

NATIONAL COUNCIL FOR
INTERNATIONAL HEALTH
2121 Virginia Ave. NW, Suite 303
Washington, DC 20037
(202) 298-5901

NCIH/CARICOM Health Manpower Project

TRIP REPORT

Traveler: F. Curtiss Swezy, Dr. PH, Health
Management Consultant

Dates: November 3, 1981 - November 26, 1981

Itinerary: November 3, 1981 : Chapel Hill, N.C. - Barbados
November 4-5, 1981 : Barbados (USAID/RDO)
November 6-11, 1981 : Guyana (CARICOM Secretariat)
November 12-14, 1981: St. Vincent
November 15-17, 1981: Antigua
November 18-19, 1981: Montserrat
November 20-25, 1981: St. Kitts (Permanent Secretaries'
Meeting)
November 26, 1981 : St. Kitts - Chapel Hill, N.C.

Purpose: To review Health Manpower Project with USAID Regional
Development Office Staff, CARICOM Secretariat and
Permanent Secretaries of LDCs (see Attachment 1).

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USAID/RDO, Barbados

The writer discussed the Project with public health and senior Mission Staff (see Attachment 2).

Mr. Mark Laskin, Regional Public Health Advisor, explained that there are four options for the Health Manpower Project:

1. NCIH can fulfill the requirements of the grant as originally designed.
2. NCIH can initiate placement of short-term health specialists immediately. This action to be followed by long-term commitment of personnel through (a) serial short-term assignments, (b) recruitment of volunteers for long-term assignments, and (c) recruitment of health personnel outside of the United States (including expatriate West Indians).
3. USAID/RDO and NCIH can identify an alternate organization and shift the grant funds to them.
4. USAID/RDO can deobligate the grant funds.

Mr. Laskin explained that his preference was for option No. 2 with emphasis on revising the budget. The total funds should be viewed as a "blank check" to be reallocated as appropriate.

Mr. Laskin expressed concern over the proportion of total Project funds presently allocated for NCIH use. As an example, he stated that other volunteer agencies conducting projects with USAID funds do not charge overhead to the project. Dr. Swezy replied that he was unaware that NCIH was expected to raise funds to support the Health Manpower Project.

Dr. Swezy also noted that he was unaware that non-U.S. personnel could be recruited under this project. Mr. Laskin provided a copy of the USAID procurement regulations stating that when U.S. sources are unavailable, others can be used (see Attachment 3).

Mr. Laskin noted that it was his understanding that NCIH is, in some way, philosophically opposed to long-term assignments of volunteers. Dr. Swezy stated that he was unaware of this constraint, but would check on it. Dr. Swezy explained that it was his understanding that the limitation was in the market place. The sources of high level physician specialists were (a) university faculty on some form of leave, and (b) specialists in a group practice. Both groups of physicians are normally constrained to short periods of time (up to 3 months) when they can volunteer their services. Dr. Swezy stated that he did not rule out longer assignments, but that he would be misleading USAID/RDO staff to give assurance of the availability of long-term volunteers on a routine basis.

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Mr. William Wheeler, USAID/RDO Director, noted that while the health needs are long-term that NCIH should be cautious not to build in dependency which might forestall the leadership of the West Indian nations from addressing their health manpower needs.

Mr. Laskin stated that the Project was due for evaluation in March, 1982. Dr. Swezy said that with Thanksgiving and Christmas approaching, it was unrealistic to believe that any volunteers would be placed in the Caribbean before January. By March there would be very little to evaluate. Conducting an evaluation in March would render the Project vulnerable to the criticism of wasting money when the evaluation obviously would not show much. Dr. Swezy suggested as an alternative that the Project be evaluated in August, 1982. At that time it could be decided to terminate the Project as it stood or grant a one-year extension with no additional funds.

University of West Indies, Faculty of Medicine, Barbados

While in Barbados, the writer and Mr. Laskin took the opportunity to visit the medical branch of U.W.I., Barbados. This school provides the second two years of clinical training for medical students. The first two years are completed at U.W.I., Jamaica.

Professor E.R. Waldron, Vice Dean for the Barbados branch, explained that the island LDCs of the Caribbean have special health manpower problems. There is a serious shortage of sub-specialty clinicians. Physicians that do practice in the islands suffer from professional isolation. They do not receive the stimulation that they would in a large urban center or at U.W.I., Barbados.

In response to a question from Dr. Swezy, Dr. Waldron stated that the U.W.I. faculty could provide a viable support system to the islands. In addition, he would welcome an institutional relationship with a U.S. medical school in performing the function of providing specialist services for the islands, particularly the LDCs.

Dr. Waldron explained that sub-specialty faculty could be freed to travel to the islands on a rotating basis. In the islands they could treat patients and be a resource to the local physicians. When a faculty member returned to Barbados, another could travel so that there would be continuity. Faculty from a U.S. medical school would be most welcome in this rotation. U.S. medical residents would also be acceptable if they would serve in the LDCs. If the U.S. faculty were willing to be preceptors for West Indian medical students, then some from Barbados could also be assigned to work in the islands. Besides providing immediate patient care, this might also encourage more West Indians to remain and practice in the LDCs upon completion of their studies.

