the Caribbean. The Project relied heavily on extra-Regional trainers and consultants at its inception, but the number of Regional trainers and consultants used increased gradually, and by the Project's completion only Regional personnel were used. This therefore helped achieve fulfilment of the objective of developing Regional competence in the area of Health Management Training.

Action Plans were developed and implemented by training participants and many worthwhile changes were implemented within the national Systems through these.

The Project also trained a total of eight persons from the various countries as Organization Development Officers/Management Trainers. The majority of these persons are now actively involved in Management Training, especially in the vital areas of team-building of Primary Health Care District Teams.

Technical assistance was provided to each country as requested and based on an assessment of needs and availability of funds. A total of 42 person-months of Technical Assistance was delivered under the Project. Major areas of Technical Assistance were the development of Primary Health Care Projects/Model District Health Teams (15.5 person-months), Health Planning (8 person-months), Health Information Systems (11.5 person-months). Technical Assistance was also given with the development of the Barbados Prescription Drug Plan. The Countries are now able to build on the Technical Assistance received, particularly in the area of Primary Health Care and Health Information Systems.

Due to the financial constraints of the Participating Countries it was necessary to provide material assistance to each in order to ensure effective implementation of the Project. In addition to various commodities needed for training, books, etc., funds totalling US\$59,204 were allocated to the countries.

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From time to time key personnel from the Participating Countries were brought together to share experiences to their mutual benefit. Invariably these meetings and conferences became joint ventures with the Regional Office of PAHO/WHO and other International Health Organizations. One such conference focussed on the development of the "Regional Strategy and Plan of Action for Primary Health Care". Other Special Activities have included workshops on Health Information Systems, and country-specific workshops on Primary Health Care. A conscious effort was made to have regional activities in as many countries as possible.

The financial management of the Project presented the greatest challenge due to uncertainties about the availability of additional funds, a problem which first reared its head about 15 months after execution of the original Grant Agreement and which remained with the Project to its conclusion.

The Project has met the majority of its objectives as set out, but recognized at an early stage that it could in no way satisfy the Management Training needs of the Participating Countries. These were underestimated in the first instance. This has been brought home forcibly at each Annual Project Evaluation Meeting; and at intervening evaluation sessions held with the Country Coordinators.

At the end of the Project, the need is clearer than ever for more persons to be trained, particularly in the area of team work, than has been possible under the Project. Also, attrition due to migration and other forms of mobility has contributed to a continuing need for training in basic management skills.

The Project was able to attain and maintain its impact largely through the network of capable country Coordinators. These Coordinators were originally expected to give 50 percent of their time to Project-related

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activities and 50 percent to their substantive duties. This proved not to be a very practicable arrangement and resulted in most Coordinators having to do one and a half jobs to cope with the work required outside of working hours to orient and assist trainers and other technical experts. Some countries were very understanding and made every effort to provide some form of relief. Where this was done the benefits in terms of what the Coordinator was then able to draw from the Project to the Country has been significant.

The Project was closely monitored both by USAID and CARICOM. Quarterly reports were sent from CARICOM to USAID, starting in 1980. Annual Project Evaluations were conducted by the Project Advisory Group. An external mid-Project evaluation was also carried out by a group of three United States Management and Training Experts. This resulted in some modification of the original Project design. Internal country-specific evaluations were also carried out by the country Coordinators with reports submitted to Regional meetings for this purpose. These reports were based both on an assessment of the Project's effectiveness in meeting its stated objectives, and in meeting the objectives which were set by each country at the beginning of the Project. Appendix A is a slightly modified report of the second internal evaluation meeting in which each country (except Saint Lucia) presented an assessment. Appendices B and C are also minor modifications of country feedback on progress with the implementation of Primary Health Care and Health Information Systems, respectively.

Baseline data on the status of Health Management in the countries was collected using a pre-set questionnaire before Project implementation and repeated 3 years later.

Many positive changes have taken place over the period. Although it is not possible to verify that all these changes were as a result of the Project, the Project can, however, take credit for a significant amount of

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these changes since it was the only new major variable introduced in the Region over the time period. Several International Organizations have been active in the Region in the area of health but they had been here for several years prior to the Project.

MAJOR PROBLEMS

During the life of the Project major problems were encountered with transportation, communication, late arrival and inadequacy of equipment and supplies, location of Project headquarters and uncertainty about the adequacy of funds. Details of the impact of these have been recorded in the three previous annual reports.

These problems persisted through year 4, but were reduced in magnitude as Project staff developed skills in dealing with them. Indeed, the only pressing problem that remained in year 4 related to financial management. Problems in this area involved plans being made for the expenditure of US\$30,000, which it was discovered four months before Project completion date, was not available to the Project. As a result activities under two contracts had to be curtailed and the contracts amended; and other activities and assistance promised to the countries were either not honoured or were significantly reduced.

The settlement of the Westinghouse contract, terminated in February, 1981, was finally effected in August, 1982, after much delay and debate. This, however, resulted in a net return of approximately US\$20,000 for Project use.

Acceptance by USAID of the use of Regional air services, reduced to a great extent some of the problems with travel. Recommendations Nos. 4 and 5 relate to AID regulations.

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A significant number of problems resulted from the location of the Project's headquarters in Guyana which is currently experiencing difficulty with foreign exchange, and which is situated at considerable distances from the loci of the main part of the Project's activities. Recommendation No. 6 is made in relation to this.

INTERVENING VARIABLES

Several factors intervened during the life of the Project which either enhanced or retarded progress. These factors were more significant during year one than at later times primarily because after the first year's experience the staff became more adept at planning for and coping with them.

The majority of these variables had to do with changes in senior and key personnel, mainly Health Ministers (8 countries), Permanent Secretaries (5 countries), change of Governments (3 countries), Elections (6 countries), change of Chief Medical Officers (6 countries). This had a disruptive effect in terms of suspension of some plans and slowing down of some activities while orientation and motivation of new personnel were undertaken. It is remarkable, however, that although these changes have resulted in a change in emphasis in some countries, no change in direction occurred.

Also, during the first year of the Project four Coordinators were changed. The situation, however, stabilized in the later years and this enhanced greatly the gains made by the Project in some countries. There were some countries, however, where the Coordinators' workload and commitment to other activities detracted from what could have been gained.

Activities by other organizations both enhanced and detracted from the Project from time to time. In some cases after agreements were arrived at with the countries and dates were set for training, separate

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arrangements would be made for some other workshop or conference, perhaps a week before or following. Due to the fact that the same personnel were involved, it sometimes meant that they were unable to attend training sessions, since they could not be away from their place of work for such long periods. The situation, however, improved in the later stages of the Project, but nonetheless it was not possible to involve those persons who had previously been missed.

On the other hand, several very positive gains were made because of the presence and cooperation of several individuals and the Caribbean Regional Coordinator of PAHO/WHO in Barbados. Without their help the highly successful Primary Health Care Workshop in Saint Lucia, 1981, the Health Information Systems Workshop in Grenada, 1980, the Planning Process Workshops in Grenada, Belize, Antigua and St Kitts-Nevis, among other events, may not have become a reality. Additionally, the involvement of PAHO in Dominica contributed greatly to that country's ability to attain its objectives and to rebuild its Health Care system after the disastrous hurricanes of 1980 and 1981.

2. SUMMARY OF PROJECT ACHIEVEMENTS

2. 1. PROGRESS IN MEETING STATED OBJECTIVES

Over the 4 $\frac{1}{2}$ -year period, from September, 1978 to December, 1982, the Project made systematic progress towards the attainment of its objectives. Appendix D is a summary of the activities of the Project during the years 1978-1982.

Table I outlines progress in meeting the Project's stated objectives.

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TABLE I

Progress of the Project in Meeting its Stated Objectives

Project Objectives	A c h i e v e d			Not Achieved	Comments
	75-100%	50-74%	Under 50%		
1. Increased knowledge and use of management concepts and skills by personnel at all levels of the Health System.	✓				Outcome of action plans and evaluation reports given by participants and coordinators indicate that this objective has been met by most participants. However, it should be pointed out that the existing system in some countries and work situation in others have impeded the ability of some participants to apply their newly-gained knowledge.
2. Improved teamwork, both vertically and horizontally, throughout the health organizations of countries, particularly in relation to multi-disciplinary district health teams.		✓			Participants and observers in countries indicate some measure of achievement here. Progress has been variable, but in no country has there been improved teamwork <u>throughout</u> the organization. /...

TABLE I

Progress of the Project in Meeting its Stated Objectives

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Project Objectives	A c h i e v e d			Not Achieved	Comments
	75-100%	50-74%	Under 50%		
2. (contd.)					Several district teams are now functioning more effectively but it was possible under the Project to train only one or two teams out of a potential 7-9 teams. Additionally, adequate provision was not made for the extensive follow-up with problem-solving and conflict resolution exercises that are generally necessary to ensure that a team is really functioning effectively.
3. Improved use of operational tools of management by mid-level personnel in the Ministries of Health.		✓			Participants reported considerable gains in this area. Most of these tools were given in Package C, the module on Supervisory Management. This module was limited to only 20-24 middle managers in each country. There is a need, however, for these skills to be taught to additional personnel who in some countries are classified as top managers, especially where there was no prior management training.

TABLE I

Progress of the Project in Meeting its Stated Objectives

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Project Objectives	A c h i e v e d			Not Achieved	Comments
	75-100%	50-74%	Under 50%		
4. Enhanced ability of top and mid-level managers to plan, design, implement and evaluate health sector programmes				✓	This module was withdrawn after the mid-project external evaluation because of an anticipated lack of funds and the belief that such training would have been provided by other organizations operating in the Region. This has not, however, materialized and a pressing need remains in this area.
5. Implementation of sector-wide planning process in at least six countries.		✓			Planning Process Workshops were held in 4 countries, viz. Grenada, Antigua, Belize and St Kitts/Nevis. Sector-wide planning was also carried out in St Vincent, where a Health Plan was developed and approved by Cabinet. Failure to meet this objective fully was due mainly to: (a) problems over the availability of funds which resulted in an inordinate delay in getting a full-time Health Planner on staff; (b) problems with the /...

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TABLE I

Progress of the Project in Meeting its Stated Objectives

Project Objectives	Achieved			Not Achieved	Comments
	75-100%	50-74%	Under 50%		
5. (contd.)					initial prime contractor personnel whose work in Montserrat, St Vincent, Saint Lucia and Antigua was not found by the countries to be beneficial. (Additional follow-up is required to ascertain whether all countries involved in the PP Workshops have continued with sector-wide planning.)
6. Operation of effective information systems in all participating Countries, and reinstitutionalization of annual reporting.			✓		An effective information system is in place in three of the nine Participating Countries. All countries have, however, updated their information systems. Nevertheless, this remains a major problem area due mainly to: (a) the inadequacy of suitably qualified staff to implement, administer and maintain HIS in the countries; (b) problems in most countries with getting doctors to complete required forms; /...

TABLE I

Progress of the Project in Meeting its Stated Objectives

Project Objectives	A c h i e v e d			Not Achieved	Comments
	75-100%	50-74%	Under 50%		
6. (contd.)					(c) a situation where the work done by the initial prime contractor personnel was not found beneficial by the countries; (d) a misunderstanding with PAHO in 1980 which effectively blocked the employment by the Project of a full-time Health Information Systems Officer; (e) shortage of funds which prevented full usage of consultant's time to the end of the Project.
7. Improved coordination of internal and external resources within the countries		✓			The Project Coordinators have been used increasingly by most countries to coordinate internal resources. Progress has been slower with external resources as this tends to remain exclusively in the domain of some Permanent Secretaries. Where any kind of training of a sector-wide nature is involved, however, there is a tendency in all countries to use the Coordinators for these efforts; but there remains much room for improvement in this area which would have potential benefit to the countries. /...

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TABLE I

Progress of the Project in Meeting its Stated Objectives

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Project Objectives	A c h i e v e d			Not Achieved	Comments
	75-100%	50-74%	Under 50%		
8. The establishment of an ongoing operational programme within CARICOM, to coordinate and support health management activities and resources of the Region.	✓				CARICOM now has on its full-time staff a Health Management Specialist and a Health Development Officer who have already initiated support of health management activities and resources of the Region. The addition of a Health Information Systems Specialist would greatly enhance the efforts of this team.

2. 1.1. General Comment

The Project has achieved much success considering the limited time-frame of actual activities (3½ years) for the scope and variety of activities involved. Success seems more evident on an individual level, with much knowledge gained by participants as a result of training and workshop/seminar activities. Changes in the systems themselves have, however, been slow but are highly visible where they have taken place, e.g., St Vincent, Dominica and Grenada. The countries, however, now seem ready for an Organizational Development Approach. See Recommendation #28.

A major problem area continues to be that of implementation of change. The original project design made no provision for ensuring follow-up and providing assistance with the implementation of change. This role was taken on partially by the Project Manager, but the extent of the task was far beyond her ability to cope, in combination with her other duties.

Some countries have, however, grown in their ability to implement projects as shown by the growth and extension of the Primary Health Care districts, and implementation of upgraded Health Information Systems. The elimination of Objective #4 from the Project is felt by all countries to have been a negative step and programme planning, implementation and evaluation remain major areas of need. Recommendations #s 18-20 are made in relation to PHC; #s 23-27 in relation to HIS; and #21 in relation to Project Planning and Implementation.

Lack of material resources was more significant than lack of manpower in limiting the amount of change that was implemented. Several very worthwhile and necessary Action Plans had to be shelved for lack of funds. This was distressing, particularly when this occurred in the area of environmental sanitation, or the transportation

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of staff to rural and underserved areas. Given adequate funding, the countries can go a long way towards helping themselves in their struggle for Health for All By the Year 2000. Recommendation #30 relates to this.

Despite the inability of the Project to provide full manpower for the training of more than one team in each country, there has been significant development in team work, with participants at all levels being more aware of the scope of their fellow workers and more supportive of each other's projects, etc. The need to continue work in this area is fully recognized by all countries. See Recommendations #s2, and 8-16.

Three countries - Dominica, Grenada and Saint Lucia - initiated team training of their senior management/technical team. St Vincent, Grenada, Dominica and St Kitts-Nevis have also taken steps with the assistance of their own trained management development officers/management trainers to extend their team building exercises to other health districts. Much remains to be done in this area, but the countries have definitely developed competence in this regard. External assistance is, however, still required to spread the load taken on by the one trained person in each country and to "trouble shoot" at times when teams get bogged down by interpersonal conflicts or through inadequately developed decision-making skills. See Recommendation #21.

The late implementation of the Planning Process Workshops proved to be a definite drawback. The first was initiated in March, 1982. It was found that after these Workshops the countries required much assistance with their planning as all countries began expressing a desire to develop a Plan. The Project has been unable to respond adequately to this need due to lack of funds and manpower, e.g., Belize and Antigua were left unserved after the

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Workshops. Much assistance was gained from the Caribbean Office of PAHO/WHO, but the resources that could be mustered both by CARICOM and PAHO remain inadequate to meet the needs. See Recommendations #s 17 and 22.

As indicated earlier, assistance with Health Information Systems remains a major area of need. All countries do, however, recognize the importance of an adequately functioning Health Information System, and each has tried within its limitations and the limitations of the Project to implement or update its System. All countries can clearly benefit from additional assistance and follow-up; and CARICOM should resume efforts to provide a Health Information Systems Specialist on staff. See Recommendation #23.

The employment of a full-time Health Management Specialist and Health Development Officer on the staff of CARICOM augurs well for the future of health management in the Region. Additional advantages would probably result if increased efforts at internal and external coordination are made, particularly internal coordination, since considerable untapped skills remain in each country which could add significantly to the health status of the population, e.g., Community Development Officers are not used as effectively as they might be to facilitate community participation in Health.

Regardless of how much effort is made by the Ministries, however, there are certain basic things which they cannot do without additional funds, and it is clear at the moment that assistance with material resources must be the sine qua non of any future development programme. While the limited material resources that were provided under the BHMDP were greatly appreciated by all countries, it is a fair assumption that the Project could have doubled its impact in terms of provision of services to "the most vulnerable and underserved;

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the poor, rural communities; young children and mothers" if it could have assisted the countries with more material resources, e.g., a refrigerator, communication equipment, transportation.

The Project has stimulated great enthusiasm in Primary Health Care and the goal of "Health for All by the Year 2000". Progress is being held up, among other factors, by outdated health legislation. Recommendation #29 relates to this.

2. 2. Achievements in Relation to Undertakings of the Caribbean Community

The Project was able to fulfil all its undertakings in a highly satisfactory manner. Each undertaking and its outcome are summarized below:

a. "Continue to identify and define problems in the area of health management".

This was done through interviews, questionnaires, discussions and observation. It was possible to ensure that some of these problems were solved, but at the Project's completion there remained myriad health management problem areas yet to be comprehensively addressed, through training and technical assistance, e.g.:

- Health Care financing
- Budgeting and the management of budgets
- Supplies management
- Project development, implementation, monitoring and evaluation
- Decentralization/Deconcentration of decision-making
- Interpersonal skills

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- Leadership skills
- Decision-making skills
- Intersectoral and intrasectoral linkages/coordination
- Personnel policies to ensure status needs are met, optimum motivation, etc.
- Human resources planning
- Intersectoral planning
- Health economics
- Job descriptions, clear role definitions and expectations
- Health Information Systems, records and a basic understanding of health statistics by senior personnel
- Sharing of information and expertise among countries
- Accessibility of information/knowledge on recent developments in PHC to personnel at all levels of the health care delivery system
- Updating of legislation
- Involvement of the community in decision-making in matters related to their health
- Wider understanding and use of the planning process
- Implementation of Change

Country-specific assessment of how effectively the problems identified were dealt with can be found in Appendix A.

- b. "Prepare the Project work plan and ensure its timely implementation".

The Secretariat was generally successful in this area after some initial starting-up problems. The usual procedure was to submit to country Coordinators for their inputs, a draft work plan annually or before a training module was

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to begin. Invariably this resulted in little change to the plan once it was in final form. However, there was a need to alter the plan from time to time usually to accommodate a changed situation in one or more countries. This generally required switching dates between countries so that contracts could be adhered to as much as possible. Countries were very cooperative in this regard. A copy of the Project's work plan is attached as Appendix E.

c. "Schedule and coordinate logistic activities".

As Project activities gained momentum, this posed an increasing challenge, but the Project rapidly developed the capacity and flexibility necessary to cope with the exigencies including those arising from the location of Project headquarters.

d. "Design curricula for the various training modules".

Three training modules were designed:

- i. Package A - Basic Management skills - was designed to improve basic management skills and to provide a conceptual framework for top, middle and line managers so that they could better understand their roles, functions and responsibilities as managers within the health care delivery system. Topics addressed included Management functions, Time management, Planning, Organization principles, Communication, Leadership, etc. A copy of the module's time-table is attached as Appendix F.

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- ii. Package B - Team Building and Teamwork - provided a forum for team building/teamwork with a view to fostering the Primary Health Care Approach, the effective coordination of the promotive, preventive, curative and rehabilitative components of health care delivery; and to enable health practitioners at all levels, particularly the district level, to function as effective teams in the delivery of services to and with the community. Topics addressed in this module included Team development, Roles, Problem solving, Leadership, Planning and evaluation, Conflict, Power and influence, Decision-making. A copy of the module's time-table is attached as Appendix G.

- iii. Package C - Supervisory Management - provided middle managers with practical, applicable skills needed in their role as supervisors. Topics addressed in this module included Role of the supervisor, Personal life goals, Planning, Job Analysis and job description, Management by Objectives, Motivation and morale-building, Delegation, Training and development methods, Report writing. A copy of ~~the~~ module's time-table is attached as Appendix H.

Modifications to these modules were done necessary, particularly the Team Building module, which was modified so that it would be used by the senior Technical teams responsible for the health services in Dominica, Grenada and St. Vincent.

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- e. "Determine the appropriate mode of response to specialized technical assistance requests from the Participating Countries and provide positive reinforcements to the Participating Countries by ensuring rapid deployment of technical assistance".

Within the limitations of the Project, specialized technical assistance was provided either through the use of technical experts in-country, or through attachments of key personnel to programmes in other countries.

Forty-two person-months of Technical Assistance were provided under the Project. Major areas of Technical Assistance were Model District Health Team, Health Planning and Health Information Systems. Appendix I outlines the nature of technical assistance received by each country and the dates and duration of these. An assessment of the relevance and effectiveness of these efforts to the countries can again be found in Appendix A which incorporates the country Coordinators' reports on the perceived value of the Project's activities to their countries.

- f. "Integrate project activities with other health activities as well as with other sectors in the region".

Through the use of a Coordinator in each country it was possible to satisfy the first part of this undertaking. This was an essential task since the small size of the countries resulted in the same personnel being involved in several health activities. Coordination was required not only to minimize or avoid overlap of activities,

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content, etc., but also to ensure that workshops, conferences and seminars of a similar nature were not held too close together, resulting in frequent absences of limited staff from their substantive tasks.

The vital importance of intersectoral integration was increasingly stressed as the Project developed and is now more generally recognized as an essential element in the goal of Health for All. However, much remains to be done to achieve optimum results.

- g. "Maintain an active system of communication with the Participating Governments and local Project Coordinators as well as key agencies and institutions".

This was achieved through regular written updates in the early stages, the telephone and periodic written communication in the later stages, and throughout the Project, personal contacts of field staff while on travel duty, as well as more formal meetings with Coordinators, national Ministries of Health and regional institutions.

- h. "Report periodically on the Project to the Health Ministers Conference and carry out the decisions of the Conference pertaining to and consistent with this Project".

From the Project's inception CARICOM presented a Progress Report to the annual Health Ministers Conference. Relevant Resolutions adopted by the Conference which are in various stages of implementation focussed on Primary Health Care

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and such other post-project issues as alternative methods of financing health services, and the scope of related follow-up action. Meanwhile, CARICOM has appointed on its staff a Health Development Officer and a Health Management Specialist, in keeping with its undertaking under the Grant Agreement to ensure on-going assistance to the Participating Countries in health management development after the Project ends.

- i. "Assemble basic materials for the Management Development Resource Centres and collect and disseminate supplementary materials to establish a centre in each country".

This was satisfactorily completed. A total of approximately 100 books on general and health management were provided to each country over a 3½-year period. One hundred and thirty books are at project headquarters. Journals and other publications from international agencies were also directed to the centres. Unfortunately, all countries have not fully established their centre (see Country presentations at Appendix A). There is also a dearth of Caribbean materials in the centres due to limited available publications. This problem needs to be addressed since countries have a lot to gain from each other but do not know where to look for required help.

Within each country the need exists for sub-centres, since staff in the rural areas do not have ready access to the central resource centres.

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- j. "Develop and maintain a system to identify personnel of the Region with special skills related to health".

This process, initiated on a ad hoc basis under the Project, is being developed more systematically under the more recently established Health Manpower Project. As a result, the substantial nucleus of a Directory of Regional Health personnel is already available as a resource to all Participating Countries.

- k. "Conduct periodic evaluation of Project activities".

Project evaluation took three forms. Firstly, there was evaluation involving the Participating Countries themselves through their Coordinators. Reports were completed and presented in joint session. Three such sessions were held -

- #1 - Antigua, January, 1980 - REP. 80/1 - PC/HMP
- #2 - St Kitts/Nevis - October, 1980 -
REP. 81/2 - PC/HMP
- #3 - Barbados - June, 1982 - REP. 82/2/44 - PC/HMP

Virtually the full #3 Report is reproduced in Appendix A, since it gives the last available assessment by the countries of their perceived value of the Project. As a result of the earlier evaluation reports by countries, modifications were made to the Project which greatly enhanced its final effectiveness.

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Secondly, three previous annual evaluations were done by the Project Manager and submitted to the Project Advisory Group: REP. 80/1 PE/HMP; REP. 81/2 PE/HMP; REP. 82/3 PE/HMP. The first report dealt primarily with the monitoring of progress in meeting the Project's objectives, and financial management. Recommendations for changes were also made. The two subsequent reports were able to deal more with evaluation of project impact, particularly the impact of training through Action Plan implementation and follow-up, and the implementation of the Primary Health Care approach as a result of the technical assistance provided through the Model District Health Team projects.

Thirdly, an external mid-project evaluation was conducted by a team of health management and training experts from APHA* commissioned by USAID. Their findings were largely positive. Some modification of the Project resulted from this. CARICOM assumed full responsibility for Project implementation. Another major modification was that the fourth module on Project Planning and Implementation was deleted from the Project. This was done largely as a cost-saving measure, and also because it was felt that another Regional agency would have been able to provide this training. Unfortunately, this has not materialized and the need remains unmet.

A final external evaluation is anticipated in 1983. Baseline data collected at the beginning of the Project and recording the status of health management in such major areas as orientation programmes, training plan, written

*American Public Health Association

communication, promotion policies, regular meetings, evaluation, policies and procedures, clear lines of communication, community participation, organizational charts, job descriptions, staff development, etc., can be used as a basis for determining whether any lasting changes have taken place in the system now that the Project would have made participants more aware of the necessity of these tools for good management. The Project has available on record changes that had taken place between 1979 and June, 1982.

In addition, CARICOM was requested to:

- i. Develop and maintain a system to identify the personnel who will receive training under the Project.

This area presented some problems due to the fact that standard categories such as 'top', 'middle' and 'line' were used to describe managers who should participate in training. Whereas these categories are clear in the Developed World and in larger territories of the Region, they become blurred in the smaller territories. The problem was further compounded by the fact that most managers at all levels had never received any formal management training. This meant that the imparting of skills to "middle" managers tended to provide them with more skills than their supervisors and created potential for conflict. The Project therefore found it necessary to conduct additional training sessions to deal with this. Despite this approach there remained a number of persons who should have received training but who did not, due to financial limitations of the Project.

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The system finally used was to let the countries decide which of their managers could most benefit from the modules as roughly outlined, and then to modify the modules to meet country-specific needs and levels (knowledge and experience of participants).

A record was kept both in-country and in the Secretariat of all personnel who received training.

- ii. Ensure that timing, roles and duties of Technical Assistants are clearly understood by all parties.

This remained a major challenge in the early stages, largely because the countries seemed to expect that consultants were experts at everything, and because the consultants used came with their own frames of reference, thus when left to their own devices, did what they thought ought to be done rather than what was needed. Guidelines were finally developed (see Appendix J) for use by all countries in preparing to receive technical assistance.

Appendix K documents all reports done under the Project. It quotes the reference numbers, titles of reports, dates, and by whom they were prepared.

3. RECOMMENDATIONS

The following recommendations are based on the experience of the Project:

1. In view of the compelling need for continued health management development in the Region:

CARICOM redouble its efforts to ensure that gains made under the BHMDP are cemented and developed.

