

CLASSIFICATION
PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-447

1. PROJECT TITLE HEALTH MANPOWER PLANNING			2. PROJECT NUMBER 538-0054	3. MISSION/AID/W OFFICE RDO/C
5. KEY PROJECT IMPLEMENTATION DATES A. First P/O-AG or Equivalent FY <u>81</u> B. Final Obligation Expected FY <u>83</u> C. Final Input Delivery FY <u>84</u>			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>538-84-04</u> <input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION	
6. ESTIMATED PROJECT FUNDING A. Total \$ <u>1,186,138</u> B. U.S. \$ <u>512,138</u>			7. PERIOD COVERED BY EVALUATION From (month/yr.) <u>July 1982</u> To (month/yr.) <u>July 1984</u> Date of Evaluation Review <u>May 4, 1984</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., program, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. Meeting to be convened for AID, CARICOM, PAHO, NCIH, and participating countries to discuss project achievements and future health Manpower Planning activities.	CARICOM	June 1984 (completed)
2. RDO/C to determine whether to provide limited additional technical assistance in computer technology for strengthening data base.	RDO/C RPHA Holly Wise	December 1984

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS <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 N/A <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Project Agreement <input type="checkbox"/> PIO/P	10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT 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 N/A
--	--

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles) Holly Wise: RDO/C RPHA Terry Goldson CARICOM Neville Selman: RDO/C POP/A Russell Morgan NCIH Darwin Clarke: RDO/C SPS/Eval. T. Brown: RDO/C D/DIR <i>B</i>	12. Mission/AID/W Office Director Approval:  Typed Name <u>WILLIAM B. WHEELER</u> Date <u>August 30, 1984.</u>
--	---

~~XXXXXXXXXX~~
XD-AAP-853-A

International Health

National Council for

2100 Pennsylvania Avenue, N.W., Suite 740
Washington, D.C. 20037



FINAL PROJECT EVALUATION REPORT

Health Manpower Planning Project

Number 538-0054

Funded by:

The Regional Development Office/Caribbean
U.S. Agency for International Development

Grantee:

The National Council for International Health
in Cooperation with
The Caribbean Community Secretariat (CARICOM)

Submitted by

Merrill M. Shutt, M.D., M.P.H.
University of North Dakota
Department of Community Medicine

May 8, 1984

TABLE OF CONTENTS

I. SUMMARY 1

II. EVALUATION METHODOLOGY..... 7

III. PROJECT DESCRIPTION AND IMPLEMENTATION 8

 A. in of the Project..... 8

 B. istration..... 9

 C. ces..... 10

 D. mentation..... 11

IV. ANALYSIS OF VOLUNTEER COMPONENT..... 15

 A. Criteria for Assignment Approval for Volunteer Placement 15

 B. Performance by NCIH/CARICOM in Responding to Request for Volunteers.... 15

 C. Impact of Volunteers on the National Health Services..... 17

 D. Register of Specialties..... 22

 E. Cost Efficiency..... 23

 F. Prospects for the Future..... 24

V. ANALYSIS OF HEALTH MANPOWER PLANNING COMPONENT..... 25

 A. The CARICOM Health Manpower Planning Unit..... 25

 B. Strategy for Health Planning..... 25

 C. Progress on Implementation..... 26

 D. Prospects for the Future..... 28

VI. DISCUSSION..... 31

 A. Regional vs. Country Health Manpower Planning..... 31

 B. Role of the University of the West Indies..... 32

 C. Lessons Learned..... 32

 D. Unplanned Effects..... 33

 E. Options for USAID's Consideration..... 34

ATTACHMENTS

A. Consultant's Scope of Work.....

B. Draft Project Evaluation Summary (PES) Part II.....

C. List of Persons Contacted.....

D. Original Project Budget.....

E. Report of the Task Force Planning Meeting.....

F. Computation of Cost Efficiency.....

G. A Three Phase Approach to Health Manpower Planning.....

H. Health Manpower Information.....

I. Sample Country Health Manpower Data.....

111

I. Summary

This is the final Project evaluation of an Operational Program Grant in the amount of \$512,138 granted to the National Council for International Health (NCIH) originally for the period September, 1980 to September, 1982 to support a Health Manpower Planning Project. The Project is intended to accomplish two related major things relative to solving health manpower needs in the lesser developed English-speaking Caribbean nations: (1) assist participating countries in health manpower planning by providing selected health personnel (volunteers); (2) establish a health manpower planning capacity within CARICOM. It was intended that CARICOM would maintain the health manpower planning capacity after Project end.

The evaluation was conducted by Dr. Merrill M. Shutt, Department of Community Medicine, University of North Dakota, assisted by Mr. Neville Selmen, Regional Development Office/Caribbean, between April 9 and May 4, 1984. The evaluation is based upon: interpretations from interviews in Washington, D. C., Barbados, Guyana, St. Lucia and Dominica; observation; and reading of all or nearly all related Project documentation.

A. Implementation

The Project was slowed in its early stages because of great distances involved between the major participants (NCIH and CARICOM), the fact that they hadn't worked together previously, and delays in recruiting a CARICOM coordinator. After these administrative delays, NCIH and CARICOM signed a Sub-Grant Project Agreement June 1, 1981. There were later delays because of conflicting views between USAID and NCIH on the emphasis the various Project components should receive. This was resolved in favor of NCIH -- both components, not just the volunteer aspect,

would receive attention. More delays occurred later for technical reasons; no one envisioned the difficulty attendant to gathering baseline data related to health manpower from eight separate island-nations. After several non-funded extensions, the Project currently is due to end July 27, 1984.

Once the Project was in place, both NCIH and CARICOM have shown high degrees of administration and management. Inputs were appropriate and timely, and responsive to Project needs.

Both portions of the Project Purpose have been accomplished, but not to the degree anticipated, and not within the timing originally planned. The relevance and outreach of CARICOM in relationship to health manpower planning has been strengthened by the establishment of a health manpower planning unit which has related effectively with the Ministries of Health of the lesser developed Caribbean nations, the University of the West Indies, AID and PAHO. It currently is the most effective health manpower planning body operating for the Caribbean. It has developed the capacity to identify, recruit, and support the placement of West Indian volunteers, and to a lesser extent, US volunteers. It has not developed the financial capacity to carry on these activities at Project levels beyond AID support.

B. Observations Concerning the Volunteer Aspects

1. NCIH and CARICOM have been relatively successful in responding to LDCs' requests for short-term (3-6 months) medical and health personnel. They responded to 25 of 43 valid requests for assistance. In seven of these cases the country withdrew the request, and in three cases, refused an offered volunteer. In most of those 10 cases, the reason was the country had sought and found assistance from other sources.

2. Twelve US and eight West Indian volunteers were provided. The Project was unable to recruit a single West Indian residing in the States, although this option was the preference of the LDCs second only to Caribbean nationals resident in the West Indies.

3. The services provided were largely secondary and tertiary level medical care; very little was provided which could be considered at a primary health care level.

4. The Project costs associated with recruiting and processing the volunteers was a cost efficient method of providing these services.

5. The activity was only one source of temporary health/medical personnel for the LDCs. Other sources include the French, British and Peace Corps. The LDCs sometimes would request assistance from one or all sources simultaneously. These requests were not coordinated by the donor agencies involved.

6. While the countries were appreciative of the volunteers' services, the short assignment period (3 months in the case of Americans), the volunteers' frequently required adjustment to different cultural and medical systems, and absence of the support system to which the volunteers were accustomed very largely limited the impact the volunteers had on the health system to that of an extra pair of hands. There were some exceptions.

7. CARICOM, through its Project-established Health Manpower Unit, has the knowledge and contacts (but not the funds) to continue this function, although it would be difficult for it to identify and process US volunteers absent an institutional base in the US.

8. The Project has failed to develop a registry of Caribbean medical specialists living in the US and the Caribbean. The registry as it exists is too rudimentary to be useful.

C. Observations Concerning the CARICOM Health Manpower Planning Component

1. A Health Manpower Planning Unit has been established and is functioning with Project support funds at CARICOM. Continued funding of the unit by CARICOM is doubtful unless donor funding can be identified. The Kellogg Foundation has been approached.

2. If the member nations wish it, it is likely that the major functions of the planning unit could be carried on by seconded staff once existing manpower data are entered into a Project-provided IBM computer. This is in process.

3. The Health Manpower Planning Unit, with assistance from the LDCs and in collaboration with PAHO, has generated health manpower data of high quality and of great potential usefulness in manpower planning. These data are being refined; there is a way to go before individual plans for health manpower needs in the eight LDCs can be drawn up, and a much longer way to go before a regional plan can be formulated; indeed, it may not be feasible.

4. In the views of health officials from two Ministries of Health interviewed, the health manpower information generated to date will be much more useful for national versus regional health manpower planning.

5. PAHO and CARICOM have developed a close relationship regarding health manpower planning partially as a result of this activity, and PAHO likely will provide limited continuing support to CARICOM's activities.

6. The loss of two of the top leadership of the CARICOM Health Section, through retirement in one case and death in the other, may diminish the vigor of the Health Section. A replacement for the Chief is being sought.

D. Lessons Learned

A private, voluntary organization (in this case NCIH) is an effective mechanism to interface between the private sector in the US and governmental and quasi-governmental organizations overseas.

2. NCIH has used successfully the strategy of being generally reactive to host country needs rather than being strongly proscriptive. On its part, CARICOM has done a creditable job of anticipating and articulating the needs expressed by the cooperating countries. This process has resulted in CARICOM being in a much stronger position to carry on those parts of the Project for which the countries express continuing interest, with concurrent decreased continued dependency upon NCIH or AID.

3. It is important before Project implementation that all parties involved be in accord in their expectations. The LDC Ministries of Health very clearly were and are more interested in filling immediate gaps in their health manpower, while the PVO and AID had longer-term health manpower planning as their major agenda. This lack of congruence of objectives has resulted in some misunderstandings and resentments, and as an end result, neither agenda has been fully answered.

4. The Project has shown that using volunteer US health professionals is a cost efficient way of providing this expertise. The use of US volunteers, however, is less cost efficient and probably has less health impact than the use of similar volunteers from the area served.

5. The use of volunteers in this Project has had little developmental impact. In part this is because of the predominance of secondary and tertiary level medical skills, as opposed to primary health skills, of the volunteers requested and provided.

6. A method was explored during this Project whereby US university faculty members would replace Caribbean faculty of the West Indies. These in turn would serve as temporary manpower replacements-cum-instructors in the LDCs. The advantages of this would be that the US volunteer would be more familiar and productive in another university role than he/she would be as a direct health provider in a different culture and medical delivery system, while his Caribbean colleague would be much more productive within the health systems of the LDCs. This plan was

never implemented largely due to costs (for two volunteers in order to fill one post and the unresolved matter of dealing with the private practices of the Caribbean professionals), but could be further explored in future similar activities.

7. The Operational Program Grant mechanism does not lend itself well to the standard AID evaluation methodology. This is more observation than criticism, but the Log Frame is a very useful planning and evaluation tool. Its absence in the Operational Program Grant makes the evaluation process less objective and more subjective than is the case in more standard AID Projects.

E. Unplanned Effects

There has been one major unexpected result of this Project: the cooperation which has developed between two major regional organizations with health planning components, PAHO and the Health Section of the CARICOM Secretariat. Largely because of the Project's health manpower planning activities, these two organizations with congruent interests have developed a higher degree of cooperation and collaboration than existed prior to this activity. This should extend well beyond the life of Project.

F. Options for AID's Consideration

Five options for next steps are presented in Chapter VI Discussion. The consultant recommends Option 5, which is to terminate the Project formally at its expected termination (July 27, 1984) or before if funds run out, but by using other AID or USAID resources, provide support for a wrap-up meeting for all concerned parties, and for limited additional technical assistance in computer technology, should this Project be unable to fund them.

II. EVALUATION METHODOLOGY

This evaluation is intended as an end of Project evaluation, as called for in the Operational Program Grant. The Scope of Work was developed collaboratively by USAIA/RDO-C and NCIH, and is presented as Attachment A.

The evaluation was conducted April 9 - May 5 by a consultant (Dr. Merrill M. Shutt, University of North Dakota) with assistance of Neville Selmen, USAID/RDO-C. The consultant was briefed in Washington by NCIH and AID, reviewed documents, held discussions with PAHO, and had telephone conversations with USAID employees with Project experience, NCIH Grants Advisory Committee members, and a number of returned volunteers. In Barbados, he was briefed by USAID, reviewed documents, met with PAHO, and was unsuccessful in contacting the principal UWI contact (Dr. E.R. Walrond). With Selmen, he visited CARICOM headquarters two days in Guyana, and then proceeded alone to St. Lucia and Dominica, where he interviewed senior health officials, and an American and West Indian (Barbadian) volunteer. Returning to Barbados, he presented a verbal debriefing to members of the RDO/C Mission. The report was drafted in Washington.

