PDWAG 024

CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) – PART I

Report Control Symbol U-447

1. PROJECT TITLE	2. PROJECT NUMBER	3. MISSION/AID/W OFFICE
Health Development Planning and Management (HDPM) American Public Health Association	936-5901.1	S&T/H/HSD

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)

☒ REGULAR EVALUATION ☐ SPECIAL EVALUATION

5. KEY PROJECT IMPLEMENTATION DATES	6. ESTIMATED PROJECT FUNDING	7. PERIOD COVERED BY EVALUATION
A. First PRO-AG or Equivalent FY 81	A. Total $ 2,500,000	From (month/yr.) October 1981
B. Final Obligation Expected FY 86	B. U.S. $ 2,500,000	To (month/yr.) March 1984
C. Final Input Delivery FY 86		Date of Evaluation Review

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

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. Agreement with APHA on program budget for 4 and 5 that reflects evaluation reccomendations.	ST/H/HSD:A Randlov APHA:Gerald	Oct. 1984
2. Issue PIO/T reflecting budget/program revisions.	ST/H/HSD/:A Randlov	Nov. 1984
3. Amend Co-operative Agreement Between A.I.D. and APHA	SER/CM APHA:Gerald	Nov. 1984
4. Completion of all significant research activities	V.W.I.	Oct. 1984
5. Start of On-Campus Training Program	V.W.I.	Oct. 1984
6. Develop Evaluation Plan for In-Service and On-Campus Training Programs	APHA/VWI	April 1985

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

- ☐ Project Paper
- ☒ Financial Plan
- ☐ Logical Framework
- ☒ Project Agreement
- ☐ Implementation Plan e.g., CPI Network
- ☐ PIO/T
- ☐ PIO/C
- ☐ PIO/P
- ☐ Other (Specify) _____
- ☐ Other (Specify) _____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

- A. ☐ Continue Project Without Change
- B. ☐ Change Project Design and/or
  - ☒ Change Implementation Plan
- C. ☐ Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)

S&T/H/HSD: Donald C.E. Ferguson, Project Officer
APHA/HDPM: Alfred Gerald, HDPM Program Director
APHA/HDPM: Richard Thelwell, HDPM Project Administrator
UWI/Jamaica: Leslie Robinson, UWI Pro-Vice Chancellor

12. Mission/AID/W Office Director Approval

Signature

Typed Name: Ann Van Dusen

Date: 11/8/84

AID 1330-18 (3-78)

PROJECT EVALUATION SUMMARY (PES) -- PART II

13. Summary

The Executive Summary of the attached Evaluation Report (pp. 1-6) details the current project situation and need not be repeated. The Office of Health concurs with the Evaluation Executive Summary.

The Health Development Planning and Management Project (HDPM) is an AID/Washington funded project contractually procured by means of a Cooperative Agreement with The American Public Health Association and Subagreements with the University of the West Indies and the University of Pittsburgh.

It consists of four major components:

1) On-Campus training of health managers and planners,
2) In-Service training of personnel in health ministries in four countries of the Caribbean region,
3) Provision of technical assistance in health management to Caribbean nations,
4) An applied health services research program.

The project has a five-year duration and began in October 1981 and will reach a PACD on September 30, 1986.

14. Evaluation Methodology

This evaluation was a regular, scheduled mid-term evaluation of the HDPM project. Its purpose was to measure progress, assess performance within project components, and provide information on which to base project course correction as needed.

The team consisted of a financial analyst/public health administrator funded by the PRITECH project, a management specialist and a university health sciences educator funded by the MEDEX project, and an A.I.D. direct-hire project design and health policy team member funded from A.I.D OE funds.

Methodology consisted of 1) extensive document study and review prior to, during, and after the field visits, 2) visits to the Cooperators (APHA, UWI and PITT), 3) field visits to UWI, St. Lucia, Barbados, Trinidad and Jamaica, 4) discussions and interviews at Ministries of Health in all countries served by the project, 5) interviews of mission staffs in Jamaica and Barbados, 6) review of financial records and reports at APHA, UWI, and in ST/H, 7) examination of project files and project products in Washington and the field, and 8) a series of indepth interviews with all project staff members.

15. External Factors

There were no major changes in project setting or government policies impacting on the major purpose of the project over the period covered by this evaluation.

16. Inputs

The delay in bringing a Research Officer into place and the uncertain and uneven quality of studies undertaken as part of the research component resulted in the evaluation team's agreement with the Project Officer who believed losses should be minimized by phasing out this component of the project.

Legal and procedural requirements of the University of the West Indies has resulted in slippage in initiating the On-Campus Diploma program. The original project design was unrealistic in its assumptions concerning teaching manpower requirements for the Diploma course.

The in-service component has had an over-generous resource allocation. To provide the On-Campus component with more adequate resources, reallocation of existing resources has been made in the activities budget. Scope remains essentially the same but a gradual phase-down of outside inputs over remaining project life has been planned.

17. Outputs

Research outputs have not been of quantity or quality sufficient to justify continuation. Phase-out of this component has been implemented.

The On-Campus component of the project has been delayed for a number of reasons. The Evaluation Report (pp. 28-32) discusses associated problems and difficulties and recommends a course of action (see Ferguson to Gerald letter of 6/1/84) with which the Office of Health generally concurs (pp. 33-34 of the Evaluation Report.)

18. Purpose

The project purpose is to establish at the University of the West Indies the sustained capability to work with Ministries of Health and other West Indian institutions within the region to:

1) Train health planners and managers,
2) Give technical assistance in health development planning and management to countries' governments and health sector institutions,
3) Conduct an applied health services research program to improve the delivery of services.

The third element--applied health services research has been phased out after the determination had been made that this component was consuming resources with rather limited returns on investment. Inasmuch as on-campus training, in-service training, and technical assistance activities gave evidence of return and value for funds invested, these components have been continued.

19. Goal/Sector Goal

The goal of this project is "to provide support to the governments of the West Indies to strengthen their capabilities to plan and manage health sector resources in order to improve the health of their populations." The goal and purpose of the project remains valid as do the basic underlying assumptions. Some modification of the OVI's and other aspects of the Logical Framework are called for however, and a Logical Framework revision included on pages 85-88 of the attached Evaluation Report details a more accurate reflection of what can be expected given experience and lessons learned to date from this project.

20. Beneficiaries

The beneficiaries of this project will be the people, governments and institutions of the Caribbean region through a project which satisfies the criterion of Sec. 104(c) of the FAA as a "measure(s) to improve management of health programs, and other services and suppliers to support health and disease preventive programs." Individual beneficiaries will be those receiving increased access, higher quality, more affordable or more efficient and effective health services in countries served.

21. Unplanned Effects

Unplanned effects cannot yet be assessed. Products produced to date have not had time to result in quantitative impact on the health sector.

22. Lessons Learned

It was evident to the project Officer that design of this project required greater detailed knowledge of higher level education in the Caribbean region. Procedural arrangements within Caribbean Universities and particularly within the regional and regionally supported University of the West Indies introduced constraints which could not be glossed over or ignored. These omissions have been rectified.

A second major lesson is that such projects cannot be managed by an AID/W Project Officer by remote control. The "filtration-factor" operating when reports are massaged at three levels before reaching the A.I.D Project Officer results in "straining-out" of needed information and particulars. Unless on-site field visits can be made twice yearly at least to the project site by the Project Officer, such projects are better managed by missions from inception.

23. Special Comments

The evaluation team's conclusions and recommendations are largely concurred in by both the Project Officer and the Office of Health. The majority of recommendations made will be implemented in coming months.

A copy of the Final Evaluation Report is attached.

AGENCY FOR INTERNATIONAL DEVELOPMENT
HEALTH DEVELOPMENT PLANNING AND MANAGEMENT PROJECT

MID PROJECT EVALUATION

Cooperative Agreement No AID/DSPE-5901-A-00-1039-00
American Public Health Association
University of Pittsburgh
University of West Indies

February 3-29, 1984

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20. Research Protocol: Trinidad MIS Study

ACKNOWLEDGEMENTS

The evaluation team humbly acknowledges the uncomplaining and forthcoming assistance it received every step along the way. The task of project evaluation, meant to be helpful, too often becomes confrontational, and the team is gratified not to have had that experience on this assignment. While acknowledging all assistance to the team, specially warm thanks are due to the UWI officials at all 3 campuses. They gave their time unstintingly and responded openly to our many questions. Pro Vice Chancellor Robinson went out of his way to show us Carribean hospitality, as did Mr. Richard Thelwell, APHA Project Administrator. Mr. Thelwell's knowledge and energy most considerably facilitated our task, and we sincerely thank him for his assistance.

EXECUTIVE SUMMARY

The Health Development Planning and Management (HDPM) Project is an AID-Washington funded activity implemented by a Cooperative Agreement between AID and American Public Health Association. APHA, in turn, has subcontracted with the Universities of the West Indies and Pittsburgh. The long-term Project Goal is to institutionalize planning and management capabilities of the governments of the West Indies. The immediate Project Purpose is to establish at the University of the West Indies the sustained capability to work with Ministries of Health and other West Indian institutions within the region to:

A. Train health planners and managers.

B. Give technical assistance in health development planning and management to country governments and health sector institutions.

C. Conduct an applied health services research program to improve the delivery of services.

The five-year Project started October, 1981, and has an estimated life of project cost of 2.5 million U.S. Dollars.

This mid-term external evaluation, required by the Cooperative Agreement, was conducted by a four-person team between February 7 and February 29, 1984. The team convened in Washington where it was briefed by AID, the APHA and the University of Pittsburgh (PITT) and reviewed appropriate documents. Arriving in Jamaica February 12, the team reviewed additional documents, was briefed by the APHA Project Administrator and officials of the University of the West Indies (UWI), then consulted and interviewed UWI administrators and project-related faculty members, officials of the Government of Jamaica's Ministry of Health and Administrative Staff College, and the USAID/Jamaica Office of Health, Nutrition and Population. The team dispersed on February 17 to the other three Project-related countries, St. Lucia, Barbados and Trinidad/ Tobago, where they consulted, inter-alia, representatives of the respective Ministries of Health, UWI administrators and faculty, the USAID Regional Health Officer/Caribbean, PAHO, and the Caribbean Center for Development Administration (CARICAD). They made site visits to health facilities, and attended in-service training sessions being conducted under HDPM aegis. The Team reconvened in Jamaica on February 22, conducted additional interviews with UWI and PAHO, drafted its report, then verbally presented and discussed the findings of the evaluation with the

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Mona-based members of the HDPM Executive Committee, including the APHA Project Administrator, and with USAID/Jamaica. The team departed Jamaica February 29, after which the Team Leader (William Callen) completed and edited the draft.

The project has four major component activities:

A. On-Campus training, for which a post-baccalaurate diploma course in health management is to be established.

B. In-Service training, in which the UWI Department of Extra-mural Studies (DEMS) is to work with Ministries of Health of the four Project-related countries to provide in-service health management training of a type desired by each country's Project coordinating body, the Country Program Committee.

C. Research, developed to support the training and technical assistance components, is to be conducted through the UWI Institute of Social and Economic Research (ISER).

D. Technical assistance through indigenous experts, under which an indigenous pool of personnel skilled in management and planning is to be developed and/or identified, and a registry prepared and circulated.

The components and administrative/financial arrangements are discussed below.

A. On-Campus Training

This component, certainly the key component necessary to give the UWI the sustained capability to train health planners and managers, is behind initial expectations and, in-spite of repeated inter-faculty meetings, consultations and discussions during the APHA Internal Review conducted in July, 1982, is in danger of faltering. While the Faculty of Social Sciences has provided resources and generally fulfilled its obligations, the Faculty of Medicine has not made sufficient input to make even the on-going first course of a projected five-course diploma program proceed as planned. In part, this is a fault of Project design, which did not budget resources for this component and which either overlooked or ignored the workload in relation to responsibilities of the Department of Social and Preventive Medicine, that department which logically would provide most of the medical faculty's input. Additionally, the University Academic Committee has not yet formally established the proposed diploma program, nor officially designated the Faculty where it will be housed. The Team has recommended that the Project provide funding for additional staff support to the University in order to assist it to conduct the full diploma program beginning

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in the fall of 1984. The Team has urged the UWI to obtain official sanction for the diploma and officially designate the Faculty where it will be housed. Additionally, we have recommended administrative and budget changes which will better coordinate the on-campus program, including the development of curricula and the adaptation of existing training courses where appropriate. Finally, the Team considers it imperative that two complete rounds of the diploma program be conducted during the life of the Project in order to market the program and adequately test curricula. We have recommended that unless the diploma program is initiated during the fall of 1984, AID should seriously consider deleting this component of the Project and reducing funding accordingly.

B. In-Service Training

This component clearly is the most successful component, well-conceived and well-executed. Successful in-service management and planning training sessions, using a problem related modular base, have been conducted in conjunction with the Ministries of Health in St. Lucia and Barbados, and have just been initiated in Trinidad/Tobago. We feel the activity has great potential for adaptation and duplication in other Caribbean nations, and to bolster this potential, we have recommended that the process be evaluated for impact and the methodology more fully documented. We recommend that HDFM resources for in-service training be reduced in duration in Trinidad, given the high capability of that MOH Planning Unit. Since St. Lucia serves as a model for the lesser-developed nations, we recommend that the period of St. Lucia's in-service support be extended in order to further institutionalize and decentralize the process to district level. In Jamaica, UWI expertise and experience in in-service training might be productively shared with the ongoing training activities funded from resources other than HDFM. The ample availability of other resources to the Jamaican MOH leads the Team to recommend that HDFM funding not be used for in-service training implementation costs in Jamaica but only for technical advice. Finally, to expand the impact of this component, the Team recommends that the in-service training component be made available to two of the lesser developed Caribbean nations if they request it.

C. Research

The partners of the Cooperative Agreement opted for a two-pronged approach to health services research in health planning and management. The first was a general sector study, beginning with a State of the Art Study (SOAS) and an annotated bibliography, bolstered by additional sector studies suggested by gaps in the SOAS. The second approach was to conduct country specific investigations selected by the local Country Program Committees in each of the four targeted countries. The results to date are disappointing. The quality and utility of the research

generally has been low and completion slow. The most useful piece to date has been the annotated bibliography. We recommend that general sector studies beyond the ones completed or currently underway not be conducted, unless they clearly can be linked to the delivery of services and are subject to improved quality control, including the utilization of a research consultant (collaborating consultant), the request by a client, and monitbring of the research by a research task force. Similarly, we have recommended that ongoing country-specific studies be completed, but that additional country-specific studies be conducted only under the same quality control measures outlined above.

D. Technical Assistance through Indigenous Experts

The HDPM project has given less priority to this component than others; nonetheless, it has developed a computerized listing of over 100 names, about a fifth of whom are non-West Indians. The Team has recommended that attention now be given to screening the existing list and, in collaboration with appropriate regional institutions, increase efforts to identify greater numbers of West Indians skilled in planning and management to expand the registry. We have made recommendations to improve the quality of the Registry, as well as to soon give it a wide circulation. A second element of this component, establishment of a Resource Center at the Institute of Social and Economic Research, has proceeded quite well. Recommendations on this subcomponent deal largely with the acquisition of additional appropriate materials and their expanded utilization. Finally, we have recommended that the burden of the Registry eventually be taken from the AFHA Project Administrator and institutionalized at UWI, possibly in the ISER or within the Department of Extra-Mural Studies.

E. Financial Analysis

The evaluation team spent significant time looking at the financial reporting system, level of expenditure per line item, level of effort and pipeline analysis. There was also an attempt to estimate component costs.

The team recommends a modification in reporting to facilitate project management's use of the finance reports; some redistribution of line items; the development of a programmatic budget; an increase in the revolving fund and overhead rate of the UWI; and close supervision of the project expenditures in Year III to avoid cost overruns.

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F. Major Recommendations

The Team found the Administrative arrangements bewilderingly complex. They include AID central and regional organizations (AID-W, 'DO/C), AID/Jamaica, the APHA central and field office, University of Pittsburgh, UWI (with its two involved faculties and three campuses), and Ministries of Health of four sovereign nations. The Team feels AID and APHA have been remiss in signing or approving cooperative agreements and subcontracts which fail to more adequately delineate responsibilities and budgetary priorities between the recipient and sub-recipients of the agreements. As was the case in an earlier similar arrangement (Development and Evaluation of Integrated Health Delivery Systems - DEIDS), the arrangement eventually proved workable, but only because of good will and repeated permitted discrepancies between what was written and what was done. The project team has recommended that:

1) Prior to negotiating a similar arrangement in the future, recommend that AID should examine the contracting process, particularly from the standpoint of efficiency and accountability, in order to ascertain whether such complexity is is necessary. 2) The current agreements should be modified to strengthen the delineation of responsibility and to reflect that delineation through appropriate rebudgeting. 3) The role of the University of Pittsburgh should be altered to permit it (legally) to assist in research which, along with its involvement in the on-campus component, would appear to be a legitimate role. 4) Portions of the APHA budget should be shifted in order for UWI to arrange for inter-regional travel and consultation. The UWI, which appears in its sub-contract to have been given all implementation responsibilities for conducting the Project activities, has not been given adequate resources to do so. 5) UWI should rebudget its funds to adequately support each component activity. 6) The Administrative arrangements should be clarified, and a responsible UWI liaison person identified for each project responsible UWI liaison person identified for each project component. The heaviest onus resulting from the existing arrangements has fallen on the Project Administrator, who not being a part of the UWI faculty, has no administrative power within the University hierarchy, but must "administer" by advising, at the same time being subject to veto by cental offices in APHA and AID. 7) AID should provide adequate travel funds to facilitate legally required monitoring by the AID project officer, or make other administrative arrangements to permit it. The current administrative arrangements, coupled with existing agency constraints, have made it difficult if not impossible for the AID Project Officer to monitor the Cooperative Agreement adequately.

In closing, the team feels the goal and purpose of the Project remain valid, in that successful management and planning of health resources are necessary in the Caribbean and are appropriate areas for AID assistance. To accomplish the purpose of the Health Development Planning and Management Project,

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however, modifications based on the findings and recommendations summarised above are urgently required. AID and the collaborating organizations need to negotiate and legally finalize these modifications within the next three months in order to avoid serious project disruption and negative programmatic consequences.

SUMMARY OF RECOMMENDATIONS

AID and APHA Action

2.4.6 ✓ Project Design. At the final evaluation of the HDPM project, AID should carefully assess the administrative process, in terms of effectiveness, efficiency and accountability, to establish the feasibility and/or design conditions on similar programs with such complex administrative structure.

2.4.3 ✓ Project Management. The AID project officer should be authorized to attend the Project Advisory Board Meeting twice yearly and review project progress on-site. The APHA project manager in Washington should provide ons-site guandance and assessment with visits to the four participating countries approximately three times yearly, including participation in the Advisory Board Meetings.

2.4.4 ✓ Project Reporting. The project administrator should convene with APHA/W and AID/W four times yearly to review and discuss each quarterly report. He should also meet quarterly with RDO/, U.S.AID/Jamaica, PAHO and other appropriate groups to facilitate information exchange and coordination.

3.3.4 ✓ Implementation Deadline. UWI should proceed forcefully and expediently in attempting to begin the diploma program in Fall 1984. At least two rounds of training must be completed in order to establish a market for the program and to develop a tested curriculum. To have reasonable hope of achieving project expectations in regards to the on-campus component, it is imperative that the diploma begin as planned. Should it not begin in Fall 1984, AID should seriously consider deleting this component with concurrent reduction of funding.

4.5.4 ✓ Extension of In-Service Training. St. Lucia. The Ministry of Health and Housing, St. Lucia, should be invited to indicate its interest in extending the duration of the in-service component in order to further decentralize and institutionalize the planning and mangement functions of the FHC system. Should the Ministry be interested, the Project favorably should consider a well-justified plan for utilization of such an extension.

4.5.5 ✓ Staff-Tutor Position. - Trinidad/Tobago. AID should favorably consider ~~APHA's~~ a formally expressed request for the additional position requested.

7.8.5? UWI Overhead Increase. Consideration should be given to properly determining UWI's real overhead rate which is estimated by UWI to be much higher than the presently charged rate of 10%. UWI should be allowed to charge additional overhead to permit it to properly develop the institutional capacity to plan and respond to opportunities and potential contracts in the region. Capitalization is a basic foundation of institution building. This should not put an extra burden on the UWI budget because devaluation has reduced the Jamaican based project costs by 55%.

7.8.9? UWI Revolving Fund. Increase the revolving fund at UWI to $100-K. At present, UWI has over expended its revolving funds by $90,000. This is due to the reporting lag time between the three other project areas and Mona.

APHA and PITT Action

2.4.2 ✓ University of Pittsburgh. University of Pittsburgh should be asked to consult in the design and implementation of research activities as well as in the development of course materials and field experiences for on-campus training. Perhaps, they could also assist in the evaluation of in-service training. It is appropriate that the PITT liaison attend all Advisory Board Meetings; and if a project coordinating committee is formed, PITT should be invited to some if its meetings as a way to develop useful interchange.

6.5.1 ✓ University of Pittsburgh. The University of Pittsburgh should be invited to play an active role in research and the PITT subcontract modified to reflect health services research responsibilities.

7.8.2 ✓ PITT Other Direct Costs. A line item should be created in the PITT agreement to cover other direct costs. At present, PITT is expending ODC without a line item.

APHA and UWI Action

2.4.1 — Project Coordination. An operational project coordinating group should be formed chaired by the project administrator, and made up of the in-service education coordinator, the research coordinator and the on-campus training coordinator (Until the on-campus coordinator is appointed, the chairman of the curriculum working group should sit with this group.) This is an operational not an executive or advisory committee. It should meet monthly or even biweekly to share information and coordinate activities among the four program elements. The project administrator

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cannot take on the four operational roles - which belong to UWI - he can however, facilitate collaboration and move decision processes to the appropriate level.

3.3.3 ✓ Diploma Program Staffing. The Senior Researcher position has been formally transferred to a Course Coordinator position. This may not be enough. In addition to clerical and part-time staff support for the interdepartmental work group an additional full-time equivalent teaching staff position should be budgeted to carry out curriculum development and teaching in the diploma program. Creation of these positions should have priority for allocation of resources over all other project activities (except in-service), including UWI research, University of Pittsburgh consultancies and other expatriate consultancies. APHA and AID should take the steps necessary to promptly facilitate whatever re-budgeting is required.

4.5.7 Elimination of HDPM Support to Implementation of In-Service Training, Jamaica. Funds for management related in-service training for PHC is available from USAID/Jamaica sources through the Health Management Improvement Project. Accordingly, the more limited resources available to HDPM should be utilized in Jamaica only for technical assistance to providers of in-service training, while module development and implementation of training should be funded from other sources.

4.5.8 Consideration of Reduction of In-Service Component, Trinidad/Tobago. Because of the high degree of readiness and innate capabilities of the Trinidad/Tobago Ministry of Health and Environment's Planning Unit, it may be very likely that it can assume full responsibility for the in-service activity after 6-9 months of HDPM assistance. If so, HDPM could utilize its resources profitably elsewhere.

5.4.1 Use of Indigenous Consultants. HDPM should actively promote the use of indigenous consultants wherever possible, including teaming those with limited experience with consultants of greater experience. This teaming is particularly useful in areas of specialization which are inadequately represented in the region.

5.4.2 Registry Improvement. With input from the proposed working group, the Registry of Consultants should be should be refined to provide specific planning and management categories such as personnel, drugs and supplies as well as details related to work experience, research and publications, previous consultant

in the in-service component, and should be conducted in order for the results to be available to the Project by the time of the final external project evaluation.

4.5.2 ✓ Documentation of Methodology. The Project should more explicitly document its country-by-country in-service training methodology and process of module development for use as models for adaptation by other English-speaking Caribbean nations.

5.4.5 ✓ Resource Center Development. Consultant reports and project generated materials on all components should be indexed in the Resource Center. Key resource documents identified in the Annotated Bibliography of the State-of-the-Art Study as well as selected basic health planning and management literature, from international and indigenous sources, should be acquired and included in the collection.

5.4.6 Resource Center Dissemination. A categorical listing of Resource Center documents should be shared with Executive and Country Committees, PAHO, CARICAD, CARICOM< ASC/Jamaica and appropriate UWI faculty, with semi-annual addenda.

6.5.2 ✓ Research Coordinator. Designate a specific person (Research Assistant) at ISER to be responsible for Health Services Research who will coordinate with a resource consultant(s) at Pittsburgh to assist in defining research protocols and evaluating the three ongoing research studies (MIS, Trinidad; and Human Resources, Jamaica: final update of SOAS).

6.5.3 ✓ Research Quality Control. For any research beyond the 3 ongoing tasks in 6.5.2 above no research should be attempted unless:

a. It is a coordinated effort between all the different components of the project, including the training sections.

b. There are specific terms of reference and proscriptive detailed research protocols.

c. There is an interested and involved client, either Ministry of Health or a health organization, who will implement the findings of the study. In this context, groundwork must be done to determine if the particular research task is not duplicative or overlapping with other research.

* d. A qualified Caribbean principal consultant (principal investigator) is teamed up with an experienced collaborating consultant.

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activities and availability for short or long-term consultancies.

7.8.1 ✓ Programmatic Budget. A detailed project programmatic budget should be worked out in coordination with the project modification exercise, following the guidelines in 7.7 section. UWI should participate fully in this exercise. The detailed programmatic budget should also try to identify UWI inputs for planning purposes.

7.8.6 ✓ Budget Line Item Comparability. Each line item on all of the agreements should be brought into harmony. The UWI budget, for example, has three line items, different from the other agreement: innovative projects, training workshops and workshop materials. These could be collapsed into other direct costs (ODC), in-service or on-campus as the case may be.

7.8.7 ✓ Reporting Forms. The recommendations for reporting in 7.2 section should be implemented if the forms are satisactory to all concerned.

UWI Executive Committee Action

2.4.5 ✓ Executive Committee. The project team should consider rotating the executive meetings among the participating countries to promote increased focus on the non-Mona project activities.

Money - cost more. Over management

3.3.5 Faculty of Medicine Input. Every effort should be made to directly involve the Faculty of Medicine in the planning and implementation of the remaining first course and the entire diploma program for next year.

3.3.6 ✓ Study Grants. The project should consider supporting the economic costs of a selected number of promising health planners and managers from the non-campus countries for the next two years, to increase the potential for their participation given the small islands' economic constraints, and provide an expanded student base for the demonstration years of the program.

4.5.3 ✓ In-Service Training for Non-Campus Islands. The project should offer in-service training of the type developed in this project to at least two eligible non-campus nations should there be interest expressed by the nations. Such training should be coordinated carefully with a newly proposed UWI offering of a correspondence with a newly proposed course Certificate in Community Health Management, which will be offered on a challenge/outreach basis.

(+)

4.5.6 ✓ Expanded Role of Staff-Tutor. The project should

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expand the role of the three Staff-Tutors to include coordinating, monitoring and reporting responsibilities for all off-campus components of the HDPM Project.

4.5.9 Executive Symposia. If any additional Executive Symposia are to be considered, they should: be clearly justified on a specific country basis; be carefully designed to meet objectives; guarantee appropriate participation; and be systematically implemented to support the objectives of the other ongoing Project components. CARICAD and the Jamaica Administrative Staff College have demonstrated experience which could be appropriately tapped in planning and implementing such an activity, on a limited basis, but results should be carefully assessed and judged relative to other ongoing activities before being expanded further. Any future Executive Symposia should have the integrated input of all four Project components in the design, and preferably the execution, of the Symposia.

the Exec Symposia benefits the diplomat program.

5.4.3 ✓ Registry Dissemination. The improved registry of consultants should be disseminated and discussed at Executive and Country Program Committee meetings. It should be widely circulated to participating governments, international and regional agencies such as AID/W, RDO/C, U.S.AID/Jamaica, APHA/W, UWI, University of Pittsburgh, Adminstrative Staff College in Jamaica, PAHO, CARICOM, CARICAD, OECS, consultants and other appropriate entities.

5.4.4 ✓ Institutionalization of Registry. The registry should be institutionalized at UWI, either in the Department of Extra-Mural Studies or at the ISER Documentation Centre, preferably by the end of Year IV.

5.4.7 ✓ Technical Assistance Coordination. The Project should more effectively link the technical assistance component with in-service training. The In-Service Training and Development Coordinator should use her contacts in the country training activities to help identify and screen potential consultants. Consultants should also be included in the in-service training programs as appropriate, either as resource personnel or as participants who could benefit from further training and experience.

6.5.4 ✓ To the extent that project management feels that research can/cannot be effective and quality control implemented, the Executive Committee should seek to negotiate for reallocation of research resources.

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7.8.3 Allocation of Consultant Funds. If feasible, the remainder of the line item "consultants" should be moved from PITT's budget to APHA's budget 1/3 and UWI's budget 2/3. This represents the present consultant use ratio. The chairman of the Executive Committee should be responsible for all decisons relating to UWI project unexpenditures.

7.8.4 Allocation of Travel Funds. If feasible, the travel budget should be reallocated between APHA's budget 1/3 and UWI's budget 2/3. UWI would expend from this line item following its quarterly travel plan. Regional travel arangements would be cleared with RDO/C and extra-regional travel with AID/W, S and T Health.

UWI Programmatic Action

3.3.1 ✓ Administration Diploma Program. Either UWI Vice-Chancellor Preston or Pro Vice Chancellor Robinson should immediately confer with the two Deans of Medicine and Social Science to confirm whether they endorse administrative placement of the Health Management Diploma Program within the Faculty of Social Science - If so, the decision must be officially established. This was the recommendation of the December, 1982 Curriculum consultancy Committee - but it is not clear whether it has the support of both faculties and is still considered the best course of action.

3.3.2 Curriculum Planning. The most critical issue facing HDPM at UWI is adequate staffing and the administrative approval of the on-campus diploma program in health management. Staffing was a critical omission in design of the project and it must be remedied immediately. An inter-department work group responsible for development of the diploma program was established by the 1982 Curriculum Consultancy Committee. This work group should be reactivated. Planning needs to occur for student enrollment in already existing course modules and teaching resources identified for new course modules. If part-time money is required for work-group activities, it should be provided by HDPM. UWI should assume the leadership in the work group activity and not let it fall to the Project Administrator who is not a UWI staff member.

4.5.1 Impact Evaluation. The Project should develop an evaluation plan, collect appropriate data and conduct an analysis in order to assess impact and/or outcome of the in-service training component in at least the three nations where in-service training is now underway. The evaluation design and implementation should include input from evaluation experts not intimately involved

e. A research task force for each research project is formed to accomplish a,b,c,d above, composed of:

a. Research Coordinator, ISER

b. Principal Consultant, (principal investigator)

c. Rep. of Local Country Committee or Rep. of Client (user group)

d. Collaborating consultant, participant from other organizations who might have experience in similar research.

7.8.8 ✓ <u>Salaries of Positions</u>. New job slots in the direct salaries line items should be created as needed for UWI and identified by project modification. The title of Senior Reseacher should be changed to On-Campus Coordinator to cover the costs of executing that function.

7.8.10 ✓ <u>Cash Flow and Programmatic Accounting</u>. The existing budget should be followed to avoid a cash flow problem (see section 7.5). The new programmatic budget should be implemented following project modificaton and strictly adhered to. All accounts should be kept by the recipient on a programmatic basis.

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1. BACKGROUND

1.1 Mid-Project Evaluation Procedure

This report contains the findings of a project evaluation carried out during February, 1984. The external evaluation team consisted of four consultants appointed by AID. They were directed to complete a mid-project evaluation of the Health Development Planning and Management Cooperative Agreement between AID and the American Public Health Association (APHA), including collaborative sub-agreements between APHA and the University of the West Indies and the University of Pittsburgh. Members of the evaluation team were as follows:

William Callen, Ph.D., School of Public Health and Community Medicine, University of Washington, Team Leader.

John Burns, Management Sciences for Health, Boston

M.M. Shutt, M.D., School of Medicine, University of North Dakota.

Anne Tinker, Office of Health, Bureau of Science and Technology, A.I.D./W.

The evaluation procedures are described in Appendices. Appendix 1 contains the evaluation Scope of Work. Appendix 2 identifies all individuals interviewed by the evaluation team. Appendix 3 provides a list of project documents reviewed.

Preparatory work for the financial and budgetary evaluation was begun by Mr. Burns at APHA on February 2, 1984. The full evaluation team gathered in Washington, D.C. on February 7, 1984. They reviewed the AID project files and subsequently were briefed by principals from AID, the University of Pittsburgh and the American Public Health Association. The following week the team traveled to Jamaica where they were briefed by the APHA Project Administrator, and interviewed University of West Indies administrative officials, members of the Departments of Extra-mural Studies, Government. Management, Social and Preventive Medicine, and the Institute of Social and Economic Research. They also met with officials from the Jamaican Ministry of Health, the Jamaican Administrative Staff College, and U.S.AID/Jamaica staff. Early in the third week, the team split up to travel to Barbados, St. Lucia and Trinidad. There they met with University faculty, Ministry of Health, AID/RDO Health Officer, CARICAD, and PAHO U.S.AID/Jamaica representatives who had cognizance of the HDPM Project. In mid-week they returned to

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Jamaica where the team met with the UWI Vice Chancellor, PAHO, and then met in executive session and drafted this report.

The findings of this report have been discussed with members of the Project Executive Committee resident at the University of the West Indies, Jamaica campus. The report has also been shown in draft form to APHA and the AID Project Officer. Thus, while all concerned may not entirely agree with this document, it has been prepared in such an interactive manner that it represents the reasonable input of all concerned.

1.2 A.I.D. Objectives for HDPM

The central Science and Technology Bureau of AID/W initiated the Health Development Planning and Management (HDPM) Project as a means to develop indigenous health management expertise within countries or regions where such expertise was needed. The HDPM project was designed to provide something more than short-term, ad-hoc management training. The goal is that institutionalized health planning and management training resources be brought about within developing countries. Indigenous resources will reduce country dependence on donors for training. The HDPM Project, if successful, would also accelerate the process of upgrading quality of health management in countries benefitting from Project grants.

The HDPM approach is particularly appropriate since the social, political and cultural conditions of individual countries cannot be fully addressed by external consultants and foreign based training institutions. Thus, HDPM presents an alternative to programs which invite senior level health managers to US and other foreign universities for graduate level training. In addition, the HDPM initiative has been timely because there are countries and regions that have the institutional readiness to move in the direction of self-reliance in health planning and management training.

Five planning grants of $50,000 each were awarded to organizations wishing to develop a cooperative program between a U.S. institution with expertise in health management and a country or region whose health sector and related training institutions wished to develop their indigenous expertise. Two competitively bid five year Cooperative Agreements were then awarded in September 1981. One was to Johns Hopkins University in collaboration with Indonesia. The other, the subject of this evaluation report, was to the American Public Health Association in collaboration with the University of the West Indies and the University of Pittsburgh.

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The University of the West Indies has three campuses and is supported by fourteen Caribbean nations. The HDPM Cooperative Agreement designated cooperative health sector activity in three of these nations: Jamaica, Barbados, and Trinidad, which have UWI campuses, and in St. Lucia, a non-campus country.

A review of selection criteria for award of the collaborative agreements indicates that HDPM was intended to be an adaptable, developmental project. Forty five (45) points were awarded for conceptual design and understanding of the objectives addressed by HDPM; thirty five (35) points for qualification and experience of collaborating groups; while only twenty (20) points were awarded for project planning and staffing. Clearly it was not expected that planning for detailed outputs and inputs (such as those of a log frame matrix) be the principal measure of eligibility for the HDPM project. The project award was based on the experience of the collaborators and their ability to understand and flexibly implement the goals of institutional development in health planning and management training.

The Request for Application (RFA) noted that the type of program and pace of development would vary with the countries involved. It encouraged initiative in design and implementation to meet country specific needs. However, the RFA did insist that projects actively involve the Ministry of Health plus other major public health institutions and development ministries such as Planning, Finance and Interior. The RFA also exhorted the collaborating institutions to develop multiple training curricula suitable to students from all levels and all areas of operations, including opportunities for in-service education. The RFA urged that curricula make use of materials based on case studies and data from indigenous health sector operations.

1.3 Collaborating Institutions

American Public Health Association APHA was the lead agency in planning the Caribbean HDPM project and it is the prime recipient of the Cooperative Agreement with AID. Thus, it is responsible for fiscal management of the Project and overall project administration. It negotiated sub-contracts with the two collaborating institutions. As prime contractor, it has the prerogative of defining roles and responsibilities and, more importantly, redefining activities and budgets as the Project evolves. (Note: Any such redefinition is subject to concurrance by AID.)

University of Pittsburgh. Because APHA is not a training institution and the HDPM project is intended to assist the Caribbean nations in establishing and strengthening their health management training resources, The University of Pittsburgh joined the proposal as a university resource with previous ties to the Caribbean and well established programs in health management and planning. The designated principal investigator from the University of Pittsburgh was Gordon McLeod, MD., then

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Chairman of the Department of Health Services Administration in the School of Public Health. The School of Public Health has previously collaborated with Prof. Standard's UWI Department of Social and Preventive Medicine in an A.I.D. funded family planning education project. Thus, University of Pittsburgh was no stranger to Jamaica and UWI.

University of the West Indies UWI began at Mona, Kingston, Jamaica in 1948 as a University College affiliated with the University of London. In the early 1960's UWI became an independent university and established two other campuses, one at St. Augustinne in Trinidad and the other at Cave Hill, Barbados. The institution has eight faculties (called schools in the American system) including Medicine, Social Sciences, Natural Science, Arts and General Studies, Agriculture, Engineering and Law. Each Faculty has a Dean at one campus with a corresponding Vice-Dean at each of the other two campuses. Although theoretically all campuses are equal, the Mona, Jamaica, campus is the oldest, the largest in enrollment and holds the deanships in Social Sciences and Medicine which are critical for this project.

UWI serves the English speaking Caribbean Islands. It is financially supported by fourteen separate Caribbean nations (CARICOM), the three larger of which are the seats of the three UWI campuses. As a typical university with many departments organized into faculties using the consultative and committee governance structure normal to universities, UWI governance is further complicated by having each of its faculties spread over three semi-autonomous, geographically far-flung campuses. Thus, approval of new programs on one campus requires the concurrence of parallel committees on two other campuses. This is not unworkable, but it clearly takes longer to formalize new programs under such a system.

During the planning phase of this project, several UWI Departments played a key role. The Department of Social and Preventive Medicine in the Medical School was a principal in design of the project. Professor Sir Kenneth Standard, Head of that department, was named as UWI principal investigator in the proposal submitted in reponse to the AID's request for a cooperative agreement. UWI also has a very active department of Extra-Mural Studies which has administered many technical and certificate programs and has branches throughout CARICOM. The Department of Extra-mural Studies was involved early in project planning. It continues to play an active role in the Project by carrying out the in-service training component. The Faculty of Social Sciences had three groups designated to play a role. The Department of Government (public administration), the Department of Management (business administration) had the disciplines complementary to the Department of Social and Preventive Medicine in development of on-campus training in health management. Finally, the Institute of Social and Economic Research (ISER) in the Faculty of Social Sciences was designated to carry out project research.

1.4 Caribbean Regional Needs

The state of health management in many Caribbean countries is the object of continuing concern. This concern stems from several sources:

- inadequate reform of systems inherited from the colonial period to make them responsive to national conditions and needs;
- deficiencies in services to the people and mismanagement of scarce resources; and
- inappropriateness of management systems to implement new health policies that emphasize primary health care, improvements in coverage, and intersectoral collaborations in health.

The need then, goes beyond merely providing current services more efficiently but requires an extensive reform of systems at all levels and the development and delivery of substantially revised programs.

The HDFM project seeks to support these national efforts through its training, research and technical assistance components. In order to understand whether the HDFM Project is relevant and effective, the management training needs of Caribbean health managers must be understood. To this end it is useful to identify pertinent findings from a recent field survey, based on interviews and observations, that examined the situation of Caribbean health managers. The terminal report of an extensive one year project conducted by Dr. S. Kelley Moseley in 1976-77 contains important information regarding the training needs in Health Administration for the Caribbean (Moseley, S.K. "Training of Health Administrators in the Commonwealth Caribbean: Terminal Report," WHO/AMRO, 1977).

The needs assessment conducted by Dr. Moseley in preparation for the development and implementation of courses for teaching health administration in the region, characterized the needs for management training at the macro level in five areas. A summary of the problem areas identified is as follows:

1. Following independence from the British Colonial experience, local governments became responsible for not only providing health care, but ensuring economic progress, improving road, housing, and a variety of other activities in a developing economy. As priorities necessarily were directed to critical demands "funds for health education and management were placed in a very low priority."

2. Managers of the systems were generally trained as administrators, operators or clerks, not as policy makers or decision makers; this resulted in a highly centralized

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organization where most decisions were being made at the Ministry, Permanent Secretary or Cabinet level.

3. Senior decision makers in the health system were characterized as generalists, lacking substantive training and knowledge in either health or management. Identification of professional confrontations between physicians and nurses and the Permanent Secretary was cited as an illustrative example of this problem.

4. Day-to-day operations of the health system were guided by policies and procedures carried over from the colonial period and created barriers for individual initiative, innovation and work performance.

5. Career development and promotion procedures were based on seniority rather than merit evaluation.

Moseley's survey of 30 government and health leaders of the Caribbean revealed that over 70% felt that the major problem facing the health system was a lack of health organization.

At the micro level of management needs for individuals, Moseley identified the importance of proficiency in dealing with environmental, organizational and interpersonal aspects of management. He also emphasized the importance, if management change and improvement are to occur, of vertical integration of management training programs at three basic levels in the administrative structure, i.e., policy makers, mid-level managers, and supervisors.

2. ADMINISTRATIVE ARRANGEMENTS

2.1 TERMS OF THE COOPERATIVE AGREEMENT

The Cooperative Agreement between AID and APHA was signed on September 30, 1981. The Cooperative Agreement identified a long term goal, three short term goals, four major activities, a series of tasks under each category of activity along with a set of outputs related to each activity. Key personnel were identified and a general project budget was identified allocating $2,500,000 over five years in approximately equal annual increments.

The long term goal of the Caribbean HDPM is to build an indigenous and self-sustaining capability for health planning and management in the Caribbean Countries. The short-term goals is to establish an institutional capability at the University of West Indies to:

A. Train health planners and managers

B. Give (indigenous) technical assistance in health planning and management to Caribbean Governments and health sector institutions.

C. Conduct an applied health services research program to improve service delivery.

Four major activities were agreed upon to meet the goals. Training was to include (i) in-service training through UWI Department of Extra-Mural Studies and (ii) on-campus training through the combined Faculties of Medicine and Social Sciences. (iii) Health Services research was to be carried out through the UWI Institute of Social and Economic Research. (iv) Technical assistance was to be carried out through an indigenous pool of health management personnel.

The project tasks and outputs proposed in the cooperative agreement and sub-agreements will be discussed in following chapters of this report. A separate section will be devoted to each of the four agreed upon activities. In general, the specified tasks call for needs assessment, planning, implementation and evaluation of each activity. Two or three briefly described outputs are identified for each activity.

Six key personnel were identified in the cooperative agreement. They included Dr. MacLeod from University of Pittsburgh, the program Manager, Dr. Gerald, and a project administrator (to be named) from APHA, plus an in-service training coordinator and two in-service resident tutors from UWI. It is not clear why resident tutors (to be named) were considered key personnel. Dr. Standard of UWI was not designated as one of the key personnel. In fact, no one at UWI outside the Department

of Extra-Mural Studies was listed as key personnel. Thus key personnel at UWI were designated for only one of the four activities, and no named faculty person at UWI was identified as key.

Project managment suggested that the omission of named key personnel from UWI was deliberately done to foster institutional, not personal, responsibility for program development and to avoid the unnecessary complication of AID approval for key personel changes. In the opinion of the evaluation team, however, institutions are made up of people, some of whom are truly "key" to designated activities. AID would not have been remiss if it had insisted that key personnel from UWI be named.

2.2 PROJECT ADMINISTRATION

Project Administration is highly complex, involving several AID offices, three collaborating institutions in different locations, five university faculties on three distinct campuses, four different ministries of health, dissimilar core groups for training in each country, and several advisory and operational committees. The Project design did not clearly or adequately delineate administrative, technical and budgetary authorities and responsibilities between the collaborators and interested parties.

AID has had earlier experience using a tripartitile arrangement with APHA and an American University working collaboratively with developing country institutions. As was the case in the development and evaluation of Integrated Health Delivery Systems (DEIDS) project, the arrangement eventually, proved workable, but was difficult to get started.

At the final evaluation of the HDFM Project, AID should carefully assess the administrative process, in terms of effectiveness, efficiency and accountability, before embarking on a similar program with such a complex administrative structure.

AID. Project administration has involved a number of AID personnel with different responsibilities and perspectives. The cooperative agreement designated the AID Project officer in the Office of Health, Science and Technology Bureau, as the responsible person for providing technical and programmatic direction for the Project. This level of authority, plus the requirement of AID concurrence in all staffing and budgetting revisions implies the need for consistent, constant and on-site Project officer involvement, However, travel budget constraints have severely limited the ability of the Project Officer to adequately guide and monitor project activities in the field. Furthermore, there have already been three different Project Officers assigned during the first two and one half years.

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AID's Health and Nutrition Division of the Bureau of Latin America and the Caribbean participated in the review and selection of the APHA HDPM proposal. The Division continues to provide regional guidance and review to S&T/H. The Regional Development Office for the Caribbean (RDO/C) in Barbados reviews and clears all travel within the Caribbean and serves as the Project's regional AID liaison. USAID/Jamaica coordinates HDPM activities in that country with other ongoing bilateral and central activities.

The distance of the Project Officer from the field site and travel restrictions which prevent systematic monitoring, some friction between the central office's demonstration Project objectives in the large islands and RDO/C's focus on the poorer small islands, and continuously changing personnel in all offices have made effective program management difficult. Transfer of project management to the region would be desirable, but seems unworkable given the fact that the Project involves activities covering countries with two different AID local offices, and that RDO/C and USAID/Jamaica feel their staff is fully occupied with a work load of bilateral and other regional projects. Both RDO/C and USAID/Jamaica encouraged more systemmatic reporting of HDPM activities, as well as coordination with other donors, particularly, PAHO and CAFCAD.

APHA. APHA/Washington handles day to day administration, consultancy approvals, budgetary and expenditure processing, record keeping and the final preparation and distribution of reports, as well as the payment of consultant and travel expenses. The Project Manager maintains contact with and secures project activity approvals from the AID Project Officer. He also provides guidance to and approves activities of the Project Administrator in Jamaica, as well as activities of the subcontractors.

The Project Administrator, assisted by a UWI appointed assistant and secretary, is located in the Department of Extra-Mural studies at the Univesity of West Indies, Mona campus. The location is appropriate as the Mona Campus is the administrative center of the institution which the Project seeks to strengthen. However, as is mentioned elsewhere, the Project Administrator is not on the UWI staff and therefore, cannot act for UWI nor can he require their action. If he acts for APHA he is always subject to correction from the program manager in APHA/Washington. His location at Mona also distances him from the other UWI campuses and ingenders perceptions of the project as a Mona-centered activity. A final dilemma confronting the role of the Project Administration is that he is a West Indian paid in U.S. dollars on a U.S. salary scale. This has created a not unjustifiable resentment on the part of UWI staff who are paid several times less than the Project Administrator.

The Project Administrator is Executive Secretary to both the Advisory Board and the Executive Committee. His job description includes responsibility for project communication,

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collaboration among relevant parties, compliance of project activities, quality of products, evaluation and project modification, and supervision of the HDPM project staff, Resource Center and consultant registry. We feel that his role in the project team, particularly with respect to UWI, needs to be more clearly delineated, so that UWI, not the Project Administrator, is held accountable for specific tasks more directly. He can then facilitate communication, coordinate activities, call elements to account if they are not performing as expected, and bring them together in problem solving sessions when problems arise and decisions are needed.

The Project Administrator has performed in a competent and and dedicated manner and accomplished considerable progress with minimum friction under complex and difficult circumstances. The team feels, however, that he should not undertake tasks appropriately the resposibility of UWI and that his principle task should be to improve communication and coordination systems to facilitate information exchange.

The internal evaluation of August 4, 1982, recommended a newsletter be circulated regularly on the Project. The first was developed at the end of 1983 but never cleared by APHA/W or distributed. We feel that an additional burden of paperwork on the Project Administrator is not necessary, and that the quarterly reports, coupled with regular personal inter-change, will provide effective information sharing and coordination.

2.3 SUB-AGREEMENTS

University of Pittsburgh - Two sub-contracts were signed under the collaborative agreement. The sub-contract between APHA and the University of Pittsburgh indicates that the University of Pittsburgh will make consultant services available as they are identified in the project's annual work plans. University of Pittsburgh agreed to provide up to a maximum of 12 person months consultant services per year plus 10 person months secretarial services and up to 3.75 person months of Dr. MacLeod's services as liaison officer for the sub-agreement. Consultation was to be provided in the area of in-service training and on-campus training. Consultation in development of research and technical assistance was not included.

There was significant delay in signing the APHA-Pittsburgh sub-contract. It was finally negotiated and signed at the end of the first project year - one year late.

The role of the University of Pittsburgh symbolizes a dilemma inherent in the design of the project. The project is intended to transfer American capability in health management training to the Caribbean but on the other hand it is to use and develop management expertise acknowledged to be already extent in the Caribbean. Pitt was given no contractual role in research. Its help with in-service training was not needed. When the

curriculum consultancy committee was formed, and charted the course for on-campus training, Pitt played no role - and none was assigned for the future. We feel that Pitt could have been more proactive in identifying ways to be helpful and offering its services, rather than merely waiting for assistance requests.

University of West Indies - The APHA-UWI subcontract was quickly negotiated and signed by December 1981. Everyone of the detailed activities, inputs and outputs identified in the cooperative agreement between AID and APHA are repeated word for word in the UWI sub-contract. The sub-contract further states: "the subrecipient (UWI) will be responsible for all professional and technical activities of this sub-agreement." In other words, responsibility for the entire set of activities designated in the original cooperative agreement were formally delegated to the University of the West Indies as sub-contractor. Given this heavy load of responsibility which seems to have been accepted by UWI , it is quite remarkable that no individual in the sub-contract has been designated as liason officer or manager of activities. Again, the only key person identified is the coordinator and two resident tutors for in-service training. The budget does show that provision had been made for two research staff but not as key personnel. No positions or salary were budgeted for staff to carry out on-campus training or technical assistance activities.

It is hard to understand how the sub-contract between APHA and UWI could have received approval from AID. Furthermore, it is difficult to understand why either APHA or UWI would negotiate a contract that delegated such a broad range of responsibilities with no provision made for the staffing and resources needed to carry out all necessary activities.

The tontract between APHA and UWI should make clear what APHA is responsible to do versus what UWI is responsible to do. The way the contract is written each side is responsible for everything.

This error in design is symbolized in the role of the project administrator. He is expected to do everything but his legitimate power is limited. He cannot act for UWI, nor can he make them act if they do not want to cooperate.

Despite the fact the the project administrator is not a UWI employee, his coordinating role is key. UWI activities fall into several organizationally separate departments. If a UWI liaison were appropriately designated for each of the separate activities the project administrator could play an essential role in planning and coordinating activities.

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2.4 RECOMMENDATIONS

1. Project Coordination

An operational project coordinating group should be formed chaired by the project administrator, and made up of the in-service education coordinator, the research coordinator and the on-campus training coordinator. (Until an on-campus coordinator is appointed, the chairman of the curriculum working group should sit with this group.) This is an operational not an executive or advisory committee. It should meet monthly or even bi-weekly to share information and coordinate activities among the four program elements. The project administrator cannot take on these four operational roles - which belong to UWI - he can however, facilitate collaboration and move decision processes to the appropriate level.

2. University of Pittsburgh

University of Pittsburg should be asked to consult in the design and implementation of research activities as well as in the development of course materials and field experiences for on-campus training. Perhaps, they could also assist in the evaluation of in-service training. It is appropriate that the PITT liaison attend all Advisory Board meetings: and if a project coordinating committee is formed, PITT should be invited to some of its meetings as a way to develop useful interchange.

3. Project Management

The AID project officer should be authorized to attend the Project Advisory Board Meeting twice yearly and review project progress on-site. The APHA project manager in Washington should provide on-site guidance and assessment with visits to the four participating countries approximately three times yearly, including participation in the Advisory Board Meetings.

4. Project Reporting

The project administrator should convene with APHA/W and AID/W four times yearly to review and discuss each quarterly report. He should also meet quarterly with RDO/C, USAID/Jamaica, PAHO and other appropriate groups to facilitate information exchange and coordination.

5. Executive Committee

The project team should consider rotating the executive

meetings among the participating countries to promote increased focus on the non-Mona project activities.

6. Project Design

At the final evaluation of the HDPM project, AID should carefully assess the administrative process, in terms of effectiveness, efficiency and accountability, to establish the feasibility and/or design conditions on similar programs with such complex administrative structure.

3.0 CAMPUS-BASED TRAINING

3.1 Design

On-campus training activities under this project were planned tb achieve three major project outputs. The outputs promised in the contract are as follows:

1. A cross-faculty (Medicine and Social Sciences) degree granting program in health management with curricula adapted to the Caribbean region.

2. Four courses on specialized topics of concern to health management in the Caribbean, for degree/diploma certificate students.

3. Trained UWI faculty to teach the degree granting program.

As was pointed out earlier, HDPM was funded with adaptation and development in mind. It did not begin with a carefully designed, predictable set of inputs and outputs. Thus, it should come as no surprise that the outputs envisioned midpoint in the project are both different and more specific than the original outputs. What is not always clear from the semi-annual reports and work plans is just how and why change occurred in the expected outputs. The change and some background for the change is described here.

3.2 Progress To Date

First, a degree granting program is not planned at this time. The decision has been made that a one year diploma program will be instituted instead. A diploma program is a graduate level program of one or more years that accepts post baccalaurate students plus experienced personnel who are considered to have the practical equivalent of a bachelor's degree. The diploma differs from the certificate in as much as a certificate is normally an undergraduate program that is shorter and less extensive than a degree program. Neither a certificate nor a degree program is planned at this time. If a degree program had been initiated, it would had to have been a bachelor's level (three year) program, because a master's program could not exist without a bachelor's as prerequisite. Thus, a diploma program that would attract experienced students from a variety of health related backgrounds was the preferable choice.

The second output promises four courses in specialized topics of concern to Caribbean health management. It should be made clear that a "course" in the British University (UWI) context refers to a sequence of studies covering a full academic year. Just one course in this context is equivalent to two courses in a semester system or three courses in a U.S. quarter system. To project an output of four courses implies the

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addition of a large amount of new curriculum materials and the addition of almost two full time staff -- something never envisioned in this program. For instance, the new one year diploma in health management would normally consist of five courses plus a summer internship. To require an output of four new courses would imply that 80% of the diploma program would rely on new course materials, rather than using/modifying existing courses from the collaborating departments. This is unrealistic. Even at this point in time, it is difficult to quantify how much new course material should be expected as a project output. However, since one new course, Health and Social Organization, has been designed and is currently being offered during the 1983-84 academic year, the course outputs one could reasonably project at this time might be stated as follows: At least one new course of spcialized concern to Caribbean health management will be designed and offered to diploma/degree students and enough additional courses or course modules in health management will be offered to form an integrated diploma program in health management.

The output projected to train faculty to offer relevant courses is still valid, except that they must teach in a diploma rather than a degree program. A good beginning to this faculty development goal was made in September, 1983 when the Social Sciences staff involved in the new Health and Social Organization course participated in a course planning/faculty development workshop at the University of Pittsburg.

Early in the second year of the project a curriculum development process for on-campus training was begun at UWI. A senior consultancy committee was formed under the chairmanship of Prof. Mills, Dean of Social Sciences. Other members of the committee were:

Mr. U. Salmon, Head, Department of Management

Dr. E. Jones, Head, Department of Government

Prof. Sir K. Standard, Head, Department of Social and Preventive Medicine

Prof. Rex Nettleford, Head, Department of Extra-Mural Studies

This team was assisted by two external consultants: Morris Schaefer, DPA, University of North Carolina and Clara Kimbro, D.Sc., Johns Hopkins University. In addition, seven staff from the cooperating departments participated along with the HDPM Project Administrator.

The consultancy committee report, dated December 1982, documents the need for health management improvement and confirms the plan for a one year, five course diploma program in health management (See Appendix B). The report stated that this was to be a joint Faculty program administratively based in the Office

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of the Dean of Social Sciences. Course titles and content areas were identified, along with topic areas to be included in teaching. Content of topic areas, interconnection between topics and faculty resource areas for each topic were identified.

To follow up on this curriculum plan, an inter-departmental working group was designated, comprised of the seven staff members present and the HDFM project administrator. Under guidance of the HDFM executive committee, the working group was assigned a series of tasks preparatory to three outcomes: (1) implementation of first course in health management to be offered in 1983-1984, (2) implementation of a diploma program to be offered beginning in 1984-1985, (3) consideration and provisional planning for including a six month internship with the diploma program. The work group was directed to develop a specific, phased implementation plan including student recruitment, course scheduling (making use of existing course and module offerings in other diploma programs), and development of modules and courses unique to the new diploma program. The document does not define how leadership of this working group was to be determined. In the absence of a designated chairperson, it could be assumed that the leadership role fell to the project administrator.

In the fourteen months between the publication of the Curriculum Consultancy Committee report and now, some progress has been made. But some serious pitfalls have also emerged. At this time the development of a strong on-campus training program is seriously at risk of failure and in the opinion of this evaluation team, strong, immediate action must be taken to recover much of the ground cost.

Progress following December 1982 Curriculum Proposal. In the Spring of 1983 it became apparent that a senior faculty person would be required to coordinate development of the diploma program. An individual was identified who was acceptable to both Medicine and Social Sciences. Preliminary discussions were held and the project administrator then wrote the AFHA program manager asking that this person be hired under the AFHA contract since the UWI salary scale was too low to attract such a candidate. Dr. Gerald appropriately noted that hiring directly through UWI was the correct procedure. He stated that a contract modification would have to be received and approved by AID/W because both a new position and rebudgeted funds would be required. He noted that the process would take six months to negotiate and legitimize. In late June, the Project Administrator appealed again asking that some way be found to hire the candidate on the AFHA budget. At this point, there was a hiatus of three months, presumably allowing informal discussion of the issue between the principals involved. Finally, in October, Dr. Gerald formally responded to Mr. Thelwell clearly refusing to proceed in hiring the candidate as an AFHA employee and stating that the UWI should decide whether they wish a contract modification to create a new position. At that point the Senior Researcher resigned and a position became vacant in the UWI contract budget. It was decided to transfer the senior

researcher position to on-campus training coordinator, and the AID project officer subsequently approved the action. While negotiations were underway attempting to hire the candidate in question, there was further devaluation of the Jamaica dollar. The candidate turned down the job because the UWI salary offered was inadequate. In effect an entire year has been lost attempting to recruit a certain candidate and the diploma program is now in urgent need of a coordinator to plan for courses for the coming academic year. A new recruitment process is beginning. We can only hope that UWI will act expeditiously and that AFHA through Dr. Gerald and Mr. Thelwell will do whatever can be done to facilitate and support the University recruiting and hiring process. If the diploma program does not begin in Fall, 1984, the whole project is vitiated.

1983-84 Course in Health and Social Organization. This course was developed as a pilot course for the diploma program. It was designed to include four topic areas - two be taught by staff from the department of social and preventive medicine and two to be taught by social sciences staff. The on-campus training coordinator was expected to teach the two medical care topics while social sciences staff were assigned to teach the other two topics. Because the coordinator had not been recruited the order of topics was reversed and four social sciences staff began team teaching the course in Fall, 1983 as scheduled.

Before the course began the teaching staff traveled to the University of Pittsburgh where they participated in a faculty development workshop on team teaching methods and course content. Nine students were enrolled. (Three subsequently withdrew because they learned that University regulations prevented applying course credit toward the as yet unapproved diploma program.) At the end of February when the social sciences topics were complete, a teacher for the medical care components had not yet been identified. Since the Department of Social and Preventive Medicine did not have staff available, a younger physician is being recruited from the Ministry of Health to teach the remaining course topics. The team teaching approach will continue so it can be expected that the inexperienced teacher found, if she accepts the position, may have the benefit of peers on the team to successfully complete the course.

One of the students and all the social sciences teachers were interviewed about the course. Evaluation report by Ms. Browne, Course Coordinator, was also reviewed. In general the course has been satisfactory. The students noted the lectures were good but their tutorial (discussion) sessions were too often cancelled - presumably because of a lack of Caribbean specific case materials for the course. The faculty appeared to have worked hard and responsibly but they were unhappy that additional part-time pay proposed for their extra work had not yet been received. (The project administrator told us the pay is coming but the paperwork had been delayed or misplaced within the UWI system.)

Formal University Approval of the Diploma Program. Before the first course began it was submitted to the Faculty of Social Sciences for approval. At that time they also approved in principle the concept of the diploma program. This spring the additional four courses and the diploma program as a whole must be submitted to the Board of Studies at each of the three campuses, then to the Social Sciences Faculty Executive Committee (May) and then to the University Academic Committee (last meeting in June). Nothing to date has been done to solicit these committee approvals. The time schedule is now such that expeditious action must be taken if the program is to be approved to begin in the Fall.

At the same time as Social Science Faculty approval is being elicited, a similar process will be pursued with the Faculty of Medicine. Although the diploma courses will not be offered in Medicine, the staff from Social and Preventive Medicine will be expected to teach and examine students in the diploma program. When the concurring approval of the pilot course was requested last June, the Faculty of Medicine asked for more documentation before they could concur in setting up the course. Thus, concurring approval of the diploma program cannot be expected on a mere courtesy or pro-forma basis. When interviewed, the Dean of Medicine, Dr. Wray, did state that approval of the courses and the diploma program could be expected from his Board of Studies in March.

All in all, the failure to recruit an on-campus training coordinator, the misadventure in lining up medical faculty to teach the pilot course and the extensive committee reviews required to approve the diploma by June gave the evaluation team a great sense of anxiety about the future of the diploma program. Added to the delays is the problem of student recruitment. Informal student recruitment must begin before the diploma is officially approved. Students from ministries of health should now begin the process of applying for study leave. Applications must be received and most study leave positions allocated before June. Informal student recruitment can be done, but it is not the customary procedure, and it is doubtful whether informal recruitment will elicit applications from outside Jamaica. To encourage applicants from small island countries it seems expedient that money be put in the budget to pay the economic costs of training from small island countries.

One final comment should be made about the status of the Faculty of Medicine in this project. Dean Wray recognizes that the diploma program is now expected to be housed in the Faculty of Social Sciences with Social Sciences recruiting special teaching from Medicine. He also sees it as more properly working the other way. If this reflects the general position of Medicine it could delay the final diploma approval process and create roadblocks to student recruitment and effective Medical Faculty teaching in the program. Resolution of this conflict must be confronted and resolved at the Vice Chancellor's level.

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3.3 Recommendations

1. Administration Diploma Program

Either UWI Vice-Chancellor Preston or Pro Vice Chancellor Robinson should immediately confer with the two Deans of Medicine and Social Science to confirm whether they endorse administrative placement of the Health Management Diploma Program within the Faculty of Social Science - If so, the decision must be officially established. This was the recommendation of the December, 1982 Curriculum Consultancy Committee - but it is not clear whether it has the support of both faculties and is still considered the best course of action.