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2. In view of the investment put into their training, and the experience gained:

Countries be encouraged as far as possible to use the Coordinators of the BHMDP, particularly those who received training as Management Trainers/Organizational Development Officers, as the nucleus of any further health development effort.

3. In view of the continuing problems in most countries with implementation of plans and technical assistance recommendations:

Any future management development project make provision for implementation follow-up and follow-through, at least in the short term.

4. Because of the difficulties encountered by endeavouring to comply with the United States Federal Travel Regulations:

For any future AID-funded project a waiver should be obtained at an early stage so that Regional carriers can be used.

5. Since most countries have a traditional mixture of British and American equipment, and spare parts are such a critical factor in the continued use and maintenance of major equipment:

For any future AID-funded project a waiver should be obtained so that equipment purchased in countries can be compatible with their major stock and easier source of spare parts.

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6. Because of the stress, cost and reduced efficiency and effectiveness engendered by the extensive travel and necessity to be in close proximity to areas where change is being initiated:

CARICOM locate the headquarters of any Project requiring intensive travel and work on site in the LDCs, centrally in one of the LDCs.

7. Because of an apparent tendency for every new effort to start from scratch as if nothing had gone before, and the potential for negative response by countries to this:

The reports of all conferences, seminars, workshops in the area of health in the past five years, and any country-specific reports should form an essential component of the orientation of new staff in the Health Section, particularly those embarking on developmental projects.

8. Since training remains an ongoing need in each country:

Ministries of Health, as part of their human resources development efforts should:

- (a) Take steps to bring about the articulation of a national training policy;
- (b) Include in their budgets provision for "Training" or broadening its scope where provision already exists to include the cost of -

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- (i) training in-country in basic management skills for all new managers;
 - (ii) upgrading the competence of existing managers, particularly in the areas of communication, interpersonal relationships, implementation planning, problem-solving and decision-making;
 - (iii) establishing and developing functional teams in each district and at the central level to facilitate the implementation of PHC;
 - (iv) training and retraining of existing staff to broaden their scope for meeting the health needs of their communities in view of the intensified Primary Health Care thrust;
- (c) Fully support Regional human resources development efforts and training at a Regional level of persons for whom this cannot be economically provided in-country, but whose skills are vital to continued implementation of PHC, e.g., health statisticians, nurse practitioners, etc.

9. In view of the reluctance of some Permanent Secretaries and Chief Medical Officers to participate in training programmes with their juniors:

Support be given to CARICAD and other Regional Training projects for senior managers which could provide intersectoral training for this level of staff.

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10. Notwithstanding Recommendation 9 and the demonstrated necessity that Permanent Secretaries and CMOs be fully attuned to the thinking of their staffs, and be part of any proposed planned change efforts:

Training sessions for senior managers in-country should not be held if Permanent Secretaries and Chief Medical Officers decline or are unable to attend at least the first two days fully. Authority should be given to trainers to cancel training if postponement cannot be arranged.

11. Since implementation of Action Plans currently offers the most effective method of evaluating the impact of training:

Action Plans be used in all future Management Training Sessions; where Action Plans are used, these be viewed as an integral part of training; no certificates be issued to persons who do not at least attempt an Action Plan and attend the required follow-up session/s.

12. In view of the rapid turnover of staff in the Region:

The training function in health be not concentrated in one person, but a core of trainers, who can share the training function among themselves while retaining their substantive functions, be trained for each country.

13. Because of the difficulty in distinguishing between top and middle managers in most countries and the additional problem of releasing all top managers or all middle managers for training at one time:

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Future training programmes be geared to the need for senior and junior (line) managers rather than adhere to the categories of top, middle and line.

14. Recognizing that District Medical Officers of Health (DMOs) have particular training needs since most of them have received little or no training in Public Health or Management and are required to function as team leaders in Public Health:

The possibility of training for all District Medical Officers in a manner similar to that done in Dominica in November, 1982, be explored by CARICOM with the countries as a matter of priority.

15. Since there is not now available in most countries adequate expertise to undertake effective management training:

Governments continue to support the TC/DC (Technical Cooperation Among Developing Countries) arrangement initiated under the BHMOP, whereby those persons who were trained as Management Trainers/Organizational Development Officers, share their expertise among countries to their mutual benefit.

16. In countries where training units exist which can be used to further strengthen intersectoral understanding and coordination:

Ministries of Health work closely with national training units to maximize the benefits of intersectoral training, share expertise and enhance the skills available to the health sector.

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17. In view of the fact that time and financial constraints did not permit of Planning Process Workshops being held in all countries:

CARICOM work together with PAHO towards the completion of this exercise in all Participating Countries.

18. In relation to the continued implementation of Primary Health Care on a country-specific basis:

- (a) All countries which initiated pilot Model District Health Team projects take cognizance of the relevant Evaluation Reports done by the University of the West Indies Consultants;
- (b) All countries which have not so far held country-specific Workshops in Primary Health Care, seek the assistance of CARICOM, PAHO and UNICEF to mount these at the earliest opportunity;
- (c) Countries seek the assistance of PAHO/WHO or CARICOM in assessing the economic implications in the short term of the extension of Primary Health Care country-wide so that a planned, attainable approach can be taken.

19. Bearing in mind that the effective implementation of Primary Health Care has cost implications, which the countries are not presently able to afford:

CARICOM redouble its efforts to assist countries with funds for the procurement of basic equipment and supplies that are appropriate and can be maintained in-country.

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20. In view of the fact that the countries of the Region have agreed on a common definition of Primary Health Care and are at different stages of development:

- (a) Any future manpower development projects in the Region give high priority to the use of attachments to those programmes which are working effectively and efficiently;
- (b) Continued efforts be made to bring together key personnel responsible for PHC, such as PHC Directors, Coordinators, Team Leaders, Health Information and Planning Personnel on a regular annual basis to exchange learnings;
- (c) Governments be urged to support TC/DC arrangements whereby persons with expertise in one country can be loaned to share that expertise with another country;
- (d) CARICOM maintain a monitoring role in the assessment of progress towards achieving the targets and objectives set in the Regional Strategy and Plan of Action.

21. Since most Governments are increasingly obliged to seek funding from external sources in order to move forward with the implementation of PHC and there is little expertise in the country to develop acceptable project proposals and implement and monitor them:

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Training in Project Planning, Development and Management be a priority objective in any future health training/development Project.

22. Since Participating Countries are making concerted efforts to develop comprehensive health plans:

CARICOM make every effort to work together with PAHO/WHO to help the countries achieve this objective.

23. In view of the BHMDP's inability to achieve the objective of having effectively functioning health information systems in all countries:

CARICOM make every effort to appoint a Health Information Specialist on staff, as a priority, so that this person could work together with the PAHO/WHO Statistician to attain this objective.

24. Where there are now no trained statisticians/statistical officers on staff in the countries:

Countries seek fellowships for such training as a matter of urgency.

25. Since the recommendations made at the Regional Workshop on Health Information Systems held in Grenada, July 11-13, 1980, and adopted by Resolution at the Sixth Conference of Ministers Responsible for Health are still valid:

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These recommendations form the basis for any further work in the development of HIS in the Region.

26. In view of the fact that countries were able to highlight the weaknesses and strengths of the HIS Projects that were implemented thus far at the Workshop in Antigua in June, 1982 (Appendix C):

The proceedings of the Antigua Workshop on Primary Health Care be made available to persons in all countries, who are responsible for the implementation and monitoring of Health Information Systems.

27. Since all health workers need to understand the workings of their health information system:

Funds be located to train persons to man the HIS in each country and to interpret and use the data to the best advantage.

28. Given that changes in individuals do not necessarily bring about organizational changes:

An organizational development approach be used as a basis for future Health Management Development in the Region.

29. In view of the need to ensure support for the PHC thrust:

The health legislation in the Region be updated as soon as possible to ensure necessary support to the PHC thrust.

30. Due to the critical shortages of material resources and the possibility that this situation will be irreversible in the near future:

Any future project give priority to assisting the countries with material resources as a matter of priority.

31. In view of the setbacks experienced by some countries in getting their Resource Centres fully established:

The CARICOM Health Management Development Officer follow up on the establishment of these and continue assisting countries in the building up of these centres.

32. In recognition of the wealth of information available to PAHO/WHO and UNICEF on Primary Health Care and other aspects of Health Care Delivery pertinent to this area:

Countries be encouraged to communicate directly with these international organizations for assistance in establishing resource centres at district level.

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4. BENEFICIARIES

Benefit was derived from Training, Technical Assistance, Material Resources and Special Activities.

4. 1. TRAINING

The direct beneficiaries of the Training are the 1,342 individuals who participated in the three training "Packages", the eight persons trained as Management Trainers/Organizational Development Officers; the five persons who took courses at FACT*, Jamaica, in supplies management; the 102 who were exposed to planning process training in Grenada, Antigua, Belize and St Kitts-Nevis; the three health statisticians (statistical officers) and two medical doctors who received attachments to the Primary Health Care Unit at the UWI; and the senior nursing officer whose attachment was to the Health Ministry in Barbados.

Table II shows the distribution of persons who received training in Basic Management skills (Package A); Team-Building (Package B), and Supervisory Management (Package C) by country.

There were an additional 173 persons trained in Team-Building in Dominica, Grenada, St Kitts/Nevis, Saint Lucia and St Vincent and the Grenadines, as these countries have moved forward in their implementation of Primary Health Care. The persons trained as Management Trainers/Organizational Development Officers bore the brunt of the training in this area, with the assistance of one trainer provided by the Project. Thus CARICOM has fulfilled one of its aims of developing capability to deliver management training in the Region.

*The Finance and Accounting College of Training

TABLE II

Persons who received Basic Management Training
in Packages A, B and C by Country

Country	P A C K A G E					Total
	A			B	C	
	TOP	MID	LINE			
Antigua	24	24	49	24	44	165
Barbados	46	46	46	36	33	207
Belize	20	24	42	19	43	148
Dominica	22	25	21	16	37	121
Grenada	21	24	47	48	43	183
Montserrat	14	16	24	12	18	84
St Kitts/Nevis	19	24	46	16	19	124
Saint Lucia	21	26	48	21	43	159
St Vincent and the Grenadines	20	26	49	20	36	151
Total	207	235	372	212	316	1,342

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In Belize training of Primary Health Care teams has been carried out mainly by the Medical Officer of Health responsible for PHC with assistance from the Project Coordinator from time to time.

The indirect beneficiaries of the training are the various sections of the Ministries of Health and other ministries* in which participants served. These benefits were reflected in the Action Plans completed by participants as a result of their training. Among the most positive results of Action Plans during the life of the Project were as follows:

Antigua and Barbuda

The preparation of job descriptions and an up-to-date organization chart for administrative officers of the Ministry of Health and personnel attached to the World Food Programme Unit.

Barbados

Implementation of an Infection Control Committee, and completion of the following:

- (i) An In-Service Training Programme for Dental Assistants;
- (ii) An induction/orientation programme for Public Health Assistants;
- (iii) Reorganization of work shifts of nursing and general staff attached to a district hospital.

*Persons were trained from the Ministries of Health, Education, Agriculture, Youth and Community Development, Office of the Prime Minister, Finance, Planning and the Fire Department.

Belize

A reduction in the incidence of social diseases in Dangriga, and the procurement of an entire laboratory to facilitate tests and analyses.

Dominica

- (i) The implementation of new clinical laboratory techniques;
- (ii) The launching of a programme to reduce the incidence of typhoid in the Portsmouth Health District by 75%.

Grenada

The reorganization of the transportation system at the General Hospital and for the Mosquito Control Programme.

Montserrat

The compilation of an operating room procedure manual, and delivery of in-service programmes to sensitize operating room personnel regarding the care, maintenance and operation of the equipment and supplies.

St Kitts/Nevis

The amalgamation of the Youth and Community Development Division and the Social Welfare Department into a single unit.

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Saint Lucia

A proposal for a new organizational structure for the Administration, Finance and Accounting Sections of the Ministry of Communications and Works. Also the compilation of detailed job descriptions for positions in these sections.

St Vincent and the Grenadines

Implementation of an evaluation mechanism to appraise the performance of supervisors at CANSAVE; and a reorganization of the Health Services in CANOUAN.

From the examples given above, it appears, therefore, that co-workers, the Ministries of Health and other ministries and the various communities benefited from the training offered.

Community benefit was most marked as a result of Package B training which was designed to develop more effective team functioning. The impact of this training has resulted in health professionals striving harder to work together as teams in the interest of their communities. Appendix L is an example of the type of commitment undertaken by teams as a result of their training. Experience has proven that most teams carry out their commitments. Indeed, the team efforts have been so successful in St Vincent, Dominica and Grenada, that communities are themselves requesting extension of services.

All countries have not benefited from the training in supplies management. Results are noticeable in only three of the five countries; one country transferred the trainee almost as soon as he returned from training, and the other country's programme seems destined not to get off the ground, a situation which is attributed to lack of space. The follow-up on this activity was handed over to PAHO since that Agency has expertise in this area.

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Two of the health statisticians who were attached to UWI were able to make significant contributions to the updating and development of the HIS in their countries. However, the third was transferred soon after he returned from his attachment.

Seven of the nine participants who began training as Management Development Trainers/Organizational Development Officers are actively involved with management training in their respective countries. To date they have trained more than 200 persons in sessions lasting from one day to one week, usually with the assistance of a Trainer from CARICOM or CARICAD. Thus the countries' health sectors as a whole are benefiting from the training given to this group.

As a consequence of training in the Planning Process, trainees have been able to participate more fully in the development of their National Health Plans.

4. 2. TECHNICAL ASSISTANCE

The countries as a whole benefited from the Technical Assistance efforts, particularly in the area of Model District Health Teams (6 countries) and Health Information Systems (4 countries). Initial assistance given in HIS was not viewed as beneficial by countries.

Barbados now has a Prescription Drug Plan which the Project helped to fund, and steps have been taken to use this as the basis of a formulary for some of the L.D.C.s. Appendix M gives the distribution of Technical Assistance by country.

Progress of countries in implementing the PHC Approach has been measured using a pre-set questionnaire as a guide - Appendix N.

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This tool was directed at ascertaining changes at the central, district and community levels. Findings indicated very satisfactory progress in most countries -- see Reports Nos:

01/2 TA-MDHT on Antigua
04/2 TA-MDHT on Dominica
05/3 TA-MDHT on Grenada
08/2 TA-MDHT on Saint Lucia, and
09/3 TA-MDHT on St Vincent and the Grenadines,

and Appendices A, B and C.

A Health Plan was developed for St Vincent and the Grenadines - Report No. 09/2 TA-HP. This has gained Cabinet approval and is being implemented. The country should therefore benefit from a more organized approach to the development and delivery of their health services.

A Health Plan was initiated and partially completed under the Project for Grenada - Report No. 05 TA-HP. It is now being completed by PAHD since the Project could not finance it wholly. Even with the sections completed under the Project, however, Grenada has been able to utilize its Plan to secure assistance for its environmental health development from an international agency.

The Health Information System developed for St Vincent and the Grenadines - Report No. 09 TA-PHC/HIS is also being successfully implemented (see Appendix C). A similar system was developed with Saint Lucia - Report No. 08 TA-PHC/HIS, but at the time of preparing this Report there is no direct feedback on its progress. The development of the HIS in Grenada - Report No. 05 TA-PHC/HIS - was rather late in starting (October, 1982) and it is therefore difficult to comment on at this stage. Like the St Vincent HIS, however, it is being developed

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in tandem with the Health Plan. One therefore hopes that its implementation will be as successful. The Ministry of Health, St Vincent, reports much benefit from the information in terms of their improved ability to plan.

Antigua, St Kitts/Nevis and Montserrat have updated their HIS, and much progress is reported to date (see Appendix C). However, as previously mentioned, there remains considerable work to be done in most countries to ensure that full benefit can be derived from the Health Information Systems. Recommendations 23 - 27 were made in relation to this.

4. 3. MATERIAL RESOURCES

All countries received some commodities, though on a limited scale. The majority of these were intended to support training efforts, and did contribute to the success of that component.

In other areas some countries benefited more than others because they were earlier with their requests, which were honoured as far as possible before funding became a grave concern. Appendix O is the list of commodities (hardware) supplied to countries. Appendix P is the list of those purchased for Project Headquarters in Guyana. Except for training equipment the vehicle proved to be the commodity appreciated most.

Unfortunately, requests from all deserving countries could not be met, and this greatly curtailed their ability to move ahead with their efforts towards achieving the goal of Health for All. Additionally, spare parts for vehicles posed a problem. Recommendations are made in relation to resources.

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The utilization of the Learning Resource Centres does not appear to be as extensive as one would have wished. Their status in each Participating Country is found in the country-specific reports - Appendix A. Problems with location and accessibility will have to be addressed. Recommendations 31 and 32 were made in relation to this.

4. 4. SPECIAL ACTIVITIES

The entire Region benefited from what is considered the paramount Special Activity under the Project, viz., the development of the Regional Strategy and Plan of Action for Primary Health Care - Paper No. W/PHC 81/1/20. This is being used on a Regional basis as a guide for the implementation of PHC. The proceedings of the Workshop which initiated the development of this strategy provide excellent reference material - Report No. 81/1/35 W/PHC. This activity received substantial backing from PAHO/WHO, UNICEF and UWI.

Country-specific workshops in PHC have been conducted in four of the nine Participating Countries under the auspices of the Project. Thus the gospel of PHC is being spread.

The Regional Workshop on HIS held in Grenada in 1980 - Report No. 80/1 W/HIS - provides the background reference for those developing and upgrading HIS in the Region.

The two Evaluation Workshops held in Antigua in June, 1982 - Report No. 82/0/46 W/PHC, Primary Health Care; and Report No. 82/2/46 W/HIS, Health Information Systems - provided an excellent opportunity for the countries to share information, and gain knowledge from the activities, successes and weaknesses of others. Participants generally found these to be exceedingly helpful. Senior personnel involved in the delivery of PHC in the Region are now aware of what each other is doing, and

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have expressed the desire to meet at regular intervals in the future. This activity has a very strong motivational factor and should be encouraged. Recommendation 20 relates to this.

4. 5. COUNTRY-SPECIFIC OBJECTIVES

One very special activity undertaken in the early stage of the Project was to have each country identify outcomes which they would like to see as a result of the activities of the Basic Health Management Development Project. These objectives are stated in Appendix D and formed a basis for the Coordinators to direct their efforts and the efforts of the Project. Comments related to the fulfilment of these are found in Appendix A.

In summary, the majority of the objectives were met or are being met. This gives validity to claims made so far that the Project has been beneficial.

COUNTRY-SPECIFIC ASSESSMENT OF THE ACHIEVEMENTS OF THE
BASIC HEALTH MANAGEMENT DEVELOPMENT PROJECT - BARBADOS, JUNE, 1982

EXTRACT From Report of the Second Internal Evaluation Meeting of the
CARICOM/AID Basic Health Management Development Project

REP. 02/2/44 PC/HMP

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7. The representative of Antigua and Barbuda stated that training in Package 'A' was successful. Some persons who had attended the sessions had completed work on the Action Plans. As a result of this training, Antigua and Barbuda was in a position to boast of a well-run and properly stocked medical stores, improved communication within the various sections of the Ministry of Health, and educational programmes for diabetics which were aimed at reducing ~~repeated~~ hospitalisation.

8. In Package 'B', twenty-four (24) members of the Model District Health Team were given the opportunity of receiving training in team building. This exercise was done before the Project was launched. The officers were not then working as a team and so some of them did not grasp the true meaning of team work. It was then identified that there was need for additional training in communication, interpersonal relationship and conflict resolution.

9. As a follow-up, Mr. Alston Fergusson, the then CARICOM Management Trainer, had visited Antigua and Barbuda to assist in the problem areas with the Model District Health Team. Special attention was given to the Health Information System.

10. There were two cycles in Package 'C' and it was completed in 1982. The number of attendances was forty-four (44), and from all reports and the evaluation by the participants, the training received was very beneficial and suitable to their needs.

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11. She continued that it was difficult to evaluate the benefits of this training as many officers had been engaged in various workshops and other duties. The Action Plan Follow-up was scheduled from August 12, and it was hoped that other interference would not prevent the officers from completing their Action Plans.

12. A Planning Process Workshop was conducted on May 17-21, 1982. The overall objective of the Planning Process Workshop was to strengthen Health Planning Process as a means of developing and implementing the Primary Health Care Approach. Unfortunately, the above was untimely because certain key personnel were otherwise engaged. Despite the non-involvement of those key persons, participation was high.

13. As an exercise which followed, participants were divided into groups to study the draft policy statement and to consider modifications, if possible. In light of their functions and experience, participants were able to come up with a suggested modification Policy, which included Primary Health Care Services. A Committee was formed to present the recommendations to the Honourable Minister.

14. Two (2) officers received two weeks' training in Project Planning in St. Vincent in 1981. From what was expected in the submission of a project, the training time was considered to be too short. However, the officers were now in a position to make a better presentation when seeking financial assistance.

15. The District Medical Officer, H-6, and the Statistician were attached on separate occasions to the Primary Health Care Unit at the University of the West Indies (UWI), Jamaica, and had observed the Primary Health Care Project.

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16. The Health Statistician on her return, presented a report to the Central Committee of the Model District Health Team Project. Recommendations had been approved and modified in certain areas. She has since implemented the National HIS. The visit of the Medical Officer had not, to date, been beneficial to the national efforts.

17. In the area of Technical Assistance, a report was submitted on the Health Information System in Antigua and Barbuda by two experts. This report was unsatisfactory, since it documented what was already known.

18. The report on the Model District Health Team was scrutinised by members of the Central Committee and all were satisfied with the contents. As a result of this, the Model District was launched and off to a good start.

19. There were seventeen (17) recommendations, eight of which had been implemented. There were five which would be implemented in the near future. The four remaining recommendations might be implemented, but two depended on a population census, which was long overdue. One was a long-term project and the other depended on permission given to the Ministry of Health to have a Maintenance Unit at the Medical Division.

20. The Central Committee had been constrained in its activity because of lack of finance and Medical Officers of Health. This situation had contributed to the non-implementation and the delay in the implementation of five recommendations.

21. The Library Resource Centre was located at the Holberton Hospital. Plans were being made to have a library set up in the Ministry Headquarters where it would be more accessible. A recent

circular was sent out to all managers, stating the names of the books and the objective of the library. This acted as a stimulant to users. It was felt that the books utilised should not be the only consideration for evaluation. Consideration should be given to the number of persons who made use of the books.

22. The "Country-Specific" Objectives had all been attempted in different areas in the Ministry of Health, except for the one which dealt with planning. These objectives were considered to be still relevant and positive attempts would be made to have the objectives met throughout the Ministry.

23. In conclusion, the representative of Antigua and Barbuda made the following requests:

- (i) Financial assistance for the purchase of equipment, supplies and extension to existing Health Centres;
- (ii) Assistance with the reorganisation of the Ministry of Health;
- (iii) Continued training for line officers in the Ministry of Health.

24. In the discussions which followed this presentation, the Meeting agreed that in order to motivate and involve the District Medical Officers and Private Medical Practitioners in Primary Health Care and Health Information Systems, training should be team oriented rather than concentrated on doctors only.

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Barbados

25. The representative of Barbados stated that the three Training Packages 'A', 'B', and 'C' had been well received by the participants and that benefits had accrued not only to the participants but to the Ministry of Health and the public. Some of the benefits which he identified were:

- (i) the design of forms and the revision of the filing system in the Public Health Engineering Department by three participants from the seminar;
- (ii) the Organisation of Friends of the St. Lucy Hospital who visited the inmates on a regular basis; and
- (iii) an organisation at the Geriatric Hospital which had organised a harvest festival to raise funds.

26. The course participants themselves had gained confidence and were planning to schedule their work more effectively, as well as using their initiative to bring about improvement in their respective departments. The participants found, however, that Packages 'A' and 'B' could have been more Caribbean oriented.

27. In the area of Technical Assistance, Barbados had received assistance in the improvement of its prescription drug service. This had resulted in the establishment of a National Drug Formulary.

28. The Learning Resource Centre had been established. The books, especially in the field of Management, were in demand and were used by course participants as well as other health personnel.

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29. The "Country-Specific" Objectives related to the improvement of communication within the Ministry of Health and with other Ministries, the improvement of worker participation in decision-making as well as their leadership skills, and the exposure of managers to budgeting, were partially met. The development of procedural guidelines for accomplishing tasks, the preparation of job descriptions and the implementation of an effective mechanism for the evaluation of programmes, while relevant were still to be done. An awareness of the country's health policy has been created, however.

30. In the discussion which followed this presentation, the Secretariat representative informed the Meeting that it was hoped that the Drug Formulary which had been prepared for Barbados would form the basis of a common drug formulary for the Less Developed Countries (LDCs).

31. In answer to a query on the peripheral changes which might have occurred as a result of the training programmes, the Barbados representative stated that whereas it was too soon after the programme to attempt a comprehensive evaluation of these, some had occurred. He cited the rodent control and aedes aegypti programmes as two instances where, because of participation in the training courses, workers had been motivated to demand and organise seminars/workshops on management and team building. He also stated that the establishment of a Management Training Committee was being considered.

Belize

32. In the absence of the Belize representative, the Secretariat representative presented this report. She stated that the Model District Health Team had been broken down into its component Packages because of a lack of funding for the Project.

Nineteen (19) persons had been trained in the same district where the Model District Health Team was to operate through Package 'B'. The lack of transportation had been a major constraint to the implementation of the Action Plans. There is a need to continue to increase the level of expertise in Health Planning with continued emphasis on personnel development.

33. A Planning Process Workshop was held in Belize with the assistance of PAHO/WHO, Jamaica, May 24-28. This was very well received. The Hon. Minister, Chief Medical Officer and the Senior Administrative Secretary participated. As a result they are now involved in the development of their Health Plan.

34. A Learning Resource Centre had been established central to the residents of Belize City. The establishment of sub-centres in each district was being considered since the distance between the centres militated against proper utilisation of the books obtained.

35. There had been a delay in the provision of a Mobile Health Clinic because the vehicle which was to be used for this purpose had to be converted.

36. All of the Country-Specific Objectives had been partially met, except the one which pertained to a properly functioning supplies system. The Health Information System was in the process of development. A supplies management person was trained in Jamaica, through the courtesy of the Jamaica Government.

37. The representative concluded by stating that some of the problems that had been experienced by Belize were common to all countries which had participated in the Project.

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Dominica

38. The Dominica representative stated that Package 'A' was not really relevant to the needs of his country, but that Package 'B' had had a telling impact in relation to Primary Health Care. Other workshops on Team Building had been requested by the country. He was unable to assess the impact of Package 'C' at the time because it had just been completed. Team Development Workshops had been carried out in four districts in preparation for the implementation of the Model District Health Team in those areas. Two persons had been trained in St. Vincent in the areas of Project preparation and Project evaluation and one person had been trained in Organisational Development.

