ASSESSMENT OF THE CURRENT STRUCTURE AND OPERATIONS OF THE PRIMARY HEALTH CARE SYSTEM IN ST. LUCIA

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30th MAY 2002

I INTRODUCTION

The Government of St. Lucia has embarked on a process of health reform with the Ministry of Health as the key stakeholder for the planning, implementation and evaluation of this process. To this end the Ministry of Health prepared a document entitled "Health Sector Reform Proposals – Quality Services for Life" in March 2002 to guide the reform process. To quote from the front page of the document "Quality of Life is determined by choices. It is essential that we give our people the tools to be aware and to make the most appropriate choices, thus empowering them to experience the maximum quality of life." (p3). This document was prepared with wide participation from many stakeholders in the health sector, including communities, and reflects the policy framework and strategic approach which the Ministry of Health proposes to take in the development of the St. Lucia health system. It is in this context that the Pan American Health Organisation/ World Health Organisation (PAHO/WHO) was requested by the Ministry of Health to analyse the primary health care system in St. Lucia as one phase of the health reform process. The specific terms of reference of the consultancy were to assess the current structure and operations of the primary health care services in St. Lucia and submit preliminary proposals for optimisation of the resources for delivery of these services. Specifically the consultants were to undertake the assessment of the primary health care (health centre based) services with reference to:

- Utilisation levels of existing primary health care service
- Mix and volume of current primary health care services
- Current services provided vis–à-vis a new service model of polyclinics and health centres
- Systems of patient referral and back referral between various levels of care
- Any proposed new approaches to health care being introduced, such as day surgery, outpatient surgery, home car, etc. and their likely impact on the delivery of primary health care services
- Mechanisms to enhance the focus on mental health and drug abuse with their integration into community health services
- Number of health centres that are needed in St. Lucia and their location
- Entities and mechanisms that have been introduced or are being introduced to facilitate social participation and control in planning, delivery and management of primary health care services
- Mechanisms to strengthen the district health teams

- Changes being introduced in the management contracts or commitments between the different levels of the primary health care system including the use of the private sector
- Involvement of health workers or their representatives' participation in the reform of primary health care services
- Current staffing patterns vis-à-vis the need to meet reformed primary health care services

We were accordingly recruited by PAHO/WHO to carry out this study in close collaboration with the authorities in St. Lucia. In keeping with the terms of the contract the methodology adopted included site visits, interviews with stakeholders, focus group discussions, review of the available literature and collection of relevant data. We visited St. Lucia on two separate occasions. The first visit was from 17th February to 2nd March 2002 and this was followed by the second visit from 17th to 28th March 2002. All the health centres and hospitals were visited and discussions held with key staff at these institutions. In addition the Hon. Minister and the Parliamentary Secretary for the Ministry of Health as well as senior technical and administrative staff at the head office of the Ministry were also consulted. Meetings were also held with the staff of the Mental Hospital, Transition House (Drug Abuse), the Department of Human Services, the Ministries of Labour, Social Transformation, Home Affairs and Education, the Nurses Association and the Non-governmental Organisations that work closely with the Ministry of Health. Focus group discussions were conducted with groups of nurses, nutritionists, health educators, dentists, district doctors, pharmacists and public health inspectors. At *Appendix 1* is a list of the persons consulted. At the end of the first visit a debriefing meeting was held with the health officials to discuss our findings and at the end of the second visit a similar debriefing meeting was held to present both the preliminary findings and recommendations. At both meetings the officials of the Ministry of Health expressed satisfaction with the results of the consultation and were in general agreement with the findings and proposed recommendations. These debriefing documents were submitted to PAHO/WHO at the end of each visit for their information and review in keeping with the terms of the contract.

II OVERVIEW OF THE HEALTH SYSTEM

2.1 Socio- economic and demographic data

The island of St. Lucia has a total land space of 238 sq. miles (616 square kilometres) and is 27 miles long and 14 miles wide. The total estimated population in the year 2000 was 155, 996. In that same year it was estimated that 49% of the population was male and 51% female while 50 % of the population was in the age group 15 – 44 years and 32% under 15 years of age. The annual growth rate was estimated at 1.7% between 1991 and 2000. The majority of the population live on the coastal areas and the less mountainous areas in the interior. A good network of roads links the various communities and villages to the main towns in the north and south of the island. This is supported by a good telecommunications system which covers the remote villages as well as the main population centres. Over the past twenty years the economy has been characterised by peaks and troughs. The erosion of preferential treatment for bananas, increased competition in export markets and a reduction in concessionary aid inflows contributed to the poor performance of the economy between 1993 and 1997. The period since 1998 can be described as a period of recovery and reinforcement. (see Annual Report of the Chief Medical Officer, p11). A National Poverty Assessment Survey of 1995 showed that 25% of the population were poor based on their

expenditure on selected food and non-food items. Of this about 16% of the urban population and 30 % of the rural population were poor. In terms of gender approximately 25.5% of males and 24.7% of females were found to be poor. (ibid p12). As far as literacy levels are concerned the last Literacy Survey (1990) only focussed on the 15-65 years age group and showed the 54% of the sample was literate, 27% illiterate and that 70% of the illiterate population was women. Illiteracy was highest in the rural areas, particularly in the banana and former sugar cane areas. (ibid p13).

2.2 Health Situation

As far as health indicators in the year 2000 are concerned the crude death rate was 5.3 per 1000 population, the infant mortality rate 13 per 1000 live births, the neonatal mortality rate 11 per 1000 live births, perinatal mortality 25 per 1000 live births and maternal mortality 10 per 10,000 live births. Life expectancy at birth was estimated at 71 years for males and 77 years for females. The ten principal causes of death in the year 2000, showing the number of deaths and the rate per 100,000 population were as follows:

PRINCIPAL CAUSES OF DEATH	NUMBER OF DEATHS	RATE
1 Malignant neoplasms	135	87
2 Heart Disease	130	83
3 Cerebrovascular disease	87	56
4 Diabetes mellitus	85	54
5 Accident and adverse effects	62	40
6 Homicide	31	20
7 Hypertensive disease	27	17
8 Bronchitis, emphysema, asthma	24	15
9 Perinatal causes	24	15
10 Pneumonia and influenza	10	11

No morbidity data were available but the mortality patterns provide insights into the major causes of illness. *Cardiovascular diseases* accounted for 34% of all deaths during the period 1996 to 2000. This strongly indicates the need for health promotion and disease prevention strategies to address the risk factors of this disease and reduce morbidity levels. For the same period 1996 – 2000 there was an annual average of 137 deaths from *malignant neoplasms* representing 15% of all deaths. Males represented 55% of all deaths from malignant neoplasms. For males the major cause of these deaths was prostate cancer (32%) while for females these were breast (19%) and cervix (16%). These data indicate the need for strong programmes of early detection and management of this health problem. *Diabetes* also accounted for 426 or 9.4% of all deaths during the period 1996-2000 with 67% of these deaths occurring in women. Again this indicates the priority that should be placed on prevention and control measures such as healthy diets, exercise and on the management of the disease at the health centre levels of the system. Although there were no major epidemics of communicable diseases reported in the year 2000, these diseased are still present. *STD/HIV/ AIDS* remain a serious problem. A total of 813 cases of STD's were reported in the year 2000 and by the end of that year the total cumulative

number of AIDS cases had risen to 138 cases of which 58% were males. The cumulative total of HIV infections since 1985 is 266 of which children under 15 years represent 15% and adults 15-44 years represent approximately 67%. With regard to the progress of the epidemic the number of reported cases in 1985-1988 more than doubled by 1997-2000. About 77% of the HIV infections were in heterosexuals while 10% were mother- to -child transmissions. Vector –Borne diseases remain a threat to St. Lucia. Between 1996 and 2000 there was a total of 47 cases of confirmed dengue fever with the highest number of cases (24) reported in 1999. *Dengue* remains endemic to some areas in St. Lucia. In relation to other diseases *Tuberculosis* remains of major concern as between 1993 and 2000 a total of 154 cases were registered. A total of 9 new cases were reported in the year 2000. A National Tuberculosis Management Committee was established in the Ministry of Health to address this problem. Finally there were 12 cases of *Leprosy* (Hansen Disease) reported in 2000.

2.3 Health Services

The Government of St. Lucia endorses the WHO concept that health is not merely the absence of disease or infirmity but a state of physical, mental and social well being. In addition it regards the pursuit of good health as a fundamental human right and ensures that health policies are consistent with developmental, educational and socio-economic and health promotion concepts. The public health sector dominates the management and delivery of health services in St. Lucia as the private sector is relatively small in comparison. Many health professionals work both in the public and private sectors. The major national health policies that guide the public health system can be summarised as follows:

- Improve the health system using the primary health care/ preventive approach while simultaneously increasing the quality and availability of secondary and tertiary care
- Improve inter-ministerial collaboration and consultation with private sector groups in the management of the health system
- Earmark a major part of the annual national health budget for delivery and improvement of the health services while improving the capacity of the government health services to generate revenues
- Strengthen the regulatory functions of the Ministry and other agencies within the health sector
- Apply the principles of human rights to HIV/AIDS cases and collaborate with other agencies for the prevention and control of the disease
- Utilise cost-effective and cost-benefit approaches to the use of technology, medical supplies and drugs
- Develop and retain a cadre of highly trained, committed, motivated, professional, administrative and technical staff to provide quality care to the entire population
- Develop a management system that is accountable, progressive, communicative and functional where service productivity is the objective
- Pursue a policy that is designed to control population growth to enable an acceptable level of socio-economic development to be achieved within the constraints of available resources
- Implement and enforce regulations that will protect workers' health and ensure their safety

- Ensure that development programmes are not detrimental to the balance of the ecosystem and enforce regulations to develop and maintain a sanitary, pollution free and healthy environment for all citizens.
- Utilise a multi-sectoral approach to prevent and control alcohol and substance abuse as well as to treat and rehabilitate those in need of these services
- Make community participation an integral part of the decision-making process at all levels of the health system
- Give priority to the provision of health services to specific vulnerable at-risk groups like the poor, expectant and nursing mothers, the elderly, chronically ill and disabled persons, and persons infected by communicable diseases

An organisation chart showing the head office structure of the Ministry of Health is provided at *Appendix 2*. The major divisions/institutions of the Ministry through which these policies are implemented are as follows:

1 Agency Administration responsible for finance, budgeting and accounting, general support functions, resource mobilisation, central procurement and human resource management

2 Corporate Planning responsible for information systems, planning and project management, health systems development and collaborates in policy development and analysis

3 Victoria Hospital which provides in-patient and out-patients services and is the main specialist *(*tertiary level) hospital

4 St. Jude Hospital which provides in- patient and out- patient services and is a second specialist *(*tertiary level) hospital receiving only partial financing from government

5 Soufriere and Dennery community hospitals which provide a basic level of hospital care with minimal in-patient and mainly out-patient services

6 Mental Health Services which provides mainly institutional care and some outreach follow-up *(*out-patient services) for mentally ill patients as well as services for alcoholic and drug dependent patients

7 Public Health Services under the direction of the Medical Officer (Health) and the Chief Medical Officer. These services involve the technical directorate of the Ministry and include personal , community and environmental health services through a network of public health institutions

8 Primary health care services which is an integral part of the public health services and covers all programmes delivered at the health centre level e.g. MCH/ Family Planning, communicable disease control, dental services etc.

The annual budget of the Ministry of Health, Human Services, Family Affairs and Gender Relations for the financial year 2001 – 2002 amounted to EC$ 62,855, 555 (Recurrent $53,090,177 and Capital $9,764,378). In reviewing the annual budgetary allocations to the Ministry over the period 1991 – 2000 the annual budget increased about 10% each year. However health's share of the national budget has declined from 12.1% in 1991 to 7.5% in 2000. In this latter year 63% of the budget was allocated to Secondary Care while Primary Health Care Services received 21%.

III REVIEW OF THE PRIMARY HEALTH CARE SYSTEM AND SERVICES

3.1 Management System

3.1.1 Policy Framework

The existing network of health centres and district hospitals clearly indicates that the public health services in St. Lucia are organised in keeping with the Primary Health Care concepts of the Alma Ata Declaration (1977). This network consists of a number of well distributed health centres that are within easy reach of the communities they serve. In addition the staffing patterns and type of health services offered to communities indicate that there is some consistency in role and function of health centres within the network. However it was not possible to obtain any documentation that outlined the primary health care policy for St. Lucia based on the political philosophy and socio-economic conditions of the country. Such a document (or manual) would have outlined such issues as the district health team concept, the management systems to be used, the services to be delivered, the staffing patterns, and the role of individuals in maintaining their own health and of communities in ensuring a health environment. It would provide valuable guidance to the health centres in managing the services they provide and ensure consistency in the way these services are organised and delivered. At *Appendix 3* is a suggested outline of the contents of such a document and should be adjusted as needed to prepare the proposed document for St. Lucia.

In addition the changing epidemiological profile of the population with the shift from communicable to chronic diseases underline the importance of health promotion and disease prevention strategies as fundamental to the effective and efficient delivery of community based health services. The Health Sector Reform Proposals Document for St. Lucia in defining health and the determinants of health outlined the partnership that must be maintained between the government, communities and societies to ensure the wellbeing of a population. This conceptual framework needs to be reflected in the way the primary health care services are organised and delivered. These services at present have a disease oriented focus rather than emphasising the wellness concept.

The Health Sector Reform Document provides an excellent basis for guiding the development of the health system over the next five years. However it should be reviewed and finalised through discussions with key stakeholders and be used as the strategic plan for moving the health system forward. Such a strategic plan is essential for development of the primary health care system since the total health system is so closely integrated.

3.1.2 Levels of Care and relationship between public health facilities

The services provided by the Ministry of Health are based on two levels of care, namely hospitals and health centre based services. The hospitals can be sub-divided into district hospitals and specialist *(*tertiary) hospitals. The role of the district hospitals have been downgraded in practice to the provision of very limited in- patient service with most patients being referred directly from the health centres to the two tertiary hospitals, St. Jude and Victoria. In addition the district hospitals at Soufriere and Dennery as well as the Vieux Forte and other selected health

centres offer out-reach specialised services that are not provided at most health centres (see table below). Patients are accordingly referred from the regular health centres to these health facilities where specialised clinics are provided. The decisions about the composition and location of these services seem to be made by the professional staff on an ad hoc basis.

FAXCILITIES/ SERVICES	DERMATOLOGY	PAEDIATRICS	MENTAL HEALTH	VISION SCREENING	HEARING SCREENING	DENTAL SERVICES
BABBONNEAU		X		X		
MICOUD	X	X	X			
LA RESSOURCE		X				
VIEUX FORT	X	X	X			X
DENNERY			X			
GROS ISLET		X				X
MONCHY		X				
CASTRIES		X				X
ETANGS		X				
SOUFRIERE	X	X	X			X
LA FARGUE		X				
JACMEL		X				
ANSE-LA-RAYE	X	X	X			
CANARIES	X		X			
TI-ROCHER MICOUD			X			
MON REPOS			X	X	X	
MARCHAND						X
ENTREPOT					X	
LABOURIE	X					

There is clearly the need to rationalise this health services delivery system by defining those health centres which provide basic services, those that function as referral health centres for specialised services (e.g. Mental Health, Dermatology etc.), the role of the district hospitals and polyclinics and the interface of these services with the (tertiary) hospitals of St. Jude and Victoria. The availability of space at health centres, their geographic proximity to patients served and transportation routes would be some of the criteria which should be used in determining the most appropriate health centres for these referral clinics. The Health Sector Reform document proposed that there should be three levels of care for St. Lucia namely health centres, polyclinics and hospitals. In this conceptual framework the district hospitals would be redefined as polyclinics and their relationship with the health centres in their catchment population more clearly defined. The polyclinics would function as the first referral level for these health centres by providing specialised clinics for patients seen at the health centres and will refer patients to the hospital system as required. Specialists from the hospitals would also hold clinics at these polyclinics and have admission privileges at the hospitals. The fee structure at the polyclinic level must be such that it does not provide a perceived or real barrier for clients who need to access these services. This comment has already been made about accessing services at the Dennery Hospital.

