



MINISTRY OF HEALTH

HIGHLIGHTS OF KEY INITIATIVES 2017-2018

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Improving Clients' Experience

1 Compassionate Care

1.1 Background

- 1.1.1** The Ministry of Health (MoH), under the leadership of the Minister of Health, the Hon. Dr. Christopher Tufton, has embarked upon improving care and services delivered in all hospitals, health clinics and community health programmes by introducing a patient-centred approach to be adopted in the health system. Patients and users of the health system expect medical/clinical interventions delivered with respect and some level of emotional support. To this end the Ministry of Health has developed the Compassionate Care Volunteer Policy and Programme that provides guidelines, strategies and actions to enable a shift from the current culture to one in which care and services are delivered in a compassionate environment.
- 1.1.2** The Ministry of Health has, in the past two years, shifted the discussion on how the health system currently functions, to one which prioritizes a patient-centred environment. The MoH is focused on the preparation of staff and stakeholders for a change in the practices and approach to patients. Given the context of scarce human resources, the MoH foresees the managed involvement of volunteers to support patient-centred care.

1.2 Status

- 1.2.1** Cabinet approval of the Cabinet Submission on the Compassionate Care Policy and Programme has paved the way for the following initiatives that are being implemented:
- 1.2.1.1** Sensitisation on the Compassionate Care Policy and Programme has taken place with the Senior Directorate of the Regional Health Authorities and hospital Chief Executive Officers (CEOs).
- 1.2.1.2** The Compassionate Care Volunteer Programme will be piloted at the Kingston Public and Victoria Jubilee (VJH) hospitals and the launch was held at the VJH in March 2018.

- 1.2.1.3 Discussion of Compassionate Care at the Regional Health Authority and the Hospital Management Committee Levels.
- 1.2.1.4 Sensitization of and soliciting of the participation of executive and professional leadership at both hospitals leading up to the launch and beyond.
- 1.2.1.5 Sensitization, orientation and ongoing training of staff at all levels at both pilot hospitals, including management, professional, and support staff, is underway.
- 1.2.1.6 Recruitment and selection of volunteers is the responsibility of the facility, guided by the requirements of the Compassionate Care Volunteer Policy. The current Friends of the Hospital will be integrated into the programme. Volunteer recruitment for the pilot facilities is underway; to date in excess of twenty volunteers have been recruited.

1.3 Physical and Infrastructure Improvement

- 1.3.1 An important consideration for patient-centred care is the patient's physical comfort and his/her psychological well-being while in the care of doctors, nurses and other providers of health services within health facilities. Research has demonstrated that this socio-ecological dimension, where care is delivered in a positive, clean and informed atmosphere and environment, adds to the quality and safety in which care is delivered. To this end, the facilities (patient waiting and consultation areas and lavatory) at the Victoria Jubilee Hospital Outpatient Antenatal Clinic were upgraded. This service provides care to pregnant mothers and gynaecological services. This clinic hosts in excess of one hundred patients daily, from Mondays to Fridays.

1.4 Public and Stakeholder Awareness

1.4.1 A number of agencies have taken an interest in Compassionate Care and want to be a part of this initiative:

1.4.1.1 The Women's Resource and Outreach Centre (WROC) under the leadership of the Department of Community Health and Psychiatry, University of the West Indies, has expressed commitment and solidarity with Compassionate Care. Their main focus and participation is geared towards women and children. The Department of Community Health and Psychiatry will itself focus on the general health and wellbeing of the patient.

1.4.1.2 The Jamaica Council of Churches and their counterpart the World Council of Churches have given their commitment to fostering Compassionate Care.

1.4.1.3 The British Council (British High Commission) supports Compassionate Care as a major initiative for changing the culture of the local health care system. They have expressed their ongoing support and interest in the professional leadership training programme being developed for implementation in June 2018.

1.4.1.4 The Pan American Health Organisation (PAHO) has endorsed the Ministry of Health's thrust towards enabling and sustaining a health care system that embraces compassionate care. PAHO is working with the Ministry of Health to establish initiatives/programmes to effectively institutionalize and sustain compassionate care. PAHO will provide technical support for ongoing training in professional leadership, and in the implementation of strategies for enhanced customer service, effective management of patients' complaints, and maintenance of patient safety.

1.5 Next Steps

- 1.5.1** A volunteer orientation programme for the pilot facilities will be conducted in the first quarter of FY 2018-2019 and specialized training of volunteers based on assigned service units will be done.
- 1.5.2** Upgrading of the VJH Accident and Emergency Department
- 1.5.3** Training of staff and the phased introduction of Compassionate Care in hospitals in each Regional Health Authority
- 1.5.4** Production of volunteer uniforms
- 1.5.5** A symposium on Compassionate Care will be held within the Financial Year 2018-19 to provide the opportunity for health care leaders, heads of academic health organisations, policy makers and regulators to acquire greater knowledge and a shared appreciation of Compassionate Care, and recognize the critical role they play in influencing a patient-centred culture in the health system.

2 Reduced Waiting Time Project

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

2.1 Background

2.1.1 In June 2016, the Ministry of Health embarked on an initiative to reduce waiting times in the emergency departments (EDs) of eight hospitals across the island. These emergency departments have in common, heavy utilization by the general public as their first contact with the health services. The large emergency department volume has resulted in overcrowding in the emergency departments and long waiting times to be seen. This project involved improving the process of customer service and assessment and redirecting non-emergency cases from hospital A&E departments to the closest designated health centre.

2.1.2 The eight (8) hospitals involved were Cornwall Regional, Savanna La Mar, St. Ann's Bay Regional, Kingston Public, Spanish Town, Mandeville Regional and May Pen Hospitals, as well as the Bustamante Hospital for Children. The participating health centres are mainly those in proximity to these hospitals; they are: Mount Salem in St. James, St. Ann's Bay in St. Ann, Comprehensive and Glen Vincent in Kingston, St. Jago Park in St. Catherine, Mandeville in Manchester and May Pen in Clarendon. The exception was the Greater Portmore Health Centre in St. Catherine (which was necessary because of the volume of visitors to KPH A&E from that region of St. Catherine).

2.2 Objectives

2.2.1 The goal of the project is to decrease waiting times in the emergency departments of public hospitals. The main objectives are to:

- 2.2.1.1 Increase usage of curative services at health centres by a) extending opening hours from 8 am to 5 pm to 8 am to 8 pm, and b) enhancing services provision in the health centres, such as nebulizations, rehydration, minor surgical procedures, ECGs and specialist services.
- 2.2.1.2 Improve the efficiency in the A&E departments by standardizing and computerizing the triage process.
- 2.2.1.3 Improve physical infrastructure of the waiting areas
- 2.2.1.4 Enhance customer service

2.3 Status

2.3.1 Extended hours of service

- 2.3.1.1 Up to February 2018, nine health centres have extended opening hours; this included the eight identified above, plus the St. James Comprehensive Health Centre. Due to the relocation of some services at the CRH to the Mount Salem Health Centre, extended opening hours were instead instituted at the St. James Comprehensive Health Centre.
- 2.3.1.2 Utilization of health centres has increased since the inception of the project. A review of the first year of the project from September 2016 to August 2017 has shown that the number of clinic curative visits at the health centres in the project has increased appreciably compared to the two previous years. Overall, there was a forty-one percent (41%) increase in visits from 2015-2016 to 2016-2017 compared to a thirteen (13%) increase from 2014-2015 to 2015-2016.
- 2.3.1.3 In the one year period, September 2016 to August 2017, two hundred and fifty thousand visits were recorded to the select health centres. Sixty thousand and ninety-one visits occurred during the extended hours at the eight health centres accounting for approximately twenty percent (20%) of total visits.

2.3.2 Increased Access to Services

- 2.3.2.1 The Emergency Severity Index (ESI) System of Triage was introduced in all nineteen emergency rooms across the island. This standardized the triage system used to rank patients according to severity; and for the purpose of this project, it allowed for the referral of Level 5 patients (patients which can be seen safely in a non-emergency setting such as a health centres).

2.3.3 Strengthened Triage System

- 2.3.3.1 The Bustamante Hospital times to triage changed significantly over the one-year period. There has been an increase in the number of patients who wait less than thirty minutes to be triaged and a general decrease in the number of clients being seen in the longer time periods.
- 2.3.3.2 In September 2016, thirty four percent (34%) of patients were triaged under thirty minutes while in August 2017, sixty nine percent (69%) of patients were triaged under thirty minutes.
- 2.3.3.3 Ninety percent (90%) of patients are now triaged under one hour compared to fifty nine percent (59%) in September 2016.

2.3.4 Strengthened Information System

- 2.3.4.1 The computerization of the triage process has enabled the streamlining of triage and allowed for the monitoring and evaluation of the process. The completion of the process was achieved at Bustamante Hospital for Children (BHC) in the first year of the project and was completed in Mandeville General Public Hospital and May Pen Hospital in the second year. Spanish Town Hospital and St. Ann's Bay hospitals are to be completed before the end of the second project year.
- 2.3.4.2 The implementation at BHC allowed for analysis of the data for the first project year and resulted in interventions to improve the times to triage.

2.4 Next Steps

- 2.4.1** By March 2019, extended opening hours will be instituted in the Black River, Santa Cruz, Morant Bay and Annotto Bay health centres. The extended hours will be from 4pm-8pm or 4pm -9pm.
- 2.4.2** Infrastructure work for Phase 2 Health Centres: Black River and Savanna-La-Mar health centres will be completed in the next six months.
- 2.4.3** Computerization of triage process in other hospitals to allow for analysis and information to inform decision-making regarding interventions for improving patient flow.
- 2.4.4** Phase 3 of the project will take place in 2018-2019. At that time the addition of other health centres in the catchment area of the hospitals targeted in Phase 1 and 2 are required to be addressed as well as the expansion to four additional hospitals. The four hospitals for Phase 3 would be Linstead Hospital, Percy Junor Hospital, Falmouth Hospital and Port Maria Hospital. Eight (8) health centres should be targeted for interventions: the four health centres close to the Phase 3 hospitals and four health centres from catchment areas of Phase 1 hospitals.
- 2.4.5** Launch Public Education Programme to sensitize the public on appropriate use of emergency facilities and primary care centres.

3 Public Sector Pharmacy Partner Private Pilot Programme (PSPPPP)

The PSPPPP will increase the options public patients have to fill specific Vital, Essential and Necessary (VEN) prescription drugs. In addition to public health facilities such as DrugServ, public patients will be able to visit a participating Pharmacy Partner to fill their prescription and this should reduce waiting time and make it easier to get medications.

3.1 Background

3.1.1 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 DrugServ 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.

3.1.2 Given the country's high demand for outpatient pharmacy services, projected at approximately 2.2 million scripts annually, the NHF adopted a model where both public and private pharmacies dispense pharmaceuticals to outpatients. In FY 2016/2017, the Fund entered into contractual arrangements with select private pharmacies to increase the number of access points across the country and reduce customers' waiting time.

3.1.3 Private Pharmacy Partnership (PPP) programme is characterised by the following features:

- 3.1.3.1 Patients register for the programme using GoJ Health Card or NHF Card
- 3.1.3.2 A representative basket of drugs (VEN list items) is placed in participating pharmacies
- 3.1.3.3 The drugs are owned by NHF
- 3.1.3.4 Pharmacies are paid a dispensing fee of \$600 (\$400 by NHF and \$200 by patient)

3.1.4 Special prescription pads are utilized to aid in monitoring

3.1.5 The pilot phase of the initiative was launched on in May Pen, Clarendon on December 19, 2016; since then a total of seventeen (17) private pharmacies have been registered on the programme. These are located in May Pen, Clarendon (5), Cross Roads, Kingston (7) and Montego Bay, St. James (5).