39. One person had received an Attachment in Stores Accounting but had been subsequently transferred to the Traffic Department and so nothing was gained from this Attachment.

40. The Dominica representative reported that about 90 per cent of the respondents stated that they had benefited in the following areas:

- (i) designing Action Plans;
- (ii) planning work programmes;
- (iii) improved communications;
- (iv) improved leadership skills;
- (v) understanding human behaviour;
- (vi) better management of time;
- (vii) improved problem-solving techniques.

41. Among other benefits mentioned by various persons interviewed were:

- (i) improved interpersonal relationships;
- (ii) better understanding of human behaviour;
- (iii) resolving conflicts;
- (iv) ability to motivate others.

42. Dominica had received Technical Assistance for developing its Health Information System and Model District Health Team. With regard to Health Information System, the recommendation outlined in the report submitted by the consultants from Analysis Group Inc. were never implemented since the Ministry of Health was receiving assistance from PAHO in development of a Health Information System.

43. Recommendation 5 in the Model District Health Team Report was not completely met as there was an acute shortage of financial resources. Despite this, this recommendation was being worked at with a view to implementation.

44. The Report presented by Garrett and Bennett was very applicable, and most of the recommendations embodied therein had been implemented.

45. A Learning Resource Centre had been established. Those persons who had utilised the books were those who had been exposed to some management training and wanted added information for self-development in the field. The books were under-utilised and he opined that this was because of the inadequate publicity that had been given to the Resource Centre, and the negative attitude of public servants in relation to personal growth.

46. Dominica had partially met most of its Country-specific Objectives. The objectives which were not met would subsequently be met, since they formed the basis for the successful implementation of Primary Health Care in the island. There was a concerted effort on the part of the Ministry of Health to have those implemented as soon as possible. For Primary Health Care to succeed, effective mechanisms for evaluation of programmes were to be introduced.

47. He identified the benefits the country attributed to the Project as:

- (i) improved communication among the various departments within the Ministry of Health;
- (ii) more emphasis was being placed on planning programmes at all levels within the Ministry;
- (iii) there was a concerted effort from the top level to include as many persons involved in the decision-making process as possible;
- (iv) there was a better utilisation of the available human and financial resources within the Ministry of Health;
- (v) a deliberate effort was being made by the Ministry to have effective teams at Ministry and District levels; and
- (vi) there was improved co-ordination of activities between the Ministry of Health and other health-related sectors.

48. He concluded that the training needs of Dominica were:

- (i) Basic Management Training for mid-level persons in health (ward sisters, executive secretaries, health visitors, etc.);
- (ii) Training in Team Development for members of District Teams;

- (iii) Personnel and Supervisory Management
Training for District Medical Officers;
- (iv) Leadership Training for Family Nurse.
Practitioners, Health Visitors and Health
Education Officers;
- (v) Training in Accounting and Budgeting for
senior staff within the Ministry.

49. In answer to a query on the training needs, the Dominica representative stated that there were plans to appoint one person to work with the training unit to identify the needs, programmes and resources. Dominica might require assistance from CARICOM with Management personnel to assist in designing programmes. There were also plans for the continuous training of newcomers to the system. Dominica also hoped that regional resource persons would be identified since they would be more attuned to the realities of the local situation.

Grenada

50. In his presentation, the representative of Grenada stated that a review of the activities of the Project had indicated that in Package 'A', the number of Health personnel from the administrative and technical levels who had been trained as managers were as follows: Top 18, Middle 44, Line ~~44~~: 47

51. In Package 'B', the opportunity was seized upon to train Health personnel from various sectors in Team Development. The major objective was to train team leaders in various sectors, who could then go back and develop teams in their various sectors. This approach sensitised and prepared the way for the training in Team Development for the Model District Health Team in St. David's.

52. The MDHT had established a firm linkage with the central administration which had resulted in speedy problem-solving, evaluation, and programming of activities. As a result of the planning of activities, there had been a significant increase in home visits, detection of specific diseases, health problems and of the many psycho-social factors that affected the health of the individual and family in the various communities in the Parish of St. David's. The data was being analysed in the development of the Health Sector Plan, the results of which would be used as guidelines for the development of Primary Health Care in the remaining Parishes of Grenada, Carriacou and Petit Martinique.

53. In Package 'C', the opportunity was taken to develop inter-sectoral co-ordination, by involving personnel in key areas from the Prime Minister's Office, and the Ministry of Education. The number of personnel benefiting from this exercise was 42.

54. In order to ensure continuity of programme and action, the Ministry of Health had established a training committee comprised of Senior Officials within the Ministry; a Primary Health Care Committee with intersectoral linkage chaired by the Minister which met weekly; and a monthly Heads of Department meeting. These committees were supposed to provide updated information on developments within the health sector, and a forum for discussing key issues such as Management Training and Health Services Programming.

55. The Ministry had also made provision for a Management Development Officer in its staff development programme. There was close collaboration between the Grenada In-service Training Unit and the Ministry of Health in the provision of training for Health personnel, including support staff.

56. He continued that there were still people who needed to be trained but that some definition of top, middle and line management had to be done. There was also need to develop the system before the managers could function effectively. In choosing people to be trained at the various management levels the objectives of the Packages were considered and then persons were chosen according to the relevance of their educational attainments. Some modification was also done to the Training Packages so as to make them more relevant to the local needs. There were plans for the continuous training of newcomers to the system.

57. He reported that there was a lack of data which could support the recommendations of the Consultants, and that assistance was needed for analysing the data collected and for providing some simple statistical training. Assistance was also needed to reduce the number of forms currently in use in the Ministry of Health, and to show personnel how to utilise existing forms.

58. He was unable to provide any supplementary report from the centres because the assignment was incomplete. When these reports were collated and analysed a Health Sector Plan would be developed with the assistance of the Caribbean Community Secretariat and Pan American Health Organization (PAHO).

59. He concluded that the books which had been sent had not been utilised because the Ministry of Health planned to provide proper library facilities in the new administrative block.

Montserrat

60. The representative of Montserrat informed the Meeting that during the period 1979-1982, 57 persons from top, middle and lower levels of the department and other related agencies/departments had been involved in Package 'A', representing senior persons from all

disciplines in Health had been involved in Package 'B' and 18 persons from Supervisory level in Health and related areas had been involved in Package 'C'.

61. Further staff training in Management would be done by the National Training Unit which had already designed a training manual for all levels of staff.

62. It would also be possible for specific in-service activities for Health personnel to be conducted within the department with assistance from local resource persons, if needed.

63. Montserrat had received Technical Assistance in the area of Organisational Analysis. The assistance given for Health Planning took the form of a Report which was not really utilised. However, the Ministry had set up a Committee to develop a Health Plan and progress was being made. A draft Health Policy had been accepted by the Minister and short-term objectives had been developed. Costing was still to be done.

Health Information System

64. Montserrat was represented at a Workshop in 1980 but later in the year the then Coordinator retired and very little was done to implement recommendations from the Workshop. An attempt had been made to collect and organise a Health and Health-Related Data System, and it was hoped that in the not too distant future a Health Information System would be established.

65. A major problem facing the implementation of any Health Information System was the reluctance of doctors to provide health data from their private offices. The statistics in the Health Report reflected only the information from Government institutions and clinics. The onus of collecting such was carried by the nurses.

66. Activities, objectives and target dates in the fields of dental and environmental health, medical, para-medical and nursing services had been drafted and submitted to the Minister. These drafts would be revised and developed in the medium and long term, especially with regard to providing increased services to the geriatric population.

67. The representative of Montserrat also reported that they were unable to have a Planning Process Workshop because of unavailability of staff. There was still need for a Planning Process Workshop. There was a lack of commitment to Primary Health Care at the highest technical level of staff. In addition to this, there was a rapid turnover of staff at the senior technical level.

68. In the discussions which followed this presentation, it was suggested that use could be made of the Nutrition Council which already existed as a vehicle for intersectoral co-ordination in Primary Health Care. Use could also be made of the Technical Co-operation Among Developing Countries (TCDC) in order to get resource persons to conduct the necessary workshops. It was also suggested that the trained mid-level personnel could try to help to develop staff morale .

St. Kitts/Nevis

69. The representative of St. Kitts/Nevis stated that Packages 'A', 'B' and 'C' had been well received by the participants, and that Package 'A' was still in use for training Health personnel. There had been a Workshop in Breast-Feeding and an Item-Writing Workshop for Nurse Examiners. There had also been a two-week basic Management Training Programme for nurses.

70. Health personnel had also participated in a number of Training Programmes outside the State in the areas of -

- Ward Administration for Nurses;
- Health Science Tutors and Health Services Management;
- Community Health Nursing;
- Community Health Nursing for Primary Health Care;
- Mental Health Training for Tutors;
- Ophthalmic Nursing;
- Basic Training for Public Health Inspectors;
- Dental Auxiliary Training, X-ray Technology; and
- Laboratory Technology, Cytotechnology and Pharmacy.

71. He considered, however, that there was a need for in-depth training for present and potential divisional heads in Project Design and Implementation and further training for Manpower Development.

72. St. Kitts/Nevis had received Technical Assistance in the areas of Organisational Analysis, the development of a Health Information System and Model District Health Team. All of the Consultants' recommendations on Organisational Analysis and the Health Information Service were applicable to the State and some of them had already been implemented. Of the recommendations made on the Model District Health Team, three were not applicable and the others were in different stages of implementation.

73. In commenting on the Consultants' Reports, he stated that although the Organisational Analysis Report documented what had already been done, it enabled the health personnel to get a focus on the problems. The Health Information Systems Report was not as useful as it could have been. The Report on the Model District Health Team was considered to be the most meaningful of the three Reports

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and of extreme importance to the implementation of Primary Health Care. The recommendations from this Report which would not be implemented were those which pertained to the creation of the post of Senior Health Sister which was considered to be a superfluous post to those which have already been implemented, such as the convening of a Primary Health Care Workshop, the introduction of Health Education in schools and the co-ordination of youth activities.

74. Steps were being taken to set up a Health Education Unit, and there were plans to train two additional Health Educators. Assistance was being sought for acquisition of ambulances. Electricity and telephones were being installed in all Health Centres, and the Health Information Systems had been strengthened. There were also plans to revitalise the food and nutrition unit, establish more clinics for hypertensives and diabetics and to provide additional housing for the aged and indigent.

75. The Country-Specific Objectives were all still relevant and had been partially met. It was planned to continue to provide training for personnel and to prepare professional and management bulletins. The Learning Resource Centre has not yet been set up since it was planned to incorporate it with the College of Further Education. Some of the material had been utilised in the preparation of lectures and for general information but others were not used because the books tended to be similar in content.

76. In concluding his presentation, the representative of St. Kitts/Nevis opined that his country had benefited from the Project in the areas of improved managerial skills, motivation of personnel for Primary Health Care and the preparation of manuals and a policy statement.

77. In the discussions which followed this presentation, it was suggested that the distance-teaching programme at the University of the West Indies might be suitable for the needs of the LDCs in training medical personnel for Primary Health Care, and that the Commonwealth Secretariat's Programme for the Small States might be of some assistance in the provision of ambulances and other equipment.

St. Vincent and the Grenadines

78. The representative of St. Vincent and the Grenadines stated that persons from outside of the Ministry of Health had been trained in Package 'B'. This, he considered, established a foundation for the intersectoral linkages required by Primary Health Care. There were still a number of persons in the system who required Basic Management Training but the problem arose as to who should be considered as a middle or line manager. Personnel had also participated in workshops on collecting health information, team development and project design and evaluation. Personnel had also reviewed the Health Information System and defined Primary Health Care in the context of St. Vincent and the Grenadines. One person had been trained in the Supply Management of Drugs and one nursing supervisor had been attached to the Barbados unit for training in Primary Health Care and Health Information Systems. On her return she was able to supervise and strengthen the Health Information System in the Clinics. He reported that participants have stated that because of the training which they have received they have derived the following benefits:

- (i) greater understanding of the functions of management and their application to health;
- (ii) more effective communication;

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- (iii) had developed Action Plans to solve problems;
- (iv) had learnt how to plan work;
- (v) better management of time/how to manage time and delegate responsibilities;
- (vi) how to orientate new employees;
- (vii) how to write good reports;
- (viii) greater understanding of how to motivate others to work.

79. Participants also reported that they had made the following direct interventions in their organisation, since receiving training:

- (a) organised a system of orientation for new employees;
- (b) worked out and discussed job description with all members of staff.

80. In terms of training, participants felt that the training offered under the Project was very useful and should be continued. Reference was made to the number of persons who had been exposed and the benefits that such exposure must bring to the country.

81. It was suggested that a core of local trainers should be developed in-country to maintain the momentum already established in training Health personnel in Management.

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82. The Ministry of Health had cognisance of the need for training in Health Management Development and Team Building on a continuous basis. The Ministry of Health proposed to utilise the services of the local Project Coordinator, presently being trained as an Organisational Development Officer/Management Trainer in identifying these needs and in planning and implementing training programmes to address them.

83. St. Vincent and the Grenadines had received Technical Assistance in Health Planning, Health Information Systems and the Model District Health Team. Both the Health Information System and Model District Health Team Reports were considered and had addressed actual areas and were applicable. Some of the recommendations of the Health Information System Report were in the process of being reviewed prior to implementation. The Clinic Information System had been implemented in all comprehensive clinics and was to be implemented on a phased basis in the other clinics. The Model District Health Team had been inaugurated in August 1981. Two other Districts were to be inaugurated in August 1982. Lack of finance had, however, hindered the acquisition of proper transportation and communication facilities in the Model District.

84. The Learning Resource Centre had not been established because repairs were needed to the room which had been allocated to it. However, because of the interest displayed by the staff, some of the books had been loaned. It was hoped that there would be a greater utilisation of the materials provided when the necessary space was available. The Country-Specific Objectives, however, were all still relevant and had been partially met. They would all be fully met as resources permitted.

85. He concluded that St. Vincent and the Grenadines had benefited from the Project in the following ways:

- (i) training in Health Management Development for all categories of health workers at various levels;
- (ii) assistance in the development of District Health Teams;
- (iii) assistance in upgrading the Health Information System;
- (iv) assistance in developing a 5-year Health Plan - this was the first time that there had been a plan;
- (v) improvement of Drug Supply Management through training of Medical Storekeeper.

86. He also recognised that there would continue to be need for support from experts working with regional organisations in order to successfully launch some of the proposed programmes.

87. In the discussions which followed this presentation, the Meeting considered that some emphasis had been laid on Project Design, Programming and Implementation, and that most countries felt that they had not yet acquired the necessary level of skills to do this. Some use could be made of an existing CDB Programme in this area.

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88. The Meeting also considered that -

(a) levels of managers should be defined before any further training programmes were undertaken;

(b) some training would have to be done for senior managers such as the Permanent Secretaries and Chief Medical Officers, so that they could be sensitised as to the objectives of the Project.

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A. Equipment required for the Functioning
of the Model District Health Team

Antigua

- (a) C.B. Unit
- (b) Clinical Equipment
- (c) Office Equipment

Dominica

- (a) Radio Communication Set
- (b) Stand-by Generator
- (c) Refrigerator
- (d) Office Equipment
- (e) Laboratory Equipment

Montserrat

One bulldozer for land-fill method of refuse disposal

St. Kitts/Nevis

- (a) Vehicle for Transportation
- (b) Tractor-type Bulldozer

Saint Lucia

ABSENT

St. Vincent and the Grenadines

- (a) C.B. System
- (b) Four-wheel Drive Vehicle for Transportation

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B. List of Equipment and Supplies necessary
to extend Primary Health Care

Antigua

- (a) Five Vehicles
- (b) Drugs
- (c) Refrigerators
- (d) Sanitation Equipment
- (e) Dental Equipment
- (f) Laboratory Facilities
- (g) C.B. Units

Dominica

- (a) Drugs
- (b) Clinical Equipment
- (c) Transportation

Grenada

A 14-seater Vehicle

Montserrat

- (a) Clinical Equipment
- (b) Renovation of three Clinics

St. Kitts/Nevis

Clinical equipment

Saint Lucia

ABSENT

St. Vincent

- (a) Transportation
- (b) Drugs
- (c) Clinical Equipment
- (d) Office Equipment

C. All Countries would require the following
Equipment/Supplies for each Primary Health
Centre/Clinic

- 1 Desk
- 1 Filing Cabinet - 4 drawers
- 6 pairs Dissecting Forceps
- 6 pairs Dressing Forceps
- 1 each Steriliser Forceps: Bowl, Cheatle
- 1 each Steriliser Forceps Jar
- 6 each Kidney-shaped Basins - 6"
- 6 Gallipots - 4 ozs.
- 6 S.S. Bowls - 6" x 8"
- 1 Instrument Tray with Lid
- 1 S.S. Dressing Trolley
- 1 Sphygmomanometer - desk
- 1 Sphygmomanometer - aneroid
- 1 Child's cuff for Sphygmomanometers
- 2 Stethoscopes
- 2 Sterilising Drums - 9" x 9"
- 1 Steriliser
- C.H.A. Bags complete
- Nurses Visiting Bags
- Midwifery Bags
- 1 Each Needle Holder
- Set Needles
- 1 Each Stitch Scissors
- 1 Each Haemocytometer

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6 Thermometers

1 Each Adult Scale (in Kilos)

1 each Infant Scale (in Kilos)

1 Comparator

1 Food Thermometer

1 Ultraviolet Lamp

1 Cesspool Emptier

1 Each Examination Couch

1 Each Anglepoise Lamp

1 Each Refrigerator

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COUNTRY FEEDBACK OF EXPERIENCES IN PRIMARY HEALTH CARE
UNDER THE BASIC HEALTH MANAGEMENT DEVELOPMENT PROJECT -
ANTIGUA AND BARBUDA, JUNE, 1982

EXTRACT from Report of Workshop on the Management and Administration
of Primary Health Care in the Eastern Caribbean:
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17. The Meeting received the following presentations from the respective Member States on their experiences in Primary Health Care.

THE DOMINICA EXPERIENCE IN PRIMARY HEALTH CARE

Ms O. Williams and Mr J. Fabien

18. The Dominica representatives outlined that country's experience and projections in the implementation of the PHC system. That country envisaged the removal of the vertical lines of command along which programmes were presently organized and managed and the substitution of a team approach at all stages and levels. To bring this about, three levels of responsibility and authority had been identified:

- (i) policy-making level;
- (ii) programme-formulation level;
- (iii) programme-execution level.

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At the district level, there would be a programme-execution team which would implement proposed targets and goals. The District Medical Officer would be leader of the team and any problems that could not be solved by the Medical Officer would be referred to a Central Technical Committee.

19. This system provided for a change in the delivery of health care that emphasised health centres in the districts, manned by health-care teams. The State had been divided into seven health districts, with each district being further sub-divided into health centre areas. Each district was served by a Type I or II health centre. There would be one major Type III health centre for serving referred patients and supplying drugs. This type III health centre would be the administrative headquarters for the district.

20. The village base had been strengthened and each community was encouraged to form a village health committee which would be involved in taking decisions concerning their own health.

21. In the actual implementation of the programme, Dominica gave special priority to:

- (a) administrative development - strengthening of management at all levels;
- (b) manpower development - the sensitization of health workers to the goals and objectives of PHC;
- (c) community participation;
- (d) prevention and control (manuals on preventative aspects of PHC were distributed);
- (e) environmental health;
- (f) food and nutrition;
- (g) maternal and child health;
- (h) dental health - focussing on prevention and promotion.

22. A Central Technical Committee had been formed, which was responsible for setting goals for PHC.

23. Some constraints encountered by the project were:

- lack of adequate financial resources;
- rapid staff turnover, especially in the nursing sector;
- recruitment of foreign doctors for short periods;
- lack of adequate transport facilities.

24. In the course of discussion, it was revealed that Dominica's successes and strong points in PHC could be attributed to:

- (a) assistance received in the period of reconstruction after Hurricane David by the Pan American Health Organization (PAHO) and other agencies which enabled Dominica to upgrade its health facilities;
- (b) the preparation of both community and staff for the system. An in-service education coordinator had identified basic problems in the community and had done a six-week training programme for members of the community;
- (c) the training of special community health nurses. These nurses who had been trained to overcome the problem of nurses not wanting to work in rural areas, needed to have academic qualifications, as evidenced by a school leaving certificate, but they also had to be both recognized and recommended by their communities. They would be legally registered nurses and would work under the supervision of a district nurse;
- (d) the involvement of the community during the planning phase, thus capturing the interest of the community from the outset;

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- (e) intersectoral coordination at the community level. At the community level, agricultural, social and welfare organizations, etc. often came together with health personnel. This coordination was unfortunately not extended to the central level, and the Central Technical Coordinating Committee did not meet regularly.

25. The Dominica representatives explained that many health centres were nearing completion, staff had been identified for all areas and the programme was expected to be fully implemented by August, 1983.

26. The Meeting was of the opinion that commitment was the key to success and that the first objective of PHC should be to increase the quality and quantity of services to the population.

THE PRIMARY HEALTH CARE EXPERIENCE - ST VINCENT AND THE GRENADINES

Mr W. Barbour

27. The representative of St Vincent and the Grenadines stated that the Georgetown Model District Health Team had been established as the initial step in implementing the PHC system in St Vincent and the Grenadines.

28. This model district health team was initiated in November, 1980. The team functioned at three different levels: the village, district (core) and central levels. In the Georgetown health district there were five village level teams. All the health workers in the Clinic area along with members of the community form a village level health team. They identified their problems and planned, implemented and evaluated programmes geared towards the solution of these problems. This was done with the support of other members of the district team who have district-wide responsibilities.

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29. At the district level, a core of professionals was responsible for planning, coordination and administration of the district health team's activities. (The core team is made up of the District Medical Officer, Dispenser, Public Health Inspector, Agriculture Officer, Community Development Workers as well as all of the District Nurses and Health Care aide from clinic areas and one community leader). The core team meets at least once per month.

30. General meetings of the entire district team were held at least once every quarter to review the work and programmes of the team, and to solicit the general feelings of the group members.

31. The team had undertaken programmes in the areas of Venereal Disease Control, a clinic for food handlers, a refuse disposal programme and a clean-up campaign at New Chapmans. In addition to these, the district health team was in the process of planning an intensive programme aimed at grappling with the problem of Adolescent Pregnancy.

32. The team had encountered initial problems in the areas of team leadership and community participation. The Doctor was identified at the central level as the leader of the team, but due to the rapid change-over of expatriate doctors this presented a problem; thus the role and function of a team leader was still to be fully addressed. The community was beginning to take a more active part in the programmes and this could be attributed to the new and more efficient services received through the PHC approach; the two-day workshop which had been conducted (in which they had been involved), and the highlighting of the successes of the team on its Achievement Day.

33. The team was still severely handicapped in the implementation of its programmes by the unavailability of transportation and the lack of communication facilities in some areas.

34. In conclusion, he stated that the Ministry of Health proposed to extend the district health team concept to two other health districts in August, 1982, following the final evaluating of the performance of the Georgetown model district health team scheduled for July, 1982.

35. In the discussion which followed this presentation, the representative of St Vincent and the Grenadines stated that team building had been undertaken prior to finalizing the PHC approach to health care delivery, but that the lack of community involvement could account for the initial non-participation of the community in the programme.

36. In an effort to encourage the PHC workers, attempts were being made to provide better housing facilities for the district nurses and this had been successful. Preference was also given to the workers in the field when selections were being made for training programmes. With regard to anomalies that existed in the present salary structure for health workers, attempts were being made to correct this.

THE GRENADA EXPERIENCE IN PRIMARY HEALTH CARE

Ms Stella Best

37. The Grenada representative stated that Grenada was in the process of preparing a Health Sector Plan which was to be fully integrated into the National Soci-economic Development Plan.

38. The model district health team was launched in St David's in October, 1981. Prior to the launching of the team, a workshop was held for health personnel and community members. This workshop was aimed at the sensitization of the community and the health team to the concept of PHC in their particular context; the identification of possibilities for improvement in the existing health services; and the understanding of the role of Health in the total development of the community. This workshop was followed by a one-week team building workshop for team members. At the end of the workshop, the team chose the Family Nurse Practitioner as its leader.

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39. She explained that the team leader was a member of the National Primary Health Care Committee (NPHCC) an intersectoral committee which was chaired by the Deputy Minister of Health. The NPHCC was both a policy-making and planning body. The model district health teams held monthly meetings which were attended by one member of the NPHCC. At these meetings, the activities of the clinics and community were reviewed and work plans were evaluated. The team members also attended various community meetings.

40. The Model District Health Team intended to be more involved in community activities and to:-

- (i) assist in identifying and solving community health and related problems;
- (ii) mobilize the community in national "Clean-Up Campaigns";
- (iii) increase health awareness through Health Education talks;
- (iv) collaborate with other Primary Health Care Teams;
- (v) seek training for members of the team;
- (vi) encourage parents of children who did not attend school to make the necessary arrangements to attend;
- (vii) study the problem of child abuse and make recommendations;
- (viii) assist in solving the problems of teenage pregnancies.

41. The Team had experienced the following constraints -

- inadequate quantities of basic drugs;
- insufficient space and seating accommodation in patients' waiting area;
- inefficient system of distribution of supplies;
- a vehicle that was unsuitable for the roads and terrain in the Parish.

42. She detailed the following as the impact on the community of the PHC approach -

- (i) improved quality and quantity health care was now available and accessible to community members who could see health care being delivered in their homes;
- (ii) there was a greater information flow from community to Health Professionals;
- (iii) community members participated fully in planning their own health care programmes and there was smoother interaction between team members and members of the community;
- (iv) the School Health Programme in the district was being re-activated since members of the team did routine school visits, gave health education talks, carried out screenings and referred students to various specialists as the need arose.

43. In answer to queries raised, the representative of Grenada stated that the health care delivery system in St David's had been improved because of the team approach. She also stated that Grenada had effective intersectoral coordination at all levels of the system because

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of inputs made by the community in decision-making; effective communication at all levels of the system; strong commitment of the political leadership.

SUMMARY OF KEY ELEMENTS IN PRESENTATIONS TO DATE
AND A LOOK INTO THE FUTURE

Dr. José M. Paganini

44. Dr Paganini's presentation focussed on the positive changes which would be required in organizations and institutions if the implementation of PHC was to be successful.