Dr. Waldron had two cautions for U.S. faculty and medical residents coming to the Caribbean. First, they must be prepared to work in collegiality with West Indian physicians. U.S. faculty will have the latest technology, but West Indian doctors are experienced in working within the framework and limitations of the Caribbean; both should view the exchange as a learning experience. Second,

/ . . .

it will be acceptable to bring U.S. medical residents to the Caribbean for part of their training. But, if there are no plans to rotate West Indian medical students and residents to the U.S., do not call it an "exchange" program. Foreign sponsored programs have created antagonisms with such "exchange" programs in the past.

CARICOM Secretariat

The writer reviewed the Project with staff of the Health Section and Central Administration of CARICOM. A courtesy call was paid on Mr. Roderick Rainford, Deputy Secretary General.

A series of management procedures were addressed. A format was developed for the recruitment and mutual support of volunteers by NCIH, CARICOM and host countries (see Attachment 4). Respective responsibilities, and financial support of volunteers by the three parties, were specified.

A standardized Letter of Agreement between CARICOM and the participating volunteer was drafted. This was edited and approved by the CARICOM legal staff (see Attachment 5). This provides a legal basis for the volunteer working in the Caribbean. Individual nations will be responsible for licensure.

A form was drafted to be used by host countries in specifying the kind of health specialization required (see Attachment 6). The form is designed to provide an appropriate description of the expectations the host country has of the health professional. In addition, information will be elicited that will better prepare the volunteer to function within the context of the Caribbean health delivery system. Provision is made for describing constraints in existing equipment, supplies and staff.

The forms for evaluation at the end of the service, by both host country officials and volunteers, were revised (see Attachments 7 and 8). An attempt was made to make the evaluation forms congruent with the form requesting a health specialist volunteer.

Senior Health Officials, St. Vincent and the Grenadines

The writer met with senior officials in the Ministry of Health and Community Development. Details of the manpower project were discussed. Dr. Swezy stated that the Project would recruit volunteers and bring them to the Caribbean. A small honorarium would be paid by CARICOM to the health specialist as a show of respect. In turn, CARICOM will expect host nations to provide lodging and food. CARICOM is stressing the importance of the countries of the Caribbean sharing the services of the health specialists.

Mr. Owen Cuffy, Permanent Secretary for Health, stated that St. Vincent is most anxious to share the services of the medical specialists with other islands. The most pressing need in St. Vincent is for a psychiatrist. They are willing to share such a specialist with Saint Lucia.

Mr. Cuffy stated that due to the expense of bringing a health volunteer to the Caribbean, it might be appropriate to recommend a minimum length of service, perhaps three months. Dr. Swezy stated that this would be a good topic to discuss at the meeting of the Health Secretaries in St. Kitts.

Senior Health Officials, Antigua

The Project was also discussed with senior staff of the Ministry of Health in newly independent Antigua. Dr. Swezy explained that as a volunteer program, it is reasonable to expect assignments to be short-term, one to three months.

Dr. Cuthwin Lake, Acting Medical Superintendent, Holberton Hospital, stated that the health needs are long-term. At present, Antigua's most pressing problem is for an anesthetist.

Acting Permanent Secretary, Mrs. Audrey Henry, stated that a former resident of Antigua, now an anesthetist in Toronto, had indicated that he might be willing to return to Antigua to work during the winter months. Dr. Swezy stated that it was perfectly acceptable to have West Indians participate in the Project.

The Chief Medical Officer, Dr. A.I. Boyd, initiated a series of telephone calls with Dr. D. Jarvis of Toronto. After some days consideration, Dr. Jarvis stated that he was unable to participate in the program on a volunteer basis at this time.

Senior Health Officials, Montserrat

A visit was made to the island of Montserrat to discuss the Project with officials of the Ministry of Education, Health and Welfare.

Montserrat, with a small population (12,000) is unable to retain many health professionals. Senior health officials feel a need for assistance in many specialty fields. They stated that they are willing and anxious to share the services of volunteers under this Project.

Support to the government dental program has been provided by Canadian volunteers under the direction of Vernon Buffong, DDS, MPH, Chief of this division for some years now (see Attachment 9). Dental teams come from Canada for periods of one week or more to treat patients. A current important gap is lack of Montserratian dental nurses to initiate a community dental health program.

The Principal Nursing Officer, Ms. Florence Daley, noted that there is a problem with sufficient nursing staff for the hospital. Dr. Swezy stated that it might be possible to recruit a nurse/midwife to assist, particularly with obstetric services. Ms. Daley stated that this would be a significant contribution to the operation of the hospital. She said the volunteer could stay in a private room in the adjacent nurse hostel; all meals are provided.

Dr. Swezy called Ms. Nancee Neel in Florida. Ms. Neel stated that she was most interested in going to Montserrat as a volunteer. If the Project had moved forward as originally scheduled, she would have taken the assignment. In the interim, she has accepted a job beginning in the new year. Regrettably, she is no longer in a position to serve as a volunteer.

Meeting, Secretaries of Health, St. Kitts

A meeting was held with Secretaries of Health from the LDCs of the Caribbean (see Attachment 10). The meeting was chaired by Dr. Phillip Boyd of CARICOM.

Dr. Boyd explained that the health professionals to be provided under this project were volunteers. As such, the time they would make available is limited, one to three months.

Terrence O.B. Goldson explained that the Project budget and cost would be shared between the host nations. Project funds will be used for transportation and a small honorarium. Host nations will be expected to provide lodging and food for the volunteers.