3.2 Objectives

3.2.1 The PPP was initiated to improve access points for medications and improve customers' experience in accessing pharmacy services. The specific objectives of the programme are to:

- 3.2.1.1 Reduce the waiting time for patients to receive medication
- 3.2.1.2 Test public patients' acceptance of the service option
- 3.2.1.3 Improve customer satisfaction to 85%
- 3.2.1.4 Identify potential gaps of the programme

3.3 Status

3.3.1 Results from the pilot revealed an average wait time of twenty-six minutes for the nine top performing pharmacies for the period of March to May 2017. Approximately 94% of patients were satisfied with the wait time to receive their medications.

3.3.2 Over 20,000 prescriptions have been filled and 98% of customers surveyed approved of the \$200 service fee. Greater patronage of pharmacies closest to hospitals and town centres was observed.

3.3.3 Customers and providers, for the most part, were satisfied with the programme; overall, 90% of respondents were satisfied with the level of service received. Feedback from the pilot revealed that satisfaction among providers was high as 92% of providers were satisfied with the programme. In addition, 73% of providers were appreciative of the

benefits realised from the programme, while 79% were satisfied with the patient base the programme brought to their pharmacies.

3.3.4 From the inception of the pilot programme to end of March 2018, partner pharmacies have filled 72,301 prescriptions.

3.3.5 Contracts for an additional thirty-five pharmacies, spread across the island, have been signed in March 2018 bringing the total number of PPP Pharmacies to fifty-two (52).

3.4 Challenges

3.4.1 Sustainability as it relates to adequate funding for the overall drug programme is a concern. There has also been some resistance from providers regarding the fees

3.5 Related Next Steps

3.5.1 In conjunction with the transfer of pharmacy services from the Regional Health Authorities (RHAs) to the NHF, full-time and scheduled pharmacy services will be reintroduced in underserved locales increasing the number of access points to nearly 170.

3.5.2 In support of improving the convenience and accessibility of filling prescriptions for public patients, the NHF has developed a NHF Quick Prescript App which will be available via the Google Play Store and the App Store. The NHF Quick Prescript App allows patients with a prescription issued by a doctor from a public health facility to i) take a photograph of their prescription; ii) submit their prescription to the NHF Quick Prescript processing centre, indicate items required and preferred pick-up location; and iii) collect their medication from any DrugServ or partner pharmacy.

Strengthening Health Systems

4 Information Systems for Health

The health information system provides the underpinnings for decision-making and has four key functions: data generation, compilation, analysis and synthesis, and communication and use. The health information system collects data from the health sector and other relevant sectors, analyses the data and ensures their overall quality, relevance and timeliness, and converts data into information for health-related decision-making (WHO, 2008)

4.1 Background

- 4.1.1 Modernisation of the health information infrastructure for enhanced health information to inform evidence-based decision-making and quality of service delivery to clients remains an essential priority. In furtherance of the need to modernize the health information landscape and enhance service delivery for clients and evidence-based decision-making, the Ministry has made progress on initiatives already underway with emphasis on the PAHO/WHO supported National Plan of Action for Information Systems for Health (IS4H) and the electronic Patient Administration System (ePAS).
- 4.1.2 The Ministry and PAHO/WHO entered into a Technical Cooperation Agreement for Information Systems for Health for a period of at least three (3) years which commenced in April 2017.
- 4.1.3 The PAHO/WHO has defined IS4H as:
“The integrated effort for convergence of interconnected and interoperable systems, data, information and knowledge, processes, standards, people and institutions supported by ICTs that help to produce information for planning and decision-making.”
- 4.1.4 A National Plan of Action for IS4H, aligned with PAHO’s renewed framework and taking into consideration the progress made by the MoH, was completed during September 2017.

4.2 Goal and Objectives of the IS4H Plan of Action

4.2.1 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 data and strategic information using the most cost-effective ICT tools.

4.2.2 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. Furthermore, the Plan seeks to define and implement strategies, policies and standards for interoperable and interconnected E-Health systems, and best practices in health data management for improving decision-making and well-being. The Plan also takes into consideration the current National Health Information System Strengthening and E-Health Strategy, existing pilot projects and implementations, as well as systems and structures; therefore, it will be based on the assumption of incremental strengthening.

4.2.3 The Plan of Action consists of six (6) work streams.

4.2.3.1 Governance - Establishing a national governance structure for IS4H and developing a medium-term national-scope strategy for advancing IS4H. The Governance Model will also serve to guide plans, investments and the technical approach for IS4H development in the country.

4.2.3.1.1 Specific actions include the National Governance Structure, IS4H Maturity Model Pilot Assessment, Functional Model for Assessment of major disciplines involved in IS4H including Information Technology, and the review and refreshing of the current National Health Information System Strengthening and E-Health Strategy 2014-2018.

4.2.3.2 EHR Platform Component Solutions Due Diligence - Gathering information and evidence to support decisions on the selection of health information technology solutions for public health facilities that will be capable of integrating

into a national EHR platform architecture, with attention to current implementations of Open Source and Proprietary systems.

- 4.2.3.2.1 Specific actions include gaining an understanding of the functionalities and costing models of existing Electronic Health Records (EHR) systems globally through developing and publishing a Request for Information (RFI), developing Terms of Reference for vendors of EHR solutions, and conducting a Technology Readiness Assessment of the Open Source GNU Health platform and UHWI's HIMS Solution with the development of a Business Case for each solution.
- 4.2.3.3 **National EHR Architecture** - Establishing a national EHR architecture that will enable information to be shared across public and private health care provider organizations and stakeholders for clinical and population health management.
 - 4.2.3.3.1 Specific actions include rationalisation of paper-based health forms to prepare for electronic solutions, development of a national Data Dictionary, and designing and implementing the National EHR Business, Information and Technical Architectures. The architecture will also serve as a state-produced guide for E-Health solution selection and implementation for the private sector, NGOs and other interests.
- 4.2.3.4 **Policy and Legal Framework** - Addressing major gaps in the policy and legal frameworks that can be a barrier to fully implementing IS4H.
 - 4.2.3.4.1 Specific actions include the development of a National IS4H Policy, completion of the Personal Health Information Protection Policy as a precursor to legislation for safeguarding patient health data, and implementing a National Privacy Programme for public health care facilities based upon the policy/legislation.
- 4.2.3.5 **Telehealth/Telemedicine** - Advancing telehealth/telemedicine capacity in Jamaica through the implementation of a pilot project that will help to evaluate technology, infrastructure, clinical outcomes and supporting policy/protocol.

4.2.3.5.1 Specific actions include developing a Telehealth/Telemedicine Pilot Project Charter as well as the relevant policies and clinical protocols.

4.2.3.6 **IS4H Education and Knowledge Sharing** - Advancing national knowledge regarding various aspects of IS4H through training and through engagement with experts in other countries with related experience and knowledge.

4.2.3.6.1 Specific actions are related to IS4H study tours in Latin America and India thereby seeking to strengthen South-South Collaboration.

4.3 Status of PAHO IS4H Mission December 2017

4.3.1 The PAHO/WHO IS4H Team Mission to Jamaica was conducted over the period December 4-8, 2017 in order to advance specific initiatives of the Plan of Action. Various stakeholders attended mainly from the health and technology sectors.

4.3.2 The objectives of this Mission along with the major accomplishments over the period are described below:

4.3.2.1 To conduct a maturity assessment based on PAHO's Maturity Model Tool (IS4H-MM) Level 2 – Public health facilities with EHR managed. The IS4H-MM is a new tool for assessing the maturity levels of Information Systems for Health and the organizational capabilities of a country, region or institution to operate, interact and benefit from its IS4H.

4.3.2.1.1 *Achievement* – The assessment was conducted at selected health facilities. The draft report has been completed and the Ministry is poised to review and validate the findings. Recommendations from the report will be incorporated into the Plan of Action for implementation. The Ministry will be awarded a Certification of the IS4H Maturity Level achieved through this Assessment. The findings on maturity level and national capacity will prove useful as a guide for future investments in IS4H.

4.3.2.2 To explore an IS4H Functional/Operational Model to inform the future organisational structure. The Functional Model describes the key functions needed to effectively sustain IS4H. These include mainly the key functions of the disciplines of Information Technology, Health Information Management (Health Records Services) and Health Informatics.

4.3.2.2.1 *Achievement* - The Functional Model has been completed. This tool will be used as the basis of an assessment of IS4H across the Ministry and the Regional Health Authorities. The assessment will include the functions and operations of the core disciplines mentioned above.

4.3.2.3 To develop the draft framework for the IS4H Governance Structure which include the National IS4H Steering Committee.

4.3.2.3.1 *Achievement* – The outline of the Terms of Reference for the National IS4H Steering Committee has been completed. An implementation plan for governance at other levels (MoH Head Office and Regional) is pending.

4.3.2.4 To advance the Request for Information (RFI) to vendors of EHR Systems through a consultation process with relevant local stakeholders.

4.3.2.4.1 *Achievement* – The RFI is completed. The MoH will undertake a review and commence procurement procedures.

4.4 Status of Current E-Health Initiatives

4.4.1 The implementation of the electronic Triage System as a module of the electronic Patient Administration System (ePAS) has been expanded to include a total of five (5) hospitals' Emergency Departments. These are Bustamante Hospital for Children, Mandeville Regional Hospital, May Pen Hospital, Black River Hospital and the Percy Junor Hospital. The benefits of the eTriage System are streamlining the process to the completion of Triage, tracking patient movement between providers, adaptation to the Emergency

Severity Index (ESI) 5-level system now widely implemented, providing data on waiting time, workflow by 4-hour arrival time blocks for patients as well as by weekday and ESI level. Moreover, multiple providers are able to access a patient's record as needed. The reports are generated monthly for all five facilities and help to identify and resolve system-level problems.

4.5 Next Steps

- 4.5.1** Establish a National IS4H Steering Committee with the participation of all major stakeholders, including various Government MDAs, Non-Governmental Organizations, academia and the private sector.
- 4.5.2** Secure investments required for the development of the National E-Health architecture in collaboration with the Ministry of Science, Energy and Technology (MSET) and other partners.
- 4.5.3** Priority attention to the policy and legislative components of the National Plan of Action through collaboration with the PAHO/WHO Country Office.
- 4.5.4** Keep abreast of and comply with other key existing and emerging legislation including the National Identification and Registration Act, 2017; Data Protection Act, 2017; the Electronic Transactions Act; the Open Data Policy and the Cybercrimes Act.

5 Health Financing - National Health Insurance Plan

In Jamaica advances are being made on several fronts which include, inter alia, the removal of out-of-pocket payment, increasing government spending on health insurance coverage, and expanding coverage under the NHF. These are all contributing to the view that Jamaica is approaching universal coverage. (World Bank, 2013)

5.1 Background

- 5.1.1** Alongside the creation of the National Health Fund (NHF), the abolition of out-of-pocket payment at public health facilities in Jamaica represents one of the most notable health financing reforms in the country's history. In its design, the NHF was considered as the first phase in the implementation of a full-fledged National Health Insurance scheme, which the country has examined from the 1930s. Data from the Jamaica Survey of Living Conditions (STATIN and PIOJ) indicate that there are consistently high levels of direct out-of-pocket payments (averaging around 28% of total health spending) alongside limited coverage in private insurance pools (averaging about 18% of the population,) resulting in access-to care-challenges for the population.