45. He stated that there were policies, National and Regional Strategies and Plans of Action, as well as clear definitions of objectives related to health institutions in order to increase their efficiency, coverage, efficacy, impact and quality of services. In order to start immediate action and to put into practice these policies, strategies and plans, a managerial process or managerial logic had to be implemented at the Central Technical/Ministry of Health (MOH) level. That would entail a reorganization of the technical level at the MOH and a clear definition of responsibilities at central technical level and district and local level. A planning and programming process with a definition of broad programme areas and detailed programming would have to be carried out simultaneously, between the technical and operational levels. At that stage, a manual dealing with a definition of standards and norms was essential.

46. He continued that the development of the HIS would have to be done together with the development of the planning and programming process. He defined the characteristics of a HIS as population-based, problem-oriented, person provider and period-specific, practical and related to a planning, programming process.

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47. He concluded that the development of the managerial process at all levels of the health sector would permit, facilitate and encourage the development of other PHC strategies, including Community Involvement, Resources Development, Intersectoral linkages, Technical Co-operation among Developing Countries (TCDC), Research in appropriate technology; and that many aspects of the managerial process could take place at the same time. Detailed programming of some programmes might be carried out while the master plan of action was still under consideration, or the activation of some programmes and the development institutions might precede the formulation of certain other programmes. In real life national health development could proceed from any point in the cycle, provided the necessary political will and support existed at government level.

PROPOSED REORIENTATION OF THE SYSTEM -
SAINT LUCIA

Dr L. St Prix

48. The Government of Saint Lucia planned to implement PHC in the State through:

- (a) systematic planning and evaluation of programmes and services;
- (b) increasing the management capability of PHC personnel by in-service training programmes, supplemented by overseas training;
- (c) improving health facilities, integrating the primary, secondary and tertiary health care/delivery systems.

49. In the development of PHC in the six health districts of Saint Lucia, the Government planned to improve and expand in some cases, programmes and services offered in the areas of:

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- care of the aged;
- care of the handicapped;
- communicable disease control;
- community mental health services;
- control of sexually transmitted diseases;
- curative services;
- dental health programmes;
- diabetes control;
- disease surveillance;
- early cancer detection;
- environmental control;
- family planning;
- food hygiene programmes;
- health education;
- hypertension control;
- maternal and child health;
- nutrition;
- pharmaceuticals;
- T. B. control;
- vector control; and
- veterinary health.

50. The Government had plans for continuing the training of the health personnel through in-service programmes supplemented by overseas training where necessary.

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51. The Soufriere Health District was chosen as the model district and it was intended that the experience gained would be utilized in the expansion of PHC to the other five health districts.

52. The model district team was launched in Soufriere on 1 February, 1981, after a one-week period of training in team work, principles of management and development.

53. The team also underwent two three-day workshops in team development, and coping with and solving problems within the team. Further training was given to the aides to conduct a medical and environmental census in the model health district. This training was carried out to facilitate efficient collection of demographic data to effectively implement health care delivery in the district.

54. One of the first programmes undertaken by the team had been to conduct a community survey and health census within the model district in order to establish baseline information for planning and future evaluation of the project, and to obtain a demographic profile of the population to be served by the team. The coding of the information collected was in its final stage.

55. Because of the high cost of obtaining specialist services outside the model district, Consultants in obstetrics and gynaecology, paediatrics, dermatology and ophthalmology based at Victoria Hospital in Castries, provided specialist services on a regular basis at Soufriere Hospital, and saw referrals from the District Medical Officers and Community Health Nurses.

56. The main limitation of the programme was the unavailability of the prescribed drugs within the Model District. It was planned to reactivate a Board of Consultants who would look into the issue of modifying and updating the drug formulary.

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57. After repairs were carried out in the X-ray Units of the Soufriere Hospital, the services of a Radiographer were made available to the Model District. X-rays are free of cost and the community has expressed its full satisfaction at the development.

Dental Health in the Model District

58. Prior to the introduction of the Model District, dental services were provided to the area once a week. The dental department in the Model District became operative in September, 1981. Dental clinics were being carried out by a Dental Surgeon and a Dental Nurse who was resident in the community. In addition, a School Dental Health Education Programme was in progress at the various schools in the Model District.

59. An oral assessment survey was carried out in the schools in February. Through the survey the oral condition and needs of the students would be known. This survey was to be carried out throughout the island but the Model District had been chosen as the starting point.

60. With the assistance of Partners of America, a handicap census was carried out in December, 1981, in the Model Health District. A seminar on the Rehabilitation and Training of the disabled in the community was attended by the Community Health Aides. The Training Programme would help the Aides compile an efficient and workable register of the handicapped, their addresses, health history and other important information. There had been visible improvement in the quality of life of many disabled people in the community.

Community Participation

61. This important aspect of Primary Health Care has not been successful within the Model District. It was noted that this community was a complex one and in the past had not shown much enthusiasm for Community activities.

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Failures of the Health Team

62. The Team was also unsuccessful in its efforts to conduct programmes in the control of alcoholism and drug abuse and family planning.

63. The Team was constrained in its efforts by the following factors -

- (i) no budgetary control;
- (ii) no control of staff transfers and replacements;
- (iii) insufficient training of Team in team development and team concept;
- (iv) insufficient community participation;
- (v) inadequate team cohesion;
- (vi) poor communication due to distance between Team Members, and between the district and the central level;
- (vii) no concise rules and guidelines for Team Members - those were to be developed;
- (viii) Team Leader shared job responsibilities and Team Management;
- (ix) no Secretary or secretarial equipment was available for use by the Team;
- (x) temporary loss of transportation for Team Members.

64. In the discussions which followed this presentation, the Saint Lucia representative explained that they were in the process of trying to identify alternative sources of funding for PHC internally. The Secretariat representative suggested that use be made of existing Community Programmes, such as the Community Division Programmes in an attempt to stimulate community participation. She also pointed out that Saint Lucia was using a planned, phased approach to implementing PHC, and that the need for baseline information in some simplified fashion was also highlighted in this presentation.

ANTIGUA AND BARBUDA

Dr R. Williams

65. The Antigua representative explained that Antigua & Barbuda had made slow progress with its PHC approach. Its attempts at implementing the system had been inhibited by interpersonal and organizational problems and the approach taken to implementation. Antigua & Barbuda had, however, finally managed to overcome most of these difficulties and was making strides with community participation and utilizing the team approach. A workshop had recently been held in the community to sensitize people to Primary Health Care.

66. The Technical Committee was now meeting regularly and it was looking forward to the result of the evaluation which was currently being carried out. There remains strong commitment to this approach, but much help is still required.

ST KITTS-NEVIS

Dr J. Astaphan

67. The St Kitts-Nevis representative reported that there were five medical districts in St Kitts and three in Nevis, which were giving public health and primary health care services through 11 health

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centres. Health sisters and district nurses, etc., operated from these centres daily and were supported by the clinical services of District Medical Officers. A referral system operated between community health centres and hospitals. In order to obtain the required number of community workers, the St Kitts-Nevis Government intended to introduce Nurse Practitioners, Community Workers and Environmental Health Aides into the system.

68. He informed the Meeting that three model projects, with three model teams had been established. Each team was coordinated by the District Medical Officer, and each district had a PHC Committee, comprising medical, paramedical and intersectoral personnel, as well as representatives of the clergy and community. In one of these projects, the principle of total community involvement had been applied and house-to-house visiting and detailed questionnaires had been utilized to select primary targets (persons and programmes) for PHC services. In another area, manpower needs had been set by recruiting retired and part-time nurses on a volunteer basis. At the centres, education sessions were conducted and out-patient services provided in many areas. When the information and data from these three model district health teams have been compiled completely and analysed, then the extrapolations and correlations would be made to formulate a universal approach for the entire State.

69. The National Committee for PHC, he explained, was responsible for the implementation of the system, and reported to the Minister of Health via the Medical Officer of Health who was the National Coordinator of PHC services. This Committee comprised members of all medical and paramedical disciplines, public health personnel, personnel engaged in planning, community leaders and community members.

70. Discussions subsequent to this presentation revealed that St Kitts-Nevis had just begun to implement its PHC system. That country

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had also done two intersectoral workshops which had been successful largely because of the smallness of the country and the organization of the workshop by nationals themselves.

71. With regard to its district teams, St Kitts-Nevis had no team leaders, only coordinators and great emphasis was placed on team spirit.

STRATEGIES FOR REORIENTING THE SYSTEM TO FACILITATE PHC
IN THE EASTERN CARIBBEAN

72. Participants from each country worked in small groups to set out specific proposals for the re-orientation of its PHC system:

Saint Lucia

Budgeting - the Saint Lucia representative felt that that country should set out a separate budget for PHC, within a time-frame. The budget should also reflect joint ventures with related sectors such as housing and education. As an additional source of funds, workers and the community could make small contributions.

Motivation - country health education programmes and team building exercises should be launched and perpetuated. Monetary or other forms of recognition for services rendered should also be provided.

Decentralization - scarce health personnel (specialists) should be allocated to districts and rotated to ensure equal distribution.

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Nobilization - there should be development of programmes for the community based on needs identified by the community and probably on the initiative of the community's health team.

Sensitization - this could be achieved through use of the mass media, and devices such as lectures and individual contacts.

Montserrat

Montserrat was in favour of a PHC Workshop for two to three days in October, to sensitize communities and PHC personnel. This would involve radio talks. That country would also:

- set up a technical committee comprising community resource people (nutrition, agriculture, sanitation and health);
- reorganize the present system to concentrate on families;
- establish a community profile;
- utilize existing groups;
- set up workshops for doctors on records and reporting;
- write manuals on policy and procedure (norms and standards).

Dominica

Budgeting - the budget should reflect basic allocations for each district team for: simple maintenance of health facilities; conducting training sessions for staff and community; travelling costs; and basic supplies. Donations from voluntary groups and fund raising activities by community groups should provide alternative sources of funds.

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Motivation - grievance and disciplinary committees should be formed at all levels and rewards in the form of training or increments should be offered to outstanding personnel.

Mobilization - existing groups in the community should be used to identify health problems and to implement and evaluate these programmes.

Sensitization - this was to be achieved through public education programmes.

An evaluation of the system should be conducted.

Intersectoral Coordination - the national PHC Committee should be revitalized.

The role of each member of the team should be clearly defined in manuals and the team should have specific roles and mission statements, as well as set objectives of what they wanted to achieve.

Grenada

The Grenada representative reported that that country had developed a national plan to reflect PHC, but that in addition, there was a finance programme for external aid in which it was hoped that PHC would be reflected. Alternative sources of funds could be obtained from donations from individuals and friendly organizations (both local and abroad, fund raising activities in the community, and gifts and grants from international organizations.

Continuing evaluation of the system should be done to determine the health status of the community, disease patterns, population to be

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served, socio-economic factors influencing the quality of life, and management structure required.

Decentralization

There was need for decentralization in the administrative structure and especially in the reallocation of funds.

Mobilization

The agricultural sector and youth organizations should be mobilized to help those in PHC.

Motivation

Grievance and disciplinary committees, training and salary increments should be used to motivate personnel.

St Vincent and the Grenadines

The representative from St Vincent and the Grenadines indicated that the following areas of the PHC system in that country needed to be improved:

- (a) specific areas of health such as immunization, maternal and child health, family planning, nutrition and environmental health;
- (b) day care centres.

With regard to the District Team and the Community he felt the need for:

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(a) Team

- the extensions of the district health care team in all districts in St Vincent and the Grenadines by 1985, beginning with two health teams at the end of July, 1982;
- provision of necessary transport for use of team members to carry out their programme;
- organization of fund raising drives;
- making the DMO team leader, but selecting a dynamic coordinator. Teams should also identify roles and functions of its members and any plan made should have a time-frame and figures attached to it;

(b) Community

- community involvement in problem identification and solution;
- workshops for the sensitization of the community.

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APPENDIX C

COUNTRY FEEDBACK OF EXPERIENCES WITH THE IMPLEMENTATION OF
HEALTH INFORMATION SYSTEMS UNDER THE BASIC HEALTH MANAGEMENT
DEVELOPMENT PROJECT - ANTIGUA AND BARBUDA, JUNE, 1982

EXTRACT from Report of Workshop on Health Information Systems to support
Primary Health Care in the Eastern Caribbean:
A Review of Developments to Date

REF. 02/2/46 W/HIS

OBJECTIVES, EXPECTATIONS AND ORGANISATION
OF WORKSHOP

MS. M. PRICE (CARICOM)

6. Ms Price in her presentation drew the attention of the participants to the Objectives of the Workshop. These were identified as:

- (i) to provide a forum for countries which have been attempting to develop and HIS for PHC, to share their experiences;
- (ii) to analyse critically the approaches taken by the different countries;
- (iii) to allow countries which were in the process of developing their HIS to benefit from the inputs and experiences of other countries;
- (iv) to enable countries that were in an earlier stage of development of their HIS to select or adapt their approaches based on approaches in other countries;
- (v) to enable CARICOM and the Pan American Health Organisation/ World Health Organisation (PAHO/WHO) to strengthen and further co-ordinate their efforts in assisting the countries of the Region in the development and implementation of their HIS.

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7. The Meeting then received respective Country Reports.

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St. Vincent and the Grenadines

8. Dr. Jesudason reported that in November 1981, the Government of St. Vincent and the Grenadines, through its Ministry Responsible for Health, with technical assistance from the CARICOM/AID Basic Health Management Development Project, embarked on the development of a National Health Plan (1982-86) which would cater for the PHC needs of the country.

9. Specifically, this new initiative was geared -

"to develop a management system which would ensure planning, programming, implementation, monitoring, evaluating and updating the PHC approach to ensure continuous responsiveness to the changing health care needs"

of St. Vincent and the Grenadines, as recommended by Resolution 6, Section 8 of the Seventh Meeting of the Caribbean Conference of Ministers Responsible for Health.

10. Central to the reorganisation and planning of the health services to effectively promote PHC, was the creation of an HIS which will assist in the management of the total system.

11. As a direct consequence, the Ministry of Health sought and received from the CARICOM/AID Basic Health Management Development Project, the services of two consultant statisticians for a total of two-and-one-half man-months (between 15 November and 15 February) to evaluate the then existing HIS and to advise on a new and more meaningful system. This was done in two phases.

12. The HIS in St. Vincent and the Grenadines has been duly evaluated and the recommendations made have either been already implemented, or in the process of being implemented.

13. The present HIS in St. Vincent and the Grenadines, it was explained, was only about three months old and it was, therefore, premature to attempt any detailed evaluation. It was obvious, however, that it had already contributed to the quality of patient care at the clinic level, as well as providing useful information at all levels. A copy of the Health Information System Report and Users Manual was made available to each country delegation.

14. It was noted also that, as the structure, functions and programmes of PHC changed, the Information System would have to be adopted to meet the changing needs.

15. For the information of the Workshop, some indication of the problems St. Vincent and the Grenadines had experienced in the setting up of the HIS were outlined as well as some of the solutions.

16. Dr. Jesudason stated that before the new HIS was implemented, he had found that in many cases specific diagnoses were not made and only symptoms were recorded on patients' cards. In addition, handwriting was often illegible and doctors complained that filling out records was too time-consuming. It was however impressed upon doctors that the organisation of their time was important and that factors like punctuality would free time for record-writing. They were also instructed to write their records in block letters. As a partial solution to the problem, a system of appointments for patients was set up so as to enable doctors to have enough time to pay more attention to individual patients.

17. In the initial stages of the setting up of the system, nurses tended also to resent the additional amount of paper work required. However, the purpose and functions of the system were explained to them through the holding of a workshop, and they have even taken the initiative of deciding on the system of cards to be used.

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18. The system also helped in solving the problem of availability of drugs. Whereas in the past, the dispenser alone was responsible for the ordering of drugs, and had difficulty in keeping abreast of needs, the doctor and the dispenser now work in conjunction with each other.

19. One major difficulty to be solved was that of follow-up treatment of referrals in the community after examination and treatment by consultants. It is hoped, that when house officers are appointed to help consultants in the next financial year, the problem of making and keeping of records of these referrals would be solved.

20. In respect of the collation of information in St. Vincent and the Grenadines, this has been done for activities such as maternal and child health, midwifery, etc. Reports on these are submitted monthly to the statistician in the Ministry of Health and these are in turn sent to the SNO. A separate report is done on immunisation and pregnant mothers. Reporting on communicable diseases is also done by doctors. However, this is not usually submitted weekly to the Ministries, as required. The HIS covers areas such as drugs - availability and type; hospitals - bed turnover, etc.; environmental health - availability of pipe-borne water, numbers in households, etc.

21. In St. Vincent and the Grenadines, the Family Nurse Practitioner, working in the government service, is permitted to write prescriptions and these are accepted by government dispensers. Her diagnosis is also accepted, but when in doubt, she can consult a doctor.

22. In practice, it was stated that the HIS was being developed in stages since each service required information to aid in its planning and evaluation.

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23. The view was expressed that St. Vincent and the Grenadines had been successful thus far, because of the commitment of Dr. Jesudason, the Chief Medical Officer, and the Senior Nursing Officer (SNO). The SNO had been sent to Barbados to examine the system there so that she could improve on the Vincentian system on her return. Also contributing to her success, the SNO explained at this point, were the weekly meetings held with the DMO, District Nurse, Dispenser and Community Health Aides, where the week's activities were reviewed and plans made. She also held monthly meetings with nurses to review problems and make recommendations. The fact that the HIS had been developed as part of the national health plan of St. Vincent and the Grenadines was also seen to be a reason for the success enjoyed there.

24. Suggestions were put forward to deal with the problems being experienced. One delegate explained that her country used a simple referral form which could perhaps be utilised in St. Vincent and the Grenadines. Another delegate also said that nurses sometimes visited hospitals to see who would be discharged and to get an idea of referrals, but that this was found to be time-consuming. Obtaining required cards for recording patient information also proved to be problematic; St. Vincent and the Grenadines needed a priority system so that the medical service could produce its own cards and not have to wait on the government's printery. The problem of obtaining a filing cabinet was, however, solved when nurses improvised by using a box. In the long run however, there is still need for filing cabinets.

25. The Meeting stressed that the HIS should be an integral part of the management process and that data should not be collected in a vacuum, but should be tied to management process. An HIS was important because nurses and doctors were not only producers of information, but also users; they needed to know what was going on in the health centres, etc. (e.g.

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what drugs were being used) so that they could plan. In St. Vincent and the Grenadines, with the aid of the HIS, nurses had been able to ascertain that mothers were not making the required number of follow-up visits to clinics. Another example of the importance of the HIS was revealed when it was stated that two statistical studies had proved that available records prior to the HIS had been 75 per cent off mark.

26. It was felt that the key "learnings" of the St. Vincent experience were:

- (i) the HIS was not the responsibility of only one person, the statistician; but of all members of the team;
- (ii) commitment could be obtained when needs were seen to be met;
- (iii) dialogue was needed;
- (iv) the system should be part of the management process;
- (v) standards and norms were needed so that the system could be monitored;
- (vi) mapping was important to assess the progress and knowledge of the team;
- (vii) the process should be incremental and commensurate with resources and capability;
- (viii) information must be analysed and utilised;

- (ix) community participation was essential to success - the health educator had utilised the radio to make people understand the need for the appointment system in the health centre;
- (x) feedback was important since it ensured that those who helped to supply the information realised how it had been utilised. This would also aid the improvement of the quality of information.

Dominica

27. The Dominica representative stated that the development of an information system for Primary Health Care in Dominica had been undertaken as an integral part of the development of Primary Health Care itself. The information system was still in an evolutionary phase and was to be implemented in three experimental districts. She explained that the health services system now evolving in Dominica was structured at three main levels with three basic functions.

28. The three levels were: the National Government Level, the Central Technical Level and the District Level. The functions of these levels were identified as Policy Formulation, Plan and Programme Formulation, setting of objectives and goals and implementation. The development of the HIS was started from the health services delivery end.

29. The location of 46 health centres of all types, including seven major district health centres (type III) were identified on maps and their geographic catchment areas defined. The results of the 1901 census were used to calculate the catchment areas and population for each health centre.

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30. A set of forms had been developed and used in four districts in 1981 to document the characteristics of the district, its health resources and the current level of activities. These forms were now being revised in the light of experiences gained and would become the annual health assessment 'forms', which would link the information and data derived during an operational year to the programming of services for the following years.

31. The norms and standards developed at the central level and the goals set were translated into a summary form. This would be done annually at the Central Technical Level and would provide some parameters for making estimates of persons eligible for different services as well as helping to identify the indicators and their values for control measures. Drugs, supplies, materials and transport requirements would be calculated on a district basis. Equal emphasis would be placed on the non-human and human resources.

32. Once a programme had been established with assured resources, then a Plan of Action would be prepared for and by each unit in full coordination within each district. Two forms have been established for this purpose - one for the smaller health centres which receive support and one for the major health centre which provided support to its satellites.

33. Because of the small number of activities occurring in any one area, monitoring for control was done on a quarterly basis. A weekly monitoring system has been developed relating to -

- (i) the presence of staff in the unit;
- (ii) the fulfilment of agreed support functions;
- (iii) the functioning of the supply system;

- (iv) the equipment and utilities of the unit;
- (v) the communication to management of the positive functions performed and problems encountered.

34. Two separate types of forms were developed, one for the smaller units and one for the major units. These activities necessitated the use of new forms. For other activities, the current forms were to be utilised with modifications where necessary.

35. A Household Card was also being developed which would serve to link other forms relating to individuals within the household and to identify households at risk.

36. A register of the households had been designed to record the month of visit and the type of staff making the visit. The numbering of households was being coordinated on an intersectoral basis. Multiple households in the same structure, and changes in the households would be identified by a letter suffixed to the structure number.

37. Individuals in the community would be identified for record purposes - by the household number followed by the last two digits of the year of birth. The final identification of a person would be through their full names.

38. For monitoring and control purposes, data would be extracted from this register on a quarterly basis by the visiting supervisor, and incorporated in the quarterly monitoring report.

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39. Data would not be required more than once a year from all household cards to provide information - which was community-based rather than service-based on households in the area, population by age and sex, births, deaths and migration outside the area, immunisation coverage, sanitation: water supply, excreta disposal and refuse disposal and prevalence of certain chronic conditions. These items would provide a major part of the 'Health Assessment' which was needed to recycle the programming of services, and the review of policy, plan, programme, standards, norms and goals when indicated.

40. In relation to the medical care programme, the system of patient-held record was in operation to provide a continuity of care. This would be supplemented at the clinic by a General Morbidity Record. The form had been designed so that it could be used by a medical officer or any other person providing care to the patient. The records would differentiate between services provided by doctors and others and between new, old, referred and transferred cases. The Referral System and the Notification System were linked to the medical care system.

41. Monitoring of patient care would be performed by the District Medical Officer who would review during each supervisory visit, the entries made on the record since his previous visit, examine whether the action taken/treatment given were appropriate for the condition seen. He would also examine the system to ascertain whether or not it was functioning properly.

42. During the annual health assessment activity, an analysis based on a sample of the records for the year would be performed to assess type and frequency of conditions seen at a unit, new, old and referred, and also the functioning of the referral system, analyse activities relating to diseases for which special programmes existed or were envisaged and link data from this record to data generated through special programmes.

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43. The information system was intended to be operated at peripheral and district levels mainly by the technical staff providing the health services. Data extraction and processing which was not immediately utilisable by the peripheral or district levels would not be required from them. The Health Statistician and her two assistants at the central level would therefore undertake all the data extraction and processing at district and peripheral level which related to annual reports, health assessment and evaluation. Data gathering would be kept to the minimum compatible with regular need and use. Sporadic requirements would be dealt with on an ad hoc basis.

44. The training which is needed for all staff was intended to be given as part and parcel of their technical refresher training.

45. In the discussion which followed this presentation, the following points emerged:

- that Dominica's organisation and approach were commendable since all levels of decision-making were considered. Norms, and standards were being established so that the information to be gathered would determine whether these were met;
- the resources needed were balanced by the resources available;
- the use of the census data provided some of the necessary baseline data and the use of the census numbers provided the base for an inter-sectoral approach to data collection;
- non-human resources were identified. Some systems could fail because not enough attention was paid to these;

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- data gathering was kept to a minimum.
The people involved in data collecting were also involved in designing the system;
- provision was made for staff training and development;
- the approach to implementing an HIS was incremental;
- a potential weakness existed in the system of collecting data from the periphery.
Data gathered should be sent to the Central Health Statistical Office, rather than requiring persons to go from the central level to collect the data.

Saint Lucia

46. In his presentation, the Saint Lucia representative stated that the HIS was still in the embryonic stage and that at the time the person who had been trained as Health Statistician had left the Ministry of Health. However, efforts were being made to train a statistician since it was envisaged that the HIS would be incorporated as an integral part of PHC.

47. The HIS had been introduced and was being tested in the Model District, Soufriere. Because it was found that data already existing was inaccurate and unreliable, a needs assessment was done and efforts were made to collect the necessary baseline data for establishing priorities. This data would be incorporated into a continuous health centre record. It was proposed to conduct workshops which would include training in PHC and HIS. All members of teams would be trained at the same time.

48. The draft document for the HIS envisages the use of available resources utilising the information collected and collated by the field workers. The reporting chain would be from the clinic to district to central level.

49. In the discussion which followed this presentation, the Meeting considered that the Saint Lucian experience had shown clearly the need to sensitise, educate and reorient people into any system before it could work effectively; that historical planning was unreliable; that a reporting system merely transmits information, therefore, some attention must be paid to the quality of the information that goes into it; and that standards and norms are essential but must be both practical as well as financially realistic.

Antigua and Barbuda

50. The Antigua and Barbuda representative stated that the HIS being developed was a modification of the system that had been observed to be operating in Jamaica. The system which had previously existed in Antigua and Barbuda was concerned mainly with data collection. The system had now been modified to collect the data, process it, interpret it and finally to disseminate the information in a usable form to all persons affected by the system. In order to do this, several types of reports were prepared on either a weekly, monthly, quarterly or annual basis. There was however a problem of staff shortage so that feedback was not being sent as readily to the districts.

51. In developing the HIS, a Central Planning Committee for information to support PHC in Antigua and Barbuda had been established.

52. The Health Statistician headed the Health Information System Planning Sub-committee which was charged with the responsibility to:

- (i) consider various information systems and design an information system appropriate to the needs and objectives of Primary Health Care in Antigua and Barbuda;
- (ii) develop the necessary mechanisms for the implementation of the system;
- (iii) train relevant personnel in the use of the system;
- (iv) implement the system;
- (v) monitor and evaluate the system.

53. Use was also made of work done by previous interrelated committees. The major components of the system were identified as:

- (i) the institutions;
- (ii) the health centres/clinics;
- (iii) the Health Statistical Unit;
- (iv) the Central Statistical Unit;
- (v) the District Medical Officers;
- (vi) the Registrar's office;

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(vii) the Medical Records Department;

(viii) the Public Health Sector (Central Board of Health).

