

**IIC DATA SHEET****1. CONTROL NUMBER**  
PN-AAJ-588**2. SUBJECT CLASSIFICATION (698)**  
NC00-0000-G326

of a low-cost in-service training program for primary health care workers in  
Jamaica, 1978-1980; final report  
ORS (100)

**3. CORPORATE AUTHORS (101)**

Johns Hopkins Univ. School of Hygiene and Public Health

**6. DOCUMENT DATE (110)**

1981

**7. NUMBER OF PAGES (120)**

314p.

**8. ARC NUMBER (170)**

JM610.6953.J65

**9. REFERENCE ORGANIZATION (190)**

Hopkins

**10. SUPPLEMENTARY NOTES (500)**

(Includes Casebook of guidelines for in-service training of primary health care team, by  
Willie Mae Clay-Brown)

**11. ABSTRACT (950)****12. DESCRIPTORS (920)**Health personnel  
Medical personnel  
Community health servicesTraining methods  
Health educationJamaica  
Public health**13. PROJECT NUMBER (150)**

532004000

**14. CONTRACT NO. (140)**

AID/1a-C-1233

**15. CONTRACT  
TYPE (140)****16. TYPE OF DOCUMENT (160)**

JM  
610.6953  
J65

**THE JOHNS HOPKINS UNIVERSITY**  
**SCHOOL OF HYGIENE AND PUBLIC HEALTH**  
*615 North Wolfe Street • Baltimore, Maryland 21205*



**DEVELOPMENT OF A LOW-COST IN-SERVICE TRAINING PROGRAM  
FOR PRIMARY HEALTH CARE WORKERS IN CORNWALL COUNTY, JAMAICA  
1978-1980**

**Final Report of AID Contract No. AID-c-1233**

**"HEALTH IMPROVEMENT FOR YOUNG CHILDREN"**

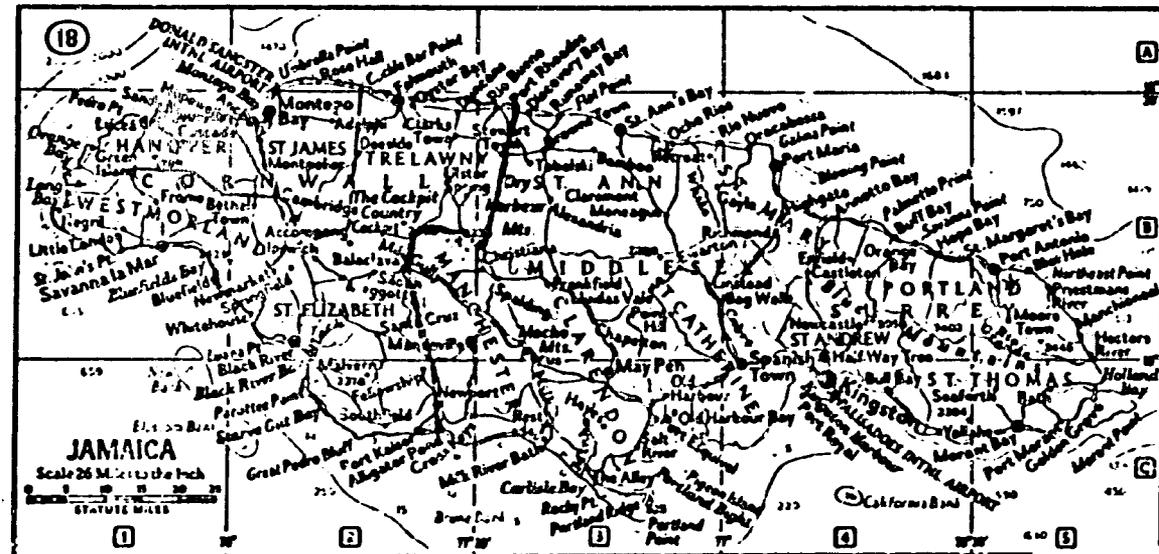
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**Willie Mae Clay, Deputy Leader for Clinical Training**

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## I. EXECUTIVE SUMMARY

Jamaica has been in the fortunate position of providing world leadership in exploring new ways of implementing primary health care. Under WHO, the worldwide goal of achieving "Health for All by the Year 2000" has become more than a slogan, many countries are now engaged in successful programs to implement these objectives. Jamaica started field activities well before most other countries became aware of the potentials of the new approaches. Long before the Alma Ata World Conference on Primary Health Care in 1978, the trials had been made by the University of West Indies under Dr. Kenneth Standard of methods that have proved most important in beginning to resolve long standing problems of effective training for a basic level health care worker. The Jamaican experience with Community Health Aides has been tremendously useful to other countries in the Caribbean and elsewhere in opening up understanding of innovative approaches.

Having made these remarkable contributions it is important that the experience of Jamaica receive careful evaluation. The new government has the opportunity to learn from what has been done, select those activities that have been most fruitful and move on to make further improvements in ambulatory health care.

This report of a collaborative program provides a chance to review an important experience which we feel contributed significantly to improving quality of health care for people in need in rural areas. The original plans for this collaboration were an ambitious effort to improve primary care in Cornwall County but changing relationships led to considerable reduction in the scope of work. All of the activities for assistance in management and in

evaluation were shifted to other groups. This project then became sharply focussed on efforts to improve continuing education and in-service training for members of the primary health care team. Only one of our two long term consultants was assigned to Cornwall County. Mrs. Willie Mae Clay-Brown proved remarkably effective in setting up systematic in-service training activities. Most important were her efforts to increase capacity of regular staff to continue the process of training. She helped in role definitions and development of manuals. She worked with county leadership in general planning and management to improve services.

The other consultant, Mr. Mark Gross, was assigned to the training branch in the Ministry of Health. Here his role was to help with overall planning for training in the country. Specific activities included setting up workshops and a particular emphasis on training of trainers.

The various consultants from Johns Hopkins University contributed technical knowledge and insights on matters for which they were specifically requested. In addition, Johns Hopkins provided public health training for selected personnel in Jamaica's Ministry of Health and Environmental Control, including planners, health educators and medical officers of health. During the lifetime of this project, Johns Hopkins School of Hygiene and Public Health also prepared senior graduates for short term assignments in Jamaica with PAHO, HOPE and the University of West Indies nurse practitioners program. It was a period of extremely fruitful collaboration.

Particular mention should be made of the casebook included with this report which was prepared by Mrs. Willie Mae Clay. It represents a synthesis of experience put together in such a way as to provide guidance for those who will be continuing the in-service activities in Jamaica.

Finally, we are pleased to express our appreciation for this opportunity to work with our wonderful Jamaican colleagues. The challenges are great but the potentials are also great. Further development of the innovative approaches which have been initiated can make a profound contribution to the health of the Jamaican people.

**Carl E. Taylor, M.D., Dr.P.H.**

**Principal Investigator**

**1981**

## II. Jamaica Report Recommendations

### A. Recommendations at Parish Level

In-service training is an ongoing process with direct relation to specific problems occurring in day-to-day services. Effectiveness at the Parish level depends on the designation of training officers, who may be either full time or part time, but should be directly involved in regular ongoing services. Training officers who participated regularly in organization and implementation of in-service workshops and supervisors of daily activities would be in the best position to assist in identifying programs suitable for reviewing or upgrading basic knowledge and techniques of health care workers. In this process they should, of course, get the direct involvement and feedback from the workers who are receiving the in-service training.

Training officers will presumably be working under a demanding schedule and therefore will benefit from a set of standard guidelines to assist in program design and development. The figure, Program Planning to Evaluation (Figure 3, Casebook) is intended to assist trainers in conceptualizing the general scope and effort required for program initiation, but should be adjusted to reflect specific local requirements.

Examples of useful training activities at parish level include:

- (1) developing in-service programs which encourage workers in VD investigation to interact with workers in family planning services;
- (2) stimulating community awareness through planned, regularly scheduled Community Health Education Seminars and use of the mobile film unit in each parish; and
- (3) developing "Health Education Packages" with supportive materials and equipment to assist trainers in emphasizing the health teachings.

**B. Recommendations at County Level**

A systematic process for annual review of the aims, objectives, and functions of the inservice training structure is proposed. Health workers from the periphery should be brought in to provide input into this process. Primary Care and Training Branch officers would play an advisory role in their participation. Areas for review and consideration of priorities include:

The roles of Training Coordinator, Committee, Teams, and programs; Supervision; and Referral Information/Monitoring System; Logistic/Supplies; Community participation; Continuing Education and Evaluation.

County Training Coordinator: A person located at the county level with the overall responsibility for coordinating in-service training activities in Cornwall County will facilitate productivity and strengthen the parish training teams. A Senior Health Educator seems most appropriate for the position. This person should take responsibility for overall stimulation and coordination of activities. To provide consistent participation of all responsible officials, a training committee should meet regularly bringing together persons from county and parish level.

**In-Service Training Teams**

Parish in-service training teams should share the responsibility for coordinating in-service programs, in addition to their regular duties. It is important to recognize that because, unless preventive interventions are made early, consistent motivation of training teams to maintain high output is difficult. One example of training team weariness that occurred in Cornwall was the gradually increased occurrence of incompleting quarterly schedules for parish training functions. Members of the team said that in-service training responsibilities became so intense that they interfered with the regular functions of the posts they held. Viability of the teams is threatened when this

happens. When in-service training officers assume training responsibilities in addition to their appointed jobs, there must be allowance of time to perform the activities associated with in-service training. Formal delegation of some duties of the training officer to another staff member when in-service training needs are being performed may lessen the pressure on training team workers. This arrangement would undoubtedly have to be worked out with the Senior Medical Officer and the Ministry of Health.

**C. Relationship with the Ministry of Health, Jamaica**

An expanding Primary Care System requires better utilization of existing health staff and this requires training appropriate to their new functions. Some staff members will be placed in positions where they are required to provide services and perform functions that were not part of their initial job descriptions. Lesser trained personnel frequently perform functions unofficially that they have not been trained in or tasks may go undone, not because the person cannot do it, but because of fear of reprisal. This is a waste of effective manpower and often results in good skills being lost to the health service. Changing conditions require adjustments of the potential capabilities of all personnel. Cornwall County's inservice training team have the ability to identify and assist the Training Branch to train selected personnel to expand their skills and improve their capability to function in the new role.

Strengthening the link between the Ministry Training Branch and Primary Health Care training activities at county level would be of two fold benefit. First, the Training Branch would be more aware of Cornwall's needs and how to assist them and secondly, materials for revising the various field manuals could be based on practical measures which have emerged from relevant field activities.

**D. Relations With University of West Indies**

1. Arrangements should be strengthened for UWI involvement in the in-service and regular training of various levels of health personnel.

a. Medical students - a continuing activity that seems extremely valuable and important.

b. Other health professionals - i.e., public health nurses, nurse practitioners, nutritionists, etc. are all categories of workers who need intensive field experience both in regular and in-service training. The use of Cornwall County as what WHO has termed a "Field Practice Area" has great potential for Jamaica. A major constraint is working out arrangements for local service people to have joint faculty appointments. In a two-way exchange regular faculty members should be used to assist in teaching in-service training courses where specialized competence is needed.

c. Assist in development of educational modules for auxiliary and community worker in-service training and development of training capacity.

d. Cooperate in management and planning of all training for primary health care.

2. Appropriate mechanisms for faculty development should strengthen institutional capacity in evaluation and research on the training and use of the primary health care team.

**E. International Agency Efforts**

To assure continuity and long-term success of training efforts such as those in Cornwall County, there is a need to follow up with periodic contributions from persons skilled in technical assistance for primary health care training. International agencies could considerably strengthen in-service and regular

training capacity in the following ways:

1. Facilitate and assist in the development of potential long-term institutional linkages to improve teaching, research and action in primary health care.

2. Sponsor short-term training courses in educational methods, carried out in partnership with U.S. universities for academic content and methodology for field experience to be provided to University and Ministry of Health personnel.

3. Include a human resources development component with all major grants. This component should include a structure for:

- a. initial training,
- b. scheduled reviews of common problems encountered in routine service delivery, and attempts to find solutions; and
- c. periodic retraining efforts to augment knowledge and skills required in daily work.

### III. HISTORICAL DEVELOPMENT

Following political independence in 1962, successive Jamaican governments have intensified efforts to provide broad health services throughout the Island. Training for physicians, nurses, midwives, and other health personnel was expanded, new medical facilities built, and participation in international health activities increased. There were, however, many recurring problems to overcome: the economy based largely on agricultural exports, aluminum ore processing, and tourism was fragile and suffered major fluctuations; emigration of middle and upper level professional staff was a constant drain; expectations for health services increased as education and other modernization diffused more widely.

Among the many efforts made to extend health care to underserved communities was an experimental program to train Community Health Aides (CHAs), sponsored by the University of the West Indies, Department of Social and Preventive Medicine, and the Ministry of Health and Social Security of the Jamaican government. Begun on an experimental basis in 1967 under the leadership of Professor Kenneth Standard and his staff, the new category of health workers was intended to bridge the gap between ambulatory medical facilities and the people living in the community. Jointly chosen by the community and the health staff, trained for three to four months, working in the field and the health center, and paid a modest government salary, these persons were expected to carry out the functions of health education in nutrition, environmental sanitation, family planning, follow up of patients seen in clinic, and provision of simple home care to the aged and needy in the community. After gradual expansion of the program and careful evaluation, the results were judged to be highly satisfactory, and a larger scale implementation of the CHA

program was proposed. Social, economic, and political forces combined in the early 1970s to encourage this thrust, and approximately 1,000 CHAs were trained, employed, and assigned to work in all parts of the country by the mid-1970s.

These efforts in training and use of community health workers were critically examined by participants in the various programs as well as external evaluators. In 1973, Alderman et al published an article in Lancet about the young-child nutrition program in Jamaica, bringing attention of the scientific audience to the use of locally trained and recruited health workers to reduce mortality and morbidity among young children in rural Jamaica<sup>1</sup>. Shortly afterwards, Standard and Ennever published their description of the training of health auxiliaries in the West Indies<sup>2</sup>. In 1975, Dr. Carl Taylor served as a consultant on a US/AID sponsored evaluation team to review the current activities and effects of the Jamaican Community Health Aides. Evaluation efforts seemed to indicate that the CHAs were contributing significantly to improved health status and nutrition of children, and declining infant mortality rates. However, the number of health personnel with advanced training available for supervision and CHAs was limited, and many people were concerned about the problems of integrating this larger new cadre into ongoing primary care services.

During the mid-1970s government policy continued to emphasize extension and improvement of rural primary care services, and several large programs were initiated with external assistance of multilateral and bilateral agencies. A World Bank loan was obtained for building and equipping 56 new health centers of four types throughout Cornwall County and renovating and expanding others in a program to be completed by 1981. These new facilities were one part of a comprehensive revision of primary care policies intended to be gradually

implemented nationwide. Roles and functions of all health professionals, including CHAs, were expected to be analyzed, restructured, and expanded.

In 1976 the Government of Jamaica sought technical assistance in the area of human resource development and invited the United States Agency for International Development to collaborate in the primary care efforts. Doris Storms, from Johns Hopkins, was a member of the AID assessment team. Agreement was reached that top priority should be given to health planning, in-service education and evaluation efforts. Primary attention would be focussed on developing the activities in its first stages in the Cornwall County area.

#### Cornwall County Activities

Although the new policies were national in scope, one of the areas where activities would be implemented earliest was in Cornwall County, or the Western Region, as it is also called. In this county with five parishes and about 600,000 population in a region of rugged mountains and fertile coastal plains, it was planned to have 57 new facilities (one center was funded by the Netherlands government in addition to 56 built through the World Bank loan), along with necessary furnishings, equipment, supplies, and vehicles. In order to adequately utilize these new premises and equipment, it was obvious that a major investment in health manpower was necessary. Given the critical state of the economy and the severe shortage of middle and upper level personnel, it was not possible for any significant numbers of new personnel to be recruited, trained, or maintained. In 1978 in the country as a whole, there were about 1150 CHAs, 260 midwives, 100 staff nurses, 150 public health nurses, 400 health inspectors, and 65 physicians working full or part time in primary care. In the Western Region, CHAs numbered approximately 405, district midwives 90, staff nurses 25, public health inspectors 85, and about 10 full and part-time physicians served in

primary care posts. Many posts were vacant due to lack of candidates and finances. Despite the heavy overload of many key personnel, the only means of implementing the new decentralized, regionalized health care system was retraining of current staff members. Fortunately many strategic leaders at different levels were willing to proceed with the arduous program of in-service training for the more than 800 health and support personnel who would be involved in carrying out the new policies. Some limited but significant technical assistance was supplied by several multilateral and bilateral agencies.

US/AID provided a training advisor in Cornwall County and some supplemental training funds through the Health Improvement for Young Children Project. A policy decision had been made to assign the other US/AID technical assistance staff member to the Ministry of Health and Environmental Control in Kingston. This was intended to enhance the spread of technical assistance throughout the Island. The major costs in staff time and operating expenses came from Jamaican government resources.

#### In-Service Training Committee

With the strong backing of the regional and national administration, the first phase of in-service training began in mid-1978 with the organization of a county committee of about 25 members, composed of three or four representatives from each parish plus regional staff. These were mainly public health nurses, public health inspectors, and health educators, nutritionists, and physicians when available. The committee met monthly for several hours each time and reviewed, discussed, and decided on the most salient and urgent topics to be included in the first phase of the continuing educational program. It was evident that all staff needed to have a clearer understanding of the new policies, that close interprofessional teamwork would be necessary, and that improved

communication and management skills should be included in the first cycle. Furthermore, it was decided that more detailed information was required concerning the knowledge and skills of service staff in emergency primary care. The Type I Health Center --the smallest, most numerous, and widely scattered primary care facility -- would have initial attention.

#### Non-Residential Workshops

These general learning goals led the county committee to plan an extended series of two-day non-residential workshops for 15 to 22 participants, each program to be held in several locations in all five parishes. The training staff was composed of a core group from the regional administration plus leaders in the concerned parish. Trainees came by local transportation each day, received food, and were given a travel allowance. The sessions were held in health centers, schools, churches, and other available facilities.

The instructional objectives and basic format were uniform in all seminars throughout the county, but modifications were made according to local needs after the training staff reviewed the pre-test given at the beginning of the first day. All participants received a detailed listing of objectives, content, methods to be used, resources, and evaluation techniques for the workshop. Mimeographed summaries of essential facts and concepts were given to everyone present. The learning approaches included some lectures, but major emphasis and time were spent in group discussion, role plays, and problem solving exercises.

After discussion by the group the optimum management for these and other clinical and management problems was agreed upon in accordance with the guidelines for the Type I Health Center. Teaching aids consisted of chalkboards, flip charts, posters, and flannel graphs. No project equipment was used. At the close of the second day an evaluation period was conducted with forms

completed by trainers and staff, and additional time was given for discussion by all who attended.

This program was repeated 29 times over a six-month period between April and October 1978 with a total of 687 participants. Less than 50 eligible participants in the entire county did not take part in any session. Table I provides a breakdown of trainees by professional category and parish.

There were expected and unexpected problems encountered in dealing with food, transportation, and finding meeting places. At times the funds designated for the workshops were not immediately available. The regional leadership demonstrated strong support by finding temporary means to meet costs until the budgeted funds arrived.

As indicated in more detail in other sections of this report, the Cornwall County program proceeded primarily with a focus on In-Service Training. In the first phase informal training teams were formed in each parish and a County Wide Training Committee functioned as a planning, management, and evaluation group for the educational activities. The first workshop concentrated on emergency primary care and general knowledge of the new government policies. Subsequent teaching units dealt with family planning, sexually transmitted diseases, nutrition, dental, medical record keeping, and gastroenteritis.

As the Training Committee met on a monthly basis, a number of administrative issues and problems emerged. The resulting discussion led to the formation of Problem Solving Teams for pilot districts in each parish. These management teams made regular visits to the pilot districts and made considerable progress in working out new patterns of management processes. This effort also was useful in identifying topics which were incorporated in the in-service program.

Over the three year program almost all the paid staff had direct involvement in the in-service training program. Gradually the parish training teams became more formalized and gained confidence and an ongoing momentum.

### Lessons Learned

In conclusion, it would be possible to make some general observations and recommendations based on the project experience. In order to develop the most stable infrastructure for in-service training in Cornwall County, hindsight would suggest:

1. The length of the project and program should have been at least five years. Two to three years was much too short a time to get a reasonably effective long-term outcome of the investment. An additional two years would have allowed more consolidation and development of permanent staff and management processes.
2. It would probably have been wiser to have maintained the two expatriate training personnel in Montego Bay rather than assign one in Kingston. This would have provided a somewhat stronger "critical mass" and more documentation and training materials could possibly have been developed. This is not to discount the very significant achievements which were accomplished.
3. The University of the West Indies probably should have been directly involved in Cornwall County feasibility studies and the design of in-service training activities from the very beginning. Universities and other traditional institutions for the training of health workers have an important role to play in extending health care to underserved communities. During every consultant visit, Johns Hopkins project staff held an informal meeting with faculty from the University of the West Indies. Unfortunately, this institutional linkage was never

formalized, and local university participation was lacking in annual and semi-annual review meetings of the Cornwall County project.

Project experience clearly showed the value of designating at least one person to manage, formulate and guide the in-service training program on a permanent basis. If in-service training activities are to continue in Cornwall County, plans should be made to designate and develop a position for a primary care in-service training co-ordinator. Ideally, this person should have worked with Mrs. Clay-Brown for at least a year in 1980.

**References:**

- 1 Alderman, M.H. et al. "A Young-Child Nutrition Programme in Rural Jamaica." The Lancet, May 26, 1973, pp. 1166-1169.
- 2 Standard, K.L. and Ennever, O. "Training of Health Auxiliaries in the West Indies." Reimpreso de Educacion medica y salud, Vol. 9, No. 3, pp.285-295, 1975.

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DC:ml WP7

## CHRONOLOGICAL OVERVIEW OF PROJECT ACTIVITIES

<u>Date</u>	<u>EVENTS</u>
Oct.26, 1977	Signing of the agreement between US/AID and Johns Hopkins
Nov.1, 1977	Effective date of contract
Jan.2-8, 1978	Mark Gross consultation to Jamaica
Jan.8-15, 1978	Dory Storms. Carl Taylor consultation in Jamaica
Jan.22-Feb.3,1978	Robert Parker and Ahmed Moen consultation in Jamaica
Feb.1, 1978	M. Gross arrival for long-term assignment in Kingston
Feb.6, 1978	Willie Mae Clay begins 2 week orientation in D.C.
Feb.13, 1978	D. Storms - consultation in Jamaica
Mar.1, 1978	W.M.Clay arrives in Montego Bay to begin long term assignment
Sep.13-23, 1978	Dennis Carlson consultation in Jamaica
Jan.7-13, 1979	D. Storms and Matthew Tayback consultation in Jamaica
Feb., 1979	Submission to AID of 1st Year's Report
Mar.4-10, 1979	D. Carlson consultation in Jamaica
Apr.18, 1979	Contract amended to establish Kingston as duty post for M.Gross (retroactive to contract start date)
Jun.3-9, 1979	Consultation of D. Carlson in Jamaica
Aug.29, 1979	Contract amended to change scope of work
Sep.16, 1979	W.M.Clay leave of absence
Oct.31, 1979	M. Gross returns to U.S. - assignment completed
Jan.1, 1980	W.M. Clay returns to Jamaica
Feb.29-Mar.3,1980	C. Taylor consultation in Jamaica
Oct.1-10, 1980	D. Carlson consultation in Jamaica
Dec.31, 1980	W.M. Clay returns to U.S.
Mar.9, 1981	Contract extended to April 15, 1981 W.M.Clay to work addition 6 weeks (2/1/81 to 3/15/81) to aid in completion of Final Report

**CASEBOOK OF GUIDELINES FOR IN-SERVICE TRAINING**  
**OF PRIMARY HEALTH CARE TEAM**

**Willie Mae Clay-Brown**

**Cornwall County, Jamaica, W.I.**

**1981**

**CASEBOOK OF GUIDELINES FOR IN-SERVICE TRAINING**  
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**1981**

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## ACKNOWLEDGEMENTS

I would like to acknowledge the interest and encouragement of Dr. Anthony J. D'Souza, Senior Medical Officer, Cornwall County, that greatly facilitated the organization of the Cornwall Training Component. I am deeply grateful to him.

In appreciation to Cornwall County Health Administrative staff who at different times and for varying periods during 1978-1980, worked with the training team to develop primary care services in Cornwall, I would like to make special mention of Mrs. E. Mac Farguhar, Regional Nursing Supervisor, who worked conscientiously with the team, and Dr. Barry Wint, Acting Senior Medical Officer of Health, Cornwall County, for his never-ending support.

In addition, I am grateful to the Ministry of Health and Social Security officials for their guidance in the training efforts of Cornwall's team. A special thanks to the Chief of the Training Branch and her staff.

This casebook of training guidelines could not have been developed without the training officers who unselfishly gave time and effort to upgrade the performance of self and others to improve primary care services in Cornwall.

My sincere thanks go to:

(St. James Parish)

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I express sincere appreciation to my colleagues, Dr. Carl E. Taylor, M.D., Dr. P.H., Ms. Doris Storms, MPH, and Dr. Dennis Carlson, M.D., MPH, for their most able assistance. To the typists Ms. Maureen Dever and Mrs. Martha List, I owe a special word of thanks.

The funds expended in the preparation of this casebook were drawn from the project "Health Improvement For Yong Children," funded by the United Agency for International Development. I am grateful to USAID for their support of this project.

**CASEBOOK OF GUIDELINES FOR IN-SERVICE TRAINING  
OF PRIMARY HEALTH CARE TEAM**

**I. PURPOSE**

The purpose of inservice training activities were to promote the development of knowledge, skills, and attitudes for the enhancement of Primary Care practices in Cornwall County, Jamaica. Cornwall County Health Administration's (CCHA) training team endeavored to develop a systematic process to upgrade and maintain staff competence through inservice education and training.

Primary health care training activities in Cornwall between 1978 and 1980 provides the basis for this inservice training casebook. It records the guidelines which were developed by the training team in Cornwall . It covers training, needs assessment, program design, implementation, and evaluation. This casebook is further intended to be used as a tool to evaluate past training methodologies in order to revise or adapt those methods that have proved useful, to upgrade strategies that require upgrading and discard those that are no longer feasible or effective.

No attempt has been made to cover all inservice training programs or methodologies for primary care development; however, compiled inservice training activities in Cornwall County over a three-year span may be useful to Cornwall's training team. It may also be adapted for use in counties outside Cornwall and perhaps in other developing countries.

## II. BACKGROUND SUMMARY

Health services in Jamaica have traditionally been divided into two distinct components, preventive health services and curative services. Previously health services have been delivered mainly through hospitals and health centres throughout the island. Since 1962 government policy directs that emphasis be placed on community based "Primary Health Care" services; however, inadequate health facilities, staff shortages and limited resources contributed to a weakened health system in Jamaica.

In an effort to upgrade Jamaica's health service, the second Jamaica Population Project (national with regional scope), financed jointly by the Government of Jamaica and the World Bank, was launched in 1977. Reorganization of health services and retraining of health professionals including community health aides was part of the overall plan to revise health care delivery in Jamaica. Emphasis placed by the Ministry of Health and social security (MOHSS) on community based services involved the restructuring of primary care staff relationships and services at field level. Reorganization of primary care services features a series of interlocking health centres providing integrated preventive and curative services ranging from the entry or basic care level (Type I) to the more complicated or extensive services (Types II and III). The Type I staff consists of one midwife and two community health aides; Type II staff includes all Type I staff plus a Public Health Nurse, Staff Nurse, Dental Nurse, Public Health Inspector, a Nutrition Assistant, and a visiting Medical Officer; Type III staff includes all Type II staff plus a Medical Officer, Dental Surgeon, Nurse Practitioner, Senior Public Health Nurse, Senior Public Health Inspector, Clerk, Pharmacist, and an Assistant Nurse. Health Centre staff

working together as a team were responsible for the provision of extended primary health care services for the community, specifically for rural communities (See Figure 1). Subsequently, the Ministry of Health and Social Security supported the training of physicians, nurses, midwives and other health workers, especially for rural communities.

Cornwall County Health Administration (CCHA) was established in 1977 with responsibility for administration and management of all primary care services in the Western Health Area. The principal objectives of CCHA is to provide an adequate primary health care system for the people of the County.

Sub-objectives include:

- a. "reduction of malnutrition among children 0-4 years of age and anemia in pregnant and lactating women"
- b. "fertility reduction through further development of health and family planning service"
- c. "improved coverage of antenatal and postnatal nutrition and immunization services in accordance with national objectives"
- d. "eliminate deliveries unattended by trained personnel"\*

Cornwall County was the pilot project for restructuring of field health services through a decentralized Health Administration. Types I, II and III health centres which offered three levels of health care in Cornwall, facilitated the provision of extended primary health care services. Inservice training programs outlined by the Primary Care branch of the Ministry of Health provided the guidelines for those inservice training programs conducted in Cornwall to upgrade the skills of field staff in order to provide an improved health service.

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\* Recent Developments in Primary Health Care, Cornwall County, 1980, Dr.A.J.D'Souza

Figure 1

PRIMARY HEALTH CARE IN-SERVICE EDUCATION  
 CORNWALL COUNTY PRIMARY HEALTH CARE SERVICES  
 \*CCHA = Cornwall County Health Administration

Type of Centre Population to be served	Staff Present	Services Provided	Relationship Between Primary and Secondary Services in the Country
Type I 4,000	District Midwife (DM) Community Health Aides (CHA) Cleaner/Attendant	<ol style="list-style-type: none"> <li>Weekly MCH Clinics, e.g., Prenatal and Postnatal and Child Health Clinics</li> <li>Weekly immunization</li> <li>Nutrition demonstrations and distribution of food supplements</li> <li>First aid and daily dressing</li> <li>Home visiting by DM, CHA</li> <li>Home deliveries by DM</li> <li>Health education and information</li> <li>Mothercraft and other community activities</li> <li>Health Committee meetings</li> <li>Follow-up of referrals and other health centres, hospitals</li> <li>Daily family planning</li> </ol>	<p>Type I → Type II</p> <p>↓</p> <p>District Hospital</p>
Type II 10,000	Type I staff as well as: Visiting Medical Officer (VMO) Public Health Nurse II (PHN) Public Health Inspector (PHI) Staff Nurse (SN) School Dental Nurse (SDN) Driver, Orderlies	Type I services as well as: <ol style="list-style-type: none"> <li>Primary Care Sessions by MO, NP</li> <li>Weekly MCH Clinics</li> <li>Environmental health services</li> <li>Dental services</li> <li>School health services</li> <li>Food handlers clinics</li> <li>Insertion of IUDs</li> <li>Supervision of Type I HC by PHI, PHN</li> <li>Operation of drug window</li> <li>Treatment and follow up of referrals from Types I and III, hospitals</li> </ol>	<p>Type II → Type II</p> <p>↓</p> <p>District Hospital</p>
Type III 20,000	Type II staff as well as: Medical Officer (Dental) (MDO) Surgeon Nurse Practitioner (NP) PHN III SPH II Pharmacist Assistant Nurse (AN)	Type II services as well as: <ol style="list-style-type: none"> <li>Specialist and communicable disease clinics</li> <li>Daily primary care clinics by MO, NP</li> <li>Supervision of Type I, II HCs</li> <li>Treatment of patients referred from Types I, II</li> <li>In-service training of health personnel</li> </ol>	<p>Type III → Type IV</p> <p>↓</p> <p>District Hospital</p>
Type IV	Type III staff as well as: Medical Officer (Health) Chief PHN Senior PHN Senior PHN, Grade I Health Educator (HE) Medical Technologist (MT)	Type III services as well as: <ol style="list-style-type: none"> <li>Administration, supervision, and evaluation health care services in the parish</li> <li>Implementation of health policies at parish level</li> <li>Coordination of primary and secondary health care in the parish</li> <li>Training of parish health personnel</li> <li>Laboratory services</li> </ol>	<p>Type IV ← MOH, Parish</p> <p>↕</p> <p>CCHA, Cornwall Regional Hospital</p> <p>↕</p> <p>District Hospital</p>

### **III. RATIONALE FOR INSERVICE EDUCATION**

#### **Definition**

Continuing (inservice) education consists of planned learning experiences beyond a basic education program. These experiences are designed to promote the development of knowledge, skills, and attitudes for the enhancement of employee skills, thus improving the delivery of health care to the public.

The purpose of inservice education is to maintain and improve competence in all fields of practice for professional growth. Changes within a given profession have a direct influence on the kinds of inservice training in which one participates. Programs are geared to the needs of the participants and the health needs of the population.

#### **Assumptions**

Inservice is essential for maintaining competence in all fields of practice. It is necessary for the personal growth and professional maturity of individuals.

Inservice needs are affected by:

1. Changes in licensure laws
2. Legislature changes which influence health care
3. Health research and associated advances in science
4. Changes in demographic characteristics.
5. Increased consumer demand in regard to health
6. Increase in the number and variety of health personnel.

### Goals and Functions

The primary goal of inservice education is to assure the continued competence of all personnel in the delivery of health services to the people. It also includes goals related to personal and professional development.

### Objectives Of Such Programs Are To:

1. Promote individual responsibility of staff for their own continued learning and its application to practice.
2. Assess continually and respond to immediate as well as long range needs of staff.
3. Provide learning experiences through which staff attain or increase their competence, and promote the design, implementation, and evaluation of progress.
4. Maintain flexibility and responsiveness in the system to learning needs of the staff.
5. Demonstrate new content and the competence required because of changes in the health care delivery system.
6. Continually assess and periodically evaluate the effectiveness of the program.
7. Establish accurate continuing education records.

The experiences relating to each objective will be presented in the section that follows:

### Suggested Standards

1. Each specific education activity is designed to implement the objective of the organization.
2. The program is relevant to the needs of the learner and the health needs of the consumer.
3. Learning (behavioral) objectives are defined for educational activity

and are used as a basis for setting content and experience for students.

4. Innovative approaches are used in planning, conducting, and evaluating progress.
5. Education activities are implemented through a variety of teaching methodologies to achieve objectives.

#### IV. DESCRIPTION OF ACTIVITIES IN CORNWALL COUNTY

The County of Cornwall comprises five (5) parishes with a population of approximately 600,000 - about one quarter of the population of Jamaica. Nearly 80 percent of Cornwall's population is rural, while 59 percent of Jamaica's population is rural. Primary care is provided in the county mainly through health centres and maternal and child health clinics. Due to the shortage of primary care facilities and staff, particularly in rural areas, the accessibility to health services has been inadequate. In order to deal with the chronic weakness of health services in Jamaica, the Jamaican Government with assistance from the World Bank launched the second population project (JPPII) in 1977.

Cornwall County was the pilot region programmed for building and equipping fifty seven (57) new health centres under JPPII. The project also included provisions for training programs to expand the capacity of Cornwall's health staff to administer a progressive primary care service. Paucity of training funds influenced the organization of workshops and seminars implemented in 1978 and 79 in Cornwall. Workshop courses had to be limited to one to two days for each training program and were intensive in content. Participant size was kept at a minimum of twenty (20) and a maximum of twenty-five (25). Larger groups made control difficult for one to two trainers. Staff members with broad experience who had taken specific courses beyond their basic training assisted as resource persons for inservice programs. Professionals within the community were also recruited to conduct appropriate training sessions when possible.

Cornwall County Health Administration utilized existing field staff to provide increased health services by expanding their primary care skills through inservice training.

**A. Development of Inservice Training Teams**

Dr. Anthony J. D'Souza, Senior Medical Officer (of Health) introduced the recommendations that initiated the chain of events which led to the formation of inservice training teams in Cornwall County, Jamaica.

Inservice training for health personnel was primarily done by supervisory or senior members of the various health departments, until recent years when "Health Educators" became a part of the system. In each of the five (5) parishes of Cornwall County, there is a post for one (1) health educator and one (1) county post at administrative level. During 1978-1980 approximately fifty percent of the six posts were unfilled. When the push came to escalate "Primary Care" training to redefine roles of health workers, it was clear that the number of persons conducting inservice training had to be expanded. Additional trainers to teach inservice education for reorganization of health services at the field level were not available to Cornwall.

Cornwall's training advisor and other members of the administration collaborated with the senior medical officer to discuss and plan possible solutions to the existing situation, the need to implement a program and insufficient staff to do so. Dr. D'Souza pointed out that if Cornwall was to upgrade and expand their primary care services, the challenge to organize and carry out the methods for achieving this would have to be chiefly accepted by current staff. He maintained that within Cornwall's health cadre there were capable individuals who could be requested to assist with inservice training activities. The training committee began to vigorously promote the idea that each primary care worker

was a "health educator"; that knowledge was most beneficial only if it is passed on to another, "Each One Teach One."

The first step taken by Cornwall's administrative officers in increasing the span of training coordinators, was to delegate the overall inservice training responsibilities to two key members of the health team from each parish. These persons agreed to recruit two to three other team members in the parish to assist them in coordinating the primary care inservice program. The principal criteria for making the selections was that the person(s) be willing to undertake the responsibility in addition to their existing portfolio. Medical officers, Chief Public Health Inspectors and Public Health Nursing Supervisors nominated individuals they thought would be capable of assisting productively with inservice training. The persons chosen were oriented to their specific task, to provide coordinators in each parish of the country.

By April, 1978, Cornwall County had acquired a team of training coordinators in each parish of the county. The training groups were interdisciplinary comprised of an officer(s) from each of the following categories of health workers:

Public Health Nurses

Health Educators

Public Health Inspectors

Nutrition Assistants

The importance of establishing and maintaining a line of communication to the community's needs was a major priority. In an attempt to rejuvenate community health committees that were no longer viable, the training coordinators and other health centre personnel were encouraged by county officers to become health committee members in their districts.

The coordinators in turn initiated the organization of health committees in areas where they did not exist. As a committee member, the opportunity to promote community utilization of the district health facilities and to be responsive to community needs was enhanced.

As inservice training sessions for Cornwall's field staff increased; the number of functions relegated to parish coordinators increased also. Examples of functions to be carried out in support of implementing inservice programs include:

- identifying training needs
- preparing visual aids
- providing/identifying resource personnel
- coordinating transportation for participants
- identifying a suitable venue for conducting training
- identifying sources for lunches and refreshment
- assisting with the development of quarterly inservice training parish schedules for the parish
- summarize evaluation reports on selected inservice training programs
- maintain records of trainee attendance at seminars/workshops
- assist in obtaining specific equipment for training workshops.

Parish coordinators gained considerable experience in organizing and coordinating inservice training activities and many were motivated to upgrade their own training abilities.

**B. ROLE REDEFINITION WITHIN PRIMARY HEALTH CARE TEAMS**

The upgraded Primary Care Health system in Jamaica provided a wider range of health services for the community, specifically in the underserved areas. Cornwall County's staff coverage for existing health facilities was inadequate and few additional staff was envisaged for the new centres.

The entire health team realized that financial constraints prevented an increase in their staff cadre. Extended health services for the Cornwall population required them to accept additional responsibilities. In order to provide the upgraded primary care services, retraining for almost all categories of field level staff was necessary.

The District midwife's and the community Health Aides were permanent staff who performed in the Type I health centres and provided services in the field as well (home deliveries, advising mothers, food demonstrations, etc.) As the principal person in the Type I Centre, the midwife's managerial responsibilities broadened considerably. In addition, community Health Aides functioned in an expanded capacity as supportive team members. In order to effectively fulfill their obligations, it was occasionally necessary to interchange roles.

Cornwall's training team developed inservice training programs for parish primary care workers to facilitate adaptation to an expanding health system, beginning with Type I health centre roles and functions. The basis for role redefinition was the Type I health Centre manual developed by the Ministry of Health in 1977 (footnote) It described the changing job responsibilities of health personnel in a Type I facility and listed the health services provided by the centre with referral or liase activities associated with other centres.

Staff nurses, a group that performed under an outdated job description for many years, merited recognition of their work in Primary Care. Programme planners piloted the implementation of "Technical Group Meetings (TGM) in Cornwall County.

The objective of the TGMs was to provide an opportunity for active participation of the Staff Nurses in defining their role in the Type II and III health centres. The process involved a series of one day meetings with staff nurses and TGM instructors in each parish to compile descriptive input of daily tasks performed by them. In second phase of the process was a four (4) day residential work shop in which the Principal Medical Officer of Primary Care, and the Assistant Nursing Officer for Jamaica assisted a task force of staff nurses, Administrative department heads, the Acting Senior Medical Officer of Health and the TGM instructors from Cornwall to prepare a report of recommendations defining the "Role of the Staff Nurse" in Type II and III health centres for the Ministry of Health. The report was submitted to the Ministry to assist in defining the role for staff nurses in Type II, III Health Centres throughout Jamaica.

Public Health Inspector and Public Health Nurse representatives participated in workshops to define their role in Primary Care. These workshops conducted by the Ministry's Training Branch were to be repeated until primary care roles were defined for all categories of health personnel.

#### Development of Educational Modules Based on Role Redefinition

The integration of secondary and primary care services resulted in the decentralization of many health centre responsibilities. Under the revised approach to Primary Care, no team member should perform a function which a lesser trained person can do. With the new addition of health centres in

Cornwall, more team leaders in the clinic became accountable for the operations of the centre. Changed roles required close interaction between team members for sharing ideas and considerations of recommendations for meeting community needs. To be able to do this, primary care staff had to have good insight into their own personalities in order to function well as a team members. Change for some is often painful. Inservice training associated with Interpersonal Relationships pointed out that as a member of the system, one had a responsibility to promote the goals of the system. Emphasis was placed on acceptance of the changing role and new tasks.

The incorporation of simulated health centre situations into training programs gave participants an opportunity to analyze their reactions when they had to demonstrate their ability to make decisions, recognizing the limitations. Role play was a significant part of the training process, since through acting trainees gave a feedback of the amount of primary care information they had assimilated.

Group work, such as developing health centre work rosters; making teaching visual aids; collecting health centre data; completing referral forms; ordering supplies; charting community statistics; planning specialty clinics; etc. was assigned to trainees to perform for the specific purpose of clarifying any questions and misinterpretations of these functions, as being a part of their changing role. This type of exercise allowed staff to indicate those functions expected to be carried out by them, for which they would require additional training.

Inservice training programmes had have both theoretical and clinical aspects were usually conducted for multi-disciplinary groups in theory and training to upgrade clinical skills for groups of single category workers. Many clinical skills previously performed by one category of health worker were

becoming skills performed by two or more categories. For example, blood taking at Food Handlers Clinic in Cornwall, prior to 1980, was done by the Public Health Nurse. Public Health Inspectors began a rotation in the Cornwall Regional Hospital laboratory to learn the techniques associated with acquiring this skill. Another example in taking Blood Pressures - many community health Aides expanded their skill to include this task and Cornwall's Public Health Inspectors participated in a one-day inservice training session to acquire basic techniques of blood pressure taking. Expanding primary care demanded an interchange of roles

### **Strengthening Team Functioning**

The Ministry of Health conducted the first of two "Training of Trainers" workshops from January 22 to February 2, 1979. The workshop objective was to provide formal training for selected parish teams. Curriculum of the workshop included:

- curriculum planning
- selection of training goals
- writing of educational objectives
- integrated instruction and learning techniques. and
- evaluation.

Upon completion of the "Training of Trainers" workshops, Cornwall's coordinators advanced their qualifications from coordinators of inservice training to inservice training officers. The officers utilized their acquired skills to contribute more to the development of primary care. At this stage, inservice officers were developing training objectives and programs based on needs identified in their parishes. These parish programs were integrated into county level training.

A second "Training of Trainers" workshop was conducted by the Ministry from April 2nd to April 22nd 1979. Supervisory and senior staff who assisted with inservice training in Cornwall were among those selected by administrative leaders to attend these workshops. Cornwall's inservice training component increased in numbers and strengthened their competency in improving primary care services. As a result the inservice training committee altered the regularly scheduled monthly meetings with parish training teams to every three months beginning June 1980. However, training teams agreed to meet once a month in their respective parishes and elect one member to be responsible for reporting the parishes' training activities and its progress at senior officers conferences at parish level. At the county level, the senior medical officer and his administrative staff provided input regarding inservice training activities based on training reports from parish representatives.

Cornwall County piloted the use of health personnel informally trained to coordinate inservice training in primary health care. Although the majority were initially unfamiliar with advanced training techniques, formal training was provided by the Ministry of Health to upgrade their skills and increase their ability as well as their confidence in delivering quality health care.

As a result of interest and demand more health workers were trained, thus Cornwall's training cadre expanded from four (4) members per parish in 1978 to seven (7) by December 1980.

## **V. DESCRIPTION OF IMPLEMENTATION PROCESS**

### **A. Functional Relationship of Cornwall County Training Component**

The Primary Care division of the Ministry of Health sanctioned the retraining of physicians, nurses and other categories of field personnel for reorganization of the health care system. Dr. C. Moody, Principal Medical Officer of Health, Primary Care, drafted an implementation plan of training programs covering a five (5) year period. It indicated comprehensive graduated levels of inservice education for all categories of primary care staff.

Representatives from the entire Primary Health Care Service attended work shops conducted by the Ministry. The objective was to orient participants to the proposed training to upgrade primary care and to identify inservice training needs for all categories of workers. Participants compiled lists of topics for inservice training programmes, that would upgrade knowledge attitudes and skills of primary care staff in their respective parishes.

Cornwall County Health Administration members and the Training Adviser constituted the team of program planners for inservice training. The group assessed training needs identified for upgrading the capabilities of Cornwall's field staff to provide expanded primary care services. Due to financial constraints, inservice training programs were designed to utilize a practical approach for implementation. Parish health officers formed teams of training coordinators who assisted county trainers to identify training needs and document training activities in the county

1. The Senior Medical Officer of Health (SMOH) leads Cornwall County's Health Administrative (CCHA) team to coordinate the Primary Care activities of the Ministry of Health and Social Security (MOHSS)

2. Cornwall County Health Administration feeds training information to the SMOH and Training Advisor based on reports of training needs identified on the field by parish training teams and the Inservice Training Committee (ISTC).

3. The committee not only reported directly to the SMOH but in addition, written monthly reports of Cornwall's training activities were submitted to the Primary Care and Training Branch of the Ministry.

4. The Training Advisor who was directly responsible to the SMOH advised the ISTC on the development of primary care inservice programs for Cornwall's field staff. The Advisor played a major role in the design and coordination of management training programs for members of Cornwall's administrative staff. Parish training officers who were formally trained by the Ministry of Health, worked directly with the Parish Medical Officer (Health) and Training Advisor to implement training programs and prepare reports for documentation to the Training Branch.

Inservice training conducted from the National Level for Primary Care personnel in Cornwall was coordinated with the ISTC and the Chief of the Training Branch.

Attached is an organization chart (Figure 2) showing the diagram of the Inservice Training Component and their functional relationships in Cornwall County Health Administration.

Management and communication skills were the major training needs identified for upgrading health staff to become proficient in (a) supervising the efficiency of primary care staff and services and (b) promoting harmonious team functioning among co-workers.

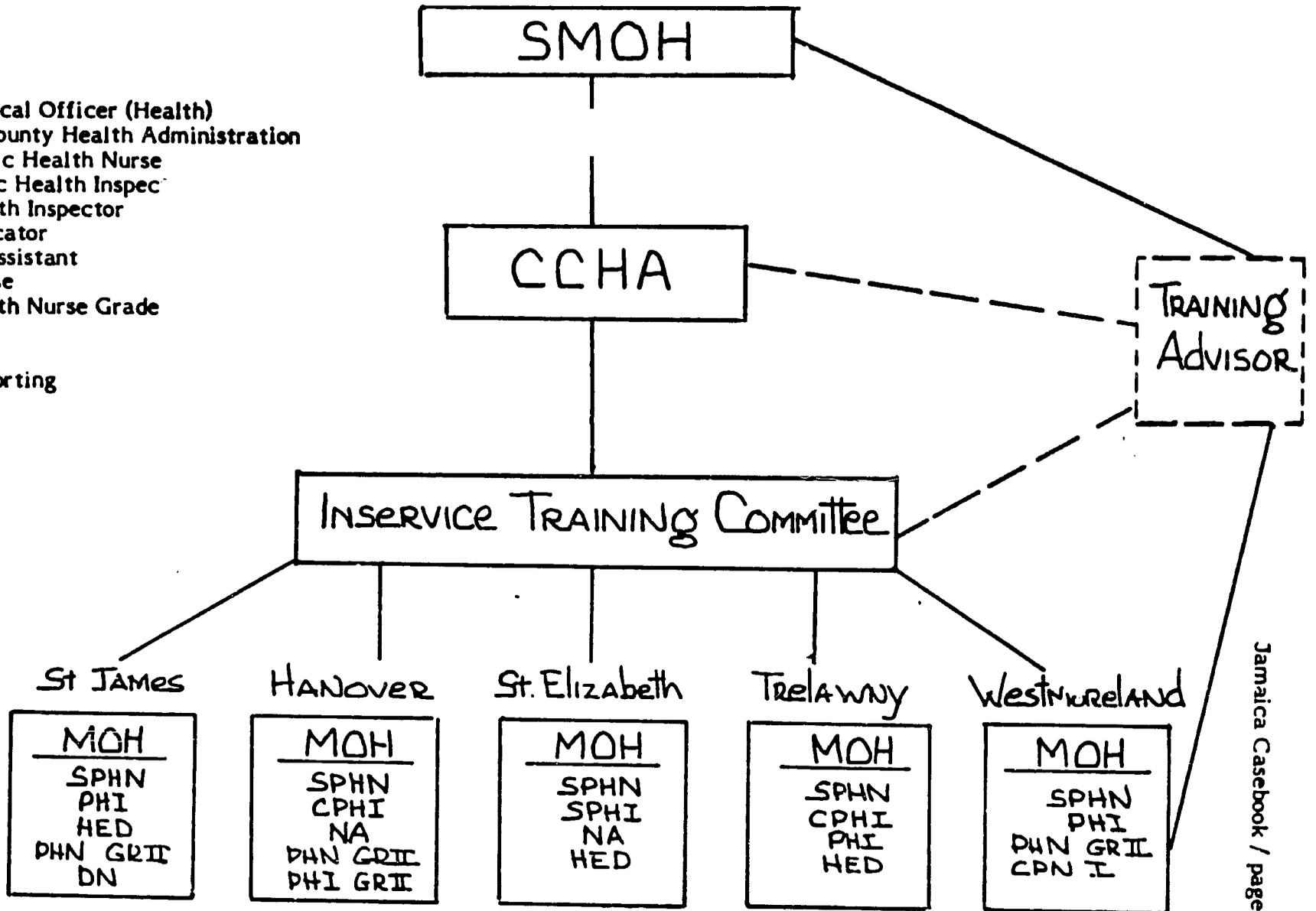
Figure 2:

# FUNCTIONAL Relationship of CORNWALL COUNTY TRAINING COMPONENT

Key:

- SMOH Senior Medical Officer (Health)
- CCHA Cornwall County Health Administration
- SPHN Senior Public Health Nurse
- CPHI Chief Public Health Inspector
- PHI Public Health Inspector
- HED Health Educator
- NA Nutrition Assistant
- DN Dental Nurse
- PHN GR Public Health Nurse Grade

----- Advisory  
 ————— Direct Reporting



Two-day workshops in organization, supervision, planning, interpersonal relationships, and interviewing and counselling, was implemented for six hundred eight seven (687) health workers in Cornwall. These training sessions initiated in April and completed in October 1979, headed the list of programs for retraining of primary care staff at all levels.