5.2 Objectives

- 5.2.1** Work is apace on the development of a policy proposal and road map for the sustainable implementation of a National Health Insurance Plan for Jamaica. The proposal will address elements relating to the benefits package, which includes:
- Level of financing
 - Sources of financing
 - Legislative changes
 - Provider network
 - Requisite administrative and organizational structures

5.3 Status

- 5.3.1** The NHF signed a six-month contract in December 2017 with Sanigest Internacional for the development of a policy proposal and road map for the design and effective implementation of a sustainable National Health Insurance Plan (NHIP) for Jamaica.
- 5.3.2** This is in keeping with the Ministry of Health's 10-year strategic plan, and will also closely follow the World Health Organization's (WHO) strategy for Universal Access to Health and Universal Health Coverage which was adapted by Jamaica at the Regional Committee of the WHO held in Washington D.C. in 2014.
- 5.3.3** Work is well underway on the execution of the consultancy for the development of a NHIP for Jamaica. Elements related to the financial review and the expenditure on health have been completed with the draft proposal submitted March 2018.

5.4 Next Steps

- 5.4.1** Stakeholder consultations, inclusive of medical groups, the nurses' association, private insurance companies, pharmacy and diagnostic groups, and trade unions, will be organised to provide comments on the draft proposal.
- 5.4.2** It is anticipated that by the end of the first quarter of the financial year that the consultancy will be completed inclusive of the policy proposal and road map.

6 Bilateral Cooperation between Jamaica and the UK

6.1 Background

6.1.1 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). 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.

6.1.2 Approximately one thousand specialist nurses are required to fill the positions of critical care, nephrology, accident and emergency, paediatric, neonatology, operating theatre, psychiatry and midwifery. As is the situation globally, the chronic shortage of health workers, in particular specialist nurses, emanates from high migration rates and limited domestic 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.

6.1.3 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.

6.1.4 Jamaica currently has forty 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% are 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 sixty critical care nurses.

6.1.5 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.).

6.2 Overview of Training of Nurses Initiative

6.2.1 The bilateral partnership for the training of nurses hinges on four pillars:

6.2.1.1 Training of specialist nurses

6.2.1.1.1 A minimum of thirty-five registered nurses will 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 (to fulfil UK immigration policies.) This will allow for 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. Jamaican nurses will 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.

6.2.2 Shared employment

6.2.2.1 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.

6.2.3 Nurse exchange

6.2.3.1 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.

6.2.4 Nurse educators/faculty exchange

6.2.4.1 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.

6.3 Status

6.3.1 The Ministry of Health, led by Dr. the Honourable Christopher Tufton, MP has engaged various stakeholders in the UK, including the Home Office, regarding the proposed Bilateral Training Programme. Based on discussions with the Home Office, the following are issues for consideration:

6.3.1.1 Visas

6.3.1.1.1 Home Office confirmed that Jamaican nurses would require Tier 5 or 6 visa. This is a Government Exchange visa.

6.3.1.1.2 Requirements:

- Identify an individual/an entity in the UK who will act as a sponsor who is expected to manage the entire UK/JA collaboration.
- This is required for a sponsorship code
- A pin number will be required on visa application form

- Jamaican nurses would therefore be seen as super-numeracy under this classification
- Language test is not a requirement
- The Objective Structured Clinical Examination (OSKI) is not required. However, at the end of the six months, nurses may opt to take the OSKI in order to obtain Nursing and Midwifery Council (NMC) registration.

6.3.1.2 **Salary**

6.3.1.2.1 Jamaican nurses would go to the UK as additional staff

6.3.1.2.2 They can be offered a salary as a Band 3 or 4. This would recognize them as qualified nurses, but not NMC qualified nurses

6.3.1.2.3 Home Office indicated that Band 3 payment is acceptable under the tier 5 or 6 visa classification, which complies with the minimum wage guidelines.

6.3.1.3 **Timelines**

6.3.1.3.1 A detailed scheme is to be provided to the Immigration Minister with a proposed start date of April 2018.

6.3.1.3.2 Since discussions in January 2018 led by the Hon. Minister of Health, Dr. Christopher Tufton, the Department of Health has reconfirmed interest in pursuing this bilateral programme given the mutual benefits that would be gained by both countries. The Department of Health advised of a possible solution to the issue of the requirement of a sponsor. It recommended that the Nursing and Midwifery Council in the UK could act as sponsor for the nurses to be trained and as such the nurses participating in the programme would not be restricted by institution.

6.4 Bilateral Cooperation between Jamaica and China

- 6.4.1** A two-month internship programme is being pursued between the Governments of the Peoples Republic of China and Jamaica for the training of critical care nurses having completed ten months training in Jamaica;
- 6.4.2** Eighteen nursing students and five nursing coordinators/preceptors from the University Hospital of the West Indies and the Ministry of Health who will accompany the students are confirmed for the programme. Proposed departure date for China is June 2018.

6.5 Next Steps

- 6.5.1** The issue of financing of the UK programme is to be resolved and it will be explored whether grant funding may be available through programmes such as the UK's Global Health Fund. The London South Bank University will be in further discussions with the Department of Health regarding the development of a project proposal for the programme and avenues of funding.
- 6.5.2** A Memorandum of Cooperation has been proposed to be executed between the Ministry of Health and the London Southbank University.
- 6.5.3** The Ministry is also looking to collaborate with Leeds Teaching Hospital. Discussions have begun regarding the nursing curriculum in Jamaica to understand better how this might align with UK Critical Care STEP (National Competency Framework for Registered Nurses in Adult Critical care) education package.
- 6.5.4** Draft MOU for the bilateral collaboration between Jamaica and China will be developed.

7 Development of Ten-Year Strategic Plan

7.1 Background

- 7.1.1** 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 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 twenty years and is now at the point where it needs to be critically reviewed.
- 7.1.2** 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. It is noted 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.
- 7.1.3** The need for health sector reform 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 have resulted in an increased burden of Non-communicable Diseases (NCDs); continued threat of communicable diseases, and high level of trauma due to violence and motor vehicle accidents.
- 7.1.4** The NCD challenge has the potential to have substantial economic impact, due to the growing number of working-age 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.

- 7.1.5** The Ministry of Health (MOH) has contracted a consultant 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 toward universal access to health and universal health care coverage aligned with Vision 2030, and 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.
- 7.1.6** 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 health care 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. and concluded in 2013, evidenced the need and laid the foundation for the development of the ten-year strategic plan.
- 7.1.7** The Ministry has convened a high level multi-sectoral, multi-stakeholder Oversight Committee to guide this initiative.
- 7.1.8** The Ministry has engaged IOS Consulting Inc. to develop the ten-year strategic plan which will include the following deliverables:
- Updated Situational Analysis
 - Revised Standard Comprehensive Essential Benefits Package (SCEBP)
 - A Human Resources Plan
 - An Administrative Restructuring Plan
 - An Infrastructure Improvement and Procurement Plan

7.1.8.1 Monitoring and Evaluation (M&E) Metrics for the ten-year Strategic Plan

7.1.8.2 A three-year implementation plan

7.1.9 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 have influenced outcomes.

7.2 Status

7.2.1 To date, the following has been accomplished:

7.2.1.1 The IOS Consultant completed the updated Situational Analysis in February 2018 and is expected to complete the first draft of the Ten-Year Strategic Plan in FY 2018 - 2019. The Plan will incorporate the National Health Insurance Plan currently being developed as well as the findings and recommendations of the PAHO's health service review which was completed in 2017.

- 7.2.1.2 The draft outline of the plan was presented by the Consultant, and the MoH in consultation with the Steering Committee provided feedback and guidance to the Consultants on the direction of the Ministry on critical elements of the proposed plan. IOS is expected to consult with a list of stakeholders, which is to be endorsed by the Ministry.

7.3 Next Steps

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

- 7.3.1.1 Finalization of the Revised Standard Comprehensive Essential Benefits Package (SCEBP);
- 7.3.1.2 Completion of the Human Resources Plan;
- 7.3.1.3 Completion of an Administrative Restructuring Plan;
- 7.3.1.4 Completion of an Infrastructure Improvement and Procurement Plan;
- 7.3.1.5 Ongoing stakeholders consultation;
- 7.3.1.6 Finalization of the ten-year strategic plan;
- 7.3.1.7 Finalization of M&E Metrics for the ten-year strategic plan;
- 7.3.1.8 Finalization of a three-year implementation plan.

Effectively Addressing the Non-Communicable Diseases Threat

8 Jamaica Moves

Practising 30 minutes of moderate exercise daily leads to a
healthy life resulting in more ...

More moments, more memories, and more life

8.1 Background

- 8.1.1 Physical inactivity is a leading risk factor for non-communicable diseases (NCDs) and global mortality. The World Health Organization 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 thirty minutes of moderate physical activity several times a week.
- 8.1.2 The World Health Organization's (WHO) (2010) Global Recommendation of Physical Activity for Health advocates 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.
- 8.1.3 The 2008 Jamaica Health and Lifestyle Survey reports that three in ten 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) supports the need for increasing physical activity levels.
- 8.1.4 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.
- 8.1.5 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, supports the National Strategic and Action Plan for the Prevention of Non-Communicable Diseases (2013-2018).

8.2 Objectives

8.2.1 Against this background the Jamaica Moves initiative was launched to target individuals across the lifespan. Jamaica Moves will:

- 8.2.1.1 Promote physical activity among the populace;
- 8.2.1.2 Educate individuals on practical means of fostering healthier eating habits.

8.3 Status

8.3.1 Jamaica Moves was implemented in the Financial Year 2017/2018 with the official launch held on the 7th of April 2017, World Health Day. This launch signalled the beginning of a corporate challenge, a media campaign and island-wide activities to encourage the population to move. Prior to the formal launch, a Jamaica Moves video was released on YouTube which featured the Honourable Minister of Health along with the National Focal Points for Nutrition, Physical Activity and Non-Communicable Diseases. This video served as a soft launch for Jamaica Moves with the take home messages being engage in physical activity for at least 30 minutes a day and eat healthier to reduce your chances of acquiring NCDs to live longer.

8.3.2 Through Jamaica Moves, the Ministry of Health has been able to lead by example in its efforts to promote healthy eating and physical activity. For the 2017 Sigma Run, the Ministry of Health mobilized the participation of one hundred 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.