Dr. Swezy explained that a constraint on recruiting volunteers was lack of sufficient details on positions to be filled; as a guide for the Secretaries a form had been developed to elicit the kind of information that NCIH requires to recruit volunteers. Dr. Swezy emphasized the importance of specifying limitations and constraints on each position. This will permit NCIH to demonstrate the challenge of each position and the important gap the volunteer will be filling as opposed to a routine assignment.

The Secretaries identified the following priority areas where they desire volunteer assistance:

1. Psychiatrist: regional, stationed in Saint Lucia
2. Anesthetist : regional, stationed in Antigua
3. Radiologist : Saint Lucia
4. Anesthetist : Belize

ATTACHMENT 1

CONSULTANT DUTIES



NATIONAL COUNCIL FOR
INTERNATIONAL HEALTH
2121 Virginia Ave. NW, Suite 303
Washington, DC 20037
(202) 298-5901

October 25, 1981

Dr. F. Curtiss Swezy
815 Emory Drive
Chapel Hill NC 27514

Dear Curt:

This letter is to confirm our discussions regarding you as a consultant to NCIH for our Caribbean Health Program. The conditions of your consultancy are identified below:

Period: October 26 - December 5, 1981

Purpose

1. To review with the NCIH Advisory Committee, NCIH staff and AID/Washington, the status of the Caribbean Program.
2. To meet with AID/CRO staff in Barbados and CARICOM, Project representatives and staff in Guyana to review the status of the project and to determine the steps necessary to get volunteer placements in selected LDCs as soon as practical.
3. To travel to selected Caribbean LDCs and attempt to work out the technical, managerial and financial arrangements with the local government officials, regarding the placement of a volunteer in two countries.
4. To travel to St. Kitts to participate in the November 19, 1981 meeting of the Ministries of Health and explain the purpose of the NCIH/CARICOM project.
5. To provide NCIH/CARICOM, AID/CRO and AID/W with a written report of your field activities and findings, together with a list of recommendations for proceeding with the program.

A draft copy of the recommendations will be presented to NCIH by November 23, 1981. The final report will be submitted to NCIH by December 5, 1981.

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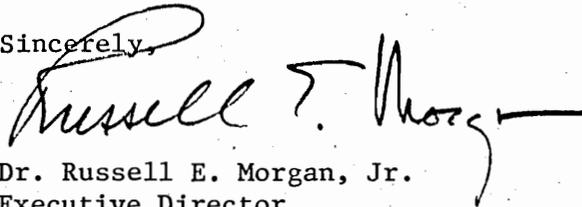
During your consultation, while out of the U.S., NCIH will pay for your necessary travel and per diem at the regular U.S. government rate.

Please complete the attached form, which is the basis on which we compute and justify your daily rate.

If during the course of your consultancy, the timetable for your activities needs to be amended, we can do this by mutual agreement.

We are pleased that you are working with us and we look forward to your successful consultancy and report.

Sincerely,

A handwritten signature in black ink, appearing to read "Russell E. Morgan, Jr.", with a horizontal line extending to the right from the end of the signature.

Dr. Russell E. Morgan, Jr.
Executive Director

Encl.

cc: Ms. N. King

ATTACHMENT 2

KEY OFFICIALS CONTACTED

USAID/RDO, Barbados

William B. Wheeler, Director
Mark Laskin, Regional Public Health Advisor
Allen Radlov, Public Health Advisor

U.W.I., Barbados, Faculty of Medicine

Professor E.R. Waldron, Vice Dean

CARICOM

Roderick Rainford, Deputy Secretary General
Evan S. Drayton, Administrative Officer
Dr. Phillip Boyd, Chief, Health Section
T.O.B. Goldson, Health Manpower Project Coordinator

St. Vincent Ministry of Health and Community Development

The Honourable Peter Ballantyne, Minister
Owen Cuffy, Permanent Secretary
Dr. H.A. Jesudason, Senior Medical Officer
John McBride, Hospital Administrator

Antigua Ministry of Health

The Honourable C.M. O'Mard, Minister
Mrs. Audrey B. Henry, Acting Permanent Secretary
Dr. A.I. Boyd, Chief Medical Officer
Dr. Cuthwin Lake, Acting Medical Superintendent

Montserrat Ministry of Education, Health and Welfare

G.M. Cassell, Permanent Secretary
George Calsey, Permanent Secretary, Manpower and Administrator
Dr. Bata Kothari, Senior Surgeon
Dr. Vernon Buffong, Chief, Dental Health
Miss Florence Daley, Principal Nursing Officer
Miss Rosalind Richards, Senior Nurse/Midwife

Health Secretaries' Meeting, St. Kitts

Mrs. Audrey B. Henry, Acting Permanent Secretary, Antigua
O. Hector, Permanent Secretary, St. Christopher and Nevis
G.M. Cassell, Permanent Secretary, Montserrat
E. Usher, Permanent Secretary, Belize
Mrs. Dorcas Braveboy, Permanent Secretary, Grenada
Cornelius Lubin, Permanent Secretary, Saint Lucia
Mrs. Veta Brown, First Assistant Secretary, Bahamas

ATTACHMENT 3

USAID SOURCE WAIVER

reimbursement for such purpose, the Grantee agrees to refund to AID the entire amount of the purchase.