Efficiency and effectiveness of Primary Health Care services in Cornwall was to be evaluated by a team from the Department of Social and Preventive Medicine at the University of the West Indies. The team proposed to develop a standardized method or format that allowed Cornwall officials to periodically assess staff and services to maintain a high level of competence in Primary Care.

#### **B. Identification of Training Needs**

In keeping with the Ministry's priority in Primary Health Care, during 1977 a number of conferences and workshops were conducted by the Ministry for key members of the entire health services staff in Jamaica. These task forces held discussions to determine what training programs were indicated to promote primary health care policies and to develop strategies for the implementation of the Primary Care Program.

Among the activities held were:

1. Berkley Beach Conference - attended by a cross-section of health workers
2. The Mallards Hyatta Beach Conference - attended by a cross section of health workers
3. District Medical Officers Workshops
4. Public Health Inspectors Workshop

5. Regional Nursing Supervisors and Senior Public Health Nurses Workshops
6. Health Educators Seminar
7. One day Seminar for Senior Staff - Ministry of Health and Donor Agencies

Out of these conferences and workshops the decision was made to conduct inservice training programs for primary care staff to ensure an understanding of the following:

- a. the objectives of the primary care program
- b. the plans for the implementation of the primary care program
- c. the need to develop a positive attitude in staff working in the primary care program
- d. the need to develop supervision, management and clinical skills.

Given these training needs and the number of primary care workers to be trained, inservice training programs for "changing roles" were planned for island-wide implementation.

The Training Branch with only two (2) program oriented officers was unable to meet all the needs for training and due to the economic constraints in the Ministry, programs were implemented in part or not as extensively as proposed or in some regions, postponed for an undetermined time.

### **C. Formation of Training Committees - County Level**

Seminars and workshops to identify training that would meet the objectives for expanding Jamaica's Primary Health Care Program were conducted by the Ministry of Health. Cornwall, like other counties in the Island, selected representatives from each parish to participate. The group developed lists of training needs that were indicated for each category of worker for role

redefinition. Teams for individual parishes further defined the training necessary for team members to upgrade their knowledge, attitudes and skills in Primary Care.

Cornwall's Senior Medical Officer of Health organized a group (The Regional Nursing Supervisor, County Health Educator, Nursing Advisor and a Senior Public Health Nurse) from the administrative staff to commence planning for expanding inservice training for Primary Care personnel

The Health Improvement for Young Children project started in 1978 and was funded jointly by the Government of Jamaica and the United States Agency for International Development. The project's main objective was to train primary care staff to improve the delivery of primary care services in Cornwall County. Technical assistance from the Johns Hopkins University, Baltimore, Maryland USA was provided by the project to assist the Jamaican Government to develop its primary health care staff services. Mr. Mark Gross, Management Training Specialist, joined the Training Branch at national level and Mrs. Willie Mae Clay joined the Cornwall County's Health Administration Team as Training Adviser. Her primary responsibility was to assist Cornwall County's personnel to develop training methodologies for implementation of primary care programs to upgrade field personnel.

Even though members of the planning committee had full responsibilities to their appointed jobs, they assisted the Training Advisor in developing a systematic approach to intensive inservice training. The committee recruited personnel from parish level to aid in coordinating inservice training activities. Coordinators provided feedback to the committee on community and staff needs for consideration in planning inservice training. The committee, chaired by the Training Advisor, convened once a month but during the interim, members collaborated to collate information on community, health centre or staff needs;

plan /nservice training strategies; and examine training progress for revision or adaptation. The Training Advisor or a representative from the Committee, reported monthly on inservice activities in primary care at Parish Senior Officers, Public Health Nurses and Cornwall County Health Administrative Conferences. Suggestions, recommendations and problems arising from these meetings were in turn addressed at the monthly inservice committee meetings for consideration. As parish training officers gained increased experience in inservice training implementation, members were gradually integrated into the inservice training committee, expanding the group from five (5) members in 1978 to twenty-five (25) in 1980.

**D. Process of Identifying Content of Educational Modules**

"Health for all by the Year 2000" signifies the goal of Jamaica's Primary Health Care System. The principal objective of Cornwall County Health Administration's training component is to develop, implement, and evaluate inservice education and training programs that support the objective of the country's health sector.

In 1978 the three year schedule of primary care training programs outlined by the MOH to upgrade field personnel emphasized the following:

- 1979      Developing pilot districts
- Promoting training programs for improvement of management in understaff areas.
- Developing the changing roles of primary care staff
- Developing the change role of the District Medical Officer.

**1980: Upgrading Primary Health Care Skills**

- Promoting programs to upgrade community facilities.

**1981: Promoting programs for community development.**

Addressing problems that affect a lesser number of people (i.e., problems of the handicapped).

The outline served as a comprehensive guideline for Cornwall's programme planners of inservice education. The process for designing the program revolved around the extent and nature of inservice training in which planners developed primary case pretests that Public Health Nurses distributed to field personnel in each of Cornwall's health districts. The subject matter was based on material that was necessary to carry out basic level primary care services in the Type I Centre. In order to design adequate inservice training, avoid redundancy in knowledge and reinforce areas where needed, planners screened the pre-test responses for an indication of the level of PHC knowledge acquired by the staff.

**E. Evaluation of Training Process**

During the initial stages of role redefinition through in-service training, an ongoing evaluation of workshop materials, content, and methods of presentation prevailed. Evaluation of the training processes provided early assessment of the need for program modification. At the time, this exercise seemed to offer the best means of assessing whether the in-service material was considered useful and was being presented in a manner that allowed maximum comprehension. Workshop evaluation forms requested that participants rate the training sessions on a graded scale and write any comments they felt would assist planners to improve the workshops. Comments made by trainees on evaluation forms proved to be more meaningful if participants were given detailed instructions with explanations on the use of the evaluation form. Course conductors were requested to allow participants ample time to complete all forms. Hurried completion of forms resulted in erratic rating of the training sessions, or no

feedback on the overall evaluation ratings, and a highlight of the compiled written comments at the end of each workshop. These feedback sessions were productive in that participants related their feelings of being considered by the workshop organizers. Participants were informed if any revisions in the training workshops were based on their recommendations. Program coordinators reviewed the workshop materials and methods of presentation upon completing a program in each parish before beginning another.

This type of evaluation with degrees of variations was primarily used by Cornwall's in-service training officers to evaluate the training process. Pre-and post-tests, questionnaires, and observation as a means of evaluating training programs were used less often than the rating forms. Cornwall County's Health Administration wanted a mechanism developed whereby they would be able to evaluate the efficiency and effectiveness of the primary care services and staff at intervals using a standardized method. This method of evaluation will ultimately be developed by a team from the Department of Social and Preventive Medicine (DSPM) at the University of the West Indies. Members of DSPM's team started the evaluation process in September 1979.

The first phase objective was to evaluate training of community Health Aides and District Midwives done through training workshops and other in-service sessions in 1978-79.

Two research assistants from DSPM's team who were based in Cornwall County collated the data for the preliminary reporting sessions by using two approaches. structured interviews and questionnaires to:

- a. assess staff knowledge related to selected topics covered in training sessions.
- b. assess the extent to which nutritional knowledge was being correctly

applied by midwives and community health aides during child welfare clinics in pilot and non-pilot health areas.

The following are examples of findings resulting from evaluation done in one of Cornwall's five (5) parishes.

**LEVELS OF KNOWLEDGE OF SELECTED TOPICS**

<b><u>Levels of Knowledge</u></b>	<b><u>Topic</u></b>
<b>Most known</b>	Growth and development of the young child Interpersonal relationships General Nutrition Layette and clothing
<b>Average</b>	Gastroenteritis Communications Poisons and Accidents Dental Health Nutrition
<b>Least Known</b>	Interviewing Medical Terms and their meaning Mental retardation management

The random sampling (12 midwives and community health Aides) was small therefore no statistical tests were performed, rather the information was primarily descriptive. Further training sessions on those topics that were least known was the recommendation by the researchers.

**APPROPRIATENESS OF NUTRITIONAL ADVICE GIVEN TO MOTHERS  
OF CHILDREN 0-24 MONTHS OF AGE**

<u>Area</u>	<u>Appropriateness of Advice</u>			<u>Total</u>
	<u>Good %</u>	<u>Fair %</u>	<u>Poor %</u>	
Pilot (n = 40)	28	72	0	100
Non-pilot (n - 40)	7	90	3	100
Total	18	81	2	100

Specific conclusions were that staff possessed a fair knowledge of nutrition. However, in view of its importance, periodic updating of staff's knowledge in this area was considered. More practical training (Nutritional interviewing and counseling) for midwives and community Health Aides was recommended.

The Department of Social and Preventive Medicine's team was still in the process of completing the evaluation of in-service training in Cornwall at the end of 1980. The team plans to extend the evaluation process to include evaluation of the effectiveness of Cornwall's Health Services.

**F. Cost Considerations**

Planning a residential training programme usually provides meals, transportation, lodging, handouts, pen, paper, etc., for participants. A residential program has its advantages in terms of convenience for the program organizers and the participants; however, the overall costs exceeds that of non-residential training. During 1979 and 1980, the average cost for hotel accommodations per person in Montego Bay was sixty dollars (US \$60) per day. Thus, conducting a residential program for approximately 700 Cornwall's Public

Health Committee staff was not feasible.

Budgeting for the two (2) day workshops for 687 field staff required programme planners to consider the following for costing:

- Transportation:** Travel expense reimbursement for participants, resource personnel and program planners;
- Meals:** Lunches (catered or box)  
Refreshments, cups, napkins, plastic ware
- Training Materials:** Portable easels, blackboards, pens, paper, chalk, folders, stencils, markers, duplicating ink, duplicating paper, tape, flip charts, handouts, projector, film, slides
- Venue:** Rentals vary depending on owner and location  
Preparation of the building; cleaning solutions
- Resource Personnel:** Many professionals in the community charge fees by the hour

The minimum cost of the two-day in-service training sessions was estimated to be \$5,678 (Jamaican dollars) or JS\$ 8.26 per person (at the exchange rate of 1.67, the cost would be US\$ 4.94 per person). The expense for providing lunch to participants at J\$3/person/day = J\$4122. Travel costs were estimated to be J\$869 (J\$2/person qualifying for travel reimbursement/day). There was also an expense for coffee break of 50¢/person/day, or J\$687. These expenditures reflect the direct costs of the training sessions.

Food for program participants was the major expenditure for implementing in-service training in Cornwall. To acquire adequate lunches in the most rural

communities was often difficult. When planning, it was crucial to research the sources for obtaining lunches for the training sessions and to notify participants if food was not available. Participants were asked to supply their own lunches on numerous occasions and reimbursed if the funds allowed.

Transportation costs for participants and resource personnel also constitute a large expenditure. Travel expense reimbursement was kept at a static rate of two dollars (US \$2) per day per person. Program planners had to know the distance participants were required to travel from their base since this often was the determinant of the workshop venue. When possible, training workshops were centrally located in the parishes, thereby reducing participant travel.

## **VI. SUMMARY OF IN-SERVICE TRAINING ACTIVITIES 1978-80**

Since the organization of Cornwall County Health Administration (CCHA) in 1977, inservice training activities to maintain competence of health workers was a part of administrative responsibilities. The formation of parish training teams and an inservice training committee instituted the formal integration of inservice training component of CCHA.

As an integral part of the Primary Health Care Team, training officers played a major role in the identification of health staff and community needs for inservice training programs. They coordinated training activities for workshops and seminars. Due to severe financial constraints, inservice training programs for Cornwall were developed to generate a minimal amount of expense. Training team members assisted in reducing training expenditures by organizing transport pools for participants, locating and arranging no-fee resource personnel and venues and contributing teaching aides for training programs. Training officers carried out training functions that were sanctioned by the Senior Medical Officer of Health (SMOH) and the Inservice Training Committee (ISTC)..

The following table will show the various constraints and alternatives taken while developing the pilot workshops and seminars.

**CONSTRAINTS: INSUFFICIENT TRAINING FUNDS**

<b><u>Problems Encountered</u></b>	<b><u>Alternative Action Taken</u></b>
Insufficient training	<ul style="list-style-type: none"> <li>-requested participants bring pen, pencils, supplies</li> <li>-used back of old calenders to make charts, posters.</li> </ul>
Insufficient funds meals	<ul style="list-style-type: none"> <li>-collected contributions for refreshments</li> <li>-trainees purchased refreshments</li> <li>-trainees donated makings for cool drinks (sour oranges, grapefruit, sour sap, sugar, ice)</li> <li>-participants brought lunches from home</li> <li>-limited subsistence reimbursement (\$3 for lunch; \$.50 for cool drink)</li> </ul>
Decreased travel mileage allowance	<ul style="list-style-type: none"> <li>-allowed reimbursement for travel</li> <li>-reimbursement limit set at \$2 per day per person</li> <li>- pooled rides</li> <li>- training site centrally located in the parish</li> <li>- authorized travel reimbursement for limited vehicles per parish (1 to 2)</li> <li>-early reservation of Health Department vehicle for transportation of trainees/trainers</li> </ul>
Inability to engage venue for no fee	<ul style="list-style-type: none"> <li>-utilize schools (during summer) and colleges (most fees are gratis)</li> </ul>
Inability to provide hotel accommodations for resource personnel who travel long distances	<ul style="list-style-type: none"> <li>-established privileges for accommodations in nursing/doctors quarters attached to Cornwall Regional Hospital</li> </ul>
Inability to hire sufficient preceptors for clinical trainees (primary care)	<ul style="list-style-type: none"> <li>-resources recruited from within health services (i.e., MO(H), SPHN, CPHI)</li> <li>-private practitioners within community</li> <li>-utilized secondary care staff (matrons, ward sisters), Medical Officers (Health)</li> <li>-utilized qualified industry trainers (Kaizer Bauxite Medical Centre)</li> </ul>

The committee, a body within CCHA, had overall responsibility for the assessment of training needs, program design and objectives. Among training programs implemented by inservice training teams in Cornwall were management and communication skill workshops. (APPENDIX I) Training goals were to prepare field staff to deliver expanded services from Type I health centres by assuming management and leadership functions and interacting appropriately as a team.

An update in Family Planning theory and practices for Cornwall's Primary Care Workers presented a major challenge for Cornwall's trainers. (APPENDIX II) For those categories of staff that demonstrated the need, F.P. clinical skill training was still being implemented in each parish at various levels at the close of 1980. The problem of pregnancies among teenagers increasing in Cornwall County would probably receive positive interventions from primary care workers if they were adequately motivated and prepared to promote family planning practices.

Sexually Transmitted Diseases (STD) is another problem that threatens family life. Cornwall's trainers coordinated activities with the Training Branch to upgrade STD knowledge for case finders to improve methods in STD investigation and reporting. (APPENDIX III) Each health worker was charged with the responsibility of educating the community in the benefits from practicing effective family planning and the methods for control of sexually transmitted diseases.

Primary Care staff were better equipped to manage urgent situations through participation in First Aid training. (APPENDIX IV) Successful completion of Certified First Aid Training including Basic Life Support by nine (9) training officers furthered the training teams' ability to conduct F.A. inservice training. First Aid and Basic Life Support training was planned for

expansion in 1981 to include programs for community members, airport personnel, and schools. The certification of the remaining training officers who completed the course but did not take the exam was also proposed for 1981.

Dental/Nutrition inservice education seminars brought together two (2) groups of health workers who usually worked independently. (APPENDIX V) These groups, Health Educators and Nutrition Assistants and School Dental Nurses, and Assistants worked with group leaders, County nutritionist and Dental Surgeon to conduct Health Education seminars for Cornwall's health cadre. Through working together to promote adequate dental/nutritional health, the groups became more aware of each other's role in primary care.

Three weeks of Medical Records and Statistic Theory combined with one week of practical training for a selected group of staff constituted Cornwall's program of longest duration. (APPENDIX VI) Trainer efforts was to train a core group that would disseminate acquired information to other personnel involved in recording health centre data. This training activity increased the numbers of personnel utilizing standard procedures for performing medical records and statistical functions. When procedures for medical records and statistics are standardized at national level for the island, the transition from Cornwall's methods to national standards can be made with ease.

A mobile film unit provided by the JPP II project for Cornwall County furnished an additional means for carrying the health message to the community. One person whose primary responsibility was to drive a government vehicle, was trained to operate the unit. This did not allow for maximal usage of the film projector. A Health Educator recruited assistance from Associated Press International (API) to assist in inservice training for trainers to learn the mechanisms of operating a 16 mm movie sound projector. (APPENDIX VII) Two technicians from API donated their time and efforts to train fifteen (15) training

officers and agreed to donate additional supervision time until proficiency was acquired. The Training Advisor arranged for a list of Health Education films to be acquired for Cornwall's training team through the "Health Improvement for Young Childrens" project.

The inservice training committee contributed significantly to the development of Cornwall's Primary Health Care Team. The committee met on a regular basis to plan inservice training activities and was regarded as a supportive component of the administration's organization. With limited resources, all training activities for Cornwall's team were structured to be low in cost with all efforts at organizing training programs originating internally, with little outside intervention. Inservice training programs were consistently structured toward systemization, however this did not restrict the committee in its sensitivity to the needs of Primary Care staff outside Cornwall County. The Training Branch and the Ministry of Health held a one-day workshop in Montego Bay for regional health supervisors outside Cornwall to familiarize them with the training methodologies instituted in Cornwall. Continued performance of training team and committee members could become at risk if training functions and activities for Cornwall were not consistently coordinated at county level.

After working with Cornwall County's Health Administration team for three years, the overall progress in primary care development of staff and service could best be stated by saying, "the surface has just been scratched." Changes that occur (politically, socially, individually) require consistent assessment of short and long term goals and the most effective way to meet them. Cornwall has made considerable progress in primary care development, particularly in the utilization of its staff to provide an extended service. Management training for various categories of staff was implemented at different levels. This in no way met the amount of training indicated, especially

in key areas (drugs, supplies, transportation, personnel, accounts) to maintain an effective primary care service. Future activities of the administrative team would be those that promote the development of a primary health care system that totally met the needs of staff and community.

## **VII. SUGGESTIONS FOR FUTURE ACTIVITIES**

### **A. Parish Level**

#### **Follow-up For Specific Programs**

The Epidemiological Unit of the Ministry depend on the sentinel stations in the field to supply the necessary data for disease investigation and control. Many health workers and clerical officers performing medical record and statistical functions have had no prior exposure to detailed statistical practices. Since Cornwall County is fortunate to have a statistical officer at county level, a periodic update on statistical practices, specifically collection of demographic data for recording health centre staff would be in order. Training officers who participated in previous medical records workshops would assist the statistical officer with implementing the inservice training.

#### **Family Planning Update - Sexually Transmitted Disease (STD)**

To reduce the problem associated with decreased utilization of family planning practices and uncontrolled sexually transmitted diseases, maximal efforts of primary care staff and community members alike must be put in force. Workers in V.D. investigations and family planning services are missing an opportunity to assist each other in their efforts by not interacting more closely. Procedures to promote family planning may in turn provide information for follow-up by STD investigators. Looking ahead, it may be beneficial for the two disciplines to become actively involved with each one's plans of action and pool efforts to obtain optimal results.

#### **Mobile Film Unit Training (16 mm movie sound projector)**

Participants will acquire proficiency with the use of the mobile film unit and generator. However, during the training period, it was pointed out that

operators of the unit needed to have a basic knowledge of the parts and how they functioned and how to detect and remedy simple mechanical problems. At that time the plan was to implement a future training session for participants that would enable them to:

- a. duplicate the generating unit,
- b. diagram the connections of the unit,
- c. compile a dictionary of the unit's parts and
- d. describe the functions of the parts.

The dictionary will be used as a reference guide for training officers operating the unit. The more information trainers can learn about the units functioning, the less request would be made for servicing due to proper handling of the equipment.

#### **Community Health Education**

Primary Health Care workers have a responsibility to stimulate community members to recognize their needs and expectations. These efforts to raise community awareness can be assisted by inservice training officers through presentations of health education seminars. They would include information on topics that would hopefully motivate community participation in the development of health programs. Each topic could be developed into a health education package. The package would have instructions on methods for presentation of the topic content. These would also be supportive materials and equipment to assist trainers in emphasizing the health teachings. The inservice training committee (ISTC) would be generally responsible for developing "Health Education Packages" that could be stored in a central location for easy accessibility by the training officers. An inventory of the training packages would be maintained by the ISTC with the training officers and other members of the Primary Care Team assisting in acquiring materials for developing an

extensive variety. Parish training teams would be able to rely on a source at county level for acquiring resource material, for community health education.

An example of a Health Education Package is as follows:

**Disaster Preparedness (D.P.)**

- a. Orientation instructions (methods for presentation of D.P. content)
- b. Handouts (descriptive precautions, safety measures)
- c. Appropriate Film(s)
- d. Charts, posters
- e. List of supplies (basic items, ways to improve)

**First Aid Including Basic Life Support** measures could also be developed into health education packages for community presentation. One package (Basic First Aid) would include instructions in the management of injuries such as lacerations, wounds, poisons and the second package (Basic Life Support) would include materials to instruct one in measures to sustain life. The use of life size demonstration models would be effective in that community participants would be able to participate in the demonstration exercise.

The above are only two of several types of health educational seminars or training sessions that training officers could organize and present with minimal assistance. Most officers have been trained in advanced first aid and operation of the Mobile Film Unit. Community organizations, health committees, community councils, service groups, churches, and schools have been very receptive to film supported health educational programs.

**Trainers Guidelines - Programme Planning to Evaluation**

In an effort to reduce planning time, Training Officers who are working under a demanding schedule may design programs that consist of only a broad general outline. The problem with this is that it assumes everyone concerned

knows and agrees to the specific details. According to the training proposed, details made explicit lessen the possibility of: \*

- plan not being well understood
- major parts of the program forgotten
- unrealistic in terms of the time allotted
- unrealistic in terms of personnel needed.

To assist Cornwall's training team to reduce the total time of a program by demanding that adequate time be allowed for the initial planning, the attached set of guidelines was developed (Figure 3). The chart of Guidelines was developed on the principles of programme evaluation review techniques (PERT). The actual steps to consider however were based on activities of programme planners during inservice training implementation in Cornwall County. The guidelines can be adjusted to reflect specific training programmes adequately detailed so that important events in the program plans are identified for all to see and work with.

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\* Arnold, Mary F.1966."Health Program Implementation Through PERT"  
Western Regional Office, APHA.

Figure 3

**TRAINING GUIDELINES -- PROGRAM PLANNING TO EVALUATION**

**STEPS TO CONSIDER BEFORE--**

<u>Writing Program Objectives</u> → <u>Writing Program Syllabus</u> → <u>Finalizing Trainee List</u> → <u>Implementing Program</u>			
<b>Training Needs</b>  Short/Long Term Goals Budget Needs/Estimate Pre-test Post-test Programme Funding Trainees Trainers Program Orientation Trainees SMOH Primary Care (MOH) Training Branch (MOH) INSERVICE TRAINING COMMITTEE Method of Evaluation	<b>Programme Objectives</b>  Time Table Content Venue Budget Proposed Teaching Materials Feasability of Programme Draft Trainee Transportation Trainer Transportation Liase Personnel Typist	<b>Finalized Revised Program Evaluation</b> <u>CONFIRMED:</u> Trainers Training Schedule Training Supplies Teaching Aids Transportation Meals Budget Approval Funding Source Responsibilities of: Liase Officer MO(H) Training Branch CCHA	<u>RE-CONFIRM:</u>  1. Trainee List 2. Venue 3. Availability of teaching materials transportation meals 4. Accessibility to Training Fund 5. Alternative Plan for the Unforeseen 6. Venue Readiness 7. Documentation of Training 8. Reporting to Training Committee

**B. County Level**

The development of a systematic process for an annual review of the objectives, goals, and function of the inservice training committee and the training officers is proposed. A critical look at specific areas within the health system may increase the opportunity to maintain effectiveness in training. Health workers from the periphery should be brought in to provide input into this process. Primary Care and Training Branch officers would play an advisory role in their participation. Areas for review and consideration of priorities include:

<p><b>Training Coordinator: Training Committee:</b></p>	<p>Management, Guidance, Continuing Education Stimulate community participation; Increase community capacity to look after themselves; Organization of health committees</p>
<p><b>Training Teams:</b></p>	<p>Priorities among health problems; Epidemiologically defined needs; Feedback pattern for the community Task Analysis</p>
<p><b>Training Program:</b></p>	<p>Establish primary care training program for one year; Involvement of county level schools (Diploma Nursing/Midwifery) as resource/preceptors; Documentation procedure</p>
<p><b>Supervision Restructure:</b></p>	<p>Ability; confidence; respect</p>
<p><b>Information system and monitoring</b></p>	<p>Type/amount of information collected; Indicators for continual application in the system;</p>
<p><b>Logistics/Supplies:</b></p>	<p>Involve community organizations; Delegate responsibilities</p>
<p><b>Community:</b></p>	<p>Definition of priorities in health care/education; commitment to the health system</p>

<b>Referrals:</b>	Primary to secondary care; Type I to Type II to Type III; Uniformity; Initiation and receiving
<b>Retraining/Continuing Education</b>	Task Oriented; Human resource; Upgrade/Improve/Standardize health message
<b>Evaluation</b>	Cost effectiveness; Local application; Community acceptability

### **In-service Training Committee**

Since no post for a County Training Coordinator exists, or is likely to be created, a Senior Health Educator who represents a leader for continuing education seems most appropriate for the position. Distance and terrain often make communication of in-service training activities difficult. A person located at the central level with the overall responsibility for coordinating in-service training activities in Cornwall County will facilitate productivity and strengthen the parish training teams. The proposed job description of such a person would be as follows:

#### **County Training Coordinator**

The Training Coordinator is a senior member of the health team who assumes responsibility for the coordination of in-service education programs for all staff members of the Cornwall County Health Department.

#### **Duties:**

The Coordinator will be responsible to the Senior Medical Officer and will be responsible for:

1. Coordinating training activities proposed by in-service education officers.

2. Assisting parish in-service education officers to identify staff and community needs for further training or service.
3. Coordinating training activities proposed by the Training Branch, and the Ministry of Health and Social Security.
4. Identifying resource persons to carry out education program to meet staff needs.
5. Collecting and maintaining current data of training programs.
6. Assisting with the design and implementation of training programs within his/her capabilities.

### **In-service Training Teams**

Parish in-service training teams more or less shared equally the responsibilities for coordinating in-service programs. As the amount of training expanded and the number of programs to be implemented increased, the teams began to exhibit signs of weariness. One must remember that these groups of staff accepted training responsibilities in addition to their regular duties. It is important to recognize the signs of team effort breakdown because, unless preventive interventions are made early, consistent motivation of the groups to maintain high output is difficult. One example of training team weariness that occurred in Cornwall was the gradually increased occurrence of incompleting quarterly schedules for parish training functions. Members of the team related that in-service training responsibilities left little time to carry out the functions related to the posts they held. In my estimation, the viability of the teams is threatened when this is happening.

As long as the in-service training officers will assume training responsibilities in addition to their appointed jobs, the suggestion is that there be some allowances of time to perform the activities associated with in-service training. By delegating some of the duties of that officer to another staff

member when in-service training needs are being performed may lessen the pressure on the training teams. This arrangement would undoubtedly have to be worked out with the Senior Medical Officer and the Ministry of Health.

### **Management Training: Pilot District**

The County of Cornwall has designated a health district in each parish as a pilot district. These districts represent the model in health facilities, services, and personnel. A team from Cornwall County Health Administration visited each pilot district monthly to assess problems in its development, interventions needed, and to plan future courses of action (See Figure 4). The problem solving team have had increasing difficulty in scheduling pilot district visits due to other duties of the individual members. The deployment of major problem solving responsibilities for pilot districts from County personnel to specific staff members in each health district may best be achieved through in-service training. Training should be tailored for individuals selected, and include those specific areas that would facilitate the participants to promote the development of model health facilities in pilot districts. In-service training programs to support the above objective should include the following:

#### **1. Process of Planning**

- a. Principles, types
- b. Steps in planning
- c. Planning in action

#### **2. Organizing**

- a. Formal and informal
- b. Coordination
- c. Division of work
- d. Delegation of authority
- e. Assigning activities

Figure 4

PILOT DISTRICT DEVELOPMENT IN CORNWALL COUNTY

Health Centre	Problem Identified	Intervention	Further Action Required
Type I	1. Floor in waiting area sinking. 2. Compound needs fencing. 3. Water pipe to clinic broken off. 4. Vandalism (2 toilet bowls, 1 wash basin) 5. Burglar bars needed for both doors. 6. Electricity unavailable. 7. Sterilizer or hot plate needed. 8. No Midwife.	<ul style="list-style-type: none"> <li>- Items 1 through 8 :</li> <li>- Staff met with representative from Lions Club. Needs outlined. Date set for meeting at Clinic Site.</li> </ul>	<ul style="list-style-type: none"> <li>- Mobilize community to aid in protection of property (e.g., via Health Committee).</li> </ul>
	<ul style="list-style-type: none"> <li>- Clients attend wrong clinic</li> </ul>	<ul style="list-style-type: none"> <li>- Clinic roster posted.</li> </ul>	<ul style="list-style-type: none"> <li>- Educate community re: specific clinic schedule and attendance.</li> </ul>
	<ul style="list-style-type: none"> <li>- No Health Committee</li> </ul>	<ul style="list-style-type: none"> <li>- Guidelines for organization of health committee provided</li> </ul>	<ul style="list-style-type: none"> <li>- Assistance in organization of health committee from health educator.</li> </ul>
	<ul style="list-style-type: none"> <li>- More skill needed to implement family planning/nutrition programme</li> </ul>	<ul style="list-style-type: none"> <li>- Update family planning/nutrition programmes via inservice training</li> </ul>	<ul style="list-style-type: none"> <li>- Ascertain specific needs; e.g., (1) who needs training and (2) what specific areas. Coordinate in-service as needed.</li> </ul>
	<ul style="list-style-type: none"> <li>- No food supplements</li> <li>- No food demonstrations</li> </ul>	<ul style="list-style-type: none"> <li>- Food supplements supplied.</li> <li>- Food demonstration resumed.</li> </ul>	<ul style="list-style-type: none"> <li>- Adequate space for storage of food supplements.</li> <li>- Adequate supplies/equipment for food demonstration.</li> </ul>
	<ul style="list-style-type: none"> <li>- Faulty plumbing.</li> </ul>	<ul style="list-style-type: none"> <li>- None to date.</li> </ul>	<ul style="list-style-type: none"> <li>- Supply preventive maintenance.</li> </ul>
	<ul style="list-style-type: none"> <li>- Need new building.</li> </ul>	<ul style="list-style-type: none"> <li>- None to date.</li> </ul>	<ul style="list-style-type: none"> <li>- New building to be built under JA.PP 11.</li> </ul>
	<ul style="list-style-type: none"> <li>- Organization re: Cleaner attendant Fulltime staff and full employment.</li> </ul>	<ul style="list-style-type: none"> <li>- Matter to be referred to Parish Council.</li> </ul>	<ul style="list-style-type: none"> <li>- Reorganization of staff.</li> </ul>
	<ul style="list-style-type: none"> <li>- Type II services needed; building not secure.</li> </ul>	<ul style="list-style-type: none"> <li>- None to date as new health centre being built in the area.</li> </ul>	<ul style="list-style-type: none"> <li>- Security measures for existing building.</li> </ul>
	<ul style="list-style-type: none"> <li>- Supplies needed: B.P. Instrument Uristics Furniture (chair, refrigerator)</li> </ul>	<ul style="list-style-type: none"> <li>- B.P. instrument provided</li> <li>- Uristics provided.</li> <li>- Order included in County estimates.</li> </ul>	<ul style="list-style-type: none"> <li>- Preventive maintenance</li> <li>- System for ordering before supply depleted.</li> <li>- Follow-up by Administrator.</li> </ul>

Health Centre	Problem Identified	Figure 4 (continued) Intervention	Further Action Required
Type II	<ul style="list-style-type: none"> <li>- Electrical fixtures/benches in disrepair.</li> <li>- Road leading to Health Centre rough and dangerous.</li> <li>- No adult scales.</li> <li>- No food demonstration kits.</li> <li>- No electricity, water.</li> <li>- Minor misconception re: registration.</li> <li>- Type I services offered from Type II Centre.</li> </ul>	<ul style="list-style-type: none"> <li>- Advised to contact N.D.A.</li> <li>- MO(H) to contact Parish Council</li> <li>- Adult scale provided.</li> <li>- Fund raising program in planning stages.</li> <li>- Owner of building contacted by Chief Public Health Inspector.</li> <li>- Clarification of registration procedure.</li> <li>- Gradual increase in number of clinic services.</li> </ul>	<ul style="list-style-type: none"> <li>- MO(H)/Administrator to follow up.</li> <li>- Request assistance for road repair in writing and in person.</li> <li>- Preventive maintenance.</li> <li>- Community Involvement.</li> <li>- Follow up at Administrative level.</li> <li>- Monitoring system by Supervising Nurse.</li> <li>- Provision for conducting Type II services.</li> </ul>
Type III	<ul style="list-style-type: none"> <li>- Drugs - orders received inadequate, expired dates.</li> <li>- Inadequate supply of stationery.</li> <li>- Roof leaking in 6 places.</li> <li>- Water supply inadequate.</li> <li>- Difficult building access for stretcher patients/supplies,etc.</li> <li>- No notice board/floor mats.</li> <li>- <u>Records</u> - Inadequate supply.</li> <li>- No resident dentist.</li> </ul>	<ul style="list-style-type: none"> <li>- Ordering, receiving system classified with medical stores by Chief Pharmacist</li> <li>- Determine who is responsible for supply distribution.</li> <li>- Recommend areas be marked with paint for easy identification.</li> <li>- Reserve water tank to be requested.</li> <li>- Identify area of grounds suitable for drive in ramp.</li> <li>- Health Committee mobilized to raise funds for mats.</li> <li>- Supplies of cards from statistical officer to p.d.</li> <li>- Cuban dentist visiting once a week.</li> </ul>	<ul style="list-style-type: none"> <li>- Routine monitoring by Public Health Nurse/Chief Pharmacist.</li> <li>- Order supply, maintain supply.</li> <li>- Letter dispatched to contractors for immediate action.</li> <li>- Administration to follow up.</li> <li>- Assess the possibility of vehicle ramp.</li> <li>- Continued support of Health Committee by all staff members.</li> <li>- Each pilot district staff to estimate number of clinic cards needed for one year. Order for clinic cards must originate from Parish MO(H).</li> <li>- Recruit full-time dentist/dental nurse for p.d.</li> </ul>

### **3. Staffing**

- a. Policy and process
- b. Recruitment, selection
- c. Orientation, training, development.

Problem solving teams within each health district would then assume primary responsibility for identifying problems in the pilot districts and initiate positive interventions for solving them (See Figure 5 for the format of the committee control system and monitoring.) The Cornwall County Health Administration would, however, continue to be responsible to the health district teams for pilot district development.

#### **Orientation Program**

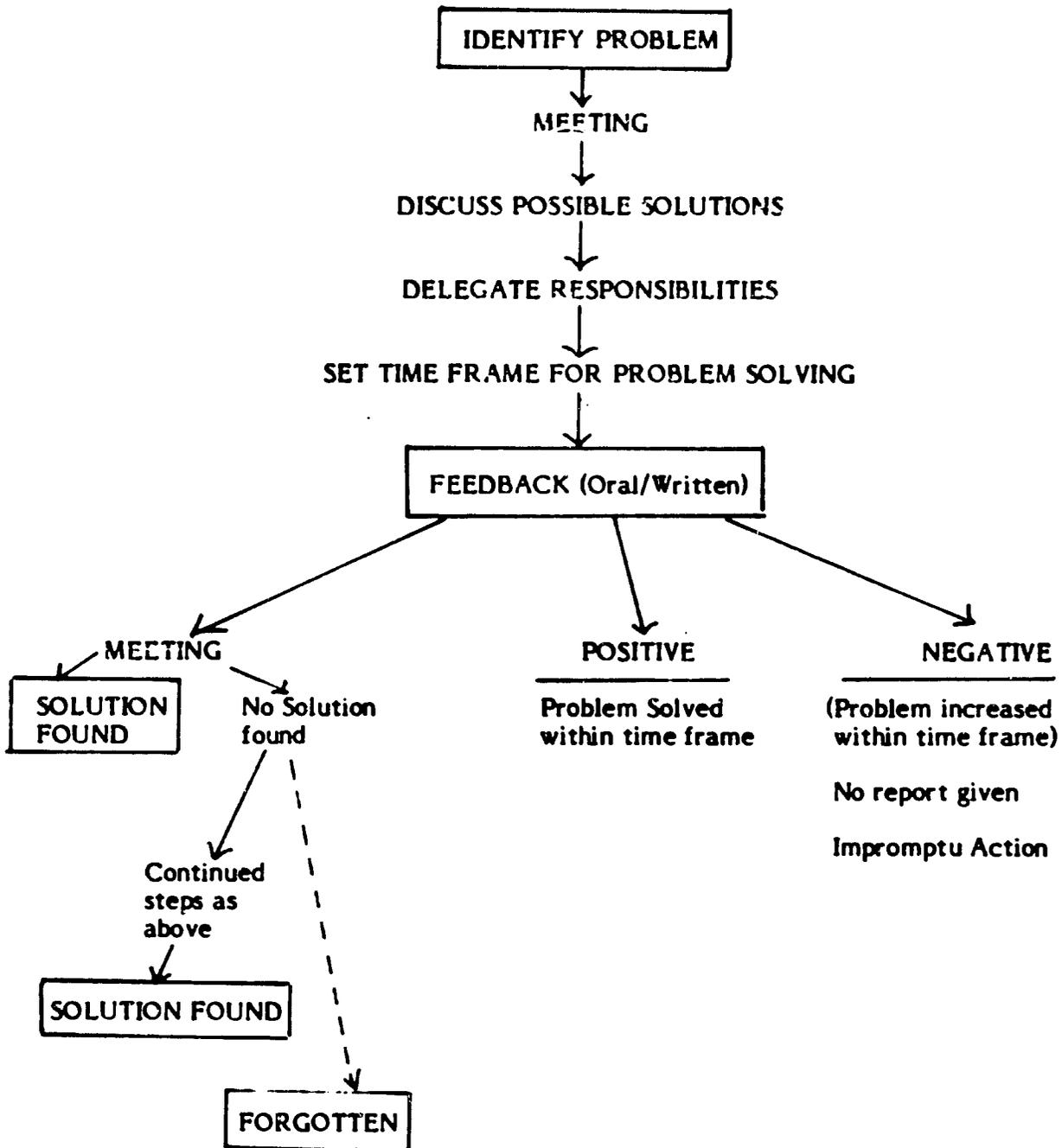
Employees entering the Primary Health Care system for the first time frequently begin the appointed duties with little or no orientation to the surroundings or their responsibilities. A basic program for orienting new employees and old employees functioning in new positions could be developed through the efforts of Cornwall's training team and the personnel department. Responsibilities of staff participating in the orientation program would be based around the following program activities for an employee:

- Orientation to CCHA (policies and procedures organizational structure, etc.)
- Orientation to personnel functions (salary, leave, sick time, etc.)
- Orientation to specific job specifications
- A minimum of one day on the job activity with a senior staff member in attendance
- A one-day tour of primary care facilities with an overview of objectives of the services

An estimated minimum of four days orientation for an employee in a given post facilitates smooth integration into the system.

Figure 5

PILOT DISTRICT FORMAT FOR PROBLEM SOLVING COMMITTEE



**C. Ministry of Health - Training Branch**

**Recognizing Staff Capability**

An expanding Primary Care System requires full utilization of all health staff. What has been known to happen is, some staff members are placed in the position where they are required to provide services and perform functions that are not a part of their role. Lesser trained personnel unofficially perform functions that they have not been trained in or tasks may go undone, not because the person cannot do it, but because of fear of reprisal. This is a waste of effective manpower and often results in good skills being lost to the health service. Employees who demonstrate the potential to expand their capability in performing primary care functions should have the opportunity to do so. Cornwall County's inservice training team have the ability to identify and assist the Training Branch to train selected personnel to expand their skills. Some examples of skills for which specific primary care workers could be trained to upgrade their performance ability are:

**Community Health Aides**

Blood Pressures  
 Eye Screening  
 Time Test (reading & Placing)  
 Monitoring immunization records  
 Immobilizing a Fracture  
 Pregnancy Tests on Urine

**Public Health Inspector**

Drawing Blood  
 Suturing  
 Removal of Sutures  
 Placing PPD

**Staff Nurse**

Suturing  
 Taking Blood  
 Insertion/Removal  
 IUDs

**Manuals**

Strengthening the link between the Training Branch and Primary Health Care field activities in Cornwall would be of two fold benefit. First, the Training Branch would be more aware of Cornwalls needs and how they could best assist them and secondly, relevant materials for inclusion in type II and III manuals could be gleaned.

## **APPENDICES**

APPENDIX I  
Primary Care Workshops in  
Management/Communication Skills

A number of forms were used in the organization of the Primary Health Care Workshops in Management/Communication Skills. The explanation and purposes of these forms follow:

Form I Presents the management/communication skills to be covered by a Primary Care Workshop. The purpose of this form is to present the basic concepts that staff would need to understand in order to perform their tasks effectively in a Type I Centre.

These program objectives represent the expected behavior of staff members in relation to the health services being provided to the community.

Form II Schedules for the two-day workshop are found in Forms IIa and IIb. The content areas that are marked "major emphasis" provide specific information to be included by the Instructor. This is an attempt to insure uniformity in content in all parish training workshops.

Form III displays the pretests which are to be distributed at the beginning of a workshop. It should be completed by all participants in order to identify the areas of content that require extra input. It is recommended that the test be repeated at the end of the presentations. Information from a post-test gives an indication as to whether or not the material presented in the workshop was understood by the participants.

Form IV(a).

It is important to give out evaluation forms on the first day with an explanation of: (a) how to use the evaluation forms; (b) the importance of answering all questions. Form IVa and Form IVb are the questions which were distributed to workshop participants.

**Participants are to fill in the first three items on the Evaluation Form at the end of the first day. Items 4, 5, and 6 are to be completed before the end of the second day. The evaluation results are to be tallied before the conclusion of the workshop in order to give feedback to the participants.**

**A. Basic Ideas to be Presented**

1. Leadership is interchangeable--passes from one to another.
2. Roles of health team members are being expanded which necessitates additional training.
3. In order to understand others, we must understand our own behaviour.
4. Delivering a message effectively involves more than just words.
5. To insure the delivery of health services that meet the needs of the community, proper organization of the clinic staff, equipment, and records is necessary, i.e., scheduling for complete coverage of clinic (8:30 AM-5:00 PM), uniform recording system, appointments, full utilization of existing staff.

**B. Objectives**

Health team members will be helped to:

1. Make appropriate decisions in delivering primary health care.
2. Delegate work assignments when acting as team leader.
3. Cooperate with all team members and provide assistance to others as needed.
4. Accept their changing role and assume responsibility for new tasks.
5. Recognize their own particular assets as well as their limitations.
6. Recognize that there are individual differences and deal with them effectively.
7. Prepare and present health information which will be easily understood by the community.
8. Produce visual aids to facilitate them in health teaching.
9. Prepare a roster of work assignments, schedule patients for clinic, record and report accurately.
10. Demonstrate skill in gathering information and providing advisory and referral services when working with community members.

## FORM II A

## PROTOCOL FOR PRIMARY HEALTH CARE

## Two-Day Workshop

**GOAL:** To maintain uniformity in the presentation of all Primary Health In-Service Workshops in the County of Cornwall.

**OBJECTIVE:** To develop a format based upon workshop objectives and basic ideas for the presentation of training content.

FIRST DAY SCHEDULE

8:30 AM	Attendance General Information	Check off list AM Purpose of the Workshop Orientation to the day's schedule
8:40 AM	Rationale for In-Service Rating and Evaluation  Distribute evaluations  Pretest -- Form III	Printed handout and/or ten minute presentation  Clarify: demonstrate method for completing the forms if necessary. Elicit questions  Ask group to complete in 15 minutes
9:15 AM	Interpersonal Relationships	Content to be principally based upon and developed around Idea No. 3, Objective No.5, No.6, Form I
<b>MAJOR EMPHASIS: PERSONALITIES/BEHAVIORS THAT PROMOTE/INHIBIT GOOD INTERPERSONAL RELATIONSHIPS IN PRIMARY HEALTH CARE SETTING</b>		
10:15 AM	B R E A K	
10:30 AM	Communication	Content to be principally based upon Ideas No. 1 and 4, and developed around Objectives No.3 and 10, Form I
<b>MAJOR EMPHASIS: EXPECTATIONS, RESPONSIBILITIES FROM EACH TEAM MEMBER, SPECIFICALLY TYPE I CENTRES</b>		
12:00 Noon	L U N C H	
1:00 PM	Attendance	Check off list PM
1:10 PM	Interviewing and Counseling	Discussion and Role Play
2:00 PM	Health Team Relationships	Content to be principally based upon Ideas No. 2, 3 and 4 developed around Objectives No. 7 and 10



## FORM II B

SECOND DAY SCHEDULE: TYPE I CENTRE WORKSHOP

8:30 AM	Attendance	Check off list - AM
8:40 AM	General Information	Orientation to the day's schedule
9:00 AM	Management Skills Supervision	Content to be principally based upon Ideas No. 2 and 5 and developed around Objectives 1,2,3 and 10
MAJOR EMPHASIS: TYPE I CENTRE ( TYPE I ORGANIZATION PROCEDURE)		
10:15 AM	B R E A K	
10:30 AM	Organization	Expectations of team leaders as they relate to Organization
11:30 AM		Relate specifically to Organization of services in Type I Centre in role play
12:00 Noon	L U N C H	
1:00 PM	Attendance	Check off list - PM
1:10 PM	Planning	Content to be principally based upon Idea No. 5 and developed around Objectives No. 1,2,3,7,8,9 and 10
MAJOR EMPHASIS: IMPROVED PERFORMANCE OF THE HEALTH TEAM		
2:00 PM	Technique and Procedure of Referral System	Content to be principally based upon Ideas No. 1,2,3,4,5,6,9 and 10
MAJOR EMPHASIS: EFFICACY OF SERVICES FOR THE COMMUNITY SERVED		
3:00 PM	B R E A K	
3:10 PM	Reinforcement of points previously raised	Panel Discussion/Role Play/Questions and Answers
3:45 PM	Review	A participant will review the basic ideas and objectives involved and from his/her notes, highlight the material that covers the idea and objectives respectively.
4:10 PM	Evaluation	To include overall assessment of total presentations specifically as they relate to the objectives.

## FORM III

## QUESTIONNAIRE

## PRIMARY HEALTH CARE: TYPE I CENTRE

1. What is your definition of primary health care?
2. What health workers make up the Primary Health Care Team?  

Type I	Type II	Type III
--------	---------	----------
3. Who are the (non-health) members of the community who are associated with the health team?
4. Write the location of each Type I Health Centre in your area, along with the Type II and Type III Centres that will be used as back-up.  

Type I	Type II	Type III
--------	---------	----------
5. Who are the health workers that will be stationed in a Type I Centre?
6. At what hour will the Centre open?
7. At what hour will the Centre close?
8. How many people will the Type I Centre provide health services for? Pick one.  

10,000	4,000	8,000
--------	-------	-------
9. Who are the health workers that will be making regular scheduled visits to the Type I Centre?
10. What health services will be provided from the Type I Centre?
11. Where would you refer a person who has a problem that cannot be managed by a Type I Health Centre?
12. A mother brings her eight month old baby to you. You find he has a fever of 100°F. His tongue is red and dry. Mother states that the baby has had at least five liquid stools each day for three days. What do you do?

FORM IVa

EVALUATION OF IN-SERVICE WORKSHOP-PRIMARY HEALTH CARE

Position \_\_\_\_\_

Parish \_\_\_\_\_

Date \_\_\_\_\_

Please rate each session on a scale of 1-5 by circling a number; 1 is the LOWEST rating, 5 is the HIGHEST.