- 8.3.3** Through the Jamaica Moves website, TV and newspaper ads, brochures, posters and social media campaigns content have been created and shared to promote positive behaviour change. Using these platforms, physical activity ambassadors from different walks of life have been sharing their testimonies of how they have benefitted in a significant way from increasing their frequency and intensity of physical activity.
- 8.3.4** In an effort to continue educating the society on the importance of proper nutrition, physical activity and the risk factors of NCDs, Jamaica Moves has maintained an active multi-media educational campaign. The Ministry of Health launched the Living with an NCD campaign, the Get Moving Challenge and the Get Moving Corporate Challenge to promote national physical activity and nutrition change.
- 8.3.5** The Living with an NCD campaign was launched to generate discussion around various types of NCDs using real life scenarios. Six testimonials from individuals living with NCDs have been packaged and shared on-line, in print and on television to help encourage other persons facing similar challenges.
- 8.3.6** The Get Moving Challenge enhanced the Jamaica Moves social media presence through friendly competition between fourteen influential members of the private and public sector as they took steps towards a healthier lifestyle. These influential members of society were used to market the importance of physical activity through their commitment to 10,000 steps or 30 minutes of physical activity per day.
- 8.3.7** The Jamaica Moves Get Moving Corporate Challenge was launched to encourage corporate companies across Jamaica to invest in the health of their employees. The main aim of this initiative is to increase productivity and provide companies with a platform to help improve the health of their employees. Companies were allowed to register teams of up to one hundred employees to compete in six races across the island. The Ministry of Health was able to use this initiative to introduce wellness programmes and workshops to the companies and over 1200 employees registered in the 2017 circuit. Sixteen private and public sector organizations across Jamaica participated in the 2017 circuit, with

Victoria Mutual, Rainforest Seafoods and the Jamaica National Group being the victors. The Get Moving Corporate Challenge 2018 circuit is now underway.

- 8.3.8** The Jamaica Moves Road Tour facilitated the collection of data on NCDs, as well as promoted physical activity throughout the regions. To date, public health screenings and activity sessions have been conducted in Kingston, Trelawny, Montego Bay, Hanover, Westmoreland, Mandeville, St. Elizabeth, Clarendon and St. Thomas. Approximately 5,000 health tests (blood pressure, blood sugar, cholesterol, BMI, etc.) have been conducted and over 4,000 persons were engaged in doing physical activity for over one (1) hour and were provided with samples of healthy food options.
- 8.3.9** UWI Moves, which was another initiative under the Jamaica Moves umbrella, took place once a week throughout September to December 2017. It was used to encourage a healthy lifestyle among youth at the University of the West Indies.
- 8.3.10** On February 13, 2018, the Ministry received an award for Jamaica Moves in the category of Health and Wellness from the RJR GLEANER communication group.
- 8.3.11** Areas have been identified as potential walking trail sites and consultations have commenced for their branding as official Jamaica Moves locations. Areas approached so far include, Mona Dam, Hope Pastures in the Kingston & St. Andrew area, Falmouth Hospital in Trelawny, Dump Up Beach in St. James and sites in Hanover.
- 8.3.12** Jamaica Moves has formed partnerships with a number of private and public sector stakeholders who share its mission and vision; one such partnership is with the Obesity Prevention Programme. Additionally, the work of the National Food Industry Task Force was intensified through partnership with the Jamaica Moves Campaign.
- 8.3.13** Jamaica Moves has also developed activities around the following globally recognized days: Move for Health Day; World No Tobacco Day; World Mental Health Day and World Diabetes Day.

8.4 NEXT STEPS

- 8.4.1 Continue to raise public awareness through the staging of events and multi-media campaigns across the island to promote physical activity, healthy eating and screening.
- 8.4.2 Improve the streamlining of partnerships such as those with schools through HYPE, the Obesity Programme and the NFITF to promote healthy eating.
- 8.4.3 Begin the process of institutionalizing Jamaica Moves as the “Umbrella Programme” for health promotion of NCDs, promoting the message **3x3 = increased physical activity, healthy eating and regular health checks at the community, school and corporate levels.**
- 8.4.4 Strengthen the sustainability and security of Jamaica Moves by aligning it with evidence-based and data-driven corporate, operational and work plans.
- 8.4.5 Develop walking trails in areas where authorization has been granted and continue identification and consultation to designate and brand at least one walking trail in each parish.

9 Introduction of the HPV Vaccine

9.1 Background

9.1.1 The Ministry instituted the Human Papillomavirus (HPV) Vaccination Programme in schools in October 2017. The Programme targets girls 11-12 years who are entering high schools, which amounts to approximately 20,000 girls annually. The bivalent HPV vaccine will provide 90 – 100% protection against HPV types 16 and 18. The Ministry is pursuing HPV vaccination as a primary prevention method against cancer of the cervix, which is the second leading cause of cancer-related mortality among women in Jamaica. The HPV Vaccination Programme is a main strategy to achieve the goal of reducing premature mortality from cancer by 25% by 2025.

9.2 Status

9.2.1 The vaccine was administered over a ten week period. Throughout 150 schools, 22,338 girls were targeted and 6,172 or 28% received the vaccine. Eleven percent or 1,709 parents formally opted out. The low uptake was attributed to the fact that the public education programme of the Ministry of Health was overshadowed by negative media publicity.

9.3 Next Steps

9.3.1 The second dose of the vaccine will be administered to girls who received the first dose of the vaccine before the close of the school year, and the first dose of the vaccine will also be offered to girls who did not receive the vaccine in October to December 2017.

9.3.2 Strategies geared at mitigating the negative publicity include:

- Airing of testimonials and the launch of a media campaign
- Utilizing the existing evidence i.e. the fact that 6,172 students have been vaccinated without any record of any adverse events attributable to vaccination or immunization.
- Increased support from and collaboration with the Ministry of Education
- Ongoing sensitization sessions geared at allaying fears by providing credible information on the HPV vaccine.

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.*

10.1 Background

10.1.1 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 (French, 2001). 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 urgently. 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); obesity is associated with 67% of all deaths in Jamaica.

10.1.2 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 already 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.

10.1.3 The far-reaching effect of available energy-dense snacks and other food products, sugar-sweetened beverages (SSBs), 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.

10.1.4 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 was conceptualised as an oversight and review committee, comprised of experts in different government and non-government sectors – academia, policy and regulation, advocacy, education, health, and food processing/manufacturing. It was officially launched in March 28, 2017, with a budget approved in July 2017 and a secretariat (technical officer) installed in November 2017.

10.2 Objectives

10.2.1 Government efforts internationally have centred around the three regulatory measures (i.e. fiscal policies, marketing, labelling) but the Government of Jamaica will go 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:

10.2.1.1 Food Labelling

10.2.1.1.1 Mandatory nutrition facts panel on all packaged retail grocery foods and beverages

10.2.1.1.2 Standardized understandable nutrition labels on all packaged retail grocery foods and beverages

10.2.1.1.3 Mandatory nutrition labelling on menus and menu boards in chain restaurants and other food outlets

10.2.1.2 Food Marketing

10.2.1.2.1 Mandatory nutrition standards for all foods in schools based on the national food-based dietary guidelines

10.2.1.2.2 Limitation of the sale and sponsorship of unhealthy food products in schools

10.2.1.2.3 Reduction in children's exposure to unhealthy food advertising through all channels

10.2.1.2.4 Reduction in portion sizes of energy dense foods and beverages

10.2.1.3 Product Reformulation

10.2.1.3.1 Time-bound salt, fat and sugar content for specific food product categories to meet national standards

10.2.1.3.2 Mandatory removal of artificial trans-fats in all food products

10.2.1.3.3 Food service outlets and vendors to improve the quality of foods sold

10.2.1.4 Advocacy and Communication

10.2.1.4.1 Fiscal policy options to align with the nutritional value of foods as voluntary approaches are not sufficient at combatting NCDs

10.2.1.4.2 Public education and specific stakeholder training on:

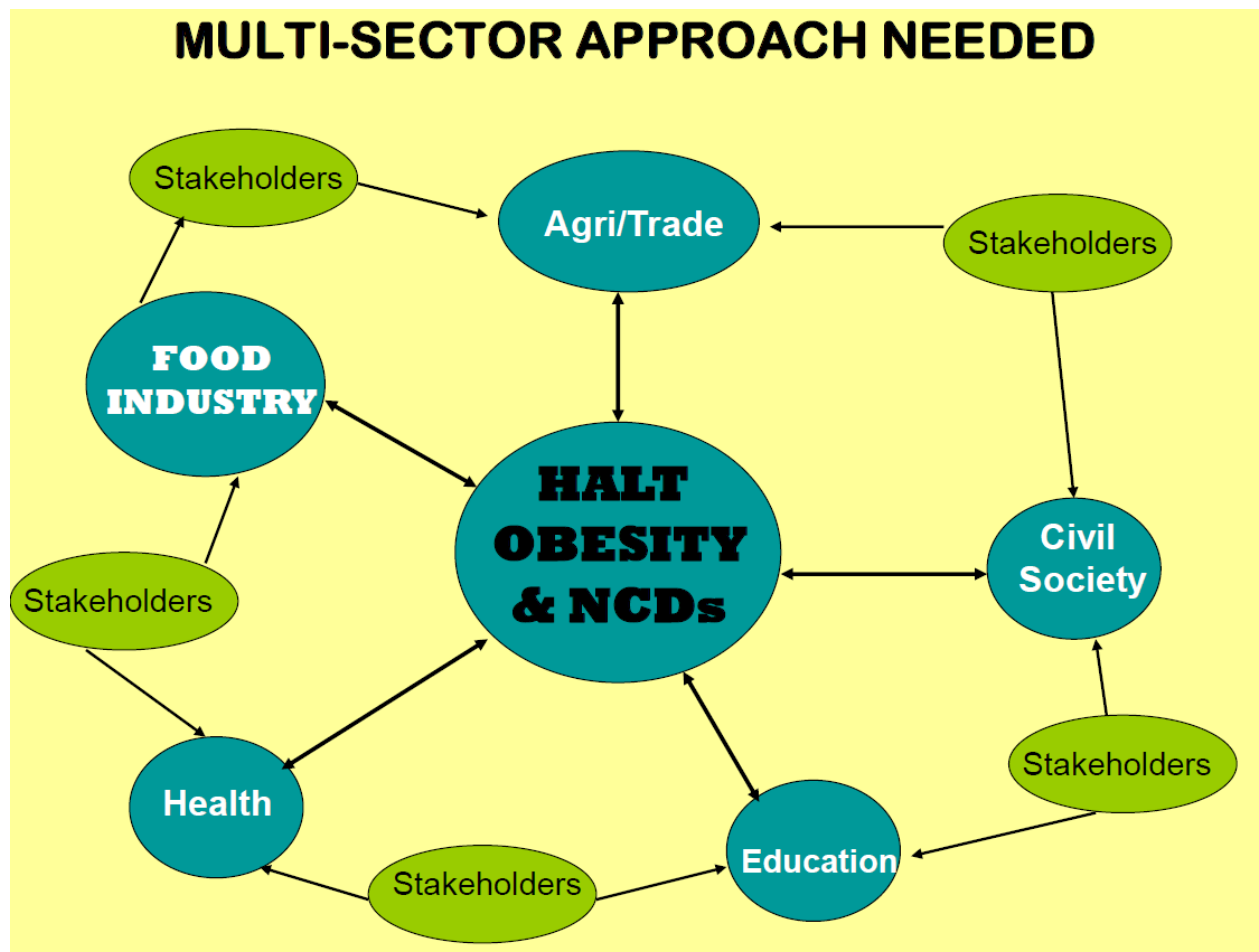
- the dangers of unhealthy eating;
- the use of food labels;
- the incentives and disincentives of fiscal policy initiatives. Support for food manufacturers and vendors in using healthier ingredients.

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

10.3 Composition of the Task Force

10.3.1 The NFITF is a skilled and experienced group, with broad multisectoral representation consistent with sound governance and successful consultation. The composition and

name of the Task Force – NFITF, deliberately connects to its aim of being 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 labelling, the food industry can provide foods that enable consumers to achieve better nutrition.