2. Curriculum Planning

The most critical issue facing HDPM at UWI is adequate staffing and the administrative approval of the on-campus diploma program in health management. Staffing was a critical omission in design of the project and it must be remedied immediately. An inter-department work group responsible for development of the diploma program was established by the 1982 Curriculum Consultancy Committee. This work group should be reactivated. Planning needs to occur for student enrollment in already existing course modules and teaching resources identified for new course modules. If part-time money is required for work-group activities, it should be provided by HDPM. UWI should assume the leadership in the work group activity and not let it fall to the Project Administrator who is not a UWI staff member.

3. Diploma Program Staffing

The Senior Researcher position has been formally transferred to a Course Coordinator position. This may not be enough. In addition, to clerical and part-time staff support for the inter-departmental work group, an additional full-time equivalent teaching staff position should be budgeted to carry out curriculum development and teaching in the diploma program. Creation of these positions should have priority for allocation of resources over all other project activities (except in-service), including UWI research, University of Pittsburgh consultancies and other expatriate consultancies. AFHA and AID should take the steps necessary to promptly facilitate whatever re-budgeting is required.

4. Implementation Deadline

UWI should proceed forcefully and expediently in attempting to begin the diploma program in Fall 1984. At least two rounds of training must be completed in order to establish a market for the program and to develop a tested curriculum. To have reasonable hope of achieving project expectations in regards to

the on-campus component, it is imperative that the diploma begin as planned. Should it not begin in Fall 1984, AID should seriously consider deleting this component with concurrent reduction of funding.

5. Faculty of Medicine Input

Every effort should be made to directly involve the Faculty of Medicine in the planning and implementation of the remaining first course and the entire diploma program for next year.

6. Study Grants

The project should consider supporting the economic costs of a selected number of promising health planners and managers from the non-campus countries for the next two years, to increase the potential for their participation given the small islands' economic constraints, and provide an expanded student base for the demonstration years of the program.

4. IN-SERVICE (OFF-CAMPUS) TRAINING

4.1 DESIGN

The cooperative agreement (C.A.) describes the major activities of the Project, including (page 2):

"In-Service Training through the Department of Extra-Mural Studies of the UWI.

In-Service Training will provide opportunities for participants to (a) increase their understanding about management theory, (b) their skills in applying these lessons in their work places and, (c) engage in activities which reinforce both their understanding and application of management skills."

Page 49 of the C.A. states:

"In order to perform these major activities, the Recipient and collaborators will carry out the following tasks:

1. In-Service Training

   1.1 Analyze the needs for improving the management and planning performance of health sector personnel and organizations in each participating country.

   1.2 Design and develop the curricula, the methods of instruction, admission criteria and supporting and reinforcing activities (e.g., consultations, attachments to Regional institutions, research activities of the Project, workshops, seminars).

   1.3 Assess the number of instructors, the training skills and competencies needed to conduct this training program.

   1.4 Select, recruit, prepare, support/supervise, and evaluate (according to established guidelines) a staff resource pool.

   1.5 Monitor and evaluate the conduct of the In-Service training program."

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Page 9 lists the major Project outputs, including:

"In-Service Training

1. Modular In-Service training curricula adapted to local conditions.

2. Approximately 60 trained health managers from four outreach courses.

3. Pool of 30 tutors/consultants equipped with knowledge and skills necessary to conduct the In-Service training."

The sub-contract between APHA and UWI repeats the foregoing nearly verbatim, while the sub-contract between APHA and PITT (page 2) calls for PITT to undertake, under In-Service training, the first three of the five tasks listed in the Cooperative Agreement, and makes no reference to outputs.

From the beginning of the formation of the APHA - UWI - PITT team, the lead in conceptualizing and later implementing the Project's in-service training component has been taken by the UWI Department of Extra-Mural Studies (DEMS). The primary author of the in-service component of the APHA Technical Application for the Cooperative Agreement, Dr. Phillis Macpherson-Russell of the DEMS, later was appointed HDPM Project Training and Development Coordinator, thus providing a highly desirable continuity between design and implementation of the in-service training component.

Training Process. Dr. Macpherson-Russell's academic background is education, not health or medicine. Accordingly, she elected the strategy of concentrating on the process of transferring management and planning principles rather than pre-designing specific course content. The approach used was problem-solving based, with country-specific content decided upon by the Country Program Committee. A modular approach was then utilized, with module design varying widely between countries, depending upon the level and experience of the in-country participants, health system problem identified for priority attention, and depending on varying constraints on time available to in-country participants. Thus, while the differences are great between the modular content of the two countries well along in the in-service training component (St. Lucia and Barbados), there are points of congruence on the management/planning principles, infused. The same undoubtedly will be true for the program in Trinidad (formally initiated during the drafting of this report) and in Jamaica, which is scheduled to begin in April-May of 1984.

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4.2 PROGRESS TO DATE

General Comments During the first year of the Project, it was necessary to devote much time and effort in St. Lucia and Barbados establishing working relationships and communication between the Ministry of Health and UWI participants, and forming concensus about the nature, content and methodology of the program to be undertaken. The Advisory Board accepted the programs for inclusion in the second year's work plan, and the programs were approved by both Country Program Committees. The plans for each country are presented as Appendix 10.

The decision had been made in the first year of the Project to start the in-service training in St. Lucia and Barbados in the second Project year, and add Trinidad and Jamaica the third year. Both of the latter countries have evidenced impatience, wanting to initiate in-country activities earlier, but have accepted the timing established by Dr. Macpherson-Russell and the Executive Committee.

ST. LUCIA. In St. Lucia, Primary Health Care had been established as a policy, but had no program associated with it. The Country Program Committee, chaired by the Permanent Secretary, rarely convenes formally as such but functions on a day-to-day working basis. By consensus, the group agreed the focus of the in-service training in St. Lucia would be to assist the Ministry in preparation of personnel to manage the planned Primary Health Care System. In spite of some early reservations of the role of in-service training on the part of some senior ministerial officials, they agreed to participate (in part, at least, because they concurrently were granted access to a research activity of high priority to them, solid waste disposal). The group decided not to involve heads of departments directly in the training, but to target the next tier of health providers: this in order to gain greater replicability of the training given the component's expected two-year duration. (The Department heads later were more directly engaged in order to secure their full support.) The Medical Officer of Health, administratively responsible for Primary Health Services, became a joint coordinator for in-service training with the HDPM In-Service Training and Development Coordinator, and fifteen participants (4 from headquarters in Castries and 11 from other health districts) were selected by the Permanent Secretary and Department Heads following selection criteria. One participant later dropped out.

Between February and July, 1983, seven modules were developed and presented in St. Lucia, using as staff Dr. Macpherson-Russell, the Medical Officer of Health and three Caribbean short-term consultants. Most members of this National Team did not consider themselves as managers, so the first four modules concentrated upon personal development and the development of managerial and technical skills. The fifth module

largely prepared a district level program, and modules 6 and 7 dealt with implementation of the district program.

The district level program was predicated upon earlier Ministerial identification of three areas for intervention into primary health care; health information systems, standardization of norms and procedures in the health care services, and increasing community participation in planning of health services. Regarding the first (health information systems), the HDPM National Team, building upon an earlier CARICOM-sponsored model district project in Soufriere, did the planning and training for district-wide systematic household health and environmental surveys intended to eventually include every household in the nation. The information being collected by regular MOH employees (mostly community and environmental health aides) is transferred to household folders kept in the District Health Center. The process, started in Soufriere then Vieux Fort on the southern part of the island, is proceeding northward, with a target completion date of September, 1984, the projected end of HDPM in-service training in St. Lucia. A team member was told this schedule may be ambitious, but at a minimum by September, 1984 each district level team will have been trained by the HDPM National Team, and the survey will have been completed for most of the island. Intended uses of the considerable information collected by this process (in addition to clinical use in the health center), include compilation of demographic data, delineation of target populations, indicators for evaluation, indicators of health status, supply system information and epidemiologic surveillance information. It likely will be necessary for the MOH to secure donor support for processing this data. The survey instruments and household health folder are available in the HDPM-APHA Field Office.

Standardization of norms and procedures has begun in at least two ways. During the modular training period each participant developed one or more draft protocols for procedures related to PHC using a format developed by the team. These have not been formally reviewed by the MOH to-date, but do represent an HDPM contribution to the process. Additionally, the Medical Officer for Health is well along working with the Ministry in establishing for the first time a managerial and administrative framework for operating the country's busiest health center in Castries.

The third element, community input into planning of health services, has not been conceptualized as yet.

There have been additional spin-offs of the HDPM in-service training in St. Lucia. The Permanent Secretary, who himself took an HDPM-sponsored short-term course at Management Sciences for Health, says for the first time there is understanding and communication concerning planning and management throughout all levels of the Ministry. A training manual for data collection was prepared for Vieux Fort which can be adapted for other district's use. A systematic tabulation of what and when

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specific services are offered by each of the country's 26 health centers was prepared and circulated by a National Team member. The Head of the Bureau of Health Education, three of whose personnel were members of the National Team, liked the process so much she asked the National Team to conduct a three-day planning workshop for her Bureau, which they did. At the district level, the National Team members will head up district teams comprised of "associates" of the National Team. This will help institutionalize the HDPM planning and management process in St. Lucia. Finally, and perhaps most importantly, the National Team de-facto has become the core planning unit in the Ministry of Health for PHC.

A problem in in-service training in St. Lucia was the difficulty in identifying an individual to serve as the Staff-Tutor. The function was served on a part-time basis by the Staff-Tutor from Barbados until December 1983, when a National Team member, a Senior Public Health Inspector, assumed the role. Of note, decision was taken early that it would not be feasible to attempt to link the in-service training to the research in solid waste disposal. As a result, the two have proceeded independently of each other.

The Medical Officer for Health feels strongly that the two-year period of Project assistance has been very helpful, but in St. Lucia's case is too short. With the momentum engendered to date, he is concerned that wihout additional support some gains will be lost. He was not explicit in the nature or duration of the assistance he hoped for.

BARBADOS. The in-service training in Barbados faced different situations than in St. Lucia. As examples: there have been frequent turnovers at the senior levels of the Ministry; hence, there has been inconsistent top-level support. (One plan to address this is by the use of Executive Symposia.) The participants of the Core Group, all senior managers readily visualized themselves as managers, so they needed no role redefinition as was the case in St. Lucia. In Barbados, a Staff-Tutor was identified and appointed very early (October 1982), so she could share the administrative, tutorial and liaison burden with the HDPM In-Service Training and Development Coordinator. The Country Program Committee was formally established as such throughout the project. Because of constraints on the senior participant's time, it was decided the course material would be presented in modular form through a series of staggered 1-3 day meetings totalling 30 days. Integration of services was selected as the key focus of the program. From the beginning, there was an attempt to link in-service training and the project research components. The presence of a UWI Campus on Barbados provided more ready access to administrative and technical support.

The first half of the first module was presented by the HDPM Training Coordinator June 29-July 1, 1983 and the second half July 20-22. The topic was Management of Change. Of 22 proposed

participants from all major sectors of the Ministry, 19 attended all or most of the ensuing sessions.

Subsequent modules included:

-- Health Policies and Planning, by Chief Project Officer, MOH, August 5, 12, 19.

-- Health Laws, by Chief Parlimentary Counsel, August 26 and September 2.

-- Financial Management, by the Financial Comptroller, MOH, September 9, 16, 23, 30, and October 7.

-- Midway Evaluation, October 14.

-- Personnel Management, by the Senior Administrative Officer (AG) MOH, and Deputy Permanent Secretary, MOH, with participation by four members of the Personnel Division, MOH, October 21, 28, and November 4, 11.

-- Information Systems and Evaluation Systems, by Head of the Department of Management Studies, UWI, November 4, 11 and December 2, 9.

The above modules are very well documented in quarterly reports produced by the Staff-Tutor, available in the HDPM-APHA Field Office.

Two additional modules are scheduled during the first quarter of 1984:

-- Integration of Health Services, by the Vice Dean, UWI Medical School.

-- Planning Change Effect, by the HDPM Training and Development Coordinator.

The team attended an in-service training session on the subject of financial resources by Dr. Blackman. Seventeen participants were present and Professor Waldron served as conference organizer.

Phase II of the Barbados in-service program will be comprised of projects to be undertaken by Core Group members individually or with other members for the purpose of improving aspects of management related to the integration of health services. A listing of possible projects appears in Appendix 11, an "Update on Health Development Planning and Management Programme, Barbados."

While projects per se have not yet been initiated, there are tangible activities emerging from the Barbados in-service activity. A Core Group Drafting Committee has met on at least four occasions to draft portions of a 'state of the health

services of Barbados' document including expressions of concern and recommendations, which, when completed following full modular presentation, will be presented to the Permanent Secretary for his consideration. More immediately, these senior managers have been made much more aware of the administrative and management strengths and weaknesses of all major areas of the Ministry, and, within their spheres of influence, they already are attempting to change the system towards more efficient and effective services. The interpersonal relationships fostered by the in-service training also have pointed out available areas of departmental interaction which previously have not been considered or utilized.

A concern expressed to the Evaluation Team was the infrequent attendance of the in-service component by two prominent MOH officials. This apparently caused some disappointment and concern to other members of the Core Group.

TRINIDAD AND TOBAGO. After extensive planning by the Country Program Committee and the HDFM In-Service Training Coordinator, the in-service training component was launched officially during the drafting of this report. The theme of the in-service component is strengthening the Administrative System for the Promotion of Primary Health Care. The modular training will be presented on a one-day weekly basis beginning March 15. The first six months will focus on the questions of Ministerial linkages between hospital and primary health care. Subsequently, the focus will be on county level management. Twenty Core Group participants have been selected, as have adjunct groups for decentralization, linkages between health care and hospitals, and a special adjunct group (Appendix 12).

A unique aspect of the Trinidad and Tobago in-service component is that it is housed in the Ministry of Health and Environment Planning Unit, and is viewed as an integral part of the Ministry's activities.

This is the first country program where there has been a planned link between the in-service and research components. The research on management information systems at the health center level should present implementable improvements in MIS that will tie into the in-service focus on community level management.

Although not a part of the Cooperative Agreement, the Project desires to appoint a Staff-Tutor for the Trinidad and Tobago in-service component, and formally has requested authority through APHA and AID. APHA has forwarded the request to AID; at the time of this draft, AID was in process of approving the request.

JAMAICA Because of the existence of an AID supported management project (Health Management Improvement Project-HMIP) ongoing in Jamaica, a decision was taken early to phase - in the

Jamaica in-service component after those of the other three nations. Accordingly, the activity is scheduled to begin in April or May, 1984.

The Evaluation Team was told by responsible officials in the Ministry of Health that they view the HDPM Project clearly as complementary to, rather than duplicative of, the HMIP.

The Country Program Committee has met nine times and an Executive Symposium has been conducted. The country specific research activity chosen is the design and implementation of management services delivery at the parish level. The MOH officials interviewed feel that in-service training could help the implementation of the research activity.

EXECUTIVE SYMPOSIA

HDPM introduced an activity originally not included in the design entitled "Executive Symposia." The objective, as stated in the workplan for Year II, was to conduct a series of two-day symposia for top-level management, including the political leadership, to involve them in project activities and expose them to modern management techniques. HDPM planned that the Faculty of Social Sciences, with input from the Faculty of Medicine, would conduct two symposia for each remaining year in each participating country. The symposia would utilize services of CARICAD in the Eastern Caribbean, Administrative Staff College in Jamaica, UWI Faculty, and consultants. They would focus on an identified area of management skill training and promote corporate and overall project integration.

UWI consultants Drs. Jones and Duncan prepared recommendations for the formulation of a Program for Executive Symposia in September 1983. They indicated constraints to effectively implement the symposia as: (1) concern that the symposia were not integrated with the in-service training activities and in competition with it; (2) no clear, sustained definition of the concept and; (3) lack of awareness of the concept and its implications in the field. Furthermore, some viewed the symposia as a management training forum, others as serving a project review and coordinating function. The consultants proposed a fusion of both concepts. The symposia, in our view, have assumed an ambitious role, with objectives overlapping with existing committees and operating mechanisms, and potentially distracting project priority attention and resources from the originally designed component activities.

To date, three Executive Symposia have been conducted. The first was held in St. Lucia in July 1982, and focused on basic management concepts related to the Caribbean context. It was conducted by the Coordinator for Training and Development and was less formally structured than subsequent symposia, which were organized under the aegis of the Dean of Social Sciences, UWI. The second symposium, conducted in Jamaica in December 1983,

focused on planning for Health for All by the year 2000. Ministry of Health officials were enthusiastic that the symposium had provided a forum for discussion of a topic relevant to their planning needs. The third was held in St. Lucia in January 1984, and focused on management by objectives and results. Ministry of Health officials in Barbados expressed interest in the conduct of symposia as a means to sensitize the high levels of the Ministry to health management needs.

There has been no perceptable link between the symposia, on-campus training, in-service training, and research. In general, while there was wide recognition of the need for high level support of health management improvement throughout the region, there was a lack of concensus on how best that could be achieved. Some expressed concern that an even greater need existed to reach government leadership outside the health sector, such as in Finance, Planning, Education, etc., to underline the significance of health to economic productivity and human development in the national context. In our opinion, the Executive Symposia seem to be a low priority compared to ongoing activities originally designed for the Project which need more immediate Project staff attention.

4.4 SUMMARY CONCLUSIONS

Of the major components of the Project, the in-service component has adhered closest to the planned methodologies and to achievement of goals. With the exception of evaluation, it has accomplished all tasks listed in the Cooperative Agreement on schedule in the original two countries (St. Lucia and Barbados). Based on this track record and the groundwork preparation already accomplished in Jamaica and Trinidad/Tobago, there is little reason to doubt the ability to be equally successful in these countries. The same optimistic projection pertains to full achievement of the component's outputs: the component is well along on its way towards fulfilling the outputs.

At midpoint in the Project, the In-Service Training and Development Coordinator feels it is too early to evaluate the impact of component. We agree. It is not however, too early to plan for such an evaluation, for without it, this apparently successful Project component will lose part of its current attractiveness and potential for adaptation and replication. This will be further addressed in the Recommendations section below.

A similar argument can be made for more explicit and complete country-by-country documentation of methodology and module development. While these clearly are country-specific, we believe that there are much experience and materials generated by this component that, if properly documented, could be very useful for application elsewhere.

The experience in St. Lucia has already demonstrated the

contribution that this form of in-service training can make to the non-campus Caribbean countries' capability "to institutionalize planning and management capabilities by supporting and bolstering participating countries' efforts to plan and manage health sector resources," the stated Goal in the Cooperative Agreement. Efforts should be made at the earliest opportunity to share this expertise with other non-campus, English-speaking, eligible Caribbean nations.

It is likely that the Ministry of Health and Housing in St. Lucia can come forward with a plan to extend the current two-year project time for in-service training in order to further institutionalize and decentralize the planning and management process. This would give the UWI time also to further refine its in-service methodology for use in the non-campus nations.

The utility of a full-time Staff Tutor has been well demonstrated in Barbados, and we agree with the Project's assessment of a similar need at Trinidad/Tobago. Moreover, we believe the Staff Tutor role should be expanded to include a coordinating, monitoring and reporting role for all off-campus aspects of the HDPM, including research and technical assistance components.

It appears to us that the potential for redundancy is extraordinarily high in Jamaica between the off-campus activities of HDPM and other activities of AID, USAID, PAHO and other donors. As examples, this HDPM activity, as well as PAHO, already have done research on the management of health services at the parish level. The HDPM attempt generally was considered of low utility, while the PAHO report is due for release soon. PRICOR, sponsored by AID/W, is doing an operations research time and motion study of primary health workers. Moreover, USAID/Jamaica through the Health Management Improvement Project supports PHC in-service training. Accordingly, in spite of the apparent high expectations from the HDPM Project on the part of the Jamaican Ministry of Health, we believe that already available resources should be targeted to meet their in-service needs. HDPM should make the in-service expertise at UWI available to the MOH for technical assistance in in-service training; but module development and training implementation should be funded from other sources. Finally, we consider the utility of the Executive Symposia to be marginal and feel that project priorities would be better placed within the four components of the original project design.

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4.5 RECOMMENDATIONS

1. Impact Evaluation

The Project should develop an evaluation plan, collect appropriate data and conduct an analysis in order to assess impact and/or outcome of the in-service training component in at least the three nations where in-service training is now underway. The evaluation design and implementation should include input from evaluation experts not intimately involved in the in-service component, and should be conducted in order for the results to be available to the Project by the time of the final external project evaluation.

2. Documentation of Methodology

The Project should more explicitly document its country-by-country in-service training methodology and process of module development for use as models for adaptation by other English-speaking Caribbean nations.

3. In-Service Training for Non-Campus Islands

The project should offer in-service training of the type developed in this project to at least two eligible non-campus nations should there be interest expressed by the nations. Such training should be coordinated carefully with a newly proposed UWI offering of a correspondence course Certificate in Community Health Management, which will be offered on a challenge/outreach basis.

4. Extension of In-Service Training, St. Lucia

The Ministry of Health and Housing, St. Lucia, should be invited to indicate its interest in extending the duration of the in-service component in order to further decentralize and institutionalize the planning and management functions of the PHC system. Should the Ministry be interested, the Project favorably should consider a well-justified plan for utilization of such an extension.

5. Staff-Tutor Position -- Trinidad/Tobago

AID should favorably consider APHA's formally expressed request for the additional position requested.

6. Expanded Role of Staff-Tutor

The Project should expand the role of the three Staff-Tutors to include coordinating, monitoring and reporting responsibilities for all off-campus components of the HDFM Project.

7. **Elimination of HDPM Support to Implementation of In-Service Training, Jamaica**

Funds for management related in-service training for PHC is available from USAID/Jamaica sources through the Health Management Improvement Project. Accordingly, the more limited resources available to HDPM should be utilized in Jamaica only for technical assistance to providers of in-service training, while module development and implementation of training should be funded from other sources.

8. **Consideration of Reduction of In-Service Component, Trinidad/Tobago**

Because of the high degree of readiness and innate capabilities of the Trinidad/Tobago Ministry of Health and Environment's Planning Unit, it may be very likely that it can assume full responsibility for the in-service activity after 6-9 months of HDPM assistance. If so, HDPM could utilize its resources profitably elsewhere.

9. Executive Symposia

If any additional Executive Symposia are to be considered, they should: be clearly justified on a specific country basis; be carefully designed to meet objectives; guarantee appropriate participation; and be systematically implemented to support the objectives of the other ongoing project components. CARICAD and the Jamaica Administrative Staff College have demonstrated experience which could be appropriately tapped in planning and implementing such an activity, on a limited basis, but results should be carefully assessed and judged relative to other ongoing activities before being expanded further. Any future Executive Symposia should have the integrated input of all four Project components in the design, and preferably the execution, of the Symposia.

5. TECHNICAL ASSISTANCE

5.1 DESIGN

There is growing consensus in the region that technically competent individuals exist within Caribbean institutions, ministeries and local organizations, that such expertise can contribute to indigenous development, and that those individuals who are familiar with local conditions and problems should be utilized wherever possible. Thus, the fourth activity of the Project, as defined in the Cooperative Agreement, is the development, utilization and support of an indigenous pool of technically skilled personnel, managers and health planners, to provide expert advisory services to governments, other health sector institutions, bilateral and international donors. In order to perform this activity, the recipient and collaborators were to carry out the following tasks:

1. A qualitative and quantitative assessment of demand fr technical assistance.

2. Development of indigenous technical assistance by executing the following actions:

   a. survey and select indigenous experts based on their capabilities and assessment of technical assistance demands in participating countries;

   b. register, support, supervise, evaluate and promote use of indigenous experts according to established guidelines;

   c. establish and maintain a Registry of Managers and Trainers of proven skills in relevant areas;

   d. conduct Registry searches to identify consultants for designated users;

   e. collect and store information on individual consultancies supplied through the program and disseminate it to interested users.

3. Design and operate a clearinghouse for publications and visual aid materials useful for practicing health managers and planners.

4. Utilize technical assistance personnel to contribute to the in-service training program.

5.2 Progress To Date: Registry

The Cooperative Agreement and sub-agreement with APHA and UWI, respectively, contain identical language with respect to development of the technical assistance component, with no specification of relative responsibilities. In practice, the Project Administrator has assumed predominant responsibility for the activity to date. The Institute of Social and Economic Research (ISER) of the Faculty of Social Sciences, with its existing documentation center, is assisting in the establishment of the clearinghouse element of the technical assistance component, namely the HDPM Resource Center.

An assessment of demand for technical assistance was not prepared nor a needs assessment formally conducted. Discussions with members of the Advisory, Executive and Country Program Committees suggest the view that technical needs are first best met, wherever possible, by local expertise in-country. The idea of a regional pool of expertise is professionally promoted and has political appeal, but preference is often expressed for US consultants who may have more experience and international prestige.

In the absence of country specific assessments of need and perceived demand, the Project Administrator has focussed entirely on supply, identifying regional experts and organizational resources through his personal and institutional contacts and by distributing bio-data forms. UWI has assisted in the recruitment process. While the initial design called for a roster solely of indigenous technical experts, the Project Administrator is also including US consultants identified through the HDPM project. The consultants are entered into the Project Administrator's personal Osborne computer in his office by name, specialization and country or organizatic ' affiliation. The Registry now includes 105 consultants, of iom 26 are American, 28 Jamaican, 22 Barbadian, 14 Trinidadian and 7 St. Lucian, and 8 other West Indian.

The specialization categories vary in specificity , and some categories, i.e., parisitology, engineering, sociology, are not management classifications. One individual is listed under specialization only as a Dr. Ph.D. candidate. The Project Administrator indicated difficulty in knowing how to classify some consultants who were generalists or possessed qualifications in multiple fields. Consultants have not been screened nor references or experience evaluated. No methodology for evaluating consultant performance has yet been developed. The Project Administrator realizes that more work is required before the registry can be effectively utilized by potential users. He considers the activity less of a priority than the other components which demand more immediate attention. He anticipates the eventual development of a roster of approximately 50-75 screened and available consultants.

The Project Administrator has distributed the preliminary

consultant list to members of the Executive Committee, CARICAD, ASC, OECS and the Governments of Trinidad and Jamaica which requested it. Some have added suggestions and indicated the need for improved specialization categories. The MOH Permanent Secretary in St. Lucia has indicated disappointment at not having received a list. PAHO and CARICAD also are developing consultant lists and indicate interest in coordinating with HDPM. We understand that CARICOM and the Organization of Eastern Caribbean States have consultant lists as well.

Up to the time the Work Plan for Year 3 was prepared, nineteen consultancies had been completed under the project, ten focusing on on-campus training, four on research, three on in-service training, and two on a report on the Executive Symposia and Network of Caribbean Consultants. Of the sixteen consultants used, one was from the University of North Carolina, one from Johns Hopkins University, six from the University of Pittsburgh and eight from the Caribbean. As Drs. Jones and Duncan point out in their consultancy report on the Network, the various con ultancy reports and recommendations prepared under the Project have not been collectively analized, reported or systematicaly followed through. The report also provides useful recommendations for improving the data in the registry.

According to the Project Administrator, the registry has been used twice as a resource by the Senior Researcher to identify consultants for the research component, namely Phyllis Green and Philbert Morris. The Project Administrator has not actively promoted its utilization, given the need for further work on it and the fact that funds must be found outside the project to support consultancies not directly associated with HDPM activities. Project staff feel that promotion of the registry will raise expectations among participating countries for ad hoc technical assistance. This will result in pressure to use Project funds to meet short term needs as opposed to long term institution building objectives.

Constraints to the utilization of indigenous consultants include the following:

- Qualified individuals in the region are already over extended with too many responsibilities;

- Qualified consultants find it extremely difficult to turn down hard currency consultancies and, therefore, agree to undertake an assignment although they are too overworked to be able to complete it in the time required;

- Few indigenous consultants have track records in the consultant field, and many lack familiarity with consultant procedures;

- Traditional reliance on the "old boy network" and political connections persists;

- Easily identified donor or other funding to finance consultations is generally lacking.

The Project Administrator plans to convene a working group including representatives from CARICAD, PAHO, Administrative Staff College in Jamaica, and UWI to examine the selection, screening, and classification of potential consultants as well as develop an implementation plan for continuing management of the registry, dissemination, information sharing and guidelines for consultant utilization. Mechanisms for evaluation and follow-up of findings and consultant recommendations need to be developed and standardized. The registry should be compatible with that of other potential user organizations to the extent possible. The Project Administrator needs to be encouraged to work with Country Program Committees, UWI and regional organizations to specify technical assistance needs, review the Registry accordingly and undertake special searches for consultants in categories where indigenous capability is most lacking. This effort should be coordinated with skills upgrading in the on-campus and in-service training program. We feel it would be most appropriate for the Registry to include only indigenous consultants, with expatriate consultants having HDPM regional experience as an addendum. This might be expanded to include non-Caribbean individuals with expertise identified as needed in health planning and management but not readily available indigenously. Identification of the universe of U.S. consultants with Caribbean experience (not involved in HDPM) is beyond the scope of this activity.

5.3 Progress to Date: Resource Center

The Resource Center, located at the ISER Documentation Center, is developing a collection of material relevant to health management in the Caribbean. UWI plans that the Documentation Center serve as a regional resource bank with communications to CARICOM, CARICAD, and other UWI Campuses, etc. HDPM plans to help develop access to repositories and data base services such as MEDLINE. While the Resource Center began as a part of the technical assistance component, after the Year 1 work plan it was moved under the Research component in work plan Year 2. The Project Administrator explained that the shift was due to the fact that the documentation would be housed in ISER which was responsible for research, and that the materials would be particularly useful to the research effort.

No official documents quantify the projected magnitude of the documentation collection nor provide a specific plan as to by whom and how the materials will be utilized and disseminated. The collection contains approximately 900 indexed documents, housed in two bookcases and listed alphabetically by author and

key word in a catalogue print-out. These items include research reports, conference papers, policy documents, training programs, journal articles, and a few documents on microfilm. ISER's Documentation Center, covering a total area of 7,500 square feet, includes a reading room, study areas, microfilm room, seminar room, and administrative and planning literature. According to a participant we interviewed who is auditing the Health and Social Organization on-campus course, the course students use the Resource Center for assigned readings, in addition to two major textbooks which each student possesses. According to the University of Pittsburgh liaison, the project has not requested any assistance with documentation.

The UWI In-Service Coordinator, Research Coordinator and on-campus teaching staff from Social Sciences and Medicine need to identify basic planning, management and training resource materials appropriate for their respective components, and work with APHA and Pitt to try to acquire them for the Resource Center. Project Research staff might be the most appropriate coordinator of this effort. Given resource limitations, attempts should be made to secure documents from WHO, PAHO, APHA, PITT, and other such organizations. Other programs funded by AID, such as University of Hawaii/MEDEX, Management Sciences for Health/PRITECH, Johns Hopkins University/HDPM, Population Information Program, and University Research Corporation/PRICOR should also be able to provide relevant materials at little or no cost. Project staff and Country program Committees should be encouraged to identify and acquire indigenous health planning and management materials to develop as complete a documentation of Caribbean related experience as possible. An evaluation tool also needs to be developed to monitor and assess utilization and appropriateness of the center materials.

While the original design called for utilization of technical assistance personnel to contribute to the in-service training program, no operational link exists between the registry development/utilization and the in-service training activities. The in-service training program has relied on individuals identified by the respective Ministries of Health in each country. The Coordinator of the in-service training programs views the Resource Center as useful if it can provide indigenous, country specific materials, as well as basic WHO and other major worldwide health management documents.

5.4 Recommendations

1. Use of Indigenous Consultants

HDPM should actively promote the use of indigenous consultants wherever possible, including teaming those with

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limited experience with consultants of greater experience. This teaming is particularly useful in areas of specialization which are inadequately represented in the region.

2. Registry Improvement

With input from the proposed working group, the Registry of Consultants should be refined to provide specific planning and management categories such as personnel, drugs and supplies as well as details relating to work experience, research and publications, previous consultant activities and availability for short or long term consultancies.

3. Registry Dissemination

The improved registry of consultants should be disseminated and discussed at Executive and Country Program Committee meetings. It should be widely circulated to participating governments, international and regional agencies such as AID/W, RDO/C, USAID/Jamaica, APHA/W, UWI, University of Pittsburgh, Administrative Staff College in Jamaica, PAHO, CARICOM, CARICAD, OECS, consultants and other appropriate entities.

4. Institutionalization of Registry

The registry should be institutionalized at UWI, either in the Department of Extra-Mural Studies or at the ISER Documentation Centre, preferably by the end of Year IV.

5. Resource Center Development

Consultant reports and project generated materials on all components should be indexed in the Resource Center. Key resource documents identified in the Annotated Bibliography of the State-of-the-Art Study as well as selected basic health planning and management literature, from international and indigenous sources, should be acquired and included in the collection.

6. Resource Center Dissemination

A categorical listing of Resource Center documents should be shared with Executive and Country Committees, PAHO, CARICAD, CARICOM, ASC/Jamaica and appropriate UWI faculty, with semi-annual addenda.

7. Technical Assistance Coordination

The Project should more effectively link the technical assistance component with in-service training. The In-Service Training and Development Coordinator should use her contacts in the country training activities to help identify and screen potential consultants. Consultants should also

be included in the in-service training programs as appropriate, either as resource personnel or as participants who could benefit from further training and experience .

6. HEALTH SERVICES RESEARCH

6.1 DESIGN

The project technical application stated that the research component of the HDPM was intended to be supportive of the campus based training, in-service training and technical assistance. Results of the research were to serve as a guide for in-service training, provide developing material for the Health Management Diploma and identify areas of need for T.A. The research was to be conducted on two levels, one to cover the four targeted countries in general (Jamaica, St. Lucia, Barbados and Trinidad/Tobago) and the other to cover country specific studies of a particular management problem in each of the four countries.

The technical application described research according to a WHO working group definition, "Health Services Research is concerned with problems in the organization, staffing, financing, utilization and evaluation of health services."(World Health Organization, Education of Management in Health Services, Report on a Working Group, Copenhagen: WHO Regional Office of Europe.)

The technical application (138-140) lists four major objectives for the reseach component:

1. Information System: Development of a user-oriented health information system.

2. Training: Train health services researchers.

3. Knowledge Base: Provide relevant materials for regional health planning and case studies for health management course.

4. Evaluation and Assessment: Establish a framework to assess the efficiency and effectiveness of approaches.

The above objectives are not contradictory to the training oriented objectives outlined earlier in the technical application. However, differing statements of objectives do tend to confuse the issue whether the main goal of research is to be supportive of the training sections or to directly improve health management. The logical matrix identifies the main research objectives in a third way. It reverts to the goal of using research to support training and to technical assistance, but it now introduces the term "operational research" instead of "health services research." An operations research focus could have provided an important specification of research objectives. Unfortunately the term was not defined. Operations research is a term that suggests research which is problem based, client oriented and client solvable. O.R. investigations are conducted to examine a problem identified by a client in its organization, management or field implementation, with the ultimate production

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of a set of recommendations or options which the client can test and apply to solve the problem. If this terminology had been consistently used and defined it might have served to focus the research component.

LOGICAL MATRIX (FIRST YEAR WORK PLAN)

Elements of Project: Immediate Objective for Research

To utilize operational research in training, as a problem solving tool in the management of health systems and as a source of information in the carrying out of expert technical advisory functions.

Success Criteria

Appreciable demand and usage of information resulting from operation research undertaken by Ministries of Health, the Institute of Socio-Economic Research of UWI and other related regional institutions in the field of health management.

Verifiers

Resource Center records on content of the collection and the usage of this new source of information.

External Factors

Acceptance and effective use of a pool of indigenous consultants by other international agencies, bilateral organizations as well as by the countries of the region.

6.2 PROGRESS TO DATE

The partners of the Cooperative Agreement opted for a two-pronged approach to health services research in health planning and management. The first was a general sector study, beginning with a State of the Art Study (SOAS) and an annotated bibliography, bolstered by additional sector studies suggested by gaps in the SOAS. The second approach was to conduct country specific investigations selected by the local Country Program Committee in each of the four targeted countries. The results to date are disappointing. The quality and utility of the research generally has been low and completion slow. Generally, the research carried out did not tie into the other components and was too ambitious as well as not being specific enough to be an effective training too. The research deadlines were continously rolled back. The HDPM Work Plan for Year 01 (1981-

ACTIVITY	TARGET DATE	COMPLETED
Formulates terms of reference State of the Art (SOA)	3/82	7/82
Appoint research staff	5/82	9/92
Select consultants	6/82	11/82
Review four country studies	7/82	still in process
End general sector study	8/82	still in process
Conduct workshops	9/82	still in process
Formulate further sample research studies	10/82	still in process

This schedule was not adhered to, as the completion dates show.

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Internal Evaluation. The internal evaluation team reviewed the research component in July of 1982 and made the following three recommendations:

a. "The senior research associate should be hired immediately as well as a consultant to coordinate the state of the art study.

b. The senior research associate should prepare plans and methodology for all research.

c. Steps should be taken to expedite the state of the art study and approval should be sought from AID to postpone the contractual completion date from 9/82 to 11/82."

The Internal Review clearly identified the principal and continuing research problem areas and forewarned project management about difficulties with the State of The Art Study and the research methodology.

Difficulties and constraints. A principal constraint on progress has been the difficulty UWI had in identifying the Senior Research Associate, who was only hired in September of 1982. Another difficulty was the interpretation of the varied research objectives as laid out in the project document. This was compounded by the lack of available experienced health management researchers and the Project's inability to define a topic and clearly lay out a research protocol and move towards implementation.

University of Pittsburgh's Research Involvement. PITT, since the inception of the project, has been very interested in the research component, and fielded several consultants to assist in the identification of management problems for research and definition of methodologies. For an unknown reason research was not included as an area of responsibility for PITT in the sub-agreement.

HDPM's Tie in with Other Research.

a. There is little coordination between the PRICOR "PHC Team Efficiency and Productivity Study" at the Department of Social and Preventive Medicine.

b. The Health Management Improvement Project while working in ten areas of management could certainly have benefited from HDPM experience. However, the contacts that did occur were not related to research activities, perhaps because the research was hardly started by HDPM until mid-1983.

c. There was some preliminary interaction between HDPM and PAHO's PHC team which has been analyzing and reporting management practices and linkages at the Jamaican district level since 1981.

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Prime Responsibility for Research. According to the APHA/UWI subagreement, ISER is responsible for the research. "The overall responsibility for coordinating the research component... rests with Institute for Social and Economic Research...; responsibility for designing, programming, implementing and reporting on the general sector study rest with ISER at Mona" (page 152). Regrettably, ISER did not have input from the University of Pittsburgh to help with research task identification and protocol preparation during 1983 when the research actively began.

The APHA Project Administrator de facto has had to assume a proactive role in the research component. This was not foreseen by the technical application. Those additional efforts have further diluted the administrative role without making the research component effectively productive.

In the future, ISER should be encouraged to take a more active and positive technical and management role for research. The assistant research associate's responsibilities should be to coordinate all the research activities, not just Jamaica.

6.3 GENERAL SECTOR STUDY

The General Sector Study was to be composed of a major sector study of health management practices on the Caribbean "and additional training related investigative or evaluative exercise as may be required to develop research skills for course participants." The first part of the general sector study is generally referred to as the State of the Art Study (SOAS).

The State of the Art Study, even though first projected to be completed by September 30, 1982, was not begun until October 1982. The specific objectives of the SOAS were laid out in the Technical Application with a detailed outline of the intended content of the reports on Pages 142 143. (See Appendix 13.) Regrettably, the Technical Application guidelines were not followed, although the internal review had identified the SOAS as an area of difficulty. The research component outputs are presented in the logical matrix as follows:

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LOGICAL MATRIX

Research Outputs

State of the Art (regional health management). Four country specific studies (problem solving). Documented periodic update of State of the Art (3rd and 5th year).

Success Criteria

Results of research are reflected in the new curriculum at UW in the Inservice Training Programs in each of the four countries, as well as in standard setting in health management.

Verifiers

Reports and updates on the State of the Art Study. Reports on country specific studies.

PROGRESS TO DATE

The Barbados SOAS. This study was designed to be a forerunner of the regional State of the Art Study. This study entitled "State of the Art Ministry of Health, Barbados," gives a good succinct picture of that country's management systems. and was produced between December, 1982 and January, 1983. This study is valuable for anyone studying health management in the region and certainly useful for anyone studying Barbados.

The Regional State of the Art Study (SOAS). The Regional State of the Art Study was initiated October 1982 and is still being worked on at this time . This long awaited key document was to provide a need assessment, document baseline management information and be used for the development of the training and technical assistance activities. Its tardy preparation, lack of substantive data and important errors of fact have greatly reduced its value. The study itself was carried out by someone only nominally qualified for health management research. Charts and tables presented for different countries for comparison are incomparable because they are presented in different units using different indices. The report has not met expectations and consequently project has commissioned two consultants to edit and expand the original document. The second part of the SOAS, an annoted bibliography, contains a good basis for identification of

the documentation available in the Caribbean on management and health and as such is a valuable reference tool.

Work is in progress to finish the State of the Art Study by April, 1984. Two consultants are engaged and have developed a six part questionnaire (See Appendix 14) to generate data to fill in gaps in the SOAS. The hazard of such an extensive approach is generating more data than is actually necessary for the study, particularly at this late date in the Project.

At this point in time (mid-project), the SOAS has past the point of general usefulness. Relevant titles from the bibliography should be included in the resource center at ISER, No futher work or updates on SOAS/General Sector Survey should be undertaken beyond completing the work in progress by the two consultants now engaged. ISER should distribute the SOAS to all participants in Project related research and training activities and to potentially interested organizations.

Regional Management Problem Specific Studies. These are intended to be natural outgrowths of the State of the Art Study and part of the overall general sector research. These studies have been planned to be specific, prescriptive studies which could be used to implement changes in particular management subsystems throughout the region. As seen by Project Administration, the studies should be practical management tools with implementation plans. In order for this approach to work it is necessary to have well defined areas of study and proscriptive research protocols. To date no protocols have been produced, no regional or national health organization is seeking out HDPM to execute a practical regional study and there is still no involvement of the training components in the research process.

Four general sector studies have been planned.

1. Human Resource Development. This study has been begun and is being carried out by a human resource specialist attached to the Administrative Staff College. The terms of reference are as follows: "Analyze the historical development and main characteristics of the human resources management function in the Health Sector." Scope: "To elaborate proposals for corrective action within the framework of existing constitutional arrangements of Regional Public Services with regard to the current budgetary constraints." ((See Appendix 15); Questionnaire Appendix 16).) Such terms of reference need further specification towards a prescriptive, implementable, management problem solving outcome.

2. Organization and Planning. This study has only reached the most rudimentary planning stage even though it was to have begun in January 1984 according to the Year III Workplan.

3. Management Information System (MIS). It is thought that this study could to be an extension or continuation of the Trinidad country specific study which has just gotten underway.

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4. Materials Management. Project leadership has until now been unable to identify a more specific topic for this task and has been unable to identify a potential consultant with qualifications for its execution.

In evaluating progress and relative priority for these general sector studies, the evaluation team sees no urgency for their completion. The human resource study should be finished to the level of the existing contract, based on clearly specified revised terms of reference and a new proscriptive research protocol. As the organization and planning study has not begun and its objectives not clearly defined, it should be held back until mechanisms for better research quality control can be established.

Before the Management Information System Study is initiated, the Trinidad MIS Research should be carefully studied and analyzed for applicability as a potentially implementable instrument of change and an educational tool. Materials management should be set aside unless or until a need is identified for a focused product.

6.4 COUNTRY SPECIFIC STUDIES

The country specific studies were designed to answer particular needs of the Ministries of Health in each of the four countries, as voiced through the HDPM local country committee. In general, the topics have been identified at the country level and implementation of the studies has been supported by the country committees and local ministries. These studies were to help the respective Health Ministries to solve health management problems and to provide case material for training, field experience for participants as well as to contribute to the body of knowledge about management problems in the Caribbean. Regrettably, these goals were not uniformly met.

JAMAICA

Integrated Health Care Delivery at the Parish Level. The purpose of the task was to identify potential strengths and constraints of the health care delivery process. A report has been produced, but it tends to be a sociological overview of interaction and linkages between different levels and elements of the system without any substantive or particular reforms identified to assist the implementation process. Certain members of the Country Program Committee resented the fact that only one consultant name was presented to them for the job. The Country Program Committee felt that the report was a first broad stroke of the brush with further research definitely called for. (See Appendix 17). As a result, another consultant in operations and management has been contacted to develop an implementable strategy for integrated health service. The term of reference

for this task is in preparation. It is hoped by the country committee that this report will be a "nuts and bolts" study. (See Appendix 18)

ST. LUCIA

Management of Solid Waste Disposal. This task is a subject of great political and economic importance for St.Lucia. The MOH of St.Lucia suggested the topic in mid 1981. However, the term of reference was only drafted in January 1983 and work started April 1983. This consultation was executed by two consultants, a St.Lucia Engineer as principal investigator and a collaborating consultant from the University of Pittsburgh. The output of the task is to be a feasibility study that could sell the project to a potential donor. (See Appendix 19)

The consulting report has been in preparation since March 1983 and under review since September 1983. The draft version reviewed by the evaluation team was not developed to the level of describing a potentially "bankable" project.

BARBADOS

Patient Flow in Casualty/OutPatient Services. This has been a much studied priority problem in Barbados. The research task was to examine the inefficiencies in the patient treatment process at the Queen Elizabeth Hospital in Bridgetown. The subject was suggested by the MOH for study, but the study was not initiated because of poor communication, changing key personnel at the ministry and the low level of country committee organization. The Government of Barbados and the USAID Mission have just signed a protocol to provide long term T.A. to assist the reorganization effort.

TRINIDAD AND TOBAGO

Improved Health Management at District Level Through MIS. The MIS study began in Trinidad in January 1983. Trinidad has a strong local committee and has designated a specific subcommittee to direct the consultant in this research task. This study suffered startup difficulties in obtaining ministry blessing and slow HDPM project administrative documentation. This task has a good potential for a productive outcome because of the quality of the consultant, the level of interest by the country committee and the amount of detail to the terms of reference and methodology. (See Appendix 20)

Conclusions. The Jamaica study of integrated health care at the parish level may be redundant to a PAHO study now nearing completion. Therefore, it should not be continued without specific research protocols and close county committee coordination. The solid waste study should be completed and

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delivered to the St. Lucian Government as soon as possible; but no further solid waste research should be undertaken. The Barbados casualty study is no longer an issue and should be dropped from the work plan. Finally, the Trinidad MIS should be finished and analyzed to identify its potential value to users if it is to be extended into the three other countries.

6.5 GENERAL RECOMMENDATIONS

Research has been the weakest area of the project. It has not met its goals and deadlines, satisfied objectives, been properly defined or addressed the purposes of the Project. Because of the above problems, serious recommendations have to be proposed.

1. University of Pittsburgh

   The University of Pittsburgh should be invited to play an active role in research and the PITT subcontract modified to reflect health services research responsibilities.

2. Research Coordinator

   Designate a specific person (Research Assistant) at ISER to be responsible for Health Services Research who will coordinate with a resource consultant(s) at Pittsburgh to assist in defining research protocols and evaluating the three ongoing research studies (MIS, Trinidad; and Human Resources, Jamaica; final update of SOAS).

3. Research Quality Control

   For any research beyond the 3 ongoing tasks in #2 above no research should be attempted unless:

   a. It is a coordinated effort between all the different components of the project, including the training sections.

   b. There are specific terms of reference and proscriptive detailed research protocols.

   c. There is an interested and involved client, either Ministry of Health or a health organization, who will implement the findings of the study. In this context groundwork must be done to determine if the particular research task is not duplicative or overlapping with other research.

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d. A qualified Caribbean principal consultant (principal investigator) is teamed up with an experienced collaborating consultant.

e. A research task force for each research project is formed to accomplish a,b,c,d above, composed of:

Research Coordinator, ISER

Principal Consultant (principal investigator)

Rep. of Local Country Committee or Rep. of Client (user group)

Collaborating consultant, participant from other organizations who might have experience in similar research.

4. To the extent that project management feels that research can/cannot be effective amd quality control implemented, the Executive Committee should seek to negotiate for reallocation of research resources.

7. FINANCIAL SECTION

7.1 BACKGROUND

An analysis of the Project expenditures is an appropriate indicator of the direction and dynamism of a project. This chapter deals with analysis and interpretation of the expenditures. A few points should be noted.

1. UWI received its revolving fund in April 1982, 7 months after the start of the project.

2. Reporting has been slow within the UWI system and AID/APHA reporting needs and procedures have not been made clear to UWI.

3. The contents of this section are drawn from work sheets prepared at APHA using their financial reports and later verified with UWI.

4. UWI is expected to implement the project with only 49% of the total grant amount. (34% under direct subcontract and approximately 15% travel and consultant funds administered by APHA.)

7.2 FINANCIAL REPORTING SYSTEM

Financial Reporting System. The month to month computerized financial accounts as presently prepared by the APHA Accounting Department for their intenal use are not adequate for the needs of APHA/HDPM Project Management. A more descriptive monthly accounting report of expenditures could be produced by adding 12 to 18 characters of description next to the code for each of the expenditures in a presently unused section of an existing column (field) on the report form. This could obviate the necessity of preparing a work sheet by hand from the computer printout.

The report which is currently in use for external reporting aggregates the monthly expenditures for sub-contractors under one line item. This method is too general to give an accurate picture of expenditure trends and levels of effort, since The sub-contracts line item covers 50% of the total amount of the grant. The sub-contract line item should be ventilated out to show the individual line items of each of the sub-recipients. The resulting report form could serve as an invaluable project management tool. (See fig. 7.A)

Following discussion with APHA Project Management, APHA Accounting Department and the AID contracting and technical offices, it has been agreed that one financial report could satisfy the needs of everyone. See Fig. 7.A for a facsimile of this form. An additional indicator that could be added, which

PROPOSED MONTHLY FINANCIAL REPORT FORMAT MONTH OF: _____

Figure 7-A

ACCOUNT #	CATEGORY	A L. O. P. BUDGETED AMOUNT	B CUMULATIVE BUDGETED AMOUNT TO DATE	C EXPENDITURE THIS MONTH	D ENCUMBRANCES TO DATE	E EXPENDITURES + ENCUMBRANCE THIS MONTH (C + D)	F CUMULATIVE EXPENDITURES (C + F LAST MONTH)	G UNEXPENDED BALANCE (B - F)	H BALANCE % TO DATE (G ÷ B) PERCENTAGE
[illegible]									
[illegible]	Salaries								
[illegible]	Fringe benefits								
[illegible]	Overhead								
[illegible]	Consultants								
[illegible]	Travel per diem								
[illegible]	O. D. C.								
	SUB-TOTAL								
[illegible]									
[illegible]	Salaries								
200	Fringe benefits								
300	Overhead								
400	Consultants								
500	Travel per diem								
600	O. D. C.								
	SUB-TOTAL								
[illegible]									
100	Salaries								
200	Fringe benefits								
300	Overhead								
400	Consultants								
500	Travel per diem								
600	O. D. C.								
	SUB-TOTAL								
	GRAND TOTAL								

would probably necessitate a programming modification at APHA, would be to add a percentage column to indicate unexpended balance to give a better grasp of the actual numbers being presented to Project Management.

An additional problem is that encumbrances are not considered in any of the accounting systems. A system of encumbrances should be established and programmed. (APHA, according to informal sources, is in the process or re-instating this system.)

The semi-annual reports do not contain financial or fiscal information. Because levels of expenditure are such an essential part of planning and project success, the semi-annual report should cover finances and actual levels of expenditures and projections.

Budget Line Item Nomenclature: This nomenclature should be collapsed into standard line items as represented in the APHA contract to remove some vague and duplicative line items such as innovative projects, training facilities and training workshops. This would certainly facilitate accounting from UWI's perspective as well as make the format for reporting more standard.

7.3 LEVEL OF EFFORT ANALYSIS

APHA Level of Effort. The USAID/APHA agreement states:

Direct Salaries:	155.5	PM/LOP @ 31 PM/Year
Consultants:	72	PM/LOP @ 14 PM/Year

[Note: PM:. Person Months LOP: Length of Project]

APHA has provided both a Project Manager and Administrative Assistant. The Project Manager now spends 1/2 time on the Project. It is difficult to establish and differentiate the consultant level of effort for APHA and PITT because APHA pays all the consultants except for PITT faculty. One can identify that only 20% of the allocated funds for consultants have been expended at the 40% point in the Project. From this one could assume that the Project has only received half of the expected consultations.

UWI Level of Effort. The APHA/UWI sub-agreement states:

Direct Salaries:	441.	PM/LOP @ 88.2 PM/Year

The university has spent 76% of its budgeted amount for direct salaries. The LOE has fallen below expected level because of a few vacancies in the first year. There is a need at present to create new slots for in-service tutors as well as modify the

senior research title to on-campus coordinator. The evaluation team envisions need for an additional full time equivalent (FTE) teaching position.

PITT Level of Effort. The APHA/PITT sub-agreement states:

- Direct Salaries: Coordinator

  3 3/4 PM/LOP @ 3/4 PM/Year

  Secretary

  10 PM/LOP @ 2 PM/Year

  Consultants

  60 PM/LOP @ 12 PM/Year

The University of Pittsburgh has provided the services of the coordinator and secretary as detailed in the agreement. A lack of information did not permit the detailed analysis of consultant level effort. PITT has only expended 13% of its consultants line item.

APHA and PITT have to date only spent $50,000 of the consultants line item, leaving a life of project amount available of $210,000.

7.4 LEVEL OF EXPENDITURE

Recapitulation of Project Expenditures. The information for this section was drawn from three financial data files prepared by APHA. These files were up to date to September 30, 1982 recapitulating the expend.ture of Year 1 and Year II. Some adjustments were made to accomodate encumbrances carried forward and late reports of Year II expenses submitted in January 1984. Figures are rounded off to the nearest thousand.

PROJECT EXPENDITURES BY RECIPIENT

YEAR 1 AND YEAR II - TABLE 7-B

	LOP BUDGET YR I&II	BUDGETED YR I&II	EXPEND. YR I&II	BUDGET YR I&II	LIFE OF PROJECT BALANCE
UWI	851	299	263	36	587
	34% of grant		88% exp.		
PITT	391	109	64	46	327
	16% of grant		58% exp.		
APHA	1,258	488	507	(19)	750
	50% of grant		104% exp.		
TOTAL	2,500	896	834	62	
			93% exp.		1,600

* An adjustment has been made to the APHA travel line item of $232K from the PITT travel line item. (See APHA letter to Pittinger 1/18/84.)

The above table indicates that UWI is slightly under expended (88%) and PITT only participating at 58% of the planned level. The overall project has spent only 33% of the LOP funds at the 40% (2 years of 5 years) point in the project.

EXPENDITURES BY LINE ITEM PER COLLABORATOR

Table 7-C is a rounded off accounting of expenditures following the main line items of the budgets of the various agreements. The table gives a breakdown of expenditures with some percentages for comparison. A few points are important to note:

a) UWI still has a balance of 74% of its budgeted funds unexpended for direct salaries. The balance is $434-K.

b) UWI's draw down on these 434K US dollars will be less because of the Jamaican devaluation.

US-$	434-K	@ 1.78 to Jamaican $	= J $722,520	budgeted
US-$	434-K	@ 3.25 to Jamaican $	= J$1,410,500	currently available

Difference.....J$637,980

As only approximately 70% of the direct services are paid in J-$, the rest in Eastern Caribbean and Barbados Dollars about $445,000 Jamaican dollars will be generated.

c) All recipients have expended more than was budgeted for other direct costs (ODC). APHA consumed 8-K more than the budgeted life of Project. ODC amount. PITT expended an ODC line item which was not contractually established. UWI consumed 55% of the LOP budgeted ODC amount in 40% of the time.

d) PITT which has not been participating to the anticipated level has only expended 16% of their LOP budgeted amount.

e) A total of 130-K has been paid out for overhead:

	EXPEND	OVERHEAD RATE	OVERHEAD
APHA	505,000	18%	92,000
PITT	63,000	29%	18,000
UWI	260,000	8%	22,000

f) 50% of the total LOP travel per diem line item has been utilized.

FISCAL YEAR 1982/1983 - To September 30, 1983

Table 7C

	APHA				PITT				UMI				TOTAL	
	L.O.P. BUDGET	YR. I & YR. II BUDGET	YR. I & YR. II EXPENS.	L.O.P. BALANCE	L.O.P. BUDGET	YR. I & YR. II BUDGET	YR. I & YR. II EXPENS.	L.O.P. BALANCE	L.O.P. BUDGET	YR. I & YR. II BUDGET	YR. I & YR. II EXPENS.	L.O.P. BAL.	CUMUL L.O.P. BUDGET	CUMUL L.O.P. BALANCE
A. Personal direct labor	416	153	146	270 65%	28	46	27	1 4%	588	202	154	434 74%	1,032 41%	705
B. Fringe benefits	83	32	21	62 75%	57	11	6	51 89%	65	22	17	48 74%	205 8%	161
C. Overhead	355	142	92	263 74%	90	30	18	72 80%	76	27	22	54 71%	521 21%	389
D. Consultants	46	16	42	2 5%	216	15	8[2]	208 96%	0	0	0	0	260 10%	210
E. Travel Per Diem[1]	331	146	167	164 50%	0	0	0	0	0	0	0	0	331 13%	164
F. Other direct costs	29	9	37	<8[3]>	0	8	4	<4>	121	46	67	54 45%	150 6%	42
G. TOTAL	1,258[4] 50%	487	505	753 60%	391 16%[4]	110	63	328 84%	850 34%[4]	297	260	590 69%	2,499[5] 99%	1.671

1 : Due to rounding total @ 2.5 million

4 : % age of total budget

3 : indicates deficit spending

2 : Faculty consulting

5 : Includes $212-K transferred from PITT Budget

N.B.- All amounts to nearest thousand, U.S. Dollars

7.5 PIPELINE ANALYSIS AND PROJECTION

According to the financial status report $1,500-K have been authorized, of which 649-K are unexpended as of November 30th, 1983. Because none of the recipients maintain emcumbered accounting it is difficult to determine the unencumbered unobligated pipeline. The project has spent less than budgeted for the past two years cumulatively, however, if spent 50% more in Year II than budgeted. If the project continues to expend at the Year II rate for Year III the letter of credit will be drawn to near zero by July, 1984. Steps should be taken to avoid this.

7.6 COMPONENT COST

Because of the bookkeeping it was only possible to estimate the component costs. Even though the original budgets and work plans were laid out programmatically the accounts were never kept programmatically. It was never clearly stated or made a contractual obligation to the recipients that they were responsible for programmatic bookkeeping.

In order to determine an index to estimate component expenditures the staff and consultants travel and pay register was totalled according to component. This produced a percentage index of:

Project Development/Start Up	15%	-	$ 125-K
On Campus	23%	-	$ 191-K
In-Service	33%	-	$ 275-K
Research	29%	-	$ 242-K
	TOTAL	-	$ 834-K

When these expenditures ARE extrapolated to the total to date expenditure of $834-K, it indicates an estimate of component cost. Note that all administration costs are spread out over the four activities. Each component cost would be commensurately lower if administration were considered to be a separate component.

Cost of State of the Art Study. The SOAS has cost a great deal more than anticipated because of problems outlined in the Research Section. According to APHA Field Office estimates the cost has been J-$ 120,000 without consultants and overhead. By the time the SOAS is finished in April 1984 it will cost by conservative estimate U.S. $85,657.

	J$	US$
Base	$ 120,000	
10% overhead	$ 12,000	$ 74,157
2 Burton and Layne Consultancies in December 1982/February 1984		$ 11,500
		$ 85,657

No administrative expenses are prorated onto the SOAS. Therefore, this represents an under-estimate of actual cost.

7.7 PROPOSED BUDGETARY ACCOUNT NUMBERS

In Table 7-D an accounting system is proposed which allows for ready ventilation and regrouping of expenditure for analysis. The first digit represents the line item; the second, the recipient; and the third, the project component. This system is compatible for use with off-the-shelf spreadsheet software.

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TABLE Z-D

CENTURIES		
100	Direct Salaries	
200	Fringe Benefits	
300	Overhead	LINE ITEMS
400	Consultants	
500	Travel & Per Diem	
600	Other Direct Costs	

DECADES		
10	APHA	
20	PITT	RECIPIENTS
30	UWI	

UNITS		
0	All Components	
1	Administration	
2	On-Campus	
3	In-Service	COMPONENTS
4	Research	
5	Technical Assistance	

Every expense should be attributed to one component. Those salaries that are not a direct part of a technical component should be attributed to the administration component.

The following are a few examples: APHA's fringe benefits

attributed to administration would be 211; total for travel and per diem would be 500.

PITT overhead attributed to on-campus activities would be 322; total for all on-campus would be 002.

UWI other direct costs would be 634. Total UWI direct costs would be 630.

7.8 RECOMMENDATIONS

1. Programmatic Budget

A detailed project programmatic budget should be worked out in coordination with the project modification exercise, following the guidelines in 7.7 above. UWI should participate fully in this exercise. The detailed programmatic budget should also try to identify UWI inputs for planning purposes.

2. PITT Other Direct Costs

A line item should be created in the PITT agreement to cover other direct costs. At present PITT is expending ODC without a line item.

3. Allocation of Consultant Funds

If feasible, the remainder of the line item "consultants" should be moved from PITT's budget to APHA's budget 1/3 and UWI's budget 2/3. This represents the present consultant use ratio. The chairman of the Executive Committee should be responsible for all decisions relating to UWI project unexpenditures.

4. Allocation of Travel Funds

If feasible, the travel budget should be reallocated between APHA's budget 1/3 and UWI's budget 2/3. UWI would expend from this line item following its quarterly travel plan. Regional travel arrangements would be cleared with RDO/C and extra-regional travel with AID/W, S and T Health.

5. UWI Overhead Increase

Consideration should be given to properly determining UWI's real overhead rate which is estimated by UWI to be much higher than the presently charged rate of 10%. UWI should be allowed to charge additional overhead to permit it to properly develop the institutional capacity to plan and respond to opportunities and potential

contracts in the region. Capitalization is a basic foundation of institution building. This should not put an extra burden on the UWI budget because devaluation has reduced the Jamaican based project costs by 55%.

6. Budget Line Item Comparability

Each line item on all of the agreements should be brought into harmony. The UWI budget, for example, has three line items, different from the other agreement: innovative projects, training workshops and workshop materials. These could be collapsed into other direct costs (ODC), in-service or on-campus as the case may be.

7. Reporting Forms

The recommendations for reporting in 7.2 above should be implemented if the forms are satisfactory to all concerned.

8. Salaries of Positions

New job slots in the direct salaries line items should be created as needed for UWI and identified by project modification. The title of Senior Researcher should be changed to On-Campus Coordinator to cover the costs of executing that function.

9. UWI Revolving Fund

Increase the revolving fund at UWI to $100-K. At present, UWI has over expended its revolving funds by $90,000. This is due to the reporting lag time between the three other project areas and Mona.

10. Cash Flow and Programmatic Accounting

The existing budget should be followed to avoid a cash flow problem (see 7.5 above). The new programmatic budget should be implemented following project modification and strictly adhered to. All accounts should be kept by the recipient on a programmatic basis.