	Presentation and Delivery					Clarity					Usefulness					Participation				
1. Interpersonal Relationships	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
2. Communications	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
3. Interviewing and Counseling	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
4. Organization: Type I Centre	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
5. Planning: Improved Performance of Health Team	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
6. Supervision	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5

FORM IVb

**Objective:** In your opinion, to what extent were the Seminar Objectives met?  
Health Team Members will be helped to:

	<u>Not at All</u>	<u>To Some Extent</u>	<u>Completely</u>
1. Make appropriate decisions in delivering primary health care:	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. Delegate work assignments when acting as team leaders:	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. Cooperate with all team members and provide assistance to others as needed:	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. Accept their changing roles and assume responsibility for new tasks:	<input type="text"/>	<input type="text"/>	<input type="text"/>
5. Recognize their own particular assets as well as their limitations:	<input type="text"/>	<input type="text"/>	<input type="text"/>
6. Recognize that there are individual differences and deal with them effectively:	<input type="text"/>	<input type="text"/>	<input type="text"/>
7. Prepare and present health information which will be easily understood by the community:	<input type="text"/>	<input type="text"/>	<input type="text"/>
8. Prepare a roster of work assignments, schedule patients for clinic, and record and report accurately:	<input type="text"/>	<input type="text"/>	<input type="text"/>

## FORM Va

## SITUATIONS YOU MAY ENCOUNTER AT A TYPE I HEALTH CENTRE

Please give brief answers to the questions following each situation described:

- a. A man has fallen down a hill and injured his arm. You unwrap the dirty towel that is covering his arm and find a large area of skin has been scraped off. The area is covered with dirt and sand. There is moderate bleeding. The arm is not broken. What do you do?
- b. The nearby gardener has sustained a large, deep cut on his hand from a saw. There is heavy bleeding. What do you do?
- c. There has been a car wreck with several people injured and they are brought to your Centre. One man complains that he cannot get his breath and he is bleeding from his mouth. What position can you put him in to help both these problems immediately?
- d. The second man has a broken arm but he is walking around and says he is OK. What do you do for him?
- e. A mother brings her eight month old baby to you. You find he has a fever of 103°F. His tongue is red and dry. Mother states the baby has had at least five liquid stools per day for three days. What do you do?
- f. A three year old has ingested paint thinner that was left in a soda bottle. What do you do?
- g. A young mother finds her two year old with an open aspirin bottle. There is evidence of chewed aspirin in the baby's mouth. What do you do when the child is brought to you?
- h. A young boy is burned with a kerosene lamp. When he reaches you there are many blisters on the back of his hands extending up his arms. What do you do?
- i. A young woman six months pregnant comes to you complaining of feeling sick. You learn she has been feeling dizzy with headaches for two days. During your examination you notice that her feet are swollen, her blood pressure is 200/110 and she has gained eight pounds since she visited two weeks ago. What do you do?
- j. A teenager stops in on her way from school because she has a nosebleed. You notice blood oozing from both nostrils. What do you do?
- k. A five year old falls down while running with a bottle and gets a cut on his arm. What do you do?
- l. A man is brought to you by a neighbor who states that the man was shot in the chest. He is breathing, but you notice the sound of air coming from the wound. What do you do?

## FORM Vb

This sheet should be used with the situations listed on Form Va.

## URGENT SITUATIONS

How do you manage these problems? Would you:

- a. Manage the problem at your Type I Health Centre?
- b. Refer to a Type II, III, IV Health Centre or Hospital?

The following actions may be taken by Type I Health Centre staff to manage the stated situations. Actions are listed in order of priority (what is done first):

- a. Stop the bleeding (direct pressure)  
Elevate the arm  
Cleanse the wound and observe for extent of injury  
Sterile dressing  
Tetanus immunization (full series if necessary)
- b. Stop bleeding (direct pressure)  
Cleanse wound and observe for extent of injury  
Sterile dressing  
Or refer for suturing to Type II Centre or Hospital  
Tetanus immunization
- c. Lie client on his side with head and chest raised  
Immediately transport to hospital
- d. Splint arm  
Check vital signs and observe for any other injuries  
Refer to hospital or Type III/IV for casting
- e. Immediately refer to Hospital or Type IV (life threatening situation)  
Tepid sponge during transfer
- f. Hospital or Type III or Type IV referral  
Do not induce vomiting
- g. Give milk (one half glass, if available)  
Observe the child for two to three hours  
Advise parent to observe the child for signs of lethargy
- h. Cleanse burns; do not open blisters  
Sterile ointment/dressing  
Tetanus prophylaxis  
Have an M.D. check the wound as soon as possible
- i. Immediately refer to Hospital (possible eclampsia)
- j. Instruct the teenager to breathe through her mouth  
Gently but firmly pinch both nostrils for 10-15 minutes  
Release and observe  
If bleeding continues, repeat nostril pressure

**FORM Vb**  
**Urgent Situations, continued**

- k. Cleanse wound
  - Look for glass particles
  - Apply pressure to stop bleeding
  - Tetanus immunization
  
- l. Cover the wound; do not stop air hole
  - Immediately transport to the Hospital

## APPENDIX II

Family Planning Update

Two major health problems having a negative effect on improved family life in Cornwall County are an escalated birth rate among teenagers and an increased incidence of sexually transmitted diseases (STD). Eighteen percent of Cornwall County's population are women between the ages of 15 and 44 (childbearing age), and 45 percent of the population is under 15 years of age. These figures specify a population at risk for both problems - pregnancy and STD. Cornwall County's Health Administration agreed with its trainers that positive interventions could be made through in-service education and training of the primary care team. Since the STD Division of the Ministry of Health was planning a national in-service training program, Cornwall concentrated its efforts on a Family Planning Update for all primary care staff.

Medical Officers of Health and Family Planning clinic staff reported a general decline in the promotion of family planning methods among health workers. The most outstanding reason for this, although many were cited, was a large percentage of staff providing family planning services were not comfortable with the responsibility, did not possess an in-depth knowledge of contraceptive methods, contra-indications, and side effects. They were reluctant to perform or precept trainees in practical family planning skills such as pap smears, pelvic examinations, and insertions of intrauterine devices. Although the skills were learned by a number of midwives and Public Health Nurses, unfortunately, these skills were not used often enough to maintain competency. Discussions with members of the National Family Planning Board, the Training Branch of the Ministry of Health, the Principal Medical Officer of Primary care, and supervisory nursing personnel in Cornwall provided information which assisted in developing an approach to family planning in-service training.

INSERVICE TRAINING - CORNWALL COUNTY

PRIMARY HEALTH CARE - FAMILY PLANNING UPDATE

Theory/Practical

Macro Objective:

To upgrade the knowledge, skills and attitudes of program participants in Family Planning practices

Specific Objectives:

At the end of the training program, participants will be able to :

- conduct an interview and record pertinent family planning (F.P.) information
- assist clients by giving family planning advice based on fact
- assist clients to select a suitable method
- dispense contraceptives (i.e. pills, condoms, etc.)
- promote F.P. practices within the community

Practical Objectives:  
(Clinical)

At the end of the practical training program participants will be able to perform the following according to accepted procedure:

- |                         |                                    |
|-------------------------|------------------------------------|
| - breast examination    | - fit diaphragm                    |
| - pelvic examination    | - insert intrauterine device (IUD) |
| - pap smear             | - remove intrauterine device (IUD) |
| - administer injectable | - report/record abnormal findings  |

INSERVICE TRAINING - CORNWALL COUNTY

PRIMARY HEALTH CARE - FAMILY PLANNING UPDATE

PROGRAMME TOPICS/CONTENTS

Introduction to Family Planning (F.P.)

- Population growth and control
- Family planning practices (county/regional)

Attitudes Toward Family Planning

- Past and Future growth of world population
- Population growth in our contry

Role of Health Workers in Family Planning

- be informed of the choices
- promote improved family life

Family Planning Interviewing Principles

- maintaining confidentiality
- communication skills

Family Planning Record Keeping

- Standardizing F.P. records
- Maintaining F.P. records for easy retrieval of statistical data

INSERVICE TRAINING - CORNWALL COUNTY

PRIMARY HEALTH CARE - FAMILY PLANNING UPDATE

PROGRAMME TOPICS/CONTENT

**Anatomy and Physiology of Human Reproductive Organs**

- permanent sterility (males/females)

**Taking A Papsmear**

- Why
- When
- How

**Breast/Pelvic Examination**

- determining the abnormal from the normal

**Family Planning Methods**

- Contra indications
- side effects

Injectables

Pills

Condom

Diaphragm

Intrauterine Device (IUD)

} When/How

insert/remove

PRIMARY HEALTH CARE IN-SERVICE EDUCATION  
FAMILY PLANNING UPDATE (THEORY)

DATE	TIME	GROUP	SUBJECT MATTER	METHOD	RESOURCE PERSONNEL	EVALUATION
Day I	9:00 AM-9:30 AM	Public Health Nurses Public Health Inspectors Staff Nurses District Midwives Community Health Aides	Registration			
	9:30-9:45 AM		Opening Exercises			
	9:40-10:15 AM		Introduction to Family Planning: a. What is Family Planning? b. Why Family Planning?		Senior Public Health Nurse	
	10:15-10:30 AM	B R E A K				
	10:30-11:45 AM		Attitudes Toward Family Planning in Jamaica	Panel Discussion	Moderator, 4 persons from County	
	12:00-1:30 PM	L U N C H				
	1:30-2:30 PM		Role of Health Workers in Family Planning	Group Discussion	Nursing Coordinator, CCHA	
	2:30-3:30 PM		Recordkeeping as it Relates to Family Planning		Statistical Officer, CCHA	
	3:30-4:00 PM		Review	Review	Review	Evaluation

PRIMARY HEALTH CARE IN-SERVICE EDUCATION  
FAMILY PLANNING UPDATE

DATE	TIME	GROUP	SUBJECT MATTER	METHOD	RESOURCE PERSONNEL	EVALUATION
Day II	9:00-9:15 AM	Public Health Nurses Public Health Inspectors Staff Nurses Community Health Aides District Midwives	Registration			
	9:10-10:30 AM		Anatomy and Physiology of Human Reproductive Organs	Lecture	Medical Officer of Health	
	10:30-10:45 AM	B R E A K				
	10:45 AM-12:00 PM		Methods of Family Planning: Contraindications, side effects	Plenary Group Sessions	Medical Officer of Health	Questionnaire
	12:00-12:30 PM		When, Why, and How to Take a Pap Smear	Lecture, Demonstration	Medical Officer of Health	Questionnaire
	12:30-2:00 PM	L U N C H				
	2:00-3:00 PM		Principles of Interviewing as they Relate to Family Planning		Health Educator	
	3:00-4:00		Communication skills, Interpersonal Relationships	Lecture, Discussion, Role Play	Health Educator	
	4:00-4:30 PM		R E V I E W	REVIEW	REVIEW	Evaluation

FAMILY PLANNING PRETEST

Please complete in 20 minutes.

1. How does the pill prevent pregnancy?

2. List four side effects of the pill:

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_

3. How often should the pill be taken?  
If a client misses taking one pill on one day, what should you advise?

4. List four major reasons why women should not take the pill:

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_

5. What effect does the coil have on the male partner?

6. How does the coil prevent pregnancy?

7. List four side effects of the coil:

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_

Family Planning Pretest  
Page 2

8. What information do you give a client before giving depo-provera?
9. What is tubal ligation?
10. If a condom slips off during intercourse, what effect will this have on the woman?

## IN-SERVICE TRAINING

### FAMILY PLANNING UPDATE

#### Worksheet for Training Officers: Acceptable responses for Family Planning Pretest

This worksheet is a guide to assist Training Officers in assessing areas where major emphasis should be applied when conducting training sessions. Please observe for the inclusion of the "Correct Concept" in answers to Pretest questions. Listed below are some acceptable responses to the Family Planning Pretest. Fewer than 15 correct responses indicates a need for family planning update.

#### Question 1:

- Inhibits ripening of ovum
- Inhibits ovulation
- Body stops producing eggs
- Hormone/s in pill suppress ovulation

#### Question 2:

- Nausea, vomiting
- Weight gain
- Breast fullness/tenderness
- Menstrual irregularities
- Increased vaginal discharge
- Depression
- Mood swings
- Anxiety
- Fatigue
- Cholasma
- Lowered libido
- Elevation in blood pressure

#### Question 3:

- Every day/daily
- One pill daily
- Every night

- 3b. -Take the missed pill along with the next day's pill at the regular time
- Take two pills as soon as she remembers
  - Take one pill the next morning and one at night
  - Continue to take the pills and use a condom until the next period

#### Question 4:

- Hypertension
- Thrombophlebitis
- Known or suspected breast or genital cancer

Family Planning Pretest Answer Worksheet  
Page 2

Question 4, continued:

- Liver disease
- Suspected pregnancy
- Unexplained uterine bleeding
- Varicosities
- Diabetes

Question 5:

None

Question 6:

- Prohibits implantation of a fertilized ovum
- Acting as a foreign body in the uterus

Question 7:

- Excessive bleeding
- Cramping
- Longer/heavier menstrual bleeding
- Dysmenorrhea
- Excessive vaginal discharge
- Spotting/bleeding between periods

Question 8:

- Must receive injection every three months
- May expect irregular menses
- May expect amenorrhea after first six months
- Risk of benign breast tumor
- Risk of permanent loss of fertility

Question 9:

- Cutting and tying of both fallopian tubes
- Tying of fallopian tubes to prevent the union of egg and sperm
- Ligation of fallopian tubes to prevent pregnancy
- Cutting off of the tubes

Question 10:

- None
- None, however, pregnancy may occur

APPENDIX III

Sexually Transmitted Diseases

Developing countries such as Jamaica have high birth rates, low death rates, and falling infant mortality rates. With the high incidence of sexually transmitted diseases (STD) in adolescents, this creates a demographic situation in which a large number of potential recruits to the STD epidemic are added each year. The answer to this frightening cataclysm must rest jointly with the effective policies for population and STD control.

Ignorance of the facts about sexually transmitted diseases and failure to provide adequate sex and family life education to young people are undoubtedly important factors in the current epidemic. Professional education ("Major Sexually Transmitted Diseases (STD)." Dr. A.R. Brathwaite.) in STD serves two important functions: firstly, to make health workers aware of the clinical manifestations and management of these diseases; secondly, and very importantly, to inculcate the correct attitudes and approaches in patients. Sexually transmitted diseases survive because of public ignorance about them, secrecy, guilt, and inadequate health care. Mass education programs should be initiated to teach people about human sexual behavior and STD. The medical professional must share its knowledge so that all men and women have precise information about the signs and symptoms, complications and treatment of these diseases.

Overall Objectives:

At the end of the two day training course the participants will:

1. Have further knowledge of the aims and objectives of the STD program.
2. Have further knowledge of the manifestations, complications, diagnosis, treatment, and epidemiology of STD.
3. Be able to identify constraints to sexually transmitted disease control in their area and work out solutions for them.
4. Be able to do client interviewing, contact tracing, field investigation, and referral of clients.

PRIMARY HEALTH CARE IN-SERVICE EDUCATION  
SEXUALLY TRANSMITTED DISEASES

Overall Objectives

At the end of the two day training course the participants will:

1. Have further knowledge of the aims and objectives of the sexually transmitted disease program.
2. Have further knowledge of the manifestations, complications, diagnosis, treatment, and epidemiology of sexually transmitted diseases.
3. Be able to identify constraints to sexually transmitted disease control in their area and work out solutions for them.
4. Be able to do client interviewing, contact tracing, field investigation, and referral of clients.

PRIMARY HEALTH CARE IN-SERVICE EDUCATION  
SEXUALLY TRANSMITTED DISEASES TWO DAY WORKSHOP

STD TOPICS/CONTENT

DAY I

Morning

Welcome/Introduction  
Chairman

Aims and Objectives of the Sexually Transmitted Disease  
Workshop

Epidemiology of Sexually Transmitted Diseases

Health Education: STD

Afternoon

Non-specific Sexually Transmitted Diseases

--Manifestation

--Diagnosis

--Treatment

--Complications

Review and Assessment

DAY II

Morning

Sexually Transmitted Diseases

--Manifestation

--Diagnosis

--Treatment

--Complications

Principles of Interviewing and Contact Tracing

Afternoon

Identification of Sexually Transmitted Diseases

Program Constraints and Solutions (Group Work)

Plenary Session

Post Test and Evaluation

## PRIMARY HEALTH CARE IN-SERVICE EDUCATION

## SEXUALLY TRANSMITTED DISEASES

## SELF-EVALUATION TEST

Please circle the correct answer.

1. In which sex do symptoms of gonorrhoea develop where they would most likely be noticed?
  - a. Male
  - b. Female
2. Which of the following statements is true?
  - a. Sexual contact causes venereal disease.
  - b. Venereal disease is usually passed from one person to another through sexual contact.
3. Against which disease does the body build a natural immunity?
  - a. Syphilis
  - b. Gonorrhoea
  - c. Neither
4. About how many people were reported with gonorrhoea in Jamaica in 1978?
  - a. 1,600
  - b. 16,000
  - c. 36,000
5. Which of the following diseases was contracted by more people in Jamaica in 1978 than measles, mumps, chicken pox, TB, typhoid, and influenza combined?
  - a. Syphilis
  - b. Gonorrhoea
6. If a woman thinks she has contracted gonorrhoea, which would be the smart thing for her to do?
  - a. Wait until someone catches it from her to make sure.
  - b. Go to a doctor or health department clinic and ask for a test for gonorrhoea.
  - c. To avoid embarrassment, go to a doctor and ask for a complete physical examination.
7. The best test to diagnose gonorrhoea in a woman is:
  - a. a smear
  - b. a culture
  - c. a blood test
8. All people who have syphilis know they are infected.
 

True      False
9. The symptoms of syphilis will not go away unless one receives proper medical treatment.
 

True      False

10. Syphilis and gonorrhoea in Jamaica occur most frequently in which age group?  
a. 15-19      b. 20-24      c. 25-29

11. The incubation period of primary syphilis is one to seven days following exposure.

True      False

12. Chancres of the lip are the most common extragenital lesions.

True      False

13. A negative darkfield examination automatically excludes primary syphilis.

True      False

**MATCH THE DISEASE WITH THE APPROPRIATE SIGNS OR SYMPTOMS**

- |                         |  |
|-------------------------|--|
| 14. Gonococccemia       | a. Vesicular, pustular, purpuric lesions on genitals |
| 15. Primary syphilis    | b. Hard, non-tender genital ulcer                    |
| 16. Secondary syphilis  | c. Vesicular, tender eruption on genitals            |
| 17. Congenital syphilis | d. Hutchinson's triad                                |
| 18. Herpes progenitalis | e. Discrete papular lesions on palms and soles       |

19. Secondary syphilis is manifested by:

- a. A generalized, macular, papular, vesicular, or pustular eruption
- b. A generalized eruption which is painless and nonpruritic except in its follicular form.
- c. A hard, discrete, nonpainful lymphadenopathy.
- d. Vesicular lesions on palms and soles.
- e. Mucous patches in the mouth, glans penis, and vagina.

20. In cases of secondary syphilis, the blood test is always positive.

True      False

21. Venereal warts are of viral origin and are not due to secondary syphilis.

True      False

Sexually Transmitted Diseases  
Self-Evaluation Test  
Page 3

22. Gonorrhea and syphilis can be contracted from the same exposure.  
True      False
23. Once a person has contracted gonorrhea, he or she can never contract it again.  
True      False
24. The term "syphilis" is  
a. Schaudinn and H  
b. Neisser  
c. Fracastoro  
d. Leviticus (15: )
25. An 18 year old male patient was diagnosed as having acute gonorrheal urethritis of two days' duration. When asked about sexual contacts, he admitted exposure with five girls. Their names and the dates of exposure are described below. One of these girls must be infected. Which one?  
a. Abigail: ten weeks ago  
b. Barbara: six weeks ago  
c. Carmen: five weeks ago  
d. Deborah: four weeks ago  
e. Ellen: one week ago

**PRIMARY HEALTH CARE IN-SERVICE EDUCATION  
EVALUATION FORM  
MINISTRY OF HEALTH AND SOCIAL SECURITY**

Name of Course \_\_\_\_\_

Position \_\_\_\_\_

Parish \_\_\_\_\_

Date \_\_\_\_\_

Please respond to each question on a scale of 1-6, with 1 being the LOWEST rating and 6 the HIGHEST.

1. Do you think the physical setting for the course was conducive to constructive work?

1 2 3 4 5 6 Please comment: \_\_\_\_\_

\_\_\_\_\_

2. Please indicate your opinion of the course in terms of:

--the level of participation throughout 1 2 3 4 5 6

--the degree of openness throughout 1 2 3 4 5 6

--The degree of interaction throughout 1 2 3 4 5 6

Any other comments: \_\_\_\_\_

\_\_\_\_\_

3. Please indicate your opinion on the length of the Training Course: 1 2 3 4 5 6

Any other comments: \_\_\_\_\_

\_\_\_\_\_

4. In your opinion, what are some of the ways in which the course could be improved?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Topic	Presentation						Delivery						Content						Usefulness to You						Comments, Suggestions
	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	
1. Epidemiology of Sexually Transmitted Diseases	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	
2. Health Education: STD	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	
3. Manifestation, Diagnosis, Treatment, Complications of Gonorrhea	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	
4. Manifestation, Diagnosis, Treatment, Complications of Syphilis	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	
5. Manifestation, Diagnosis, Treatment, Complications	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	
6. Principles of Contact Tracing and Interviewing	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	

Any Additional Comments:

PRIMARY HEALTH CARE IN-SERVICE EDUCATION

Draft: STD Workshop Budget, July 21, 1980

Venue: Cornwall Regional Hospital, Nursing School, Classroom No. 1 Participants: 42

Dates: July 30-31, 1981

<u>Coffee/Tea Break</u>	<u>Lunch/ Drink</u>	<u>Supplies</u>	<u>Travel</u>	<u>Hotel Accomodations</u>	<u>Miscellaneous</u>	<u>Expenditure Breakdown</u>		
100	1,004	154.50	348.00	198.00	200.00	Coffee/Tea Break	\$	50.00 x 2 days
						Lunch/Drink		502.00 x 2 days
						Supplies:		
						Folders		
						Paper		
						Pencils		
						Bristol Paper		154.50
						<u>Travel (two vehicles)</u>		
						.30 x 440 miles	St. Elizabeth	\$ 132.00
						.30 x 400 miles	Westmoreland	120.00
						.30 x 120 miles	Hanover	36.00
						.30 x 160 miles	Trelawny	48.00
						.30 x 40 miles	St. James	12.00
						<u>Accomodations</u>		
						Three persons for two nights, \$33 each		
<u>Total:</u> \$ 2,004.50								

PRIMARY HEALTH CARE IN-SERVICE EDUCATION

CATEGORY	NO.	PRETEST AVERAGE	STD SEMINAR EVALUATION TEST MONTEGO BAY, JULY 30-31, 1980			NO.	PRETEST AVERAGE	NO.	POST-TEST AVERAGE	% IMPROVE- MENT
			NO.	POST-TEST AVERAGE	% IMPROVE- MENT*					
Public Health Nurse	11	52/100	8	68/100	16/100, 30.8%					
Public Health Inspector	8	52/100	8	64/100	12/100, 23.1					
Staff Nurse	5	47/100	6	55/100	17.1					
Nurse Practitioner	1	36/100								
Midwife				80/100						
Technical Assistant (STD)	1	64/100	1	72/100	8/100, 12.5					
Clerk (STD)	1	32/100	1	52/100	20/100, 62.5					
All Categories	28	48/100	26	65/100	35.4%					

\*Taking original score as 100%.

PRIMARY HEALTH CARE IN-SERVICE EDUCATION  
ASSESSMENT OF STD EVALUATION RESULTS FOR CORNWALL COUNTY

Pretest range span: 32

Post-test range span: 20

Note: Two participants did not complete both the pre- and post tests, therefore percentages for them were eliminated from the evaluation assessments.

Conclusion: The percentage of STD knowledge acquired by the group at the end of the STD training session increased over the level of STD knowledge the group indicated prior to beginning the seminar.

Recommendation: A minimum pretest average of 85% be set by Cornwall's in-service training committee. The STD in-service training should be rescheduled for this group and implemented as necessary to reach the goal of the pretest average. Yearly updates in Sexually Transmitted Disease investigation are suggested for all field primary care workers.

APPENDIX IV

First Aid/Basic Life Support Workshop

Primary care providers are often the first to encounter a situation that demands the use of basic first aid skills. First Aid Training is an ongoing program structured for all levels of health workers.

Successful completion of certified Cardio Pulmonary Resuscitation (CPR) training for nine (9) training officers upgraded Cornwall training Teams' ability to expand basic life support programs within the primary care system and the community.

First Aid and Basic Life Support Workshop materials follow:

## Cornwall County

## PRIMARY HEALTH CARE IN-SERVICE EDUCATION

## POSSIBLE SITUATIONS IN A TYPE I HEALTH CENTRE

Please give brief answers to the questions following each situation described.

1. A man has fallen down a hill and injured his arm. You unwrap the dirty towel that is covering the arm and find that a large area of skin has been scraped off. The area is covered with dirt and sand. There is moderate bleeding. The arm is not broken. What do you do?
2. The nearby gardener has sustained a deep, large cut on his hand from a saw. There is heavy bleeding. What do you do?
3. There has been a car wreck with several people injured and they are brought to your centre. One man complains that he cannot get his breath and he is bleeding from his mouth. What position can you put him in to help both these problems immediately?
4. The second man has a broken arm but he is walking around and says he's OK. What do you do for him?
5. A mother brings her eight month old baby to you. You find he has a fever of 103°. His tongue is red and dry. Mother states that the baby has had at least five liquid stools each day for three days. What do you do?
6. A three year old has ingested paint thinner that was left in a soda bottle. What do you do?
7. A young mother finds her two year old with an open aspirin bottle. There is evidence of chewed aspirin in the child's mouth. What do you do when the child is brought to you?
8. A young boy is burned with a kerosene torch. When he reaches you there are many blisters on the back of his hands extending up his arm. What do you do?
9. A young woman six months pregnant comes to you complaining of feeling sick. You learn she has been feeling dizzy with headaches for two days. During your examination you notice her feet are swollen, her blood pressure is 200/110, and she has gained eight pounds since she visited two weeks ago. What do you do?
10. A teenager stops by on her way from school because she has a nosebleed. You notice blood oozing from both nostrils. What do you do?
11. A five year old falls down while running with a bottle and gets a cut on his arm. What do you do?
12. A man is brought to you by a neighbor who states the man was shot in the chest. He is breathing, but you notice the sound of air coming from the wound. What do you do?

## Cornwall County

## PRIMARY HEALTH CARE IN-SERVICE EDUCATION

## FIRST AID

**Objectives:** At the end of the first aid course, the participants will be able to adequately:

1. Recognize the signs and symptoms of specific poisonings and administer the correct antidote.
2. Cleanse and disinfect skin lacerations, abrasions, and puncture wounds.
3. Administer tetanus antitoxin when required.
4. Apply appropriate measures to promote healing.
5. Differentiate among the various types of burns and apply the appropriate treatments.
6. Apply a secure splint correctly to immobilize the fractured area.
7. Administer eye wash, and remove foreign bodies, i.e., dust particles, cinders.
8. Give artificial respirations, control hemorrhage, give external cardiac massage.
9. Teach the community how to prevent accidents and to take care of minor injuries which occur in the home.
10. Recognize his/her ability to manage the emergency situation and make the appropriate referral as required.

## Cornwall County

## PRIMARY HEALTH CARE IN-SERVICE EDUCATION

## FIRST AID COURSE

## EMERGENCY PRIMARY HEALTH CARE

Name \_\_\_\_\_

Date \_\_\_\_\_

1. If direct pressure and elevation do not stop bleeding from an arm or leg, what should you do next?
  
  
  
  
  
  
  
  
  
  
2. When should you loosen a tourniquet?
  
  
  
  
  
  
  
  
  
  
3. The steps for preventing shock, and for giving first aid for shock, are:
  - 1.
  
  
  
  - 2.
  
  
  
  3. Get medical help as soon as possible.
4. Name one reason why you should begin artificial respiration as soon as possible.
  
  
  
  
  
  
  
  
  
  
5. Name one way to open an airway which is blocked by the victim's tongue.
  
  
  
  
  
  
  
  
  
  
6. a. What is the FIRST thing you should do in cases of poisoning by mouth?  
  
  
  
  
  
  
  
  
  
  
b. Name three types of poisons for which you should NOT induce vomiting:
  - i.
  
  
  
  - ii.
  
  
  
  - iii.
  
  
  
  
  
  
  
  
  
  
7. What can you do to help the doctor identify the type of poison?

First Aid Course  
Page 2

8. Name one way to relieve the pain of a minor (first degree or small second degree) burn.
9. What is the first thing you would do in caring for a severe chemical burn of the skin?
10. Name ONE of the two symptoms that help you tell the difference between heat stroke and severe heat exhaustion.
- | <u>Heat Stroke</u> | <u>Heat Exhaustion</u> |
|--------------------|------------------------|
| _____              | _____                  |
11. Both conscious and unconscious victims of head injuries should be checked frequently to see if there is a need for:
12. What should definitely NOT be done to an infected wound?
13. In what three places should you prevent movement in order to immobilize a fracture (or suspected fracture) of the forearm?
- 1.
  - 2.
  - 3.
14. a. If a person must be turned, and you suspect a back fracture, you should:
- b. Whenever possible, a victim with a fracture (or suspected fracture) of the back should be:

First Aid Course  
Page 3

15. A person who has been under medical care for a heart condition has a heart attack. You have him lying down and he is breathing adequately. While someone else is calling the doctor, you should:
16. What is the principal danger in epileptic attack?
17. There is only one situation in which you should slap a person on the back to dislodge a foreign object. Which of the following is it?
- \_\_\_\_\_ a. The person is breathing adequately, and is coughing to try to dislodge the object.
- \_\_\_\_\_ b. The person has stopped breathing, or is having great difficulty breathing. The person turns blue and appears near death.
18. What is the principal danger in moving an injured person?

**PRIMARY HEALTH CARE IN-SERVICE EDUCATION  
FIRST AID COURSE FINAL EXAMINATION\***

Answer ALL questions in Sections A, B, and C, and THREE questions in Section D.

Section A: True or False

Please circle the appropriate answer.

- |   |   |   |
|---|---|---|
| 1. The air contains 20% of oxygen.  | T | F |
| 2. Respiration is breathing.  | T | F |
| 3. The body uses 6% of the oxygen in air.   | T | F |
| 4. The exchange of gases takes place in the lungs.  | T | F |
| 5. The mouth is part of the respiratory system.   | T | F |
| 6. Fractures are first priorities.  | T | F |
| 7. The toe and fingernail can indicate tight bandages.  | T | F |
| 8. Two triangular bandages are made from a piece of calico 48 inches square.                            | T | F |
| 9. Breathing has stopped, mouth-to-mouth respiration is used when face is damaged and jaw is fractured. | T | F |
| 10. One hand is used in heart compression of an infant.   | T | F |
| 11. If a casualty is still in contact with high voltage, rescue should be attempted.                    | T | F |
| 12. A lacerated wound is caused by a dagger.  | T | F |
| 13. Direct pressure is applied at the pressure points.  | T | F |
| 14. The tongue can block the airway.  | T | F |
| 15. Water reduces pain in burns.  | T | F |
| 16. Vomit helps a doctor to identify the type of poison.  | T | F |
| 17. The blood pressure rises in bleeding.   | T | F |
| 18. Pressure to a wound can be applied for longer than 20 minutes.                                      | T | F |
| 19. All wounds must be lowered.   | T | F |
| 20. Internal bleeding is visible in vomit.  | T | F |

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\*Kaiser Bauxite Company, Discovery Bay, Jamaica

First Aid Final Examination  
Page 2

Section B: Multiple Choice

Please choose the best answer/answers. A question may have more than one answer.

21. What is the objective of first aid treatment?
- a. To sustain life
  - b. To promote recovery
  - c. To prevent the condition from becoming worse
  - d. To arrange disposal
22. Diagnosis is done by the use of:
- a. History of the incident
  - b. Signs
  - c. Symptoms
  - d. Observation and treatment
23. Examples of signs are:
- a. Change in color of skin and face
  - b. Condition told by casualty
  - c. Variations from normal
  - d. None of the above
24. The four levels of consciousness and explanation are:
- a. Full consciousness: able to speak and answer questions
  - b. Drowsiness: can be roused with difficulty
  - c. Stupor: easily roused, but lapses into unconsciousness
  - d. Coma: cannot be roused by any stimuli
25. What is the responsibility of the First Aider?
- a. Get history of the incident
  - b. Assess the situation
  - c. Give immediate and adequate treatment
26. What is the first priority at an incident?
- a. Take charge
  - b. Control traffic
  - c. Reduce any danger to self and casualty
  - d. All of the above
27. What are the general rules for carrying out treatment?
- a. Gently and quickly, in a confident manner
  - b. Reassurance and encouragement
  - c. Paying attention to casualty's requests
  - d. Keeping careful watch
  - e. Repeatedly asking the casualty how he is feeling

Section B, continued

28. How much clothing should be removed?
- All
  - To expose injury
  - None
  - Enough so as to be able to treat the injury
29. When should the recovery position NOT be used?
- Face and jaw injury
  - Fracture of hip
  - Internal bleeding
  - Spinal injury
30. The stages of respiration are:
- Lungs
  - Inspiration
  - Pause
  - Expiration
  - Diaphragm
31. What local conditions affect the airway:
- Spasm
  - Obstruction
  - Suffocation
  - Compression of the neck
  - Compression of the chest
32. How long can the brain be deprived of oxygen before it is permanently damaged?
- Eight minutes
  - Four hours
  - Four minu
  - None of t      bove
33. What are the            s of choking?
- Blocked            ay
  - Inabilit, -- speak
  - Grasping of neck
  - Inability to breath
  - All of the above
34. What is a condition affecting the nerves which controls respiration and causes asphyxia?
- Poisoning
  - Electrical injury
  - Muscular contraction
  - Spinal injury

Section B, continued

35. What is the rate of application of external heart compression and mouth-to-mouth resuscitation?
- When the First Aider is alone, five heart compressions followed by one quick lung inflation
  - When the First Aider is alone, 15 heart compressions followed by two quick lung inflations
  - With two First Aiders, five heart compressions followed by one deep lung inflation
36. How may poison enter the body?
- Through the lungs
  - By the mouth
  - By injection
  - By absorption
37. In the case of poisoning by mouth, the casualty is given:
- Lukewarm water
  - Milk
  - Barley water
  - Ice
38. A diabetic casualty may be given:
- Water
  - Sugar
  - Table salt
39. In the case of sucking wound, the First Aider must:
- Remove the casualty immediately to the hospital
  - Immediately cover the wound
  - Give emergency resuscitation
40. A casualty may die from lack of oxygen because:
- The airway is blocked
  - Blood circulation has stopped
  - Breathing has stopped

Section C: Fill in the Blanks

41. Name and describe the four types of wounds:
- -

Section C, continued

41. Name and describe the four types of wounds, continued:

3.

4.

42. Name and describe two types of fractures:

1.

2.

43. List four methods the First Aider uses for protection of self and casualty:

1.

2.

3.

4.

44. Name three methods of improvising a sling:

1.

2..

3.

45. Name four methods of transporting a casualty:

1.

2.

3.

4.

Section C, continued

46. Name five causes of poisoning:

- 1.
- 2.
- 3.
- 4.
- 5.

47. Name four causes of asphyxia:

- 1.
- 2.
- 3.
- 4.

Section D: Essay

Please answer any THREE of the following questions.

48. Describe step-by-step the application of a triangular bandage:

Section D, continued

49. Describe step-by-step the application of bandages for a spinal injury:

50. Describe the procedure for a blanket lift (step-by-step):

Section D, continued

51. Describe the actions of a First Aider at a road accident:

APPENDIX V

Dental/Nutrition Presentation

A high prevalence of dental disorders has always existed in Jamaica, with few dental needs being met by dentists. Among the group most commonly affected with dental problems are pregnant and lactating women. Inadequate nutrition is frequently the contributing factor to dental disease in this population.

Cornwall County, like other regions in Jamaica, has almost no full-time dentists, and nutritionists or nutrition assistants are not available for adequate coverage in the County. This leads Cornwall County's Health Administration to depend on its field staff to promote nutrition and dental health care. Different levels of health personnel have always tried to incorporate dental health education into nutrition teaching without any formal guidelines. In April 1975 Cornwall received its first Dental Nurse to work in one of its parishes and now there is a total of approximately 12 distributed throughout the County to provide care for 200,000 schoolchildren. The usual placement for Nutrition Assistants is:

one in each of the five parishes;

one Nutritionist at the County level.

There are presently three positions vacant for Nutrition Assistants and one Nutritionist (at County level).

The in-service training team felt that an update of dental/nutrition information for health personnel would facilitate the goal of community health education. The team initially organized one day of in-service sessions for Nutrition Assistants, Dental Nurses, and Health Educators. This group was charged with the responsibility for conducting dental/nutrition in-service sessions for training coordinators who would then conduct the sessions for all other primary health staff until everyone had been updated. The aim of the training update was to optimally use all personnel in medical(dental) and nutrition work to maximize our efforts.

The dental/nutrition information (Objectives/Outline Presentation) that follows was used for the in-service training. Flip charts, posters, handouts, including dental models, provided support material for visual aids.

Evaluation and Recommendations

These in-service presentations (dental/nutrition), begun in February 1979, assisted in not only reinforcing vital health education information, but also brought two health disciplines (Dental Nurses and Public Health Nurses) together to work in support of each other's primary interests.

The presentations have become a part of the regularly scheduled in-service training sessions at Community Health Committee meetings, Zone Conferences for Community Health Aides, and other monthly in-service group meetings for midwives, inspectors, clerks, etc.

The Dental Nurses who were not totally involved with coordinating in-service training (Cornwall's Training Team had one Dental Nurse) would probably be of valuable assistance to the training team if given the opportunity to do so in whatever capacity they are capable of. The need to extend dental/nutrition education in Cornwall must continue to remain in the foreground of in-service needs since it is not foreseeable that the dental/nutrition staffing problem will improve in the near future.

PRIMARY HEALTH CARE IN-SERVICE TRAINING

DENTAL/NUTRITION PRESENTATION OUTLINE

A. Introduction

1. Instructor and assistants
2. Objectives of seminar

B. Advice to Pregnant and Lactating Women

1. Nutrition requirements for pregnant women; foundation of fetal teeth
2. General nutritional advice for young child feeding, schoolchildren, adolescents, and adults

C. Dental Caries and Carbohydrates

1. Conditions that predispose to poor dentition
2. Points of nutritional intervention

D. Nutritional Deficiencies Related to Dental Disease

E. Formation of Teeth

F. Care of the Teeth

**PRIMARY HEALTH CARE IN-SERVICE TRAINING**

**NUTRITION/DENTAL OBJECTIVES**

At the end of the seminar the students will be able to:

1. Counsel a pregnant mother to:
  - a. Improve her diet so that her health and baby's health is maintained.
  - b. Identify foods that she should include in her diet that will aid in the formation of her baby's teeth.
2. Give advice about adequate diet for young children, adolescents, and adults.
3. Demonstrate the correct way to clean teeth for children and adults.
4. Relate to clients supporting nutritional information to maintain dental health.
5. Relate to clients supporting dental information to maintain nutritional health.
6. Identify simple dental problems and make appropriate referrals.
7. Recognize the common symptoms of dental problems associated with poor nutrition and inadequate oral hygiene.

## PRIMARY HEALTH CARE IN-SERVICE TRAINING

## DENTAL NUTRITION

- A. Healthy teeth and gums are important for maintaining health as they are needed for the proper digestion of foods. The formation and maintenance of healthy teeth and gums depend primarily on:

- a. good nutritional practices
- b. good oral hygiene

If our bodies are to function normally and if we are to remain healthy, then it is important that we eat a mixture of foods from the four basic food groups daily. By eating a mixture of foods, the greater the likelihood the body will receive the nutrients needed for the formation of strong teeth. Studies have shown that the incidence of dental caries is less in people who eat a balanced diet containing a wide mixture of foods.

What are the nutrients needed for the formation of teeth?

- a. Calcium, phosphorus, and flouride, which are present in the dentin and enamel
- b. Vitamin A, which helps in the formation of enamel
- c. Vitamin D, which promotes the absorption of calcium and phosphorus from the gut
- d. Vitamin C, needed for the formation of dentin. An adequate supply of protein and energy is also essential.

How can we make sure that we get these nutrients from our diets  
By eating a mixture of foods from the four basic food groups:

- a. Staples
- b. Animal foods
- c. Peas and beans
- d. Vegetables

Calcium can be obtained from foods such as: mackerel, sardines, herring (if the bones are eaten), milk and milk products, eggs, peas and beans, kale, bush cabbage.

Sources of Vitamin A are: dark green leafy vegetables, red and yellow vegetables, milk and mild products, liver, kidney, eggs, fruits, e.g., mango, pawpaw.

Sources of Vitamin C are: dark green leafy vegetables, fruits (citrus)

Phosphorus is widely available in foods and a dietary deficiency is rare. With the exception of fish products, most foods have a low flouride content; consequently, it is important to encourage supplementing the concentration in the water, if the naturally occurring amount is not sufficient.

## B. Advice to Pregnant and Lactating Women

The foundation of the first teeth is laid down before birth. The formation of the teeth starts at about six weeks and the hardening process at about the fourth month of pregnancy. It is therefore important that attention be paid to the nutrition of the pregnant woman. In pregnancy and lactation, there is an increased need for energy, protein, vitamins, and calcium. The additional nutrients can be obtained if the woman eats large quantities of the same mixtures of foods from the four basic food groups. She should try to include the calcium-rich foods in her diet as this mineral tends to be low in the diets of many women before and during pregnancy. The fetus acquires most of its calcium in the last trimester when the skeletal growth is maximum and the teeth are being formed.

Note: The nutritional requirements of teenagers (under 17 years of age) are greater than those of adult women because of the extra demands of growth.

### Oral Hygiene

Some foods can cause the teeth to decay if they remain on the teeth for too long, so the mother must be advised to brush the teeth regularly. When using a toothbrush, the bristles should get between the teeth and the gums.

Women often notice that their gums bleed more during pregnancy. With the hormonal changes taking place in the body at this time it is more important that the area between the teeth and the gums have no deposits. Bleeding will stop in a few days if this area is cleaned. Bleeding gums is a disease and if it is not stopped, the teeth will become loose and "shaky." This is because the bone under the gums "moves away" from the deposit, causing the teeth to get loose.

If a mother has any problems with her teeth, e.g., pain and abscess, she should go to see a dentist. Extractions can be done during pregnancy.

### Young Children and Adolescents

In young children it is necessary to ensure that the hardening of the teeth continues. If the teeth lack sufficient calcium and other materials necessary to build firm dentin and dense enamel, then the teeth become more prone to decay. The baby teeth erupt some time in the latter half of the first year and the permanent teeth are already beginning to form at birth; it is important that the two sets of teeth are not allowed to "rot away."

How can the young child get the nutrients needed for healthy tooth formation?  
From the diet--some general nutrition advice for the feeding of young children:

0-4 months      Breast milk

At four months introduce porridge and breast milk

At six months introduce dinner; the baby needs more nutrients at this stage and it is essential that the child be given a mixture of foods from the basic four food groups. See the food source lists for calcium, vitamins.

Baby's teeth can decay quickly if he falls asleep without swallowing his food--milk, porridge, juice. Therefore, the mother should try to prevent the baby from falling asleep during feeding.

### Schoolchildren

The same general nutrition advice applies to schoolchildren. They need to eat a mixture of foods daily and the mothers should discourage the use of foods which provide empty calories, such as kisko pops, aerated water, candy. Sweets should only be taken at meal times and should not be taken as snacks between meals.

#### C. Dental Caries and Carbohydrates

1. Dental caries (decay) is a complex disease, influenced by many variables. In the main it is produced by local factors, but pre-eruptive nutrition can influence the ability of the tooth to be susceptible to or resistant to decay. Caries is initiated by the local fermentation of carbohydrates within the plaque matrix by bacterial enzymes.

The extension, or promotion of caries is the result of frequent between-meal eating of sticky, sweet snacks, often without the benefit of an otherwise balanced diet and of normal cleansing and hygiene.

1. Frequency, not amount, of sugar is more critical.
2. Sugar taken at mealtimes, even if in larger amounts, is less destructive than snacking.
3. Ability fo carbohydrates to stick to teeth and gums (i.e., time retained in mouth) increases damage.
4. All sugars provide a substrate for microbes to produce lactic acid, and also provide nutrition for energy and proliferation of the microbes themselves. Order of decreasing cariogenicity of sugars: sucrose, glucose, maltose, lactose, fructose, sorbitol, xylitol.
5. Research shows less caries incidence in people having a balanced diet.
6. Normal cleansing:
  - a. Salivary flow and amount plus normal muscle (lips, tongue, cheeks) does part of the job.
  - b. Stagnant sugars (stuck on teeth or gums or resting around the teeth while sleeping) are more available for the bacteria.
7. Hygiene
  - a. It is the sugars in a plaque matrix that bacteria can use.
  - b. Plaque takes 24 hours to get organized into a usable matrix.

#### 2. Points of Nutritional Intervention

1. Continued emphasis on balanced diet, especially during pregnancy and early childhood.
2. No breast feeding or bottle feeding (except plain water) when the baby might fall asleep during mid-feeding.
3. Encourage eating at meals (especially sweets), not between.
4. Stress school lunches that are less cariogenic (few sweets, foods that are not sticky) and nutritional.
5. Stress oral hygiene--at least rinsing the mouth whenever you eat anything.

D. Nutritional Deficiencies

<u>Nutrient</u>	<u>Related to Formation, Eruption, Alignment</u>	<u>Dental Disease</u>
Calcium and Phosphorus	Hypoplasia (ameloblasts don't function) Hypocalcification (inadequate mineralization)	Increased susceptibility to caries (roughness increases plaque retention) Increased periodontal disease (plaque retention and increased or accelerated bone resorption)
Vitamin D	Hypoplasia of enamel and dentin	Roughness (more caries prone)
Vitamin A	Hypoplasia of enamel Crowding and stunting of teeth	Increased periodontal disease, especially with trauma
Vitamin C	Irregularly calcified dentin (atrophy of odontoblasts)	Increased periodontal disease (decreased wound healing) Decreased caries with increased Vitamin C
Vitamin B complex		Inflamed lips, tongue, mucosa
Protein	Smaller, poorly calcified teeth Delayed eruption Hypoplasia Crowding and rotation (inadequate jaw development)	Periodontal changes in tissue Increased bone resorption Decreased resistance to spread of infection

## E. Relation of Nutrition to Dental Health

- A. Formation of teeth
- B. Eruption and alignment
- C. Dental health and disease (caries and periodontal)

## Formation of Teeth: Function of Various Nutrients

- A. Calcium and phosphorus--rigidity
  1. Enamel 96% mineral (hydroxyapatite  $\text{Ca}_{10}(\text{PO}_4)_6(\text{OH})_2$ )
  2. Dentin, cementum and bone 70%
- B. Vitamin D: Calcification of enamel and dentin
- C. Vitamin A: Calcification of enamel and dentin
- D. Vitamin C: Calcification of enamel and dentin
- E. Flouride: Acid-resistant hydroxyapatite)
- F. Protein: Organic matrix of enamel and dentin
- G. Balanced diet in general: Promotive of normal growth and preventive of disease (infection and fever)

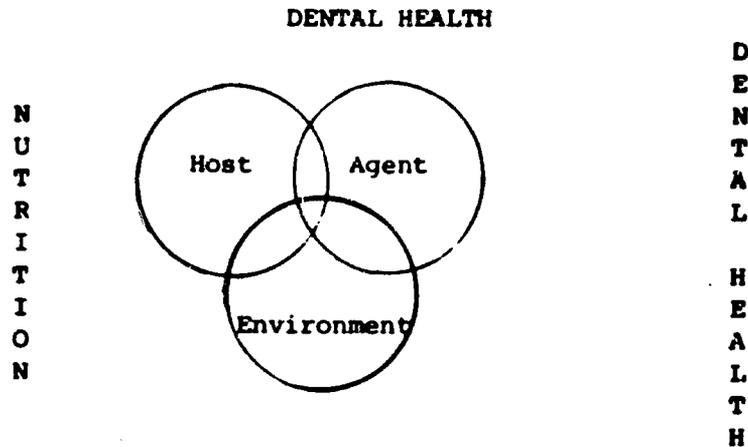
F. Care of the Teeth

- A. For baby: gums, tongue, and newly erupting teeth should be wiped daily with a soft cloth.

- B. Advise introduction of soft tooth brush at about nine months. Brush after every feeding. Adult must brush child's teeth until the child is about eight years old. Small circular motions of the brush are used all over the teeth.
- C. Regular brushing is essential; most important before going to bed.
- D. Alternatives to brushing, though not as good: eating fruits and vegetables, rinsing the mouth after eating anything.
- E. Teeth should be checked regularly, ideally twice per year. Do not wait to take the child to the dentist for the first time until he has a bad tooth.

Regular visits to the dentist should begin in childhood and continue throughout adult life.

## PRIMARY HEALTH CARE IN-SERVICE TRAINING



## EPIDEMIOLOGY

## I. Host

## A. Heredity

1. Salivary function and composition
2. Size and shape of teeth
3. Anatomy of developmental fissures on teeth

## B. Nutrition

1. Optimal flouride amounts during:
  - a. Mineralization
  - b. Awaiting eruption
  - c. Erupting
  - d. Maturing
  - e. Maintenance

2. Vitamin A, C, D
3. Calcium and phosphorus
4. Protein

## C. Salivary Glands

1. Inactive during sleep
2. Atrophic due to absence of solid food (also with fluid diets) or due to functional disorder

## II. Agent

- A. Factors that enhance microbe's ability to grow and remain alive at low pH

- B. Ability to produce acid from entrapped food
- C. Ability to exert low degree of pathogenicity
- D. Prevalence in human population
- E. Difficulty in eradicating

III. Environment

- A. Availability of suitable material (predominantly sucrose) for agents
- B. Kinds of food consumed
- C. Money available to purchase desirable foods, also snacks
- D. Availability and use of routine dental care
- E. Flouridation of water supplies
- F. Geography
- G. Availability of snack foods (e.g., at schools)

**APPENDIX VI**

**Medical Records and Statics Workshop**

In support of a standardized primary care recording system for Cornwall County, a four (4) week medical records training course (theory/practical) provided instruction in recording and basic statistical practices. Trainees who participated (15 clerical officers) agreed to pass acquired information to newly hired clerks, Community Health Aides, Midwives and other personnel involved with recording clinical data.