3 1.3 Management of Primary Health Care Services

The primary health care services are managed from the central level of the Ministry of Health in that the programmes that comprise these services are managed as vertical programmes. For example the medical clinics, the dental services, the nutrition services, the health education programmes, environmental health services and the nursing services are managed by senior professional staff at the Head Office of the Ministry of Health. These field staff are therefore accountable to their seniors at the Head Office for the quality performance of their functions and often there is inadequate supervision to ensure the efficient and effective delivery of services. In addition the health centre based health staff often focus on their own health functions with little and sometimes no co-ordination among the services they provide at the health centre level. At the Head Office itself the absence of a Medical Officer (Health) who has responsibility for the management of all primary health care services results in a lack of co-ordination among the Head Office primary health care managers in their planning and implementation of services. The management structure for primary health care services needs to be clearly established with the appointment of a Medical Officer (Health) to take responsibility for the planning and implementation of all these services. In addition there is need to establish regional health teams (with a team leader) with responsibility for management of the primary health care services for a given grouping of health centres. Finally, at each health centre, management teams should be established to manage all services to be delivered to the catchment population served by that health centre. Such teams will include all health staff who deliver services to that catchment population e.g. public health inspectors, health educators, dentists, medical doctors, nursing staff, pharmacists and nutritionists. There will be a designated team leader for each health centre team with responsibility for the health centre based management process.

One of the most important functions for the health centre based management team is to maintain a health status profile of the catchment population it serves. At present there is no such data available. The available data covers only the services that were delivered and this data is disaggregated in that it is kept by the different programme managers at the central level. This data should be available at each health centre. In addition the health centres need to collect data on the health status of the population they serve. Only 30% of the health centres were able to report their catchment population within 10% accuracy. This data is available and should be updated using the data now published in the 2001 Population and Housing Census prepared by the Government Statistics Department. In addition the nursing staff and Community Health Aides make household visits to each house in the catchment population during which they perform tasks such as the measurement of the blood pressure of some household members and test the blood of others for diabetes. They also assess the health status of the environment. This data should be used to provide a more detailed profile of the community health status. The Epidemiology Unit and Planning Unit of the Head Office of the Ministry should take responsibility for designing the contents of the health profile and give guidance and technical support to health centre teams in the collection, analysis and utilisation of this data.

Data collection and analysis are essential elements for determining the priority programmes which should be delivered to a community. At present there is no comprehensive planning and programming process for delivering priority primary health care services. The nursing personnel have developed programme plans for new initiatives for the current year but have not used this

approach to programme all primary health care programmes. Further the other primary health care programmes are not guided by annual programme plans. As a result the objectives to be achieved by the primary health care programmes and the strategies to be used are not always specific, clear and measurable. In a few health centres the logical framework methodology is used for the new nursing initiatives but this is the exception. The basic approach used is the programme planning Gantt chart approach. Even so the methodology is not always rigorously applied. It is essential to have a well defined programme planning methodology with quantitative and qualitative indicators to measure progress. A programme planning manual should be used to train primary health care workers in its appropriate use and ensure uniformity in the programming process. In addition the preparation of such annual programme plans should be fully integrated into the budgeting process to ensure the availability of resources to implement programmes. Such a programming planning process will ensure that indicators are developed to measure achievements in terms of outputs/ activities and impact.

The supply management system for sundries and cleansing material is managed by the Community Nursing Services based on an assessment of the needs of each health centre. In reviewing the status of these supplies with each health centre the nurse in charge indicated that there was no problem with the availability of these supplies. The supplies provided were adequate for the needs of the health centre and the Nursing Administration at the Ministry's Head Office responded to their needs in a timely manner. There is evidence that the best values are sought from suppliers in procuring these supplies as the Nursing Administration keeps a record of which suppliers offer the best prices. At each health centre a stock card is kept by the community health nurse to record the receipt and distribution of these supplies. In addition the supplies are kept in a locked cabinet. The Deputy Permanent Secretary has expressed the need for this inventory control system to be examined to ensure that it functions efficiently and effectively. This system should therefore be analysed and systems established so that it is part of the ministry wide system of procurement of these items to achieve the best price through bulk purchasing with selected suppliers. In addition the distribution and stock control systems for these supplies should be analysed and the most efficient and effective system established for the management of these supplies at the Head Office and health centre levels. The new system should ensure that health centres always have in stock the supplies needed for their smooth functioning.

There was considerable discussion on the fees charged to patients who attend the health centres. At present there is no fee charged to see a medical doctor at any health centre. There is however a small fee charged for pharmaceuticals and all patients are required to pay this fee as long as they have the financial resources. The pharmacists often consult with the community health aide, who, in most districts, has first-hand information on the economic status of community members, to decide whether a patient should be made to pay. The clear policy is that no one should be denied services at the health centre because they are unable to pay the required fees. The inconsistency between the fee structure at district hospitals, where clients must pay to attend medical clinics and the free medical services provided at health centres needs to be addressed. One doctor moved a clinic from a district hospital because it was felt that the fee structure at that institution would deny some needy patients access to care. This could easily lead to the underutilisation of the district hospitals and the polyclinics (where similar fees are proposed) and over utilisation of some health centres. If the proposed new primary health care network is to

work efficiently and effectively then the fee structure for the health centre and polyclinic levels must be compatible. In both levels no patient must be denied access to care because of the inability to pay. In addition the contract between the Ministry of Health and the St. Jude Hospital allows that institution to establish its own fee structure. This is essential for the survival of the hospital since the government only pays the salaries of hospital staff and requires the hospital to collect fees to cover all other operational expenses. However the proposed health system envisages the St. Jude hospital as an integral support facility to the health centre and polyclinic network in the south of the island. If this referral network is to work the fee(s) structure at St. Jude should not be a barrier for accessing these hospital services. The hospital should put in place an assessment system to ensure that no patient is denied this access. Alternatively the Ministry of Health can contract the St. Jude hospital to provide specific services to selected target populations referred from the health centre services at a negotiated fee that is in keeping with government fees at the Victoria Hospital in the north of the island.

3.1.4 Involvement of health staff and key stakeholders in the health reform process

The team entrusted with the preparation of the Health Reform Proposals document for St. Lucia held discussions with a wide cross section of health personnel and stakeholders. This was verified in discussions with key members of the Health Reform Secretariat including Dr. Stephen King who was the Chairperson. This team began working in September 1997 and completed its task in March 2000. In the Acknowledgements at the front of the report the key persons, institutions and associations consulted were listed and included the staff of the Ministry of Health and health institutions, the community nurses, the Nurses Association, the Medical and Dental Association, and the Civil Service Association. In addition many community groups were consulted with the assistance of the Ministry of Agriculture, Ministry for Community Development, environmental health officers and community nurses. In our meetings with these groups they verified their involvement in this process. However since some of this consultation took place in some cases three to four years previously they had to be reminded of the consultations. This was particularly true for a few of the community nursing staff and community health aides. The representatives of the Associations however were clear about their involvement in the process and their contributions. These groups identified critical areas of concern and made recommendations as to how they may be addressed. It was clear however that the gap between the preparation of the Health Reform Proposals in March 2000 and this consultancy in February / March 2002 had dulled memories and slowed the momentum of the change process.

Yet the interest for taking action to improve the health services remains very strong. The Ministry therefore should establish a Health Reform Unit or Committee which reports to and is guided by the Permanent Secretary and is charged with the responsibility for implementing the reform process. This team should update health workers on the current status and plans for moving the reform process forward and be the key players in making things happen. The Health Planning Unit must be the driving force in this Reform Unit or Committee. A newsletter can be used to circulate information of the priority reform issues and the programmes being implemented to address these issues. In addition key stakeholders should be updated and involved as needed in the reform process. The Medical and Dental Association and the Nurses

Association should be utilised to support the reform process as they can use their considerable influence to enhance this process.

3.2 Services Delivered at the Primary Health Care Level

3.2.1 Network of health facilities

There is a well distributed network of government health centres that serve the different communities in St. Lucia. This network has been established on the basis of population distribution, transportation routes and the unwritten policy guideline that each health centre should serve a catchment population within a radius of no more than three (?) miles. This network **(***see Appendix 4*) is adequate to meet the needs of the population and should be retained to ensure easy access by the community and ready outreach programmes to the community served. If the new thrust of disease prevention and health promotion in keeping with the wellness approach is to be effective then this network is essential for proactive programmes that reach out into the communities with a strong focus on lifestyle changes. Any consideration to reduce this network should consider not only the workload of the health centre but also the potential loss of outreach to the community in keeping with the wellness approach.

The Marchand Health Centre in Castries has a large catchment population but is badly located in that it is on a very busy main road. The noise of the traffic and the dust make it almost impossible to provide proper patient care. Blood pressures cannot be taken properly and talking to patients above the noise of the traffic is impossible. The health centre should be closed and the services relocated to the Entrepôt Health Centre which is a much better building, well appointed with lots of space in a quiet location just ten minutes by car from Marchand. The catchment population for Marchand can have easy access to Entrepôt through negotiations with the public minibus transport sector.

The closure of the health centre at Boguis two years ago has resulted in that catchment population travelling to the Babonneau health centre for service. This has resulted in severe overcrowding of that health centre, especially when two doctors provide clinics on the same day. Consideration should be given to holding one clinic on Monday and the other on Wednesday. This health centre is also in need of repairs and should be renovated as a matter of high priority to provide better services to the community. There was the suggestion that a new health centre should be constructed at Laguerre. However this need should be evaluated after the renovation of Babonneau has been completed and the services there improved. If necessary outreach clinics to Laguerre can be provide rather than establishing a health there in that community.

. Many of the health centres visited were in need of maintenance and repairs. For example the health centres at Saltibus and La Fargue are infected with termites while Rich Fond has broken windows and Vannard is sinking. There are other health centres in need of repairs. In addition the use of space within some health centres should be evaluated in consultation with the health centre staff. Many health centres have nursing quarters that are not utilised appropriately as nurses no longer live at the health centres. What is needed is a review of the allocation of space at each health centre to ensure better use of the space for patient care. For example the nutritionists need proper space for food demonstrations while the pharmacists should be re

located to provide space for consultations with patients. The responsible unit within the Ministry of Health should make an inventory of all health centres to determine the repairs needed, prioritise and cost these repairs and develop a phased repair programme tied to the annual budgeting process. The shortage of equipment, such as autoclaves, in some health centres should also be addressed as this affects the quality of care. A similar inventory should be done of equipment at health centres to determine equipment needs based on treatment protocols and such equipment provided on a priority basis.

3.2.2 Access and coverage of services

The well distributed health centre network described above ensures that all communities in St. Lucia have geographic access to health services. These health centres provide a basic package of health care services that cover important programmes such as maternal and child health, family planning, chronic diseases control including cancer screening for women and dental services. *Appendix 5* shows the utilisation of the curative services in health centres i.e. those services provided by nurses and doctors to patients suffering from acute episodic illness or chronic diseases. The national average of visits per resident reflects adequate coverage by this service especially since these figures do not capture visits to private providers or to the hospitals for similar services. Those health centres at the high end of the scale serve populations beyond their designated catchment areas and special studies would be required to separate the utilisation by the designated catchment populations. In a few health centres dental health services are provided and mental health clinics are held by visiting staff from the Mental Hospital with follow-up support from health centre staff through supervision of medications for patients as needed. Some specialist clinics are also provided at selected health centres by visiting specialists. These services include dermatology, paediatrics, vision screening and hearing screening. These services should be located at the proposed polyclinics and should be expanded to include ophthalmology, chronic diseases and ENT services in keeping with the epidemiological pattern of the communities.

Each region has a nutrition officer, a family life educator/ health educator and an environmental health officer who have visiting relationships with the health centre staff as they are not based there. These staff need to be fully integrated into the health centre teams and be involved in joint planning and programming of services for the community. The environmental health programme was previously closely integrated into the health centre based programmes but this has changed as the public health inspectors now operate independently of the health centre team. This is much more the case in the northern as opposed to the southern section of the island.

There is no structured School Health Programme as there are only ad hoc interventions for screening at ages five and eleven years and to meet requests from school principals. School Health Programmes are key components of a primary health care service. There is need to develop such programmes for St. Lucia in a structured and comprehensive manner with full collaboration of the education sector. These programmes should include components on family life education, immunisation, screening, environmental health, nutrition services and lifeskills development

Although the health centre teams (e.g. Laborie, Mongouge) provide some valuable outreach programmes to the communities they serve these visits tend to be disease driven in response to the need for follow-up of health centre patients. There is little focus on the wellness concepts and on establishing a healthy community in keeping with health promotion and disease prevention concepts of wellness. The community outreach programmes have been affected by security concerns of health staff when making community visits, lack of travelling arrangements and the shortage of community health aides. These aides have commented on the security problems they face in some communities adversely affecting their home visits and community outreach activities. One solution to this is to pay them a small travelling allowance while another is to provide each region with a vehicle which can be used to transport them. The district medical officers in some districts do not make home visits emphasising the need for clear policy guidelines on this issue. The initiatives taken to provide clinics for vision and hearing screening are laudable even though limited in scope. These need to be expanded to reduce the dependence on outside assistance and be programmed in a more systematic way. Twenty –five percent (25%) of the women in St. Lucia in 2001 who were pregnant were teenagers. This clearly indicates the need for a more aggressive Health and Family Life Education programme and a review of the policy regarding access to family planning methods for adolescents as some nurses are not prepared to give family planning supplies to adolescents 15 years and under.

The dental health services are provided in nine of the health centres and are inequitably distributed with the majority of operatories in the northern part of the island. The need for a structured dental health policy and plan to guide the delivery of these services at the central and health centre levels was recognised by the dental staff consulted. Such a programme should emphasise dental health promotion and prevention interventions such as fluoridation, and should target the school age population as a priority group.

One of the major challenges faced by the health centre based services is the lack of data on the services provided by the private sector in the communities they both serve. Since this data is not available there is an underestimation of the coverage of primary health care services in communities. Some system of collaboration with the private health sector should be designed and implemented to ensure closer collaboration between the private and public sectors. The data also show evidence that patients by-pass the health centres and prefer to use the public hospitals for services available at the health centres. The reason for that is not clear but could be related to the difficulty in seeing doctors at crowded health centres and the availability of drugs and supplies at the hospitals. This has resulted in the Victoria Hospital establishing a special primary care clinic in the Accident and Emergency facilities to deal with such patients.

The establishment of a fee system for accessing services at the health centres has resulted in controversial discussions on whether this is a barrier for accessing services. There is no doubt that the government needs additional funds to continue to provide quality care to patients. However the policy is clearly enunciated that no one will be denied care because they are unable to pay. The assessment of the clients' ability to pay is sometimes based on the possession of a health card and on the advice of community health aides who have intimate knowledge of their communities and can indicate those who can pay and those who cannot. The policy re fees should be reviewed and updated and the method of administering the fee collection system should be such that no financial barriers are erected to deny those clients in need of services.

It is clear from the forgoing analysis that there are many areas in which the primary health care services can be strengthened. One priority area is the development of an adolescent health programme, based on existing data including the reproductive health survey. Such a programme should include a more aggressive and consistent family life education programme and should build on existing initiatives within the Ministry as well involve other government agencies such as Youth Affairs and Education. A well designed community mental health programme is a logical step for improving the mental health services and has the support of the key stakeholders in the Ministry, the Golden Hope Hospital and the community nursing services. Such a programme should include the screening of patients at selected clinics offered at health centres, the training of health centre staff in the diagnosis and management of selected mental health patients using clearly defined protocols, the education of family members in sharing the management of mental health patients who are family members, a community education programme to address the problem of stigma against mental patients, lifeskills development among school children and the involvement of community groups to form a network of support for community members with mental health problems. This needs to be coupled with a phased de-institutionalisation of patients at the main Mental Health hospital.

There is also a growing drug abuse problem and the Ministry of Health has limited involvement in this programme. Turning Point, which is part of the Ministry of Health, provides institutional care for drug addicts but has a limited capacity to meet the demands. In addition it has close links with the Golden Hope Hospital in the management of patients. The main community outreach programmes on drug abuse are managed by the Ministry of Legal Affairs through the Substance Abuse Advisory Council and its Secretariat. The primary health care services need to forge closer links with this Secretariat and be more actively involved in community outreach programmes.

The use of the Accident and Emergency Departments at Victoria and St. Jude Hospitals by non-emergency patients needs to be analysed to determine the reasons for bypassing the health centre based services. A survey should be done of these patients to determine their reasons for bypassing the health centres and the results used to improve services at the health centre levels and relieve the hospitals of this unnecessary workload. The STI/HIV/AIDS programme is now managed as a vertical programme with strong leadership from the central level clinic staff and little involvement of the health centres. The health centres should take a more active role in this programme so that the entire health team is addressing the fight against this pandemic. The strategic plan for this programme should be completed as soon as possible and health centre staff should be involved in collecting community based data and have clear roles in the management and implementation of the programme.