The evaluation, then, is based on the consultant's interpretation of Project documents, quarterly reports, consultant reports, reports of returned volunteers, Advisory Committee reports, and perceptions of interviews with AID, USAID, NCIH, CARICOM and PAHO representatives, Ministry of Health officials, and active and returned volunteers.

The AID Log Frame is a useful evaluation adjunct to assist objectivity. Its absence from Operational Program Grants, including this one, perforce leads to a more subjective method of evaluation such as the one described above.

A draft Project Evaluation Summary (PES) Part II is appended as Attachment B for the AID Log Frame.

The list of persons contacted appears as Attachment C.

III. PROJECT DESCRIPTION AND IMPLEMENTATION

A. Origin of the Project

The Project arose from several reinforcing events. In mid-1979, Ambassador Phillip Habib recommended increased assistance to the Caribbean area, with special attention to health. At about the same time, the USAID Regional Development Office/Caribbean (RDO/C) received a request from St. Lucia for assistance in providing three specialized medical professionals to fill gaps in its health delivery system. Requests from other countries followed.

RDO/C requested consultants (Drs. Ned Wallace and Reginald Gipson) to:

Identify specific short and long term health manpower needs expressed by Ministry of Health Officials in Antigua, Dominica, St. Lucia, St. Vincent and CARICOM Secretariat Health Officials.

Determine possible USAID responses to these needs and recommended action.

Explore and recommend possible mechanisms for involvement of US Private Voluntary Organizations (PVOs) with Eastern Caribbean countries in the development and implementation of health projects.

Wallace and Gipson recommended, inter alia, that the National Council of International Health (NCIH) would be an appropriate Private Voluntary Organization (PVO) to assist in provision of health volunteers to the nation for short-term impact, and in creating within the Caribbean Community (CARICOM) secretariat a health manpower division for longer-term impact. Acting upon these recommenda-

tions, RDO/C asked the NCIH to submit a proposal for assistance. On September 24, 1980, a Project Grant Agreement (AID Project No. 538-0054) between NCIH and RDO/C was signed. The period covered was for 2 years, in the amount of \$512,138.

The purpose of the Project is enunciated in the Project Grant Agreement:

The purpose of this Grant is to establish a Health Manpower Planning capacity within CARICOM in order to 1) improve the relevance and outreach effectiveness of CARICOM's programs and services related to regional primary health care needs; and 2) assist participating countries in health manpower planning by providing selected health personnel, and related technical services. The project provides for the participation of the member countries of the Caribbean Community (CARICOM), with the principal focus placed on assisting those which are less developed.

The different parties had different expectations from the Project. Putting it overly simply, USAID, NCIH and CARICOM gave more emphasis to the longer-term developmental health manpower planning aspect, while the eight lesser developed participating countries were looking for immediate help in filling what they considered serious gaps in their health manpower. Although both major groups agreed to the provision of voluntary manpower, the countries hoped for long-term (2-3 year) assistance, while the Project was designed to provide only short-term (3-6 months) assistance. These perceptual differences caused some disgruntlement during implementation.

B. Administration

The Project operates under an Operating Program Grant between NCIH and USAID RDO/C. The USAID Project Officer is the RDO/C Health Development Officer.

For the NCIH, a Program Manager bears overall responsibility under guidance from the Executive Director. The Program Manager is supported by a Program and Training Coordinator, a Program Assistant and Secretary. None of the foregoing are paid full-time by the Grant.

NCIH has appointed from its membership a Grant Review Committee of 4 university and PVO based personnel. This committee, whose function is to give project overview, was appointed after the signing of the Project Agreement.

NCIH signed a Sub-Grant Project Agreement with the CARICOM in Guyana to co-manage the venture. The 2 year Sub-Project Grant Agreement originally was for the period June 1, 1981 to May 31, 1983. An NCIH/CARICOM Project Coordinator (a Jamaican national) is assisted by a Secretary, and a statistician seconded from the CARICOM Statistics Office for a 14 month period.

An ad hoc CARICOM Project Advisory Committee is composed of representatives from the Ministries of Health of the eight so-called lesser developed nations of the English-speaking Caribbean (Antigua, Belize, Dominica, Grenada, Montserrat, St. Christopher and Nevis, St. Lucia, and St. Vincent and the Grenadines). The Ministry of Health representatives usually are the Permanent Secretary and/or the Director of Health Services. (In the Sub-Project Grant Agreement the foregoing are referred to as Country Coordinators). Additional members of the committee are representatives of CARICOM, NCIH, PAHO, Project Hope, the International Eye Foundation and the University of the West Indies. Meeting approximately annually, the Committee has the purpose of exchanging information, ensuring coordination, preventing wasteful duplication and to advise in the development of the regional manpower strategy. This committee has met 3 times.

C. Financing

The budget as it appeared in the original two year Project Agreement appears

as Attachment D. It allocated \$114,500, or 22 percent of the \$512,138 for expenditure by CARICOM, and \$397,638 or 78 percent for expenditure by NCIH.

The CARICOM expenditures were forecast for personnel, staff travel and per diem, and direct costs. NCIH expenditures were forecast for personnel, fringe benefits, staff travel and per diem, consultants' fees and travel, volunteer travel and per diem, other direct costs, evaluation and overhead.

The budget was cast in a two year time frame. Although there have been Project extensions nearly doubling the Life of Project, there has been no addition of funding.

Actual expenditures by the two parties can be closely estimated as the Project winds down. Approximately \$307,000, or 60 percent will be expended by NCIH, and \$205,000 or 40 percent by CARICOM. In large part this shift towards parity has been occasioned by CARICOM's later assumption of responsibility for funding costs associated with West Indian volunteers.

D. Implementation

The Project's implementation was delayed at the onset by the time it took to recruit the NCIH/CARICOM Project Coordinator, and negotiation of the Sub-Project Grant Agreement between NCIH and CARICOM. Once the agreement was signed, smooth progress was blocked by USAID asking the Project to concentrate on the volunteer component, holding the health manpower planning in abeyance. This was resolved only after NCIH offered to help USAID find a replacement for itself (NCIH). The offer was refused, and the original agreement upheld.

In September of 1981, the Advisory Committee, while reaffirming an emphasis on the volunteer aspects, declared their support of the original program design. The first Caribbean national volunteer was placed in September, 1981. The first two US volunteers were placed in February, 1982, 16 months after the Project Grant Agreement was signed, and 8 months after the Sub-Project Grant Agreement went into effect. In July, 1982, five months after placement of the first US volunteers,

the first evaluation called for under the Project Grant Agreement was conducted by Leonard S. Rosenfeld, M.D., M.P.H., Professor of Health Policy and Administration of the University of North Carolina. His major recommendations, and the USAID/NCIH/CARICOM responses are summarized below:

1. USAID should grant a non-funded Project extension to September 24, 1982, 18 months following the termination date of the original agreement.

Response: A series of non-funded extensions have been granted by USAID. The Project is now due to terminate July 27, 1984.

2. Short-term volunteer assignment should be continued, transferring as much administrative responsibility as possible to CARICOM.

Response: Volunteer assignments accelerated, so that by the end of the Project, 12 US and 8 Caribbean nationals will have served. NCIH transferrred full responsibility to CARICOM for recruiting and travel of Caribbean national volunteers, as well as payment of per diem and honorarium for all volunteers.

3. Conduct ^Lan inventory of health manpower in the region.
4. Develop a system for collecting uniform data from the region.

Response: In February, 1983, CARICOM seconded a statistician to the Health Section of CARICOM for a six month period, largely to accomplish these. CARICOM extended his service, and he received Project support through April 1, 1984. In these endeavors, he received technical assistance from a consultant, Dr. Gordon De Friese, of the University of North Carolina. The success in these endeavors is described in Chapter V.

5. A task force should be constituted for development of an expanded program of regional organization of manpower.

Response: The Task Force was organized under the chairmanship of Professor Sir Kenneth Standard of the University of the West Indies. The report of that meeting (Attachment E) is of interest, as it highlights some of the different perceptions of the Project held by various participants.

The appointment of the statistician to the Health Manpower Unit in February, 1983, and the subsequent consultation by Dr. DeFriese in May, 1983 really marked the onset of the Health Manpower Planning component of this activity. Once again, implementation was slower than anticipated, but this time more for technical than for administrative reasons; no one anticipated the difficulty required to obtain the baseline data required. This has now been accomplished (See Chapter V), and is being transferred to an IBM-XT computer provided by Project funds, and being installed (April, 1984) at CARICOM headquarters in Guyana.

To summarize implementation: delays have characterized implementation of the Project. These have resulted from a combination of causes; different perceptions by participants of the emphasis to be placed on the various components of the Project; administrative delays occasioned by different organizations working together for the first time over long distances; and technical delays occasioned by an unawareness at Project onset of the difficulty in obtaining baseline health manpower data from eight developing countries. The major commodity input was a computer, installed three months late because of procurement delays. Nonetheless, it is functioning with personnel trained with Project assistance. Technical inputs in the form of consultants and volunteers were appropriate in quantity and quality, and supplied generally in timely fashion.

The Project has done well in achieving three of the four major outputs. It has produced volunteers, established a health manpower planning unit within CARICOM, and produced baseline information useful for country and regional health manpower planning. It has failed to develop a useful registry of Caribbean national medical specialists

resident in the US and the West Indies. All these aspects are discussed in more detail in Chapter IV and V.

IV. Analysis of the Volunteer Placement Component

A. Criteria for Assignment Approval for Volunteer Placement

The Sub-Grant Project Agreement between NCIH and CARICOM clearly specifies the criteria for approving the assignment of volunteers for up to six months:

1. The request from the host country is of an emergency nature to meet a critical health delivery need;
2. The request is for temporary replacement of an established professional position, and is not creating a new position in the health delivery system;
3. The request strengthens the primary health aspects of medical service delivery;
4. The request is accompanied by a detailed request form.

Very early in the Project, the Permanent Secretaries of Ministries of Health, while indicating displeasure that longer-term placements were not the Project's intent, added their desire that volunteers be recruited in the following descending order: (a) from the West Indies; (b) West Indian nationals now living in the U.S. or Canada; and, (c) United States nationals.

B. Performance by NCIH/CARICOM in Responding to Requests for Volunteers

Tables I, II and III show the disposition of requests for volunteers, the technical specialty and origin of placed volunteers, and the technical specialty of volunteers requested but whom the Project was unable to place.

Of 50 requests, 43 were in acceptable form and deemed by the Project as appropriate. Of these, the Project responded to 25, and was unable to respond to 8. In the 10 other cases, 7 requests were withdrawn by the requesting country and three volunteers were not accepted (frequently because the country found assistance

TABLE I. DISPOSITION OF REQUEST FOR VOLUNTEER PLACEMENT

	Antigua	Belize	Dominica	Grenada	Montserrat	St. Kitts	St. Lucia	St. Vincent	Total
Number of requests	5	8	10	3	6	3	9	6	50
Form of request acceptable	5	5	9	3	6	3	9	6	46
Deemed appropriate by Project	4 ^{a/}	5	8	3	6	2 ^{f/}	9	6	43
Offer made to country	3	5	4	2	5	2	6	4 ^{h/}	31
Country withdrew request	-	1 ^{c/}	5 ^{d/}	1 ^{e/}	-	-	-	-	7
Country refused nominee	2	-	-	-	-	-	1 ^{g/}	-	$\frac{i/}{3}$
Project unable to respond	1	-	1	1	1	-	2	2	8
No. of requests responded to	1	4	2	1	5	2	6	(4) ^{h/}	25
No. of volunteers placed	(1) ^{b/}	4	2	1	5	2	6	4	20

a Request for Health Planner provided by CARICOM, but not by Project

b Volunteer identified, but funded by HOPE

c Country pursuing employment on full time basis

d Three personnel provided by another country

e One person identified by Project, funded by PAHO

f A regional pathologist is available through PAHO

g Country later stated wanted permanent appointee, not volunteer

h Shared volunteers with St. Lucia

i One more was refused, but replaced with an acceptable alternative and therefore it does not appear as a number on this sheet

from other sources). Eliminating these latter 10 cases, the Project responded (by placement) to 76% of appropriate requests.

Table II shows that of the twenty volunteers placed, 12 (60%) were from the U.S., none were West Indians living in the U.S., and 8 (40%) were from the Caribbean. The inability of the Project to induce Caribbean nationals in the US to return as volunteers was one of the disappointments expressed by the two Ministries of Health visited. NCIH made strong efforts to identify and recruit US and Canadian Caribbean nationals, but was unable to induce any to serve as volunteers.

Of 12 physicians placed, 9 (75%) were from the U.S., and 3 (25%) from the Caribbean. Of 8 non-physicians placed, 3 (38%) were from the US, and 5 (62%) from the Caribbean. It is obvious that the relationship of the majority of the volunteers, particularly the physicians, to primary health care delivery is tenuous at best; 8 of the 9 physicians are secondary or tertiary level care physicians. Only the reports of the family practitioner and one psychiatrist showed significant involvement in community health activities. Of the non-physicians, reports are available in files from only the 3 Americans; an interim report of a West Indian was acquired during the field trip. Of these, 2 (the nurse-midwife and the nutritionist) report community health activities.