54. The information system was designed to produce information on:

(a) the status of the environment;

(b) the health status of the community;

(c) community organisations, involvement and social resources;

(d) health resources, material manpower and existing services;

(e) social and demographic characteristics of individuals and families;

(f) health education programmes.

55. The Health Statistical Unit was the centre of the Health Information System and was supervised by the Health Statistician. The Chief Medical Officer was the immediate supervisor of the Statistician, therefore there was a continuous communication between both on all aspects of the Health Information System.

56. Tabular and graphic presentations had been prepared and displayed to show trends in disease patterns, etc. and to enable close surveillance of epidemics. The Unit also served as a research centre and was called upon from time to time to assist with surveys, etc.

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Methods of Collecting, Processing
and Transmitting Data

57. The health personnel from the six medical districts of Antigua and Barbuda were required to submit statistical information to the Statistical Unit on a regular basis through organised channels.

58. Natality, morbidity and mortality statistics were collected and tabulated on a weekly and monthly basis. Public health data, hospital statistics and demographic data were also collected and processed on an annual basis. Statistical information on all the services offered by the clinics was also reported to the Unit monthly for tabulation.

59. During the implementation phase of the system, discussions were held with staff who were also trained in the use of reporting forms, reporting and recording procedures, the new communication channels and the relevance and importance of the data to be collected. The necessary equipment for implementing the system had been procured, and the launching of local health committees had also begun.

60. A target date had been set for the launching of the project but this was not met because of the many problems encountered during the implementation process. Despite what was considered to be thorough planning, there were delays because of the non-arrival of equipment and supplies, shortage of funds and unavailability of staff.

61. However, the committee did foresee some constraints and had decided in the interest of time, to make the best use of available resources for the short term until the long-term resources could be acquired. This necessitated the ordering of priorities.

62. Since the launching of the Model District, several difficulties had retarded the progress of the Information System. Some of these were due to external factors which were constantly affecting the recording and reporting mechanism of the system. The information flow was not working smoothly and the quality of data received from some areas was not of the standard expected.

63. The major difficulties responsible for this were identified as:

- refusal of clients to give necessary information and to return for follow-up;
- lack of cooperation due to poor attitudes of staff who lacked the team approach;
- inaccurate completion of forms - which led to late tabulation of data;
- lack of manpower at Central Statistical Unit to process forms, hence no feedback to users of data;
- lack of budgeted finance for Primary Health Care to provide for adequate facilities, equipment and supplies;
- non-compliance of hospital staff causing inefficient referral system;
- lack of forms due to breakdown and other priorities at the Government printery;

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- disruption within the filing system caused by clients not attending the correct clinic;
- one records clerk to serve the Model District where several clinics were held at the same time. It was therefore necessary to fully train the Community Health Aides and District Nurse Midwives into operating the system;
- inadequate space at health centres.

64. In the discussions which followed this presentation, the Meeting noted:

- (i) the commitment displayed by the Health Statistician and the role that she had played in the planning of the health services;
- (ii) the use of the HIS as a managerial tool and as part of the managerial process;
- (iii) the need for procedures for operating and maintaining the system and the use that was made of available expertise;
- (iv) the modification of the system through continuous valuation;
- (v) the need for a strong central statistical unit as well as some career structure for HIS workers.

65. The Meeting suggested:

- (i) that the people who were to implement the system should become more involved in the design of the forms to be used and other related procedures;
- (ii) that in-service training of community and hospital-based personnel could be carried out simultaneously. This could help to bridge the gap in the referral system.

Grenada

66. The Grenada representative reported that the Government of Grenada intended to expand and reorient the National Health Service along the lines of Primary Health Care. In its approach, one of the important factors listed in the draft policy statement on health was the construction of dynamic units for planning, compilation of statistics, preparation of project proposals and the dissemination of information.

67. Grenada was in the process of preparing a three-year Health Sector Plan and reorganising its Health Information System with the assistance of PAHO/WHO and CARICOM/AID.

68. The State of Grenada was divided into seven districts which included the islands of Carriacou and Petite Martinique. Data was collected from these districts and pooled at the Ministry of Health in different departments, viz. Statistical, Registrar General's and Environmental Health. The data collected dealt with vital statistics, population, epidemiological records, immunisation, morbidity, housing and sanitation.

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69. Data dealing with morbidity and immunisation were received monthly from the six Health Centres, twenty-seven visiting stations and three hospitals. These reports were prepared and mailed by the district nurses to the statistical department where they were collated, recorded and filed.

70. Weekly reports on communicable diseases were sent to CAREC and Washington; monthly immunisation reports went to CAREC and an annual report was prepared by the Department and distributed to Heads of departments within the Ministry. Births and deaths were recorded in the districts where they occurred, and the information was then sent quarterly to the Registrar General's office from the District Revenue Offices. In the areas of Environmental Health, such information as the number of houses, water and sanitary facilities and the population was gathered.

71. A Health Planning/Programming Workshop was held last March as part of the preparation for the writing of the three-year Health Sector Plan. One of the groups dealt with health information. Certain guidelines were set, most of which had been accomplished so far, e.g., total population, birth rate, death rate, rate of natural increase, migration, maternal mortality rate, infant mortality rate, disease specific mortality, gross domestic product life expectancy, etc.

72. There were some problems which the Ministry of Health was currently investigating with a view to having the situation remedied, e.g. late reporting of data, under-reporting (infant mortality), office/storage space, recruitment/training (staff) and amendment to existing law. At the moment all vital events must be registered according to place of occurrence.

73. The Grenada representative explained that it had attempted to amalgamate the systems by linking the Registrar General's office with the Ministry of Health. This was advantageous since vital statistics were very important

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to the HIS. Its Health Information Committee included a Health Educator, Nurses Educator, Health Statistician, Registrar General and Pharmacist.

Montserrat

74. The Montserrat representative stated that Montserrat was in the process of reorienting its HIS since a review of the previous system had shown that the information generated was meaningless.

75. The standard data was collected from community services and the district nurses prepared health profiles of their districts. These were matched and the information generated from this exercise, as well as from that conducted at the hospital, were used to reassign staff to areas of need. This information also showed that there was a decline in the need for maternal and child health services but an increase in the number of elderly persons who would require attention. This information was also being used as the basis for a National Health Plan.

76. Workshops were held for the nurses on their relation to the system. The hospital referral system functioned effectively because of the close relations developed between community and hospital-based practitioners at the workshops.

77. The Community Health Aides functioned in a multisectoral context. They reported to the various sectors about the problems which they had identified. The Public Health nurses followed through on the health reports and the other sections followed through on theirs.

78. Because Montserrat was small there were only two levels in the system - the periphery and the centre. The clinic nurses used the information collected in their districts to evaluate and plan. At the central

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level, the information was collated monthly by the statistical clerk. This information would be collated and disseminated on a yearly basis and compared with that from the previous year. Use was made of the media to publicise activity in the health field.

79. The Montserrat representative also stated that nurse practitioners functioned in the districts in place of the DMOs because the system was hospital-oriented and the doctors seldom visited the districts. Since there was a common budget for health services, adequate funds were provided at the district level. Health needs were also reflected in the budgets of the other ministries.

80. The key "learnings" which emerged from this presentation were the integration of primary and secondary systems of health care; the progressive shift of resources in the direction of PHC which can be effected through a system where both areas had equal access to resources; the multisectoral role of the community worker; and the use of the HIS in manpower planning, monitoring trends, and effect of preventative methods and in the integration of common services and facilities.

81. The Meeting also noted the commitment and leadership that was exercised in Montserrat in relation to PHC and HIS.

St. Kitts-Nevis

82. The St. Kitts-Nevis representative reported on the state of the HIS in that country. According to her, the old informal HIS was being upgraded into a formal information system. The old system had the following weaknesses:

- (i) the Statistical Unit of St. Kitts-Nevis was manned by one person;

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- (ii) no statistical officers were at health centres;
- (iii) a major problem of under-reporting existed, e.g. particularly reports from District Medical Officers at health centre level;
- (iv) reports submitted were often late;
- (v) information was not used for management, e.g. planning, monitoring, evaluation or decision-making;
- (vi) there was not a two-way flow of data between levels.

83. A phased approach was adopted, whereby emphasis was placed on priority programmes. One such priority area which had been selected was the nursing service with a focus on maternal and child health, nutrition and disease surveillance, and communicable disease control.

84. Primarily, the HIS had responsibility in the following areas;

- (i) collecting and processing of the data required by the various levels of the health service;
- (ii) generation of all statistical data needed by these levels;
- (iii) transmission of data to the users and cooperation with them to facilitate prompt and accurate generation of appropriate information;

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- (iv) design and initiation and control of primary statistical records and report systems;
- (v) design and updating of basic data and files necessary for the operation of the health service;
- (vi) production and analysis of demographic data such as population and vital statistics.

85. For the system of reporting each medical district and health centre reported to the Medical Officer of Health who in turn, reported to the Chief Medical Officer. Each branch of the services was responsible to its head of department and all data and statistics were being handled by the Health Statistician and the Health Educator.

SMALL WORKING GROUPS WITH ASSISTANCE
FROM TECHNICAL PERSONNEL

The country groups reported to the Meeting as follows:

Antigua and Barbuda

86. Antigua and Barbuda was awaiting its formal health policy document which would include Primary Health Care (PHC) as well as a drug policy. However, the Model District was being evaluated. Although team cooperation and community participation were poor at the inception of the programme, these had improved because both the team and the community had been sensitised and attitudes had improved. Continual sensitisation would be carried on by means of workshops, community health committees and the development of an active plan. Although the Health Information System (HIS) was plagued by a

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manpower shortage at the central statistical level and a shortage of forms, a system for the entire district had been instituted..

87. Antigua and Barbuda's HIS was in the process of development and was being refined, thus providing a strong foundation for countrywide implementation.

St. Vincent and the Grenadines

88. St. Vincent and the Grenadines had a broad health policy statement which encompassed the PHC approach to health care delivery. It was hoped that the health teams would be extended to all districts by 1985.

89. It was proposed to establish a planning committee which would be called the Maternal and Child Health Family Life Education Committee. There would be six programme sub-committees which would have a five-year development plan - maternal and child health and family planning; the model district health team; nutrition and health education; immunisation and day care.

90. It was planned that the community would identify the problems in the districts and would be involved in implementing the solutions to the problems. The team leader would be the District Medical Officer (DMO) but the teams would elect a coordinator for all activities. The team would be involved in the identification of the roles and functions of its members and of health care norms and standards. The team would also formulate its own plans which would be systematically evaluated using the HIS. Teams would also engage in fund raising, so as to finance part of their activities.

Saint Lucia

91. Saint Lucia proposed a programme of sensitisation and other activities with related sectors. There would be a separate budget for PHC activity and programme costs would be reflected within this budget. A form of health

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insurance, similar to the national insurance scheme was being considered for financing the programmes. An evaluation of the Model Health District would be conducted in July 1982.

92. Future plans included continuing the education programme through team building exercises at meetings and through the use of the mass media; and providing some form of recognition for persons engaged in PHC and HIS through opportunities for individual development and training.

93. It was also planned to allocate health resources to health districts according to the needs of each particular district. In order to ensure uniform quality of service scarce personnel and resources would be shared.

Montserrat

94. Montserrat had already developed a health plan and was in the process of costing it. It was planned to reorganise the health services so that the focus would be on families. There were plans to develop community profiles using existing groups and to formulate policy manuals for the districts. Consideration was also being given to incorporating the Technical Committee for PHC which utilised community resource personnel into the Public Health Advisory Committee which was intersectoral.

95. There was the problem of lack of reporting from private practitioners, and the need to sensitise the community to the fact that the health facilities were for use by all. In order to alleviate these problems it was proposed to have an intersectoral workshop in October 1982 and a workshop for doctors on recording and reporting.

Dominica

96. The health budget of Dominica made provision for training, travel costs and district supplies. Efforts were being made to afford recognition to outstanding personnel in the system through opportunities for training and increment on salaries. The PHC committee was intersectoral and was chaired by the Minister of Health. The Permanent Secretary in the Ministry of Health was coordinator of this committee.

Grenada

97. Grenada was in the process of developing a national, social and economic development plan in which the national plan would be incorporated.

98. There was a need for financial provisions for PHC to be better reflected in these plans. Some attention was being paid to alternative sources of funding such as donations, fund raising and gifts and grants from international agencies. There was also need to decentralise the administrative structure.

99. It was planned to evaluate the disease patterns of the population, manpower, goals and objectives of the system, the managerial process and the influence of social and economic conditions on the population.

100. In the area of personnel relations, Grenada planned to establish Grievance and Disciplinary Committees and to award increments on salaries and prizes to outstanding staff.

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COMPARATIVE ANALYSIS OF STRENGTHS AND
WEAKNESSES OF DIFFERENT APPROACHES

101. Countries were analysed on the basis of six different components of the managerial process.

Health Diagnosis

102. It was felt that most countries did their health diagnosis on a local as opposed to a national level. Surveys had been done in model districts and health centres. It was, however, necessary to know if the HIS would provide reliable information on a national level as well.

Health Programme Formulation

103. Every country had indicated a planning team, technical committee or other body which sat to formulate national policy. The constitution of these committees varied, but ideally they should include a statistician and an accountant and there should be dialogue between these two.

Health Policy Formulation

104. Every country had realised the importance of policy formulation and had either developed or were in the process of developing one.

Detailed Programming

105. Dominica, St. Kitts-Nevis and St. Vincent and the Grenadines had documented their norms and standards. In most countries this was now being done in a piecemeal fashion. All countries should have committees responsible for setting norms and standards for all sectors in a conscious and systematic way. A committee should also look at the realism of chosen goals and evaluate successes and failures.

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Implementation Monitoring

106. All countries had recognised the need to supervise the information system at all stages and phases.

Evaluation

107. All countries had recognised the need for evaluation, but as a result of the newness of the scheme in all countries, this had not yet been done.

108. In conclusion, some of the needs of an information system were stressed. These were identified as:

- long-term planning - a 4-5 year plan should be drafted;
- involvement of users of information from the beginning of the design process;
- commitment of resources - Governments should seriously look at the need to appoint a Health Statistician and different grades of this type of personnel ensuring at the same time a structure of promotion;
- a systems approach - ensuring that there was an input within the information system from every sector of the health services;
- gearing of the system towards the needs of the community.

SUMMARY OF RECOMMENDATIONS AND CONCLUSIONS

109. THE MEETING:

Agreed that -

- (i) the Health Information System for Primary Health Care (PHC) should be a part of the overall PHC system and it should be developed as part and parcel of the development of a managerial process for PHC, although it was sometimes necessary for the development of the Health Information System (HIS) to be staggered to meet the needs in accordance with the available resources at the time, the ultimate goal should be a reflection of the PHC approach in the HIS;
- (ii) the managerial process which the HIS should support, includes the following:
 - (a) formation of a health policy;
 - (b) health diagnosis - including the determination of health sector resources available both at the national and local levels;
 - (c) detailed programming and programme formulation; the conscious and systematic documentation of norms and standards for all components of the PHC system, the resources needed and to be programmed, alternative strategies and costs;

- (d) implementation;
 - (e) monitoring: checking progress of implementation against norms and standards;
 - (f) evaluation against objectives and goals to establish degree of achievement and to indicate necessary changes.
- (iii) the following factors would be important to the success of the HIS:

(a) Commitment

The goals of the system could only be realized if there was:

- (i) definite commitment on the part of all involved, i.e. the health workers, both technical and administrative and the political leadership;
- (ii) adequate feedback to all levels, including the community;
- (iii) distribution of responsibility for the efficient functioning of the HIS among key personnel throughout the implementation and evaluation.

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(b) Sensitisation

Adequate preparation of workers at all levels and potential users and contributors to the HIS in all stages of the development of the system as far as possible.

- (c) Sensitisation of the community and all related sectors in the aims and objectives of the HIS before its implementation.

(d) Design of HIS

- (i) A systems approach is necessary, in that the various elements of the system should be identified and linked together in a logical way;
- (ii) the HIS should be designed in accordance with levels of decision-making;
- (iii) an incremental approach for the development of HIS sub-systems should be adopted in accordance with the priority areas of needs and resources available;
- (iv) an examination of the existing system should precede the designing or re-designing of a new system and use should be made of work that may have been already done;

- (v) the design of the HIS should be for the production of minimum information that has been predetermined as being needed, and should be flexible enough to meet changing needs.

(e) Mannpower Development

- (i) Training of manpower at all levels in the production and utilisation of information for management purposes;
- (ii) there was a definite need for a career structure and incentives (e.g. promotion) for health information personnel within the health care delivery system. Efforts should be made to improve the status and authority of the HIS workers;
- (iii) responsibility for the system should not rest wholly on one person (e.g. statistician) since the departure of that person could lead to collapse of the system.

(f) Implementation of the HIS

- (i) The incremental approach to implementation, commensurate with available resources, should be adopted;
- (ii) the development of manuals which would detail norms and standards would contribute to proper implementation and monitoring of the system;

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- (iii) it must be ensured that the inputs of every part of the system were linked so that nothing was omitted when the incremental approach was used.

(g) Monitoring and Evaluation

- (i) It is necessary that the system be properly monitored in order to ensure that the data are collected completely, and on time and that the information generated is relevant to the needs of the users;
- (ii) there is need for developing procedures for monitoring the operation and maintenance of the HIS;
- (iii) mapping was important in order to assess progress.

(h) Communication

- (i) Effective use could be made of the media so as to publicise the aims, objectives and achievements of the programme;
- (ii) there should be clear channels of communication along all levels of the system;
- (iii) feedback was very important;
- (iv) there should be a work plan for the design, implementation and evaluation of the HIS, which would enable the country to identify and programme the HIS development activities;

- (v) future annual meetings of this nature would be most beneficial and agreed to forward the following recommendations to the Regional Health Ministers Meeting in Barbados:
- (i) the Health Information System for Primary Health Care (PHC) should be a part of the overall PHC system and it should be developed as part and parcel of the development of a managerial process for PHC;
 - (ii) the goals of the system could only be realised if there was definite commitment on the part of all involved, i.e. the health workers, both technical and administrative and the political leadership;
 - (iii) there was a definite need for a career structure and incentives (e.g. promotion) for health information personnel within the health care delivery system.

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SUMMARY OF ACTIVITIES OF BASIC HEALTH
MANAGEMENT TRAINING PROJECT 1978-1982

August 1978-December 1979

- | | | |
|-------------|------|---|
| August | 1978 | - Execution of Project Grant Agreement between CARICOM and USAID |
| April | 1979 | - Selection of Project Manager and Management Trainer |
| May | 1979 | - Selection of Westinghouse Electric Corporation (Health Systems) as one of five potential companies out of a field of 14 to provide Training and Technical Assistance to Participating Countries |
| June | 1979 | - Appointment of Project Manager |
| July | 1979 | - Appointment of Management Trainer |
| July | 1979 | - Conclusion of Contract Negotiations with Westinghouse Health Systems |
| July-August | 1979 | - Orientation and Update Visit of Project Manager and/or Management Trainer to Participating Countries |
| August | 1979 | - Execution of Contract with Westinghouse (Health Systems) |
| August | 1979 | - Purchase Orders Initiated for Commodities Needed for Training |
| September | 1979 | - Arrival of Westinghouse (Contractor) Curriculum and Training Team |
| September | 1979 | - Curriculum Development for Training Arm of the Project 'Package A' |
| September | 1979 | - Orientation of Co-ordinators, and Involvement in Curriculum Development |
| September | 1979 | - First Meeting of Project Advisory Group |
| October | 1979 | - Commencement of Training Package 'A' in Barbados and Antigua |
| November | 1979 | - Commencement of Training Package 'A' in Saint Lucia and Montserrat |
| November | 1979 | - Collection of Baseline Data for Evaluation in Saint Lucia and Montserrat |
| December | 1979 | - Collection of Baseline Data for Evaluation in St. Kitts and St. Vincent |

January-December 1980

January 7-8	First Package 'A' Training Evaluation Meeting	Antigua
January 9-10	Programme Review Meeting, CARICOM/Westinghouse	Antigua
January 18	Second Advisory Group Meeting First Project Evaluation Meeting	Barbados
January 19	First Planning Meeting - Health Information Systems Workshop	Barbados
January 14	Package 'A' Training	St. Kitts/N/A
February 5	Package 'A' Training	Grenada
February 4-29	Organisational Analysis - Technical Assistance	Saint Lucia
February 25	Package 'A' Training	Belize
March 18	Package 'A' Training	St. Vincent
February 27-29	Action Plan Follow Up	Barbados
March 1-30	Health Planning - Technical Assistance	Antigua
March 5-7	Action Plan Follow Up	Saint Lucia
March 25-27	Action Plan Follow Up	Antigua
March 28	Second Planning Meeting - Health Information Systems Workshop	Antigua
March 31-April 2	Action Plan Follow Up	Montserrat
April 1-30	Health Planning - Technical Assistance	St. Vincent
April 9-11	Programme Review Meeting, CARICOM/Westinghouse	Guyana
April 17-18	First Interagency Planning Meeting for Primary Health Care Workshop	Guyana
April 14-May 9	Additional Cycles Package 'A'	Barbados
May 9, 12, 13	Action Plan Follow Up	St. Kitts/N/A
May	Health Planning - Technical Assistance	Saint Lucia
May 13-19	Additional Package 'A' Cycle	St. Vincent
May	Model District Health Team - Technical Assistance	Antigua

May	Organisational Analysis - Technical Assistance	Montserrat
May 27-June 2	Additional Package 'A' Cycle	Antigua
May-June	Organisational Analysis - Technical Assistance	St. Kitts/N/A St
June	Arrival of Commodities in Countries	Eight Participating Countries
June 9-13	Additional Package 'A' Cycle	Belize
June 12	Presentation of Paper on Evaluation of Project	Washington, USA
June 23-27	Additional Package 'A' Cycle	Saint Lucia
June 24-27	Budget Review Meeting with Westinghouse	Miami, USA
June-July	Course in Supplies Management for Belize, Dominica, Grenada, Saint Lucia, St. Vincent	Jamaica
July 7-29	Package 'A' Training	Dominica
July 9	Second Interagency Planning Meeting for Primary Health Care	Grenada
July 10	Third Planning Meeting HIS Workshop	Grenada
July 11-13	Health Information Systems Workshop	Grenada
July 15-31	Needs Assessment re Health Information Systems	Barbados Belize Grenada Montserrat Saint Lucia
August	Arrival of Commodities	Dominica
August 1-31	Needs Assessment re Health Information Systems	Antigua Dominica St. Vincent
August	Model District Health Team - Technical Assistance	Belize
September	Arrival of Vehicle	Saint Lucia Antigua
September	Model District Health Team - Technical Assistance	Dominica
September 1-3	Action Plan Follow Up	Grenada
September 22-24	Action Plan Follow Up (Additional Cycles)	Barbados

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September	Completion of Technical Assistance with Prescription Drug Plan	Barbados
October 1-3	Evaluation and Planning Meeting with Coordinators and Westinghouse	St. Kitts/N/A
October 6-10	Pre-testing of Team Development Package - "Package B"	St. Kitts/N/A
October 13-18	Project Manager's Participation in Training of Trainers Workshop - CARICAD	Barbados
October 17- November 15	Mid-Project Evaluation External Evaluation Organised through APHA	Guyana Antigua Barbados Dominica St. Kitts/N/A Saint Lucia St. Vincent
October 20-24	Action Plan Follow UP Considerations for Implementation of MDHT Project	Antigua
November 3-7	Action Plan Follow Up	St. Vincent
November 12-18	Package 'B' Training	St. Vincent
November 10-14	Action Plan Follow Up	Dominica
November 24-28	Package 'B' Training	Grenada
November 24-28	Package 'B' Training	Barbados
December 4-10	Package 'B' Training	Dominica
December 10-11	Planning Meeting for Primary Health Care Workshop	Montserrat

January-December 1981

January 5-9	Package 'B' (Team Building) Training	Barbados/ Saint Lucia
January 6-9	Project Redesign Meeting	Guyana
January 20-26	Package 'B' (Team Building) Training	Antigua Montserrat
January 26	Third Project Advisory Group Meeting - Presentation of Project Manager's Second Evaluation Report	St. Vincent
January 28	Participation in Joint CARICOM/PAHO Meeting	Barbados
January 30	Closing Date for Submission of Proposals for Training of Management Trainers/ Organisational Development Officers	Guyana
February 1	Launching of Model District Health Team Project	Saint Lucia
February 1	Delivery of three Mopeds, MDHT Project	Saint Lucia
February 2-6	Package 'B' (Team Building) Training	Belize
February 5	Launching of Model District Health Team Project	Antigua
February 16	Termination of Prime Contract with Westinghouse Health Systems and Sub-contracts with LURIJOS, UWI and AGI	Guyana/USA
February 16-28	Health Project Development Management Workshop - in collaboration with CDB and CARICAD	St. Vincent
March 9-20	Model District Health Team Development - Technical Assistance (First Phase)	St. Vincent
March 30- April 10	Assessment of Functioning of Model District Health Team and Assistance in Development of Strategies to Deal with Team Functioning Problems	Antigua
April 6-16	Model District Health Team Development - Technical Assistance (First Phase)	Belize Grenada
April 13-24	Assessment of Functioning of Model District Health Team and Assistance in Development of Strategies to Deal with Team Functioning Problems	Saint Lucia
April 27-May 8	Assessment of Functioning of Model District Health Team and Assistance in Development of Strategies to Deal with Team Functioning Problems	Dominica

May 14	Launching of Model District Health Team	Dominica
May	Cataloguing of Books Ordered for Learning Resource Centres	Guyana
May	Arrival of Books for Learning Resource Centres	Countries
May	Commencement of Payment of Monthly Honoraria to Project Coordinators - Retroactive to October 1980	Guyana
May 13	Execution of Grant Agreement (Amendment No. 3) for Final Tranche of US\$234,000 Under Original Grant	Guyana Barbados
May 18-29	First Training Session of Management Trainers/Organisational Development Officers	Barbados
June 6	Final Planning Meeting for Primary Health Care Workshop	Saint Lucia
June 7-13	Primary Health Care Workshop - co-sponsored by CARICOM/AID, UWI, PAHO/WHO, UNICEF, APHA	Saint Lucia
June 19-26	Attachment of CMO, St. Kitts/Nevis and a District Medical Officer, Antigua	Jamaica (PHC Unit, UWI)
July 14-16	Participation of Project Manager in Regional Health Ministers Conference	Belize
August 18- September 1	Model District Health Team Development - Technical Assistance (First Phase)	St. Kitts/N/A
August 27	Execution of Grant Agreement (Amendment No. 4) - providing additional grant of US\$300,000 - committing a further sum of US\$200,000 to complete Project, as modified - extending "Project Assistance Completion Date (PACD)" to December 31, 1982	Guyana/Barbados
August 30	Launching of Model District Health Team Project	St. Vincent
September 1-15	Curriculum Development Package 'C' (Supervisory Management)	Guyana
September 5-19	Attachment of Health Statistician, Grenada	Jamaica/Antigua
September 13-27	Model District Health Team Development - Technical Assistance (Follow Up)	Grenada
September 15	Appointment of Management Development Officer	Guyana
September 17-18	Country Specific Primary Health Care Workshop	Grenada
September 21- October 2	Second Module: Training of Management Trainers/Organisational Development Officers	Barbados

