



MINISTRY OF HEALTH
HIGHLIGHTS
OF KEY INITIATIVES

2016 - 2017

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SUMMARY HEALTH STATISTICS: 2016

Indicators	2016 Calendar Year
Total Inpatients	189,374
Total Hospital Speciality Outpatients Visits	648,884
Visits to A&E/Casualty	669,962
Total Surgeries	35,787
Total Births	33,359
Average Length of Stay	5.7 days
Total Drugs Dispensed	2,014,449
Total Visits to Health Centres	1,561,104



Improving the Patient's Experience with the Public Health System



1. COMPASSIONATE CARE AND VOLUNTEERISM PROGRAMME

"As I walked on the ward my mom was on the bed, on a bed pan, and she was falling off and she was in pain and agony. She had been left like that for over an hour. There was no nurse call button so between groans my mom had tried to call a nurse. I walked to the nurses' station and stood no one took notice of me so I cried out loud, 'somebody come and help my mother.' Nobody came and I shouted at the top of my voice, 'please, somebody come and help my mother.' A nurse stood up and walked towards my mom's bed. As we went back in with the nurse, she said, "oh, we'd forgotten about her." I asked, "can't you hear?" She is crying and at that point on reaching mom's bed she grabbed my hand and said, "please don't let me die in here" The nurse that came in said: I am so sorry, we had forgotten about her; yes, she has been there for some considerable time.

- Experience of a daughter of a public health centre patient

1. OVERVIEW

- 1.1 The outpouring of public cries concerning the real or perceived sub-standard treatment meted out to patients/users of the public health system made necessary the development and implementation of strategies to improve the way in which care and services are delivered by the Ministry of Health (MOH). The MOH recognizes that it is critical to ensure that health care staff possesses the technical skills and competence to deliver care. However, it is equally as important that care and services are delivered to patients with compassion.



- 1.2 Compassionate care must be practiced across all levels of services, which should include pre-service delivery, point of service delivery and after service delivery. It must begin with respect for patients' requirements and tolerance with patients' expressions and expectations. Regional Boards, Hospital Management Committees, Parish Managers, executive management, senior management, middle management, and health professionals must be united in enabling a higher standard of care and service in hospitals and health centres. Compassion includes 'empathy, respect, and recognition of the uniqueness of another individual'.
- 1.3 Quality health care seeks to ensure improvement across all levels of the health system - inclusive of how health care workers interact and engage with patients/users of the service. Health Volunteerism in the Jamaican context is the act of individuals and organizations giving time willingly to assist in the care of patients and the overall advancement of health services without the expectation of financial gain. The MOH recognizes the important role of volunteers in the delivery of health care services and in enabling a compassionate environment by unpacking the activities requiring more time and patience from health care workers' duties. Integrating volunteerism in the health system will allow health care workers to focus on their essential duties and can result in fewer instances of staff burnout.



2. OBJECTIVES

2.1 Overview

While volunteering is not new for the health care facilities, the Ministry is in the process of implementing a structured volunteer programme at all public hospitals, public health centres, and community care. In this regard, a Compassionate Care and Volunteer Policy will be enacted to provide the standards and guidelines for the volunteer programme. In the first phase, the programme is targeted at Type A and B hospitals in the health regions, including the University Hospital of the West Indies, as well as Health Departments, hospitals and clinics at the parish level. Implementation will commence in Financial Year 2017/2018 and the Ministry projects the engagement of 600 volunteers across the regions by the end of the period.

2.2 Partnerships

2.2.1 Establishing partnerships is essential for the sustainability of the Volunteer Programme. At present, a critical component of the volunteer programme is the group of volunteers called Hospital Auxiliaries/Friends of Hospitals. This group of mature individuals is responsible for the fundraising activities of the volunteer programme and the daily scheduling and registration of volunteers. Hospital Auxiliaries will work closely with human resources in the generation of the daily list of volunteers for deployment in the hospitals.



2.2.2 Partnerships will also be forged with civil society, service organizations, churches, community centres, schools, non-governmental organizations and international partners to enable an effective and sustainable volunteer programme.

2.2.3 The World Health Organization (WHO) recognizes the importance of volunteers and supports the embedding of volunteerism within the public health system. The WHO has developed the principles for Volunteerism that communicates clearly the philosophy and sets the standard by which both developed and developing countries, Jamaica included, should be guided to create guidelines, policies and legislation for the implementation of health volunteerism locally. Assistance will be sought from the World Health Organization/Pan-American Health Organization (WHO/PAHO) to achieve successful implementation.

2.3 **Volunteers**

2.3.1 The Volunteer Programme will include the involvement of volunteers from the age of 14 and includes high school, college and university students. Volunteers will be classified as skilled – medical doctors, nurses, professions supplementary to medicine; unskilled –secondary and tertiary students, individuals from communities, retired individuals; and international volunteers – organizations supplying volunteers for service, Diaspora.



2.4 Volunteer Selection

2.4.1 A robust system for background checks and screening of volunteers will be established. This will entail the provision of Police Records; Declaration of Good Standing; references; photo identification; proof of immunization; and recommendations from school principals or guidance counselors for student volunteers. Potential volunteers will also undergo a screening process in the form of an interview at the public health facility. A self-declaration form will be developed that will require information on past and current medical condition(s), and (or) any legal issues and employment/work history. An accompanying medical evaluation may also be required to support the individual's suitability.

2.4.2 Volunteers will be required to comply with the requirements of operational policies of the organization in which they are placed, the volunteerism policy/charter and other rules established by the organization. They will also sign a confidentiality clause prohibiting the divulging of patient information, as well as other organizational information that may be deemed confidential.

3. STATUS

3.1 The Compassionate Care and Volunteerism Policy has been developed. A Cabinet Submission seeking approval for the policy has been prepared and will be submitted to Cabinet.



3.2 The Action Plan for the Compassionate Care and Volunteer Programme (2017-2019) has been developed and presents the core initiatives along with timelines for establishing the Programme.

4. NEXT STEPS

4.1 The Ministry, in partnership with the relevant stakeholders, will pursue the following actions as effort continues towards establishing the Volunteer Programme across the four health regions:

- Implementation of the Director of Volunteer Service position in the Regional Health Authorities.
- Public education on Volunteerism and Compassionate Care initiatives to improve health care services.
- Develop and implement training for staff at all levels in the Regions.
- Identification and screening of volunteers.
- Phased roll-out of Volunteer Programme.



2. REDUCED WAITING TIME PILOT PROJECT

A key contributory factor to the overcrowding of Accident and Emergency Departments (A&E) island-wide is accessing of care in A&E departments for conditions that could be appropriately managed at health centres. Through this pilot, that traffic is being steered to primary care facilities where these conditions can be appropriately handled.

1. OVERVIEW

- 1.1. A major challenge currently being experienced by Jamaicans who interface with the public health system is the time it takes for them to see a doctor and receive treatment. In this regard, over the past two months, the Ministry of Health has conducted time and motion studies in the Accident and Emergency (A&E) departments at a number of hospitals and concluded that the majority of patients waited more than one hour just to be assessed or triaged, with some waiting in excess of three hours.
- 1.2. The Ministry has instituted a pilot intervention in eight (8) major health centres and eight (8) hospitals to reduce the time it takes for a patient to see a doctor. This pilot involves improving the process of customer service and assessment and redirecting non-emergency cases from hospital A&E departments to the closest designated Health Centre.



1.3. The eight (8) hospitals involved in the pilot project are Cornwall Regional, Savanna La Mar, St. Ann's Bay, Kingston Public, Spanish Town, Mandeville Regional and May Pen Hospitals, as well as the Bustamante Hospital for Children. The participating Health Centres are mainly the ones in proximity to these hospitals: Mount Salem in St. James, St. Ann's Bay, Comprehensive and Glen Vincent in Kingston, St. Jago Park in St. Catherine, Mandeville in Manchester and May Pen in Clarendon; the exception being the Greater Portmore Health Centre in St. Catherine, that is not in proximity to a hospital. However, it was necessary to include that health centre because of the volume of visitors to KPH's A&E from that region of St. Catherine.

2. OBJECTIVES

- 2.1. The goal of the project is to decrease waiting times in the emergency departments of public hospitals. The main objectives are to:
- i. Increase usage of curative services at Health Centres thus decreasing hospital A&E department visits by a) extending opening hours from 8 am to 5 pm to 8 am to 8 pm and b) enhancing services provision such as nebulizations, rehydration, minor surgical procedures, ECGs and specialist services.
 - ii. Improve the efficiency in the A&E departments by standardizing and computerizing the triage process.
 - iii. Improve physical infrastructure of the waiting areas



- iv. Enhance customer service

3. STATUS

3.1. Extended hours of service

3.1.1. Extended hours in all the targeted health centres were fully implemented in October 2016. Opening hours were extended to 8pm in six health centres (Slippen Road Comprehensive Health Centre, Glen Vincent Health Centre, Greater Portmore Health Centre, St. Ann's Bay Health Centre, Mandeville Health Centre and May Pen Health Centre) under the project and support was provided for two health centres (St. Jago Park Health Centre and Mount Salem Health Centre) that had previously started extended hours. Provisions for increased staff and enhanced security services were made in the targeted health centres.

3.1.2. Utilization of health centres has increased since the inception of the project; the number of visits to the health centres during the extended hours has increased by 60%. This reflects increased diversion of patients to health centres from the hospitals and a change in behaviour where persons now go to the health centres in the evening hour rather than visiting the emergency rooms.



3.2. Increased Access to Services

3.2.1. Provisions were made for increased opening hours of pharmacy and phlebotomy services and for access to radiology services for patients from health centres at some hospitals (Kingston Public Hospital and Spanish Town Hospital) and for improvements in delivery of radiology and laboratory results to the health centres.

3.2.2. Resources were provided to allow for enhancement of services such as nebulizations and minor procedures in the targeted health centres. Electrocardiogram (ECG) service was introduced at the St. Ann's Bay Health Centre.

3.2.3. Patient satisfaction has also improved from the expansion of the facilities in the hospitals and health centres and increased access to services such as pharmacy, laboratory services, radiology and ECGs.

3.3. Improved Customer Service

3.3.1. Organizational and operational improvements were done in the waiting rooms of eight emergency departments to improve the aesthetics, provide 24 hour customer service, increased supervision by nursing staff and a transparent streamlined processing to triage.



3.3.2. Twenty-four hour customer service areas were established in eight hospitals. Customer service booths were established in all the hospitals.

3.3.3. Waiting times have improved in some health centres as clients exercise the option to return during the extended hours when the facilities are less crowded.

3.4. Strengthened Triage System

3.4.1. Facilities were put in place to improve the time to triage in eight hospitals by increasing the number of triage stations and providing staff and equipment for vital signs assessment. The number of triage stations was increased in four hospitals (Mandeville, Cornwall Regional Hospital, St. Ann's Bay Hospital, Bustamante Hospital for Children) allowing for increase in staff at peak times.

3.4.2. Nurses' Stations that provide supervision of the waiting areas were established in all hospitals. This allows for monitoring of waiting patients thus decreasing the incidents of clients deteriorating undetected in busy waiting areas.

3.5. Infrastructural improvements

3.5.1. Infrastructural improvements were made to the waiting areas in five hospitals (Bustamante Hospital for Children, Mandeville Hospital, St.



Ann's Bay Hospital, Savanna-la-mar Hospital, Cornwall Regional Hospital).

3.5.2. Space for consultations was increased in the St. Ann's Bay and Mount Salem Health Centre. This allowed more doctors to work thus decreasing the waiting times in the health centre.

3.5.3. Staff morale has improved due to general improvements in workspaces

3.6. Strengthened Information System

3.6.1. Computerization of the triage process commenced in one hospital (Bustamante Hospital for Children) and this has allowed for the monitoring of triage times.

4. NEXT STEPS

4.1. The computerization of the triage process is to continue in four additional hospitals in the first quarter of 2017/2018.

4.2. An additional four hospitals and four health centres will be targeted for interventions in 2017/2018.



4.3. Training in triage and customer service will be done in all hospitals in June 2017, to ensure an efficient and transparent triage process in hospitals and to correct some issues that contribute to long triage times. This is expected to further decrease the times that patients wait in the emergency departments.



3. PUBLIC PRIVATE PHARMACY INITIATIVE FOR OUT-PATIENT PHARMACY SERVICES

Implementing a public-private initiative with pharmacies would draw on the network of private pharmacies to assist in the delivery of pharmacy services to public patients and increase access points in a fiscally prudent manner. The country has approximately 500 private pharmacies. Engaging 165 of these private pharmacies would increase access points by 188% (253 access points) and reduce the ratio of outpatient's prescriptions to the number of pharmacies.

1. OVERVIEW

1.1. Since 2011, the National Health Fund (NHF) assumed responsibilities for the procurement, warehousing and distribution of pharmaceuticals and medical supplies to the national health care system as well as filling outpatient public scripts at Drug Serv pharmacies. The NHF is committed to providing an efficient pharmacy service marked by excellent customer service. However, there are challenges in filling outpatient scripts due mainly to a limited number of public sector pharmacies.



2. OBJECTIVES

2.1. Given the country's high demand for outpatient pharmacy services, projected at approximately 2.2 million scripts annually, it was proposed that the NHF adopt a model where both public and private pharmacies dispense pharmaceuticals to outpatients. The Fund entered into contractual arrangements with select private pharmacies which will significantly increased the number of access points across the country.