(c) Geographic Source and Order of Preference

Except as may be specifically approved or directed in advance by the Grant Officer *under paragraph 15(b) above*, all other goods (e.g., equipment, materials, and supplies) and services, the costs of which are to be reimbursed under this Grant and which will be financed with United States dollars, shall be purchased in and shipped from only "Special Free World" countries (i.e., AID Geographic Code 935) in accordance with the following order of preference:

- (1) the United States (AID Geographic Code 000),
- (2) "Selected Free World" countries (AID Geographic Code 941),
- (3) the cooperating country,
- (4) "Special Free World" countries (AID Geographic Code 935).

*This implements a
Blanket Source Waiver
by Acting Administrator
2/10/78 R-1*

(d) Application of Order of Preference

When the Grantee procures goods and services from other than U.S. sources, under the order of preference in 15(c) above, it shall document its files to justify each such instance. The documentation shall set forth the circumstances surrounding the procurement and shall be based on one or more of the following reasons, which will be set forth in the Grantee's documentation:

- (1) the procurement was of an emergency nature, which would not allow for the delay attendant to soliciting U.S. sources,
- (2) the price differential for procurement from U.S. sources exceeded by 50% or more the delivered price from the non-U.S. source,
- (3) impeiling local political considerations precluded consideration of U.S. sources,
- (4) the goods or services were not available from U.S. sources, or
- (5) procurement of locally available goods or services, as opposed to procurement of U.S. goods and services, would best promote the objectives of the Foreign Assistance Program under the Grant.

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(e) The Grantee's Procurement System

- (1) The Grantee may use its own procurement policies and procedures provided they conform to the geographic source and order of preference requirements of this provision and paragraphs 3 and 4, Attachment O of OMB Circular No. A-110.
- (2) If the Grantee's procurement policies and procedures have been reviewed against the procurement requirements of paragraphs 3 and 4 of Attachment O to OMB Circular No. A-110 and have been approved by

ATTACHMENT 4

NCIH, CARICOM, AND HOST COUNTRY

SUPPORT OF VOLUNTEERS

CARICOM/NCIH REGIONAL HEALTH MANPOWER PROJECT

Responsibilities of Various Agencies

NCIH

1. Initial identification of professional.
2. Submission of particulars for appropriate licensure.
3. Briefing of professional in Washington, D.C.
4. Air travel arrangements (USA/Host Country).
5. Debriefing at end of assignment.

CARICOM

1. Continual liaison with participating countries.
2. Participation in selection and placement of professional.
3. Follow up contact for licensure with responsible country.
4. Signing agreement.
5. Payment of monthly honorarium.
6. Inter-country transportation.
7. Resolution of administrative problems.
8. Review of evaluations.

HOST COUNTRY(S)

1. Specifying needs.
2. Acceptance of nominee.
3. Supporting volunteer in country.
 - (a) licensure after submission of particulars
 - (b) in-country briefing
 - (c) settling administrative details
 - (d) lodging/subsistence
 - (e) internal transportation
 - (f) administrative supervision and professional support services
 - (g) debriefing at end of assignment
 - (h) evaluate volunteer's performance

ATTACHMENT 5

CARICOM - VOLUNTEER LETTER OF AGREEMENT

PROTOTYPE

HEALTH VOLUNTEER AGREEMENT

BETWEEN: CARIBBEAN COMMUNITY (hereinafter referred to as CARICOM)

Bank of Guyana Building, Georgetown, Guyana

Cable: CARIBSEC

Telex: GY 2263 CARISEC

AND

HEALTH VOLUNTEER: Name :

Speciality:

Address :

(hereinafter referred to as VOLUNTEER)

NATURE AND SCHEDULE OF SERVICES

The VOLUNTEER hereby agrees to:

a) Work in the _____, _____ in
(facility) (location)

_____ under the administrative direction
(country)

of _____ as a _____.
(title) (professional task)

Specific duties will include:

i)

ii)

iii)

iv)

STATUS OF VOLUNTEER

The VOLUNTEER shall be considered as having the legal status of an independent contractor and shall not be considered in any respect as being a member of the Staff of the CARICOM Secretariat.

EFFECTIVE DATE

The effective date of this Agreement is the date of Signature by the VOLUNTEER and CARICOM.

PERIOD OF AGREEMENT

The services to be performed under this Agreement shall be completed on _____ or on such later date as mutually agreed in writing.

NOTICE OF TERMINATION

Either party may terminate this AGREEMENT by providing seven days notice in writing.

RIGHTS AND OBLIGATIONS

The rights and obligations of the VOLUNTEER are strictly limited to the terms and conditions of this AGREEMENT. Accordingly, the VOLUNTEER shall not be entitled to any benefit, payment, subsidy, compensation, entitlement or other expense under the provisions of this AGREEMENT.

REPORTS

Two weeks before the completion of the services agreed upon, the VOLUNTEER shall submit to the Head of his Unit or Department, a report on the services performed. This report will detail tasks accomplished, problems encountered, if any, and recommendations on any future follow-up action or modifications necessary for the continuation of these tasks.

A copy of this report should be forwarded to the CHIEF of the Health Section, CARICOM Secretariat.

TITLE RIGHTS

The title rights, copyrights, and all other rights of whatsoever nature in any material produced under the provisions of this AGREEMENT shall be vested exclusively in CARICOM.

UNPUBLISHED INFORMATION

The VOLUNTEER shall not communicate to any person or other entity any unpublished information made known to him/her by CARICOM in the Course of performing his/her duties under the terms of this AGREEMENT except upon the written authorization of CARICOM.