10.4 Status

10.4.1 The Annual Report (2017-2018) of the National Food Industry Task Force was finalised and presented to the Ministry of Health. One of the recommendations posited was a sugar tax to accompany the other initiatives of labelling, education and reformulation.

10.4.2 The National Food Industry Task Force submitted a discussion paper on Sugar-Sweetened Beverages to the Ministry of Health in 2017.

10.4.3 The Task Force through the sub-committees held several consultations with food industry partners and made presentations such as “*The Role of the Task Force Policy Development*” to the Global Health Advocacy Group on January 16, 2018

10.4.4 The specific achievements of the sub-committees are listed below:

10.4.5 Product Reformulation

10.4.5.1 The Task Force has solicited 102 industry partners to submit the nutritional content of key foods.

10.4.5.2 A draft criteria for the assessment of the nutrition profile of pre-packaged foods has been established based on the PAHO Nutrient Profile Model

10.4.5.3 Procurement has commenced for software which will enable the analysis of the nutritional content of foods. Furthermore a project has been designed and approved to secure the necessary funds to facilitate the laboratory analysis of samples.

10.4.6 Food Labelling

10.4.6.1 The Task Force completed a review of the labelling guidelines and policies for pre-packaged foods in Jamaica and found that the nutrition Facts Panel is not a requirement for pre-packaged foods. It was recommended that the nutrition Facts Panel be a mandatory requirement for all pre-packaged foods.

10.4.6.2 Consultations with technical stakeholders from PAHO, CODEX and CARICOM Regional Organisation Standards and Quality (CROSQ) led to the development of a proposed Front of Package (FOP) labelling and mandatory nutrition Facts Panel

10.4.6.3 Local food industry partners were sensitised on the proposed Nutrition Facts Panel and FOP labelling through a stakeholder meeting in Kingston. A second

sensitisation planned for Montego Bay was not realized due to low response and inclement weather.

10.4.7 Food Marketing

10.4.7.1 The Ministry through the Task Force collaborated on the development of the draft National School Nutrition Policy in December 2017, with special emphasis on the marketing of foods to the school population.

10.4.7.2 Preliminary work has been initiated to facilitate discussions with food service outlets and restaurants regarding the display of nutritional information.

10.4.8 Education, Advocacy and Communication

10.4.8.1 The NFITF launched two mass media campaigns to promote healthy drinking habits using multiple media platforms – print, on-line and radio. The “Are you drinking yourself sick?” mass media campaign launched in November 2017 focused on adults whilst the child-focused campaign was launched in early 2018.

10.4.8.2 A Symposium entitled “Fiscal Measures to Prevent Obesity/NCDs in Jamaica: Focus on Sugar-Sweetened Beverages” was successfully held in January 2018. One of the main features of this event was to discuss the challenges and implications of introducing the Sugar-Sweetened Beverages (SSBs) Tax. Information sharing has also advanced through collaboration with policy makers and other key stakeholders to explore the efficacy of such a tax in Jamaica.

10.5 Next Steps

10.5.1 Activities scheduled for the remainder of the fiscal year 2017/2018 and activities scheduled for the upcoming fiscal year 2018/2019 are outlined below.

10.5.1.1 Product Reformulation

10.5.1.2 Continue soliciting formulation information from manufacturers.

10.5.1.3 Desk analysis of nutrient profiles of foods submitted

- 10.5.1.4 Acknowledge “health progressive” companies
- 10.5.1.5 Start procurement process to obtain equipment for upgrading of laboratories for ingredient testing
- 10.5.1.6 Laboratory analysis of selected food items
- 10.5.1.7 Consultation with small “bag drink” producers
- 10.5.1.8 Review relevant legislative provisions on product formulations

10.5.2 Food Labelling

- 10.5.2.1 Maintain involvement in the CROSQ committee on food labelling
- 10.5.2.2 Work closely with CROSQ to adopt a front of package warning label, to be presented to stakeholders
- 10.5.2.3 Follow up on cost and subsample testing by Jamaica Health and Lifestyle Survey
- 10.5.2.4 Draft TOR and Scope of Work for consultant to develop the guidelines on food labelling and modification of nutrition facts panel
- 10.5.2.5 “Reading Food labels” - Public education sessions in collaboration with Heart Foundation Jamaica and the Global Health Advocacy Project (overlaps with Communication sub-committee)

10.5.3 Food Marketing

- 10.5.3.1 Support the finalisation of the National School Nutrition Policy and develop the accompanying standards and guidelines.
- 10.5.3.2 Support the implementation of the National School Nutrition Policy
- 10.5.3.3 Assess the supply of unhealthy foods and beverages in public schools and institutions
- 10.5.3.4 Review Broadcasting Commission laws which pertain to marketing to children

10.5.3.5 Sensitise School Principals and parents on the National School Nutrition Policy

10.5.4 Education, Advocacy and Communication

10.5.4.1 Educate the public on reading and understanding nutrition labels on pre-packaged foods

10.5.4.2 Publish the proceedings of the symposium (“Fiscal Measures to Prevent obesity/NCDs – Focus on Sugar Sweetened Beverages”) for future reference in Jamaica and elsewhere

10.5.4.3 Engage parents of school-aged children

10.5.5 Consultations and sensitisation sessions with stakeholders and interest groups will continue to be a priority to further the agenda of the Task Force. Education, communication and advocacy will also continue to play a significant role, in support of the other activities.

11 Public Health and Cannabis

11.1 Background

11.1.1 The Ministry of Health has made considerable strides to facilitate the access by patients to medicinal cannabis products in keeping with promoting Jamaica as a forerunner in the worldwide medicinal cannabis industry. As outlined in the Dangerous Drugs (Amendment) Act, 2015 (DDA), the Ministry of Health (MOH), is responsible for the registration and regulation of all cannabis and cannabis-related products (including hemp) and all precursor products that are manufactured for medicinal cannabis use in Jamaica. It is responsible for issuing and regulating all licenses/permits for medicinal cannabis and medicinal cannabis products locally.

11.1.2 The Medicinal Cannabis Unit (MCU) was established in the MOH in July 2017 despite the lack of a budgetary allocation. Every effort has been made by this unit to accommodate the medicinal cannabis industry in Jamaica. Sixty-one medicinal cannabis products have been registered by the MCU. Manufacturing of these products are done locally and overseas. Permits for locally manufacturing medical cannabis products have to be obtained from the Cannabis Licensing Authority (CLA) and the Pharmacy Council. Without manufacturing permits, companies with registered products have no choice but to consider the importation of these products for distribution in Jamaica. Import

MoH Position on Medical Cannabis

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.

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.

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.

permits, granted by the MCU, and distribution licenses will be required for companies to import drugs produced overseas. Distribution licenses are obtained from the Ministry of Health and the Pharmacy Council. This has been a hindrance in the local production and availability of these products for use by patients.

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 (e.g. 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. A register of these physicians will be kept by the MoH and shared with the CLA and Pharmacy Council.

11.1.3 Though not mandatory, the MOH strongly recommends training (this can be done overseas, local, face-to-face or online) in the area of medicinal cannabis by all persons involved in providing these products for patients. A registry of trained persons is kept at the MOH. To date, 137 persons have been trained in the use of medicinal cannabis, which include physicians, pharmacists and researchers.

11.2 Status

11.2.1 Since July 2017, the MCU has done or facilitated the following activities:

11.2.1.1 The registration of sixty-one medicinal cannabis products and five medicinal cannabis applicators (devices).

11.2.1.2 The provision of two local manufacturing entities with Good Manufacturing Practices (GMP) certification for producing medicinal cannabis products.

11.2.1.3 Over thirty travel permits awarded to tourists/visitors/returning residents for travel with prescription medicinal cannabis products that are not available locally.

11.2.1.4 Five medicinal cannabis permits have been granted to local residents for medicinal cannabis as recommended by their attending locally registered physicians. These patients have also been facilitated

with importation permits for their prescription items due to local unavailability.

11.2.1.5 Draft Ethical Guidelines for Medicinal Cannabis Research has been completed by a local consultant to facilitate local clinical trials involving medicinal cannabis.

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 six 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.

11.3 Talk di Truth Ganja Youth Public Education Campaign

11.3.1 The National Council on Drug Abuse is the government agency with the mandate to educate the general public on the prevention of the indiscriminate use of drugs, investigation of illegal medical and security issues surrounding drug abuse as well as research. “Talk di Truth” is the agency’s Ganja Youth Public Education Campaign with the overall goal to delay youth initiation into ganja use by influencing attitudes and norms and showing the benefits of delayed use. The project targets youth through the avenues of social media, radio and television youth programmes, and in-school interventions. “Talk di Truth” has achieved the following:

- Multi-sectoral campaign support
- Support from the entertainment industry
- Thirty media exposures of aspects of the campaign
- Radio Jingle
- Youth programme TV sponsorship
- Training of peer leaders
- Material development & distribution
- Increased social media engagement

11.4 Next Steps

11.4.1 Public Education Strategy

- 11.4.1.1 There is consensus that a public education strategy is urgently required to address the implications of the changes in the treatment of cannabis 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 emphasize prevention of use by the vulnerable - children, pregnant mothers, and persons living with or predisposed to mental illness, among other key groups.

11.4.2 Funding

- 11.4.2.1 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 are needed for this initiative.

Combatting Communicable Diseases

12 Vector Control Programme

12.1 Background

12.1.1 Over the past years, Jamaica has been on high alert due to the threat of new and re-emerging diseases. The vector control programme is a priority of the Ministry of Health which uses an integrated approach at individual and community levels to decrease the risk and burden of vector borne diseases on the general population. The vector control programme is guided by the Ministry of Health and implemented in the Regional Health Authorities through the Parish Health Department. The major strategies include: (1) an integrated approach; (2) social mobilization; (3) collaboration with other sectors; (4) using surveillance and epidemiological information for decisions; and (5) building capacity.

12.1.2 The main thrust of the vector control programme is to decrease the populations of vectors, the main one being the *Aedes aegypti* mosquito; the mosquito that transmits Zika, dengue, chikungunya and yellow fever viruses. Activities geared at prevention of the reintroduction of malaria are also done. The vector control programme is routinely implemented by 207 vector control workers. The following are the routine activities:

- Surveillance – species identification, determining distribution and abundance of mosquito vectors.
- Destruction of breeding sites to kill the immature stages of the mosquito.
- Treatment of containers to destroy larva.
- Destruction of adult mosquitoes through space spraying (fogging).
- Operational research

12.2 Status

12.2.1 In 2017, there were no outbreaks of vector-borne diseases. The Ministry will, however, continue to monitor vector-borne disease conditions locally and globally and will tailor its vector control activities based on the epidemiological situation that presents.

12.2.2 Enhancement of the *Aedes aegypti* Surveillance System A sentinel surveillance system was implemented to aid in the monitoring of the abundance and distribution of the *Aedes aegypti* population. This information will form part of an early warning system for disease transmission.