2.2. This recommendation was against the background of the following major issues:

2.2.1. **Waiting time** - Long waiting times across hospital and DrugServ pharmacies.

2.2.2. **Access points** - Limited access to pharmaceuticals at primary health care facilities. This resulted in patients who receive curative services at health centres converging on Drug Serv and hospital pharmacies, creating pressure points at these few locations.

3. STATUS

3.1. **Pilot Phase:** After consultation with stakeholders NHF commenced the pilot phase of the PPP Pharmacy initiative. Three areas were selected for the pilot, 1) Clarendon to include pharmacies within a 2 Km radius of May Pen



Hospital, 2) the Cross Roads area in Kingston and St. Andrew and subsequently 3) Montego Bay.

3.2. The pilot phase of the initiative was launched on December 19, 2017; since then a total of seventeen (17) private pharmacies have been registered on the programme. These are located in May Pen (5), Cross Roads, Kingston (7) and Montego Bay (5). To date, over nine thousand (9000) prescriptions have been processed at participating pharmacies at a cost of \$3.2 million and with an average wait time of approximately 10 minutes. The feedback from patients and pharmacists has been positive.

3.3. The goals to be achieved through this pilot include:

1. Gathering of empirical data to support the PPP benefits outlined above
2. Conducting preliminary analysis of the PPP service
3. Identifying and correcting operational issues before going ahead with a full implementation.

3.4. Other features of the PPP Pharmacy Initiative:

1. Patients register for the programme using GoJ Health Card or NHF Card
2. A Representative basket of drugs (VEN list items) is placed in participating pharmacies
3. The drugs are owned by NHF
4. Pharmacies are paid a dispensing fee of \$600 (\$400 by NHF and \$200 by patient)



5. Special prescription pads are utilized to aide in monitoring

4. NEXT STEPS

- 4.1. Subsequent to the pilot period, the intent is for the Public Private Initiative (PPI) for the dispensing of pharmaceuticals to be implemented across the island in a phased approach
- 4.2. The proposal is to add another 50 pharmacies in the next year. The estimated cost of service for the additional pharmacies is \$125 million.
- 4.3. The total estimated cost to the government for providing pharmacy services through sixty-seven (67) private pharmacies is \$167.2 million.



Strengthening Health Systems



5. INFORMATION SYSTEMS FOR HEALTH

At any point in time, the public health care facilities manage over 6 million paper-based records with the retrieval time for one record varying from less than or more than 10 minutes more than 10 minutes. It is therefore easy to contemplate how retrieval contributes to the waiting time of patients. While electronic medical records is the immediate focus of the Ministry, digitizing of paper-based records and incorporating health analytics for improved health information and decision-making is also being pursued.

1. OVERVIEW

1.1. The Ministry of Health (MOH) has a primarily paper-based system for patient records. However, there has been ongoing work to establish an electronic system. In furthering these efforts, the Pan American Health Organization (PAHO) was engaged by the Ministry to provide technical advice and assistance in developing a roadmap for the successful and sustainable implementation of E-Health solutions. In November 2016, a PAHO team of experts visited Jamaica and conducted a Rapid Situational Analysis of Information Systems. In addition, a High-Level Information Systems for Health meeting for the Caribbean was convened under the theme: *“Advancing Public Health in the Caribbean Region”*.



1.2. Following the high-level meeting held November 7-8 2016 in Jamaica, the Ministry requested PAHO's technical cooperation to discuss the implementation of recommendations from the meeting. In addition, the Ministry solicited concrete recommendations for implementing a National Plan of Action aligned with PAHO's renewed framework for Information Systems for Health (IS4H). In February 2017, PAHO presented recommendations for Jamaica and suggestions for immediate next steps. The MOH has secured with PAHO/WHO an agreement for Technical Cooperation which will cover initiatives under a National Plan of Action for Jamaica.

1.3. The engagement of the PAHO/WHO has been a turning point for the Health Information System strengthening pathway for Jamaica. The Ministry is receiving guidance from a team of experts in the field and this will help to guarantee an approach that is grounded in evidence. Foundational and core initiatives are being given priority and these will guide decision-making and implementation. These include decisions on which systems are to be adopted, how to interconnect solutions across the public and private sectors and how to ensure that personal health information is safeguarded.

2. OBJECTIVES

2.1. The goal of the Jamaica Plan of Action is to implement a better decision and policy-making mechanism in the country through health systems that ensure



universal, free, and timely access to quality and open data¹ and strategic information using the most cost-effective Information Communication and Technology (ICT) tools.

2.2. The main objective of the Plan is to introduce a renewed vision that helps to establish a general framework of operation and a common understanding of the specific components of Information Systems for Health for Jamaica. The plan seeks to define and implement strategies, policies, standards for interoperable and interconnected systems, and best practices in health data management for improving decision-making and well-being under the framing of four overarching strategic approaches: 1) universal access to health and universal health coverage, 2) health in all policies, 3) eGovernment, and 4) open and big data initiatives. The Plan will also take into consideration the National eHealth strategy, existing pilot projects and implementations, as well as systems and structures; therefore, it will be based on the assumption of incremental strengthening.

3. STATUS

3.1. The Ministry will shortly complete the E-Health Pilot Project of the Jamaica Electronic Patient Administration System (ePAS) in St. Elizabeth involving the Santa Cruz Health Centre, the Black River Hospital and the Health Department. Implementation is complete at the Santa Cruz Health Centre. Benefits of the

¹ Open data refers to data that anyone can access, use or share



implementation include a standards-based, integrated and modular system of clinical and administrative functionalities with universal access to patient health records across sites, faster patient registration, the generation of less paper, coordinated patient care among providers within a facility, access to records based on users' roles, and very importantly maintaining custody and control of the patients' records by the State and within the borders of Jamaica.

3.2. In addition, the electronic Triage (eTriage) Module of the ePAS has been piloted at the Emergency Department of the Bustamante Hospital for Children. The eTriage Module also records triage processing times inclusive of waiting time and completion time which is useful for evaluating the delivery of services.

3.3. The estimated cost of implementation of Jamaica ePAS software including eTriage and Disease Notifications Modules (3.1 to 3.4) is \$29.2 million. This included initial consultancy, manpower, software customization and development costs. The health analytics and reporting tool is estimated at \$900,000. For 12 health departments to implement a Disease Notifications Module of ePAS and four new hospitals for eTriage cost is approximately \$10.7 million.

3.4. Furthermore, The Class 1 Notifiable Diseases module of the Jamaica ePAS which allows for data collection and reporting in a central data system for Class 1 Notifiable Diseases has been piloted.



3.5. The Ministry is also in the process of advancing a system to improve the timeliness of reporting and the scope of analytics in health care.

3.6. With the gradual move to electronic health records being pursued by the Ministry, there is the need to digitize existing paper medical records. As such, the Ministry is in the process of assessing tools for use in the phased digitizing of paper medical records.

3.7. Within the Jamaican context, there has been growing interest in telemedicine which is the utilization of telecommunication and information technology to provide clinical care and/or assistance from a distance. The Ministry has received offers of telemedicine systems from various countries and has observed demonstrations for two systems. However, before a system can be implemented, a determination of Jamaica's requirements for a telemedicine system inclusive of but not limited to implications for policy and practice standards, IT infrastructure and procurement specifications, must first be established. The template for the requirements of telemedicine will be addressed through the PAHO/WHO Technical Cooperation to develop a National Plan of Action.

3.8. In fostering local and international support for strengthening the collection, collation, analysis and utilization of health information, the Ministry has developed a document entitled "The Jamaica Information System for Health"



that outlines the desired direction for improving information systems for health in Jamaica. Sharing of the documents has commenced.

4. NEXT STEPS

4.1. Going forward, the Ministry intends to:

- Review and align the Jamaica National Health Information System Strategy with the renewed IS4H Vision and Model of PAHO/WHO. The final National Plan of Action for IS4H will form the basis of the priority actions for IS4H.
- Establish a Steering Committee with the participation of all major stakeholders, including various government departments, non-governmental organizations, the University of the West Indies (UWI), and the private sector.
- Identify and regulate the standards to be used throughout the entire IS4H Framework.
- Define the legal framework to accompany the national IS4H strategy that improves the health of the population by means of timely, efficient, and reliable management of standardized information, through the intelligent use of affordable and sustainable ICTs.
- Create Business Cases for the major existing E-Health solutions with costing and models for sustainability and interoperability to determine their feasibility.
- Create a national IS4H blueprint for selecting and implementing health related applications, including epidemiological and telemedicine solutions.



- Consider the establishment of a technical working group with specialists of advanced telecommunication infrastructures of academic networks as collaborators.
- Promote the creation of a national bandwidth policy specifically focused on health and education needs.
- Endorse the development of certification (by the MoH supported by a technical partner) and standardization of systems for the use of ICTs in health and encourage institutions to undergo external quality evaluations. ICT infrastructure including the Wide Area Network Design documentation via consultancy and network cabling, network equipment, servers and computers would cost an estimated \$42.4 million.
- Support interoperability of health information systems at all levels, especially at the semantic level, which deals with the structure for data exchange and codification.
- Identify Health Analytics solutions for routine reporting and in-depth health analytics, which include predictive/forecasting potential.
- Encourage the development of eLearning as a training tool for health professionals and provide the social and technological support for access to resources.
- Convene scientific societies and health institutions of the Region to encourage them to exchange and take advantage of local, national, and regional experiences



- Promote the use of the Electronic Health Record, raising the awareness of the population about the importance of adequate management of clinical information and the potential benefits.



6. HEALTH FINANCING

As countries progress towards universal health, they face a number of options with regards to health financing. All options call for strategic decisions in all health financing functions, bearing in mind that a particular function does not define the health financing system:

- Collection of revenues: i.e. sources of funding (general taxation, contributory regimes, others) and perspective on fiscal space.
- Pooling of funds: i.e. who will be covered and what arrangements will be in place to manage the risks of the entitled population with the defined governance and administrative mechanisms.
- Paying for services: i.e. general allocation of resources; provider payment mechanisms in particular (design of contracts with providers, decisions on provider choice) and strengthening the first level of care.

All in the framework of a definition of benefits to be guaranteed for the population with an emphasis on quality and equity.

1. OVERVIEW

- 1.1. The meeting “Health Financing toward Universal Health in Jamaica: International experiences and policy options” organized by the Ministry of Health Jamaica (MOH) and the Pan American Health Organization/World



Health Organization (PAHO/WHO) took place 8-9 December 2016 in Kingston.

1.2. The general objective of the forum was to bring together government and stakeholders to discuss feasible options on health financing alternatives with an emphasis on a National Health Insurance Scheme.

1.3. The specific objectives of the forum were to:

- Provide a conceptual framework on Health Systems financing
- Facilitate exchange of experiences with countries of the Region of the Americas and other relevant experiences
- Discuss financing, regulation and governance to support the design and implementation of National Health Insurance (NHI) schemes
- Provide a formal presentation of a proposal for debate on improving health financing in Jamaica with strategic objectives and implementation goals.

1.4. The Conference explored the complexity of introducing a National Health Insurance Scheme and the need for a phased roll out with clear definition of the benefits to be guaranteed and strong governance and regulatory mechanisms. The importance of national dialogue and public education during the process was recognized. It was concluded that to enhance health financing and advance toward universal health, actions in health financing strategies alone are not sufficient, but that an integrated approach to



transforming the health system, addressing the health system's inefficiency and the health care delivery structure was crucial.

1.5. It was noted that in the latest attempt to establish a NHI scheme in Jamaica (Green Paper 1997), the implementation of the NHI was envisioned to be a combination of an independent statutory agency and the creation of a competitive market, functioning under the overall oversight of a Health Insurance Commission.

1.6. Participants discussed several options to enhance health financing for universal health including sources for revenue and payment mechanisms as well as measures related to the other strategic lines to enhance efficiency of the health system and equitable access to quality care. The methodology utilized during the meeting to critically analyze health financing options involved a mix of keynote presentations from PAHO and MOH, panel presentations on national, regional and global experiences and small group work.

2. OBJECTIVES

2.1. Policies and Strategies

2.1.1. Advancing toward Universal Health requires an integral approach along the following four simultaneous, interdependent strategic lines of the resolution adopted by the PAHO member states:



- Expanding equitable access to comprehensive, quality, people- and community-centered health services
- Strengthening stewardship and governance
- Increasing and improving financing with equity and efficiency, and advancing toward the elimination of direct payments that constitute a barrier to access at the point of service
- Strengthening inter-sectoral coordination to address the social determinants of health that ensure the sustainability of universal coverage.

2.1.2. Enhancing health financing for universal health entails transformation of the health system; a profound change in the model of care and the organization of health service delivery and addressing segmentation and fragmentation.

2.1.3. Definition of benefits in terms of a guaranteed package of service for the population with an emphasis on quality and equity.

2.1.4. Health financing options call for strategic decisions in all health financing functions

2.1.5. A constant focus on efficiency and value for money as a pillar of health system sustainability.

2.2. Health Financing options

2.2.1. Sources of Efficiency gains

2.2.1.1. Health system efficiency may be improved by:



- Increasing the response capacity of the first level of care, generating the right balance between all levels of care, decisively moving toward integrated health service delivery networks
- Rationalizing the introduction and use of medicines and other health technologies
- Promoting improvements in procurement mechanisms and supply chain management, seeking economies of scale (e.g. through the PAHO Strategic Fund)
- Information systems for decision making

2.2.2. Pooling of funds

2.2.2.1. Key questions: who is covered and what arrangements will be in place to manage risks of the entitled population with the defined governance and administrative mechanisms.

