

PD-ABC-952
72262

PROJECT ASSISTANCE COMPLETION REPORT

Project Title: Immediate Health Care Services and Development
Project Numbers: 543-0003 and 538-0149
Funding Period: FY 1984 - 1990
LOP Funding: \$6,555,000
Implementing Agency: Project HOPE
PACD: June 30, 1990

I. PURPOSE

The purpose of the Project was to provide trained medical resources to meet the emergency need for health services created by the abrupt departure of Cuban health professionals after the October 1983 U.S. military intervention and to assist Grenada in achieving a self-reliance in the development of an appropriate and affordable health care system.

II. BACKGROUND

In January 1984 the Office of Foreign Disaster Assistance (OFDA) provided \$200,000 to Project HOPE to initiate the provision of medical and dental services in Grenada and to stabilize its health services delivery system following the departure of Cuban medical personnel after the U.S. intervention. On February 16, 1984 the Deputy Assistant Administrator for the Latin America and Caribbean region authorized the Immediate Health Care Services Project (543- 0003) in the amount of \$1,529,000. An authorization amendment in 1985 increased the life of project funding from \$1,529,000 to \$4,305,454 and introduced the "health systems strengthening" component to the Cooperative Agreement. Under this phase HOPE began initiatives designed to improve health management, planning and infrastructure.

Early in FY 1986 it was decided to expand the work of the Project HOPE cooperative agreement to include the provision of technical assistance, limited equipment and supplies associated with the opening of the mental health facilities which were recently constructed. At about the same time, a decision was made by AID/Washington to discontinue the "543" project number series and to put all new funds into the RDO/C "538" series of project numbers. For this reason the Project Hope Cooperative Agreement was financed by two project numbers until the 543-0003 authorization expired on February 2, 1987.

III. SUMMARY OF INPUTS AND ACCOMPLISHMENTS

At the height of project activities (1986), Project HOPE had a contingent of over 30 full time American personnel working in the Ministry of Health including 10 allied health personnel (a sanitarian, drug supply manager, health planner, biomedical technician, medical records specialist, health educator, a medical technician, a pharmacist, a solid waste management specialist and an environmental health specialist); 13 physicians (a family practice physician, three pediatricians, two general surgeons, an orthopedic

surgeon, an anesthesiologist, a radiologist, a public health physician, an internist, an obstetrician/gynecologist and a pathologist); four nurse educators and a mental health team of six specialists (a psychiatrist, psychiatric social worker, activities therapist and three psychiatric nurses). Over the life of the project a total of 122 person years of resident technical assistance was provided to strengthen the health system of this island of 96,000 inhabitants.

Most of the positions noted above were in the field for a minimum of 3 years prior to their planned departure or replacement by Grenadian, other West Indian or non-West Indian long-term MOH employees. (One of the roles of Project HOPE was to identify, recruit and train as necessary long term replacements for expatriate Project HOPE personnel.)

Over the six years of the project a number of health sections were either established (e.g., health economics, biomedical equipment maintenance, MOH computer center), or re-structured/revitalized (e.g., health education, medical records, environmental health, mental health, sanitation/solid waste management).

In addition, a number of individuals were trained in-country on-the-job and through special training programs such as the post-basic training program for nurses, cytology, ultrasound radiography, psychiatric nursing, community-based mental health, and vital/health statistics. A smaller but still significant number of health care workers received third-country training (either U.S.-based or within the Caribbean) in areas such as medical records keeping, biomedical technology maintenance, solid waste management and environmental health.

Two innovative teaching technologies were introduced during the cooperative agreement: (1) Grenada was linked to the slow-scan satellite regional University of the West Indies Distance Teaching Experiment (UWIDITE) system which allowed them to both receive and initiate teaching programs in health systems management, and (2) a program was initiated to rotate UWI medical registrars (medical residents) from the Barbados Cave Hill campus through the General Hospital in Grenada. This latter program allowed Grenada to benefit from medical specialties which otherwise would not have been available to them.

The project was completed in June 1990 although Project HOPE elected to remain in Grenada financed by other U.S. government sources (e.g. the American Schools and Hospitals Abroad program) and some of their own core funds. By the close of the Project AID had obligated a total of \$6,555,000 to the Project HOPE cooperative agreement.