12.2.3 Reinstallment of the Temporary Workers Programme for the period June – August, 2017. Seven hundred and fifty persons were engaged for the period and were distributed as indicated in table 1. Three parishes ended their programmes in December 2017. Five (5) of the temporary workers continued at the National Public Health Laboratory as part of the Sterile Insect Project. The outcomes of this programme are:

- The parishes were able to cover a wider area as it relates to inspection and repeat inspections
- Areas not frequently surveyed were covered
- Development and wide distribution of educational material conducted
- Over 400,000 house inspection cards distributed
- Increase in the number of containers identified, destroyed and treated.

Table 12.1. Distribution of temporary workers by parish under the Temporary Worker Programme June – August 2017

No.	Parish	# of Workers
1.	KSA	110 (*6 to Vector Lab)
2.	St. Thomas	40
3.	St. Catherine	120
4.	Clarendon	100
5.	Manchester	60
6.	St. Elizabeth	50
7.	Westmoreland	40
8.	Hanover	30
9.	Trelawny	30
10.	St. James	60
11.	St. Ann	50
12.	St. Mary	30
13	Portland	30
	Total	750

12.2.4 Mosquito Control and Research Unit (MCRU). The MCRU was launched March, 2017 and the laboratory facility on the grounds of the University of the West Indies was officially opened January 2018. The Unit was established to address major research gaps in the prevention and control of mosquito borne diseases. The MCRU is a collaborative effort between the Ministry of Health and UWI, which will focus on operational field research to provide evidence and tools to support mosquito control interventions.

12.2.5 Sterile Insect Technique (S.IT.) - One of the main thrusts of the MCRU will be the piloting of the Sterile Insect Technique as part of the Integrated Management Approach. The Ministry of Health is a counterpart on the International Atomic Energy Agency's (IAEA) project titled "Strengthening Regional Capacity in the Latin American and the Caribbean for Integrated Vector Management Approaches with a Sterile Insect Component to Control Aedes Mosquitoes as Vector of Human Pathogen particularly Zika virus". This project was launched in 2016 in light of the severe impact of Zika Virus in these two regions.

12.2.6 Jamaica is one of several countries to pilot the use of the sterile insect technique. The duration of the project is four years (2017-2021). The project will be piloted in one community, with the release of 500,000 male mosquitoes weekly for the duration of the test stage.

12.2.7 The implementation of the project in each country is a partnership between Jamaica and the IAEA. The IAEA will 1) donate most of the equipment to facilitate mass rearing and release; and 2) provide capacity building opportunities in the area of mass rearing of mosquitoes through training workshops and fellowships. Jamaica is expected to build the facility for the mass rearing of the mosquitoes, hire and pay the staff to manage the insectary, and release the sterile mosquitoes.

12.2.8 Activities under this project commenced in 2017 with the arrival of several pieces of equipment from the IAEA. A mosquito colony has been established and surveillance activities have commenced in the pilot area.

12.2.9 USAID – Zap Project. ZAP was launched in Jamaica in October 2017 as a component of USAID’s Zika response throughout Latin America and the Caribbean, with the purpose of reducing and controlling the presence of mosquitoes responsible for transmitting Zika and other diseases such as Dengue and Chikungunya. The programme ends July 2018.

12.2.10 ZAP Jamaica will work closely with the Ministry of Health and other stakeholders in the following areas:

- Supporting the organizational development of the MCRU, including operational plans and budgets
- Establishing an insectary for the MCRU housed at UWI for key entomological operational research activities as well as an insectary at the MOH National Lab.
- Piloting and testing of new biological methods to control vectors (Bti)
- Conducting entomological monitoring and surveillance to evaluate the campaign’s effectiveness and to track mosquito populations
- Introducing new data tools and databases to identify hot spots and potential outbreaks

12.2.11 The insectary for the MCRU has been completed and progress has been made in establishing the insectary in a box (retrofitted container) at the National Public Health Laboratory. Zap has also commenced testing of the new larvicide.

12.2.12 Insecticide Resistance Monitoring. The Ministry of Health has partnered with the UWI Natural Product Institute under the MCRU to conduct island-wide evaluation of the chemical used in the vector control programme to determine efficacy. Testing commenced in 2017 and will continue to completion in June 2018.

12.2.13 Charcoal Project. This is a collaboration with the Bureau of Standards to assess the effectiveness of charcoal in reducing oviposition in forty-five gallon drums (or other containers over ten gallons) and will end April 2018.

12.2.14 Red Cross Zika Project. The Ministry partnered with the Jamaica Red Cross in the implementation of their USAID Zika project. The Ministry developed the training manual and conducted training of their field officers/volunteers who were involved in vector control activities.

12.3 Next Steps

12.3.1 Establishment of early warning system for vector-borne diseases with the introduction of arbovirus surveillance in mosquitoes

12.3.2 Training and re-certification of vector control workers

12.3.3 Completion of Entomology Insectary – NPHL

12.3.4 Emergency Response capacity maintained

13 National HIV/STI Programme

13.1 Background

13.2 The National HIV/STI Programme is currently guided by the National Integrated Strategic Plan for Sexual and Reproductive Health, 2014 – 2019. The National HIV Programme (NHP), led by the Ministry of Health, is delivered within a collaborative frame as the need for multisectoral involvement is critical. The participation of key government ministries and civil society in HIV various programmes has been a best practice in the HIV response. This multi-sectoral response has succeeded in maintaining adult HIV prevalence at a stable level below 2% since the mid-1990s. From inception of the HIV Programme, the Ministry of Health (MOH) had integrated HIV prevention, treatment, care and support services into the primary health care system.

13.2.1 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. Jamaica, while in a position to access further funding from Global Fund and PEPFAR (U.S. President's Emergency Plan for AIDs Relief), is only eligible for funding for programmes targeting only those most at risk thereby limiting the availability of support for other key strategies directed at the general population.

13.2.2 Sustainability of the National Programme is critical. It is important to develop and implement a sustainability plan for the HIV programme being mindful that fewer funding opportunities exist, and while 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 a new national strategic plan, documentation of the human resource needs for sustainability of programmes, negotiation with the Ministry of Health, Regional Health Authorities 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 programme. Other

important strategies include rationalization, integration with primary and secondary health care approaches, and government subventions for HIV-related NGOs.

13.3 Objectives

13.3.1 The HIV-specific objectives of the strategic plan are:

- 13.3.1.1 Reduce by half, the number of new HIV infections by 2019
- 13.3.1.2 Increase to 65%, coverage of ARV treatment for PLHIV by 2019
- 13.3.1.3 Increase to 90% the proportion of PLHIV on ART one year after initiating therapy
- 13.3.1.4 Reduce the number of HIV-related deaths by 25% by 2019
- 13.3.1.5 Eliminate vertical transmission of HIV by 2015

13.4 Status

13.4.1 Jamaica has an estimated HIV prevalence of 1.7% among the general population; however, surveys show higher HIV prevalence in at-risk groups. A 2017 survey of sex workers found that 2.0% of female sex workers were HIV infected; in 2011, a survey of 453 men who have sex with men (MSM) found that approximately one out of every three MSM was HIV infected; a 2006 survey of prison inmates indicated that approximately 3.3% of inmates are HIV positive, and a 2015 survey among homeless persons identified that 13.8% were HIV positive.

13.4.2 The AIDS mortality rate has declined from 17.6 deaths/100,000 population in 2011 to 13.0 deaths/100,000 population in 2016. There is continued targeted scaling up of the HIV testing programme, allowing for earlier diagnosis. In addition to the introduction of public access to antiretroviral drugs over a decade ago, drug availability for 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 30,000 persons are currently living with HIV in Jamaica with approximately 12% being unaware of their status.

13.4.3 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 that this is the major gap in the HIV treatment and care response. Failure to adhere to treatment and care is a barrier to further reducing transmission and AIDS morbidity and mortality. Stigma and discrimination have been a challenge for both the prevention and the treatment and care components of the HIV response.

13.5 Next Steps

13.5.1 Continue HIV testing to identify persons living with HIV (PLHIV)

13.5.2 Develop and implement programmes focused on improving linkage to care, retention in care, and viral suppression among PLHIV

13.5.3 Continued advocacy for funding to sustain the NHP, inclusive of the development of a sustainability plan and the engagement of civil society partners in service delivery

13.5.4 Advocacy for integrated SRH/HIV programmes for young people

Protecting the Health of Mothers and Children

14 Programme for the Reduction of Maternal and Child Mortality

14.1 Background

14.1.1 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.

14.1.2 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:

- 14.1.2.1 Newborn and emergency obstetric care;
- 14.1.2.2 Quality of primary health care services and referral system;
- 14.1.2.3 Health workers training and research;
- 14.1.2.4 Support to the health seeking behaviour of target population and the role of civil society; and
- 14.1.2.5 Institutional support for project implementation.

14.2 Objectives

14.2.1 PROMAC is expected to achieve the following objectives:

- 14.2.1.1 improved newborn and emergency obstetric care in eleven newly established high dependency units in six hospitals across the country;

- 14.2.1.2 improvements in primary health care services for high risk pregnancies; and
- 14.2.1.3 enhanced clinical knowledge and skills of health professionals

14.3 Status Overview Of PROMAC Components

14.3.1 Newborn and Emergency Obstetric Care (Component 1)

14.3.1.1 This component focuses on the establishment of nine maternal and neonatal High Dependency Units (HDUs) across five (5) ¹referral hospitals in Jamaica (Victoria Jubilee Hospital, Cornwall Hospital, Spanish Town Hospital, St. Ann's Bay Hospital, Bustamante Hospital for Children); a total of fifty-nine HDU beds (twenty maternal and thirty-nine neonatal), The component also includes the supply of maternal and neonatal hospital equipment to support the HDUs; a total value of €4,000,000.

14.3.1.2 For 2017/2018, the following were achieved under Component 1:

- 14.3.1.2.1 Successful completion of contract to supply Neonatal HDU equipment to Mandeville Regional Hospital
- 14.3.1.2.2 Civil works contracts for the construction of the HDUs at all facilities have been awarded.
- 14.3.1.2.3 Contracts in progress to procure and supply equipment for ten (10) remaining HDUs
- 14.3.1.2.4 Building applications for Cornwall Regional Hospital, Victoria Jubilee Hospital, Spanish Town and the Bustamante Hospital for Children have been approved.

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

14.3.2.1 Component 2 includes the physical rehabilitation of primary health care 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.

14.3.2.2 For 2017/2018, the following were achieved under Component 2:

14.3.2.2.1 Six (6) ambulances have been deployed to six (6) primary health care centres, namely, Mandeville, St. Jago Park, Annotto Bay, Savanna La Mar Health Centres; Chapleton and Alexandria Community Hospitals.

14.3.2.2.2 One hundred and fifty (150) fully equipped midwife bags have been delivered to the Ministry of Health for dissemination to the regions.

14.3.2.2.3 The Radiographic and Ultrasound equipment are being delivered to the four health centres and two community hospitals under the contract.

14.3.3 Health Workers Training and Research (Component 3)

14.3.3.1 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-Foetal Medicine; (ii) Anaesthesiology; (iii) Ultrasound diagnosis, (iv) training of nurses and other health care 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.