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October 1	Appointment of Two Associate Management Trainers (one against vacant post of Management Trainer)	Guyana
October 5-16	Pre-test and Review of Package 'C' Training	Barbados
October 7-14	Team Building Workshop	Grenada
October 8	Meeting of Project Manager and Project Coordinators to Consider Plans to End of Project	Barbados
October 11-24	Model District Health Team - Technical Assistance (Follow Up)	St. Vincent
October 19	Launching of Model District Health Team	Grenada
October 14- December 4	Assignment of Management Development Officer re Development of Health Plan	St. Vincent
October 30- November 30	Assignment of CARICOM Statistician to Assist Management Development Officer	Barbados/ St. Vincent
October 6- November 6	Package 'C' (Supervisory Management) Training	St. Kitts/N/A
November	Country Specific Workshop in Primary Health Care	St. Vincent
November	Meeting with PAHO to Coordinate Activities for Belize	Jamaica
November	Meeting with Canadian High Commissioner re Assistance for Belize	Jamaica
November	Health Information Systems Workshop	St. Vincent
November 16-27	Package 'C' (Supervisory Management) Training	Grenada/St. Vincent
November 23-26	Project Manager's Participation in PAHO Technical Advisory Meeting	St. Kitts/N/A
December 7-18	Package 'C' (Supervisory Management) Training	Grenada/St. Vincent
December 10	Meeting of Project Manager with PAHO Staff Members to Coordinate Plans for 1982 (Dr. Paganini and Mr. Robles)	Barbados

January-December 1982

January 11-22 } February 1-12 }	Package 'C' Training	(Barbados (Saint Lucia
January 10 - February 15	Technical Assistance: Health Information Systems	St. Vincent and the Grenadines
January 22	Meeting of Project Advisory Group	Barbados
January 25	Action Plan Follow-up: Package 'C'	St. Kitts/Nevis
January 25-26	Ministerial Consultation on Primary Health Care	St. Kitts, Nevis
January 31 - February 6	Attachment of Senior Nursing Officer, St. Vincent and the Grenadines to Ministry of Health	Barbados
February 6-21	*Country Initiated Team-Building Workshop	(Dominica
February 22-) March 5) March 16-) April 26)	Package 'C' Training	(Antigua and Barbados ((Saint Lucia
March 1-13	Technical Assistance: Model District Health Teams	St. Kitts/Nevis
March 1- April 15	Technical Assistance: Health Information Systems	Saint Lucia
March 2-9	Primary Health Care Workshop	St. Kitts/Nevis
March 4-10	Workshop on Model District Health Teams	St. Kitts/Nevis
March 8-9	Action Plan Follow-up: Package 'C'	St. Vincent and the Grenadines
March 11-12	In-Country Primary Health Care Workshop	St Vincent and the Grenadines
March 17-18	Action Plan Follow-up: Package 'C'	Grenada
March 22-26	Planning Process Workshop	Grenada
March 25 - April 4	Country Initiated Team-Building Workshop	Saint Lucia
March 29-April 8	Technical Assistance: Model District Health Teams	Dominica
April 13-16) April 19-22)	Country Initiated Team-Building Workshop	St. Vincent and the Grenadines
April 19-30	Package 'C' Training	Montserrat

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April 19-30 May 10-21	Package 'C' Training	Dominica
April 26-27	Action Plan Follow-up: Package 'C'	Barbados
May 2	Action Plan Follow-up: Package 'C'	St. Kitts/Nevis
May 4-8	Technical Assistance: Health Information Systems	St. Vincent and the Grenadines
May 9-16	Technical Assistance: Health Information Systems	St. Kitts/Nevis
May 10-14	Planning Process Workshop	Antigua and Barbuda
May 10-21	Training of Trainers/Organization Development Officers (Module 3)	Barbados
May 15-16	Action Plan Follow-up: Package 'C'	Grenada
May 16-June 4	Technical Assistance: Health Information Systems	Saint Lucia
May 17-18	Action Plan Follow-up: Package 'C'	Saint Lucia
May 25-June 2	Planning Process Workshop	Belize
May 26-June 4	Action Plan Follow-up: Package 'C'	Belize
May 31-June 13	Technical Assistance: Model District Health Teams	Antigua and Barbuda
June 7-8	Regional Workshop on Primary Health Care	Antigua and Barbuda
June 9-11	Regional Workshop on Health Information Systems	Antigua and Barbuda
June 15-18	Internal Project Evaluation Meeting	Barbados
June 21-July 3	Training of Trainers/Organization Development Officers (Module 4)	Barbados
July 5-16	Technical Assistance: Model District Health Teams	Saint Lucia
July 19-30	Technical Assistance: Model District Health Teams	St. Vincent and the Grenadines
August 12	Action Plan Follow-up: Package 'C'	Antigua and Barbuda
August 16	Action Plan Follow-up: Package 'C'	Montserrat
August 19	Action Plan Follow-up: Package 'C'	Dominica
August 30- September 3	Country Initiated Team-Building Workshop	St. Kitts/Nevis
October 8-12	Preparation for Primary Health Care Workshop for District Medical Officers	Dominica

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October 10-22	Planning Process Workshop	St. Kitts/Nevis
October 6- November 15	Technical Assistance: Health Information Systems	Grenada
November 1-12	Country Initiated Team-Building Workshops	St. Vincent and the Grenadines
November 17-19	Primary Health Care Workshop for District Medical Officers	Dominica
November 29- December 3	Country Initiated Team-Building Workshop	St. Kitts/Nevis
November 22- December 3	Technical Assistance: Model District Health Teams	Grenada
December	Country Initiated Workshops on Primary Health Care	Grenada

*Each Country Initiated Team-Building Workshop was organized by the Project Coordinator and conducted with the newly trained Organization Development Officer/Management Trainer playing a leading role as co-trainer with one trainer supplied by the Project.

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In the six weeks following the workshop, the Gingerland district team met on three occasions. Several areas of endeavour were proposed and consequently dealt with:

- (a) Discussions were held with the Permanent Secretary in the Ministry of Nevis Affairs re communication with and support for the team by government. It was agreed that one Assistant Permanent Secretary under whose portfolio health lies would become a team member and would liaise with the Ministry. It was also agreed that telephones would be installed in all clinics at the completion of the present telephone line expansion programme.
- (b) Discussions were held with the only active district health team in St. Kitts. It was agreed that a joint radio programme would be sponsored by both teams with a view to airing primary health notices and information.

Following this agreement, discussions were held with the General Manager of the local radio station. These led to the donation of radio time at 9.00 a.m each Monday for primary health. It is the feeling of the Gingerland team members that more 'prime' time is desirable. Negotiations with the radio station will continue.

- (c) Sanitation was considered, and it was felt that a local garbage dump was urgently needed in Gingerland. An area has been identified by a committee chosen from team members and it is at present being presented to the Nevis Local Council for ratification. More frequent visits by the only garbage truck has also been agreed on.

- (d) A committee was created to consider and recommend equipment and supplies that would be needed to outfit the Gingerland Clinic for its role in Primary Health Care. A report has since been delivered to the team leader and will be sent to the Ministry of Nevis Affairs and the Ministry of Health.
- (e) Discussions with the Superintendent of the Local Hospital and with the Permanent Secretary, Nevis Affairs have led to the agreement that a mini dispensary will be created at Gingerland Clinic. At the beginning it will consist of the apprentice dispenser at the hospital who will organise a mobile dispensary. In the future a staff member at the clinic will be trained to assume his role. This proposal begins in effect in approximately two weeks from this date.
- (f) Individual committees have been created to conceive and report on details of projects:
- (1) to combat malnutrition;
 - (2) to expand the school health programme;
 - (3) to compile a list of the geriatric and the disabled in Gingerland in specific and Nevis in general.

Each of these committees have been given a time frame of one month to report on the skeletal structure of these projects and a further two months to get agreement, hear discussions and to present the completed project for final approval by the district team. Each of these projects should be completed and be ready to be evaluated as to effectiveness at the end of two years.

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- (g) Discussions were held with the senior police officer in Nevis, with all doctors and with representatives of all nursing sectors (Hospital and public health etc.) re use of ambulance and improvement of service. General agreement was reached on some issue, such as procedure for summoning the ambulance. Other issues, involving relationship between ambulance drivers and hospital orderlies remain unresolved, but discussions continue.

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TIMETABLE - MODULE A
(TOP MANAGEMENT)

APPENDIX F

95/1

	Day 1	Day 2	Day 3	Day 4	Day 5
8:30	Registration				
9:00	Opening	Organisation	Feedback	Motivation	Decision Making
9:30	Why Management 60 1.1	Principles			Exercise Cont'd
	15 Coffee				
10:00	Expectations				
10:30	120 2.1	120 2.1	120 3.1	120 4.2	120 5.2
	60 1.1a	15 Coffee	15 Coffee	15 Coffee	15 Coffee
11:00	Management	Communication			Open Systems
11:30	Functions	Process and	Supervision	Team Building	Planning
12:00	75 1.2	75 2.2	75 3.3	75 5.1	45 5.3
		75 2.3			Trainers
12:30	Lunch				Evaluation
1:00	60	Lunch	Lunch	Lunch	30 1.6
1:30	Time Management		Leadership & Leadership Stylus Exercise	Action Planning	
2:00	75 1.3	Communications and Group Dynamics		60 1.5	Action Planning
2:30	Planning				
3:00	60 1.4	105 2.4	105 3.2		105 1.5
3:30	30 Coffee	15 Coffee	15 Coffee	Decision Making "In Basket" Exercise (Coffee)	15 Coffee
4:00	Action Planning	Action Planning	Action Planning		Course Evaluation
	45 1.5	60 1.5	60 1.5	120 5.2	60
4:30	Evaluation	Evaluation	Evaluation	Evaluation	Close Down
	1.6	1.6	1.6	1.6	

MID-MANAGEMENT

	Day 1	Day 2	Day 3	Day 4	Day 5
8:30	Registration				
9:00	30 1.1				Team Building
9:30	Expectations Orientation Norms, Logistics	Organisation Principles	Feedback	Motivation	
10:00					75 5.1
					Action Planning
10:30	105 1.1a	120 2.1	120 3.1	120 4.2	45 1.5
	15 Coffee	15 Coffee	15 Coffee	15 Coffee	15 Coffee
11:00					
11:30	Functions of Management	Planning	Leadership	Supervision	Preparation
12:00	75 1.2	75 1.4	75 4.2	75 3.3	75 4.1
12:30					
1:00	Lunch	Lunch	Lunch	Lunch	Lunch
	60	60	60	60	60
1:30	Action Planning				
2:00	30 1.5	Action Plan- ning 1.5	Action Planning	Action Planning	Group Presentations and Critique of Director Planning Exercise (Coffee)
2:30	Time Management (Coffee)				
	75 1.3	60 1.5	60 1.5	60 1.5	
3:00	Communication	Communication and Group Dynamics (Coffee)	Disaster Planning Exercise (Coffee)	Disaster Planning Exercise (Coffee)	105 4.1
3:30					Course Evaluation
4:00					60
	75 2.2	120 2.4	120 4.1	120 4.1	
4:30	Evaluation	Evaluation	Evaluation	Evaluation	Open
	15 1.6	15 1.6	15 1.6	15 1.6	

LINE MANAGEMENT

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	Day 1	Day 2	Day 3	Day 4	Day 5
8:30	Registration				
9:00	30 1.1	Organisation Principles	Feedback	Motivation	Conflict Management
9:30	Expectations Orientation	75 2.1	60 3.1		75 4.3
10:00	90 1.1a	Communications	Supervision		Action Planning (Coffee)
10:30	15 Coffee	45 2.2	60 3.1	105 4.2	
11:00		15 Coffee	15 Coffee		
11:30	Functions of Management	Communications	Supervision	Leadership and Team Building	75 1.5
12:00	75 1.2			3.2	Preparation
12:30	Lunch	75 2.2	75 3.3	90 5.1	30 4.1
1:00	60	Lunch	Lunch	Lunch	Lunch
1:30	Time Management	60	60	60	60
2:00	90 1.3	Action Planning	Action Planning	Action Planning	Group Presentations and Critique (Coffee)
2:30	Planning	60 1.5	60 1.5	60 1.5	
3:00	45 1.4	Communication and Group Dynamics	Disaster Planning	Disaster Planning Exercise	105 4.1
3:30	15 Coffee				
4:00	Action Planning	105 2.4	105 4.1	105 4.1	Course Evaluation
4:30	45 1.5	15 Coffee	15 Coffee	15 Coffee	60
	Evaluation	Evaluation	Evaluation	Evaluation	Open
	15 1.6	15 1.6	15 1.6	15 1.6	15

NATURES, DATES AND DURATION OF TECHNICAL
ASSISTANCE RECEIVED BY COUNTRIES

Nature of Technical Assistance	Country	Dates	No. of P/Mths.	
Health Planning	Antigua	March 1980	2.0	8.0
	Montserrat	June 1980	2.0	
	Saint Lucia	May 1980	2.0	
	St. Vincent	April 1980	2.0	
Model District Health Team	Antigua	May 1980	2.0	15.5
		1-13 June 1982	0.5	
	Belize	August 1980	0.5	
		6-13 April 1981	0.5	
	Dominica	September 1980	2.0	
		29 March-8 April 1982	0.5	
	Grenada	6-16 April 1981	1.0	
		13-27 Sept. 1981	1.0	
		22 Nov.-2 Dec. 1982	0.5	
	St. Kitts-Nevis	18 Aug.-1 Sept. 1981	1.0	
	1-13 March 1982	1.0		
Saint Lucia	June 1980	2.0		
	5-16 July 1982	0.5		
St. Vincent	March 1981	1.0		
	12-23 October 1981	1.0		
	19-30 July 1982	0.5		
Organisational Analysis	Montserrat	May 1980	1.0	3.0
	St. Kitts-Nevis	May/June 1980	1.0	
	Saint Lucia	February 1980	1.0	

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Nature of Technical Assistance	Country	Dates	No. of P/Mths.	
Health Information Systems (needs assessment)	Barbados	15-31 July 1980	0.5	
	Belize	- do -	0.5	
	Grenada	- do -	0.5	
	Montserrat	- do -	0.5	
	Saint Lucia	- do -	0.5	
	Antigua	1-31 August 1980	0.5	
	Dominica	- do -	0.5	
	St. Vincent	- do -	0.5	
	St. Kitts-Nevis	February 1981	0.5	
	(Development of Systems)	St. Vincent	November 1981	1.0
		10 Jan.-15 Feb. 1982	2.0	
		4-8 May 1982	0.25	
Saint Lucia		1 Mar.-15 Apr. 1982	1.5	
		16 Mar.-4 June 1982	0.75	
St. Kitts-Nevis		9-16 May 1982	0.25	
	Grenada	6 Oct.-15 Nov. 1982	1.5	11.5
Prescription Drug Plan	Barbados	Between Nov. 1979-Sept. 1980	4.0	4.0
				42.0

TEAMBUILDING DESIGN/TRAINING BRIEF

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
8:30	REGISTRATION	INTRO: TEAM BUILDING AND DEVELOPMENT CYC CYCLE	LEADERSHIP AND TEAM BUILDING	ISSUES OF CHANCE STRATEGIES FOR DEVELOPMENT	PLANNING AND EVALUATION EXERCISE
9:00	OPENING CEREMONY	ROLES IN TEAM MEETINGS EXERCISE			
9:30	COFFEE	COFFEE	COFFEE	COFFEE	COFFEE
10:00	GROUP EXERCISE				
10:30	ORIENTATION EXPECTATIONS	ROLES IN TEAM MEETINGS EXERCISE	PLANNING AND EVALUATION	WORK TEAMS	WORK TEAMS
11:00	INTRO TO TEAM FUNCTIONING EXERCISE	PROBLEM SOLVING EXERCISE	WORK TEAMS	WORK TEAMS	PRESENTATION
11:30	FEEDBACK				CRITIQUE
12:00					
12:30			ORGANISATIONAL RELATIONSHIPS	CONFLICT, POWER AND INFLUENCE	COURSE EVALUATION
1:00	SNACK BREAK	SNACK BREAK	SNACK BREAK	SNACK BREAK	SNACK BREAK
1:30	TEAM DEVELOPMENT SURVEY - DISCUSSION	TEAM DEVELOPMENT SURVEY - DISCUSSION	TEAM DEVELOPMENT SURVEY - DISCUSSION	TEAM DEVELOPMENT SURVEY - DISCUSSION	COURSE EVALUATION
2:00					

*Based on a Training Day of 5½ hours with no lunch. Adjustments to be made both in time and design to fit specific country needs.

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TIMETABLE - MODULE C
SUPERVISORY MANAGEMENT PROGRAMME
TIMETABLE

Revised

TIME	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
8.30	Opening Exercises 1.1	Personal Life Goals Planning 105 mins. 2.1	Human Behaviour (Individual) *Theory Input 60 mins. 3.1	Human Behaviour (Groups) *Experiential Exercise *Theory Input *Games 105 mins. 4.1	Motivation and Morale Building 120 mins. 5.1
9.30	The Role of the Supervisor in CARICOM Region *Caselettes Discussion		Job Analysis and Job Description	Management by Objectives	Training and Development Methods *O-J-T
12.30	165 mins. 1.2	120 mins. 2.2	165 mins. 3.2	120 mins. 4.2	105 mins. 5.2
L U N C H					
1.30	*Course Objectives *Learning Contract *Course Overview	Time Management	Job Analysis and Job Description	Delegation	Report Writing
2.00	75 mins. 1.3	75 mins. 2.3	75 mins. 3.2	75 mins. 4.3	75 mins. 5.3
					Interim Evaluation 30 mins.

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Revised

DAY 6	DAY 7	DAY 8	DAY 9	DAY 10
Change and Resistance to Change *Caselettes Discussion 120 mins. 6.1 Simulation LEGO EXERCISE 105 mins. 6.2	Planning and Scheduling Work 75 mins. 7.1 *Performance Appraisals 7.2 *Interviewing and Counselling 7.3 *Discipline 7.4	Leadership *Experiential Exercise 120 mins. 8.1 Network Analysis and Project Management 105 mins. 8.2	Budgeting *Costing and Cost Control Techniques 150 mins. 9.1 Decision Making 60 mins. 9.2	*Development of Back Home Plan 10.1 *Review of Learning Contract 10.2 *Preparation of Post Course Evaluation Vehicle 10.3
L U N C H				
Orienting New Employees 75 mins 6.3	*Handling Complaints and Grievances 75 mins. 7.5	Network Analysis and Project Management 75 mins. 8.2	Decision Making 75 mins. 9.3	End of Course Evaluation and Closure 10.4

Appendix J(A)

GUIDELINES FOR PREPARATION FOR TECHNICAL ASSISTANCE
UNDER THE BASIC HEALTH MANAGEMENT DEVELOPMENT PROJECT

NOTE TO: PERMANENT SECRETARIES, CHIEF MEDICAL OFFICERS AND
PROJECT COORDINATORS

1. PREPARATION FOR HEALTH PLANNING -

A. Before Consultants arrive:-

- i. Permanent Secretary and/or Chief Medical Officer to:
 - a) Discuss with Heads of Departments concerned the nature of proposed visit and canvass their views on what elements they feel should be included in the plan;
 - b) Communicate expectations to CARICOM for transmission to Westinghouse (Health Systems) or independent Consultants as the case may be;
 - c) Review Government's Health Policy if available or request the Health Minister to articulate same;
 - d) Review the Regional Health Policy in the "Declaration on Health for the Caribbean Community" to ensure that proposed plan would be as closely aligned to this as possible;
 - e) Review the extract from the Jamaica Health Plan - Ministry of Health Jamaica;

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- f) Review the extract from article by Oscar Gish
UNICEF Publication# 42; (copy attached)
- g) Review any other available material on Health
Planning;
- h) Begin to formulate own ideas of what the Health
Plan should entail.

11. The Project Coordinator to:

- a) Be involved, if possible, in all discussions
re proposed Health Plan;
- b) Review all information listed under (b) to (d) above;
- c) Ensure that orientation programme and other necessary
arrangements for the success of the venture are
well in hand.

B. On arrival of Consultants:

- a) Discuss expectations and get agreement either to
original or modified expectations;
- b) Write out agreed terms of reference for Consultants -
five copies:
 - 1 to file
 - 1 to Consultant
 - 2 to CARICOM
 - 1 to Westinghouse (if not independent Consultant)

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- c) Consultant (s) to provide time plan for meeting objectives;
- d) Agreement support to be provided by the Country - five copies to be distributed as above;
- e) Provide orientation for Consultant(s) and assist in overcoming any difficulties as necessary;
- f) Ensure that Ministry and other personnel necessary to the Consultants' effective functioning are notified and available to the Consultants;
- g) Ensure that background information as well as necessary equipment, is readily available to the Consultants.

C. During the course of the Consultants' stay in Country:

- a) Meet periodically to review elements under Section B above and to discuss progress in meeting objectives as planned;
- b) Provide feedback to CARICOM re progress and any perceived problems that may impede or retard the meeting of expectations;
- c) Give approval to any questionnaires that may be distributed in country;
- d) Make input into final report;
- e) Constantly bear in mind the time limitations on the Consultants' and strive always to expedite and facilitate their work.

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D. On completion of assignment:

- a) Give feedback to Consultant(s) as requested;
- b) Complete and submit evaluation as requested by CARICOM, using required format.

Evaluation to be completed within 2 weeks of receiving copies of the Consultants' final report.

2. MODEL DISTRICT HEALTH TEAM

A. Before consultants arrive:

i. Permanent Secretary and/or Chief Medical Officer to:

- a) Meet with Senior Department Heads and others involved in existing delivery of primary health care and if possible secure their views on what elements they feel should be included in this exercise. Try to reach a decision on location to be used; required manpower, materials and possible financial implications. Keep minutes of those discussions.

The technical experts are expected to work with you to design a Model District Health Team.

Their assistance will be provided in two phases:

- the design phase
- the follow up phase one year later.

You will need to ensure the design can be implemented and it may therefore be necessary for a select committee to work very closely with the technical experts. In addition to team-designing the experts can be requested to:

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- assist you with clarification of roles and job definition, functions, tasks, responsibilities and relationships of health team members as well as the community.
- provide guidelines for further definition of roles etc.
- prepare guidelines and related documents essential to the proper functioning of the proposed team
- review, revise or design the health information system to be used in this primary care effort.

If members of your proposed team are already identified and available the Consultants can work with them to ensure understanding and get feedback on the practicability of the design, roles, functions etc.

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 - b) Explore the implications of involving these elements and if possible do some preliminary work aimed at making them available;
 - c) Communicate decisions and if possible copy of minutes of meetings to CARICOM;
 - d) Review Government's Health Policy if possible or request the Health Minister to articulate same;
 - e) Review the Regional Health Policy in the "Declaration on Health for the Caribbean Community";
 - f) Review, revise and update the National Health Plan if available;
 - g) Read any available material on Primary Health Care.

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- ii. The Project Coordinator to:
 - a) Be involved in all discussions re proposed Model District Health Team;
 - b) Review all information listed under section (i) above;
 - c) Ensure that orientation programme and other necessary arrangements for the success of the venture are well in hand.

- B. On arrival of Consultants:-
 - follow procedure listed under Preparation for Health Planning

- C. During course of Consultants' stay:-
 - follow procedure listed under Preparation for Health Planning

- D. On completion of Project:-
 - follow procedure listed under Preparation for Health Planning.

3. ORGANISATIONAL ANALYSIS

- A. Before consultants arrive:

- i. Permanent Secretary and/or Chief Medical Officer to:

- a) Discuss with senior Department Heads the nature of the technical assistance to be received. Basically the technical experts in this area are supposed to take a critical and analytical

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look at your total organization, its structure, functions and interrelationships within the existing context and make recommendations regarding how the organization can be made to function more effectively and efficiently. They have been charged with the responsibility of assisting you "to promote the achievement of the highest level of excellence in the delivery of Health Services through appropriate structural improvements which focus on organizational effectiveness and organizational health";

- b) Identify key elements or areas which you would not want them to overlook.

ii. Coordinator to:-

- a) Be involved in all discussions related to the above;
- b) Ensure that orientation programme and other necessary arrangements for the success of this venture are well in hand;

B. On arrival of Consultants:

- follow procedure listed under Preparation for Health Planning

C. During course of Consultants' stay:

- follow procedure listed under Preparation for Health Planning

D. On completion of Project:

- follow procedure listed under Preparation for Health Planning

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4. HEALTH INFORMATION SYSTEMS

Guidelines on this area will be developed at the HIS Workshop scheduled to be held in Grenada from July 11-13/80 and will be conveyed to you as soon as possible thereafter.

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GUIDELINES FOR PREPARATION FOR HEALTH INFORMATION SYSTEMS
ASSESSMENT VISITS

Purpose

To provide an understanding of the current information systems used in the process of collecting health and other data used in the generation of health information.

Materials for the Visit

- (a) Copies of all reports (annual, weekly, etc.) which are produced by current health information/statistics systems.
- (b) Copies of all forms used in the data collection processes.
- (c) Statements of missions (goals, objectives) for the relevant departments involved in the health system.
- (d) Organisation charts of National Health Care Delivery System.
- (e) Organisation charts/lists of health facilities;
- (f) Any written materials describing the information system.
- (g) Any written materials describing procedures for the "users" of the information system.
- (h) Any reports, papers, or other documents which were developed regarding the current system's effectiveness.
- (i) Lists of Ministries (outside of Health) which supply inputs to the Health Information Systems.
- (j) Lists of Ministries supplied information by the Health Information Systems.
- (k) Examples of items identified in (i) and (j).

The Consultants would like to discuss current Health Information Systems with the following:

- (a) Persons using Health Information Systems output for management, planning or programming.*
- (b) Persons preparing various statistical reports from Health Information Systems outputs.*
- (c) Persons identified in (a) and (b) above at perhaps, national district and community levels.*
- (d) Health information Systems (statisticians, data processors, clerks, etc.)*.
- (e) Director of Health Information Systems.