8. RESPONSE TO EVALUATION SCOPE OF WORK

The evaluation Scope of Work identified twenty-five (25) questions which are of concern to A.I.D. project management. Although most of these questions are addressed elsewhere in this report, they are re-capitulated here on an issue-by-issue-basis.

1. To what extent have project output requirements been met?

Achievement of output requirements varies among the four project components. At mid-point in the project in-service training is meeting its output requirements and is proceeding on schedule as planned. The technical assistance component is also achieving its goals although much can be done to extend and improve the outputs. Having revised its ouput requirements, the on-campus training component is making limited progress towards its goals. Unless concerted effort is made in the next six months, and additional resources budgeted for this component, it stands in danger of failing to meet its intended output. Finally, the research component has made little effective progress toward its goals. Projected deadlines have not been met; no acceptable studies have yet been published; and the two studies nearing completion (SDAS and St. Lucia Country Specific study) are of questionable utility.

2. Relative to EOPS (End of Project Status), has the project made sufficient progress to this point of time?

Sufficient progress has been made with the in-service and technical assistance components. Research has not made sufficient progress, and this deficiency cannot be entirely overcome. Finally, the on-campus training program is falling behind schedule. As a result, some of the resources originally budgeted for research should be re-directed toward on-campus training to insure a successful outcome for that key component.

3. Are contract inputs and outputs achieved to date of sufficiently high quality?

No regular staff resources were budgeted as input to development of the on campus program. As a result, development of the component is at risk of failure. If the delay caused by this lack of input can be overcome, the output planned to date shows promise of good quality. As for the research component, the regular staff hired did not have the research background necessary to insure quality outputs, nor were adequate consultancies arranged to insure good quality control on the research methodology. The inputs and outputs achieved to date for the in-service and technical assistance components have been of good quality.

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4. Have the parties (APHA, UWI, PITT)) to this project performed adequately given field realities, particulars of the Cooperative Agreement, and the Subagreements?

In general, the parties have worked very hard to carry out a project with complicated administrative arrangements and unclear delineation of responsibilities.

5. Are the Cooperators approximating the implementation plan satisfactorily?

The Cooperators have not been meeting the implementation plan as anticipated. The project was slow to start and most of the first year was lost before staff were hired and all subagreements finalized. In addition, the annual workplans have set unrealistic goals and timelines. Therefore, despite reasonable implementation in some of the components, implementation seldom follows the projected "plan."

6. In what way have project expenditures differed from projected costs? Are discrepancies justified in the light of country and project realities?

This is discussed in Section 7.3, Level of Effort Analysis. The University of West Indies has spent 76% of its budgeted amount for direct salaries. This level of expenditure has fallen below that expected because of delay in filling positions in the 01 year. On the other hand, there is now a need to create new salary positions for in-service tutors, to transfer its senior research title to on-campus coordinator and create an additional full-time equivalent teaching position for the diploma program. Unexpended funds for the 01 year plus an increase in Jamaican dollars available due to recent devaluation may create enough funds to make rebudgeting possible. However, if UWI salaries are increased this summer, additional funds may have to be allocated from the general consulting budget in order to adequately staff UWI activities.

Only 20% of the allocated funds for consultants have been expended at the 40% point in the project. To a certain extent this appears to be due to the fact that U.S. consultants have not been called on as much as may originally been expected. Whatever the reason, the level of effort required to date for consultants indicates that some consultant money may be made available for other purposes.

7. Have reporting requirements been met adequately?

Although reporting requirements appear to have been met, the complicated administrative and institutional interrelationships require unusual efforts to insure adequate technical reporting.

Financial reporting has been show within the UWI system and AID/APHA reporting requirements have not been made clear to UWI.

8. Are changes in reporting requirements recommended?

To insure effective communication of technical reports the project administrator should travel to Washington, D.C., to personally present and explain the quarterly project reports. He also should meet regularly with the RDO/C and AID/Jamaica staffs to explain project development.

The semi-annual reports should include enough fiscal information to identify level of expenditure and projections. All accounts should be kept by the recipient on a programmatic basis and reported as such, using recommended reporting improvements identified in Section 7.2., Financial Reporting System.

9. Has the contractor exercised sound technical, fiscal and management skills in implementing this project?

This is basically a sound project, but there are several deficiencies. Administrative arrangements have been ambiguous because they do not clearly spell out the mutual responsibilities of contractors (APHA) and subcontractors (UWI and PITT); insufficient resources were budgeted for the campus-based training component; the research objectives have not been consistently and clearly stated in a operations research framework, leading to misdirection in staffing and implementation of research projects.

10. Is the level of output completed by the contractor consistent with the level of funds provided?

UWI is expected to implement the entire technical scope of work for the project with 34% of the grant funds, plus an additional 15% consultant and travel funds administered through APHA.

On-campus training has been under-funded and is accordingly slow to develop. In-service, technical assistance and research have been reasonably well funded. Of these three only research has little to show for the funds expended.

11. Are the purpose and assumptions of the project still valid?

The evaluation team considers that the goals and purpose of the project remain valid in that successful management and planning of health resources are necessary in the Caribbean. The indigenous expertise and technical assistance resources currently available to the University of West Indies justify the assumption that this is an appropriate area for AID assistance. However, the team must

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temper its optimism in the qualification that, given the lack of a formal needs assessment, the successful initiation of and responsive demand for the diploma program, coupled with demonstrated management improvement will be the ultimate test.

12. In the light of lessons learned to date by the cooperators, what elements of the Project should be redesigned?

The team recommends that current Cooperative Agreements should be modified to strengthen the delineation of responsibility and to reflect that delineation through appropriate rebudgeting (see Executive Summary, Part E and recommendations at end of Chapter 2, Administrative Arrangements). Specific recommendations in this regard are as follows:

a) UWI should rebudget its funds to adequately support each component activity, particularly the campus-based training component.

b) If feasible, portions of the APHA budget should be shifted to UWI in order for UWI to arrange for interregional travel and consultation.

c) The role of the project administrator should be clarified and a responsible UWI liaison person identified for each project component.

d) The role of the University of Pittsburgh should be altered to allow it (legally) to assist in research.

13. Have there been any deviations from project goals?

Project goals remain as first stated.

14. Are facilities adequate?

Facilities are adequate. Project administration is housed on UWI campus in the offices of the Department of Extra-mural Studies. This appears to be very appropriate.

15. Is the staffing appropriate?

There was is no staffing budgeted for the on-campus training component. This is a serious deficiency which must be immediately remedied. Other staffing is appropriate.

16. Within the existing project budget are staffing changes recommended?

The senior researcher position is being appropriately transferred to on-campus training coordinator. An additional full-time equivalent teaching position should be created to assist the on-campus training coordinator.

The staff tutor position in St. Lucia should be extended an additional year.

17. Are the financial resources of the project justified in terms of accomplishments and outputs?

With the exception of research which has produced limited ouput, the resources invested are proportional to the accomplishments to date and this seems to be a justifiable use of AID funds.

18. Is the on-campus component of the project appropriately located within the academic institution?

The diploma program in health management is provisionally located within the Faculty of Social Sciences. This is entirely appropriate since the majority of the expertise required for teaching the diploma courses lies with Social Sciences.

It should be noted that this administrative location will not be final until the University Executive Committee formally approves the diploma program. Since the location is not final and since the Faculty of Medicine alternatively could provide an appropriate location for the diploma program, the evaluation team has urged the Vice Chancellor's Office to expediate final approval and location of the diploma program.

19. Are the project governance and administrative procedures effective and appropriate?

This project has been implemented under a Cooperative Agreement which legally places primary management authority in the hands of the AID Project Officer. Since this also is a very complicated, flexibly designed project, it requires a great deal of careful attention and experienced direction from the project officer. Unfortunately, during the first two and one-half years the project has had three different project officers. Furthermore, AID restrictions on staff travel have restricted on-site monitoring. These circumstances almost insure tardy and inappropriate governance procedures by AID.

The governance procedures within and between APHA and UWI appear appropriate although one could expect they would be more effective if contracted responsibilities were more clearly delineated.

20. Should a followup project be envisioned or a similar project be considered for another country, what changes should be made in design that are suggested by the lessons learned to date?

1. A regional project cannot be effectively administered

from AID/Washington without provision for adequate project officer travel. A similar multi-faceted project should not be designed with regional scope; or, if some regional scope is desirable, it should address a limited and well-defined set of activities, such as in-service education.

2. The tripartite institutional agreement between APHA, PITT and UWI creates unnecessary confusion about roles and responsibilities. One U.S. institution is enough, with other U.S. resources brought to bear on an individual consultant basis.

3. The four project components were not operationally integrated in the project design. Thus, the four components became four sub-projects each with its own pace and direction. Design of any follow-on project should clarify how separate components will interact on a practical, operational basis.

4. A needs assessment should be programmed into the initial project year.

21. **Is there likely to be a need for future AID assistance of this type?**

The concept of inter-institutional development projects seems quite timely. AID could do much to build LDC indigenous resources through institutional development particularly in the areas of operations research and management training.

22. **Is a needs assessment which was not programmed before project initiation desirable at this point in time?**

The progress of the Project is essentially demonstrating need as each component is being implemented. A formal needs assessment would not be useful at this time, although it should have been explicitly called for in Year 01 as rationale for the General Sector Study.

23. **What are the post-project plans of the UWI for maintenance of the on-campus health management program? Are they realistic and feasible?**

UWI administration appears sincerely committed to establishing an ongoing diploma program in health management. The feasibility of this remains to be demonstrated. Curriculum planning must be completed and the diploma program must be offered next year in order to market the program and establish some estimate of the level of demand. Only when this is done can planning be completed to generate the necessary budget and staffing for an ongoing program.

24. Does the operations research component appear to be contributing to the goal of the Project? If so, how so, and if not, why not?

Unfortunately, the Project does not have a well-defined operations research component. This is discussed in Section 6.1, Research Design. The research component falls short of O.R. If O.R. had been clearly defined and established in the Project design, the research component might have presented a stronger contribution to project goals.

25. What changes are suggested for any component of the Project, including should it be expanded to more countries?

Research activities should be reduced in scope and priority in order to insure adequate resources for campus-based training. In-service training should not be implemented in Jamaica. Instead, it should be offered to one or two of the small island CARICOM countries.

9. PROPOSED LOGICAL FRAMEWORK REVISION

LOGICAL FRAMEWORK

Project Title and Number: Health Development Planning and Management

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal To provide support to the governments of the West Indies to strengthen their capabilities to plan and manage health sector resources in order to improve the health of their populations.	Measures of Goal Achievement: -Health sector resources allocated in West Indian Ministries of health in accord with planned priorities and targets. -Health management technique and process improve service delivery. -Health status of West Indies population improves.	-Examination of ministries' health plans, budgets and expenditures. -Audits of management techniques, examination of management regulations and guidelines. -Life expectancy increases, age-specific mortality declines; rates of natural population increase lessen.	Assumption for Achieving Goal Targets: -West Indian government are receptive to changing health planning/management practices, and will utilize assistance. -Improved health planning and management will contribute to improved health status. -Political stability will permit institutionalization of improved health planning/management practices in governments assisted by the Project.

Project Title and Number: Health Development Planning and Management

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Purpose -To establish at the University of the West Indies the sustained capability to work with West Indian Ministries of Health to -Train health planners and managers -Facilitate access to a pool of indigenous health management consultants -Promote and carry out health services research	**End of Project Status** 1) The UWI Faculties of Social Science and Medicine collaboratively viewed by CARICOM Nations as offering and attractive, competitive source for provision of on-campus health planning and management training to CARICOM Ministries. -UWI solicited by governments and donors to conduct problem-related health planning and management in-service training. 2) UWI a functioning segment of a larger network supporting and providing qualified consultants in health planning and management. 3) Operational research in health services accepted by the region as a useful planning and management tool. 4) Assisted governments have improved capability to plan and manage health sector resources.	1) Funding and staffing for on-campus health management program supported by contributing nations. -Enrollment figures for on-campus training substantiates countries' participation. -Proportion of West Indians seeking health planning and management training from extra-regional sources drops when compared to those seeking training from UWI. -Examinations of funding documents pertaining to inservice training performed by UWI. -Examination of in-service training documentation and evaluation reports. 2) Examination of requests for services and reports of consultants identified in Registry. -Analysis of utilization by extra-regional sources of information and services of Resource Center at ISER. 3) Examination of operational research protocols, research reports, and evaluations of follow-on actions. 4) Analysis of health plans, budgets and expenditures demonstrates move towards congruence. -Country-specific analysis of health planning and management practices demonstrate movement towards identified goals.	-Quality of the UWI Program will be perceived by Caribbean countries to be equal or superior to programs available extra-regionally. -UWI and contributing nations will provide resources to sustain Project initiated activities. -Project-supported inservice training and research methodologies can be adapted for use in other Caribbean nations. -Governments and donors will be aware of, value, and utilize indigenous consultant and support services identified and supported by the Project. -Governments will coordinate planning and budgeting processes in order to allocate resources to the health sector sufficient to achieve agreed upon priorities and targets.

Project Title and Number: Health Development Planning and Management

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs: 1) Problem-based, modular designed methodology for inservice training development, tested, documented and evaluated. 2) An institutionalized after-first (post-baccalaureate) degree diploma course in health management developed tested, implemented and evaluated. 3) A roster of qualified West Indian consultants available for interregional health planning and management identified, screened, and established at UWI. 4) A resource center for health management and planning developed, stocked, indexed and maintained at UWI. 5) Health services problem oriented operations research methodology developed, tested, refined and conducted.	Magnitude of Outputs: 1) Problem based in-service training conducted in conjunction with Ministry of Health of at least five nations including two lesser developed nations (St. Lucia, Barbados, Trinidad and two lesser developed countries). Technical assistance in health planning/management provided to one nation (Jamaica). 2) Beginning in the Fall of 1984, two rounds of the University based diploma course administered to a total of 20 West Indians. 3) One computerized registry of at least 100 West Indian potential consultants physically located and maintained by UWI, serving nation and donor clients from the region. 4) A resource center of over 100 publications established at ISER. 5) At least two (St. Lucia, Trinidad) and up to four (Barbados, Jamaica) country-specific health operational research activities completed. State of the Art document in health management completed for campus nations and St. Lucia. Annotated bibliography completed. At least two pieces of general health services research (eg., Management Information Systems and Human Resources) completed by UWI.	1) Examination of curricula, records of methodology, and reports of in-service training evaluations. Examination of Technical Assistance reports. 2) Health management diploma program officially approved by 3 UWI campuses and UWI administration by Summer 1984. Examination of diploma course curriculum, course outline and staff assignments. Observation of classes beginning Fall of 1984 and 1985, including analysis of country of origin and career aspirations of students. 3) Observation and qualitative analysis of Registry. Analysis of usenge reports of Registry. 4) Observation of Resource Center at ISER, including index and records of services provided. 5) Analysis of applications of research findings of country-specific research. Examination of research protocols and reports of research.	1) Participating countries will participate fully in design and implementation of inservice training. UWI can mobilize resources in time to establish diploma course before Fall, 1984 deadline. Participating countries administratively and financially will support attendance of students for on-campus program. 3) Qualified West Indian consultants in health planning and management can be identified and will agree to being placed on the Registry. 5) The utility of health services operations research will be perceived and requested by participating countries.

LOGICAL FRAMEWORK

Project Title and Number: Health Development Planning and Management

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Inputs A.I.D. 1. Funding for Cooperative Agreement 2. Project Monitoring 3. Internal Evaluations Recipient(s) of Cooperative Agreement 1. Project Implementation 2. Technical Assistance 3. UW faculty positions 4. Commodity support 5. Internal evaluation Cooperating Countries 1) Support candidates for on campus course 2) Participate in inservice training research	Implementation Target (Type and Quantity) A.I.D. 1) $2.5 Million over 5 years 2) Logistic support for Project Officer 3) One evaluation in years 3, one in year 5 Recipient(s) of Cooperative Agreement 1) Implementation according to time lines, work plans 2) As negotiated to achieve Project Purpose 3) As negotiated to achieve Project Purpose 4) As negotiated to achieve Project Purpose Cooperating Countries 1) 20 candidates total in year 4 and 5 2) At least 15 members/country selected by Country Program Committee. -Country specific research topic identified at least two countries	A.I.D. 1) Project documents 2) Trip reports; evaluation reports 3) Evaluation reports Recipients 1) Review of Cooperative Agreement, work plans 2-5) Evaluation reports Cooperating Countries 1) University records 2) Project Records, site visits	A.I.D. 1) Funding can be provided in timely fashion 2) A.I.D. procedures and funding will permit adequate monitoring Recipients 1) Cooperative Agreement will adequately delineates responsibilities of all parties involved 2) Appropriate T.A. will be provided, and will be utilized by the Project 3) U.W.I. can provide adequate positions to achieve Project purposes 4) Administration procedures provide limited commodity provision in timely fashion Cooperating Countries Appropriate candidates will be identified, supported Host countries willing to participate in inservice training, research

January 18, 1984

MEMORANDUM

TO: S&T/HP, James E. Sarn

THRU: S&T/H, George Curlin

FROM: S&T/H/HSD, Donald C.E. Ferguson

SUBJECT: Scope of Work for the Evaluation of Cooperative Agreement AID/DSPE-5901-A-00-1039-00

I. Project Title: Health Development Planning and Managment/APHA/Caribbean

A. Project No: 936-5901
B. Cooperative Agreement No: AID/DSPE-5901-A-00-1039-00
C. A.I.D. Project Manager: Donald C.E. Ferguson, S&T/H/HSD

II. Contractor/Principal Investigator:

A. Cooperative Agreement: American Public Health Association Washington, D.C.
i. Subagreement 1: University of the West Indies, Mona, Kingston, Jamaica.
ii. Subagreement 2: University of Pittsburgh, Pittsburgh, Pa.

B. Project Director (APHA): Dr. Alfred Gerald
i. Subagreement Director (UWI): Pro-Vice Chancellor Leslie B. Robinson
ii. Subagreement Director (PITT): Dr. Gordon MacLeod, School of Public Health

III. Purpose of the Evaluation: Scheduled Project Mid-Term Evaluation

This Cooperative Agreement which runs through 1986, calls for a Mid-Term External Evaluation. The evaluation is to assess project progress, management and performance, and provide recommendations for change for the balance of project life.

IV. Dates and Places of Evaluation:

The evaluation is scheduled to begin February 7, 1984. Planned itinerary is as follows:

Feb. 7-8	Team orientation by S&T/H Project Manager Rosslyn, Va.
Feb. 9-10	Site visit to American Public Health Assoc. Washington D.C.
Feb. 12	Team departs for Jamaica Team meeting and document review
Feb. 13-16	Site visits to UWI, USAID/Kingston, MOH
Feb. 18	Departure of two team members to Trinidad Departure of two team members to Barbados
Feb. 19	Begin writing and reading of additional documents
Feb. 20-21	Site visits to MOH/Trinidad and UWI Trinidad campus Site visits to MOH/Barbados, RDO/C, and Barbados site of O.R. study
Feb. 22	One team member visits MOH St. Lucia and OR study site
Feb. 23	Team returns to Kingston, Jamaica
Feb. 24	Interviews with APHA Project Manager in Kingston
Feb. 27-29	Report writing and coordination, Kingston, Jamaica Team leader departs team leaves drafts with team leader prior to departure.
March 20	Final draft reviewed by Project Manager
March 30	Final report submitted to AID/W

V. Composition of the Evaluation Team:

The evaluation team will include specialists in the following areas:

a) health management and health management training
b) in-service training/health care organization/ministries of health
c) health project evaluation, project design, and AID health program, policy and procedures
d) university-based health training and education programs, operations research..

A four person team comprised of three non-AID and one AID direct-hire specialists will be assembled. All team members will be seasoned, experienced professionals in their areas of specialty. Three team members have been selected, and a fourth is currently being recruited. Team members selected are as follows:

Dr. William Callan, University of Washington, School of Public Health

Dr. M. Bud Shutt, University of North Dakota School of Medicine, Team Leader

Ms. Anne G. Tinker, Chief, Health Services Division, Office of Health

Mr. John Burns, Staff Associate, Management Sciences for Health

VI. Cost of the Evaluation:

Exclusive of the direct-hire team member, total costs are estimated at $29,000. Several support mechanisms will be used to reach desired team members.

VII. Project Background:

This project, initiated on September 30, 1981, is one of two sub-projects located in two geographical regions under a single project umbrella. The HDPM/Indonesia shares several objectives in common with the HDPM/Caribbean project, although the particulars of project organization and activities differ.

The primary objective of the HDPM/Caribbean Project is to institutionalize health management, planning and development in the region as reflected in the major components of the project:

a) institutional development of an on-campus degree in health management at the UWI Mona Campus in Jamaica
b) development of in-service training curricula and methods for ministries of health in the region with demonstration efforts in Trinidad, Jamaica, Barbados and St. Lucia
c) development of a roster of indigenous consultants in the region to assist in health management problem solving and solution development
d) operational research support and creation of a resource center in the service of above objectives
e) raising the interest and capabilities of ministry staffs in health management in the countries partcipating during the life of project.

VIII. Problems and Issues to be Assessed by the Evaluation Team:

1. To what extent have contract output requirements been realized?
2. Relative to the EOPS (End of Project Status), has the project made sufficient progress to this point in time?
3. Are contract inputs an outputs achieved to-date of sufficiently high quality?
4. Have the parties (APHA, UWI, PITT) to this project performed adequately given field realities, particulars of the Cooperative Agreement, and the Subagreements?
5. Are the Cooperators approximating the implementation plan satisfactorily?
6. In what ways have project expenditures differed from projected costs?
   Are discrepancies justified in the light of country and project realities?

7. Have reporting requirements been met adequately?
8. Are changes in reporting requirements recommended?
9. Has the contractor exercised sound technical, fiscal and management skills in implmenting the project?
10. Is the level of output completed by the contractor consistent with the level of funds provided?
11. Are the purpose and assumptions of the project still valid?
12. In the light of lessons learned to date by the Cooperators, what elements of the project should be redesigned?
13. Have there been any deviations from project goals?
14. Are facilities adequate?
15. Is the staffing appropriate?
16. Within the existing project budget are staffing changes recommended?
17. Are the financial resources of the project justified in terms of accomplishments and outputs?
18. Is the on-campus component of the project appropriately located within the academic institution?
19. Are the project governance and administrative procedures effective and appropriate?
20. Should a follow-on project be envisioned or a similar project be considered for another country, what changes should be made in design that are suggested by the lessons learned to date?
21. Is there likely to be a need for future AID assistance of this type?
22. Is a needs assessment which was not programmed before project initiation desirable at this point in time?
23. What are the post-project plans of the UWI for maintenance of the on-campus health management program? Are they realistic and feasible?
24. Does the operations research component appear to be contributing to the goal of the project? If so, how so, and if not, why not?
25. What changes are suggested for any component of the project? (including expansion to other countries?)

IX. List of Documents to be provided to Evaluation Team:

1. Request for Propcsal
2. Contractor Proposal
3. Cooperative Agreement (APHA)
4. Subagreement (UWI)
5. Subagreement (PITT)
6. Workplan Year I and Year II
7. Annual Report Years I and II
8. Draft State of the Art document
9. Executive Committee Reports
10. Selected Consultant Reports
11. Internal Evaluation

X. Proposed Schedule of Events:

Week 1.	Tues.-Wed:	Rosslyn, Va. Team assembles and meets AID Project Officer, LAC/HN staff.
	Thurs-Fri:	Washington, D.C. Site visit to APHA. Meetings with Project Director and project personnel, review contractor files.
	Saturday:	Team departure for Kingston, Jamaica
	Sunday:	Document review.
Week 2.	Mon-Fri:	UWI site visit, Mona Campus. Interviews with those involved in on-campus, in-service, and research components of project based in Jamaica. Visit to MOH Jamaica, USAID/Kingston, and APHA Project Manager. Subagreement (UWI) file review.
	Saturday:	Two team members depart for Trinidad. Two team members depart for Barbados.
	Sunday:	Writing and document study.
Week 3.	Monday:	Trinidad sub-team visits UWI/Trinidad campus and Trinidad MOH. Barbados sub-team visits MOH, research site, and RDO/C.
	Tuesday:	One team member departs Barbados to St. Lucia. Other team members continue visits begun Monday.
	Wednesday:	Sub teams return to Kingston, Jamaica from Trinidad, Barbados and St. Lucia.
	Thursday:	A.M. Team meets in plenary. P.M. Team meets with Project Manager Thelwell for question period and discussion.
	Fri-Sun:	Report organization and writing assignments by Team Leader.
Week 4.	Mon-Tues:.	Report writing.
	Wednesday:	Drafts delivered to Team Leader prior to departure. Team departs Jamaica.

Recommendation:

That you approve the scope of work outlined above for evaluation of the Health Development Planning and Managment Project/Caribbean.

Approved: _____

Disapproved: _____

Date: 1/19/84

Clearances:

ST/H: A. Tinker AT Date: 1/15/84
H. Destler HD Date: 1/15/84
ST/PO: F. Campbell Date: 1/19/84
K. Milow Date: 1/19/84
G. Eaton Date: 1/19/84

ST/H/HSD:DCFerguson:rn:1/16/84:Revised 1/18/84:x59649:0464R

Persons Contacted

Washington DC

A.I.D.

Ms. Paula Feeney, Health and Nutrition Officer, Latin American Bureau

Dr. Donald C.E. Ferguson, Officer of Health, Science and Technology Bureau

Robert Ware, AID Contracts Officer, CM/COD

APHA

Dr. Susi Kessler, Associate Executive Director, International Health Programs

Dr. Alfred N. Gerald, Deputy Director-Program Manager, International Health Programs

University of Pittsburgh

Dr. John Cutler, Head Department of Health Services Administration

Dr. Gordon MacLead, Department of Health Services Administration, HDMP Project Liaison

APPENDIX

Persons Contacted

Washington D.C.

A.I.D.

Ms. Paula Feeney, Health and Nutrition Officer, Latin American Bureau

Dr. Donald C.E. Ferguson, Officer of Health, Science and Technology Bureau

Robert Ware, AID Contracts Officer, CM/COD

APHA

Dr. Susi Kessler, Associate Executive Director, International Health Programs

Dr. Alfred N. Gerald, Deputy Director-Program Manager, International Health Programs

University of Pittsburgh

Dr. John Cutler, Head Department of Health Services Administration

Dr. Gordon MacLead, Department of Health Services Administration, HDMP Project Liaison

Jamaica

Administrative Staff College

Ms. Phyllis Green

AID Jamaica

Mr. John Corry, Health Nutrition, Population Officer
Ms. Francesca Nelson, Health Nutrition, Population Officer

APHA

Dr. Richard Thelwell, Project Administrator

Government of Jamaica

Ministry of Health

Mr. Rupert Ramcharan, Permanent Secretary
Ms. Edna Tulloch, Health Planner
Dr. John McCardy, Chief Medical Officer
Dr. Carmen Bowen Wright, Primary Health Care
Mr. Cedric Taylor, Personnel and Management
Ms. Evette Lee, Health Planner, also UWI HPDM student
Dr. Christine Moody, Project Coordinator, Health Management Improvement Project

PAHO

Dr. Isabel Eleta, Community Development Advisor

University of West Indies

Mr. A.Z. Preston, Vice Chancelor
Mr. L.R.B. Robinson, Pro-Vice Chancelor (Planning)
Dr. S.R. Wray, Dean, Faculty of Medicine
Prof. G.E. Mills, Dean, Faculty of Social Sciences
Prof. Sir Kenneth L. Standard, Head, Department of Social and Preventive Medicine
Dr. Edwin S. Jones, Head, Department of Government
Mr. Uriel H. Salmon, Head, Department of Management Studies
Dr. John Greene, Acting Director, Institute of Social and Economic Resources
Mrs. Hermaine McKenzie, Head, Department of Sociology
Prof. Ralston Milton Nettleford, Professor of Extra-Mural Studies
Dr. Marjorie Holding, Department of Social and Preventive Medicine
Mrs. Patricia DeSai, Lecturer, Department of Social and Preventive Medicine

Dr. Satharine I. Maharaj, Lecturer, Department of Social and Community Medicine
Dr. Mike Fitzhenly, Lecturer, Department of Social and Community Medicine
Ms. Joan Rawlins, Research Assistant, Institute of Social and Economic Resource
Dr. Phyllis Macpherson-Russell, Consultant, Human Resource Development, Department of Extra-Mural Studies
Mrs. Ina Barrett, Lecturer, Department of Government
Mr. Locksley Lindo, Sr. Lecturer, Department of Management Studies
Ms. Linnette M. Harriss, Assistant Lecturer, Department of Government
Mr. Leon Wilson, Bursar

Barbados

AID

Mr. Allen Randlov, Regional Health and Population Officer, RDO/C

Caricad

Dr. Selwyn Smith, Director
Dr. Aubrey Armstrong, Training Officer
Dr. Fredrick Nunes, Training Officer

Ministry of Heath

Dr. Allison Daniels, Permanent Secretary
Mr. Carl Yard, Assistant to the Permanent Secretary; Coordinator, Country Programmer Committee
Mr. Cortez Nurse, Director of Planning and Project Design
Dr. Leonore Harney, Chief Medical Officer

University of West Indies, Cave Hill Campus

Dr. Farley Brathwaite, Vice-Dean, Social Sciences
Prof. Mickey Waldron, Vice-Dean, Medicine
Dr. John Mayers, Head, Department of Management Studies
Ms. Una Clarke, Resident Tutor, Department of Extra-Mural Studies

PAHO

Dr. Harry Drayton

Caribbean Development Banks

Dr. Courtney Blackman, Director

Consultants

Sir: Carlisle Burton, Kt., O.B.E.
Mr. Edward Layne

St. Lucia

Mr. Cornelius Lubin, Permanent Secretary, Ministry of Health and Housing (MHH)
Dr. Anthony DeSousa, Chief, Medical Officer, MHH
Dr. James St. Catherine, Medical Officer of Health, MHH
Mr. Russell Combie, (Staff-Tutor), Senior Public Health Inspector, MHH
Mr. John LaForce, Public Health Inspector, Castries City Council
Personnel of Bexon District Public Center
Ms. Marilyn Floissac, UWI, Resident Tutor, St. Lucia

Trinidad and Tobago

Ministry of Heath

Hon. Neville Connell, Minister
Mr. Bertram Ifill, Permanent Secretary
Dr. Norma Andrews, Permanent Medical Officer
Dr. Karen Sealey, Planning
Mrs. Joyce Bicep, Staff Economist, Planning

University of West Indies, St. Augustine Campus

Dr. Lloyd E.S. Braithwaite, Pro Vice Chancellor
Mr. W.C. Parris, Vice Dean, Social Sciences, Senior Lecturer
Mr. Philbert Morris, Department of Mathematics

PAHO

Dr. Hal Dyer, Trinidad

Dr. Peter Carr, Washington D.C.

APPENDIX 3

List of Documents Reviewed

The following represents a partial listing of the major documents reviewed. The team has access to file materials within the APHA and HDPM, including financial files, additionally, there were draft portions of several consultants' reports which were not listed because either the author or approximate date could not be identified by the team.

A. Administrative Staff College, Jamaica

Administrative Reform Enquiries in Jamaica, 1942-1980, vol 1, (Jan. 1983) and vol. II (April, 1983), Margaret Priestley.

Employee Morale in the Jamaican Civil Service, Phyllis A. Green, Derek S. Gordon, Edwin, S. Jones, 1983.

Report on First Executive Symposium Ministry of Health, Jamaica, December 1 and 8, 1983.

B. Agency of International Development

Cooperative Agreement No.: DSPE-5901-A-00-1039-00, September 30, 1981.

Project Evaluation Summary (PES), RDO/C Basic Health Management Training Project, October 26, 1983.

Request for Application (RFA) for Cooperative Agreement (CA) AID-DSPE-1028: Health Development Planning and Management, July 20, 1981.

C. American Public Health Association

Health Development Planning and Management Application grant, October 30, 1980.

Health Development Planning and Management Project (HDAM) Technical Application, Vol. 1 and 2 (undated).

HDPM Semi-annual reports:
October 1, 1981 - April 30, 1982
May 1 - September 30, 1982
October 1, 1982 - March 31, 1983

April 1 - September 30, 1983

Report of Internal Review Team, August 4, 1982.

Subcontract between the University of Pittsburgh and the American Public Association, 1982.

Subcontract between the University of the West Indies and the American Public Association, December 18, 1981.

D. Caribbean Centre for Development Administration (CARICAD)

Case method: A guide for Caribbean Trainers, Carston M. Simmons, July 1981.

Handout for Management by Objectives and Results Executive Symposium, January 19-20, 1984.

A Draft Application to HDPM for funding at Executive Symposia (undated).

Report on Management by Objectives and Results Executive Symposia, St. Lucia, January 19 and 20, 1984.

1984 Work Programme (undated).

E. Caribbean Community (CARICOM)

Evaluation of the Model District Health Team Project, St. Lucia, August, 1982.

F. Health Development Planning and Management Project

Caribbean Community Health Management: The State of the Art (draft): Omawale and Sonia Subaran. Institute of Social and Economic Research, University of West Indies, March, 1983.

Final Report on Constraints to Integrated Health Management at Parish Level, Barry Chevannes (UWI), November 21, 1983.

HDPM Barbados, Quarterly Reports:
- October - December, 1982
- January - March, 1983
- April - June, 1983
- July - September, 1983
- October - December, 1983

HDPM Consultant Report on the Development and Implementation of the First Course in the HDM Programme: Health and Social Organization, Ruth C. Browne (UWI), September 28-December 13, 1983.

HDPM Consultants Report on the Formulation of a programme for Executive Symposia and the Development of a Network of Consultants, Edwin S. Jones (UWI) and Neville C. Duncan (UWI), September 23, 1983.

HDPM Project District Level Programmer, St. Lucia, Vieux Fort Health Center, June 27 - July 7, 1983: Training Manual for Data Collection.

HDPM Executive Committee Minutes:
February 5, 1982
May 5, 1982
October 15, 1982
January 18, 1983

HDPM Inservice Training Program, St. Lucia, Report on Module V and the District Level Program, Consultant Trip Report by Ms. Shirley Fletcher June 11 - July 9, 1983.

HDPM Project Work Plan and Summary Budget for Year II (undated).

HDPM Project Work Plan and Summary Budget for Year III 1983-1984 (undated).

HDPM Quarterly Report, May 1 - July 31, 1982.

HDPM Update Report, February - March, 1982.

Health Services Management in the English Speaking Caribbean - State of the Art Study of the Ministry of Health - Barbados, Carlisle Burton, Kt., OBE, December, 1982.

Improvement in the Castries Health Center Services Draft (undated).

Management Training for Physician Administrators in Barbados and Trinidad, John L. Coulehan (PITT), August 6, 1982.

Report of the UWI Curriculum Consultancy Team: Gladstone Mills (UWI) Chairman, Clara Kimbro (Johns Hopkins), Morris Schaefer, (North Carolina).

Solid Waste Disposal Research, St. Lucia, Draft Report, Paul Hippolyte, August, 1983.

Trip report to Barbados and St. Lucia to initiate Curriculum Consultancy, Lan G. Rawson (PITT), May 14-18,

1982.

Trip Report to St. Lucia Draft, January 11-24, 1984, Maurice Shapiro (PITT).

G. University of West Indies

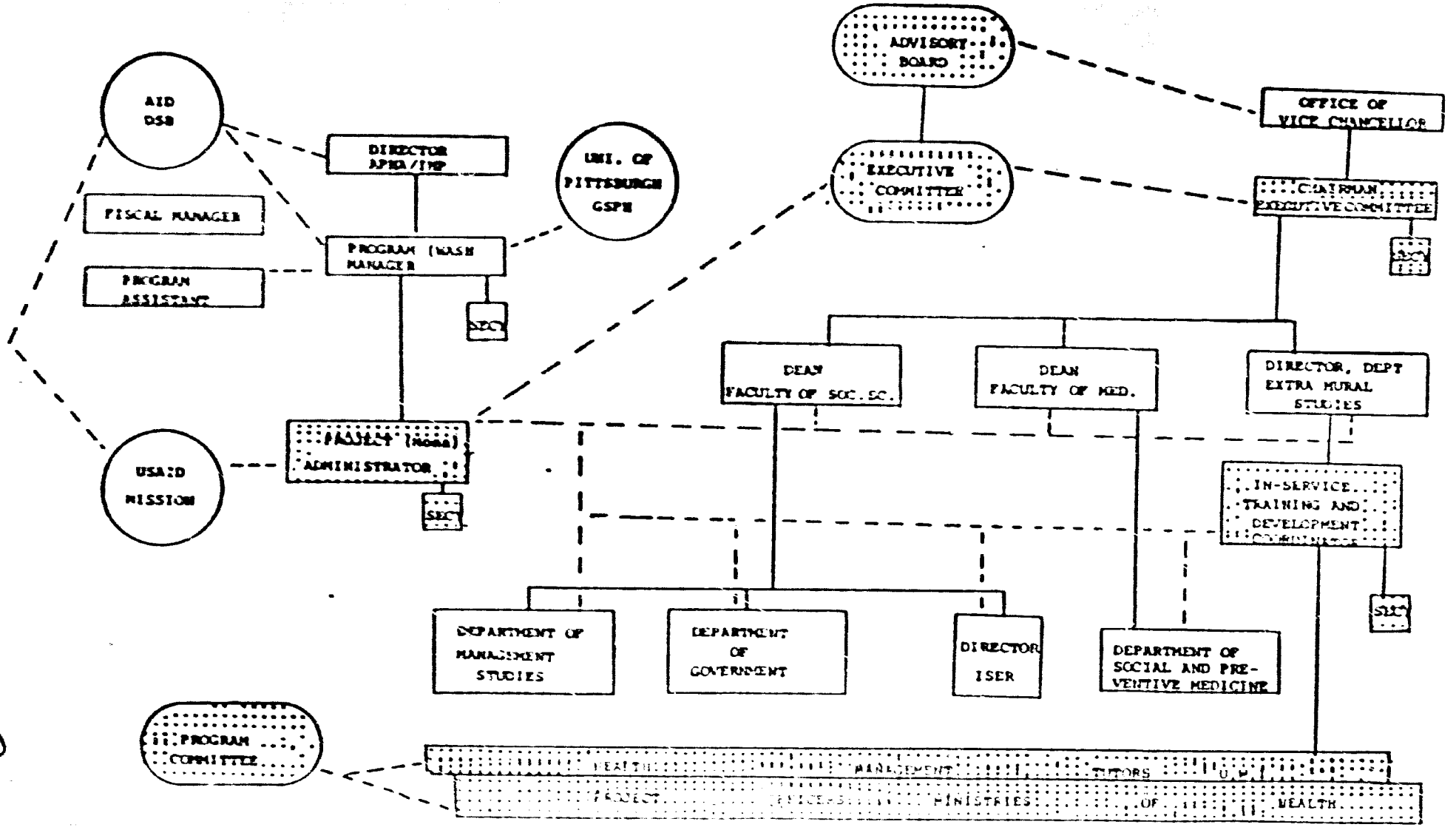
Brochure, Certificate in Community Health Management (CCAM) Challenge/Outreach, part time programme.

Case Studies Prepared by the University of the West Indies for use in the Regional Programme of Continuing Education in Administration of Family Planning Programmes (AMRO-1312), 1974-78.

Department of Social and Preventive Medicine, 25th Anniversary Booklet, April 1957 - April 1982.

University of West Indies Calendar Vol. II, Academic Year 1981-1982.

HDPH ORGANIZATION CHART



LOGICAL MATRIX

ELEMENTS OF PROJECTS	SUCCESS CRITERIA	VERIFIERS	EXTERNAL FACTORS
Outputs (CONT'D)			
o Reinforcements: - attachments - projects - problem solving activities - study programs	o Tutors/Consultants/Researchers have established ongoing supportive relationship with Health Managers	o Records of follow-up on reinforcement activities in the Ministries of Health o Records of completed courses and interventions.	
o Training of 30 tutors/consultants/researchers - associates of the indigenous pool of management consultants.			
o Technical Assistance			
o Documented Report on assessment of needs	o UWI Consultants Registry System and Resource Center operational and utilized by Government, UWI faculty, consultants with International & Bi-lateral agencies.	o Report on services provided by consultants drawn from the pool. o Consultant reports on assignments. o Government responses/evaluation of consultancies.	o The establishment of attractive fee structure for consultants
o Registry of health management consultants.			
o Health Management Resource Center installed at UWI			
o Research			
o State of the Art Report (regional health management)	o Results of research are reflected in the new curriculum at UWI, in the In-Service Training Programs in each of the four countries, as well as in standard setting in health management.	o Reports and updates on the State of Art Study. o Reports on Country specific studies.	
o Four country specific studies (problem focussed.			
o Documented periodic update of State of the Art (3rd & 5th year)			

LOGICAL MATRIX

ELEMENTS OF PROJECTS	SUCCESS CRITERIA	VERIFIERS	EXTERNAL FACTORS
Outputs			
A. On-Campus Training			
o Two optional courses - Year 1	o Increasing number of UWI students in the Faculty of Medicine elect courses in management offered by the Faculty of Social Science.	o Transcripts of record of students enrolled in the Diploma of Community Health and Diploma of Public Health courses at UWI who have elected to take management courses.	o Continued financial and other support from external sources for the planned duration of the project.
o Two additional optional courses Year 2	o Increasing number of students who have completed the degree course in Health Management or otherwise trained for management roles in the Health Sector	o Other student records.	o Acceptance and support of the project by the Ministries of Education.
o A cross faculty health management degree course offering at UWI beginning Year 3 and beyond	o Adequate number of UWI faculty members with recognized capability to teach Health Management courses.	o UWI Curriculum incorporating the new degree course in health management.	
o Upgraded UWI Faculty in Health Management skills (study grants short term courses, attendance at seminars, workshops, etc.)			
B. InService Training & Development			
o At least one major on the job training exercise for key health managers (job focussed - career focussed) in each of the four participating countries.			
o Consultation Services - direct assistance to managerial staff in Ministries of Health to carry out research to analyze and solve country specific management problems	o Participating countries with active Health Management Development Programs in which the consultants, methods, and materials developed by the InService Training and Development Component of HDPM are effectively utilized	o Correspondence between Project Administrator and governments.	o Participating Governments adoption of personnel policies such as to ensure retention of adequate number of trained Health Managers.

Appendix 5

LOGICAL MIX
HEALTH DEVELOPMENT PLANNING & MANAGEMENT PROJECT
(HDPM)
WEST INDIES 1981-1986

ELEMENTS OF PROJECT	PROCESS CRITERIA	VERIFIERS	EXTERNAL FACTORS
Development Objectives			
o To improve the practice of management in the health sector in the English Speaking Caribbean and to provide an adequate supply of trained managers capable of better designing, planning and managing the health systems.	o Evidence of improvement in the utilization of human, financial, material, information, and time resources in the management of Health Services to attain satisfactory levels of health care for the total population.	o Existence of documented plans, procedures, guidelines, regulations, and systems for the sound management and control of health sector programs.	o Priority governments assign to health sector in terms of the overall budget, staffing, policy decisions, etc.
Immediate Objectives			
o To build institutional capability at UWI to develop and implement courses of study off and on campus which will meet present and future needs for trained health managers in the region.	o Regular offering at UWI of a degree course in health management and continued inservice training in management in each of the four participating MOHs by the beginning of Year 1.	o Course evaluation reports, records of attendance and performance at UWI; reports on training activities and on management development within the MOHs.	o Action taken by Governing Body of UWI (Senate) and other accreditation bodies to recognize and approve courses.
o To make accessible to governments, particularly Ministries of Health (MOH), as well as regional and country health institutions, the services of a pool of indigenous experts capable of meeting needs for technical assistance in health management.	(1) o 10-20 middle and/or senior level managers working in each of the participating MOHs trained in health management.	o UWI Consultancy Registry records on usage of the service and of performance evaluation of both the service and the consultants.	o Capacity of UWI and individual governments to financially support activities initiated by this project after withdrawal of present financial support.
o To utilize operational research in training, as a problem solving tool in the management of health systems, and as a source of information in the carrying out of expert technical advisory functions.	o Appreciable demand and usage of information resulting from operational research undertaken by Ministries of Health, the Institute of Socio-Economic Research of UWI and other related regional institutions in the field of health management.	o Resource Center records on content of the collection and the usage of this new source of information.	o Acceptance and effective use of a pool of indigenous consultants by other international agencies, bilateral organizations as well as by the countries of the region.
o To develop an ongoing collaborative relationship between the University of the West Indies and the University of Pittsburgh in the training of health managers		o Research Reports, Consultancy Reports and Evaluations.	

(1) Approximately sixty trained health [illegible]

Appendix 5

LOGICAL MATRIX

ELEMENTS OF THE PROJECT	SUCCESS CRITERIA	VERIFIERS	EXTERNAL FACTORS
Inputs			
A. On-Campus Training			
o 10 P/M Lecture Hours o 10 P/M Curriculum Consultancy (Pitt) o UWI Accreditation o Seminars Workshops Grants for UWI Faculty upgrading.	o UWI Health Management Curriculum established and accredited. o Adequate number of UWI Faculty members exposed to advanced Health Management training.	o Project reports o UWI records o Ministry records o Evaluation reports	o Financial support from external sources for planned project duration.
B. Inservice Training and Development			
o 4 P/M Consultancy to analyze country specific problems o 8 P/M consultancy for Reinforcement:-attachments, projects, problem solving activities, study programs, etc. o 10 P/M consultancy for training of 30 tutors/consultants/researchers o 3 P/M UWI/Pitt Curriculum Consultancy Team o 1 full time coordinator, Inservice Training & Development. o 2 Full time Resident Tutors	o Improved management practices in Ministries of Health of the participating countries	o Project reports o UWI records o Ministry plans, management procedures, and practices o Evaluation reports	o Ministries decision to assign high priority to improvement of management practices.
C. Technical Assistance			
o 15 P/M Management Support Consultants o 4 P/M consultancy for Assessment of needs for T.A. in the region o Part time Administrative Assistant/Jamaica o Part time Project Administrator	o Increase use of indigenous consultants by Ministry of Health and other regional and international agencies. o Impact of efficiency of management in the Ministries of Health	o Consultants reports o Evaluations o Ministry records	o Competition among various sectors for the use of services of limited number of indigenous experts in management in general and health managers in particular. o Unattractiveness of fee structure for consultants
D. Research			
o 4 P/M consultancy for problem definition in 4 countries o 4 P/M consultancy for State of the Art Study o 4 P/M consultancy for four Country Specific Studies	o Wide utilization of research findings for training in management throughout the region as well as for decision making and problem solving within the Health Sector.	o Consultancy register records o Ministry records o Consultancy reports o Evaluation reports	

Appendix 5

TABLE 1

COUNTRY	ECONOMY: GNP per capita (US$)	DEMOGRAPHY: Population (,000)	% Population <5 years	Total Infant Mort. Rate	Neo-natal Infant Mort. Rate	1-4 Year mortality	No. of years to double population	No. of years to double population	UNDERNUTRITION: % of birth-weights under 2500g	% of under five year olds underweight: Gomez I	Gomez II & III	Hosp. Case Fatality Rate for PEM & Gastroenteritis	% Paediatric admissions due to PEM and/or gastroenteritis
TIGUA	716 (A)	73 (B)	11.7 (B)	28.4 (A)	14.2 (A)	1.0 (B)			8.2 (A)	25.5 (C)	3.65 (C)	5.8 (A)	24.2 (B)
PAULS	2620 (C)	200 (C)	19 (H/C)	28.4 (A)	18.2 (A)	1.2 (K)	34 (A)	34 (A)	9.6 (A)				
BADOS	1940 (C)	247.3 (B)	8.9 (B)	28.3 (B)		1.2 (B)	80 (C)	80 (C)	19.0 (B)	36.1 (p) (B)	3.4 (p) (B)		
IZE		128.3 (B)	19.1 (B)	38.5 (A)	17.0 (A)	4.5 (B)				40 (c) (F)	19.2 (F)		
ITISH VIRGIN ISLANDS		12 (I)	27.8 (I)	24.5 (I)	10.0 (A)	0.8 (K)			5.6 (A)				
MAN		12 (I)	13.2 (I)	17.8 (I)		0.8 (K)			7.9 (B)	14.1 (c) (B)	2.0 (c) (B)		
MINICA	440 (C)	81 (B)	13.0 (B)	21.9 (B)		1.4 (B)			10.5 (B)	38.6 (p) (B)	12.1 (p) (B)		23.4 (B)
NADA	530 (C)	110.4 (B)	13.4 (B)	29+ (A)	25? (A)	1.9 (B)	42 (C)	42 (C)	12.2 (B)	29.1 (c) (B)	10.6 (c) (B)	9.6 (A)	
ANA	550 (B)	825.4 (B)	14.7 (B)	50 (C)		5.8 (K)	33 (C)	33 (C)	12.2 (B)	43.0 (p) (D)	17.7 (p) (D)		
AICA	1110 (C)	2200 (C)	15.8 (I)	15 (C)		4.2 (K)	31 (C)	31 (C)	11-14 (A)	31.1 (p) (B)	17.8 (p) (B)		
TSERRAT	745	11 (I)	13.5 (I)	38.6 (A)	33.4 (A)	1.5 (K)			14.4 (A)	19.8 (c) (B)	2.5 (c) (B)		
KITTS-EVIS	560	47.9 (B)	11.4 (B)	46.9 (A)	22.7 (A)	1.3 (K)			13.3 (A)	32.5 (c) (B)	6.9 (c) (B)		20.8 (B)
NT LUCIA	630 (C)	110.8 (B)	17.6 (B)	30.4 (B)	8.7 (A)	2.3 (B)	25 (C)	25 (C)	9.7 (A)	32.8 (p) (1974) (B)	4.2 (p) (1978) (B)	4.1 (A)	14.4 (B)
VINCENT	380	100.4 (B)	16.7 (B)	64.4 (B)	20.9 (A)	4.3 (B)			10.4 (B)	22.7 (p) (B)	7.8 (c) (B)		40.9 (B)
INAD	2110 (C)	400 (C)	16.1 (I)	30 (C)		2.6 (K)	30 (C)	30 (C)					
NIDAD	2910 (C)	1067.0 (B)	12.1 (B)	25.6 (B)		1.5 (B)	37 (C)	37 (C)		36.8 (p) (B)	12.5 (p) (B)		
S & ICOS		6 (I)	15.8 (I)	17.5 (I)							<7 (F)		
D LDC	560	3283000		110 (C)			34 (C)	34 (C)					
D MDC	6260	1131000 (C)		20 (C)			111 (C)	111 (C)		16	4		
D Regional 1 SPA 2000	—			<30		<2.4							

*(c) = clinic sample

(p) = population sample

TABLE 2

COUNTRY	ANAEMIA		OVERNUTRITION			FOOD SUPPLY						
	% Anaemic		% Obese		Diabetes Mortality Rate (/00,000 age adjusted)	% Households With Adequate Diet			Total Food Available as % Recommended		% Nutrients Locally Produced	
	Pre-school (<11 g/dl)	Pregnant Women (<11 g/dl)	(>20% Std. W/H) Women	Men		Energy	Protein	Iron	Energy	Protein	Energy	Protein
ANTIGUA					17 (A)							
BAHAMAS		33 (A)			5 (E)							
BARBADOS			32 (J)	7 (J)	21 (E)	42 (F)	58 (F)	39 (C)	130.1 (F)	174.4 (F)	42 (F)	24 (F)
BELIZE					10 (E)							
BRITISH VIRGIN ISLANDS												
CAYMAN	42.7 (C)											
DOMINICA					8 (E)							
GRENADA	38.0 (C)	.1 (C)			16 (E)	44 (<5 yr) (B)	82 (<5 yr) (B)					
GUYANA	41.0 (C)	55 (C)	39 (J)	13 (J)				42 (C)	70.7 (B)	107.0 (B)		
JAMAICA	76.0 (C)	45 (C)	24 (J)	5 (J)	26 (E)	25 (F)	36 (F)	69 (C)	125.2 (F)	146.5 (F)	66 (F)	58 (F)
MONTSERRAT		85							112.3 (F)	158.1 (F)	54 (F)	38 (F)
ST. KITTS-NEVIS	21.6 (C)											
SAINT LUCIA	14.3 (C)	22 (C)	28	2.4	7 (E)							
ST. VINCENT					15 (E)	28 (F)	70 (F)	73 (C)	100.9 (F)	125.6 (F)	35 (F)	33 (F)
SURINAME	20 (F)				21 (E)							
TRINIDAD					16 (E)				123.9 (F)	151.2 (F)		
TURKS & CAICOS		(C)	28 (J)	12 (J)	37 (E)	60 (F)	69 (F)	66 (C)	108.0 (F)	134.9 (F)	51 (F)	29 (F)
WORLD LDC												
WORLD MDC			17-32 (UK) (J)	18 (UK) (J)	6.5 (N. Amer.) (E)				100 (H) 133 (H)			

Capital letters in brackets beside figures indicate data source

TABLE 3

COUNTRY	INFRASTRUCTURE		PROGRAMMES								
	Food & Nutrition Council	Nutrition Officer	Food & Nutrition Policy	Nutr. Surveillance System	Growth Charts in Use	National Breast-feeding Action Plan	Oral Rehydration in Use	Supplementary Foods through MCH	'Meal Planning for Diabetics' in Use	Tertiary Care for PEM based on 'Treatment Manual'	Community Health Aids employed
ANTIGUA	Yes	No	Draft	/	Yes	Yes	Yes	Yes	Yes	Yes	Yes
BAHAMAS	No	No	No	No	Yes (A)	No		No	Yes		
BARBADOS	Yes	Yes	No	//	Yes	No		No	Yes		Yes
BELIZE	Yes	No	No	No	Yes	Yes		No	Yes		
BRITISH VIRGIN ISLANDS	No	No	No	No	Yes	No	No (A)		Yes		
CAYMAN	Yes	No	No	/	Yes	No			Yes		No
DOMINICA	Yes	Yes	Yes	/	Yes	Yes	Yes	Limited	Yes		
GRENADA	Yes (A)	Yes	Yes	//	Yes (A)	Yes	Yes	Yes	Yes	No (A)	
GUYANA	Yes	Yes	Yes	//	Yes	Yes		Yes	Yes		Yes
JAMAICA	No	Yes	Yes	//	Yes	Yes	Yes	Yes	Yes		Yes
MONTSERRAT	Yes	Yes	Yes	//	Yes	Yes	No	Yes	Yes		No
ST. KITTS-NEVIS	Yes	Yes	No	///	Yes (A)	No		Yes	Yes		No
SAINT LUCIA	Yes	Yes	Yes	//	Yes	Yes	Yes	Yes	Yes	Yes (A)	
ST. VINCENT	Yes	No	Draft	No	Yes	Yes	No	No	Yes	No (A)	
SURINAME	No	No	No	No	Yes	No	No	No			
TRINIDAD	No	Yes	No	No	Yes	No	Yes	No	Yes		
TURKS & CAICOS	No	No	No		Yes	No			Yes		No

Capital letters in brackets beside figures indicate data source

SOME FACTS ABOUT THE UNIVERSITY OF THE WEST INDIES

WHAT IS THE UNIVERSITY?

It began as the University College of the West Indies in 1949 but was granted University status in 1962. The University of the West Indies now grants its own degrees and is supported by and serves fourteen different territories in the West Indies. The territories which support the University and which send students for the various courses are:

Antigua	Grenada
Bahamas	Jamaica
Barbados	Montserrat
British Honduras	St. Kitts-Nevis-Anguilla
British Virgin Islands	St. Lucia
Cayman Islands	St. Vincent
Dominica	Trinidad & Tobago

SITING OF THE UNIVERSITY CAMPUSES

The University consists of three campuses.-

Cave Hill in Barbados (established in 1963)

St. Augustine in Trinidad (established in 1960)

Mona in Jamaica (established in 1948)

'In Jamaica the Mona campus consists of several departments and four Halls of Residence. The campus occupies 653 acres stretching from Papine to August Town. This land is leased by the governing bodies of the University from the Government of Jamaica for 999 years at a peppercorn rental. The Faculty of Medicine which is also sited on the Mona Campus includes the University Hospital of the West Indies, a teaching hospital, which caters to the people of Jamaica as well as other sections of the Caribbean.

HALLS OF RESIDENCE

There are four Halls of Residence which houses undergraduate students viz, Taylor Hall, Mary Seacole Hall, Chancellor Hall and Irving Hall.

FUNCTIONS OF THE UNIVERSITY

'The University prepares persons for undergraduate and postgraduate degrees in Agriculture, Arts and General Studies, Education, Engineering, Law, Medicine, Natural Sciences, Social Sciences. It also awards Diplomas and Certificates in Public Administration, International Relations, Management Studies, Nursing Education, Nursing Administration, Social work, Mass Communications.

Appendix 7

OPPORTUNITIES FOR LEARNING

In addition to its degree and diploma and certificate programmes, the University, through the Department of Extra Mural Studies provides adults and adolescents with opportunities for intellectual and cultural activities and prepares students for examinations such as GCE which serve as a stepping stone to higher learning.

STRUCTURE OF THE UNIVERSITY

The University is divided into eight Faculties - Arts & General Studies, Medicine, Law, Social Sciences, Natural Sciences, Education, Agriculture and Engineering. Each Faculty is headed by a Dean and Vice Dean. The Faculties are then split up into departments, each of which has a departmental head.

HOW THE UNIVERSITY WORKS

The University conducts its business through a series of committees which all report to Council, the highest body of the University. Members of Council include the Chancellor, the Vice Chancellor, Campus Principals and Deans of the Faculties.

Council normally meets once a year in the Main Administrative buildings at Mona with representatives from all the territories and University bodies. The next meeting of Council takes place on April 2nd and 3rd, 1982.

SOME IMPORTANT UNIVERSITY COMMITTEES AND WHAT THEY DO

COUNCIL

The highest governing body of the University. It receives and considers an Annual Report as well as an audited statement of Accounts of the work of the University each year.

THE SENATE

The Senate consists of University Officers including the Vice Chancellor, the Pro-Vice Chancellor, the Campus Principals, the Dean of the Faculties, the Professors, the Librarian and others.

The Senate is the academic authority of the University and exercises control and general direction for research instruction and examinations and the award of Degrees, Diplomas, Certificates and other distinctions.

FINANCE & GENERAL PURPOSES COMMITTEE

This Committee deals with all matters connected with the receipts and expenditure of money within the University and meets at least six times a year.

There are several other committees within the University in the various Faculties. These meet from time to time on their own, but they all report to the Senate Committee which sets guidelines for their activities, and a final report is submitted to Council each year.

TIME OF WORK AT THE UNIVERSITY

The bulk of activity at the University is conducted between 8:30 a.m. and 4:30 p.m. the normal working day, but the teaching departments continue well into the night with lectures and other activities.

...../3

THE PEOPLE IN CHARGE AND WHAT THEY DO

The Chancellor is appointed by Council and presides at meetings of this body, the graduation ceremony and performs such duties as may be conferred on him by the University Charter. The Chancellor may hold office for seven years.

The Vice Chancellor is also appointed by Council and holds office for a period decided by that body. The Vice Chancellor is the administrative head of the institution and exercises general supervision over the educational arrangements of the University. He is responsible to Council for the maintenance and promotion of good order and efficiency of the University.

Pro-Vice Chancellors act for the Vice Chancellor in his absence. Some have specific responsibilities eg. security, development and planning, and research.

Deans of the Faculties are appointed by Senate on the nomination of the Faculty Board. The Dean is the administrative head of the Faculty.

The Registrar acts as Secretary to the Council and the Senate and, through his staff, services all committees set up by the Council, the Senate and the Boards of Faculties respectively.

The University Bursar handles the University's accounts and receives all money on behalf of the institution.

SOME NAMES YOU SHOULD KNOW

The chief administrators at the University at Mona are:

The Vice Chancellor	Mr. A.Z. Preston
The Pro-Vice-Chancellors	Prof. L.R.B. Robinson
	Dr. F.P. Augier
	Professor G.C. Lalor
The Registrar	Mr. C.E. Jackman
The University Bursar	Mr. L. Smith
The Bursar, Mona	Mr. L.H. Wilson
The Estate Manager	Mr. D.C. Charley
The Personnel Officer	Mr. K. Miller
The Deputy Personnel Officer	Mrs. Winnie Mills

UNIVERSITY OF THE WEST INDIES, MONA
PUBLIC RELATIONS OFFICE
3RD MARCH, 1982.

Health Development, Planning, and Management Project (HDPM)

UWI

Curriculum Consultancy

December 1982

SUMMARY

In response to the needs of many Caribbean countries for improved health management capability, UWI will establish and refine over the next four years an On-Campus training programme in health management. This programme, coordinated with the In-Service Training and Development, Research, and Technical Assistance components of the HDPM Project in suporting national health development, will be a joint programme of the Faculties of Medicine and Social Sciences. The main participating departments are Government, Management Studies, and Social and Preventive Medicine. The programme will involve all campuses of UWI, as well as other contributing departments.

Although consideration was originally being given to the introduction of an undergraduate degree programme, in the light of subsequent discussions with a variety of persons, it has been agreed that an initial offering of an interdepartmental Diploma in Health Management would be more appropriate. Hence, it is proposed that such a programme should commence in October 1984, on both a full-time and part-time basis. Later, development of a certificate and/or degree programme might be undertaken. It is hoped that even while the phased implementation of the Diploma in Health Management (DHM) is taking place, the main participating departments would offer special modifications of existing diploma programmes in public administration, management studies, and community health that would serve as an interim response to the training needs of health managers in Caricom countries. In 1983-84 an initial health management course will therefore be offered.

The study programme in health management will integrate subjects in community health, management methods, social policy and health system organization, with the learning of appropriate and emerging techniques. Its objective will be to prepare students to function as health managers in the context of the changing health policies of the Caricom Countries, in a variety of roles in the upper and middle management levels of those national health systems.

The academic programme of the Diploma in Health Management (DHM) will, on a full-time basis, extend over one academic year and, on a part-time basis, over a minimum of two years. The programme will include five courses and will require completion of a field project following the end of the academic programmme. The inclusion of a six month internship requirement is to be considered.

Academic programme development will be linked with an educational process involving key health sector and related national programme development leaders and will draw on information support from the Institute of Social and Economic Research, on the resources developed by the HDPM Technical Assistance Component, and on HDPM support of faculty development.

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Emphasis in pedagogy will be on applicative problem-solving, interactive learning methods and techniques, based upon the student's firm understanding of the conceptual basis of health policy, management technology, and community health work. Appropriate materials, integrated into learning packages that are consistent with course structures and non-academic learning activities will be prepared, tested and utilized.

Policy guidance of the programme will continue to be provided by the HDPM project mechanisms of the Advisory Board and Executive Committee supported by the Curriculum Consultancy Team and Country Programme Committees. For continuing development of the study programmes, an interdepartmental curriculum working group has been formed. The group consists of:

Department of Government
Ms. Ina Barrett
Ms. Lynette Harris

Department of Management Studies
Mr. Locksley Lindo

Department of Social and Preventive Medicine
Dr. Marjorie Holding-Cobham
Dr. Winsome Segree

In-Service Training and Development
Dr. Phyllis MacPherson-Russell

Institute of Social and Economic Research
Dr. Omawale

HDPM Project Administrator
Mr. Richard Thelwell

Accessibility of academic learning opportunities in health management will be progressively increased by arrangement for part-time academic studies, by extension of the programme base into continuing education, and by utilization of the newer education and communication techniques, through a pattern that will involve all UWI Campuses and some of the non-Campus Countries. Complementary to such increased accessibility, the On-Campus health management educational effort will include provisions for management training modules to be integrated into the education of various categories of health and health-related professionals and para-professionals, as well as into their continuing education programmes, e.g., the undergraduate MBBS, Diploma in Public Health, Diploma in Community Health, and Family Medicine Residency programmes.