- Seek to have as many persons in as few fund-pooling as possible in order to guarantee cross subsidization across age, health and socioeconomic status.
- Delinking contribution from entitlement and ensuring proper mechanisms to protect groups in conditions of vulnerability with no contributory capacity
- Provision of health services can be public or private, sometimes including choice of provider.

2.2.3. Purchasing services



2.2.3.1. The way that health purchasers pay health care providers to deliver services is a critical element of strategic purchasing. Each payment system is based on one or more provider payment methods or mechanisms. Each method creates a different set of incentives and may be appropriate in different contexts. A payment mechanism can be defined as a type of contract among two or more players—patients, providers, and payers—that incentivizes appropriate care and minimizes the risk of opportunistic behavior. The participants offered the following guidance:

- Allocation of resources to service providers should favor incentives that promote equity and efficiency and established in accordance with the defined set of benefits.
- Prioritization of the first level of care, with the objective of improving its response capacity
- Provider payment mechanisms; design of contracts with providers, decisions on provider choice, should work as incentives toward the integration of care in the form of integrated health services delivery networks and towards transforming the model of care towards a primary health care strategy

2.2.4. Design and Implementation of a health system transformation with emphasis on a National Health Insurance scheme



2.2.4.1. All who were present now acknowledge that the road towards a Universal Health requires a substantial number of years. The presentations and discussions made the following observations:

- Health financing systems are complex and reflect the overarching values that guide overall health systems transformations.
- A phased implementation is recommended; often in stages that tackle national priorities starting with the vulnerable populations and/or services to be covered.
- Inclusion of all relevant actors from early on in the design and planning process is critical, as complex decisions require involvement and support from stakeholders
- The design of the regulatory framework in health financing reform is a critical determinant of its success.
- Establishing clear working mechanisms to maintain close collaboration throughout the process with key stakeholders
- Public Relations campaign to timely raise awareness of the importance of the process
- Internal capacity building required to maintain a functional information system.



Table 2: Key Design Factors for National Health Insurance Plan

Design factors	Recommendations
Purpose/Goal	Complement NOT completely displace other financing mechanisms
Administration	Public Administration/Insurer through NHF
Membership/coverage	All residents ...to be issued unique membership cards in the long run, starting with a stepwise approach (short-medium term)
Benefit package	<ul style="list-style-type: none"> • Standard Benefit Package (SBP) –broad package responding to health needs with focus on primary and preventive care in first phase. • SBP to be guaranteed—available; quality; timely; financial protection; enforceable • Homogenous across the health system as a whole
Provider network	<ul style="list-style-type: none"> • Registered, licensed, tax-compliant providers offering services in the SBP. • Payment as per contract terms
Sources of funds	<ul style="list-style-type: none"> • Mix--Payroll Deductions; Government Contributions for selected groups; • Other earmarked taxes/levies.
MIS-IT applications	‘End to end’ from membership to utilization audits.
Implementation phasing	By levels of care (starting with the 1 st level) and/or by population groups (starting with groups facing vulnerabilities)

3. Health System Transformation

3.1. The present health system challenges include:

- Lack of coordination between providers in the health system
- Under resourced first level of care and by-passing of this level: hospital emergency rooms considered a better choice and a “one-stop shop”
- Decentralization model not perceived to be delivering expected results
- Orientation: Strong focus on treatment; limited focus on prevention/behavior modification
- Weak primary prevention; lack of health education/health promotion



- Distinction to be made of health care as a social good and medical care as a business
- No formal system to assess the incorporation and distribution of new technologies
- Medicines procurement fragmented; NHF for public sector, private sector separately
- Allocation of public resources to the health system not prioritized and not regarded as an investment
- Public's perception of "free" health care
- Size of the informal sector as a potential challenge for contributory regimes

3.2. Feasible options for health system transformation for equitable access to quality care include:

- Strengthening primary health care (the first level of care) and effectively implementing a primary health care strategy
- Strengthening coordination and partnerships between public and private providers, but also between public providers
- Expansion of health network with private sector involvement
- Strengthening inter-sectoral collaboration to address health determinants such as pollution, injuries, food security, housing
- Bringing services close to the people (overcoming geographic and infrastructural barriers)
- Reorientation from focus on treatment of patients towards focus on health of the people and the communities



- Re-define service level agreements with RHAs to enable 'health outcomes' to be community driven
- Robust and modern Health Information System, including digitization of medical records for sharing of information and reducing waste of duplication of services
- Centralizing the procurement of medicines for the entire sector
- Definition of a sound essential drugs list

3.3. Feasible revenue options considered

3.3.1. The revenue collection function was not overly emphasized though important to the health financing system. The recommended sources of funding spanned the spectrum from general taxation, earnings from fees to contributory regimes. The participants offered the following bold suggestions:

- Expanding NHF, "sin taxes" and other sources of earmarked public funds for health
- Reimbursement of costs from private insurance companies
- Consumption tax (sugar products, high fat foods): consumption taxes added value is bringing the Informal Sector into the 'Tax Net'
- Replicate some sub regional experiences regarding health tourism
- Introducing \$1 health tax for tourists
- Capitation model mentioned, but doubt raised about the feasibility in Jamaica
- Restructuring the NHT to be the housing and health tax



- National health insurance premium

3.4. Some capacities required

3.4.1. Universal Health/National health insurance can only be realized, the participants learnt through strong commitment to advancing toward the goal. Leadership and social mobilization were the adhesive and to keep the vision intact required the following:

- Cabinet decision-making: Strong political will and leadership role
- Legislative, technological and technical capacities
- Technical capabilities in health financing mechanisms design and implementation
- Government system capacity of identifying persons with private insurance at point of service
- Campaign to facilitate a culture shift toward persons willingly using their insurance cards at the point of service, or enforcing the identification of users through information systems in order to verify insurance status.

4. STATUS

4.1. The workshop closed with the following conclusions:

- The country presentations and deliberations demonstrated that the process to establish a NHI scheme is lengthy (and very complex)
- However, for Jamaica it did represent a starting infancy, but a continuation of a process that started 30+ years earlier



- NHI becoming a reality rests on resolute leadership at all levels and participation of many stakeholders
- The consensus was that a phased approach be taken to implementing the NHI and the benefits offered should be applied through the NHF
- Priorities will be determined in the context of universality, universal access to health and universal health coverage
- Ensuring quality access, especially to those who can now not afford, needs specific attention
- Recognition that actions in health financing functions alone are not sufficient, but also an integrated approach to transform the health system

5. NEXT STEPS

- 5.1. The meeting report will be utilized as the discussion document from which an internal team can develop guidelines for the process. Part of this involves identifying key issues to guide the process of national dialogue.
- 5.2. Public education and discussion forums will be organized all over the country in appropriate language understandable to the public.
- 5.3. A roadmap will be crafted and will reflect the path to:
 - Determine the priorities,
 - Structuring and sequencing the phases,
 - Setting timelines



5.4. In the short term, full time expertise will be recruited to advance the process under the leadership of the NHF.



7. BILATERAL COOPERATION BETWEEN JAMAICA AND THE UK

1. OVERVIEW

1.1. Jamaica has been experiencing the effects of shortages of health workers, which is a significant and ongoing global health workforce issue. Of particular concern for Jamaica, is the chronic shortage of nurses, predominantly specialist nurses in all areas (critical care, nephrology, accident and emergency, paediatric, neonatology, operating theatre, psychiatry and midwifery inter alia). As at 2008, the ratio of nurses per 1,000 population was 1.1 in Jamaica compared to the World Bank benchmark of 1.73 nurses per 1,000 population.

1.2. Approximately 1,000 specialist nurses are required to fill the positions of critical care, nephrology, accident and emergency, paediatric, neonatology, operating theatre, psychiatry and midwifery inter alia. As is the situation globally, the chronic shortage of health workers, in particular specialist nurses, emanates from high migration rates and limited capacity for adequate and quality training. Over the last three years, Jamaica lost 29% of its critical care nursing workforce to migration, which has severely hindered the capacity to deliver efficient and effective care.



- 1.3. The recruitment and retention of critical care nurses is paramount to Jamaica. In recent times, this shortage of critical care nurses has had a severe impact on health service delivery resulting in health service rationing in areas such as elective and semi-elective surgeries, reduction in ICU admissions, increased workload on limited staff, which may negatively impact patient outcomes. It is projected that a minimum of 140 critical care beds are needed to meet the current demands for patient care, and this would require a cadre of 840 critical care nurses.
- 1.4. Jamaica currently has 40 critical care beds in the public health system. Each critical care bed requires at least two critical care nurses per shift, that is, six critical care nurses for a 24- hour period. A basic staffing plan of 240 critical care nurses is required, however only 56% is currently employed within the public health system. The current situation sees one nurse to two or more critically ill patients. Additionally, high dependency units (HDU) have been established across the country and will require a minimum of 60 critical care nurses.
- 1.5. The Government of Jamaica proposes to expand its capabilities to increase its pool of nurses for entry to the public health system through bilateral partnerships with countries such as the UK. A proposal for a bilateral partnership for the training of nurses has been presented to Health Education England (H.E.E.).



2. OBJECTIVES

2.1. The bilateral partnership for the training of nurses, hinges on four pillars:

2.1.1. Training of specialist nurses

A minimum of 35 registered nurses is proposed to be enrolled in the critical care training programme in Jamaica annually. Advanced clinical training for approximately 85% of the enrolled nursing cohort will be pursued in the UK for six months. This will allow Jamaican nurses to gain experience in working in the UK as well as facilitate increased enrolment by local training institutions thereby increasing the numbers of trained and qualified specialist nurses. It is further proposed that Jamaican nurses be paid UK salaries based on their grades during the training period in the UK. A Memorandum of Understanding (MOU), not exceeding a period of three years, will be established between Jamaica and the UK.

2.1.2. Shared employment

Under the proffered partnership agreement, shared employment of nurses is proposed. The UK would benefit by having access to a consistent supply of nurses trained in their country setting, whilst Jamaican nurses would acquire practical work experience in an international setting.

2.1.3. Nurse exchange



Nurses from the UK would be deployed to work in Jamaica's public health system for a period of one year. The Government of Jamaica (GoJ) will facilitate housing in government owned facilities and salaries and associated benefits will be in accordance with GoJ rates and policies.

2.1.4. Nurse educators/faculty exchange

Under the bilateral agreement, each cohort of nurses to enter the UK will be accompanied by a local faculty member. Furthermore, educators will be recruited and/or a faculty exchange will be established to bolster the educator to student ratio at local training institutions. In addition, training of nurse educators in the UK will be pursued. Housing will be facilitated in government owned facilities and salaries will be in accordance with GoJ rates and paid in local currency.

3. STATUS

- 3.1. In April 2017, a meeting was held with UK delegates and representatives of the Ministry of Health (MoH) to discuss the training of nurses' initiative. The UK is in favour of the proposal; however, further refinement of the proposal will be undertaken by H.E.E to strengthen gaps identified in the four pillars.
- 3.2. With respect to the training of specialist nurses, the following needs to be taken into consideration:



- Designating a 'Preparing to Fly' period prior to Jamaican nurses entering the UK
- Acquire familiarity with working in the UK
- Education package that includes academia plus practice, for example a post graduate certification
- Attractive offers enabling nurses to return to Jamaica

3.3. The risks inherent in the shared employment concept needs careful assessment and appropriate mechanisms inclusive of contractual agreements will need to be designed to ensure nurses' return to Jamaica

3.4. Concerns raised with the nursing exchange programme related to the return of UK nurses at the end of the period and the disparity in the age of retirement for UK and Jamaican nurses.

3.5. Funding for the nursing training initiative will be shared between Jamaica and the UK. The H.E.E. has developed a draft financial model which is to be finalized. The UK Hospital Trust as well as H.E.E will also bear some costs relating to salary and accommodation for Jamaican nurses.

4. NEXT STEPS

4.1. A UK delegation will visit Jamaica in June 2017 to observe the local nursing programme.



- 4.2. On the side of the GoJ, the Ministry of Education will be engaged and a multi-sectoral working group will be established to work through all aspects of the initiative.
- 4.3. The Honourable Minister of Health will visit London in May 2017 to finalise discussions with the Department of Health regarding the training of nurses. This will be followed by the signing of the Statement of Intent and the MOU by both parties later in the 2017/2018 Financial Year.
- 4.4. The Ministry of Health is also pursuing a bilateral partnership with Canada for the training of nurses. The Minister of Health for Ontario will visit Jamaica in June 2017 for continued discussions.



8. DEVELOPMENT OF TEN-YEAR STRATEGIC PLAN

1. OVERVIEW

1.1. In 1997, the country experienced a major health sector reform that culminated in the promulgation of the National Health Services Act (1997), which gave effect to the decentralization of health service delivery and creation of the four (4) Regional Health Authorities (RHAs). As a result, the responsibility for the operational management for health care delivery in the public sector was transferred to RHAs. However, there has been a perception that the administrative reform did not translate into improved service delivery. This health reform policy has not been effectively evaluated after nearly 20 years and is now at the point where it needs to be critically reviewed.