SPECIAL PROVISIONS

Recognising that the VOLUNTEER is providing highly specialized professional services on a voluntary basis, and noting further that he/she is prohibited from receiving any emoluments under the terms

of this AGREEMENT, while in _____, the following
(country)

special provisions are included to provide basic subsistence to
the VOLUNTEER while in _____.
(country)

a) FOOD AND LODGING

The GOVERNMENT of _____ will provide
(country)

food and lodging at no cost to the VOLUNTEER, while he/she
is in _____.
(country)

b) HONORARIUM

CARICOM will provide an HONORARIUM at the rate of
US \$ _____ a month, for each month that the VOLUNTEER provides
services under this AGREEMENT.

This HONORARIUM will be forwarded directly to the VOLUN-
TEER at the end of each month of satisfactory service.

c) While this AGREEMENT is in force, CARICOM will cover at
its expense the risk of illness and accidents of the VOLUNTEER,
in accordance with the provisions of a group health insurance
scheme, and a group personal accident scheme.

WAIVER

I already have health and accident insurance which will re-
main in effect during the period of my voluntary service for CARICOM.

Therefore, I waive CARICOM'S obligation to provide this coverage
for me.

(volunteer)

(date)

NEGOTIATION OF DISPUTE

Any dispute arising out of this AGREEMENT shall be settled by
negotiation.

VOLUNTEER

CARICOM

Name: _____

Name: _____

Title: _____

Title: _____

Signature: _____

Signature: _____

Date: _____

Date: _____

ATTACHMENT 6

REQUEST FORM

CARICOM/NCIH REGIONAL HEALTH MANPOWER PROJECT

REQUEST FORM

POOLED HEALTH SPECIALIST

1. Specialist required _____
2. Countries sharing specialist
a) _____
b) _____
c) _____
3. Title of position _____
4. Location(s) of budgeted position(s)
e.g. Hospital _____
District _____
City/Island() _____
5. Position code(s) (if any) _____
6. If post not shown on budget
is there approval to operate
and fund post? YES Explain:
NO _____

7. Name of last holder of post
(substantive or acting) _____
8. Time post vacant _____
9. Name and Title of administrative
supervisor _____

10. Salaries budgeted by countries
a) _____/month
b) _____/month
c) _____/month

EQUIPMENT:

List available equipment, by work location, appropriate for tasks to be performed. Particularly note relevant gaps in equipment or substitution of less desirable equipment that the specialist will be required to utilize.

SUPPLIES:

List available supplies, by work location, appropriate for tasks to be performed. Note possible limitations and interruptions as well as substitutions that health specialist will be expected to make.

REQUESTED:

NAME: _____

TITLE: _____

SIGNATURE: _____ DATE: _____

APPROVED:

NAME: _____

TITLE: _____

SIGNATURE: _____ DATE: _____

REV. 11/81

ATTACHMENT 7

VOLUNTEER'S EVALUATION FORM

CARICOM/NCIH REGIONAL HEALTH MANPOWER PROJECT

VOLUNTEER EVALUATION

Name of Volunteer _____

Specialization _____

Country(s) Assigned _____

From _____ to _____

I. RECRUITMENT

1. How were you contacted?

2. What orientation did you receive?

c) Passage/transport: were travel arrangements to the country, within the country and between countries suitably arranged?

d) Lodging and subsistence: was housing and food suitable?

e) Honorarium: did you receive payments in a timely fashion?

3. Training: what, if any, instruction/teaching activities did you perform?

III. RECOMMENDATIONS

1. What recommendations would you make on:

a) Information you would like to have had before starting the assignment.

b) Equipment.

c) Supplies.

d) Subordinate Staff.

e) Referral Systems.

f) Community participation.

g) Administration.

h) Travel.

ATTACHMENT 8

HOST NATIONS' EVALUATION FORM

ATTACHMENT 9

**CANADIAN VOLUNTEER SUPPORT
TO MONTSERRAT DENTAL PROGRAM**

Scientific

The results of clinical, radiologic examination and treatment of a group of Montserratian children by a Canadian Dental Association volunteer are reported. Orodonal anomalies, caries prevalence and treatment accomplished are outlined.

The importance of the continued participation of Canadian dental volunteers is stressed, to help prevent, control and treat the high rate of dental caries observed.

Pedodontics in Montserrat

Murray H. Diner, DDS
Montreal

Vernon Buffong, DDS
Plymouth, Montserrat, W.I.

J. Victor Legault, DDS
Montreal

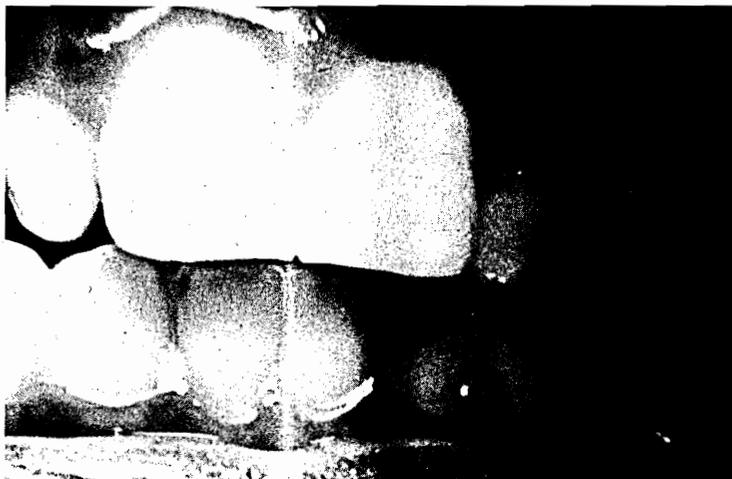


Fig 1 Peg-shaped permanent maxillary lateral incisors.