Table III shows the technical speciality of volunteers requested but whom the Project was unable to place. Five of the 8 requests are for tertiary care level physicians, and 3 for non-primary health care specialities.

C. Impact of Volunteers on the National Health Services

The impact of the types of services provided by the volunteers frequently do not lend themselves to quantification; where they might (numbers of patients seen, numbers of surgeries performed, numbers of clinics held, numbers of staff or

TABLE II: TECHNICAL SPECIALITY AND ORIGIN OF VOLUNTEERS PLACED

<u>Technical Speciality</u>	<u>Origin</u>	
	U.S.	Caribbean
<u>Physician</u>		
Anesthesiologist	2	-
Ear, nose, throat	-	1
Family practitioner	1	-
Radiologist	1	-
Psychiatrist	4	1
General surgeon	<u>1</u>	<u>1</u>
	(9)	(3)
 <u>Non-Physicians</u>		
Dental nurse	-	2
Hosp. engineer	1	-
Medical records	-	1
Medical technician	-	2
Nutritionist	1	-
Nurse-midwife	<u>1</u>	<u>-</u>
	(3)	(5)
TOTAL	12	8

TABLE III. TECHNICAL SPECIALITY OF VOLUNTEERS REQUESTED WHICH PROJECT WAS UNABLE
TO PLACE

<u>Technical Speciality</u>	<u>Number</u>
Anesthesiologist	3
Ear, nose, throat specialist	1
Hospital administrator	1 ^{a/}
Psychiatric nurse	2
Surgeon	<u>1</u>
	8

a. an interested West Indian was identified, but could not be released by his
country

patients trained, numbers of lives saved, etc), Project records did not require, nor do they show, these kinds of data. Some estimates of impact on health services (but not on health status) can be made on qualitative data, including written and telephone reports from returned American volunteers, evaluation reports from host country officials (only 5 are available), discussions with limited numbers of host country personnel (only two host countries were visited), and personal observation of one U.S. and one Caribbean volunteer in the field.

Given the criteria for volunteer selection, any service provided by the volunteer (e.g., patient care, technology transfer, didactic teaching, administrative and management technical assistance) theoretically would not have been provided in the volunteer's absence. In the instance of patient care, however, the theoretical is just that; if the volunteer didn't provide the service, in many cases someone else would, albeit at a cost of overtime or of medical evacuation to a site where appropriate services were available.

The following comments concern only the American volunteers. With some exceptions to be noted, the short assignments (48-88 days, including travel time and in-country orientation) were too brief to impact the health system significantly beyond the supplying of an extra pair of hands. This is not to denigrate the volunteer who universally brought high expectations of service, but results from unfamiliarity with customs and the medical services delivery system in the country, lack of access to technology and support services he/she is accustomed to, pre-occupation with the provision of living support such as housing, transport, security and food (of variable availability and quality in the various countries), feelings of isolation and abandonment, and the necessity to establish harmonious and synergistic working relationships with his fellow health providers (while acceptance by patients was reported high, this was not always the case by other members of the health team).

The exceptions to the forgoing include the considerable in-service training and technology transfer accomplished by the volunteers, usually on a one-to-one basis, but in at least 2 instances (a psychiatrist and nurse-midwife) on a group basis. Nearly all those with whom the volunteers reacted in this manner were receptive and appreciative. (The volunteers, of course, learned as well as taught). Major system changes apparently occurred in at least two sites, as a result of two volunteers: in one, administrative and management of a psychiatric hospital was improved, group therapy reintroduced, case studies introduced, and an extraordinarily vibrant, helpful private voluntary organization formed. In the other, a "first-ever" inventory of hospital equipment was accomplished, and a preventive maintenance system established.

Making a positive if small impact on the health system was the fact that some volunteers donated books, equipment, and out-of-pocket contributions to further health objectives.

While not a direct impact on health services, the volunteers "flew the flag" for the U.S. and for U.S. medicine. Whether intentionally or unintentionally on their parts, this should favorably impact exchange between the US and Caribbean health systems as cooperation between them expands, as it almost invariably will given the declining role played by some other nations.

Of the eight West Indian volunteers, four were from Barbados, two from Jamaica, and one each from St. Lucia and Guyana. Three of the West Indian volunteers had six month tours. In two other cases, after a month period as a volunteer, the volunteers accepted permanent posting in Montserrat. No host-country evaluations were prepared on the West Indian volunteers, but it seems reasonable that the Caribbean volunteers, because of cultural and health system familiarity, would be productive much more rapidly than the US group.

D. Registry of Specialities

The Original Operational Program Grant, called upon NCIH to:

"assist CARICOM by identifying and developing as a specialized part of the NCIH Voluntary Health Manpower Assistance Clearinghouse, both a listing of US based private and voluntary organizations, and a listing of individual health specialists, especially Caribbean nationals living in the US, who have skills which can be used to respond to the immediate health manpower needs of CARICOM countries."

The concept was that with such a listing or registry, health manpower planners and administrators in the Caribbean could access these people to attempt to induce them to provide services in the lesser developed nations. To achieve this end, NCIH brought the Project coordinator to Washington in order to familiarize him with the then-existing clearinghouse mechanism, and to introduce him to some universities/PVOs with access to numbers of Caribbean nationals resident in the US. Additional contacts were made in Toronto. As mentioned above, the Project never has been able to induce a West Indian national living in the US or Canada to serve as a volunteer. Moreover, the attempts by CARICOM to list significant numbers of Caribbean nationals of the types described have resulted in only scant listings of most specialities, and is in a form too rudimentary to be useful. This evaluator got the impression that getting names and addresses of qualified people has been linked to their being willing to be listed and to serve as volunteers, and a methodology for doing so has received little priority.

E. Cost Efficiency

The approach used in this analysis is to estimate the costs of the volunteer component under this project, and then compare this with the estimated costs of the services provided by the volunteers had the countries had to purchase them. Since it is impossible to quantify and the cost the individual tasks/services performed by the volunteers (e.g., patients seen, persons taught, lives saved, technologies transferred, etc.), the estimated cost of buying the volunteer's time must serve as a surrogate of value or benefit received.

Attachment F shows the computations used for this analysis. The computations show that \$159,564, or approximately 31 percent of the total Grant, can be attributed as the US contribution to the volunteer component. With the contributions of the host countries included, costs of supplying the volunteer services under the Project are estimated at \$204,684. The value of the total services provided by the volunteers (the cost to the countries had they purchased these same services) is estimated at \$303,812. One might conclude the Project provided the services at 67 percent of their value, and legitimately that the Project provided the volunteer services in a cost efficient manner.

It is important, however, additionally to examine the nature (not the quality) of the services provided. As discussed earlier, the services of the US volunteers very largely were tertiary medical rather than primary health in nature.

The figures in Attachment F show that US volunteers provided 610 work days of service at an average daily market value of about \$292. West Indian nationals provided 466 work days at an average daily market value of \$31. Generally, the services provided by the US volunteers were performed by highly specialized physicians, while those performed by the West Indians were of lower technical requirement and largely performed by non-physicians. In spite of this, it would cost more on a daily basis to recruit the lowest-cost American volunteer than it would the highest cost West Indian, were they available.

F. Prospects for the Future

CARICOM has the capacity to identify, recruit and process both US and Caribbean nationals, although processing US volunteers would be difficult without a continued US formal contact. It has established contacts and linkages not only with NCIH, but with other PVOs and universities which on a collegial basis would likely assist in the process, should there be continuing demand for short-term US specialists. The cost of travel likely would mitigate against much such recruitment, as would the fact that the countries still can attract long-term volunteer services from both the British and the French.

The CARICOM Secretariat is well able to serve as a clearinghouse or broker for inter-island exchanges of professionals, should the participating countries wish them to continue this function.

It has been suggested that the embassies of the Organization for Eastern Caribbean States (OECS) could help register West Indian nationals living in the United States and Canada, and serve as an intermediary between CARICOM countries and West Indian nationals abroad. It might be that OECS would have the same difficulties inducing Caribbean nationals living in the US and Canada to volunteer as were experienced by NCIH and CARICOM.

Completion of the registry (see above) might help facilitate recruitment of Caribbean nationals living in the islands or abroad; this appears to be a legitimate function for the Health Section to pursue.

V. ANALYSIS OF HEALTH MANPOWER PLANNING COMPONENT

The Project Grant Agreement starts "The purpose of this Grant is to establish a Health Manpower Planning capacity within CARICOM in order to". It is important to note then from the Project's conceptualization, this has been more the intent of AID, NCIH and CARICOM, and less the desire of the LDCs, which were more interested in immediately meeting their short term manpower needs by the use of the volunteer component of the activity.

A. The CARICOM Health Manpower Planning Unit

The mechanism for establishing the health manpower planning component was to fund a new health manpower planning unit within the Health Section of the CARICOM Secretariat in Guyana.

The unit originally consisted of a Project Coordinator with secretarial support. After the mid-project evaluation (July, 1982), this staff was bolstered by a statistician seconded from the Statistics Office of CARICOM, originally for six months. CARICOM later agreed to extend his use through March 31, 1984, when Project support funds ran out for his continued support. Subsequent to March, however, he has continued his relationship to the Project, and as this evaluation is being drafted, is entering accumulated data onto the Project-provided IBM-XT computer system.

B. Strategy for Health Manpower Planning

The strategy for achieving regional health manpower planning was evolutionary. While the Project Grant Agreement expressed the needs and general objectives, it awaited the mid-term evaluation by Leonard S. Rosenfeld, M.D., M.P.H., to add the important objectives of conducting a health manpower inventory and developing methods for a state/regional cooperative system for accumulating current data on a

uniform basis.

In close collaboration with PAHO, a three-phase approach to health manpower was developed by PAHO and CARICOM (see Attachment G) and reviewed with UWI, the Ministries of Health and USAID in March, 1983. During Phase I, each country's current health manpower situation would be inventoried. Phase II, intercountry workshops, would follow to promote health manpower planning, provide leadership for on-island activities, and develop an appropriate small country methodology for health manpower planning. During Phase III, within country activities, by using the core group from Phase II, the CARICOM/PAHO group would then assist formulation of national health manpower plans for each country. Assumably, but not stated, a future Phase IV would be promoted to develop a regional health manpower plan for the LDCs of the English-speaking Caribbean.

C. Progress on Implementation

To accomplish the inventory (Phase I), the CARICOM statistician drafted a set of survey instruments. These were later modified, field tested, and remodified with the assistance of a consultant, Gordon DeFriese, Ph.D., Director of the Health Services Research Center of the University of North Carolina. This process, as well as a description of the survey instruments, are fully described in Dr. DeFriese's comprehensive Report of Technical Consultation Visit, National Council for International Health/Caribbean Community Secretariat Health Manpower Project, May 25-30, 1983.

The statistician, sometimes alone, often with the assistance of other personnel from the CARICOM health section, and frequently with active participation of PAHO, made a series of visits to the individual countries to gather baseline data. It soon became evident, because of the lack of central availability, and sometimes the fugitive nature of the information sought, that this process would take very

much longer than anticipated. Some countries did not have the information readily available. In some, it was sprinkled about several governmental agencies, and in others, it existed largely in the minds of various health and other government officials. Attachment H, prepared by the statistician, presents a detailed account of the problems and progress. The raw material from Phase I has been collated into a series of country booklets which have been distributed to the individual countries, and collected as a single volume available from CARICOM. Each country's specific document contains tables presenting four major types of information:

Table 1A - Health Manpower Situation - Technical Professional Posts

Table 1B - Health Manpower Situation - Major Technical/Professional Groups

Table 2A - Projected Changes (during the next five years) for Technical/
Professional Posts

Table 2B - Projected Changes for Major Technical/Professional Groups

An appreciation for the quality and usefulness of this data, as well as for the differences between the tables, can be gained by referring to Attachment I, which shows a sample page from each table from one of the countries. The columns headed "position code" were left to accommodate establishing comparability of health positions amongst the nations. This has now been accomplished (at least provisionally) and is being entered onto the computer in Georgetown.

This represents the first time that up to date health manpower data of this quality has been available in these eight nations.

Phase II, the intercountry meetings, has been deferred until after the completion of the original Phase III. This has occurred in part because of the unexpectedly long time required for data collection, and currently because funds may run out of this Project before the intercountry meetings can be scheduled.

Phase III, country meetings with the purpose described above, are on-going. This likely will require a number of visits to each country. During the first visits of the CARICOM/PAHO team, the major purposes are to insure that the health planners are fully vested in the health manpower planning process, and to further refine the generated data. Three countries (Dominica, St. Lucia, and St. Vincent) have had these initial visits. After completion of the initial visits, and should funding be available, the current plan is to conduct a series of 3-day national workshops to identify and prioritize health manpower development issues; to articulate a national policy on health manpower development; to propose alternative strategies for implementation; and to select those which are most appropriate.