APPENDIX IV

Possible Sequencing of Subjects in a Five-Course Structure

HEALTH AND SOCIAL ORGANIZATION	POLICY ISSUES AND INSTITUTIONS IN	HEALTH MANAGEMENT PROCESS	HEALTH RESOURCES MANAGEMENT	ANALYTICAL METHODS FOR HEALTH MANAGEMENT
Concepts of Health Determinants of Health	Theories of State and Social Welfare Health in Development	General and Social Systems Theory Planning for Health	Health Financial Management	Health Status Measurement (Biostatistics)
Health System and Health Organization	Health Economics	Project Planning and Management Evaluation and Control (Communication)	Support Systems Development and Management Organizational Structuring	Analytical Methods-A
Institutional and Role Behaviors in Health	Health Law Ideological and Policy Issues	Information Management Marketing, Promotion and Coordination	Human Resources Development and Management (Communications) Operations Management	Analytical Methods-B

Key: 1. October-December Term, 2. January-March Term, 3. April-June Term

Appendix 9

HDPM PROJECT

The "First Course" in the DHM Programme

"HEALTH AND SOCIAL ORGANIZATION"

UNIVERSITY OF WEST INDIES

DEVELOPMENT WORKSHOP IN HEALTH MANAGEMENT AND PLANNING

at

Department of Health Service Administration
Graduate School of Public Health
UNIVERSITY OF PITTSBURGH
09/05/83 - 09/10/83

From Dean Faculty of
Social Sciences
February 1983

From Consultant Report
Maurice Schaffer, DPA
May 1983

BSS (M) P
36
1982/83

UNIVERSITY OF THE WEST INDIES

HEALTH DEVELOPMENT PLANNING AND MANAGEMENT PROJECT

PROPOSAL FOR INTRODUCTION OF NEW COURSE

It is proposed that the Faculties of Medicine and Social Sciences should jointly offer a course entitled 'Health and Social Organization', to begin in October, 1983. The course will be offered mainly through the Departments of Government, Management Studies, Sociology and Social and Preventive Medicine.

This course is intended as the initial component of a five-course programme leading to a Diploma in Health Management which is currently being planned. It is expected that these plans will be completed with a view to introducing this Diploma Programme in October, 1984

The development and delivery of this course represents one aspect of the implementation of the Health Development Planning and Management Project, funded by the USAID through APHA and administered by the UWI. As members are aware (minutes of Faculty Executive Committee Meeting held February 9, 1982), the Project which commenced in 1982, was developed in response to the needs of the English-speaking Caribbean countries for strengthening and improving their health management capa bility.

While plans are being made to develop the curriculum for the other four countries, it is proposed that the course 'Health and Social Organization' will be offered on a full-time basis, as an optional course to students who are registering in the existing Diploma in Public Administration, or as an additional course in the Diploma in Management Studies, or as a special course to qualified persons practising in Health Administration who are desirous of improving their theoretical/conceptual knowledge of the health-related aspects of their administrative functions. The time-table for teaching and examining this course is being arranged to coincide with the University academic year. The time schedule will be finalized after a joint examination has been made of the teaching hours for the com-pulsory courses in the Diplomas in Management Studies and Public Administration.

Detailed planning, material development and scheduling are being pursued by the Curriculum Working Group of staff from both Faculties to whom we are grateful for producing the first draft of this paper.

Overall Course Objective

To provide the student with a knowledge of the Caribbean Health Sector and with the skills required for its effective management.

Specific Course Objectives

At the completion of the course the student is expected to:

1. Be aware of selected concepts of health;
2. Be able to identify various determinants of health and disease,
3. Have knowledge of, and be able to critically analyse the components of the health system and organization of the health services,
4. Have knowledge of institutional and role behaviours and be able to analyse role relationships in the health system and their influence in organizational effectiveness,
5. Be able to apply knowledge gained in the course to the solution of specific organizational problems in the health system.

Teaching Method

Since the content of this course will be mainly theoretical, the teaching method will be based on lectures and seminars. However, the didactic approach will be supplemented by use of the case study method by which students will be challenged to solve problems presented through information about situations drawn from "real world" experiences.

Research for case study material is currently being carried out by the Institute of Social and Economic Research as a component of the HDPI Project.

Course Content and Syllabus are set out in an Appendix.

Qualifications for Admission to the Course

Any candidate for the Diploma in Public Administration or Diploma in Management Studies may register for this course as an option. The course may also be offered to specially admitted students who:

1. are graduates of an approved university, or
2. hold an approved technical or professional qualification from an approved body, or

3. have in the opinion of the University practical experience or other qualifications of special relevance to the course.

Examinations

Candidates will be subject to the rules and regulations governing the examination of students in the Diploma Programmes. If on registering, this course is added to the total Programme load, the grant of the diploma will not be dependent on his passing this extra course. If, however, the course is taken as an optional in the total programme, the candidate will be required to pass this course in order to qualify for the Diploma.

The Board of Studies is asked to recommend that approval be given to the introduction of the course, Health and Social Organization as an optional subject in the Diploma in Public Administration and the Diploma in Management Studies.

Dean, Faculty of Social Sciences

February, 1983

APPENDIX

1. Concepts of Health: Biological, physical and socio-cultural factors in definitions of health, environmental factors in health, individual and community health in the Caribbean setting, the role of the individual in the maintenance of health, health needs of various age groups.

   · 9 hours

2. Determinants of health and disease. Epidemiological principles and methods, ecological relationships to health embracing biological, chemical, physical and social environments, etiologies of some diseases important in the Caribbean. Awareness of the importance of health status measurements.

   · 15 hours

3. Health System and Health Services Organization. Principles of primary health care, health sector components and organization, inter-sectoral concepts of health system, demography as it relates to health services, public health systems, ideals and realities, governmental/private relations.

   · 21 hours

4. Health institutional and role behaviours: Social structures in health organizations and sectors; professions and professionalization, provider and patient roles, task allocations among providers, technological innovation, social innovation, organizational effectiveness.

   · 21 hours

DRAFT SEQUENCE OF TOPICS IN HEALTH & SOCIAL ORGANIZATION

1983 - 84

Introduction:

The following listing presents a compilation and revision of earlier suggestions by the writer and is provided as a point of departure for the U.W.I. Curriculum Working Group's efforts to arrive at a final specification for the course. This listing is subject to challenge on the basis of alternate logics and approaches to the subjects, factors particular to the Caribbean situation, and such circumstances as faculty or documentary availabilities.

Items marked with asterisks (*) are those on which additional information has been provided in a letter to R. Thelwell from M. Schaefer, dated February 9, 1983. A double asterisk refers to a communication to Dr. M. Holding-Cobham of December 1982 in relation to DPH/DCM teaching in the January - March term of 1983.

The listing assumes three contact hours per week.

Week No.	Topics
	Start of Michaelmas Term
1.	CONCEPTS OF HEALTH AND DISEASE
1.	Course Introduction and Overview Health as a Social Norm (Vickers **) Health as a Function of Growth and Ageing
2.	Medical Models of Health and Disease; Acute, Degenerative Socio-culterual Concepts of Health, Historical & Current
3.	Roles of Individuals, Community and the Health Services Individual and Community Health in the Caribbean

II. DETERMINANTS OF HEALTH AND DISEASE

4. Epidemiological Principles and Methods
5. Overviews of Health Determinants
   a. McKeown, Blum *
   b. Ecosystem Models *
6. Examples of Caribbean diseases linked to domestic/community environments
   Examples of Caribbean diseases linked to work environment and pollution
7. Examples of Caribbean communicable diseases (several types of vectors)
8. Examples of Caribbean diseases involving social transmission (STD, substance abuse, traffic accidents)
   Degenerative diseases in the Caribbean
9. Diseases in Relation to Lifestyle; Caribbean aspects; aspects of Social Class

   Summary of Module

10. (Student Performance)

End of Michaelmas Term; Start of Hilary Term

III. HEALTH SYSTEM AND HEALTH SERVICE ORGANIZATION

11. Health Protection and Promotion as a Societal Function
    Intersectoral Character of the Health System
12. Health Sector in Relation to Health System; Public and Private Sub-Sectors
    Primary Health Care Philosophy as Moving Sector toward System **
13. Primary Health Care Policies and Programmes in the Caribbean

14. Organization of Function of Health Care Institutions *
15. Issues in Health Care Organization *
16. Human Resources for Health *
17. Regulation and Financing of the Health Sector *
18. (Student performance)

IV. HEALTH INSTITUTIONAL AND ROLE BEHAVIOUR

19. Formal Organization Models; Sources of Deviation in the Health Sector
20. Alternative Models of Organization *

End of Hilary Term; Start of Trinity Term

21. Social Structures and Relations in Health Organizations*
    Professions and Professionalization *
22. Role of Science and Technology in Health; Impacts on Institutions, Providers and Clients *
23. Organization of Tasks and Personnel; Concepts of "Team" *
24. Motivation; Organizational and Social Innovation*
25. Organizational Effectiveness: Concepts, Criteria and Problems

26 - 30 (Student Performance; Case Problem in Organizational Effectiveness? Examination Period).

Appendix 10

UWI - DEPARTMENT OF EXTRA-MURAL STUDIES

HEALTH DEVELOPMENT PLANNING AND MANAGEMENT PROJECT

TRAINING AND DEVELOPMENT COMPONENT
IN-SERVICE PROGRAMMES

ST. LUCIA AND BARBADOS

OCTOBER 1982 - SEPTEMBER 1983

The In-Service Programmes in St. Lucia and Barbados are being developed in accordance with the plans submitted in the HDPM Project Document. The overall aim is to improve the capability of the health systems through personal development and organizational development over a two-year period. The main features of modular instruction and related assignments during the intervals, co-ordinated with supportive activities with staff groups supervised by the participants, are common to both programmes; but the organization is different as is the focus of the thrust.

In St. Lucia and in Barbados, considerable time and effort have been spent in securing consensus about the nature of the programme to be undertaken and in establishing a working relationship between Ministry of Health officials and UWI staff. Both programmes have been approved by the respective Country Programme Committee, after being accepted by the Advisory Board for inclusion in the Work Plan for Year 2. The Executive Committee is being asked to offer further comment and advice about the details presented in this document.

PROGRAMME IN ST. LUCIA

Preparatory Actions

Acting on the decision of the Advisory board at the meeting on October 23, 1982, the Training and Development Co-ordinator has spent four weeks in St. Lucia during the period November, 1982 to February, 1983 in order to plan the details of the programme and arrange for the necessary administrative support.

In addition to the key personnel in the Ministry of Health - the Permanent Secretary, the Director of Health Services and the Medical Officour of Health - other Health officials have been included in the development of the programme. The opportunity has also been taken to brief the Minister of Education and the Minister of Community Development about the plans because of the importance of these two Ministries to the success of the efforts at the community level. The Director of Finance and Planning and the Director of Training have also been kept informed of the plans which are being developed.

Heads of Departments have participated in selecting the members of the National Team and have agreed to arrange release time needed for the Programme. A meeting with prospective members of the National Team was held on January 19, 1983. (See Appendix 111)

Arrangements have now been made for secretarial services at the University Centre; but it has not been possible to employ a Staff Tutor (Health Management). Administrative support is available through the collaboration of the Resident Tutor and the co-operation of the Ministry of Health has been assured through the Permanent Secretary. The programme is being co-ordinated jointly by the Medical Officer of Health and the Training and Development Co-ordinator (HDPC Project).

Focus of the Programme

The Government of St. Lucia is committed to making adequate Health Care available to all its citizens and to developing the concept of Primary Health Care as stated in the Alma Ata Declaration of 1978. During the period 1981 to 1985, it is intended to implement the policy of establishing six Health Districts for the delivery of Primary Health Care and a part of the implementation plan is increasing the management capability of Primary Health Care personnel by in-service training programmes, supplemented by overseas training.

The HDPC Project can support directly the efforts of the Government to increase its management capability through the In-Service Programme which aims to assist the Ministry of Health in the preparation of personnel to manage Primary Health Care and establish the system envisaged.

Design of the Programme

In order to meet the needs of the St. Lucia Ministry of Health and the targets of the HDPM Project, the In-Service Programme has been designed to provide instruction and support for Health Workers at three levels - National, District and Community. Fifteen members of the National Team will participate in a programme consisting of seven one-week instructional modules, coordinated with field work related to the Health Districts, over a period of five to six months. The National Team will in turn conduct training and development activities to improve the managerial competence of Health Workers at the District and Community levels over a period of twelve to eighteen months, with support from the HDPM Project. It is expected that some 150 persons in Health and Health-related agencies island-wide will be helped to improve their management capability and that the management requirements of Primary Health Care will be established.

During Year 3 of the HDPM Project, members of the National Team will engage in a variety of activities to reinforce learnings and support change efforts.

Participants in the Programme

Four kinds of participants will be included in the Programme and play different roles.

1. National Team The fifteen persons selected to form the National Team are representative of the categories of Health Workers involved in Primary Health Care - Medical, Nursing, Environmental, Public Health, Education (See Appendix 1) - and are distributed through all six Health Districts.

2. District Team Members of the District Team will include members of the National Team, who will perform special organizing and leadership roles, as well as other Health Workers in the District Hospitals and Health Centres and in the Environmental Health programmes. Certain officers in the Ministries of Education, Community Development and Agriculture, who have District responsibilities, may also be included as members of the District Team.

3. Community Teams In addition to all the Health Workers who relate to a Health Centre, members of Community Teams will include personnel who work in Health-related Ministries and members of the Health Committees.

4. Senior Staff in the Ministry of Health Senior Administrative and supervisory staff have important roles to play in the conduct and supervision of the Programme. Specific inputs will be determined co-operatively, as the details are developed, especially in relation to the field work and activities at the District and Community levels.

Objectives of the Programme

In keeping with the over-all aim of the HLPM Project to increase the management capability of the Ministry of Health, the In-Service Programme has the following objectives which complement those that guide the work of the Ministry of Health in relation to PHC:

- To increase awareness and understanding of PHC, as it is being developed in St. Lucia
- To plan for the effective implementation of the Government's policy for PHC
- To prepare a group of persons to play differentiated roles in PHC
- To create a network of persons in Health and Health-related agencies committed to PHC
- To provide information about Health programmes
- To develop and establish policies and procedures for managing PHC
- To provide opportunities for developing and practising skills for increasing personal and organizational effectiveness.

Content of the Programme

The content is being defined within the framework provided by analysis of roles to be performed by participants at each level - National, District and Community. For the National Team, four roles have been identified.

- The personal role as an individual Health Manager
- The role of Health Manager as a Public Servant
- The role of Health Manager as a Technician
- The role of Health Manager as a District/Community Leader

In the performance of these roles, individual participants and the Team as a whole will need to acquire certain information and skills, develop or improve certain characteristics/behaviour and establish certain relationships.

Details of the content are presented in the attached Matrix (Appendix 1)

It is intended that the members of the National Team, in consultation with senior administrative and supervisory staff in the Ministry of Health, will refine this Matrix and develop similar Matrices to guide activities at the District and Community levels.

A basic tenet of Primary Health Care is the importance of the involvement of the individual in the promotion of health for himself his family and his community. To be consistent with this concept, the methodology used in the preparation of promoters of PHC must be based on involvement and participation. Hence, considerable emphasis will be placed on learner-centred approaches and on accountability in the learning process.

Schedule for the Programme

It has been agreed that members of the National Team, representing all six Health Districts, will participate in the In-Service Programme over the period February - July, 1983. However, it is expected that two new Districts will be established in 1983 and the remaining three will be established in 1984. The National Team will be available to assist in the development of each District as it comes on stream, while continuing to engage in appropriate on-going activities in their own District.

Dates have already been set for the modules to be conducted for the National Team in order to facilitate arrangements for release time. A proposal for some meetings at the District level has also been prepared, but this may need adjustment.

The schedule appears below:

NATIONAL TEAM

Module	1	Monday, February 20 - Friday, March 4	- 5 days
Module	2	Thursday, March 24 - Thursday, March 31	- 6 days
Module	3	Monday, April 25 - Friday, April 29	- 5 days
Module	4	Tuesday, May 24 - Friday, May 27	- 4 days
Module	5	Monday, June 20 - Friday, June 24	- 5 days
Modules	6 & 7	Monday, July 18 - Friday, July 29	- 10 days
			35 days

DISTRICT TEAM

# 1 Week	1	Wednesday, June 1 - Friday, June 3	- 3 days
	2	Wednesday, June 8 - Friday, June 10	- 3 days
	3	Wednesday, June 15 - Friday, June 17	- 3 days
		Monday, July 4	- 1 day
		Thursday, August 4	- 1 day
		Thursday, September 1	- 1 day
			12 days
# 2 Week	1	Wednesday, June 29 - Friday, July 1	- 3 days
	2	Wednesday, July 6 - Friday, July 8	- 3 days
	3	Wednesday, July 13 - Friday, July 15	- 3 days
		Thursday, August 11	- 1 day
		Thursday, September 8	- 1 day
			11 days

Soufriere Health District will organise 14 days of work over 6 months, beginning after Module 2.

Resource Persons

The two co-ordinators - Dr. James St. Catherine and Dr. Phyllis Macpherson-Russell - will provide continuity in planning and executing the programme and will assume responsibility for the conduct of some modules or parts of modules. Dr. St. Catherine will be responsible for the Field Work.

Discussions have been held with Dr. Gnawale, Mrs. Ina Barrett and Dr. Marjorie Holding-Cobham at Mona and with Mr. John Mayers at Cave Hill to enlist their comments and support for planning and teaching. As the details are more firmly identified other UWI staff may be asked to assist.

Potential Resource Persons in St. Lucia are being considered and contact has been made with CAHEC in order to obtain assistance during the Field Work experiences.

Staff for Modules 1 and 2

The focus of Modules 1 and 2 will be on personal development and on the role of Health Managers in the Public Service. The planning and initiation of the Field Work will also be an integral part of these modules. The staff for Modules 1 and 2 are expected to be:

Co-ordinators: Dr. St. Catherine and Dr. Macpherson-Russell
Human Resources Development Consultant: Mrs. Shirley Fletcher
Administrator: Miss Una Clarke, Staff Tutor (Health Management), Barbados

In addition to Dr. St. Catherine, Ministry of Health officials closely associated with the development and implementation of the In-Service Programme are Dr. Cornelius Lubin, Permanent Secretary and Dr. Anthony D'Souza, Director of Health Services. The Heads of Departments are being invited to participate in the planning of the Field Work on the last day of each Module and to assist in supervising the activities agreed upon.

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PROGRAMME IN BARBADOS

Preparatory Actions

Acting on the decision of the Advisory Board at the meeting on October 23, 1982, the Training and Development Co-ordinator has spent two weeks in Barbados during the period November 1982 to January 1983 in order to plan the details of the programme and arrange for the necessary administrative support.

In addition to attending a meeting of the Country Programme Committee in November 1982, where the focus of the programme was officially accepted, the Training and Development Co-ordinator and the Staff Tutor (Health Management) have met with the Deputy Permanent Secretary, the Co-ordinator of the HDM Project in the Ministry of Health, the Chief Medical Officer, the Chief Nursing Officer and the Senior Personnel Officer in order to arrive at firm decisions regarding the nature and design of the programme and the steps to be taken before beginning the modules in May 1983.

In order to secure the integration of the Programme in the on-going activities of the Department of Extra-Mural Studies in Barbados and the administrative and technical assistance of UWI Personnel at Cave Hill, the Training and Development Co-ordinator has had discussions with the Resident Tutor, the Staff Tutor, the Finance Officer and Head of the Unit of Administration and Accounting in the Faculty of Social Sciences.

It is proposed that, as the details of the Programme are developed during March and April, 1983, the opportunity should be taken to brief other members of the UWI and the Ministry of Health as well as the Minister of Health, and the Minister of Education. The briefing of the Minister of Health has become very important as there has been a change of Minister recently.

It has been agreed that an Officer in the Ministry of Health will be named to work directly with the Staff Tutor (Health Management) in order to facilitate the development and administration of the Programme.

Focus of the Programme

At a meeting of the Country Programme Committee on November 25, 1982, it was decided that the HMPH Project should support the Ministry of Health's efforts to increase the effectiveness of managing the Integrated Health Services. It was also agreed that the participants in the Programme would be respesentative of the Services island-wide.

Design of the Programme

The Programme, which is intended to cover a two-year period, envisages the involvement of two groups of Health personnel - a Core Group of some fifteen senior managers and a Staff Group of some 150 persons from the divisions and institutions - whose input are vital to the maintenance of an effective, efficient service.

In order to accommodate the practical difficulties senior managers will experience in arranging to free themselves for active participation in this Programme, the plan for the Core Group calls for a series of short (one-day or two-day) seminars/workshops at regular intervals over an eight-month period beginning in May 1983. A total of 30 days of activity is being planned.

The programme for the Staff Group will be planned with the Core Group and implemented from September 1983. A total of 28 days of on-the-job activities is presently being considered and will involve all members of the Staff Group and Core Group in their respective divisional or institutional settings.

During Year 3 of the HMPH Project appropriate attachments will be arranged for members of the Core Group of senior managers in the Programme.

Participants in the Programme

The selection of the participants in the Core Group is proceeding on the basis of the following criteria:

- Importance of position to success of the Programme
- Influence in the system
- Willingness to participate
- Availability for active participation

In order to secure maximum coverage of interests and develop workable agreements for action, the distribution of Core Group members within the following five categories of Health personnel will be taken into account:

1. Senior Professional and Scientific Group
2. Senior Nursing Administrative Group
3. Senior Technical Group
4. Senior Administrative Group (Ministry of Health)
5. Managers of Support Services

It is anticipated that each manager selected as a member of the Core Group will have about ten staff members with whom he/she works directly in a division or institution. Members of the Staff Group will be determined after the Core Group has examined the nature of the desirable activities to be undertaken within their locations.

Objectives of the Programme

The objectives of the Programme in Barbados have not yet been agreed upon as they must be reviewed when the participants have been selected. However, the programme will be consistent with the overall aim of the HDPM Project to increase the management capability of the Ministry of Health and the following objectives are in keeping with that aim:

- To provide an opportunity for senior managers to examine the management of the Integrated Health Services in Barbados and devise plans for improvement
- To develop greater understanding of the policies governing the Health Services
- To identify and examine obstacles to increasing managerial effectiveness and plan for alleviating the situation
- To acquire/improve skills to increase personal and organizational effectiveness
- To offer support for change over an extended period of time.

Content of the Programme

The Programme will focus on examining questions, issues, options related to the Management of Integrated Health Services; developing action plans; and instituting appropriate improvements.

The details of the seminars/workshops will be determined according to the needs identified by the participants; but, it is anticipated that the following topics or areas of study will form the basis for examining the roles and functions of Managers in the Integrated Health Services and provide opportunities to acquire knowledge, practise skills, make plans and initiate action:

- Health Laws and policies
- Personnel Management
- Time management
- Financial Management
- Planning
- Manpower Development
- Information Systems
- Communication Systems

Schedule for the Programme

Dates have not yet been fixed for the seminars/workshops, but the outline has been determined, as follows:

A. Core Group: May - December 1983

May - June	6 Days	3 two-day meetings
July - September	12 "	4 one-day meetings per month
October - November	6 "	4 one-day meetings per month
December	4 "	2 two-day meetings
	30 Days	

B. Staff Group September 1983 - July 1984

(i) 90 Participants

September	4 Days	4 days per month
October - March	24 "	per group of 10 - 20
	28 Days	

(ii) 60 Participants

January - July	28 Days	4 days per month per group of 10 - 20

Resource Persons

Because of the kind of schedule that is necessary for the Barbados Core Group Programme, the Training and Development Co-ordinator will not be present at all the seminars/workshops. It is expected that Miss Clarke (Staff Tutor) and Mr. John Mayers will provide the continuity needed in planning and executing the Programme in collaboration with the Ministry of Health.

Resource Persons will be determined according to the areas of study selected during the next two months. However, it is anticipated that staff at Cave Hill, Government Officers, private consultants and staff in Regional/International Organizations stationed in Barbados can provide the pool of persons with the expertise required.

Phyllis Macpherson-Russell
Training & Development Co-ordinator
IDPH Project

February 8, 1983

APPENDIX 1

UNIVERSITY OF THE WEST INDIES - MINISTRY OF HEALTH, ST. LUCIA

HEALTH DEVELOPMENT PLANNING AND MANAGEMENT PROJECT

IN-SERVICE PROGRAMME FOR PRIMARY HEALTH CARE

NATIONAL TEAM

CATEGORY	CASTRIES	HEALTH DISTRICT GROS ISLET	VIEUX FORT	DENNERY	SOUFRIERE	ANSE LA RAYE	TOTAL
Medical Officer of Health	James St. Catherine						1
District Medical Officer				Martin Didier	Lincoln St. Prix		2
Family Nurse Practitioner			Leila Harrachsingh			Marlene Lawrence	2
Nursing Supervisor	Una Thomas			Cecil Gibson			2
Public Health Nurse			Beatrice Vincent				1
Public Health Inspector		Marcel Pevrier	Russell Comme		Emmanuel Bob	Joseph Mezard	4
Family Life Educator	Josephine Aubertine						1
School Health Co-ordinator			Catheline Mathurin				1
Primary Tutor	Francis Barnett						1
Statistical Officer	Itsemarie Cooper						1
Total	5	1	4	2	2	2	16

Co-ordinators: Dr. James St. Catherine, Ministry of Health

Dr. Phyllis Macpherson-Russell, UWI-HDPM Project

Best Available Document

[illegible]	[illegible]	PUBLIC SERVANT	TECHNICIAN	DISTRICT/COMMUNITY LEADER
[illegible]			- project planning	
[illegible]	Persons in National [illegible] Officers in related ministries	- Head Office - MCH/other Govt. agencies (Edu. Agric. Comm. Dev.)	- Health Team (Hospital District, Health Centre) - Schools (principals, teachers) - Family Planning association - Related ministries	- Officers in related ministries - Church groups - Voluntary organisations - Farmers, fishermen, (occupational groups) - hotels, manufacturers, commercial groups
[illegible]		- Team spirit - - Commitment to PHC - Sense of urgency - Belief in success of PHC	- Persistence - Task-oriented - Helpfulness - Respect, appreciation	

[illegible] Russell/ [illegible] Catherine
[illegible], [illegible]

Appendix 10

Best Available Document

APPENDIX 11

HDH: PROJECT - TRAINING AND DEVELOPMENT COMPONENT

FRAME-WORK FOR IN-SERVICE PROGRAMME DEVELOPMENT IN ST. LUCIA

AREAS	ROLES OF HEALTH MANAGERS			
	PERSON	PUBLIC SERVANT	TECHNICIAN	DISTRICT/COMMUNITY LEADER
KNOWLEDGE	- Position in health hierarchy - Job description - Roles & responsibilities - HDH Project support - Management theory	- Health Policy - PHC Plan - Financing of Health - Govt. Development Plans - Inter-agency mechanisms - Inter-Sectoral Co-ordination - Supply system - Incentive policies	- Health Programme - Health Targets - New procedures - H.I.S. - Referral system - Linkages between PHC/secondary & tertiary - Facilities - Personnel	- Research Surveys - Boundaries of District, Communities - Role of Govt. agencies in area and programme - Profile of Community resources
SKILLS	- Communications - Planning - Management Style - Organising skills - Decision-making	- Analysis of data - Interpretation of policies - Development of plans from policies - Budget preparation analysis	- Preparing materials for programmes - Demonstration, teaching - Presentation and Management of technical data - Investigations Maintenance of Supplies - Implementation - Management of resources	- Conduct of meetings - Planning programmes - Organising drives, surveys - Teaching - Making speeches, representations - Audience participation

Best Available Document

UPDATE

on

HEALTH DEVELOPMENT PLANNING AND MANAGEMENT PROGRAMME

BARBADOS

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U.W.I - MINISTRY OF HEALTH, BARBADOS

HEALTH DEVELOPMENT PLANNIONG AND MANAGEMENT PROJECT

OFF -CAMPUS PROGRAMME

PARTICIPANTS BY AREAS

MINISTRY OF HEALTH	POSITION	DEPARTMENT
1. ALLEYNE, D.P.	Financial Controller	Accounts Section
2. BROWNE, Charley	Chief Public Health Officer	Public Health Inspectorate,
3. ESTWICK, McDonald	Superintendant of Works & Maintenance	Ministry of Health
4. MILLER, Beverley Rose	Senior Medical Officer	Ministry of Health
5. NURSE, Cortez	Chief Project Officer	Project Design and Implementation Unit
6. WALROND , Marjorie	Chief Public Health Nurse	Public Health Nursing Unit.
PUBLIC HEALTH		
7. CONLIFFE, Wilton	Senior Public Health Engineer	Public Health Engineering Unit
8. FERDINAND, Elizabeth	Medical Officer of	Maurice Byer Polyclinic
9. MUKERJEE, Dilip Kumar	Medical Officer of Health	Warrens' Polyclinic
10. SPRINGER, Talcie	Senior Health Sister	Black Rock Polyclinic
PSYCHIATRIC HOSPITAL		
11. BANNISTER, Patricia	Ag. Medical Superintendant	Psychiatric Hospital
12. GREENIDGE, Newlands	Hospital Director	• •
13. HOWARD, Emerson	Deputy Principal Nursing Officer	• •
QUEEN ELIZABETH HOSPITAL		
14. INNISS, Peggy	Principal Tutor	School of Nursing

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PARTICIPANTS BY AREA CONTI.

Q.E.H CONTI.

15. MILLINGTON, Neville	Assis. Hospital Director	Q. E. H
16. RAMSAY, Dorothy	Assistant Matron	" " "
17. ST.JOUR-JOHNSON, Heather	Senior Medical Social Worker	" " "
18. YOUNG, Greta	Sister Recovery Room	" " "

NUTRITION CENTRE

19. YARDE, Elaine	Nutrition Officer

January 31, 1984
UWI: EMD:HDPM

DR. PHYLLIS MACPHERSON- RUSSELL - Training and Development Coordinator

MISS UNA CLARKE - Staff Tutor H.D.P.M

PART II

The second phase of the H.D.P.M (Barbados) Programme consists of Projects to be undertaken by Core-Group members individually or with other members for the purpose of improving some aspects of management related to the integration of the Health Services.

Under consideration are such projects as : -

- Continuity of Patient Care - Student Nurse oriented.
- Coordination of Services offered in Polyclinics.
- management of Nurses Records.
- Discharge Planning (Hospital Social Worker/ Public Health staff).
- Improvement of the Ministry's Transport System.
- The Geriatric Hospital - Historic review - one hundred years of service.
- Continuing In Service Education - Nutrition oriented.
- Development of the Planning Process in the Ministry using "Planning Cells"
- Improvement of working conditions and relationships - Polyclinic staff.
- Upgrading Environmental legislation - Environmental Engineering Division.
- Research Public Health problems with a view to improving Environmental Health.
- The final modules to precede this phase are - module 7 - Integration of Health Services - by Professor E.R.Walrond and Module 8 - Planning Change Effort - by Dr. P. Macpherson.

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LIST OF MODULES, DATES, TOPICS, COORDINATORS, RESOURCE PERSONNEL/ DESIGNATIONS

1983

DATES	MAIN TOPICS	COORDINATORS	PRESENTER /DESIGNATIONS
MODULE I			
June 29 - July 22	Management of Change	Dr. P. Macpherson	Dr. P. Macpherson - Training & Development Coordinatror H.D.P.M
MODULE II			
Aug - 5 - 19	Health Policies and Health Planning	Mr. C. Nurse	Mr. C. Nurse - Chief Project Officer - Ministry of Health
MODULE III			
Aug 26- Sept 2	Introduction to Health Laws - Mental Health Act	Miss Yolande Bannister	Chief Parliamentary Counsel
MODULE IV			
Sept 9 - Oct 7	Financial Management - Supplies Management - Maintenance- Building /Equipment - Drug Supplies	Mr. D.P. Alleyne " " " " " " " " "	Mr. D.P.Alleyne Financial Controller -Ministry of Health Miss M. Quintyne- Supplies Officer - Q.E.H Mr. L. Etheridge-Executive Engineer - Ministry of Health Mr. L. Prescod, Assistant Drug officer
OCT 14	Midway Evaluation	Miss U. Clarke	Miss U. Clarke-Staff Tutor HDPM
MODULE V			
Oct 21 - Nov 11	Personnel Management - Introduction -function of Ministry's Personnel - Overview - Personnel Management - Public Services Commissions	Miss U.Clarke, Mrs.A.Gollop & Mr. C. Yard " " " " " " " " " " " "	Mrs.A. Gollop - Ag. S.A.O Mr. C. Yard- Deputy P.S Sir Carlisle Burton

DATES	MAIN TOPICS	COORDINATORS	PRESENTER /DESIGNATIONS
	- Public Services Regulations /Discipline	Miss U. Clarke, Mrs.A.Gollop and Mr. C. Yard	Mr. U. Parris - S.P.O
	- Civil Establishment Orders	• • • • •	Mr. F. Parris- Head of Civil Service
	- Personnel Management/ Industrial Relations	• • • • •	Mr. St.E Licorish and Mr. W. Spencer- Labour Dept.
	- General Orders / Disciplinary Rules	• • • • •	Mrs.Gollop, Messrs Yard, U. Parris & F. Parris
MODULE VI			
Nov 18- Dec 9	Introduction to Mangem Information	Mr. John Mayers	
	- Developing a Data [Systems	• • •	Management Studies U.W.I
	- Computers & Health Information [Systems	• • •	Miss Maxine McClean
	- Organisational Redesign	• • •	Mr. Stewart Bishop
	- Methods of appraisal -Overview of	• • •	Dr. Jamal Khan
	- Discussion, Review, Evaluation	• • •	Miss M. McClean Mr. Mayers etal.

January 31, 1984
UWI: EMD: HDPM

UNIVERSITY OF THE WEST INDIES/MINISTRY OF HEALTH & ENVIRONMENT TRINIDAD AND TOBAGO
HEALTH DEVELOPMENT PLANNING AND MANAGEMENT PROJECT
IN-SERVICE PROGRAMME

FEBRUARY 1984 - SEPTEMBER 1985

THEME OF THE PROGRAMME: Strengthening the Administrative System for the Promotion of Primary Health Care

PARTICIPANTS IN THE PROGRAMME:

I. A. The Core Group

COUNTY STAFF

1. Dr. Le Maitre - C.M.O.H. (Caroni)
2. Dr. G. Maynard -C.M.O.H. (St. Geo. Central)
3. Dr. Ramlal - C.M.O.H. (Victoria)
4. Dr. Dattadeen - S.M.O. (Pt. Fortin Area Hosp.)
5. Ms. S. Proctor - C.H.V.(St.A./St.D)
6. Ms. Y. Sylvester - Pharmacist (Caroni)
7. Mrs. Joseph - Health Educator (St. Patrick)
8. Mr. Rahaman - P.H.I. (Nariva/Mayaro
9. Mr. Yearwood - Social Worker (St. Geo. West)
10. Mrs. L. Romano - Area Administrator (St. Geo. East)

(Representatives of County Staff)

CENTRAL OFFICE (EXECUTIVE MANAGERS)

1. Dr. N. Andrews - P.M.O.(C.S.)
2. Dr. E. Laurent - P.M.O.(E.H.)

CENTRAL OFFICE (TECHNICAL MANAGERS)

1. Mrs. M. McShine - D.P.H.N.
2. Mr. Grandison - C.P.H.I.

(Senior Officers of County Staff)

1. Dr. Karen Sealey - Ag. D.P.H.S.
2. Mrs. Joyce Bicep - Economist, H.P.S.

1. Mrs. Rita Daniel - A.O.(V) Personnel
2. Mr. Parmanand - A.O.(IV) Personnel
3. Mr. K. Chung - A.E.II (Finance)
4. Miss P. Colthrust - A.O.(V) Administration

(Main areas of Administrative support for County Staff)

Total number of Core Group - 20

II. ADJUNCT GROUPS- DECENTRALIZATION

(b) Personnel

1. Miss Yvonne Smart - A.O.IV- Discipline
2. Ms. S. Bideshi - Ag. A.O.IV- (I-R)
3. Mrs. Vierra - A.O. IV - (E & S)
4. Mrs. G. Small - A.O. II - (R & P)

(c) Finance

1. Mr. Boodoosingh - Procurement Officer
2. Mrs. S. Taylor - Accountant III
3. Mr. Rajwant - Accountant Executive I
4. Mr. Cockburn - Manager, Central Supplies

(d) Planning

1. Mr. Bissram - Statistics
2. Mr. G. Harry - A.O. V
3. Ms. J. Worrell - A.O. IV

(e) Office & General Administration

1. Mr. L. Brown - A.O. IV
2. Ms. M. Blandin - A.O. II

III. ADJUNCT GROUPS - LINKAGES BETWEEN PRIMARY HEALTH CARE & HOSPITALS

(f) Institutions

NORTH

1. Dr. J. Wong - H.M.D.
2. Dr. Pereira - Director,A/E
3. Mrs. Y. Cuthbert - Social Worker
4. Mrs. V. Heath - Junior Matron

SOUTH

5. Mrs. T. Huggins-Maurice - Matron
6. Mr. James - Hospital Manager
7. Dr. Yip Hoi - H.M.D.
8. Mrs. K. Foster - Matron

(g) Executive Managers

1. Mr. Bertram Ifill - P.S.
2. Dr. E. Quamina - C.M.O.
3. Miss V. Foster - P.N.O.

Central Office

Executive Managers

1. Dr. S. Lutchman - P.M.O.(I)
2. Dr. R. Dougdeen - P.M.O.(E)

Technical

3. Mrs. E. Daly-Diaz- Nursing Superintendent(Curative)

IV. ADJUNCT GROUP - SPECIAL

(h) Special Officers

1. Mr. E. Guy - Train
2. Dr. M. Nichol - C.M.O.H. (Tobago)
3. Mr. Jacobs - O & M
4. Mr. Ali - Hospital Plant Engineer

Specific Objectives

- Identify major patterns in the historical evolution of health care systems in Jamaica, Trinidad and Tobago, Barbados, and St. Lucia.
- Analyse the political/administrative context for delivery of health care services in each of the four islands.
- Identify social and cultural patterns influencing health and health care utilization.
- Undertake a critical review of the evolution of public policy on health.
- Analyse the conomics of health services in each of the four islands.
- Analyse the role of multilateral and bilateral health agencies.

Suggested Outline of Partial or Terminal Reports of the General Sector Study

- Introduction and overview of the health care system
- Political-Administration system
- Health service administration and planning
  - Administrative Structure
  - Health Planning
  - Health Priorities
- Health status determinants (socioeconomic, cultural and political)

- **Economic and Financial Aspects of Health care**

  ___Personal payment
  ___Charity
  ___Industry
  ___Voluntary insurance
  ___Social insurance
  ___General revenue
  ___Problem areas

- **Health Facilities**

  ___Hospitals - public and private
  ___History of hospitals
  ___Hospital functions and trends
  ___Hospital administration and financing
  ___Regionalization of health facilities
  ___Health centers and other facilities
  ___Problem areas

- **Delivery of Preventive Services**

  ___Environmental control
  ___Communicable disease control
  ___Maternal child health services
  ___Family planning
  ___Other preventive programs
  ___Problem areas

- **Health Care Regulations**

  ___Review of health legislation
  ___Regulation of health professionals
  ___Regulation of other health care resources
  ___Regulation of health care performance
  ___Problem areas

- **Health Planning**

  ___The role of government in health care delivery
  ___The role of the private sector in health care delivery
  ___Problems of co-ordination and control

- **Formulation of a Research Agenda for the Future**

- **Conclusions**

CARIBBEAN COMMUNITY HEALTH MANAGEMENT

QUESTIONNAIRE FOR STATE OF THE ART STUDY

BACKGROUND

1. Describe the part played in the management and the delivery of health services by (a) local government authorities (b) community health committees.

2. What is the extent of the contribution of the private sector in Health Services in your country?

3. Describe the use of Boards/Committees/Councils in Health Services in your country.

4. List 5 outstanding historical features or land marks in the development of Health Services of your country.

5. Suggest 5 topics for research in Health which would be of benefit to your country or the Caribbean region.

6. What was the effect of the report of the W.I. Royal Commission (Moyne Report) on health services in your country?

7. List the subjects other than Health in the portfolio of your Minister responsible for Health.

8. Describe any mechanisms, formal or informal, which exist for intersectoral coordination or cooperation in health matters in your country.

9. Do you see any room for the improvement of intrasectoral (i.e. within your Ministry of Health) coordination?

10. Describe the benefits, real or potential, which accrue from membership of (a) CARICOM (Health Desk and Health Ministers' Conference) and (b) the PAHO Caribbean Coordinator's Office.

11. Describe the progress of Medical Social Work in your country.

12. Describe the organisation of Health Education in your country.

13. To what extent are the public information media used for promoting health:- regularly, occasionally, at crisis or special events only?

14. Indicate the prevalence of Health Insurance through private Insurance Schemes in your country?

15. What, if any, is the extent of health coverage in the National Insurance (Social Security) Scheme?

16. What progress has been made with plans for a national health service?

17. What is the role of the Ministry of Health in preparedness against natural and man-made disasters?

HEALTH SECTOR PLANNING AND RESEARCH

1. Identify the key actors in the Health Planning process by completing the attached MATRIX of organisational Units/ Decision Levels.

2. Identify the roles played in the planning process by:-

   - private sector organisations

   - para-statal organisations (statutory Boards etc.)

   - the general public (community participation).

3. Is there a separate Planning Division/Unit/Section? If so, how is it organised?

4. What is the machinery for harmonizing the health sector plan with the wider national Development Plan?

5. What arrangements exist for intersectoral coordination?

6. What arrangements exist for intra-sectoral coordination?

7. What are the plans for achieving the objectives of "HEALTH FOR ALL BY YEAR 2000"?

8. Do you see a role for the Caricom Health Desk in the Planning process? If so, elaborate.

9. Suggest areas of research which you think would improve -

   (a) delivery of health care

   (b) general management in health.

10. What organisational arrangements exist for health research.

11. How are research efforts funded?

HEALTH SECTOR FINANCING

1. Give comparative data on Current Expenditures over past five fiscal years as it related to the overall national budget as follows:-

FISCAL YEAR	HEALTH SECTOR ALLOCATION $	NATIONAL BUDGET $	% OF NATIONAL BUDGET
1978-79			
1979-80			
1980-81			
1981-82			
1982-83			

2. Give a breakdown of the distribution of the Health Secto budgetary allocation among the major sub-sectors. E.G. Hospita Services, Health Centres, Drugs, Health care facilities (atruc-tures), Health Education and Training etc.

3. List the major sources of Health Sector financing e.g. National Annual Estimates, external financing (indicating Loan/Donor Agencies), etc.

4. List the major sources of Health Sector Revenues.

5. List the major Health Care Facilities constructed or otherwise established over the past five (5) years and indicate approximate costs.

6. Give comparative data on Capital Expenditure over past five fiscal years as it related to the overall National Capital Budget as follows:-

FISCAL YEAR	HEALTH SECTOR CAPITAL BUDGET $	NATIONAL CAPITAL BUDGET $	% OF NATIO BUDGET
1978-79			
1979-80			
1980-81			
1981-82			
1982-83			

7. Give comparative data showing Personal Emoluments (salarie wages, etc.) as a percentage of annual health sector budget over past five (5) years.

FISCAL YEAR	NATIONAL BUDGET $	HEALTH SECTOR PERSONAL EMOLUMENTS $	%
1978-79			
1979-80			
1980-81			
1981-82			
1982-83			

HEALTH MANAGEMENT INFORMATION SYSTEM

1. What organisational arrangements exist for health information? For example, is there a separate unit for conducting public relations connected with health development and health delivery?

2. Are there any mechanisms for feedback from the community concerning the relevance of services and service hours?

3. What mechanisms (Committees etc.) exist for facilitating the flow of information among the various health sector organisations/institutions.

4. What arrangements exist for the collection, storage and retrieval of health information. For example, is there a computerized system for data collection etc.?

5. Is there a unit for the processing of health statistics? If so, how is it organised?

6. How is the health information system geared to meeting the strategy of Health for All by year 2000?

7. Are there any arrangements for the exchange of information with other health administrations within the Region?

8. Describe briefly the role played by the media in the health information system.

HUMAN RESOURCE SYSTEMS

1. Describe the procedures (negotiation and legislation) for obtaining additional staff positions in the Ministry of Health.

2. Describe recruitment, selection and appointment procedures mechanisms.

3. To what extent does the Ministry of Health participate in (a) terms and conditions of service (b) appointments (c) discipline of staff.

4. (i) List the agencies and courses used in the past five years for training of staff, especially management staff.

   (ii) If available give statistics of management training at middle and senior levels.

   (iii) To what extent have the persons trained in management been able to influence or assist the delivery of services?

5. To what extent has Health suffered from brain-drain to (a) other government agencies (b) the private sector (c) abroad.

6. Does Health exercise any personnel powers by delegation from central authorities?

7. List 5 problems experienced in personnel management.

8. What is the extent of unionisation of Health staff?

9. List the professional organisations in Health and say whether they operate as professional organisations fully or also attend to Union problems.

10. Give a list of new types of staff introduced in your country within the past ten years.

11. What are the superannuation benefits receivable by health staff from Government Pension Legislation and National Insurance (Social Security) Legislation.

12. List any manpower surveys that have taken place in the past ten years.

13. List your suggestions for improving personnel management in Health or alternatively suggest topics in personnel management for research.

14. To what extent do you think that current training courses for middle and senior health managers provide adequate orientation to -

(i) legal systems;

(ii) financial systems;

(iii) economic and social systems;

(iv) modern technological aids to management science.

NON-HUMAN RESOURCE SYSTEMS

1. Is there a Central Government Supply/Purchasing system to which the Ministry of Health must conform?

2. Are there any exemptions from the use of the Central Supply Department? For example, can Health purchase directly specialist items such as medical equipment or drugs?

3. What constraints do you identify as militating against an effective supply management system.

4. List any reports which have been made concerning the operation of Health and medical supply systems.

5. Describe the system of accountability for public funds.

6. What is the date of the most recent legislative order for (a) Financial Rules/Regulations (b) Supply Rules/ Regulations.

7. Are the Financial Regulations and the Supply Regulations considered to be up to date?

8. How does the Ministry of Health get its buildings and equipment maintained?

9. What constraints, if any, can you identify as militating against the effectiveness of the system for maintenance?

10. Would a set of model Health Laws developed by CARICOM be of any use to the Ministry of Health?

11. What is the present use or, in your opinion, the potential of electronic data processing equipment and word-processors in Health for (a) programs (b) records (c) management of financial resources (d) personnel.

RESEARCH ON MANAGEMENT OF HUMAN RESOURCES IN THE HEALTH SECTOR IN THE COMMONWEALTH CARIBBEAN

Terms of Reference

1. Objectives

a) To analyze the historical development and main characteristics of the human resources management function in the health sector of the English-speaking Caribbean;

b) on the basis of the above, to propose policy prescriptions aimed at significant improvement in the attainment of organizational goals.

2. Scope

a) To examine and analyze present structure and operation of the human resources management function in the health sector of at least 5 territories of the region, possibly Jamaica, Trinidad and Tobago, Barbados, St. Lucia and Belize to determine the historical and current obstacles to the optimum utilization of available human resources by means of interviews of appropriate officials and study of relevant documents;

b) to obtain relevant data on the region through consultation with such regional organizations as CARICOM, CARICAD, OECS, AND UWI;

c) to examine previous recommendation on this subject made by regional and international agencies, especially CARICOM, WHO, PAHO, IBRD and USAID to determine the degree of implementation of policy prescriptions;

d) to elaborate proposals for corrective action within the framework of existing constitutional arrangements of regional public services and with due regard to the current budgetary constraints within the region;

[illegible] Are you employed in the government or private sector? Circle number.

1. GOVERNMENT ..... Please skip to [illegible]
2. PRIVATE

[illegible] PRIVATE

[illegible] Were you ever employed in the civil service?

1. YES
2. NO

[illegible] YES

[illegible] What was your last post in the civil service?

_____

[illegible] How long were you in the civil service? (years)

_____

[illegible] CIVIL SERVICE

[illegible] Do you presently work on a part-time basis on your own account or for others outside of the Civil Service?

Thank you very much for your co-operation and patience.

HEALTH DEVELOPMENT PLANNING AND MANAGEMENT PROJECT

MANAGEMENT OF HUMAN RESOURCES IN THE HEALTH SECTOR OF THE COMMONWEALTH CARIBBEAN

This survey is being done in order to get a better understanding of how employees in the health sector feel about the management of human resources in their area of work. Please use a pencil and answer all questions. If you wish, you may write additional comments in the margin or the blank spaces. These comments are welcome and will be taken into account.

THANK YOU FOR YOUR HELP

Appendix 16

Q.1 Do you generally get up to date information on matters which affect you at work, such as new policies, regulations on employee benefits? (Circle number)

1. REGULARLY
2. SOMETIMES
3. RARELY EVER
4. NEVER

Q.2 Do you find that personnel matters concerning you, such as leave, promotion and training have generally been dealt with quickly? (Circle number)

1. VERY QUICKLY
2. FAIRLY QUICKLY
3. FAIRLY SLOWLY
4. VERY SLOWLY

Q.3 Which of the following is generally true about your job? (Please tick those you think are true)

		Tick
1	THE SECURITY OF EMPLOYMENT IS QUITE GOOD	___
2	THE PRESTIGE OF THE JOB IS QUITE HIGH	___
3	THE CHANCES FOR PROMOTION ARE QUITE GOOD	___
4	THE WORK IS INTERESTING	___
5	LEAVE AND VACATION BENEFITS ARE QUITE GOOD	___
6	THE PAY IS NOT BAD	___
7	THE HOURS ARE CONVENIENT	___
8	THE PHYSICAL WORKING CONDITIONS ARE QUITE GOOD	___
9	YOU HAVE TIME TO DO THE JOB PROPERLY	___
10	YOU HAVE ENOUGH AUTHORITY TO DO THE JOB	___
11	TRAINING AND EDUCATION IS AVAILABLE	___

Q.4 All in all, how satisfied would you say you are with your job? (Circle number)

1. VERY SATISFIED
2. QUITE SATISFIED
3. NOT VERY SATISFIED
4. NOT SATISFIED AT ALL

Q.5 Up to now, have you seen yourself as having a life time career in the civil service? (Circle number)

1. YES
2. NO
3. NOT DECIDED

Q.6 What single thing would most make you want to leave the health field?

_____

_____

Q.35 When did you start working in this post?

19___

Q.36 When did you start working in the health field?

19___

Q.37 What is your present annual gross salary (earnings)

_____

Q.38 In terms of the importance of your kind of work indicate the gross annual salary you feel you should be getting?

_____

Q.39 What is the highest level of education you have received? (Circle number)

1. PRIMARY WITHOUT QUALIFICATIONS
2. PRIMARY WITH QUALIFICATIONS
3. SECONDARY WITHOUT CERTIFICATE
4. SECONDARY WITH CERTIFICATE
5. COLLEGE
6. UNIVERSITY UNDERGRADUATE
7. UNIVERSITY POSTGRADUATE

Q.40 What are the highest training or academic qualifications you have received?

_____

Q.41 What is your marital status? (Circle number)

1. MARRIED
2. SINGLE - NEVER MARRIED
3. DIVORCED
4. WIDOWED
5. SEPARATED

Q.42 Do you have any children? (Circle number)

1. YES
2. NO

Q.43 Sex (Circle Number)

1. MALE
2. FEMALE

Q.44 Age _____

Q.45 Work Location (Circle number)

1. CAPITAL CITY
2. RURAL STATION

Q.27 Are you currently acting in your post? (Circle number)

1. YES
2. NO

Q.28 Are you satisfied with your rate of promotion? (Circle number)

1. VERY SATISFIED
2. FAIRLY SATISFIED
3. NOT VERY SATISFIED
4. NOT AT ALL SATISFIED

Q.29 Do you have a performance evaluation system by which you are rated by your supervisor on the quality of your work? (Circle number)

1. YES
2. NO ---------- If no, please skip to Q.31

IF YES

Q.30 Do you have regular or on-going assessments by your supervisors or in the course of the year? (Circle number)

1. YES
2. NO
3. DON'T KNOW

Q.31 Do you think the present system of job classification adequately takes into account the scope and importance of the work you do, relative to other grades in the health field? (Circle number)

1. VERY ADEQUATELY
2. FAIRLY ADEQUATELY
3. NOT VERY ADEQUATELY
4. NOT ADEQUATELY AT ALL

Q.32 Do you find that those in senior management in the health field have sufficient knowledge of the work you do to give adequate guidance? (Circle number)

1. HAVE ENOUGH KNOWLEDGE
2. HAVE SOME KNOWLEDGE BUT NOT ENOUGH
3. HAVE INADEQUATE KNOWLEDGE

Q.33 Can you list the main obstacles to adequate recruitment of trained staff in your field?

_____

_____

_____

Q.34 What is your present substantive post and classification grade?

_____

Q.7 Are you satisfied with the possibilities for further training in your area of work? (Circle number)

1. VERY SATISFIED
2. FAIRLY SATISFIED
3. NOT VERY SATISFIED
4. NOT AT ALL SATISFIED

Q.8 Have you received any form of training since you joined the health field? (Circle number)

1. YES
2. NO ---------- If no, please skip to Q.12

IF YES:

Q.9 Have you received any in-service training, on-the-job training, or training in special seminars, workshops or courses? (Circle number)

1. YES
2. NO

IF YES Please indicate areas in which training was received

	TICK
1. TECHNICAL OR APPRENTICESHIP	___
2. SECRETARIAL	___
3. CLERICAL/OFFICE METHODS	___
4. ACCOUNTING	___
5. MANAGEMENT	___
6. PARA-PROFESSIONAL/PROFESSIONAL	___

Q.10 When was the last time you received training?

19__

Q.11 After your training did you find that you were able to use your new skills and knowledge? (Circle number)

1. YES
2. NO

Q.12 Please list the areas of in-service/on the job training which you think are most needed at this time.

_____

_____

_____

Q.13 Have you received any long-term advanced training lasting one academic year or more and leading to academic qualifications such as certificates, diplomas and degrees, since joining the health field? (Circle number)

1. YES
2. NO ---------- If no, please skip to Q.17

Q.34 Was the most recent training conducted locally or overseas? (Circle number)

1. LOCALLY
2. CARIBBEAN
3. U.S.A.
4. CANADA
5. U.K.
6. OTHER

Q.35 Did this training relate to work you were doing before or did it fit you for work in other fields? (Circle number)

1. WORK YOU WERE DOING
2. WORK IN OTHER FIELDS
3. BOTH

Q.36 On your return to the service did you find that your work assignment allowed you to fully use your new training? (Circle number)

1. YES
2. NO

Q.37 List the areas of advanced training which you think are most needed at this time.

_____

_____

_____

Q.38 In your experience is the length of temporary employment a problem in the health field? (Circle number)

1. A VERY BIG PROBLEM
2. A FAIRLY BIG PROBLEM
3. A SMALL PROBLEM
4. NO PROBLEM AT ALL

Q.39 Are you permanently appointed, on probation, temporary or on contract? (Circle number)

1. PERMANENTLY APPOINTED
2. ON PROBATION
3. TEMPORARY
4. ON CONTRACT OR PROJECT

Q.40 Is shortage of staff a problem in your section? (Circle number)

1. A VERY BIG PROBLEM
2. A FAIRLY BIG PROBLEM
3. A SMALL PROBLEM
4. NO PROBLEM AT ALL

Q.21 Given the circumstances, in your area of work, do you feel that the available personnel are efficiently utilized? (Circle number)

1. VERY INEFFICIENTLY UTILIZED
2. INEFFICIENTLY UTILIZED
3. EFFICIENTLY UTILIZED
4. VERY EFFICIENTLY UTILIZED

Q.22 In your experience, how quickly are vacancies in your section filled? (Circle number)

1. VERY QUICKLY
2. FAIRLY QUICKLY
3. FAIRLY SLOWLY
4. VERY SLOWLY

Q.23 In your area of work is there a system by which future vacancies by way of retirements and termination of contracts are identified as early as possible? (Circle number)

1. YES
2. NO
3. DON'T KNOW

IF YES:

Q.24 Does this system operate on a regular basis? (Circle number)

1. REGULARLY
2. SOMETIMES
3. HARDLY EVER
4. NEVER

Q.25 In your experience, how long does it usually take for your section to get replacement for staff who have left? (Circle number)

1. IMMEDIATELY
2. LESS THAN THREE MONTHS
3. THREE TO SIX MONTHS
4. SIX MONTHS TO ONE YEAR
5. OVER ONE YEAR
6. ONE TO TWO YEARS
7. DONT KNOW

Q.26 Is inadequately trained staff a problem in your section? (Circle number)

1. A VERY BIG PROBLEM
2. A FAIRLY BIG PROBLEM
3. A SMALL PROBLEM
4. NO PROBLEM AT ALL

SERVING SOCIETY

Appendix 17

AMERICAN PUBLIC HEALTH ASSOCIATION

1015 Fifteenth Street, N.W., Washington D.C. 20005 • (202) 789-5600

PROTECTING HEALTH

MEMORANDUM

TO: Sarita W. Henry
S&T/Health AID

DATE: June 15, 1983

FROM: Dr. Alfred N. Gerald
Program Manager, IHP

SUBJECT: Request Approval for Nomination of Consultant, for Travel, and for Mission or Regional Clearance under Contract AID/DSPE-5901-A-00-1039-00.

Name of Consultant: Barry Chevannes, MA, MSc, PhD
CV attached

Nature of Assignment:

1) The consultant will study, in collaboration with the ISER Senior Research Fellow, the socio-economic and socio-political factors of importance to the successful design and implementation of a management system for integrated health care delivery at the parish level.

2) Specifically, the consultant will interview key personnel, including consumers, in the health care system, review relevant documents, published and unpublished, and generally observe the operation of the management system in order to identify potential constraints and strengths.

3) The consultant will submit an interim report to ISER 4 weeks after the commencement of the assignment. If the study is incomplete after 8 weeks from the commencement, another interim report should be submitted at that time. The final report must be submitted not later than 3 months from the start of the assignment.

Date/Duration of Assignment: Commence in June for 30 working days

Country of Assignment: Jamaica

APPROVED: Sarita W. Henry
Sarita W. Henry, S&T/Health AID

Remarks: See attached letter

Date: June 17, 1983

TERMS OF REFERENCE

JAMAICA COUNTRY SPECIFIC STUDY

A HEALTH CARE MANAGEMENT SYSTEM AT THE PARISH LEVEL

The Consultant is expected to work with the ISER Research staff and the concerned Ministry officials to achieve the following:

1. To review previous work on the subject of Health Care Delivery Systems at the parish level in Jamaica.

2. To examine the legal, institutional and other factors pertinent to the project.

3. To interview Ministry officials and otherwise collect additional information required to produce a complete documentation of the existing situation at the parish level.

4. To identify operational constraints which impede efficient and effective delivery of Health Care at the parish level.

5. To formulate recommendations for an improved management system.

6. To present the results of the above together with implementation plan to the HDPM Country Programme Committee.

7. To prepare a final report.

OUTPUTS

1. The Consultant/ISER is expected to submit a detailed protocol for the study.

2. The Consultant/ISER will be expected to deliver an interim report at the completion of item 4 above. This report will provide a basis for discussion with Ministry officials and project personnel.

3. A final report with an executive summary and a detailed implementation plan of the agreed recommendations is expected to the end of June.

4. Three copies of all reports should be submitted to the Project Administrator.

Appendix 19

INTERISLAND
Architects and Planners

PO BOX 697 o RODNEY BAY o CASTRIES o ST LUCIA WI o TEL 20430 o CABLE INTERAR

16th March, 1983

Mr. R. Thelwell,
H.D.P.M. Project,
University of the West Indies,
Mona Campus,
Mona, JAMAICA

Richard,

As promised in our conversation of the 15th March 1983 I forward terms of reference formulated for the one-man month consultancy project on Solid Waste Management.

Evaluation & Documentation Process

1. The evaluation of existing proposals in the many recommendations made to the Government of St. Lucia; a review of existing policies and methods and their alternatives;

2. Refuse Collection and Disposal System Data;

3. Outlining of emerging conditions and problems, and the generation of new proposals;

4. An examination of Management processes and structures.

The Formulation of a Solid Waste Management Programme

5. The development of a Bankable Solid Waste Project

Follow up Consultancy

6. The generation of in-depth proposals for the Management of the Solid Waste Management Programme.

The terms of reference include item 1. to 5.

Yours sincerely,

Paul Philippides

Health Development Planning and Management Information Project.

Methodology

The Programme Committee has requested that the research must attempt to answer the following questions:

- What are the information needs of the Community services with respect to management and planning.
- What are the appropriate forms of organization and technology that must be adopted to meet the needs identified.

Problem Definition

We must first of all recognise that information is being collected and fed into the system; that such information is already being used for management and planning; and that there is already in place an organizational structure which treats the information.

Task I Our first task is to define clearly the existing organizational structure, and to chart carefully the information flow throughout the structure.

We must define the organizational chart as it exists in theory. Chart the information flow along this structure.

Define bottlenecks unofficial information routes, nonfunctioning routes.

We will, thus, have outlined the existing position, both as it is defined on paper and as it actually functions.

Task II We will then need to clarify this outline. We will investigate carefully the information needs at each level.

Catalogue the differences between actual and expected needs at each level.

Assess attitudes, and weigh opinions on the efficiency of the current system.

Task II (Cont'd)

When we will have finished the above tasks, we will have a clear idea of what information is being collected; and of what information flows where, and why. Only then can we determine what other data (if any) needs tobe collected.

Management Structure Redefinition

Difficulties in the operation of a management information system can be due to faculty organizational structure; to malfunctioning of an inherently well-designed structure; or to a lack of data inputs.

Task III The next task, therefore, is to present to appropriate authority an analysis of those structural other faults which prevent the efficient flow of adequately-presented information.

It will be necessary to have some feedback on what structural changes are unlikely (because of social, political or other factors).

In assessing what needs to be done, we expect to receive some guidelines from previous studies. We will expect to use any appropriate findings from the Peat, Marwicke Mitchell study.

MIS Design

At this stage we would have presented a paper on the methodology for the second part of the assignment.

The next group of tasks will involve the actual design of an MIS and the assessment of appropriate technology.

We propose to use one country, and one health center in it, to test what we propose.

TIMING

We propose to spend not more than 7 man days (out of the short 24 given to the project) on the tasks in the first part; and to carry this out after whatever period the meeting of busy health officers will permit.

P. Morris

SCOPE OF WORK FOR EVALUATION OF HEALTH DEVELOPMENT PLANNING AND MANAGEMENT PROJECT

629-5901

Background

Cooperative Agreement No.#DSPE-5901-A-00-1039-00 between the American Public Health Association (APHA) and the United States Agency for International Development (AID) was executed on September 30, 1981 with a starting date of October 1, 1981.

The goal of this project is "to institutionalize planning and management capabilities" of the countries of the the English speaking Caribbean by "supporting and bolstering" their efforts to "plan and manage health sector resources".