Montserrat, a colony of Great Britain, is a small, 39 square mile Eastern Caribbean island which is located 30 miles south-west of Antigua. This lush tropical island is the home of approximately 13,000 people. Montserrat has enjoyed considerable constitutional advances achieving political stability and has also developed a uniquely hospitable environment, making one's visit most enjoyable.

Public health dentistry in Montserrat is administered by a full time dental surgeon (Dr. Vernon Buffong) assisted by two United States Peace Corps Volunteer dental hygienists, three local dental assistants and volunteer Canadian dentists. Prior to 1976, the latter were sponsored by the Canadian Dental Association, through the support of grants from the Canadian International Development Agency.¹ However, these grants from the

Canadian International Development Agency were terminated recently and the involvement of the Canadian Dental Association in the Caribbean Dental Program is presently under review. This situation is most unfortunate since, during the past year 23 Canadian volunteers have served on the islands of St-Lucia, Dominica and Montserrat.² This has been due to the efforts of Dr. George Burgman, chairman of the program. Montserrat has received monthly volunteer service since June 1972, but there are indications that the above-mentioned withdrawal of support will cause a reduction in participation by Canadian dentists. At this time, the dentists who continue to volunteer their services for a month or longer are required to make their own arrangements and to pay their own travel expenses.

Under the Government Dental Health Service in Montserrat, those people entitled to receive care range

from pre-school to secondary school age children, pregnant women, institutionalized persons, members of the Health Department, Police Department, and those persons classified as indigent. This is an ambitious undertaking.

The nursery school association operates 10 nursery schools for three to five year old children. There are 16 primary schools (accommodating children from five to 15 years of age) of which 12 are government operated, two are church governed and the remaining two are privately operated. There are also two junior secondary and one secondary school. The total school population is approximately 3,600 children.

This situation is somewhat unique in that this population is relatively stable and homogeneous, readily lending itself to examination and observation. This article is, therefore based on the observation and treatment of 132 Montserratian children by a Canadian volunteer (Murray H. Diner).

METHODS AND MATERIALS

Sixty-eight boys and 64 girls from two to 15 years of age (mean 9.56) were examined and/or treated in one of the two available operatories of the Glendon Hospital Dental Clinic in Plymouth, Montserrat. The remaining operatoriy was utilized by the resident dentist, Dr Vernon Buffong. Most patients were brought to the clinic in the early morning from their schools. Additional patients came to the dental clinic on their own.

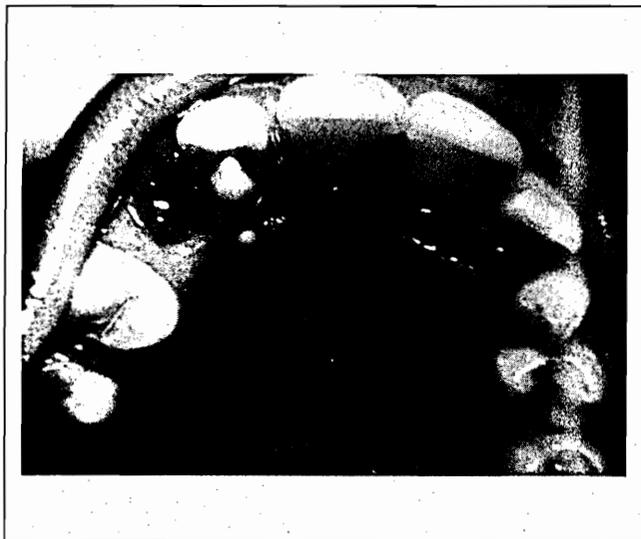


Fig 2 T-shaped permanent right maxillary lateral incisor.

All procedures recorded were carried out by the same dentist, aided by a full-time assistant. The dental operatoriy was suitably equipped and included an x-ray unit. Clinical examinations were conducted with the aid of dental mirrors, explorers and an air-water syringe. One maxillary anterior periapical and two bite-wing radiographs were taken of each patient except those who were too young to benefit from such a survey.

RESULTS

Dental and Oral Anomalies — A total of 87 patients presented a variety of anomalies (Table 1) observed as a result of the clinical and/or radiologic examinations.

Among the eight patients with cross-bites (6.06 per cent of all the patients examined), only one had a unilateral posterior cross-bite, while the remainder manifested minor tooth malpositions creating cross-bites of one or two opposing teeth. These findings were equally distributed in the anterior and posterior regions of the mouth.

The most apparent and frequent malocclusion observed was the anterior open-bite (10.60 per cent of all patients examined). Through questioning, it was ascertained that these particular malocclusions were associated with thumb and finger sucking habits.