IV. DEVELOPMENT IMPACT

Given the wholesale nature of Project HOPE's scope of work in Grenada, it is not unexpected that while some of the programs and skills imparted undoubtedly were institutionalized to a greater or lesser degree, the lifespan of others were not much longer than the Project HOPE presence. The Project objective of designing an "effective" and "affordable" health care system from the ground up proved somewhat difficult to accomplish given the broader government

objectives of reducing the size of the public sector workforce. Thus, for example, Project HOPE's mandate to introduce a community mental health program to reduce the incidence of institutionalization required them to hire and train community mental health aides at a time when the Ministry was being directed to reduce its personnel levels.

MOH officials readily point to the early provision of medical specialists in 1984 as filling a crucial gap in their health care delivery system. A number of these medical positions were eventually assumed by Grenadians or other West Indians recruited by Project HOPE and the MOH. HOPE and MOH efforts to recruit medical specialists who left Grenada during the Maurice Bishop regime for opportunities in North America were often unsuccessful due to the poor MOH salaries and the weak and confused state of the Ministry itself. A number of these original recruits have since left government service; some of them have been replaced.

Replacing the Project HOPE medical team was also made more difficult by the unwillingness of Project HOPE to collaborate with the St. George's Medical School, an off-shore U.S. teaching facility based in Grenada. The refusal of Project HOPE to incorporate medical skills which were available to the country in the St. George's teaching faculty into the revised health system developed by Project HOPE, prevented this long-term resident resource from being tapped by the government to the maximum extent possible. This dialogue between the Ministry of Health and the medical school has begun with the departure of HOPE personnel.

The legacy of auxiliary health care workers trained by Project HOPE is generally positive although many have moved on to new assignments within or outside of the Ministry of Health, resulting in a new cadre of workers who did not benefit from the training programs of Project HOPE. The MOH continues to suffer from a constant brain drain of top level workers.

Three project areas particularly stand out as having significant development impact. First was the effort to link Grenada to the UWIDITE system. This facility continues to be well-used by the Grenadians for skills upgrading and health education programming. Second was the multi-faceted mental health program. Implemented in concert with the opening of the new acute and chronic care facilities built after the Intervention, mental health services were profoundly upgraded from custodial to therapeutic care standards. A community-based mental health program introduced under the Project prepared health care workers and non-health care community workers (e.g., police) to work with individuals on an out-patient basis to reduce institutionalization. Finally, the introduction of basic principles of health economics has continued to manifest itself in improved budget planning.

Areas which were less successful included solid waste management which despite approximately 5 years of resident technical assistance by a sanitary engineer and solid waste management expert remains a very severe health problem in Grenada, and the UWI registrars rotation program which has since been discontinued due to a lack of interest and funding by the Ministry.

V. RECOMMENDATIONS FOR CONTINUING MONITORING

No additional formal monitoring is recommended.

VI. LESSONS LEARNED

Several lessons for future project design can be gleaned from the Immediate Health Care Services and Development Project. The first relates to the comprehensive nature of the Project itself. The awesome scope of the project--in effect, to rebuild a weak, inefficient and foreign (Cuban)-run system--was overwhelming in itself. Coming on the heels of the period of political and social disorientation which followed the Intervention, the implementing agency adopted a "take charge" approach which in many instances prevented the Project from being fully integrated with the Ministry of Health.

Second, the sheer size of the HOPE resident contingent--over 30 strong at one point--suggested to some that the Ministry was no longer perhaps run by Cubans, but by a parallel group of Americans. It was not uncommon, for example, for specialists recruited by Project HOPE to feel they were part of the "HOPE Team" rather than an employee of the Ministry which paid their salaries. Future projects should be mindful of the influence which comes organically with such large influxes of advisors.

Finally, the breadth of the scope of work was unrealistically large. Despite the significant financial investment of USAID and the momentous contribution of person months and years, at the close of the activity it is fair to say that institutionalization was not fully complete (or that it would be in the foreseeable future). Project HOPE maintained that additional financing should have been provided to complete the job although this request was financially beyond AID's capabilities considering the size of the country and the amount of resources which were already spent. A different conceptual approach, perhaps one which would have separated the various activities into distinct phased components, would have allowed the host government to participate more fully in project management and administration rather than overwhelming them with sheer numbers of persons and endeavors.

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Clearances:

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C/PRGM:PLerner	<u>In draft</u>	Date	<u>06/25/91</u>
PRGM/ECON:DClarke	<u>In draft</u>	Date	<u>06/25/91</u>
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