D. Prospects for the Future

As reported in the forgoing, CARICOM has developed an institutional health manpower planning capability which likely is unparalleled in the Caribbean. It has attracted PAHO interest, cooperation and collaboration far beyond anyone's expectations at the beginning of the Project. It has developed both a methodology and a baseline health manpower data of immense potential value for country and regional planning.

The next steps are dependent upon a number of variables:

- a) The availability of funding to CARICOM to provide for the continued participation of CARICOM staff in these health manpower activities. The funding could come from CARICOM's own resources, or it could come from donors.
- b) The continuing availability to CARICOM of staff of the caliber now employed. The administrative skills of the Project Coordi-

nator and the statistical/health manpower planning/ computer skills of the statistician are the types of skills marketable elsewhere. Should these key personnel depart, and adequate replacements not be acquired, the CARICOM health manpower planning capability would be significantly diminished.

- c. The degree of interest expressed by participating nations in continuing long-term health manpower planning initiatives. It was clear from visits to representatives of Ministries of Health of the two LDCs visited that the health manpower planning component of this Project was of secondary interest to them when compared to the volunteer manpower component. They did, however, emphasize the usefulness of the country specific information produced by the Project, and indicated it would be used in differing fashions for country-specific health manpower planning. Officials of neither country, however, sounded like strong advocates for regional planning. To the extent that their views are or are not typical of the eight LDCs will influence the CARICOM Secretariat's priority given to continuing this activity.
- d) The priorities of the replacement (to be appointed) of the retired Chief of the CARICOM Health Section. The recently retired Chief was a highly energetic respected Caribbean health professional whose

eminence helped shape CARICOM health policy. His replacement may have differing priorities and a differing ability to influence policy, including that related to health manpower planning.

- e) The continuation and expansion of CARICOM's computer capability. While not as important as the others, the Project-provided computer technology has opened new vistas for CARICOM. This technology was introduced late in the activity (April, 1984) and may need continued nurturing to reach full potential.

VI. DISCUSSION

The Project has been administered well by both NCIH and CARICOM. Communication between themselves and amongst them and the participating nations was as good as distance and communications systems allowed. As noted, inputs were timely and appropriate.

Both portions of the purpose have been accomplished, but not to the degree anticipated, and not within the timing originally planned. The relevance and outreach of CARICOM in relationship to health manpower planning have been strengthened by the establishment of a health manpower planning unit which has related effectively with the Ministries of Health of the lesser developed Caribbean nations, the University of the West Indies, AID and PAHO. It currently is the most effective health manpower planning body operating for the Caribbean. It has developed the capacity to identify, recruit, and support the placement of West Indian volunteers, and to a lesser extent, US volunteers. It has not developed the financial capacity to carry on these activities at Project levels beyond AID support.

A. Regional vs. Country Health Manpower Planning

A question only partly posed by this project, and not answered, is whether it is feasible, on a regional basis, to attempt health manpower planning. Although the health systems in the 8 LDCs are similar, each has characteristics unique to itself. Moreover, resources and priorities differ amongst the islands. Without question, what is helpful to one may be of help to others, and to the extent that all can share a common pool of information (such as afforded by this project), each may benefit. The Project quest for a "regional health manpower plan", however, may be unobtainable.

B. Role of the University of the West Indies

The Project designers envisioned a key role, at least in a collaborative sense, for the University of the West Indies. The UWI has been fully informed at all points regarding Project progress. Its participation in meetings of the Advisory Committee has been an active one. A special task force regarding manpower strategy was chaired by Professor Sir Kenneth Standard of UWI. Three of the volunteers (all of the West Indian physicians) were UWI faculty.

A method was explored during this Project whereby US university faculty members would replace Caribbean faculty of the West Indies. These in turn would serve as temporary manpower replacements-cum-instructors in the LDCs. The advantages of this would be that the US volunteer would be more familiar and productive in another university role than he/she would be as a direct health provider in a different culture and medical delivery system; while his Caribbean colleague would be much more productive within the health systems of the LDCs. This plan was never implemented largely due to costs (for two volunteers in order to fill one post and the unresolved matter of dealing with the private practices of the Caribbean professionals), but could be further explored in future similar activities.

In summary, the role played by UWI was participatory and supportive, although somewhat different from that originally envisioned.

C. Lessons Learned

1. A PVO (in this case NCIH) is an effective mechanism to interface between the private sector in the US and governmental and quasi-governmental organizations overseas.

2. In this Project, the NCIH has used successfully the strategy of being generally reactive to host country needs rather than being strongly proscriptive. On its part, CARICOM has done a creditable job of anticipating and articulating the needs expressed by the cooperating countries. This process has resulted in

CARICOM being in a much stronger position to carry on those parts of the Project for which the countries express continuing interest, with concurrent decreased continued dependency upon NCIH or AID.

3. It is important before Project implementation that all parties involved be in accord in their expectations. In this activity, the LDC Ministries of Health very clearly were and are more interested in filling immediate gaps in their health manpower, while the PVO and AID had longer-term health manpower planning as their major agenda. This lack of congruence of objectives has resulted in some misunderstandings and resentments, and as an end result, neither agenda has been fully answered.

4. The Project has shown that using volunteer US health professionals is a cost-efficient way of providing this expertise. The use of US volunteers, however, is less cost-efficient and probably has less health impact than the use of similar volunteers from the area served.

5. The use of volunteers in this Project has had little developmental impact. In part this is because of the predominance of secondary and tertiary level medical skills, as opposed to primary health skills, of the volunteers requested and provided.

6. The Operational Program Grant mechanism does not lend itself well to the standard AID evaluation methodology. This is more observation than criticism, but the Log Frame is a very useful planning and evaluation tool. Its absence in the Operational Program Grant makes the evaluation process less objective and more subjective than is the case in more standard AID Projects.

D. Unplanned Effects

There has been one major unexpected result of this Project: the cooperation which has developed between two major regional organizations with health planning components, PAHO and the Health Section of the CARICOM Secretariat. Largely

because of the Project's health manpower planning activities, these two organizations with congruent interests have developed a higher degree of cooperation and collaboration than existed prior to this activity. This should extend well beyond the life of Project.

E. Options for USAID's Consideration

One major document, a report from Gordon DeFriese and Ernest Patterson on their impressions of long-term CARICOM health manpower planning capabilities, has yet to be prepared. In its absence, following are some options USAID may wish to consider:

Option 1:

1. Extend both components of the activity

a. Advantages

- i. More of the total original Project purpose may be accomplished.
- ii. The LDCs would appreciate continued volunteer services.
- iii. CARICOM would have a longer period to prepare to assume responsibility for continuing activities.
- iv. Should current Project funding not permit it, time would be provided in order to convene a meeting of all concerned parties for a wrap-up meeting.
- v. Similarly, time would be afforded for greater computer experience and capability.

b. Disadvantage.

- i. The time required to gain significantly more towards the Project purpose would likely be a year or more. Not only

would more time be required, but also more funds.

- ii. It is difficult to justify AID's providing secondary and tertiary level medical care providers, given AID's emphasis on primary health care.
- iii. At Project end, CARICOM likely will be as ready to assume responsibility for follow-on activities as it ever will be. An extension would stifle self sufficiency and foster dependence.
- iv. Other mechanisms may be available to convene a meeting of concerned parties and to provide additional computer support backstopping, should present Project funding be insufficient to provide these.

- 2. Option 2 - Extend the volunteer component, but stop support for health manpower planning
- 3. Option 3 - Extend the health manpower planning component, but stop support for volunteers

The advantages and disadvantages of either are included under Option 1.

- 4. Option 4 - Terminate support for both components.

- a. Advantages

- i. The Project has accomplished nearly all that might reasonably be expected with USAID support. The seed has germinated
- ii. The LDCs have access to other sources of volunteers more appropriate to provide secondary and tertiary medical care.

iii. CARICOM's self sufficiency would be enhanced.

b. Disadvantages

- i. There are two loose ends, namely a wrap-up meeting and insurance the computer capability at CARICOM is well established. At this time, it is unknown whether current Project funding will permit these. Confidence in this recommendation would be strengthened if these loose ends did not exist.

5. Option 5 - A variation of option 4: Terminate the Project formally at its expected termination or before if funds run out, but by using other AID or USAID resources, provide support for a wrap-up meeting of all concerned parties, and for limited additional technical assistance in computer technology, should this Project be unable to fund them.

This option retains the advantages and largely offsets the disadvantages of Option 4, and is recommended by this consultant.

NCIH/CARICOM HEALTH MANPOWER PROJECT EVALUATIONSCOPE OF WORK

NCIH will retain the services of an external consultant for the purpose of evaluating the NCIH/CARICOM Health Manpower Project. The evaluator will review the accomplishments of the project in relation to the goals of the grant. An assessment will be made of appropriateness and success of tasks from the perspective of AID, CARICOM, the LDC health ministries and NCIH. To accomplish this task the consultant will work in collaboration with Mr. Darwin Clark of the AID/Barbados Program Office, pending his availability.

Specifically, the evaluator will:

- o review project design and relevance to system needs
- o assess the responsiveness of the program to the LDC health manpower needs
- o analyze management or project implementation including
 - recruitment and placement of health volunteers (U.S. and West Indian), its impact on the national health services, its cost effectiveness and its acceptance by host countries
 - involvement of University of West Indies (UWI)
 - assumption of ever-increasing program management responsibilities by CARICOM
 - project review by Permanent Secretaries
 - mid-project review and adjustment
- o analyze implementation of health manpower information system including
 - design of health manpower survey instrument
 - assessment of usefulness of health manpower data for manpower planning at both the national and regional levels
 - training of CARICOM statistical staff
 - collating health manpower data
- o examine progress being made toward the production of a Caribbean health manpower plan
- o discuss CARICOM institutional support of activities after project completion
- o discuss prospects for the viability of the program with specific recommendations for termination or extension

DRAFT PROJECT EVALUATION SUMMARY (PES). PART II

14. Evaluation methodology

This evaluation is intended as an end of Project evaluation, as called for in the Operational Program Grant. The Scope of Work was developed collaboratively by USAIA/RDO-C and NCIH, and is presented as Attachment A

The evaluation was conducted April 9 - May 5 by a consultant (Dr. Merrill M. Shutt, University of North Dakota) with assistance by Neville Selmen, RDO-C. The consultant was briefed in Washington by NCIH and AID, reviewed documents, held discussions with PAHO, and had telephone conversations with USAID employees with Project experience, NCIH Grants Advisory Committee members, and a number of returned volunteers. In Barbados, he was briefed by USAID; reviewed documents, met with PAHO, and was unsuccessful in contacting the principal UWI contact (Dr. E.R. Walrond). With Selmen, he visited CARICOM headquarters two days in Guyana, and then proceeded alone to St. Lucia and Dominica, where he interviewed senior health officials, and an American and West Indian (Barbadian) volunteer. Returning to Barbados, he presented a verbal debriefing to members of the RDO/C Mission. The report was drafted in Washington.

The evaluation, then, is based on the consultant's interpretation of Project documents, quarterly reports, consultant reports, reports of returned volunteers, Advisory Committee reports, and perceptions of interviews with AID, USAID, NCIH, CARICOM and PAHO representatives, Ministry of Health officials, and active and returned volunteers.

15. External Factors

Three significant external factors occurred during the (extended) life of

Project which impacted the Project. The first was the multiforce intervention in Grenada, which was a divisive matter among the nations represented by CARICOM, which has a Sub-Project Agreement with NCIH under this Project. This necessitated some adjustments in travel schedules and planned meetings that had project relevance. The second factor was the death in one case and retirement in another of two of the top leaders in the Health Section of CARICOM as the Project was ending. Depending on the vigor of successor leadership, this may influence the ability of CARICOM to sustain the health manpower planning functions after USAID support ends. The third factor concerns the frequent turnover of senior health officials, particularly Permanent Secretaries, of the nations involved in the Project. This has required frequent reeducation on the Project objectives; this seems to be part of the cost of doing business in the Caribbean.

16. Inputs

Commodities provided under the Project were minimal; the major input was an IBM computer intended to be in place, with technical assistance, by January, 1984. The procurement process was delayed in part because of Mission involvement in the aftermath of Grenada, with the result the computer was installed in April, only three months before the Project is due to end. This will reduce the time available during Project life to gain familiarity and experience.

Technical inputs in the form of consultants and volunteers were appropriate in quality and quantity, and supplied generally in a timely fashion. In the case of volunteers, once a proper request was received, a problem was identification, recruitment and processing of an appropriate volunteer. Response time for US volunteers (from receipt of a request to an offering of services) varied from a week to five months, with the average approximately six weeks. One volunteer was provided a year after the request, but the delay was on the requesting country's

end. West Indian consultants, when identified, were provided more rapidly.