The Consultants would like to visit a few key locations in the Health Information Systems data collection process (e.g. clinics, hospitals).

*Representative sample of individuals with different Health Information.

PROJECT DOCUMENTATION

CARIBBEAN COMMUNITY SECRETARIAT REPORTS

General

Project Information Handbook. Sept. 1979

Project Advisory Committee

REP. 79/1/23 AG/HMP

Report of the First Meeting of the Project Advisory Group. Guyana, 24 Sept. 1979

REP. 80/2/9 AG/HMP

Report of the Second Meeting of the Project Advisory Group. Barbados, 18 Jan. 1980

REP. 81/3/0 AG/HMP

Report of the Third Meeting of the Project Advisory Group. St. Vincent, 28 Jan. 1981

REP. 82/4/11 AG/HMP

Report of the Fourth Meeting of the Project Advisory Group. Barbados, Jan. 1982

Project Coordinators

REP. 79/1/24 C/HMP

Report of the First Meeting of the Coordinators of the Health Management Development Project. Guyana, 26-28 Sept. 1979

Project Evaluation

REP. 80/1 PE/HMP

BHMDP: First Project Evaluation Report. Margaret P. Price, Project Manager. Jan. 1980

REP. 81/2 PE/HMP

BHMDP: Second Project Evaluation Report. Margaret P. Price, Project Manager. Jan. 1981

REP. 82/3 PE/HMP

BHMDP: Third Project Evaluation Report. Margaret P. Price, Project Manager. Jan. 1982

REP. 83/4 PE/HMP

BHMDP: Fourth Project Evaluation Report. Margaret P. Price, Project Manager. Jan. 1983

Training Evaluation

REP. 80/1 PC/HMP

Report of the First Training Evaluation of the CARICOM/AID Basic Health Management Development Project. Antigua, 7-8 Jan. 1980

REP. 80/2 PC/HMP

Report of the Evaluation and Planning Meeting of the CARICOM/AID Basic Health Management Development Project. St. Kitts/Nevis, 1-3 Oct. 1980

REP. 82/2/44 PC/HMP

Report of the Second Internal Evaluation Meeting of the CARICOM/AID Basic Health Management Development Project. Barbados, 15-18 June 1982

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Workshop Reports

- REP. 81/1/35 W/PHC Report of the Workshop on Primary Health Care, Saint Lucia, 7-13 June 1981
- REP. 81/1/35A W/PHC Strategy and Plan of Action for the Caribbean Community. June 1981
- REP. 80/1 W/HIS Report of the Workshop on Health Information Systems in the Commonwealth Caribbean. Grenada, 11-13 July 1980
- REP. 82/8/40 W/PHC Report of Workshop on the Management and Administration of Primary Health Care in the Eastern Caribbean: a review of developments to date. Antigua and Barbuda, 7-8 June 1982
- REF. 82/2/46 W/HIS Report of Workshop on Health Information Systems to support Primary Health Care in the Eastern Caribbean: a review of developments to date. Antigua and Barbuda, 9-11 June 1982
- REP. 82/1/10 M/PHC Report of the Ministerial Consultation on Primary Health Care. St. Kitts-Nevis, 25-26 Jan 1982

CONTRACTOR REPORTS

<u>Ref. No.</u>	<u>Date</u>	<u>Title</u>	<u>Author</u>
79/1 TR-MT	Aug 4-Dec 31, 1979	Basic Health Management Training: First Progress Report	Westinghouse Electric Corporation (Health Systems) USA
79/1 TR-MT	Aug 4-Dec 31, 1979	Appendix (2/80) Basic Health Management Training: First Progress Report	do.
80/2 TR-MT	Jan 1-Apr 30, 1980	Basic Health Management Training: Second Progress Report	do.
80/3 TR-MT	May 1-Aug 31, 1980	Basic Health Management Training: Third Triannual Progress Report, Program Year 1	do.
81/1 TR-MT	Dec 1981	Report on Consultants' Activities - September 1-October 31, 1981 <u>Package C Curriculum Design, Pretest and Training in Guyana, Barbados and St. Kitts/Nevis</u>	Clarvis J. H. Joseph Director, Lurijos Management Consultants, Antigua
81/2 TR-MT	Dec 1981	Report on Project Activities During November-December 1981 <u>Package C Training in Grenada and St. Vincent</u>	do.
81/3 TR-MT	Nov 1981	Interim Report for the Training of Organizational Development Officers/Management Trainers	Sincos Consultants <u>Management Consulting and Training</u>

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CONTRACTOR REPORTS (Contd.)

<u>Ref. No.</u>	<u>Date</u>	<u>Title</u>	<u>Author</u>
04 TR-TD	Feb 1982	Team Development Workshop for Members of the Central Technical Team - Ministry of Health, Commonwealth of Dominica	Sincos Consultants Management Consulting and Training, Barbados
82/1 TR-MT	Feb 1982	Report on Project Activities During January 6-February 16, 1982 Package C Training in Saint Lucia and Barbados	Clarvis J. H. Joseph Director, Lurijos Management Consultants, Antigua
82/2 TR-MT	April 1982	Report on Project Activities During February-March 1982 Package C Training in Belize and Antigua	do.
02/3 TR-MT	May 1982	Report on Project Activities During April 1982 Package C Training in Dominica and Montserrat	do.

TRAINING MANUALS

<u>Date Compiled</u>	<u>Title</u>	<u>Design Team</u>
Nov 1980	BHMDP: Package 'A' Training: Resource Notebook (Revised) Basic Management	(Westinghouse Electric Corporation Consultants: . (Loyd Hunt), Clarvis Joseph, (Marilyn Harris, (Amanda Fother-Austin (CARICOM Management Trainer: (Alston A. Fergusson
Dec 1980	BHMDP: Package 'A' Training: Trainer's Manual (Revised) Basic Management	(Loyd Hunt), Clarvis Joseph, (Marilyn Harris, (Amanda Fother-Austin (CARICOM Management Trainer: (Alston A. Fergusson
Sept 1980	BHMDP: Package 'B' Training: Resource Notebook (incl. Trainer's Manual) Team-Building/Teamwork	Westinghouse Electric Corporation Consultants: William M. Deutshmann, Marilyn E. Harris CARICOM Management Trainer: Alston A. Fergusson
Sept 1981	BHMDP: Package 'C' Training: Resource Notebook Supervisory Management	CARICOM Staff: Alston A. Fergusson, George R. D. Rutherford, Harold A. Lutchman Consultants: Clarvis Joseph, Lakeram Singh, Amanda Fother-Austin
June 1980	Primary Health Care	Halmond C. Dyer

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TECHNICAL ASSISTANCE REPORTS

Model District Health Teams

<u>Ref. No.</u>	<u>Date</u>	<u>Title</u>	<u>Author</u>
<u>Antigua</u>			
01/1 TA-MDHT	May 1980	Development of Model District Health Teams in Antigua	K. L. Standard, Robert Benjamin
01/2 TA-MDHT	June 1982	Evaluation Report on Implementation of Primary Health Care Through the Development of Model District Teams in Antigua	Marjorie Holding-Cobham
<u>Dominica</u>			
04/1 TA-MDHT	Oct 1980	Toward Primary Health Care in Dominica: the Model District Health Team	Esmond Garrett, Mary Bennett
04/2 TA-MDHT	Apr 1982	Report on the Evaluation and Implementation of Primary Health Care through the Development of Model District Health Teams in Dominica	Kenneth L. Standard
<u>Grenada</u>			
05/1 TA-MDHT	Apr 1981	Development of Model District Health Teams in Grenada <u>[First Report]</u>	Marjorie Holding-Cobham, Kenneth L. Standard
05/2 TA-MDHT	Sept 1981	The development of Model District Health Teams in Grenada	Marjorie Holding-Cobham, Kenneth L. Standard
05/3 TA-MDHT	Dec 1982	Evaluation of Model District Health Team Project in Grenada	Kenneth L. Standard, Marjorie Holding-Cobham
<u>St. Kitts/Nevis</u>			
07/1 TA-MDHT	Sept 1981	The development of Model District Health Teams in St. Kitts/Nevis: proposed structure, strategies and plan of action for the delivery of primary health care in St. Kitts/Nevis	Marjorie Holding-Cobham, Kenneth L. Standard
07/2 TA-MDHT	Mar 1982	Report on the development of Model District Health Teams in St. Kitts/Nevis <u>[Second Report]</u>	Marjorie Holding-Cobham, Kenneth L. Standard

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Model District Health Teams (Contd.)

<u>Ref. No.</u>		<u>Title</u>	<u>Author</u>
<u>Saint Lucia</u>			
08/1 TA-MDHT	Aug 1980	The Model District Health Team: proposed structure and strategies for the delivery of primary health care in Saint Lucia	Kenneth L. Standard, Leland R. Bennett
08/2 TA-MDHT	Aug 1982	Evaluation of Model District Team Project, Saint Lucia	Marjorie Holding-Cobham
<u>St Vincent and the Grenadines</u>			
09/1 TA-MDHT	Mar 1981	The Model District Health Team in St Vincent	Esmond Garrett, Marjorie Holding-Cobham
09/2 TA-MDHT	Oct 1981	The Development of Model District Health Teams in St Vincent	Marjorie Holding-Cobham, R. Cortez Nurse
09/3 TA-MDHT	July 1982	Evaluation Report on the Model District Health Teams in St. Vincent and the Grenadines	Marjorie Holding-Cobham
<u>Health Information Systems</u>			
01 TA-HIS	Jan 1981	Health Information Systems Assessment Report - Antigua	Analysis Group Inc.
02 TA-HIS	Dec 1980	Health Information Systems Assessment Report - Barbados	do.
03 TA-HIS	Dec 1980	Health Information Systems Assessment Report - Belize	do.
04 TA-HIS	Dec 1980	Health Information Systems Assessment Report - Dominica	do.
05 TA-HIS	Nov 1980	Health Information Systems Assessment Report - Grenada	do.
06 TA-HIS	Nov 1980	Health Information Systems Assessment Report - Montserrat	do.
07 TA-HIS	Feb 1981	Health Information Systems Assessment Report - St. Kitts/Nevis	do.
08 TA-HIS	Nov 1980	Health Information Systems Assessment Report - Saint Lucia	do.
09 TA-HIS	Nov 1980	Health Information Systems Assessment Report - St Vincent	do.
02 TA-MIS	Nov 1981	A Management Information System for the Barbados Drug Service	Systems Group of Companies
00 TA-OHC/HIS	Apr 1982	Primary Health Care Information Systems Report - Orientation Manual- Saint Lucia	Gwendoline I. Harvey-McCloggan

Health Information Systems (Contd.)

<u>Ref. No.</u>	<u>Date</u>	<u>Title</u>	<u>Author</u>
09 TA-PHC/HIS	Feb 1982	Primary Health Care Information Systems Report - Orientation Manual - St Vincent	Gwendoline I. Harvey-McCloggan
05 TA-PHC/HIS	Nov 1982	Primary Health Care Information Systems Report - Orientation Manual - Grenada	do.

Health Planning

01 TA-HP	Jul 1980	Preplanning Review of the Health Status and Effectiveness of the Health Services in Antigua	L. Bertrand, B. E. C. Hopwood
05 TA-HP	Undated	Draft Three-Year Health Plan 1982-1985 - Ministry of Health, Grenada, Carriacou and Petit Martinique	R. Cortez Nurse; George Clarke
06 TA-HP	Aug 1980	Guidelines for the Planning of Health Services in Montserrat	L. Bertrand, B. E. C. Hopwood
08 TA-HP	Aug 1980	Preplanning Review of Health and Health Services in Saint Lucia	L. Bertrand, B. E. C. Hopwood
09/1 TA-HP	Aug 1980	Preplanning Review of the Health Services in State of St. Vincent	L. Bertrand, B. E. C. Hopwood
09/2 TA-HP	1982	Draft Five-Year Health Plan 1982-1985 - Ministry of Health, St. Vincent and the Grenadines	R. Cortez Nurse

Organizational Analysis

08 TA-OA	Jul 1980	Organizational Analysis for Health - Saint Lucia	Veronica Elliot
07 TA-OA	Sep 1980	Organizational Analysis of the Health System in St. Kitts/Nevis	Justin O. Vincent, Wain Iton
06 TA-OA	Aug 1980	Organizational Analysis of Health Division of Ministry of Education, Health and Welfare in Montserrat	Wain Iton, Ina Barrett

BASIC HEALTH MANAGEMENT PACKAGE 'B'
NEVIS - 30/8/82-3/9/82

TEAM ACTION PLAN

Preamble

We at the above workshop see as our goal the concept of mental, physical and social health for all in Nevis by the year '2000'.

We accept Primary Health Care as the only practical vehicle by which this goal may be achieved. We are resolved to mold ourselves into a viable, effective District Health Team, using members present as our core and co-opting others as the need arises. We intend to promote intersectoral coordination, and strive for total community involvement as we progress to our goals.

We propose to meet monthly, at first, and then to construct a schedule which fits our group as roles become clearly defined. We see as our immediate activities, on going exercises at team development, attitudinal monitoring and evaluation of team effectiveness. We plan team projects including research and informative reporting.

We intend to redress specific problems that we see as constraints to our overall goals. These are:

- (a) Communication: We intend to make immediate representation to the Ministry of Nevis Affairs re installation of a telephone at the Gingerland Health Centre and public telephones at strategic points in the district.

We plan an immediate feasibility study, using co-opted technical advisors from the radio station, re the advisability of citizen band and ham radio usage.

(b) Transport: We see transport as an essential tool in the stimulation of community involvement. We feel that care clinic staff must be facilitated either with transport or with an adequate travelling allowance to allow full mobility. Ambulance services will be scrutinised carefully by a committee of team members whose roles outfit them for such a task. District Medical Officer, Nurses, Hospital representatives and police are suitable choices.

(c) Equipment and supplies: We appreciate the urgent need to outfit the clinic with adequate equipment and supplies to meet demands for basic surgical procedures; for pharmaceutical needs; for record keeping, and for all other services vital to efficient Primary Health Care.

Total lists of supplies needed will be compiled and copies sent to government, to service clubs, and to external funding agencies. We also intend to create fund raising activities for team and community to help in this aspect.

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- (d) Lack of awareness and motivation: We recognise as a serious constraint the lack of awareness of and motivation towards our general goals, by supportive sectors especially the Ministry of Nevis Affairs. We recognise that health has not been made a top priority and in fact it is difficult to identify a single individual under whose portfolio health may be seen to lie. Our proposals for addressing this constraint includes representation to government by the personal approach, by providing relevant reports to various sectors including government and by constant news reports concerning our efforts.
- (e) Poor access to news media: We recognise the far-reaching possibilities for community notification of bulletins, and indeed for total community education, if full use were made of news media. We intend to make immediate deputation to Ministry of Nevis Affairs and to the Ministry of Home Affairs, seeking prime time programs dealing with Primary Health Care information and education. We plan seeking advertisement spots throughout regular television and radio programmes. We would encourage use of the Primary Health Care concept in advertisement by private business.
- (f) Resistance to change by team members and community: We predict some conflict in the community when changes are proposed.

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We recognise the existence of interest groups; of negative cultural and social beliefs and practises; and of normal frictions in a society where the aged predominate. We accept our role as instruments of necessary change as we strive to our goal of health for all. We embody the concept of 'change only if necessary' and will make every effort to examine any proposed change with special regard to harmful effects. We feel that total communication of ideas and concepts, and community education in general, are useful tools in the resolution of conflicts that may arise.

Recognising that conflicts to change may arise from financial constraints, we endeavour to stimulate fund raising by team and by community efforts. We plan using carefully scrutinised and trained aides to ensure maintenance of good interpersonal relationships between community and team.

- (g) Further education of Health team members and supportive staff: We propose to seek immediate help from external agencies (e.g. USAID, CIDA etc) for the establishment of a library stocked with reference literature relevant to primary health care; to team development; and to the prevention and cure of common diseases. We will leave no stone unturned to procure films and visual aids useful in the continuing education of team members and community.

We intend to pursue available courses and workshops that might aid the development of our district health personnel.

We recognise the existence of serious long term problems in our community and resolve to begin on-going projects to combat these and to alleviate their antisocial effects:

(1) Teenage Pregnancy and Family Planning:-

We suggest that the following actions be found useful for addressing this serious problem:

- (a) Integration of sex education in school programmes;
- (b) Proper training of teachers involved in sex and family life education;
- (c) Active parent teacher meetings;
- (d) Seeking funding for major sex education programme;
- (e) Dispensing of sex education on a confidential basis to teenagers and adults. This must include antenatal and postnatal sessions;
- (f) Self Help projects e.g. sewing classes, to occupy time and to encourage self reliance.

- (2) Negative or harmful cultural beliefs: We see a need for research into our local cultural beliefs. We believe that negative cultural values may only be changed by education. We plan community education programmes via news media, group meetings and by school lectures.

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We also recognise that it is difficult to get necessary change in inherited beliefs unless we can get and maintain community respect and trust.

- (3) Alcohol and other drug abuse: We recognise the use of marijuana and the abuse of alcohol as serious problems in our society. We intend to create clinic sessions for guidance. We plan major community awareness programmes via news media, posters, films. We intend to encourage A.A Group meetings and to encourage enforcement of laws which have become ineffectual due to neglect.

- (4) Juvenile Delinquency: This shall be redressed by
 - (a) encouraging entertainment centres;
 - (b) by extra mural education including a possible industrial school in Nevis;
 - (c) encouraging laws excluding youth from alcohol retail establishments and gambling institutions;
 - (d) providing useful alternative to idleness by self-help projects.

- (5) Common Diseases: e.g. diabetes, hypertension, sicklecell disease, venereal disease.

We intend to create and continue programmes leading to the recognition of all diabetics, hypertensives, etc. in the island of Nevis. We plan to create free, easily available testing centres utilizing community volunteers. We plan community education via news media re such aspects as causes, prevention, cure and nutritional relationships relationships as it applies to each condition.

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(6) Malnutrition: We recognise the following precipitants which predispose Nevisian infants to malnutrition:

- (1) Teenage Pregnancy;
- (2) Early introduction of expensive artificial milk feeds or unnutritious local foods e.g. bush tea.
- (3) Migration of parents abroad;
- (4) Low socio-economic status;
- (5) Unwise shopping with limited funds;
- (6) Lack of personal hygiene and home sanitation leading to chronic worm and bacterial infestation;
- (7) Increased parity.

Specific redress for each of these social problems will be considered in turn.

(7) School Health Programme: This needs expanding to include schedule talks, counselling sessions and physical examination. We plan to utilise that new creature the 'Nurse practitioner' in playing a major role in this programme.

Teacher training, we also see as being of supreme importance.

(8) Rehabilitation of disabled: We see the need for proper registration of the disabled in our society. We intend to complete this within three (3) months from project initiation. We see the need for training community volunteers and health aids to begin home visiting and general care. We also recognise the urgent need for funding to provide services and equipment e.g. wheel chairs etc.

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We plan approaching local and external agencies for same. We intend initiating community contribution collecting and fund raising as adjuncts.

- (9) Geriatric community services: We recognise serious implications to our society if we neglect the aged. We propose seeking a panel of community volunteers to register the aged and to lend all possible care. We will exert pressure on the Ministry of Nevis Affairs to provide nursing aids who can be trained to offer more extensive home care to those in need. The usefulness of the present pension and free service schemes in existence will be studied and recommendations made, taking into account community views on the subject. We intend to plan rehabilitative exercises for the geriatric including re-employment.
- (10) Mosquito, Fly and Rodent Control: We propose an on-going committee to recommend feasibility projects for the above. We will lean heavily on the Public Health Inspectorate giving all assistance with community education and recommendation for legal backings.

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DISTRIBUTION OF TECHNICAL ASSISTANCE
BY COUNTRY

APPENDIX M

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Type of Technical Assistance	Antigua	Barbados	Belize	Dominica	Grenada	Montserrat	St. Kitts/ Nevis	Saint Lucia	St. Vincent	Total in Person Months
Model District Health Team	2.5 pm		1 pm	2.5 pm	2.5 pm		2 pm	2.5 pm	2.5 pm	15.5
Health Planning	2.0 pm					2.0 pm		2.0 pm	2.0 pm	8.0
Org Analysis						1.0 pm	1.0 pm	1.0 pm		3.0
Information Systems	0.5 pm	0.5 pm	0.5 pm	0.5 pm	2 pm	0.5 pm	0.5 pm	2.75pm	3.75pm	11.5
Drug Plan		4.0 pm								4.0
	5	4.5	1.5	3	4.5	3.5	3.5	8.25	8.25	42.0

CARICOM/AID

BASIC HEALTH MANAGEMENT DEVELOPMENT PROJECT

Protocol for the Evaluation of the Model District
Health Team Projects

The attached information will be elicited by the consultants in an effort to ascertain:

1. the level of progress made by your country in relation to the implementation of Primary Health Care;
2. the progress made by the MDH Team itself;
3. the Community's perception of the impact of the MDHT Project on the health care delivery system in the area where the project is undertaken with a view to:
 - (a) making recommendations and suggestions to the countries re alternate strategies, etc. where applicable;
 - (b) assisting in the determination of readiness to expand the Project to other districts;
 - (c) getting feedback to CARICOM to assist in the determination of immediate and future steps to be taken in assisting countries of the Region in moving towards fulfilment of the goal of Health for All by the Year 2000.

The data will be collected by the evaluators in three sections:

Section I - from senior persons in the Ministry of Health

Section II - from persons in the district team

Section III - from members of the communities of the respective districts.

Additionally, the evaluators will look at various indicators of care delivery in a comparable area to ascertain whether there are any indicators, even at this early stage of implementation, that the Primary Health Care Approach as attempted in your country, has potential for improving the level of health of the population.

7. Are objectives and goals for PHC clearly spelt out at the national level?

8. Are objectives and goals clearly spelt out at the district level?

Any recommendations or suggestions re 3-8 above?

Strategy

9. Is there a strategy and plan of action for implementation of:

- (a) intersectoral co-ordination;
- (b) community participation;
- (c) reorientation of the health services;
- (d) the regional environmental health strategy;
- (e) the maternal and child health strategy;
- (f) the food and nutrition strategy;
- (g) the dental strategy;
- (h) other - specify.

Any recommendations or suggestions re above?

Services

10. Has a manual for PHC been written?

Yes	No	In Dev. Stage	Comments

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	Yes	No	In Dev. Stage	Comments
<p>If yes, what programmes have been included?</p> <p><u>List</u></p>				
<p>11. Is there a Veterinary Public Health</p> <ul style="list-style-type: none">- Unit; or- Programme <p>From what Ministry does this unit function?</p>				
<p>12. Is there a Health Education Unit or Programme within the Ministry?</p> <p>Any recommendations or suggestions re above?</p>				
<p><u>Facilities</u></p>				
<p>13. Have the facilities needed for the delivery of Primary Health Care been defined?</p>				
<p>14. Do these facilities exist in the Model District? If yes, have adequate arrangements been made for maintenance of these facilities?</p>				

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Yes	No	In Dev. Stage	Comments
If they do not exist, what are the problems being faced? List.			
Any recommendations or suggestions re above?			
<u>Staff</u>			
15. Is there a trained Medical Officer of Health employed in the Health Service?			
Is there a post on the establishment?			
If no, are there plans to employ a M.O.(H), train a M.O. to become a M.O.(H)?			
16. Has a decision been taken regarding the amount of time that Physicians (D.M.O's) are required to work in the Health Centres and the district in order to satisfy the needs of the Community?			
17. Are there Nurse Practitioners employed in the Health Service? Have Medico-Legal guidelines for the performance of their duties been drawn-up and formalised?			
18. Have job descriptions been developed for all categories of workers in the Model District? If yes, have these been discussed with the workers for whom they were developed?			
(If they have not been developed, are they now being looked at? seen to?			
When will they be in place?			

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19. Is there any formal In-service training programme to upgrade the skills of existing health workers in the Model District?

If yes, how often?

- weekly
- fortnightly
- monthly
- every 3 months
- every 6 months
- annually
- other (specify)

Any recommendations or suggestions re 15-19 above?

Health Team Approach

20. Has the team approach for the delivery of Primary Health Care been adopted and implemented in the Model District? If no, why?

Explain -

Yes	No	In Dev. Stage	Comments

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Yes	No	In Dev. Stage	Comments
<p>21. Has the policy of delegation of functions to lesser trained persons within the team been adopted? Is supervision adequate?</p> <p>Any recommendations or comments re 20-21 above?</p>			

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Yes	No	In Dev. Stage	Comments
<p>26. Is there a standard list of equipment for each type of Health Centre/Unit?</p> <p>Has this equipment been supplied to the Health Centres in the Model District? If No, why? <u>Explain:</u></p> <p>Have adequate arrangements been made for proper care and maintenance of equipment?</p>			
<p>27. Is there a standard list of drugs for each type of Health Centre/Unit for Primary Care? If yes, are these being supplied in adequate amounts to the Health Centres/Units in the Model District? If they are not, what are the problems existing? <u>List.</u></p> <p>Any recommendations or suggestions re 25-27 above?</p>			
<p><u>Health Information System</u></p>			
<p>28. Has an adequate Information System been developed?</p>			
<p>29. Were new records developed for use in the Model District? Are these records used throughout the island? If No, will there be a standardisation of forms for general use?</p>			

Yes	No	In Dev. Stage	Comments
<p>30. Is Health Information disseminated on a regular basis? To whom and from whom is this information disseminated? <u>Explain:</u></p>			
<p>31. Is there regular feedback of health information from the Central Statistical Unit to the field - the source of information? Is this information used in programming? <input type="checkbox"/> evaluation <input type="checkbox"/> training <input type="checkbox"/></p>			
<p>Where? Centrally <input type="checkbox"/> Locally <input type="checkbox"/> Health Centre <input type="checkbox"/> Medical Dist. <input type="checkbox"/> Parish <input type="checkbox"/> Other, specify <input type="checkbox"/></p>			

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	Yes	No	In Dev. Stage	Comments
32. Does the Health Information System provide -				
(a) Demographic data at national level				
(b) Demographic data at district level				
(c) Delineation of target population				
(d) Indicators for evaluation				
(e) Indicators for health status				
(f) Programme cost estimates				
(g) Supply system information				
(h) Progress reports				
(i) Information on Community Organisation and Activities?				
(j) Procedural manuals				
(k) Epidemiological Surveillance Information				
Any recommendations or suggestions re 28-32 above?				
<u>Referral System</u>				
33. Has an adequate referral system been developed?				
34. Does this system include referrals -				
(a) within Primary Health Care				
(b) from primary to secondary care and back				
(c) from secondary to tertiary care and back				

Yes	No	In Dev. Stage	Comments
<p>35. Does this system include referrals to other sectors outside of health and back? If yes, please indicate.</p> <p>Any recommendations or suggestions re 33-35 above?</p>			
<p><u>Community Participation</u></p>			
<p>36. Does your Health Policy include Community Participation? If yes, in what way is this achieved? <u>Explain</u> -</p>			
<p>37. Are there -</p> <p>(a) <u>national</u> guidelines for Community Participation <input type="checkbox"/></p> <p>(b) <u>local</u> guidelines - <input type="checkbox"/></p> <p>in health programmes and projects?</p> <p>To what extent were community members involved in Community Participation?</p>			
<p>38. Is there a methodology for evaluating Community Participation?</p>			
<p>39. Is there any training of health workers in Community Participation?</p>			
<p>40. Is there training of community members for meaningful participation in health programmes?</p>			

	Yes	No	In Dev. Stage	Comments
41. How are community members encouraged to assist in the process of Community Participation? <u>Explain</u> - How often do community members meet in groups with health workers?				
43. Is there a community Health or Health Education Committee?				
43. What have been the major facilitating factors in bringing about - (a) required political will (b) reorientation of the health services (c) intersectoral coordination (d) community participation				
44. What have been the major constraints inhibiting the four factors listed above?				
45. What steps do you recommend to remove constraints? Any recommendations or suggestions re 36-45 above?				