1.2. Further, a recent audit of the public health sector has indicated that there have been gaps in leadership and governance, this situation also prompts a review of the overall system. Noting that improved leadership and governance in health will be a key requirement for the development agenda and by extension the National Development Plan - Vision 2030 and achieving the Sustainable Development Goals.

1.3. The need for reform of the health sector is also motivated by the epidemiological and demographic transition currently being experienced by



Jamaica; this is due mainly to an aging population, changes in lifestyle habits and health behaviour that has resulted in an increased burden of Non-Communicable Diseases (NCDs); continued threat of communicable diseases and the level of trauma due to violence and motor vehicle accidents.

1.4. The NCD challenge has the potential to create substantial economic impact, due to the growing number of working adults with NCDs. It is recognized that the current configuration of the country's health system is constrained to respond effectively and will have to be transformed and strengthened to contain this threat.

1.5. The Ministry of Health (MOH) has sought to put in place a consultancy to assist in recommending health reform initiatives through defined policies, and developing and costing a ten-year strategic plan (2017-2027) consistent with the country's commitment to move towards universal access to health and universal healthcare coverage aligned with Vision 2030, to inform projects/programmes intended to protect and enhance the health gains of the population and, in particular, vulnerable groups in an equitable and sustainable manner.

1.6. In furtherance of the consultancy, the MOH received a grant from the Inter-American Development Bank (IDB) to develop a comprehensive long term development plan for the national health sector to move toward universal



access to health and universal healthcare coverage aligned with Jamaica's Vision 2030, and re-align the objectives of the health sector through a reform process. A previous consultancy, "Sustainable Financing and Reform of the Health Sector to Improve Effectiveness, Efficiency and Quality and Quality of Care in Jamaica" undertaken by IOS Partners, Inc. that concluded in 2013 evidenced the need and laid the foundation for the development of the ten-year strategic plan.

1.7. The Ministry has convened a high level multi-sectoral, multi-stakeholder Staring Committee to guide this initiative.

1.8. The Ministry has contracted international experts in the form of IOS Consulting Inc. to undertake a nine-month consultancy; to be concluded in October 2017, to prepare this plan.

2. OBJECTIVES

2.1. The Consultancy will deliver the following:

- A ten-year strategic plan that will include:
 - Updated Situational Analysis
 - Revised Standard Comprehensive Essential Benefits Package (SCEBP)
 - A Human Resources Plan
 - An Administrative Restructuring Plan
 - An Infrastructure Improvement and Procurement Plan



- Monitoring and Evaluation (M&E) Metrics for the ten-year Strategic Plan
- A three-year implementation plan

2.2. The Pan American Health Organization (PAHO) is also providing technical assistance in support of the development of the ten-year Strategic Plan. These include:

- Providing a conceptual/positional document on National Health Insurance (NHI) options and international experiences to support the work of the committee in charge of drafting the NHI proposal.
- Organizing a technical meeting in Jamaica on Options for National Health Insurance to bring all stakeholders together to present the conceptual framework, international experiences and make the formal presentation of a proposal for debate on improving health financing in Jamaica with strategic objectives and implementation goals.
- Supporting the drafting of an outline for the ten-year strategic plan and accompanying the process of the steering committee to define desirable inputs of the consulting group in this process.
- Designing a project to conduct an analysis of health services decentralization and levels of integration of health services networks in the four regional health authorities, exploring factors at the national, regional and local levels that has influenced outcomes.

3. STATUS



3.1. To date, the following has been accomplished:

- The engagement of IOS Consultant Inc. to undertake the development of the ten-year strategic plan; monitoring and evaluation (M&E) metrics for the ten-year strategic plan and a three-year implementation plan.
- Initial stakeholder consultation in March 2017 by IOS Consultants;
- Review and finalization of IOS Consultants' draft work plan.

4. NEXT STEPS

4.1. On the part of the IOS consultants, the following activities will be pursued:

- Completion of the updated Situational Analysis;
- Finalization of the Revised Standard Comprehensive Essential Benefits Package (SCEBP);
- Completion of the Human Resources Plan;
- Completion of an Administrative Restructuring Plan;
- Completion of an Infrastructure Improvement and Procurement Plan;
- Ongoing stakeholders' consultation;
- Finalization of the ten-year strategic plan;
- Finalization of M&E Metrics for the ten-year strategic plan;
- Finalization of a three-year implementation plan.

4.2. Completion of PAHO's review of the health services decentralization.

4.3. Planned final submission of all reports is scheduled within 9 months.



Responding to the Non-Communicable Disease Threat



9. JAMAICA MOVES

30 minutes of moderate exercise daily along with proper nutrition leads to a health life resulting in more ...
More moments, More memories, More life

1. OVERVIEW

- 1.1 Physical inactivity is a leading risk factor for non-communicable diseases (NCDs) and global mortality. The World Health Organization (WHO) Physical Activity Fact Sheet (updated February, 2017) estimates that individuals with insufficient physical activity levels face an increased risk of mortality in comparison to individuals who engage in at least 30 minutes of moderate physical activity several times a week.
- 1.2 WHO (2010) Global Recommendation of Physical Activity for Health advocates for increasing physical activity levels among the world's populace. Increasing physical activity levels can reduce global mortality and the incidence of non-communicable diseases such as ischaemic heart disease, diabetes and breast and colon cancer.
- 1.3 The 2008 Jamaica Health and Lifestyle Survey reports that 3 in 10 Jamaicans aged 15 - 74 have insufficient physical activity levels, with females being more physically inactive. Jamaica's National Strategic and Action Plan for the



Prevention of Non-Communicable Diseases (2013-2018) support the need for increasing physical activity levels.

- 1.4 The Ministry of Health through the Regional Health Authorities has undertaken health promotion interventions in varied settings including health facilities, schools, workplaces and communities. However, the Ministry recognized the need for a more comprehensive and visible approach to facilitate population wide physical activity.

2. Jamaica Moves

- 2.1 This approach, which has been branded Jamaica Moves, targets individuals across the lifespan. Jamaica Moves, National Physical Campaign, will:
 - Promote physical activity among the populace;
 - Educate individuals on practical means of fostering healthier eating habits

3. OBJECTIVE

- 3.1 Jamaica Moves is one of several NCD interventions being pursued by the Ministry to alleviate the effects of non-communicable diseases on individuals and the health system. The four main risk factors for chronic non-communicable diseases are improper diet, lack of physical activity, tobacco smoking and alcohol abuse. The twinning of Jamaica Moves with the initiatives being undertaken by the National Food Industry Task Force along



with the instituted ban on tobacco smoking in public places reflect the elemental strategies for combatting NCDs. This three-pronged approach along with the Ministry's encouragement for early screening and testing support the National Strategic and Action Plan for the Prevention of Non-Communicable Diseases (2013-2018).

- 3.2 Jamaica Moves was launched on the 7th of April 2017, World Health Day, at Emancipation Park. This launch signaled the beginning of a corporate challenge, a media campaign and island-wide activities to encourage the population to move. Physical activity ambassadors from different walks of life will share their testimonies of how they have benefitted in a significant way from increasing their frequency and intensity of physical activity.

4. STATUS

- 4.1 Ahead of the formal launch of Jamaica Moves, the Ministry produced and released a Jamaica Moves video through YouTube and social media platforms. This video served as a soft launch for Jamaica Moves and featured the Honourable Minister of Health along with the National Focal Points for Nutrition, Physical Activity and Non-Communicable Diseases. The take home message of the video was: engage in physical activity for at least 30 minutes a day and eat healthier to reduce your chances of acquiring an NCDs and live longer.



4.2 For the annual Sigma Run, the Ministry of Health mobilized the participation of 100 members of staff inclusive of the Honourable Minister of Health. Participants wore for the first time, Jamaica Moves branded T-Shirts. This was an initial step in creating brand awareness. Staff members also participated in the Kingston City Run under that brand.

5. NEXT STEPS

5.1 Physical activity ambassadors are currently being interviewed and their stories will be edited and packaged for social media, as well as to be placed in health facilities and via media offered from key partners.

5.2 Development of a walking trail in each parish and the staging of events across the island to promote physical activity, healthy eating and screening will also be pursued.



10. THE NATIONAL FOOD INDUSTRY TASK FORCE

The Ministry of Health has accepted the expediency of effective strategies to be identified and implemented that will create a health-promoting environment to enable individuals to be provided with healthier food options while reducing the influence of marketing on unhealthy food choices. In this regard, the MOH has seen it wise to establish the National Food Industry Task Force.

The mantra to the industry players is that while the Ministry will not resile from its public health responsibility it would rather *move from voluntary to mandatory measures.*

1. OVERVIEW

1.1. Jamaica today is experiencing massive changes ranging from the proliferation of fast-food outlets to the almost total reliance on cars. This parallels the global trend which promotes excessive food intake and discourages physical activity. The spiraling increase in obesity and chronic diseases in Jamaica coupled with the rapid and expanding internal and external food trade suggests that the implementation of food and nutrition policies in Jamaica must proceed with much urgency. The impact of food policy on chronic diseases is profound and predictable and therefore calls for urgent



action. In Jamaica, the overweight/obesity trend for adults was 45% in 2000; 53% in 2008 and 60% in 2016 (JHLS, 2000; 2008; Henry, 2017), and obesity is associated with 67% of all deaths in Jamaica.

1.2. The obesity tsunami impacting Jamaica and the Caribbean is prominent in childhood. During one decade overweight and obesity rates in pre-school children changed from 6% to 14% (CFNI, 2011). This is a weighty challenge because Caribbean children have much higher rates than the global average of 5%. (de Onis, 2000; Olds 2011). Even more frightening is the observation that the risk of adult obesity is several times greater in obese children than among the non-obese. The major challenges among older children and adolescents are unhealthy eating and lack of physical activity. These stem from ineffective policies related to food supply, food processing, food marketing and transport, among others.

1.3. The far-reaching effect of available energy-dense snacks and other food products, sugar-sweetened beverages, and fast foods are regarded as leading contributors to the excessive intake of added sugar, fats and salt. In 2010, 70% of Jamaican youths aged 13-15 years reported drinking at least one sugar-sweetened beverage every day. Commercially-available foods or 'convenience foods' have become more available to satisfy the practice of increased consumption away from home as more women, who would traditionally stay at



home, enter the workforce and long distance commuting between work and home has also risen.

- 1.4. The establishment of the National Food Industry Task Force (NFITF) in Jamaica is a singularly critical development aimed at garnering the support of the food sector in helping to combat nutrition-related diseases. The Task Force started its activities on November 1, 2016.

2. OBJECTIVES

- 2.1. Government efforts internationally have centred around the three regulatory measures (i.e. fiscal policies, marketing, labeling) but the Government of Jamaica has gone beyond that and will be implementing a number of comprehensive and strategic activities to help in combatting nutrition-related diseases, based on these four strategic activities:

1. Food Labeling

- Mandatory Nutrition Facts Panel on all packaged retail grocery foods and beverages
- Standardized understandable nutrition labels on all packaged retail grocery foods and beverages
- Mandatory nutrition labeling on menu boards in chain restaurants and other food outlets



2. Food Marketing

- Mandatory nutrition standards for all foods in schools based on the national food-based dietary guidelines
- Limitation of the sale and sponsorship of unhealthy food products in schools
- Reduction in children's exposure to unhealthy food advertising through all channels
- Reduction in portion sizes of energy dense foods and beverages

3. Product Reformulation

- Time-bound salt, fat and sugar content for specific food product categories to meet national standards
- Mandatory removal of artificial trans-fats in all food products
- Food service outlets and vendors improve the quality of foods sold

4. Advocacy and Communication

- Fiscal policy options to align with the nutritional value of foods and informed more by the relative failure of the voluntary approaches
- Public education and specific stakeholder training on:
 - the dangers of unhealthy eating;
 - the use of food labels;
 - the incentives and disincentives of fiscal policy initiatives. Support for food manufacturers and vendors in using healthier ingredients.