The member states of CARICOM identified as their priorities for volunteers West Indians living in the Caribbean first, Caribbean nationals living in the US second, and US nationals third. The Project supplied 12 US nationals, no West Indians living in the US, and 8 Caribbean nationals living in the Caribbean. This represented an effort to recruit West Indians with appropriate skills requested, but an inability either to locate an appropriate candidate who was available in the West Indies, or an inability to induce a Caribbean national living in the U.S. to volunteer.

Had more funding been available, it may have been possible to recruit US medical school physicians to replace University of West Indies medical school physicians on a temporary basis. The UWI physicians then could have served as short term 'volunteers' in the participating countries. Partly for insufficient funds required for this double placement (and partly for other reasons) this concept did not come to fruition.

17. Outputs

The following items, which could be considered outputs, have been extracted from the OPG, Sub-Project Agreement and implementation plans.

1. Recruitment of short term volunteers to fill vital gaps in the health systems of the eight participating countries (NCIH and CARICOM).

No magnitude was placed on this output. Of 50 requests for assistance, 43 were in acceptable form and deemed appropriate for project assistance. 25 requests were filled, 7 requests were withdrawn by the country, 3 offered volunteers were refused by requesting countries (often because the countries had requested and received help elsewhere), and the Project was unable to respond to 8 requests. If the 10 requests (7 withdrawals, 3 refusals) are eliminated, the Project 'filled' 76 percent of requests, a respectable figure given the high technical level of the volunteers requested.

40

A cost efficiency analysis showed the Project to be a cost efficient method of providing services.

2. A Health Manpower Unit established in CARICOM.

This has been accomplished by Project support of a Project coordinator, secretary, and statistician (the statistician was seconded from the Statistical Division of CARICOM), and their subsequent acceptable performance of volunteer recruitment/placement, and the collection, processing and distribution of health manpower planning information. Computer capability (IBM - XT micro computer and software) is being installed, and on-site instruction being provided.

3. A regional health manpower plan to meet the priority health manpower needs in the eight LDCs.

The Project, with PAHO and host country collaboration, has collected base-line health manpower information of great potential use in national and regional manpower planning. This represents Phase I of a projected three phase activity. Phase II was to be an inter-country meeting of concerned health and other officials to discuss the findings, and Phase III was to be a series of country meetings in which local health manpower planners would be instructed to fully use the base-line information for developing manpower projections of needs and strategies to meet these needs.

The information collected to date has been collated into a series of individual country documents, which in turn have been collected into a master document (available at CARICOM). The individual country documents have been distributed to the LDCs, and CARICOM/PAHO representatives have started the process of the country meetings (Phase III above), with Phase II being deferred likely until after Project end and after the end of Phase III.

The documents, and more so the data from which they are derived, (now being installed in a computer), appear to be useful for individual country health

41

manpower planning. Once they are vested by the LDC's, CARICOM/PAHO feel strongly the process can be extended reasonably to regional health manpower planning, which apparently would stem from the intercountry meetings where the desires of the Ministries of Health would be expressed. From discussion with representatives from two of the Ministries (St. Lucia and Dominica), they are less sanguine of the regional application of this planning process.

4. Registry of Specialities

The original Grant Agreement called upon NCIH to

"assist CARICOM by identifying and developing as a specialized part of the NCIH Voluntary Health Manpower Assistance Clearinghouse, both a listing of US based private and voluntary organizations, and a listing of individual health specialists, especially Caribbean nationals living in the US, who have skills which can be used to respond to the immediate health manpower needs in CARICOM countries."

The concept was that with such a listing or registry, health manpower planners and administrators in the Caribbean could access these people to attempt to induce them to provide services in the lesser developed nations. To achieve this end, NCIH brought the Project Coordinator to Washington in order to familiarize him with the then existing clearinghouse mechanism and to introduce him to some universities/PVOs with access to numbers of Caribbean nationals resident in the US. Additional contacts were made in Toronto. Few names were submitted of potential volunteers. Moreover, the attempts by CARICOM to list significant

42

numbers of Caribbean nationals of the types described have resulted in only scant listing of most specialities, and is in a form too rudimentary to be useful. This evaluator got the impression that getting names and addresses of qualified people has been linked to their being willing to be listed and to serve as volunteers, and a methodology for doing so has received little priority.

18. The purpose of the Project is enunciated in the Project Grant Agreement:

The purpose of this Grant is to establish a Health Manpower Planning capacity within CARICOM in order to 1) improve the relevance and out-reach effectiveness of CARICOM's programs and services related to regional primary health care needs; and 2) assist participating countries in health manpower planning by providing selected health personnel, and related technical services. The project provides for the participation of the member countries of the Caribbean Community (CARICOM), with the principal focus placed on assisting those which are less developed.

This is stated somewhat differently in the Sub-Project Grant Agreement, perhaps more appropriately:

The purpose of the AID Grant to NCIH is to: 1) improve the relevance and outreach effectiveness of CARICOM's programs and services related to regional primary health manpower needs; and 2) assist participating countries in health manpower planning by providing selected health personnel, and related technical services. In this project the participating

43

countries are the Member Countries of the Caribbean Community (CARICOM), with the principal focus placed on assisting those which are less developed. Specifically, the grant will help to establish a Health Manpower Unit within the Health Section, in compliance with Resolution 32 of the Sixth Meeting of the Conference of Ministers Responsible for Health, held in Grenada in July, 1980.

Both portions of the purpose have been accomplished, but not to the degree anticipated, and not within the timing originally planned. The relevance and outreach of CARICOM in relationship to health manpower planning have been strengthened by the establishment of a health manpower planning unit which has related effectively with the Ministries of Health of the lesser developed Caribbean nations, the University of the West Indies, AID and PAHO. It currently is the most effective health manpower planning body operating for the Caribbean. It has developed the capacity to identify, recruit, and support the placement of West Indian volunteers, and to a lesser extent, US volunteers. It has not developed the financial capacity to carry on these activities at Project levels beyond AID support.

While end of Project status indicators as such are not specified in Project documents, by inference the output of "developing a regional health manpower plan to meet the priority needs of CARICOM countries, including promoting the relevance of education and training of professional and allied health personnel in participating countries" would imply the End of Project Status of the LDC's using that plan on a regional basis to help meet their manpower needs. Even with the multiple extensions of the Project, the plan has not been developed, largely because no one anticipated the difficulty in obtaining the baseline information

4/4

from which such planning must originate. The Project now has secured the raw data, and CARICOM and the LDCs are in the process of organizing and refining these data in order to use them for manpower planning, certainly on an individual country basis, and later, perhaps, on a regional basis.

19. Goal/Subgoal

Goals and subgoals are not articulated in the Project documentation. If one assumes the goal to be the improvement of health status of the Caribbean peoples, the Project has contributed to this goal directly (albeit it in small measure) by the provision of temporary replacements for health providers in 8 LDC Ministries of Health, and indirectly by developing a health manpower planning capacity within CARICOM, and less so within the LDC's. This capacity eventually should favorably impact on health status.

20. Beneficiaries

The direct beneficiaries of the volunteer segment are the patients who received hands-on medical services of the volunteers. There was no record kept of their quantities. The indirect beneficiaries are the Ministries of Health of the LDCs which received limited amounts of technical assistance in administration and management from volunteers. The direct beneficiaries of the health manpower planning component were the CARICOM secretariat and the LDC's Ministries of Health, which improved skills necessary for planning the manpower needs to, inter alia, help reduce infant mortality and control population growth. The indirect beneficiaries are those segments of the LDC populations which eventually will be reached by the manpower developed in response to the planning.

45

21. Unplanned Effects

There has been one major unexpected result of this Project: the cooperation which has developed between two major regional organizations with health planning components, PAHO and the Health Section of the CARICOM Secretariat. Largely because of the Project's health manpower planning activities, these two organizations with congruent interests have developed a higher degree of cooperation and collaboration than existed prior to this activity. This should extend well beyond the life of Project.

22. Lessons Learned

a. A private, voluntary organization (in this case NCIH) is an effective mechanism to interface between the private sector in the U.S. and governmental and quasi-governmental organizations overseas.

b. In this Project, the NCIH has used successfully the strategy of being generally reactive to host country needs rather than being strongly proscriptive. On its part, CARICOM has done a creditable job of anticipating and articulating the needs expressed by the cooperating countries. This process has resulted in CARICOM being in a much stronger position to carry on those parts of the Project for which the countries express continuing interest, with concurrent decreased continued dependency upon NCIH or AID.

c. It is important before Project implementation that all parties involved be in accord in their expectations. In this activity, the LDC Ministries of Health very clearly were and are more interested in filling immediate gaps in their health manpower, while the PVO and AID had longer term health manpower planning as their major agenda. This lack of congruence of objectives has resulted in some misunderstandings and resentments, and as an end result, neither agenda has been fully answered.

d. The Project has shown that using volunteer US health professionals is a cost efficient way of providing this expertise. The use of US volunteers, however, is less cost efficient and probably has less health impact than the use of similar volunteers from the area served.

e. The use of volunteers in this Project has had little developmental impact. In part this is because of the predominance of secondary and tertiary level medical skills, as opposed to primary health skills, of the volunteers requested and provided.

f. A method was explored during this Project whereby US university faculty members would replace Caribbean faculty of the West Indies. These in turn would serve as temporary manpower replacements-cum-instructors in the LDCs. The advantages of this would be that the U.S. volunteer would be more familiar and productive in another university role than he/she would be as a direct health provider in a different culture and medical delivery system, while his Caribbean colleague would be much more productive within the health systems of the LDCs. This plan was never implemented largely due to costs (for two volunteers in order to fill one post and the unresolved matter of dealing with the private practices of the Caribbean professionals), but could be further explored in future similar activities.

g. The Operational Program Grant mechanism does not lend itself well to the standard AID evaluation methodology. This is more observation than criticism, but the Log Frame is a very useful planning and evaluation tool. Its absence in the Operational Program Grant makes the evaluation process less objective and more subjective than is the case in more standard AID Projects.

LIST OF PERSONS CONTACTED

Washington

NCIH

Dr. Russell E. Morgan, Jr., Executive Director
Mr. Graeme Frelick, Program and Training Coordinator
Mr. Edward Rimer, Program Assistant
Dr. F. Curtiss Swezy, Program Manager

AID

Ms. Paula Feeney - Health and Nutrition Adviser, Health and Nutrition
Division, Bureau for Latin America and the Caribbean
Dr. Clifford Pease - Deputy Director, Office of Health, Bureau for Science
and Technology
Ms. Louise B. Wise - Caribbean Public Health Adviser-Designate, RDOC, Barbados

PAHO

Mr. Peter Carr, Health Management Advisor, Health Systems Development

By telephone

Dr. Michael Alderman - Cornell Medical Center; NCIH Grant Review Committee
Mr. Vern E. Atwater - Volunteer
Dr. Gordon DeFrieze - Univ. North Carolina; Health Manpower Consultant
Dr. Steve and Ms. Sandra Laney; Volunteers
Mr. Mark Laskin - IPPF WHR, New York; (AID)
Dr. Richard Meltzer - Project Hope
Mr. Allen Randol - AID
Dr. Janice Stevens - Volunteer

Barbados

USAID - RDOL

Mr. Ted Morse, Deputy Director

Dr. Willard Boynton, Health and Population Officer

Mr. Darwin Clarke, Evaluation Officer

Mr. Don Harrison, Economist

Mr. Terry Liercke, Program Officer

Mr. Neville Selman, Health and Population Officer

PAHO

Dr. Mervyn Henry, Caribbean Programme Coordinator

Dr. Harry Drayton - Health Manpower Specialist

Guyana

CARICOM

His Excellency the Secretary General, Roderick Rainford

Mr. George Boyd, Pharmacist

Mr. Frederick Duncan, Statistician

Mr. Terence Goldson, NCIH/CARICOM Project Coordinator

Ms. Marion Harding, Nursing Officer

Ms. Audrey Hinchcliffe, Acting Chief, Health Section

Mr. George Rutherford, Health Management Specialist

Other

Mr. Ernest Patterson, Computer Systems Analyst

41

St. Lucia

Mr. Cornelius Lubin, Permanent Secretary Ministry of Health and Housing

Dr. A.M. D'Souza, Director of Health Services

Dr. Krishna Prasad, Registrar in Psychiatry, Golden Hope Hospital

Dr. Eugene Taylor, Volunteer

Sister Wittfield, Ward Sister, Golden Hope Hospital

Dominica

Ms. Nedorra Shaw, Permanent Secretary, Ministry of Health, Education,
Youth Affairs, Sports and Culture

Dr. D.O.N. McIntyre, Health Services Coordinator

Ms. Roxanne Barnett, Volunteer (Barbados)