3.2.3 Quality of services provided

It was clear from our discussions that the health professionals at the health centre level are well trained to carry out their specific functions as part of the health team. However there were few written guidelines to guide the delivery of these services. There is an old MCH manual which needs to be updated as recognised by the Nursing Administration Team. The need to update all existing manuals and prepare new ones where none existed was accepted by the primary health

care team as they appreciated the need to standardise the provision of services and enhance the quality of care.

The medical records system at the health centre level is inadequate for the provision of efficient services and for ensuring continuity of care. Some health centres produced about ten quire books each with patients names for different types of services e.g. injections. However there was no patient record for each patient that showed all care received at the health centre. The patients themselves were required to keep a patient book showing services received but this system is not reliable as some patients abuse the book system. Some nursing staff believe that the absence of a proper medical record system leads to abuse of the health centre services by patients who see more than one doctor at health centres for the same episode of illness getting duplicate medications and wasting the time of medical staff. The need to reintroduce an updated version of the Household Health Folder should be addressed to improve the quality and continuity of care. These folders were used about a decade ago but fell into disuse. The reasons given for this were the lack of materials to maintain a steady supply of folders and the attitude of health professionals, mainly doctors, who felt that it was too much paper work. The Gros Islet Polyclinic has just introduced a new medical record system and this must be evaluated in the light of the proposed Household Folder to ensure that one standard medical records system is used.

The laboratory services provided at the majority of health centre are restricted to the collection of samples that are sent to the hospital level for testing and feedback of results. This is so even in those health centres where space was allocated for laboratory services e.g. Anse La Raye. This results in considerable delay in obtaining test results with the consequent drop in the quality of services delivered. A comprehensive study needs to be done to determine the laboratory services to be provided at the health centre, polyclinic and hospital levels of the system and the interface between these levels to ensure quality services. The Government Pathologist should take the lead in this activity with strong collaboration from the health teams at the various levels of the system and with technical assistance from CAREC.

The access to pap smears is an issue that is directly related to the laboratory services and quality of care provided. Over the past year the Community Nursing Staff feel that the failure to obtain timely pap smear results from Victoria Hospital had seriously affected the quality of services delivered to clients. In many cases the clients had to use the private laboratory and St. Jude Hospital laboratory to get the test done at a fee of $15 and $20 respectively. Many clients could not afford this fee. During our last visit at the end of March 2002, however, some of the health centres were happy that the pap smears results were now being returned to them in about two weeks after the pap smears were referred to the laboratory at Victoria Hospital which provides this service free of charge. The hospital laboratory staff must be given special commendation for their heroic efforts to bring the testing up to date and it is hoped that this speedy provision of results will be maintained with strong support from the Senior Management Team in the Ministry of Health.

At some health centres the location and state of the building affect the quality of care that can be provided. The buildings are in disrepair or lack adequate space for managing the number of patients that come for service particularly at the medical doctors' clinics or are affected by their

location being too close to a busy main road with dust and noise problems. As mentioned earlier many health centres have live-in accommodation for nurses which is now inefficiently utilised while the space available for providing services to the public is cramped. Some nutrition officers and pharmacists complained that this hampered the quality of education and guidance they can provide to the clinic attendees.

Most health centres felt that the supplies they received were adequate for the provision of quality care even though there were intermittent shortages of items such as dressings and plaster (e.g. La Fargue HC) and pharmaceutical items. These pharmaceutical shortages affected chronic disease patients from time to time and may be a contributing factor in some of these patients who turn up out of control at the Accident and Emergency Hospital Unit. Priority should be given to ensuring that essential pharmaceuticals are always available at health centres. The Chief Pharmacists has prepared an action plan for the development of the Pharmaceutical Services that include computerisation of the inventory and this should be given serious consideration. Even when the drugs are available the fee structure may deny some patients access to these hypertensive and diabetic drugs. The availability of equipment was another issues raised by health centre staff. Most had the essentials but lacked some critical items. Sometimes equipment had been sent for repairs and had not been returned by the maintenance department for almost two years (e.g. autoclave at Etangs HC). An inventory should be made of the equipment at each health centre and a master plan developed to make available to each health centre the equipment needed to provide quality services in keeping with its functions. Such a list should include nebulizers, autoclaves, emergency trolleys etc.

Discussions with the District Medical Officers (DMOs) and the Community Health Nurses highlighted the major issue of overcrowding at the DMO's clinic. At most health centres between fifty and sixty patients come to these four-hour clinics to be seen by the doctor. It is clear that quality care cannot be provided if the doctor has to see all these patients. In most of these clinics there is no screening of patients by the family nurse practitioner or any other health professional. To improve the quality of care provided at the doctor's clinic the family nurse practitioner has to be involved in the screening of all patients and referring only those patients that need to be seen by the doctor. This will require stronger partnerships between the doctor and family nurse practitioner in managing the doctor's clinic. It will also mean that additional family nurse practitioners will be needed as they are already fully occupied with carrying out other health functions. In addition policies and protocols would have to be established that would give the family nurse practitioner the legal right to provide such support at the DMO's clinic to cover such issues as drawing of blood, suturing of wounds etc.

The present supervisory practices at the health centre level involve very little assessment of the quality of care delivered to patients in keeping with protocols. The focus is more on quantitative data and on in-service education. These are important aspects of the supervisory function. However greater priority needs to be put on the evaluation of the quality of services delivered and the impact of these services on the health of clients using research methodologies such as case studies in patient management.

3.2.4 Referral Systems for primary health care patients

Although there is a system for the referral of patients between hospitals and health centres it is not functioning efficiently. The forms exist for both levels of care but the information on patients is not being effectively transferred to ensure proper follow up care. A major difficulty is in the transfer of information from the hospitals to the health centres. The absence of a single form for use by both levels of care contributes to this problem. In addition many patients are self referred in that they bypass the health centres and go directly to the hospitals. The lack of a close working relationship between the hospital and health centre staff adds to this breakdown in the referral system. The Chief Medical Officer should take the lead, in collaboration with the hospital and health centre patient care teams, in designing a single form for use by both levels of the system. Once this if defined and implemented the hospital and health centre personnel should meet on a regular basis to review common issues of patient care in relation to the referral system. The hospital and health centre staff should also be encouraged to spend time, as part of their orientation, working at both levels of the system so that they can appreciate the level of interface needed between the two levels.

3.2.5 The role of polyclinics and district hospitals and their interface with health centres and main hospitals

The Health Sector Reform Proposals document for St. Lucia recommended the introduction of polyclinics and defined an important aspect of their role as providing 24 hour emergency services for urgent medical care. These services will be co-ordinated by the emergency medical technicians and the family nurse practitioner. The proposed polyclinics will also allow access to doctors, specialists and laboratory and radiology services for people in need of care who do not require hospitalisation for more than 24 hours. They serve a defined population and function as referral centres for patients seen at the health centres in their catchment area. All referrals will be done by doctors and nurses working with defined protocols. They support the primary health care functions of their health centres in the provision of specialist clinics in priority areas such as medicine, surgery, obstetrics, orthopaedics, mental health, dermatology, paediatrics, dental services, radiology (diagnostic imaging), physiotherapy, electro-cardiography, audiology screening and nutrition. They also refer patients to the tertiary level hospitals. All polyclinics will have dedicated ambulance services in house for the transportation of patients when necessary. The polyclinics also function as training centres for health staff in different aspects of public health. The suggested staffing of the polyclinic include the following personnel:

- District Medical Officers
- Family Nurse Practitioners
- Nurse-Midwives
- Registered Nurses
- Public Health Nurses
- Dentist
- Dental Nurses and Dental Aides
- Family Care Workers
- Pharmacists
- Mental Health Practitioners

- Psychiatric Nurse
- Environmental Health Officer
- Health Educator
- Family Life Educator
- Field Nutrition Officer
- Multi-Purpose Technician

The proposal is to establish five polyclinics strategically located across the island to ensure appropriate coverage for the entire population. Accordingly polyclinics are proposed for Gros Islet, Soufriere and Dennery as well as in the tertiary hospitals of Victoria and St. Jude.

In general the proposed functions of the polyclinic are relevant to the health needs of St. Lucia. At present the first phase of the Gros Islet Polyclinic has been commissioned and has just begun to provide limited services. The health centre aspects of the clinic are now being established and staff trained accordingly. In addition there is an extra walk-in medical clinic. The X- Ray, laboratory and emergency services are not yet operational. The conversion of the Soufriere and Dennery District Hospital into polyclinics should also be undertaken on a phased basis. This should only be done after the Gros Islet Polyclinic is providing all the polyclinic services based on the four buildings (of the proposed seven) so far constructed. In the case of Soufriere and Dennery the existing staff can serve as the hard core of personnel needed to staff the polyclinics.

The organisation structure and reporting relationships for staff employed at the polyclinic should be clearly defined. The Administrator of each polyclinic must be in charge of all staff allocated to the polyclinic and function as their boss. However this staff will be required to follow the technical norms and standards as laid down by the technical directorate of the Ministry of Health. Since the polyclinics form part of the primary health care network the Administrator of each polyclinic should report to the Medical Officer (Health) who, in turn, reports to the Chief Medical Officer. The Gros Islet Polyclinic should develop an Operations Manual that will define the goal of the polyclinic, its organisation structure and staff reporting relationships, its functions, the policies and programmes that guide the operations of the polyclinic and the health centres and catchment population served. Similar manuals should be developed for Soufriere and Dennery polyclinics.

At *Appendix 6* is a proposed network of referrals and reporting relationships between the polyclinics and health centres. This chart shows that both Castries and Vieux Forte health centres, although not polyclinics with emergency medical services, will nevertheless function as referral centres for selected groups of health centres. In many respects they are already performing these functions. The x-ray and laboratory services at these polyclinics, as well as at Vieux Forte and Castries health centres, would need to be established in keeping with their functions. The decision on the establishment of a National Public Health Laboratory at the Gros Islet Clinic should be included as part of the proposed study on levels of laboratory services needed to support the primary health care services. A study should be done to determine the demand after 4.00 p.m. for accident and emergency and maternity services at the Victoria and St. Jude hospitals and the cost-effectiveness of establishing such services at the proposed polyclinics on a 24 hour basis.

3.2.6 The impact of day surgery, outpatient surgery and home care on the primary health care services

At present day surgery and out-patient surgery are only performed at Tapion (the private hospital) and at St. Jude. No such surgery is done at the Victoria Hospital because of the lack of an appropriate facility. Health centres are not sufficiently involved in the follow-up management of these patients as they are managed as outpatients of these hospitals. When the Victoria Hospital re-introduces these services, as funds become available for such a facility, the health centres should be required to play a key role in the follow-up of patients. This will require a strong referral system between hospitals and health centres, the training of health-centre based staff, the development of treatment protocols for health centres and the provision of equipment and supplies to support the required patient care.

3.3 Human Resources for the delivery of primary health care services

3.3.1 Health centre staff

The community health nurse, the community health aide and the health centre attendant comprise the core staff for the delivery of nursing services at the health centre level. Many other health professionals have a visiting relationship. These include the nutritionist, family nurse practitioner, pharmacist, public health nurse and the medical doctor all of whom provide valuable services as key members of the highly motivated health centre based team. In addition the dental team, the mental health officers, the dermatologist and the paediatrician conduct clinics at selected health centres. The other members of the community based primary health care team comprise the environmental health officer, the health educator and the family life educator based in the schools. This staff mix is appropriate for delivering the primary health care services. However the amount of staff rather than the mix is the important issue. If the family nurse practitioners are to assist more at the district medical officer's clinic then their numbers need to be increased. This will require an increase in the number of family nurse practitioners (FNP) as there is only one FNP per region at present. In addition the sharing of the same nurse by two health centres, such as is the case with Entrepôt and Ti Rocher/Castries, compromises the provision of services at both facilities resulting in underutilisation of the facilities. Each health centre should be provided with its own community health nurse. The community health aide (CHA) is required to visit each household in the catchment population at least once for the year. However the ratio of CHAs to the catchment population served varies from 1: 2000 population to 1: 5000 population. At *Appendix 7* is a table showing the distribution of CHA's by health centre and catchment population in March 2002. This ratio should be standardised. The role of the CHAs can be expanded to collect baseline data on the health of the households they visit and use this to prepare baseline data on the health status of the population and integrate this data into the reintroduced household folder.

The functions of the DMO's also need clarification as they relates to the making of home visits. Some doctors refuse to make home visits, others charge a fee for such visits while many doctors make these visits for no charge. The making of home visits should be part of their required functions and such visits should be undertaken only when the services of the doctor are needed and the patient is unable to come to the health centre. (There has been at least one case where the

visit made was not necessary.) The integration of the Primary Health Care team in joint planning and programming of services has already been mentioned as a priority need. At present some primary health care workers (e.g. environmental health officers, health educators) operate in isolation from the rest of the health team leading to an uncoordinated approach to providing services. This isolation is sometimes caused by shortage of staff. Priority should therefore be given to the filling of posts in key areas such as community health aides, environmental health officers, community health nurses and health and family life educators. All the primary health care team members stressed the lack of training as a major area of concern. Training is essential for sharpening knowledge and skills and motivating staff to perform. An annual training plan should be prepared for all primary health care workers based on training needs of the service and funds provided in the national and international programmes of support to the Ministry of Health. In addition a strategic human resource development plan should be prepared, of which this annual training must be a part, to provide the staff needed for the reformed primary health care services, including the polyclinics.

3.3.2 Polyclinic staff

The role and function of the polyclinics have already been discussed in a previous section of this document and the proposed staffing pattern has been spelled out in detail. There are core functions of the polyclinic which require specific staffing patterns so that all polyclinics will have similar staff. However additional services may be provided based on the special needs of the target population served e.g. curative services at the Dennery Polyclinic for snake bites. The Gros Islet polyclinic is now being staffed and can provide medical, nursing, pharmaceutical and dental services. Emergency services are coming on stream. The proposals in the health reform document included the need for health educators, family life educators, social workers, environmental health officers and medical specialists in such fields as paediatrics and dermatology. The Gros Islet polyclinic should be used as the pilot to determine the most appropriate staff mix based on demand for services and available resources. This experience should then be used to guide the staffing of the other polyclinics which may have additional functions such as management of patients who will only have a 24 hour stay in the polyclinic.

3.4 District Health Teams

3.4.1 Primary health care teams

In discussions with many of the primary health care staff they clearly articulated their experiences of over a decade ago when the district team concept for the management of primary health care services functioned in pilot communities in St. Lucia. This no longer exists partly because of a lack of clear policy, renewed emphasis on vertical programmes with control from the Head Office of the Ministry of Health and the shortage of staff. These teams had elected leaders who co-ordinated the work programmes of all primary health care staff that served a common catchment population such as a district or region. The nursing staff at the primary health care level in each region, continue to meet regularly to plan, implement and evaluate their programmes. The other primary health care professionals meet separately under the guidance of the technical managers at the Head Office of the Ministry. Rarely do they sit and plan together.

The result is a fragmented approach to planning and implementing services to meet the needs of communities served. It also leads to the inefficient use of resources.

The management of the primary health care system should be revitalised by the introduction of the health team concept at the health centre and regional levels. At each health centre the Community Health Nurse (CHN) should be designated the team leader and be held responsible for co-ordinating the services delivered to the heath centre catchment population. The specific technical officers will be responsible for the technical competence of work performed in keeping with norms and standards of the ministry. The environmental health officers, the medical officers, the dentists, the health educators will be part of the team. This health centre team will be responsible for the preparation of annual programmes and budgets, for finalisation at regional level, to meet the needs of the population it serves and will perform all the management functions of planning, organising, motivating, communicating, implementing and evaluation of programmes. In each health region served by a polyclinic or the larger health centres of Vieux Forte and Castries, a regional health management team should be established, under the leadership of the most suitable senior member of the public health team with the required managerial and leadership skills. This regional health manager will have responsibility for co-ordinating the work of all the health centres in that region. The functions of the regional health management team will be the management of all public health services delivered to the catchment population of the region**.** In many respects the regional plans and programmes will summarise those of the health centres but may have special regional programmes to meet special health needs. In addition each region will be provided with a budget to support the programmes to be delivered and will be responsible for the implementation, monitoring and evaluation of these programmes as well as assessing the impact of these programmes on the health of the communities served.