**Instruction material for the four-week course follows:**

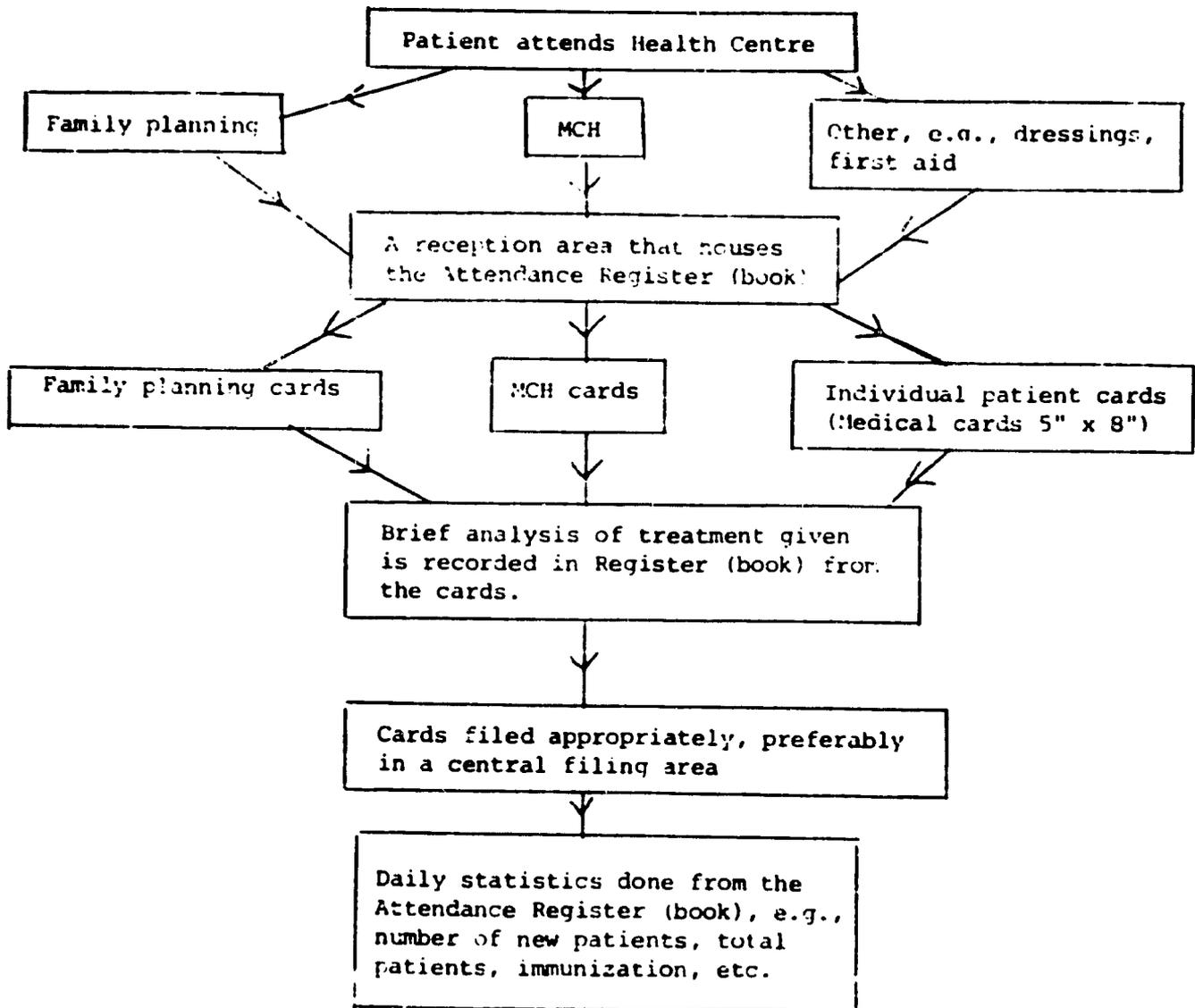
**PRIMARY HEALTH CARE IN-SERVICE EDUCATION**  
**Four Weeks In-Service Training in Medical Records and Statistics, Cornwall County**

**Abbreviations:** MR=Medical Records; S=Statistics; PHC=Primary Health Care; HC=Health Centre; CRH=Cornwall Regional Hospital; CCHA=Cornwall County Health Administration; MRC=Medical Records Office

WEEK	OBJECTIVE	CONTENT	METHOD	EVALUATION	RESOURCES
	For the management of MR/S in Type III, IV HCs.	Introduce broadly MR/S as separate entity: i.e., why? What is?	Practical, theoretical sessions at CHR, in the field	Discussion, questionnaires, observation on the spot; evaluation by supervisors	MRO, CCHA; MRO, CRH; Deputy MRO, CRH; Administrator, CCHA; Personnel Officer, CCHA; Supervisors, various sections of MR Department.
Week 1	Specific Objectives: To understand the Unit System of MR, i.e., integration within the PHC system.	a. Basic filing techniques; b. Methods of filing; c. Tracing systems; d. Master Patient Index; e. Appt. systems	Lectures on the concept of integration, basic filing techniques, tracing systems. Practical session in the Filing Rm, Appt. Desk, outpt. Clinics, CRH.	Questionnaire, discussion, on the spot evaluation by supervisors of the various sections.	Personnel in charge of H/CS, MRO, MRO Deputy
Week 2	Specific Objectives: To understand, appreciate the need for statistical compilation or information gathering in the form of figures.	a. Registration; b. Numerical summary of daily activities; c. Compilation of statistical returns.	Lectures on tabulation/ compilation of figures, accuracy, classification, practical session in the Casualty Dept., CRH.	Questions and answers, observation on the spot, evaluation by supervisor.	MRO/Statistical Officer, CCHA (input from Statistical Unit), MRO, CRH
Week 3	Specific Objectives: To get an understanding of the making of policies and why we need certain policy.	a. The working of MCHC related to personnel matters; b. The CCHA structure/Organization; c. Confidentiality; d. Medico-legal matters; e. Maintenance of supply/equipment	Lectures on the topics outlined. Signing of a declaration of secrecy. Lecture on ordering/stock taking. Exposure to the Medico-Legal Desk, CRH.	Questionnaire, observation, discussion	Personnel officer, CCHA. Administrator, CCHA. Input from Miss Ellis on supplies, MRO, CCHA
Week 4	Specific Objectives: Promote proper MR/S Practices in the field.	Actual work in HC, e.g. Registration, appointments, etc.	Practical work in the field.	Observations and on the spot evaluation by the person in charge of the HC.	Public Health Nurse NG III or Sister

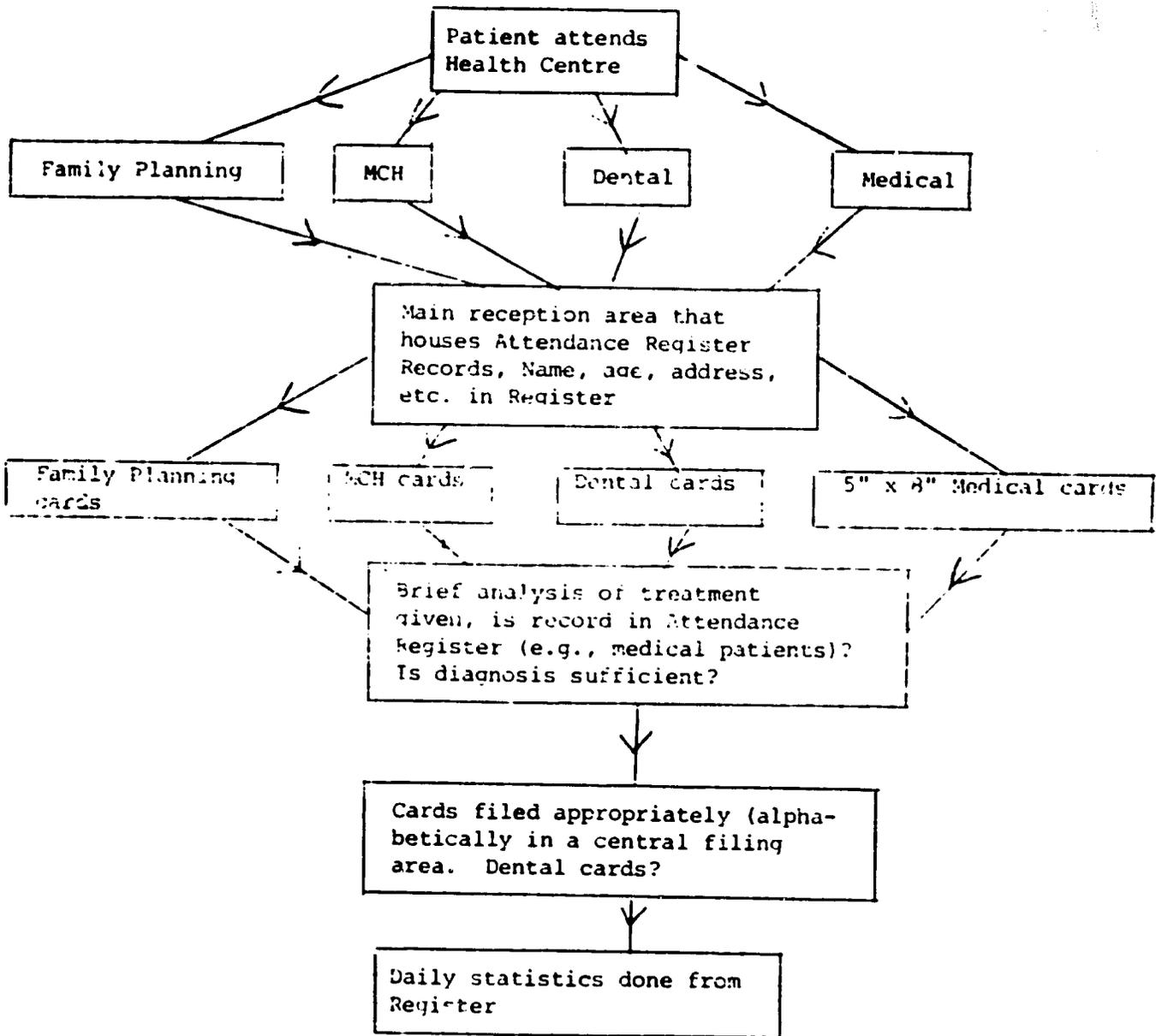
## PRIMARY HEALTH CARE IN-SERVICE EDUCATION

## TYPE I HEALTH CENTRE



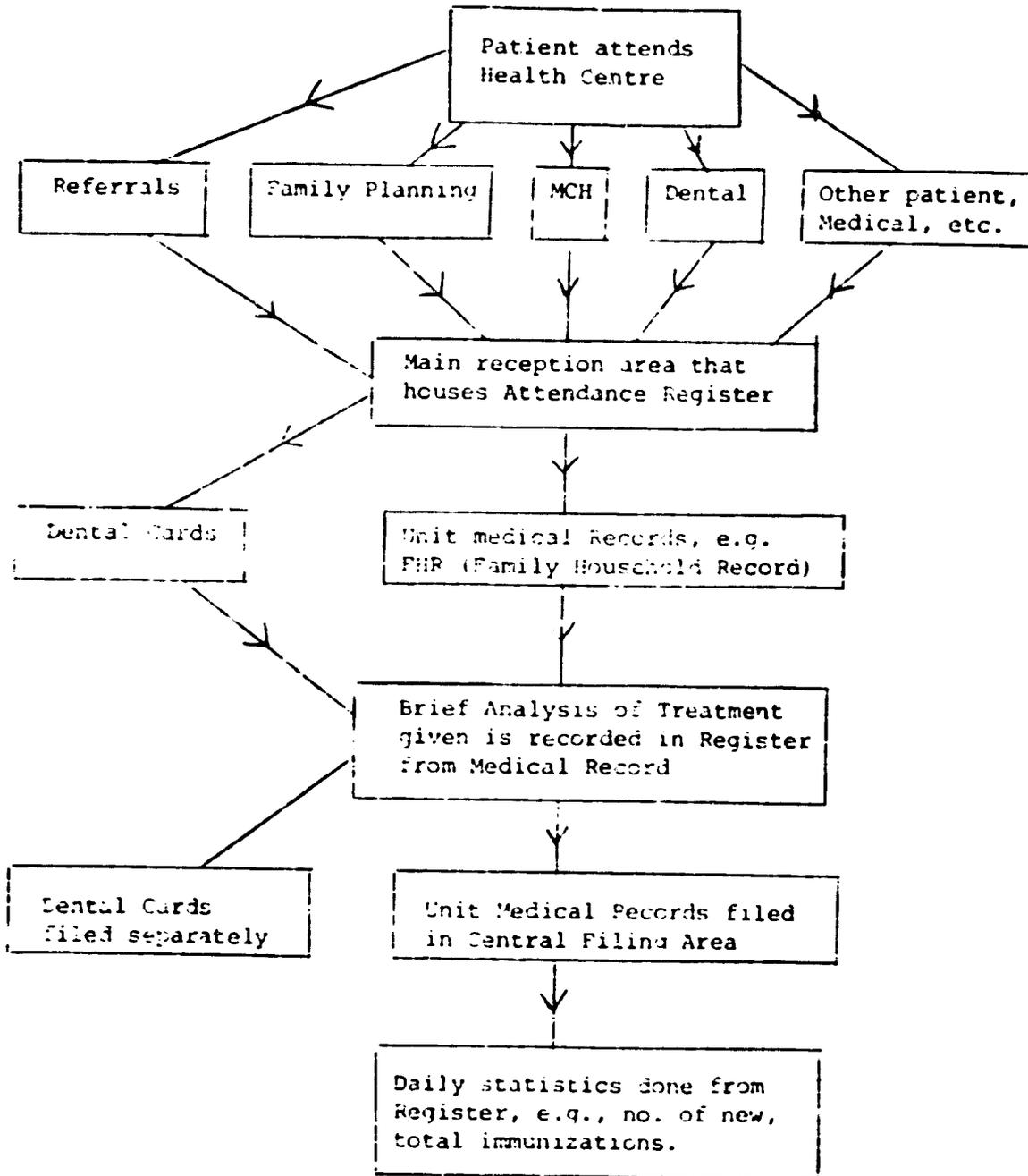
PRIMARY HEALTH CARE IN-SERVICE EDUCATION

TYPE II HEALTH CENTRE



PRIMARY HEALTH CARE IN-SERVICE EDUCATION

TYPE III AND IV HEALTH CENTRES





**PRIMARY HEALTH CARE IN-SERVICE EDUCATION**  
**EVALUATION OF IN-SERVICE TRAINING PROGRAM**  
**MEDICAL RECORDS/STATISTICS**

Position \_\_\_\_\_

Parish \_\_\_\_\_

Date \_\_\_\_\_

Please rate each session on a scale of 1-5, with 1 being the **LOWEST** rating and 5 the **HIGHEST**.

<u>Sessions</u>	<u>Presentation, Delivery</u>	<u>Clarity</u>	<u>Usefulness</u>
1. The personnel function (Resource manpower, pay, grading, etc. MOHEC Policy along above lines.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
2. In-service training: its role in the development of management structure. Cover induction and orientation	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
3. Discussion/Practical Session	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
4. Medico-Legal matters, including confidentiality, ownership, and consent.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
5. Preservation and destruction of medical records and X-rays. Policy of MOHEC.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
6. Standardization: Medical records task force, international standard paper size.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
7. Duties and responsibilities of the Medical Records and statistical personnel.	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

**APPENDIX VII**

**Mobile Film Unit Training Session**

A mobile film unit for Cornwall County provided by the Jamaican Population Project II (JPP II) enhanced Cornwall's training teams' ability to reinforce written and verbal health messages, especially in remote communities. Instructors from the Agency for Public Information (API) coordinated in-service training to increase knowledge and develop the skills of training officers in the use of a 16 mm movie sound projector operating from the mobile generating unit.

Outline for the training session follows:

PRIMARY HEALTH CARE IN-SERVICE EDUCATION  
PROGRAM BUDGET FOR MOBILE FILM UNIT

DATE	VEHICLE TRAVEL	MILES	PARTICIPANTS	LUNCH	DRINK	MISCELLANEOUS	EXPENDITURE BREAKDOWN
Day I November 10, 1980	From Base (CRH) To Westmoreland To Base	110	St. Elizabeth 3 Westmoreland 3 Trainers 2 Driver 1 <u>TOTAL 9</u>	\$ 72.00	\$ 6.30	\$ 20.00	Mileage: .40/mi. Lunch: \$8.00/person Drink: .70/person Misc: duplication, handouts
Day II November 12, 1980	From Base To Trelawny To Base	44	St. James 4 Trelawny 3 Trainers 2 Driver 1 <u>TOTAL 10</u>	80.00	7.00	20.00	
Day III November 14, 1980	From Base To Hanover To base	35	Hanover 4 Trainers 2 Driver 1 <u>7</u>	56.00	4.90	15.00	
<b>TOTALS:</b>		<b>Mileage: 189</b>	<b>Total county participants: 17</b>	<b>\$208.00</b>	<b>\$18.20</b>	<b>\$55.00</b>	
							Travel: \$ 75.60 Lunch: 208.00 Drink: 18.20 Misc.: 55.00 <u>TOTAL \$ 356.80</u>

PRIMARY HEALTH CARE IN-SERVICE EDUCATION  
 CORNWALL COUNTY IN-SERVICE EDUCATION PROGRAMME

MOBILE FILM UNIT TRAINING SESSION

NOVEMBER 10-12, 1980

**Programme Objective:** To develop/improve the knowledge and skills of participants in the use of a 16 mm sound projector operating from a mobile generating unit.

DATE & TIME	GROUP	SPECIFIC OBJECTIVES	METHODOLOGY	RESOURCE PERSONS	MEANS OF EVALUATION
Nov. 10-12, 1980	In-Service Training Co- ordinators, Cornwall County	<p>At the end of the session, the participants will:</p> <ol style="list-style-type: none"> <li>1. Know the names and functions of the various parts of:           <ol style="list-style-type: none"> <li>a. 16 mm movie sound projector</li> <li>b. the generating unit.</li> <li>c. accessories to a, b.</li> </ol> </li> <li>2. Make proper connections between the generating unit and the projector.</li> <li>3. Load and operate the projector using appropriate size films.</li> <li>4. Rewind films after projecting.</li> <li>5. Detect and remedy trouble shooting area of           <ol style="list-style-type: none"> <li>a. projector</li> <li>b. generating unit.</li> </ol> </li> <li>6. Carry out simple maintenance practices as outlined in the manuals supplied.</li> </ol>	Lecture, discussion, practice sessions	Technicians from the Agency for Public Information	Observation during practice sessions

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**MONTHLY REPORTS:**

**Mark Gross, Project Leader  
(Primary Care Training Advisor)**

MARK GROSS, PRIMARY CARE TRAINING CONSULTANT

Report of Activities - February 15, 1978 to March 31, 1978

Summary of Activities

The first six weeks of the project were spent in orientation both in Montego Bay and in Kingston. After a few days completing paper work in the American Embassy in Kingston, I traveled to Montego Bay on February 21, 1978. (The difficulty in communication among the various sections of the project became evident since Dr. Tony D'Souza had not been informed of my arrival in Kingston and when I called to arrange my trip to Montego Bay, he seemed somewhat upset particularly since all the hotels were full.) For the next thirteen days I visited various health centers and clinics in the Parishes of St. James, Westmoreland, St. Elizabeth, and Hanover. The services being delivered in the various types of centers by the Public Health Nurses, District Midwives, and Community Health Aides are quite good given the constraints of shortages of supplies and equipment and the large number of patients. I also participated in home visiting with the District Midwife and the Community Health Aide. During these visits I was able to develop an appreciation for the difficulties in delivering health services to the rural areas of Jamaica.

On March 5, 1978 I returned to Kingston in order to begin the process of being introduced to and develop my relationship with the various personnel at the Ministry of Health. I also met and had discussions with individuals in USAID, HOPE, PAHO, and the National Family Planning Board.

At this time a definitive role for me has not developed even though there had been discussions and decisions made prior to my arrival. However, Miss Hyacinth Stewart and myself are looking at the type I Centers and attempting to delineate the types of services that will be offered by the District Midwife and the Community Health Aides. We will be working on the job descriptions and functions of the District Midwife and Community Health Aides in the Type I Center. Upon completion of this exercise we hope to be able to develop inservice training programs that will permit these two categories of health workers to function in accordance with the goals and objectives of the primary health care system. At this time management training seminars are not being developed since the actual system of management has not been developed to the point where guidelines could be developed concerning supervision, referral networks, record keeping, ordering of supplies, transportation, etc.

Meetings Attended

Jamaican Population Project II (JJP II), Heads of Project Meeting - 2/23 & 3/30/78  
Primary Health Care Staff Meeting - 3/13, 3/20/78  
Cornwall County Health Administration - 3/17/78  
Workshop for District Medical Officers, 3/3-5/78  
Conference on Mental Handicaps - 2/24/78

### Plans

The plan at this point is to work in the following areas:

1. To develop an outline of the list of services to be provided through the type I centers.
2. To develop appropriate job descriptions for the District Midwife and the Community Health Aide.
3. To discuss the possible format of inservice training programs for the District Midwife and the Community Health Aide based on 1 & 2.
4. To begin to explore the problems in the management of the primary health care system.

### Problems

1. There are scarce Jamaican resources available at this time to carry out any new inservice training programs or seminars in relation to the primary health care system.
2. There are scarce Jamaican resources available at this time to produce manuals for the Type II and III Centers.
3. The clinical services to be offered in the Type I, II, and III Centers have not been developed to the point that clear and concise manuals, inservice training programs or job descriptions could be developed on a nationwide scale.

### Recommendations

1. I don't feel that a data information specialist could be fully utilized at this time. There have been recent attempts to implement a new record system for the primary health care system. This record system was intended to meet the patients, clinics, and Ministry's needs. However, it is unlikely that this system will be implemented in the near future since printing and supplies are costly and the personnel who are to use these records are somewhat hesitant to implement another new program. Possibly after the new fiscal year has begun and new funds are "earmarked" by the Ministry for this project, the information specialist could be most useful. At this time approximately 25 Family Nurse Practitioners will be using the "new" record system as a pilot project.
2. A management person could be helpful. There is an emphasis in the primary health care system in developing adequate and accurate job descriptions. Along with this need there is a vital need to look at the possible referral patterns within the system and its implications on the transportation of supplies, personnel, patients, and communications. Dr. Tony D'Souza will soon need someone in Cornwall to help with the management problems resulting from his opening of approximately 20-30 new health centers in his region. The Ministry itself could also utilize a person who could help in the solving of some of the problems that will developed in the management of a Nationwide System of Primary Health Care.

(signed) Mark Gross

Report of Activities - April 1 to April 30, 1978

Summary of Activities

This past month was spent primarily working on four major areas. The first area was in attempting to inform Miss Gladys Gilbert, Acting Health/Population/Nutrition Advisor at USAID-Jamaica, about our contract. Miss Gilbert was not aware of the latest revisions to the contract. We attempted to develop a PERT chart outlining the goals for the project. This became somewhat complicated since the goals and objectives in her document through Project Implementation Order were in many respects different than the newest stated objectives and goals. I hope that these meetings have produced a clearer overview of the purposes of this project.

The second area was in developing a job description for the District Midwife. In attempting this task, Miss Hyacinth Stewart and I looked at the services that might be provided in the Type I facility and began working on a task list for the midwife. We concentrated primarily on the administrative and supervisory tasks. However, this exercise was curtailed since we felt that anything we developed would not necessarily accurately reflect the tasks which the midwife would perform since there has not been an official document distributed which delineates the kinds of services that will be offered in the various health centers. It was also felt that possibly Miss Stewart and I were moving a little too fast on this project. (I later learned that the Midwifery Association is currently working on the Midwife's job description which will eventually be presented to the Ministry of Health and Public Service for reclassification.)

The third area was in the development of a possible outline for an inservice training program in Management for Senior Tutors in the Nursing and Midwifery Schools. This outline was developed during meetings with Miss Dumont, Assistant Nursing Officer, Education; Mr. Peter Carr, PAHO; Dr. Una Reid, PAHO; Miss Hyacinth Stewart, and myself. Because of administrative problems and cost, this course will be developed and presented in stages over the next 18-24 months.

The last area was in the review and revision of the Maternal and Child Health Reference Manual and the Community Health Worker Manual. Dr. Deen Ashley, Miss Hyacinth Stewart, Mrs. Minion Anderson, Mrs. Nell Allison, and I participated in the initial discussions. When the manuals have been technically reviewed, the training branch will participate in the final editing process.

Plans

1. To work on the development of a draft for services to be delivered in the Type I facility.
2. To work on the job description of the District Midwife.
3. To continue the development of the management workshops for Senior Tutors in the Nursing and Midwifery Schools.
4. To work on the Maternal and Child Health and Community Health Workers Manuals.
5. To work with the Senior Public Health Inspector and his committee in developing a workshop for Public Health Inspectors which has as its objective a redefinition of the Public Health Inspector's role in the Primary Health Care System.

### Problems

1. Funding for inservice training programs remains a problem.
2. Because of the lack of a detailed document outlining the services to be offered in the various health centers, it is difficult to develop accurate and useful job descriptions for the various health workers.
3. Along with No.2, the lack of a functional analysis has hindered the development of appropriate inservice training programs.

### Recommendations

1. A management person could be quite helpful. Both the Ministry in Kingston and the Cornwall Regional personnel could benefit from consultation in this area. Perhaps Dr. Tim Baker might be an appropriate person. It would be best if either Dr. Taylor or Ms. Storms would discuss this with Dr. Patterson.
2. Dennis Carlson would be of great assistance to both Willie Mae and myself. Perhaps the latter weeks of June might be best.
3. It might be advantageous for someone from the Ministry to visit the School of Hygiene and Public Health in order to become acquainted with the personnel who might be available for consultation - (Dr. Taylor had previously made this suggestion.)

### Requests

1. It would be helpful if the training branch could receive some standard texts on Health Planning, Management, Health Team Development, etc.
2. I would appreciate any materials concerning workshops on Management or Curriculum Development.
3. The planning committee for a workshop in August, 1978 for Public Health Inspectors which has as its overall objective the redefinition of the Public Health Inspectors' role in the Primary Health Care system has placed on the Agenda a session dealing with this definition and an overview of Primary Health Care. The committee suggested that perhaps Dr. Taylor might be the most appropriate person to deliver this talk. This, of course, is tentative pending your concurrence, availability, and finances.
4. In order to prevent any confusion or misunderstandings between myself and personnel in the Ministry of Health and USAID-Jamaica, it would be helpful if copies of regular summaries of Hopkins communications with USAID-Washington, USAID-Jamaica, and the Ministry of Health that pertain to this project be provided to both myself and Willie Mae Clay.

(signed - Mark Gross)

Report of Activities - May 1, 1978 to June 30, 1978

Summary of Activities

The last two months have not been as active or productive as I had anticipated. This was primarily due to the lack of needed direction and consultation concerning the proposed inservice education program being developed by the training division. In discussions with Miss Hyacinth Stewart it was decided that a more effective and efficient approach to a nationwide program would be to develop a proposal which would outline the basic skills needed for all health workers in the Primary Health Care System. This is a deviation from the original idea of developing specific inservice education programs for each category of health worker. We have a draft of the administrative skills completed and have been waiting for approval of the overall concept as well as specific content from Dr. Christine Moody.

During May a considerable amount of time was devoted to working on the Maternal and Child Health Manual to be completed this year. My effort was primarily in working on the format and in editing.

I was able to devote some of my time to the development of a one-day workshop for Senior Nursing Tutors on the topic of budgeting. Miss Norma Dumont, Assistant Nursing Officer, Education is currently on long leave but we have tentatively planned two one-week workshops in October and November of this year. The main area of emphasis will be in the development of management skills.

In June a one-day workshop for Chief and Senior Public Health Inspectors was held. At this time the proposal for and the objectives of the major workshop for a selected group of Public Health Inspectors were outlined. The final draft of this workshop's agenda should be completed soon. The training branch and specifically myself were actively involved in the planning of this workshop.

Plans

1. To work on the development of a general philosophy for the training branch with particular emphasis on the branch's role in the Ministry in relation to inservice training.
2. To work on completing the Maternal and Child Health Manual by September.
3. To continue working on the development of the workshop for a select group of Public Health Inspectors to be held in August.
4. To work with personnel in the Cornwall Region and specifically Willie Mae Clay to continue the progressive development of inservice training programs.

Problems

1. Funding for inservice training programs still remains a concern. The training branch was informed on June 20, 1978 that monies were available but that the process by which these monies could be obtained was not clear.
2. Because of the inability to meet with Dr. Christine Moody who has carried the duties of her own post and that of the Chief Medical Officer, we have not been able to obtain the needed guidance to commence with the distribution of the skeletal outline of inservice training that has been developed by the training branch.

Recommendations

1. A management person would be very beneficial to the further development of the Ministry. This person could be best used at this time by the Senior persons in the Ministry.
2. It would be helpful if the training branch could receive some standard texts in Health Planning, Management Health Team Development, etc.
3. We would appreciate information concerning workshops and courses in Management and Curriculum Development.
4. The training branch would also appreciate current literature about PIEGO as well as catalogs from the School of Hygiene and Public Health.
5. It would be quite beneficial if someone from the Ministry be invited to the School of Hygiene and Public Health to meet persons who might be consultants to the project. In this way the Ministry would be better able to recommend and select appropriate individuals for consultation.  
(signed - Mark Gross)

Report of Activities - July 1, 1978 to July 31, 1978

Summary of Activities

July has in general been an active month. Mr. Ralph Faloon, Health Educator in the Primary Health Care Unit, and I continue to work on the Maternal and Child Health Manual. We are hoping that this document will be ready for the printers by the end of September.

I have also been actively participating in the planning of the Public Health Inspectors' Workshop to be held in August of this year. It is hoped that the Inspectorate will be able to develop a document which will outline their roles and responsibilities in the new Primary Health Care system.

Miss Hyacinth Stewart and I have met with the Assistant Training Officer, the Health Educator, and the Head of Education for the National Family Planning Board. We discussed training in general within the Ministry of Health and also inputs which the Training Branch may have in the National Family Planning Board's training programs. We hope that there will be better coordination between the Training Branch and the National Family Planning Board as a result of this meeting.

I have also made two (2) trips to Cornwall County to work with Ms. Willie May Clay and Dr. Tony D'Souza. The first trip's objective was to consult with Ms. Clay concerning the inservice training being undertaken in the Cornwall Region. The second trip's objective was to introduce Mr. Gary Cook, USAID Public Health Advisor, to the Cornwall County personnel. Dr. Tony D'Souza, Mr. Cook and I were able to devote a considerable amount of time to discussing the problems connected with the project's implementation. Mr. Cook was also able to visit a Type I and Type III Center both under construction.

### Plans

1. To assist Mr. Ralph Faloon in the completion of the MCH Manual.
2. To assist in the implementation of the workshop for Public Health Inspectors.
3. To continue working with Cornwall County personnel in the development of inservice training programs.
4. To finalize plans for inservice training for Midwives.

### Problems

1. Funding for inservice training programs continues to be a problem.
2. We have still not been able to obtain needed consultation and approval for the skeletal outline for inservice training programs in management for all Primary Health Care workers.

### Recommendations

1. If there are any appropriate workshops or seminars concerning curriculum development and management for personnel in the Health Care System, we would appreciate receiving this information.
2. In discussions with individuals in the Ministry of Health and in Cornwall, it appears that "short term" consultants are not seen as useful as long term consultants. Thus, if possible, perhaps consultants who would come to Jamaica to assist us in this project should come for longer periods of time and should be able to return to Jamaica on a regular basis.

Thank you for sending the materials that I had requested. I am also very appreciative of the articles being sent by Ms. Storms. Appropriate materials are sometimes difficult to obtain.

(signed - Mark Gross)

### Report of Activities - August 1, 1978 to August 31, 1978

The workshop for Public Health Inspectors to evaluate their traditional role and to develop proposals on their new roles and functions within the Primary Health Care System was held from August 8 to August 11. I was able to participate in the workshop from August 8 to August 10. This workshop appeared to be very profitable for the Public Health Inspectorate. A draft of the entire proceedings was made available to each participant at the conclusion of the workshop with the expectation that each participant would disseminate the information within his own parish. The Panamerican Public Health Organization will be printing the final document of this meeting.

On August 3 Miss Hyacinth Stewart discussed with Dr. Christine Moody by telephone the need to meet with her to discuss the skeletal outline for inservice training programs in Management of the Type I Health Center. Since Dr. Moody was leaving the island for a meeting and would then be on leave, Miss Stewart was informed that this meeting could wait until she returned to the Ministry in October. However, while I was attending the Public Health Inspectors Workshop, Dr. Moody and I were able to devote some time to discussing inservice training programs for Primary Care and she was at that time satisfied with the skeletal outline developed by the Training Branch. On returning to Kingston, Dr.

Patterson's secretary called requesting that I meet with Dr. Patterson concerning inservice training programs.

The meeting with Dr. Patterson was very enlightening. She stated that she felt that I was to develop a comprehensive inservice training program including management and clinical tasks for all categories of Primary Health Care workers from the Cleaner Attendant and Driver to the Medical Officer of Health. At the end of this meeting it was decided that I would work on developing a comprehensive inservice training program for primary health care workers emphasizing management tasks for the Community Health Aide, the District Midwife, the Public Health Nurse, and the Public Health Inspector.

### Plans

1. To assist Mr. Ralph Faloon in the completion of the Maternal and Child Health Manual.
2. To complete the first draft of inservice training programs for Primary Health Care Workers.
3. To develop strategies for implementing the Primary Health Care inservice training programs on an island wide basis.

### Problems

1. Funding for inservice training continues to be a problem. (Willie Mae Clay has received some monies for training but these monies are not coming from our project requests.)

2. The training Branch is not seen by the Director of Personnel under whose portfolio the Training Branch falls as being involved in developing and implementing inservice training programs. However, the Chief Medical Officer and the Principal Medical Officer in charge of Health feel differently. Inservice training programs will continue to be difficult to develop and implement through the Training Branch as long as this dichotomy exists.

I hope that all is going well in Baltimore and that the coming school year will be rewarding for the Department, the students, and the School.

(signed - Mark Gross)

## Report of Activities - September 1, 1978 to October 31, 1978

### Summary of Activities

Early September was spent in developing and arranging the agenda for Dr. Dennis Carlson's visit. Dr. Carlson arrived on September 13 and the ensuing eleven (11) days though hectic, were very profitable. The details of Dr. Carlson's visit have already been reported.

After Dr. Carlson's departure, work on the "familiarization workshop" for personnel holding key positions in the health care system began. The main objective of the workshop was to discuss Primary Health Care Training and to develop a system to ensure continuous and standardized training throughout the parishes. However, at a meeting called by Dr. Khanna, Country Representative for the Pan American Health Organization, a concern was expressed that the

Ministry was approaching PAHO for funding for a variety of training programs without apparent coordination within the Ministry. Dr. Khanna suggested that it would be useful to her and probably other "donor agencies" if a meeting could be held to:

- (1) Appraise participants of the Ministry of Health's Primary Health Care Training Programmes 1977-1978.
- (2) Analyse these programs and develop a strategy for the coordination and implementation of future training programs.
- (3) Identify human and financial resources available through "donor agencies".

Because of this, all work on the "familiarization workshop" was postponed and plans for the new workshop were made.

The workshop was attended by most of the Ministry of Health's personnel who have major program responsibilities plus representatives from PAHO, USAID, UNICEF, UNFPA, University of the West Indies, National Family Planning Board, Project Hope, Ministry of Local Government, Ministry of Youth and Sports, West Indies School of Public Health, Kingston School of Nursing and representatives of Cornwall Regional Health Administration. From this meeting it is apparent that there are many persons and organizations interested in training and that many of the programs that have been carried out are done on an ad hoc basis without any coordination. It was also apparent that the role of the Training Branch within the Ministry of Health was not clear.

In October Mrs. Nellie Allison, Mr. Peter Carr (PAHO) and myself conducted three separate one day workshops dealing with Supervision and Leadership. These workshops were attended by Community Health Aids, Staff Nurses, Public Health Nurses, Public Health Inspectors and Medical Students.

I have also been working with Miss Norma DuMont, Assistant Nursing Officer (Education) in developing a workshop for Nursing Tutors on Curriculum Development. This workshop is scheduled for the end of November.

Finally, the Training Branch completed plans for the "familiarization workshop" which was held in Montego Bay on November 1, 1978. The participants for this workshop were the Medical Officers of Health, Regional Public Health Inspectors, Regional Health Education Officers, Regional Nutrition Officers and Regional Nursing Supervisors. The main objectives of this workshop was to discuss Primary Health Care Training and to develop a system to ensure continuous and standardized training throughout the parishes through the developing of a team of training co-ordinators within each parish to be coordinated regionally. As a result of this meeting the decision was made to move ahead with the development of these teams and that the names of the training coordinators would be submitted to the Training Branch by the end of November with training of the coordinators to begin in January.

Plans

1. To work on the development of the training workshops for the training coordinators.
2. To work with Miss DuMont in the Curriculum Development Workshop for Nursing Tutors.

Problems

1. Funding the programs remains a problem. According to Dr. Linda Haverberg the monies for our project have been distributed through the Ministry of Finance to the Ministry of Health. However, since these funds apparently have not specifically been "ear marked" for this project the monies went into general revenue and are "lost."

2. The Training Branch is currently being re-evaluated since there is a new Director of Personnel as well as a new Acting Permanent Secretary. With the severe financial constraints placed on the Ministry of Health, it appears that the training Branch's need will not be given a very high priority. Thus any personnel who leave will not be replaced. Training Programs will continue to be developed and implemented without any input from the Training Branch.

3. In my opinion it appears that the implementation of the Training of Trainers workshops will be exceedingly difficult since the Training Branch does not have any control over training monies and must rely on other programs, whose priorities seem to be always changing, for funds. However, we will continue to plan and develop a syllabus for this training in hopes that funds will be released.

(signed - Mark Gross)

**SUMMARY OF YEAR I HEALTH IMPROVEMENT OF YOUNG CHILDREN ACTIVITIES  
RELATED TO THE PRIMARY CARE TRAINING CONSULTANT  
February 15, 1978 - December 31, 1978**

The project "Health Improvement for Young Children" between the Johns Hopkins University, the United States Agency for International Development, and the Government of Jamaica - Ministry of Health - was initially designed to assist the Cornwall County Health Administration to decentralize the Primary Health Care System, to devise the curriculum and the training of health care providers, to improve the management and data, collection systems, and to improve and increase the efficiency of the support services within the Cornwall County. However because of the delay in the actual start of the project certain changes were felt necessary. Thus, the Primary Health Care Training Consultant was assigned to work with the Chief of the Training Branch of the Ministry of Health as well as the Training Co-ordinators in each parish to identify training needs and to develop and implement training programs.

The major difficulty encountered by this change was that the role for the Primary Care Training Consultant within the Ministry of Health was not defined. Thus, a considerable amount of time was devoted during the first six (6) months of the project to the informal development of the Primary Care Training Consultants' relationship to the Training Branch and other groups within the Ministry who were involved in training. During the first six (6) months of the project a considerable amount of time and effort were devoted to a wide variety of tasks, many of which are not completed or are waiting for implementation. Some of the tasks are:

- (1) Maternal and Child Health Manual
- (2) Skeletal outline for management in the Type I Health Centre
- (3) Skeletal outline for Midwifery inservice training
- (4) Development of the Training Branch's role within the Ministry

The first four (4) months of the project were spent in the development of two (2) seminars whose focus was on Primary Health Care Training, the role of the Training Branch and the development of parish Training Co-ordinators. Efforts were made to develop the proposed Training of Trainers workshop to be held January 22 to February 2, 1979.

The current plan for 1979 is to develop and implement the Training of Trainers Workshop. The workshop will be of two (2) weeks duration with the participants coming from all the parishes. Because of the need to keep the size of the group at 25 participants there will need to be two workshops in order to accommodate all the participants. The first workshop is scheduled to begin on January 22, 1979 with the second to follow approximately four (4) to six (6) weeks later.

The first major inservice training that the New Parish Training Co-ordinators will mount is a workshop for Midwives in Management and Supervision of the Type I Centre as well as selected clinical skills. The Training Branch and the Midwifery Consultant from the University of the West Indies will work closely with the new Training Co-ordinators in the implementation of the Midwifery training programs.

Major Constraints Encountered

- (1) The role and expectations of the Primary Care Training Consultant were not clear resulting in confusion and misunderstanding among individual and groups with responsibility for training.
- (2) The Training Branch is not seen as being the central coordinating point for training within the Ministry.
- (3) Program areas within the Ministry plan and implement their own training programs resulting in little coordination of programs.
- (4) Inadequate and untrained manpower in the training Branch to develop and implement programs for the entire Ministry.
- (5) Constant confusion regarding funding for various training programs.
- (6) Shortage of training materials - i.e., paper, pencils, stencils, etc.
- (7) No official posts for training within the Ministry.
- (8) Crisis orientation to planning resulting in programs which are sometimes repetitive and upon their completion the outcomes - evaluations are not properly analyzed in order to provide data and information for effective planning.
- (9) Limited collaboration with Willie Mae Clay due to difficulties in reimbursement of expenses and an inadequate subsistence allowance.

Major Activities

- (1) Participating in planning and implementing the following workshops or seminars:
  - (A) Public Health Inspectors Workshop in Primary Health Care
  - (B) Supervision and Management Seminars
  - (C) Health Educators Annual Conference
  - (D) Curriculum Development for Senior Nursing Tutors
  - (E) Role of the Training Branch for Ministry staff and Donor Agencies
  - (F) Training of Trainers for Senior Ministry Field staff
- (2) Developed skeletal outline for management and supervision in the Type I Health Center
- (3) Participated in JPPII and Primary Health Care Meetings
- (4) Provided continuing consultation to the Chief of the Training Branch
- (5) Provided consultation to a variety of health agencies and providers in regards to training in Primary Health Care.

(signed)  
Mark Gross  
Primary Care Training Consultant

**MONTHLY REPORTS:**

**Willie Mae Clay-Brown**  
**Deputy Leader for Clinical Training**

**WILLIE MAE CLAY, DEPUTY LEADER FOR CLINICAL TRAINING,  
CORNWALL COUNTY, JAMAICA**

**Report of Activities - March, 1978**

I arrived from Kingston in Montego Bay on Thursday, March 2, 1978. Friday, March 3rd, I accompanied Dr. D'Souza to Cornwall Regional Hospital where I was introduced to members of the Public Health Staff. Miss Carol Brown, Administrative Assistant to Dr. D'Souza, provided me with a proposed itinerary for the month of March. The itinerary reflected a well thought out schedule; one that could afford me the opportunity to become oriented to the Cornwall Nursing Administration; Public Health Inspectors; Regional Nursing Supervisor; Health Educators; In-service Education Committee members and Clinics within the County.

Based on my observations in Clinics; Conferences with Public Health Nurses; midwives; Community Health Aides; Family Planning Staff; District Medical Officers; Mrs. McFarguhar and Dr. D'Souza, I proposed that I develop a programme of work. The work programme would reflect a realistic set of goals, activities and projected target dates for completion of each phase of work.

The type I Centres will begin operation in approximately six (6) months, therefore, those individuals staffing these Centres will participate in the initial in-service training sessions for Primary Care Management and delivery. The methodology for planning and implementing these sessions will be worked out by the Health Education Officers, Mrs. McFarguhar and myself. All plans for the in-service training sessions will be subject to Dr. D'Souza's approval.

(signed - Willie Mae Clay)

**Report of Activities - April, 1978**

The county of Cornwall is in the process of adapting to change within its health care delivery system. In an effort to prepare the primary health care staff to function effectively in the type I centres, it was necessary to scrutinize their capabilities in the following areas:

- (a) the ability of staff to work as a team;
- (b) the management/supervisory skills of the district midwife;
- (c) the willingness of the public health nurse to delegate duties;
- (d) the ability of community health aid to perform tasks necessary for the expanded role;
- (e) the active involvement of the public health inspector; etc.

The need for orientation with regard to responsibilities and expectations associated with the team concept in the primary health care setting was identified. One of the major steps we have taken to accomplish this was to develop an intensive primary health care workshop.

This in-service training session covers two eight hour days and the content is based on practical ideas and objectives for primary health care delivery. Each training session is attended by a multi-disciplinary trainee group (i.e., PHIs DMs PHNs CHAs Nutrition Assistants). The objectives and goals of the training

sessions are designed to increase the efficiency of the participants in the operation of the type I centres.

This training has been implemented in the parish of St. James with the initial sessions on April 17th and 18th, 1978 at Cornwall Regional Hospital. These training sessions will be carried to all parishes in the county of Cornwall on a scheduled basis.

Report of Activities - May, 1978)

The Primary Health Care Workshop is in progress in the parish of St. James. The projected date for completion of this initial stage of the training for all type I health staff in St. James in June 20, 1978. For the Primary Health Care training sessions, I have developed basic ideas, objectives, and evaluation forms in order to maintain uniformity throughout the County of Cornwall. Enclosed are copies of the protocol and related material. It is my goal to have completed these training sessions for all Type I health staff in the remaining four parishes by October 1978.

I have met regularly with Dr. D'Souza and Mrs. McFarguhar to discuss the areas where there is need for additional training, specifically in clinical skills. These sessions are being planned to be scheduled into the on-going parish conferences with major input for myself and the Public Health Nurse in charge of the area. ✓

I am happy to report that the Mobile Clinic is on the road. Thanks to all of you who helped make it possible. I will be accompanying the nurse who travels with the Unit on a scheduled basis to do some direct patient care.

(signed - Willie Mae Clay)

Report of Activities - June, 1978

The ending of June marks the completion of the initial phase of the Primary Health Care two-day workshops for the parish of St. James. For this training period, the workshops were evaluated and up-graded on an on-going basis. The feedback from the trainees has been positive overall. The comments from each trainee regarding further training needs for expanding roles in Primary Health Care have been tabulated and practical training sessions are being scheduled for all categories of Type I staff based on these needs. The major problems I have encountered in conducting the training sessions were the lack of funds for training and the shortages of supplies, e.g., paper, ink, chalk, stencils, etc.

I have been informed by Dr. D'Souza that the funds for training are at the Ministry of Finance. However, the mechanisms for getting these funds have not been worked out as yet. Needless to say, this will hamper my ability to move ahead with training in the other parishes as scheduled. Since the economic situation is critical here, I would appreciate it if a letter could be sent or a telephone call made to the appropriate person or persons at the Ministry regarding the release of training funds.

Mark Gross and Miss Hyacinth Stewart are developing a skeleton outline of tasks performed by Primary Health Care Workers. I received a call from Miss Stewart on July 5 requesting that I participate in the developing of this outline. I will be going to the Ministry of Health to work with them along these lines. Both Mark and Miss Stewart will be making regular visits to Cornwall for co-ordination of training between the county and the national level.

(signed - Willie Mae Clay)

Report of Activities - July, 1978

The two-day primary health care workshops continue for the County of Cornwall. There has been an addition to the workshop material content. A short pre-test questionnaire is given to the participants at the beginning of the first day's session. To ensure that the material relating to the pre-test is discussed, the responses are reviewed early in the session by the resource person.

I have also developed a series of clinical situations one may encounter in a Type I centre. The training group is given these situations on the second day with the instructions to give brief answers regarding the action to be taken in each situation. Based on the answers given, I am able to assess to some extent the area where the need is greatest for up-dating clinical knowledge. Enclosed are copies of the pre-test questionnaire and clinical situations.

I have held on-going inservice training meetings with the County Health Educators and the training officers designated for each parish. These training officers, although recently having undertaken this task, are oriented to all aspects of the primary health care in-service format. They are instrumental in helping organize the workshop participants as well as aiding the health educators with conducting the training sessions. I see these training officers as an asset to the County of Cornwall in that they are learning the method surrounding in-service workshops. Upon completion of my assignment at Cornwall, it is my hope that these skills attained by the training officers will provide support to the health educators in coordinating and organizing future in-service training.

On July 31, 1978 Mr. Gary Cook, Public Health Adviser for USAID and Mr. Mark Gross were in Montego Bay at Cornwall County Health Administration. Mr. Cook was especially interested to learn about the primary health care in-service training and the progress of the Jamaica Population Project II project in relation to Cornwall County. Dr. D'Souza provided the information on the latter and both Mr. Gross and Mr. Cook were guests at the in-service training committee meeting, chaired by myself on that same day. Mr. Cook has assured Dr. D'Souza and me that he will endeavor to assist us with any problems arising with regard to public health training.

The training funds promised under PL480 for in-service training in Cornwall has still not materialized in spite of frequent reminders to USAID and Ministry of Health in Kingston. At the moment my budget for training is zero. Please continue your efforts to have the funds released.

(signed - Willie Mae Clay)

Report of Activities - August, 1978

Primary Health Care Workshops

The remaining parishes to complete the in-service training for the Type I Centres are Trelawny and Hanover. This initial phase of primary health care training will be completed by October 4, 1978 for the County of Cornwall. For each of the five parishes in the county, an in-service report on the workshops and a summary of the evaluations is being prepared. Copies of this report will be submitted to Dr. D'Souza, the training branch of the Ministry of Health and the County Health Educator.

In-Service Training

I have received the draft outline for primary health care in-service on the national level submitted by the Ministry of Health. I expect that the outline will be finalized during the time that Dr. Carlson will be in Jamaica for consultation. Plans are made to discuss with all persons involved with training, those areas that I feel can be realistically dealt with on a county basis.

Training Fund

I am pleased to report that the sum of \$12,500 was made available from the Family Planning Board for the parishes of Westmoreland, St. James and Hanover. These monies will probably have to be shared with Trelawny and St. Elizabeth for the time being. Thanks from the Cornwall staff for your help in obtaining these funds.

(signed - Willie Mae Clay)

Report of Activities - September, 1978

Primary Health Care In-service Training

October 4 marks the completion of the basic training for Type I Centre health staff. A total of approximately 600 persons participated in the two-day workshops. Based on previous in-service training and the recent workshops, I feel that the foundation has been laid for Primary Health Care Team Function. However, it is essential that this foundation be built upon and expanded with ongoing in-service training.

On September 20, 1978, I chaired a meeting with the in-service Training Committee members, the senior staff (Medical Officers of Health, Public Health Nurses, Health Educator, Public Health Inspectors) and Dr. Dennis Carlson. The purpose of this meeting was to report to the group on in-service training up to this point and to get input and feedback on all aspects of training for the County of Cornwall.