50

BUDGET

Attachment D

HEALTH MANPOWER PLANNING

NATIONAL COUNCIL FOR INTERNATIONAL HEALTH

	Year 1	Year 2	Total	
<u>NCIH</u>				
1.0	<u>Staff</u>			
1.1	Health Manpower Specialist	30,000	31,800	61,800
1.2	Secretary	13,500	14,300	27,800
1.3	Fringe Benefits (24% salaries)	10,400	11,064	21,504
1.4	Staff Travel & Per Diem	12,300	11,100	23,400
2.0	<u>Consultants</u>			
2.1	Consultants Fee	10,500	10,500	21,000
2.2	Consultants Travel	12,244	9,236	21,240
3.0	Other Direct Costs	14,100	15,523	29,623
4.0	Voluntary Health Manpower Assignment (Travel & Per Diem)	40,000	60,000	100,000
5.0	Evaluation Team	10,000	15,000	25,000
6.0	Overhead (20%)	30,568	35,703	66,271
	Sub-Total =	<u>\$183,612</u>	<u>\$214,026</u>	<u>\$397,638</u>
<u>-CARICOM</u>				
1.0	Health Manpower Coordinator	35,000	40,000	75,000
	Secretary	4,000	4,200	8,200
2.0	Staff Travel & Per Diem	7,000	8,500	15,500
3.0	Direct Costs	7,800	8,000	15,800
	Sub-Total =	<u>\$-53,800</u>	<u>\$ 60,700</u>	<u>\$114,500</u>
	Total =	\$237,412	\$274,726	\$512,138

REPORT
OF THE
TASK FORCE PLANNING MEETING
FOR THE
HEALTH MANPOWER PROJECT

Kingstown, St. Vincent
23 February 1983

CHAIRMAN: PROF. SIR KENNETH STANDARD
HEAD
DEPARTMENT OF SOCIAL AND PREVENTIVE MEDICINE
UNIVERSITY OF THE WEST INDIES

TASK FORCE PLANNING
MEETING FOR THE HEALTH
MANPOWER PROJECT

REP 83/1/16 HMP (TF)

Kingstown, St. Vincent
23 February 1983

13 April 1983

CHAIRMAN: PROF. SIR KENNETH STANDARD
HEAD
DEPARTMENT OF SOCIAL AND PREVENTIVE
MEDICINE
UNIVERSITY OF THE WEST INDIES

CONTENTS

	<u>Paragraphs</u>
1. INTRODUCTION	1
2. REPRESENTATION	2
3. ELECTION OF CHAIRMAN	3
4. ADOPTION OF AGENDA	4
5. PROCEDURAL MATTERS	5
6. OBJECTIVES OF TASK FORCE	6-11
7. ISSUES TO BE CONSIDERED - SUGGESTIONS FROM PERMANENT SECRETARIES AND OTHER PARTICIPANTS	12-18

Paragraphs

8.	PRESENTATION ENTITLED "BLINDNESS - PREVENTION AND TREATMENT PROGRAMME: AN ALTERNATE APPROACH" BY DR. R. MEADERS	19-25
9.	TASK FORCE STRATEGY AND ORGANISATION OF TASK FORCE AND WORK PROGRAMME	26-29
10.	DATA TO ASSIST TASK FORCE	30-33
11.	ANY OTHER BUSINESS	34

ANNEXES

- I List of Participants
 - II Agenda
-

REPORT OF THE MEETING

INTRODUCTION

The Task Force Planning Meeting for the Health Manpower Project was held in St. Vincent and the Grenadines on 23 February 1983.

REPRESENTATION

2. A list of participants attending the Meeting is attached as Annex I to this Report.

ELECTION OF CHAIRMAN

3. Professor Sir Kenneth Standard was elected to chair the Meeting.

ADOPTION OF AGENDA

(Agenda Item 2)

4. The Draft Agenda was adopted as the Working Agenda and is attached as Annex II to this Report.

PROCEDURAL MATTERS

(Agenda Item 3)

5. The Meeting fixed its hours of work.

OBJECTIVES OF TASK FORCE

(Agenda Item 4)

6. Sir Kenneth Standard drew the attention of the Meeting to page 24 of the document entitled "National Council for International Health/Caribbean Community Secretariat Health Manpower Project: An Evaluation", where

100
10

the objectives of the Task Force were outlined. The paper suggested that, "the Task Force be responsible for preparing a detailed report setting forth a plan for development of health manpower within the framework of a comprehensive programme of regional organisation of health services. It was further proposed that, the Task Force be constituted of personnel from the Caribbean Community (CARICOM) Secretariat, with representation from the National Council for International Health (NCIH), the University of the West Indies (UWI) Medical School, and participating countries to formulate a plan and seek financial assistance in launching the programme.

7. In the discussions on the recommendation, it was pointed out that there were in fact two tasks to be accomplished; the establishment of a comprehensive programme for the regionalisation of medical services, and the manpower planning exercise. Some delegations raised the question as to whether the regionalisation of health services, as suggested in the paper was really feasible, given the current stage of development of the integration movement.

8. In response it was pointed out that there should be an attempt to identify which of the services could be regionalised and to create a three-tier structure in the health services - basic services to be had at all levels; more specialist services at the national level; and then for the most advanced operations, two or three centres where the relevant skills could be located.

9. It was further suggested that only in this context could the manpower needs of the Region be considered on a regional basis.

10. The Meeting was reminded that the paper was merely a recommendation on future action. It was the responsibility of the representatives of the territories to decide whether a task force was really necessary, and on its functions.

11. THE MEETING:

Suggested that paragraph 1 of the summary of recommendations should be recorded to read "Health Manpower Development in the Caribbean with the use of unspent balances for a period of

Noted the recommendations of the Paper by L.S. Rosenfeld entitled "National Council International Health/Caribbean Community Secretariat Health Manpower Project: An Evaluation".

ISSUES TO BE CONSIDERED - SUGGESTIONS FROM PERMANENT SECRETARIES AND OTHER PARTICIPANTS

(Agenda Item 5)

12. The Barbados representative indicated that Barbados had already established a task force to examine the rationalisation of its health services and that in his view, the responsibilities and recommendations of the regional Task Force might conflict with those of the national groups.

13. The Saint Lucia representative informed the Meeting that the Organisation of Eastern Caribbean States (OECS) Secretariat was bringing together various health agencies to coordinate their activities. It was uncertain that the necessity of a task force as proposed would result from these consultations.

14. The Grenada representative pointed out that most countries in planning their health manpower resources would not do so in isolation from

1...

51

the rest of the national needs. Accordingly, a regional Task Force on health manpower might be ineffective since it would not be able to take account of the national needs. Similarly, the St. Vincent and the Grenadines representative stressed that that country had allocated 60 per cent of its allotted European Development Fund (EDF) funding over the past four years to health requirements, and that any future expansion of this allocation would be highly questionable. However, he recognised the need to coordinate services within the Region.

15. The Montserrat representative indicated that his country needed assistance in preparing the manpower development plan, and the Antigua and Barbuda representative noted that any proposed regional plan would have to take into account the differing manpower needs of each territory.

16. The Pan-American Health Organisation (PAHO) representative reminded the Meeting that part of the mandate of the Task Force would be to take account of national requirements.

17. The Dominica representative observed that the objective of the Task Force should be to assist Member Countries in the development of their health manpower planning and then to examine whether or not regionalisation of health services was feasible. He added that the regionalisation of health manpower planning was not an immediate priority in Dominica, although it might become so in the future.

18. THE MEETING:

Noted the comments of the Permanent Secretaries of the Ministries of Health.

PRESENTATION ENTITLED "BLINDNESS -
PREVENTION AND TREATMENT PROGRAMME:
AN ALTERNATE APPROACH" BY DR. R. MEADERS

(Agenda Item 6)

19. The Meeting considered the submission by Dr. R. Meaders of the International Eye Foundation (IEF) on the Saint Lucia National Blindness - Prevention and Treatment Programme. In both his Paper and presentation, Dr. Meaders outlined the strategy used to train medical personnel in the treatment of blindness. Firstly, he indicated that an assessment was made as to the cause of eye diseases and blindness in Saint Lucia based on a review of hospital records and interviews with local medical personnel. Using the findings of the study, a training programme for physicians, ophthalmic nurses and general duty nurses was set up. Routine and speciality eye clinics were opened and public awareness programmes developed. The emphasis of the entire programme was on the training of staff already working in Saint Lucia and ensuring that they were able in their turn to continue the training process for other local personnel. Most of the training was carried out in the Region.

20. In the discussions which followed, the United States Agency for International Development (USAID) representative suggested that this model could be applied to other specialities in the area of health care and that the UWI personnel should be involved in any future exercises.

21. The Secretariat representative congratulated the Saint Lucia government, the IEC and USAID for creating such an efficient and timely project. He remarked that care should be taken to train back-up personnel who could replace any that might be lost. Furthermore, there should be provision for specialists who had benefitted from the training to eventually sit examinations for certificates.

1...

51

22. The USAID representative informed the Meeting that USAID was considering extending the programme in Saint Lucia; and if any other country cared to mount a similar project (either in eye care or any other specialty that they deemed fit) they should contact Dr. Meaders of USAID and the CARICOM Secretariat as quickly as possible.

23. Dr. Meaders also requested the cooperation of PAHO, NCIH and other international bodies in the mounting of similar projects and suggested that there was a need to prioritise areas for training.

24. The PAHO representative stressed that UWI should be involved in the certification exercise and that the training of specialists should not be done in isolation from UWI's post-graduate courses.

25. THE MEETING:

Noted the submission of the IEF representative;

Commended the Saint Lucia Government, the IEF and USAID on the success of the project;

Further noted the suggestion that UWI be more closely involved in the project;

Recommended that any other Member Country wishing to set up a similar project should contact USAID, the IEF representative and send a copy of the letter to the CARICOM Secretariat.

TASK FORCE STRATEGY

(Agenda Item 7)

and

ORGANISATION OF TASK FORCE AND WORK PROGRAMME

(Agenda Item.8)

26. The PAHO representative suggested that there should be a team of researchers visiting each territory with the aim of both researching manpower needs and of assisting the Member Countries with their own planning requirements, and in collecting the necessary baseline data. Further, there should be a series of inter-country workshops to train officials in the planning process. Finally, there should be a draft paper presented giving guidelines as to how the Region's medical services could be strengthened and systematised. He indicated that PAHO was particularly concerned about the needs of individual countries in the area of technical cooperation and inquired how PAHO and the CARICOM Secretariat could collaborate to meet these needs.

27. The Secretariat representative stressed that while there was need to examine national manpower requirements, there was also a pressing need to offer some services at the regional level since not all the territories were able to provide treatment for all medical problems.

28. The Chairman suggested that from the discussions it appeared that the Task Force concept as presented should not be pursued in the manner suggested, but that a Working Group should meet in Barbados the following Monday to examine an appropriate strategy for meeting the needs as they had been expressed by the Permanent Secretaries. It was stressed that

the Paper on the Regionalisation of Health Services would still be forthcoming, and that Sir Kenneth Standard and Dr. Philip Boyd should collaborate in this effort.

29. THE MEETING:

Thanked Dr. Rosenfeld for his report and expressed its appreciation to USAID for its support of the project;

Congratulated Mr. George Rutherford for his commendable efforts in advancing the training done under the CARICOM/AID Basic Health Management Development Project;

Agreed that there should be a three-phased approach to the problem -

Phase I: the CARICOM Secretariat, PAHO/WHO and UWI should jointly organise a "Working Group/Party" to assist individual Member States with the preparation of a Health Manpower Situation Analysis to include:

- (a) organisational structure; job specifications/ occupation profiles;
- (b) current staffing patterns and levels;
- (c) significant trends;
- (d) estimation of the personnel who will need to be trained/retrained to meet the requirements of the Services - as projected in their National Health Plans (NHPs);

Phase II: Inter-country workshops would be implemented on a phased basis;

Phase III: Within-country training utilising as "trainers" those who participated in the "inter-country workshops";

Further agreed that -

- (i) Professor Sir Kenneth Standard and Dr. Philip Boyd should collaborate in the preparation of a blueprint on the regionalisation of health services among CARICOM Member States;
- (ii) the organisation of the Working Groups would be agreed on subsequent to the meeting by the Working Group scheduled to meet in Barbados, and that the results of this meeting would be made available to the Permanent Secretaries as early as possible.

DATA TO ASSIST TASK FORCE

(Agenda Item 9)

30. The Secretariat representative informed the Meeting that the proposed approach was for the Statistician to collate the available statistics on health manpower in the Region, and suggested that in keeping with the principle of operational research, that the officer work closely with his local counterpart in each of the territories. He pointed out that Rosenfeld's Evaluation Report had stressed the absence of data and suggested a two-phased approach - an examination of the existing situation and the projections for the future.

1000

(5)

31. The PAHO representative supported the proposal that the local personnel in each country should be involved in the study so as to have all national concerns included in the final report.

32. The Grenada representative repeated the concern of the Meeting that in all these exercises the emphasis should be on action rather than study since most Member Countries were already fully aware of their needs.

33. THE MEETING:

Noted the submission by the Secretariat representative.