3.5 Community participation and involvement including collaboration with other sectors

3.5.1 Community Participation

The importance of community participation is fully accepted by the primary health care staff but this is not aggressively reflected in the in their community based programmes. At present the outreach programmes at the health centre level are limited and there are few community groups involved in health programmes. These include the Fathers and Mothers Groups, Diabetes and Hypertension Committees, Youth Groups, Lions Club and Club 60. Some health centre staff, especially those who live in their communities, work hard with community groups giving guidance and support to their health programmes. However many communities are concerned with poverty alleviation issues and are less committed to voluntary community health work. Some of the key factors affecting community participation include a lack of sustained interest by community members, changing social values, lack of interest in health lifestyle issues, increasing violence which threatens the security of health workers and inadequate transportation to support community outreach programmes. The regional health teams must be provided with transport, security, supplies and materials so that they can play a leadership role in mobilising the community. Many other ministries of government, such as the Ministry of Social Transformation, Culture and Local Government, work with community groups and the health

centre staff can form alliances with these ministries to in establishing and maintaining community groups with a health and wellness agenda.

The Bureau of Health Education in the Ministry of Health has a key role in stimulating community participation using the health promotion approach and these educators must provide the leadership for establishing and working with community groups. Some of the successful programmes with community groups can be used as case studies. The Bureau must also train the primary health care team in the use of modern health promotion strategies and the use of best practices for effective behaviour change. The increasing number of health problems in St. Lucia that result from inappropriate lifestyles (e.g. diabetes, hypertension, substance abuse, STI/HIV/AIDS) emphasise the high priority that must be given to community outreach programmes for behaviour change.

3.5.2 Intra and Intersectoral Collaboration

The Department of Human Services of the Ministry of Health and the Primary Health Care Services have responsibility for addressing several health issues that are common to both organisations. These include adolescent reproductive health, health of the elderly, provision of glasses and identifying clients in need of social benefits. There is good collaboration between these two arms of the Ministry at the level of the community health aide regarding household assessments. However in such areas as patient referrals between the two institutions and in fee exemption for clients who go to health centre for services this collaboration needs to be strengthened.

The definition of health as not merely the absence of disease but a state of wellbeing that allowing each individual to live a socially and economically productive life has emphasises the importance of collaboration with other sectors in achieving health for all. In this context there is limited intersectoral collaboration at the health centre and health region levels in promoting the health of communities. This collaboration is reflected at some health centres in joint programmes with the education sector on school health programmes, with the agriculture sector on kitchen garden nutrition programmes, and with the Ministry for Social Transformation, Culture and Local Government on poverty alleviation programmes. However different units of the Ministry of Health such as the Environmental Health Unit and the Bureau of Health Education have strong links with the school system.

In discussions with the senior management team of the Ministry of Education they referred to the National Population Council and the Committee of Permanent Secretaries as two national policy organisations that were critical in coordinating the human resource sector of the government. All health related ministries were part of the Population Council at this policy making level and decisions were taken on issues of health including primary health care issues. The Human Resource Group of Permanent Secretaries also is an influential body for achieving Intersectoral coordination in health matters. The role and function of both these organisations should be examined by the Ministry of Health and appropriate strategies developed to revitalise either or both of these groups to serve the needs of the Ministry of Health.

The Family Life Education (FLE) programme is recognised as critical aspect of the school curriculum and was implemented some eleven years ago at the primary and secondary school levels as well as in the Teachers' Training College. This FLE programme deals with sex and sexuality, management of the environment, health welfare and lifestyles, eating and fitness and social emotional and spiritual wellbeing. There is also a Health Promotion in Schools programme that is in its early stage of implementation. The FLE programme in the school system needs to be continuously monitored and evaluated to ensure that it is having the intended impact on behaviour change. In addition the nursing fraternity at the primary health care level needs to be more fully integrated into the FLE programme and the Bureau must take the lead in making this happen.

The schools can be contacted directly by health centre staff to plan and implement health interventions such as immunization and screening for sight and hearing problems. The nutritionists visit schools to deliver talks and give demonstrations. The Ministry of Agriculture has a Green House programme in schools. The nutritionist also collaborates with the School Feeding Programme in the preparation of well balanced meals. There is also an Environmental Health Programme in Schools with strong support from the environmental health officers in the Ministry of Health. Some secondary schools have a lifeskills development programmes which deals with such issues as drug abuse, parenting and conflict resolution. The Human Services Division of the Ministry of Health works closely with the schools on this programme. There is also a structured School Dental Health Programme that includes dental health promotion, prophylaxis and dental care for children. The need is for an integration of all these initiatives and the development of a comprehensive School Health Programme.

This Ministry of Social Transformation, Culture and Local Government is a very important partner for the Ministry of Health in that their small team of social workers are invaluable allies in improving the health of communities. This ministry is responsible for community mobilisation and can co-ordinate the efforts by government agencies to consult with communities. The ministry officials outlined the number of government agencies that need to hold such consultations and stressed the fragmented nature of these consultations where each agency does its own consultation. They pointed out that some communities suffer from "consultation fatigue". The ministry is willing to play a co-ordinating role in facilitating such consultation and involving more than one sector in a consultation meeting. The community groups established by this ministry can also be used by the health workers to promote healthy living. The Ministry of Health must be more proactive in building alliances with this ministry in addressing the health needs of communities.

The Ministry of Home Affairs and Gender Relations has the responsibility for several residential institutions that require the full range of health services. At present the ministry has its own structure with ad hoc arrangements with doctors, psychiatrist and dentists who visit the facilities once per week. The DMOs are involved and attend on rotation. The ministry stressed the need for a structured health programme in the prisons and the need for the Ministry of Health to support the design of such a programme. In addition the Ministry of Health, through the Gros Islet clinic, provides health services to inmates at the Boys Training Centre, although there is need for a policy decision on this. Similar services are provided for the Women Support Centre but these initiatives need to be systematically organised and supported by the necessary policy

decisions. Port Health is another area of collaboration between these two ministries that needs to be strengthened. The Ministry of Labour has responsibility for Occupational Health and Safety which is an important function of the environmental health officers in the Ministry of Health. The "wellness of the worker at the workplace" and occupational related illness should be areas for joint collaboration between the two ministries. Where the health personnel need additional skill development, the Ministry of Labour can provide support by conducting training programmes for selected health staff to upgrade knowledge and skills.

Finally there are many non-governmental organisations (NGOs) that work closely with the Ministry of Health and receive a small annual subvention from the government. These include the Red Cross, the Cancer Society, the Sickle Cell Association and the Blind Welfare Association. They all have the challenge of inadequate funds to deal with the demands for their services. However they get some international support that helps to relieve this shortage and improve the quality of services that they offer. The Red Cross is very active in training (First Aid, CPR) as well as community and school health education programmes that include HIV/AIDS education sessions. They are also play a key role in Disaster Preparedness. The Sickle Cell Association caters for children all over the island and offers a very well organised programme using the health centre based community paediatric clinics. The patients are identified at birth and parents, hospital and health centre staff are intimately involved in the programme. Patients are referred overseas for treatment as needed. The private sector is a major source of funding for providing ongoing financial support for these patients. The programme works in close collaboration with the Victoria Hospital. The Cancer Society focuses on public education and offers support for palliative care. They send patients to Barbados, Martinique and Trinidad and Tobago. The Society maintains the Cancer Registry and works closely with the Victoria Hospital. However the shortage of funds makes it difficult to provide financial support to patients who need chemotherapy, many of whom simply wait to die. The Blind Welfare Association is involved in the training of teachers to identify eye problems among students and has an active follow- up programme in schools. The Association also works closely with the health centre staff and provide training to nurses on vision screening. The collaboration with the Epidemiologist in the Ministry of Health in strengthening the data base for the programme indicates the close linkages with government. Shortage of funds is a major deterrent for improving the coverage and quality of services offered. It is clear that all these NGOs not only work closely with the government health services but are vital partners in the delivery of primary health care services. This partnership must be maintained and strengthened.

IV SUMMARY OF FINDINGS AND RECOMMENDATIONS

4.1 MANAGEMENT SYSTEMS FOR PRIMARY CARE SERVICES

4.1.1 Policy Framework

Findings

- There is no clearly defined Primary Health Care policy for St. Lucia adapting the Alma Ata definition to the political and socio-economic conditions of the

country but the Health Reform document contains a proposed framework for this
- The primary health care services have a disease oriented focus rather that an emphasis on wellness

Recommendations

- The Ministry of Health needs to develop a Primary Health Care document clearly defining the approach for St. Lucia and emphasising the wellness concept. Such a document (See *Appendix 3*) should include:
    - Geographic access to services e.g. radius of three miles for each health centre
    - Levels of Care concept, types of services to be provided and staffing patterns at each level i.e. health centre, polyclinic and the role of the hospital
    - Size of population coverage per community health aide
    - Health promotion and disease prevention strategies including community participation and intersectoral collaboration
    - The district/ regional health team concept in the management of primary health care services

- The Ministry of Health should review and finalise the Health Reform Proposal and use this as the blueprint for the long-term development of the health services in St. Lucia

4.1.2 Levels of Care and relationships between public health facilities

Findings

- The two defined basic levels of care in the health system are the hospitals and health centre based services
- The role of the District Hospitals need to be more clearly defined in their relationships to the health centres and main hospitals
- The role of the new polyclinic at Gros Islet needs to be clearly defined in its relationship to the Victoria Hospital and the health centre services in regions

Recommendations

- The primary health care services should have three levels comprising health centres, polyclinics and interface with hospitals as described in the health reform proposals for St. Lucia.
- The polyclinic would serve as the first referral level for the health centres and would provide diagnostic services and specialist services e.g. dermatology, paediatrics and mental health
- The district hospitals at Dennery and Soufriere should function as polyclinics

- The main hospitals, Victoria and St. Judes, should function as second referral level for the primary health care system except for Castries and Vieux Forte health centres where they would function as first level of referral for diagnostic services
- The Gros Islet Polyclinic would serve the following health centres : Grand Reviere, Monchy, Babonneau, Fond Assu
- The Dennery Polyclinic would serve the following health centres: La Ressource, Rich Fond, Mon Repos and Ti Rocher – Micoud
- The Polyclinic at Soufriere would serve the following health centres: Mongouge, Canaries, Fond St. Jacques, Etangs, La Fargue, Delcer
- The health centres at Castries and Vieux Forte would operate as modified polyclinics providing first level referral for specialist services but would not duplicate the diagnostic services available at Victoria and St. Jude Hospitals
- The Vieux Forte health centre would function as the first level of referral for the following health centres: Desruisseaux, Labourie, Saltibus, Belle Vue and Grace
- The Castries health centre would function as the first level of referral for all the health centres in Regions 7 and 8 namely La Clary, Ti- Rocher, Bexon, Marchand, Entrepôt, Ciceron, Vannard, Anse La Raye, Jacmel and La Croix Maingot

4.1.3 Management of Primary Health Care services

Findings

- The primary health care programmes are vertical programmes managed from the central level of the Ministry and are inadequately co-ordinated at the regional and health centre levels as there is no designated manager for the health regions
- The absence of a full time Medical Officer (Health) at the head office of the Ministry of Health contributes to the lack of co-ordination and dynamic leadership of the primary health care services
- The health regions and health centres do not have a profile of the health needs of the populations they serve. Only 30% of the health centres reported their catchment population within 10% accuracy
- The health centre staff have good relationships with the communities they serve and those who have been at the health centre for some time have intimate knowledge of community members, especially when they come from or live in the community
- There is no comprehensive planning and programming of health services at the health centre and regional levels based on the health needs of the catchment population.
- The information collected is throughput and not outcome or impact related which limits its usefulness to workload predictions
- There is little or no analysis of the data at the health centre level for the management of services, except at the Dennery Hospital

- The programmes delivered at the health centre level are not clearly supported by budgetary requests based on a programme budget approach thus making it difficult for the health teams to obtain resources for programme execution
- Some regions and health centres have broad plans that cover new nursing initiatives only and these need to be defined in greater detail for implementation, monitoring and evaluation purposes
- The management contract between the St. Jude Hospital and the Ministry of Health allows the hospital to independently determine its fee structure that could result in inequity in access to services
- There is no evidence in the field that the Epidemiological Unit of the Head Office of the Ministry guides the health centre staff in the analysis and utilisation of community health data
- The supply management system for sundries and cleansing material to health centres is managed by the Community Nursing Service with the Principal Nursing Officer using an estimation of consumption levels for each health centre to determine requisition and distribution patterns. There is evidence that "best values" are sought in purchasing these supplies. Each health centre maintains a stock card to track the receipts and distribution of these supplies

Recommendations

- The management of the primary health care programmes should be decentralised to the regional level with technical support from the programme managers at the central level of the Ministry
- The regional health teams should develop and maintain a profile of the health status of the catchment population they serve with support from the Epidemiology Unit of the Head Office of the Ministry
- The Epidemiology Unit should guide and train the regional health team in the analysis and utilisation of the data collected which should reflect not only the workload but the impact of the services provided
- The regional health teams, with strong support from the Planning Unit of the Ministry, should develop regional health plans to address the priority health needs of the catchment population using the data collected. These plans should be monitored and evaluated on a systematic basis
- This regional health planning process should be integrated into the budgetary process to ensure that funds are provided to support implementation
- The fee structure for services at the primary health care level should be reviewed to ensure uniformity across all government health institutions including St. Jude Hospital
- The Technical Directorate of the primary health care services at the Head Office of the Ministry should be strengthened by the urgent appoint of a full time Medical Officer (Health) to manage these services
- The Primary Health Care Directors and Heads should resume meeting on a regular basis to give coordination and leadership to the primary health care services at head office and field levels

- The existing supply management system for sundries and cleaning materials for the Community Nursing Services should be analysed with a view to integrating this system into a ministry wide system for the procurement of these items to achieve cost efficiency. In addition the distribution and stock control system at the health centres should be analysed with a view to covering all supplies used by all services at the health centre.

4.1.4 Involvement of health workers and the key stakeholders in the Health Reform process

Findings

- Many health workers at the primary health care level are not aware of and have not participated in discussions on the health reform process in St. Lucia
- The community and other key stakeholders (e.g. Medical Association) were consulted in the initial phases of the reform process but this consultation has not been maintained
- The Medical Association were key participants in the initiation of the Health Reform process and this leadership role has not been sufficiently utilised to support the reform process and enable the Association to play a key role in its formulation and implementation

Recommendations

- The workers in the Ministry of Health at both Head Office and field levels should be updated on the current status and plans for moving the health reform process forward and be actively involved in their formulation and implementation
- The community and other key stakeholders should be kept abreast of the health reform process and be involved as partners
- The Ministry of Health should establish a small committee of senior technical and administrative health staff with responsibility for implementing the health reform process, including the recommendations of this report, based on decisions made by the policy makers in the Ministry. This committee should have close links with the Health Planning Unit which should function as a secretariat to the Reform Committee.

4.2 SERVICES DELIVERED AT THE PRIMARY HEALTH CARE LEVEL

4.2.1 Network of health facilities

Findings

- The existing network of health centres, based on population distribution and workload, is adequate to meet the needs of the population, particularly in keeping with the wellness concept as envisioned in the reform document
- The effectiveness of the network is affected by the lack of a team approach at the regional level in co-ordinating all the work of these health centres
- The efficiency of the network is reduced by the bottlenecking of the referral system which relies on the two main public hospitals emphasising the need for an intermediate level of services that is not now provided at the District Hospitals
- The closure of the health centre at Bogus two years ago has resulted in part of that catchment population going to Babonneau health centre for services resulting in overcrowding of that health centre especially at the doctors clinic. In addition the health centre is in need of repairs to building and essential equipment

Recommendations

- The existing network of health centres should be retained in order to ensure easy access by the community and ready outreach to the population by the members of the health team.
- In the Castries region the Marchand health centre should be closed and the services relocated to the Entrepôt health centre. Easy access by the catchment population to Entrepôt would be facilitated by negotiating with the transportation sector to ensure the availability of transportation
- Any consideration to reduce the number of centres in the network need to take into account not only the workload of the services provided at the centre but the opportunity cost of the loss of outreach to the community in light of the wellness approach contemplated in the reform of the sector
- The Babonneau health centre should be renovated as a matter of priority to provide better service to the community. Consideration should be given to holding the doctors clinic on Monday and Wednesday rather than holding both clinics on Wednesday. The suggestion that a new health centre should be established at Laguerre should be evaluated after the renovation of the Babonneau health centre based on improvements needed in service delivery at that health centre. The possibility of an outreach clinic in Laguerre as opposed to a health centre should be considered as one option
- The health centre at Vannard should be repaired or relocated as a matter of urgency as the building is sinking
- A comprehensive assessment of the condition of the health centre equipment, buildings and the utilisation of space should be undertaken and a special programme developed to improve the quality and use of these facilities. This could form the basis for a special project to support the improvement of those facilities.