Anomalies of tooth morphology were found in 18 patients (13.64 per cent), wherein enamel hypoplasia represented 83.33 per cent (15 patients) of these particular abnormalities. Only one patient, having a history

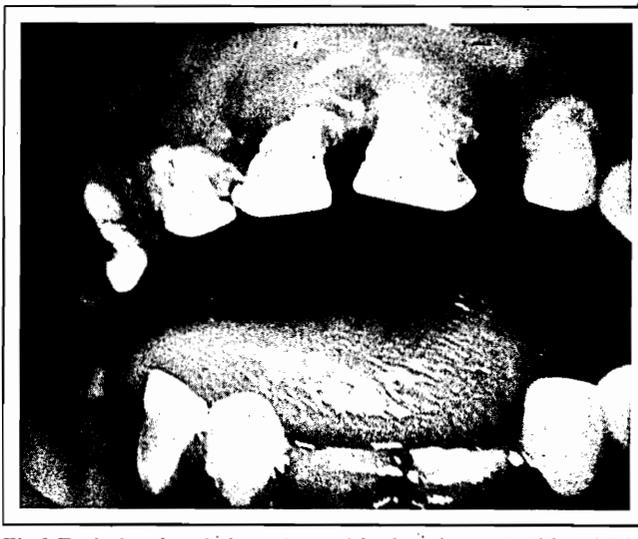


Fig 3 Typical carious lesions observed in the primary dentitions of the Montserratian children examined.

of premature birth, exhibited the characteristic clinical appearance of generalized enamel hypoplasia of the complete primary dentition. The remaining patients possessed more localized enamel defects, evident on no more than four teeth, with equal distribution in both dentitions.

Peg-shaped permanent lateral incisors (Fig 1) were found in two patients (1.52 per cent) while only one T-shaped permanent lateral incisor was observed (Fig 2).

Tetracycline stains were evident in only one patient, while extrinsic discolorations were visible in seven other cases.

Only two cases of congenital absence of permanent lateral incisors were observed, one being unilateral, the other bilateral.

The most prominent soft tissue lesion in evidence, observed in 27 children (20.45 per cent), was a draining alveolar fistulous tract due to dento-alveolar abscesses. Although 5.30 per cent of the patients examined presented with significant calculus deposits, periodontitis was diagnosed clinically and radiographically (generalized bone loss and pocket formation) in only one case.

DENTAL CARIES

Considering the severe dental neglect observed in the patients, it was not surprising that the principal complaint of 61 children (46.21 per cent) was pain directly resulting from extensive dental caries (Fig 3). In addition, preschool children manifested the decay pattern characteristic of "milk bottle caries"³ and, as a group,



Fig 4 Arrested caries observed in most primary dentitions.

accounted for 67.69 per cent of the decayed primary maxillary incisors and 26.19 per cent of the carious first primary molars observed. Active caries were further responsible for the fistulae observed in 20.45 per cent of the patients examined.

With the exception of five patients (3.79 per cent) who clinically and radiographically were caries-free, clinical evidence of arrested decay, as described by Brauer et al⁴, was not infrequent among the remaining children (Fig 4).

TREATMENT

Table 2 indicates the types and quantities of various treatment procedures accomplished under local anaesthesia during a one-month period. In an effort to complete their treatment needs, 20 children were given additional appointments but only six (30 per cent) kept these appointments. Three other patients cancelled their appointments in advance while the remaining 11 (55 per cent) were not heard from.

DISCUSSION

Table 1 indicates that 20.56 per cent of the patients examined presented with dento-alveolar abscesses. Table 2 shows that 97.59 per cent of the extractions performed were due to irreparable carious lesions. Furthermore, 46.21 per cent of the principal complaints were painful carious lesions. Although 3.79 per cent of our sample was caries free, Brauer et al⁴ estimate that only 7 per cent of the population is caries free, further indicating an abnormally high caries rate in the patients examined.

These results stimulated investigation into the nutritional habits of the Montserratian population. Since sugar cane is not cultivated in Montserrat and all sugar and sugar products are imported, the Government Statistics Office in Plymouth, Montserrat⁵, was able to supply the information shown in Table 3.

The most important criteria in the evaluation of a well balanced diet must be the relationship between caloric and nutritional value. Fruits and vegetables, for example, furnish vitamins and minerals with few calories and whole grain cereals and bread are rich in vitamins and also furnish calories, while sugar, honey, syrups and candy are high in calories but do not contribute nutritive elements. Therefore, since there exist numerous carbohydrates of greater nutritive value, such sugars, syrups and their by-products are not considered as being essential elements of our diet.⁶

A further breakdown of nutritional needs shows that the requirements of the average person in terms of carbohydrate consumption approximates 180 lbs. of carbohydrates per year. When we consider that Canadians consume 109 lbs. per person per year in sugars and syrups⁷ alone, it is easy to understand why we are a well-fed but poorly nourished, caries prone population. The Montserratian population, not having our varied and plentiful food supplies, while maintaining an equally excessive consumption of sugars, consequently suffers more.

The high incidence of carious primary, maxillary incisors, first molars and mandibular first molars, suggesting "milk bottle caries", was confirmed on direct questioning of parents. The addition of large quantities of sugar to the contents of infants' bottles was found to be an accepted and current practice.

An additional example of excessive sugar consumption was uncovered upon the discovery of guava jam, jelly and guava "cheese". The guava fruit comes from a tree or shrub of the same name (*Psidium Guajava*) which grows in the tropics. Guava "cheese", (not to be confused with any dairy product), is a consistent jelly

substance, cut up into small cubes, rolled in sugar and eaten by the handful as candy would be — a favorite between-meal snack. Furthermore, the recipes for these jams, jellies and candies, which are routinely made in the home, call for excessive quantities of sugar.

This excessive and frequent sugar consumption is unfortunately compounded by a generalized absence of regular hygiene practices and low dental I.Q., with 96.21 per cent of the patients examined presenting with poor oral hygiene.