The following comments were consensus of the group:

- (a) the Primary Health Care workshops were fruitful;
- (b) the team concept is working; being put into practice
- (c) all categories of staff entered into a learning process together and shared ideas; learned about each other's roles

- (d) participants identified needs for future training in order to expand roles
- (e) the multi-disciplinary approach to training be continued in order to maintain the team concept

There was lengthy discussion on the proposed training for the remainder of 1978. First-aid and visual-aids for the health teaching were the areas we felt could be completed by the end of the year. The proposed curriculum for 1979 was introduced and will be finalized in the next meeting on October 17, 1978.

#### Heads of Project Meeting - Ministry of Health - Kingston

On September 21, 1978, the following recommendations were made by the Chief Medical Officer, Dr. A.W.Patterson:

- (a) all documentation on the Primary Health Care Two-Day Workshops be forwarded to the Health Education Director, Miss Daisy Gold
- (b) a group of supervisory level health staff working in primary health care outside Cornwall County spend one day in Cornwall County to look at the primary health care training method
- (c) the familiarization workshop be followed by a trainer of trainees' workshop to develop a trainee team. For example, two persons from each parish to conduct in-service training throughout the four regions.

I feel that the above recommendations came about based on the progress made in Cornwall County in Primary Health Care in-service training.

#### Consultation Visit - Dr. Dennis Carlson

I want to thank Dr. Carlson for being in Cornwall for consultation with me. His advice and recommendations were well received by the Cornwall staff. The training team was very receptive to his ideas and his shared experiences in Public Health. I was especially pleased with his suggestion that functions performed by health workers should be as wide as possible. Trainers should describe, teach and supervise people to do the broadest amount of functions that they can do. These are concepts that I endorse and will continue to reinforce.

#### Outstanding Problems

1. overwhelming need for health care - shortage of health workers.
2. the inability of a large number of lesser trained workers (Community Health Aides, District Midwives) to adequately perform clinical tasks
3. hesitancy of senior staff to dissolve/delegate to lesser trained people those duties that can competently be managed by them

#### Possible Solutions

1. the hiring of more health workers.
2. upgrade skills of lesser trained workers to their maximum level; adapt the concept "each one teach one"

3. the clinical trainer for the country (DLCT) work diligently with core people to provide the needed training, particularly in regard to deligation of responsibilities.

(signed - Willie Mae Clay)

Report of Activities - October, 1978

The Cornwall County Health Administration organized (November 1,1978) a one-day workshop for the Training Branch of the Ministry of Health. Participants in the workshop included Regional Nursing Supervisors, Public Health Inspectors, Medical Officers of Health, Health Educators, Nutritionists and Mr. Peter Carr from PAHO. The major emphasis was to familiarize all parties with the primary health care in-service training methods being carried out in Cornwall County with possible implementation of same throughout the island.

Enclosed are copies of the in-service material developed for Cornwall and distributed to each participant in the workshop. The objectives were clearly stated for the day and everyone involved worked hard to meet them by the close of the session.

Mr. Mark Gross will be forwarding a report from the training branch regarding the guidelines for in-service training from the Ministry level.

In-Service Training

Visual Aid one day workshops have begun in Cornwall (Hanover, St. James) Family Planning and First Aid sessions are planned and the objectives have been worked out for each. Enclosed are copies. We will be continuing the same procedure as for previous workshops. Each parish training officer will be responsible for submitting a report to the training coordinator at the completion of each phase of training for the parish. The trainee groups will continue to be multidisciplinary.

Primary Health Care Two-Day Workshops

Enclosed are copies of In-service Training Reports for the County of Cornwall.

(signed - Willie Mae Clay)

SUMMARY OF TECHNICAL ASSISTANT FOR CORNWALL COUNTY HEALTH ADMINISTRATION  
DEPUTY LEADER FOR CLINICAL TRAINING (DLCT)  
MARCH 1978 THROUGH DECEMBER 1978

**Primary Health Care Training: Type I Health Staff**

Assessment of Training Needs: The DLCT visited existing Type I Centres, Consulted with Dr. D'Souza, Senior Medical Officer (Health), Regional Nursing Supervisor, County health staff and County Health Educator. The projected training needs for a seminar held for the county health staff in January '78 was reviewed. The DLCT agreed that inservice training in communication skills and management skills would lay the foundation for all disciplines of staff to interact harmoniously together with a work situation. An appropriate approach to team functioning was to emphasize and reinforce the team concept.

Planning: (In-service Training) The economic situation in Jamaica can best be described as critical. Funds for inservice training at the onset were not available from the Ministry of Health. The appropriate training funds from USAID/Hopkins could not be located at Ministry of Finance. The need for implementation of Primary Health Care inservice was evident since Type I health centres were to begin operation in approximately six months from my arrival on March 1, 1978. Health staff had to be prepared to deliver expanded services from type I centres; interact appropriately as a team and assume management and leadership functions, hence the following plan of action was developed:

1. Each training group would total a minimum of fifteen (15) participants and a maximum of twenty two (22).
2. Each training session (intensive workshops) would be limited to two days - covering Communication Skills on Day 1 and Management Skills on Day 2.
3. The training sessions would be conducted in the most centrally located area for each parish to minimize travel costs.
4. The trainee groups include representatives from all disciplines of primary health care staff.

Expanding Training Staff

5. Incorporate two (2) senior public health nurses to assist as resource person with training.
6. Choose a public health inspector from each parish to assist with coordination of the training sessions.

Development/Implementation of Two Day Workshop

The DLCT developed a set of basic ideas to reinforce the team concept and to emphasize the expectations (expanded roles) of type I health staff as stated in the Type I Manual. Secondly specific objectives and goals were set for all training content to be based upon, in addition to a format for delivering the training sessions. This format allowed uniformity in conducting training sessions

throughout the county. Finally, an evaluation form was designed to be used at the end of each training session. Lunch and transport had to be provided by the participants until funds could be available for reimbursement.

The two day workshops began in St. James on April 21, 1978 and ended in Hanover on October 4, 1978. A total of six hundred and eighty seven (687) members of health staff completed the inservice training sessions.

The overall evaluations indicated the success of the training. In fact the Ministry of Health Training Branch held a one day workshop in Montego Bay for Regional Health Supervisors outside of Cornwall to familiarize them with the training methodology as was instituted in the County of Cornwall.

#### Inservice Training

Seminar: Cornwall Regional Hospital  
Participants: Post Partum Staff Nurses (20-25)  
Topic: "Rationale for Inservice Education"

Seminar: Cornwall Regional Hospital  
Participants: Public Health Inspectors/County Cornwall (30)  
Topic: Management of (1) Poisons; (2) Accidents; (3) Burns

Practical Training Sessions: Cornwall Regional Hospital  
Participants: Public Health Inspectors/ County Cornwall  
Procedures: Bandaging; Applying Splints; Blood Pressure  
Techniques

#### DLCT Activities 1979:

1. Evaluate Type I Health Centre: Cornwall
  - a. Services
  - b. Staff performance
2. Coordinate Inservice Training for Cornwall.
3. Assess field experiences in a pilot area in order to
  - a. provide input for Type II Manual
  - b. provide input for Type III Manuals

#### Projected Curriculum for 1979 (Inservice) Cornwall

1. First Aid
2. Family Planning
3. Nutrition/Dental
4. Early Stimulation for Children with Behavioral Problems
5. Methods of Reporting/Recording (Clinical Management)
6. Methods of Data Collection (Administrative Control)

#### Problems Encountered

1. Use of venues that were available without charge to the County. Unavailability of venues required rescheduling of sessions.
2. Shortage of materials and supply for training.

- 3. Additional responsibility for resource Public Health Nurses to existing heavy work schedule.**
- 4. Lack of official posts for parish inservice training officers.**
- 5. Resistance from some key Public Health Nurses to have Community Health Aides learn the techniques for taking blood pressure.**
- 6. Reduction in the amount of mileage allowed for travelling officers.**
- 7. Cessation of any Public Health Nurse's involvement as resource persons for inservice training where Community Health Aides are involved (result of protest against alleged unsatisfactory treatment metered out to one of their colleagues).**
- 8. Overall insufficient health manpower in Jamaica/Cornwall.**
- 9. Insufficient manpower in training branch (M.O.H.)**
- 10. Lack of built-in mechanism for DLCT to procure allocated training funds.**

**(signed - Willie Mae Clay)**

(1979) Report of Activities - January, 1979

Primary Health Care: Two Day Workshop Inservice

The basic training in management/communication skills for type I health staff is completed in Cornwall County. A two-day workshop is hardly adequate to ensure that type I staff will immediately adapt fully to their expanded role. The necessary assistance, backup and reinforcement for these health workers will be provided by the writer and the inservice training team. The Regional Nursing Supervisor (Mrs. McFarguhar) will be working with the Senior Nurse in the County to monitor staff performances and health services in order to facilitate primary health care team functioning as per the type I manual and the inservice training. An evaluation study of knowledge attitudes and performance of Type I staff is scheduled to be implemented in April 1979.

Inservice Training: Nutrition/Dental Seminar

The County Nutritionist (Miss P. Trotter) and Dr. Warpeha (Dental Surgeon) completed the inservice information and the writer developed the student/teacher objectives (copies enclosed). On January 17, 1979 the second of two one-day seminars was held at Cornwall Regional Hospital for Health Educators, Nutrition Assistants, Dental Nurses and Nurse Educators on hospital staff. The objective of the training coordinators is to improve the dental/nutritional status of the community through health education.

Special Training Objective: to increase the level of awareness in primary health care staff of:

1. the relationship of poor dental health and inadequate nutrition

poor dentition ----- nutrition problems  
inadequate nutrition ----- dental problems

2. to provide all training officers with dental/nutrition health education materials for upgrading skills of primary health care staff.
3. to assist training officers with the methodology for conducting nutrition/dental seminars.

These seminars will be conducted for all primary health care staff in Cornwall County in addition to coordinating these sessions with hospital training officers.

Training of Trainers Workshop

Training Board Medical Officer (Health) conducted a 2 week workshop (January 22 - February 2 1979) in Kingston. The objective of the workshop was to provide participants with the knowledge and skills to train other health workers in primary health care implementation. The writer participated in the workshop as a resource person. Resource activities included:

- (a) working with groups in leading group discussions; developing teaching/learning objectives;
- (b) assisting participants to develop a training programme;
- (c) conducting case study presentations;

- (d) assisting group participants to develop training skills (job instruction exercise)
- (e) assist with programme evaluation.

Three of the eight participants from Cornwall County were not previously members of the inservice training team. The training gained from attending the workshop will enhance the ability of the existing inservice training team as well as provide additional training officers. The goal is to eventually have a team of four training officers in each parish of Cornwall with the ability to identify training needs and the skills to develop and evaluate training programmes. The logistics for interaction of the newly trained training officers into the system will be taken up at the February 12th inservice committee meeting.

(signed - Willie Mae Clay)

### Report of Activities - February 1979

#### Primary Health Care Inservice Training: Dental/Nutrition Health Education Seminars:

A training officer from each parish in the county is conducting the above seminars for community health aides and district midwives. The initial emphasis on dental/nutrition health is being placed within this group of health workers. Since these staff members make regularly scheduled visits to homes within the community, this allows for a positive influence on the family's dental/nutritional health habits. There will also be dental/nutrition seminars presented at community health committee meetings by training officers to facilitate reinforcement of community awareness. The focus is on prevention of dental/nutrition problems via health education.

#### Family Planning Update:

Cornwall County's primary health care staff have participated in family planning inservice training at various levels; however, the need for reinforcement of family planning education and methodologies is indicated in Cornwall. The plan to update family planning information for all categories of primary health care staff (PHNs, DM, S/N, PHI, CHAs) is as follows:

- (a) give the enclosed pre-test to each staff member in each of the five (5) parishes;
- (b) use the results of the pre-test as an indicator for areas of family planning that require major emphasis; and
- (c) construct each family planning update seminar to (1) meet the stated objectives; (2) address the areas of weakness as per the pre-test (3) motivate participants to encourage family planning practices within the community.

The resource persons are being selected, pre-test has been given in one parish and enclosed are copies of the pre-test, objectives and draft of the program. The training team project the first family planning update seminar for one of the five parishes in Cornwall to begin approximately March 23rd.

In general the health staff have had to deal with several constraints that have had an impact on inservice training over the past three to four months. The major ones are:

1. the professional decision of the public health nurses regarding inservice training for community health aides;
2. separation of some midwives from the trainee group due to a dispute involving a community health aide;
3. infrequent meetings of the parish coordinators and their medical officer of health for specific inputs into training programs; and
4. Crisis (i.e., gasoline strikes, mail strikes, telephone strikes, Typhoid and Gastroenteritis outbreak.

In spite of these constraints the in-service training team continues to strive to function as a team. However, the multidisciplinary approach to inservice training and the participants will hopefully resume once the major issues are solved. Inservice training for Cornwall County continues although the progress has slowed somewhat and the prospected curriculum for 1979 is being planned and implemented.

(signed - Willie Mae Clay)

#### Report of Activities - March 1979

##### Primary Health Care Inservice Training (First Aid - Emergency Care)

New Health Centers are being handed over to the County of Cornwall for occupancy and the delivery of health services to the community. Recognizing that all categories of health staff have participated in first aid at various levels, the major focus of this training program is on "Emergency Primary Health Care." At present, physicians for health centers are few in numbers and most centers will be staffed with midwives, community health aids, public health inspectors, nurse practitioners and staff nurses. The aim of the training officer for the county is to prepare all health staff to react appropriately in an emergency situation. The emergency training program (copies enclosed) has started in the parish of Westmoreland. The number of training sessions needed to complete this training program will vary from parish to parish; depending on the numbers of participants in each training session, resources, etc. Progress in this area will be reported in subsequent monthly reports.

##### Family Planning Update

Trelawny: The training coordinators have conducted the family planning pretest among the health care providers. The results are being reviewed by the coordinators and the clinical trainer. The MOH, Dr. B. Sagoe will be assisting with the inservice update. The practical aspect of the training (Pap Smear, Post natal exam, Pelvic Exam) for the midwives will be provided at the postnatal clinic in Trelawny under the supervision of the public health nurse.

Development of the Pilot Areas - Cornwall County

A problem solving team has been formed within the Cornwall Health Administration. This team includes the SMOH, the Chief Pharmacist (Hospital), the County Administrator, The Statistical Officer, the County Health Educator, Regional Nursing Supervisor, the Nutritionist and the Training Officer from Johns Hopkins (Baltimore). The objective of the team is to assist the pilot area health staff to function as a model in the delivery of health care. Each pilot area in the county is being visited on regularly scheduled basis. The problem solving team meets with the pilot area staff (Types I, II, III) as a group on the initial visit. All aspects of primary health care in pilot area is presented and reviewed. Issues raised are documented and discussed. Based upon the needs identified, each member of the problem solving team plan their specific input into the development of the pilot area. A plan of intervention is decided upon by the pilot area group and the problem solving team. In spite of the many constraints the administration team is faced with (inadequate staff, shortage of supplies, etc.) the importance for development of the pilot areas is recognized by all concerned. The implementation of "model" primary health care services in these areas will hopefully serve as a catalyst for all the surrounding health districts. Followup information on pilot area development will be included in subsequent reports.

(signed - Willie Mae Clay)

Report of Activities - April 1979

Primary Health Care Inservice Training  
(First Aid Emergency Care)

The Emergency Primary Health Care Training Programme was initiated in the parish of Westmoreland. The first two-day session was attended by approximately 30 health workers from that parish. However, the training sessions could not continue concurrently for the remainder of the health staff due to various constraints.

One of the major constraints was the time requested for the medical officer of health to contribute to the training sessions as a resource person. This time added an additional demand on an existing heavy work schedule. In view of this, the primary health care training was deferred for the remainder of May in that parish.

The Inservice Training Committee met on May 14th. The problem of insufficient resource personnel regarding emergency primary care was discussed. The parish training officers were willing to assist as resource persons in this training, but felt they needed to be trained in the methods of emergency care. In order to provide this training for the training officers, the writer contacted Mr. Con Pink, the qualified First Aid Trainer, associated with the Red Cross. The Emergency Care Training Programme for Cornwall County staff was presented to Mr. Pink, and the objectives for the training programme were discussed. Mr. Pink agreed to provide the necessary assistance in the form of qualified trainers to assist with training the trainers in a three-week course at Cornwall Regional Hospital. At present, there are 17 training officers taking the course. A post course exam will be given to the trainers and certificates will be awarded upon success or completion of this exam.

Hence the number of resource personnel for conducting the Emergency Care Training Programmes will be expanded since parish training officers will be equipped with the methods for conducting emergency care training. Training officers are encouraged to coordinate the inservice training with the medical officer of health and senior staff in each parish. The recommendation from the training committee is that the Primary Health Care Emergency Training Programme be carried out in stages according to the availability of participants and the specific training needs of health staff related to emergency care.

(signed - Willie Mae Clay)

### Report of Activities - May 1979

#### Family Planning Update

Funds for implementation of the inservice training in family planning have been identified. The estimated budget for this inservice training has been submitted to Dr. C. Moody, Principal Medical Officer, and Dr. A. D'Souza, Senior Medical Officer of Health, Cornwall County. A copy of the training programme and the training budget have also been submitted to Mrs. H. Bulgin at the Training Branch, Ministry of Health. Dr. Moody informed the writer that the training funds can be obtained from the National Family Planning Board. A letter requesting the same has been forwarded to the National Family Planning Board Director, Mr. Sam Cheddar.

The projected date for the Family Planning Inservice Training to begin in Trelawny is June 26, 1979. The writer is optimistic that once the training funds are available family planning update inservice training can continue throughout the five parishes in the county of Cornwall.

#### Development of the Pilot Areas

Problem areas of priority are being identified by the Problem Solving Committee. Enclosed are copies of the initial reporting on the progress in the development of the pilot districts in Cornwall. Further strategies for interventions to unresolve problems are being looked at by the Cornwall County Health Administration staff and health staff in the pilot districts.

Parish training officers are encouraged to liaise with pilot district staff in order to identify specific areas where trainers may have an input. This concept is being reinforced at inservice training meetings as well as being endorsed by Dr. C. Moody, Principal Medical Officer for Primary Care. Further progress in the development of pilot area will be reported in subsequent reports.

(signed - Willie Mae Clay)

SUMMARY OF ACTIVITIES - JANUARY TO AUGUST 1979

Technical Assistance to Cornwall County

- Participated in:**
- A JPP II Monthly Meetings - Ministry of Health, Kingston
  - B Cornwall County Health Administration Monthly Meetings - Montego Bay
  - C Senior Nursing Administrative Meetings, Cornwall County
  - D Conducted Inservice training (learning objectives) sessions for Senior Nurse Administrators.
- Planned and Chaired:**
- A Inservice Training Committee Meetings (monthly)
  - B Development of Pilot District Committee Meetings monthly (accompanied Cornwall Health Team on pilot district visits)
  - C Procedure Manual Committee Meetings; participated in seminar for Senior Cornwall Nursing Staff re Writing Procedures; Johns Hopkins University Consultant, Dr. D. Carlson, attending
- Resource for:**
- A Training of trainers workshop; two weeks duration - Ministry of Health, Kingston (assisted with course instruction and programme evaluation)
  - B Management and supervision training for midwives; Ministry of Health; one week duration - Kingston
- Co-Ordinate:**
- A Inservice Training Programmes
  - B Inservice computer processing for maternal and child health programme - Cornwall County
- Liaise with:**
- A Training Branch - Ministry of Health and Environmental Control
  - B Primary Care Division - Ministry of Health and Environmental Control
  - C Cornwall County Health Administration; N.B. Monthly reports submitted to the above divisions.

Inservice Training

Nutrition/Dental Health Education

Assisted with planning/developing inservice training material; developed teacher/student

objectives; assisted with preparation of dental/nutrition visual aids and dental models; resource for inservice training seminars for Cornwall County; conducted nutrition/dental health education class for Jamal students.

Family Planning Update:

Family planning pretest; developed training objectives; developed training programme; coordinated resource materia/personnel; drafted budget for training program.

Emergency Primary Health Care (First Aid)

Developed training objectives; developed training programme; coordinated certificate training course for trainers; drafted budget for training programme; provided training manuals for trainers.

Inservice training budget for 1979-1980 has been drafted and submitted to the Ministry of Health, Kingston.

INSERVICE TRAINING CORNWALL COUNTY  
PRIMARY HEALTH CARE

The inservice training programme for Cornwall County was temporarily interrupted due to the flooding on June 12, 1979 in Western Jamaica, especially Westmoreland, Hanover and St. Elizabeth. The aftermath resulting required every individual in the health department to assist in minimizing the effects of the flood on the health of the people.

The inservice training teams are made up of health personnel who were key people in organizing and instituting health measures following the flood. The training consultant assisted the County with flood reporting and disease surveillance. Much restorative work is yet to be done; however, inservice training officers are preparing to resume training in Cornwall.

The Training Consultant will be on leave for four months beginning September 1979, resuming duties January 1980. Mrs. Mavis Whitter-Kind, Senior Public Health Nurse Hanover, will be coordinating inservice training activities for Cornwall with the training officers.

INSERVICE TRAINING PROGRAMMES - SEPTEMBER 1979 - DECEMBER 1979  
FAMILY PLANNING UPDATE: Implementation is planned for September 1979

- Strategy: a. Conduct family planning pretest; assess results  
 for b. plan course content, resource material  
 trainees c. identify resource personnel  
 d. determine method of evaluation  
 e. determine method of reporting/documentation

Date of implementation of programme is dependent upon receipt of training funds (due by August 30).

EMERGENCY PRIMARY CARE - FIRST AID

The training officers will be completing this certificate course on September 20, 1979. The emergency inservice training for primary health care staff will be coordinate/implemented by the training teams in each parish. The major requirement for effective implementation of this programme will be the availability of required equipment for training (e.g., film, bandages, splints, stretcher, etc.) Necessary equipment can be purchased with training funds.

A life size model for demonstration of C.P.R. (cardio pulmonary resuscitation) would be an invaluable asset to training, therefore plans are in progress to acquire the same for the training department of Cornwall.

(1980) Report of Activities - January through March

Training activities in Cornwall County were markedly curtailed during September through December 1979. Widespread flooding in Cornwall during June 1979 left an aftermath of damage to roads, homes, health facilities thereby creating a situation of alert by all public health personnel against impending disease outbreak. In addition, an explosion in the maintenance department of Cornwall Regional Hospital resulted in the closure of the hospital for several weeks. In general the economic decline in Jamaica has had severe impact on health staff specifically training/travelling officers. The travelling allowances have been decreased, in some cases no travelling expenses are reimbursed.

However, the parish training teams remain viable and those proposed inservice programs (Family Planning Update, Emergency Care including First Aid) were implemented in part during this period. Progress to date is as follows:

<u>Parish</u>	<u>Program</u>	<u>Theory</u> (All Primary Health Care Staff)	<u>Practical</u> (Midwives Staff Nurses)
Str. James	FP Update	Completed	Pending
Trelawny	"	Completed	Pending
Westmoreland	"	Completed	Pending
Hanover	"	Completed	Pending
St.Elizabeth	"	Completed	Pending

In order to avoid redundancy in training, the practical aspect of the Family Planning Update program is being conducted for those midwives practicing in Cornwall County who expressed a need to have specific skills upgraded (pelvic examination, pap smear; fitting for diaphragm, insertion/removal IUD). The major obstacle for parish training teams in implementing this training is the unavailability of experienced resource persons. In addition, some practical training sessions were deferred due to industrial actions involving midwives. A clinical training program for midwives is being organized at national level. Mrs. Beryl Chevannes, Midwifery Advisor to the Ministry is coordinating the program for the island. Mrs. Chevannes has agreed to assist the training coordinator in Cornwall to provide the resource personnel/facilities to train those midwives in the skills identified.

#### Emergency Care including First Aid (Certificate Course)

Certificates will be awarded to nine (9) training officers who successfully completed the First Aid examination (written/practical). The examinees included three (3) Public Health Nurses, three (3) Public Health Inspectors, one (1) School Dental Nurse and one (1) Nutrition Assistant. These officers, along with others who completed the course but did not take the examination, plan to implement future inservice programs in Emergency Care for Primary Care staff in Cornwall. A life sized model for teaching cardiac pulmonary resuscitation (CPR), training manuals on basic life support and pamphlets have been provided for the training teams to assist in conducting inservice programs.

#### Medical Records and Statistics

On February 4, 1980, inservice training in medical records and statistics was implemented for Cornwall. The four (4) weeks course, three (3) weeks of theory and practical at Cornwall Regional Hospital and (1) week of field practice in various health centers throughout the county was attended by fifteen participants. Trainees included clerical officers, one health educator, one public health nurse and one public health inspector.

Mr. Lloyd Thompson, Medical Records Officer, Cornwall County and Mrs. Willie Mae Clay-Brown, Training Advisor, developed and coordinated the course (Course copies enclosed)

#### Major Course Objectives

The main objective of the training program was:

1. to provide trainees with the basic knowledge and methodologies in medical record functions;
2. to assist in primary care staff development for maintaining a standardized recording system.

#### Specific Short Term Goals for Participants

Upon completion of the training course, participants set out to initiate/develop/facilitate the following record keeping functions in pilot district health centers:

1. Registration Book - Daily registration of each patient attending the health center; documentation of relevant statistical data; daily summary.  
Purpose: To allow for easy retrieval of statistical data re: health center services; disease incidence/prevalence; population flow etc.
2. Appointment System - Health Care providers use appointment book(s) that are provided to schedule patient appointments; patients provided with written appointment cards.  
Purpose: To facilitate an organized smooth functioning health facility; to aid staff in planning health center functions.
3. Integration of Patient Records - Each patient's clinic records (medical, antenatal, postnatal, family planning, etc.) be filed together in one docket; all dockets filed in one central location in the health center.  
Purpose: To facilitate all procedures involved with maintenance of clinic records, referrals, etc; to diminish the incidence of duplicate records/lost records and fragmentation of records. To facilitate continuity of care (evaluating the patient as a whole).

Ongoing evaluation of the above revised record keeping functions in the pilot districts is in progress. In some of the health centers the adaptation is slow, however, there is evidence of improvement of the system in others. Consistent support from the training officers and medical records officer to personnel working with the health center records is essential. In addition, course participants are charged with the responsibility of assisting other health staff to use/maintain the revised system and give the trainers feedback regarding its efficacy. Further reporting will be included in subsequent reports.

(signed - Willie Mae Clay-Brown)

#### Report of Activities - April 1980

#### Inservice Training Activities - Cornwall Country

##### Family Planning Update:

Inservice training teams in each parish of Cornwall identified midwives, staff nurses and public health nurses to be upgraded via inservice training for the following skills:

1. Pelvin examination (differentiate the normal from abnormal findings)
2. Pap smear (take a pap smear demonstrating accepted techniques)
3. Fitting diaphragm (measure/fit client with diaphragm using accepted technique)
4. Insertion of intrauterine device (IUD) (demonstrate the accepted method of insertion of an IUD)

Resource persons for trainees include nurses and midwives with family planning training and field experience. Determination of the trainee's competency will ultimately be the decision of the supervisor/preceptor. Each trainee is required to perform a minimum of five of Nos. 1, 2, 3 procedures and a minimum of ten of No. 4

Methods of evaluation of the family planning update training programme (theory and practical) include administering the family planning pretest as a post test to all participants. In addition, a recommendation of an assessment of the increase of new acceptors of family planning methods be done in each parish six months following the completion of the training program.

If primary care workers are concerned about the 1979 statistics indicating a market escalation of the birth rate specifically among teenagers then an unbounding thrust to promote the family planning concept must be undertaken by primary health care staff.

#### Major Constraints in Promoting Family Planning

1. Ethnic beliefs re contraceptives (e.g., having out an individuals' lot of children)
2. Negative attitudes re family planning (community members, males and females/health providers)
3. Inadequate facilities (old health centers, no exam couch, speculums, no facility for sterilizing, no water and electricity)
4. Insufficient trained staff/under-staffing.
5. Trained personnel in family planning but not performing family planning functions.
6. Insufficient supply of contraceptive supplies (diaphragms, pap smear kits, coils) at major health centers.

#### Recommendations for Promoting/Improving Family Planning Acceptance

1. Organize a Family Planning Promotion Committee to conduct a community programme in each health district to promote family planning; recruit new acceptors using Community Health Aides, Public Health Inspectors, midwives, staff nurses, as field recruiters.
2. Set a target goal and deadline for each health district to increase their number of family planning acceptors by a specific percentage after determining the numbers of clients using family planning methods.
3. Provide field recruiters with family planning handout literature and contraceptive kit to assist with the education of the community.
4. Equip all health centers with the necessary equipment for conducting family planning sessions.
5. Incorporate private practitioners who see teenagers for sexually transmitted diseases to include family planning education in their sessions and offer clients a choice of contraceptive methods or refer them to a primary health care center.
6. Involve parents of teenagers in the campaign through PTA meetings, health committee meetings, and community council meetings.
7. Increase the numbers of postpartum clinic sessions monthly in the health centers specifically for increasing the opportunities to promote family planning
8. Involve the National Family Planning Board members in the campaign to provide support/back-up for the county promoters of family planning.

TECHNICAL GROUP MEETINGS (T.G.M.)

"Development of the Role of the Staff Nurse  
in the Type II and III Health Centres"

The staff nurse, a member of the Primary Health Care Team, has carried out health delivery functions in absence of a clearly defined role. In the Cornwall region as the primary care programs expanded, the needs surfaced for recognition and identification of the expanding role of the staff nurse in the Type II and III health centers. It was felt that the nurses themselves should play a key role in this exercise.

Through a new approach of the Technical Group Meetings (TGM), opportunity for active participation of this category of staff in defining their role and getting their input on issues in order to improve the health services in the region was instituted in Cornwall. The initial series of TGM's Phase I were conducted in each parish for all staff nurses during the month of May 1980 (see attached Phase I summary). Specific data collated from TGM Phase I will be presented to officials of the Nursing Division, Mrs. L. Bragg, Assistant Nursing Officer, and Mrs. Hunger-Scott, Principal Nursing Officer of Ministry of Health, Kingston, for their input/recommendations prior to moving on to Phase II.

A four-day workshop (TGM Phase II) will be conducted in Montego Bay for staff nurses, representatives from Primary Care/Nursing Division of the Ministry in order to further the process of role identification. The workshop is tentatively scheduled for June 23 through June 26, 1980.

Phase III will be a post workshop for the coordinators and the technical advisor with input from Nursing Division at intervals. The outcome of the entire exercise will be preparation of a document "The Role of the Staff Nurse in Type II/III Health Centres" which, it is hoped, will be finally incorporated into the Health Centre Manual of the Ministry of Health.

(signed - Willie Mae Clay-Brown)

Report of Activities - July 1980

Inservice Training

Family Planning Update

To supplement the increased awareness and understanding of the need for primary care workers to promote family planning practices, the training advisor and the training committee is formulating detailed written steps for carrying out family planning procedures. In addition, the Committee have agreed to reinforce the method for evaluating trainees performance by developing a standardized evaluation form to be used by the evaluation. This form will assist the preceptors to maintain uniformity in the evaluation process as well as provide written documentation of the trainees achievements for the personnel file.

Officials at the National Family Planning Board (NFPB) are aware of the inservice training update programs for primary care workers in Cornwall County. Copies of collated data, (recommendations/constraints) re: FP programs are being forwarded to the NFPB.

Technical Group Meetings: Role of the Staff Nurse in Type II/III Health Centers

Preparation of the document, "Role of the Staff Nurse" continues. The planned four (4) day residential workshop began on June 30th at Holiday Inn Hotel, Montego Bay. In addition to staff nurse representatives from each parish, the participants included Dr. B. Wint, Acting SMOH; Dr. C. Moody, Principal Med. Officer Primary Care; Mrs. L. Bragg, Asst. Nsg. Officer MOHSS; Miss Norma DuMont, Nursing Education MOHSS; Miss Maria Rankine, Deputy Director Bureau of Health Education and Mrs. Flash-O'Sullivan Regional Nsg. Supervisor KSAC. Representatives from each category of primary health care also provided resource assistance.

The workshop ended with the development of a second working draft of the proposed document. The Training Advisor, Mrs. Clay-Brown, the Regional Nsg. Sup., Mrs. McFarguhar, Senior Public Health Nurse, Mrs. Lowe and the health educator from the Bureau of Health Education, Mrs. C. Stewart met together in a post workshop to further develop the material for the final draft. September 8, 1980 is the proposed deadline for completion of the document "Role of the Staff Nurse in Type II/III Health Centers." As stated in prior reports, the document is slated for printing and to be included in the existing health center manuals.

(signed - Willie Mae Clay-Brown)

Report of Activities - August 1980

Inservice Training Activities

Training Teams (Parish): The inservice training committee meeting held in September 1980 at Cornwall Regional Hospital proved to be extremely productive. The main focus of the meeting was to address issues regarding training teams functioning, training programs and community health education. Dr. Barry Wint, Acting Senior Medical Officer for Cornwall joined the proceedings in the afternoon session. Dr. Wint reminded the trainers of their responsibility to community health education and health committee involvement. Enclosed is a copy of the minutes from the meeting for further updating of training plans and progress in Cornwall.

Development of Pilot Districts:

Cornwall County Health Administration's problem solving team continues to visit pilot districts. The team exchange ideas and give recommendations with/to personnel. Progress in the development of pilot districts include (1) an increased effort to recruit needed staff, resulting in some filled vacant posts; (2) a system for ordering and receiving drugs and a drug distribution plan; (3) addition of three pharmacists (one assigned to a pilot area); (4) upgrading of recording of functions resulting in an improved client/data flow and record retrieval; (5) direct discussions by problem solving committee members and owners of rented health centers, resulting in increased sensitivity to occupying staff needs (i.e., building security, electricity, water); (6) health committee assistance and individual community member assistance with building maintenance/repairs, beautifying ground and fund raising activities for food

demonstrations. Senior officers in Cornwall have agreed to followup on pilot district issues and include development discussions in parish monthly conferences.

Role of the Staff Nurse

The final draft "Role of the Staff Nurse in Type II/III Health Centre" is being types. A copy of this document will be forwarded to the Department of International Health by October 31, 1980.  
(signed - Willie Mae Clay-Brown)

**Primary Care Training Advisor**  
**Technical Assistance to Cornwall County**  
**A Summary - January - December 1980**

**By**

**Willie Mae Clay-Brown**

**BEST AVAILABLE DOCUMENT**

**INTRODUCTION:**

Cornwall County (now known as the western health area) is the area where the training advisor is assigned. Cornwall County Health Administration (CCHA), the organization of the Ministry of Health responsible for the delivery of primary health care in Cornwall, provides the supportive staff with which the advisor works. Major areas of advisor responsibilities include:

continuous consultation in inservice training for parish training officers;  
assist to strengthen the health management system in Cornwall;  
assist as a resource person for administrative staff in Cornwall County; and  
participate in the evaluation of training.

With the assistance of training teams, medical officers of health, health educators, and senior staff members, key inservice training programs were conducted for primary care workers in Cornwall. The primary objective of the programs was to upgrade the knowledge and skills of participants so that they can provide the highest quality of primary care to the community. Inservice training committee members meet with the training advisor monthly to upgrade training programs, review progress in implementation and to coordinate training officers activities in the county.

Research Associates in the Department of Social and Preventative Medicine at the University of the West Indies, Mona, are presently evaluating the impact of inservice training on primary care, in terms of health staff functions and efficiency and effectiveness of health services. Results of the evaluation should provide a baseline for on-going assessment of the existing infrastructure and future projections in primary care. The main objective of the Training Advisor is to carry out all responsibilities in a manner that permits the government of Jamaica personnel, (national, central, local level) maximum opportunity for increasing their own skills and capabilities.

#### TRAINING PROGRAMS - CORNWALL COUNTY

##### Emergency Care (Basic Life Support) including First Aid

Nine training officers were awarded certificates for successful completion of the examination on emergency care including first aid. Seven officers completed the training course but did not sit the examination. The certified officers (qualified to teach Cardio Pulmonary Resuscitation (CPR) along with the officers not yet certified, will be assisting with conducting the training throughout the county. Medical officers (Health) and hospital personnel are encouraged to become involved in this training.

Training teams plan to expand the programs in 1981 to include community members, airport personnel and schools.

##### Training Advisor Recommendations:

Training officers not certified become certified in 1981;

Training officer, Senior Public Health Inspector Lloyd Hamilton have overall responsibility for the life-size model for teaching CPR;

All training officers participate in yearly update and review of basic life support including first aid;

Training officers work with health committees to ensure community involvement.

### Family Planning Update (Theory and Practical)

Rising birth rate, especially among teenagers in Jamaica necessitates extensive family planning (f.p.) training of all primary care workers, including ancillary and support staff. To assist health personnel to be continually motivated to promote family planning practices, trainers provide current information on f.p. methodology and organize needed clinical exposure and supervision for midwives and staff nurses, public health nurses and nurse practitioners who need the update. The f.p. clinical skills namely breast examination, pelvic examination, pap smear, insertion and removal of intra uterine device (I U D) and fitting a diaphragm, the latter being least requested by clients. A major constraint in family planning implementation, is, family planning services comes under no specific person(s) portfolio at local level, therefore, f.p. promotion is the responsibility of all primary care workers. Unlike family planning organizations in the past, an entity in itself. Progress to date in implementation of the training program is completion of training in f.p. theory and near completion of f.p. practical update training in Cornwall.

Consistent evaluation of f.p. training and services results in the training teams in each parish taking responsibility for developing detailed procedures for each f.p. clinical skill. These procedures enable trainees to practice like approach in performing the f.p. skills, similarly, evaluators who are supervising the clinical trainees have a common yardstick in the procedures to measure competency. Since I U D s and diaphragms are least promoted by f.p. providers and least used by f.p. clients, trainees often are faced with inadequate opportunity to gain expertise in performing these procedures. Trainers are

facilities where this exposure (I U D and diaphragm) can be obtained. These facilities can then become a reference point for clients seeking this service.

#### Constraints and Recommendations:

If a rising teenage birth rate in a declining economy is accepted by all concerned with the health of Jamaica, then this phenomenon must be reversed urgently. There is often shortage of family planning supplies and equipment in the field, however, officials at the National Family Planning Board (NFPB) assures that family planning supplies are in adequate supply at central level. Some providers of family planning services are reluctant or uncomfortable in promoting and distributing family planning methods.

The rapidly escalating birth rate, among teenagers. Primary care personnel in Cornwall have designated this problem as a priority on the list of training programs. Yearly, an island wide update of family planning practices, especially emphasizing the physiological, psychological and economic ramifications of an exploding population in an economically deprived society, should be implemented for primary care staff. However, training of personnel is not enough to ensure the family planning services are being utilized. For adequate monitoring of family planning in Cornwall, the suggestion is, officials at NFPB in conjunction with the training branch delegates overall responsibility for family planning programs and services to a group of groups in each region; specific duties delegated to responsible persons with comparable enumeration; and a closer working relationship between NFPB, training branch and Parish training teams for ongoing feedback of family planning progress.

## Medical Records and Statistics (Theory and Practical)

A four (4) week training course, was conducted for 15 participants, twelve (12) being clerical officers within the primary care system in Cornwall. Overall program objective was to provide trainees with medical records, recording and statistical information and practices that could be used to maintain a standardized recording system in Cornwall. Trainees understood that they would pass acquired information on to newly hired clerks, community health aides, midwives, and other health personnel involved with recording clinical data. This approach for implementation of a uniform recording system was done primarily because (a) clerical posts and clerical officers in primary care are inadequate and (b) recording functions are done by various staff members in the health centres resulting in varied recording practices. Standardization of medical records for the island at national level has not been completed. Adjusting the medical record system implemented in Cornwall to the national standard is not envisaged as a major difficulty. Especially, since central level officials in primary health care are in consultation with the training advisor regarding local training programs in keeping with objectives and projections at the

### Recommendations:

All clerical officers entering the system and/or other health personnel performing recording functions be oriented and instructed in the record keeping methodologies used in Cornwall. Training officers and clerks who have the expertise in medical records and statistics would be responsible for guiding the team members in these functions. Health facilities performing medical record functions are widespread and these statistical functions are a vital part of an effective primary care system.

The county's medical records officer could benefit greatly if there were available staff to work with him to monitor the records system. The training advisor has assisted the county officer in this effort. Senior personnel attached to a health facility is the most likely person to liaise with the county officer regarding record keeping functions. It has not been determined at present, who will be responsible for monitoring, ordering, receiving and distributing record supplies. In future this system will undoubtedly be in place and meanwhile the existing recording system is being steadily accepted and adapted in Cornwall County resulting in improved statistical retrieval.

#### Mobile Film Unit Training

Inservice training committee officers identified this training need primarily based upon:

- (a) the need to disseminate health information in the community
- (b) the availability of a mobile film unit provided for Cornwall County under Jamaican Population Project II (JPP II)
- (c) the willingness of members from each parish training team to be trained in operation of the film unit.

Fifteen (15) training officers including two (2) county drivers and three (3) health educators participated in the training program. Overall aim of the program was to increase the knowledge and develop the skills of participants in the use of 16 mm. movie sound projector operating from a mobile generating unit. Trainers with expertise in this skill, assist primary care educators to expand/extend health information into communities via visual aids (films). The written and verbal health teachings thereby being reinforced. The agency for Public Information (API) worked with training officers to conduct three (3) one day training sessions. The training officer, Mrs. D. Simpson reported

positive feedback from participants, however, they expressed a desire to have additional practical time. API technicians agreed to donate additional time to trainees until proficiency in operating the projector and generator, detecting problems and carrying out simple maintenance problems is acquired.

#### Recommendations:

Training teams in each parish plan inservice programs to include relevant film presentations. Actual use of the projector during training programs offers further exposure to operation of the film unit. A list of films for health education has been selected and the request to obtain them through the project "Health Improvement for Young Children" submitted to the project director. A film library is proposed for Cornwall's training unit.

#### Training Teams (Recommendations)

Inservice training officers in Cornwall have accepted the responsibilities for assisting in training for primary care personnel. Each of these officers carry a full portfolio for which he/she is primarily responsible outside of their training duties. Coordination of training needs and training programs with the officers and the advisor has continued consistently since 1978. Since no post for a county training coordinator exists, it is strongly recommended that such a post be created for continued coordinating practices. It is further recommended that the post be filled with a senior health educator. Health educators should take an active role as "leaders" for parish training teams, and assist the teams to continue to remain viable and productive. Medical officers of health and senior staff members working cohesively with the training officers can ensure continued strides in upgrading the skills of staff in primary care.

## Development of Pilot Districts

A designated health district in each parish of Cornwall is considered a "pilot district". These districts, in various stages of their development, will ultimately become the "model" districts for other areas to pattern. Cornwall County Health Administration initiated a system whereby a team from its staff have been working specifically to further the development process. To date the progress has been slow and inconsistent due to numerous and varied reasons. The major constraint encountered in developing health districts is insufficient staffing. The number of posts available for staff is inadequate and even if the posts were available, finances to fill the posts are near non existence.

Supplies is another key area that if it is not in sufficient quantity can only result in a compromise of the health services offered. Health center supplies allocated to Cornwall under the J P P II Program have been arriving in the county sporadically over the past year with a marked improvement of deliveries in the last six (6) months. Those health centers that have adequate supplies are the ones that are increasing the numbers of clinics (maternal and child health, family planning and medical) thereby expanding the services.

Coverage for providing pharmaceutical services in the pilot districts is inadequate. One (1) pharmacist and one (1) technician for a medical district is considered minimum coverage for providing pharmaceutical services. At present, there is 20% pharmacy coverage based on the minimum needed for five parishes. The public health nurses and staff nurses however, have continued to put the needs of the community first and assist by ordering, receiving and dispensing drugs where necessary.

A chief pharmacist at county level coordinates the monitoring of drug services with the senior medical officer of health and the pilot district staff. Primary care services offered in the pilot districts are presently being evaluated by the Department of Social and Preventative Medicine at The University of the West Indies. Reporting sessions from the research associates provide additional opportunities for CCHA to evaluate progress and constraints in pilot district development and to plan interventions.

To encourage parish health staff to assume major responsibility for developing their pilot district, CCHA recommends the following:

- (a) Senior officers in each parish with pilot district staff, assess the outstanding problems and possible ways to resolve them;
- (b) monthly pilot district review and reporting become integrated into senior officers conferences;
- (c) a flow sheet indicating pilot district development progress be kept at the health district with a copy sent to CCHA;
- (d) a master flow sheet of the county's pilot districts progress posted at CCHA.

The problem solving team envisages this strategy as one that would allow for increased involvement of pilot district staff in the upgrading of their facilities and services.

There is a lot to be done, some examples being, refurbishing of old buildings in the districts, providing adequate storage for records, food supplement and drug supplies; organize and reactivate functional health committees, maintaining an effective rodent control, obtaining water/electricity where necessary, etc. however, the effort has begun with evidence of overall improvements made through the hard work of a number of dedicated persons.

### TECHNICAL GROUP MEETINGS (TGM)

In an attempt to improve the overall quality of Health Care offered to the people of Jamaica, emphasis has been placed on the intensification of Primary Health Care. The Cornwall County was identified as a Pilot area in the further development of this approach. The need surfaced for recognition and identification of the changing roles of health staff surfaced as the Primary Care Program expanded. Cornwall's Training Advisor organised and implemented a series of technical Group Meetings (TGM) to work through the process of role identification of the Staff Nurse. Staff Nurses in Cornwall County played a key role in this exercise.

The document, "Role of the Staff Nurse in Type II/III Health Centres", was prepared and relates to the following:-

- Staff Nurse's functions associated with major health problems in the Communities.
- The Staff Nurse's responsibility along with other members of the Health Team for collection of epidemiological community data.
- Health Centre staff relationship.
- The Staff Nurse's function in relation to In-Service Training.
- The Staff Nurse's role in the Community.
- The Staff Nurse's contribution to Health Planning.
- The Staff Nurse's role in Disaster Preparedness.

The document will serve as a reference for the identification of functions for which knowledge and skills must be acquired in order to promote Primary Care Services, (Curative and Preventive).

## CONCLUSION

Training is a major component in preparing the Health Team for an effective Primary Care Delivery System. Cornwall County's Health staff have participated in many Training Programs to upgrade their knowledge and skills in Primary Care. A base line of training has been provided via the In-Service Training Programs co-ordinated and conducted by the Training Advisor over the past three years and programs conducted prior to 1978. The acquired training provides the catalyst for building an efficient/effective Primary Care Team both regionally and locally. In retrospect of the realities of training strategies, an important point must be emphasised. In an effort to complete as much training as possible in order to provide expanding health services, quite often the time is not taken to evaluate the effects of training. To put this another way, trainees are sometime not given an opportunity to practice what they've learned before additional training is scheduled for them. Hence trainees require re-training or re-orienting to procedures they have been previously trained to do.

Lastly, all training disciplines (local, regional, national) must work together because working independent of each other does not allow for uniform methodologies and integration of strategies.

Cornwall County's Health staff recognizes In-Service Training as an indispensable factor for an effective Primary Health Care Delivery System. They have agreed to consistently work toward this goal.

**CONSULTANTS' REPORTS**

PROPOSAL FOR COORDINATION OF THE UNIVERSITY OF THE WEST INDIES  
AND THE MINISTRY OF HEALTH AND ENVIRONMENTAL CONTROL PROJECT  
"ASSESSMENT OF THE COMMUNITY HEALTH AIDE PROGRAM" AND  
THE CORNWALL COUNTY PROJECT "FUNCTIONAL ANALYSIS"

After reviewing the two projects and possible areas of overlap,  
the following conclusions were reached:

1. Both projects are studying the current role of the CHAs. The University/MOHEC project is looking specifically at the CHAs, their supervisors, and households visited by the CHAs. The Cornwall project is studying the CHAs along with other members of the primary care team, supervisory relationships among all staff, as well as interactions of all team members with individuals in the community.
2. The methods utilized by the University/MOHEC project involve a larger sample of CHAs and PHNs with a limited amount of information being collected. The Cornwall project is sampling fewer health workers but more categories of workers and involves collection of much more detailed information about the health services and perceived health needs of the communities using a number of approaches that differ from the University/MOHEC project.
3. The sampling techniques employed by the two projects will produce minimal overlapping of CHAs being observed or interviewed. Similarly, there will be only a minimal amount of overlapping of households being interviewed by the two projects. The only major area of overlapping will be in interviews of public health nurses.

4. Proposed types of information to be collected do not overlap to any degree except in the area of supervision and PHN opinions about the CHA program.

The following suggestions are therefore being made:

1. Both projects proceed as currently planned keeping each other informed of the other's progress, problems, and results at all stages of the studies.

2. Because there are major differences in methods and types of data being collected, it will be very useful to compare the results of the two projects in terms of future plans for ongoing assessment of health services in Jamaica. It is the general feeling that the two studies complement each other and will not be a duplication of effort.

3. In the one major area of overlap (PHN interviews) care will be taken to exclude repetitive questions from the Cornwall project interview which will follow after the University/MOHEC project. It was felt that the University/MOHEC project would not be in a position to incorporate additional items required by the Cornwall project in its PHN interviews since their interviewers will not be able to carry out more involved interviews. Under these conditions, careful explanations to the PHNs in Cornwall County will be carried out to elicit their cooperation in the interviews of the two projects.

4. It was suggested that the same interviewers not be used for both projects. It was felt that somewhat more qualified individuals be selected for the more detailed Cornwall studies and that locally recruited interviewers would be much more acceptable in the communities studied.

## CORNWALL COUNTY PROJECT--FUNCTIONAL ANALYSIS COMPONENT--

## PROPOSAL FOR DATA COLLECTION

I. AIMS

- A. To provide baseline information about current health needs and primary health care services in Cornwall County that will be useful for curriculum review and continuing education (in-service training), strengthening of health services management and supervision and identification of information essential for effective management and supervision.
- B. To assess and measure changes in health services and health needs after appropriate modifications have been made in curriculum, training, management, and supervision.
- C. To adapt methods of data collection to the Jamaican setting that can be used on a continuing basis to monitor health services development.
- D. To provide detailed information about the Cornwall County health services which will assist replication of appropriate aspects of these services on an island-wide basis.