- The equipment needs of health centres should be determined based on treatment protocols and such equipment provided on a priority basis.

4.2.2 Access and coverage of services

Findings

- There is a well distributed network of health centres in St. Lucia to serve the population
- The basic package of primary health care services cover the important areas of maternal and child health, chronic diseases including cancer screening and dental health but there is insufficient inclusion of health centre staff in programmes on mental health and the control of STI/HIV/AIDS and no adolescent health programme.
- In a few health centres mental health services are provided by visiting staff from the Mental Hospital with follow-up support from health centre staff through supervision of medication as needed. This is not a widespread practice in the primary health care services even though all the health regions have the need for a well designed Community Mental Health Service
- The primary health care services must establish closer linkages with the Ministry of Legal Affairs in the management of community based Drug Abuse programmes
- There is still evidence of the bypass of health centre services by clients who prefer to use the public hospitals for services available at the health centre level. For example Victoria Hospital has established a special primary care clinic in its Accident and Emergency Area to deal with such patients
- Although the health centre teams provide a valuable outreach programme from the health centres, their community visits tend to be disease and programme driven in response to follow-up of health centre patients rather than focussing on wellness concepts and maintaining a healthy community as envisioned in the health reform document.
- The community outreach health programmes have been affected by issues of security, difficulty with travelling, the lack of a clear policy on the role of the district medical officer and the shortage of community health aides
- Each region has a nutrition officer and family life educator/ health educator but they have a visiting relationship to the health centre and their inputs to the regional health programmes are not always fully integrated
- There is no structured School Health Programme in the regions as interventions tend to be ad hoc and based on requests from the school principals
- At present some specialists services are provided at selected health centres thereby upgrading the services available at health centres e.g. Dermatology, Psychiatry, Paediatrics. This initiative can be expanded to

include outreach services from the main hospitals in other specialities based on community health needs

- The environmental control programme previously had a strong community base but has become highly centralised resulting in a separation of the environmental health officers from the regional health teams. The shortage of these officers has contributed to this separation process
- There is no data at the regional level on the type and coverage of services delivered by the private sector resulting in an underestimation of the coverage of primary health care services
- The impact of fees on the access to health centre based services is not clear. Some anecdotal information suggests that the introduction in 1996 of the fee to see the DMO caused a reduction in the number of patient visits. In addition there is also similar information that the lack of a fee for service has contributed to the over-utilisation and abuse of these services
- The initiatives being implemented for the screening of hearing and vision should be lauded. However they are limited by the dependence on outside assistance and not programmed in a systematic way and provides limited coverage
- The level of teenage pregnancy in St. Lucia remains high as twenty-five percent of the women in St. Lucia in 2001 who were pregnant were teenagers. This suggest the need for a more aggressive and consistent programme on Health and Family Life Education and a review of the policy regarding the access to family planning services provided for adolescents
- There is no structured policy or plan for the delivery of dental health services at the central and health centre levels. Dental operatories exist in nine of the health centres and are distributed inequitably with the majority in the northern zone of the island

Recommendations

- The Ministry of Health should develop an adolescent health programme using available data including the adolescent reproductive health survey results building on existing initiatives relevant to adolescent health within the departments of the Ministry (e.g. Human Services Department, Community Nursing Department) and across government agencies (e.g. Youth Affairs, Education
- A more aggressive and consistent programme on Health and Family Life Education should be an essential part of the proposed Adolescent Health Programme
- The policy towards access to family planning services for adolescents 16 years and under should be clearly defined and consistently applied throughout the government health system
- There is urgent need for a well designed Community Mental Health Programme with full integration of the primary health care staff in its

planning and implementation. Such a programme should involve the de-institutionalisation of care, the reduction of stigma in communities, early case finding and efficient and effective rehabilitation.

- The main components of such a mental health programme should include defining levels of care and protocols for patient management, the roles of different levels of health staff and the community, training of staff, public education and community participation in patient management and acceptance
- Closer links must be established between the primary health care services and the Ministry of Legal Affairs in the planning and implementation of Drug Abuse programmes at the community level
- A survey should be conducted of all patients attending the Accident and Emergency Departments at Victoria and St. Jude Hospitals to determine the reasons for non- accident and emergency patients attending these facilities and by- passing the health centre based services. The results of this survey should be used to inform decisions on the improvement of the health centre services
- The family life educators, nutritionists and environmental health officers should become fully integrated into the health centre teams and participate in joint planning and implementation of programmes
- The School Health Programmes should be planned in a structured and comprehensive manner in collaboration with the education sector and should include the main components of Health and Family Life Education, Immunisation, Screening and Environmental Health
- The HIV/ AIDS/STI programme should be better integrated into the primary health care system to ensure that the entire health team is mobilised in the fight against this pandemic. The development of the strategic plan for St. Lucia should be expedited and community based prevalence data collected and utilised in the management of the programme
- The provision of specialist health services should be done in close collaboration with the two main hospitals and their scope should be expanded to include ophthalmology, chronic diseases and ENT services in accordance with the epidemiological pattern of the problems affecting the community. These services should be located at the polyclinics
- A system of collaboration with the private health sector should be designed and implemented to include the types of data to be collected on services provided by the private sector
- The policy re fee for services in the primary care should be reviewed and updated to ensure consistency in their application and to ensure that there are no barriers to effective access of these services
- A dental health policy and strategic plan should be developed which should emphasise dental health promotion and prevention interventions such as fluoridation, and should target the school age population as a priority to be served by the programme

- The community health aides should be provided with a travelling allowance to reduce security risks and improve the efficiency of the home visiting and community outreach activities. Alternatively each region can be provided with a vehicle that would be used to transport these workers to and from their communities

4.2.3 Quality of services provided

Findings

- Even though the health professionals at the health centre level have been well trained, there are few written protocols to standardise the provision and enhance the quality of primary health care services. Those that have been written need to be updated
- The current medical records system in primary care does no lend itself to efficient continuity of care and contributes to patient abuse of the services through unnecessary multiple visits to the medical clinic by the patients. The recent introduction of a new medical record at the Gros Islet Polyclinic is a step in the right direction
- The laboratory services at most health centre are limited to the taking of samples and specimens with all testing done at the Victoria Hospital, St. Jude Hospital or the private laboratory even though some health centres have allocated laboratory space
- The community health nurse also feels that the access to pap smear results in a timely manner has been affected by the failure of the Victoria Hospital to provide timely results and leads to the need to use the private laboratory for these services at a $15 fee which some clients cannot afford. The fee at St. Jude Hospital is $20
- At some health centres the location and state of the building affects the quality of services delivered and the health of the staff e.g. Marchand, Vannard, Fond St. Jacques and Rich Fond
- Many health centres have live- in accommodation space for nursing staff which is not now efficiently utilised while the space available for providing services to the public is cramped
- Most health centres felt that the supplies they receive are adequate for the provision of quality care. Intermittent shortages were reported on pharmaceutical items
- The present supervisory practices used at the health centre does not include a thorough analysis of the quality of the services delivered in keeping with established protocols but focuses rather on the use of quantitative data and some in-service education
- There is overcrowding at the DMO' clinic at most health centres where between 50 and 60 patients are required to be seen in a 4 hour session making it difficult to provide quality care

Recommendations

- As part of the programme planning exercise an assessment should be made of the protocols needed for the delivery of primary health care services and these protocols should be prepared or updated on a priority basis
- The Ministry of Health needs to consider the re- introduction of an updated version of the Household Health Folder at health centres to improve the quality, efficiency and effectiveness of the primary health care services. This folder should include the medical records information for each member of the household. In this regard the medical record introduced at the Gros Islet Polyclinic should be evaluated and incorporated into the proposed system
- A comprehensive study should be done to determine the laboratory services to be provided in support of the primary health care services at each level of care i.e. health centre, polyclinic and hospital. The Government Pathologist should take the lead in the implementation of this activity in close collaboration with the primary health care team and CAREC.
- The Victoria Hospital should ensure the provision of consistent, timely and efficient pap smear services to the primary health care services in support of the cancer screening programme. Negotiations should be held with the administration at the St. Jude Hospital re their participation in supporting this programme.
- The constant availability of essential pharmaceutical and supplies for priority programmes such as the control of chronic diseases and mental health needs to be assured in the primary health centres. The proposals for the reform of the Pharmaceutical Services should be reviewed in the light of this need.
- The supervisory functions at the health centre level should include a thorough analysis of the quality of services provided and the extent of compliance with the relevant protocols
- The medical clinics run by the medical doctors should be reorganised so that only patients who need to see the doctor do so on a referral basis. This will involve the family nurse practitioner and the community health nurse playing a more integral part in these clinics conducted at the health centre level. An alternative solution to this problem is the full time employment of the district medical officer thereby doubling the amount of hours available from the doctors.

4.2.4 Referral system for primary health care patients

Findings

- Although referral forms exist for use by both hospitals and health centres information on patients is not being transferred for proper follow-up care
- The main breakdown in the referral system is in the transmission of information from the hospital to the health centre services
- The absence of one single form for use by both the health centres and hospitals contributes to this breakdown in the flow of information
- Many patients who go to the hospital are self-referred thereby bypassing the health centre services
- The lack of close working relationship between staff at the hospital and health centre levels mitigates against the effectiveness of the referral system
- The fee for service system operating in the St. Jude hospital is having a negative impact on some primary health care programmes e.g. antenatal, pap smears

Recommendations

- The Chief Medical Officer should review the existing referral forms and design a single form for use by both the hospitals and health centres, in consultation with hospital and health centre based personnel
- The hospital and health centre personnel involved in the referral process should meet on a regular basis to review common issues in relation to patient care with special emphasis on the referral system.
- The hospital and health centre staff should be encouraged to spend time as part of their orientation programmes working in both areas so that they can appreciate the levels of interface needed between both levels of care

4.2.5 The role of polyclinics and district hospitals and their interface with health centres and main hospitals

Findings

- In general the functions of the polyclinic as articulated in the health reform document are relevant and appropriate for St. Lucia. However the need for a 24 hour service should be evaluated in the light of the most cost effective way of meeting the demand for services. The relationship with the hospitals would also need to be clarified
- There is no fully functioning polyclinic at the present time as the Gros Islet Polyclinic has just been commissioned and is still being made operational. The health centre aspects of the clinic are now being established and staff trained accordingly. The X-Ray, laboratory and

emergency services are not yet operational. The only difference at present is the extra walk in medical clinic and the presence of the administrative staff

- The relationship of the Gros Islet polyclinic to the region (s) it serves has not been defined, including its reporting relationship within the health region and there is no specific document that defines the goal of the institution and the policies and programmes to guide the services provided by the institution
- The organisation structure and reporting relationships of staff assigned to the Gros Islet Polyclinic needs to be defined as some staff assigned to the clinic still are supervised administratively by their technical supervisors outside the polyclinic
- The relationship between the proposal to establish a National Public Health Laboratory and the laboratory at the Gros Islet Polyclinic should be clarified in order to expedite the commissioning of the Polyclinic
- At the Dennery Hospital the inpatient hospital services are almost non-existent. The main focus of the hospital is Accident and Emergency Services, delivery of low risk pregnant women and health centre based services. It has a high referral rate to Victoria Hospital (35%)
- The District Hospitals are not staffed at present to function as recuperation centres for patients treated at the main hospitals. However no serious effort has been made to upgrade their services so that they can function in this way
- The laboratory services at District Hospitals are limited to the collection of specimens for testing at the Victoria and St. Jude Hospitals
- The present workload of the Victoria and St. Jude hospitals suggest that these institutions can cope with the demand for their in-patient services and there is no need for District Hospitals to relieve this workload
- The in-patient statistics on the District Hospitals show a very low occupancy rate reflecting underutilisation of these in patient facilities and low cost-efficiency in the operation of these facilities
- The District Hospitals are not organised to give appropriate support to the health centre in the management of referrals and the provision of x-ray and laboratory services so that the reliance on the Victoria and St. Jude Hospitals can be reduced and patients provided with a more efficient service

Recommendations

- A study should be conducted to determine the demand for Accident and Emergency and Maternity Services after 4.00 p.m. at Victoria and St. Jude, Dennery and Soufriere hospitals and the cost –effectiveness of establishing those services at the polyclinics on a twenty-four basis
- The Gros Islet management team should develop an Operations Manual that would define the Goal of the polyclinic, the policies and programmes

that guide the operations of the polyclinic, the organisation structure and reporting relationships of staff and the catchment population served. Such manuals should also be developed for the proposed polyclinic at Dennery and Soufriere

- The Administrator of the Gros Islet and all other polyclinics should report to the Medical Officer (Health) at the Head Office of the Ministry. All staff working within the polyclinics should have administrative reporting relationships to the Administrator and technical supervision from the respective senior technical staff at the regional and central levels
- The decision to establish a National Public Health Laboratory at Gros Islet Polyclinic should be included as part of the study on the levels of laboratory services to support the primary health care services
- The polyclinics should be organised to give appropriate support in the management of referrals from health centres and the provision of x-ray and laboratory services

4.2.6 The impact of day surgery, out-patient surgery and home care on the primary health care services

Findings

- Day-surgery and out-patient surgery are performed at the private hospital, Tapion and the St. Jude Hospital. At present no such service is provided at the Victoria Hospital because of lack of a facility. However the intention is to reintroduce these services when funds become available for such a facility
- These patients are managed through follow-up visits to the respective hospitals and are not systematically referred to the health centre services for follow-up care
- There is no flow of information from the hospitals to the health centre level so that the centres can monitor the health status of these patients
- The health centre based services are not fully equipped to provide follow up care for day surgery and out-patient surgery patients
- The community health nurses, the family nurse practitioner and the community health aides are the key health workers in facilitating the provision of home care by health centre staff based on information they get from their field visits and from the community members

Recommendations

- The health centre should be adequately prepared with the appropriate protocols, equipment and supplies to provide follow-up care to day surgery patients referred from the main hospitals

- The updated referral system should be used to provide timely and appropriate information to health centres on follow- up care for such patients

4.3 HUMAN RESOURCES FOR DELIVERY OF PRIMARY HEALTH CARE SERVICES

4.3.1 Health centre staff

Findings

- The community health nurse, the community health aide and the health centre attendant are the core staff that run the health centre based nursing services. This group displays a high level of motivation. All other health professionals provide support on a visiting basis.
- The family nurse practitioner, the public health nursing supervisor, the nutritionist, the dentist, pharmacist and the district medical officer provide essential support for priority programmes on a visiting basis
- The family life educator works independently at the school and community level with little co-ordination of this programme with that of the health centre team
- There is a fairly wide variation in the coverage provided by the CHAs from 1: 2000 pop. to 1: 5000 pop indicating the need to establish a norm that would better facilitate the effective implementation of the wellness concept as outlined in the health reform document
- In a few health centre areas the CHA visits each household at least once per year while in other health areas this is not the norm
- The sharing of one nurse between two health centres, such as currently exists between Entrepôt and Ti Rocher, compromises the provision of services at both facilities resulting in underutilisation
- There is no well defined annual training plan for the development of health centre staff in keeping with service needs. This contributes to a high level of demotivation among primary health care workers
- The role of the District Medical Officer needs to be clarified particularly in respect of their participation in the district health team and consistency in the performance of their duties
- The provision of home care by district medical officers is left to the discretion of these officers often resulting in the charging of fees and the refusal of some DMOs to perform these duties

Recommendations

- The health centre programming process should be used to integrate the services provided by visiting professionals and the family life educator to ensure a coordinated response to the health needs of the community

- The Ministry of Health needs to establish a norm of population: CHA ratio taking into consideration the geographic distribution of the population and the need to ensure effective implementation of the wellness concept. This norm should be used to staff health centres appropriately
- The community health aides should be required to conduct a baseline survey of the households in their catchment area which is updated on a periodic basis (at least once per year). The Household Health Folder should be reviewed and updated to form the basis of this baseline data
- To ensure the integrity of primary health care system priority must be given to the filling of posts in key areas such as the community health aides, environmental health officers, pharmacists, community health nurses and health/ family life educators
- An annual training plan should be developed for all primary health care workers based on inputs from the regional and health centre levels. The funding of this plan should be aggressively pursued using national and international resource
- There is urgent need to develop a strategic human resource development plan for primary health care staff and implement this plan in keeping with the proposed reform of the health system based on available financial resources. The Sir Arthur Lewis Community College should be used as a resource in the planning and implementation of this strategic plan
- The district medical officers should be more involved in giving technical support to the teams at health centre and regional levels and participate more fully in the community outreach and health promotional activities
- The Ministry of Health should clarify the policy with regards to home visits by district medical officers and ensure that this policy is followed

4.3.2 Polyclinic staff

Findings

- The staffing of the proposed polyclinics is being determined by the health care needs and demands of the population served which would define the services to be provided based on available resources
- The proposed staffing for the Gros Islet Polyclinic is still being finalised as the policlinic is now becoming operational
- The preliminary proposals for polyclinic services, as outlined in the health reform document, include all those staff necessary for the proper functioning of a health centre as well as laboratory, x-ray and emergency medical services.
- The Gros Islet Polyclinic at present is staffed to provide medical, nursing and dental services, with appropriate clinical support staff, and emergency medical services. The proposals in the health reform document included the need for health education specialists, family life educators, social workers, pharmacists, nutrition officers, medical specialists (e.g.

dermatology, paediatrics) and environmental health officers at least on a visiting basis. This is in keeping with the health promotion and wellness concept as proposed in the reform document

Recommendations

- The staffing pattern for other polyclinics should be based on experiences gained in establishing the Gros Islet Polyclinic and the specific health needs of the populations they serve

4.4 "DISTRICT" HEALTH TEAMS

4.4.1 Primary Health Care teams

Findings

- The "District" health team concept no longer exists at the Primary Health Care level of the health services
- The nursing staff at the primary health care level continue to meet on a regular basis to plan the work of health centres and regions
- The team concept for Primary Health Care was piloted at least fifteen years before at the District/ Regional level but the lack of a clearly articulated policy, renewed emphasis on vertical programmes with control from the head office of the Ministry and the shortage of health staff has led to the breakdown of the team concept involving all primary health care workers at the health centre and regional levels
- The job descriptions of the public health nurse and the community health nurse give them administrative responsibility over the nursing functions in the region and health centres respectively while no one is responsible for all health services delivered at the regional and health centre levels
- The lack of Health Centre and Regional Health teams has resulted in a fragmented approach in planning and programming of health services to meet the health needs of the communities served and the more effective use of resources

Recommendations

- The management of the primary health care programmes should be strengthened at the health centre and regional levels by the reintroduction of the primary health care team concept.
- These programmes should be under the co-ordination of regional team managers with technical support from the technical directors of the Ministry.