ANY OTHER BUSINESS

(Agenda Item 10)

34. There being no other business the Meeting ended with the usual exchange of courtesies.

69

AGENDA

1. ELECTION OF CHAIRMAN
 2. ADOPTION OF AGENDA
 3. PROCEDURAL MATTERS
 4. OBJECTIVES OF TASK FORCE
 5. ISSUES TO BE CONSIDERED - SUGGESTIONS FROM
PERMANENT SECRETARIES AND OTHER PARTICIPANTS
 6. PRESENTATION ENTITLED "BLINDNESS - PREVENTION AND
TREATMENT PROGRAM"
 - An Alternate Approach - by Dr. Robert Meaders
 7. TASK FORCE STRATEGY
 8. ORGANISATION OF TASK FORCE AND WORK PROGRAMME
 - In-country Visits
 - Draft Report
 - Final Report
 9. DATA TO ASSIST TASK FORCE
 10. ANY OTHER BUSINESS
-

COMPUTATION OF COST EFFICIENCY

A. Cost of Volunteer Component of this Project

National Council for International Health

Salaries

Health Manpower Specialist	51,981
Assistant/Secretary	29,178
Fringe benefits	20,545
Staff travel/P.D.	15,693
Direct costs	31,505
Overhead	<u>63,240</u>
Subtotal	\$212,142

This subtotal reflects costs of all Project activities. The percentage of these attributed to the volunteer component (vs. the health manpower planning component) is estimated to be 40%.

40% x 212,142 -	84,857
Volunteer travel	<u>16,396</u>
Subtotal	101,253

CARICOM

Salaries

Manpower Coordinator	93,317
Secretary	11,576
Statistician (no salary attributed to volunteers)	--
Direct costs	<u>9,799</u>
Subtotal	114,692

66

Percentage of subtotal estimated attributable to volunteer activities = 35%

35% x 114,692 -	40,142
Volunteer Honorarium/PD	<u>18,169</u>
Subtotal	58,311
	<hr/>
<u>Subtotal US Project Costs</u>	\$159,564

Participating LDCs

Housing-Transport \$30 per volunteer
day x 1504 days = \$ 45,120

Total Costs \$204,684

The above reflects a best estimate of total project expenditures for the volunteer component, based on informed estimates of allocations of staff time spent on the various components of the Project. I have used 40 percent for NCIH staff: NCIH feels the attribution should be lower, about 30 percent. The host countries' contributions of housing, transportation (when provided) and staff time for orientation, supervision and administration, varied drastically from country to country and from volunteer to volunteer. For this analysis, they are calculated at a cost equal to the current per diem for food and incidentals paid a US volunteer (\$30 per day).

B. Value of Services Received

For this analysis, volunteer services are valued by estimating median daily earnings rates by technical speciality, and multiplying these by the estimated number of work days during the volunteer's tours of duty. These are done separately by origin of the consultant. To this are added transportation, per diem and malpractice insurance. The estimates of daily rates admittedly are arbitrary, and could vary greatly depending upon each potential volunteer's age,

experience and earning history. The total represents an approximation of what it would have cost the participating countries to purchase the services of the volunteers utilized during the Project's existence.

	Technical Speciality	Estimated ^{1/} Annual Inc.	Daily ^{2/} Rate	Served	Days Worked ^{3/}	Total
<u>Technicians</u>						
U.S.	Anesthesiologist	93,270	358.73	96	69	24,752
	Family Practice	93,270	358.73	80	57	20,448
	Hospital Engineer	30,000	115	55	39	4,485
	Nurse Midwife	30,000	115	93	66	7,590
	Nutritionist	25,000	96	80	57	5,472
	Radiologist	93,270	358.73	87	62	22,241
	Psychiatrist	93,270	358.73	305	218	78,203
	Surgeon	93,270	358.73	59	42	15,067
	Subtotal			855	610	178,158
West Indies	Dental Nurse	7,200 ^{4/}	28	214	153	4,284
	Ear, Nose, Throat Spec.	20,000	77	14	10	770
	Medical Records	7,200	28	182	130	3,640
	Medical Technician	7,200	28	214	153	4,284
	Psychiatrist	20,000	77	6	6	462
	Surgeon	20,000	77	19	14	1,078
	Subtotal			649	466	14,518
<u>Travel:</u> (Same as for Project)						16,396
<u>Per Diem</u> ^{5/} (food and incidentals)						45,120
Housing, Transportation (Same as in Project)						45,120
Malpractice Insurance						4,500
Total						303,812

- 1/ US physician's earnings median net for physicians from 13 states: Source:
Medical Economics, February 6, 1984
- 2/ Yearly rate divided by 260 days
- 3/ 5 day work week
- 4/ West Indian earnings adjusted to include allowances and, in the case of
physicians, private practice earnings
- 5/ Higher than in Project. The rate was increased from \$15 to \$30 a year ago.
Also, some volunteers waived this. This calculation assumes all accepted
full per diem.

101

A THREE-PHASE APPROACH TO HEALTH MANPOWER PLANNING IN THE L.D.C.
AND SMALLER STATES OF THE COMMONWEALTH CARIBBEAN

OVERALL OBJECTIVE:

To assist Governments to estimate the numbers and types of personnel who will need to be appropriately trained and/or retrained over a five year period - to meet the requirements of the Health Services, as projected in their National Health Plans.

P H A S E I

(April to July 1983)

PREPARATION OF A HEALTH MANPOWER SITUATION ANALYSIS

Each country's current Health Manpower situation will be analysed in the context of the prevailing Health situation, and will include:

- (i) Organisational structure of the Ministry of Health; and of the system of Health Services delivery; and any proposed reorganisation.
- (ii) Current staffing patterns and levels:
 - numbers of budgeted staff posts:
 - numbers of full time, part-time, temporary/supernumerary incumbents.
 - geographical distribution
- (iii) Significant trends in staffing levels:
 - leaving/turnover rates
 - transfer of functions.

(iv) Staff productivity:

- numbers and types of services provided per unit time
- proportion of time spent on service, support and other activities.

(v) Training institutions/programs for Health personnel available locally and regionally

- number of places available annually per program at each local and regional institution.
- numbers of applications for admission per year.
- "dropout" and "failure" rates per program per year.

METHODOLOGY:

At least three "instruments" will be designed: one to elicit information on organisation and staffing patterns/levels; significant trends and staff productivity (i to iv above)

one to be administered to each staff member of each Ministry of Health and

one from which information on training institutions and programs will be derived. (v above)

The instruments will first be pretested in SAINT LUCIA during April '83, by a joint CARICOM-PAHO Team: Mr. F. Duncan and Ms. M. Hinchcliffe (CARICOM), Dr. H. Drayton and Mrs. Gloria Noel (PAHO).

72

Thereafter, PAHO-CARICOM-UWI Teams will be constituted from among those listed below, to administer the revised instruments in the other L.D.C and smaller states.

It is anticipated that each country visit will be for no longer than 5 (five) working days, and that Phase I (for the 8 LDC, including Belize) will be completed by July 1983.

Copies of the questionnaires will be forwarded to the Ministry of Health, in each case, at least two weeks prior to the start of the team visit.

<u>CARICOM:</u>	Mr. F. Duncan	<u>PAHO:</u>	Dr. H. Drayton
	Mr. T. Goldson		Ms.G. Noel
	Ms. M. Hinchcliffe		Dr. J. Paganini
	Mr. R. Rutherford		Mr. F. Sadek

U.W.I. (to be selected after consultation with Sir Kenneth Standard and Dr. F. Nunes.)

- d) UWI: (to be named after discussion with Sir Kenneth Standard and Dr. F. Nunes.)

TEACHING/LEARNING MATERIALS:

The Teaching/Learning materials for each Workshop will derive from:

- (i) The Health Manpower Situation Analyses prepared during Phase I.
- (ii) Any additional information from each participating country that may be relevant to the planning process, including: National Health Plans; Goals and Targets for the services; Health Manpower Policies.
- (iii) Health Manpower Planning Process:
HEW Document No. HRA 76-14013: (Aspen Systems Corporation), Washington D.C.
- (iv) Manpower and Primary Health Care: Richard A. Smith (Ed.)
University Press of Hawaii, Honolulu (1978)
- (v) Health Manpower Planning: Hall T.L. & Mejia A (Eds.)
WHO, Geneva (1970).
- (vi) Guidelines for Health Manpower Planning: Hornby P, Ray D.K, Shipp P.J., and Hall T.L: WHO, Geneva (1960)
- (vii) Realistic Manpower Planning for Primary Health Care: Smith, Richard (1960), pp. 61-73 of Report of an Expert Group: Special Health Problems of Island Developing and other Specially Disadvantaged Countries: Commonwealth Secretariat

75

SCHEDULE:

<u>YEAR</u>	<u>QUARTER</u>	<u>VENUE</u>	<u>PARTICIPATING COUNTRIES</u>
<u>1984</u>	3	St. Vincent	Grenada Saint Lucia St. Vincent & the Grenadines
<u>1983</u>	4	Antigua	Anguilla Antigua BVI (Tortola) Dominica Montserrat St. Kitts-Nevis
<u>1984</u>	1 or 2	Nassau, Bahamas	Bahamas Bermuda Belize Cayman Islands Turks & Caicos Is.

PHASE 3

January 1984 -

WITHIN-COUNTRY ACTIVITIES

Within-country activities utilising as the core group, those who participated in the Inter-country Workshops, to formulate National Health Manpower Plans in each country. Such activities will include the training of other nationals in the techniques of planning, monitoring and evaluation.

* * * *

A Regional Seminar will be convened during the first Quarter of 1984 - at which results will be presented, and an assessment will be made of the extent to which the overall objective will have been achieved.

11

Attachment H

HEALTH MANPOWER INFORMATION

CARICOM/NCIH HEALTH MANPOWER PROJECT

HEALTH MANPOWER INFORMATION

<u>COUNTRY</u>	<u>DATE VISITED</u>	<u>STATUS OF HEALTH MANPOWER PLANNING ACTIVITIES</u>	<u>STATUS OF HEALTH MANPOWER INFORMATION</u>	<u>WORK DONE</u>
SAINT LUCIA Pilot Test	March 1983	No systematic HMP activities existed. The National Health Plan (1981) did not deal comprehensively with HM Planning and the implementation of the plan was hindered because of disagreement on strategies for dealing with additional Manpower Requirements.	A relatively well develop Personnel record keeping system existed. This system was managed by the Executive Officer (Personnel) and produced summaries of Staff Complement and turnover every quarter. <u>The major weakness which existed in the system and which existed in all other countries visited</u> was that the system was not designed to provide the kind of data required for Manpower Planning. It was designed and used specifically for the day to day management of individual employees. As a result information on the age, qualifications, performance of individuals were not available. Also information on turnover rates, number of persons in training by type, expected graduation dates etc. were not readily available.	The forms designed for use in the study were tested and subsequently redesigned. The information collected during this pilot test was used to create the initial data set for Saint Lucia. (See Gordon Defriese's Report for details of this pilot test). The relative difficulty encountered in collecting different types of data highlighted the need to have a criterion for deciding the cost/benefit of collecting such data and the possibility of substituting certain types of information with others. However, such a criterion had to result from a knowledge of how the data collected would be used, apart from its general usefulness.
SAINT LUCIA	June 1983	see above	see above	After the pilot test in March 1983, a model for forecasting five year health manpower shortages and surpluses was designed (see Defriese Report).. Certain types of data required for use in this model were not collected during the March Pilot Test and prior to visiting St. Vincent and Grenada, the additional data were collected. Interviews were held with departmental heads to obtain most of the additional data.