The elected stratagy is to establish collaborative relationships between institutions and organizations in the Caribbean region and the U.S.A. to build in those countries and territories during the course of the project, a sustained capability to:

... Train health planners and managers

B. Give technical assistance in health development planning and management to all health sector institutions; and

C. Conduct an applied health service health program to improve the delivery of services.

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Major collaborators in the execution of this project include: the Ministries of Health of Barbados, Jamaica, St. Lucia and Trinidad and Tobago; the three campuses (Mona, Jamaica; St. Augustine, Trinidad; and Cave Hill, Barbados) of the University of the West Indies; the University of Pittsburgh and the American Public Health Association. An important goal of this strategy is the incorporation of private resources (technical knowledge and skills) which are abundant in the region, but which are not consciously oriented or structured to meet the specific needs of the health sector.

Due to the last minute signing of the agreement as indicated above, and the nature of the many complex factors which influence the internal management of this project (academic schedule of two universities, decision-making process in four countries, and bureaucratic procedures of APHA and AID) no significant activities (outside of recruitment of key staff) could be carried out during the first trimester (October 1, 1981 to December 31, 1981).

During the period January 1982 to the present, project activities have concentrated on the establishment and consolidation of project management functions, staffing, marketing of the project in the four participating countries, detailed programming of activities and establishing working relationships with national, international and private agencies engaged in similar activities within the Caribbean areas.

Collaborative bodies have been established and are fully functional at all levels. The HDPM Advisory Board providing over-all guidance, the Executive Committee responsible for programming and execution, and the four Country Program Committees overseeing country specific activities have all been structured, organized and, with the exception of Jamaica, are all actively pursuing the goals and objectives of this project. Key staff have been appointed with the exception of the Research Associate which is in progress. Visits have been made to all participating countries for discussions with government officials (chiefly MOH), UWI administration and faculty (Cave Hill and St. Augustine), USAID field officers, PAHO area and CARICOM representatives as well as other private and semi-official groups - BIMAP, CARICAD, and others. Detailed description of project activities carried out during this initial period is given in the Semi-Annual Report - Oct. 1, 1981 to April 30, 1982 - and subsequent quarterly reports

Purpose

The purpose of the evaluation is:

- To provide timely and appropriate controls for project management which meet the needs of the day-to-day administration of the project.

- To determine the extent to which the planned outputs of the project are being produced in an economical an timely fashion (efficiency).

- To review project activities and make recommendations for the second year work plan. These recommendations will provide a basis for policy decisions within the coordinating bodies (Advisory Board, Executive Committee and Country Program Committees).

Statement of Work

The American Public Health Association, as executing agent and in close collaboration with the Chairman of the Executive Committee and Pro-Vice Chancellor (Planning) of the University of the West Indies, has selected a five person team that reflects the interest and concerns of the University of the West Indies, University of Pittsburgh, American Public Health Association, Caribbean Nationals and AID to undertake the evaluation.

The persons selected collectively have recognized status as management trainers, general or public administrators, health administrators and persons familiar with the environment (Academic, and Caribbean countries development processes).

Technically HDPM has only been operational for a period of a little over six months, and therefore, it is too soon to demonstrate the effectiveness of the changes, if any, generated by project outputs.

The evaluation exercise will give maximum attention to project administration. To accomplish this, the team will concentrate on examining the planned versus actual project outputs.

This internal exercise will be limited to evaluating the efficiency with which the project is being managed. The efficiency of the project is defined as the extent to which the planned outputs are produced in an economical and timely fashion. This will be done in each of the four project areas namely; 1) On-Campus Training, 2) In-service Training and Development, 3) Research and, 4) Project Management.

The Evaluation Review will generate answers to the following questions:

a. What has the project achieved to date?

b How does this achievement compare with expected performance?

c. What is the likelihood of the project as designed and currently managed achieving its ultimate purpose?

d. Should the project design and/or management structure be modified in order to achieve the expected impact on health planning and management in the affected countries?

e. What unplanned changes have occurred to date and what are their effects?

In addition to the above questions, the Review should also answer these forward-looking questions:

a. What alternatives to the current work plan merit consideration?

b. Could the same purpose be achieved more efficiently by other means?

c. What specific changes would improve project performance?

d. Is the communication system in use adequate to meet the needs of the project? If inadequate, suggest alternatives.

e. Is the management system adequate to meet project needs?

Based on reviews of project documentation (project proposal, Cooperative Agreements, Reports of Meetings of Project Coordinating Bodies, visits to participating countries) and interviews with UWI authorities and staff, national authorities and other relevant individuals, the team will report on the state of development on each component of the project, state conclusions and make recommendations to achieve the over-all purpose of the evaluation.

Country Specific Evaluation

Team representatives will analyse the project activities in each country in terms of:

1. Consistency of local project objectives with overall project goals.
2. Perceptions by key individuals of project goals and methods.
3. Logical integration of project activities into the curriculum development activities.
4. The suitability of the health management issues identified for teaching case studies and research. Is the

analytical process for identifying and dealing with these issues appropriate?

5. Is appropriate use being made of the technical cooperation/consultancies? Specifically, are the areas chosen for technical consultant activity the highest priority? Are there any plans for follow-up on consultant recommendations?

The field portions of this exercise at the Mona campus and selected participating countries should be executed during a two week period beginning July 19th.

The field portion will be followed by work sessions in APHA Headquarters/Washington, D.C. and will evaluate briefings both at APHA and AID on findings and recommendations before proceeding to finalize the Evaluation Report which is due on or before August 25, 1982.

Reporting

The report will contain:

(a) an objective review of the project performance to date.

(b) an assessment of efficiency in the project management to date and of perceived impact of project activities undertaken, current or anticipated.

(c) an analysis of costs and

(d) recommendations for project modifications in both design and work plan.

Roles and Responsibility

One of the members will be designated "team leader" and he will be working closely with the Chairman of the Executive Commmittee and the Project Administrator and report to the APHA Project Manager. Individual members of the team may visit and interview project staff, national authorties and other relevant individuals in any or all of the four participating countries.

The following materials will be mailed to the members of the evaluation team for review no later than June 23, 1982:

1) Original project proposal submitted to AID
2) Cooperative Agreement between AID and APHA
3) Subcontract between APHA and UWI
4) Subcontract between APHA and University of PITT
5) HDPM Semi Annual Report (10-1-81 to 4-30-82)
6) Board and Committee Meeting Minutes and selected Correspondence

The evaluation team will convene in Jamaica at the University of the West Indies under the chairmanship of Sir Carlisle Burton on July 19, 1982. They will be briefed by the Chairman of the HDPM Executive Committee and Pro-Vice Chancellor (Planning) of UWI, Professor L. Robinson and the Project Administrator, Mr. R. Thelwell.

PC)

The team will proceed to organize itself and discuss the plan of work and the implementation thereof, delegating responsibilities among themselves to visit each of the participating countries to make contact with members of the country program committees, if formed, Ministry of Health officials, UWI faculty and staff, and representatives of private institutions as warranted.

The opportunity to interview any level UWI employee connected with the project and review additional and updated material from the Project Administrator will be arranged for the next two or three days.

About the third day, the members of the team previously selected will visit one or more of the participating countries to interview and meet with those persons mentioned above. One member of the team will stay in Jamaica to interview, etc.

During the latter part of the second week, on August 4th the team will meet at APHA in Washington for a couple of days to discuss findings, summarize conclusions, and decide on recommendations. A typed report is due at APHA headquaters within twenty (20) days after completion of the debriefing in Washington, D.C.

ATTACHMENTS

Project Proposal submitted to AID

Cooperative Agreement between AID and APHA

Subcontract betwen APHA and UWI

Subcontract between APHA and PITT

HDPM Semi Annual Report

Board and Committee Meeting Minutes and Selected Correspondence

AGENCY FOR INTERNATIONAL DEVELOPMENT
HEALTH DEVELOPMENT PLANNING AND MANAGEMENT PROJECT

MID PROJECT EVALUATION

Cooperative Agreement No AID/DSPE-5901-A-00-1039-00
American Public Health Association
University of Pittsburgh
University of West Indies

February 3-29, 1984

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9. Report: First Course in Diploma Program, Workshop at University of Pittsburgh, September, 1983
10. Report: In-Service Programme, St. Lucia and Barbados
11. Report: Update on HDPM In-Service Programme, Barbados, Fall, 1983
12. In-Service Program Participants, Trinidad and Tabago
13. Specific Ojectives for State of the Art Study
14. Questionnaire: State of the Art Study
15. Terms of Reference: Preliminary Jamaica Study
16. Terms of Reference: Jamaica Country Specific Study
17. Terms of Reference: St. Lucia Country Specific Study
20. Research Protocol: Trinidad HIS Study

ACKNOWLEDGEMENTS

The evaluation team humbly acknowledges the uncomplaining and forthcoming assistance it received every step along the way. The task of project evaluation, meant to be helpful, too often becomes confrontational, and the team is gratified not to have had that experience on this assignment. While acknowledging all assistance to the team, specially warm thanks are due to the UWI officials at all 3 campuses. They gave their time unstintingly and responded openly to our many questions. Pro Vice Chancellor Robinson went out of his way to show us Carribean hospitality, as did Mr. Richard Thelwell, APHA Project Administrator. Mr. Thelwell's knowledge and energy most considerably facilitated our task, and we sincerely thank him for his assistance.

EXECUTIVE SUMMARY

The Health Development Planning and Management (HDPM) Project is an AID-Washington funded activity implemented by a Cooperative Agreement between AID and American Public Health Association. APHA, in turn, has subcontracted with the Universities of the West Indies and Pittsburgh. The long-term Project Goal is to institutionalize planning and management capabilities of the governments of the West Indies. The immediate Project Purpose is to establish at the University of the West Indies the sustained capability to work with Ministries of Health and other West Indian institutions within the region to:

A. Train health planners and managers.

B. Give technical assistance in health development planning and management to country governments and health sector institutions.

C. Conduct an applied health services research program to improve the delivery of services.

The five-year Project started October, 1981, and has an estimated life of project cost of 2.5 million U.S. Dollars.

This mid-term external evaluation, required by the Cooperative Agreement, was conducted by a four-person team between February 7 and February 29, 1984. The team convened in Washington where it was briefed by AID, the APHA and the University of Pittsburgh (PITT) and reviewed appropriate documents. Arriving in Jamaica February 12, the team reviewed additional documents, was briefed by the APHA Project Administrator and officials of the University of the West Indies (UWI), then consulted and interviewed UWI administrators and project-related faculty members, officials of the Government of Jamaica's Ministry of Health and Administrative Staff College, and the USAID/Jamaica Office of Health, Nutrition and Population. The team dispersed on February 17 to the other three Project-related countries, St. Lucia, Barbados and Trinidad/ Tobago, where they consulted, inter-alia, representatives of the respective Ministries of Health, UWI administrators and faculty, the USAID Regional Health Officer/Caribbean, PAHO, and the Caribbean Center for Development Administration (CARICAD). They made site visits to health facilities, and attended in-service training sessions being conducted under HDPM aegis. The Team reconvened in Jamaica on February 22, conducted additional interviews with UWI and PAHO, drafted its report, then verbally presented and discussed the findings of the evaluation with the

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Mona-based members of the HDPM Executive Committee, including the APHA Project Administrator, and with USAID/Jamaica. The team departed Jamaica February 29, after which the Team Leader (William Callen) completed and edited the draft.

The project has four major component activities:

A. <u>On-Campus training</u>, for which a post-baccalaurate diploma course in health management is to be established.

B. <u>In-Service training</u>, in which the UWI Department of Extra-mural Studies (DEMS) is to work with Ministries of Health of the four Project-related countries to provide in-service health management training of a type desired by each country's Project coordinating body, the Country Program Committee.

C. <u>Research</u>, developed to support the training and technical assistance components, is to be conducted through the UWI Institute of Social and Economic Research (ISER).

D. <u>Technical assistance</u> through indigenous experts, under which an indigenous pool of personnel skilled in management and planning is to be developed and/or identified, and a registry prepared and circulated.

The components and administrative/financial arrangements are discussed below.

A. <u>On-Campus Training</u>

This component, certainly the key component necessary to give the UWI the sustained capability to train health planners and managers, is behind initial expectations and, in-spite of repeated inter-faculty meetings, consultations and discussions during the APHA Internal Review conducted in July, 1982, is in danger of faltering. While the Faculty of Social Sciences has provided resources and generally fulfilled its obligations, the Faculty of Medicine has not made sufficient input to make even the on-going first course of a projected five-course diploma program proceed as planned. In part, this is a fault of Project design, which did not budget resources for this component and which either overlooked or ignored the workload in relation to responsibilities of the Department of Social and Preventive Medicine, that department which logically would provide most of the medical faculty's input. Additionally, a formal decision has not yet been taken on the Faculty which will have responsibility for the program and approval of its introduction by the University Academic Committee has not yet been obtained. The Team has recommended that the Project provide funding for additional staff support to the University in order to assist it to conduct

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the full diploma program beginning in the fall of 1984. The Team has urged the UWI to obtain official sanction for the diploma and officially designate the Faculty where it will be housed. Additionally, we have recommended administrative and budget changes which will better coordinate the on-campus program, including the development of curricula and the adaptation of existing training courses where appropriate. Finally, the Team considers it imperative that two complete rounds of the diploma program be conducted during the life of the Project in order to market the program and adequately test curricula. We have recommended that unless the diploma program is initiated during the fall of 1984, AID should seriously consider deleting this component of the Project and reducing funding accordingly.

B. In-Service Training

This component clearly is the most successful component, well-conceived and well-executed. Successful in-service management and planning training sessions, using a problem related modular base, have been conducted in conjunction with the Ministries of Health in St. Lucia and Barbados, and have just been initiated in Trinidad/Tobago. We feel the activity has great potential for adaptation and duplication in other Caribbean nations, and to bolster this potential, we have recommended that the process be evaluated for impact and the methodology more fully documented. We recommend that HDPM resources for in-service training be reduced in duration in Trinidad, given the high capability of that MOH Planning Unit. Since St. Lucia serves as a model for the lesser-developed nations, we recommend that the period of St. Lucia's in-service support be extended in order to further institutionalize and decentralize the process to district level. In Jamaica, UWI expertise and experience in in-service training might be productively shared with the ongoing training activities funded from resources other than HDPM. The ample availability of other resources to the Jamaican MOH leads the Team to recommend that HDPM funding not be used for in-service training implementation costs in Jamaica but only for technical advice. Finally, to expand the impact of this component, the Team recommends that the in-service training component be made available to two of the lesser developed Caribbean nations if they request it.

C. Research

The partners of the Cooperative Agreement opted for a two-pronged approach to health services research in health planning and management. The first was a general sector study, beginning with a State of the Art Study (SOAS) and an annotated bibliography, bolstered by additional sector studies suggested by gaps in the SOAS. The second approach was to conduct country specific investigations selected by the local Country Program Committees in each of the four targeted countries. The results to date are disappointing. The quality and utility of the research

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generally has been low and completion slow. The most useful piece to date has been the annotated bibliography. We recommend that general sector studies beyond the ones completed or currently underway not be conducted, unless they clearly can be linked to the delivery of services and are subject to improved quality control, including the utilization of a research consultant (collaborating consultant), the request by a client, and monitoring of the research by a research task force. Similarly, we have recommended that ongoing country-specific studies be completed, but that additional country-specific studies be conducted only under the same quality control measures outlined above.

D. Technical Assistance through Indigenous Experts

The HDPM project has given less priority to this component than others; nonetheless, it has developed a computerized listing of over 100 names, about a fifth of whom are non-West Indians. The Team has recommended that attention now be given to screening the existing list and, in collaboration with appropriate regional institutions, increase efforts to identify greater numbers of West Indians skilled in planning and management to expand the registry. We have made recommendations to improve the quality of the Registry, as well as to soon give it a wide circulation. A second element of this component, establishment of a Resource Center at the Institute of Social and Economic Research, has proceeded quite well. Recommendations on this subcomponent deal largely with the acquisition of additional appropriate materials and their expanded utilization. Finally, we have recommended that the burden of the Registry eventually be taken from the APHA Project Administrator and institutionalized at UWI, possibly in the ISER or within the Department of Extra-Mural Studies.

E. Financial Analysis

The evaluation team spent significant time looking at the financial reporting system, level of expenditure per line item, level of effort and pipeline analysis. There was also an attempt to estimate component costs.

The team recommends a modification in reporting to facilitate project management's use of the finance reports; some redistribution of line items; the development of a programmatic budget; an increase in the revolving fund and overhead rate of the UWI; and close supervision of the project expenditures in Year III to avoid cost overuns.

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F. Administrative Arrangements

The Team found the Administrative arrangements exceedingly complex. They include AID central and regional organizations (AID-W, RDO/C), AID/Jamaica, the APHA central and field office, University of Pittsburgh, UWI (with its two involved faculties and three campuses), and Ministries of Health of four sovereign nations. The Team feels AID and APHA have been remiss in signing or approving cooperative agreements and subcontracts which fail to more adequately delineate responsibilities and budgetary priorities between the recipient and sub-recipients of the agreements. As was the case in an earlier similar arrangement (Development and Evaluation of Integrated Health Delivery Systems - DEIDS), the arrangement eventually proved workable, but only because of good will and repeated permitted discrepancies between what was written and what was done.

Prior to negotiating a similar arrangement in the future, we recommend that AID should examine the contracting process, particularly from the standpoint of efficiency and accountability, in order to ascertain whether such complexity is necessary. The current agreements should be modified to strengthen the delineation of responsibility and to reflect that delineation through appropriate rebudgeting. The role of the University of Pittsburgh should be altered to permit it (legally) to assist in research which, along with its involvement in the on-campus component, would appear to be a legitimate role. Portions of the APHA budget should be shifted in order for UWI to arrange for inter-regional travel and consultation. The UWI, which appears in its sub-contract to have been given all the implementation responsibilities for conducting the Project activities, has not been given adequate resources to do so. UWI should rebudget its funds to adequately support each component activity. The heaviest onus resulting from the existing arrangements has fallen on the Project Administrator, who not being a part of the UWI faculty, has no administrative power within the University hierarchy, but must "administer" by advising, at the same time being subject to veto by cental offices in APHA and AID. The administrator's role should be clarified and a responsible UWI liaison person identified to implement Executive Committee decisions for each project component. AID should provide adequate travel funds to facilitate legally required monitoring by the AID project officer, or make other administrative arrangements to permit it. The current administrative arrangements, coupled with existing agency constraints, have made it difficult if not impossible for the AID Project Officer to monitor the Cooperative Agreement adequately.

In closing, the team feels the goal and purpose of the Project remain valid, in that successful management and planning of health resources are necessary in the Caribbean and are appropriate areas for AID assistance. To accomplish the purpose of the Health Development Planning and Management Project, however, modifications based on the findings and recommendations

summarised above are urgently required. AID and the collaborating organizations need to negotiate and legally finalize these modifications within the next three months in order to avoid serious project disruption and negative programmatic consequences.

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SUMMARY OF RECOMMENDATIONS

AID and APHA Action

2.4.6 Project Design. At the final evaluation of the HDPM project, AID should carefully assess the administrative process, in terms of effectiveness, efficiency and accountability, to establish the feasibility and/or design conditions on similar programs with such complex administrative structure.

2.4.3 Project Management. The AID project officer should be authorized to attend the Project Advisory Board Meeting twice yearly and review project progress on-site. The APHA project manager in Washington should provide ons-site guandance and assesement with visits to the four participating countries approximately three times yearly, including participation in the Advisory Board Meetings.

2.4.4 Project Reporting. The project administrator should convene with APHA/W and AID/W four times yearly to review and discuss each quarterly report. He should also meet quarterly with RDO/, U.S.AID/Jamaica, PAHO and other appropriate groups to facilitate information exchange and coordination.

3.3.4 Implementation Deadline. UWI should proceed forcefully and expediently in attempting to begin the diploma program in Fall 1984. At least two rounds of training must be completed in order to establish a market for the program and to develop a tested curriculum. To have reasonable hope of achieving project expectations in regards to the on-campus component, it is imperative that the diploma course begin as planned. Should it not begin in Fall 1984, AID should seriously consider deleting this component with concurrent reduction of funding.

4.5.4 Reduction of HDPM Support to Implementation of Inservice Training, Jamaica. Funds for management related in-service training for PHC is available from USAID/Jamaica sources through the Health Management Improvement Project. Accordingly, the more limited resources available to HDPM should be utilized in Jamaica for technical assistance to providers of in-service training, while module development and implementation of training should be funded from other sources.

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4.5.5 Staff-Tutor Position. -- UWI, St. Augustine Campus. AID should favorably consider UWI's formally expressed request for the additional position requested.

7.8.5 UWI Overhead Increase. Consideration should be given to properly determining UWI's real overhead rate which is estimated by UWI to be much higher than the presently charged rate of 10%. UWI should be allowed to charge additional overhead to permit it to properly develop the institutional capacity to plan and respond to opportunities and potential contracts in the region. Capitalization is a basic foundation of institution building. This should not put an extra burden on the UWI budget because devaluation has reduced the Jamaican based project costs by 55%.

7.8.9 UWI Revolving Fund. Increase the revolving fund at UWI to $100-K. At present, UWI has over expended its revolving funds by $90,000. This is due to the reporting lag time between the three other project areas and Mona.

APHA and PITT Action

2.4.2 University of Pittsburgh. University of Pittsburgh should be asked to consult in the design and implementation of research activities as well as in the development of course materials and field experiences for on-campus training. Perhaps, they could also assist in the evaluation of in-service training. It is appropriate that the PITT liaison attend Executive Committee Meetings; and if a project coordinating group is formed, PITT should be invited to some if its meetings as a way to develop useful interchange.

6.5.1 University of Pittsburgh. The University of Pittsburgh should be invited to play an active role in research and the PITT subcontract modified to reflect health services research responsibilities.

7.8.2 PITT Other Direct Costs. A line item should be created in the PITT agreement to cover other direct costs. At present, PITT is expending ODC without a line item.

APHA and UWI Action

2.4.1 Project Coordination. U.W.I. should re-examine its organizational and operational structure. The team suggests that an operational project coordinating group should be formed chaired by the Project Administrator, and made up of the in-service education coordinator, the research coordinator and the on-campus training

coordinator (Until the on-campus coordinator is appointed, the chairman of the curriculum working group should sit with this group.) This is an operational staff group not an executive or advisory committee. It should meet monthly or even biweekly to share information and coordinate day to day activities among the four program elements. The Project Administrator cannot take on responsibility for the four operational roles - which belong to UWI - he can however, facilitate collaboration and move decision processes to the appropriate level.

3.3.3 Diploma Program Staffing. The Senior Researcher position has been formally transferred to a Course Coordinator position. This may not be enough. In addition to clerical and part-time staff support for the interdepartmental work group an additional full-time equivalent teaching staff position should be budgeted to carry out curriculum development and teaching in the diploma program. Creation of these positions should have priority for allocation of resources over all other project activities (except in-service), including UWI research, University of Pittsburgh consultancies and other expatriate consultancies. APHA and AID should take the steps necessary to promptly facilitate whatever re-budgeting is required.

4.5.7 Extension of In-Service Training, St. Lucia. The Ministry of Health and Housing, St. Lucia, should be invited to indicate its interest in extending the duration of the in-service component in order to further decentralize and institutionalize the planning and management functions of the PHC system. Should the Ministry be interested, the Project favorably should consider a well-justified plan for utilization of such an extension.

5.4.1 Use of Indigenous Consultants. HDPM should actively promote the use of indigenous consultants wherever possible, including teaming those with limited experience with consultants of greater experience. This teaming is particularly useful in areas of specialization which are inadequately represented in the region.

5.4.2 Registry Improvement. With input from the proposed working group, the Registry of Consultants should be refined to provide specific planning and management categories such as personnel, drugs and supplies as well as details related to work experience, research and publications, previous consultant activities and availability for short or long-term consultancies.

7.8.1 Programmatic Budget. A detailed project programmatic budget should be worked out in coordination with the project modification exercise, following the guidelines in 7.7 section. UWI should participate fully in this exercise. The detailed programmatic budget should also try to identify UWI inputs for planning purposes.

7.8.6 Budget Line Item Comparability. Each line item on all of the agreements should be brought into harmony. The UWI budget, for example, has three line items, different from the other agreement: innovative projects, training workshops and workshop materials. These could be collapsed into other direct costs (ODC), in-service or on-campus as the case may be.

7.8.7 Reporting Forms. The recommendations for reporting in 7.2 section should be implemented if the forms are satisactory to all concerned.

UWI Executive Committee Action

2.4.5 Executive Committee. The project team should consider rotating the executive meetings among the participating countries to promote increased focus on the non-Mona project activities.

3.3.5 Faculty of Medicine Input. Every effort should be made to directly involve the Faculty of Medicine in the planning and implementation of the remaining first course and the entire diploma program for next year.

3.3.6 Study Grants. The project should consider supporting the economic costs of a selected number of promising health planners and managers from the non-campus countries for the next two years, to increase the potential for their participation given the small islands' economic constraints, and provide an expanded student base for the demonstration years of the program.

4.5.3. In-Service Training for Non-Campus Territories. In-service training of the type developed in this project should be offered to additional non-campus nations. Ideally, at least two eligible non-campus nations should be added to this project, provided there be interest expressed by the nations. Alternatively in view of the importance of the Cave Hill Campus iin development of UWI programs in non-campus territories as well as the possibility to establish firmer linkages between on-campus and off-campus activities in Barbados itself, it would be advantageous to extend, HDPM in-service support in Barbados.

4.5.6 **Expanded Role of Staff-Tutor.** The project should expand the role of the three Staff-Tutors to include coordinating, monitoring and reporting responsibilities for all off-campus components of the HDPM Project.

4.5.8 **Executive Symposia.** If any additional Executive Symposia are to be considered, they should: be clearly justified on a specific country basis; be carefully designed to meet objectives; guarantee appropriate participation; and be systematically implemented to support the objectives of the other ongoing Project components. CARICAD and the Jamaica Administrative Staff College have demonstrated experience which could be appropriately tapped in planning and implementing such an activity, on a limited basis, but results should be carefully assessed and judged relative to other ongoing activities before being expanded further. Any future Executive Symposia should have the integrated input of all four Project components in the design, and preferably the execution, of the Symposia.

5.4.3 **Registry Dissemination.** The improved registry of consultants should be disseminated and discussed at Executive and Country Program Committee meetings. It should be widely circulated to participating governments, international and regional agencies such as AID/W, RDO/C, U.S.AID/Jamaica, APHA/W, UWI, University of Pittsburgh, Adminstrative Staff College in Jamaica, PAHO, CARICOM, CARICAD, OECS, consultants and other appropriate entities.

5.4.4 **Institutionalization of Registry.** The registry should be institutionalized at UWI, either in the Department of Extra-Mural Studies or at the ISER Documentation Centre, preferably by the end of Year IV.

5.4.7 **Technical Assistance Coordination.** The Project should more effectively link the technical assistance component with in-service training. The In-Service Training and Development Coordinator should use her contacts in the country training activities to help identify and screen potential consultants. Consultants should also be included in the in-service training programs as appropriate, either as resource personnel or as participants who could benefit from further training and experience.

6.5.4 **Research Budget** The project can be successful without fulfilling its research goals. Research need not be discontinued - it is not a high priority at this point in the Project. To the extent that project management

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feels that research can/cannot be effective and quality control implemented, the Executive Committee should seek to negotiate for reallocation of research resources.

7.8.3 Allocation of Consultant Funds. If feasible, the remainder of the line item "consultants" should be moved from PITT's budget to APHA's budget 1/3 and UWI's budget 2/3. This represents the present consultant use ratio. The chairman of the Executive Committee should be responsible for all decisons relating to UWI project expenditures.

7.8.4 Allocation of Travel Funds. If feasible, the travel budget should be reallocated between APHA's budget 1/3 and UWI's budget 2/3. UWI would expend from this line item following its quarterly travel plan. Regional travel arangements would be cleared with RDO/C and extra-regional travel with AID/W, S and T/Health.

UWI Programmatic Action

3.3.1 Administration Diploma Program. Either UWI Vice-Chancellor Preston or Pro Vice Chancellor Robinson should immediately confer with the two Deans of Medicine and Social Science to confirm whether they endorse administrative placement of the Health Management Diploma Program within the Faculty of Social Science - If so, the decision must be officially established. This was the recommendation of the December, 1982 Curriculum consultancy Committee - but it is not clear whether it has the support of both faculties and is still considered the best course of action.

3.3.2 Curriculum Planning. The most critical issue facing HDPM at UWI is adequate staffing and the administrative approval of the on-campus diploma program in health management. Staffing was a critical omission in design of the project and it must be remedied immediately. An inter-department work group responsible for development of the diploma program was established by the 1982 Curriculum Consultancy Committee. This work group should be reactivated. Planning needs to occur for student enrollment in already existing course modules and teaching resources identified for new course modules. If part-time money is required for work-group activities, it should be provided by HDPM.

4.5.1 Impact Evaluation. The Project should develop an evaluation plan, collect appropriate data and conduct

an analysis in order to assess impact and/or outcome of the in-service training component in at least the three nations where in-service training is now underway. The evaluation design and implementation should include input from evaluation experts not intimately involved in the in-service component, and should be conducted in order for the results to be available to the Project by the time of the final external project evaluation.

4.5.2 Documentation of Methodology. The Project should more explicitly document its country-by-country in-service training methodology and process of module development for use as models for adaptation by other English-speaking Caribbean nations.

5.4.5 Resource Center Development. Consultant reports and project generated materials on all components should be indexed in the Resource Center. Key resource documents identified in the Annotated Bibliography of the State-of-the-Art Study as well as selected basic health planning and management literature, from international and indigenous sources, should be acquired and included in the collection.

5.4.6 Resource Center Dissemination. A categorical listing of Resource Center documents should be shared with Executive and Country Committees, PAHO, CARICAD, CARICOM< ASC/Jamaica and appropriate UWI faculty, with semi-annual addenda.

6.5.2 Research Coordinator. Designate a specific person (Research Assistant) at ISER to be responsible for Health Services Research who will coordinate with a resource consultant(s) at Pittsburgh to assist in defining research protocols and evaluating the three ongoing research studies (MIS, Trinidad; and Human Resources, Jamaica; final update of SOAS).

6.5.3 Research Quality Control. For any research beyond the 3 ongoing tasks in 6.5.2 above no research should be attempted unless:

a. It is a coordinated effort between all the different components of the project, including the training sections.

b. There are specific terms of reference and proscriptive detailed research protocols.

c. There is an interested and involved client, either Ministry of Health or a health organization, who will implement the findings of the study. In this context, groundwork must be done to determine if the particular research task is not duplicative or overlapping with other research.

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d. A qualified Caribbean principal consultant (principal investigator) is teamed up with an experienced collaborating consultant.

e. A research task force for each research project is formed to accomplish a,b,c,d above, composed of:

   a. Research Coordinator, ISER

   b. Principal Consultant, (principal investigator)

   c. Rep. of Local Country Committee or Rep. of Client (user group)

   d. Collaborating consultant, participant from other organizations who might have experience in similar research.

7.8.8 Salaries of Positions. New job slots in the direct salaries line items should be created as needed for UWI and identified by project modification. The title of Senior Reseacher should be changed to On-Campus Coordinator to cover the costs of executing that function.

7.8.10 Cash Flow and Programmatic Accounting. The existing budget should be followed to avoid a cash flow problem (see section 7.5). The new programmatic budget should be implemented following project modificaton and strictly adhered to. All accounts should be kept by the recipient on a programmatic basis.

1. BACKGROUND

1.1 Mid-Project Evaluation Procedure

This report contains the findings of a project evaluation carried out during February, 1984. The external evaluation team consisted of four consultants appointed by AID. They were directed to complete a mid-project evaluation of the Health Development Planning and Management Cooperative Agreement between AID and the American Public Health Association (APHA), including collaborative sub-agreements between APHA and the University of the West Indies and the University of Pittsburgh. Members of the evaluation team were as follows:

William Callen, Ph.D., School of Public Health and Community Medicine, University of Washington, Team Leader.

John Burns, Management Sciences for Health, Boston

M.M. Shutt, M.D., School of Medicine, University of North Dakota.

Anne Tinker, Office of Health, Bureau of Science and Technology, A.I.D./W.

The evaluation procedures are described in Appendices. Appendix 1 contains the evaluation Scope of Work. Appendix 2 identifies all individuals interviewed by the evaluation team. Appendix 3 provides a list of project documents reviewed.

Preparatory work for the financial and budgetary evaluation was begun by Mr. Burns at APHA on February 2, 1984. The full evaluation team gathered in Washington, D.C. on February 7, 1984. They reviewed the AID project files and subsequently were briefed by principals from AID, the University of Pittsburgh and the American Public Health Association. The following week the team traveled to Jamaica where they were briefed by the APHA Project Administrator, and interviewed University of West Indies administrative officials, members of the Departments of Extra-mural Studies, Government, Management, Social and Preventive Medicine, and the Institute of Social and Economic Research. They also met with officials from the Jamaican Ministry of Health, the Jamaican Administrative Staff College, and U.S.AID/Jamaica staff. Early in the third week, the team split up to travel to Barbados, St. Lucia and Trinidad. There they met with University faculty, Ministry of Health, AID/RDO Health Officer, CARICAD, and PAHO U.S.AID/Jamaica representatives who had cognizance of the HDPM Project. In mid-week they returned to

Jamaica where the team met with the UWI Vice Chancellor, PAHO, and then met in executive session and drafted this report.

The findings of this report have been discussed with members of the Project Executive Committee resident at the University of the West Indies, Jamaica campus. The report has also been shown in draft form to APHA and the AID Project Officer. Thus, while all concerned may not entirely agree with this document, it has been prepared in such an interactive manner that it represents the reasonable input of all concerned.

1.2 A.I.D. Objectives for HDPM

The central Science and Technology Bureau of AID/W initiated the Health Development Planning and Management (HDPM) Project as a means to develop indigenous health management expertise within countries or regions where such expertise was needed. The HDPM project was designed to provide something more than short-term, ad-hoc management training. The goal is that institutionalized health planning and management training resources be brought about within developing countries. Indigenous resources will reduce country dependence on donors for training. The HDPM Project, if successful, would also accelerate the process of upgrading quality of health management in countries benefitting from Project grants.

The HDPM approach is particularly appropriate since the social, political and cultural conditions of individual countries cannot be fully addressed by external consultants and foreign based training institutions. Thus, HDPM presents an alternative to programs which invite senior level health managers to US and other foreign universities for graduate level training. In addition, the HDPM initiative has been timely because there are countries and regions that have the institutional readiness to move in the direction of self-reliance in health planning and management training.

Five planning grants of $50,000 each were awarded to organizations wishing to develop a cooperative program between a U.S. institution with expertise in health management and a country or region whose health sector and related training institutions wished to develop their indigenous expertise. Two competitively bid five year Cooperative Agreements were then awarded in September 1981. One was to Johns Hopkins University in collaboration with Indonesia. The other, the subject of this evaluation report, was to the American Public Health Association in collaboration with the University of the West Indies and the University of Pittsburgh.

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The University of the West Indies has three campuses and is supported by fourteen Caribbean nations. The HDPM Cooperative Agreement designated cooperative health sector activity in four of these nations: Jamaica, Barbados, and Trinidad, which have UWI campuses, and in St. Lucia, a non-campus country.

A review of selection criteria for award of the collaborative agreements indicates that HDPM was intended to be an adaptable, developmental project. Forty five (45) points were awarded for conceptual design and understanding of the objectives addressed by HDPM; thirty five (35) points for qualification and experience of collaborating groups; while only twenty (20) points were awarded for project planning and staffing. Clearly it was not expected that planning for detailed outputs and inputs (such as those of a log frame matrix) be the principal measure of eligibility for the HDPM project. The project award was based on the experience of the collaborators and their ability to understand and flexibly implement the goals of institutional development in health planning and management training.

The Request for Application (RFA) noted that the type of program and pace of development would vary with the countries involved. It encouraged initiative in design and implementation to meet country specific needs. However, the RFA did insist that projects actively involve the Ministry of Health plus other major public health institutions and development ministries such as Planning, Finance and Interior. The RFA also exhorted the collaborating institutions to develop multiple training curricula suitable to students from all levels and all areas of operations, including opportunities for in-service education. The RFA urged that curricula make use of materials based on case studies and data from indigenous health sector operations.

1.3 Collaborating Institutions

American Public Health Association APHA was the lead agency in planning the Caribbean HDPM project and it is the prime recipient of the Cooperative Agreement with AID. Thus, it is responsible for fiscal management of the Project and overall project administration. It negotiated sub-contracts with the two collaborating institutions. As prime contractor, it has the prerogative of defining roles and responsibilities and, more importantly, redefining activities and budgets as the Project evolves. (Note: Any such redefinition is subject to concurrance by AID.)

University of Pittsburgh. Because APHA is not a training institution and the HDPM project is intended to assist the Caribbean nations in establishing and strengthening their health management training resources, The University of Pittsburgh joined the proposal as a university resource with previous ties to the Caribbean and well established programs in health management and planning. The designated principal investigator from the University of Pittsburgh was Gordon McLeod, MD., then

Chairman of the Department of Health Services Administration in the School of Public Health. The School of Public Health has previously collaborated with Prof. Standard's UWI Department of Social and Preventive Medicine in an A.I.D. funded family planning education project. Thus, University of Pittsburgh was no stranger to Jamaica and UWI.

University of the West Indies UWI began at Mona, Kingston, Jamaica in 1948 as a University College affiliated with the University of London. In the early 1960's UWI became an independent university and established two other campuses, one at St. Augustinne in Trinidad and the other at Cave Hill, Barbados. The institution has eight faculties (called schools in the American system) including Medicine, Social Sciences, Natural Science, Arts and General Studies, Agriculture, Engineering and Law. Each Faculty has a Dean at one campus with a corresponding Vice-Dean at other campuses. Although theoretically all campuses are equal and the Deanships rotate, the Mona, Jamaica, campus is the oldest, the largest in enrollment and at present holds the deanships in Social Sciences and Medicine which are critical for this project.

UWI serves the English speaking Caribbean Islands. It is financially supported by fourteen separate Caribbean nations (CARICOM), the three larger of which are the seats of the three UWI campuses. As a typical university with many departments organized into faculties using the consultative and committee governance structure normal to universities, UWI governance is further complicated by having each of its faculties spread over three semi-autonomous, geographically far-flung campuses. Thus, approval of new programs on one campus requires the concurrence of parallel committees on two other campuses. This is not unworkable, but it clearly takes longer to formalize new programs under such a system.

During the planning phase of this project, several UWI Departments played a key role. The Department of Social and Preventive Medicine in the Medical School was a principal in design of the project. Professor Sir Kenneth Standard, Head of that department, was named as UWI principal investigator in the proposal submitted in reponse to the AID's request for a cooperative agreement. UWI also has a very active Department of Extra-Mural Studies which has administered many technical and certificate programs and has branches throughout CARICOM. The Department of Extra-mural Studies was involved early in project planning. It continues to play an active role in the Project by carrying out the in-service training conponent. The Faculty of Social Sciences had three groups designated to play a role. The Department of Government (public administration), the Department of Management (business administration) had the disciplines complementary to the Department of Social and Preventive Medicine in development of on-campus training in health management. Finally, the Institute of Social and Economic Rerearch (ISER) in the Faculty of Social Sciences was designated to carry out project research.

1.4 Caribbean Regional Needs

The state of health management in many Caribbean countries is the object of continuing concern. This concern stems from several sources:

- o inadequate reform of systems inherited from the colonial period to make them responsive to national conditions and needs;
- o deficiencies in services to the people and mismanagement of scarce resources; and
- o inappropriateness of management systems to implement new health policies that emphasize primary health care, improvements in coverage, and intersectoral collaborations in health.

The need then, goes beyond merely providing current services more efficiently but requires an extensive reform of systems at all levels and the development and delivery of substantially revised programs.

The HDPM project seeks to support these national efforts through its training, research and technical assistance components. In order to understand whether the HDPM Project is relevant and effective, the management training needs of Caribbean health managers must be understood. To this end it is useful to identify pertinent findings from a recent field survey, based on interviews and observations, that examined the situation of Caribbean health managers. The terminal report of an extensive one year project conducted by Dr. S. Kelley Moseley in 1976-77 contains important information regarding the training needs in Health Administration for the Caribbean {Moseley, S.K. "Training of Health Administrators in the Commonwealth Caribbean: Terminal Report," WHO/AMRO, 1977}.

The needs assessment conducted by Dr. Moseley in preparation for the development and implementation of courses for teaching health administration in the region, characterized the needs for management training at the macro level in five areas. A summary of the problem areas identified is as follows:

1. Following independence from the British Colonial experience, local governments became responsible for not only providing health care, but ensuring economic progress, improving road, housing, and a variety of other activities in a developing economy. As priorities necessarily were directed to critical demands "funds for health education and management were placed in a very low priority."

2. Managers of the systems were generally trained as administrators, operators or clerks, not as policy makers or decision makers; this resulted in a highly centralized

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organization where most decisions were being made at the Ministry, Permanent Secretary or Cabinet level.

3. Senior decision makers in the health system were characterized as generalists, lacking substantive training and knowledge in either health or management. Identification of professional confrontations between physicians and nurses and the Permanent Secretary was cited as an illustrative example of this problem.

4. Day-to-day operations of the health system were guided by policies and procedures carried over from the colonial period and created barriers for individual initiative, innovation and work performance.

5. Career development and promotion procedures were based on seniority rather than merit evaluation.

Moseley's survey of 30 government and health leaders of the Caribbean revealed that over 70% felt that the major problem facing the health system was a lack of health organization.

At the micro level of management needs for individuals, Moseley identified the importance of proficiency in dealing with environmental, organizational and interpersonal aspects of management. He also emphasized the importance, if management change and improvement are to occur, of vertical integration of management training programs at three basic levels in the administrative structure, i.e., policy makers, mid-level managers, and supervisors.

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2. ADMINISTRATIVE ARRANGEMENTS

2.1 TERMS OF THE COOPERATIVE AGREEMENT

The Cooperative Agreement between AID and APHA was signed on September 30, 1981. The Cooperative Agreement identified a long term goal, three short term goals, four major activities, a series of tasks under each category of activity along with a set of outputs related to each activity. Key personnel were identified and a general project budget was identified allocating $2,500,000 over five years in approximately equal annual increments.

The long term goal of the Caribbean HDPM is to build an indigenous and self-sustaining capability for health planning and management in the Caribbean Countries. The short-term goals is to establish an institutional capability at the University of West Indies to:

A. Train health planners and managers

B. Give (indigenous) technical assistance in health planning and management to Caribbean Governments and health sector institutions.

C. Conduct an applied health services research program to improve service delivery.

Four major activities were agreed upon to meet the goals. Training was to include (i) in-service training through UWI Department of Extra-Mural Studies and (ii) on-campus training through the combined Faculties of Medicine and Social Sciences. (iii) Health Services research was to be carried out through the UWI Institute of Social and Economic Research. (iv) Technical assistance was to be carried out through an indigenous pool of health management personnel.

The project tasks and outputs proposed in the cooperative agreement and sub-agreements will be discussed in following chapters of this report. A separate section will be devoted to each of the four agreed upon activities. In general, the specified tasks call for needs assessment, planning, implementation and evaluation of each activity. Two or three briefly described outputs are identified for each activity.

Six key personnel were identified in the cooperative agreement. They included Dr. MacLeod from University of Pittsburgh, the program Manager, Dr. Gerald, and a project administrator (to be named) from APHA, plus an in-service training coordinator and two in-service resident tutors from UWI. It is not clear why resident tutors (to be named) were considered key personnel. Dr. Standard, originally named as principal investigator, was not designated as one of the key personnel. In

fact, no one at UWI outside the Department of Extra-Mural Studies was listed as key personnel. Thus key personnel at UWI were designated for only one of the four activities, and no named faculty person at UWI was identified as key.

Project managment suggested that the omission of named key personnel from UWI was deliberately done to foster institutional, not personal, responsibility for program development and to avoid the unnecessary complication of AID approval for key personel changes. In the opinion of the evaluation team, however, institutions are made up of people, some of whom are truly "key" to designated activities. AID should have insisted that key personnel from UWI be named.

2.2 PROJECT ADMINISTRATION

Project Administration is highly complex, involving several AID offices, three collaborating institutions in different locations, five university faculties on three distinct campuses, four different ministries of health, dissimilar core groups for training in each country, and several advisory and operational committees. The Project design did not clearly or adequately delineate administrative, technical and budgetary authorities and responsibilities between the collaborators and interested parties.

AID has had earlier experience using a tripartitile arrangement with APHA and an American University working collaboratively with developing country institutions. As was the case in the development and evaluation of Integrated Health Delivery Systems (DEIDS) project, the arrangement eventually, proved workable, but was difficult to get started.

At the final evaluation of the HDPM Project, AID should carefully assess the administrative process, in terms of effectiveness, efficiency and accountability, before embarking on a similar program with such a complex administrative structure.

AID. Project administration has involved a number of AID personnnel with different responsibilities and perspectives. The cooperative agreement designated the AID Project officer in the Office of Health, Science and Technology Bureau, as the responsible person for providing technical and programmatic direction for the Project. This level of authority, plus the requirement of AID concurrence in all staffing and budgetting revisions implies the need for consistent, constant and on-site Project officer involvement, However, travel budget constraints have severely limited the ability of the Project Officer to adequately guide and monitor project activities in the field. Furthermore, there have already been three different Project Officers assigned during the first two and one half years.

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AID's Health and Nutrition Division of the Bureau of Latin America and the Caribbean participated in the review and selection of the APHA HDPM proposal. The Division continues to provide regional guidance and review to S&T/H. The Regional Development Office for the Caribbean (RDO/C) in Barbados reviews and clears all travel within the Caribbean and serves as the Project's regional AID liaison. USAID/Jamaica coordinates HDPM activities in that country with other ongoing bilateral and central activities.

The distance of the Project Officer from the field site and travel restrictions prevent systematic monitoring. The central office's demonstration Project objectives in the large islands differ somewhat from RDO/C's focus on the poorer small islands. Continuously changing personnel in all offices have made effective program management difficult. Transfer of project management to the region would be desirable, but seems unworkable given the fact that the Project involves activities covering countries with two different AID local offices. Furthermore RDO/C and USAID/Jamaica feel their staff is fully occupied with a work load of bilateral and other regional projects. Both RDO/C and USAID/Jamaica encouraged more systemmatic reporting of HDPM activities, as well as coordination with other donors, particularly, PAHO and CAPCAD.

APHA. APHA/Washington handles day to day administration, consultancy approvals, budgetary and expenditure processing, record keeping and the final preparation and distribution of reports, as well as the payment of consultant and travel expenses. The Project Manager maintains contact with and secures project activity approvals from the AID Project Officer. He also provides guidance to and approves activities of the Project Administrator in Jamaica, as well as activities of the subcontractors.

The Project Administrator, assisted by a UWI appointed assistant and secretary has his office in the Department of Extra-Mural studies at the Univesity of West Indies, Mona campus. The location is appropriate as the Mona Campus is the administrative center of the institution which the Project seeks to strengthen. However, as is mentioned elsewhere, the Project Administrator is not on the UWI staff and therefore, cannot act for UWI nor can he require their action. His location at Mona also distances him from the other UWI campuses and engenders perceptions of the project as a Mona-centered activity. A final dilemma confronting the role of the Project Administrator is that he is a West Indian paid in U.S. dollars on a U.S. salary scale. This could create continued resentment on the part of UWI staff who are paid much less than the Project Administrator.

The Project Administrator is Executive Secretary to both the Advisory Board and the Executive Committee. His job description includes responsibility for project coordination, collaboration among relevant parties, compliance of project activities, quality of products, evaluation and project

modification, and supervision of the HDPM project staff, Resource Center and consultant registry. We feel that his role in the project team, particularly with respect to UWI, needs to be more clearly delineated, so that UWI, not the Project Administrator, is held accountable for specific tasks more directly. He can then facilitate communication, coordinate activities, call elements to account if they are not performing as expected, and bring them together in problem solving sessions when problems arise and decisions are needed.

The internal evaluation of August 4, 1982, recommended a newsletter be circulated regularly on the Project. The first was developed at the end of 1983 but never cleared by APHA/W or distributed. We feel that an additional burden of paperwork on the Project Administrator is not necessary, and that the quarterly reports, coupled with regular personal inter-change, will provide effective information sharing and coordination.

2.3 SUB-AGREEMENTS

University of Pittsburgh - Two sub-contracts were signed under the collaborative agreement. The sub-contract between APHA and the University of Pittsburgh indicates that the University of Pittsburgh will make consultant services available as they are identified in the project's annual work plans. University of Pittsburgh agreed to provide up to a maximum of 12 person months consultant services per year plus 10 person months secretarial services and up to 3.75 person months of Dr. MacLeod's services as liaison officer for the sub-agreement. Consultation was to be provided in the area of in-service training and on-campus training. Consultation in development of research and technical assistance was not included.

There was significant delay in signing the APHA-Pittsburgh sub-contract. It was finally negotiated and signed at the end of the first project year - one year late.

The role of the University of Pittsburgh symbolizes a dilemma inherent in the design of the project. The project is intended to transfer American capability in health management training to the Caribbean but on the other hand it is to use and develop management expertise acknowledged to be already extent in the Caribbean. Pitt was given no contractual role in research. Its help with in-service training was not needed. When the curriculum consultancy committee was formed, and charted the course for on-campus training, Pitt played no role - and none was assigned for the future. We feel that Pitt could have been more actively involved in identifying ways to be helpful and offering its services, rather than waiting for assistance requests.

University of West Indies - The APHA-UWI subcontract was quickly negotiated and signed by December 1981. Everyone of the detailed activities, inputs and outputs identified in the

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cooperative agreement between AID and APHA are repeated word for word in the UWI sub-contract. The sub-contract further states: "the subrecipient (UWI) will be responsible for all professional and technical activities o. this sub-agreement." In other words, responsibility for the entire set of activities designated in the original cooperative agreement were formally delegated to the University of the West Indies as sub-contractor. Given this heavy load of responsibility which seems to have been accepted by UWI , it is quite remarkable that no individual in the sub-contract has been designated as liason officer or manager of activities. Again, the only key person identified is the coordinator and two resident tutors for in-service training. The budget does show that provision had been made for two research staff but not as key personnel. No positions or salary were budgeted for staff to carry out on-campus training or technical assistance activities.

It is hard to understand how the sub-contract between APHA and UWI could have received approval from AID. Furthermore, it is difficult to understand why either APHA or UWI would negotiate a contract that delegated such a broad range of responsibilities with no provision made for the staffing and resources needed to carry out all necessary activities.

The contract between APHA and UWI should make clear what APHA is responsible to do versus what UWI is responsible to do. The way the contract is written each side is responsible for everything.

This error in design is symbolized in the role of the APHA Project Administrator. He is expected to do many things but his legitimate power is limited. He cannot act for UWI, nor can he make them act if they do not ant to cooperate.

Despite the fact the project administrator is not a UWI employee, his coordinating role is key. UWI activities fall into several organizationally separate departments. Coordination depends on the Executive Committee and the Project Administrator acting as executive secretary of that committee. If a UWI liaison were appropriately designated for each of the separate components the project administrator could play an essential role in planning and coordinating day to day activities without falling into the trap of taking on activities that are not his responsibility.

2.4 RECOMMENDATIONS

1. Project Coordination

U.W.I. should re-examine its organizational and operational structure. The team suggests that an operational project coordinating group should be formed chaired by the project administrator, and made up of the in-service education coordinator, the research coordinator and the on-campus training coordinator. (Until an on-campus coordinator is appointed, the chairman of the curriculum working group should sit with this group.) This is an operaional staff group not an executive or advisory committee. It should meet monthly or even bi-weekly to share information and coordinate day to day activities among the four program elements. The project administrator cannot take on responsibility for these four operational roles - which belong to UWI - he can however, facilitate collaboration and move decision processes to the appropriate level.

2. University of Pittsburgh

University of Pittsburg should be asked to consult in the design and implementation of research activities as well as in the development of course materials and field experiences for on-campus training. Perhaps, they could also assist in the evaluation of in-service training. It is appropriate that the PITT liaison attend Executive Committee meetings; and if a project coordinating group is formed, PITT should be invited to some of its meetings as a way to develop useful interchange.

3. Project Management

The AID project officer should be authorized to attend the Project Advisory Board Meeting twice yearly and review project progress on-site. The APHA project manager in Washington should provide on-site guidance and assessment with visits to the four participating countries approximately three times yearly, including participation in the Advisory Board Meetings.

4. Project Reporting

The project administrator should convene with APHA/W and AID/W four times yearly to review and discuss each quarterly report. He should also meet quarterly with RDO/C, USAID/Jamaica, PAHO and other appropriate groups to facilitate information exchange and coordination.

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5. Executive Committee

The Project should consider rotating the executive meetings among the participating countries to promote increased focus on the non-Mona project activities.

6. Project Design

At the final evaluation of the HDPM project, AID should carefully assess the administrative process, in terms of effectiveness, efficiency and accountability, to establish the feasibility and/or design conditions on similar programs with such complex administrative structure.

3.0 CAMPUS-BASED TRAINING

3.1 Design

On-campus training activities under this project were planned to achieve three major project outputs. The outputs promised in the contract are as follows:

1. A cross-faculty (Medicine and Social Sciences) degree granting program in health management with curricula adapted to the Caribbean region.

2. Four courses on specialized topics of concern to health management in the Caribbean, for degree/diploma certificate students.

3. Trained UWI faculty to teach the degree granting program.

As was pointed out earlier, HDPM was funded with adaptation and development in mind. It did not begin with a carefully designed, predictable set of inputs and outputs. Thus, it should come as no surprise that the outputs envisioned midpoint in the project are both different and more specific than the original outputs. What is not always clear from the semi-annual reports and work plans is just how and why change occurred in the expected outputs. The change and some background for the change is described here.

3.2 Progress To Date

First, a degree granting program is not planned at this time. The decision has been made that a one year diploma program will be instituted. A diploma program is a graduate level program of one or more years that accepts post baccalaurate students plus experienced personnel who are considered to have the practical equivalent of a bachelor's degree. The diploma differs from the certificate in as much as a certificate is normally an undergraduate program that is shorter and less extensive than a degree program. Neither a certificate nor a degree program is planned at this time. If a degree program had been initiated, it would had to have been a bachelor's level (three year) program, because a master's program could not exist without a bachelor's as prerequisite. Thus, a diploma program that would attract experienced students from a variety of health related backgrounds was the preferable choice.

The second output promises four courses in specialized topics of concern to Caribbean health management. It should be made clear that a "course" in the British University (UWI) context refers to a sequence of studies covering a full academic year. Just one course in this context is equivalent to two courses in a semester system or three courses in a U.S. quarter system. To project an output of four courses implies the

addition of a large amount of new curriculum materials and the addition of almost two full time staff -- something never envisioned in this program. For instance, the new one year diploma in health management would normally consist of five courses plus a summer internship. To require an output of four new courses would imply that 80% of the diploma program would rely on new course materials, rather than using/modifying existing courses from the collaborating departments. This is unrealistic. Even at this point in time, it is difficult to quantify how much new course material should be expected as a project output. However, since one new course, Health and Social Organization, has been designed and is currently being offered during the 1983-84 academic year, the course outputs one could reasonably project at this time might be stated as follows: At least one new course of spcialized concern to Caribbean health management will be designed and offered to diploma/degree students and enough additional courses or course modules in health management will be offered to form an integrated diploma program in health management.

The output projected to train faculty to offer relevant courses is still valid, except that they must teach in a diploma rather than a degree program. A good beginning to this faculty development goal was made in September, 1983 when the Social Sciences staff involved in the new Health and Social Organization course participated in a course planning/faculty development workshop at the University of Pittsburg.

Curriculum Planning: Early in the second year of the project a curriculum development process for on-campus training was begun at UWI. A senior consultancy committee was formed under the chairmanship of Prof. Mills, Dean of Social Sciences. Other members of the committee were:

Mr. U. Salmon, Head, Department of Management

Dr. E. Jones, Head, Department of Government

Prof. Sir K. Standard, Head, Department of Social and Preventive Medicine

Prof. Rex Nettleford, Head, Department of Extra-Mural Studies

This team was assisted by two external consultants: Morris Schaefer, DPA, University of North Carolina and Clara Kimbro, D.Sc.,Johns Hopkins University. In addition, seven staff from the cooperating departments participated along with the HDPM Project Administrator.

The consultancy committee report, dated December 1982, documents the need for health management improvement and confirms the plan for a one year, five course diploma program in health management (See Appendix B). The report stated that this was to be a joint Faculty program administratively based in the Office

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of the Dean of Social Sciences. Course titles and content areas were identified, along with topic areas to be included in teaching. Content of topic areas, interconnection between topics and faculty resource areas for each topic were identified.

To follow up on this curriculum plan, an inter-departmental working group was designated, comprised of the seven staff members present and the HDPM project administrator. Under guidance of the HDPM executive committee, the working group was assigned a series of tasks preparatory to three outcomes: (1) implementation of first course in health management to be offered in 1983-1984, (2) implementation of a diploma program to be offered beginning in 1984-1985, (3) consideration and provisional planning for including a six month internship with the diploma program. The work group was directed to develop a specific, phased implementation plan including student recruitment, course scheduling (making use of existing course and module offerings in other diploma programs), and development of modules and courses unique to the new diploma program. The document does not define how leadership of this working group was to be determined. Apparently, Miss Barrett of the Department of Government was designated as chairperson of this group.

In the fourteen months between the publication of the Curriculum Consultancy Committee report and now, some progress has been made. But some serious pitfalls have also emerged. At this time the development of a strong on-campus training program is seriously at risk of failure and in the opinion of this evaluation team, strong, immediate action must be taken to recover much of the ground cost.

<u>Progress following December 1982 Curriculum Proposal</u>. In the Spring of 1983 it became apparent that a senior faculty person would be required to coordinate development of the diploma program. An individual was identified who was acceptable to both Medicine and Social Sciences. Preliminary discussions were held and the project administrator then wrote the APHA program manager asking that this person be hired under the APHA contract since the UWI salary scale was too low to attract such a candidate. Dr. Gerald appropriately noted that hiring directly through UWI was the correct procedure. He stated that a contract modification would have to be received and approved by AID/W because both a new position and rebudgeted funds would be required. He noted that the process would take six months to negotiate and legitimize. In late June, the Project Administrator appealed again asking that some way be found to hire the candidate on the APHA budget. At this point, there was a hiatus of three months, presumably allowing informal discussion of the issue between the principals involved. Finally, in October, Dr. Gerald formally responded to Mr. Thelwell clearly refusing to proceed in hiring the candidate as an APHA employee and stating that the UWI should decide whether they wish a contract modification to create a new position. At that point the Senior Researcher resigned and a position became vacant in the UWI contract budget . It was decided to transfer the senior

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researcher position to on-campus training coordinator, and the AID project officer subsequently approved the action. While negotiations were underway attempting to hire the candidate in question, there was further devaluation of the Jamaica dollar. The candidate turned down the job because the UWI salary offered was inadequate. In effect an entire year has been lost attempting to recruit a certain candidate and the diploma program is now in urgent need of a coordinator to plan for courses for the coming academic year. A new recruitment process is beginning. We can only hope that UWI will act expeditiously and that APHA through Dr. Gerald and Mr. Thelwell will do whatever can be done to facilitate and support the University recruiting and hiring process. If the diploma program does not begin in Fall, 1984, the whole project is vitiated.

1983-84 Course in Health and Social Organization. This course was developed as a pilot course for the diploma program. It was designed to include four topic areas - two be taught by staff from the department of social and preventive medicine and two to be taught by social sciences staff. The on-campus training coordinator was expected to teach the two medical care topics while social sciences staff were assigned to teach the other two topics. Because the coordinator had not been recruited the order of topics was reversed and four social sciences staff began team teaching the course in Fall, 1983 as scheduled.

Before the course began the teaching staff traveled to the University of Pittsburgh where they participated in a faculty development workshop on team teaching methods and course content. Nine students were enrolled. (Three subsequently withdrew because they learned that University regulations prevented applying course credit toward the as yet unapproved diploma program.) At the end of February when the social sciences topics were complete, a teacher for the medical care components had not yet been identified. Since the Department of Social and Preventive Medicine did not have staff available, a younger physician is being recruited from the Ministry of Health to teach the remaining course topics. The team teaching approach will continue so it can be expected that the inexperienced teacher found, if she accepts the position, may have the benefit of peers on the team to successfully complete the course.

One of the students and all the social sciences teachers were interviewed about the course. Evaluation report by Ms. Browne, Course Coordinator, was also reviewed. In general the course has been satisfactory. The students noted the lectures were good but their tutorial (discussion) sessions were too often cancelled - presumably because of a lack of Caribbean specific case materials for the course. The faculty appeared to have worked hard and responsibly but they were unhappy that additional part-time pay proposed for their extra work had not yet been received. (The project administrator told us the pay is coming but the paperwork had been delayed or misplaced within the UWI system.)

Formal University Approval of the Diploma Program. Before the first course began it was submitted to the Faculty of Social Sciences for approval. At that time they also approved in principle the concept of the diploma program. This spring the additional four courses and the diploma program as a whole must be submitted to the Board of Studies at each of the three campuses, then to the Social Sciences Faculty Executive Committee (May) and then to the University Academic Committee (last meeting in June). Nothing to date has been done to solicit these committee approvals. The time schedule is now such that expeditious action must be taken if the program is to be approved to begin in the Fall.

At the same time as Social Science Faculty approval is being elicited, a similar process will be pursued with the Faculty of Medicine. Although the diploma courses will not be offered in Medicine the staff from Social and Preventive Medicine will be expected to teach and examine students in the diploma program. When the concurring approval of the pilot course was requested last June, the Faculty of Medicine asked for more documentation before they could concur in setting up the course. Thus, concurring approval of the diploma program cannot be expected on a mere courtesy or pro-forma basis. When interviewed, the Dean of Medicine, Dr. Wray, did state that approval of the courses and the diploma program could be expected from his Board of Studies in March.

All in all, the failure to recruit an on-campus training coordinator, the misadventure in lining up medical faculty to teach the pilot course and the extensive committee reviews required to approve the diploma by June gave the evaluation team a great sense of anxiety about the future of the diploma program. Added to the delays is the problem of student recruitment. Informal student recruitment must begin before the diploma is officially approved. Students from ministries of health should now begin the process of applying for study leave. Applications must be received and most study leave positions allocated before June. Informal student recruitment can be done, but it is not the customary procedure, and it is doubtful whether informal recruitment will elicit applications from outside Jamaica. To encourage applicants from small island countries it seems expedient that money be put in the budget to pay the economic costs of training from small island countries.

One final comment should be made about the status of the Faculty of Medicine in this project. Dean Wray recognizes that the diploma program is now expected to be housed in the Faculty of Social Sciences with Social Sciences recruiting special teaching from Medicine. He also sees it as more properly working the other way. If this reflects the general position of Medicine it could delay the final diploma approval process and create roadblocks to student recruitment and effective Medical Faculty teaching in the program. Resolution of this conflict must be confronted and resolved at the Vice Chancellor's level.

3.3 Recommendations

1. Administration Diploma Program

Either UWI Vice-Chancellor Preston or Pro Vice Chancellor Robinson should immediately confer with the two Deans of Medicine and Social Science to confirm whether they endorse administrative placement of the Health Management Diploma Program within the Faculty of Social Science - If so, the decision must be officially established. This was the recommendation of the December, 1982 Curriculum Consultancy Committee - but it is not clear whether it has the support of both faculties and is still considered the best course of action.