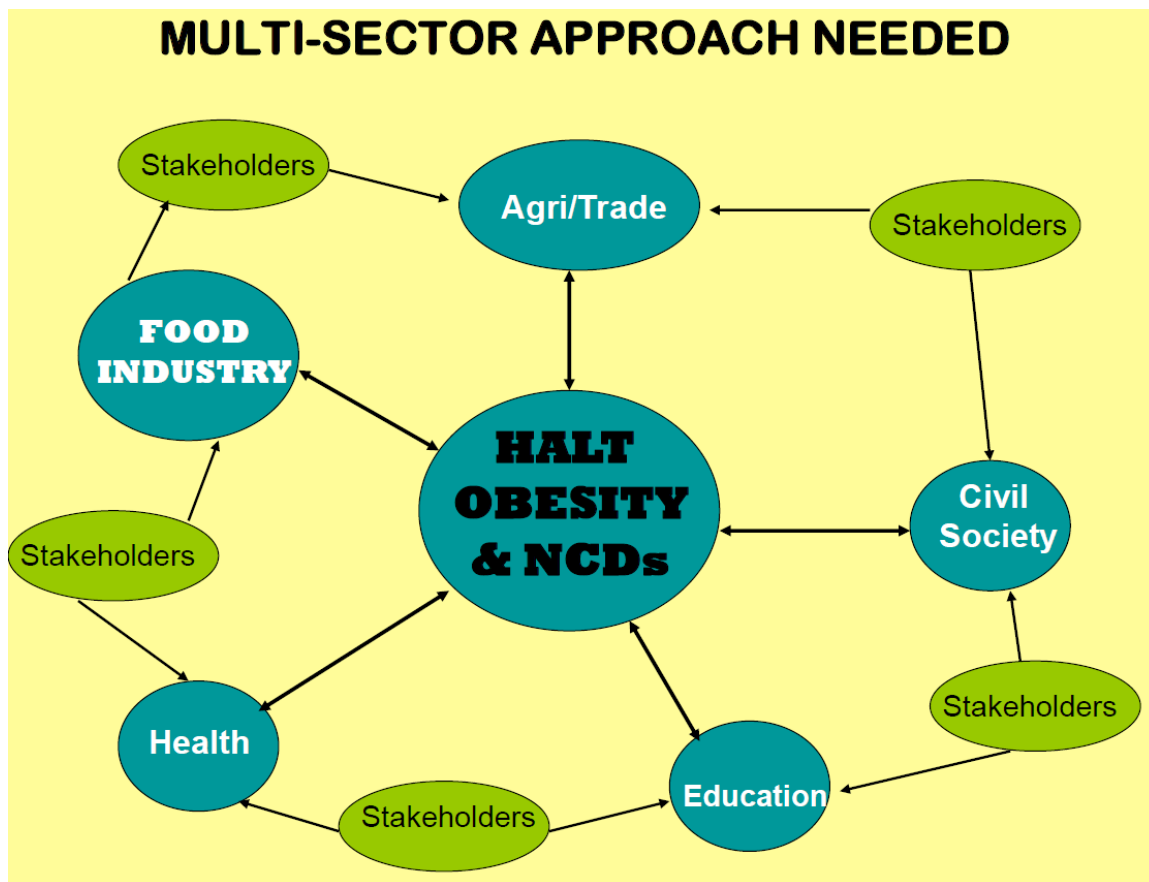


Finally, the strategic objectives are also an appropriate mix of demand and supply interventions.

3. Composition of the Food Task Force

3.1. The NFITF is a very skilled and experienced grouping with broad multisectoral representation consistent with sound governance and successful consultation. In that regard, so both the name and composition of the Task Force was deliberate. The food industry is a critical player in any potentially successful long-term strategy to prevent obesity. By producing new products low in energy density and low in sodium (salt), as well as through socially responsible marketing and labeling, the food industry can provide foods that enable consumers to achieve better nutrition.





4. STATUS

4.1. The National Food Industry Task Force has submitted a report containing their findings and recommendations to improve nutritional knowledge, behaviour, and practices in Jamaica.

- Notably, a proposal inclusive of budget has been drafted for the four strategic areas for action – food labelling, food marketing, product reformulation and advocacy and communication



- Furthermore, a fiscal policy option paper on combatting obesity and NCDs in Jamaica has been drafted

5. NEXT STEPS

- 5.1. The recommendations of the NFITF will be submitted to the Ministry of Health. These recommendations will be reviewed and assessed in terms of feasibility. Approved recommendations will be submitted to Cabinet for ultimate approval.
- 5.2. Outside the specific recommendations of the NFITF and complementing its work, the following are essential:
 - 5.2.1. Create a national fund with contributions for donor, development agencies and government to support obesity prevention initiatives.
 - 5.2.2. Forge private and public initiatives to fund outreach programmes that will facilitate increase availability and affordability of fruits, vegetables, legumes and ground provisions and foster development of healthy lifestyle programs.
- 5.3. Stakeholder consultations will be organized with internal and external stakeholders to gain their feedback on the recommendations of the Task Force



11. MENTAL HEALTH AND HOMELESSNESS TASK FORCE

Over 500 stable patients at the Bellevue Hospital have officially been discharged from the hospital but are forced to remain at the facility because there are no provisions in their communities to accommodate them and because effectively, they have been abandoned by their relatives or caregivers. In some cases, there is no identified relative or guardian.

1. OVERVIEW

- 1.1. The Mental Health Services in Jamaica have improved significantly since Independence. Tremendous progress has been made in deinstitutionalizing the treatment of mental illness, integrating mental care within the general health services and developing the community mental health services. Many more psychiatrists and mental health practitioners have been trained and employed and a broader range of mental health specialist services offered. Knowledge of the brain and the treatment of mental illnesses have also continued to evolve.
- 1.2. However, significant challenges remain. Jamaica has become plagued by very high rates of violence giving rise to many children and adults with post-traumatic stress disorder, personality disorders, depression and anxiety. Family



unions are weak and frequently unstable with poor parenting skills. The community mental health services are severely under resourced and unable to cope with the many needs including early diagnosis and treatment. Stigma and discrimination towards persons with mental illness needs to decrease and social support for families with mentally ill persons is woefully inadequate, resulting in many such persons being deserted in hospitals or becoming homeless.

1.3. There are mounting social and economic challenges, including but not limited to; high unemployment rate, weak family structures and inadequate access to social services such as housing, water, and supportive home care. As a result, many persons fall through the existing social safety net. Such persons include children, adults and the elderly who are abandoned in hospitals by families who find it difficult to cope. Many other persons resort to living on the streets or in temporary shelters. This issue is associated with a growing concern in the society about the homeless and the destitute and a need for the Government to find ways to address this problem

1.4. The Honourable Dr. Christopher Tufton, Minister of Health, received Cabinet's assent to establish the Task Force on Mental Health and Homelessness (MHHTF) in June 2016 to make recommendations for improving the mental health services and addressing the needs of the homeless in Jamaica. The Task Force reports directly to the Honourable Minister of Health and was to serve for a five-month period.

2. Task Force Terms of Reference



2.1. The deliverables of the MHHTF are to:

5. Review the processes involved in the public-public partnership between the Ministries of Health and Local Government, and to make recommendations on how to implement the initiative.
6. Propose an implementation plan to foster a successful transition to a “New Bellevue Hospital.”
7. Provide guidance on inputs that should foster these objectives; which include inter alia:
 - Establish a MOU outlining agreement between parties
 - Guidance on governance arrangements/oversight
 - Review of legal and policy framework
 - Prepare the concept paper
8. Provide technical guidance on all aspects of the separation and implementation e.g. staffing, provisions(parties responsible) and transfer implications; physical demarcation; overall best practices for the differentiation process; as well as Ministry of Health’s role in determining protocols for which person(s) are placed in the facility (current guidelines for infirmaries being utilised at Bellevue hospital).
9. Make recommendations on the most appropriate payment structure for Ministry of Health/Bellevue to finance the “new infirmary” and arrangements for shared overheads and proximate amenities.



10. Make recommendations on appropriate housing solutions for:
 - In hospital homeless
 - Outdoor homeless
 - Forensic psychiatric patients
11. Make recommendations on the appropriate method of including the proposed Church psychological/counselling services to augment the mental health services currently offered by the MOH.

3. OBJECTIVES

- 3.1. The Government of Jamaica sought guidance/plan of action from the Task Force under the following objectives:
 1. Promoting the mental health, social well-being and productivity of the Jamaican people
 2. Promotion and development of community mental health.
 3. Integration of mental health services within primary health care and other health and social services.
 4. Deinstitutionalization of mental health services and a redefinition of the role and rebranding of Bellevue Hospital.
 5. Improvement in the scope and quality of mental health services especially for infants, children and adolescents



6. Address the needs of the homeless and reduce the number of persons remaining in hospital beds following discharge from hospital.
7. Development of the Forensic Psychiatric Services
8. The improvement of social services to address the needs of the indigent, the homeless and the aging population
9. Propose feasible policies, plans, programmes, guidelines, MOUs and other agreements or measures including changes in the Mental Health Act or Regulations to realize these lofty objectives and goal.

4. Composition of the Task Force

- 4.1. The members for Task Force included representatives from key Ministries and Agencies that have a stake in the issues along with select Non-Governmental Organisations (NGOs). The Ministries named were Ministry of Health, Local Government and Community Development and Ministry of Justice. The Agencies/ Government Departments named were Bellevue Hospital, Department of Correctional Services, Board of Supervision, National Health Fund, and the Kingston and St. Andrew Mental Health Services. The NGOs were Food for the Poor, Choose Life International and the University of the West Indies.



5. STATUS

5.1. The Task Force has completed deliberations and a report on the findings and recommendations has been submitted to the Ministry. The main recommendations provided by the Task Force are as follows:

- Develop a cadre of Community Health Aides trained to make regular visits to the homes of vulnerable children
- Strengthen the community mental health services
- Further integrate the Mental Health Services within primary health care
- Develop a new Mental Health Law
- Improve the cadre of Psychiatric Nursing Aides and Community Health Aides trained to intervene and mediate in conflict in order to break the cycle of violence
- Establish more safe green areas
- An increase in the capacity of infirmaries
- Develop long-term nursing care facilities through public/private partnerships
- Financial proposal of the resources required for implementation



6. NEXT STEPS

6.1. Following the review of the findings and recommendations of the Task Force, the Ministry has identified a number of areas which will be pursued/for immediate pursuit. These include:

6.1.1. The integration of the recommendations of the Task Force in the Ministry's Ten-Year Development Plan

6.1.2. Development of a two to three-year Action Plan with timelines for:

- Acquiring 3 to 4 vehicles dedicated for mental health services regionally
- Establishing a monitoring mechanism for the RHAs and the Ministry
- Reducing stigmatization and increasing acceptance amongst relatives and in communities for people living with mental health conditions
- Strengthening community-based approach for mental health
- Instituting a programme to identify and treat persons
- Establishing a public education programme

6.1.3. Training of community health workers in communities

6.1.4. Establishing a Chronic Care Facility at the Bellevue Compound

6.1.5. Develop and source assistance/partnerships for an outreach programme to the homeless



6.1.6. Relocating social cases from hospitals to infirmaries and ensuring adequate numbers of public health nurses for persons who require a higher level of care

6.1.7. Costing of initiatives



12. PUBLIC HEALTH AND CANNABIS

1. OVERVIEW

1.1 The Dangerous Drugs (Amendment) Act, 2015 was passed to provide for “among other things, the modification of penalties for the possession of ganja in specified small quantities and the smoking of ganja in specified circumstances, and for a scheme of licences, permits and other authorizations for medical, therapeutic or scientific purposes”. This amendment has been referred to as the ‘decriminalization of cannabis’.

1.2 Implications of Amendments to the Dangerous Drugs Act

1.2.1 Public Perception

Reports from key stakeholders in the law-enforcement, education and health sectors, have been consistent regarding public perception of the recent Amendments to the Dangerous Drugs Act. The perception, particularly among youth, is that ganja is now a legal drug to be used at leisure regardless of location, age, quantity and context.

1.3 Lack of enforcement of laws

1.3.1 The lack of enforcement of laws concerning possession and smoking of ganja will lead to a breakdown in law and order and deterioration of non-smokers’ rights to enjoy smoke free environments especially in public spaces.



1.3.2 Appropriate regulation must focus on protecting public health. Policy structures must be based on the need to keep harm to a minimum and should be guided by science.

1.4 Issue

Prevalence of Cannabis Use

1.4.1 *Among the General Population* - The use of marijuana continues to be embedded in aspects of the Jamaican culture and it remains the most commonly used illicit drug with a lifetime prevalence of 18% among the general population (Jamaica Health and Lifestyle Survey, 2008).

1.4.2 *Among Secondary School Population* - A National Secondary School Survey (NSSS) was collaboratively conducted in 2013 by the National Council on Drug Abuse (NCDA) and the Organization of American States (OAS), which indicated a 20.7% prevalence of marijuana use among secondary school students. The survey also revealed that prevalence was higher among males (26.4%) than females (19.4%) and highest among the 15-16 age group (26.55%). The average age of first use of marijuana was 12 years.

1.4.3 *NCDA Drug Treatment Programme* - 90% of the adolescents seen in the NCDA's drug treatment program are referred due to problems associated with marijuana use. The treatment reports reflected a 54% increase in students enrolled in a ganja prevention programme called "STEP-UP" since the decriminalization of possession of 2 ounces or less of ganja.

1.5 Access to Marijuana Among The Secondary School Population



1.5.1 There is a worrisome reality concerning the access to and availability of marijuana among the secondary school population, with approximately 50% reporting that it was available in and around school compounds. Additionally, 1 in 5 students who reported marijuana use was at risk for misuse. A significantly higher proportion of students who used marijuana reported having behavioural and academic problems.

1.6 Role of Parenting Factors in the Prevalence Among Secondary School Population

1.6.1 Parenting factors played a role in the prevalence of marijuana, in that it was significantly lower among students whose parents were actively involved in their lives and significantly higher among students whose parents were not actively involved.

1.7 Public Health Impact of Cannabis

1.7.1 There are serious implications for the health and well-being of people who use the substance, for example, tetrahydrocannabinol or THC, the chemical responsible for most of marijuana's psychological effects impairs psychomotor performance, reaction time and perception and has major implications for public safety within a medicalized, decriminalized and legalized context.

1.7.2 Locally, the impact of cannabis on cognitive functioning (including memory) along with the existing challenges with education/literacy in school children and the increased prevalence of cannabis use and misuse by Jamaican adolescents is



a major concern, such as incidence of '*drugged driving*', dangerous and harmful reactions to the consumption of ganja edibles. There are edibles (cookies, sweets, etc.) present in the Jamaican context – some being sold within prominent schools.

1.7.3 Recent Sunday Gleaner report of Ganja Babies at CRH (March 2017) “A 50 per cent jump in the number of children seeking assistance at public medical facilities for ganja-related illnesses ... since decriminalised in 2015, is causing worry for local health officials.....”