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CARICOM/AID BASIC HEALTH MANAGEMENT DEVELOPMENT PROJECT
TOOL FOR THE EVALUATION OF MDHT PROJECT

SECTION 2

DISTRICT LEVEL QUESTIONNAIRE

	Yes	No	In Dev. Stage	Comments
1. Does the team have a copy of the country's health policy?				
2. Is a copy of your country's Health Plan available to all members of your health team?				
<u>Health Team</u>				
3. Has the team approach for the delivery of PHC been adopted and implemented in your district? If no, what are the problems? List.				
4. Has the team assessed the needs of the community?				
5. Can all the needs of the community be met by the existing team?				
6. What other major needs or problems exist which are outside the scope of the present members to meet?				
7. Which professional disciplines for which there is now a definite need are missing from the team?				
8. Does your health team include Community Members? If yes, list categories and numbers.				

	Yes	No	In Dev. Stage	Comments
Indicate functions of Community Members				
9. Has the policy of delegation of functions to lesser trained persons within the team been adopted?				
10. Is there an In-Service training programme to upgrade the skills of team members? If yes, how often? State -				
11. Are regular team meetings held? If yes, how often? State - Do they have educational, problem solving, planning and programming components?				
12. Are you and your team members satisfied with the progress being made in the implementation of PHC? at the MDHT level. If no what are the areas of dissatisfaction? List -				
13. If yes, to what do you attribute success?				

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13. Rate the following on a one to five scale from poor (1) to excellent (5) to reflect your estimation of the functioning of the team
- a - Communication among members 1 2 3 4 5
 - b - Communication with control level 1 2 3 4 5
 - c - Communication with the community 1 2 3 4 5
 - d - Team problem solving 1 2 3 4 5
 - e - Team decision making 1 2 3 4 5
 - f - Team work on specified tasks 1 2 3 4 5
 - g - Team decision making 1 2 3 4 5
 - h - Team problem solving 1 2 3 4 5

14. Identify reasons for success or failure in any of the above.

15. Have Job Descriptions been developed for members of the Health Team? If yes, were members of the team involved in developing Job Descriptions?

Are members of the Health Team performing the tasks outlined in the J.Ds?

Yes	No	In Dev. Stage	Comments

	Yes	No	In Dev. Stage	Comments
30. Are the services readily accessible to the Community?				
31. Have tools been developed for evaluating the services given?				
32. Is there a need to improve the services offered?				
What are the requirements for improvement? List				
33. Is there a Community Mental Health Programme?				
34. Are laboratory services readily available? Where? a) Centrally. b) Locally				
35. Are there easily available and adequate supportive secondary care services?				
36. What are your recommendations for improving services? <u>Facilities</u>				
37. Are all facilities planned for your Model District on stream?				
38. Has a system been developed for maintenance of buildings in your district? If yes, is this system operating satisfactorily? If no, what are the suggestions for improvement? List				

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39. Indicate the general condition of each health facility.

	<u>State of Repair</u>	<u>Adequacy of Space</u>
<u>Facility</u>	<u>Good</u> <u>Fair</u> <u>Poor</u>	<u>Adequate</u> <u>Not Adequate</u>

	Yes	No	In Dev. Stage	Comments
<u>Health Information System</u>				
40. Is your present Health Information System adequate?				
41. Are there regular weekly or monthly submissions of reports to the Central Statistical Unit?				
42. If yes, is there regular feedback from that unit to the field?				
43. Is available data utilised in				
a) programming				
b) planning				
c) evaluation				
at field level?				
44. Is your system of retrieval of information i.e. filing, storage etc. developed?				
45. Is your supply system linked into your Health Information System?				
46. What recommendations does the team have re the Health Information System?				
<u>Referral System</u>				
47. Is the present referral system adequate?				

	Yes	No	In Dev. Stage	Comments
<p>48. Does this system include referrals</p> <p>a) Within Primary Care among team members</p> <p>b) From PHC to secondary Care and back</p> <p>c) From PHC to other Health related sectors and back</p>				
<p>49. Are members of the team satisfied with the feed back from referrals to other areas from PHC system?</p>				
<p>50. If the present referral system is not adequate, what recommendations do you have for its improvements?</p>				
<p><u>Equipment and Supplies</u></p>				
<p>51. Are the a) Health Centres b) Staff</p> <p>in your district supplied with the basic equipment necessary for them to function properly?</p> <p>If no, list equipment needed.</p> <p><u>Health Centre</u> <u>Staff</u></p>				
<p>52. Is the district adequately supplied with</p> <p>a) Drugs</p> <p>b) Office supplies</p> <p>c) Other essential supplies</p> <p>(list)</p>				

	Yes	No	In Dev. Stage	Comments
<p>55. Is there adequate transportation for staff to travel within their area of work?</p> <p>If no, who are most affected?</p> <p>List -</p>				
<p>56. Is there telephone service or other direct communication link between health facilities?</p>				
<p>57. What recommendations do you have in relation to transportation?</p>				
<p><u>Residence</u></p>				
<p>58. Do all the staff of the model district live in the area in which they work?</p>				
<p>If no, list those who do <u>not</u> by category and area.</p>				
<p><u>Category</u></p>				
<p><u>Area of Work</u></p>				
<p>Is this a satisfactory situation?</p>				
<p>59. List the existing circumstances that would deter staff from living in the area in which they work.</p>				

53. Is there a system for adequate maintenance of equipment?

If yes, is this system satisfactory?

If no, what are the suggestions for improvement?

List

Communication-Transportation

54. Is there an ambulance service in your district?

If yes, is it adequate?

If there is no ambulance service how are patients transported from one facility to the next?

Is this satisfactory?

Yes	No	In Dev. Stage	Comments

	Yes	No	In Dev. Stage	Comments
65. What recommendations do you have in relation to the role and involvement of your community?				
<u>Intersectoral Co-ordination</u>				
66. Do members of your health team work along with members of other sectors?				
67. If yes, is this done on - (a) official level; or (b) unofficial level?				
What is necessary to maintain this liaison?				
Elaborate -				
68. What recommendations or suggestions do you have in relation to community participation?				

60. What recommendations do you have in relation to the place of residence of members of the core team?

The Community

61. Has a Community Profile been done in your district?
If no, is there a tool available for developing such a profile?

62. Is there a readily available list of Community Organisations which function in your district?
If no, can this be done?
If no, explain -

63. Have Community Health Committees been established?

64. State the level at which the Community participates in Health Activities -

- Identification of needs:
- Group meetings with staff:
- Programme Planning:
- " Implementation:
- " Evaluation:
- Fund Raising:
- Assisting in Clinic Activities:

Yes	No	In Dev. Stage	Comments

CARICOM/AID BASIC HEALTH MANAGEMENT DEVELOPMENT PROJECT
TOOL FOR THE EVALUATION OF THE MDHT PROJECT

SECTION 3

COMMUNITY LEVEL QUESTIONNAIRE

The health workers in your district have changed their method of functioning over the past year - Have you noticed any difference?

Yes

No

If yes, what difference have you noticed in terms of

- 1) The number of service offered to the Community
- 2) The quality of services offered to the Community (specify which)
- 3) The attitude of the health workers towards patients/members of the Community
- 4) The environment
- 5) The involvement of members of the community in matters **related** to their health

What do you think of the changes?

What recommendations do you have for improving the quality of health care in your district?

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SUMMARY DISTRIBUTION LIST CARICOM/AID Health Management Development Project Training Equipment/Supplies	Antigua	Barbados	Delize	CARICOM	Dominica	Grenada	Montserrat	St. Kitts/N	Saint Lucia	St. Vincent	TOTAL
Desk top printing calculator with display and memory	-	-	-	1	-	-	-	-	-	-	1
Pocket Portable Electronic calculators	-	-	-	4	-	-	-	-	-	-	4
16mm Sound Projectors	1	-	-	1	1	1	1	1	-	-	6
Overhead Projector with Attachments	1	-	-	1	1	1	1	1	-	-	7
Projector storage covers	1	-	-	1	1	1	1	1	1	-	7
DYS/DYV Replacement lamps	1	-	-	1	1	1	1	1	1	1	8
Cassette Deluxe classroom recorders	1	1	1	1	1	1	1	1	1	1	10
Da Lite Screens (60' x 60')	1	-	-	1	1	1	1	1	-	-	8
Tuffy Tables (Wilson Corporation)	1	1	1	1	1	1	1	1	1	1	10
Portable cassette recorders	-	-	-	3	-	-	-	-	-	-	3
Catalogue Cabinets	-	1	-	1	1	-	-	-	-	-	3

ADDITIONAL COMMODITIES PURCHASED FOR PROJECT HEADQUARTERS

IN GUYANA

Four-drawer filing cabinets and file pockets	(4)
Upright stationery cupboards	(2)
Stencil filing cabinet	(1)
Olympia typewriters	(2)
Electric fans	(3)
Executive Desks	(2)
Executive Chairs	(2)
Typists' Desks	(2)
Conference table - small	(1)
Steel Chairs	(8)
Xerox Photocopier	(1)
File dips	(2)
Guillotine	(1)
Wire desk trays	(6)
Fan wall brackets	(3)
Carrying cases	(9)

COUNTRY SPECIFIC OBJECTIVES

(Extracted from Report of Assessment Visits by
Project Manager and Management Trainer)

ANTIGUA

The following outcome objectives were developed by the Project Manager from the information given by the staff at both meetings. They are to be revised or updated by the Coordinator and brought to Guyana in September 1979. They would form part of the Project's evaluation.

1. There is effective communication of all levels within the Ministry of Health and with the Community.
2. Ideas and plans are effectively translated into action.
3. There is clear role definition of personnel at all levels.
4. There are clear lines of responsibility and accountability.
5. Personnel are evaluated regularly in an objective and constructive manner.
6. Planning is done in a global and logical fashion rather than on the spur of the moment and piecemeal.
7. Interpersonal relationships within the Ministry is good (effective and constructive).
8. Health personnel are sensitive to the needs of the public and others and display positive attitudes in meeting these needs.

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9. Administrative staff are able to resolve conflicts quickly and decisively.

BARBADOS

The programme would be considered successful in Barbados, if on completion there was evidence that:

1. There is improved communication both horizontally and vertically within the Ministry of Health.
2. Effective communication between the Health Ministry and other Ministries or agencies which impact on the delivery of Health Care.
3. Leadership skills are acquired by participants to assist in the execution of policy.
4. Ministry personnel being fully aware of the Health Policy of the Country.
5. All relevant personnel being involved in decision making in areas affecting their functioning.
6. Health personnel making decisions within the scope of their responsibility and effecting such decisions.
7. Development of procedural guidelines for accomplishing tasks.

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8. Job descriptions for all personnel would be prepared.
9. Exposure of health managers to budgeting and monitoring of funds allocated to specific programmes.
10. An effective evaluation mechanism for programmes as well as all levels of staff is designed.

BELIZE

Evidence of the Programme's success in Belize will be measured to the extent that there is evidence of:

1. Improved effectiveness of the participants as managers.
2. Improved communication both vertically and horizontally within the Ministry of Health.
3. Clear definition and demarcation of roles, areas of responsibility and accountability.
4. Improved interpersonal relationships.
5. Effective functioning of the supply system.
6. Functional coordination of support systems (transportation, housekeeping, maintenance, etc).
7. Involvement of the middle and line managers in the decision making process in so far as it involves them.

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8. The district health teams functioning effectively.
9. Dynamic leadership in the Health Sector.
10. Improved liaison and integration of departments in the Health Sector.
11. Orientation and inservice programs are available to health workers.
12. Personnel and programs in the Health Sector are being effectively evaluated.
13. Specifically stated health policies which are known to all.
14. Effective planning in relation to Health Manpower.
15. Improved intersectoral communication.

DOMINICA

These outcome objectives have been worded by the Project Manager from information gathered from the persons present at both meetings. They are to be revised and updated, altered and clarified within the Ministry of Health in Dominica. They would be used as part of the Project's evaluation.

The Project would be considered successful in the Commonwealth of Dominica if upon completion there is evidence of:

1. Improved communication both vertically and horizontally at all levels within the Ministry of Health.

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2. Effective communication between the Ministry of Health and other Ministries or agencies which may have an impact on the delivery of health care.
3. Coordination and cooperation between the preventive and curative arms of the Ministry of Health.
4. An awareness among Health workers of the Health Policy of the country.
5. Attitudinal changes with health personnel displaying positive, constructive and respectful attitudes towards each other and the general public.
6. Clear role definition, responsibility and accountability.
7. Constructive and creative problem solving at all levels within the Ministry.
8. Acceptance of responsibility by those delegated to do so and a willingness to make decisions and take responsibility for decisions made.
9. Improved leadership skills by individuals at all levels within the Ministry of Health.
10. Total involvement at all levels in planning Health programmes.
11. An effective mechanism for evaluation of Health programmes.

12. Improved method of reporting and recording by all sections within the Health Ministry.
13. Improved counselling techniques being used by supervisors.
14. Equipment and supplies are effectively maintained.
15. Support services, e.g. transportation, laundry, housekeeping are properly organized.

GRENADA

1. Improvement of communication both horizontally and vertically within the Ministry.
2. Job description for personnel for establishment and casual workers.
3. A group 'task force' Planning Unit to be established and to monitor programmes at:
 - (a) development levels
 - (b) operational levels
4. Finance section to be trained in budgeting and the personnel department be strengthened and given training under the Caribbean Aid Training Programme.

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5. Inter-ministerial Communication.
6. Health Programmes to be spelled out and regional assistance sought for development of audio-visual aids.
7. Basic equipment to be obtained for Maternal and Child Health Services (Ministry of Health) and vehicles for transport of staff in Ministry of Health, Environmental sanitation, and *aedes aegypti*/malaria programmes.
8. Development of nutritional programmes by the Grenada Food and Nutrition Council.
9. Health Programme Planning/Health Services development Manpower available and needed 1981-1986. All these are components of the goals set out in the National Health Plan.

(These were submitted at a later stage).

MONTSERRAT

The purpose of this session was to identify specific objectives towards the achievement of which the training programme could be aimed. Initially this meant identifying problems which one or more members of the group felt were the result of poor management or identifying desirable states which it was felt would be brought about by the practice of more efficient management. This session was well responded to and the following needs were identified:

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1. Better interpersonal relationships.
2. More effective communications within and between different departments within the Health Services.
3. Better utilization of resources: physical, financial and human.
4. Persons at lower levels to more readily assume responsibility and make decisions within the scope of their authority.
5. Changes in work attitudes so that persons would become more 'business like'.
6. Greater productivity in terms of greater output of services without increases in personnel or plant.
7. Managers to practise more effective delegation.
8. Managers to be more effective in training subordinates.

ST. KITTS/NEVIS

Unfortunately time did not allow for the discussion of those in the Meeting No. 1. In Meeting No. 2 the following were given as possible terminal objectives.

The Project would be considered successful in the State of St. Kitts/Nevis if at its completion:

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1. Communication both vertically and horizontally is improved at all levels within the Ministry of Health.
 - There are clearly stated policies and procedures where applicable.
 - The lines of communication and reporting relationships **are clear**
 - Persons in the health care delivery sector are involved in the making of decisions and policies that affect them.
2. There is a change in attitude towards work/service/other personnel of persons at all levels within the Ministry of Health.
3. There is coordination of efforts in the delivery of health care.
4. At the Ministry level there is more of a balance in emphasis between health and education; if possible as separate Permanent Secretary for Health and Welfare and one for education.
5. Clear role definitions within concomitant responsibility and authority.
6. Job descriptions for all personnel.
7. Decision making and acceptance of responsibility at the appropriate levels.

The country Coordinator would review and revise these objectives and submit additional objectives at the September 1979 visit to Guyana.

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SAINT LUCIA

The Project would be considered successful in Saint Lucia, if at its completion there was evidence of:

1. Effective communication both vertically and horizontally, at all levels within the Ministry of Health.
2. Effective communication between the Ministry of Health and other Ministries whose functions impact on health care delivery.
3. Persons within the Ministry of Health being fully aware of the Health Policies of the country.
4. Role clarification with clearly defined limits of authority, responsibility and accountability.
5. Proper delegation.
6. Persons making decisions within the scope of their role and acting on these.
7. All relevant persons being included in decision making in areas affecting their functioning.
8. Involvement of the financial managers and health managers in budgeting and the monitoring of financial progress as programmes proceed.
9. A special officer doing health planning.

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10. Orientation programmes implemented for all personnel;
this must include operational policies, procedures, etc.
11. Clearly defined promotional policies, career ladder determination, etc.
12. An effective evaluation mechanism for all levels of staff.

These objectives will be revised and updated, added to or deleted by the Coordinator with inputs from other senior health personnel. The decision related to the preparation of a special officer to do health planning will be made after the completion of Package A.

ST. VINCENT

This was discussed briefly, but only with the Project Coordinator. He would broaden the input base and revise, add to, modify and prioritize these as necessary. The present outcome objectives are that the programme would be considered successful in St. Vincent if at its completion:

1. There is evidence of improved communication both horizontally and vertically within the Ministry of Health.
2. Decisions are made readily and appropriately at the correct level.
3. There is clear role definition of health workers (job descriptions).

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4. Areas of responsibility and accountability are clearly spelled out and adhered to.
 5. There is evidence of sound planning in the health sector.
 6. Manpower planning is done and recommendations made to educators.
 7. There are clearly stated health policies which are known to and understood by all health workers.
 8. There is a state Registry for health professionals.
 9. As much training of health professionals as is possible is done in St. Vincent.
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Issues to be Addressed in Relation to the Development
of the Primary Health Care Approach

The countries have embraced the Primary Health Care Approach as the vehicle for enabling them to achieve the goal of "Health for All by the Year 2000". However, taken as a whole they are still groping towards a clear understanding of the concepts involved in this approach and in translating these concepts into meaningful action aimed at meeting the needs of their country-specific situations. It is noteworthy that as the Project wound down towards its closure and faced financial constraints, the countries showed increased understanding and commitment to the Primary Health Care Approach. They then began to demand assistance in laying their foundations at a time when funds were inadequate to assist them to do so. It is hoped that this help will be forthcoming in greater measure.

The major issues are identified in this Addendum to the Project Manager's Final Report in the hope that greater awareness of them might be of positive influence to those who would continue assisting the countries in this very vital area. Such issues must be addressed when viewing the implementation of PHC in the context of the LDCs of the Commonwealth Caribbean:

1. Commitment at policy level can be meaningless if not matched by positive action. Commitment to the PHC Approach is often expressed, but due to lack of material and manpower resources the necessary change cannot be made. Repeated statements of policy without corresponding action is likely to affect credibility.

2. The Health Care Delivery System is so closely patterned after the Western-developed world systems, and both providers and recipients within the system are so geared and oriented to the type of services provided in the Developed World that they tend to discredit any other approach. Additionally, most of the doctors are trained in the standard

hospital curative-based model and do not find it easy to change their orientation. The above two factors, coupled with the inability of most governments to remunerate their doctors adequately and therefore as a matter of necessity must allow them private practice, militate actively against the implementation of the Primary Health Care Approach.

3. Health Care workers at all levels still get their rewards from remaining independent within the system. There are no external motivators for team work. Even within a discipline, e.g. Nursing, curative and preventive sectors may not be motivated to work as a team and often tend to view each other with suspicion. Their work is isolated and may often be in conflict as seen when the question of referrals of patients between levels is addressed. Because of these factors the question of developing effective teams where the team leader is the person with demonstrable leadership skills regardless of his/her principal discipline is a troublesome one and continues to hamper the teams. It is observed that the barrier to change is often less within the district teams themselves, than among the senior ranks of the professions at the ministry level. It has increasingly been demonstrated that this can be overcome, but continuing dialogue and clear, understandable and acceptable plans are necessary to facilitate reorientation and ensure support and cooperation in this area. Personnel must clearly understand where and how their status needs are going to be met.

4. The assertion that PHC should be provided at a cost the country can afford is somewhat of a 'red herring' in the context of most of the countries. It is impossible to bring about the necessary change within the system without some initial outlay, e.g. to provide transport, etc. for the workers to get to currently unserved areas, to transport and store vaccines, or to mobilize the communities. Additionally, increased ~~services~~ services at the district level will result initially in a greater demand for services at the secondary and tertiary levels. The

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change must therefore be planned, and funds made available in the initial stages of implementation. By the same token, reorientation of care givers is an absolute essential since, as mentioned earlier, their existing orientation is towards expensive Western-type medicine, and this is not likely to be easily changed.

5. Existing laws and bye-laws are not conducive to the implementation of the PHC approach. New workers are often not protected under the laws and anyone resistant to the team concept of leadership has only to refer to the laws enacted sometime in the 1920s to make the point that no one else but the doctor can be the leader of the team no matter how transient that doctor is, or how difficult it is for him/her to communicate with other team members and the community. Laws must therefore be updated.

6. The small sizes of the countries, difficulty of terrain, etc. pose problems often unique to each country. There is, however, much in common between countries and much that can be gained and shared. There as yet exists no effective Regional mechanism for this; the result is that often two or more countries can be struggling to solve a problem already solved in another, and which solution can be adapted and applied. The need for an ongoing Regional forum for the sharing of developments in PHC cannot be overemphasized.

7. The Public Services of the Caribbean are unique, despite their similarities to other Commonwealth countries. This uniqueness needs to be understood by those who would propose changes and make recommendations. At the inception of the BHMDP much advice was given and reports written which joined the other unimplemented and unimplementable reports on the shelves. Governments must be assisted to ensure that those who give them costly advice do so with a clear understanding of the context within which the advice would be applied.

8. There is a tendency to regard a consultant as something of a wizard. This has two negative impacts: firstly he is expected to "know all", and very little effort is made to orient him/her or to ensure that there is mutual understanding of what is expected of him/her during his/her stay in the country. The result of this is often the production of highly technical reports which meet the requirements of the funding agencies but cannot be properly understood or utilized by those left behind in the countries. The second negative impact is that very often the consultant states only what has repeatedly been said by local staff. When this is held up for its brilliance to the local staff they invariably are turned off and do not support the very recommendations which they have been struggling for years to get recognized.

9. The question of team leadership remains a thorny one. In most instances it is impeding progress. Leaders, regardless of their discipline, require much support and assistance since invariably their training has geared them to function independently.

10. Another major issue which must be addressed is the utilization of local expertise. Considerable funds have been expended by Regional and International organizations to train personnel who in a significant number of cases are not utilized when they return home. Invariably, they are either transferred or promoted, but to all intents and purposes the countries lose a valuable resource. There is a need for Training policies in most countries, that would also explicitly set out the expectations of both parties as a result of an individual receiving training.

11. A final major issue which is closely allied to the above is the question of who participates in training, conferences and workshops, etc. There seems to be a tendency for a regular set of personnel to attend conferences and workshops regardless of the topic or direct relevance to

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their line of work. There seems to be no expectation or commitment on the part of those attending to report back or impart knowledge gained, to those in line who are directly involved in the particular area. Again, clear policy guidelines are noticeably absent. Indications from some countries seem to be that conferences and workshops are used by senior personnel as a form of reward rather than as a forum where ideas, etc. can be gained and shared in a manner which will have the most direct impact on the countries.

12. It is worth repeating that the countries are still in their infancy in their implementation of the PHC Approach. Some countries have held country-specific workshops in PHC while others, building on the knowledge gained from their pilot Model District Health Team Project, have moved ahead to apply the approach on a country-wide basis. All countries are, however, still in need of additional training, assistance with needs assessment and population surveys, organizational development, reorientation of the existing health care delivery system, intersectoral coordination, community participation, health information system and resources planning and mobilization. Above all, they require assistance with material resources to implement what they already know is required.

13. A partial inventory of available technical capabilities and resources in the Region is given hereunder:

- (i) There is in each country at least one person capable of rendering assistance along with the Community Development Department and other sectors, which have a bearing on health care delivery.

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- (ii) In seven of the participating territories, there is at least one trained person who can initially liaise with external agencies to develop team-building and teach Basic Management skills to Health Managers.
- (iii) All States have local coordinators, who have some experience in the coordination of projects, such as the Basic Health Management Development.
- (iv) There is the capability to provide assistance with the Primary Health Care Approach at the University of the West Indies.
- (v) There is the capability to assist managers in Supplies Management at FACT in Jamaica.
- (vi) There is expertise on Project Planning, Design, Monitoring and Evaluation at the CDB (hard projects).
- (vii) Training in Health Education can be obtained through the facilities of the UWI.
- (viii) Training in Health Statistics can be obtained from CAST in Jamaica.
- (ix) There is the capability in the Region to provide Technical Assistance in Health Planning, Health Information Systems and Primary Health Care (PAHO/WHO).
- (x) There are Management Consultancy firms in the Region who can assist CARICOM with Management Training (LURIJOS, Antigua and SINCOS, Barbados).

- (xi) There is expertise in the Region for the provision of Management Training (UG, UWI).
- (xii) There exist within CARICOM:
 - (a) Curricula for the Training of Trainers and Organizational Development.
 - (b) A Regional Strategy and Action Plan for the Implementation of Primary Health Care, Dental Health, Maternal and Child Health Care, and Environmental Health.
- (xiii) Training in Health Economics (UWI/CAST).
- (xiv) Legal Drafting, using the facilities of CARICOM.

FACT	-	Finance and Accounts College of Training, Jamaica
CAST	-	College of Arts, Science and Technology, Jamaica