2. Curriculum Planning

The most critical issue facing HDPM at UWI is adequate staffing and the administrative approval of the on-campus diploma program in health management. Staffing was a critical omission in design of the project and it must be remedied immediately. An inter-department work group responsible for development of the diploma program was established by the 1982 Curriculum Consultancy Committee. This work group should be reactivated. Planning needs to occur for student enrollment in already existing course modules and teaching resources identified for new course modules. If part-time money is required for work-group activities, it should be provided by HDPM.

3. Diploma Program Staffing

The Senior Researcher position has been formally transferred to a Course Coordinator position. This may not be enough. In addition, to clerical and part-time staff support for the inter-departmental work group, an additional full-time equivalent teaching staff position should be budgeted to carry out curriculum development and teaching in the diploma program. Creation of these positions should have priority for allocation of resources over all other project activities (except in-service), including UWI research, University of Pittsburgh consultancies and other expatriate consultancies. APHA and AID should take the steps necessary to promptly facilitate whatever re-budgeting is required.

4. Implementation Deadline

UWI should proceed forcefully and expediently in attempting to begin the diploma program in Fall 1984. At least two rounds of training must be completed in order to establish a market for the program and to develop a tested curriculum. To have reasonable hope of achieving project expectations in regards to the on-campus component, it is imperative that the diploma begin as planned. Should it not begin in Fall 1984, AID should seriously consider deleting this component with concurrent reduction of funding.

5. Faculty of Medicine Input

Every effort should be made to directly involve the Faculty of Medicine in the planning and implementation of the remaining first course and the entire diploma program for next year.

6. Study Grants

The project should consider supporting the economic costs of a selected number of promising health planners and managers from the non-campus countries for the next two years, to increase the potential for their participation given the small islands' economic constraints, and provide an expanded student base for the demonstration years of the program.

4. IN-SERVICE (OFF-CAMPUS) TRAINING

4.1 DESIGN

The cooperative agreement (C.A.) describes the major activities of the Project, including (page 2):

"In-Service Training through the Department of Extra-Mural Studies of the UWI.

In-Service Training will provide opportunities for participants to (a) increase their understanding about management theory, (b) their skills in applying these lessons in their work places and, (c) engage in activities which reinforce both their understanding and application of management skills."

Page 49 of the C.A. states:

"In order to perform these major activities, the Recipient and collaborators will carry out the following tasks:

1. In-Service Training

   1.1 Analyze the needs for improving the management and planning performance of health sector personnel and organizations in each participating country.

   1.2 Design and develop the curricula, the methods of instruction, admission criteria and supporting and reinforcing activities (e.g., consultations, attachments to Regional institutions, research activities of the Project, workshops, seminars).

   1.3 Assess the number of instructors, the training skills and competencies needed to conduct this training program.

   1.4 Select, recruit, prepare, support/supervise, and evaluate (according to established guidelines) a staff resource pool.

   1.5 Monitor and evaluate the conduct of the In-Service training program."

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Page 9 lists the major Project outputs, including:

"In-Service Training

1. Modular In-Service training curricula adapted to local conditions.

2. Approximately 60 trained health managers from four outreach courses.

3. Pool of 30 tutors/consultants equipped with knowledge and skills necessary to conduct the In-Service training."

The sub-contract between APHA and UWI repeats the foregoing nearly verbatim, while the sub-contract between APHA and PITT (page 2) calls for PITT to undertake, under In-Service training, the first three of the five tasks listed in the Cooperative Agreement, and makes no reference to outputs.

From the beginning of the formation of the APHA - UWI - PITT team, the lead in conceptualizing and later implementing the Project's in-service training component has been taken by the UWI Department of Extra-Mural Studies (DEMS). The primary author of the in-service component of the APHA Technical Application for the Cooperative Agreement, Dr. Phillis Macpherson-Russell of the DEMS, later was appointed HDPM Project Training and Development Coordinator, thus providing a highly desirable continuity between design and implementation of the in-service training component.

Training Process. Dr. Macpherson-Russell's academic background is education, not health or medicine. Accordingly, she elected the strategy of concentrating on the process of transferring management and planning principles rather than pre-designing specific course content. The approach used was problem-solving based, with country-specific content decided upon by the Country Program Committee. A modular approach was then utilized, with module design varying widely between countries, depending upon the level and experience of the in-country participants, health system problem identified for priority attention, and depending on varying constraints on time available to in-country participants. Thus, while the differences are great between the modular content of the two countries well along in the in-service training component (St. Lucia and Barbados), there are points of congruence on the management/planning principles infused. The same undoubtedly will be true for the program in Trinidad (formally initiated during the drafting of this report) and in Jamaica, which is scheduled to begin in April-May of 1984.

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4.2 PROGRESS TO DATE

General Comments During the first year of the Project, it was necessary to devote much time and effort in St. Lucia and Barbados establishing working relationships and communication between the Ministry of Health and UWI participants, and forming concensus about the nature, content and methodology of the program to be undertaken. The Advisory Board accepted the programs for inclusion in the second year's work plan, and the programs were approved by both Country Program Committees. The plans for each country are presented as Appendix 10.

The decision had been made in the first year of the Project to start the in-service training in St. Lucia and Barbados in the second Project year, and add Trinidad and Jamaica the third year. Both of the latter countries have evidenced impatience, wanting to initiate in-country activities earlier, but have accepted the timing established by Dr. Macpherson-Russell and the Executive Committee.

ST. LUCIA. In St. Lucia, Primary Health Care had been established as a policy, but had no program associated with it. The Country Program Committee, chaired by the Permanent Secretary, rarely convenes formally as such but functions on a day-to-day working basis. By consensus, the group agreed the focus of the in-service training in St. Lucia would be to assist the Ministry in preparation of personnel to manage the planned Primary Health Care System. In spite of some early reservations of the role of in-service training on the part of some senior ministerial officials, they agreed to participate (in part, at least, because they concurrently were granted access to a research activity of high priority to them, solid waste disposal). The group decided not to involve heads of departments directly in the training, but to target the next tier of health providers; this in order to gain greater replicability of the training given the component's expected two-year duration. (The Department heads later were more directly engaged in order to secure their full support.) The Medical Officer of Health, administratively responsible for Primary Health Services, became a joint coordinator for in-service training with the HDPM In-Service Training and Development Coordinator, and fifteen participants (4 from headquarters in Castries and 11 from other health districts) were selected by the Permanent Secretary and Department Heads following selection criteria. One participant later dropped out.

Between February and July, 1983, seven modules were developed and presented in St. Lucia, using as staff Dr. Macpherson-Russell, the Medical Officer of Health and three Caribbean short-term consultants. Most members of this National Team did not consider themselves as managers, so the first four modules concentrated upon personal development and the development of managerial and technical skills. The fifth module

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largely prepared a district level program, and modules 6 and 7 dealt with implementation of the district program.

The district level program was predicated upon earlier Ministerial identification of three areas for intervention into primary health care; health information systems, standardization of norms and procedures in the health care services, and increasing community participation in planning of health services. Regarding the first (health information systems), the HDPM National Team, building upon an earlier CARICOM-sponsored model district project in Soufriere, did the planning and training for district-wide systematic household health and environmental surveys intended to eventually include every household in the nation. The information being collected by regular MOH employees (mostly community and environmental health aides) is transferred to household folders kept in the District Health Center. The process, started in Soufriere then Vieux Fort on the southern part of the island, is proceeding northward, with a target completion date of September, 1984, the projected end of HDPM in-service training in St. Lucia. A team member was told this schedule may be ambitious, but at a minimum by September, 1984 each district level team will have been trained by the HDPM National Team, and the survey will have been completed for most of the island. Intended uses of the considerable information collected by this process (in addition to clinical use in the health center), include compilation of demographic data, delineation of target populations, indicators for evaluation, indicators of health status, supply system information and epidemiologic surveillance information. It likely will be necessary for the MOH to secure donor support for processing this data. The survey instruments and household health folder are available in the HDPM-APHA Field Office.

Standardization of norms and procedures has begun in at least two ways. During the modular training period each participant developed one or more draft protocols for procedures related to PHC using a format developed by the team. These have not been formally reviewed by the MOH to-date, but do represent an HDPM contribution to the process. Additionally, the Medical Officer for Health is well along working with the Ministry in establishing for the first time a managerial and administrative framework for operating the country's busiest health center in Castries.

The third element, community input into planning of health services, has not been conceptualized as yet.

There have been additional spin-offs of the HDPM in-service training in St. Lucia. The Permanent Secretary, who himself took an HDPM-sponsored short-term course at Management Sciences for Health, says for the first time there is understanding and communication concerning planning and management throughout all levels of the Ministry. A training manual for data collection was prepared for Vieux Fort which can be adapted for other district's use. A systematic tabulation of what and when

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specific services are offered by each of the country's 26 health centers was prepared and circulated by a National Team member. The Head of the Bureau of Health Education, three of whose personnel were members of the National Team, liked the process so much she asked the National Team to conduct a three-day planning workshop for her Bureau, which they did. At the district level, the National Team members will head up district teams comprised of "associates" of the National Team. This will help institutionalize the HDPM planning and management process in St. Lucia. Finally, and perhaps most importantly, the National Team de-facto has become the core planning unit in the Ministry of Health for PHC.

A problem in in-service training in St. Lucia was the difficulty in identifying an individual to serve as the Staff-Tutor. The function was served on a part-time basis by the Staff-Tutor from Barbados until December 1983, when a National Team member, a Senior Public Health Inspector, assumed the role. Of note, decision was taken early that it would not be feasible to attempt to link the in-service training to the research in solid waste disposal. As a result, the two have proceeded independently of each other.

The Medical Officer for Health feels strongly that the two-year period of Project assistance has been very helpful, but in St. Lucia's case is too short. With the momentum engendered to date, he is concerned that wihout additional support some gains will be lost. He was not explicit in the nature or duration of the assistance he hoped for.

BARBADOS. The in-service training in Barbados faced different situations than in St. Lucia. As examples: there have been frequent turnovers at the senior levels of the Ministry; hence, there has been inconsistent top-level support. (One plan to address this is by the use of Executive Symposia.) The participants of the Core Group, all senior managers readily visualized themselves as managers, so they needed no role redefinition as was the case in St. Lucia. In Barbados, a Staff-Tutor was identified and appointed very early (October 1982), so she could share the administrative, tutorial and liaison burden with the HDPM In-Service Training and Development Coordinator. The Country Program Committee was formally established as such throughout the project. Because of constraints on the senior participant's time, it was decided the course material would be presented in modular form through a series of staggered 1-3 day meetings totalling 30 days. Integration of services was selected as the key focus of the program. From the beginning, there was an attempt to link in-service training and the project research components. The presence of a UWI Campus on Barbados provided more ready access to administrative and technical support.

The first half of the first module was presented by the HDPM Training Coordinator June 29-July 1, 1983 and the second half July 20-22. The topic was Management of Change. Of 22 proposed

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participants from all major sectors of the Ministry, 19 attended all or most of the ensuing sessions.

Subsequent modules included:

-- Health Policies and Planning, by Chief Project Officer, MOH, August 5, 12, 19.

-- Health Laws, by Chief Parlimentary Counsel, August 26 and September 2.

-- Financial Management, by the Financial Comptroller, MOH, September 9, 16, 23, 20, and October 7.

-- Midway Evaluation, October 14.

-- Personnel Management, by the Senior Administrative Officer (AG) MOH, and Deputy Permanent Secretary, MOH, with participation by four members of the Personnel Division, MOH, October 21, 28, and November 4, 11.

-- Information Systems and Evaluation Systems, by Head of the Department of Management Studies, UWI, November 4, 11 and December 2, 9.

The above modules are very well documented in quarterly reports produced by the Staff-Tutor, available in the HDPM-APHA Field Office.

Two additional modules are scheduled during the first quarter of 1984:

-- Integration of Health Services, by the Vice Dean, UWI Medical School.

-- Planning Change Effect, by the HDPM Training and Development Coordinator.

The team attended an in-service training session on the subject of financial resources by Dr. Blackman. Seventeen participants were present and Professor Waldron served as conference organizer.

Phase II of the Barbados in-service program will be comprised of projects to be undertaken by Core Group members individually or with other members for the purpose of improving aspects of management related to the integration of health services. A listing of possible projects appears in Appendix 11, an "Update on Health Development Planning and Management Programme, Barbados."

While projects per se have not yet been initiated, there are tangible activities emerging from the Barbados in-service activity. A Core Group Drafting Committee has met on at least four occasions to draft portions of a 'state of the health

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services of Barbados' document including expressions of concern and recommendations, which, when completed following full modular presentation, will be presented to the Permanent Secretary for his consideration. More immediately, these senior managers have been made much more aware of the administrative and management strengths and weaknesses of all major areas of the Ministry, and, within their spheres of influence, they already are attempting to change the system towards more efficient and effective services. The interpersonal relationships fostered by the in-service training also have pointed out available areas of departmental interaction which previously have not been considered or utilized.

A concern expressed to the Evaluation Team was the infrequent attendance of the in-service component by two prominent MOH officials. This apparently caused some disappointment and concern to other members of the Core Group.

TRINIDAD AND TOBAGO. After extensive planning by the Country Program Committee and the HDPM In-Service Training Coordinator, the in-service training component was launched officially during the drafting of this report. The theme of the in-service component is strengthening the Administrative System for the Promotion of Primary Health Care. The modular training will be presented on a one-day weekly basis beginning March 15. The first six months will focus on the questions of Ministerial linkages between hospital and primary health care. Subsequently, the focus will be on county level management. Twenty Core Group participants have been selected, as have adjunct groups for decentralization, linkages between health care and hospitals, and a special adjunct group (Appendix 12).

A unique aspect of the Trinidad and Tobago in-service component is that it is housed in the Ministry of Health and Environment Planning Unit, and is viewed as an integral part of the Ministry's activities.

This is the first country program where there has been a planned link between the in-service and research components. The research on management information systems at the health center level should present implementable improvements in MIS that will tie into the in-service focus on community level management.

Although a third staff tutor position is not a part of the Cooperative Agreement, the Project desires to appoint a Staff-Tutor for the Trinidad and Tobago in-service component, and formally has requested authority through APHA and AID. APHA has forwarded the request to AID; at the time of this draft, AID was in process of approving this appropriate request.

JAMAICA Because of the existence of an AID supported management project (Health Management Improvement Project-HMIP) ongoing in Jamaica, a decision was taken early to phase - in the

Jamaica in-service component after those of the other three nations. Accordingly, the activity is scheduled to begin in April or May, 1984.

The Evaluation Team was told by responsible officials in the Ministry of Health that they view the HDPM Project clearly as complementary to, rather than duplicative of, the HMIP.

The Country Program Committee has met nine times and an Executive Symposium has been conducted. The country specific research activity chosen is the design and implementation of management services delivery at the parish level. The MOH officials interviewed feel that in-service training could help the implementation of the research activity.

4.3 EXECUTIVE SYMPOSIA

HDPM introduced an activity originally not included in the design entitled "Executive Symposia." The objective, as stated in the workplan for Year II, was to conduct a series of two-day symposia for top-level management, including the political leadership, to involve them in project activities and expose them to modern management techniques. HDPM planned that the Faculty of Social Sciences, with input from the Faculty of Medicine, would conduct two symposia for each remaining year in each participating country. The symposia would utilize services of CARICAD in the Eastern Caribbean, Administrative Staff College in Jamaica, UWI Faculty, and consultants. They would focus on an identified area of management skill training and promote corporate and overall project integration.

UWI consultants Drs. Jones and Duncan prepared recommendations for the formulation of a Program for Executive Symposia in September 1983. They indicated constraints to effectively implement the symposia as: (1) concern that the symposia were not integrated with the in-service training activities and in competition with it; (2) no clear, sustained definition of the concept and; (3) lack of awareness of the concept and its implications in the field. Furthermore, some viewed the symposia as a management training forum, others as serving a project review and coordinating function. The consultants proposed a fusion of both concepts. The symposia, in our view, have assumed an ambitious role, with objectives overlapping with existing committees and operating mechanisms, and potentially distracting project priority attention and resources from the originally designed component activities.

To date, three Executive Symposia have been conducted. The first was held in St. Lucia in July 1982, and focused on basic management concepts related to the Caribbean context. It was conducted by the Coordinator for Training and Development and was less formally structured than subsequent symposia, which were organized under the aegis of the Dean of Social Sciences, UWI.

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The second symposium, conducted in Jamaica in December 1983, focused on planning for Health for All by the year 2000. Ministry of Health officials were enthusiastic that the symposium had provided a forum for discussion of a topic relevant to their planning needs. The third was held in St. Lucia in January 1984, and focused on management by objectives and results. Ministry of Health officials in Barbados expressed interest in the conduct of symposia as a means to sensitize the high levels of the Ministry to health management needs.

There has been no perceptable link between the symposia, on-campus training, in-service training, and research. In general, while there was wide recognition of the need for high level support of health management improvement throughout the region, there was a lack of concensus on how best that could be achieved. Some expressed concern that an even greater need existed to reach government leadership outside the health sector, such as in Finance, Planning, Education, etc., to underline the significance of health to economic productivity and human development in the national context. In our opinion, the Executive Symposia seem to be a low priority compared to ongoing activities originally designed for the Project which need more immediate Project staff attention.

4.4 SUMMARY CONCLUSIONS

Of the major components of the Project, the in-service component has adhered closest to the planned methodologies and to achievement of goals. With the exception of evaluation, it has accomplished all tasks listed in the Cooperative Agreement on schedule in the original two countries (St. Lucia and Barbados). Based on this track record and the groundwork preparation already accomplished in Jamaica and Trinidad/Tobago, there is little reason to doubt the ability to be equally successful in these countries. The same optimistic projection pertains to full achievement of the component's outputs; the component is well along on its way towards fulfilling the outputs.

At midpoint in the Project, the In-Service Training and Development Coordinator feels it is too early to evaluate the impact of component. We agree. It is not however, too early to plan for such an evaluation, for without it, this apparently successful Project component will lose part of its current attractiveness and potential for adaptation and replication. This will be further addressed in the Recommendations section below.

A similar argument can be made for more explicit and complete country-by-country documentation of methodology and module development. While these clearly are country-specific, we believe that there are much experience and materials generated by this component that, if properly documented, could be very useful for application elsewhere.

The experience in St. Lucia has already demonstrated the contribution that this form of in-service training can make to the non-campus Caribbean countries' capability "to institutionalize planning and management capabilities by supporting and bolstering participating countries' efforts to plan and manage health sector resources," the stated Goal in the Cooperative Agreement. Efforts should be made at the earliest opportunity to share this expertise with other non-campus, English-speaking, eligible Caribbean nations.

It is likely that the Ministry of Health and Housing in St. Lucia can come forward with a plan to extend the current two-year project time for in-service training in order to further institutionalize and decentralize the planning and management process. This would give the UWI time also to further refine its in-service methodology for use in the non-campus nations.

The utility of a full-time Staff Tutor has been well demonstrated in Barbados, and we agree with the Project's assessment of a similar need at Trinidad/Tobago. Moreover, we believe the Staff Tutor role should be expanded to include a coordinating, monitoring and reporting role for all off-campus aspects of the HDPM, including research and technical assistance components.

It appears to us that the potential for redundancy is extraordinarily high in Jamaica between the off-campus activities of HDPM and other activities of AID, USAID, PAHO and other donors. As examples, this HDPM activity, as well as PAHO, already have done research on the management of health services at the parish level. The HDPM attempt generally was considered of low utility, while the PAHO report is due for release soon. PRICOR, sponsored by AID/W, is doing an operations research time and motion study of primary health workers. Moreover, USAID/Jamaica through the Health Management Improvement Project supports PHC in-service training. Accordingly, in spite of the apparent high expectations from the HDPM Project on the part of the Jamaican Ministry of Health, we believe that already available resources should be targeted to meet their in-service needs. HDPM should make the in-service expertise at UWI available to the MOH for technical assistance in in-service training; but module development and training implementation should be funded from other sources. Finally, we consider the utility of the Executive Symposia to be marginal and feel that project priorities would be better placed within the four components of the original project design.

4.5 RECOMMENDATIONS

1. Impact Evaluation

The Project should develop an evaluation plan, collect appropriate data and conduct an analysis in order to assess impact and/or outcome of the in-service training component in at least the three nations where in-service training is now underway. The evaluation design and implementation should include input from evaluation experts not intimately involved in the in-service component, and should be conducted in order for the results to be available to the Project by the time of the final external project evaluation.

2. Documentation of Methodology

The Project should more explicitly document its country-by-country in-service training methodology and process of module development for use as models for adaptation by other English-speaking Caribbean nations.

3. In-Service Training for Non-Campus Territories.

In-service training of the type developed in this project should be offered to additional non-campus nations. Ideally, at least two eligible non-campus nations should be added to this project, provided there be interest expressed by the nations. Alternatively in view of the importance of the Cave Hill Campus in development of UWI programs in non-campus territories as well as the possibility to establish firmer linkages between on-campus and off-campus activities in Barbados itself, it would be advantageous to extend HDPM in-service support in Barbados.

4. Extension of In-Service Training, St. Lucia

The Ministry of Health and Housing, St. Lucia, should be invited to indicate its interest in extending the duration of the in-service component in order to further decentralize and institutionalize the planning and management functions of the PHC system. Should the Ministry be interested, the Project favorably should consider a well-justified plan for utilization of such an extension.

5. Staff-Tutor Position -- UWI: St. Augustine Campus

AID should favorably consider UWI formally expressed request for the additional position requested.

6. Expanded Role of Staff-Tutor

The Project should expand the role of the three Staff-Tutors to include coordinating, monitoring and reporting responsibilities for all off-campus components of the HDPM Project.

7. Reduction of HDPM Support to Implementation of In-Service Training, Jamaica

Funds for management related in-service training for PHC is available from USAID/Jamaica sources through the Health Management Improvement Project. Accordingly, the more limited resources available to HDPM should be utilized in Jamaica for technical assistance to providers of in-service training, while module development and implementation of training should be funded from other sources.

8. Executive Symposia

If any additional Executive Symposia are to be considered, they should: be clearly justified on a specific country basis; be carefully designed to meet objectives; guarantee appropriate participation; and be systematically implemented to support the objectives of the other ongoing project components. CARICAD and the Jamaica Administrative Staff College have demonstrated experience which could be appropriately tapped in planning and implementing such an activity, on a limited basis, but results should be carefully assessed and judged relative to other ongoing activities before being expanded further. Any future Executive Symposia should have the integrated input of all four Project components in the design, and preferably the execution, of the Symposia.

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5. TECHNICAL ASSISTANCE

5.1 DESIGN

There is growing consensus in the region that technically competent individuals exist within Caribbean institutions. ministeries and local organizations, that such expertise can contribute to indigenous development, and that those individuals who are familiar with local conditions and problems should be utilized wherever possible. Thus, the fourth activity of the Project, as defined in the Cooperative Agreement, is the development, utilization and support of an indigenous pool of technically skilled personnel, managers and health planners, to provide expert advisory services to governments, other health sector institutions, bilateral and international donors. In order to perform this activity, the recipient and collaborators were to carry out the following tasks:

1. A qualitative and quantitative assessment of demand for technical assistance.

2. Development of indigenous technical assistance by executing the following actions:

   a. survey and select indigenous experts based on their capabilities and assessment of technical assistance demands in participating countries;

   b. register, support, supervise, evaluate and promote use of indigenous experts according to established guidelines;

   c. establish and maintain a Registry of Managers and Trainers of proven skills in relevant areas;

   d. conduct Registry searches to identify consultants for designated users;

   e. collect and store information on individual consultancies supplied through the program and disseminate it to interested users.

3. Design and operate a clearinghouse for publications and visual aid materials useful for practicing health managers and planners.

4. Utilize technical assistance personnel to contribute to the in-service training program.

5.2 Progress To Date: Registry

The Cooperative Agreement and sub-agreement with APHA and UWI, respectively, contain identical language with respect to development of the technical assistance component, with no specification of relative responsibilities. In practice, the Project Administrator has assumed predominant responsibility for the activity to date. The Institute of Social and Economic Research (ISER) of the Faculty of Social Sciences, with its existing documentation center, is assisting in the establishment of the clearinghouse element of the technical assistance component, namely the HDPM Resource Center.

An assessment of demand for technical assistance was not prepared nor a needs assessment formally conducted. Discussions with members of the Advisory, Executive and Country Program Committees suggest the view that technical needs are first best met, wherever possible, by local expertise in-country. The idea of a regional pool of expertise is professionally promoted and has political appeal, but preference is often expressed for US consultants who may have more experience and international prestige.

In the absence of country specific assessments of need and perceived demand, the Project Administrator has focussed entirely on supply, identifying regional experts and organizational resources through his personal and institutional contacts and by distributing bio-data forms. UWI has assisted in the recruitment process. While the initial design called for a roster solely of indigenous technical experts, the Project Administrator is also including US consultants identified through the HDPM project. The consultants are entered into the Project Administrator's personal Osborne computer in his office by name, specialization and country or organizational affiliation. The Registry now includes 105 consultants, of whom 26 are American, 28 Jamaican, 22 Barbadian, 14 Trinidadian and 7 St. Lucian, and 8 other West Indian.

The specialization categories vary in specificity , and some categories, i.e., parisitology, engineering, sociology, are not management classifications. One individual is listed under specialization only as a Dr. Ph.D. candidate. The Project Administrator indicated difficulty in knowing how to classify some consultants who were generalists or possessed qualifications in multiple fields. Consultants have not been screened nor references or experience evaluated. No methodology for evaluating consultant performance has yet been developed. The Project Administrator realizes that more work is required before the registry can be effectively utilized by potential users. He considers the activity less of a priority than the other components which demand more immediate attention. He anticipates the eventual development of a roster of approximately 50-75 screened and available consultants.

The Project Administrator has distributed the preliminary

consultant list to members of the Executive Committee, CARICAD, ASC, OECS and the Governments of Trinidad and Jamaica which requested it. Some have added suggestions and indicated the need for improved specialization categories. The MOH Permanent Secretary in St. Lucia has indicated disappointment at not having received a list. PAHO and CARICAD also are developing consultant lists and indicate interest in coordinating with HDPM. We understand that CARICOM and the Organization of Easterr Caribbean States have consultant lists as well.

Up to the time the Work Plan for Year 3 was prepared, nineteen consultancies had been completed under the project, ten focusing on on-campus training, four on research, three on in-service training, and two on a report on the Executive Symposia and Network of Caribbean Consultants. Of the sixteen consultants used, one was from the University of North Carolina, one from Johns Hopkins University, six from the University of Pittsburgh and eight from the Caribbean. As Drs. Jones and Duncan point out in their consultancy report on the Network, the various consultancy reports and recommendations prepared under the Project have not been collectively analized, reported or systematicaly followed through. The report also provides useful recommendations for improving the data in the registry.

According to the Project Administrator, the registry has been used twice as a resource by the Senior Researcher to identify consultants for the research component, namely Phyllis Green and Filbert Morris. The Project Administrator has not actively promoted its utilization, given the need for further work on it and the fact that funds must be found outside the project to support consultancies not directly associated with HDPM activities. Project staff feel that promotion of the registry will raise expectations among participating countries for ad hoc technical assistance. This will result in pressure to use Project funds to meet short term needs as opposed to long term institution building objectives.

Constraints to the utilization of indigenous consultants include the following:

- Qualified individuals in the region are already over extended with too many responsibilities;

- Qualified consultants find it extremely difficult to turn down hard currency consultancies and, therefore, agree to undertake an assignment although they are too overworked to be able to complete it in the time required;

- Few indigenous consultants have track records in the consultant field, and many lack familiarity with consultant procedures;

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- Traditional reliance on the "old boy network" and political connections persists;

- Easily identified donor or other funding to finance consultations is generally lacking.

The Project Administrator plans to convene a working group including representatives from CARICAD, PAHO, Administrative Staff College in Jamaica, and UWI to examine the selection, screening, and classification of potential consultants as well as develop an implementation plan for continuing management of the registry, dissemination, information sharing and guidelines for consultant utilization. Mechanisms for evaluation and follow-up of findings and consultant recommendations need to be developed and standardized. The registry should be compatible with that of other potential user organizations to the extent possible. The Project Administrator needs to be encouraged to work with Country Program Committees, UWI and regional organizations to specify technical assistance needs, review the Registry accordingly and undertake special searches for consultants in categories where indigenous capability is most lacking. This effort should be coordinated with skills upgrading in the on-campus and in-service training program. We feel it would be most appropriate for the Registry to include only indigenous consultants, with expatriate consultants having HDPM regional experience as an addendum. This might be expanded to include non-Caribbean individuals with expertise identified as needed in health planning and management but not readily available indigenously. Identification of the universe of U.S. consultants with Caribbean experience (not involved in HDPM) is beyond the scope of this activity.

5.3 Progress to Date: Resource Center

The Resource Center, located at the ISER Documentation Center, is developing a collection of material relevant to health management in the Caribbean. UWI plans that the Documentation Center serve as a regional resource bank with communications to CARICOM, CARICAD, and other UWI Campuses, etc. HDPM plans to help develop access to repositories and data base services such as MEDLINE. While the Resource Center began as a part of the technical assistance component, after the Year 1 work plan it was moved under the Research component in work plan Year 2. The Project Administrator explained that the shift was due to the fact that the documentation would be housed in ISER which was responsible for research, and that the materials would be particularly useful to the research effort.

No official documents quantify the projected magnitude of the documentation collection nor provide a specific plan as to by whom and how the materials will be utilized and disseminated. The collection contains approximately 300 indexed documents, housed in two bookcases and listed alphabetically by author and

2'1'1

key word in a catalogue print-out. These items include research reports, conference papers, policy documents, training programs, journal articles, and a few documents on microfilm. ISER's Documentation Center, covering a total area of 7,500 square feet, includes a reading room, study areas, microfilm room, seminar room, and administrative and planning literature. According to a participant we interviewed who is auditing the Health and Social Organization on-campus course, the course students use the Resource Center for assigned readings, in addition to two major textbooks which each student possesses. According to the University of Pittsburgh liaison, the project has not requested any assistance with documentation.

The UWI In-Service Coordinator, Research Coordinator and on-campus teaching staff from Social Sciences and Medicine need to identify basic planning, management and training resource materials appropriate for their respective components, and work with APHA and Pitt to try to acquire them for the Resource Center. Project Research staff might be the most appropriate coordinator of this effort. Given resource limitations, attempts should be made to secure documents from WHO, PAHO, APHA, PITT, and other such organizations. Other programs funded by AID, such as University of Hawaii/MEDEX, Management Sciences for Health/PRITECH, Johns Hopkins University/HDPM, Population Information Program, and University Research Corporation/PRICOR should also be able to provide relevant materials at little or no cost. Project staff and Country program Committees should be encouraged to identify and acquire indigenous health planning and management materials to develop as complete a documentation of Caribbean related experience as possible. An evaluation tool also needs to be developed to monitor and assess utilization and appropriateness of the center materials.

While the original design called for utilization of technical assistance personnel to contribute to the in-service training ogram, no operational link exists between the registry developme.../utilization and the in-service training activities. The in-service training program has relied on individuals identified by the respective Ministries of Health in each country. The Coordinator of the in-service training programs views the Resource Center as useful if it can provide indigenous, country specific materials, as well as basic WHO and other major worldwide health management documents.

5.4 Recommendations

1. Use of Indigenous Consultants

HDPM should actively promote the use of indigenous consultants wherever possible, including teaming those with

limited experience with consultants of greater experience. This teaming is particularly useful in areas of specialization which are inadequately represented in the region.

2. Registry Improvement

With input from the proposed working group, and based on assurance that the Registry does not duplicate the work of other organizations such as CARICOM, the Registry of Consultants should be refined to provide specific planning and management categories such as personnel, drugs and supplies as well as details relating to work experience, research and publications, previous consultant activities and availability for short or long term consultancies.

3. Registry Dissemination

The improved registry of consultants should be disseminated and discussed at Executive and Country Program Committee meetings. It should be widely circulated to participating governments, international and regional agencies such as AID/W, RDO/C, USAID/Jamaica, APHA/W, UWI, University of Pittsburgh, Administrative Staff College in Jamaica, PAHO, CARICOM, CARICAD, OECS, consultants and other appropriate entities.

4. Institutionalization of Registry

The registry should be institutionalized at UWI, either in the Department of Extra-Mural Studies or at the ISER Documentation Centre, preferably by the end of Year IV.

5. Resource Center Development

Consultant reports and project generated materials on all components should be indexed in the Resource Center. Key resource documents identified in the Annotated Bibliography of the State-of-the-Art Study as well as selected basic health planning and management literature, from international and indigenous sources, should be acquired and included in the collection.

6. Resource Center Dissemination

A categorical listing of Resource Center documents should be shared with Executive and Country Committees, PAHO, CARICAD, CARICOM, ASC/Jamaica and appropriate UWI faculty, with semi-annual addenda.

7. Technical Assistance Coordination

The Project should more effectively link the technical assistance component with in-service training. The In-Service Training and Development Coordinator should use her

contacts in the country training activities to help identify and screen potential consultants. Consultants should also be included in the in-service training programs as appropriate, either as resource personnel or as participants who could benefit from further training and experience .

6. HEALTH SERVICES RESEARCH

6.1 DESIGN

The project technical application stated that the research component of the HDPM was intended to be supportive of the campus based training, in-service training and technical assistance. Results of the research were to serve as a guide for in-service training, provide developing material for the Health Management Diploma and identify areas of need for T.A. The research was to be conducted on two levels, one to cover the four targeted countries in general (Jamaica, St. Lucia, Barbados and Trinidad/Tobago) and the other to cover country specific studies of a particular management problem in each of the four countries.

The technical application described research according to a WHO working group definition, "Health Services Research is concerned with problems in the organization, staffing, financing, utilization and evaluation of health services."{World Health Organization, Education of Management in Health Services, Report on a Working Group, Copenhagen: WHO Regional Office of Europe.}

The technical application (138-148) lists four major objectives for the reseach component:

1. Information System: Development of a user-oriented health information system.

2. Training: Train health services researchers.

3. Knowledge Base: Provide relevant materials for regional health planning and case studies for health management course.

4. Evaluation and Assessment: Establish a framework to assess the efficiency and effectiveness of approaches.

The above objectives are not contradictory to the training oriented objectives outlined earlier in the technical application. However, differing statements of objectives do tend to confuse the issue whether the main goal of research is to be supportive of the training sections or to directly improve health management. The logical matrix identifies the main research objectives in a third way. It reverts to the goal of using research to support training and to technical assistance, but it now introduces the term "operational research" instead of "health services research." An operations research focus could have provided an important specification of research objectives. Unfortunately the term was not defined. Operations research is a term that suggests research which is problem based, client

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oriented and client solvable. O.R. investigations are conducted to examine a problem identified by a client in its organization, management or field implementation, with the ultimate production of a set of recommendations or options which the client can test and apply to solve the problem. If this terminology had been consistently used and defined it might have served to focus the research component.

LOGICAL MATRIX (FIRST YEAR WORK PLAN)

Elements of Project: Immediate Objective for Research

To utilize operational research in training, as a problem solving tool in the management of health systems and as a source of information in the carrying out of expert technical advisory functions.

Success Criteria

Appreciable demand and usage of information resulting from operation research undertaken by Ministries of Health, the Institute of Socio-Economic Research of UWI and other related regional institutions in the field of health management.

Verifiers

Resource Center records on content of the collection and the usage of this new source of information.

External Factors

Acceptance and effective use of a pool of indigenous consultants by other international agencies, bilateral organizations as well as by the countries of the region.

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6.2 PROGRESS TO DATE

The partners of the Cooperative Agreement opted for a two-pronged approach to health services research in health planning and management. The first was a general sector study, beginning with a State of the Art Study (SOAS) and an annotated bibliography, bolstered by additional sector studies suggested by gaps in the SOAS. The second approach was to conduct country specific investigations selected by the local Country Program Committee in each of the four targeted countries. The results to date are disappointing. The quality and utility of the research generally has been low and completion slow. Generally, the research carried out did not tie into the other components and was too ambitious as well as not being specific enough to be an effective training too. The research deadlines were continously rolled back. The HDPM Work Plan for Year 01 (1981-1982) sets the goal for research as follows:

ACTIVITY	TARGET DATE	COMPLETED
Formulates terms of reference State of the Art (SOA)	3/82	7/82
Appoint research staff	5/82	9/92
Select consultants	6/82	11/82
Review four country studies	7/82	still in process
End general sector study	8/82	still in process
Conduct workshops	9/82	still in process
Formulate further sample research studies	10/82	still in process

This schedule was not adhered to, as the completion dates show.

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Internal Evaluation. The internal evaluation team reviewed the research component in July of 1982 and made the following three recommendations:

a. "The senior research associate should be hired immediately as well as a consultant to coordinate the state of the art study.

b. The senior research associate should prepare plans and methodology for all research.

c. Steps should be taken to expedite the state of the art study and approval should be sought from AID to postpone the contractual completion date from 9/82 to 11/82."

The Internal Review clearly identified the principal and continuing research problem areas and forewarned project management about difficulties with the State of The Art Study and the research methodology.

Difficulties and constraints. A principal constraint on progress has been the difficulty UWI had in identifying the Senior Research Associate, who was only hired in September of 1982. Another difficulty was the interpretation of the varied research objectives as laid out in the project document. This was compounded by the lack of available experienced health management researchers and the Project's inability to define a topic and clearly lay out a research protocol and move towards implementation.

University of Pittsburgh's Research Involvement. PITT, since the inception of the project, has been very interested in the research component, and fielded several consultants to assist in the identification of management problems for research and definition of methodologies. For an unknown reason research was not included as an area of responsibility for PITT in the sub-agreement.

HDPM's Tie in with Other Research.

a. There is little coordination between the PRICOR "PHC Team Efficiency and Productivity Study" at the Department of Social and Preventive Medicine.

b. The Health Management Improvement Project while working in ten areas of management could certainly have benefited from HDPM experience. However, the contacts that did occur were not related to research activities, perhaps because the research was hardly started by HDPM until mid-1983.

c. There was some preliminary interaction between HDPM and PAHO's PHC team which has been analyzing and reporting management practices and linkages at the Jamaican district level since 1981.

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Prime Responsibility for Research. According to the APHA/UWI subagreement, ISER is responsible for the research. "The overall responsibility for coordinating the research component... rests with Institute for Social and Economic Research...; responsibility for designing, programming, implementing and reporting on the general sector study rest with ISER at Mona" (page 152). Regrettably, ISER did not have input from the University of Pittsburgh to help with research task identification and protocol preparation during 1983 when the research actively began.

The APHA Project Administrator de facto has had to assume a proactive role in the research component. This was not foreseen by the technical application. Those additional efforts have further diluted the administrative role without making the research component effectively productive.

In the future, ISER should be encouraged to take a more active and positive technical and management role for research. The assistant research associate's responsibilities should be to coordinate all the research activities, not just Jamaica.

6.3 GENERAL SECTOR STUDY

The General Sector Study was to be composed of a major sector study of health management practices on the Caribbean "and additional training related investigative or evaluative exercise as may be required to develop research skills for course participants." The first part of the general sector study is generally referred to as the State of the Art Study (SOAS).

The State of the Art Study, even though first projected to be completed by September 30, 1982, was not begun until October 1982. The specific objectives of the SOAS were laid out in the Technical Application with a detailed outline of the intended content of the reports on Pages 142 143. (See Appendix 13.) Regrettably, the Technical Application guidelines were not followed, although the internal review had identified the SOAS as an area of difficulty. The research component outputs are presented in the logical matrix as follows:

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LOGICAL MATRIX

Research Outputs

State of the Art (regional health management). Four country specific studies (problem solving). Documented periodic update of State of the Art (3rd and 5th year).

Success Criteria

Results of research are reflected in the new curriculum at UW in the Inservice Training Programs in each of the four countries, as well as in standard setting in health management.

Verifiers

Reports and updates on the State of the Art Study. Reports on country specific studies.

PROGRESS TO DATE

The Barbados SOAS. This study was designed to be a forerunner of the regional State of the Art Study. This study entitled "State of the Art Ministry of Health, Barbados," gives a good succinct picture of that country's management systems. and was produced between Dec ber, 1982 and January, 1983. This study is valuable for anyone studying health management in the region and certainly useful for anyone studying Barbados.

The Regional State of the Art Study (SOAS). The Regional State of the Art Study was initiated October 1982 and is still being worked on at this time . This long awaited key document was to provide a need assessment, document baseline management information and be used for the development of the training and technical assistance activities. Its tardy preparation, lack of substantive data and important errors of fact have greatly reduced its value. The study itself was carried out by someone only nominally qualified for health management research. Charts and tables presented for different countries for comparison are incomparable because they are presented in different units using different indices. The report has not met expectations and consequently project has commissioned two consultants to edit and expand the original document. The second part of the SOAS, an annoted bibliography, contains a good basis for identification of

the documentation available in the Caribbean on management and health and as such is a valuable reference tool.

Work is in progress to finish the State of the Art Study by April, 1984. Two consultants are engaged and have developed a six part questionnaire (See Appendix 14) to generate data to fill in gaps in the SOAS. The hazard of such an extensive approach is generating more data than is actually necessary for the study, particularly at this late date in the Project.

At this point in time (mid-project),the SOAS has past the point of general usefulness. Relevant titles from the bibliography should be included in the resource center at ISER, No futher work or updates on SOAS/General Sector Survey should be undertaken beyond completing the work in progress by the two consultants now engaged. ISER should distribute the SOAS to all participants in Project related research and training activities and to potentially interested organizations.

Regional Management Problem Specific Studies. These are intended to be natural outgrowths of the State of the Art Study and part of the overall general sector research. These studies have been planned to be specific, prescriptive studies which could be used to implement changes in particular management subsystems throughout the region. As seen by Project Administration, the studies should be practical management tools with implementation plans. In order for this approach to work it is necessary to have well defined areas of study and proscriptive research protocols. To date no protocols have been produced, no regional or national health organization is seeking out HDPM to execute a practical regional study and there is still no involvement of the training components in the research process.

Four general sector studies have been planned.

1. Human Resource Development. This study has been begun and is being carried out by a human resource specialist attached to the Administrative Staff College. The terms of reference are as follows: "Analyze the historical development and main characteristics of the human resources management function in the Health Sector." Scope: "To elaborate proposals for corrective action within the framework of existing constitutional arrangements of Regional Public Services with regard to the current budgetary constraints." {(See Appendix 15); Questionnaire Appendix 16).} Such terms of reference need further specification towards a prescriptive, implementable, management problem solving outcome.

2. Organization and Planning. This study has only reached the most rudimentary planning stage even though it was to have begun in January 1984 according to the Year III Workplan.

3. Management Information System (MIS). It is thought that this study could to be an extension or continuation of the Trinidad country specific study which has just gotten underway.

4. Materials Management. Project leadership has until now been unable to identify a more specific topic for this task and has been unable to identify a potential consultant with qualifications for its execution.

In evaluating progress and relative priority for these general sector studies, the evaluation team sees no urgency for their completion. The human resource study should be finished to the level of the existing contract, based on clearly specified revised terms of reference and a new proscriptive research protocol. As the organization and planning study has not begun and its objectives not clearly defined, it should be held back until mechanisms for better research quality control can be established.

Before the Management Information System Study is initiated, the Trinidad MIS Research should be carefully studied and analyzed for applicability as a potentially implementable instrument of change and an educational tool. Materials management should be set aside unless or until a need is identified for a focused product.

6.4 COUNTRY SPECIFIC STUDIES

The country specific studies were designed to answer particular needs of the Ministries of Health in each of the four countries, as voiced through the HDPM local country committee. In general, the topics have been identified at the country level and implementation of the studies has been supported by the country committees and local ministries. These studies were to help the respective Health Ministries to solve health management problems and to provide case material for training, field experience for participants as well as to contribute to the body of knowledge about management problems in the Caribbean. Regrettably, these goals were not uniformly met.

JAMAICA

Integrated Health Care Delivery at the Parish Level. The purpose of the task was to identify potential strengths and constraints of the health care delivery process. A report has been produced, but it tends to be a sociological overview of interaction and linkages between different levels and elements of the system without any substantive or particular reforms identified to assist the implementation process. Certain members of the Country Program Committee resented the fact that only one consultant name was presented to them for the job. The Country Program Committee felt that the report was a first broad stroke of the brush with further research definitely called for. (See Appendix 17). As a result, another consultant in operations and management has been contacted to develop an implementable strategy for integrated health service. The term of reference

for this task is in preparation. It is hoped by the country committee that this report will be a "nuts and bolts" study. (See Appendix 18)

ST. LUCIA

Management of Solid Waste Disposal. This task is a subject of great political and economic importance for St.Lucia. The MOH of St.Lucia suggested the topic in mid 1981. However, the term of reference was only drafted in January 1983 and work started April 1983. This consultation was executed by two consultants, a St.Lucia Engineer as principal investigator and a collaborating consultant from the University of Pittsburgh. The output of the task is to be a feasibility study that could sell the project to a potential donor. (See Appendix 19)

The consulting report has been in preparation since March 1983 and under review since September 1983. The draft version reviewed by the evaluation team was not developed to the level of describing a potentially "bankable" project.

BARBADOS

Patient Flow in Casualty/OutPatient Services. This has been a much studied priority problem in Barbados. The research task was to examine the inefficiencies in the patient treatment process at the Queen Elizabeth Hospital in Bridgetown. The subject was suggested by the MOH for study, but the study was not initiated because of poor communication, changing key personnel at the ministry and the low level of country committee organization. The Government of Barbados and the USAID Mission have just signed a protocol to provide long term T.A. to assist the reorganization effort.

TRINIDAD AND TABAGO

Improved Health Management at District Level Through HIS. The HIS study began in Trinidad in January 1983. Trinidad has a strong local committee and has designated a specific subcommittee to direct the consultant in this research task. This study suffered startup difficulties in obtaining ministry blessing and slow HDPM project administrative documentation. This task has a good potential for a productive outcome because of the quality of the consultant, the level of interest by the country committee and the amount of detail to the terms of reference and methodology. (See Appendix 20)

Conclusions. The Jamaica study of integrated health care at the parish level may be redundant to a PAHO study now nearing completion. Therefore, it should not be continued without specific research protocols and close county committee coordination. The solid waste study should be completed and

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delivered to the St. Lucian Government as soon as possible; but no further solid waste research should be undertaken. The Barbados casualty study is no longer an issue and should be dropped from the work plan. Finally, the Trinidad MIS should be finished and analyzed to identify its potential value to users if it is to be extended into the three other countries.

6.5 GENERAL RECOMMENDATIONS

Research has been the weakest area of the project. It has not met its goals and deadlines, satisfied objectives, been properly defined or addressed the purposes of the Project. Because of the above problems, serious recommendations have to be proposed.

1. University of Pittsburgh

   The University of Pittsburgh should be invited to play an active role in research and the PITT subcontract modified to reflect health services research responsibilities.

2. Research Coordinator

   Designate a specific person (Research Assistant) at ISER to be responsible for Health Services Research who will coordinate with a resource consultant(s) at Pittsburgh to assist in defining research protocols and evaluating the three ongoing research studies (MIS, Trinidad; and Human Resources, Jamaica; final update of SOAS).

3. Research Quality Control

   For any research beyond the 3 ongoing tasks in #2 above no research should be attempted unless:

   a. It is a coordinated effort between all the different components of the project, including the training sections.

   b. There are specific terms of reference and proscriptive detailed research protocols.

   c. There is an interested and involved client, either Ministry of Health or a health organization, who will implement the findings of the study. In this context groundwork must be done to determine if the particular research task is not duplicative or overlapping with other research.

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d. A qualified Caribbean principal consultant (principal investigator) is teamed up with an experienced collaborating consultant.

e. A research task force for each research project is formed to accomplish a,b,c,d above, composed of:

Research Coordinator, ISER

Principal Consultant (principal investigator)

Rep. of Local Country Committee or Rep. of Client (user group)

Collaborating consultant, participant from other organizations who might have experience in similar research.

4. Research Budget The Project can be successful without fulfilling its research goals. Although research need not be discontinued, it is not a high priority at this point in the Project. To the extent that project management feels that research can/cannot be effective and quality control implemented, the Executive Committee should seek to negotiate for reallocation of research resources.

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7. FINANCIAL SECTION

7.1 BACKGROUND

An analysis of the Project expenditures is an appropriate indicator of the direction and dynamism of a project. This chapter deals with analysis and interpretation of the expenditures. A few points should be noted.

1. UWI received its revolving fund in April 1982, 7 months after the start of the project.

2. Reporting has been slow within the UWI system and AID/APHA reporting needs and procedures have not been made clear to UWI.

3. The contents of this section are drawn from work sheets prepared at APHA using their financial reports and later verified with UWI.

4. UWI is expected to implement the project with only 49% of the total grant amount. (34% under direct subcontract and approximately 15% travel and consultant funds administered by APHA.)

7.2 FINANCIAL REPORTING SYSTEM

Financial Reporting System. The month to month computerized financial accounts as presently prepared by the APHA Accounting Department for their intenal use are not adequate for the needs of APHA/HDPM Project Management. A more descriptive monthly accounting report of expenditures could be produced by adding 12 to 18 characters of description next to the code for each of the expenditures in a presently unused section of an existing column (field) on the report form. This could obviate the necessity of preparing a work sheet by hand from the computer printout.

The report which is currently in use for external reporting aggregates the monthly expenditures for sub-contractors under one line item. This method is too general to give an accurate picture of expenditure trends and levels of effort, since The sub-contracts line item covers 50% of the total amount of the grant. The sub-contract line item should be ventilated out to show the individual line items of each of the sub-recipients. The resulting report form could serve as an invaluable project management tool. (See fig. 7.A)

Following discussion with APHA Project Management, APHA Accounting Department and the AIL contracting and technical offices, it has been agreed that one financial report could satisfy the needs of everyone. See Fig. 7.A for a facsimile of this form. An additional indicator that could be added, which

Figure 7-A

PROPOSED MONTHLY FINANCIAL REPORT FORMAT

MONTH OF: _____

ACCOUNT #	Category	A L. O. P. BUDGETED AMOUNT	B CUMULATIVE BUDGETED AMOUNT TO DATE	C EXPENDITURE THIS MONTH	D ENCUMBRANCES TO DATE	E EXPENDITURES + ENCUMBRANCE THIS MONTH (C + D)	F CUMULATIVE EXPENDITURES (C + F LAST MONTH)	G UNEXPENDED BALANCE (B - F)	H BALANCE % TO DATE (G ÷ B) PERCENTAGE
[illegible]									
[illegible]	Salaries								
[illegible]	Fringe benefits								
[illegible]	Overhead								
[illegible]	Consultants								
[illegible]	Travel per diem								
[illegible]	O. D. C.								
	SUB-TOTAL								
[illegible]									
[illegible]	Salaries								
[illegible]	Fringe benefits								
[illegible]	Overhead								
[illegible]	Consultants								
[illegible]	Travel per diem								
[illegible]	O. D. C.								
	SUB-TOTAL								
[illegible]									
[illegible]	Salaries								
[illegible]	Fringe benefits								
[illegible]	Overhead								
[illegible]	Consultants								
[illegible]	Travel per diem								
[illegible]	O. D. C.								
	SUB-TOTAL								
	GRAND TOTAL								

would probably necessitate a programming modification at APHA, would be to add a percentage column to indicate unexpended balance to give a better grasp of the actual numbers being presented to Project Management.

An additional problem is that encumbrances are not considered in any of the accounting systems. A system of encumbrances should be established and programmed. (APHA, according to informal sources, is in the process or re-instating this system.)

The semi-annual reports do not contain financial or fiscal information. Because levels of expenditure are such an essential part of planning and project success, the semi-annual report should cover finances and actual levels of expenditures and projections.

Budget Line Item Nomenclature. This nomenclature should be collapsed into standard line items as represented in the APHA contract to remove some vague and duplicative line items such as innovative projects, training facilities and training workshops. This would certainly facilitate accounting from UWI's perspective as well as make the format for reporting more standard.

7.3 LEVEL OF EFFORT ANALYSIS

APHA Level of Effort. The USAID/APHA agreement states:

Direct Salaries:	155.5 PM/LOP @ 31 PM/Year	
Consultants:	72 PM/LOP @ 14 PM/Year	

[Note: PM: Person Months LOP: Length of Project]

APHA has provided both a Project Manager and Administrative Assistant. The Project Manager now spends 1/2 time on the Project. It is difficult to establish and differentiate the consultant level of effort for APHA and PITT because APHA pays all the consultants except for PITT faculty. One can identify that only 20% of the allocated funds for consultants have been expended at the 40% point in the Project. From this one could assume that the Project has only received half of the expected consultations.

UWI Level of Effort. The APHA/UWI sub-agreement states:

Direct Salaries: 441. PM/LOP @ 88.2 PM/Year

The university has spent 76% of its budgeted amount for direct salaries. The LOE has fallen below expected level because of a few vacancies in the first year. There is a need at present to create new slots for in-service tutors as well as modify the

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senior research title to on-campus coordinator. The evaluation team envisions need for an additional full time equivalent (FTE) teaching position.

PITT Level of Effort. The APHA/PITT sub-agreement states:

Direct Salaries: Coordinator

3 3/4 PM/LOP @ 3/4 PM/Year

Secretary

10 PM/LOP @ 2 PM/Year

Consultants

60 PM/LOP @ 12 PM/Year

The University of Pittsburgh has provided the services of the coordinator and secretary as detailed in the agreement. A lack of information did not permit the detailed analysis of consultant level effort. PITT has only expended 13% of its consultants line item.

APHA and PITT have to date only spent $50,000 of the consultants line item, leaving a life of project amount available of $210,000.

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7.4 LEVEL OF EXPENDITURE

Recapitulation of Project Expenditures. The information for this section was drawn from three financial data files prepared by APHA. These files were up to date to September 30, 1982 recapitulating the expenditure of Year 1 and Year II. Some adjustments were made to accomodate encumbrances carried forward and late reports of Year II expenses submitted in January 1984. Figures are rounded off to the nearest thousand.

PROJECT EXPENDITURES BY RECIPIENT

YEAR 1 AND YEAR II - TABLE 7-B

	LOP BUDGET YR I&II	BUDGETED YR I&II	EXPEND. YR I&II	BUDGET YR I&II	LIFE OF PROJECT BALANCE
UWI	851	299	263	36	587
	34% of grant		88% exp.		
PITT	391	109	64	46	327
	16% of grant		58% exp.		
APHA	1,258	488	507	(19)	750
	50% of grant		104% exp.		
TOTAL	2,500	896	834	62	
			93% exp.		1,600

* An adjustment has been made to the APHA travel line item of $232K from the PITT travel line item. (See APHA letter to Pittinger 1/18/84.)

The above table indicates that UWI is slightly under expended (88%) and PITT only participating at 58% of the planned level. The overall project has spent only 33% of the LOP funds at the 40% (2 years of 5 years) point in the project.

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EXPENDITURES BY LINE ITEM PER COLLABORATOR

Table 7-C is a rounded off accounting of expenditures following the main line items of the budgets of the various agreements. The table gives a breakdown of expenditures with some percentages for comparison. A few points are important to note:

a) UWI still has a balance of 74% of its budgeted funds unexpended for direct salaries. The balance is $434-K.

b) UWI's draw down on these 434K US dollars will be less because of the Jamaican devaluation.

US-$	434-K	@ 1.78 to Jamaican $	= J $722,520	budgeted
US-$	434-K	@ 3.25 to Jamaican $	= J$1,410,500	currently available

Difference.....J$637,980

As only approximately 70% of the direct services are paid in J-$, the rest in Eastern Caribbean and Barbados Dollars about $445,000 Jamaican dollars will be generated.

c) All recipients have expended more than was budgeted for other direct costs (ODC). APHA consumed 8-K more than the budgeted life of Project, ODC amount. PITT expended an ODC line item which was not contractually established. UWI consumed 55% of the LOP budgeted ODC amount in 40% of the time.

d) PITT which has not been participating to the anticipated level has only expended 16% of their LOP budgeted amount.

e) A total of 130-K has been paid out for overhead:

	EXPEND	OVERHEAD RATE	OVERHEAD
APHA	505,000	18%	92,000
PITT	63,000	29%	18,000
UWI	260,000	8%	22,000

f) 50% of the total LOP travel per diem line item has been utilized.

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FISCAL YEAR 1982/1983 - To September 30, 1983

Table 7C

	AFMA				PITT				UWI				TOTAL	
	L.O.P. BUDGET	YR. I & YR. II BUDGET	YR. I & YR. II EXPENS.	L.O.P. BALANCE	L.O.P. BUDGET	YR. I & YR. II BUDGET	YR. I & YR. II EXPENS.	L.O.P. BALANCE	L.O.P. BUDGET	YR. I & YR. II BUDGET	YR. I & YR. II EXPENS.	L.O.P. BAL.	CUMUL L.O.P. BUDGET	CUMUL L.O.P. BALANCE
A/ Personnel direct Labor	416	153	146	270 65%	28	46	27	1 4%	568	202	154	434 74%	1,032 41%	705
B/ Fringe benefits	83	31	21	62 75%	57	11	6	51 89%	65	22	17	48 74%	205 8%	161
C/ Overhead	355	132	92	263 74%	90	30	18	72 80%	76	27	22	54 71%	521 21%	389
D/ Consultants	44	16	42	2 5%	216	15	8[2]	208 96%	0	0	0	0	260 10%	210
E/ Travel Per Diem[1]	331	146	167	164 50%	0	0	0	0	0	0	0	0	331 13%	164
F/ Other direct costs	29	9	37	<8[3]>	0	8	4	<4>	121	46	67	54 45%	150 6%	42
G/ TOTAL	1,258 50%[4]	487	505	753 60%	391 16%[4]	110	63	328 84%	850 34%[4]	297	260	590 69%	2,499[5] 99%	1,671

5 : Due to rounding total @ 2.5 million

4 : % age of total budget

3 : Indicates deficit spending

2 : Faculty consulting

1 : Includes $232-K transferred from PITT Budget

N.B.- All amounts to nearest thousand, U.S. Dollars

7.5 PIPELINE ANALYSIS AND PROJECTION

According to the financial status report $1,500-K have been authorized, of which 649-K are unexpended as of November 30th, 1983. Because none of the recipients maintain encumbered accounting it is difficult to determine the unencumbered unobligated pipeline. The project has spent less than budgeted for the past two years cumulatively, however, it spent 50% more in Year II than budgeted. If the project continues to expend at the Year II rate for Year III the letter of credit will be drawn to near zero by July, 1984. Steps should be taken to avoid this.

7.6 COMPONENT COST

Because of the bookkeeping it was only possible to estimate the component costs. Even though the original budgets and work plans were laid out programmatically the accounts were never kept programmatically. It was never clearly stated or made a contractual obligation to the recipients that they were responsible for programmatic bookkeeping.

In order to determine an index to estimate component expenditures the staff and consultants travel and pay register was totalled according to component. This produced a percentage index of:

Project Development/Start Up	15%	-	$ 125-K
On Campus	23%	-	$ 191-K
In-Service	33%	-	$ 275-K
Research	29%	-	$ 242-K
	TOTAL	-	$ 834-k

When these expenditures ARE extrapolated to the total to date expenditure of $834-K, it indicates an estimate of component cost. Note that all administration costs are spread out over the four activities. Each component cost would be commensurately lower if administration were considered to be a separate component.

Cost of State of the Art Study. The SOAS has cost a great deal more than anticipated because of problems outlined in the Research Section. According to APHA Field Office estimates the cost has been J-$ 120,000 without consultants and overhead. By the time the SOAS is finished in April 1984 it will cost by conservative estimate U.S. $85,657.

	J$	US$
Base	$ 120,000	
10% overhead	$ 12,000	$ 74,157
2 Burton and Layne Consultancies in December 1982/February 1984		$ 11,500
		$ 85,657

No administrative expenses are prorated onto the SOAS. Therefore, this represents an under-estimate of actual cost.

7.7 PROPOSED BUDGETARY ACCOUNT NUMBERS

In Table 7-D an accounting system is proposed which allows for ready ventilation and regrouping of expenditure for analysis. The first digit represents the line item; the second, the recipient; and the third, the project component. This system is compatible for use with off-the-shelf spreadsheet software.

TABLE 7-D

CENTURIES

100	Direct Salaries	LINE ITEMS
200	Fringe Benefits	
300	Overhead	
400	Consultants	
500	Travel & Per Diem	
600	Other Direct Costs	

DECADES

10	APHA	RECIPIENTS
20	PITT	
30	UWI	

UNITS

0	All Components	COMPONENTS
1	Administration	
2	On-Campus	
3	In-Service	
4	Research	
5	Technical Assistance	

Every expense should be attributed to one component. Those salaries that are not a direct part of a technical component should be attributed to the administration component.

The following are a few examples: APHA's fringe benefits

attributed to administration would be 211; total for travel and per diem would be 500.

PITT overhead attributed to on-campus activities would be 322; total for all on-campus would be 002.

UWI other direct costs would be 634. Total UWI direct costs would be 630.

7.8 RECOMMENDATIONS

1. Programmatic Budget

A detailed project programmatic budget should be worked out in coordination with the project modification exercise, following the guidelines in 7.7 above. UWI should participate fully in this exercise. The detailed programmatic budget should also try to identify UWI inputs for planning purposes.

2. PITT Other Direct Costs

A line item should be created in the PITT agreement to cover other direct costs. At present PITT is expending ODC without a line item.

3. Allocation of Consultant Funds

If feasible, the remainder of the line item "consultants" should be moved from PITT's budget to APHA's budget 1/3 and UWI's budget 2/3. This represents the present consultant use ratio. The chairman of the Executive Committee should be responsible for all decisions relating to UWI project unexpenditures.

4. Allocation of Travel Funds

If feasible, the travel budget should be reallocated between APHA's budget 1/3 and UWI's budget 2/3. UWI would expend from this line item following its quarterly travel plan. Regional travel arrangements would be cleared with RDO/C and extra-regional travel with AID/W, S and T Health.

5. UWI Overhead Increase

Consideration should be given to properly determining UWI's real overhead rate which is estimated by UWI to be much higher than the presently charged rate of 10%. UWI should be allowed to charge additional overhead to permit it to properly develop the institutional capacity to plan and respond to opportunities and potential

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contracts in the region. Capitalization is a basic foundation of institution building. This should not put an extra burden on the UWI budget because devaluation has reduced the Jamaican based project costs by 55%.

6. Budget Line Item Comparability

Each line item on all of the agreements should be brought into harmony. The UWI budget, for example, has three line items, different from the other agreement: innovative projects, training workshops and workshop materials. These could be collapsed into other direct costs (ODC), in-service or on-campus as the case may be.

7. Reporting Forms

The recommendations for reporting in 7.2 above should be implemented if the forms are satisfactory to all concerned.

8. Salaries of Positions

New job slots in the direct salaries line items should be created as needed for UWI and identified by project modification. The title of Senior Researcher should be changed to On-Campus Coordinator to cover the costs of executing that function.

9. UWI Revolving Fund

Increase the revolving fund at UWI to $100-K. At present, UWI has over expended its revolving funds by $90,000. This is due to the reporting lag time between the three other project areas and Mona.