II. OBJECTIVES

- A. To assess perceived health needs of the population and current use of available health care services in the study area.
- B. To quantify the functions and tasks of the health care team involved in the delivery of primary health care in the study area.
- C. To analyze the information collected in order to:
  - 1. define the functions and tasks of the health care team which will more adequately meet the communities' health needs;
  - 2. determine the appropriate allocation of resources and training time for continuing education according to the felt needs and level of performance of the health care teams.

III. METHODS OF DATA COLLECTION

- A. Observational Studies: A combined work sampling and task analysis will be carried out on selected primary care staff in health centers and in the field. Each individual selected will be observed on five consecutive working days. Staff will be selected to represent each parish in the county, as well as variations between urban and rural settings.
  - 1. Preliminary estimates of staff to be observed include:
    - a. fifty community health aides--ten in each parish
    - b. ten district midwives--two in each parish

c. five staff nurses--one in each parish (three days of observation only)

d. ten public health inspectors--two in each parish

e. ten public health nurses--two in each parish

Total days of observation would be 415 (80 staff x 5 days each, 5 staff x 3 days).

2. Staff in each parish will be selected randomly. Community health aides will be stratified by rural and urban areas and years of experience.
  3. Fifth week of the month days will be excluded from observation. Activities occurring on these days will be identified from records and interviews.
  4. Methods of observation would involve intermittent instantaneous observations every two to five minutes, logging of all significant staff or service recipient interactions and completion of task check lists for selected activities such as home visits.
  5. Observations would cover the usual working hours of the staff. At the end of each day of observation a short interview form would be administered to identify all important work-related activities such as emergencies that had occurred outside of usual working hours during the prior 24 hours (or prior 72 hours for weekends).
  6. Variables to be measured in the intermittent observations include time, place, age and sex of individuals receiving services, staff interactions, the major areas of responsibility involved (functions), and specific activities and tasks. Results would be expressed in terms of percent of time spent by place, type of individual, function, etc., or actual time spent related to each of these variables.
  7. Logging of interactions would produce a total count and description of individuals served during the observation period.
  8. The task check lists would include the characteristics of individuals receiving services, the problem involved and the important tasks expected to be carried out during the selected activities. The task check list will be derived from the curriculum, written job description and supervisor's inputs. Results would be expressed as the percent of service interactions that involved carrying out these tasks. Qualitative inferences could be drawn from these data.
- B. Staff Interviews--Staff being observed will also be interviewed by the observers. In addition, all primary care staff in the county will receive a self-administered questionnaire.

1. Observed staff will be interviewed at the end of their observation period by the trained observer. The questionnaire will be used to supplement and obtain details not in the self-administered questionnaire.
2. The self-administered questionnaire will be given to all community health aides at the time of their monthly meetings with the public health nurses or nutrition assistants during the observation period. Similarly, district midwives, staff nurses, public health nurses, doctors, public health inspectors, nutrition assistants, health educators, and others, will be asked to complete the questionnaire.
3. The questionnaires will cover the following areas.
  - a. Perceptions about the major health problems of the area, i.e., causes of death, morbidity, disability and inadequate growth.
  - b. Major obstacles to improvement of health amenable to health care programs in the community.
  - c. Identification of problem related to staffing, transportation, equipment and supplies.
  - d. Current patterns of activity and time distribution of staff including estimates of the volume of services provided.
  - e. Desired changes in allocation of functions and tasks to different categories of staff.
  - f. Current and desired supervisory patterns.
  - g. Perceived adequacy of their training. Functions and tasks for which additional basic or inservice training would be desirable.
  - h. Staff characteristics that may have direct bearing on performance.
  - i. Attitudes of staff about their role as members of the primary health care team.

**C. Sample Household Survey--Households will be selected in each parish of the county to be interviewed by the trained interviewer-observers.**

1. A minimum of 200 households will be selected from each parish giving a total of at least 1,000 household interviews in the county.
2. Sampling method--All community health aide areas will be identified in each parish. Forty areas will be selected randomly in each parish and then one household will be selected randomly in each of these areas using the community health aide's household list. That household plus four additional households nearest to the first household will be interviewed (5 households x 40 areas x 5 parishes = 1,000 households).

3. Interviews will be conducted at the time of day when most family members should be expected to be at home. The most responsible woman residing in the household should be the principal respondent, but all family members present will be involved in the interview setting.
4. Information will be elicited in the following areas.
  - a. Household composition, education, occupation, etc.
  - b. Presence of chronic disabilities.
  - c. Immunization levels (individually retained cards will be cross-checked).
  - d. Identification of any visits to the household by community health aides, midwives, public health nurses, public health inspectors, etc. in the past month, reason for the visit and recall of activities carried out.
  - e. Occurrence of any birth or deaths in the household during the previous year. Cause of death and any care received prior to death will be elicited. For all births, information will be ascertained about care received during the antenatal, natal, and postnatal period, any complications, lactation history, and expenditures related to the pregnancy.
  - f. All illnesses occurring among household members during the two weeks preceding the interview will be elicited. Details of the type of problem (symptoms and complaints perceived by the ill person or mother of the ill child), duration and inability to carry out normal activities will be ascertained. The use of government or other sources of care for these illnesses will be asked for. If no care was received reasons for not seeking or receiving care will be determined, including description of use of home remedies if any. If the illness was treated, details about the source of care, distance traveled, type of services received, number of visits involved, reason for selection of a given service, and expenditures incurred will be ascertained.
  - g. Environmental conditions in and around the house will be observed by the interviewer.
  - h. All children under six will have their weight taken.
4. Interviewers will go in pairs with one interviewer asking the questions and the second interviewer recording.
5. Approximately 5 percent of households will be re-interviewed by supervisors as a quality control measure.

**D. COMMUNITY LEADER INTERVIEWS**

Interviews will be scheduled with recognized community leaders. A list identifying appropriate individuals will be designed.

In each parish, ten community health aide areas would be randomly selected from the forty in which household interviews took place. Two community leaders would be identified and interviewed on the same day the supervisor carries out the sample re-interview mentioned under the Household Interview section. This will result in interviewing 100 community leaders in the county, i.e., twenty persons for each parish.

The interview schedule will elicit information on:

1. opinions about the effectiveness of the health care team with specific reference to the community health aides as primary health care providers;
2. responsiveness of the health care team to community needs;
3. community attitudes towards the adequacy of the existing primary health care organization and possible changes and improvements they desire.

**E. Records and Statistics**

Selected information will be abstracted from records and reports currently maintained or prepared by the health team.

1. Service contacts in the home--Daily activity log books (diaries) of the community health aides and other staff carrying out home visits will be abstracted. This will be done by the observers only for those personnel included in the observation studies (50 community health aides, 10 each of midwives and public health nurses).
  - a. Thirty home visiting days will be randomly selected from the log book of each of the above staff members stratifying by month of the year and day of the week. (30 days x 70 individuals = 2,100 days).
  - b. Items to be abstracted will include number of home visits, individuals contacted (age and sex), purpose of visit and mention of selected activities or tasks.
  - c. Where available the number of supervisory contacts with community health aides made by midwives and public health nurses will also be counted.
2. Visits to clinics and health centers--At present much of this information is already collected on the public health nurses' monthly reports and is summarized in the parishes' annual reports. This should include numbers of individuals as well as visits related to specific types of services such as child care, maternity, medical, etc. Additional information that will be abstracted from a systematic sample of patient records in each health center will include:

- a. distribution of individuals attending the clinics by distance from the center;
  - b. distribution of types of health problems of individuals attending child care or medical clinics.
3. Immunization levels and levels of nutrition are already summarized by public health nurses and nutrition assistants by means of their monthly reports. These will also be utilized.
  4. Vital statistics collected in the county will be checked and verified for each year of the project by examining the birth and death certificates in the Registrar General's files.

#### IV. PLAN OF ACTION

##### A. Selection and training of data collection team

1. Ten interviewer-observers and two supervisors will be employed for the data collection. Members of the University team now being trained may possibly be utilized after they complete the University's study. However, an alternative would be to employ and train interviewers from the five parishes in Cornwall County if available. It has been suggested that health educators could function as the supervisors.
2. Four weeks of orientation and training including pretesting and modification of forms.

##### B. Data collection

1. Observations, interviews and questionnaires: 415 observation days utilizing 10 observers = 8+ weeks.
2. Household survey: 1,000 households utilizing 5 pairs of interviewers doing an average of 5 households per day = 8+ weeks.
3. Community leader interviews: simultaneously with household survey.
4. Abstracting records and reports = 2 weeks, all interviewers and supervisors.

##### C. Editing, coding, preliminary tabulations and reporting--approximately 6 weeks, requiring about one-half of the team.

##### D. Total time required--28 weeks.

Manpower required--10 interviewers x 22 weeks	60 man-months
6 interviewers x 6 weeks	
2 supervisors x 28 weeks	13 man-months

Trip Report  
on  
Consultation Visit to the  
Jamaica "Health Improvement for Young Children" Project

by

Dennis G. Carlson, Dept. of International Health,  
School of Hygiene and Public Health, Johns Hopkins University

September 13-23, 1978

I. Objectives: The objectives set prior to the visit were stated as follows:

1. To review the skeletal outline for the national level in-service training for primary health care workers in the management of Type I Health Centers possibly covering 1-2 years.
2. To consult on the implementation of the training for trainers workshop.
3. To review the outline of the regional level training program for primary health care workers in the team approach to management in Type I Health Centers.
4. To evaluate the training programs which have been conducted in St. James and Westmoreland.
5. To consult on the final evaluation of training programs.
6. To consult with Mark Gross and Willie Mae Clay on a realistic time-table for their activities from now till the end of their contracts.

Upon arrival, these objectives were discussed with Dr. A.W. Patterson and Mr. Mark Gross and agreed that top priority would be given to items 1, 2, and 3. The remainder were to be pursued to the maximum extent possible.

II. Itinerary

Wednesday	Sept. 13	Travel from Baltimore via Miami to Kingston
Thursday	Sept. 14	Orientation at the National Ministry of Health and Environmental Control (MOHEC), and USAID Mission
Friday	Sept. 15	Meetings at Ministry of Health and University of West Indies
Sat.-Sun.	Sept. 16,17	General orientation to Kingston area and eastern portion of Jamaica
Monday	Sept. 18	Travel from Kingston to Montego Bay; Orientation to Cornwall County Ministry of Health
Tuesday.	Sept. 19	Attendance at Rio Bueno Health Fair and visits to new Type III Health Center in Falmouth and Type I Health Center in Rio Bueno

Wednesday	Sept. 20	Participation in Cornwall County Health Department Inservice Training Committee; visit to Union Street Health Center and home visiting with Community Health Aides; visit to patient in Montego Bay Regional Hospital
Thursday	Sept. 21	Travel Montego Bay to Kingston; participation in Jamaican Population Project II administrative meeting and luncheon; discussions with Mrs. Haycynth Stewart-Bulgin and Training Branch Staff; meeting with Dr. A.W. Patterson
Friday	Sept. 22	Discussions with USAID officials; debriefing conference at MOHEC
Saturday	Sept. 23	Discussion with Mr. Mark Gross; return from Kingston via Miami to Baltimore

### III. Observations and Comments.

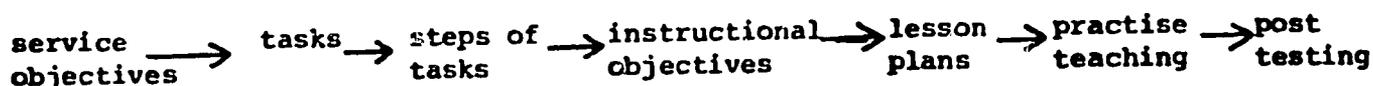
1. The ministry of Health and Environmental Control (MOHEC) is making significant progress in the implementation of its primary care program despite major constraints in finances and human resources. An extraordinary high degree of commitment to community health care and disciplined professional competence of staff members was clearly evident. A procedure manual for Type I Health Centres has been published. An extensive Maternal and Child Health manual is in editing process. Such activities in making procedures explicit will make it possible to develop instruction and supervision much more effectively.
2. The building programs of new health centers under the IMF loan is near completion. The two centers I visited showed excellent construction and appropriately modest design. A shift of emphasis towards more Type I Centers and less numbers of the more complex Type III and IV seems wise from several perspectives.
3. The In-Service Training program in two-day primary care workshops for more than 600 primary care personnel in Cornwall County demonstrates outstanding teamwork by County and Parish Staff members. A very practical curriculum has been developed which focuses mainly on solving primary clinical care problems. The emergence of teams of informal training officers in each parish complemented by county staff appears to be one excellent pattern of growth of a vigorous practical continuing education program. The combination of Public Health Nurses and Public Health Inspectors, with Health Educators when available, makes for an excellent balance of personal, community, and environmental health care. The Inservice Training Committee is focusing immediate attention on first aid learning and audio-visual teaching methods and materials. Next year's program will include topics of recording and reporting, family planning techniques, and working with health committees.

4. The present concurrent development of ongoing planning with service implementation in the Primary Care program is clearly the most effective strategy. Likewise, the interaction between national and county activities (as demonstrated between Cornwall County and Central headquarter exchange) seems likely to provide the most realistic and efficient use of limited resources. Lessons learned at county and parish levels can be incorporated into national planning and the phased implementation in other regions of the Island.
5. Plans are currently being developed for a "Familiarization Workshop" for 25 to 30 primary care staff members from all regions to be held in Montego Bay in late October and the first national Training of Trainers workshop tentatively set for November will mark a new phase of primary care implementation. The multi-disciplinary nature of primary care is illustrated in the composition of the Steering Committee under the leadership of the Training Branch of the Ministry as well as the multiprofessional character of the participants who will attend these workshops. The "skeletal outline for inservice training" provides a useful first step for the general topics which should be included. The development of more specific service objectives as derived from the procedure manuals will provide more detailed instructional objectives.

#### IV. Recommendations

1. Pilot Area Establishment. There would be many advantages to the proposed plan to specify and establish more specified "pilot area" facilities and community activities, such as in Santa Cruz where the objectives of the primary care program were carried out as thoroughly as possible. In order to make the new and modified practices as reproducible as possible in other communities it would obviously be necessary to use only the minimal available resources. Such "Pilot Areas" would provide an invaluable laboratory for planning and training purposes. Presumably they should be located in various types of health centers in each of the counties or regions.
2. Analysis of Services and Activities. Great benefits would result from a systematic analysis of the services and tasks which are going to be performed as described in the Manuals for Health Centers. These tasks could be much more efficiently standardized, taught, and supervised if the parts or components were described in detail. This is a slow and painstaking process, but the results are highly beneficial and allow significantly more delegation of functions, wider spread of knowledge via the printed page, and the growth of more uniform practise. This work needs to have participants with sufficient and recent service experience and a setting to test out the accuracy and validity of the written descriptions. This could lead to the identification of certain core tasks or functions which are to be performed by several types of workers.

3. Development of Instructional Objectives. The In-Service Training program in Cornwall County has made an excellent start in training in new procedures and problem-solving in clinical, community, and management situations. However, a great deal of elaboration is necessary to translate and transform the service goals and objectives into instructional or educational objectives which can be taught and supervised on a continuing basis. It would seem profitable to stage an intensive workshop for 8 to 10 days where the entire sequence of moving from service goals and objectives thru descriptions and analyses of the steps to be taken in these tasks, to the development of instructional objectives and, finally, to actual practise teaching of these materials, including evaluation by post-testing.



Perhaps a core group of 12-15 persons could be gathered and trained who would then use the same process in their work at the national, county, and parish levels.

Participants in such an intensive workshop might include some from central ministry, county, and parish personnel. Perhaps selected faculty from the University of West Indies and Johns Hopkins University could also be members of this workshop.

4. Mid-Level Staff Development Strategy. Given the realization of necessity to work primarily with present staff, positions, and money, it would seem particularly strategic to develop an explicit long range staff development program which included training both in Jamaica and in other countries. Some courses like the Comprehensive Health Planners Course given at Hopkins for two months each spring can be taken without or with academic credit towards a masters degree. Some universities give standard programs every year; so fairly long range planning could be done. Such specific individual career development plans may have a very positive effect on morale of the highly valuable middle echelon of personnel. The critical problem, of course, is finding the least damaging time for the person to be away.
5. Delegations of Tasks and Functions. As most practitioners and administrators recognize, the overwhelming health and disease burden of the public should result in the highest possible amount of delegation of responsibility and authority to lesser trained persons. The value of services rendered by less well-trained persons almost always outweighs the occasional dangerous situation. In particular the Community Health Aides should be encouraged to use simple technology like temperature taking and blood pressure reading. As mid-level professionals feel more secure in their own growth, it should be less of a problem to implement major delegation of tasks and functions to the less trained and far more numerous district midwives and community health aides.

6. Relationship to the University of the West Indies. A remarkably close and effective working relationship exists between the Ministry of Health and Environmental Control and the University of the West Indies, and particularly, the Dept. of Social and Preventive Medicine. Since the process of improving primary care is general and child and maternal health is particular, it is a difficult, slow, and long range effort, it would seem highly desirable if the Department of International Health of Johns Hopkins University could communicate and relate more closely with the University of the West Indies as it tries to provide consultant services to the Ministry of Health. This kind of collaborative style would have a good chance to enhance human resources more effectively in the long time perspective, as well as the short term. For example, if it is decided to have an intensive workshop on the methodologies of translating service objectives into instructional objectives, it would be highly desirable to have members of the University participating in the process.

#### V. Acknowledgements

This consultation was made enjoyable, interesting, and hopefully, useful by the thoughtful planning of many people in Kingston and Montego Bay. I was deeply impressed by the gentle, joyful, and very serious way that almost everyone performed their functions. Much appreciation is felt for the insights, information, and guidance provided by Dr. A.W. Patterson. Useful conversations of varying lengths were held with Dr. C. Moody, Mrs. Hunter-Scott, Mrs. McFarquhar, Nurse Pitter, Mrs. D. Goldson, Mrs. Hyacinth Stewart-Bulgin, Mrs. Nelli Allison, Nurse Olive Ennever, Dr. Carlos Mulrain, Dr. Esmond Garrett, Miss Ruth Hall, Mr. Ralph, Dr. Barry Wint, Mr. M. Berry, Mrs. King, Miss Marie Mathews, Dr. D. Ashley, Mrs. Kinsington, Mrs. Chanvans, Dr. Babs Sagoe. Unfortunately, Dr. A. D'Souza was out of the country, and I could not meet him. The USAID meetings with Dr. Linda Haverberg, Mrs. Gary Cook, Miss Edna Tullock, and Mr. Donor Lion were also informative and appreciated.

My host and hostesses during the visit were Mark and Gay Gross in Kingston, and Willie Mae and Tamie Clay in Montego Bay. They were very kind, helpful, and generous with their time and energy in spite of extremely busy schedules. From the viewpoint of a brief visit, it seems that they are doing excellent work as team members in a very significant and challenging health service effort.

*draft*

SUMMARY OF MEETING, MINISTRY OF HEALTH KINGSTON, JANUARY 12, 1979

**PRESENT:** Mr. Goldson (Permanent Secretary), Dr. A. W. Patterson (Chief Medical Officer of Health), Mrs. Hyacinth Stewart-Bogin (Director of the Training Branch), Dr. Linda Haverberg (Chief, Health/Nutrition/Population Division of USAID Mission to Jamaica), Mr. Gary Cook (Health-AID/Jamaica), Dr. Tony D'Souza (Senior Medical Officer of Health Cornwall County Health Administration), Mr. Mark Gross (Clinical Training Consultant), Dr. ~~Eimer~~ Dyer (Chief of Epidemiology and Acting Head of Primary Health Care Services during Dr. Moody's absence), Dr. Matthew Tayback (JHU consultant), and Mrs. Dory Storms (Campus Coordinator).

Dr. Patterson chaired this meeting which was held at the Ministry of Health in Kingston for purposes of review of the role of JHU, consideration of the question of extension of contracts, and scheduling of consultation visits that would be required in 1979.

Mrs. Storms reviewed the purpose of the visit by Tayback and Storms to Jamaica. As set forth in the initial cable, the objectives of the visit were to:

- 1) Clarify role of JHU in project;
- 2) Improvement of health in young children;
- 3) Work with D'Souza in designing alternative evaluation studies (nature, scope, methodology, cost estimates) for implementation possibly spring 1978 Cornwall;
- 4) Outline modified alternative functional analyses for Cornwall for latter development by Parker;
- 5) Present alternative evaluation studies to Patterson for selection of most appropriate design;
- 6) Review Clay and Grosss' end of year final contract report;
- 7) Schedule Carlson backup consultation to Clay and Gross for 1979;
- 8) Discuss with Haverberg improving JHU-AID/Jamaica communication; and
- 9) Taylor scheduling trip at later date with Standard to discuss collaboration of JHU-UWI on functional analysis and evaluation of Cornwall training program.

A brief summary was made of the morning's visit to Dr. Ken Standard and members of his staff at the University of West Indies. Dr. Standard said that the results

of their evaluation of the community health aides would not be available until late March. However, he provided JHU with all of the questionnaires. The three evaluation projects that have been approved by the Project Director, Dr. Patterson, were outlined to Dr. Standard and his faculty. The UWI personnel present were enthusiastic about collaborating with JHU in the designed conduct and presentation of the three studies. The time was too brief to permit working out in detail the collaboration effort. That was felt best to be left to correspondence and a meeting in February with UWI personnel.

After this report, Dr. Tayback was asked to present the three evaluation project. The evaluation project # 1 is a KAP study. Its purpose is to test the outcomes of in-service training held in Cornwall County. It is proposed that five Type I primary health care units be sampled in each of the five parishes in Cornwall. For a total of 25 health care units. Personal interviews would be held with the two community health aides, the one district midwife stationed at the primary health care unit, as well as one public health supervisor and the one public health inspector providing supervision to that primary health care unit. Thus we expect 125 interviews to be carried out. The project would call for the joint participation of JHU, UWI, and the Cornwall Regional Health Administration. The JHU Study Director for the KAP project would be Storms. UWI would appoint a Counterpart Study Director. Taking a part in the design of the questionnaire would be members from the Cornwall Regional Health Administration including Dr. Barry Went (a parish Medical Officer of Health), Mrs. MacFarquar (Regional Nursing Supervisor) and a counterpart to Willie Mae Clay in the In-Service Training Committee. Dr. Standard's group would be involved at all phases of the project from design of sampling, questionnaire, conduct of the study, analysis and diffusion of information.

This study is estimated to cost \$3,500 in U.S. dollars, excluding travel.

Evaluation project # 2 is a Time and Motion Study. Its purpose is to describe the range of functions performed by Type I personnel and their supervisors. The tentative study design is to carry out observations in Cornwall County in three Type I health facilities which has reached a reasonable level of resource allocation, manpower, medications and other supplies in accordance with what is set forth in the Type I manual. Participating in this study would be UWI, Cornwall Regional Health Office and JHU. The Hopkins Study Director for this project would be Dr. Parker. The Time and Motion Study would be design in early April and conducted at the beginning of June. The report should be ready for presentation on September 1. The cost of this project would be approximately \$8,000 in U.S. funds, excluding the cost of the trips.

Evaluation project # 3, Service Delivery Efficiency. This study was specifically requested by Dr. Patterson to evaluate whether the system of care is meeting the criteria of efficiency. That is, when it is carrying out its activities with the minimal overlap and confusion or slippage. Type I activities should be carried out in Type I centers, Type II activities should be carried out in Type II centers, and Type III activities should be carried out in Type III centers. Hospitals should not be getting inappropriate referrals and people should be utilizing the Type I, II and III health centers for Type I, II, and III activities instead of the hospital. Only the barist outlines have be sketched for the project. The project would be carried out in pilot areas island wide. The design of the project would take place somewhere around October 1979, field work would begin in January or February 1980 and the report and presentation would be available April or May 1980. JHU, UWI and Ministry of Health personnel would take part in this study. It would important

to seek wide representation since the study is to be island wide. The estimated cost for this project is approximately \$8,000 U.S. dollars, excluding the cost of travel.

Following this presentation Dr. Patterson asked for comments. Mr. Goldson raised the question of publication and asked that no publication take place until the material has been presented to the Ministry of Health. There was complete agreement on that point by Dr. Tayback and Mrs. Storms.

Dr. D'Souza noted that there had been a problem in the past with other universities in a working relationship regarding research activities. He did not foresee a problem with these three evaluation projects. In regard to the KAP studies, he encouraged that we look at the health care unit or team irrespective of whether a facility (health center) existed or not. He asked that a questionnaire be obtained from the team members some estimate of training needs for the future by asking them what they were interested in and what to incorporate into the future training programs. He also thought the questionnaire should reflect not only management content of the in-service training but also the emphasis on curative care that had been covered at that time.

There was some discussion regarding the evaluation project # 3. Dr. Patterson felt it best to look at pilot areas where the components were working to see if given the best of conditions

Dr. Patterson said that with the current budgetary restrictions, the optimum staffing levels projected for the Typ I, Type II, and Type III centers probably would not be reached in the foreseeable future. Thus, it was important to find out if there was a critical level of investment below which the Ministry could not fall. Further, she wished to establish if what was assumed about the operations of the three tiered system was correct. Dr. D'Souza pointed out that in order for the system to work they needed good medical officers of health. He thought the country should look to the younger people for change in the health system. In his opinion the MOH's would lend credibility to the primary care program. He pointed out that Type II and Type III backup was needed in order to make the Type I centers work, and he stressed that having one MOH for 20,000 population (as exists in some areas) is insufficient.

General approval was given to the three evaluation projects by the people at the meeting. Next on the agenda was the role of JHU in providing technical consultation in training. It was agreed that this was an appropriate role for JHU and that more use should be made of this resource. It was worked out that Dr. Dennis Carlson would be asked to provide technical assistance in late February or early March, and in the summer of 1979. Hyacinth Stewart-Bogin pointed out that she would like his consultations to be to the training unit and not just to Mark Gross. Dr. D'Souza said he would like to see Dr. Carlson since the last time Dr. Carlson was there, Dr. D'Souza was off the island. They all felt that Dr. Carlson had been a very valuable consultant. Dr. Patterson asked that Dr. Carlson also be scheduled for some technical assistance during 1980.

Next on the agenda was the question of better communications. Dr. Haverberg related that there were a great number of messages and telephone calls between JHU and personnel in Jamaica. She suggested that all communication go through her office (Health/Nutrition/Population Division of USAID Mission to Jamaica.) She said this would reduce the amount of communication JHU had to make with separate individuals in Jamaica and reduce some of the workload on Dr. Patterson. Dr. Patterson however, felt the communication should go through her as Project Director, and the group agreed.

The last item on the agenda was the question of extension of contracts for Mark Gross and Willie Mae Clay. Dr. Patterson reviewed the initial contract which was assigned to individuals to work with Cornwall County Health Administration and developing their in-service training capacity. Between the time the contract was developed and signed, there was movement on the part of the Governor of Jamaica to develop a primary health care system. Therefore, by the time Willie Mae Clay and Mark Gross were due to start work in Jamaica, it appeared that the Government of Jamaica had moved ahead sufficiently so that there was no need for a person at the Ministry. Mark Gross was then moved to the Ministry to work at the Training Branch.

Dr. Patterson raised the question - How have these two long term consultants worked out? - And would there be any need to continue their services after the expiration of the contract? Dr. D'Souza answered that his experience with Willie Mae Clay had been extremely positive. He felt her presence had enabled the Cornwall Regional Health Administration to move ahead in its development of in-service training capabilities. He felt that they could continue to use her and

he would like to extend her contract to August. Hyacinth Stewart-Bogin answered for the Training Branch. She said Mark had been helpful and supportive. She felt there were no measurable results but the situation was more complex than in Cornwall County. Mark had been fully occupied with the proposed Training of Trainers program. Also, Dr. Patterson asked whether Mark was needed to get the work done instead of training and developing staff? After a long discussion it was agreed that Mark was filling a service slot but not a development slot.

It was decided that Mark should remain in the Ministry of Health until June or July 1979 since the plans were to complete the Training of Trainers workshops by the end of February, and then to precede out into the parishes in helping the newly trained in-service training coordinators to prepare the midwifery training program as set up by Dr. Moody. It was estimated that this work would not be completed until the end of June 1979. Although Dr. Patterson have expressed the desire to have Mark move over to KSAC it was agreed to keep him in the Ministry of Health through June, with his assistance to KSAC whenever possible..

On the question of the extension of Willie Mae Clay's contract, the decision was to extend Willie Mae Clay if she wishes. If not, another person would be asked to fill in until December 1980 as long as Dr. D'Souza would get to interview this person in advance. The decision as to extend Mark Gross's contract would be made sometime before the 8th. of March 1979. (Mark has to sign a housing lease by the end of March.) The continuation of his contract would depend on whether or not additional personnel are hired for the Training Branch, MOHEC, so that Mark will be able to fill a development position instead of carrying out a service slot. Dr. Haverberg will look into the mechanisms for continuence of contracts.

The meeting ended at 5:30 P.M..

## TRIP REPORT - JAMAICA

March 1-8, 1980

Dr. Carl E. Taylor

### Purpose of Visit

1. Consultation with Ministry of Health in Kingston, US/AID Mission, Department of Community Medicine in UWI, and Cornwall County Health Department about present status and possible future relations in collaboration between Hopkins and Jamaica.
2. Detailed consultation with Willie May Clay and her colleagues about the Cornwall County collaboration and field activities.
3. Specific consultation on the planning to prepare Type II health manuals.

### Activities

1. Most of my time was spent in Cornwall County. Several days of field visits included visits to each type of health center. During these visits and especially in riding to and from the centers extended discussions were held with Willie May and Jamaican staff about specific details of programs. It was evident that a great deal of progress has taken place since my earlier visits and the contribution of Willie May and Mark Gross to these improvements was clear. I was impressed especially with the good working relation and rapport between Willie May and the nursing staff based obviously on the extremely affective continuing education activities.
2. A particularly important session was on my last day in Montego Bay which was a prolonged seminar with the Cornwall County nursing staff on how they could themselves undertake the functional analysis that would provide a basis for a clearer definition and reallocation of roles in sorting out the functions of personnel in Type I - II - III health centers. We spent much of the time defining objectives and discussing methodology. The intimate familiarity of the nursing staff with the practical problems at field level gave a good framework for exploring the possibilities of introducing innovations and adapting past procedures to a more rational new pattern of team work. We ended up with a fairly detailed outline of just what the group could undertake, especially the possibilities arising from meetings with health center staff.

**Trip Report - Jamaica  
March 1-8, 1980  
Dr. Carl E. Taylor**

**3. A very intensive series of discussions were held in Kingston with the groups mentioned above. In these discussions I was accompanied by Tony D'Souza and Willie Mae Clay. It was good to get the positive feedback on contributions that have been made through the Hopkins involvement.**

**Looking to the future, there seemed to be a general feeling of waiting for things to evolve. I expressed the Hopkins position as being delighted to continue the collaboration but that we would never aggressively promote involvement but would be available if we were asked. The most specific discussion was about the survey work being done in Cornwall County by the UWI team headed by Mrs. Pat Desai. There seemed to be some interest in re-exploring some of the functional analysis activities that had been proposed earlier after the present surveys were completed. The AID representatives seemed supportive if requests were made by Jamaican officials.**

## Trip Report

Kingston and Montego Bay, Jamaica  
Dennis G. Carlson - March 4-10, 1979

### I. Objectives

- A. Consult with personnel involved in in-service education in Cornwall Regional Health Administration regarding:
  - 1. two-day workshops
  - 2. monthly in-service training seminars
  - 3. development of pilot areas
- B. Consult with personnel involved in training activities in Kingston for National Ministry of Health and Environmental Control
  - 1. Training of Trainers Workshop
  - 2. other training activities

### II. Itinerary

- A. Sunday, March 4: Baltimore via Washington, D.C. to Miami, Florida, (delayed departure due to fog in Baltimore)
- B. Monday, March 5: Miami to Kingston, Jamaica  
Consulted with Mr. Mark Gross
- C. Tuesday, March 6: Kingston to Montego Bay  
Consulted with Dr. A. D'Souza and Mrs. Willie Mae Clay
- D. Wednesday March 7: Montego Bay
  - 1. visited type two health center at Adelphi (rural area) met Mrs. E. Clarke, CHA, Ms. E. Lawrence, CHA; Mrs. Mae Walker, CHA; Ms. Sadie Moodie, School Dental Nurse
  - 2. visited newly constructed type one health center at Lottery (rural area) met Mrs. M. Wright, Acting Public Health Nurse; Mrs. Hilton, Nurse, Midwife; Ms. C. McKellop, CHA; Joyce Jones, CHA; S. Miller-Allen, CHA
  - 3. met Mrs. E. Nicholson, Chief Pharmacist, Cornwall Regional Health Administration and Mr. S. Stennett, Administrator, Cornwall Regional Health Administration
  - 4. consulted with Dr. A. D'Souza, Mrs. Willie Mae Clay, and Mr. Lloyd Thompson, Medical Recorder and Statistical Officer
- E. Thursday, March 8: Montego Bay to Green Island and return via Lucea
  - 1. staff travelling from Montego Bay to Green Island included: Mrs. E.L. McFarquahar, Nursing Supervisor, Cornwall Regional Health Administration; Mrs. Nicholson, Mr. Stennett, Mr. Thompson, and Mrs. Clay.
  - 2. meeting of pilot area staff of Hanover Parish, approximately 40 persons; agenda:
    - a. pilot area organization-center referral system
    - b. staffing of primary care facilities
    - c. drug supplies
    - d. health committees
    - e. nutritionist report
    - f. environmental sanitation report
    - g. dental services report
    - h. description of Green Island area: demographic and health statistics

3. The staff included about 30 Community Health Aides, 5 or 6 Staff Nurses, 3 or 4 District Midwives, and 3 or 4 Public Health Inspectors, the part-time pharmacist, and other staff members
  4. On return to Montego Bay met with Mrs. E.L. McFarquahar, Regional Nursing Supervisor, and Mrs. Willie Mae Clay
  5. Flew Montego Bay to Kingston
- F. Friday, March 9: Met Training Branch staff MOHEC, Mrs. Hyacinth Stewart-Bulgin, Mrs. Nellie Allison, and Mr. Mark Gross
1. reviewed recent Training of Trainers two-week Workshop and plans for the next two similar workshops
  2. reviewed plans for five one-week training workshops for 300 District Midwives (60 each) to be held in Kingston with emphasis on functions of type one and type two health centers
  3. 11:30 a.m., met with Dr. Esmond Garrett at the University of West Indies; Mrs. Hyacinth Stewart-Bulgin, MOHEC; Mr. Mark Gross, MOHEC; and Mr. Gary Cook, USAID, Kingston regarding possible future collaboration. The general consensus was that there is a strong desire for collaboration between UWI and JHU. Dr. Garrett invited Mr. Mark Gross to attend the Reporting Conference at UWI on Community Health Aid functions at the end of this month.
  4. 2:00 p.m., met with Mr. Donor Lion, USAID Mission Director; Mr. Phil Schwab, USAID; Dr. Linda Haverberg-Lion; Mrs. Hyacinth Stewart-Bulgin, and Mr. Mark Gross:
    - a. Reviewed the training activities in Cornwall County and Ministry of Health and Environmental Control
    - b. Discussed collaborative activities with University of West Indies. USAID to contract with UWI [through MOHEC] to provide consulting services. UWI to implement studies as it has resources and to sub-contract with other universities according to its choice on those things that it wanted to have assistance with. UWI would be able to choose collaborators where it wished, but JHU would possibly be given a special consideration.
    - c. Problems of communication, coordination, and decision making were discussed. All plans for evaluation studies are currently held in abeyance according to USAID officials. The example of difficult communication was cited with several telegrams from USAID Kingston to USAID Washington given as examples which were not relayed on to JHU.
    - d. USAID officials expect a meeting with key leaders within a month and that clear plans will be made within two months.
  5. 3:00 p.m., met with Dr. Linda Haverberg-Lion, Mrs. Hyacinth Stewart-Bulgin, Mr. Mark Gross. Again the problems of communication and decision-making were discussed.
- G. Saturday, March 10: Informal discussions in the morning with Mr. Mark Gross on in-service training programs. At noon met informally with Dr. Wynante Patterson concerning the training program activities and evaluation studies which are in process of planning. Flew Kingston via New York City to Baltimore.

### III. Observations and Findings

- A. In-service Training and Continuing Education. These activities are proceeding extremely well in Cornwall County at two levels:
1. monthly in-service training is proceeding in each of the five parishes with five to six one day sessions in each of the areas of each parish. The topics of these one-day training programs are determined by the training Committee on a county-wide basis. Current topics include family planning, first aid review, and just recently nutrition and dental health
  2. two-day seminars. The two-day seminars are proceeding on a parish-wide basis with sessions being planned on review and upgrading of family planning knowledge and skills and an updated first aid refresher course.
  3. The organization of training activities has proceeded effectively in the past seven months. Each parish has two actively functioning training coordinators who are a public health nurse and a public health inspector. This training staff will soon be augmented to the extent possible to that a health educator and a nutritionist will join this team. The Cornwall County program is planned and implemented by a training committee which is made up of these parish training coordinators.
- The Inservice Training Program is developing extraordinarily well with a reinforcement of learning taking place at the parish level and the district level and the five or six districts within each parish. The morale and momentum of the on-going continuing education of primary care staff in Cornwall County is very high and seems to be getting maximum support from all concerned. There is some constraint in relationships between community health aides, district midwives, and public health nurses since each group recognizes that there are changes and expansions of roles taking place.
- B. The new building and upgrading of physical facilities of the primary care system in Cornwall County is proceeding on schedule. Twenty eight new health centers have been completed. The construction generally seems to be of very good quality. There is currently some difficulty in obtaining the supplies and equipment for the new health centers, but this should be at least partially remedied when the new fiscal year begins in April.
- C. Staffing. The top and middle levels of staffing for the Primary Care System is still in extremely short supply. For example, there are not adequate numbers of medical officers and public health nurses. Nor is there a likelihood that this will change in the near future. The major potential for increased efficiency and effectiveness of primary care functions still rests primarily with improving the capacities and utilization of district midwives, staff nurses, and community health aides who are available in rather adequate numbers for the Type I and Type II health centers. It is apparently obvious to all close observers that the community health aides, district midwives, and staff nurses could be used more effectively as they are trained to assume more functions. The questions of scheduling and assignment of duties within the Type I and Type II centers clearly needs additional work as the CHAs are now spending approximately 50% of their time in the clinics and 50% of their time in home visiting. While in the clinic the community health aides are not kept busy nor have been trained to perform functions that they could do if they were given additional training.

- D. Pilot area development. Each parish has identified one area within it that will serve as a pilot area for intensive analysis and improvement of primary care functions. This was the nature of the meeting held at Green Island in Hanover Parish, which I was privileged to observe and participate in. This session, held under the direction of Mrs. McFarquahar, was extremely well run with wide spread participation of all kinds and levels of people who attended. Major focus was given to problem-solving and the streamlining of relationships between the different categories and levels of primary care facilities. It was obvious that there was a high order of commitment and motivation on the part of almost all personnel to make this pilot area function at a significantly higher level of effectiveness.
- E. Procedure Manual Development for Type II and III Centers. Dr. D'Souza has placed the development of procedure manuals for Type II and III centers at top priority level. A small committee has been formed which will draft specific procedure descriptions or standing orders for tasks, functions, and services to be provided in the Type II and III centers. No doubt this will be very useful in part for the functioning of the Type I centers as well. Since the manual for Type I centers has already been developed in a form which is loose-leaf, it should be possible to add additional procedure descriptions to these Type I manuals.
- F. Health Information System (Data Collection System). A new national record system for primary care facility function is currently in the process of development. This will focus primarily on maternal and child health functions and be computer based. At the present time, there is a shortage of standard forms in some of the health centers and it is necessary to prepare report forms by hand. This seems to be a major constraint in moving on to an adequate monitoring of the primary care system.
- G. Management Processes. The active implementation of the pilot areas in Cornwall County has already served several very useful purposes, one of which is to provide an opportunity to work at the day-to-day problems of management of the system. It is also clear that additional information that is more concrete and objective is necessary in order to have more specific information on which to develop new ways of administration.
- H. Collaboration Between Ministry of Health and Environmental Control, University of the West Indies, USAID and JHU. There seems to be major problems in decision making and communication between the various institutions that are seeking to work effectively together. Part of this seems to stem from confusion as to who initiates, who implements, and who monitors activities and programs. A current case in point is the three evaluation studies that have been planned but, according to USAID Kingston, are presently "on ice." This is not a shared understanding at the Ministry of Health and Environmental Control. The Cornwall Regional Health Administration is not adequately informed of the current plans. Neither does the University of West Indies seem to understand its contributions. The Johns Hopkins University staff is likewise uncertain of what it should contribute.
- I. University of West Indies Department of Social and Preventive Medicine Collaboration. A new initiative seems to be underway which would give management of the evaluation studies to the UWI Department of Social and Preventive Medicine. The UWI staff would then sub-contract or directly involve other institutions such as universities in the process of implementing studies which the Ministry of Health requested. There seems

to be a question of whether contractual relationships would be made by University of West Indies to the Ministry of Health or the University of West Indies to USAID, Kingston. USAID, Kingston expects that not only will health studies be carried out by UWI faculty, but other areas including agriculture, education, and nutrition would be included. This development is currently in a discussion stage and has not yet been fully worked out.

#### IV. Conclusions and Suggestions

- A. The training activities at the national, regional, parish, and district levels are proceeding extraordinarily well in the situations which I observed. It is particularly gratifying to see that the experiences and precedents of new activities at the lower levels are being incorporated into the national level training activities. The reverse strengthening by the Training of Trainers Conferences, Midwives Workshops, and other continuing education activities at the top level is already having a positive effect at the regional, parish, and local levels. Many basic innovations are taking place in each of these levels, which should add considerable dynamism to further implementation.
- B. The human resources which are available could be considerably enhanced if active delegation of tasks and functions was pursued. This is particularly true for the increased ability of district midwives and staff nurses to carry out primary care functions. In turn, the community health aides could be upgraded in terms of what they are able to perform in service both in the health centers and in their home visits. There seems to be some indication that there is increased willingness for this to take place though some constraints still exist.
- C. The attention and priority given to the development of detailed, specific procedure manuals for the operation of Type II and Type III health centers should be encouraged as much as possible. It is very likely that the Type I centers can also be assisted by a major investment of energy in the drafting, revision, and reproduction of established procedures and standing orders. The Cornwall Regional Health Administration is already beginning this activity and intends to proceed as actively as possible in the next few months.
- D. The development of the pilot areas is gaining effectiveness and a great deal of good problem-solving is already taking place within that context. With serious financial constraints it is all the more important that the available human resources be strengthened by a constant emphasis on in-service training. The pilot areas will provide excellent experimental settings to try out improved methods.
- E. The collaborative relationships between the Ministry of Health, USAID, UWI, JHU, and other institutions need to be clarified soon. The possibilities of long-range contributions by university staffs are very great indeed. It would seem to be ideal to have a close, continuing relationship between the Ministry of Health and the University of the West Indies. If a stable, clearly defined collaboration with universities such as Johns Hopkins University could be worked out, there could be significant long-range benefits to health services in the primary care area.

V. Acknowledgements

I am particularly grateful to those who were willing to spend time with me in gaining insight into present activities in Cornwall County as well as Kingston. In particular, I would like to thank Dr. A. D'Souza, Mrs. E.L. McFarquahar, and Mrs. Willie Mae Clay in Montego Bay. Mrs. Hyacynth Stewart-Bulgin, Mrs. Nellie Allison, and Mr. Mark Gross were very helpful in Kingston. I appreciate the opportunities to meet with Dr. Esmond Garrett, Dr. Donor Lion, Mr. Phil Schwab, Dr. Linda Haverberg, and Mr. Gary Cook at USAID. I appreciate very much the opportunity to meet informally with Dr. Patterson at the close of my visit.

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**HEALTH IMPROVEMENT FOR YOUNG CHILDREN, JAMAICA**

**End of Year Review: 1/1/78 through 12/31/78**

**AID Project Number 5320-0400  
AID-C-1233**

**February, 1979**

**Department of International Health  
Johns Hopkins University, School of Hygiene and  
Public Health, Baltimore, Maryland**

**HEALTH IMPROVEMENT FOR YOUNG CHILDREN, JAMAICA**

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**AID Project Number 5320-0400  
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**February, 1979**

Johns Hopkins University Review and Evaluation  
AID Project Number 532-0040  
"Health Improvement for Young Children," Jamaica  
End of year review: January 1 through December 31  
1978

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INTRODUCTION

The project "Health Improvement for Young Children" between the Johns Hopkins University, the United States Agency for International Development, and the government of Jamaica, Ministry of Health, was originally designed to be executed in Cornwall Country, Jamaica. Its purpose was to assist the Cornwall County Health Administrative Office to "decentralize the primary health care delivery system; revise the curriculum and training of health care providers; improve the management and data collection systems; improve and increase efficiency of support services within Cornwall Country." (See Appendix 1) Because of the delay between the conception and commencement of the project, certain changes were proposed by the Jamaican Ministry of Health and Environmental Control (MOHEC). Thus, the Primary Health Care Consultant (Mark Gross) was assigned to work with the chief of the Training Branch, MOHEC and training coordinators in each parish in order to identify training needs and to develop and implement training programs. The Deputy Leader for Clinical Training (Willie May Clay) was assigned to assist the Cornwall Country Health Administration in the training of health care providers.

The contract changes proposed by MOHEC went beyond that of locating personnel in two different geographical locations. Essentially, the changes required in the contract shifted the focus of the project from assisting the Cornwall County Health Administration to assisting the government of Jamaica

Ministry of Health in the implementation of the primary health care system country-wide by providing technical assistance to develop the capability of the Training Branch of the Ministry of Health in design and implementation of in-service training of personnel involved in primary health care systems, using Cornwall County as one "pilot" area for these activities.

The shift in locale, and emphasis of the contract, required budget adjustments. A request for budget revision was developed with Dr. Wynante Patterson, Project Director, in conjunction with Dory Storms, JHU coordinator for the project. This was submitted to Mr. Doner Lion, Director of AID/Jamaica. (See Appendix 2) Mr. Lion responded favorably to the request for amendments to the contract (See Appendix 3), and through the assistance of AID/Jamaica a revised contract was prepared. (See Appendices 4a and 4b) At the end of the first contract year (December 31, 1978), notification of the acceptance of the revisions had not yet been received by JHU from AID/Washington.

The report that follows on the activities of the first year of the contract "Health Improvement of Young Children" is divided into (1) activities related to the Primary Care Training Consultant; (2) activities related to the Deputy Leader for Clinical Training; (3) consultations provided by the Johns Hopkins University; (4) summary of problems encountered during the first year; and (5) outline of activities for 1979 as developed by MOHEC, and agreed to by AID/Jamaica and JHU consultants Storms and Tayback during the meeting, January 7-12, 1979 in Jamaica.

**POINT I: Summary of Year One Activities Related to the Primary Care Training Consultant (Mark Gross) February 15 to December 31, 1978.**

Mr. Gross arrived in Jamaica on February 15, 1978. He and his wife were sent to Montego Bay for an initial period of orientation to the Jamaican health system, which was provided by Dr. Tony D'Souza and other members of the Cornwall County Health Administration. He then returned to Kingston and was assigned to the Training Branch of the Ministry of Health. A considerable amount of time was devoted during the first six months of the project to the informal development of the Primary Care Training Consultant's relationship to the Training Branch and other groups within the Ministry with responsibilities for training.

During the period February through July, 1978, Mr. Gross was involved in assisting member of the Training Branch in planning a large number of workshops and seminars as well as planning for development of manuals. Many of these efforts are not completed or are still waiting for implementation.

The last four months of the project were spent in the development of two seminars whose focus was on primary health care training, the role of the Training Branch and the development of parish training coordinators. His time was also spent in developing the Training of Trainers Workshop scheduled for January 22 to February 2, 1979.

In summary, the major activities of Mr. Gross during the period February 15 to December 31, 1978, were:

1. Participation in planning and implementing the following workshops or seminars:
  - a. Public Health Inspectors Workshops in Primary Health Care

- b. Supervision and Management Seminars;
  - c. Health Educators Annual Conference;
  - d. Curriculum Development for Senior Nursing Tutorials;
  - e. Role of the Training Branch for the Ministry Staff and Donor Agencies; and
  - f. Training of Trainers for Senior Administrative Field Staff.
2. Continuing consultation to the chief of the Training Branch.
  3. Consultation to a variety of health agencies and providers in regard to training and primary health care.
  4. Participation in the Jamaican Population Planning II and Primary Health Care Meetings.
  5. Development of outline for management and supervision in the Type I Health Centers (not yet implemented).
  6. Development of outline for Maternal and Child Health Manual (not yet completed).
  7. Development of outline for midwifery in-service training (not yet completed).

Mr. Gross's assessment of his activities during the first year of the project was that his productivity was limited due to a lack of role definition for his job within the Training Branch, and due to the start-up time required to adjust to the new environment. He also pointed out structural constraints pertaining to the role of the Training Branch. Although there is a Training Branch within the Jamaican Ministry of Health and Environmental Control, there are no official posts for training within the Ministry. Thus, in working with training coordinators within the parish, they actually have no official position

within the Ministry of Health. Their activities are voluntary and in addition to their regular duties. A second major constraint is that the Training Branch, MOHEC, is not seen as being the central coordinating point for training within the Ministry. Different program areas within the Ministry plan and implement their own training programs. This contributes to problems of coordination of programs and possible duplication of effort.

Mr. Gross also pointed to the constraints encountered by the shortage of manpower and materials. In his opinion, there was insufficient manpower in the Training Branch to develop and implement programs for the entire Ministry, thus reducing the Training Branch's overall effectiveness. He also noted the shortage of training materials.

Mr. Gross identified lack of planning and evaluation as further constraints to the Training Branch achieving its objectives. Without long range planning for overall training needs within the Ministry, programs that are run by different program areas within the Ministry are sometimes competitive. Upon completion of training programs, the outcomes are often not properly assessed in order to provide data and information for program management and further planning.