4.5 COMMUNITY PARTICIPATION AND INVOLVEMENT INCLUDING COLLABORATION WITH OTHER SECTORS

4.5.1 Community participation

Findings

- The outreach programmes at the health centre level are limited as there are few community groups which are involved in the programming and implementation of health programmes e.g. Fathers and Mothers group, Diabetes and Hypertension Committees, youth groups, Lions Club, Club 60
- Many communities are concerned with poverty alleviation issues and show little enthusiasm in wanting to be involved in health work at the community level
- The Ministry of Social Transformation, Culture and Local Government is responsible for mobilising the community and focussing on poverty alleviation issues. The Development Committee in each region develops a community profile which does not include a health component
- The most important constraints to greater community outreach activities on the part of health workers include a lack of sustained interest of community members, changing social values, a lack of interest in health promotion activities, increasing violence which threatens the security of health workers and insufficient transportation support from the Ministry
- Some health centre staff, particularly those who live in the community, play an important role with the few community based health groups that exist and encourage them to sustain their programmes.
- The existing health education programmes do not demonstrate the use of modern health promotion techniques which are effective in behaviour modification

Recommendations

- The Ministry of Health should collaborate with the Ministry of Social Transformation, Culture and Local Government in the development of poverty alleviation projects which focus on health issues as an entry point for mobilising communities to address health and well being issues e.g. environmental health projects
- The regional health teams must be provided with transport, security, supplies and materials to enable them to be key participants in this community mobilisation process
- The regional health team needs to be trained in the use of modern health promotion techniques and to utilise the best practices for effective behaviour change. The Bureau of Health should take the lead in planning and implementing this training

- The regional health teams, with strong leadership from the health educator, should make maximum use of existing community groups to promote health and wellbeing

4.5.2 Intra and Intersectoral collaboration

Findings

- There is very limited intersectoral collaboration at the health centre and regional levels in promoting the health of the community.
- There is evidence of limited joint programmes with the education sector, through school health programmes, the Ministry of Social Transformation, Culture and Local Government and the agricultural sector through kitchen garden nutrition programmes
- The collaboration between the Ministries of Education and Health is still ad hoc and depends on personalities rather that well defined programmes
- The Ministry of Home Affairs and Gender Relations is responsible for several residential institutions e.g. prisons, remand centre, women support centre. The residents of these institutions require the full range of health services
- The Department of Human Services and the Primary Health Care Services have several health issues in common e.g. adolescent reproductive health, health of the elderly, provision of glasses and identifying clients in need of social benefits. Whereas there is good collaboration at the level of the community health aides in the area of household assessments there is insufficient collaboration in other areas such as fees exemption and referrals between the two services in the management of patients
- The absence of data analysis and a systematic programming process have hampered the development of intersectoral collaboration
- There is insufficient collaboration between the Ministries of Labour and Health in the development of a Workers Health Programme
- The non-governmental organisations provide valuable health services to the community with very little resources and work in close collaboration with the government health services. This partnership should be strengthened.

Recommendations

- The Ministry of Health should explore the value of re-establishing the National Population Council and the Committee of Permanent Secretaries dealing with Human and Social Development as two high level policy making bodies in fostering intersectoral collaboration to address the health needs of the population and based on this assessment of their value, make proposals for the re-introduction of these bodies

- In the important programme areas, such as School Feeding, Health and Family Life Education, Hearing and Vision Screening, Dental Health and Environmental Sanitation, the Ministries of Health and Education should collaborate in the development of a comprehensive school health programme
- There should be collaboration between the Ministry of Health and the Ministry of Home Affairs and Gender Relations in providing health care to the residents of the prisons, remand centre and women support centre utilising a mix of on-site care and access to Ministry of Health facilities
- The Department of Human Services and the Primary Health Care Services should develop and implement a strategic approach for mutual collaboration
- The Ministries of Health and Labour should develop and implement jointly a workers health programme encompassing the new health promotion approach as well as the more traditional occupational health and safety concerns

V PLAN OF ACTION FOR IMPLEMENTATION OF PROPOSALS

At *Appendix 8* is a draft Plan of Action for implementing the proposals contained in this report. It covers the main activities required to implement the recommendations in this report. The timing for implementing these activities has been deliberately omitted at this draft is intended to be used as a *working document for the Health Reform Committee* that should be created to implement this report. This committee should review the plan and adjust as needed in keeping with other priorities of the Ministry of Health and the feasibility of implementing the proposals. The time-frame for each activity of the plan should be determined based on this review and if needed spread over a five year period. There are many recommendations that are within the power of the Ministry and do not need additional resources as such but need administrative decisions to utilise existing resources in a more efficient and effective manner.

The concept is that the Health Reform Committee should be the core group but will establish sub- committees to deal with specific aspects of the reform and guide, monitor and evaluate the progress of these sub- committees in accomplishing their goals. In addition some of the recommendations can be best addressed through the development of project proposals aimed at securing funding from national and international agencies. The task of the sub-committees dealing with these recommendations will be to prepare such proposals for final submission to the Head Office of the Ministry of Health and onward transmission to funding agencies.

The Health Reform Committee should be closely integrated with the Health Planning Unit, which should not only have membership on the Reform Committee but also function as a Secretariat of the Committee in information gathering and analysis and ensuring that the reform process maintains momentum. The Reform Committee will report to the Permanent Secretary and the Senior Management Team of the Ministry which will take the necessary decisions for implementing the change process.

VI CONCLUDING COMMENTS

This challenging assignment was only made possible with the support of many staff members of the Ministry of Health and officials from other Ministries and orgranisations. The full list of persons consulted (Appendix 1) is testimony to the importance placed by the health officials on this assignment as they made all the arrangements for site visits and consultations. Special mention must be made of the staff of the Community Nursing Services at Head Office and health centre level who took time off to share their knowledge with us sometimes well after sundown. Special thanks are due to Mrs Xysta Edmunds of the Planning Unit and Ms. Ava Auguste, Assistant Principal Nursing Officer who made all of the arrangements and spent many hours with us on our visits, giving of their knowledge and experience. The importance placed on the study was underlined by the debriefing sessions held at end of each of our visits to St. Lucia. The Minister and his senior management team participated in these meetings which reviewed our preliminary findings and recommendations. In addition a similar debriefing meeting was held with the primary health care managers. Each of these meetings lasted over two hours and involved a thorough review of these preliminary findings and proposals and helped to enrich this report. In the final analysis, however, the report reflects our considered views on the way forward for strengthening the Primary Health Care Services in St. Lucia based on the best practices for delivering these services. We hope that this report can make a contribution to the efforts of all those who are committed to improving the health services in St. Lucia.

APPENDIX 1

LIST OF PERSONS CONSULTED

1. Hon. Damien Greaves	Minister of Health
2. Hon. John Odlum	Parliamentary Secretary
3. Fidelis Williams	Permanent Secretary
4. John Husbands	Deputy Permanent Secretary
5. Susanna Jolie	Principal Nursing Officer
6. Dr. W. Mc. Donald Chase	Chief Medical Officer
7. Dr. K. Deligny	Senior Medical Officer
8. Anne M. Henry	Asst. Principal Nursing Officer
9. Ava Auguste	Asst. Principal Nursing Officer
10. Darrel Montrope	Chief Planner
11. Xysta Edmund	Health Planner
12. Dr. Jaime	Epidemiologist
13. Marilyn Severin	Nutritionist
14. Elaine Nicholas	Chief Pharmacist
15. Beatrice Mc Donald	Assistant Secretary
16. David Joseph	Chief Environmental Health Officer
17. Bernadette Springer	Administrator, Gros Islet Polyclinic
18. Celestine Emanus	Financial Analyst
19. Paul Meroe	CEO St Jude Hospital
20. Jennifer Clauzel	P. N. O. Dennery Hospital
21. Stewart Smith	CEO Victoria Hospital
22. Mary Ann Gopaul	Field Nutritionist
23. Genevieve Fredrick	Field Nutritionist
24. Linda Philigence	Field Nutritionist
25. Diana Doley	Field Nutritionist
26. Simone Mondesir	Field Nutritionist
27. Mavis Phillip	Field Nutritionist
28. Marcellina Williams	Dental Hygienist- La Clery
29. Andre Aneville	Dental Therapist
30. Marlene Francis	Dental Assistant –Castries
31. Cherry Ann Aulain	Dental Assistant – Marchand
32. Anissia Clery	Dental Therapist– Polyclinic/Anse La Raye
33. Novelin Vistor	Dental Assisstant – Anse La Raye
34. Chermin Maxwell	Dental Assistant – Castries
35. Dr. F. N. Samuel	Dental Surgeon – Castries
36. Merlinda Gyan	Dental Assistant – Babonneau
37. Lisa Dantes	Dental Therapist – La Clery
38. Dr. P. Archibald	Dental Surgeon – Castries
39. Dr. Eduardo Bardina	Senior Dental Surgeon

40. Dr. Ju. Pierre	Dental Surgeon
41. Sonia Alexander	Health Educator
42. Athusa Semei	Health & Fam. Life Educator-Ministry of Education
43. Edward Emmanuel	Director – Bureau of Health Education
44. Rose Aubertin	Health Educator
45. Andrena Serieux	Family Nurse Practitioner – Region 4
46. Francis Lesmond	Family Nurse Practitioner – Region 4
47. Bernadette Julien	Family Nurse Practitioner – Region 1
48. Albertina Mondesir	Family Nurse Practitioner – Region 6
49. Joycelyn Willie	Family Nurse Practitioner – Region 5
50. Jacinta Burnett	Family Nurse Practitioner – Region 8b
51. Prisca Regis Andrew	Family Nurse Practitioner – Region 3
52. Marylene Paul	Family Nurse Practitioner – Region 6
53. Anna Antoine	Family Nurse Practitioner – Region 8
54. Marie Monrose	Family Nurse Practitioner – Region 5
55. Mary J Charlery	Family Nurse Practitioner – Region 2
56. Jean Frederick	Public Health Nurse Supervisor Region 1
57. Lorna Louisy	Public Health Nurse Supervisor Region 5
58. Lucy Honora - Gaspard	Public Health Nurse Supervisor – Region 2
59. Georgiana Emmanuel	Public Health Nurse Supervisor– Region 8a
60. Linda Charles	Public Health Nurse Supervisor – Region 4
61. Claudius Desir	Public Health Nurse Supervisor – Region 3
62. Presca Ramlal	Pharmacist- Castries
63. Matthew Gabriel	Receiving Officer
64. Richard Cheong	Pharmacist -Region 8
65. Agnes St. Paul	Pharmacist – Vieux Fort
66. Genitha Andrew	Pharmacist – Castries North
67. Astrid Mondesir	Receiving Officer
68. Felicia Robinson	Director-Human Services & Family Affairs
69. Karen John- Matthews	Family Case Worker
70. Benton St. Cyr	Family Case\Welfare/Officer
71. Beverly Ann Poyotte	Family Case Worker
72. Constance – Ann Paul Akiffo	Family Case Worker
73. Lazarus Rigobert	Family Case Worker
74. Yolande Cox	Welfare Officer
75. Deborah JN Baptiste	Welfare Officer
76. Anthony Ferdinand	Welfare Officer
77. Gemma Gajadhar	Secretary
78. Jacqueline Adonis	Clerk
79. Dr. Indra Kollipana	District Medical Officer
80. Dr.Rebecca Kunavarapu	District Medical Officer
81. Dr. L. S. Yuvaraj	Medical Officer –Gros Islet Polyclinic
82. Dr. K.R. Raju	District Medical Officer- Castries