COUNTRY	DATE VISITED	STATUS OF HEALTH MANPOWER PLANNING ACTIVITIES	STATUS OF HEALTH MANPOWER INFORMATION	WORK DONE
SAINT LUCIA	March 1984	<p>The Government of Saint Lucia has decided to implement a system of regionalization and restructuring which will affect all Government Ministries. By March 1984 the Ministry of Health nearly completed its draft plans for restructuring. This restructuring exercise resulted in departmental heads submitting and discussing 5-year Manpower requirements. The Ministry has submitted for approval, a request for a Planning Unit to be established in the Ministry of Health. The proposed staff are: a Health Planner, Project Officer, Statistician and a Statistical Officer.</p>	see above	<p>The first Report completed on the basis of the data collected "Health Manpower Statistics - Saint Lucia 1983" was returned to the Ministry of Health. Discussions on the way the information in the Report could be used, future Health Manpower Planning Activities, and the possible assistance of CARICOM and PAHO could provide in carrying out such activities were discussed.</p> <p>A meeting was held with the various speciality heads at which the usefulness of the statistics in Health Manpower Planning was discussed and plans for a workshop at which critical Health Manpower Planning Development and Utilization issues could be addressed were considered. The agenda for an Inter-Country Seminar of Permanent Secretaries at the Final Advisory Meeting of the CARICOM/ACIH Health Manpower Project was also discussed with the Permanent Secretary.</p> <p>A meeting of CARICOM (represented by Frederick Duncan, Health Statistician, and George Rutherford, Health Management Specialist) and PAHO (represented by Dr. Harold Drayton, Project Manager, Allied Health Manpower Project Jose DeKovic, Managing Consultant, and Mike O'Carroll Health Planner) was also held to plan a programme for joint CARICOM and PAHO cooperation in providing future assistance to CARICOM countries in the area of Health Manpower Planning.</p>

COUNTRY	DATE VISITED	STATUS OF HEALTH MANPOWER PLANNING ACTIVITIES	STATUS OF HEALTH MANPOWER INFORMATION	WORK DONE
ST. VINCENT	June 1983	The National Health Plan addressed in a limited way, Health Manpower Planning issues. The Permanent Secretary, Snr. Medical Officer and other Department Heads were committed to carrying out the programme outlined in the Health Plan. The need for developing a methodology for determining optimum manpower requirements was highlighted. Such a need appeared critical for determining hospital nursing requirements, a critical staff category in St. Vincent and all the other countries visited.	The only Health Manpower information available were the personal files of staff members which were improperly maintained and consisted of a letter of appointment which stated the name, date of appointment and position of the employee together with information of leave and promotions. These files were kept at the Ministry of Health and were not the responsibility of any one person. In addition Departmental Heads had information on the number of staff in post and their locations.	<p>The Health Plan was reviewed and discussed. Interviews held with Departmental Heads to obtain information on the number of positions filled, persons in training and expected graduation dates, turnover rates and five year staff requirements.</p> <p>The Statistical Office, Ms Verlene Saunders was assigned by the Permanent Secretary the duties of 'Personnel Officer', and forms on which an inventory of Health Manpower could be compiled were circulated to departmental heads. Plans for the implementation of a Personnel Management Information System were also made.</p>
ST. VINCENT	March 1984	The projected nursing requirements for the Kingston General Hospital (the main hospital) and proposed job descriptions for nurses which were submitted by the Nursing Administration were being considered by the Permanent Secretary. The lack of an agreed methodology for determining staff requirements have resulted in disagreement among the nurses and between the nurses and the Administration on the submitted projected requirements.		

COUNTRY	DATE VISITED	STATUS OF HEALTH MANPOWER PLANNING ACTIVITIES	STATUS OF HEALTH MANPOWER INFORMATION	WORK DONE
ST. VINCENT		<p>The Organisation of Eastern Caribbean Secretariat (OECS) had held a seminar on human Resources Development which was attended by Departmental Heads of the Health Ministry and other countries. The seminar was considered a successful one by the Department Heads.</p> <p>Health Manpower Planning is considered a critical issue at present and assistance in this area is welcomed by the Ministry of Health.</p>	<p>The Forms circulated in June 1983 for compiling the Health Manpower Inventory were returned by the Nurses, Doctors and few other specialities.</p> <p>The information collected in June 1983 had already proved useful to the Executive Officer (Statistics) who was able to advise on training requirements based on the information provided by Departmental Heads.</p> <p>There is now a need for an intensive 3-5 day exercise to complete the collection of the data for compiling the Inventory.</p>	<p>A meeting was held with the Permanent Secretary and other Senior Medical Officer at which the statistics compiled were discussed and critical Health Manpower issues were considered.</p> <p>Another meeting was held with Department Heads to discuss the statistics compiled the need for the speedy implementation of the Personnel Management Information system beginning with the compilation of the Inventory of Health Manpower, and plans for a workshop on Health Manpower Planning Development.</p> <p>The need for a study of the Hospital Nursing Staff re Requirements and Utilization was also discussed with the Permanent Secretary, Senior Medical Officer and the Nursing Administrator.</p> <p>CARICOM assistance in conducting such a study over the period May to August 1984 was requested by the Permanent Secretary.</p>

COUNTRY	DATE VISITED	STATUS OF HEALTH MANPOWER PLANNING ACTIVITIES	STATUS OF HEALTH MANPOWER INFORMATION	WORK DONE
GRENADA		A Health Planning Unit with responsibility for all aspects of Health Planning existed. However, apart from the Health Manpower Planning Issues addressed in the National Health Plan, activity in this area were few.	The Statistical Officer in the Planning Unit was the person responsible for developing and maintaining the Health Manpower Planning Information System. However, no work was being carried out in this area. Another Officer was responsible for maintaining personnel files and PAHO assistance was obtained in designing a form for recording data on each employee which would assist in better personnel management.	The Health Plan was reviewed and discussed. Interviews were held with the members of the Planning Unit and Departmental Heads to obtain data on positions filled, persons in training, turnover rates etc. and projected five-year requirements.
DOMINICA	November 1983	Long and medium term Health Manpower Planning activities were not in progress. However matters relating to the utilization of manpower were being considered. This appeared suitable to the existing situation given the critical national issue was rebuilding after the devastating hurricanes.	The Personnel Officer maintained up-to-date information on number of positions filled, and on turnover rates in some cases. Information required for day to day Personnel Management was well kept.	Data on positions filled, vacancies, persons in training and turnover rates were collected.
DOMINICA	March 1984	The Director of Health Services Dr. McIntyre indicated that Health Manpower Planning Activities would begin after the return of one Ms. Astaphan May 1984, who is currently doing post graduate studies in Health Planning in the U.S.A.	see above	The statistics compiled were discussed and meetings were held with the new Permanent Secretary, the Director of Health Services and the Statistical Officer to discuss the development of the Personnel Management Information System.

COUNTRY	DATE VISITED	STATUS OF HEALTH MANPOWER PLANNING ACTIVITIES	STATUS OF HEALTH MANPOWER INFORMATION	WORK DONE
BELIZE	August 1983	No systematic Health Manpower Planning was in progress	Information for day to day Personnel Management was routinely kept. However, data required for long term manpower planning such as projected requirements, turnover rates, expected graduates over the next five years etc. were not available.	Discussions were held with Senior Ministry Officers and interviews with Departmental Heads were conducted to provide the information needed for making five-year Health Manpower Projections.
MINISEBAT	NOVEMBER 1983	A study on the staff requirements of the Ministry of Health was recently carried out by a British Organisation and Methods Specialist. The Government has formally accepted the recommendations of the Specialist. This study, together with the recommendations which are being implemented could be considered the most comprehensive Health Manpower Planning activity carried out in the LDCs over the past few years.	The information needed for day to day Personnel Management is readily available together with the results of the Health Manpower Study.	Data on Projected Staffing requirements, filled positions, vacancies, turnover rates etc. were collected.
ST. KITTS/NEVIS		No medium or long term HMP activities were being carried out.	Prior to the visit responsibility for keeping Health Manpower information was not assigned to any one officer. However, data required for day to day personnel management were kept by the Ministry. Information necessary for medium and long range Manpower Planning did not exist.	Discussions were held with the Permanent Secretary and interviews were conducted with Departmental Heads to obtain information on projected requirements and the other data required for making 5-year projections. Plans for implementing a Personnel Management information system were also discussed.

54

COUNTRY	DATE VISITED	STATUS OF HEALTH MANPOWER PLANNING ACTIVITIES	STATUS OF HEALTH MANPOWER INFORMATION	WORK DONE
ANTIGUA	November 1983	No medium or long term HMP activities were being carried out. The development of National Health Plan was in its embryonic stages and no time table had yet been set for the developing of Health Manpower Plans.	Personnel data were kept by three different officers in different locations (Ministry of Health Headquarters, Central Board of Health and the Holberton Hospital).	Discussions were carried out with the Permanent Secretary and the Principal Nursing Officer. The available information was also collected from the officers who kept data on Health Manpower.

Attachment I

SAMPLE COUNTRY HEALTH
MANPOWER DATA

56

SAINT LUCIA

HEALTH MANPOWER SITUATION
FOR SAINT LUCIA
AS AT APRIL 1983
FOR TECHNICAL/PROFESSIONAL POSTS

Table 1A

POSITION CODE		ESTABLISHED TECHNICAL/PROFESSIONAL POSTS 1983/84	NO. OF BUDGETED POSITIONS FOR 1983/ 1984	NO. OF POSITIONS FILLED AS AT APRIL 1983	NO. OF POSITIONS VACANT AS AT APRIL 1983	1983/84 BUDGETED SALARIES			
COUNTRY	CARICOM					EAST CARIBBEAN \$ (EC\$)		NATIONAL CURRENCY	
					TOTAL	AV. FOR BUDGETED POSITIONS	TOTAL	AV. FOR BUDGETED POSITIONS	
		<u>DOCTORS (including Dentists)</u>							
		<u>Health Medical Care Administration</u>							
		Director of Health Services	1	1	-	10	-		
		Chief Medical Officer (L1)	1	-	1	10	-		
		Medical Officer of Health (L3)	1	1	-	27 999	27 999		
		Consultant Ophthalmologist (L3)	1	1	-	30 790	30 790		
		Consultant Paediatrician (L3)	1	1	-	27 999	27 999	Same as EC\$	
		Medical Officers (L17-10) (L11-4)	13	11	2	330 360	29 412		
		Consultant Obstetrician/Gynaecologist (L6)	2	2	-	55 997	27 999		
		Specialist Officer Dermatology	1	1	-	26 770	26 770		
		<u>Golden Hope Hospital</u>							
		Consultant Psychiatrist	1	-	1	29 330	29 330		

SAINT LUCIA

PROJECTED CHANGES 1983/84 - 1987/88
TECHNICAL/PROFESSIONAL POSTS

Table 2A

POSITION CODE	POSTS REQUIRING CHANGES OVER 1983/84-1987/88	CURRENT NO. OF BUDGETED POSTS/(3) 1983/84	REQUIRED ANNUAL CHANGES IN BUDGETED POSTS/(2) OVER PREVIOUS YEAR				TOTAL REQUIRED INCREASE OVER 1983/84-1987/88	TARGET NO. BUDGETED POSTS IN 1987/88
			1984/85	1985/86	1986/87	1987/88		
<u>DOCTORS</u>								
Medical Officers		13/330 360	(2)/51 286	-	-	-	(2)/51 286	11
<u>NURSES</u>								
Nurse Practitioners		6/51 532	1/8 589	-	-	-	1/8 589	7
Public Health Nursing Supervisors		8/138 810	(1)/17 351	-	-	-	(1)/17 351	7
District Nurses		49/736 067	3/45 065	-	-	-	3/45 065	52
Nursing Assistants		5/44 313	10/88 630	-	-	-	10/88 630	15
Ward Sisters		30/366 090	5/61 005	5/61 005	-	-	10/122 010	40
Staff Nurses		68/637 906	33/309 572	8/75 047	16/150 095	13/121 953	70/656 670	138
Snr. Nursing Assts) Nursing Assts)		41/240 499	26/152 512	8/46 929	18/76 256	13/76 256	60/351 951	101
Deputy Director		-	1/	-	-	-	1/	1
MCH/Family Planning Coordinator-Tutor		-	1/	-	-	-	1/	1
Deputy Family Planning Coordinator- Tutor		-	1/	-	-	-	1/	1
School Health Co-ord (Supervisors)		-	2/	-	-	-	2/	2
District Nurses (National Family Planning)		-	1/	1/	1/	-	3/	3
District Nurses (School Health)		-	2/	-	-	-	2/	2

SAINT LUCIA

HEALTH MANPOWER SITUATION
FOR SAINT LUCIA
AS AT APRIL 1983
FOR MAJOR TECHNICAL/PROFESSIONAL GROUPS

Table 1B

GROUP CODE	TECH/PROF. STAFF CATEGORY (GROUP)	NUMBER OF BUDGETED POSTS 1983/84	NUMBER OF POSITIONS FILLED AS AT	NUMBER OF POSITIONS VACANT AS AT	RATIO OF STAFF TO 10 000 POP		1983/84 BUDGETED SALARIES		
					BUDGETED STAFF BASIS	ACTUAL STAFF BASIS	TOTAL FOR GROUP	PERCENTAGE OF SALARIES BUDGET FOR TECH/PROF. STAFF	PERCENTAGE OF TOTAL SALARIES BUDGET
	Doctors (incl. Dentists)	45	35	10	4	3	1075 946	19.6	16.3
	Nurses	259	229	54	21	19	3041 185	55.5	46.1
	Environmental Health Officer	26	23	3	2	2	360 294	6.6	5.5
	Pharmacists/Dispensers	14	13	1	1	1	177 855	3.2	2.7
	Lab. Technicians	15	12	3	1	1	208 300	3.8	3.2
	Radiographers	5	2	3	0	0	64 081	1.2	1.0
	Physiotherapist/ Occ. Therapist	6	5	1	0	0	78 475	1.4	1.2
	Nutritionists/ Dietitians	-	-	-	-	-	-	-	-
	Dental Health Aux. (excl. Doctors, dental surgeons)	6	4	2	0	0	65 990	1.2	1.0
	Health Education Personnel	5	7	2	0	0	11 428	0.3	0.2