In addition to identifying problems in role definition and structural constraints within the Ministry, Mr. Gross felt that a weakness of the first year's results in the project was the limited collaboration with Willie Mae Clay, Deputy Leader for Clinical Training, who was located at the Cornwall County Health Administration. This limited collaboration was due to difficulties in reimbursement of expenses and inadequate subsistence allowances which prevented them from conferring for a period exceeding one day.

**POINT II: Summary of Activities of Deputy Leader for Clinical Training  
(Willie Mae Clay) March through December, 1978.**

Ms. Willie Mae Clay arrived in March, 1978, and moved directly to her position at the Cornwall County Health Administration, Montego Bay, Jamaica. Her activities during the first few months consisted of an assessment of training needs. Ms. Clay accomplished this through visiting existing Type I centers, consulting with Dr. D'Souza, Senior Medical Officer (Health), the regional nursing supervisor, county health staff and the County Health Educator. A review was made of the projected training needs established by a seminar held for the county health staff in January, 1978. The DLCT agreed that in-service training in communication skills and management skills would lay the foundation for all disciplines of staff to interact harmoniously in a work situation. An appropriate approach to team functioning was to include all levels of primary health care personnel in the session so that it might reinforce the team concept.

Implementation of primary health care services in Type I Health Centers was scheduled to begin in Cornwall County approximately six months after the March 1st arrival of Ms. Clay. In this interval, health staff had to be prepared to deliver expanded services from Type I Health Centers, to interact appropriately as a team, and to assume management and leadership functions. Constraints on implementing in-service training centered around lack of funding.

PL-480 funds were to be used for the in-service training. (See Appendix 2) However, funds for in-service training were not available from the Ministry of Health during the early part of 1978. Given the meager financial resources and the urgent need for in-service training, the following plan of action for

in-service training was developed:

1. Each training group would consist of 15-22 participants.
2. Each training session would be an intensive two-day workshop. The first day would cover communication skills and the second day management skills.
3. The training sessions would be conducted in the most centrally located area for each parish to minimize travel cost.
4. The trainee groups would include representatives from all disciplines of the primary health care staff.
5. The training staff would need to be expanded. This would be accomplished through incorporating two senior public health nurses to assist as resource persons with training.
6. A public health inspector would be selected from each parish to assist with coordination of the training sessions.
7. To conserve funds, these training sessions would be taken to the parishes instead of bringing staff into Montego Bay.

Following the assessment of the training needs and the planning of in-service training, the Deputy Leader for Clinical Training proceeded to the development and implementation of the two-day workshops. First, a set of basic ideas were developed to reinforce the team concepts and to emphasize the expectations for the expanded roles of Type I health staff, as stated in the Type I manual. Second, specific objectives and goals were set for all training content. A format for delivering the training sessions was developed which allowed uniformity in conducting training sessions throughout the county. Finally, an evaluation form was designed to be used at the end of each training session.

The two-day workshops began in Saint James Parish on April 21, 1978, and ended in Hanover Parish on October 4, 1978. A total of six hundred and eighty-seven (687) members of the health staff completed the in-service training sessions. (See Appendix 5 for Summary of Activities in Cornwall County, Jamaica, In-Service Training, 1978. See Appendix 6 for Outline of Content in Cornwall County In-Service Training, 1978.)

The minimum cost of the two-day in-service training sessions was estimated to be \$5,678 (Jamaican dollars) or J\$ 8.26 per person (at the exchange rate of 1.67, the cost would be US\$ 4.94 per person). The greatest expense was for providing lunch to participants at J\$3/person/day = J\$4122. Travel costs were estimated to be J\$869 (J\$2/person qualifying for travel reimbursement/day). There was also an expense for coffee break of 50¢/person/day, or J\$687. These expenditures reflect the direct costs of the training sessions. Not included are salaries for the Deputy Clinical Leader for Training, Public Health Nurses, or Public Health Inspectors and other personnel assisting in the training program.

End of session evaluations provided indication of success of the training. (See Appendix 7 for evaluation schedule for Cornwall County in-service training, 1978). Following the completion of in-service training for the county primary health care personnel, the Training Branch and the Ministry of Health held a one-day workshop in Montego Bay for regional health supervisors outside of Cornwall County, to familiarize them with the training methodology instituted in Cornwall County.

The overall assessment of the training activities in Cornwall County during 1978 was quite positive. Much was accomplished in a very short time.

Ms. Clay and other members of the Ministry of Health regard the success of the efforts as due to the presence of an infrastructure in Cornwall County within which Willie Mae Clay could work. In place was a regional structure as represented by Dr. D'Souza, Senior Medical Officer (Health) for Cornwall County, the regional nursing supervisor, and a county health educator, and medical officers of health in three of the five parishes.

Several problems were encountered during 1978. First, there was no official post for parish in-service training officers. These persons were expected to participate in the planning, development and implementation of in-service training programs without stipends or any additional reimbursement for their efforts above the normal activities. This problem was particularly acute for public health nurses who served as training resources since they had to add this additional responsibility to an already existing heavy work schedule. Manpower in the training branch in the Ministry of Health was insufficient to assist Cornwall County in implementation of the in-service training program. Furthermore, there was a question about the continuation of the public health nurses involvement as resource persons for in-service training where community aides are involved.

Another problem encountered centered around funding. While the revised contract called for training funds to come from PL 480 monies, there was no definite mechanism for the DLCT to procure the training funds. Without the funds there was a shortage of materials and supplies for training. Furthermore, there was a problem encountered in the use of space available without charge to Cornwall County. The limitation required rescheduling of sessions.

There was a reduction in the amount of mileage allowed by the Ministry of Health for travelling officers. There were no funds from the training project to supplement the cost of mileage incurred by travelling officers in the implementation of the training programs.

Overall the in-service training program was a joint effort of the Cornwall County Health Administration, and facilitated by Willie Mae Clay, Deputy Leader for Clinical Training. The only problem of substance in the design of the curricula for the two day workshops was resistance from some key public health nurses to instruct community health aides in techniques for taking blood pressure.

In addition to the in-service training for Type I health staff, a seminar was held at the Cornwall Regional Hospital for approximately 20 to 25 post partum hospital staff nurses. The topic was "Rationale for In-Service Education," and its purpose was to familiarize hospital based personnel with the primary system. This was thought to be especially critical since hospital based staff are involved in the referral system for primary care.

A seminar was also held at the Cornwall Regional Hospital for approximately 30 public health inspectors in the country of Cornwall. The topic was management of poisons, accidents and burns. The public health inspectors are quite active in the communities within Cornwall County and often encounter situations needing first aid training. It was felt that if they had some knowledge of the management of trauma and accidents they would be able, more expertly, to extend basic coverage of health care throughout the region. As part of the training session the public health inspectors learned procedures of bandaging, applying splints, and blood pressure techniques.

**POINT III: Consultation Activities by Johns Hopkins University Personnel to the Government of Jamaica, 1978.**

Four visits were scheduled during 1978 for the Johns Hopkins University personnel. Three were of an administrative nature, and one was a technical consultation. In January 1978 Dr. Carl Taylor, Professor and Chairman of the Department of International Health, and Principal Investigator of the AID Jamaica project, and Mrs. Dory Storms, Campus Coordinator, travelled to Jamaica for the purpose of initiating the contract, and planning for the year's activities. Following that week's visit, Dr. Robert Parker and Mr. Ahmed Moen travelled to Jamaica for the purpose of designing the functional analysis, in conjunction with the Ministry of Health and the University of West Indies personnel. Discussions during this visit, as well as communication from AID/Jamaica and AID/Washington, suggested the necessity for revisions in the original JHU-MOHEC contract. Mrs. Storms travelled to Jamaica to develop in conjunction with the project director, Dr. Wynante Patterson, the revisions which were then submitted to AID/Jamaica. (See Appendices 2 and 3)

The remaining JHU scheduled visit to Jamaica was made by Dr. Dennis Carlson for the purpose of providing technical assistance to Mr. Mark Gross and members of the Training Branch, Ministry of Health, and to Ms. Willie Mae Clay and members of the training in-service committee, Cornwall County Health Administration. (See Appendix 8 for Carlson's report). The consultation appeared to be a fruitful exchange for all parties concerned.

The initial contract had called for a functional analysis to be held before the in-service training started, in order to assist in development

of the curriculum, and a second one to be held at the end of the training sessions in order to assess whether any changes had occurred in the activities of the health care providers and health care needs of the community. During the visit of Dr. Parker and Mr. Moen, it was decided by the Ministry of Health that a functional analysis would not be desirable at this time and instead should be postponed until the second year of the contract. It was felt that sufficient information would be available through a study that was being designed by Dr. Kenneth Standard, Professor and Chairman of the Department of Social and Preventive Medicine at the University of West Indies. Thus, there were no further activities during 1978 by the functional analysis specialists.

Although a substantial part of the original contract was concerned with providing technical assistance from JHU management and data information specialists to the Cornwall County Health Administration, this activity did not take place. A tentative schedule had been prepared in January 1978, outlining dates when the JHU management and data information specialists could provide consultation in Jamaica. At the January 1978 meeting between JHU representatives Taylor and Storms and members of the Ministry of Health, it was felt that the management and data information specialists should more appropriately be used to provide consultation to the Ministry of Health in Kingston, in addition to the Cornwall County Health Administration. Later in the year, however, the work of PAHO resident management consultant, Mr. Peter Carr, with members of the Ministry of Health, diminished the necessity for the short term planning, information systems and management technical assistance provided for under the JHU/AID project.

The result of all these changes was that there was minimal input by JHU

professionals during the first year of the project. Since the long term personnel, Mr. Gross and Ms. Clay, had arrived after the initial administrative visits to Jamaica, the only contact between the JHU personnel and Clay and Gross was through monthly reports from Jamaica and through one consultation visit of Dr. Carlson. JHU project personnel were concerned with insufficient feedback as to the progress in Jamaica. Although the monthly reports were quite informative, there are limitations as to what can be put in a written report, and two-way exchange is impossible.

Scheduling was also a most troublesome aspect of the project's operations during the first year because JHU personnel were involved in teaching courses and consulting in other international health projects. Thus, advanced planning for consultations in Jamaica is needed. Attempts to provide for long-range scheduling of visits were not successful.

Some confusion existed in the mechanism for effecting a consultation visit. There was no built-in mechanism for Mr. Gross or Ms. Clay to request technical assistance for themselves. Request for technical assistance had to come from the Ministry of Health. As a result, there were times when the Primary Care Training Consultant was waiting for technical assistance to be provided by JHU; JHU was waiting to receive a request for technical assistance; and the Ministry of Health did not know that either a consultation was needed or that a request had to be issued to JHU.

Another problem centered around funding. The shift of Mr. Gross to Kingston meant additional funds were expended for salary differential and living quarters allowance in Kingston. There were no funds for this since the revised contract was not approved during 1978. Funds had to be drawn from

other parts of the budget. The lack of PL 480 training funds to supplement the activities of the Primary Care Training Consultant and the Deputy Leader for Clinical Training also put strains on the project from JHU's perspective. Clay and Gross were in the position to carry out the responsibility for planning and implementing training programs without money for materials or supplies. They were expected to coordinate efforts, yet there was no money to allow them to travel for joint discussions. They were expected to work with parish in-service training coordinators, yet there was no money to reimburse travel expenses to the coordinators. There was also no money for the development of manuals. All of these activities had been budgeted for under PL 480 funds, but there was no mechanism by which Clay and Gross could obtain these monies for support of in-service training activities. Therefore, they turned to JHU to see if JHU could try to facilitate the acquisition of PL 480 funds for the project and to provide them with money directly from JHU's budget for in-service training. This was not possible according to the way the project had been designed and financed, although \$600.00 was released to Willie Mae Clay to help in the in-service training of Type I personnel. It was a frustrating experience for the Principal Investigator and the Campus Coordinator not to be able to give sufficient backup support to JHU personnel in the field.

**POINT IV: Overall Assessment of the Project "Health Improvement for Young Children."**

A review and evaluation of the JHU-MOH Health Improvement for Young Children project was held in December 1978 by members of USAID Jamaica

and JHU, the Jamaican Ministry of Health. The in-house review was also made in December at JHU. In January 1979 a review and evaluation was held in Jamaica among MOHEC, USAID, and the JHU personnel. The overall assessment of the components of the project were:

1. Willie Mae Clay had substantially contributed to the development of an in-service training committee in the Cornwall County Regional Health Administration as well as assisting in the implementation of training programs for Type I personnel.
2. Minimal progress had been made in the development of training personnel at the Training Branch. Most of Mr. Gross's time had spent in service activities, rather than development of personnel.
3. JHU's role in the project was not clear. Minimal technical assistance in training had been provided; management and data information specialists did not seem to be needed; there was no PL 480 money to support activities of JHU field personnel; plans for functional analysis had been scrapped so that a baseline measurement of functioning was not possible for evaluation purposes. The impression of JHU personnel was that the university had served as a conduit of funds, and had not contributed to the extent of its resources substantially to development, implementation or assessment of the project.

POINT V: Plans for 1979.

A. Primary Care Training Consultant

One plan for the Primary Care Training Consultant in 1979 is to assist members of the Training Branch to conduct "Training of Trainers"

workshops. There will be two workshops with approximately 25 persons each. The first workshop was scheduled to begin on January 22, 1979. The workshop will be of two weeks duration with the participants coming from a number of parishes.

Following the "Training of Trainers" workshop, the first major in-service training that the new parish training coordinators will be expected to mount is a workshop for district midwives on the management and supervision of Type I health centers. There will also be instruction on selected clinical skills for district midwives. The Training Branch and the midwifery consultant from the University of the West Indies will work closely with the new parish training coordinators in the implementation of the midwifery training program. It was decided at the January 1979 meeting in Kingston that Mr. Gross would continue with the Training Branch, assisting them in working with the parish in-service training coordinators. In addition, he would be available for consultation with the Kingston-Saint Andrew health area. It was felt that his activities in helping to develop skills of the parish in-service training coordinators would fulfill the objectives of the contract, that is, a developmental rather than a service function.

Mr. Gross's contract expires the end of October 1979. Since he has vacation time accrued, he would be leaving at the end of September, 1979. It was decided that a decision would be made in the first week in March 1979 as to whether or not to extend Mr. Gross's contract beyond the end of October. If additional personnel were hired for the Training Branch then it would be feasible to extend Mr. Gross's contract so that he might work in developing in-service training skills. Otherwise, without such personnel in the Training

Branch the service load is so great that very little development can be expected to be done.

B. Deputy Leader for Clinical Training

At the Cornwall County Administration, Montego Bay, several in-service training activities are projected for 1979. The Deputy Leader for Clinical Training will be expected to assist in in-service training for primary health care personnel focussing on (1) family planning; (2) first aid; (3) nutrition-dental; (4) methods of reporting and recording for clinical management; (5) method of data collection for administrative control; and (6) early stimulation for children with behavioral problems. Ms. Clay will also help to assess field experiences in a pilot area in order to provide input for Type II and Type III manuals. Finally, she will be participating in the evaluation of the Type I centers services and the staff performance in Cornwall County.

Ms. Clay's contract expires at the end of August 1979. Dr. D'Souza stated that he felt that they could continue to make good use of Ms. Clay's assistance in developing a strong in-service training capability if her contract were to be extended. The decision to extend one contract (Clay) or both (Clay and Gross) will be made in the first week of March by the Ministry of Health. There are no monies within the existing JHU contract to support extension of services. That would have to be done either under (1) additional funds allotted to this project, (2) under another project, or (3) under a personal service contract.

C. Role of JHU

The role of JHU was clarified at the January 1979 meeting. JHU will provide technical consultation in curriculum development and training and will conduct evaluation studies during the two years 1979 and 1980. No assistance would be required of the management and data specialists.

Technical assistance in curriculum development and training would continue to be provided by Dr. Dennis Carlson. Tentatively, it was scheduled that he would travel to Jamaica early in March and sometime in the summer. It was also expected that he would provide technical assistance to the Ministry of Health during 1980. His role would be seen as providing technical assistance to the Training Branch, Ministry of Health and to the Cornwall County Regional Health Administration.

The second major role of JHU is to work with personnel from the University of West Indies and the Ministry of Health in three evaluation projects. (See Appendix 9) Evaluation project #1 is a Knowledge, Attitude and Practice (KAP) Study. The purpose of the KAP study is to examine the benefits of in-service training programs held in Cornwall County, and to identify needs for further in-service training for Type I health staff. Evaluation project number #2 is a Time and Motion (TM) Study. The purpose of the TM study is to describe the range of functions actually performed by Type I personnel and their supervisors. These studies are to be carried out during 1979. The money for conducting these studies is to come from funds budgeted in 1978 and 1979 for the functional analysis and for the management and data information specialists.

The third evaluation project is an assessment of Service Delivery

Efficiency (SDE) in the pilot areas. The purpose of the SDE study is to assess whether the system of care meets the criterion of efficiency. That is, are Type I activities carried out in Type I centers, Type II activities carried out in Type II centers, and Type III activities carried out in Type III centers. This study is scheduled to begin as soon as the pilot areas are operating. It is expected that the design of the project would take place in September or October 1979, that the initiation of the field work would begin in January or February and the study would be completed by April 1980. Funds for the Service Delivery Efficiency Study would be supported from funds originally allotted under contract in 1980 to functional analysis and the management and consultation specialists.

Following the January 1979 meeting, a tentative schedule was drawn up of the travel that would be necessary during 1979. (See Appendix 10). This schedule, however, would be amended as needed by the Ministry of Health and by Dr. Standard and his team at the University of West Indies.

At the January meeting it was decided that the communication should continue to flow between JHU and the Project Director, Dr. Patterson (copies of correspondence to be sent to AID/Jamaica, Gross, Clay, and the Senior Medical Officer of Health, Cornwall County Health Administration) It has been suggested that there needed to be improvements in communication between JHU and AID/Jamaica. Dr. Haverberg felt that co-copies of correspondence to the Program Director would seek to keep the Health/Nutrition/Population Division better informed. It was also Dr. Haverberg's belief that the communication regarding travel should go through Mrs. Barbara Sandoval's office directly. (During 1978, JHU communication to AID/Jamaica went through

the contracting officer in Washington) The contract officer in AID/Washington has notified JHU, however, that communications to AID/Jamaica regarding consultant travel should continue to go through the contract officer. Until notified otherwise, therefore, we will send copies to both the technical and contract offices in Washington.

#### SUMMARY STATEMENT

Johns Hopkins University (JHU) values the opportunity to work with the highly motivated and cooperative officials of the Jamaican MOHEC. We consider this project to be extremely relevant and potentially productive. The opportunities for making significant contributions to the quality of life of the poorest segments of the Jamaican population are significant. However, we would like to reiterate that we do not want to be just a conduit for funds. We feel that there are significant contributions that can be made by applying our technical expertise to build up Jamaican capacity to solve their own problems, such as through working with the University on the surveys. If we cannot arrange the logistics for adequate backstopping of our long term personnel through appropriate visits and support for training then we feel it would be better for them to be employed by AID on personal contracts. We also hope to be able to contribute directly to the training of Jamaican specialists in primary health care. In summary, we continue to be eager to help but in the next year we hope that some of the problems of the past year can be resolved.

**COST REIMBURSEMENT CONTRACT WITH AN EDUCATIONAL INSTITUTION** **APPENDIX 1**

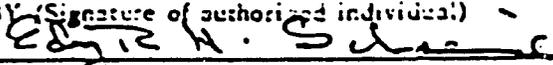
*Final-310*

AGENCY FOR INTERNATIONAL DEVELOPMENT NEGOTIATED CONTRACT NO. AID/12-C-1233

NEGOTIATED PURSUANT TO THE FOREIGN ASSISTANCE ACT OF 1961, AS AMENDED, AND EXECUTIVE ORDER 11223	TOTAL ESTIMATED CONTRACT COST <p align="center">\$380,555</p>
CONTRACT NO.: Health Improvement for Young Children	CONTRACTOR (Name and Address) <p align="center">The Johns Hopkins University</p>
PROJECT NO.: <p align="center">532-0040</p>	NAME <p align="center">615 North Wolfe Street</p>
ISSUING OFFICE (Name and Address) Agency for International Development Office of Contract Management Regional Operations Division - LA Washington, D.C. 20523	STREET ADDRESS <p align="center">Baltimore, Md. 21205</p>
ADMINISTRATION BY <p align="center"><i>Issuing Office</i></p>	CITY, STATE, AND ZIP CODE <p align="center">COGNIZANT SCIENTIFIC/TECHNICAL OFFICE</p>
MAIL VOUCHERS (Original and 3 copies) TO: Agency for International Development PER/FM/ Office of Financial Management (AD) Washington, D.C. 20523	ACCOUNTING AND APPROPRIATION DATA PROJ/T NO. <u>532-040-5-5482040</u> APPROPRIATION NO. <u>72-1111024</u> ALLOTMENT NO. <u>454-54-532-00-44-61</u>
EFFECTIVE DATE <p align="center">November 1, 1977</p>	ESTIMATED COMPLETION DATE <p align="center">December 31, 1980</p>

The United States of America, hereinafter called the Government, represented by the Contracting Officer executing this Contract, and the Contractor, an educational institution chartered by the State of Maryland with its principal office in Baltimore, Maryland, agree that the Contractor shall perform all the services set forth in the attached Schedule, for the consideration stated therein. The rights and obligations of the parties to this contract shall be subject to and governed by the Schedule and the General Provisions. To the extent of any inconsistency between the Schedule and the General Provisions and any specifications or other provisions which are made a part of this contract, by reference or otherwise, the Schedule or the General Provisions shall control. To the extent of any inconsistency between the Schedule and the General Provisions, the Schedule shall control.

This Contract consists of this Cover Page, the Table of Contents and the Schedule consisting of 10 pages, the General Provisions (Form AID 1420-23C), dated 7-1-76 & (Form AID 1420-23) dated 7-1-76, and an Appendix "A" (Operational Plan).

NAME OF CONTRACTOR The Johns Hopkins University	UNITED STATES OF AMERICA AGENCY FOR INTERNATIONAL DEVELOPMENT
BY (Signature of authorized individual) 	BY (Signature of Contracting Officer)
TYPED OR PRINTED NAME D. A. Henderson, M. D., M. P. H., Dean or	TYPED OR PRINTED NAME Gary E. Dwoskin
TITLE Edyth H. Schoenrich, M. D., M. P. H., Associate Dean	CONTRACTING OFFICER
DATE <p align="center">October 26, 1977</p>	DATE

AID 1420-23 (7-76)

LAW

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TABLE OF CONTENTS  
SCHEDULE

The Schedule, on pages 1 through 20, consists of this Table of Contents and the following Articles:

ARTICLE I	-	STATEMENT OF WORK
ARTICLE II	-	KEY PERSONNEL
ARTICLE III	-	LEVEL OF EFFORT
ARTICLE IV	-	CHANGES IN RESEARCH METHODS, PROCEDURES, OBJECTIVES, OR PHENOMENA UNDER STUDY.
ARTICLE V	-	PERIOD OF CONTRACT SERVICES
ARTICLE VI	-	ESTIMATED CONTRACT COST AND FINANCING
ARTICLE VII	-	BUDGET
ARTICLE VIII	-	LOGISTIC SUPPORT TO CONTRACTOR
ARTICLE IX	-	NEGOTIATED OVERHEAD RATES
ARTICLE X	-	SPECIAL PROVISIONS
ARTICLE XI	-	ALTERATIONS IN CONTRACT

GENERAL PROVISIONS

The General Provisions applicable to this contract consist of AID Form 1420-23C entitled "General Provisions - Cost Reimbursement Contract with an Educational Institution, "dated July 1, 1976, which includes provisions 1 through 1.2 ; and AID form 1420-23D entitled "Additional General Provisions - Cost Reimbursement Contract with an Educational Institution, "dated July 1, 1976 which includes provisions 1 through 1.7

ARTICLE I - STATEMENT OF WORK

A - DESCRIPTION OF SERVICES

For a period hereinafter set forth in the Schedule, the Contractor shall render technical advice and assistance to the Government of Jamaica (GOJ) under agreements between said Government of the United States, for the purpose of "Health Improvement for Young Children" by assisting the Cornwall County Health Administrative Office to decentralize the primary health care delivery system, revise the curriculum and training of health care providers, improve management and data collection systems, improve and increase efficiency of support services within Cornwall County.

To achieve the above, the contractor shall provide individuals who shall perform the following tasks.

1. PRIMARY CARE CURRICULUM DESIGN AND TRAINING

- a) Work with the management, information systems and functional analysis consultants and with GOJ personnel to review and revise the roles and functions of the members of the rural health care team. It is expected that this person will have primary responsibility to coordinate the work of the consultants in tandem with the Cornwall County Health Administrator.
- b) Working with other members of the Cornwall County Training Unit, develop new and revised curricula and training plans for both in-service training and training of new personnel in professional schools and certificate programs.
- c) Assist the GOJ in implementing the new and revised training programs designed under the project.
- d) Assist GOJ co-workers in the training unit to develop the skills necessary to continue the training units functions after the cessation of major technical assistance to the unit.

2. INFORMATION SYSTEMS

- a) Analyze the information needs of the MOHEC, especially as they relate to decision making to the management of the new health care system, and to the evaluation of that system and its components.
- b) Coordinate AID-supported activities related to the development and improvement of the information system within the Cornwall County project with those supported or provided by other agencies, including the U.S. Bureau of the Census and the IBRD.

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- . .c) Work with other consultants and GOJ personnel to develop, test and implement a decision-oriented information system for the MOHEC within the Cornwall County health project. The system developed should also provide information needed for the evaluation of the health care system.
- d) Help MOHEC personnel to develop and improve the skills and knowledge which they will need to manage the information systems after the initial three years of the project and to make appropriate modifications of the systems as required by changing resources and information needs.

### 3. MANAGEMENT SYSTEMS

- a) Work with the primary curriculum design, information system and functional analysis consultants and with GOJ personnel to review and revise the roles and functions of the members of the health care team.
- b) Work with other consultants and GOJ personnel to review and revise personnel policies (salaries, grades, promotion, etc.) of the MOHEC in view of the needs of the revised and decentralized health care system.
- c) Work with the information system consultant and other consultants and GOJ personnel on the revision of the MOHEC information system as it pertains to the needs of the MOHEC and of the new health care system for information.
- d) Work with other consultants and GOJ personnel to design and implement the decentralized MOHEC systems for drug and supply distribution.
- e) Assist the Project Director and other GOJ personnel in designing a system to coordinate activities in the overall Cornwall County health project.
- f) Assist the Project Director and other GOJ personnel in assuring that at the end of the first three years of project implementation the Cornwall County health care system's management personnel have the skills required to continue to operate and adjust the management systems after the cessation of major technical assistance to management.

1. ~~Review~~ the primary care curriculum design management and information systems consultants and with GOJ personnel to review and revise the roles and functions of the members of the health care team.
- b) Develop the study design and research instruments for the functional analyses of work activities carried out by rural health team members, field test the instruments, assist in the selection of the field supervisor and field observers, train the supervisor and observers and direct the gathering and editing of data in the field.
- c) Edit, analyze and interpret field data for the first functional analysis, and guide MOHEC personnel responsible for these activities in subsequent functional analyses.
- d) Communicate methods and results of the functional analysis to other project personnel and other GOJ personnel as required in order to accomplish the purposes of the overall Cornwall County Project.
- e) Train MOHEC personnel in the techniques of functional analysis in order to enable them to continue to carry out such studies after the initial three years of the project.
- f) Write and submit to the MOHEC (Project Director) and to AID reports on progress in functional analysis studies and a final report on each functional analysis carried out under the project.

## B. REPORTS

The contractor shall submit to USAID/Jamaica, the Cornwall County Health Administrator and AID/W two copies each of written progress reports of consultation in Jamaica and an end of year summary consisting of an assessment of progress, problems identified and encountered in the course of assistance, and recommended steps to resolution of these problems each contract year.

The contractor shall also prepare problem oriented interim or special reports as required by A.I.D. or Government of Jamaica. The consultants will participate in scheduled project evaluations, either by physical presence or in writing as required.

One (1) copy of each report shall be submitted to the Contracting

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Office, and to LA/DR and two (2) copies of each report shall be submitted to the AID Reference Center, Agency for International Development, Washington, D.C. 20523.

## ARTICLE II - KEY PERSONNEL

- A. The key personnel which the Contractor shall furnish for the performance of this contract are as follows:

NAME	TITLE	DURATION OF ASSIGNMENT
Mark Gross	Project Leader	21 months
Willie Mae Clay	Deputy Leader for Clinical Training	18 months

- B. The personnel specified above are considered to be essential to the work being performed hereunder. Prior to making any change in the key personnel, the Contractor shall notify the Contracting Officer reasonably in advance and shall submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the program. The listing of key personnel may, with the consent of the contracting parties, be amended from time to time during the course of the contract to either add or delete personnel, as appropriate.
- C. (1) The Contractor shall obtain A.I.D.'s approval to change the principal investigator or project leader, or to continue the research work during a continuous period in excess of three months without the participation of the approved principal investigator or project leader.
- (2) The Contractor shall consult with A.I.D. if the principal investigator plans to, or becomes aware that he will, devote substantially less effort to the work than anticipated in the Operational Plan. If A.I.D. determines that the reduction of effort would be so substantial as to impair the successful prosecution of the research, A.I.D. may request a change of principal investigator, terminate the research effort or make any other appropriate modification of the research agreement.

## ARTICLE III - LEVEL OF EFFORT

- A. The level of effort for the performance of this contract shall be 113 total person-months of direct labor divided into three (3) phases. For the purposes of this contract, a person month shall be defined as 22 days worked during a calendar month, 8 hours per day, 5 days per week, Monday through Friday.
2. The estimated composition of the total person-months of direct labor

for each phase of the contract is as follows:

<u>Category of Labor</u>	<u>Number of Person Months</u>			<u>Total</u>
	<u>Phase I</u>	<u>Phase II</u>	<u>Phase III</u>	
Key Personnel	19	20	0	39
Home Office Professional Staff	3	1.5	1.5	6
Specialists	10	6	9	25
Consultants	1.5	.75	.75	3
Cooperating Country Nationals	8	-0-	8	16
Secretarial	10	7	7	24
<b>Total</b>	<b>51.5</b>	<b>35.25</b>	<b>26.25</b>	<b>113</b>

- C. It is understood and agreed that the number of person months may vary in pursuit of the technical objective, provided such variance does not result in the utilization of the total person-months of effort prior to the expiration of the term hereof, and it is further understood and agreed that the number of months of effort for any classification except for the months of the Key Personnel may be utilized by the Contractor in any other direct labor classification if necessary in the performance of the work.
- D. The Contracting Officer may by written order, direct the Contractor to increase the average monthly rate of utilization of direct labor to such an extent that the total person months of effort, specified above, would be utilized prior to the expiration of the term hereof. Any such order shall specify the degree of acceleration required and the revised term hereof resulting therefrom.

ARTICLE IV CHANGES IN RESEARCH METHODS, PROCEDURES, OBJECTIVES OR PHENOMENA UNDER STUDY

- A. The principal investigator may change the methods and procedures employed in performing the research without making special reports on proposed actions or obtaining A.I.D. approval. However, significant changes in methods or procedures shall be reported to the Government in periodic or final technical reports. In the event the methodology or experiment is stated as a specific objective of the research work, any changes to either fall within the scope of paragraph B. below.
- B. The stated objectives of the research effort shall not be changed, except with the prior approval of the Contracting Officer.
- C. The phenomenon or phenomena under study, i.e., the broad category of research, shall not be changed except with the prior approval of the Contracting Officer.

ARTICLE V - PERIOD OF CONTRACT SERVICE

- A. The effective date of this contract is November 1, 1977 and the estimated completion date of all services required in December 31, 1980.
- B. This contract shall be performed in three (3) phases as follows:
  - Phase I : 14 months, November 1, 1977 to December 31, 1978
  - Phase II : 12 months, January 1, 1979 to December 31, 1979
  - Phase III : 12 months, January 1, 1980 to December 31, 1980
- C. In the event that the Contractor fails to furnish the level of effort set forth herein for the specified term, the Contracting Officer may require the Contractor to continue performance of the work beyond the estimated completion date until the Contractor has furnished the specified level of effort or until the estimated cost of the work for the period shall have been expended.

**ARTICLE VI - ESTIMATED COST, LIMITATION OF FUNDS**

- A. This is an incrementally funded contract.
- B. Subject to the provisions of paragraphs C and D below, the total estimated cost of this contract, is \$380,555.
- C. Until such time as this contract is fully funded, the Contractor is limited to performance of those tasks in the Scope of Work designated under "Phase I" and is limited to the obligated amount of \$159,400. Until such time as the contract is fully funded, the Contractor is subject to the Provision, Limitation of Cost (1973 June).
- D. This contract may be unilaterally modified by the Contracting Officer implementing Phase II and Phase III and providing funding for each Phase. At the time the contract is modified to implement Phase III, the Provision Limitation of Funds (1973 June), will be deleted and Provision, Limitation of Cost (1973 June) will govern.

**ARTICLE VII - BUDGET**

The following budget sets limitations for reimbursement of dollar costs for individual line items. Without the prior written approval of the Contracting Officer the Contractor may not exceed the total set forth for each phase, nor the grand total set forth in the budget hereunder, nor may the

Jamaica

Contractor exceed the dollar costs for any individual line item by more than 15% of such line item.

BUDGET

CATEGORY	AMOUNT			Total 11/1/77 - 12/31/80
	Phase I 11/1/77 - 12/31/78	Phase II 1/1/79 - 12/31/80	Phase III 1/1/80 - 12/31/80	
Salaries	\$78,950	\$55,670	\$36,380	\$171,000
Consultants	4,000	2,250	2,250	8,500
Fringe Benefits	13,272	9,267	6,181	28,720
Cooperating Country National Salaries	2,000	-0-	2,000	4,000
Allowances	30,165	20,543	16,672	67,380
Travel and Transportation	22,430	18,030	3,600	44,060
Other Direct Costs	2,940	400	1,400	4,740
Overhead	24,383	16,521	11,246	52,150
<b>Total Estimated Cost</b>	<b>\$178,145</b>	<b>\$122,681</b>	<b>\$79,729</b>	<b>\$380,555</b>

Payment of Salaries of Cooperating Country Nationals shall be made in the currency of Jamaica.

**ARTICLE VIII - COSTS REIMBURSABLE AND LOGISTIC SUPPORT TO CONTRACTOR**

**A. United States Dollar Cost**

The United States dollar costs allowable under the contract shall be limited to reasonable, allocable and necessary costs determined in accordance with the clause of the General Provisions of this contract entitled "Allowable Cost, Fixed Fee, and Payment."

**B. Logistic Support**

The Contractor shall be provided the following items of logistic support in kind for performance under the contract by the Government of Jamaica:

- Office Space
- Office Equipment
- Official Transportation in Jamaica

In addition to the above items of logistic support, the Contractor will be provided with assistance in obtaining local permits such as ID and drivers license; duty free entry for personal and household possessions; and applicable tax exemption for long term personnel assigned in Jamaica.

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ARTICLE IX - NEGOTIATED OVERHEAD RATES

Establishment of Predetermined Indirect Cost Rates

Pursuant to the provisions of the clause of the General Provisions of this contract entitled "Negotiated Overhead Rates - Predetermined", a rate or rates shall be established for each of the Contractor's accounting periods during the term of the Contract. The rate for the initial period shall be as set forth below:

	<u>Rate</u>	<u>Base</u>	<u>Period</u>
On Campus	27%	See Below	From: 7/1/77 To: 6/30/78
Off Campus	14%	See Below	From: 7/1/77 To: 6/30/78

Base: The Indirect Cost Rates set forth above shall be applied to total direct costs less items of equipment \$1,000 and over, major subcontracts \$10,000 and over, alterations and renovations \$5,000 and over, and hospitalization and other fees related to patient care.

Predetermined indirect cost rates for subsequent periods shall be established in accordance with the terms of the "Negotiated Overhead Rates-Predetermined clause of this contract.

ARTICLE I - SPECIAL PROVISIONS

- A. Principal Duty Post: The Contractor's long term technicians will be based in Montego Bay, Jamaica.
- B. Security Requirements: The Contractor shall have no access to classified material.
- C. Relationships and Responsibilities: The contractor shall receive technical directions from the MOHEC/Cornwall County and the USAID, Jamaica Office of General Development.
- D. Liaison Officials: The following officials are hereby identified as points of contact under this contract.

Jamaican Liaison Official

Cornwall County Health Administrator

AID Liaison Official

General Development Officer

Program Officer

- E. Pre Contract Costs: Provided that they are otherwise allowable pursuant to General Provision Number 7, "Allowable Cost and Payment," and the other terms and conditions of this contract, pre contract costs not to exceed \$800 for orientation of the Training Specialist will be reimbursed.

ARTICLE XI- ALTERATIONS IN CONTRACT

The following alterations have been made in the provisions of this contract:

- A. Delete General Provision Number 16 "Sub-contracts" and substitute General Provision Number 39 "Sub-contracts and Purchase Orders (September 1975)" contained in Attachment 1 in lieu thereof.
- B. Add General Provision Numbers 40 "Cost Accounting Standards," 41 "Limitation of Funds," and 42 "Advance Payment," contained in Attachment 1.
- C. Add provision "Workman's Compensation Insurance (43 U.S.C. 1651, Et Seq.)" contained in Attachment 1.

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MINISTRY OF HEALTH & ENVIRONMENTAL CONTROL

FOR COPY OR REPRODUCTION PERMISSION  
IN THIS COMMUNICATION SHOULD BE  
APPLIED TO THE DOCUMENT  
SECRETARY AND THE FOLLOWING  
REFERENCE NUMBER

10 CALEDONIA AVE.,  
P.O. BOX 475,  
KINGSTON, JAMAICA.

February 24, 1978.

Mr. Donor Lion,  
Director, AID Mission,  
Mutual Life Building,  
2 Oxford Road,  
Kingston 5.

Dear Mr. Lion,

In joint planning with the Johns Hopkins University, representatives for the implementation of the project "Health Improvement for Young Children" (AID project number 532-0040), it became apparent that certain modifications to the project would be advisable. The modifications are needed because a number of changes have occurred in the Ministry of Health since the project was originally designed over 2 years ago, and those changes bear directly on the work set forth in the agreement.

The project "Health Improvement for Young Children" was initially designed to assist the Cornwall County Health Administrative Office to decentralize the primary health care delivery systems, revise the curriculum and training of health care providers, improve management and data collection systems, improve and increase efficiency of support services within Cornwall County. The purpose of this project was to act as a "pilot" or demonstration project for a new Jamaican health delivery system. In the intervening time since the project was designed, the Government of Jamaica decided not to wait for the results of a pilot project, but to move ahead in implementing a three-tiered primary health care system throughout the country. Thus, the locale and scope of work of the project need to be shifted from Cornwall County to the larger perspective of the national health programme.

A second change that has been made is that the GOJ has decided it is not advisable to attempt decentralization of training to the regional level, but instead training functions are now centralized and coordinated in the Ministry of Health Training Unit. Policy and Procedure manuals for Type I Centres, and inservice community health aide training manuals have been completed, and are ready to be printed.

The Government of Jamaica critically needs assistance in implementation of the three-tiered primary care system, particularly in training of the clinical team and support staff in the management procedures needed to effect the desired health care in the Type I, Type II and Type III health centres being constructed with World Bank assistance. However, the assistance must be on a national level, and not restricted to Cornwall County.

Also, as the project was originally designed a functional analysis was to initiate and close the project. However, a full functional analysis is not advisable until the personnel (such as nurse practitioners) are in place, and that some of the transition has been made to the new physical facilities.

For all these reasons it appears that project plans should be updated and modified as suggested below. If AID is in agreement, we would appreciate it if AID would initiate any necessary modifications to the project documents: -

1. Assignment of the Primary Care Training Consultant to the Ministry of Health in Kingston rather than Cornwall. He will work with our Training Officer in the Ministry and with Training Coordinators in each parish to identify training needs and develop training programmes pertaining to the implementation of the three-tiered primary health care system.
2. National level development and implementation of 2-day management training seminars and intensive 5-day workshops for members of the health team, including support staff. The subject of the seminars will include channels of communication and supply management. The training of these primary health care teams will be carried out at parish level under training procedural guidelines laid down by Ministry of Health. A two-day seminar to train the trainers of the management seminar is also needed.
3. The Deputy Leader for Clinical Training will continue to be stationed in Cornwall County to assist GOJ personnel in the implementation of planned programmes for the Type I clinics.
4. Development and production of a policy and procedure manual for the Type II and III centres as well as a general reference manual. This will provide a manual for each of the proposed type health centres.
5. The management and data information consultants will be used to assist in the development of the management training seminars and the development of the policy and procedure manuals at the national level.
6. Postponement of the functional analysis until personnel are in place and half the country health personnel will have undergone the management training approximately a year from now. At the approximate time, a sample will be taken of different parishes. A comparison of health needs and health resources will be made between the selected parishes.

In order to support the modifications to this project we estimate that the following additional resources will be needed over a three-year period to support the project in the United States:

/JHU....

*Revised  
12/6/78*

JHU telephone	\$3,000
JHU postage	1,500
JHU books	300
3 additional months from the Campus Coordinator and Principal Investigator	9,000
Salary differential (Gross)	3,167
Fringes (16.5%)	2,008
Kingston quarters additional	950
2 additional Consultant trips	800
Off campus indirect costs (14%)	2,902
<b>Total</b>	<b>US \$23,627</b>

Specifically, the additional amount required for this project year (January-December 1978) to support the project in the United States is:

*Revised  
12/6/78*

JHU telephone	\$1,000
JHU postage	500
JHU books	150
Professional on campus salaries	3,000
Salary differential (gross)	1,503
Fringes (16.5%)	743
Kingston Quarters	450
7 Consultant trips (using 2 additional and moving 5 up from third project year)	2,800
Off campus indirect costs (14%)	1,420
<b>Total</b>	<b>US \$11,566</b>

In addition there is need for funding certain expenditures within Jamaica. We are seeking funds from the Ministry of Finance and appreciate your support, if possible. The following funds will be needed over a three-year period:

*Revised  
12/6/78*

Management training seminars	\$87,000
2-day parish (2175 participants)	44,000
2-day central (48 participants)	1,000
5-day parish (523 participants)	41,000
2-day central (43 participants)	1,000

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4.

B/F		\$87,000
Development & production of manuals		\$30,500
Production CHA manual	20,000	
, Production reference	500	
devel. & prod. Type II, III	<u>10,000</u>	
Functional analysis		21,000
Travel within Jamaica		<u>11,400</u>
TOTAL JAMAICAN		<u>\$149,900</u>

We hope you agree to taking these necessary steps for implementation of the agreement.

Yours sincerely,

*A. W. Patterson*  
(A. W. Patterson)  
Acting Chief Medical Officer.

September 22, 1978

Dr. A. W. Patterson  
Acty. Chief Medical Officer  
Ministry of Health & Environmental  
Control  
10 Caledonia Avenue  
Kingston 5.

Dear Wynante:

This is to reaffirm our previous oral agreement to the modifications to the Health Improvement for Young Children Project (532-0040) as outlined in your letter of February 24, 1978. Given the time that has elapsed since the project was first designed and approved and the significant changes that have occurred in the Ministry of Health & Environmental Control during that time, these modifications seem highly advisable.

Specifically, we agree to shifting the locale and scope of work of the project from Cornwall County to the larger perspective of the national health program. We agree that this change will enhance the value of project activities in implementing a three-tiered primary health care system throughout Jamaica. We also agree that the project can best support this goal by providing assistance at the national level to the Ministry of Health Training Unit.

We agree that it is advisable to await the assignment of personnel and the completion of management training for half of the country's health personnel before undertaking a full-scale functional analysis. On this point, however, we should like to suggest that a limited review of training requirements be undertaken as soon as possible. We believe that this should be done so that preliminary training plans and programs may be initiated, thereby making the best use of the expertise of the training advisors who are currently in place.

We also agree that a policy and procedure manual for the Type II and Type III centers should be developed and produced and that the management training seminars as outlined in your letter should be held. The management and data information consultants should be of assistance in these efforts.

We have taken the necessary steps to ensure that the project is adequately funded by A.I.D. to support these modifications. In addition, it is our understanding that the total amount of counterpart funds requested by the Ministry to support this project has been allocated.

In order to implement these changes, we have prepared a PIO/T amendment which I am enclosing for your information.

Best regards.

Sincerely,

Donor M. Lion  
Director

enc.

cc: ✓ Mrs. Doris Storms, JHU

DEPARTMENT OF STATE  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
WASHINGTON, D.C. 20523

October 27, 1978

The Johns Hopkins University  
615 North Wolfe Street  
Baltimore, Maryland 21205

Attn: Ms. Eileen Sklar

Subject: Contract AID/1a-C-1233, Jamaica

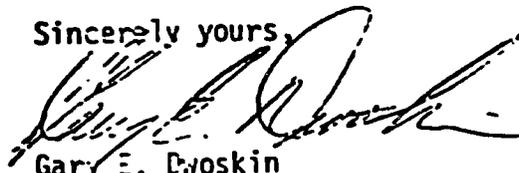
Dear Ms. Sklar:

The Agency for International Development is considering the incorporation of a revision to the scope of work of subject contract. Before the contract can be modified, it is necessary to determine the effect that such revision would have on the estimated cost or period of performance of the contract. You are requested, therefore, to review the enclosed proposed changes and advise me of the impact, if any, that they would have on the cost or term of the contract.

This letter is a request for information only, and shall not be construed as authorization to effect any change in the scope of work prior to receipt, acceptance, and execution of a contract modification; nor shall it be authorization for reimbursement of any costs incurred in preparation of the data requested herein.

If you have any questions concerning the proposed revision or the information requested, please contact Mr. LeRoy Wallin at area code 703-235-9144.

Sincerely yours,



Gary E. Dvoskin  
Contracting Officer  
Regional Operations Division - LAC  
Office of Contract Management

Enclosure: a/s

**Proposed Revisions to Contract AID/1a-C-1233**

1. Delete Article I - "Statement of Work" and substitute the following:

**"ARTICLE I - STATEMENT OF WORK**

**A. DESCRIPTION OF SERVICES**

For a period hereinafter set forth in the Schedule, the Contractor shall render technical advice and assistance to the Government of Jamaica (GOJ) under agreements between said Government and the Government of the United States, for the purpose of "Health Improvement for Young Children" by assisting the GOJ Ministry of Health and Environmental Concerns (MOHEC) in curriculum development and training of health workers, to develop and improve management and information systems, and conduct functional analysis.

1. PRIMARY CARE CURRICULUM DESIGN AND TRAINING SPECIALIST

a. Work with the management, information systems and functional analysis consultants and with GOJ personnel to review and revise the roles and functions of the members of the rural health care team.

b. Work with other members of the MOHEC's Training Unit to develop new and revised curricula and training plans for both in-service training and training of new personnel in professional schools and certificate programs. This includes development and

production of a policy and procedure manual for the Type II and Type III centers as well as a general reference manual.

c. Assist the GOJ in implementing the new and revised training programs designed under the contract.

d. Assist the GOJ co-workers in the training unit to develop the skills necessary to continue the training unit's functions after the cessation of major technical assistance to the unit.

## 2. CLINICAL TRAINING SPECIALIST

Work with the Senior Medical Officer (Health) for the Western Region (Cornwall County), Jamaica to:

a. Assist regional and parish GOJ personnel in the development of practical field training emphasizing inter-relationships of the health team.

b. Assist regional and parish GOJ personnel to work with health committees in developing methods for identification of health needs and obtaining community participation in health programs in the western region.

c. Assist regional and parish GOJ personnel in the development of field methods for support<sup>✓</sup>supervision of members of the primary health care team, with special attention to community health aides.

## B. REPORTS

1. The Contractor shall submit to USAID/Jamaica, the Senior Medical Officer (Health) for the Western Region (Cornwall County), and AID/Washington copies of each written progress report of consulta-

tion in Jamaica, and an end of year summary of activities consisting of an assessment of progress, problems identified and encountered in the course of assistance, and recommended steps to resolution of these problems each contract year.

2. The Contractor shall also prepare problem oriented interim or special reports as required by AID or the Government of Jamaica. The Contractor's specialists in Jamaica shall participate in scheduled project evaluations either by physical presence or in writing as required.

3. The reports shall be in English and shall be submitted to the following offices, in the number of copies stated:

<u>Office</u>	<u>Number of Copies</u>
Government of Jamaica MOHEC	5
USAID/Jamaica Health/Nutrition/Population Division	7
AID Washington LAC/DR	1
AID Washington Contracting Office	1
AID Washington Reference Center	<u>2</u>
Total	16"

2. Delete Article X - Special Provisions and substitute the following:

"ARTICLE X - SPECIAL PROVISIONS"

A. Principal Duty Post: The Contractor's long term technicians will be based as follows:

Primary Health Care Curriculum Design Specialist -  
Kingston, Jamaica

Clinical Training Specialist - Montego Bay, Cornwall  
County, Jamaica

B. Security Requirements: The Contractor shall have no access to classified material.

C. Liaison Officials: The following officials are hereby identified as points of contact under this contract:

1. Jamaican Liaison Officials:

a. Chief MOHEC Training Unit

b. Senior Medical Officer (Health) for the

Western Region (Cornwall County)

2. AID Liaison Official:

Chief, Health/Nutrition/Population Division

D. Pre Contract Costs: Provided that they are otherwise allowable pursuant to General Provision Number 7, "Allowable Cost and Payment," and the other terms and conditions of this contract, pre contract costs not to exceed \$800 for orientation of the Training Specialist will be reimbursed.

## THE JOHNS HOPKINS UNIVERSITY

SCHOOL OF HYGIENE AND PUBLIC HEALTH

DEPARTMENT OF INTERNATIONAL HEALTH

615 North Wolfe Street • Baltimore, Maryland 21205

C&amp;M ADDRESS: PL2076

December 6, 1978

Mr. Gary E. Dvoskin  
 Contracting Officer  
 Regional Operations Division-LAC  
 Office of Contract Management  
 Department of State  
 Agency for International Development  
 Washington, D.C. 21523

Subject: Contract AID/1a-c-1233, Jamaica

Dear Mr. Dvoskin:

In response to your letter of October 27, 1978 and my subsequent conversations with Mr. Leroy Wallin, be advised of the following remarks we have concerning the proposed changes to the Jamaica contract.