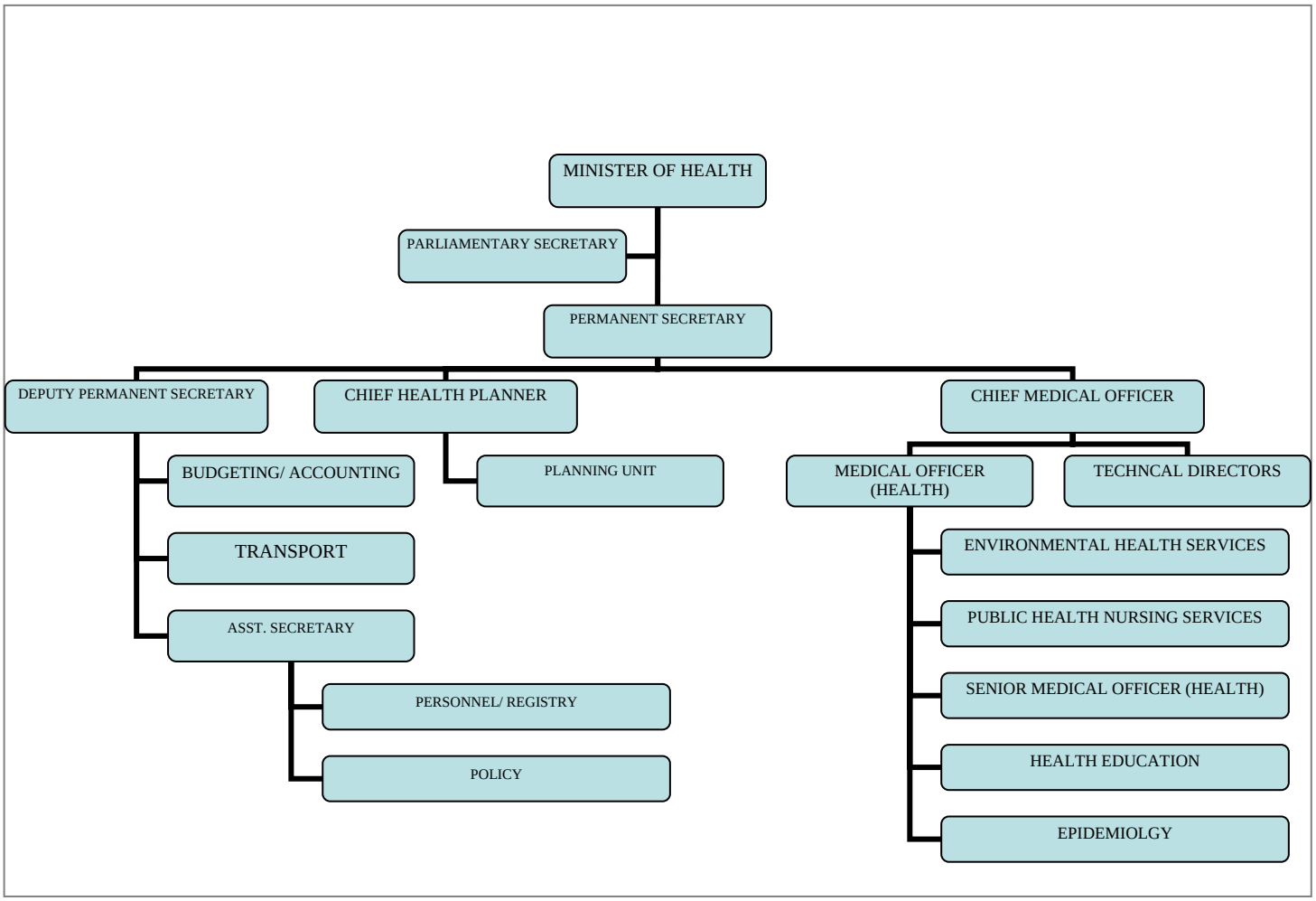
83. Dr. Little	District Medical Officer – Dennery
84. Dr. Adesanya	District Medical Officer – Southern Region
85. Dr. Gilbert Gaeriga	District Medical Officer – Gros Islet Poly.
86. Dr. Edelio Seijo Alemais	Consultant Psychiatrist
87. Angela Francis	Psychotherapist
88. Dr. Josiah Rambally	Registrar-Mental Hospital
89. M. Whitfield	Hospital Administrator- Mental Hospital
90. Joanna S. Colderon	Ward Sister- Mental Hospital
91. Dr. Ernesto Ajao	Senior House Officer- Mental Hospital
92. Donna L. Daniel	Pharmacist- Mental Hospital
93. Wendy Placide	Medical Records Officer – Mental Hospital
94. Maritza Armada	Occupational Therapist – Mental Hospital
95. Andrea Moise	Asst. Occupational Therapist
96. Lena Augustine	Staff Nurse – Mental Hospital
97. Lucy Felix	Ward Sister – Mental Hospital
98. Alicia Baptiste	Nurses Association 1st Vice President
99. Marie Nicholas	Nurses Association –Rep. of Floor Members
100 Marylene Paul	President – Nurses Association
101 Sharmaine Monnrose	Secretary – Nurses Association
102 Brenda Wilson	Com. Dev. Off. Min. of Social Transformation, Culture and Local Government (MSTC&LG)
103 Martha Blanchard	Comm. Dev. Officer (MSTC&LG)
104 Auguste Gaspard	Asst. Dir. Comm. Services (MSTC&LG)
105 Donovan Williams	Executive Director Poverty Reduction Fund (MSTC&LG)
106 Lucen Isidiu	Community Dev. Officer (MSTC&LG)
107 Marie Grace Auguste	Project Manager – Ministry of Education
108 Aquila Luncheon	Statistician – Ministry of Education (Min of Ed)
109 Marylene Charles	Planning Officer – Ministry of Education
110 Marcus Edwards	Deputy Chief Ed. Officer–Planning- Min. of Ed.
111 Chryselda Singh	Co-ordinator School Feeding Programme Min of Ed.
112 Marcia Philbert Jules	Permanent Secretary Ministry of Home Affairs and Gender Relations (MHA &GR)
113 Jacqueline Massiah	Manager Boys Training Centre – (MHA &GR)
114 Lera Pascal	Dir. Gender Relations – MHA & GR
115 Lucy Myers	O/C Probation and Parole – MHA &GR
116 Andrew James	Commissioner of Labour
117 W. Lesmond Magloire	Occup. Health & Safety Officer–Min. of Labour
118 Harold Andrew	Co-ordinator Vector control – Env. H. Dept. MOH
119 Emmanuel Bobb	Senior Env. Health Officer. MOH
120 Joseph Medard	Senior Env. Health Officer MOH (Water Quality)
121 Ernie Pierre	Env. Health Officer (Food Safety)
122 Parker Regnanan	Env. Health Officer (Food Safety)
123 Josephine Aubertin	Health Educator/ Environmental Health Officer

124	Terencia Geuillard	St. Lucia Red Cross
125	Marion Greer	St. Lucian Cancer Society
126	Sheila Wilson	St. Lucia Sickle Cell Association
127	Dr. Jacqueline Bird-Compton	Community Paediatrician
128	Denise Godin	St. Lucia Blind Welfare Association
129	Marcelline Maxwell	Community Health Aide- Dennery
130	Partricia Mathurin	Medical Records Clerk – Dennery
131	Tilet Wayne	Community Health Nurse –Dennery
132	Romula Cox	Nursing Attendant- Dennery
133	Frances St. Clair	Domestic Assistant- Dennery
134	Henrietta Vaval	Nursing Director- Victoria Hospital
135	Bibianna Baptiste	Administrator – Nursing Director St. Jude Hospital
136	Dr. Stephen King	Pathologist- Victoria Hospital
137	Dr. Kenneth Lewesy	Medical Association – St. Lucia
138	Dr. Debra Lewesy	Medical Association – St. Lucia
139	Dr. Leonard	Medical Association – St. Lucia
140	Alena Edwin	Community Health Nurse- Gros Islet Polyclinic
141	Theophilia Prospere	Community Health Nurse – Monchy Health Centre
142	Stephanie Louis	Community Health Nurse- Grand Rivere H/C
144	Ann Charmont	Health Care Attendant- Grand Rivere H/C
145	Julia Lord	Community Health Aide
146	Magdelene Alexander	Community Health Nurse-Babonneau H/C
147	Marie Nicholas	Community Health Nurse- Fond Assau H/C
148	Marcia Johnny	Community Health Nurse – La Resource H/C
149	Cecile Jermai Charlery	Community Health Nurse – Rich Fond H/C
150	Mary Serieux	Community Health Nurse – Mon Repos H/C
151	Marilyn Leshommes	Community Health Nurse – Micoud
152	Juliette Joseph	Community Health Nurse – Ti-Rocher- Micoud H/C
153	Margarete Fontenelle	Community Health Nurse – Desruisseaux H/C
154	Petronise Duplessis	Community Health Nurse – Vieux Fort H/C
155	Wilma John	Community Health Nurse – Vieux Fort H/C
156	Ingrid George	Community Health Nurse –Laborie H/C
157	Cathelina Mathurin	Community Health Nurse – Saltibus H/C
158	Molina Sadoo	Community Health Nurse – Belle Vue H/C
159	Ezeldra Poleon	Community Health Nurse – Grace H/C
160	Jacinta Brouet	Community Health Nurse – Soufriere Hospital
161	Mrs. Bobb	Hospital Administrator – Soufriere Hospital
162	Rachael Charlemagne	Community Health Nurse - La Fargue H/C
163	Roxanna Joseph	Community Health Nurse – Mongouge H/C
164	Macrina Dieudonne	Community Health Aide – Mongouge H/C
165	Fadia Auguste	Community Health Aide – Mongouge H/C
166	Barbara Charles	Health Centre Attendant – Mongouge H/C

167 Laura Charlemagne	Community Health Nurse – Etangs/ Fond St.Jacques H/C
168 Claudette Prospere	Community Health Aide- Fond St. Jacques H/C
169 Marcelline Samuel	Health Attendant – Fond St. Jacques H/C
170 Dediree Leandre	Community Health Nurse – Canaries H/C
171 Lucella Lansiquot	Community Health Aide – Canaries H/C
172 Judith Frederick	Health Attendant – Canaries H/C
173 Paula Augustin	Community Health Nurse – Delcer H/C
174 Eldrina Hollancid	Community Health Nurse – Anse La Raye H/C
175 Mary Olive Henry	Community Health Nurse – Vanard
176 Elfreda Leonty	Community Health Nurse – La Croix Maingot H/C
177 Marlene Lawrence	Community Health Nurse – Jacmel H/C
178 Patsy Welshman	Community Health Nurse – Castries H/C
179 Dawn Augustin	Community Health Nurse – La Clery H/C
180 Edith Charles	Registered Nurse – Marchand H/C
181 Calista James	Community Health Aide –Entrepot H/C
182 Albertha Harris	Community Health Nurse – Ti-Rocher H/C
183 Benedicta Payne	Community Health Nurse – Bexon H/C
184 Angella Niles	Community Health Nurse – Ciceron H/C
185 Ms. Dickson	Administrator – Tapion Hospital
186 Dale Louis	Laboratory Technician – St. Jude Hospital
187 Nahum Jn. Baptiste	Statistician – Epidemiology Unit
188 Beverly Lansiquot	Co-ordinator Dept of Health Sciences Sir Arthur Lewis Community College
189 Mr. C. Yarde	Communications Officer
190 Madeline Hippolyte	Cytotechnician –Victoria Hospital

APPENDIX 2

ORGANISATION CHART OF THE MINISTRY OF HEALTH – HEAD OFFICE



APPENDIX 3

SUGGESTED OUTLINE FOR THE DOCUMENT

"PRIMARY HEALTH CARE- THE ST. LUCIAN PERSPECTIVE"

1 INTRODUCTION

- 1.1 Public Sector Reform in St. Lucia
- 1.2 Health Sector Reform Proposals
- 1.3 "Health as a fundamental human right" and the role of the government in providing health services
- 1.4 Guiding principles for a healthy nation; Partnership between the government, communities and individuals
- 1.5 Policy decision to improve the efficiency and effectiveness of primary health care services

II THE PRESENT HEALTH STATUS

- 2.1 Demographic Data
- 2.2 Mortality Data
- 2.3 Morbidity Data
- 2.4 Water Quality; Sewage and Waste Water
- 2.5 Vector Borne Diseases
- 2.6 Land Pollution and Coastal Waters
- 2.7 Occupational Health and Safety

III CONCEPTS OF PRIMARY HEALTH CARE

- 3.1 WHO definitions and guidelines for Primary Health Care
- 3.2 Concepts of Equity, Efficiency, Coverage and Impact
- 3.3 Intersectoral collaboration in addressing wellbeing of the nation
- 3.4 Community Participation
- 3.5 Levels of Health Care concept
- 3.6 Health Promotion Concepts
- 3.7 Primary Health Care – St. Lucia

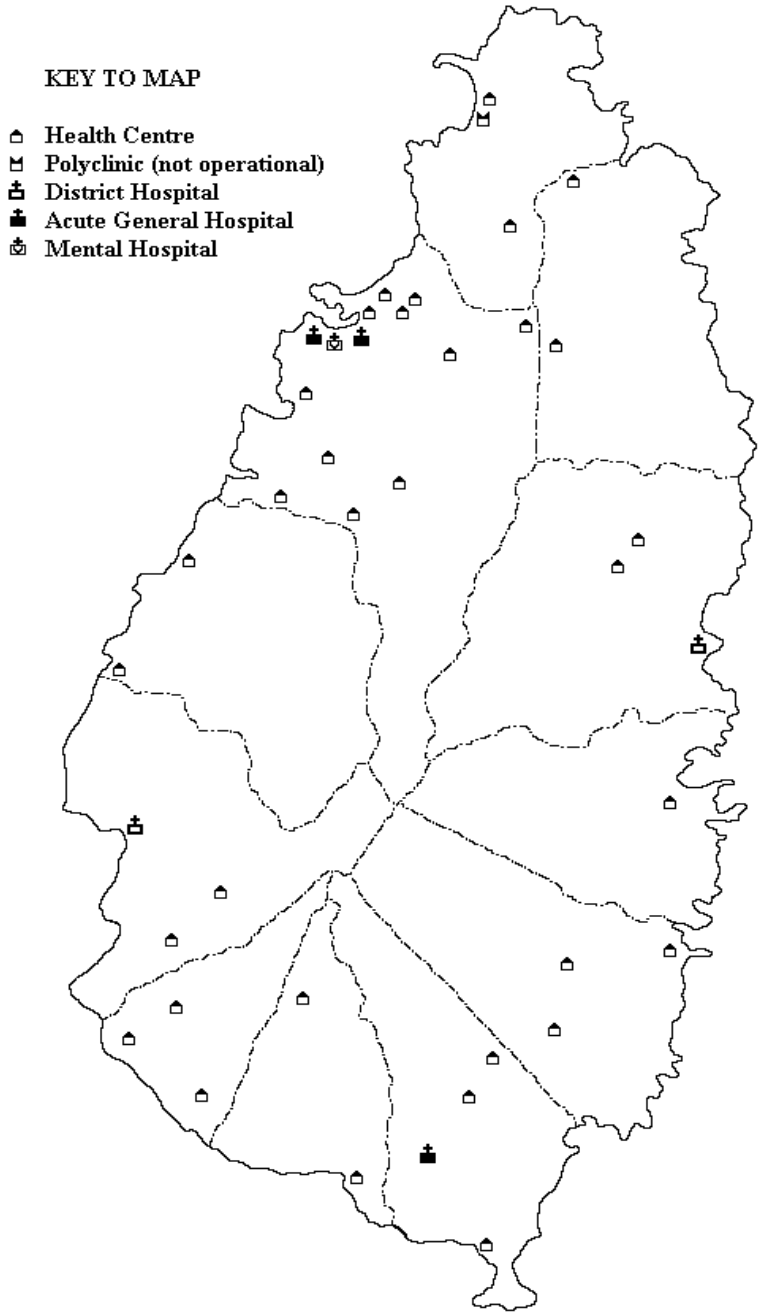
IV THE DELIVERY OF PRIMARY HEALTH CARE SERVICES

- 4.1 The Administration of the Primary Health Care Services – Head Office and Regional levels
- 4.2 The Health Team Approach at health centre and regional levels
- 4.3 Catchment Populations – Districts and Regions
- 4.4 Health Regions and Districts - Groupings
- 4.5 Data Collection and Health Profile of Regions

APPENDICES

APPENDIX 4

NETWORK OF GOVERNMENT HEALTH FACILITIES IN St. LUCIA
(Gros Islet Polyclinic now operational)