2 OBJECTIVES

2.1 Medicinal Cannabis

The Jamaican public health system can benefit from research and the subsequent development of useful cannabis products like Canasol, one of the first cannabis-containing pharmaceuticals to be developed (in Jamaica) and approved by the USA Food and Drug Administration (FDA). This requires Jamaica to actively participate and play a leading role in medical marijuana research, which should involve the study of adverse effects of marijuana.

2.2 **The Health sub-Committee** of the Cannabis Liscening Authority (CLA), which is chaired by the Chief Medical

Officer (CMO) has been working on the following initiatives: *Ethical Guidelines for Medicinal Cannabis Research; Medicinal Cannabis cards; mandatory Continuing Medical Education (CME) training programme for physicians; and Registration of cannabis products.*



2.3 The MOH Cannabis Unit is to be established to enforce the amendments to the Act, and the implementation of Medicinal Cannabis regulations.

2.3.1 *Ethical Guidelines for Medicinal Cannabis Research* are presently being crafted by a consultant and collaboratively funded by the CLA and the Jamaica Promotions Corporation (JAMPRO).

2.3.2 *Medicinal Cannabis cards* have been designed for the use by persons with evidence that they are using cannabis for Medicinal purposes. In the case of tourists this is done by providing evidence of a US-based *medicinal cannabis card* at the ports of Jamaica or by '*self declaring*' that they use medicinal cannabis. The fee for these cards payable at the ports should be incorporated into the MoH revenues.

2.3.2.1 **Proportion of CLA fees to the MOH for treatment/prevention** - The Dangerous Drugs Act allows for a 'proportion' of earnings by the CLA to be set aside for Drug Education and Treatment. This initiative is implemented in the State of Colorado, USA where 50% of funds earned from it is spent on education and treatment. Provisions must be made for this proportion of collected funds collected by the CLA for licenses to be made available to the MOH Cannabis Unit/NCDA for prevention and treatment programmes.

2.3.3 *A mandatory Continuing Medical Education (CME) training programme for physicians* registered in Jamaica, who will be prescribing/recommending medicinal cannabis for patients as well as training for others in the industry (eg smoke houses) has been completed by NeuroPsychServices. This programme will be available to those interested in the four Regional Health Authorities, with



endorsement from the Medical Association of Jamaica (MAJ) and MoH, including a CME certificate.

2.3.4 The *registration of cannabis products* (nutraceuticals and pharmaceuticals) for importation or export will be carried out by the MoH/CMO.

3 STATUS

3.1 MOH Position on Medical Cannabis

3.1.1 Extracts of specific cannabis products

The MOH supports the use of EXTRACTS (in varied CBD/THC concentrations) containing cannabis products for research and medicinal purposes, where there is scientific evidence for the use of these substances for specific conditions.

3.1.2 No support for smoked products

The MOH does not support the recreational use of cannabis or any form of smoked cannabis products, even for medicinal uses, as smoking anything is hazardous to your health. The MOH supports the use of tinctures, sub-lingual drops and topical solutions for medicinal purposes.

3.1.3 Edibles

The MOH does not support the use of 'edibles' (e.g. cannabis brownies) in any form as a method of ingesting medicinal cannabis. This method is associated



with most acute ER visits internationally, especially in adolescents. The main reason is that the amount absorbed/ingested with this method of use is unpredictable and difficult to measure. There are recent reports of research being done in this area. This can be revisited as the body of scientific evidence on the safety of this method increases.

3.1.4 Regime to Recommend/Prescribe Medical Cannabis

Only appropriately trained Physicians registered to practice medicine in Jamaica will be able to recommend cannabis for medicinal purposes to the MOH. In other jurisdictions (eg. Israel) only Specialist Doctors are allowed to recommend/prescribe cannabis for medicinal purposes. Patient applications to the MOH will need to be accompanied by the trained physician's recommendation, indicating method, dosage and condition being treated. Should be made available online. A register of these physicians will be kept by the MOH and shared with the CLA and Pharmacy Council.

3.1.5 Registration/Certification for Physicians to recommend Medical Cannabis

A mandatory certificate course is available and will be administered to interested Physicians. A MOH certificate of completion will be provided to participants. This is a requirement for registration by the MOH for prescribing/recommending cannabis.



The Course will be offered in each Health Region every 6 months, depending on the level of requests. All persons working in the field of 'medicinal cannabis' should receive appropriate mandatory training in the potential negative aspects of cannabis use in any form and should be registered by the MOH.

3.1.6 Structure to support import/export of extracts incl. travel with cannabis medicines.

4 NEXT STEPS

4.1 Public Education Strategy

It is the consensus that a public education strategy is urgently required to address the implications of these changes for various groups in our society especially targeting youth as well as to address the wide societal perception that marijuana is a safe drug. All components of the programme should have special emphasis on prevention of use by the vulnerable - children, pregnant mothers, persons living with or predisposed to mental illness, among other key groups such as drivers.

1.4.1 Funding

The MoH has contributed to the public education campaign on the Development of Medical Ganja Industry proposed by the NCDA. Further funding and inter ministerial collaboration is needed for this initiative.



Combatting Communicable Illnesses



13. ZIKA VIRUS RESPONSE

1. OVERVIEW

- 1.1. Vector-borne disease transmission across the island continues to be a public health concern. The *Aedes aegypti* mosquito which is the vector that transmits Chikungunya, Dengue, Yellow Fever and Zika viruses is present in high numbers and can be found in all fourteen parishes. It is a domesticated mosquito and breeds in containers such as drums and tyres in and around the home, workplace and communities.
- 1.2. Since 2016, the Zika Virus has emerged with symptoms manifesting as fever, rash and conjunctivitis (redness of the eyes), among others. The virus is also associated with potential neurological complications like the Guillain-Barre Syndrome and Congenital Syndrome Associated with Zika Virus (CSAZ, Microcephaly or other congenital abnormalities).
- 1.3. Zika virus infection was gazetted as a Class I notifiable disease in July 2015. This means that health care professionals are required to report to the Ministry of Health cases of possible Zika Virus infection on suspicion that a patient may be presenting with symptoms suggestive of the infection.
- 1.4. The first case of the Zika Virus (ZIKV) infection was confirmed on January 29th with an onset date of January 17th 2016. Jamaica's preparedness for the



ZIKV infection and the response after its introduction included: heightened surveillance, clinical management guidance, vector control and management, laboratory capacity strengthening, training and staffing, risk communication and public education, social mobilization, inter-sectoral collaboration, resource mobilization and international cooperation.

- 1.5. The UHWI virology testing lab is currently testing Blood/Serum PCR, Urine PCR and Serum IgM. Training in Serology IgM testing was conducted at the National Public Health Laboratory (NPHL) in July 2016, in collaboration with PAHO. Six (6) persons (4 from NPHL and 2 from UHWI) benefited from this training. An assessment is being done to determine the needs of the Laboratory to complete its preparedness to do Zika IgM testing.

2. OBJECTIVES

2.1. Response to Zika Virus

- 2.1.1. A number of initiatives have been undertaken by the Ministry of Health to prevent, control and mitigate the impact of ZikV on the population. These include:

2.2. Operation Mosquito Search and Destroy

- 2.2.1. Operation Mosquito Search and Destroy (OMSD), an inter-sectoral collaborative community-based activity was launched in February 2016. High risk mosquito breeding communities were engaged in interventions to identify and destroy mosquito breeding sites in and around the home and



community. Educational materials are provided and community members are educated in order to facilitate the behaviour change required to prevent the formation of mosquito breeding sites in these communities.

2.3. Zika Response and Control Project, Phases I and II

2.3.1. The Zika Response and Control Project takes a multipronged approach to mitigating the impact of ZikV through its focus on vector control activities; training and educating of health care workers, temporary workers and community members; increasing testing capacity; strengthening surveillance; and increasing public awareness.

2.3.2. Under Phase I of the project, the Ministry of Health has spent in excess of \$300 million through the National Health Fund (NHF), CHASE Fund and the Jamaica Social Investment Fund (JSIF) on transportation, fogging machines, chemicals, increased laboratory capacity, employment of temporary Community Workers and drain cleaning by the Parish Councils.

2.3.2.1. Phase II of the project is being funded by the NHF at a cost of \$100M. Activities occurring under this phase of the targeted intervention are the:

- Designing and implementation of vector control house inspection cards
- Continued Operation Mosquito Search and Destroy (OMSD) efforts
- Hiring and training of approximately 650 vector control aides
- Increased laboratory capacity
- Procurement of equipment and supplies
- Hiring of additional staff



- Strengthening the capacity to manage Guillain-Barre Syndrome in terms of:
 - Clinical training
 - Updating of protocols
 - Intravenous Gamma-globulin (treatment of choice) has been provided to every patient who required this treatment and the Ministry of Health continues to procure this drug.
- Increased surveillance to determine the number of breeding sites and their location
- Increased risk communication and general public awareness through the print, electronic and social media
- Testing of all symptomatic pregnant women for ZIKV
- Training of staff to deal with pregnant women and their affected children

2.4. Fund for children affected by Zika Virus Infection

Under the direction of the Honorable Minister of Health, a fund has been established to assist with the investigation and medical support of children with Congenital Syndrome related with the Zika Virus (CSAZ). To date, \$50 million has been allocated to the fund.

3. STATUS

- 3.1. As of April 10, 2017, the Ministry of Health received 9,997 Class 1 notifications of ZIKV infections. Of this number, 7,667 (77%) fit the case definition and were classified as suspected cases. There were 203 cases that



returned a positive ZIKV laboratory test (199 confirmed by PCR and four presumed positive on antibody tests).

3.2. Pregnant women accounted for 827 of notified cases, of which 698 (84%) were suspected cases and 78 of confirmed cases. There were 170 notifications of children with CSAZ with 50 suspected cases (46 Microcephaly – 35 non-severe, 11 severe; four other congenital abnormalities).

3.3. Three cases of microcephaly were classified as probable ZikV related. Of the 166 notified Zika neurological complications, 37 were suspected cases, 30 met the Brighton Criteria for GBS, seven were classified as GBS variant and 4 were Zika positive.

4. NEXT STEPS

4.1. The Mosquito Control and Research Unit (MCRU)

4.1.1. The MOH recognizes that mosquito-borne diseases have had a significant impact on the health of Jamaicans and the country's economy. In keeping with the WHO's thrust at maintaining existing mosquito control activities in countries throughout the world, the MOH collaborated with the University of the West Indies (UWI), Mona Campus in establishing a Mosquito Control and Research Unit (MCRU) which was launched at the UWI, Mona on March 31, 2017.



- 4.1.2. The activities of this Unit will help in reducing the spread of mosquito-borne diseases including Chikungunya, Dengue and Zika. The work of the MCRU is being driven by collaborative efforts between the MOH, Red Cross Jamaica, Jamaica National Youth Service, USAID, Food For The Poor (FFP) and other agencies that engaged in the OMSD activities.
- 4.1.3. The ultimate aim of the activities of the MCRU is the promotion of behaviour change required for the reduction of mosquito breeding sites in Jamaica.



14. NATIONAL HIV/STI PROGRAMME

1. OVERVIEW

1.1. Since 1988, Jamaica has had a national plan to guide the response to HIV, and a well-established National HIV/STI Programme (NHP). From the early days of the epidemic, the Government recognized the need for multi-sectoral involvement, and assured the participation of key government ministries and civil society in its various programmes. This multi-sectoral response has succeeded in maintaining adult HIV prevalence at a stable level below 2% since the mid-1990s. The Ministry of Health (MOH) has also integrated HIV prevention, treatment, care and support services into the primary health care system with a concurrent strengthening of the Sexually Transmitted Infections (STI) care and treatment programmes.

1.2. The NHP is mainly funded by the Government of Jamaica, a Global Fund Grant and a USAID Grant. However, Jamaica's reclassification as an upper middle-income country by the World Bank, has affected the country's ability to qualify for international aid from some sources, which has implications for the sustainability of various government programmes, including health (Economic and Social Survey of Jamaica, 2004). Jamaica is in a position to access further funding from Global Fund; however, as a middle income country, Jamaica is only eligible for funding for programmes targeting only those most at risk and the continued provision of treatment thereby limiting the availability of support



for other key strategies directed at the general population. Other funding options for the NHP include Government of Jamaica resources (such as the National Health Fund), private sector contributions, and other international donor funding arrangements that are presently in place.

1.3. Sustainability of the National Programme is critical. It is important to finalize and implement a sustainability plan for the national programme being mindful that fewer funding opportunities exist and whilst international funding shrinks the economy may continue to be challenged. Sustainability of the national response to HIV will depend largely on, and can only be achieved through, careful costing of the new national strategic plan, documentation of the human resources needs for sustainability of programmes, negotiation with the Ministry of Health and other relevant ministries for absorption of essential posts, negotiation with external donors for additional funds, and increased allocations in the MOH recurrent budget for the HIV/STI programme. Other important strategies include rationalization, integration with primary and secondary health care approaches and government subventions for HIV-related NGOs.

1.4. The integration of elements of the NHP into the National Family Planning Board (NFPB) to form the Sexual Health Agency represents a step towards sustainability and gives effect to one of the key strategies outlined in Vision 2030- Jamaica's National Development Plan, to "expand and improve



integration of family planning, maternal and child health, sexual and reproductive health and HIV into primary health care.”