10. Cash Flow and Programmatic Accounting

The existing budget should be followed to avoid a cash flow problem (see 7.5 above). The new programmatic budget should be implemented following project modification and strictly adhered to. All accounts should be kept by the recipient on a programmatic basis.

8. RESPONSE TO EVALUATION SCOPE OF WORK

The evaluation Scope of Work identified twenty-five (25) questions which are of concern to A.I.D. project management. Although most of these questions are addressed elsewhere in this report, they are re-capitulated here on an issue-by-issue-basis.

1. To what extent have project output requirements been met?

Achievement of output requirements varies among the four project components. At mid-point in the project in-service training is meeting its output requirements and is proceeding on schedule as planned. The technical assistance component is also achieving its goals although much can be done to extend and improve the outputs. Having revised its ouput requirements, the on-campus training component is making limited progress towards its goals. Unless concerted effort is made in the next six months, and additional resources budgeted for this component, it stands in danger of failing to meet its intended output. Finally, the research component has made little effective progress toward its goals. Projected deadlines have not been met; no acceptable studies have yet been published; and the two studies nearing completion (SOAS and St. Lucia Country Specific study) are of questionable utility.

2. Relative to EOPS (End of Project Status), has the project made sufficient progress to this point of time?

Sufficient progress has been made with the in-service and technical assistance components. Research has not made sufficient progress, and this deficiency cannot be entirely overcome. Finally, the on-campus training program is falling behind schedule. As a result, some of the resources originally budgeted for research should be re-directed toward on-campus training to insure a successful outcome for that key component.

3. Are contract inputs and outputs achieved to date of sufficiently high quality?

No regular staff resources were budgeted as input to development of the on-campus program. As a result, development of the component is at risk of failure. If the delay caused by this lack of input can be overcome, the output planned to date shows promise of good quality. As for the research component, the regular staff hired did not have the research background necessary to insure quality outputs, nor were adequate consultancies arranged to insure good quality control on the research methodology. The inputs and outputs achieved to date for the in-service and technical assistance components have been of good quality.

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4. Have the parties (APHA, UWI, PITTU) to this project performed adequately given field realities, particulars of the Cooperative Agreement, and the Subagreements?

In general, the parties have worked very hard to carry out a project with complicated administrative arrangements and unclear delineation of responsibilities.

5. Are the Cooperators approximating the implementation plan satisfactorily?

The Cooperators have not been meeting the implementation plan as anticipated. The project was slow to start and most of the first year was lost before staff were hired and all subagreements finalized. In addition, the annual workplans have set unrealistic goals and timelines. Therefore, despite reasonable implementation in some of the components, implementation seldom follows the projected "plan."

6. In what way have project expenditures differed from projected costs? Are discrepancies justified in the light of country and project realities?

This is discussed in Section 7.3, Level of Effort Analysis. The University of West Indies has spent 76% of its budgeted amount for direct salaries. This level of expenditure has fallen below that expected because of delay in filling positions in the 01 year. On the other hand, there is now a need to create new salary positions for in-service tutors, to transfer its senior research title to on-campus coordinator and create an additional full-time equivalent teaching position for the diploma program. Unexpended funds for the 01 year plus an increase in Jamaican dollars available due to recent devaluation may create enough funds to make rebudgeting possible. However, if UWI salaries are increased this summer, additional funds may have to be allocated from the general consulting budget in order to adequately staff UWI activities.

Only 20% of the allocated funds for consultants have been expended at the 40% point in the project. To a certain extent this appears to be due to the fact that U.S. consultants have not been called on as much as may originally been expected. Whatever the reason, the level of effort required to date for consultants indicates that some consultant money may be made available for other purposes.

7. Have reporting requirements been met adequately?

Although reporting requirements appear to have been met, the complicated administrative and institutional interrelationships require unusual efforts to insure adequate technical reporting.

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Financial reporting has been show within the UWI system and AID/APHA reporting requirements have not been made clear to UWI.

8. Are changes in reporting requirements recommended?

To insure effective communication of technical reports the project administrator should travel to Washington, D.C., to personally present and explain the quarterly project reports. He also should meet regularly with the RDO/C and AID/Jamaica staffs to explain project development.

The semi-annual reports should include enough fiscal information to identify level of expenditure and projections. All accounts should be kept by the recipient on a programmatic basis and reported as such, using recommended reporting improvements identified in Section 7.2., Financial Reporting System.

9. Has the contractor exercised sound technical, fiscal and management skills in implementing this project?

This is basically a sound project, but there are several deficiencies. Administrative arrangements have been ambiguous because they do not clearly spell out the mutual responsibilities of contractors (APHA) and subcontractors (UWI and PITT); insufficient resources were budgeted for the campus-based training component; the research objectives have not been consistently and clearly stated in a operations research framework, leading to misdirection in staffing and implementation of research projects.

10. Is the level of output completed by the contractor consistent with the level of funds provided?

UWI is expected to implement the entire technical scope of work for the project with 34% of the grant funds, plus an additional 15% consultant and travel funds administered through APHA.

On-campus training has been under- funded and is accordingly slow to develop. In-service, technical assistance and research have been reasonably well funded. Of these three only research has little to show for the funds expended.

11. Are the purpose and assumptions of the project still valid?

The evaluation team considers that the goals and purpose of the project remain valid in that successful management and planning of health resources are necessary in the Caribbean. The indigenous expertise and technical assistance resources currently available to the University of West Indies justify the assumption that this is an appropriate area for AID assistance. However, the team must

temper its optimism in the qualification that, given the lack of a formal needs assessment, the successful initiation of and responsive demand for the diploma program, coupled with demonstrated management improvement will be the ultimate test.

12. In the light of lessons learned to date by the cooperators, what elements of the Project should be redesigned?

The team recommends that current Cooperative Agreements should be modified to strengthen the delineation of responsibility and to reflect that delineation through appropriate rebudgeting (see Executive Summary, Part E and recommendations at end of Chapter 2, Administrative Arrangements). Specific recommendations in this regard are as follows:

a) UWI should rebudget its funds to adequately support each component activity, particularly the campus-based training component.

b) If feasible, portions of the APHA budget should be shifted to UWI in order for UWI to arrange for interregional travel and consultation.

c) The role of the project administrator should be clarified and a responsible UWI liaison person identified for each project component.

d) The role of the University of Pittsburgh should be altered to allow it (legally) to assist in research.

13. Have there been any deviations from project goals?

Project goals remain as first stated.

14. Are facilities adequate?

Facilities are adequate. Project administration is housed on UWI campus in the offices of the Department of Extra-mural Studies. This appears to be very appropriate.

15. Is the staffing appropriate?

There was in no staffing budgeted for the on-campus training component. This is a serious deficiency which must be immediately remedied. Other staffing is appropriate.

16. Within the existing project budget are staffing changes recommended?

The senior researcher position is being appropriately transferred to on-campus training coordinator. An additional full-time equivalent teaching position should be created to assist the on-campus training coordinator.

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The staff tutor position in St. Lucia should be extended an additional year.

17. **Are the financial resources of the project justified in terms of accomplishments and outputs?**

With the exception of research which has produced limited ouput, the resources invested are proportional to the accomplishments to date and this seems to be a justifiable use of AID funds.

18. **Is the on-campus component of the project appropriately located within the academic institution?**

The diploma program in health management is provisionally located within the Faculty of Social Sciences. This is entirely appropriate since the majority of the expertise required for teaching the diploma courses lies with Social Sciences.

It should be noted that this administrative location will not be final until the University Executive Committee formally approves the diploma program. Since the location is not final and since the Faculty of Medicine alternatively could provide an appropriate location for the diploma program, the evaluation team has urged the Vice Chancellor's Office to expediate final approval and location of the diploma program.

19. **Are the project governance and administrative procedures effective and appropriate?**

This project has been implemented under a Cooperative Agreement which legally places primary management authority in the hands of the AID Project Officer. Since this also is a very complicated, flexibly designed project, it requires a great deal of careful attention and experienced direction from the project officer. Unfortunately, during the first two and one-half years the project has had three different project officers. Furthermore, AID restrictions on staff travel have restricted on-site monitoring. These circumstances almost insure tardy and inappropriate governance procedures by AID.

The governance procedures within and between APHA and UWI appear appropriate although one could expect they would be more effective if contracted responsibilities were more clearly delineated.

20. **Should a follow-up project be envisioned or a similar project be considered for another country, what changes should be made in design that are suggested by the lessons learned to date?**

1. A regional project cannot be effectively administered

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from AID/Washington without provision for adequate project officer travel. A similar multi-faceted project should not be designed with regional scope; or, if some regional scope is desirable , it should address a limited and well-defined set of activities, such as in-service education.

2. The tripartite institutional agreement between APHA, PITT and UWI creates unnecessary confusion about roles and responsibilities. One U.S. institution is enough, with other U.S. resources brought to bear on an individual consultant basis.

3. The four project components were not operationally integrated in the project design. Thus, the four components became four sub-projects each with its own pace and direction. Design of any follow-on project should clarify how separate components will interact on a practical, operational basis.

4. A needs assessment should be programmed into the initial project year.

21. **Is there likely to be a need for future AID assistance of this type?**

The concept of inter-institutional development projects seems quite timely. AID could do much to build LDC indigenous resources through institutional development particularly in the areas of operations research and management training.

22. **Is a needs assessment which was not programmed before project initiation desirable at this point in time?**

The progress of the Project is essentially demonstrating need as each component is being implemented. A formal needs assessment would not be useful at this time, although it should have been explicitly called for in Year 01 as rationale for the General Sector Study.

23. **What are the post-project plans of the UWI for maintenance of the on-campus health management program? Are they realistic and feasible?**

UWI administration appears sincerely committed to establishing an ongoing diploma program in health management. The feasibility of this remains to be demonstrated. Curriculum planning must be completed and the diploma program must be offered next year in order to market the program and establish some estimate of the level of demand. Only when this is done can planning be completed to generate the necessary budget and staffing for an ongoing program.

24. Does the operations research component appear to be contributing to the goal of the Project? If so, how so, and if not, why not?

Unfortunately, the Project does not have a well-defined operations research component. This is discussed in Section 6.1, Research Design. The research component falls short of O.R. If O.R. had been clearly defined and established in the Project design, the research component might have presented a stronger contribution to project goals.

25. What [illegible] are suggested for any co[illegible] the Project, including should it be expanded to more countries?

Research activities should be reduced in scope and priority in order to insure adequate resources for campus-based training. In-service training should not be implemented in Jamaica. Instead, it should be offered to one or two of the small island CARICOM countries.

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9. PROPOSED LOGICAL FRAMEWORK REVISION

LOGICAL FRAMEWORK

Project Title and Number: **Health Development Planning and Management**

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: -To provide support to the governments of the West Indies to strengthen their capabilities to plan and manage health sector resources in order to improve the health of their populations.	Measures of Goal Achievement: -Health sector resources allocated in West Indian Ministries of Health in accord with planned priorities and targets. -Health management technique and process improve service delivery. -Health status of West Indies population improves.	-Examination of ministries' health plans, budgets and expenditures. -Audits of management techniques; examination of management regulations and guidelines. -Life expectancy increases; age-specific mortality declines; rates of natural population increase lessen.	Assumption for Achieving Goal Targets: -West Indian government are receptive to changing health planning/management practices, and will utilize assistance. -Improved health planning and management will contribute to improved health status. -Political stability will permit institutionalization of improved health planning/management practices in governments assisted by the Project.

LOGICAL FRAMEWORK

Project Title and Number: Health Development Planning and Management

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Purpose: -To establish at the University of the West Indies the sustained capability to work with West Indian Ministries of Health to: -Train health planners and managers -Facilitate access to a pool of indigenous health management consultants -Promote and carry out health services research	End of Project Status: 1) The UWI Faculties of Social Science and Medicine collaboratively viewed by CARICOM Nations as offering and attractive, competitive source for provision of on-campus health planning and management training to CARICOM Ministries. -UWI solicited by governments and donors to conduct problem-related health planning and management in-service training. 2) UWI a functioning segment of a larger network supporting and providing qualified consultants in health planning and management. 3) Operational research in health services accepted by the region as a useful planning and management tool. 4) Assisted governments have improved capability to plan and manage health sector resources.	1) Funding and staffing for on-campus health management program supported by contributing nations. -Enrollment figures for on-campus training substantiates countries' participation. -Proportion of West Indians seeking health planning and management training from extra-regional sources drops when compared to those seeking training from UWI. -Examinations of funding documents pertaining to inservice training performed by UWI. -Examination of in-service training documentation and evaluation reports. 2) Examination of requests for services and reports of consultants identified in Registry. -Analysis of utilization by extra-regional sources of information and services of Resource Center at ISER. 3) Examination of operational research protocols, research reports, and evaluations of follow-on actions. 4) Analysis of health plans, budgets and expenditures demonstrates move towards congruence. -Country-specific analysis of health planning and management practices demonstrate movement towards identified goals.	-Quality of the UWI Program will be perceived by Caribbean countries to be equal or superior to programs available extra-regionally. -UWI and contributing nations will provide resources to sustain Project initiated activities. -Project-supported inservice training and research methodologies can be adapted for use in other Caribbean nations. -Governments and donors will be aware of, value, and utilize indigenous consultant and support services identified and supported by the Project. -Governments will coordinate planning and budgeting processes in order to allocate resources to the health sector sufficient to achieve agreed upon priorities and targets.

LOGICAL FRAMEWORK

Project Title and Number: Health Development Planning and Management

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs 1. Problem-based, modular designed methodology for inservice training development, tested, documented and evaluated 2. An institutionalized after-first (post-baccalaureate) degree diploma course in health management developed, tested, implemented and evaluated. 3. A roster of qualified West Indian consultants available for interregional health planning and management identified, screened, and established at UWI. 4. A resource center for health management and planning developed, stocked, indexed and maintained at UWI. 5. Health services problem oriented operations research methodology developed, tested, refined and conducted.	Magnitude of Outputs: 1) Problem based in-service training conducted in conjunction with Ministry of Health of at least five nations including two lesser developed nations (St. Lucia, Barbados, Trinidad and two lesser developed countries). Technical assistance in health planning management provided to one nation (Jamaica). 2) Beginning in the Fall of 1984, two rounds of the University based diploma course administered to a total of 20 West Indians. 3) One computerized registry of at least 100 West Indian potential consultants physically located and maintained by UWI, serving nation and donor clients from the region. 4) A resource center of over 100 publications established at ISER. 5) At least two (St. Lucia, Trinidad) and up to four (Barbados, Jamaica) country-specific health operational research activities completed. State of the Art document in health management completed for campus nations and St. Lucia. Annotated bibliography completed. At least two pieces of general health services research (eg., Management Information Systems and Human Resources) completed by UWI.	1) Examination of curricula, records of methodology, and reports of in-service training evaluations. Examination of Technical Assistance reports. 2) Health management diploma program officially approved by 3 UWI campuses and UWI administration by Summer 1984. Examination of diploma course curriculum, course outline and staff assignments. Observation of classes beginning Fall of 1984 and 1985, including analysis of country of origin and career aspirations of students. 3) Observation and qualitative analysis of Registry. Analysis of usage reports of Registry. 4) Observation of Resource Center at ISER, including index and records of services provided. 5) Analysis of applications of research findings of country-specific research. Examination of research protocols and reports of research.	1) Participating countries will participate fully in design and implementation of inservice training. UWI can mobilize resources in time to establish diploma course before Fall, 1984 deadline. Participating countries administratively and financially will support attendance of students for on-campus program. 3) Qualified West Indian consultants in health planning and management can be identified and will agree to being placed on the Registry. 5) The utility of health services operations research will be perceived and requested by participating countries.

LOGICAL FRAMEWORK

Project Title and Number: Health Development Planning and Management

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Inputs A.I.D. 1) Funding for Cooperative Agreement 2) Project Monitoring 3) External Evaluations Recipient(s) of Cooperative Agreement 1) Project Implementation 2) Technical Assistance 3) UWI faculty positions 4) Commodity support 5) Internal evaluation Cooperating Countries 1) Support candidates for on campus course 2) Participate in inservice training research	Implementation Target (Type and Quantity) A.I.D. 1) $2.5 Million over 5 years 2) Logistic support for Project Officer 3) One evaluation in years 3, one in year 5 Recipient(s) of Cooperative Agreement 1) Implementation according to time lines, work plans 2) As negotiated to achieve Project Purpose 3) As negotiated to achieve Project Purpose 4) As negotiated to achieve Project Purpose Cooperating Countries 1) 20 candidates total in year 4 and 5 2) At least 15 members/country selected by Country Program Committee. -Country specific research topic identified at least two countries	A.I.D. 1) Project documents 2) Trip reports; evaluation reports 3) Evaluation reports Recipients 1) Review of Cooperative Agreement, work plans 2-5) Evaluation reports Cooperating Countries 1) University records 2) Project Records, site visits	A.I.D. 1) Funding can be provided in timely fashion 2) A.I.D. procedures and funding will permit adequate monitoring Recipients 1) Cooperative Agreement will adequately delineates responsibilities of all parties involved 2) Appropriate T.A. will be provided, and will be utilized by the Project 3) U.W.I. can provide adequate positions to achieve Project purposes 4) Administration procedures provide limited commodity provision in timely fashion Cooperating Countries Appropriate candidates will be identified, supported Host countries willing to participate in inservice training, research

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A. Vinker

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

April 19, 1984

MEMORANDUM:

TO: See Distribution

FROM: S&T/H/HSD, Donald C.E. Ferguson

SUBJECT: Health Development Planning and Management (HDPM) Project Caribbean Debriefing

Dr. William Callen, Chairman of the team which recently completed the mid-term evaluation of the HDPM Project with the American Public Health Association, will present the conclusions and recommendations of the evaluation on Wednesday, April 25, at 10:00 A.M. in Room 209, SA-16.

We hope you will join us.

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Appendixes 1 through 20

January 18, 1984

MEMORANDUM

TO: S&T/HP, James E. Sarn

THRU: S&T/H, George Curlin

FROM: S&T/H/HSD, Donald C.E. Ferguson

SUBJECT: Scope of Work for the Evaluation of Cooperative Agreement AID/DSPE-5901-A-00-1039-00

I. Project Title: Health Development Planning and Managment/APHA/Caribbean

A. Project No: 936-5901
B. Cooperative Agreement No: AID/DSPE-5901-A-00-1039-00
C. A.I.D. Project Manager: Donald C.E. Ferguson, S&T/H/HSD

II. Contractor/Principal Investigator:

A. Cooperative Agreement: American Public Health Association Washington, D.C.
i. Subagreement 1: University of the West Indies, Mona, Kingston, Jamaica.
ii. Subagreement 2: University of Pittsburgh, Pittsburgh, Pa.

B. Project Director (APHA): Dr. Alfred Gerald
i. Subagreement Director (UWI): Pro-Vice Chancellor Leslie B. Robinson
ii. Subagreement Director (PITT): Dr. Gordon MacLeod, School of Public Health

III. Purpose of the Evaluation: Scheduled Project Mid-Term Evaluation

This Cooperative Agreement which runs through 1986, calls for a Mid-Term External Evaluation. The evaluation is to assess project progress, management and performance, and provide recommendations for change for the balance of project life.

IV. Dates and Places of Evaluation:

The evaluation is scheduled to begin February 7, 1984. Planned itinerary is as follows:

Feb. 7-8	Team orientation by S&T/H Project Manager Rosslyn, Va.
Feb. 9-10	Site visit to American Public Health Assoc. Washington D.C.
Feb. 12	Team departs for Jamaica Team meeting and document review
Feb. 13-16	Site visits to UWI, USAID/Kingston, MOH
Feb. 17	Departure of two team members to Trinidad Departure of two team members to Barbados
Feb. 19	Begin writing and reading of additional documents
Feb. 20-21	Site visits to MOH/Trinidad and UWI Trinidad campus Site visits to MOH/Barbados, RDO/C, and Barbados site of O.R. study
Feb. 21	One team member visits MOH St. Lucia and OR study site
Feb. 22	Team returns to Kingston, Jamaica
Feb. 23	Interviews with APHA Project Manager in Kingston
Feb. 27-29	Report writing and coordination, Kingston, Jamaica Team leader departs team leaves drafts with team leader prior to departure.
March 20	Final draft reviewed by Project Manager
March 30	Final report submitted to AID/W

V. Composition of the Evaluation Team:

The evaluation team will include specialists in the following areas:

a) health management and health management training
b) in-service training/health care organization/ministries of health
c) health project evaluation, project design, and AID health program, policy and procedures
d) university-based health training and education programs, operations research..

A four person team comprised of three non-AID and one AID direct-hire specialists will be assembled. All team members will be seasoned, experienced professionals in their areas of specialty. Three team members have been selected, and a fourth is currently being recruited. Team members selected are as follows:

Dr. William Callan, University of Washington, School of Public Health, Team Leader
Dr. M. Bud Shutt, University of North Dakota School of Medicine
Ms. Anne G. Tinker, Chief, Health Services Division, Office of Health
Mr. John Burns, Staff Associate, Management Sciences for Health

VI. Cost of the Evaluation:

Exclusive of the direct-hire team member, total costs are estimated at $29,000. Several support mechanisms will be used to reach desired team members.

VII. Project Background:

This project, initiated on September 30, 1981, is one of two sub-projects located in two geographical regions under a single project umbrella. The HDPM/Indonesia shares several objectives in common with the HDPM/Caribbean project, although the particulars of project organization and activities differ.

The primary objective of the HDPM/Caribbean Project is to institutionalize health management, planning and development in the region as reflected in the major components of the project:

a) institutional development of an on-campus degree in health management at the UWI Mona Campus in Jamaica
b) development of in-service training curricula and methods for ministries of health in the region with demonstration efforts in Trinidad, Jamaica, Barbados and St. Lucia
c) development of a roster of indigenous consultants in the region to assist in health management problem solving and solution development
d) operational research support and creation of a resource center in the service of above objectives
e) raising the interest and capabilities of ministry staffs in health management in the countries partcipating during the life of project.

VIII. Problems and Issues to be Assessed by the Evaluation Team:

1. To what extent have contract output requirements been realized?
2. Relative to the EOPS (End of Project Status), has the project made sufficient progress to this point in time?
3. Are contract inputs an outputs achieved to-date of sufficiently high quality?
4. Have the parties (APHA, UWI, PITT) to this project performed adequately given field realities, particulars of the Cooperative Agreement, and the Subagreements?
5. Are the Cooperators approximating the implementation plan satisfactorily?
6. In what ways have project expenditures differed from projected costs?
   Are discrepancies justified in the light of country and project realities?

7. Have reporting requirements been met adequately?
8. Are changes in reporting requirements recommended?
9. Has the contractor exercised sound technical, fiscal and management skills in implmenting the project?
10. Is the level of output completed by the contractor consistent with the level of funds provided?
11. Are the purpose and assumptions of the project still valid?
12. In the light of lessons learned to date by the Cooperators, what elements of the project should be redesigned?
13. Have there been any deviations from project goals?
14. Are facilities adequate?
15. Is the staffing appropriate?
16. Within the existing project budget are staffing changes recommended?
17. Are the financial resources of the project justified in terms of accomplishments and outputs?
18. Is the on-campus component of the project appropriately located within the academic institution?
19. Are the project governance and administrative procedures effective and appropriate?
20. Should a follow-on project be envisioned or a similar project be considered for another country, what changes should be made in design that are suggested by the lessons learned to date?
21. Is there likely to be a need for future AID assistance of this type?
22. Is a needs assessment which was not programmed before project initiation desirable at this point in time?
23. What are the post-project plans of the UWI for maintenance of the on-campus health management program? Are they realistic and feasible?
24. Does the operations research component appear to be contributing to the goal of the project? If so, how so, and if not, why not?
25. What changes are suggested for any component of the project? (including expansion to other countries?)

IX. List of Documents to be provided to Evaluation Team:

1. Request for Proposal
2. Contractor Proposal
3. Cooperative Agreement (APHA)
4. Subagreement (UWI)
5. Subagreement (PITT)
6. Workplan Year I and Year II
7. Annual Report Years I and II
8. Draft State of the Art document
9. Executive Committee Reports
10. Selected Consultant Reports
11. Internal Evaluation

X. Proposed Schedule of Events:

Week 1.	Tues.-Wed:	Rosslyn, Va. Team assembles and meets AID Project Officer, LAC/HN staff.
	Thurs-Fri:	Washington, D.C. Site visit to APHA. Meetings with Project Director and project personnel, review contractor files.
	Saturday:	Team departure for Kingston, Jamaica
	Sunday:	Document review.
Week 2.	Mon-Fri:	UWI site visit, Mona Campus. Interviews with those involved in on-campus, in-service, and research components of project based in Jamaica. Visit to MOH Jamaica, USAID/Kingston, and APHA Project Manager. Subagreement (UWI) file review.
	Saturday:	Two team members depart for Trinidad. Two team members depart for Barbados.
	Sunday:	Writing and document study.
Week 3.	Monday:	Trinidad sub-team visits UWI/Trinidad campus and Trinidad MOH. Barbados sub-team visits MOH, research site, and RDO/C.
	Tuesday:	One team member departs Barbados to St. Lucia. Other team members continue visits begun Monday.
	Wednesday:	Sub teams return to Kingston, Jamaica from Trinidad, Barbados and St. Lucia.
	Thursday:	A.M. Team meets in plenary. P.M. Team meets with Project Manager Thelwell for question period and discussion.
	Fri-Sun:	Report organization and writing assignments by Team Leader.
Week 4.	Mon-Tues:.	Report writing.
	Wednesday:	Drafts delivered to Team Leader prior to departure. Team departs Jamaica.

Recommendation:

That you approve the scope of work outlined above for evaluation of the Health Developeent Planning and Managment Project/Caribbean.

Approved: _____

Disapproved: _____

Date: 1/19/84

Clearances:

ST/H: A. Tinker AT Date: 1/16/84
H. Destler Date: 1/5/84
ST/PO: F. Campbell Date: 1/18/84
K. Milow Date: 1/18/84
G. Eaton Date: 1/18/84

ST/H/HSD:DCFerguson:rn:1/16/84:Revised 1/18/84:x59649:0464R

Persons Contacted

Washington DC

A.I.D.

Ms. Paula Feeney, Health and Nutrition Officer, Latin American Bureau

Dr. Donald C.E. Ferguson, Officer of Health, Science and Technology Bureau

Robert Ware, AID Contracts Officer, CM/COD

APHA

Dr. Susi Kessler, Associate Executive Director, International Health Programs

Dr. Alfred N. Gerald, Deputy Director-Program Manager, International Health Programs

University of Pittsburgh

Dr. John Cutler, Head Department of Health Services Administration

Dr. Gordon MacLeod, Department of Health Services Administration, HDMP Project Liaison

Jamaica

Administrative Staff College

Ms. Phyllis Green

AID Jamaica

Mr. John Corry, Health Nutrition, Population Officer
Ms. Francesca Nelson, Health Nutrition, Population Officer

ACHA

Dr. Richard Thelwell, Project Administrator

Government of Jamaica

Ministry of Health

Mr. Rupert Ramcharan, Permanent Secretary
Ms. Edna Tulloch, Health Planner
Dr. John McCardy, Chief Medical Officer
Dr. Carmen Bowen Wright, Primary Health Care
Mr. Cedric Taylor, Personnel and Management
Ms. Evette Lee, Health Planner, also UWI HPDM student
Dr. Christine Moody, Project Coordinator, Health Management Improvement Project

PAHO

Dr. Isabel Eleta, Community Development Advisor

University of West Indies

Mr. A.Z. Preston, Vice Chancelor
Mr. L.R.B. Robinson, Pro-Vice Chancelor (Planning)
Dr. S.K. Wray, Dean, Faculty of Medicine
Prof. G.I. Mills, Dean, Faculty of Social Sciences
Prof. Sir Kenneth I. Standard, Head, Department of Social and Preventive Medicine
Dr. Edwin S. Jones, Head, Department of Government
Mr. Oriel H. Salmon, Head, Department of Management Studies
Dr. John Greene, Acting Director, Institute of Social and Economic Resources
Mrs. Hermaine McKenzie, Head, Department of Sociology
Prof. Ralston Milton Nettleford, Professor of Extra Mural Studies
Dr. Marjorie Holding, Department of Social and Preventive Medicine
Mrs. Patricia Desai, Lecturer, Department of Social and Preventive Medicine

Dr. Satharine I. Maharaj, Lecturer, Department of Social and Community Medicine
Dr. Mike Fitzhenly, Lecturer, Department of Social and Community Medicine
Ms. Joan Rawlins, Research Assistant, Institute of Social and Economic Resource
Dr. Phyllis Macpherson Russell, Consultant, Human Resource Development, Department of Extra-Mural Studies
Mrs. Ina Barrett, Lecturer, Department of Government
Mr. Lockeley Lindo, Sr. Lecturer, Department of Management Studies
Ms. Linnette M. Harriss, Assistant Lecturer, Department of Government
Mr. Leon Wilson, Bursar

Barbados

OID

Mr. Allen Randlov, Regional Health and Population Officer, RDO/C

Caricad

Dr. Selwyn Smith, Director
Dr. Aubrey Armstrong, Training Officer
Dr. Fredrick Nunes, Training Officer

Ministry of Heath

Dr. Allison Daniels, Permanent Secretary
Mr. Carl Yard, Assistant to the Permanent Secretary; Coordinator, Country Programmer Committee
Mr. Cortez Nurse, Director of Planning and Project Design
Dr. Leonore Harney, Chief Medical Officer

University of West Indies, Cave Hill Campus

Dr. Farley Brathwaite, Vice Dean, Social Sciences
Prof. Micley Waldron, Vice-Dean, Medicine
Dr. John Mayers, Head, Department of Management Studies
Ms. Una Clarke, Resident Tutor, Department of Extra-Mural Studies

PAHO

Dr. Harry Drayton

Caribbean Development Banks

Dr. Courtney Blackman, Director

Consultants

Sir. Carlisle Burton, Kt., O.B.E.
Mr. Edward Layne

St. Lucia

Mr. Cornelius Lubin, Permanent Secretary, Ministry of Health and Housing (MHH)
Dr. Anthony DeSousa, Chief, Medical Officer, MHH
Dr. James St. Catherine, Medical Officer of Health, MHH
Mr. Russell Combie, (Staff-Tutor), Senior Public Health Inspector, MHH
Mr. John Laforce, Public Health Inspector, Castries City Council
Personnel of Dennon District Public Center
Ms. Marilyn Florescac, UWI, Resident Tutor, St. Lucia

Trinidad and Tobago

Ministry of Heath

Hon. Neville Connell, Minister
Mr. Bertram Ifill, Permanent Secretary
Dr. Norma Andrews, Permanent Medical Officer
Dr. Karen Sealey, Planning
Mrs. Joyce Dicep, Staff Economist, Planning

University of West Indies, St. Augustine Campus

Dr. Lloyd E.S. Braithwaite, Pro Vice Chancellor
Mr. W.C. Parris, Vice Dean, Social Sciences, Senior Lecturer
Mr. Philbert Morris, Department of Mathematics

PAHO

Dr. Hal Dyer, Trinidad

Dr. Peter Carr, Washington D.C.

APPENDIX 3

List of Documents Reviewed

The following represents a partial listing of the major documents reviewed. The team has access to file materials within the APHA and HDPM, including financial files, additionally, there were draft portions of several consultants' reports which were not listed because either the author or approximate date could not be identified by the team.

A. Administcative Staff College, Jamaica

Administrative Reform Enquiries in Jamaica, 1942-1980, vol 1, (Jan. 1983) and vol. II (April, 1983), Margaret Priestley.

Employee Morale in the Jamaican Civil Service, Phyllis A. Green, Derel S. Gordon, Edwin, S. Jones, 1983.

Report on First Executive Symposium Ministry of Health, Jamaica, December 1 and 8, 1983.

B. Agency of International Development

Cooperative Agreement No.: DSPE-5901-A-00-1039-00, September 30, 1981.

Project Evaluation Summary (PES), RDO/C Basic Health Management Training Project, October 26, 1983.

Request for Application (RFA) for Cooperative Agreement (CA) AID DSPE-1028: Health Development Planning and Management, July 20, 1981.

C. American Public Health Association

Health Development Planning and Management Application grant, October 30, 1980.

Health Development Planning and Management Project (HDAM) Technical Application, Vol. 1 and 2 (undated).

HDPM Semi-annual reports:
- October 1, 1981 - April 30, 1982
- May 1 - September 30, 1982
- October 1, 1982 - March 31, 1983

April 1 - September 30, 1983

Report of Internal Review Team, August 4, 1982.

Subcontract between the University of Pittsburgh and the American Public Association, 1982.

Subcontract between the University of the West Indies and the American Public Association, December 18, 1981.

D. Caribbean Centre for Development Administration (CARICOD)

Case method: A guide for Caribbean Trainers, Carston M. Simmons, July 1981.

Handout for Management by Objectives and Results Executive Symposium, January 19-20, 1984.

A Draft Application to HDPM for funding at Executive Symposia (undated).

Report on Management by Objectives and Results Executive Symposia, St. Lucia, January 19 and 20, 1984.

1984 Work Programme (undated).

E. Caribbean Community (CARICOM)

Evaluation of the Model District Health Team Project, St. Lucia, August, 1982.

F. Health Development Planning and Management Project

Caribbean Community Health Management: The State of the Art (draft): Omawale and Sonia Suberan, Institute of Social and Economic Research, University of West Indies, March, 1983.

Final Report on Constraints to Integrated Health Management at Parish Level, Barry Chevannes (UWI), November 21, 1983.

HDPM Barbados, Quarterly Reports:
October - December, 1982
January - March, 1983
April - June, 1983
July - September, 1983
October - December, 1983

HDPM Consultant Report on the Development and Implementation of the First Course in the HDM Programme: Health and Social Organization, Ruth C. Browne (UWI), September 28-December 13, 1983.

HDPM Consultants Report on the Formulation of a programme for Executive Symposia and the Development of a Network of Consultants, Edwin S. Jones (UWI) and Neville C. Duncan (UWI), September 23, 1983.

HDPM Project District Level Programmer, St. Lucia, Vieux Fort Health Center, June 27 - July 7, 1983: Training Manual for Data Collection.

HDPM Executive Committee Minutes:
February 5, 1982
May 5, 1982
October 15, 1982
January 18, 1983

HDPM Inservice Training Program, St. Lucia, Report on Module V and the District Level Program, Consultant Trip Report by Ms. Shirley Fletcher June 11 - July 9, 1983.

HDPM Project Work Plan and Summary Budget for Year II (undated).

HDPM Project Work Plan and Summary Budget for Year III 1983-1984 (undated).

HDPM Quarterly Report, May 1 - July 31, 1982.

HDPM Update Report, February - March, 1982.

Health Services Management in the English Speaking Caribbean - State of the Art Study of the Ministry of Health - Barbados, Carlisle Burton, Kt., OBE, December, 1982.

Improvement in the Castries Health Center Services Draft (undated).

Management Training for Physician Administrators in Barbados and Trinidad, John L. Coulehan (PITT), August 6, 1982.

Report of the UWI Curriculum Consultancy Team: Gladstone Mills (UWI) Chairman, Clara Kimbro (Johns Hopkins), Morris Schaefer, (North Carolina).

Solid Waste Disposal Research, St. Lucia, Draft Report, Paul Hippolyte, August, 1983.

Trip report to Barbados and St. Lucia to initiate Curriculum Consultancy, Len G. Rawson (PITT), May 14-18,

1982.

Trip Report to St. Lucia Draft, January 11-24, 1984, Maurice Shapiro (PITT).

G. University of West Indies

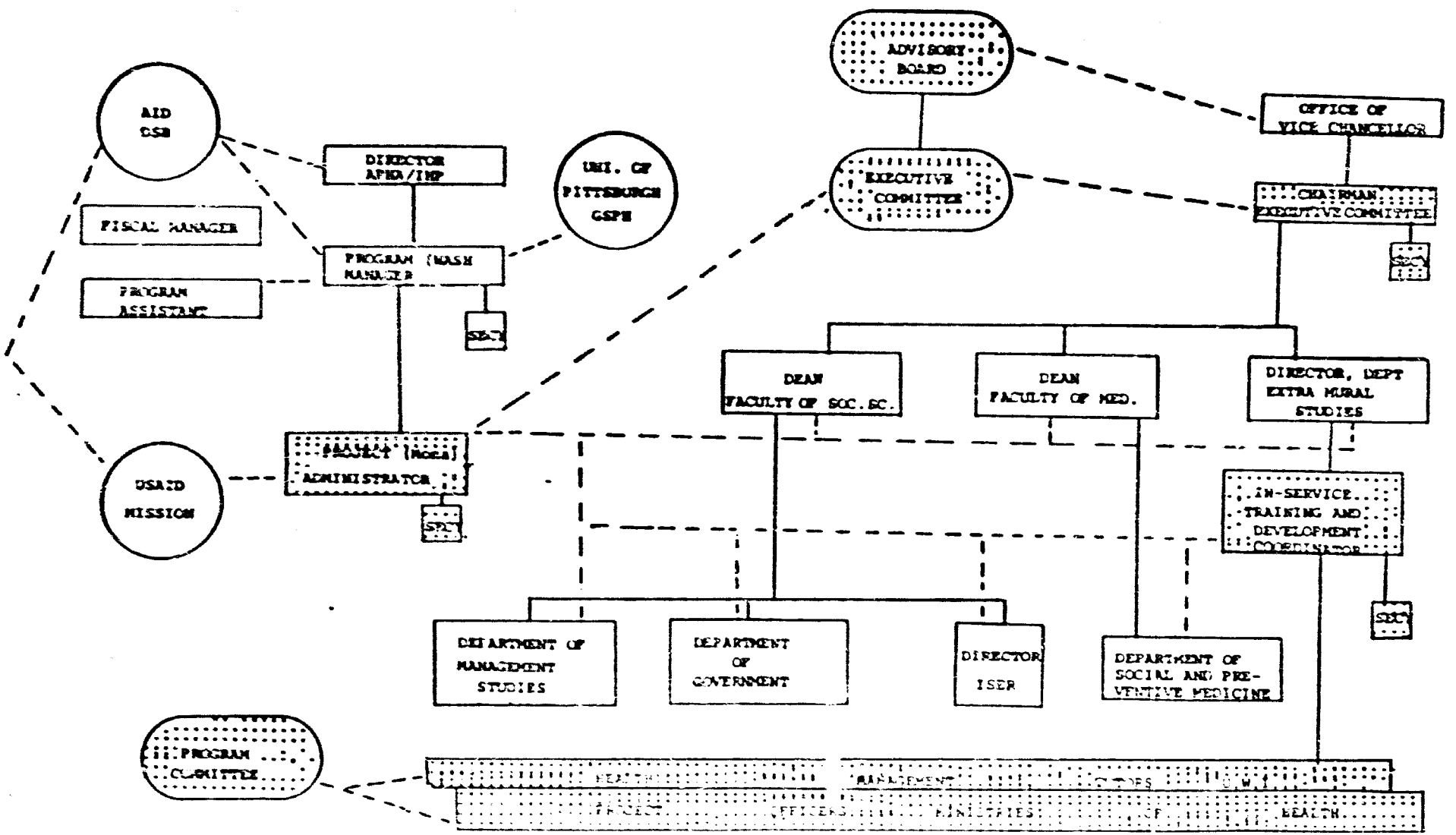
Brochure, Certificate in Community Health Management (CCAM) Challenge/Outreach, part time programme.

Case Studies Prepared by the University of the West Indies for use in the Regional Programme of Continuing Education in Administration of Family Planning Programmes (AMRO-1312), 1974-78.

Department of Social and Preventive Medicine, 25th Anniversary Booklet, April 1957 - April 1982.

University of West Indies Calendar Vol. II, Academic Year 1981-1982.

HDPM ORGANIZATION CHART



LOGICAL MATRIX

ELEMENTS OF PROJECTS	SUCCESS CRITERIA	VERIFIERS	EXTERNAL FACTORS
Outputs			
A. On-Campus Training			
o Two optional courses - Year 1	o Increasing number of UWI students in the Faculty of Medicine elect courses in management offered by the Faculty of Social Science.	o Transcripts of record of students enrolled in the Diploma of Community Health and Diploma of Public Health courses at UWI who have elected to take management courses.	o Continued financial and other support from external sources for the planned duration of the project.
o Two additional optional courses Year 2	o Increasing number of students who have completed the degree course in Health Management or otherwise trained for management roles in the Health Sector	o Other student records.	o Acceptance and support of the project by the Ministries of Education.
o A cross faculty health management degree course offering at UWI beginning Year 3 and beyond	o Adequate number of UWI faculty members with recognized capability to teach Health Management courses.	o UWI Curriculum incorporating the new degree course in health management.	
o Upgraded UWI Faculty in Health Management skills (study grants short term courses, attendance at seminars, workshops, etc.)			
B. InService Training & Development			
o At least one major on the job training exercise for key health managers (job focussed - career focussed) in each of the four participating countries.			
o Consultation Services - direct assistance to managerial staff in Ministries of Health to carry out research to analyze and solve country specific management problems.	o Participating countries with active Health Management Development Programs in which the consultants, methods, and materials developed by the InService Training and Development component of HSM are effectively utilized	o Correspondence between Project Administrator and governments.	o Participating Governments adoption of personnel policies such as to ensure retention of adequate number of trained Health Managers.

LOGICAL MATRIX

ELEMENTS OF PROJECTS	SUCCESS CRITERIA	VERIFIERS	EXTERNAL FACTORS
Outputs (CONT'D)			
o Reinforcements: - attachments - projects - problem solving activities - study programs	o Tutors/Consultants/Researchers have established ongoing supportive relationship with Health Managers	o Records of follow-up on reinforcement activities in the Ministries of Health o Records of completed courses and interventions.	
o Training of 30 tutors/consultants/researchers - associates of the indigenous pool of management consultants.			
C. Technical Assistance			
o Documented Report on assessment of needs o Registry of health management consultants. o Health Management Resource Center installed at UWI	o UWI Consultants Registry System and Resource Center operational and utilized by Government, UWI faculty, consultants with International & Bi-lateral agencies.	o Report on services provided by consultants drawn from the pool. o Consultant reports on assignments. o Government responses/evaluation of consultancies.	o The establishment of attractive fee structure for consultants
D. Research			
o State of the Art Report (regional health management) o Four country specific studies (problem focussed. o Documented periodic update of State of the Art (3rd & 5th year)	o Results of research are reflected in the new curriculum at UWI, in the In-Service Training Programs in each of the four countries, as well as in standard setting in health management.	o Reports and updates on the State of Art Study. o Reports on Country specific studies.	

LOGICAL FRAME
HEALTH DEVELOPMENT PLANNING & MANAGEMENT PROJECT
(HDPM)
WEST INDIES 1981-1986

ELEMENTS OF PROJECT	SUCCESS CRITERIA	VERIFIERS	EXTERNAL FACTORS
Development Objectives			
o To improve the practice of management in the health sector in the English Speaking Caribbean and to provide an adequate supply of trained managers capable of better designing, planning and managing the health systems.	o Evidence of improvement in the utilization of human, financial, material, information, and time resources in the management of Health Services to attain satisfactory levels of health care for the total population.	o Existence of documented plans, procedures, guidelines, regulations, and systems for the sound management and control of health sector programs.	o Priority governments assign to health sector in terms of the overall budget, staffing, policy decisions, etc.
Immediate Objectives			
o To build institutional capability at UWI to develop and implement courses of study off and on campus which will meet present and future needs for trained health managers in the region.	o Regular offering at UWI of a degree course in health management and continued inservice training in management in each of the four participating MOHs by the beginning of Year 3.	o Course evaluation reports, records of attendance and performance at UWI; reports on training activities and on management development within the MOHs.	o Action taken by Governing Body of UWI (Senate) and other accreditation bodies to recognize and approve courses.
o To make accessible to governments, particularly Ministries of Health (MOH), as well as regional and country health institutions, the services of a pool of indigenous experts capable of meeting needs for technical assistance in health management.	o (1) 10-20 middle and/or senior level managers working in each of the participating MOHs trained in health management.	o UWI Consultancy Registry records on usage of the service and of performance evaluation of both the service and the consultants.	o Capacity of UWI and individual governments to financially support activities initiated by this project after withdrawal of present financial support.
o To utilize operational research in training, as a problem solving tool in the management of health systems, and as a source of information in the carrying out of expert technical advisory functions.	o Appreciable demand and usage of information resulting from operational research undertaken by Ministries of Health, the Institute of Socio-Economic Research of UWI and other related regional institutions in the field of health management.	o Resource Center records on content of the collection and the usage of this new source of information.	o Acceptance and effective use of a pool of indigenous consultants by other international agencies, bilateral organizations as well as by the countries of the region.
o To develop an ongoing collaborative relationship between the University of the West Indies and the University of Pittsburgh, in the training of health managers		o Research Reports, Consultancy Reports and Evaluations.	

(1) Approximately ninty trained health managers will be expected to influence and improve performance of 600 additional workers through inservice training activities during the life of the project.

Appendix 5

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LOGICAL MATRIX

ELEMENTS OF THE PROJECT	SUCCESS CRITERIA	VERIFIERS	EXTERNAL FACTORS
Inputs			
A. On-Campus Training			
o 10 P/M Lecture Hours o 10 P/M Curriculum Consultancy (Pitt) o UWI Accreditation o Seminars Workshops Grants for UWI Faculty upgrading.	o UWI Health Management Curriculum established and accredited. o Adequate number of UWI Faculty members exposed to advanced Health Management training.	o Project reports o UWI records o Ministry records o Evaluation reports	o Financial support from external sources for planned project duration.
B. Inservice Training and Development			
o 4 P/M Consultancy to Analyze country specific problems o 8 P/M consultancy for Reinforcement:-attachments, projects, problem solving activities, study programs, etc. o 10 P/M consultancy for training of 30 tutors/consultants/researchers o 3 P/M UWI/Pitt Curriculum Consultancy Team o 1 Full time coordinator, Inservice Training & Development. o 2 Full time Resident Tutors	o Improved management practices in Ministries of Health of the participating countries	o Project reports o UWI records o Ministry plans, management procedures, and practices o Evaluation reports	o Ministries decision to assign high priority to improvement of management practices.
C. Technical Assistance			
o 15 P/M Management Support Consultants o 4 P/M consultancy for Assessment of needs for T.A. in the region o Part time Administrative Assistant/Jamaica o Part time Project Administrator	o Increase use of indigenous consultants by Ministry of Health and other regional and international agencies. o Impact of efficiency of management in the Ministries of Health	o Consultants reports o Evaluations o Ministry records	o Competition among various sectors for the use of services of limited number of indigenous experts in management in general and health managers in particular. o Unattractiveness of fee structure for consultants
D. Research			
o 4 P/M consultancy for problem definition in 4 countries o 4 P/M consultancy for State of the Art Study o 4 P/M consultancy for four Country Specific Studies	o Wide utilization of research findings for training in management throughout the region as well as for decision making and problem solving within the Health Sector.	o Consultancy register Records o Ministry records o Consultancy reports o Evaluation reports	

Appendix 5

COUNTRY	ECONOMY	DEMOGRAPHY							NUTRITION				
	GNP per capita (US$)	Population (,000)	% Population <5 years	Total Infant Mort. Rate	Rural Infant Mort. Rate	1-4 Year mortality	No. of years to double population	No. of years to double population	% of birth weights under 2500g	% of under five year olds underweight: Cohort I	% of under five year olds underweight: Cohort II & III	Hosp. Case Fatality Rate for ETM & Gastroenteritis	% Paediatric admissions due to ETM and/or gastroenteritis
ANTIGUA	716 (A)	73 (B)	11.7 (B)	28.6 (A)	14.2 (A)	1.0 (B)			8.2 (A)	23.5 (C)	3.65 (C)	5.8 (A)	24.2 (B)
BAHAMAS	2620 (C)	200 (C)	19 (B/C)	29.4 (A)	19.2 (A)	1.2 (B)	34 (A)	34 (A)	9.6 (A)				
BARBADOS	1940 (C)	247.3 (B)	8.9 (B)	28.3 (B)		1.2 (B)	80 (C)	80 (C)	19.0 (B)	36.1 (p) (B)	3.4 (p) (B)		
BELIZE		128.3 (B)	19.1 (B)	38.5 (A)	17.0 (A)	4.5 (B)				40 (c) (F)	19.2 (F)		
BRITISH VIRGIN ISLANDS		12 (I)	27.8 (I)	24.5 (I)	10.0 (A)	0.8 (E)			5.6 (A)				
CAYMAN		12 (I)	13.2 (I)	17.8 (I)		0.8 (E)			7.9 (B)	14.1 (c) (F)	2.0 (c) (B)		
DOMINICA	440 (C)	81 (B)	13.0 (B)	21.9 (B)		1.4 (B)			10.5 (B)	38.6 (p) (B)	12.1 (p) (B)		23.4 (B)
DOMINICAN REPUBLIC	530 (C)	110.4 (B)	13.4 (B)	29+ (A)	25? (A)	1.9 (B)	42 (C)	42 (C)	12.2 (B)	29.1 (c) (F)	10.6 (c) (B)	9.6 (A)	
GRENADA	550 (B)	825.4 (B)	14.7 (B)	50 (C)		5.8 (E)	33 (C)	33 (C)	12.2 (B)	43.0 (p) (C)	17.7 (p) (D)		
JAMAICA	1110 (C)	2200 (C)	15.8 (I)	15 (C)		4.2 (B)	31 (C)	31 (C)	11-14 (A)	31.1 (p) (B)	17.8 (p) (B)		
MONTSERRAT	745	11 (I)	13.5 (I)	38.6 (A)	33.4 (A)	1.5 (E)			14.6 (A)	19.8 (c) (B)	2.5 (c) (B)		
ST. KITTS-NEVIS	440	47.9 (B)	11.6 (B)	46.9 (A)	22.7 (A)	1.3 (E)			13.3 (A)	32.5 (c) (B)	6.9 (c) (B)		20.8 (B).
SAINT LUCIA	630 (C)	110.8 (B)	17.6 (B)	30.4 (B)	8.7 (A)	2.3 (B)	25 (C)	25 (C)	9.7 (A)	32.8 (p) (1974) (B)	4.2 (p) (1978) (B)	4.1 (A)	14.4 (B)
ST. VINCENT	350	100.4 (B)	16.7 (B)	64.4 (B)	20.9 (A)	4.3 (B)			10.4 (B)	22.7 (p) (B)	7.8 (c) (B)		40.9 (B)
SURINAME	2110 (C)	470 (C)	16.1 (I)	30 (C)		2.6 (E)	30 (C)	30 (C)					
TRINIDAD	2910 (C)	1067.0 (B)	12.1 (B)	25.6 (B)		1.5 (B)	37 (C)	37 (C)		36.8 (p) (B)	12.5 (p) (B)		
TURKS & CAICOS		6 (I)	15.8 (I)	17.5 (I)							<7 (F)		
WORLD LDC	560	3283003		110 (C)			34 (C)	34 (C)					
WORLD MDC	6260	1131000 (C)		20 (C)			111 (C)	111 (C)		16	0		
PAHO Regional Goal BY 2000				<30		<2.4							

*(c) = clinic sample
(p) = population sample

TABLE 2

COUNTRY	ANAEMIA		OVERNUTRITION			FOOD SUPPLY						
	% Anaemic		% Obese		Diabetes Mortality Rate (/100,000 age adjusted)	% Households with Adequate Diet			Total Food Available as % Recommended		% Nutrients Locally Produced	
	Pre-school (<11 g/dl)	Pregnant Women (<11 g/dl)	(>20% Ref. Wt) Women	Men		Energy	Protein	Iron	Energy	Protein	Energy	Protein
ANTIGUA					17 (A)							
BAHAMAS		33 (A)			5 (E)							
BARBADOS			32 (J)	7 (J)	21 (E)	42 (F)	58 (F)	39 (C)	130.1 (F)	174.4 (F)	42 (F)	24 (F)
BELIZE					10 (E)							
BRITISH VIRGIN ISLANDS												
CAYMAN	42.7 (C)				8 (E)							
DOMINICA					16 (E)	44 (<5 yr) (B)	82 (<5 yr) (B)					
GRENADA	38.0 (C)	1 (C)						42 (C)	70.7 (B)	107.0 (B)		
GUYANA	41.0 (C)	55 (C)	39 (J)	13 (J)		25 (F)	36 (F)	69 (C)	125.2 (F)	146.5 (F)	66 (F)	58 (F)
JAMAICA	76.0 (C)	45 (C)	24 (J)	5 (J)	26 (E)				112.3 (F)	158.1 (F)	54 (F)	38 (F)
MONTSERRAT		85										
ST. KITTS-NEVIS	21.6 (C)				7 (E)							
SAINT LUCIA	14.3 (C)	22 (C)	28	2.4	16 (E)	28 (F)	70 (F)	73 (C)	100.9 (F)	125.6 (F)	35 (F)	33 (F)
ST. VINCENT					21 (E)							
SURINAME	20 (F)				16 (E)				123.9 (F)	151.2 (F)		
TRINIDAD		(C)	28 (J)	12 (J)	37 (E)	60 (F)	69 (F)	66 (C)	108.0 (F)	134.9 (F)	51 (F)	29 (F)
TURKS & CAICOS												
WORLD LDC												
WORLD MDC			17-32 (TX) (J)	18 (TX) (J)	6.5 (N. Amer.) (E)				100 (H) 133 (H)			

Capital letters in brackets beside figures indicate data source

TABLE 3

COUNTRY	INFRASTRUCTURE		PROGRAMMES								
	Food & Nutrition Council	Nutrition Officer	Food & Nutrition Policy	Nutr. Surveillance System	Growth Charts in Use	National Breast-feeding Action Plan	Oral Rehydration in Use	Supplementary Foods through MCH	'Meal Planning for Diabetics' in Use	Tertiary Care for PEM based on 'Treatment Manual'	Community Health Aids employed
ANTIGUA	Yes	No	Draft	✓	Yes	Yes	Yes	Yes	Yes	Yes	Yes
BAHAMAS	No	No	No	No	Yes (A)	No		No	Yes		
BARBADOS	Yes	Yes	No	//	Yes	No		No	Yes		Yes
BELIZE	Yes	No	No	No	Yes	Yes		No	Yes		
BRITISH VIRGIN ISLANDS	No	No	No	No	Yes	No	No (A)		Yes		
CAYMAN	Yes	No	No	✓	Yes	No			Yes		No
DOMINICA	Yes	Yes	Yes	✓	Yes	Yes	Yes	Limited	Yes		
GRENADA	Yes (A)	Yes	Yes	//	Yes (A)	Yes	Yes	Yes	Yes	No (A)	
GUYANA	Yes	Yes	Yes	//	Yes	Yes		Yes	Yes		Yes
JAMAICA	No	Yes	Yes	//	Yes	Yes	Yes	Yes	Yes		Yes
MONTSERRAT	Yes	Yes	Yes	//	Yes	Yes	No	Yes	Yes		No
ST. KITTS-NEVIS	Yes	Yes	No	///	Yes (A)	No		Yes	Yes		No
SAINT LUCIA	Yes	Yes	Yes	//	Yes	Yes	Yes	Yes	Yes	Yes (A)	
ST. VINCENT	Yes	No	Draft	No	Yes	Yes	No	No	Yes	No (A)	
SURINAME	No	No	No	No	Yes	No	No	No			
TRINIDAD	No	Yes	No	No	Yes	No	Yes	No	Yes		
TURKS & CAICOS	No	No	No		Yes	No			Yes		No

Capital letters in brackets beside figures indicate data source

SOME FACTS ABOUT THE UNIVERSITY OF THE WEST INDIES

WHAT IS THE UNIVERSITY?

It began as the University College of the West Indies in 1949 but was granted University status in 1962. The University of the West Indies now grants its own degrees and is supported by and serves fourteen different territories in the West Indies. The territories which support the University and which send students for the various courses are

Antigua	Grenada
Bahamas	Jamaica
Barbados	Montserrat
British Honduras	St. Kitts-Nevis-Anguilla
British Virgin Islands	St. Lucia
Cayman Islands	St. Vincent
Dominica	Trinidad & Tobago

SITING OF THE UNIVERSITY CAMPUSES

The University consists of three campuses:-

Cave Hill in Barbados (established in 1963)

St. Augustine in Trinidad (established in 1960)

Mona in Jamaica (established in 1948)

In Jamaica the Mona campus consists of several departments and four Halls of Residence. The campus occupies 653 acres stretching from Papine to August Town. This land is leased by the governing bodies of the University from the Government of Jamaica for 999 years at a peppercorn rental. The Faculty of Medicine which is also sited on the Mona Campus includes the University Hospital of the West Indies, a teaching hospital, which caters to the people of Jamaica as well as other sections of the Caribbean.

HALLS OF RESIDENCE

There are four Halls of Residence which houses undergraduate students viz, Taylor Hall, Mary Seacole Hall, Chancellor Hall and Irving Hall.

FUNCTIONS OF THE UNIVERSITY

The University prepares persons for undergraduate and postgraduate degrees in Agriculture, Arts and General Studies, Education, Engineering, Law, Medicine, Natural Sciences, Social Sciences. It also awards Diplomas and Certificates in Public Administration, International Relations, Management Studies, Nursing Education, Nursing Administration, Social work, Mass Communications.

OPPORTUNITIES FOR LEARNING

In addition to its degree and diploma and certificate programmes, the University, through the Department of Extra Mural Studies provides adults and adolescents with opportunities for intellectual and cultural activities and prepares students for examinations such as GCE which serve as a stepping stone to higher learning.

STRUCTURE OF THE UNIVERSITY

The University is divided into eight Faculties - Arts & General Studies, Medicine, Law, Social Sciences, Natural Sciences, Education, Agriculture and Engineering. Each Faculty is headed by a Dean and Vice Dean. The Faculties are then split up into departments, each of which has a departmental head.

HOW THE UNIVERSITY WORKS

The University conducts its business through a series of committees which all report to Council, the highest body of the University. Members of Council include the Chancellor, the Vice Chancellor, Campus Principals and Deans of the Faculties.

Council normally meets once a year in the Main Administrative buildings at Mona with representatives from all the territories and University bodies. The next meeting of Council takes place on April 2nd and 3rd, 1982.

SOME IMPORTANT UNIVERSITY COMMITTEES AND WHAT THEY DO

COUNCIL

The highest governing body of the University. It receives and considers an Annual Report as well as an audited statement of Accounts of the work of the University each year.

THE SENATE

The Senate consists of University Officers including the Vice Chancellor, the Pro-Vice Chancellor, the Campus Principals, the Dean of the Faculties, the Professors, the Librarian and others.

The Senate is the academic authority of the University and exercises control and general direction for research instruction and examinations and the award of Degrees, Diplomas, Certificates and other distinctions.

FINANCE & GENERAL PURPOSES COMMITTEE

This Committee deals with all matters connected with the receipts and expenditure of money within the University and meets at least six times a year.

There are several other committees within the University in the various Faculties. These meet from time to time on their own, but they all report to the Senate Committee which sets guidelines for their activities, and a final report is submitted to Council each year.

TIME OF WORK AT THE UNIVERSITY

The bulk of activity at the University is conducted between 8:30 a.m. and 4:30 p.m. the normal working day, but the teaching departments continue well into the night with lectures and other activities.

...../3

THE PEOPLE IN CHARGE AND WHAT THEY DO

The Chancellor is appointed by Council and presides at meetings of this body, the graduation ceremony and performs such duties as may be conferred on him by the University Charter. The Chancellor may hold office for seven years.

The Vice Chancellor is also appointed by Council and holds office for a period decided by that body. The Vice Chancellor is the administrative head of the institution and exercises general supervision over the educational arrangements of the University. He is responsible to Council for the maintenance and promotion of good order and efficiency of the University.

Pro-Vice Chancellors act for the Vice Chancellor in his absence. Some have specific responsibilities eg security, development and planning, and research.

Deans of the Faculties are appointed by Senate on the nomination of the Faculty board. The Dean is the administrative head of the Faculty.

The Registrar acts as Secretary to the Council and the Senate and, through his staff, services all committees set up by the Council, the Senate and the Boards of Faculties respectively.

The University Bursar handles the University's accounts and receives all money on behalf of the institution.

SOME NAMES YOU SHOULD KNOW

The chief administrators at the University of Mona are:

The Vice Chancellor	Mr. A.L. Preston
The Pro-Vice-Chancellors	Prof. L.E.B. Robinson
	Dr. F.P. Aspinar
	Professor C.C. Lalor
The Registrar	Mr. C.E. Jackman
The University Bursar	Mr. L. Smith
The Bursar, Mona	Mr. L.F. Wilson
The Estate Manager	Mr. D.C. Charley
The Personnel Officer	Mr. K. Miller
The Deputy Personnel Officer	Mrs. Vianie Mills

UNIVERSITY OF THE WEST INDIES, MONA
PUBLIC RELATIONS OFFICE
3RD MARCH, 1982.

Appendix 8

Health Development, Planning, and Management Project (HDPM)

UWI

Curriculum Consultancy

December 1982

SUMMARY

In response to the needs of many Caribbean countries for improved health management capability, UWI will establish and refine over the next four years an On-Campus training programme in health management. This programme, coordinated with the In-Service Training and Development, Research, and Technical Assistance components of the HDPM Project in suporting national health development, will be a joint programme of the Faculties of Medicine and Social Sciences. The main participating departments are Government, Management Studies, and Social and Preventive Medicine. The programme will involve all campuses of UWI, as well as other contributing departments.

Although consideration was originally being given to the introduction of an undergraduate degree programme, in the light of subsequent discussions with a variety of persons, it has been agreed that an initial offering of an interdepartmental Diploma in Health Management would be more appropriate. Hence, it is proposed that such a programme should commence in October 1984, on both a full-time and part-time basis. Later, development of a certificate and/or degree programme might be undertaken. It is hoped that even while the phased implementation of the Diploma in Health Management (DHM) is taking place, the main participating departments would offer special modifications of existing diploma programmes in public administration, management studies, and community health that would serve as an interim response to the training needs of health managers in Caricom countries. In 1983-84 an initial health management course will therefore be offered.

The study programme in health management will integrate subjects in community health, management methods, social policy and health system organization, with the learning of appropriate and emerging techniques. Its objective will be to prepare students to function as health managers in the context of the changing health policies of the Caricom Countries, in a variety of roles in the upper and middle management levels of those national health systems.

The academic programme of the Diploma in Health Management (DHM) will, on a full-time basis, extend over one academic year and, on a part-time basis, over a minimum of two years. The programme will include five courses and will require completion of a field project following the end of the academic programmme. The inclusion of a six month internship requirement is to be considered.

Academic programme development will be linked with an educational process involving key health sector and related national programme development leaders and will draw on information support from the Institute of Social and Economic Research, on the resources developed by the HDPM Technical Assistance Component, and on HDPM support of faculty development.

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Emphasis in pedagogy will be on applicative problem-solving, interactive learning methods and techniques, based upon the student's firm understanding of the conceptual basis of health policy, management technology, and community health work. Appropriate materials, integrated into learning packages that are consistent with course structures and non-academic learning activities will be prepared, tested and utilized.