The practice of restorative dentistry was rendered difficult and at times impossible due to the following factors: lack of interest in seeking restorative treatment (70 per cent of the patients did not keep their appointments); behaviour problems, representing 18.18 per cent of the patients examined, wherein half of these children

Anomalies	No. of patients	% of 132 patients examined
MALOCCLUSION		
Cross bite	8	6.06
Open bite	14	10.60
FORM (tooth morphology)		
Hypoplasia	15	11.36
Peg-shaped lateral incisor	2	1.52
T-shaped lateral incisor	1	0.76
DISCOLORATION OF TEETH		
Extrinsic	7	5.30
Intrinsic (tetracycline staining)	1	0.76
TONGUE		
Geographic	1	0.76
Fissured	1	0.76
CALCULUS DEPOSITS	7	5.30
FISTULAE	27	20.45
PERIODONTITIS	1	0.76
CONGENITAL ABSENCE OF MAXILLARY LATERAL INCISORS		
Unilateral	1	0.76
Bilateral	1	0.76

	TREATMENT PROCEDURE					
	Amalgam	Composite	Disking	Extraction	Formocresol pulpotomy	Temporary cement
MAXILLA						
Incisors:						
primary	—	—	2	6	—	—
permanent	4	6	—	—	4	9
Canines						
primary	—	2	5	1	—	1
Premolars	2	—	—	—	—	—
First molars:						
primary	—	—	2	11	—	2
permanent	15	—	—	6	1	3
Second molars:						
primary	5	—	2	12	—	4
permanent	—	—	—	2	—	—
MANDIBLE						
Incisors:						
primary	—	—	—	2	—	—
permanent	—	—	—	—	—	—
Canines						
primary	—	1	2	2	—	—
Premolars	—	—	—	1	—	—
First molars:						
primary	2	—	—	10	1	4
permanent	8	—	—	13	—	5
Second molars:						
primary	11	—	—	15	5	6
permanent	1	—	—	—	—	—
TOTAL	48	9	13	83*	11	34

*81 teeth were extracted due to irreparable carious lesions; 2 primary incisors extracted due to their prolonged retention and ectopic eruption of their successors.

(12) were totally unmanageable and/or untreatable, while the other half could only be treated with great difficulty; and the excessive number of emergencies, represented by 61 patients (48.03 per cent) suffering from toothache. Therefore it is more easily understood, although very difficult to accept, that of the 198 teeth treated, 83 (41.92 per cent) were extracted.

Considering the existing dentist population ratio of 1:13,00, along with the aforementioned problems, the importance of the Canadian volunteers' presence in Montserrat becomes quite apparent. Not only is the volunteer essential for the fulfilment of the existing treatment needs, but there remains an area wherein the volunteer is even more valuable — prevention; the establishment of programs, their organization and their delivery to the population. Dentistry in Montserrat is becoming more prevention oriented, and great progress will be made by further pursuit in this area, providing the interest of the Canadian dentist remains active. Quantitative and qualitative participation is therefore a major part of the answer to the existing dental problems of the Montserratian children in particular and the entire population in general. Remuneration in the form of experience, appreciation and the high esteem in which the volunteer is held by the Montserratian population is of great value, resulting in a most rewarding adventure.

CONCLUSION

Excessive sugar consumption combined with poor

Year	1967	1968	1970	1971	1973
Sugar and chocolate confectioneries imported (lbs.)	121,038	107,620	140,532	55,124	47,903
Pure sugar imports (lbs.)	1,216,720	1,325,667	1,526,755	986,323	1,021,078
TOTAL	1,337,758	1,433,287	1,667,287	1,041,447	1,068,981
Approximate population	13,000	13,000	13,000	13,000	13,000
Consumption Pounds/person/year	102.90	110.25	128.25	80.11	82.23

oral hygiene habits were found to be the major contributing factors to the high caries experience of the Montserratian sample.

Continued efforts and expansion into the area of preventive dentistry on behalf of Canadian volunteers are essential for the successful control of dental disease in Montserratian children.

Success is dependent upon maximum participation by Canadian dentists in a well-organized program incorporating provisions for essential emergency treatments, prevention, routine treatments and continuity for the purpose of evaluation of such a program's achievements.

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Dr. Diner is a paedodontist, Marie-Enfant Hospital, Montreal, Quebec.

Dr. Buffong is with the Health Department, Glendon Hospital, Plymouth, Montserrat, W.I.

Dr. Legault is a pedodontist in private practice, Montreal, Quebec.

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ATTACHMENT 10

MEETING: PERMANENT SECRETARIES OF HEALTH

INFORMAL MEETING RE CARICOM/NCIH HEALTH
MANPOWER PROJECT - 24 NOVEMBER 1981

CHAIRMAN: DR. P. I. BOYD

DRAFT AGENDA

1. WELCOME AND INTRODUCTION OF DR. SWEZY.
2. APPROVAL OF DRAFT AGENDA.
3. REPORT ON STATUS AND ACTIVITIES UNDER PROJECT
4. PRESENTATIONS ON -
 - (a) Revised 'Request' form
 - (b) Operating procedures of Project
 - (c) Discussions on:-
 - (i) Assignment of Specialists
 - (ii) Accounting/financial arrangements
 - (iii) Administrative controls
 - (iv) Quarterly report on assignments
 - (v) End of assignment evaluation form
5. ANY OTHER BUSINESS