14.3.3.2 To date, the training achievements are as follows:

14.3.3.2.1 Fifty – one (51) scholarships awarded in the Doctor of Medicine Programme, short course in Ventilation and Obstetrics & Ultrasound under contract with the University of the West Indies

14.3.3.2.2 Ten (10) fellows trained in Maternal-Foetal Medicine, Critical Care and Neonatology to date

14.3.3.2.3 Nurses trained in specialist areas at the University of Technology: first cohort of twenty-two (22) nurses trained in post-basic midwifery; fifty nurses trained in critical care

14.3.3.2.4 Forty (40) nurses trained in post-basic neonatology through MOH In-service Training Programme

14.3.3.2.5 More than one thousand primary health care workers trained in neonatal resuscitation, obstetrics care and customer service

14.3.3.2.6 Twenty -five (25) dietitians and nutritionists trained in neonatal nutrition

14.3.3.2.7 Ongoing contract with the UWI to conduct academic research on the causes and risk factors of premature births in order to inform policy and programmes for prevention and management.

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

14.3.4.1 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.

14.3.4.2 **For 2017/2018 the following were achieved under Component 4:**

14.3.4.2.1 Contract executed with the Community Health & Psychiatry Department University of the West Indies in partnership with the Women's Resource

Outreach Centre Ltd. (WROC) to strengthen patients' rights in maternal, neonatal, and infants, and to improve the role and effectiveness of Civil Society Organizations (CSOs) in Jamaica in reducing maternal and child mortality

14.3.4.2.2 Successful completion of contract with Rise Life Management Services (R.I.S.E.), production of “Mobilizing Communities Manual for Improved Infant Health and Mortality,” as well as the mass media campaign “Healthy Baby Healthy You”.

14.3.4.2.3 PROMAC – NFPB Interim Communication and Visibility activities ongoing and successful thus far. Activities include segments on Smile Jamaica and Miss Kitty Live.

14.3.4.2.4 Successful award of services contract to Monitoring and Evaluation Consultant for the NFPB PROMAC Component to carry out baseline study, develop Monitoring and Evaluation (M&E) Framework and Plan with indicators and targets

14.3.5 Institutional Support for Programme Implementation (Component 5)

14.3.5.1 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 team's capacity in project management is a top priority (knowledge transfer).

14.3.5.2 **For 2017/2018 the following were achieved under Component 4:**

14.3.5.2.1 Training in Project Management for twenty-four MOH/Regional Health Authority officers at the Management Institute for National Development

14.3.5.2.2 External consultant completed baseline assessment for established M&E indicators

14.4 Next Steps

14.4.1 Newborn and Emergency Obstetric Care (Component 1)

- 14.4.1.1 Signing of the contracts for supervision for the establishment of the nine HDUs across the country
- 14.4.1.2 Commencement of civil works for the construction of HDUs by May 2018
- 14.4.1.3 Handing over of Maternal and Neonatal Equipment

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

- 14.4.2.1 Launch of tenders for supervision and civil works for the rehabilitation of the primary health care facilities
- 14.4.2.2 Distribution of fully equipped midwife bags to registered midwives in the regions

14.4.3 Health Workers Training and Research (Component 3)

- 14.4.3.1 Complete training of Doctors in Obstetrics Ultrasound (final cohort)
- 14.4.3.2 Continue training of doctors (2nd cohort) – short course in Fundamentals of Ventilation (Total 5 cohorts)
- 14.4.3.3 Commence training with 2nd cohort of nurses in post basic midwifery through the MOH In-Service Training Programme
- 14.4.3.4 Ongoing training of primary care health workers to build the capacity of the team

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

- 14.4.4.1 NFPB will be undertaking activities to address specific challenges in health seeking behaviour of women in the reproductive age group, including public awareness, which the Ministry of Health will continue to monitor activities as per approved work plan and budget.
- 14.4.4.2 The MOH will be working closely with the UWI Department of Community Health and Psychiatry/WROC on patient rights' advocacy initiatives.

14.4.5 Institutional Support for Programme Implementation (Component 5)

- 14.4.5.1 Regional epidemiologist to commence quarterly reporting on monitoring and evaluation indicators relating to maternal and child health
- 14.4.5.2 Alumni recognition ceremony in December 2018

15 Renewed National Oral Health Services

15.1 Background

15.1.1 Oral and Dental Health Services is a priority for the Ministry of Health, because oral health is integral and essential to general wellbeing. It is a determinant factor for quality of life for people of all ages. Oral disease burden and common risk factors such as sedentary lifestyles, tobacco and alcohol abuse, improper nutrition and obesity are significant predictors for chronic non-communicable diseases. During the period under review the Ministry's focus was on risk reduction for oral diseases and conditions. Hence, there was a re-orientation of the Oral Health Programme towards health promotion and disease prevention through the integration of other primary health care services, dental volunteer and humanitarian missions, public-private partnerships and the Jamaica Moves programme. The conceptual framework is that oral health promotion and prevention is the key to fundamental oral health improvement.

15.1.2 Good oral health matters to everyone and the health of our mouth and teeth are critical to daily living, for eating, communicating and self-esteem. There are consequences of poor oral health; these may be social, psychological and financial consequences and may manifest as halitosis (bad breath), chronic or acute orofacial pain, orofacial trauma, preterm low birth weight infant, heart attack, stroke and even oral cancers. Poor oral health can impact one's employability, a child's ability to learn, and productivity due to lost manpower hours.

15.2 Objectives

15.2.1 The aim of the National Oral & Dental Health Services is to ensure that the Jamaican population has ready access to the highest quality dental care in an environment that is safe, clean and friendly.

15.2.2 The main objectives of the National Oral and Dental Health Services are to:

- 15.2.2.1 To conduct oral health screening and surveillance programme within the target community
- 15.2.2.2 To provide prophylaxis and other preventative interventions to population subgroups
- 15.2.2.3 To deliver health education, outreach and health promotional services in schools and in communities.

15.3 Status

15.3.1 The Ministry of Health has exceeded its target of 20% coverage of the grade 1 to 6 cohort for the Dental Sealants and Fluoride Varnish campaign due largely to the collaborative efforts of the following organizations:

- Great Shape Inc
- UTech –College of Oral Health Sciences
- Corporate Sponsors such as Colgate Palmolive, Kirk distributors and Listerine.
- A Child’s Smile
- Christian Dental Mission
- Virginia Commonwealth University –Dental Programme
- International College of Dentistry
- Pierre Fauchard Academy

15.3.2 The Jamaica Moves initiative provided a significant platform for outreach and collaboration with our various programme areas.

Table 14.1. Results of the Outreach Activities

Outreach Activities Summary	Total
Total number of clients seen	6346
Total number of clients receiving health promotional package and product sampling	6000
Total number of dental prophylaxis	2546
Total number of periodontal scaling	3400
Total number of extractions	400

15.3.3 All clients were given instructions about the care of their oral health.

15.3.4 Through collaborative efforts, over 158,000 patients¹ were seen through Dental Outreach for the year.

15.3.5 On the matter of capacity, there remain significant challenges in the dental workforce leading to several service delivery gaps. Therefore for 2018/19 fiscal year, there will be advocacy for the incorporation of Dental Hygienists in the Services, due to the critical needs of this category of professionals as well support for the training of Dental Nurses/Therapists and Dental Assistants.

15.3.6 The Oral Health Services branch will be advancing the agenda for the establishment of the National Referral Centre for Oral & Dental Health Services in Jamaica for 2018/19 at the Ministry of Health's Arthur Wint Drive facility as a part of the Compassionate Care initiative toward improving "Access to Compassionate Oral Health Care". Special arrangements will be made with tertiary institutions, namely UTech, for the use of the facility for practicum for students at an agreed fee. The Centre will provide the following:

- Specialist dental public health advice and leadership on oral health issues and dental services
- Advice for the planning of dental services and the development of policy and strategy
- Assessment of oral health status and the needs and demands of local populations
- Advice on screening and surveillance programmes
- Advice and assistance with the implementation of local and national oral health action plans and health promotion programmes

¹ UTech Dental Programme collaborated in 132 outreaches across the island and contributed to 52,800 visits and 102 procedures were done; Great Shape Inc contributed to approximately 44, 000 visits and some ninety thousand procedures (90,000) being done, namely: Fillings, Root Canal Treatment, Prosthodontics - Dentures, Oral Surgery, Cleanings; Christian Dental Mission contributed to some 16,585 patients seen and about US\$800,000 worth of services; VCU Dental Programme 8,600 patients seen; A Child's smile 1548 patients were seen; Stony brook, Howard, NYU and many other Universities participated in our outreach activities

- Advise Regional Health Authority Boards on the monitoring and quality assurance of oral health services
- Support and advise Regional Health Boards in poor performance cases
- Support research and training, in-service training, as well as training in the specialty of Dental Public Health and other specialty programmes in conjunction with Education.
- Provide advanced clinical services
- Collaborate with the Bustamante Hospital for Children on the management of complex cases, especially with cleft lip and cleft palate cases.

Rehabilitation & New Investments in Critical Health Infrastructure

16 Cornwall Regional Hospital

16.1 Background

16.1.1 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.

16.1.2 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.

16.1.3 Over the last ten 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.

16.2 Status

16.2.1 In response to the poor air quality issues, the Ministry advanced the phasal scaling down of services in the main hospital building concurrent with rehabilitation works. From 2016 to the present, approximately 70% of operations have been

relocated and transferred as follows:

- The renting and retrofitting of the West Jamaica Conference Centre (WJCC) to house outpatient clinics
- The Obstetrics and Gynaecology clinic relocated to the Barnett Clinic.
- The Physiotherapy Department relocated to the WJCC.
- The Intensive Care Unit relocated to the Falmouth Hospital.
- The re-commissioning of two additional operating theatres at the Falmouth Hospital and the relocation of some surgical services to that hospital.
- Refurbishment of the male ward at the Noel Holmes Hospital to accommodate in-patients.
- Accident & Emergency Department relocated to the Mount Salem Health Centre
- Relocation of Chemotherapy services to the 8th floor to allow for the full continuation of this service.
- Containers purchased and retrofitted and laboratory services relocated to these containers
- Limited X-rays (CT examinations only) were being done on the third floor. X-ray services have been outsourced to Montego Bay Hospital and Hospiten Hospital. Radiographs are being done using the portable machine and by transfer of patients to Falmouth Hospital, Noel Holmes Hospital and Montego Bay Hospital (private). Ultrasounds are presently being done at the Mount Salem Health Centre.
- Approximately thirty social cases relocated to the Falmouth Infirmary with staff rostered to provide support.
- Containers were purchased and retrofitted and medical records relocated to these containers.

- Through the NHF Public-Private Partnership pharmacy initiative, pharmaceuticals from NHF are available at Hiltons, C&J's and Healthy Concepts Pharmacies.
- Temporary assignment of staff to the Savanna-La-Mar Public General Hospital to assist with general surgery and psychiatric cases
- Extended working hours were implemented at Community Primary Care Health Centres:
 - Westmoreland-Savanna la Mar Health Centre- extended working hours since October 2016
 - St James: Type V- Extended working hours since March 2017
- The staff quadrants located on the hospital compound was retrofitted and converted to accommodate approximately 160 in-patients, dietary and radiology departments, dental clinic, neo-natal intensive care unit, security and communication services, hospital administrative and nursing administrative staff.

16.2.2 United Nations Office of Project Services (UNOPS) was engaged in May 2017 to provide technical oversight and management of the rehabilitative works.

16.2.3 The design for the new Heating Ventilation and Air Conditioning (HVAC) System has been completed and submitted to the Ministry

16.2.4 During 2017, only essential services were in operation on the main hospital building; these services included limited ward spaces for surgical, obstetrical and gynaecology patients who required close proximity to the labour and delivery suite, special care nursery and operating theatres.