2. OBJECTIVE

2.1. The HIV-specific objectives of the strategic plan are:

1. Reduce by half, the number of new HIV infections by 2019
2. Increase to 65%, coverage of ARV treatment for PLHIV by 2019
3. Increase to 90% the proportion of PLHIV on ART one year after initiating therapy
4. Reduce the number of HIV related deaths by 25% by 2019
5. Eliminate vertical transmission of HIV by 2015

3. STATUS

3.1. Jamaica has an estimated HIV prevalence of 1.6% among the general population; however, surveys show higher HIV prevalence in at-risk groups. A 2014 survey of sex workers found that 2.9% of female sex workers were HIV infected; in 2011, a survey of 453 men who have sex with men (MSM) found that approximately 1 out of every 3 MSM was HIV infected; a 2006 survey of prison inmates indicated that approximately 3.3% of inmates are HIV positive and a 2014 survey among homeless drug users identified that 12.9% were HIV positive.



3.2. The AIDS mortality rate has declined from 25 deaths/100,000-population in 2004 to just over nine deaths/100,000 population in 2015 which represents a 64% decrease since the inception of universal access to antiretroviral treatment in 2004. In addition to the introduction of public access to antiretroviral treatment in 2004, scaling up of the national HIV testing programme and use of rapid test kits allowing for earlier diagnosis, availability of prophylaxis against opportunistic infections and improved laboratory capacity to conduct investigations such as CD4 counts, viral load and PCR tests are believed to have contributed to the decrease in deaths. Based on both modelled estimates and the case-based surveillance data, it is estimated that 29,000 persons are currently living with HIV in Jamaica with approximately 15% being unaware of their status.

3.3. Although Jamaica has successfully increased access to treatment and care services (including the 2017 implementation of the WHO treat all guidelines), analysis of data related to retention in care has shown increased loss-to-follow-up among patients on antiretroviral treatment. Failure to adhere to treatment and care is a barrier to further reducing AIDS morbidity and mortality.

4. NEXT STEPS

4.1. Continue HIV testing to identify persons living with HIV (PLHIV)



- 4.2. Reach and treat younger PLHIV, especially young men
- 4.3. Development and implementation of programmes focused on improving linkage to care, retention in care and viral suppression amongst patients on antiretroviral treatment
- 4.4. Continued advocacy for funding to sustain the NHP



Protecting the Health of Mothers and Children



15. PROGRAMME FOR THE REDUCTION OF MATERNAL AND CHILD MORTALITY

1. OVERVIEW

1.1 Reports from the United Nations indicated a 69% decline in the global under-five mortality rate for the Latin America and Caribbean region between 1990 and 2015. Neonatal deaths are declining at a slower pace than mortality for children aged 1-under 5 years and now account for a larger proportion of the under five deaths. United Nations reports also indicate a 36% decline in maternal deaths for the Caribbean between 1990 and 2015. Maternal and neonatal deaths are largely preventable as they are caused by preterm birth complications and complications during labour and delivery.

1.2 The GoJ and the European Union executed a Financing Agreement in 2013 to support the development of the Programme for the Reduction of Maternal and Child Mortality (PROMAC) in Jamaica. PROMAC is aimed at reducing deaths attributable to high-risk factors for mother and child by the establishment of high-dependency units (HDUs) at health care facilities with specialist equipment and personnel dedicated to caring for high-risk newborns and pregnant women. The five core components of PROMAC are:

1. Newborn and Emergency Obstetric Care;
2. Quality of Primary Health Care Services and Referral System;



3. Health Workers Training and Research
4. Support to the health seeking behaviour of target population and the role of civil society; and
5. Institutional support for project implementation.

2. OBJECTIVES

2.1 PROMAC is expected to achieve the following outcomes:

- improved newborn and emergency obstetric care in 11 newly established high dependency units in six hospitals across the country;
- improvements in primary health care services for high risk pregnancies; and
- enhanced clinical knowledge and skills of health professionals

3. STATUS

3.1 Newborn and Emergency Obstetric Care (Component 1)

3.1.1 This component focuses on the establishment of 11 maternal and neonatal High Dependency Units (HDUs) in six (6) referral hospitals in Jamaica (Mandeville Regional Hospital, Victoria Jubilee Hospital, Cornwall Regional Hospital, Spanish Town Hospital, St. Ann's Bay Hospital, Bustamante Hospital for Children); a total of 61 HDU beds (21 maternal and 40 neonatal). The component also includes the supply of maternal and neonatal hospital equipment to support the HDUs; a total value of €4,000,000.



3.2 Quality of Primary Health Care Services and Referral System (Component 2)

3.2.1 Component 2 includes the physical rehabilitation of primary healthcare centres, upgrading laboratory services, improving diagnostic capacity by providing medical equipment and training, as well as improving referral services by providing ambulances. Targeted facilities include four selected primary health facilities (one in each of Jamaica's health regions) and two Community hospitals providing delivery services (Alexandria and Chapelton Community Hospitals). The ambulances, radiographic and ultrasound equipment and fully-equipped midwife bags were procured to the tune of €1M.

3.3 Health Workers Training and Research (Component 3)

3.3.1 This training component targets all levels of care addressing maternal and child care. It aims at complementing the existing "Doctors of Medicine" programme for the graduate training of medical personnel of the Ministry of Health and the Regional Health Authorities. In particular the project seeks to provide: (i) training in areas of specialization that are currently not available in Jamaica such as postgraduate in Neonatology and Maternal-Fetal Medicine; (ii) Anesthesiology; (iii) Ultrasound diagnosis, (iv) training of nurses and other healthcare professionals; (v) academic research on the causes and risk factors of premature births in order to inform policy and programmes for their prevention and management; (vi) training of Community Health Aides in maternal and child health.



3.3.2 To date, 51 scholarships have been awarded/administered for training of specialist physicians and nurse educators under contract with the University of the West Indies. For Financial Year 2016/2017, the following health care professionals have completed training:

- 57 nurses have been trained in critical care and neonatology at the MoH In-service Department.
- 50 nurses have been trained in the specialist areas of post-basic midwifery and critical care
- Two nurses have completed the MSc. Nursing Education Programme. One nurse is currently enrolled in the programme.
- Approximately 1000 primary health workers and community health aides have been trained in module 3 – customer service.
- Approximately 500 nurses and midwives were trained in modules 1 and 2 – maternal and child health as well as neonatal resuscitation to date.

3.4 Support to the Health Seeking Behaviours of the Target Population and the Role of Civil Society (Component 4)

3.4.1 The support to health seeking behaviour will capitalize on the knowledge and administrative capacity of the National Family Planning Board and Non-State Actors (NSAs) to develop targeted (women of reproductive age and parents of children under 5) outreach activities on child and maternal health including nutrition, chronic disease and parenting skills. The support to civil



society organizations is aimed at their increased participation in health policy planning and monitoring as well as in patients' rights advocacy. This will enhance public awareness and understanding of health care processes and patients' rights.

3.5 Institutional Support for Programme Implementation (Component 5)

3.5.1 This component seeks to provide technical assistance for the institutional strengthening of the Ministry of Health in ensuring successful implementation of the various components of the project. In addition, building the wider MOH teams capacity in project management is a top priority (knowledge transfer).

4. NEXT STEPS

4.1 Newborn and Emergency Obstetric Care (Component 1)

- Signing of the contracts for supervision and civil works for the establishment of the 11 HDUs across the country
- Delivery of the maternal & neonatal equipment for the 10 remaining HDUs

4.2 Quality of Primary Health Care Services and Referral System (Component 2)

- Signing of the contracts for supervision and civil works for the rehabilitation of the primary healthcare facilities
- Handing over of the six (6) ambulances



- Delivery of 150 fully-equipped midwife bags, as well as the Radiographic and Ultrasound equipment to the 6 facilities to support maternal and child health care

4.3 Health Workers Training and Research (Component 3)

- Continued training of doctors in the specialist areas and nurses under the UWI contract
- Training to be completed for 50 nurses in post-basic midwifery and critical care (2nd cohort) at In- Service Training Unit and UTECH;
- Ongoing training of primary care health workers to build the capacity of the team
- In-service training of nutritionists/dieticians in neonatal nutrition which commenced in March 2017 and will be completed within this financial year

4.4 Support to the Health Seeking Behaviour of the Target Population and the Role of Civil Society (Component 4)

- NFPB will be undertaking activities to address specific challenges in health seeking behaviour of women in the reproductive age group, including public awareness.
- The MOH additionally will be working closely with the UWI on patient rights' advocacy initiatives.



16. RENEWED NATIONAL ORAL HEALTH SERVICES

BACKGROUND

- 1.1. The National Oral Health Services for the fiscal year 2017/18 will focus on a more strategic approach to the delivery of Oral and Dental Health Services. It will be the type of health service that is primarily preventive and seeks to reduce the inequities in order to achieve "Access to Good and Affordable Oral Health Care". The key public health principle here is to provide the "most good for the most people" with the resources that are available.
- 1.2. The policy objective is to ensure improved access to oral health care. This will be done through the phased implementation of a basic package of care that will include the following services:
1. Examination and treatment planning for all patients;
 2. Dental Prophylaxis with or without fluoride applications;
 3. School-based dental sealant programme targeting 20% of the 12 years olds cohorts;
 4. School and community based Fluoride Varnish Programme targeting 30% of the 5-6 year old cohort;
 5. Periodontal Scaling or Gross Scaling;



6. Mobile Dental Services to vulnerable populations and for remote locations without a dental facility; in all eighty (80) Government Health facilities, thereby providing further access to Dental Prophylaxis and Dental Restorations/Fillings;
7. Oral Health Education and Health Promotion with product sampling of tooth brushes and toothpaste;

1.3 The first phase will be the implementation of a National Sealant Programme; which is a Dental Sealant and Fluoride Varnish programme targeting the 12 and 5-6-year-old cohorts in the Primary School system and will involve services indicated at items #3 and #4.

2 OVERVIEW

2.1 Scope of the Programme is as follows:

- Perform 'Caries Risk Assessment' on targeted population using the American Dental Association Caries Risk Assessment tool for the respective cohorts.
- This programme will cover the entire island targeting Basic and Primary Schools:
 - 20% of the 12 year old cohort to receive sealants on their first and second molars.
 - 30% of the 5-6 year old cohort, to receive fluoride varnish



- Decayed Missing and Filled Teeth (DMFT) surveys to be conducted with the assistance of PAHO (Washington)
- Oral Health Education & Health Promotion using the PAHO Integrated Oral Disease Prevention Module (IODPM) and targeting health care providers, school teachers and community actors such as health educators and health aids.
- 'Tooth Brushing Campaign' along with product sampling and Dental Prophylaxis (part sponsored by Colgate Palmolive).
- Production and distribution of pamphlets and posters on good Oral Health Practices
- Incorporation of NGOs, FBOs and the Dental Associations in the provision of sealants and oral health care to the targeted population.

2.2 The Programme is expected to achieve the following objectives:

- Provision of access to preventative oral and dental health services for Primary & Basic school children in need of care, especially for our at risk and vulnerable population.
- Provision of dental care that is appropriate, of high quality, cost-effective, and acceptable to patients.
- The "smoothing" of patient flow throughout the work day thereby improving efficiencies and effectiveness in 'Service Delivery'.



- Promotion of continuity of patient care, even when there is turnover of professional staff.
- Consistent compliance with all regulatory requirements and standards of care.

3 PUBLIC/PRIVATE PARTNERSHIPS

3.1 The Ministry will also be pursuing a strategy of public/private partnerships to implement the aforementioned preventative programme. This will be done through the strengthening of partnerships with local and international oral health organizations, such as:

- The Dental Professional Bodies: JDA and Jamaica Association of Public Dental Surgeons (JAPDENS),
- Colgate Palmolive,
- Great Shape Inc! The world's largest Dental Volunteer Mission (a NGO) and Sandals Foundation as a major sponsor of Great Shape Inc.
- The University of Technology, Jamaica, College of Oral Health Sciences and University of the West Indies, Faculty of Medical Sciences Dentalprogramme (Mona)
- Food for the Poor (NGO).
- Virginia Commonwealth University (Academia)
- Christian Dental Mission (FBO).



- The Pierre Fauchard Academy
- The International College of Dentistry
- Women's Health Network

All of the partners listed above have made significant contribution to the oral health landscape of Jamaica.

4. NEXT STEPS

4.1 Going forward, the Ministry intends to:

- Implement a Chronic Non-Communicable Disease Programme to include:
 - a) Integrated clinical management of NCDs : Diabetes, Hypertension, COPDs etc
 - b) Health Education and Health Promotion:- Integrated Oral Disease Prevention Module
 - c) Oral Cancer screening.
 - d) Oral Diagnostic Services
 - e) Periodontal Services
 - f) Oral Rehabilitation Services – Prosthodontics & Endodontics
 - g) Oral & Maxillofacial Surgeries
- Initiate an Oral Health Maintenance Programme to include:
 - a) Procurement of equipment & supplies
 - b) Maintenance for equipment
 - c) Monitoring and evaluation
 - d) Clinical Audits
 - e) Monthly / Quarterly/ Annual Reports



Rehabilitating Critical Health Infrastructure



17. CORNWALL REGIONAL HOSPITAL

1. OVERVIEW

1.1. The Cornwall Regional Hospital is one of three Type A hospitals in Jamaica, and the only such facility that serves the Western region of the island. It has a bed capacity of 450 patients and offers General Medicine, General Surgery, Paediatrics, Obstetrics and Gynaecology, Psychiatry, Accident & Emergency, Orthopaedics, Urology, Otolaryngology, Plastic Surgery, Ophthalmology, Dermatology, Cardiology and Nephrology services. The hospital provides Laboratory, Radiological, Radiotherapy and Oncology, Intensive Care, Dialysis, Pharmacy, Physiotherapy and Blood Bank Services for the Western Region.