The proposed changes would have an effect on the estimated cost of the contract and we are including a justification and line item budget within this letter. As far as period of performance is concerned it may not be possible to fulfill 1A1c - Primary Care Curriculum Design & Training Specialist - Assist the GOJ in implementing the new and revised training programs designed under the contract as the Specialist is scheduled to complete his assignment in December 1979. The completion of this goal is dependent upon the speed in which progress is made by the GOJ in instituting country wide in-service training.

Additionally as discussed with Mr. Wallin, mention should be made that it was our understanding that the GOJ was to provide monies for the production of manuals and the implementation of the new and revised training programs. A budget was developed by Dory Storms, Dr. A.W. Patterson and forwarded to Donor Lion in Feb. 1978. A copy of Dr. Patterson's letter to Mr. Lion is enclosed for your information.

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We have been advised that at the present time the monies, originally to be PL480 funds, were released to the Ministry of Finance but have gone into general revenues instead of to the Ministry of Health. Per Leroy Wallin's request, a revised budget for these services is included in this letter both in U.S. and Jamaican dollars. The budget in Jamaican dollars is at current exchange rate of \$1J=\$.60 U.S. This amount would fluctuate as the exchange rate changes.

In order to support the modifications to this project we estimate that additional funding will be needed. This budget was also developed in February 1978 during the time Dory Storms was in Jamaica and is also mentioned in Dr. Patterson's letter to Donor Lion. A revision of this budget follows along with explanation of same.

We hope this information fully responds to your request. We look forward to hearing from you in the near future.

Sincerely,



Eileen B. Sklar  
Administrator

EBS/mz

Attachments

cc: Dr. Carl E. Taylor  
Ms. Dory Storms  
Vince Centurelli

BUDGET - ADDITIONAL FUNDS REQUIRED FOR JAMAICA CONTRACT

<u>Salaries</u>	<u>U.S.\$</u>	<u>Note</u>
<u>Salary differential - Primary Care Curriculum Design &amp; Training Specialist 10% for 20 months</u>	3,333	1.
<u>Campus Coordinator &amp; Principal Investigator (3 persons months)</u>	9,000*	2.
<u>Fringe Benefits</u>	3,509	3.
<u>Orientation Costs - Clinical Training Specialist</u>	500	4.
<u>Kingston Quarters Allowance (\$50 mo. x 20 months)</u>	1,000	1.
<u>Telephone</u>	3,000	5.
<u>Postage</u>	1,500	5.
<u>Books</u>	300	5.
<u>Local Overseas Travel</u>	3,000	6.
<u>Total Direct Costs</u>	25,142	
<u>Indirect Costs - Off Campus 14% (base of \$14,567)</u>	2,040	
<u>Indirect Costs - On Campus 27% (base of \$9,000 + 1,575 fringes)</u>	2,855	
<u>TOTAL COSTS</u>	30,037	

Notes

1. Original budget included salary for Curriculum Specialist to be based in Montego Bay. Salary differential and housing costs reflects adjustments for Specialist to be located in Kingston.
2. As modified, the scope of the contract is on a nationwide level vs. the original Cornwall County level only. Such a change requires more technical assistance from Campus Coordinator and Principal Investigator.

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3. Fringe Benefits reflected include fringe benefits at current level for additional salary support requested (\$2,158) plus and additional amount (\$1,351) as an adjustment to original contract to reflect expected fringe rate levels during year II (average of 17%) and year III (average of 16%).
4. Original contract did not include funds for Clinical Training Specialist to attend AID two week orientation in Washington. The \$500 is to cover transportation, meals and lodging for the orientation.
5. Monies for telephone, postage and books were not included in original contract.
6. Requested funds to cover local travel in Jamaica (\$1,000) to enable Primary Care Curriculum Design & Training Specialist and Clinical Training Specialist to meet twice monthly. \$2,000 is requested for local transportation within Jamaica for Curriculum Specialist to enable him to work with other parishes to coordinate the training activities as required in the contract.

**MANAGEMENT TRAINING SEMINAR & DEVELOPMENT &**  
**PRODUCTION OF MANUALS**

The following funds will be needed over the period January 1, 1979 to December 31, 1980 for Jamaica Ministry of Health expenditures for country-wide in-service training; in connection with this AID contract. If these funds are to be added to existing contract US. cost would be, based on current exchange rate, a total of \$38,894 (\$34,117 direct + 14% indirect \$4,777)

<u>Management Training Seminars</u>	<u>\$J</u>	<u>\$US</u>
2 day Parish	6,300	3,780
2 day Central	1,632	979
5 day Parish	5,753	3,452
5 day Central	<u>1,677</u>	<u>1,006</u>
	15,362	9,217
 <u>Development &amp; Production of Manuals</u>		
Production CHA Manual	20,000	
Production Reference	500	
Level & Prod. Type II, III	<u>10,000</u>	
	30,500	<u>18,300</u>
 <u>Functional Analysis</u>	 <u>11,000</u>	 <u>6,600</u>
 <u>TOTAL DIRECT COSTS</u>	 J\$ 56,862	 US\$ 34,117
<u>INDIRECT COSTS 14%</u>	<u>-</u>	<u>4,777</u>
	J\$ 56,862	US\$ 38,894

**TYPE:** Management Training Seminar  
**DURATION:** 2-Days  
**LOCALE:** Central Level, Non Residential  
**PARTICIPANTS:** Administrative Support Staff  
**TOPIC:** Procedures in 3 Tier Primary Health Care System

<b>PARTICIPANTS:</b>	Hospital Administrative	10
	Executive Officers	18
	Public Health Inspectors	<u>20</u>
		48

**COST:** 48 Persons  
 $\frac{x34}{\$ 1632}$  (30 Travel, 3 Coffe Break, 1 Supplies)

**REQUESTED:** \$ 1632 (JAMAICAN DOLLARS)  
 \$ 979 (US DOLLARS)

\* Average miles traveled = 60  
 Cost per mile = 25¢  
 1 Round trip 120x.25 = \* 30.00

**TYPE:** Management Training Seminar  
**DURATION:** 2 Days  
**LOCALE:** Parish Level, Non Residential  
**PARTICIPANTS:** Clinical Members, Primary Care Health Team  
**TOPIC:** Procedures in 3 Tier Primary Health Care System

<b>PARTICIPANTS:</b>	District Midwives	260	
	C.H.A.	1200	
	Staff Nurses	100	
	Health Inspectors	400	
	Public Health Nurses	150	
	District Medical Officers	<u>65</u>	
		2175	
		<u>- 600</u>	already trained in Cornwall
		1575	

**COST:** 1575 Persons  
    x4 (3 Coffee Breaks, 1 Supplies)  
 \$6,300

Travel absorbed by County Councils

**TOTAL REQUESTED:** \$6,300 (JAMAICAN DOLLARS)  
 \$3,780 (US DOLLARS)

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**TYPE:** Intensive Management Workshop  
**DURATION:** 5-Days  
**LOCALE:** Parish Level, Non Residential  
**PARTICIPANTS:** Managerial Staff in 3 Tier System  
**TOPIC:** Management of the Primary Health Care System  
(including such subjects as supply management  
and channels of communication)

<b>PARTICIPANTS:</b>	Hospital Administrators	10
	Executive Officers	18
	Public Health Inspectors	20
	District Midwives	260
	Public Health Nurses	150
	District Medical Officers	<u>65</u>
		523

**COST:** 523 Persons  
x11(7.50 Coffee Break, 3.50 Supplies)  
5753

Travel absorbed by County Councils

**REQUESTED:** \$5,753 (JAMAICAN DOLLARS)  
\$3,452 (US DOLLARS)

**TYPE:** Training of Trainers  
**DURATION:** 5-Days  
**LOCALE:** Central, Non Residential  
**PARTICIPANTS:** Trainers of Management Seminars  
**TOPIC:** Planning and Implementation of Training Seminars

**PARTICIPANTS:** Parish Training Coordinator 13  
 County Health Officers 4  
 Parish Faculty 26  
 43

**COST:** 43 Persons \*  
x39 (30 Travel, 7.50 Coffee Break, 1.50 Supplies)  
 1677

**REQUESTED:** \$1,677 (JAMAICAN DOLLARS)  
 \$1,006 (US DOLLARS)

\* Average miles traveled = 60  
 Cost per mile = 25¢  
 Round trip 120x.25 = 30.00

**MANUALS**

	<u>No. Copies</u>	<u>Jamaican Dollars</u>	<u>US. DOLLARS</u>
Type II and III	1000	10,000	
C.H.A. Inservice	2000	20,000	
Reference	50	<u>500</u>	
		30,500	<u>18,300</u>
Type 1	1000	7,000 already at printers-	paid

CORNWALL COUNTY, JAMAICA, IN-SERVICE TRAINING  
(AID/SA - C1233 - Jamaica)

Parish	Dates	No. 2-Day Sessions	Personnel Attending											Total
			PHN	PHI	SN	AN	DM	Asst. Nutr.	Asst. Dent.	H.Ed.	CHA	Clerk	Orderly	
St. James	Apr - Jun 1978	4	8	15	3	2	16	-	-	-	47	-	-	91
Trelawny	Aug - Sept 1978	7	5	13	6	1	21	1	3	-	62	1	-	113
Hanover	Aug - Oct 1978	7	4	19	4	2	10	1	2	-	130	1	-	173
St. Elizabeth	Aug 1978	3	4	8	1	-	19	1	1	5	62	-	9	110
Westmoreland	Jul - Aug 1978	8	17	29	7	-	20	1	-	8	100	5	13	200
<b>TOTAL</b>		<b>29</b>	<b>38</b>	<b>84</b>	<b>21</b>	<b>5</b>	<b>86</b>	<b>4</b>	<b>6</b>	<b>13</b>	<b>401</b>	<b>7</b>	<b>22</b>	<b>687</b>

The subject area covered related to primary health care in Type I Centers:  
 Interpersonal Relationships  
 Communication  
 Interviewing and Counselling  
 Management: Planning, Organizing, Supervision  
 Clinical Management of Urgent Situation

Appendix 6

PRIMARY HEALTH CARE INSERVICE TRAINING

FOR

TYPE I CENTRES - CORNWALL COUNTY

WILLIE HAY CLAY,  
DEPUTY LEADER FOR CLINICAL TRAINING

OCTOBER 5, 1978

BEST AVAILABLE DOCUMENT

## EXPLANATION OF FORMS

- FORM I**            The basic ideas to be presented were formed after considering the basic concepts that staff would need to understand in order to perform their tasks effectively in a Type I Centre.
- The objectives were then formulated based on the expected behaviour of staff members in relation to the health services being provided to the community.
- FORM II**            The format for the 2 day workshop evolved from the basic ideas to be presented and the objectives.
- The content areas that are marked major emphasis provide specific information to be included by the Instructor. This ensure uniformity in content in all parish training workshops.
- FORM III**            Pretest is given at the beginning of the workshop - to be completed by all participants in order to identify the areas that require extra input.
- It is recommended that the pretest be repeated at the end of the presentations. This information will give an indication as to whether or not the material presented was understood by the participants.
- FORM IV (a)**        EVALUATIONS
- It is important to give out evaluation form early on the first day with an explanation of -
- (a) how to use the evaluation forms
- (b) the importance of answering all questions
- Participants are to fill in the first three items on the Evaluation forms at the end of the first day. Items 4, 5 and 6 are to be completed before the end of the second day. The evaluation results are to be tallied before the conclusion of the workshop in order to give feedback to the participants.
- FORM IV (b)**        At the completion of the workshop, the participants are asked to evaluate the materials presented in relation to the stated objectives. It is recommended that the findings of the evaluations be given to the participants before they leave.
- FORM V (a)**        A list of situations was developed to illustrate points being made for the Instructor.
- FORM V (b)**        This form is used with form V (a) and supplies the answer to the situations.

FORM 1

TRAINING PROGRAMME - PRIMARY HEALTH CARE

A. Basic Ideas to be Presented

1. Leadership is interchangeable - passes from one to another.
2. Roles of health team members are being expanded which necessitate additional training.
3. In order to understand others, we must understand our own behaviour.
4. Delivering a message effectively involves more than just words.
5. To ensure the delivery of health service that meets the needs of the community, proper organization of the clinic staff, equipment and records is necessary, i.e. scheduling for complete coverage of clinic ( 8:30 a.m. - 5:00 p.m.), uniform recording system, appointments full utilization of existing staff.

B. Objectives

Health team members will be helped to:-

1. make appropriate decisions in delivering primary health care;
2. delegate work assignments when acting as team leader;
3. co-operate with all team members and provide assistance to others as needed;
4. accept their changing role and assume responsibility for new tasks;
5. recognize their own particular assets as well as their limitations;
6. recognize that there are individual differences and deal with them effectively;
7. prepare and present health information which will be easily understood by the Community;
8. produce visual aids to facilitate them in health teaching;
9. prepare a roster of work assignments, schedule patients for clinic, record and report accurately;
10. demonstrate skill in gathering information and providing advisory and referral services when working with community members.

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PROTOCOL FOR PRIMARY HEALTH CARE

TWO-DAY WORKSHOP

**GOAL:** To maintain uniformity in the presentation of all Primary Health Inservice Workshops in the County of Cornwall.

**OBJECTIVE:** To develop the method of presentation and content for the In-service Workshop around the basic ideas and objectives.

FORMAT FOR TWO-DAY WORKSHOP

8:30 a.m.	Attendance General Information	Check off list A.M. Purpose of the Workshop Orientation to the day's schedule
8:40 a.m.	Rationale for Inservice Training and Evaluation  Distribute Evaluations  Pretest - Form III	Printed handout and/or 10 minutes presentation  Clarify - demonstrate method for completing the forms if necessary. Illicit question.  Ask group to complete in 15 minutes
9:15 a.m.	Interpersonal Relation- ships	Content to be based upon and develop around idea No. 3, Objective No. 5, No. 6 - Form I

**MAJOR EMPHASIS** - *Personalities/behaviour that promotes/inhibits good inter-  
personal relationship in primary health care setting.*

10:15 a.m.      B            R            E            A            K

10:30 a.m.	Communication	Content to be based upon ideas No. 1, No. 4, and developed around Objectives No. 3, No. 10 - Form I
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**MAJOR EMPHASIS** - *Expectations, responsibilities from each team member, specifi-  
cally Type I Centres*

12:00 noon      L            U            N            C            H

1:00 p.m.	Attendance	Check off list P.M.
-----------	------------	---------------------

1:10 p.m.	Interviewing and Counselling	Discussion and Role Play
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2:00 p.m.	Health Team Relationships	Content to be based upon ideas No. 2, 3, and 4 developed around Objectives No. 7 and 10
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**MAJOR EMPHASIS** - *Interactions among Type I staff, other staff members and  
Community*

**SITUATION ROLE PLAY** - Role play to relate specifically to aspects of health  
team functioning in Public Health Centre setting/community  
Time for presentation of Content not to exceed the time  
for role play and demonstrations since background has been

laid by previous lectures.

The role play situation should be carefully written beforehand.

3:00 p.m.	B	R	E	A	K
3:10 p.m.	Continuation of Role Play Group Feedback				
3:45 p.m.	Review	A participant reviews the basic ideas and objectives and from his/her notes, highlights the material that covers the ideas and objectives respectively.			
4:10 p.m.	Form IV - Evaluation	Each participant will fill out a Form. This will be an individual effort.			

2ND DAY PRIMARY HEALTH CARE - TYPE I CENTRE WORKSHOP

8:30 a.m.	Attendance	Check off list - A.M.
8:40 a.m.	General Information	Orientation to the day's schedule
9:00 a.m.	Management Skills	Content to be based upon ideas No. 2 and No. 5 and developed around Objectives Nos. 1, 2, 3, 10

MAJOR EMPHASIS - Type I Centre (Type I Organizational Procedure)

10:15 a.m.	B	R	E	A	K
10:30 a.m.	Organization (contd.)				
11:30 a.m.	Expectations of team leaders as they relate to Organization				
12:00 noon	L	U	N	C	H
1:00 p.m.	Attendance	Relate specifically to Organization of services in Type I Centre in role play.			
1:10 p.m.	Planning	Check off list - P.M.			
		Content to be based on idea No. 5 and developed around Objectives Nos. 1, 2, 3, 7, 8, 9, 10.			

MAJOR EMPHASIS - Improved performance of the health team

2:00 p.m.	Technique and Procedure of Referral System	Content to be based upon ideas Nos. 1, 2, 3, 4, 5, 6, 9, 10.
-----------	--	--

MAJOR EMPHASIS - Efficacy of services for the Community served

3:00 p.m.	B	R	E	A	K
3:10 p.m.	Reinforcement of points previously raised				
3:45 p.m.	Review	Panel Discussion/Role Play/Questions and Answers			
		A participant will review the basic ideas and objectives involved and from his/her notes, highlight the material that covers the idea and objectives respectively.			

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Questionnaire - Primary Health Care Type 1 Center

What is your definition of primary health care?

What health workers make up primary health care team at Type 1, 11, & 111.

Who are the (non-health) members of the community that are associated with the health team?

Write the location of each type 1 health centre in your parish along with the Type 11 & Type 111 center that will be used as a back up.

Type 1

Type 11

Type 111

Who are the health workers that will be stationed in a Type 1 center?

At what hour will the center open? \_\_\_\_\_

At what hour will the center close? \_\_\_\_\_

How many people will the Type 1 Center provide health services for?  
10,000 4,000 or 8,000

Who are the health workers that will be making regular scheduled visits to the Type 1 center?

What health services will be provided from the Type 1 centers?

Develop a list of special problems and state at least one of the following:  
Where would you refer a person who has a problem that cannot be managed by a Type 1 health center?

4:10 p.m. Evaluation

This will include evaluation of total presentations in respect of attainment of objective as well as Form IV used on first day.

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FORM III

Questionnaire - Primary Health Care  
Type I Centre

- (1) What is your definition of Primary Health Care?
- (2) What health workers make up Primary Health Care team?  

Type I	Type II	Type III
--------	---------	----------
- (3) Who are the (non-health) members of the community that are associated with the health team?
- (4) Write the location of each Type I Health Centre in your area along with the Type II and Type III Centres that will be used as a back up.  

Type I	Type II	Type III
--------	---------	----------
- (5) Who are the health workers that will be stationed in a Type I Centre?
- (6) At what hour will the Centre open?
- (7) At what time will the Centre close?
- (8) How many people will the Type I Centre provide health services for?  
(Tick one)  

<u>10,000</u>	<u>4,000</u>	<u>8,000</u>
---------------	--------------	--------------
- (9) Who are the health workers that will be making regular scheduled visits to the Type I Centre?
- (10) What health services will be provided from the Type I Centre?
- (11) Where would you refer the person who has a problem that cannot be managed by a Type I Health Centre?
- (12) A mother brings her 8 months old baby to you. You find he has a fever of 100. His tongue is red and dry. Mother states the baby had at least 5 liquid stools each day for 3 days. What do you do?

INSERVICE TRAINING PROGRAMME

PRIMARY HEALTH CARE

M. F. Berry  
Ag. County Health Ed.

PARTICIPANTS - TYPE I HEALTH CENTRE TEAM

DAY I

TIME	SUBJECT	OBJECTIVES (SPECIFIC)	METHODOLOGY	MATERIALS
a.m.	Personality Development and Interpersonal Relationship  Communication	Participants will understand: <ul style="list-style-type: none"> <li>▪ How personality is developed</li> <li>▪ How personality affects behaviour</li> <li>▪ How personality can be changed and ways of doing this</li> <li>▪ That each individual is unique and should be treated as such</li> <li>▪ How to develop and practice the basic principles of dealing with patients and co-workers</li> <li>▪ How to avoid and resolve conflicts</li> </ul> That participants will: <ul style="list-style-type: none"> <li>▪ Understand the importance of and the use of visual aids on teaching</li> <li>▪ Know that non-verbal communication is very important in the communication process</li> <li>▪ Know that people tend to be more receptive to instructions if they are given the opportunity to make their own decisions</li> <li>▪ Know that attitudes are important in the communication process</li> <li>▪ Know that listening is vital in communication.</li> </ul>	Lecture/Discussion Class exercise Note taking  Discussion  Class exercise Note taking	<ul style="list-style-type: none"> <li>. Chalk board</li> <li>. Notes taken by participants</li> <li>. Questionnaire - See App. I</li> <li> </li> <li>Flip Chart</li> <li>Chalk board</li> <li>Questionnaire (See App. II)</li> </ul>
p.m.	Interviewing and Counselling	Participants will: <ul style="list-style-type: none"> <li>▪ know the importance of establishing rapport and endeavour to do this as</li> </ul>	Lecture/Discussion Note taking	<ul style="list-style-type: none"> <li>. Chalk board</li> <li>. Flip chart</li> <li>. Notes taken by participants</li> </ul>

E	SUBJECT	OBJECTIVES	METHODOLOGY	MATERIALS
	<p>Interpersonal Relationships</p> <p>1. Meeting demands of the status conscious community members</p> <p>2. Communication breakdown between staff members</p>	<p>this as a pre-requisite to interviewing and counselling and dealing with people in general.</p> <ul style="list-style-type: none"> <li>* know the importance of being sensitive and develop the skill of listening with empathy</li> <li>* understand the importance of confidentiality and become confidential.</li> </ul> <p>That participants will:</p> <ul style="list-style-type: none"> <li>* recognize situations that can be encountered in the work situation</li> <li>* know how to deal with these situations effectively.</li> </ul>	<p>Role Play</p> <p>Participants are given roles in various clinic situations which are acted by them.</p> <p>On completion of each scene group discussion follows. Participants discuss the important points - positive or negative and suggest ways of dealing with these situations in keeping with their learning experiences during the previous sessions</p>	<p>Written Role Play situations</p>
	<p>Co-operation among team members</p>	<p>That participants:</p> <ul style="list-style-type: none"> <li>* will understand that co-operation by each member is necessary for groups to work effectively.</li> </ul>	<ol style="list-style-type: none"> <li>1. Participants are put in groups of four and asked to fit bits of four squares together, without speaking.</li> <li>2. At the completion of the exercise, the instructor will draw from the group the positive and negative</li> </ol>	<p>Sets of 4 squares made of card board cut in three pieces, each of various sizes.</p> <p>Increase sets of 4 in keeping with the number of participants.</p>

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TIME	SUBJECT	OBJECTIVES	METHODOLOGY	MATERIALS
			attitude and behaviour that helped or hindered the completion of the task.	

**Note:**

Notes made by participants - no funds available to supply typed materials.

Role Plays are designed (a) To assess level of learning in areas discussed

(b) To highlight and emphasize important points.

A questionnaire on Interpersonal Relationship is done after the second session on Communication and immediately before the Lunch Break.

These questionnaires on Interpersonal Relationship are checked and returned to participants at the end of the day's sessions and if necessary group and or personal decisions are held based on the responses.

In conducting the sessions, all subjects are related specifically to the Type I Health Centre - its staff, services and outreach.

Group participation is an integral part of the Methodology.

INTERPERSONAL RELATIONSHIPS

APPENDIX I

1. Would you agree or disagree with the statement that your co-workers need to improve in the way they behave to others?

Agree

Disagree

(b) If you agree, please state in what ways you think your co-workers can improve in their behaviour.

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2. Do you think the way you behave to others should be improved?

(a) Yes

No

(b) If so, in what ways?

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3. Are you willing to make the effort to improve relationships in your working environment?

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4. What do you consider the first step in improving interpersonal relationships?

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5. List (6) things that are important in getting along with people.

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6. Are the following statements True or False?

(a) We would behave like the other person if we had his or her experiences

True

False

(b) People should be put in categories and treated likewise

True

False

(c) People should be seen for what they can become, not for what they are

True

False

(d) Every person is an individual and should be treated as such

True

False

(e) Praise should be given freely

True

False

(f) People should be openly criticized for their mistakes.

True

False

NAME:

ADDRESS:

HOW TO FOLLOW INSTRUCTIONS

1. Read everything before doing anything, but work as rapidly as you can.
2. Put your name in the upper right-hand corner of this paper, last name first.
3. Circle the word name in Sentence 2.
4. Underline the words - upper right hand in Sentence 2.
5. Draw a circle around the Title of this page.
6. Sign your name under the Title.
7. In Sentence 4, draw a circle around the word "Underline".
8. Write the name of your Capital city.
9. Underline all of Sentence 7.
10. Draw an X in the lower left hand of this page.
11. Draw a circle around the "X" you have just made.
12. Write the name of the Capital of Jamaica.
13. Draw a circle around the words "Capital City" in Sentence 8.
14. Speak out loud your first name when you get to this point.
15. If you think you have followed instructions to this point, call out "I Have".
16. Close your eyes and raise your left hand over your head.
17. Write the name of your Occupation.
18. Count out loud in your normal speaking voice backward from 10 to 1.
19. Now that you have read the instructions carefully, do only what Sentence 1 and Sentence 3 ask you to do.
20. Please do not give this test away by any comments or explanation. If you have read this far, pretend you are still writing. Let's see how many persons follow instructions carefully.

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INSERVICE EDUCATION TRAINING  
MANAGEMENT - TYPE I HEALTH CENTRE - PRIMARY HEALTH CARE

SUBJECT	CONTENT	OBJECTIVES	METHODOLOGY	OUTCOME
Management (with emphasis on the Type I Health Centre)	<p>Definition of Management Principles -</p> <p>Planning</p> <p>Organization</p> <p>Staffing</p> <p>Directing</p> <p>Evaluating</p> <p>Elements</p> <p>Definition of: Leadership Supervision</p> <p>Types of Leader Characteristics of Leader/Supervisor</p>	<p>To enable participants to:</p> <p>Understand and to define Management</p> <p>Utilize the principles in their day to day activities</p> <p>Facilitate and to improve the team approach to work</p> <p>To facilitate the improvement in the delivery of Primary Health Care</p> <p>Assume leadership roles as the agent of change in the organization</p> <p>Facilitate participation in the choice of leadership pattern</p> <p>Understand their own limitations.</p>	<p>1. Formal Lectures with Flash Cards</p> <p>2. Role Plays</p> <p>3. Group work</p> <p>4. Plenary Session</p> <p>5. Methods: 2, 3, 4, - were used to bring out more vividly-</p> <p>- The team approach to work</p> <p>- Delegation of duties</p> <p>- Supervision/Leadership</p>	<p>Participants will be prepared to:-</p> <p>- Plan daily activities in Type I Health Centres</p> <p>- Assume different roles without difficulty</p> <p>- Delegate duties effectively</p> <p>- Use the Referral system effectively</p> <p>- Work comfortably with other team members in the decision making process.</p> <p>- Provide leadership which is both effective and acceptable to team members</p> <p>- Collect and utilise statistics in planning programme.</p>

SUBJECT	CONTENT	OBJECTIVES	METHODOLOGY	OUTCOME
				<ul style="list-style-type: none"> <li>- Stimulate community participation in the delivery of Health Care</li> <li>- Evaluate their performance and use their information to improve services for the Community.</li> </ul>

Form (V (a))

SITUATIONS YOU MAY ENCOUNTER AT TYPE I HEALTH CENTRE

Please give brief answers to the Questions following each situation.

- (a) A man has fallen down a hill and injured his arm. You unwrap the dirty towel that is covering the arm and find a large area of skin has been scraped off. The area is covered with dirt and sand. There is moderate bleeding. The arm is not broken. What do you do?
- (b) The nearby gardener has sustained a large, deep cut on his hand from a saw. There is heavy bleeding. What do you do?
- (c) There has been a car wreck with several people injured and they are brought to your Centre. One man complains that he cannot get his breath and he is bleeding from his mouth. What position can you put him to help both these problems immediately?
- (d) The second man has a broken arm but he is walking around and says he is O.K. What do you do for him?
- (e) A mother brings her 8 month old baby to you. You find he has a fever of 103. His tongue is red and dry. Mother states the baby had at least (5) liquid stools each day for 3 days. What do you do?
- (f) A 3 year old has ingested paint thinner that was left in a soda bottle. What do you do?
- (g) A young mother finds her 2 year old with the open aspirin bottle. There is evidence of chewed aspirin in the baby's mouth. What do you do when the child is brought to you?
- (h) A young boy is burned with a kerosene lamp. When he reaches you there are many blisters on the back of his hands extending up his arms. What do you do?
- (i) A young woman 6 months pregnant comes to you complaining of feeling sick. You learn she has been feeling dizzy with headaches for 2 days. During your examination you notice her feet are swollen, her blood pressure is 200/110 and she has gained 8 lbs. since she visited 2 weeks ago. What do you do?
- (j) A teenager stops in on her way from school because she has a nose bleed. You notice blood oozing from both nostrils. What do you do?
- (k) A 5 year old falls down while running with a bottle and gets a cut on his arm. What do you do?
- (l) A man is brought to you by a neighbour who states the man who shot in the chest. He is breathing, but you notice the sound of air coming from the wound. What do you do?

**MISSING PAGE**  
**NO.** 14-16

This sheet should be used with the situations listed on Form 5A.

URGENT SITUATIONS

How do you manage these problems? Would you -

- (a) manage the problem in your Type I Centre
- (b) refer to a Type II, III, IV Health Centre or hospital?

The following actions may be taken by Type I Health Staff to manage the stated situations. Actions are listed in order of priority (what is done first).

- (a) stop the bleeding (direct pressure)  
elevate the arm  
cleanse wound (observe for extent of injury)  
dressing (sterile)  
tetanus immunization (full series if necessary)
- (b) stop bleeding (direct pressure)  
cleanse wound (observe for extent of injury)  
dressing (sterile)  
or refer for suturing (Type II Centre or hospital)  
tetanus immunization
- (c) lie client on his side with head and chest raised  
immediate transport to hospital
- (d) splint arm  
check vital signs/observe for any other injuries  
refer to hospital or Type III/Type IV for casting
- (e) immediate referral to hospital or Type IV (life threatening situation)  
tepid sponge during transfer
- (f) hospital or Type III or Type IV referral (do not induce vomiting)
- (g) give milk (one-half glass, if available)  
observe the child for two to three hours  
advise parent to observe for signs of lethargy
- (h) cleanse burns (do not open blisters)  
sterile ointment/dressing  
tetanus prophylaxis  
have an M.D. check the wound as soon as possible
- (i) immediate referral to hospital (possible eclampsia)
- (j) instruct the teenager to breathe through her mouth  
and gently but firmly pinch both nostrils (10-15 minutes)  
release-observe  
if bleeding continues, repeat nostril pressure
- (k) cleanse wound  
look for glass particles  
apply pressure to stop bleeding  
tetanus immunization
- (l) cover the wound (do not stop air hole)  
immediate transport to hospital

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**MISSING PAGE**  
**NO.** 18 - 21



Type Health Centre and Population to be served	Staff	Services	Relationship between Primary and Secondary Services in the County
	P.H.I. Staff Nurse School Dental Nurse Driver & Orderlies	<ol style="list-style-type: none"> <li>2. Weekly M.C.H. Clinics</li> <li>3. Environmental Health Services</li> <li>4. Dental Services</li> <li>5. School Health Services</li> <li>6. Food Handlers Clinics</li> <li>7. Insertion of I.U.D.'s</li> <li>8. Supervision of Type I Health Centre by P.H.I. &amp; P.H.N.</li> <li>9. Operation of Drug Window</li> <li>10. Treatment and follow-up of referrals from Types I &amp; III/Hospital.</li> </ol>	
Type I 4,000	District Midwife Community Health Aide Cleaner/Attendant	<ol style="list-style-type: none"> <li>1. Weekly M.C.H. clinics, e.g. Prenatal and Postnatal and Child Health Clinics</li> <li>2. Immunizations - weekly</li> <li>3. Nutrition Demonstrations and Distribution of Food supplements</li> <li>4. First Aid and Daily dressings</li> <li>5. Home visiting by D.M. and C.H.A.</li> <li>6. Home deliveries by D.M.</li> <li>7. Health Education and Information</li> <li>8. Mothercraft and other related Community activities</li> <li>9. Health Committee Meetings</li> <li>10. Follow-up of Referrals and other Health Centres/Hospitals</li> <li>11. Family Planning daily.</li> </ol>	<b>KEY:</b> C.C.H.A. - Cornwall County Health Administration ----- Referral in emergencies from Health Centres to Hospital on discharge from hospital to H/C.

Form (IV (a))

EVALUATION OF INSERVICE WORKSHOP PRIMARY HEALTH CARE

Position.....

Parish.....

Date.....

Please rate each session on a Scale of 1-5 by circling a number. 1 is the lowest rating, 5 the highest.

	Presentation & Delivery					Clarity					Usefulness					Participation				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
1. Inter-personal Relationships																				
2. Communications																				
3. Interviewing and Counselling																				
4. Organization Type I Centre																				
5. Planning - Improved performance of health team																				
6. Supervision																				

Objective:

In your opinion, to what extent were the Seminar Objective met? Health team members will be helped to.

	<u>Not At All</u>	<u>To Some Extent</u>	<u>Completely</u>
1. Make appropriate decision in delivering primary health care;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. delegate work assignments when acting as team leaders;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. co-operate with all team members and provide assistance to others as needed;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Accept their changing roles and assume responsibility for new tasks;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. recognise their own particular assets as well as their limitations;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. recognise that there are individual differences and deal with them effectively;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. prepare and present health information which will be easily understood by the community;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. provide visual aids to facilitate them in health teaching;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. prepare a roster of work assignment, schedule patients for clinic and record and report accurately;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. acquire skill in gathering information and providing advisory and referral services when working with community members;	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23 September 1978

**Trip Report  
on  
Consultation Visit to the  
Jamaica "Health Improvement for Young Children" Project**

by

Dennis G. Carlson, Dept. of International Health,  
School of Hygiene and Public Health, Johns Hopkins University

September 13-23, 1978

**I. Objectives: The objectives set prior to the visit were stated as follows:**

1. To review the skeletal outline for the national level in-service training for primary health care workers in the management of Type I Health Centers possibly covering 1-2 years.
2. To consult on the implementation of the training for trainers workshop.
3. To review the outline of the regional level training program for primary health care workers in the team approach to management in Type I Health Centers.
4. To evaluate the training programs which have been conducted in St. James and Westmoreland.
5. To consult on the final evaluation of training programs.
6. To consult with Mark Gross and Willie Mae Clay on a realistic time-table for their activities from now till the end of their contracts.

Upon arrival, these objectives were discussed with Dr. A.W. Patterson and Mr. Mark Gross and agreed that top priority would be given to items 1, 2, and 3. The remainder were to be pursued to the maximum extent possible.

**II. Itinerary**

Wednesday	Sept. 13	Travel from Baltimore via Miami to Kingston
Thursday	Sept. 14	Orientation at the National Ministry of Health and Environmental Control (MOHEC), and USAID Mission
Friday	Sept. 15	Meetings at Ministry of Health and University of West Indies
Sat.-Sun.	Sept. 16,17	General orientation to Kingston area and eastern portion of Jamaica
Monday	Sept. 18	Travel from Kingston to Montego Bay; Orientation to Cornwall County Ministry of Health
Tuesday	Sept. 19	Attendance at Rio Bueno Health Fair and visits to new Type III Health Center in Falmouth and Type I Health Center in Rio Bueno

Wednesday	Sept. 20	Participation in Cornwall County Health Department Inservice Training Committee; visit to Union Street Health Center and home visiting with Community Health Aides; visit to patient in Montego Bay Regional Hospital
Thursday	Sept. 21	Travel Montego Bay to Kingston; participation in Jamaican Population Project II administrative meeting and luncheon; discussions with Mrs. Haycynth Stewart-Bulgin and Training Branch Staff; meeting with Dr. A.W. Patterson
Friday	Sept. 22	Discussions with USAID officials; debriefing conference at MOHEC
Saturday	Sept. 23	Discussion with Mr. Mark Gross; return from Kingston via Miami to Baltimore

### III. Observations and Comments.

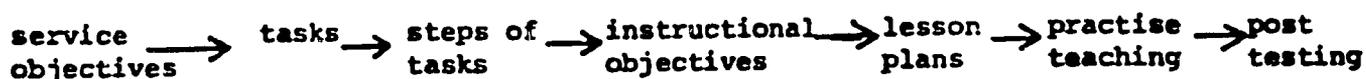
1. The ministry of Health and Environmental Control (MOHEC) is making significant progress in the implementation of its primary care program despite major constraints in finances and human resources. An extraordinary high degree of commitment to community health care and disciplined professional competence of staff members was clearly evident. A procedure manual for Type I Health Centres has been published. An extensive Maternal and Child Health manual is in editing process. Such activities in making procedures explicit will make it possible to develop instruction and supervision much more effectively.
2. The building programs of new health centers under the IMF loan is near completion. The two centers I visited showed excellent construction and appropriately modest design. A shift of emphasis towards more Type I Centers and less numbers of the more complex Type III and IV seems wise from several perspectives.
3. The In-Service Training program in two-day primary care workshops for more than 600 primary care personnel in Cornwall County demonstrates outstanding teamwork by County and Parish Staff members. A very practical curriculum has been developed which focuses mainly on solving primary clinical care problems. The emergence of teams of informal training officers in each parish complemented by county staff appears to be one excellent pattern of growth of a vigorous practical continuing education program. The combination of Public Health Nurses and Public Health Inspectors, with Health Educators when available, makes for an excellent balance of personal, community, and environmental health care. The Inservice Training Committee is focusing immediate attention on first aid learning and audio-visual teaching methods and materials. Next year's program will include topics of recording and reporting, family planning techniques, and working with health committees.

4. The present concurrent development of ongoing planning with service implementation in the Primary Care program is clearly the most effective strategy. Likewise, the interaction between national and county activities (as demonstrated between Cornwall County and Central headquarter exchange) seems likely to provide the most realistic and efficient use of limited resources. Lessons learned at county and parish levels can be incorporated into national planning and the phased implementation in other regions of the Island.
5. Plans are currently being developed for a "Familiarization Workshop" for 25 to 30 primary care staff members from all regions to be held in Montego Bay in late October and the first national Training of Trainers workshop tentatively set for November will mark a new phase of primary care implementation. The multi-disciplinary nature of primary care is illustrated in the composition of the Steering Committee under the leadership of the Training Branch of the Ministry as well as the multiprofessional character of the participants who will attend these workshops. The "skeletal outline for inservice training" provides a useful first step for the general topics which should be included. The development of more specific service objectives as derived from the procedure manuals will provide more detailed instructional objectives.

#### IV. Recommendations

1. Pilot Area Establishment. There would be many advantages to the proposed plan to specify and establish more specified "pilot area" facilities and community activities, such as in Santa Cruz where the objectives of the primary care program were carried out as thoroughly as possible. In order to make the new and modified practices as reproducible as possible in other communities it would obviously be necessary to use only the minimal available resources. Such "Pilot Areas" would provide an invaluable laboratory for planning and training purposes. Presumably they should be located in various types of health centers in each of the counties or regions.
2. Analysis of Services and Activities. Great benefits would result from a systematic analysis of the services and tasks which are going to be performed as described in the Manuals for Health Centers. These tasks could be much more efficiently standardized, taught, and supervised if the parts or components were described in detail. This is a slow and painstaking process, but the results are highly beneficial and allow significantly more delegation of functions, wider spread of knowledge via the printed page, and the growth of more uniform practise. This work needs to have participants with sufficient and recent service experience and a setting to test out the accuracy and validity of the written descriptions. This could lead to the identification of certain core tasks or functions which are to be performed by several types of workers.

3. Development of Instructional Objectives. The In-Service Training program in Cornwall County has made an excellent start in training in new procedures and problem-solving in clinical, community, and management situations. However, a great deal of elaboration is necessary to translate and transform the service goals and objectives into instructional or educational objectives which can be taught and supervised on a continuing basis. It would seem profitable to stage an intensive workshop for 8 to 10 days where the entire sequence of moving from service goals and objectives thru descriptions and analyses of the steps to be taken in these tasks, to the development of instructional objectives and, finally, to actual practise teaching of these materials, including evaluation by post-testing.



Perhaps a core group of 12-15 persons could be gathered and trained who would then use the same process in their work at the national, county, and parish levels.

Participants in such an intensive workshop might include some from central ministry, county, and parish personnel. Perhaps selected faculty from the University of West Indies and Johns Hopkins University could also be members of this workshop.

4. Mid-Level Staff Development Strategy. Given the realization of necessity to work primarily with present staff, positions, and money, it would seem particularly strategic to develop an explicit long range staff development program which included training both in Jamaica and in other countries. Some courses like the Comprehensive Health Planners Course given at Hopkins for two months each spring can be taken without or with academic credit towards a masters degree. Some universities give standard programs every year; so fairly long range planning could be done. Such specific individual career development plans may have a very positive effect on morale of the highly valuable middle echelon of personnel. The critical problem, of course, is finding the least damaging time for the person to be away.
5. Delegations of Tasks and Functions. As most practitioners and administrators recognize, the overwhelming health and disease burden of the public should result in the highest possible amount of delegation of responsibility and authority to lesser trained persons. The value of services rendered by less well-trained persons almost always outweighs the occasional dangerous situation. In particular the Community Health Aides should be encouraged to use simple technology like temperature taking and blood pressure reading. As mid-level professionals feel more secure in their own growth, it should be less of a problem to implement major delegation of tasks and functions to the less trained and far more numerous district midwives and community health aides.

6. Relationship to the University of the West Indies. A remarkably close and effective working relationship exists between the Ministry of Health and Environmental Control and the University of the West Indies, and particularly, the Dept. of Social and Preventive Medicine. Since the process of improving primary care is general and child and maternal health is particular, it is a difficult, slow, and long range effort, it would seem highly desirable if the Department of International Health of Johns Hopkins University could communicate and relate more closely with the University of the West Indies as it tries to provide consultant services to the Ministry of Health. This kind of collaborative style would have a good chance to enhance human resources more effectively in the long time perspective, as well as the short term. For example, if it is decided to have an intensive workshop on the methodologies of translating service objectives into instructional objectives, it would be highly desirable to have members of the University participating in the process.

#### V. Acknowledgements

This consultation was made enjoyable, interesting, and hopefully, useful by the thoughtful planning of many people in Kingston and Montego Bay. I was deeply impressed by the gentle, joyful, and very serious way that almost everyone performed their functions. Much appreciation is felt for the insights, information, and guidance provided by Dr. A.W. Patterson. Useful conversations of varying lengths were held with Dr. C. Moody, Mrs. Hunter-Scott, Mrs. McFarquhar, Nurse Pitter, Mrs. D. Goldson, Mrs. Hyacinth Stewart-Bulgin, Mrs. Nelli Allison, Nurse Olive Ennever, Dr. Carlos Mulrain, Dr. Esmond Garrett, Miss Ruth Hall, Mr. Ralph, Dr. Barry Wint, Mr. M. Berry, Mrs. King, Miss Marie Mathews, Dr. D. Ashley, Mrs. Kinsington, Mrs. Chanvans, Dr. Babs Sagoe. Unfortunately, Dr. A. D'Souza was out of the country, and I could not meet him. The USAID meetings with Dr. Linda Haverberg, Mrs. Gary Cook, Miss Edna Tullock, and Mr. Donor Lion were also informative and appreciated.

My host and hostesses during the visit were Mark and Gay Gross in Kingston, and Willie Mae and Tamie Clay in Montego Bay. They were very kind, helpful, and generous with their time and energy in spite of extremely busy schedules. From the viewpoint of a brief visit, it seems that they are doing excellent work as team members in a very significant and challenging health service effort.

JHU-UWI EVALUATION STUDIES FOR 1979 - 1980

UNDER CONTRACT

AID/SA-C1233-JAMAICA

Evaluation Project # 1: *Knowledge, Attitudes and Practice Study*

Evaluation Project # 2: *Time and Motion Study*

Evaluation Project # 3: *Service Delivery Efficiency in the Pilot areas*

**EVALUATION PROJECT # 1: Knowledge, Attitudes and Practice Study (KAP)**

**Purpose:**

- A. Assess benefits of the in-service training programs conducted in Cornwall County, April - August 1978,
- B. Identify needs for further in-service training for primary care staff in Type I health centers.

**Personnel:**

JHU (KAP) Study Director: Dory Storms.

UWI Counterpart Director to be designated by Dr. Standard.

Personnel from Cornwall County Regional Health Administration (persons that have been suggested are: Dr. Barry Wint, Mrs. MacFarquar, and a counterpart for Willie Mae Clay from the In-Service Training Committee.)

**Statement of Tasks and Estimate of Execution:**

February 18-24, 1979

Development of the study design and questionnaire.

To take place in Jamaica. Storms to be in Jamaica approximately 1 week.

March 1979

Selection and training of the field supervisors and interviewers. Field testing of the questionnaire.

[Suggest these activities be carried out by UWI personnel.]

April 1979

Gathering and editing of the data in the field.

[Suggest UWI supervise field work.]

Statement of Tasks and Estimate of Execution Cont'd.

May 1979

Coding, keypunching, and data production. Data analysis and interpretation. Preparation of working paper.

[Suggest these activities be carried out at JHU by Storms, UWI Study Counterpart Director and a representative from the Cornwall County Health Administration.]

June 1979

Workshop for presentation of KAP Study results and discussions of program implications.

[Suggest this activity be carried out by UWI personnel, but it be scheduled so that Parker or Carlson could attend while Parker is in Jamaica for TM Study, or Carlson for technical assistance.]

Summer 1979

Final report to Ministry of Health.

EVALUATION PROJECT # 2: *Time and Motion Study (TM)*

Purpose:

To observe the range of functions actually performed by Type I personnel and their supervisors.

Personnel:

Dr. Robert Parker, JHU Time and Motion Study Director

UWI Counterpart Study Director to be designated.

Personnel from Cornwall County Regional Health Administration. [It has been suggested that these persons be Dr. Barry Wint, Mrs. MacFarquar, and a counterpart for Willie Mae Clay from the Cornwall County Inservice Training Committee.]

Ms. Joyce Vincent, MOH Planning Unit (currently enrolled in JHU program in health planning.)

Statement of Tasks and Estimate Date of Execution:

March 25 -  
April 1, 1979

Development of study design and research instruments for the TM study. Parker and Vincent to be in Jamaica approximately 1 week.

[Suggest March 25-April 1 - Spring recess at JHU.]

May 1979

Selection and training of field observers.

June  
10-17, 1979

Gathering and editing of data in the field.

[Suggest field work be supervised by UWI personnel].

Dr. Parker would travel to Jamaica for the start of the study. [Depending on academic program, Vincent could possibly be in Jamaica by June.]

**Page 2 Evaluation Project # 2: Time and Motion Study (TM)**

**Statement of Tasks and Estimate Date of Execution Cont'd.**

**July 1979**

**Editing, analyzing and interpreting field data.  
Preparation of working paper.**

**[Suggest these activities be carried out at UWI  
with correspondence to Dr. Parker at JHU.]**

**September/  
October 1979**

**Workshop for presentation of TM study results  
and discussion of program implementation.**

**[Suggest this activity be carried out by UWI  
personnel. Date of workshop could overlap  
with visit of Tayback and Storms to Jamaica  
for purposes of SDE study].**

**October/  
November 1989**

**Final report to Ministry of Health.**

**EVALUATION PROJECT # 3: Service Delivery Efficiency in the Pilot Areas (SDE)**

**Purpose:**

Assess whether the system of care meets the criterion of efficiency, that is, are Type I activities carried out in Type I centers, Type II activities carried out in Type II centers, and Type III activities carried out in Type III centers?

**Personnel:**

Dr. Matthew Tayback, JHU Service Delivery Efficiency Study Director. Dory Storms also to participate.

UWI Counterpart Study Director to be designated.

Ministry of Health personnel should be included since project is to extend island wide.

**Statement of Tasks and Estimated Date of Execution:**

September/  
October 1979

Selection of pilot areas, development of study design and protocol.

Activity to be carried out in Jamaica. Dr. Tayback would be required to be in Jamaica one week. Storms could accompany.

December 1979

Selection and training of the field supervisors and interviewers.

January 1980

Examination of services being rendered in Type I, Type II, Type III centers and hospitals. Services inconsistent with model as set forth by the Ministry of Health will undergo interview to determine the rationale for the observed behavior.

March 1980

Editing, analyzing, and interpreting field data. Preparation of working paper.

June 1980

Workshop for presentation of data and program implications.

Summer 1980

Final report.

TENTATIVE SCHEDULE FOR 1979 TRAVEL UNDER CONTRACT AID/SA-C1233-JAMAICA

<u>Time Period</u>	<u>Approximate Duration</u>	<u>Personnel</u>	<u>Location</u>	<u>Activity</u>
February 18-24, 1979	1 week	Storms	Jamaica	Develop KAP study design and questionnaire in conjunction with UWI Counterpart Director and representatives from Cornwall County Health Administration. (Dr. Wint, Mrs. MacFarquar, and a representative from the In-Service Training Committee).
March 4-10, 1979	1 week	Carlson	Jamaica	Technical assistance to Cornwall County Regional Health Administration and the Training Branch, MOH.
March 25 - April 1, 1979	1 week	Parker & Vincent	Jamaica	Develop study design and research instruments for the Time and Motion Study in conjunction with UWI Counterpart Study Director and personnel from the Cornwall County Regional Health Administration.
May 1979	1 week	UWI KAP Study Counter- part Director and one Cornwall representative	Suggest JHU	Analyze and interpret KAP field data, prepare working paper.
June 10-17, 1979	1 week	Parker	Jamaica	Initiate the gathering and editing of the data in the field for the Time and Motion Study.

Page 2 TENTATIVE SCHEDULE FOR 1979 TRAVEL ON CONTRACT AID/SA-C1233-JAMAICA

<u>Time Period</u>	<u>Approximate Duration</u>	<u>Personnel</u>	<u>Location</u>	<u>Activity</u>
June 3-9, 1979	1 week	Carlson	Jamaica	Technical assistance to Cornwall County Regional Health Administration and the Training Branch, MOH.
September/ October 1979	1 week	Tayback & Storms	Jamaica	Development of study design and protocol for study of Service Delivery Efficiency in Pilot Areas in collaboration with UWI Study Counterpart Director and MOH personnel.

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