16.2.5 The staff clinic established in 2016 for the clinical management of reported cases remained operational. Reporting procedures and treatment regimen were established for patients, visitors and staff with symptoms of exposure.

16.3 Next Steps

16.3.1 Procurement of:

- Mechanical electrical and plumbing engineering consultants for redesign and supervision of the replacement of the mechanical electrical and plumbing system
- Architectural consultants with respect to the renovation of the operating theatres and rooms on the 5th floor, the A&E Department and the new façade to the building;
- Structural engineering consultants

16.3.2 Redesign and renovate building floors 1-3 and 8 -10

16.3.3 Installation of the new HVAC system

16.3.4 Establish additional medicine ward at the Falmouth Hospital to accommodate approximately twenty-four patients

16.3.5 Complete works at the Falmouth Hospital to accommodate a surgical ward

17 Smart Health Care Facilities in the Caribbean Project Phase (Scale-Up)



17.1 Background

17.1.1 The PAHO/WHO launched the Safe Hospital Initiative in the Caribbean in 2010 aimed at improving the safety of health facilities in disasters so that they will remain operational during and after a destructive event. The initiative provided support for member states in implementing the Plan of Action on Safe Hospitals 2010-2015 that included the training of assessors in hospital safety index, and the assessment of ten hospitals across the island using the hospital safety index tool. The assessments represent a composite total of three components: structural, non-structural and functional elements. Based on the composite assessment of each component, facilities are placed into one of three safety categories: High (A), Average (B) or Low (C)².

17.1.2 During the Plan of Action on Safe Hospitals 2010-2015, none of the ten hospitals achieved a grade A and only two of the ten hospitals received a B grade; the remaining eight were grade C.³

² These grades allow determination and prioritization of facilities that are most urgently in need of interventions to minimize the risks during disasters, and facilitate a mechanism for monitoring and evaluation of improvement activities.

³ A category C grade designates the health facility where the lives and safety of occupants are deemed at risk during disasters

17.1.3 The Safe Hospital Initiative was further developed to the Smart Hospitals Initiative with incorporation of climate change considerations for mitigation and adaptation, thereby improving environmental “greenness” of health facilities.⁴ The Smart Hospitals Initiative is designed to help health facilities in the Caribbean region make the transition to sustainability, reduce carbon footprints, and be more resilient and safer in the face of natural and man-made hazards.

17.1.4 With funding from DFID, it was launched in 2015 as a two-phased project for the Caribbean with duration from June 2015 to June 2020 and a total budget of £38.24 Million. Stipulations within the terms pertaining to project management in country included specific time frames and process flow that delineated eighteen steps leading up to the issuance of contracts for retrofitting.

17.1.5 Phase I saw to the development of a Smart Hospital Tool-Kit which comprised the following assessment instruments: Hospital Safety Index (HSI), the Baseline Assessment Tool (BAT),⁵ Green Checklist,⁶ and the Retrofitting Economical Support Tool (REST)⁷ which facilitates cost-benefit analysis (CBA) to support investment decision-making. These assessments provide territories involved in the project with evidence to inform prioritization and resource allocations.

17.1.6 Phase II is a scaling up of the project which saw to implementation in seven Caribbean Countries, including Jamaica, using the tool-kit developed in Phase I. This phase commenced April 2016 and activities started in Jamaica in August 2016.

⁴ “Greenness” for this initiative refers to improved electrical and water efficiency and enhancement of user comfort through improved indoor environmental quality.

⁵ BAT provides a baseline audit of energy and water consumption

⁶ The Green Checklist yields a rating between 0 and 100%.

⁷ REST, developed and provided by Florida International University, is used as an instrument to rank the order of prioritization for interventions within and among countries.

17.2 Status

17.2.1 Successful implementation of the project will realize three outputs:

17.2.2 Output 1: Health care facilities assessed in safe and green standards

17.2.2.1 For Jamaica, it was proposed that 150 facilities be assessed: one hundred by December 2017, and an additional fifty by May 2018. Assessment teams were constituted following a selection process based on project guidelines for participant profile and training. Participants included representatives from the MOH, National Works Agency, Jamaica Fire Brigade, Ministry of Economic Growth and Job Creation, Petroleum Cooperation of Jamaica, Parish Municipal Corporations and Regional Health Authorities. Achievement of this output is indicated by submission of completed reports to PAHO Smart Team.

17.2.2.2 Though ninety-four facilities were assessed up to the end of 2017, only thirty-nine complete assessment reports were submitted to PAHO. Challenges have been encountered with the completion and submission of assessment reports which has implications for roll-out of future project activities. PAHO will provide technical support to address these challenges.

17.2.2.3 Following the HSI and Green Checklist assessment and deliberations by the Project Steering Group five health centres were identified for retrofitting:

Table 17.1. List of Health Centres for Retrofitting

FACILITY	SMART GRADE	REST RANK
Mandeville Health Centre	C27	1
St. Ann's Bay Health Centre	B29	2
Stony Hill Health Centre	C21	3
Santa Cruz Health Centre	C22	4
Port Antonio Health Centre	C44	6

17.2.3 Output 2: Smart Standards implemented in selected health care facilities -

- 17.2.3.1 Five facilities were selected for retrofitting based on agreed criteria, as outlined in the Smart Toolkit, and the CBA.⁸
- 17.2.3.2 Selection of design firms for retrofitting works commenced with market engagement through provision of contractor's course. Selection of the firm is expected to be completed by April 2018.
- 17.2.3.3 In addition to the five facilities selected for retrofitting, eight other facilities are proposed to receive small Smart interventions. They are:
- Catherine Hall Health Centre
 - Duncans Health Centre
 - Albert Town Health Centre
 - Porus Health Centre
 - Seaforth Health Centre
 - Gayle Health Centre
 - Darliston Health Centre and
 - Sligoville Health Centre

17.2.4 Output 3: National and regional capacity to apply and promote climate smart health facilities standards enhanced

- 17.2.4.1 The major focus for realizing this output is an effective public relations strategy to an audience that includes the communities served by the shortlisted facilities, technical stakeholders (such as construction firms, engineering and geospatial information system users), climate change unit, and education and finance sectors. Indicators for this output include the number of public education or awareness campaigns to promote Smart concept across various groups, a knowledge attitude and practice (KAP) survey, and development of a survey that supports the collection of baseline information such as occupancy satisfaction survey. The purpose of the KAP survey is to support project monitoring and evaluation, to

⁸ The scope of retrofitting works should focus on the following: essential structural improvements, essential electrical improvements, roof, windows, doors, PV system, Back-Up generator including fuel storage, LED lighting, fire safety, water storage, rain water harvesting and handicap access.

enhance the project's information strategy and communication messaging and to identify gaps in knowledge about climate smart health facilities.

17.3 Next Steps

- 17.3.1** Through support from PAHO, a consulting firm has been engaged to conduct a further assessment to augment the findings of the BAT to identify the major equipment for energy and water usage within the health sector. This will entail site visits to the Bustamante Hospital for Children, the Princess Margaret Hospital and a health centre in St. Thomas, as well as interviews with facility managers and maintenance staff. The target grade to be achieved following smart interventions is A70, which is Grade Category A for HSI and minimum of 70% on the Green Checklist.
- 17.3.2** Survey of population served by facilities to be retrofitted; this will inform the development of a roadmap and investment proposal for continued roll-out of Smart Initiative
- 17.3.3** DFID Annual Review March 20-22, 2018
- 17.4** Update to staff of selected facilities and/or parish health departments and Regional Health Authorities
- 17.5** Completion of assessment and reports. A proposal for addressing outstanding assessment reports is to be developed.
- 17.6** Sign-Off on Inception Report and Design 1
- 17.7** Conservation Training: April 23-24, 2018
- 17.8** Contingency Planning Workshop April 25-27, 2018
- 17.9** Pilot ancillary staff training: July 2018
- 17.10** KAP Study following approval from MOH Ethics Committee
- 17.11** Kick-off meetings and site visits
- 17.12** Development and implementation of communication plan, including town hall meetings
- 17.13** Development/ review Facility Project Implementation Checklist by April 2018
- 17.14** Finalize decisions regarding Smart Interventions for the eight facilities.

18 Adopt-A-Clinic Programme

18.1 Background

18.1.1 Health centres have been a key component of Jamaica's primary health care system since the 1970s. The country has a three-tiered public health system (Primary, Secondary & Tertiary) wherein health centres serve as the first point of entry. Primary health care is organized by health districts through a network of health centres with different types of service delivery. There are three hundred and eighteen (318) health centres across the island that provide a range of services such as curative, health promotion and disease detection and prevention.

18.1.2 Over the years there has been considerable pressure on primary health facilities due mainly to demographic, socio-economic and epidemiological changes such as population increase, an ageing population, national fiscal constraints and high percentage of NCDs. There has also been a prevailing trend in using hospitals as the first point of access for clients. In the last six years, efforts have been undertaken to re-orient health centres as the first point of access (See Reduced Waiting Time for update on current initiatives) through improving primary health care by way of the following:

- An over \$1.5B invested in 156 facilities;
- Construction of six new health centres;
- Major infrastructure repairs and upgrades;
- Expansion of clinical, dental and pharmaceutical services in facilities, and;
- Technological upgrade of some health centres

18.1.3 Despite these efforts, many health centres still face maintenance and quality control challenges. The Ministry of Health 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. The adopter will be provided with a needs assessment of the facility, receive an annual report, have access to the facility, and may in some cases benefit from tax incentives. The MOH has identified and costed 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. In recognition of their donation, the respective facility will be branded in honour of these individuals and entities.

18.2 Objectives

18.2.1 The Adopt-A-Clinic Programme is designed to strengthen Primary Health Care (PHC) through Public Private Partnerships and Gift of Services. It will seek to accomplish this by inviting reputable individuals and organizations to be donors to health facilities across the island.

18.3 Status

18.3.1 The Ministry officially launched the Adopt-A-Clinic programme at the St. Jago Health Centre in Spanish Town in November 2017

18.3.2 Profiles of one hundred priority health centres have been developed and introduced to the diaspora through the project's website - www.adoptaclinicjamaica.co.uk

18.3.3 The Jamaican High Commission to the United Kingdom, working with the Ja55 Charities Group UK has adopted six clinics, including the Enfield Health Centre, in St. Mary. The plaque for the adoption of the Enfield Health Centre was unveiled on February 22, 2018.

18.3.4 Local corporate entities such as Seprod, Lasco, Tyre Warehouse, Massy Gas Products Limited, Rainforest Seafoods Limited, Rotary Club of North St. Andrew, Rotary Club of Negril, Mussons Group and Trade Wind Citrus have all committed to Adopt-a-Clinic, while VMBS has expressed interest in adopting fifteen health centres, at least one in each parish. Other corporate companies and individuals have expressed interest. Below is a breakdown of expression of interest in clinics per health region:

Table 18.1 Expression of interest by health centres

Health Region	Number of health centres
SERHA	21
SRHA	9
NERHA	11
WRHA	12
Total	53

18.4 Next Steps

18.4.1 The Ministry will subsequently finalize the MOU for the Adopt-a-Clinic Programme.

18.4.2 Promote Adopt-a-Clinic locally and overseas through increased focus on branding, publicity and brochures.

18.4.3 Explore the feasibility of establishing Adopt-A-Clinic as a Foundation