1.2. The hospital processes on average 18,000 discharges per year and the Accident & Emergency department records 73,000 visits annually. The facility provides specialist and subspecialist services for the Southern and North East regions as well as a wide range of investigative and therapeutic interventions that are not otherwise available outside of Kingston and St. Andrew. Its position in the tourism mecca of the country with major arrival sea and air ports makes any decrease in services a threat to the economic well-being of the country.

1.3. Over the last 10 years, there have been intermittent reports of air quality issues that have affected operations in isolated areas within the hospital. In late



2016, this problem escalated resulting in the disruption of services provided at the Cornwall Regional Hospital.

1.4. The Ministry has received support in its response to the dilemma from a number of local and international entities. Support has been received locally from the United States Embassy, the Ministries of Local Government, Education and National Security and by the Jamaica Defence Force, the Urban Development Cooperation, Food for the Poor, Missionaries for the Poor, the West Jamaica Conference Centre, The Montego Bay convention Centre, The Holy Trinity Church, Barnett Clinic, Montego Bay Hospital, Hospiten, and Sam Sharpe Teacher's College. The Pan American Health Organization (PAHO) continues to provide technical support, external collaboration on environmental health issues and resources for continued monitoring and coordination.

2. ENVIRONMENTAL TESTING RESULTS

2.1. Comprehensive environmental testing has been conducted by local and external experts to ascertain the cause of the poor air quality that has affected some areas of the facility. The reports point to the presence of high levels of humidity and mould growth as a major causative factor. This is present throughout the hospital, but is particularly high in enclosed areas; areas that are naturally ventilated are not as affected.

2.2. Furthermore, environmental testing also revealed the presence of fiberglass particles at some sections on the hospital building. Fiberglass particles



were detected on the sixth floor that originated from an accumulation of debris on that floor, and on other floors from connections to the ventilation ducts on the first to third floor. The Ministry has undertaken the necessary action of removing these materials, shutting down and sealing off the respective ventilation ducts and carrying out a thorough cleaning of the affected areas.

2.3. Results of the air quality tests indicated that asbestos particles were not present in the air. However, asbestos containing material was found in the Old Kitchen and the Incinerator room, areas that have not been in use for several years. The removal of the material from the Old Kitchen has been done. The initial stage done in March involved applying surfactant to the area to prevent dispersion of the material. At that time, since the air quality results were not completed, as a precaution, the surfactant was both applied to the surface and the air. The Incinerator room has been closed off and the abatement plan for that area is to be finalized.

2.4. The Ministry has also conducted other tests to determine the existence of other possible contributing factors to the poor air quality. The test results were negative for heavy metals and were within normal range for total volatile organic compounds, carbon monoxide levels, and inorganic compounds.

3. MINISTRY'S RESPONSE

3.1. The Ministry of Health (MOH) in partnership with the Western Regional



Health Authority (WRHA) and with the support of local and international bodies has instituted several measures to mitigate the impact on staff and patients and to continue providing care to the population served by the hospital.

3.2. The WRHA's Emergency Operations Centre (EOC) has been activated along with partial activation of the MOH's National EOC. Ministry representatives have also been deployed to the region to provide supervisory and coordinative functions. There has also been mobilization of national and external partners to alleviate shortages of resources.

3.3. A number of services have been relocated and several other measures taken to ensure continuity of care. These include:

- Movement of outpatient services to offsite locations. In order to expedite this process, several locations were initially used to house all the clinics. Since March 2017, the clinics have been relocated to the Western Jamaica Conference Centre (WJCC) which has been retrofitted for the purpose.
- The Obstetrics and Gynaecology clinic has been relocated to the Barnett Clinic.
- Relocation of Physiotherapy Department to the WJCC.
- Relocation of the Intensive Care Unit to the Falmouth Hospital.
- Relocation of some surgical services to the Falmouth Hospital with the utilization of one existing theatre and the opening of two new theatres.
- Relocation of the Accident & Emergency Department to the Mount Salem Health Centre



- Relocation of Chemotherapy services to the 8th floor to allow for the full continuation of this service.
- Relocation of the laboratory services to the Isolation building and containers are presently being retrofitted to allow more space to facilitate full functioning.
- Relocation of Pharmacy services to other locations on and off campus to facilitate easy access to medications.
- Ward space on the fourth and fifth floor will continue to accommodate fifty to eighty surgical, obstetrical and gynaecological patients who will require close proximity to essential services that will be retained at the hospital building.
- A ward at the Falmouth Hospital is being refurbished to accommodate an additional twenty surgical patients.
- A ward at the Noel Holmes Hospital is being refurbished to accommodate seventeen medical patients.
- Medical staff from the CRH will provide support for the Falmouth and Noel Holmes Hospitals.
- Some patients for surgeries are being accommodated at the University Hospital of the West Indies.
- The University Hospital of the West Indies, the Kingston Public Hospital and the Bustamante Children's Hospital are providing critical care support for the region on request.
- Twenty-three patients / Social cases have been relocated to the Falmouth Infirmary and staff is being rostered from CRH to provide support for these



patients.

- Two containers and classrooms have been identified and prepared to store medical records. Procurement of vacuums and hiring of additional staff has been completed to fast track the cleaning of records and making them available for use.

3.4. Some services require specialized spaces and these have been kept in operations on the CRH building. These services will operate on the fourth and fifth floor and include Operating theatres, Labour and Delivery Suite, and Special Care Nursery. The Ministry is taking specific actions which have been intensified to ensure the safety of these areas.

- There is ongoing maintenance and repair works to correct leaks on all floors.
- Repairs and detailed cleaning to the operating theatres and adjoining rooms on the fourth floor to accommodate surgical services and special care nursery.
- Complete assessment and repairs to the water leaks and Air Handling systems on the fourth and fifth floor followed by detailed mould cleaning.
- There is continued routine and high level cleaning in all areas as per normal routine protocols and also as indicated by the test results.

3.5. Throughout this response the Ministry of Health has put in place resources to detect, document and treat all health care workers and clients who have complaints relating to exposure to poor air quality at the Cornwall Regional Hospital. The measures include:



- The establishment of a staff clinic for the clinical management of reported cases
- A reporting procedure for all patients and visitors with symptoms of exposure to poor air quality
- A mechanism for patients to be treated for any symptoms related to poor air quality issues
- A reporting procedure for all staff members who report to work with symptoms

4. NEXT STEPS

4.1. The renovations of the staff quadrants will be completed to accommodate approximately one hundred and twenty to one hundred and sixty in-patients, dietary and radiology departments, security and communication services as well as hospital administrative and Nursing administrative staff. The Dental Clinic will also be based at the staff quadrants.

4.2. The detailed assessment of the Cornwall Regional Hospital building for electrical, plumbing and other infrastructural and operational defects is to precede the more comprehensive works to renovate the building.

4.2. The Ministry in partnership with the WRHA continues to work to return operations to a state of normalcy.



18. SMART HEALTH CARE FACILITIES IN THE CARIBBEAN PROJECT PHASE (SCALE-UP)



1. BACKGROUND

- 1.1 Jamaica along with Belize and Guyana were selected in April 2016, to participate in the successful pilot; Smart Health Care Facilities Caribbean Project funded by the United Kingdom Department for International Development (DFID).



- 1.2 Health facilities are critical assets for communities both routinely and especially in response to emergencies – disasters and other crises. Yet these facilities and health workers are often among the major casualties of emergencies, meaning that health services to affected communities is severely impacted when they are needed most.
- 1.3 It is well recognized that among the adverse direct health effects of climate change is the disruption of health services caused by climatic extremes and weather related disasters. The health sector located in the highly hazard prone region of the Caribbean has felt both the direct and indirect impact of weather disasters. The said sector also emits greenhouse gases and can significantly contribute to both mitigation and adaptation efforts by reducing its carbon footprint, and building upon its work to make health care facilities safe.
- 1.4 It is against this background that the Pan American Health Organization / World Health Organization (PAHO/WHO) has developed the Smart Hospitals Toolkit which guides the identification and implementation of practical and measurable green building designs, operations and maintenance solutions applicable to this region.
- 1.5 In April 2016, a scale up was approved with additional funding to extend the project to Belize, Guyana and Jamaica and increase support in existing target countries.
- 1.6 The Ministry of Health (MOH) in conjunction with the PAHO and DFID launched the Smart Health Care Facilities initiative for Jamaica in August 2016. This



cemented Jamaica's commitment to improving the resilience of the health sector to respond to emergencies.

2. PROJECT IMPACT

2.1 Implementation of the project will result in increased protection from disasters and climate change resulting in reduced mortality, morbidity and economic losses from disasters. It is also anticipated that there will be enhanced safety standards, a reduction in down time and damage to hospitals from natural hazards as well as a reduction in operating expenditures in terms of water and energy savings.

3. PROJECT DURATION

3.1 The project started in May 2015 and will end in May 2020.

4. IMPLEMENTING AGENCY

4.1 The implementing agency is the PAHO/WHO in collaboration with the MOH Jamaica.

5. DONOR SUPPORT

5.1 Funding is provided by DFID and the budget for all the selected Caribbean islands is £38.24M.

6. OBJECTIVES

6.1 Healthcare facilities to be assessed in safe and green standards



- 6.2 SMART standards to be implemented in selected health care facilities
- 6.3 National and regional capacity to apply and promote climate smart health facilities standards will be enhanced

7. STATUS

- 7.1 Training
- 7.2 Sixty-one (61) volunteers (engineers, architects, environmental specialists, administrators, maintenance directors etc.) were trained and certified from various Ministries, Department and Agencies to conduct the assessments
- 7.3 Baseline Audit Tool (BAT) training was completed with five (5) MOH officers participating and three (3) private sector companies

8. ASSESSMENTS

- 8.1 A total of one hundred (100) facilities (all hospitals, comprehensive, parish and district health centres) were targeted to be assessed in the first year which ends 31 July 2017
 - 8.2 80% of facilities have been assessed thus far
 - 8.3 Twenty (20) of twenty-four (24) hospitals have been assessed
9. Nine (9) priority facilities (Hope Institute and the Noel Holmes Hospital, St. Ann's Bay, Albert Town, Mandeville, Stoney Hill, Port Antonio and Santa Cruz Health Centres) were also assessed

10. NEXT STEPS



- Complete targeted assessments by the end of year one (1)
- Select the remaining fifty (50) facilities (community health centres) to be assessed in year two (2)
- Conduct BAT assessment on the priority facilities
- Prepare justification reports for priority facilities
- Conduct:
 - Knowledge, Attitude and Practice (KAP) Survey
 - contingency training
 - contractors course training
- Begin Public Relations activities to build awareness and secure the “buy in” of the end users
- Select three (3) or four (4) facilities to be retrofitted
- Select design firm(s)
- Use assessments to source funding from other entities/partners to retrofit other facilities

11. CONCLUSION

- 11.1 The government of Jamaica has fully endorsed the SMART health facilities initiative and has collaborated with several Ministries, Departments and Agencies to ensure its seamless execution. The project began in August 2016 and has remained on track for achieving the deliverables mandated by our partners.
- 11.2 The Ministry proposes to fast track the priority facilities and to seek available funding thereby reaching for the goal of health facilities that are climate-smart and



disaster-resilient, that protect the lives of patients and staff, that continue to function when they are most needed and are environmentally sustainable.



19. ADOPT A CLINIC

1 OVERVIEW

1.1 Over the years, several of the island's primary health facilities have deteriorated due to inadequate maintenance. Recognizing that the same lack of upkeep continues, the Ministry of Health (MOH) has devised a programme involving private sector entities, Non-Governmental Organizations (NGO) and individuals to 'adopt-a-clinic' to assist with the upgrades and refurbishment of these facilities. In recognition of their efforts, these individuals and entities cited for their efforts, by branding the facility.

2 OBJECTIVES

2.1 The technical team of the Ministry of Health has identified and cost the specific needs of each health facility across the island. Prospective adopters have been invited to finance specific areas to ensure the facility's efficient operations. The improvements to the facilities include routine maintenance, medical devices/equipment and internal infrastructure.

3. STATUS

3.1 The Ministry has identified 100 priority clinics Island-wide, which are the first set of health facilities being put up for adoption.



4 NEXT STEPS

- 4.1 The Ministry has so far received interests from groups, local and internationally, offering to adopt with a commitment value of approximately \$70 million and 60 clinics.
- 4.2 The Jamaican High Commissioner to the United Kingdom has commenced work on a plan involving the diaspora in the UK for 55 adoptions in commemoration of Jamaica's 55th year of Independence.
- 4.3 The Jamaican Embassy in Washington DC has also committed to encouraging Jamaicans and other friendly interests in the USA to adopt several of the island's other health facilities.
- 4.4 Locally, corporate entities like Cari-Med, Seprod and Lasco Groups have already identified the specific clinics that they wish to adopt and the Victoria Mutual Building Society (VMBS) Group has expressed an interest in adopting 15 clinics (one in each parish and in Portmore).