APPENDIX 5

UTILISATION OF CURATIVE HEALTH SERVICS AT HEALTH CENTRES IN ST. LUCIA - 2001

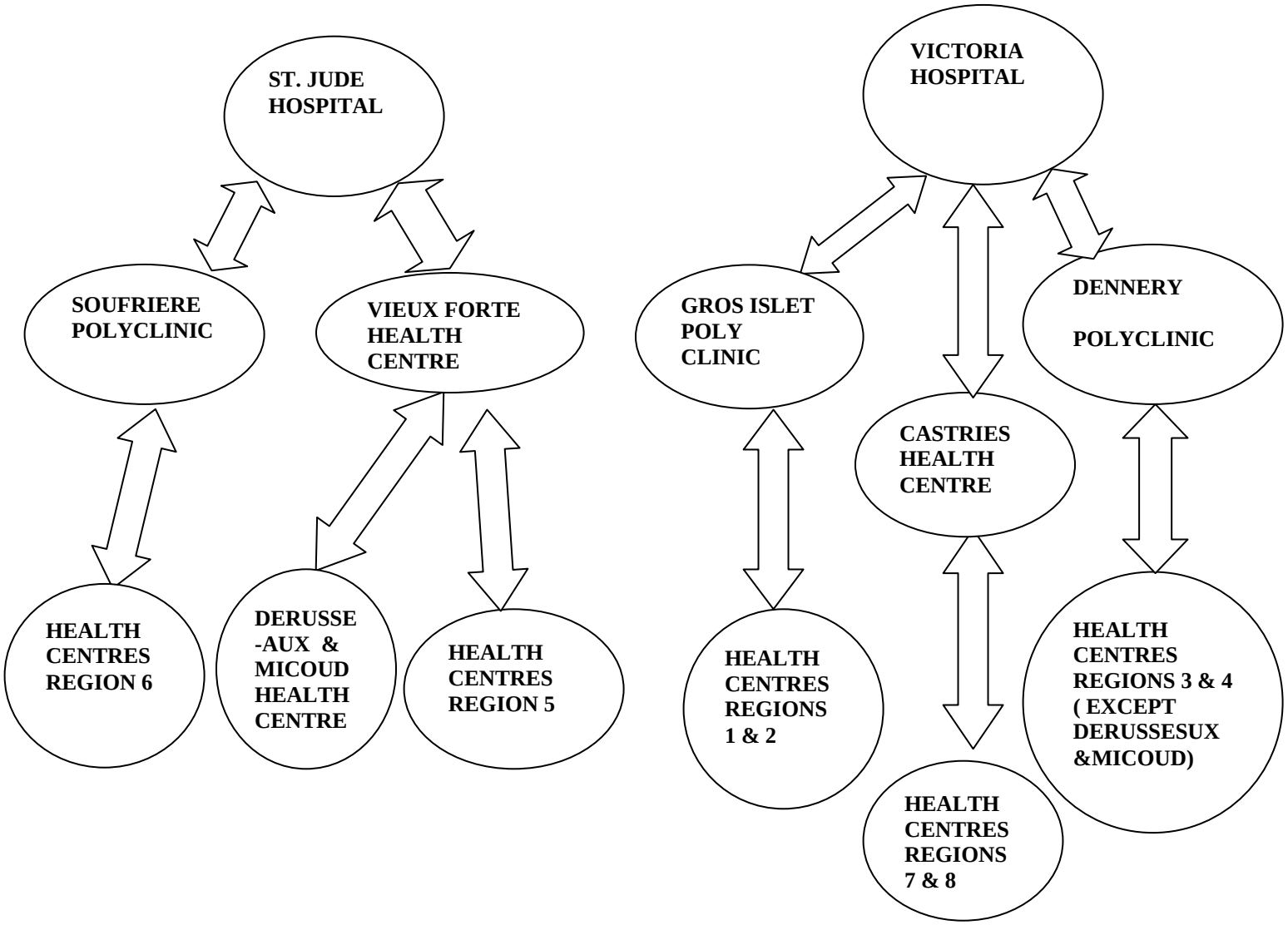
HEALTH CENTRE	CATCHMENT POPULATION	TOTAL VISITS TO CURATIVE	VISITS/POP. RATIO
REGION 1			
Gros Islet	5881	6380	1.08
Grand Riviere	3953	3109	0.79
Monchy	2796	2081	0.74
REGION 2			
Babonneau	5259	6514	1.24
Fond Assau	1620	NA	NA
REGION 3			
Dennery	4189	9047	2.12
La Ressource	4966	NA	NA
Rich Fond	3771	NA	NA
REGION 4			
Desruisseaux	4593	3451	0.75
Micoud	3785	5082	1.34
Mon Repos	4177	5059	1.21
T-Rochier/ Micoud	2719	2720	1.00
REGION 5			
Belle Vue	2231	2184	0.98
Grace	1759	NA	NA
Laborie	5974	4891	0.82
Saltibus	2692	2818	1.05
Vieux Fort	13587	10752	0.79
REGION 6			
Canaries	2083	4534	2.18
Delcer	1665	1797	1.08
Etangs	932	1252	1.34
Fond St. Jaques	1631	2252	1.38
La Fargue	3145	3285	1.04
Mongouge	2570	2975	1.16
Soufriere	6418	14248	2.22

REGION 7			
Anse La Raye	**2107**	**4594**	**2.18**
Jacmel	**1058**	**2914**	**2.75**
La Croix Maingot	**4408**	**2734**	**0.62**
Vanard	**1974**	**1868**	**0.95**
REGION 8			
Bexon	**6262**	**4334**	**0.69**
Castries	**13707**	**37583**	**2.74**
Ciceron	**5730**	**4738**	**0.83**
Entrepôt	**5127**	**2556**	**0.50**
La Clery	**7156**	**5346**	**0.75**
Marchand	**9546**	**7408**	**0.78**
Ti Rocher/Castries	**3535**	**2807**	**0.79**

National Average ***1.18***

APPENDIX 6

PRIMARY HEALTH CARE SERVICES – CHART OF PATIENT REFERRAL SYSTEM



APPENDIX 7

DISTRIBUTION OF COMMUNITY HEALTH AIDES BY HEALTH CENTRE AND CATCHMENT POPULATION IN ST. LUCIA- MARCH 2002

HEALTH CENTRE	*CATCHMENT POPULATION*	*NUMBER OF CHAs*	*CHA/POPULATION RATIO (1 CHA/pop)*
REGION 1			
Gros Islet	*5881*	*3*	*1960*
Grand Riviere	*3953*	*1*	*3953*
Monchy	*2796*	*2*	*1398*
REGION 2			
Babonneau	*5259*	*4*	*1315*
Fond Assau	*1620*	*2*	*810*
REGION 3			
Dennery	*4189*	*2*	*2095*
La Ressource	*4966*	*2*	*2483*
Rich Fond	*3771*	*2*	*1886*
REGION 4			
Desruisseaux	*4593*	*2*	*2297*
Micoud	*3785*	*2*	*1893*
Mon Repos	*4177*	*2*	*2089*
Ti Rocher/ Micoud	*2719*	*1*	*2719*
REGION 5			
Bellevue	*2231*	*1*	*2231*
Grace	*1759*	*1*	*1759*
Laborie	*5974*	*2*	*2987*
Saltibus	*2692*	*2*	*1346*
Vieux Fort	*13587*	*4*	*3397*
REGION 6			
Canaries	*2083*	*1*	*2083*
Delcer	*1665*	*1*	*1665*
Etangs	*932*	*1*	*932*
Ford St. Jaques	*1631*	*1*	*1631*
La Fargue	*3145*	*2*	*1573*
Mongouge	*2570*	*2*	*1285*
Soufriere	*6418*	*3*	*2139*

REGION 7			
Anse La Raye	***2107***	***2***	***1054***
Jacmel	***1058***	***2***	***529***
La Croix Maingot	***4408***	***2***	***2204***
Vanard	***1974***	***2***	***987***
REGION 8			
Bexon	***6262***	***2***	***3131***
Castries	***13707***	***3***	***4569***
Ciceron	***5730***	***2***	***2865***
Entrepôt	***5127***	***2***	***2564***
La Cleary	***7156***	***1***	***7156***
Marchand	***9546***	***2***	***4773***
Ti Rocher / Castries	3535	1	3535

APPENDIX 8

DRAFT WORK PLAN FOR IMPLEMENTING RECOMMENDATIONS

PROGRAMMES / ACTIVITIES	TIMING
1 ***Management Systems for Primary Health Care Services***	***(to be determined by health reform committee)***
1.1 Primary Health Care Policy	
1.1.1 Develop a Primary Health Care Policy Document that clearly defines the approach for St. Lucia with strong emphasis on the wellness concept.	
1.1.2 Review and finalise the St. Lucia Health Reform Proposals document and use as strategic plan for the development of the health services in St. Lucia	
1.2 Levels of Care and relationships between public health facilities	
1.2.1 Finalise the role and functions of health centres, polyclinics and hospitals as the three levels of care outlined in the Health Reform Proposals for the Primary Health Care Services in St. Lucia	
1.2.2 Define the number and location of government polyclinics for St. Lucia and the grouping of health centres to be served by each polyclinic	
1.2.3 Develop proposals for the establishment of polyclinics at Dennery and Soufriere Hospitals	
1.2.3 Implement proposals for the establishment of these polyclinics	
1.2.4 Review the functions of Castries and Vieux Forte health centres and develop plans for them to function as referral centres for the health centres in their catchment areas	
1.2.4 Implement proposals for strengthening Castries and Vieux Forte health centres as referral centres	
1.3 Management of Primary Health Care Services	
1.3.1 Identify the data needed to define the health status of	

catchment populations served by health centres and health regions, including data from the private sector and collect this data on an ongoing basis

1.3.2 Utilise the Community Health Aides (CHAs) to conduct baseline surveys of the households in their catchment using much of the data they now collect on household visits

1.3.3 Train health centre and regional staff in the use of these data for decision-making

1.3.4 Develop regional and health centre based programmes using the data, focussing on priority health problems, and prepare budgets to support these programmes

1.3.5 Review existing fee structure for clients using the primary health care services and ensure uniformity in fees charged to patients in keeping with that no one will be denied services because of inability to pay

1.3.6 Appoint a full-time Medical Officer (Health) as part of the head office technical directorate, with responsibility for managing the primary health care services

1.3.7 Resume regular meetings of Primary Health Care Directors and Heads to ensure coordination and give leadership to the primary health care services

1.3.8 Analyse the supply management system for supporting primary health care services and ensure that the system uses cost-effective procedures and control systems for maximising use of these supplies(e.g. sundries, cleaning materials)

1.4 Involvement of Health Workers and Key Stakeholders in the Health Reform Process

1.4.1 Establish health reform committee within the Ministry of Health, with clear terms of reference and strong support from the health planning unit

1.4.2 Utilise health reform to define the Primary Health Care concept for St. Lucia and finalise the Health Reform Proposals for St. Lucia

1.4.3 Ensure full participation of health workers and key stakeholders in defining the Primary Health Care Concept and finalising the Health Reform Document

2 Services Delivered at the Primary Health Care Level

2.1 Network of Health facilities

2.1.1 Plan and implement a programme for the closure of the Marchand health centre and the relocation of these services to the Entrepot health centre

2.1.2 Develop and implement a plan for the renovation of the Babonneau health centre as priority issue

2.1.3 Consult with health centre staff at Babonneau and arrange for the two doctors clinic to be held on two separate days (Monday and Wednesday) rather than the same day

2.1.4 Develop and implement a programme for the repair or relocation of the Vanard health centre as a matter of urgency

2.1.5 Conduct a comprehensive assessment of health centre buildings, space utilisation and equipment needed based on treatment protocols and implement a programme to improve the facilities and resources needed to provide quality service

2.2 Access and coverage of services

2.2.1 Develop and implement a comprehensive adolescent health programme with strong Intersectoral linkages and emphasising family life education and family planning services

2.2.2 Develop and implement a well designed Community Mental Health Programme integrated into the health centre services and with full participation of health centre staff

2.2.3 Conduct a survey of patients attending the Accident and Emergency Departments of Victoria and St. Jude Hospitals to determine the reasons for non- accident

and emergency patients attending the Departments for services and utilise results to improve the health centre services

2.2.4 Integrate the family life educators, health educators, nutritionists and environmental health officer more fully into the health centre and regional services through involvement in the planning and programming process

2.2.5 Provide specialists clinics at polyclinics or main health centres (Castries and Vieux Forte) in close collaboration with the main hospitals and in additional fields such as ophthalmology, chronic diseases and ENT services in keeping with the health problems of communities

2.2.6 Integrate the STI/HIV/AIDS programme into the primary health care services, as part of the strategic plan for addressing this pandemic mobilise the health centre staff as key partners in the fight against the pandemic

2.2.7 Develop and implement a joint action plan between the primary health care services and the Ministry of Legal Affairs for a Community Drug Abuse programme

2.2.8 Develop and implement a dental health policy and strategic plan, to emphasise dental health promotion and prevention of dental diseases, targeting school age populations as a priority

2.2.9 Provide Community Heath Aides with a travelling allowance or transportation to reduce security risks and improve home visiting and community outreach programmes

2.3 Quality of services provided

2..1 Develop and implement an action plan for updating and developing protocols to ensure quality in the delivery of primary health care services. Compile these protocols into a Procedures Manual for delivery of Primary Health Care Services

2.3.2 Review and update the Household Health Folder, incorporating the system now used at the Gros Islet Polyclinic and utilise at all health centres

2.3.3 Conduct a study on the laboratory services needed to support the primary health care services at each level i.e. health centre, polyclinic and hospital and implement new system

2.3.4 Provide the Victoria Hospital with all the support it needs to offer consistent, timely and efficient laboratory support, including pap smear services, to the polyclinic and health centre primary health care services

2.3.5 Analyse the reasons for occasional shortage of pharmaceuticals at health centres and implement a programme that will ensure the constant supply of drugs for priority health programmes

2.3.6 Reorganise the health centre medical clinics conducted by District Medical Officers and establish a system whereby the patients are screened and shared more equitably with the Family Nurse Practitioners

2.4 Referral Systems

2.4.1 Review the existing system and forms used for the referral of patients between the health centres and hospitals and design and implement an improved system for the treatment and follow-up of patients

2.4.2 Establish a referral committee and utilise this to implement a process for continuous assessment of the referral system by hospital and health centre staff

2.4.3 Utilise this referral committee to organise orientation programmes for hospital and health centre staff to work in both levels of care so as to appreciate the level of interface for patient management

2.5 The role of polyclinics and district hospitals and their interface with health centres and hospitals

2.5.1 Conduct a study to determine the demand for Accident and Emergency and Maternity Services after 4.00 p.m. at the Victoria, St. Jude, Dennery and Soufriere hospitals and determine the cost-effectiveness of establishing those

services at the polyclinic level on a 24 hour basis

2.5.2 Develop an Operations Manual for the Gros Islet Polyclinic to include policies, programmes, organisation structure, reporting relationships, referral systems etc.

2.5.3 Establish the Gros Islet Polyclinic in keeping with the Operational Manual which defines its role and function

2.5.4 Utilise this Operational Manual to develop similar Manuals to guide the development of the Soufriere and Dennery polyclinics

2.6 The impact of day surgery, out-patient surgery and home care on the Primary Health Care Services

2.6.1 Analyse the role of the Primary Health Care services in providing follow-up care for day surgery patients referred from the main hospitals as part of the referral system

2.6.2 Based on this analysis and the provision of day surgery and out-patient surgery at the main hospitals, equip the health centres with the appropriate treatment protocols, trained staff, supplies and equipment to manage such referrals

3 Human Resources for delivery of Primary Health Care Services

3.1 Health Centre Staff

3.1.1 Utilise the health centre programming process to integrate the services provided at all health centres by all visiting health staff to ensure a coordinated response to the health needs of communities

3.1.2 In keeping with the defined Primary Health Care Concept, establish a norm of Population: CHA ratio to ensure effective coverage of population and staff health centres in keeping with this norm

3.1.3 Develop and implement a programme for the filling of key primary health care posts such as community health aides, environmental health officers, health/ family life educators, community nurses, family nurse practitioners, pharmacists etc

3.1.4 Develop and implement a Strategic Human Resource Development Plan for Primary Health Care staff and utilise an Annual Training Programme to execute this Strategic Plan and ensure professional development aimed at improving the quality of services delivered

3.1.5 Clarify the role of the DMO with regard to home visits, provision of technical guidance to the health centre team and involvement in community outreach programmes and implement the decisions taken on these issues

3.2 Polyclinic Staff

3.2.1 Utilise the experience gained in commissioning the Gros Islet Polyclinic and data on the health needs of the catchment population in Dennery and Soufriere to establish polyclinics in these two areas

4 "District" Health Teams

4.1 Primary Health Care Teams

4.1.1 Designate the Community Health Nurse at each health centre as the team leader for all professionals who deliver services at the health centre and with responsibility for co-ordinating the planning, implementation and evaluation of services to the catchment population served by each health centre

4.1.2 Designate the most suitable public health professional with management training and skills in each of the proposed five health regions (Soufriere, Vieux Forte, Gros Islet, Castries and Dennery) as Regional Team Leader with responsibility for coordinating the planning, implementing and evaluating the work done by health centre teams and polyclinics in meeting the needs of the regional catchment population

4.1.3 Provide technical guidance and support to the health centre and regional teams in ensuring the delivery of quality health services

5 Community Participation and Involvement including Collaboration with other Sectors

5.1 Community Participation

5.1.1 Collaborate with the Ministry of Social Transformation, Culture and Local Government in the development of poverty alleviation projects and the mobilisation of communities to address health problems

5.1.2 Plan and implement training programmes for Primary Health Care Workers in the use of modern health promotion techniques and best practices for effective behaviour change

5.1.3 Work with community groups to promote health and well being in relation to priority health issues utilising the necessary transport and other supplies required for these initiatives

5.2 Intra and Intersectoral collaboration

5.2.1 Determine the usefulness of the National Population Council and the Committee of Permanent Secretaries Responsible for Human and Social Development in strengthening Intersectoral collaboration for dealing with the health needs (e.g. STI/HIV/AIDS) of the St. Lucian people and utilise these bodies as appropriate for promoting wellness nationwide

5.2.2 Strengthen the collaboration between the Ministries of Health and Education in important programme areas such as Health and Family Life Education, Hearing and Vision Screening, Dental Health and Environmental Sanitation

5.2.3 Provide technical support to the Ministry of Home Affairs and Gender Relations in providing health care to the residents of prisons, remand centres and women support centres utlising a mixture of on site care and referral to health facilities

5.2.4 Develop and implement a joint strategic plan involving the Department of Human Services and the Primary Health Care Services aimed at strengthening the collaboration between these two units of the Ministry of Health

5.2.5 Develop and implement a joint workers' health programme as a collaborative effort between

the Ministries of Health and Labour

5.2.6 Strengthen collaboration with NGOs in the delivery of Primary Health Care Services