Policy guidance of the programme will continue to be provided by the HDPM project mechanisms of the Advisory Board and Executive Committee supported by the Curriculum Consultancy Team and Country Programme Committees. For continuing development of the study programmes, an interdepartmental curriculum working group has been formed. The group consists of:

Department of Government
Ms. Ina Barrett
Ms. Lynette Harris

Department of Management Studies
Mr. Locksley Lindo

Department of Social and Preventive Medicine
Dr. Marjorie Holding-Cobham
Dr. Winsome Segree

In-Service Training and Development
Dr. Phyllis MacPherson-Russell

Institute of Social and Economic Research
Dr. Omawale

HDPM Project Administrator
Mr. Richard Thelwell

Accessibility of academic learning opportunities in health management will be progressively increased by arrangement for part-time academic studies, by extension of the programme base into continuing education, and by utilization of the newer education and communication techniques, through a pattern that will involve all UWI Campuses and some of the non-Campus Countries. Complementary to such increased accessibility, the On-Campus health management educational effort will include provisions for management training modules to be integrated into the education of various categories of health and health-related professionals and para-professionals, as well as into their continuing education programmes, e.g., the undergraduate MBBS, Diploma in Public Health, Diploma in Community Health, and Family Medicine Residency programmes.

APPENDIX IV

Possible Sequencing of Subjects in a Five-Course Structure

HEALTH AND SOCIAL ORGANIZATION	POLICY ISSUES AND INSTITUTIONS IN	HEALTH MANAGEMENT PROCESS	HEALTH RESOURCES MANAGEMENT	ANALYTICAL METHODS FOR HEALTH MANAGEMENT
Concepts of Health Determinants of Health	Theories of State and Social Welfare Health in Development	General and Social Systems Theory Planning for Health	Health Financial Management	Health Status Measurement (Biostatistics)
Health System and Health Organization	Health Economics	Project Planning and Management Evaluation and Control (Communication)	Support Systems Development and Management Organizational Structuring	Analytical Methods-A
Institutional and Role Behaviors in Health	Health Law Ideological and Policy Issues	Information Management Marketing, Promotion and Coordination	Human Resources Development and Management (Communications) Operations Management	Analytical Methods-B

Key: 1. October-December Term, 2. January-March Term, 3. April-June Term

Appendix 9

HDPM PROJECT

The "First Course" in the DHM Programme

"HEALTH AND SOCIAL ORGANIZATION"

UNIVERSITY OF WEST INDIES

DEVELOPMENT WORKSHOP IN HEALTH MANAGEMENT AND PLANNING

at

Department of Health Service Administration
Graduate School of Public Health
UNIVERSITY OF PITTSBURGH
09/05/83 - 09/10/83

From Dean Faculty of
Social Sciences
February 1983

From Consultant Report
Maurice Schaffer, DPA
May 1983

BSS (M) P
36
1982/83

UNIVERSITY OF THE WEST INDIES

HEALTH DEVELOPMENT PLANNING AND MANAGEMENT PROJECT

PROPOSAL FOR INTRODUCTION OF NEW COURSE

It is proposed that the Faculties of Medicine and Social Sciences should jointly offer a course entitled 'Health and Social Organization', to begin in October, 1983. The course will be offered mainly through the Departments of Government, Management Studies, Sociology and Social and Preventive Medicine.

This course is intended as the initial component of a five-course programme leading to a Diploma in Health Management which is currently being planned. It is expected that these plans will be completed with a view to introducing this Diploma Programme in October, 1984.

The development and delivery of this course represents one aspect of the implementation of the Health Development Planning and Management Project, funded by the USAID through APHA and administered by the UWI. As members are aware (minutes of Faculty Executive Committee Meeting held February 9, 1982), the Project which commenced in 1982, was developed in response to the needs of the English-speaking Caribbean countries for strengthening and improving their health management capability.

While plans are being made to develop the curriculum for the other four countries, it is proposed that the course 'Health and Social Organization' will be offered on a full-time basis, as an optional course to students who are registering in the existing Diploma in Public Administration, or as an additional course in the Diploma in Management Studies, or as a special course to qualified persons practising in Health Administration who are desirous of improving their theoretical/conceptual knowledge of the health-related aspects of their administrative functions. The time-table for teaching and examining this course is being arranged to coincide with the University academic year. The time schedule will be finalized after a joint examination has been made of the teaching hours for the compulsory courses in the Diplomas in Management Studies and Public Administration.

Detailed planning, material development and scheduling are being pursued by the Curriculum Working Group of staff from both Faculties to whom we are grateful for producing the first draft of this paper.

Overall Course Objective

To provide the student with a knowledge of the Caribbean Health Sector and with the skills required for its effective management.

Specific Course Objectives

At the completion of the course the student is expected to:

1. Be aware of selected concepts of health,
2. Be able to identify various determinants of health and disease,
3. Have knowledge of, and be able to critically analyse the components of the health system and organization of the health services,
4. Have knowledge of institutional and role behaviours and be able to analyse role relationships in the health system and their influence in organizational effectiveness,
5. Be able to apply knowledge gained in the course to the solution of specific organizational problems in the health system.

Teaching Method

Since the content of this course will be mainly theoretical, the teaching method will be based on lectures and seminars. However, the didactic approach will be supplemented by use of the case study method by which students will be challenged to solve problems presented through information about situations drawn from 'real world' experiences.

Research for case study material is currently being carried out by the Institute of Social and Economic Research as a component of the HDPI Project.

Course Content and Syllabus are set out in an Appendix.

Qualifications for Admission to the Course

Any candidate for the Diploma in Public Administration or Diploma in Management Studies may register for this course as an option. The course may also be offered to specially admitted students who:

1. are graduates of an approved university, or
2. hold an approved technical or professional qualification from an approved body, or

3. have in the opinion of the University practical experience or other qualifications of special relevance to the course.

Examinations

Candidates will be subject to the rules and regulations governing the examination of students in the Diploma Programmes. If on registering, this course is added to the total Programme load, the grant of the diploma will not be dependent on his passing this extra course. If, however, the course is taken as an optional in the total programme, the candidate will be required to pass this course in order to qualify for the Diploma.

The Board of Studies is asked to recommend that approval be given to the introduction of the course, Health and Social Organization as an optional subject in the Diploma in Public Administration and the Diploma in Management Studies.

Dean, Faculty of Social Sciences

February, 1983

APPENDIX

1. Concepts of Health: Biological, physical and socio-cultural factors in definitions of health, environmental factors in health, individual and community health in the Caribbean setting, the role of the individual in the maintenance of health, health needs of various age groups.

   · 9 hours

2. Determinants of health and disease. Epidemiological principles and methods, ecological relationships to health embracing biological, chemical, physical and social environments, etiologies of some diseases important in the Caribbean. Awareness of the importance of health status measurements.

   · 15 hours

3. Health System and Health Services Organization: Principles of primary health care, health sector components and organization, inter-sectoral concepts of health system, demography as it relates to health services, public health systems, ideals and realities, governmental/private relations.

   · 21 hours

4. Health institutional and role behaviours: Social structures in health organizations and sectors; professions and professionalization, provider and patient roles, task allocations among providers, technological innovation, social innovation, organizational effectiveness.

   · 21 hours

DRAFT SEQUENCE OF TOPICS IN HEALTH & SOCIAL ORGANIZATION

1983 - 84

Introduction:

The following listing presents a compilation and revision of earlier suggestions by the writer and is provided as a point of departure for the U.W.I. Curriculum Working Group's efforts to arrive at a final specification for the course. This listing is subject to challenge on the basis of alternate logics and approaches to the subjects, factors particular to the Caribbean situation, and such circumstances as faculty or documentary availabilities.

Items marked with asterisks (*) are those on which additional information has been provided in a letter to R. Thelwell from M. Schaefer, dated February 9, 1983. A double asterisk refers to a communication to Dr. M. Holding-Cobham of December 1982 in relation to DPH/DCM teaching in the January - March term of 1983.

The listing assumes three contact hours per week.

Week No.	Topics
	Start of Michaelmas Term
1.	CONCEPTS OF HEALTH AND DISEASE
1.	Course Introduction and Overview Health as a Social Norm (Vickers **) Health as a Function of Growth and Ageing
2.	Medical Models of Health and Disease; Acute, Degenerative Socio-culterual Concepts of Health, Historical & Current
3.	Roles of Individuals, Community and the Health Services Individual and Community Health in the Caribbean

II. DETERMINANTS OF HEALTH AND DISEASE

4. Epidemiological Principles and Methods
5. Overviews of Health Determinants
   a. McKeown, Blum *
   b. Ecosystem Models *
6. Examples of Caribbean diseases linked to domestic/community environments
   Examples of Caribbean diseases linked to work environment and pollution
7. Examples of Caribbean communicable diseases (several types of vectors)
8. Examples of Caribbean diseases involving social transmission (STD, substance abuse, traffic accidents)
   Degenerative diseases in the Caribbean
9. Diseases in Relation to Lifestyle; Caribbean aspects; aspects of Social Class

   Summary of Module

10. (Student Performance)

End of Michaelmas Term; Start of Hilary Term

III. HEALTH SYSTEM AND HEALTH SERVICE ORGANIZATION

11. Health Protection and Promotion as a Societal Function
    Intersectoral Character of the Health System
12. Health Sector in Relation to Health System; Public and Private Sub-Sectors
    Primary Health Care Philosophy as Moving Sector toward System **
13. Primary Health Care Policies and Programmes in the Caribbean

14. Organization of Function of Health Care Institutions *
15. Issues in Health Care Organization *
16. Human Resources for Health *
17. Regulation and Financing of the Health Sector *
18. (Student performance)

IV. HEALTH INSTITUTIONAL AND ROLE BEHAVIOUR

19. Formal Organization Models; Sources of Deviation in the Health Sector
20. Alternative Models of Organization *

End of Hilary Term; Start of Trinity Term

21. Social Structures and Relations in Health Organizations*
    Professions and Professionalization *
22. Role of Science and Technology in Health; Impacts on Institutions, Providers and Clients *
23. Organization of Tasks and Personnel; Concepts of "Team" *
24. Motivation; Organizational and Social Innovation*
25. Organizational Effectiveness: Concepts, Criteria and Problems

26 - 30 (Student Performance; Case Problem in Organizational Effectiveness? Examination Period).

UWI - DEPARTMENT OF EXTRA-MURAL STUDIES

HEALTH DEVELOPMENT PLANNING AND MANAGEMENT PROJECT

TRAINING AND DEVELOPMENT COMPONENT
IN-SERVICE PROGRAMMES

ST. LUCIA AND BARBADOS

OCTOBER 1982 - SEPTEMBER 1983

The In-Service Programmes in St. Lucia and Barbados are being developed in accordance with the plans submitted in the HDM Project Document. The overall aim is to improve the capability of the health systems through personal development and organizational development over a two-year period. The main features of regular instruction and related assignments during the intervals, co-ordinated with supportive activities with staff groups supervised by the participants, are common to both programmes; but the organization is different as is the focus of the thrust.

In St. Lucia and in Barbados, considerable time and effort have been spent in securing consensus about the nature of the programme to be undertaken and in establishing a working relationship between Ministry of Health officials and UWI staff. Both programmes have been approved by the respective Country Programme Committee, after being accepted by the Advisory Board for inclusion in the Work Plan for Year 2. The Executive Committee is being asked to offer further comment and advice about the details presented in this document.

PROGRAMME IN ST. LUCIA

Preparatory Actions

Acting on the decision of the Advisory Board at the meeting on October 23, 1982, the Training and Development Co-ordinator has spent four weeks in St. Lucia during the period November, 1982 to February, 1983 in order to plan the details of the programme and arrange for the necessary administrative support.

In addition to the key personnel in the Ministry of Health - the Permanent Secretary, the Director of Health Services and the Medical Officer of Health - other Health officials have been included in the development of the programme. The opportunity has also been taken to brief the Minister of Education and the Minister of Community Development about the plans because of the importance of these two Ministries to the success of the efforts at the community level. The Director of Finance and Planning and the Director of Training have also been kept informed of the plans which are being developed.

Heads of Departments have participated in selecting the members of the National Team and have agreed to arrange release time needed for the Programme. A meeting with prospective members of the National Team was held on January 19, 1983. (See Appendix III)

Arrangements have now been made for secretarial services at the University Centre, but it has not been possible to employ a Staff Tutor (Health Management). Administrative support is available through the collaboration of the Resident Tutor and the cooperation of the Ministry of Health has been assured through the Permanent Secretary. The programme is being co-ordinated jointly by the Medical Officer of Health and the Training and Development Co-ordinator (HRH Project).

Focus of the Programme

The Government of St. Lucia is committed to making adequate Health Care available to all its citizens and to developing the concept of Primary Health Care as stated in the Alma Ata Declaration of 1978. During the period 1981 to 1985, it is intended to implement the policy of establishing six Health Districts for the delivery of Primary Health Care and a part of the implementation plan is increasing the management capability of Primary Health Care personnel by in-service training programme, supplemented by overseas training.

The HRH Project can support directly the efforts of the Government to increase its management capability through the In-Service Programme which aims to assist the Ministry of Health in the preparation of personnel to manage Primary Health Care and establish the system envisaged.

Design of the Programme

In order to meet the needs of the St. Lucia Ministry of Health and the targets of the HMM Project, the In-Service Programme has been designed to provide instruction and support for Health Workers at three levels - National, District and Community. Fifteen members of the National Team will participate in a programme consisting of seven one-week instructional modules, coordinated with field work related to the Health Districts, over a period of five to six months. The National Team will in turn conduct training and development activities to improve the managerial competence of Health Workers at the District and Community levels over a period of twelve to eighteen months, with support from the HMM Project. It is expected that some 150 persons in Health and Health-related agencies island-wide will be helped to improve their management capability and that the management requirements of Primary Health Care will be established.

During Year 3 of the HMM Project, members of the National Team will engage in a variety of activities to reinforce learnings and support change efforts.

Participants in the Programme

Four kinds of participants will be included in the Programme and play different roles.

1. National Team The fifteen persons selected to form the National Team are representative of the categories of Health Workers involved in Primary Health Care - Medical, Nursing, Environmental, Public Health Education (See Appendix 1) - and are distributed through all six Health Districts.

2. District Team Members of the District Team will include members of the National Team, who will perform special organizing and leadership roles, as well as other Health Workers in the District Hospitals and Health Centres and in the Environmental Health programme. Certain officers in the Ministries of Education, Community Development and Agriculture, who have District responsibilities, may also be included as members of the District Team.

3. Community Teams In addition to all the Health Workers who relate to a Health Centre, members of Community Teams will include personnel who work in Health-related Ministries and members of the Health Committees.

4. Senior Staff in the Ministry of Health Senior Administrative and supervisory staff have important roles to play in the conduct and supervision of the Programme. Specific inputs will be determined co-operatively, as the details are developed, especially in relation to the field work and activities at the District and Community levels.

Objectives of the Programme

In keeping with the over-all aim of the HLMI Project to increase the management capability of the Ministry of Health, the In-Service Programme has the following objectives which complement those that guide the work of the Ministry of Health in relation to PHC:

- To increase awareness and understanding of PHC, as it is being developed in St. Lucia
- To plan for the effective implementation of the Government's policy for PHC
- To prepare a group of persons to play differentiated roles in PHC
- To create a network of persons in Health and Health-related agencies committed to PHC
- To provide information about Health programmes
- To develop and establish policies and procedures for managing PHC
- To provide opportunities for developing and practising skills for increasing personal and organizational effectiveness.

Content of the Programme

The content is being defined within the framework provided by analysis of roles to be performed by participants at each level - National, District and Community. For the National Team, four roles have been identified.

- The personal role as an individual Health Manager
- The role of Health Manager as a Public Servant
- The role of Health Manager as a Technician
- The role of Health Manager as a District/Community Leader

In the performance of these roles, individual participants and the Team as a whole will need to acquire certain information and skills, develop or improve certain characteristics/behaviour and establish certain relationships.

Details of the content are presented in the attached Matrix (Appendix 1)

It is intended that the members of the National Team, in consultation with senior administrative and supervisory staff in the Ministry of Health, will refine this Matrix and develop similar Matrices to guide activities at the District and Community levels.

A basic tenet of Primary Health Care is the importance of the involvement of the individual in the promotion of health for himself his family and his community. To be consistent with this concept, the methodology used in the preparation of promoters of PHC must be based on involvement and participation. Hence, considerable emphasis will be placed on learner-centred approaches and on accountability in the learning process.

Schedule for the Programme

It has been agreed that members of the National Team, representing all six Health Districts, will participate in the In-Service Programme over the period February - July, 1983. However, it is expected that two new Districts will be established in 1983 and the remaining three will be established in 1984. The National Team will be available to assist in the development of each District as it comes on stream, while continuing to engage in appropriate on-going activities in their own District.

Dates have already been set for the modules to be conducted for the National Team in order to facilitate arrangements for release time. A proposal for some meetings at the District level has also been prepared, but this may need adjustment.

The schedule appears below:

NATIONAL TEAM

Module	1	Monday, February 28 - Friday, March 4	- 5 days
Module	2	Thursday, March 24 - Thursday, March 31	- 6 days
Module	3	Monday, April 25 - Friday, April 29	- 5 days
Module	4	Tuesday, May 24 - Friday, May 27	- 4 days
Module	5	Monday, June 20 - Friday, June 24	- 5 days
Modules	6 &7	Monday, July 18 - Friday, July 29	- 10 days
			35 days

DISTRICT TEAM

# 1 Week	1	Wednesday, June 1 - Friday, June 3	- 3 days
	2	Wednesday, June 8 - Friday, June 10	- 3 days
	3	Wednesday, June 15 - Friday, June 17	- 3 days
		Monday, July 4	- 1 day
		Thursday, August 4	- 1 day
		Thursday, September 1	- 1 day
			12 days
# 2 Week	1	Wednesday, June 29 - Friday, July 1	- 3 days
	2	Wednesday, July 6 - Friday, July 8	- 3 days
	3	Wednesday, July 13 - Friday, July 15	- 3 days
		Thursday, August 11	- 1 day
		Thursday, September 8	- 1 day
			11 days

Soufriere Health District will organise 14 days of work over 6 months, beginning after Module 2.

Resource Persons

The two co-ordinators - Dr. James St. Catherine and Dr. Phyllis Macpherson-Russell - will provide continuity in planning and executing the programme and will assume responsibility for the conduct of some modules or parts of modules. Dr. St. Catherine will be responsible for the Field Work.

Discussions have been held with Dr. Gumvale, Mrs. Ina Barrett and Dr. Marjorie Holding-Cobham at Mona and with Mr. John Mayers at Cave Hill to enlist their comments and support for planning and teaching. As the details are more firmly identified other UWI staff may be asked to assist.

Potential Resource Persons in St. Lucia are being considered and contact has been made with CARICOM in order to obtain assistance during the Field Work experiences.

Staff for Modules 1 and 2

The focus of Modules 1 and 2 will be on personal development and on the role of Health Managers in the Public Service. The planning and initiation of the Field Work will also be an integral part of these modules. The staff for Modules 1 and 2 are expected to be.

Co-ordinators: Dr. St. Catherine and Dr. Macpherson-Russell

Human Resources Development Consultant: Mrs. Shirley Fletcher

Administrator: Miss Una Clarke, Staff Tutor (Health Management), Barbados

In addition to Dr. St. Catherine, Ministry of Health officials closely associated with the development and implementation of the In-Service Programme are Dr. Cornelius Lubin, Permanent Secretary and Dr. Anthony D'Souza, Director of Health Services. The Heads of Departments are being invited to participate in the planning of the Field Work on the last day of each Module and to assist in supervising the activities agreed upon.

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PROGRAMME IN BARBADOS

Preparatory Actions

Acting on the decision of the Advisory Board at the meeting on October 23, 1982, the Training and Development Co-ordinator has spent two weeks in Barbados during the period November 1982 to January 1983 in order to plan the details of the programme and arrange for the necessary administrative support.

In addition to attending a meeting of the Country Programme Committee in November 1982, where the focus of the programme was officially accepted, the Training and Development Co-ordinator and the Staff Tutor (Health Management) have met with the Deputy Permanent Secretary, the Co-ordinator of the IDIM Project in the Ministry of Health, the Chief Medical Officer, the Chief Nursing Officer and the Senior Personnel Officer in order to arrive at firm decisions regarding the nature and design of the programme and the steps to be taken before beginning the modules in May 1983.

In order to secure the integration of the Programme in the on-going activities of the Department of Extra-Mural Studies in Barbados and the administrative and technical assistance of UWI Personnel at Cave Hill, the Training and Development Co-ordinator has had discussions with the Resident Tutor, the Staff Tutor, the Finance Officer and Head of the Unit of Administration and Accounting in the Faculty of Social Sciences.

It is proposed that, as the details of the Programme are developed during March and April, 1983, the opportunity should be taken to brief other members of the UWI and the Ministry of Health as well as the Minister of Health, and the Minister of Education. The briefing of the Minister of Health has become very important as there has been a change of Minister recently.

It has been agreed that an Officer in the Ministry of Health will be named to work directly with the Staff Tutor (Health Management) in order to facilitate the development and administration of the Programme.

Focus of the Programme

At a meeting of the Country Programme Committee on November 25, 1982, it was decided that the HMPM Project should support the Ministry of Health's efforts to increase the effectiveness of managing the Integrated Health Services. It was also agreed that the participants in the Programme would be respesentative of the services island-wide.

Design of the Programme

The Programme, which is intended to cover a two-year period, envisages the involvement of two groups of Health personnel - a Core Group of some fifteen senior managers and a Staff Group of some 150 persons from the divisions and institutions - whose input are vital to the maintenance of an effective, efficient service.

In order to accommodate the practical difficulties senior managers will experience in arranging to free themselves for active participation in this Programme, the plan for the Core Group calls for a series of short (one-day or two-day) seminars/workshops at regular intervals over an eight-month period beginning in May 1983. A total of 30 days of activity is being planned.

The programme for the Staff Group will be planned with the Core Group and implemented from September 1983. A total of 20 days of on-the-job activities is presently being contemplated and will involve all members of the Staff Group and Core Group in their respective divisional or institutional settings.

During Year 3 of the HMPM Project appropriate attachments will be arranged for members of the Core Group of senior managers in the Programme.

Participants in the Programme.

The selection of the participants in the Core Group is proceeding on the basis of the following criteria:

- Importance of position to success of the Programme
- Influence in the system
- Willingness to participate
- Availability for active participation

In order to secure maximum coverage of interests and develop workable agreements for action, the distribution of Core Group members within the following five categories of Health personnel will be taken into account:

1. Senior Professional and Scientific Group
2. Senior Nursing Administrative Group
3. Senior Technical Group
4. Senior Administrative Group (Ministry of Health)
5. Managers of Support Services

It is anticipated that each manager selected as a member of the Core Group will have about ten staff members with whom he/she works directly in a division or institution. Members of the Staff Group will be determined after the Core Group has examined the nature of the desirable activities to be undertaken within their locations.

Objectives of the Programme

The objectives of the Programme in Barbados have not yet been agreed upon as they must be reviewed when the participants have been selected. However, the programme will be consistent with the overall aim of the HMPM Project to increase the management capability of the Ministry of Health and the following objectives are in keeping with that aim:

- To provide an opportunity for senior managers to examine the management of the Integrated Health Services in Barbados and devise plans for improvement
- To develop greater understanding of the policies governing the Health Services
- To identify and examine obstacles to increasing managerial effectiveness and plan for alleviating the situation
- To acquire/improve skills to increase personal and organizational effectiveness
- To offer support for change over an extended period of time.

Content of the Programme

The Programme will focus on examining questions, issues, options related to the Management of Integrated Health Services; developing action plans; and instituting appropriate improvements.

The details of the seminars/workshops will be determined according to the needs identified by the participants; but, it is anticipated that the following topics or areas of study will form the basis for examining the roles and functions of Managers in the Integrated Health Services and provide opportunities to acquire knowledge, practise skills, make plans and initiate action:

- Health Laws and policies
- Personnel Management
- Time management
- Financial Management
- Planning
- Manpower Development
- Information Systems
- Communication Systems

Schedule for the Programme

Dates have not yet been fixed for the seminars/workshops, but the outline has been determined, as follows:

A. Core Group: May - December 1983

May - June	6 Days	3 two-day meetings
July - September	12 "	4 one-day meetings per month
October - November	8 "	4 one-day meetings per month
December	4 "	2 two-day meetings
	30 Days	

B. Staff Group September 1983 - July 1984

(i) 90 Participants

September	4 Days	4 days per month
October - March	24 "	per group of 10 - 20
	28 Days	

(ii) 60 Participants

January - July	20 Days	4 days per month per group of 10 - 20

Resource Persons

Because of the kind of schedule that is necessary for the Barbados Core Group Programme, the Training and Development Co-ordinator will not be present at all the seminars/workshops. It is expected that Miss Clarke (Staff Tutor) and Mr. John Mayers will provide the continuity needed in planning and executing the Programme in collaboration with the Ministry of Health.

Resource Persons will be determined according to the areas of study selected during the next two months. However, it is anticipated that staff at Cave Hill, Government Officers, private consultants and staff in Regional/International Organizations stationed in Barbados can provide the pool of persons with the expertise required.

Phyllis Macpherson-Russell
Training & Development Co-ordinator
IDPM Project

February 8, 1983

Appendix 10

APPENDIX 1

UNIVERSITY OF THE WEST INDIES - MINISTRY OF HEALTH, ST. LUCIA

HEALTH DEVELOPMENT PLANNING AND MANAGEMENT PROJECT

IN-SERVICE PROGRAMME FOR PRIMARY HEALTH CARE

NATIONAL TEAM

CATEGORY	HEALTH DISTRICT						
	CASTRIES	GROS ISLET	VIEUX FORT	DENNERY	SOUFRIERE	ANSE LARAYE	TOTAL
Medical Officer of Health	James St. Catherine						1
District Medical Officer				Martin Didier	Lincoln St. Prix		2
Family Nurse Practitioner			Leila Harracksingh			Marlene Lawrence	2
Nursing Supervisor	Una Thomas			Cecil Gibson			2
Public Health Nurse			Beatrice Vincent				1
Public Health Inspector		Marcel Fevrier	Russell Combie		Emmanuel Bobb	Joseph Medard	4
Family Life Educator	Josephine Aubertine						1
School Health Co-ordinator			Catheline Mathurin				1
Primary Tutor	Francis Barnett						1
Statistical Officer	Rosemarie Cooper						1
TOTAL	5	1	4	2	2	2	16

Co-ordinators. Dr. James St. Catherine
Ministry of Health

Dr. Phyllis Macpherson-Russell
UWI-HDPM Project

[illegible]	BUROCRAT	PUBLIC SERVANT	TECHNICIAN	DISTRICT/COMMUNITY LEADER
[illegible]			- project planning	
[illegible]	- Persons in National [illegible] - Officers in related ministries	- Head Office - MCL/other Govt. agencies (Edu. Agric. Comm. Dev.)	- Health Team (Hospital District, Health Centre) - Schools (principals, teachers) - Family Planning association - Related ministries	- Officers in related ministries - Church groups - Voluntary organisations - Farmers, fishermen, (occupational groups) - hotels, manufacturers, commercial groups
[illegible]		- Team spirit - - Commitment to PHC - Sense of urgency - Belief in success of PHC	- Persistence - Task-oriented - Helpfulness - Respect, appreciation	

[illegible] Russell/ [illegible] Catherine
Denmark, [illegible]

Appendix 10

APPENDIX 11

HEM: PROJECT - TRAINING AND DEVELOPMENT COMPONENT

FRAME-WORK FOR IN-SERVICE PROGRAMME DEVELOPMENT IN ST. LUCIA

AREAS	ROLES OF HEALTH WORKERS			
	PERSON	PUBLIC SERVANT	TECHNICIAN	DISTRICT/COMMUNITY LEADER
KNOWLEDGE	- Position in health hierarchy - Job description - Roles & responsibilities - HLMH Project support - Management theory	- Health Policy - PHC Plan - Financing of Health - Govt. Development Plans - Inter-agency mechanisms - Inter-Sectoral Co-ordination - Supply system - Incentive policies	- Health Programme - Health Targets - New procedures - H.I.S. - Referral system - Linkages between PHC/secondary & tertiary - Facilities - Personnel	- Research Surveys - Boundaries of District, Communities - Role of Govt. agencies in area and programme - Profile of Community resources
SKILLS	- Communications - Planning - Management Style - Organising skills - Decision-making	- Analysis of data - Interpretation of policies - Development of plans from policies - Budget preparation analysis	- Preparing materials for programmes - Demonstration, teaching - Presentation and Management of technical data - Investigations Maintenance of Supplies - Implementation - Management of resources	- Conduct of meetings - Planning programmes - Organising drives, surveys - Teaching - Making speeches, representations - Audience participation

UPDATE

on

HEALTH DEVELOPMENT PLANNING AND MANAGEMENT PROGRAMME

BARBADOS

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U.W.I - MINISTRY OF HEALTH, BARBADOS

HEALTH DEVELOPMENT PLANNIONG AND MANAGEMENT PROJECT

OFF -CAMPUS PROGRAMME

PARTICIPANTS BY AREAS

MINISTRY OF HEALTH	POSITION	DEPARTMENT
1. ALLEYNE, D.P.	Financial Controller	Accounts Section
2. BROWNE, Charley	Chief Public Health Officer	Public Health Inspectorate,
3. ESTWICK, McDonald	Superintendant of Works & Maintenance	Ministry of Health
4. MILLER, Beverley Rose	Senior Medical Officer	Ministry of Health
5. NURSE, Cortez	Chief Project Officer	Project Design and Implementation Unit
6. WALROND , Marjorie	Chief Public Health Nurse	Public Health Nursing Unit.
PUBLIC HEALTH		
7. CONLIFFE, Wilton	Senior Public Health Engineer	Public Health Engineering Unit
8. FERDINAND, Elizabeth	Medical Officer of	Maurice Byer Polyclinic
9. MUKERJEE, Dilip Kumar	Medical Officer of Health	Warrens' Polyclinic
10. SPRINGER, Talcie	Senior Health Sister	Black Rock Polyclinic
PSYCHIATRIC HOSPITAL		
11. BARRISTER, Patricia	Ag. Medical Superintendant	Psychiatric Hospital
12. GREENIDGE, Newlands	Hospital Director	• •
13. HOWARD, Emerson	Deputy Principal Nursing Officer	• •
QUEEN ELIZABETH HOSPITAL		
14. INNISS, Peggy	Principal Tutor	School of Nursing

...../2

PARTICIPANTS BY AREA CONTI.

Q.E.H CONTI.

15. MILLINGTON, Neville	Assis. Hospital Director	Q. E. H
16. RAMSAY, Dorothy	Assistant Matron	" " "
17. ST.JOUR-JOHNSON, Heather	Senior Medical Social Worker	" " "
18. YOUNG, Greta	Sister Recovery Room	" " "

NUTRITION CENTRE

19. YARDE, Elaine	Nutrition Officer

January 31, 1984
UWI: EMD:HDPM

DR. PHYLLIS MACPHERSON- RUSSELL - Training and Development Coordinator

MISS UNA CLARKE - Staff Tutor H.D.P.M

PART II

The second phase of the H.D.P.M (Barbados) Programme consists of Projects to be undertaken by Core-Group members individually or with other members for the purpose of improving some aspects of management related to the integration of the Health Services.

Under consideration are such projects as : -

- Continuity of Patient Care - Student Nurse oriented.
- Coordination of Services offered in Polyclinics.
- management of Nurses Records.
- Discharge Planning (Hospital Social Worker/ Public Health staff).
- Improvement of the Ministry's Transport System.
- The Geriatric Hospital - Historic review - one hundred years of service.
- Continuing In Service Education - Nutrition oriented.
- Development of the Planning Process in the Ministry using "Planning Cells"
- Improvement of working conditions and relationships - Polyclinic staff.
- Upgrading Environmental legislation - Environmental Engineering Division.
- Research Public Health problems with a view to improving Environmental Health.
- The final modules to precede this phase are - module 7 - Integration of Health Services - by Professor E.R.Walrond and Module 8 - Planning Change Effort - by Dr. P. Macpherson.

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Appendix II

LIST OF MODULES, DATES, TOPICS, COORDINATORS, RESOURCE PERSONNEL/ DESIGNATIONS

1983

MODULE I	DATES	MAIN TOPICS	COORDINATORS	PRESENTER /DESIGNATIONS
	June 29 - July 22	Management of Change	Dr. P. Macpherson	Dr. P. Macpherson - Training & Development Coordinatror H.D.P.M
MODULE II				
	Aug - 5 - 19	Health Policies and Health Planning	Mr. C. Nurse	Mr. C. Nurse - Chief Project Officer - Ministry of Health
MODULE III				
	Aug 26- Sept 2	Introduction to Health Laws - Mental Health Act	Miss Yolande Bannister	Chief Parliamentary Counsel
MODULE IV				
	Sept 9 - Oct 7	Financial Management	Mr. D.P. Alleyne	Mr. D.P.Alleyne Financial Controller -Ministry of Health
		- Supplies Management	" " "	Miss M. Quintyne- Supplies Officer - Q.E.H
		- Maintenance- Building /Equipment	" " "	Mr. L. Etheridge-Executive Engineer - Ministry of Health
		- Drug Supplies	" " "	Mr. L. Prescod, Assistant Drug officer
	OCT 14	Midway Evaluation	Miss U. Clarke	Miss U. Clarke-Staff Tutor HDPM
MODULE V				
	Oct 21 - Nov 11	Personnel Management	Miss U.Clarke, Mrs.A.Gollop & Mr. C. Yard	
		- Introduction -function of Ministry's Personnel	" " " " " "	Mrs.A. Gollop - Ag. S.A.O
		- Overview - Personnel Management	" " " " " "	Mr. C. Yard- Deputy P.S
		- Public Services Commissions	" " " "	Sir Carlisle Burton

Appendix II

DATES	MAIN TOPICS	COORDINATORS	PRESENTER /DESIGNATIONS
	- Public Services Regulations /Discipline	Miss U. Clarke, Mrs.A.Gollop and Mr. C. Yard	Mr. U. Parris - S.P.O
	- Civil Establishment Orders	• • • • •	Mr. F. Parris- Head of Civil Service
	- Personnel Management/ Industrial Relations	• • • • •	Mr. St.E Licorish and Mr. W. Spencer- Labour Dept.
	- General Orders / Disciplinary Rules	• • • • •	Mrs.Gollop, Messrs Yard, U. Parris & F. Parris
MODULE VI			
Nov 18- Dec 9	Introduction to Mangement Information	**Mr. John Mayers**	
	- Developing a Data Base [Systems	• • •	Management Studies U.W.I
	- Computers & Health Information [Systems	• • •	Miss Maxine McClean
	- Organisational Redesign	• • •	Mr. Stewart Bishop
	- Methods of appraisal -Overview of	• • •	Dr. Jamal Khan
	- Discussion, Review, Evaluation	• • •	Miss M. McClean Mr. Mayers etal.

January 31, 1984
UWI: END: EDPM

UNIVERSITY OF THE WEST INDIES/MINISTRY OF HEALTH & ENVIRONMENT TRINIDAD AND TOBAGO
HEALTH DEVELOPMENT PLANNING AND MANAGEMENT PROJECT
IN-SERVICE PROGRAMME

FEBRUARY 1984 - SEPTEMBER 1985

THEME OF THE PROGRAMME: Strengthening the Administrative System for the Promotion of Primary Health Care

PARTICIPANTS IN THE PROGRAMME:

I. A. The Core Group

COUNTY STAFF

1. Dr. Le Maitre - C.M.O.H. (Caroni)
2. Dr. G. Maynard -C.M.O.H. (St. Geo. Central)
3. Dr. Ramlal - C.M.O.H. (Victoria)
4. Dr. Dattadeen - S.M.O. (Pt. Fortin Area Hosp.)
5. Ms. S. Proctor - C.H.V. (St.A./St.D)
6. Ms. Y. Sylvester - Pharmacist (Caroni)
7. Mrs. Joseph - Health Educator (St. Patrick)
8. Mr. Rahaman - P.H.I. (Nariva/Mayaro
9. Mr. Yearwood - Social Worker (St. Geo. West)
10. Mrs. L. Romano - Area Administrator (St. Geo. East)

(Representatives of County Staff)

CENTRAL OFFICE (EXECUTIVE MANAGERS)

1. Dr. N. Andrews - P.M.O.(C.S.)
2. Dr. E. Laurent - P.M.O.(E.H.)

CENTRAL OFFICE (TECHNICAL MANAGERS)

1. Mrs. M. McShine - D.P.H.N.
2. Mr. Grandison - C.P.H.I.

(Senior Officers of County Staff)

1. Dr. Karen Sealey - Ag. D.P.H.S.
2. Mrs. Joyce Bicep - Economist, H.P.S.

1. Mrs. Rita Daniel - A.O.(V) Personnel
2. Mr. Parmanand - A.O.(IV) Personnel
3. Mr. K. Chung - A.E.II (Finance)
4. Miss P. Colthrust - A.O.(V) Administration

(Main areas of Administrative support for County Staff)

Total number of Core Group - 20

II. ADJUNCT GROUPS- DECENTRALIZATION

(b) Personnel

1. Miss Yvonne Smart - A.O.IV- Discipline
2. Ms. S. Bideshi - Ag. A.O.IV- (I-R)
3. Mrs. Vierra - A.O. IV - (E & S)
4. Mrs. G. Small - A.O. II - (R & P)

(c) Finance

1. Mr. Boodoosingh - Procurement Officer
2. Mrs. S. Taylor - Accountant III
3. Mr. Rajwant - Accountant Executive I
4. Mr. Cockburn - Manager, Central Supplies

(d) Planning

1. Mr. Bissram - Statistics
2. Mr. G. Harry - A.O. V
3. Ms. J. Worrell - A.O. IV

(e) Office & General Administration

1. Mr. L. Brown - A.O. IV
2. Ms. M. Blandin - A.O. II

III. ADJUNCT GROUPS - LINKAGES BETWEEN PRIMARY HEALTH CARE & HOSPITALS

(f) Institutions

NORTH

1. Dr. [illegible] Wong - H.M.D.
2. Dr. Pereira - Director, A/E
3. Mrs. Y. Cuthbert - Social Worker
4. Mrs. V. Heath - Junior Matron

SOUTH

5. Mrs. T. Huggins-Maurice - Matron
6. Mr. James - Hospital Manager
7. Dr. Yip Hoi - H.M.D.
8. Mrs. K. Foster - Matron

(g) Executive Managers

1. Mr. Bertram Ifill - P.S.
2. Dr. L. Quamina - C.M.O.
3. Miss V. Foster - P.M.O.

Central Office

Executive Managers

1. Dr. S. Lutchman - P.M.O.(I)
2. Dr. R. Dougloon - P.M.O.(E)

Technical

3. Mrs. E. Daly-Diaz- Nursing Superintendent(Curative)

IV. ADJUNCT GROUP - SPECIAL

(h) Special Officers

1. Mr. E. Guy - Train
2. Dr. M. Nichol - C.M.O.H. (Tobago)
3. Mr. Jacobs - O & M
4. Mr. Ali - Hospital Plant Engineer

Specific Objectives

- Identify major patterns in the historical evolution of health care systems in Jamaica, Trinidad and Tobago, Barbados, and St. Lucia.
- Analyse the political/administrative context for delivery of health care services in each of the four islands.
- Identify social and cultural patterns influencing health and health care utilization.
- Undertake a critical review of the evolution of public policy on health.
- Analyse the conomics of health services in each of the four islands.
- Analyse the role of multilateral and bilateral health agencies.

Suggested Outline of Partial or Terminal Reports of the General Sector Study

- Introduction and overview of the health care system
- Political-Administration system
- Health service administration and planning
  - Administrative Structure
  - Health Planning
  - Health Priorities
- Health status determinants (socioeconomic, cultural and political)

- **Economic and Financial Aspects of Health care**

  ___Personal payment
  ___Charity
  ___Industry
  ___Voluntary insurance
  ___Social insurance
  ___General revenue
  ___Problem areas

- Health Facilities

  ___Hospitals - public and private
  ___History of hospitals
  ___Hospital functions and trends
  ___Hospital administration and financing
  ___Regionalization of health facilities
  ___Health centers and other facilities
  ___Problem areas

- Delivery of Preventive Services

  ___Environmental control
  ___Communicable disease control
  ___Maternal child health services
  ___Family planning
  ___Other preventive programs
  ___Problem areas

- Health Care Regulations

  ___Review of health legislation
  ___Regulation of health professionals
  ___Regulation of other health care resources
  ___Regulation of health care performance
  ___Problem areas

- Health Planning

  ___The role of government in health care delivery
  ___The role of the private sector in health care delivery
  ___Problems of co-ordination and control

- Formulation of a Research Agenda for the Future

- Conclusions

CARIBBEAN COMMUNITY HEALTH MANAGEMENT

QUESTIONNAIRE FOR STATE OF THE ART STUDY

BACKGROUND

1. Describe the part played in the management and the delivery of health services by (a) local government authorities (b) community health committees.

2. What is the extent of the contribution of the private sector in Health Services in your country?

3. Describe the use of Boards/Committees/Councils in Health Services in your country.

4. List 5 outstanding historical features or land marks in the development of Health Services of your country.

5. Suggest 5 topics for research in Health which would be of benefit to your country or the Caribbean region.

6. What was the effect of the report of the W.I. Royal Commission (Moyne Report) on health services in your country?

7. List the subjects other than Health in the portfolio of your Minister responsible for Health.

8. Describe any mechanisms, formal or informal, which exist for intersectoral coordination or cooperation in health matters in your country.

9. Do you see any room for the improvement of intrasectoral (i.e. within your Ministry of Health) coordination?

10. Describe the benefits, real or potential, which accrue from membership of (a) CARICOM (Health Desk and Health Ministers' Conference) and (b) the PAHO Caribbean Coordinator's Office.

11. Describe the progress of Medical Social Work in your country.

12. Describe the organisation of Health Education in your country.

13. To what extent are the public information media used for promoting health:- regularly, occasionally, at crisis or special events only?

14. Indicate the prevalence of Health Insurance through private Insurance Schemes in your country?

15. What, if any, is the extent of health coverage in the National Insurance (Social Security) Scheme?

16. What progress has been made with plans for a national health service?

17. What is the role of the Ministry of Health in preparedness against natural and man-made disasters?

HEALTH SECTOR PLANNING AND RESEARCH

1. Identify the key actors in the Health Planning process by completing the attached MATRIX of organisational Units/ Decision Levels.

2. Identify the roles played in the planning process by:-

   - private sector organisations

   - para-statal organisations (statutory Boards etc.)

   - the general public (community participation).

3. Is there a separate Planning Division/Unit/Section? If so, how is it organised?

4. What is the machinery for harmonizing the health sector plan with the wider national Development Plan?

5. What arrangements exist for intersectoral coordination?

6. What arrangements exist for intra-sectoral coordination?

7. What are the plans for achieving the objectives of "HEALTH FOR ALL BY YEAR 2000"?

8. Do you see a role for the Caricom Health Desk in the Planning process? If so, elaborate.

9. Suggest areas of research which you think would improve -

   (a) delivery of health care

   (b) general management in health.

10. What organisational arrangements exist for health research.

11. How are research efforts funded?

HEALTH SECTOR FINANCING

1. Give comparative data on Current Expenditures over past five fiscal years as it related to the overall national budget as follows:-

FISCAL YEAR	HEALTH SECTOR ALLOCATION $	NATIONAL BUDGET $	% OF NATIONAL BUDGET
1978-79			
1979-80			
1980-81			
1981-82			
1982-83			

2. Give a breakdown of the distribution of the Health Sector budgetary allocation among the major sub-sectors. E.G. Hospital Services, Health Centres, Drugs, Health care facilities (structures), Health Education and Training etc.

3. List the major sources of Health Sector financing e.g. National Annual Estimates, external financing (indicating Loan/Donor Agencies), etc.

4. List the major sources of Health Sector Revenues.

5. List the major Health Care Facilities constructed or otherwise established over the past five (5) years and indicate approximate costs.

6. Give comparative data on Capital Expenditure over past five fiscal years as it related to the overall National Capital Budget as follows:-

FISCAL YEAR	HEALTH SECTOR CAPITAL BUDGET $	NATIONAL CAPITAL BUDGET $	% OF NATIONAL BUDGET
1978-79			
1979-80			
1980-81			
1981-82			
1982-83			

7. Give comparative data showing Personal Emoluments (salaries, wages, etc.) as a percentage of annual health sector budget over past five (5) years.

FISCAL YEAR	NATIONAL BUDGET $	HEALTH SECTOR PERSONAL EMOLUMENTS $	%
1978-79			
1979-80			
1980-81			
1981-82			
1982-83			

HEALTH MANAGEMENT INFORMATION SYSTEM

1. What organisational arrangements exist for health information? For example, is there a separate unit for conducting public relations connected with health development and health delivery?

2. Are there any mechanisms for feedback from the community concerning the relevance of services and service hours?

3. What mechanisms (Committees etc.) exist for facilitating the flow of information among the various health sector organisations/institutions.

4. What arrangements exist for the collection, storage and retrieval of health information. For example, is there a computerized system for data collection etc.?

5. Is there a unit for the processing of health statistics? If so, how is it organised?

6. How is the health information system geared to meeting the strategy of Health for All by year 2000?

7. Are there any arrangements for the exchange of information with other health administrations within the Region?

8. Describe briefly the role played by the media in the health information system.

HUMAN RESOURCE SYSTEMS

1. Describe the procedures (negotiation and legislation) for obtaining additional staff positions in the Ministry of Health.

2. Describe recruitment, selection and appointment procedures/ mechanisms.

3. To what extent does the Ministry of Health participate in (a) terms and conditions of service (b) appointments (c) discipline of staff.

4. (i) List the agencies and courses used in the past five years for training of staff, especially management staff.

   (ii) If available give statistics of management training at middle and senior levels.

   (iii) To what extent have the persons trained in management been able to influence or assist the delivery of services?

5. To what extent has Health suffered from brain-drain to (a) other government agencies (b) the private sector (c) abroad.

6. Does Health exercise any personnel powers by delegation from central authorities?

7. List 5 problems experienced in personnel management.

8. What is the extent of unionisation of Health staff?

9. List the professional organisations in Health and say whether they operate as professional organisations fully or also attend to Union problems.

10. Give a list of new types of staff introduced in your country within the past ten years.

11. What are the superannuation benefits receivable by health staff from Government Pension Legislation and National Insurance (Social Security) Legislation.

12. List any manpower surveys that have taken place in the past ten years.

13. List your suggestions for improving personnel management in Health or alternatively suggest topics in personnel management for research.

14. To what extent do you think that current training courses for middle and senior health managers provide adequate orientation to -

(i) legal systems;

(ii) financial systems;

(iii) economic and social systems;

(iv) modern technological aids to management science.

NON-HUMAN RESOURCE SYSTEMS

1. Is there a Central Government Supply/Purchasing system to which the Ministry of Health must conform?

2. Are there any exemptions from the use of the Central Supply Department? For example, can Health purchase directly specialist items such as medical equipment or drugs?

3. What constraints do you identify as militating against an effective supply management system.

4. List any reports which have been made concerning the operation of Health and medical supply systems.

5. Describe the system of accountability for public funds.

6. What is the date of the most recent legislative order for (a) Financial Rules/Regulations (b) Supply Rules/ Regulations.

7. Are the Financial Regulations and the Supply Regulations considered to be up to date?

8. How does the Ministry of Health get its buildings and equipment maintained?

9. What constraints, if any, can you identify as militating against the effectiveness of the system for maintenance?

10. Would a set of model Health Laws developed by CARICOM be of any use to the Ministry of Health?

11. What is the present use or, in your opinion, the potential of electronic data processing equipment and word-processors in Health for (a) programs (b) records (c) management of financial resources (d) personnel.

RESEARCH ON MANAGEMENT OF HUMAN RESOURCES IN THE HEALTH SECTOR IN THE COMMONWEALTH CARIBBEAN

Terms of Reference

1. Objectives

a) To analyze the historical development and main characteristics of the human resources management function in the health sector of the English-speaking Caribbean;

b) on the basis of the above, to propose policy prescriptions aimed at significant improvement in the attainment of organizational goals.

2. Scope

a) To examine and analyze present structure and operation of the human resources management function in the health sector of at least 5 territories of the region, possibly Jamaica, Trinidad and Tobago, Barbados, St. Lucia and Belize to determine the historical and current obstacles to the optimum utilization of available human resources by means of interviews of appropriate officials and study of relevant documents;

b) to obtain relevant data on the region through consultation with such regional organizations as CARICOM, CARICAD, OECS, AND UWI;

c) to examine previous recommendation on this subject made by regional and international agencies, especially CARICOM, WHO, PAHO, IBRD and USAID to determine the degree of implementation of policy prescriptions;

d) to elaborate proposals for corrective action within the framework of existing constitutional arrangements of regional public services and with due regard to the current budgetary constraints within the region;

Q.46 Are you employed in the government or private sector? (Circle number)

1. GOVERNMENT ---------- Please skip to Q.50
2. PRIVATE

IF PRIVATE

Q.47 Were you ever employed in the civil service?

1. YES
2. NO

IF YES

Q.48 What was your last post in the civil service?

_____

Q.49 How long were you in the civil service? (years)

_____

IF CIVIL SERVICE

Q.50 Do you presently work on a part-time basis on your own account or for others outside of the Civil Service?

Thank you very much for your co-operation and patience.

HEALTH DEVELOPMENT PLANNING AND
MANAGEMENT PROJECT

MANAGEMENT OF HUMAN RESOURCES
IN THE HEALTH SECTOR OF THE
COMMONWEALTH CARIBBEAN

This survey is being done in order to get a better understanding of how employees in the health sector feel about the management of human resources in their area of work. Please use a pencil and answer all questions. If you wish, you may write additional comments in the margin or the blank spaces. These comments are welcome and will be taken into account.

THANK YOU FOR YOUR HELP

Appendix 16

Appendix 16 . 7 of 2

Q.1 Do you generally get up to date information on matters which affect you at work, such as new policies, regulations on employee benefits? (Circle number)

1. REGULARLY
2. SOMETIMES
3. HARDLY EVER
4. NEVER

Q.2 Do you find that personnel matters concerning you, such as leave, promotion and training have generally been dealt with quickly? (Circle number)

1. VERY QUICKLY
2. FAIRLY QUICKLY
3. FAIRLY SLOWLY
4. VERY SLOWLY

Q.3 Which of the following is generally true about your job? (Please tick those you think are true)

	Tick
1. THE SECURITY OF EMPLOYMENT IS QUITE GOOD	___
2. THE PRESTIGE OF THE JOB IS QUITE HIGH	___
3. THE CHANCES FOR PROMOTION ARE QUITE GOOD	___
4. THE WORK IS INTERESTING	___
5. LEAVE AND VACATION BENEFITS ARE QUITE GOOD	___
6. THE PAY IS NOT BAD	___
7. THE HOURS ARE CONVENIENT	___
8. THE PHYSICAL WORKING CONDITIONS ARE QUITE GOOD	___
9. YOU HAVE TIME TO DO THE JOB PROPERLY	___
10. YOU HAVE ENOUGH AUTHORITY TO DO THE JOB	___
11. TRAINING AND EDUCATION IS AVAILABLE	___

Q.4 All in all, how satisfied would you say you are with your job? (Circle number)

1. VERY SATISFIED
2. QUITE SATISFIED
3. NOT VERY SATISFIED
4. NOT SATISFIED AT ALL

Q.5 Up to now, have you seen yourself as having a life time career in the civil service? (Circle number)

1. YES
2. NO
3. NOT DECIDED

Q.6 What single thing would most make you want to leave the health field?

_____

_____

Q.31 When did you start working in this post?

19___

Q.32 When did you start working in the health field?

19___

Q.33 What is your present annual gross salary (earnings)

_____

Q.34 In terms of the importance of your kind of work rather than the gross annual salary you feel you should be getting?

_____

Q.35 What is the highest level of education you have reached? (Circle number)

1. PRIMARY WITHOUT QUALIFICATIONS
2. PRIMARY WITH QUALIFICATIONS
3. SECONDARY WITHOUT CERTIFICATE
4. SECONDARY WITH CERTIFICATE
5. COLLEGE
6. UNIVERSITY UNDERGRADUATE
7. UNIVERSITY POSTGRADUATE

Q.40 What are the highest training or academic qualifications you have received?

_____

Q.41 What is your marital status? (Circle number)

1. MARRIED
2. SINGLE - NEVER MARRIED
3. DIVORCED
4. WIDOWED
5. SEPARATED

Q.42 Do you have any children? (Circle number)

1. YES
2. NO

Q.43 Sex (Circle Number)

1. MALE
2. FEMALE

Q.44 Age _____

Q.45 Have Education (Circle number)

Q.27 Are you presently acting in your post? (Circle number)

1. YES
2. NO

Q.28 Are you satisfied with your rate of promotion? (Circle number)

1. VERY SATISFIED
2. FAIRLY SATISFIED
3. NOT VERY SATISFIED
4. NOT AT ALL SATISFIED

Q.29 Do you have a performance evaluation system by which you are rated by your supervisor on the quality of your work? (Circle number)

1. YES
2. NO → If no, please skip to Q.31

IF YES:

Q.30 Do you have regular or on-going assessments by your supervisors or in the course of the year? (Circle number)

1. YES
2. NO
3. DON'T KNOW

Q.31 Do you think the present system of job classification adequately takes into account the scope and importance of the work you do, relative to other grades in the health field? (Circle number)

1. VERY ADEQUATELY
2. FAIRLY ADEQUATELY
3. NOT VERY ADEQUATELY
4. NOT ADEQUATELY AT ALL

Q.32 Do you find that those in senior management in the health field have sufficient knowledge of the work you do to give adequate guidance? (Circle number)

1. HAVE ENOUGH KNOWLEDGE
2. HAVE SOME KNOWLEDGE BUT NOT ENOUGH
3. HAVE INADEQUATE KNOWLEDGE

Q.33 Can you list the main obstacles to adequate recruitment of trained staff in your field?

_____

_____

_____

Q.34 What is your present substantive post and classification grade?

_____

Q.7 Are you satisfied with the possibilities for further training in your area of work? (Circle number)

1. VERY SATISFIED
2. FAIRLY SATISFIED
3. NOT VERY SATISFIED
4. NOT AT ALL SATISFIED

Q.8 Have you received any form of training since you joined the health field? (Circle number)

1. YES
2. NO → If no, please skip to Q.12

IF YES:

Q.9 Have you received any in-service training, on-the-job training, or training in special seminars, workshops or courses? (Circle number)

1. YES
2. NO

IF YES Please indicate areas in which training was received

	TICK
1. TECHNICAL OR APPRENTICESHIP	___
2. SECRETARIAL	___
3. CLERICAL/OFFICE METHODS	___
4. ACCOUNTING	___
5. MANAGEMENT	___
6. PARA-PROFESSIONAL/PROFESSIONAL	___

Q.10 When was the last time you received training?

19__

Q.11 After your training did you find that you were able to use your new skills and knowledge? (Circle number)

1. YES
2. NO

Q.12 Please list the areas of in-service/on the job training which you think are most needed at this time.

_____

_____

_____

Q.13 Have you received any long-term advanced training lasting one academic year or more and leading to academic qualifications such as certificates, diplomas and degrees, since joining the health field? (Circle number)

1. YES
2. NO → If no, please skip to Q.17

Appendix 16 III A 3 ct'd

Q.14 Was the most recent training conducted locally or overseas? (Circle number)

1. LOCALLY
2. CARIBBEAN
3. U.S.A.
4. CANADA
5. U.K.
6. OTHER

Q.15 Did this training relate to work you were doing before or did it fit you for work in other fields? (Circle number)

1. WORK YOU WERE DOING
2. WORK IN OTHER FIELDS
3. BOTH

Q.16 On your return to the service did you find that your work assignment allowed you to fully use your new training? (Circle number)

1. YES
2. NO

Q.17 List the areas of advanced training which you think are most needed at this time.

_____

_____

_____

Q.18 In your experience is the length of temporary employment a problem in the health field? (Circle number)

1. A VERY BIG PROBLEM
2. A FAIRLY BIG PROBLEM
3. A SMALL PROBLEM
4. NO PROBLEM AT ALL

Q.19 Are you permanently appointed, on probation, temporary or on contract? (Circle number)

1. PERMANENTLY APPOINTED
2. ON PROBATION
3. TEMPORARY
4. ON CONTRACT OR PROJECT

Q.20 Is shortage of staff a problem in your section? (Circle number)

1. A VERY BIG PROBLEM
2. A FAIRLY BIG PROBLEM
3. A SMALL PROBLEM
4. NO PROBLEM AT ALL

Q.21 Given the circumstances, in your area of work, do you feel that the available personnel are efficiently utilized? (Circle number)

1. VERY INEFFICIENTLY UTILIZED
2. INEFFICIENTLY UTILIZED
3. EFFICIENTLY UTILIZED
4. VERY EFFICIENTLY UTILIZED

Q.22 In your experience, how quickly are vacancies in your section filled? (Circle number)

1. VERY QUICKLY
2. FAIRLY QUICKLY
3. FAIRLY SLOWLY
4. VERY SLOWLY

Q.23 In your area of work is there a system by which future vacancies by way of retirements and termination of contracts are identified as early as possible? (Circle number)

1. YES
2. NO
3. DON'T KNOW

<u>IF YES</u>:

Q.24 Does this system operate on a regular basis? (Circle number)

1. REGULARLY
2. SOMETIMES
3. HARDLY EVER
4. NEVER

Q.25 In your experience, how long does it usually take for your section to get replacement for staff who have left? (Circle number)

1. IMMEDIATELY
2. LESS THAN THREE MONTHS
3. THREE TO SIX MONTHS
4. SIX MONTHS TO ONE YEAR
5. OVER ONE YEAR
6. ONE TO TWO YEARS
7. DONT KNOW

Q.26 Is inadequately trained staff a problem in your section? (Circle number)

1. A VERY BIG PROBLEM
2. A FAIRLY BIG PROBLEM
3. A SMALL PROBLEM
4. NO PROBLEM AT ALL

SERVING SOCIETY

Appendix 17

AMERICAN PUBLIC HEALTH ASSOCIATION
1015 Fifteenth Street, N.W., Washington, D.C. 20005 • (202) 789-5600

PROTECTING HEALTH

MEMORANDUM

TO: Sarita W. Henry
S&T/Health AID

DATE: June 15, 1983

FROM: Dr. Alfred N. Gerald
Program Manager, IHP

SUBJECT: Request Approval for Nomination of Consultant, for Travel, and for Mission or Regional Clearance under Contract AID/DSPE-5901-A-00-1039-00.

Name of Consultant: Barry Chevannes, MA, MSc, PhD
CV attached

Nature of Assignment:

1) The consultant will study, in collaboration with the ISER Senior Research Fellow, the socio-economic and socio-political factors of importance to the successful design and implementation of a management system for integrated health care delivery at the parish level.

2) Specifically, the consultant will interview key personnel, including consumers, in the health care system, review relevant documents, published and unpublished, and generally observe the operation of the management system in order to identify potential constraints and strengths.

3) The consultant will submit an interim report to ISER 4 weeks after the commencement of the assignment. If the study is incomplete after 8 weeks from the commencement, another interim report should be submitted at that time. The final report must be submitted not later than 3 months from the start of the assignment.

Date/Duration of Assignment: Commence in June for 30 working days.

Country of Assignment: Jamaica

APPROVED: Sarita W. Henry
Sarita W. Henry, S&T/Health AID

Remarks: See attached letter

Date: June 17, 1983

TERMS OF REFERENCE

JAMAICA COUNTRY SPECIFIC STUDY

A HEALTH CARE MANAGEMENT SYSTEM AT THE PARISH LEVEL

The Consultant is expected to work with the ISER Research staff and the concerned Ministry officials to achieve the following:

1. To review previous work on the subject of Health Care Delivery Systems at the parish level in Jamaica.

2. To examine the legal, institutional and other factors pertinent to the project.

3. To interview Ministry officials and otherwise collect additional information required to produce a complete documentation of the existing situation at the parish level.

4. To identify operational constraints which impede efficient and effective delivery of Health Care at the parish level.

5. To formulate recommendations for an improved management system.

6. To present the results of the above together with implementation plan to the HDPM Country Programme Committee.

7. To prepare a final report.

OUTPUTS

1. The Consultant/ISER is expected to submit a detailed protocol for the study.

2. The Consultant/ISER will be expected to deliver an interim report at the completion of item 4 above. This report will provide a basis for discussion with Ministry officials and project personnel.

3. A final report with an executive summary and a detailed implementation plan of the agreed recommendations is expected by the end of June.

4. Three copies of all reports should be submitted to the Project Administrator.

Appendix 19

INTERISLAND
Architects and planners

PO BOX 697 o RODNEY BAY o CASTRIES o ST LUCIA WI o TEL 20430 o CABLE INTERARCH

16th March, 1983

Mr. R. Thelwell,
H.D.P.M. Project,
University of the West Indies,
Mona Campus,
Mona, JAMAICA

Richard,

As promised in our conversation of the 15th March 1983 I forward terms of reference formulated for the one-man month consultancy project on Solid Waste Management.

Evaluation & Documentation Process

1. The evaluation of existing proposals in the many recommendations made to the Government of St. Lucia; a review of existing policies and methods and their alternatives;

2. Refuse Collection and Disposal System Data;

3. Outlining of emerging conditions and problems, and the generation of new proposals;

4. An examination of Management processes and structures.

The Formulation of a Solid Waste Management Programme

5. The development of a Bankable Solid Waste Project

Follow up Consultancy

6. The generation of in-depth proposals for the Management of the Solid Waste Management Programme.

The terms of reference include item 1. to 5.

Yours sincerely,

Paul Kipling

Health Development Planning and Management Information Project.

Methodology

The Programme Committee has requested that the research must attempt to answer the following questions:

- What are the information needs of the Community services with respect to management and planning.
- What are the appropriate forms of organization and technology that must be adopted to meet the needs identified.

Problem Definition

We must first of all recognise that information is being collected and fed into the system; that such information is already being used for management and planning; and that there is already in place an organizational structure which treats the information.

Task I Our first task is to define clearly the existing organizational structure, and to chart carefully the information flow throughout the structure.

We must define the organizational chart as it exists in theory. Chart the information flow along this structure.

Define bottlenecks unofficial information routes, nonfunctioning routes.

We will, thus, have outlined the existing position, both as it is defined on paper and as it actually functions.

Task II We will then need to clarify this outline. We will investigate carefully the information needs at each level.

Catalogue the differences between actual and expected needs at each level.

Assess attitudes, and weigh opinions on the efficiency of the current system.

Task II (Cont'd)

When we will have finished the above tasks, we will have a clear idea of what information is being collected; and of what information flows where, and why. Only then can we determine what other data (if any) needs tobe collected.

Management Structure Redefinition

Difficulties in the operation of a management information system can be due to faulty organizational structure; to malfunctioning of an inherently well-designed structure; or to a lack of data inputs.

Task III The next task, therefore, is to present to appropriate authority an analysis of those structural other faults which prevent the efficient flow of adequately-presented information.

It will be necessary to have some feedback on what structural changes are unlikely (because of social, political or other factors).

In assessing what needs to be done, we expect to receive some guidelines from previous studies. We will expect to use any appropriate findings from the Peat, Marwicke Mitchell study.

MIS Design

At this stage we would have presented a paper on the methodology for the second part of the assignment.

The next group of tasks will involve the actual design of an MIS and the assessment of appropriate technology.

We propose to use one country, and one health center in it, to test what we propose.

TIMING

We propose to spend not more than 7 man days (out of the short 24 given to the project) on the tasks in the first part, and to carry this out after whatever period the meeting of busy health officers will permit.

P Morris