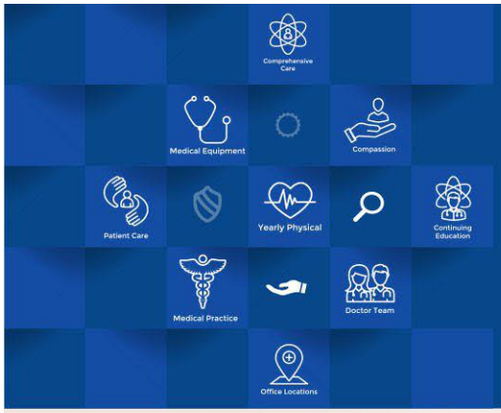


MINISTRY OF HEALTH & WELLNESS

# PRIMARY HEALTH CARE

## REFORM FOR JAMAICA

## 2021 - 2030


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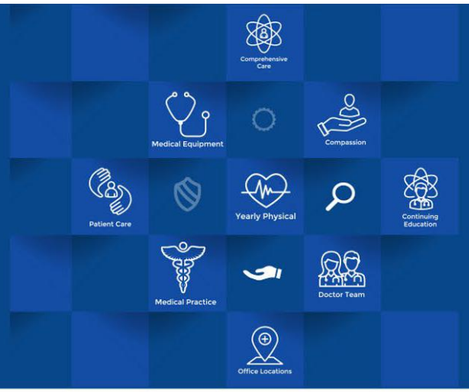


Dr. the Hon. Christopher Tufton, MP
**Minister of Health & Wellness**

The Primary Health Care Reform for Jamaica 2021-2030 signals our clear intention to meet the changing health needs of the population, including new requirements for the delivery of care in the shadow of the COVID-19 pandemic.

It details our vision for a re-imagined, comprehensive approach to improving primary care services across our facilities. This includes not only upgrading our physical infrastructure, but also making available human resources that are sufficient in number and competencies, and the introduction of an information systems for health that supports the delivery of care.

The next decade is to see the reorganisation of primary health care services to deliver on efficiency through an integrated health systems network replete with technologies that provide safe access to patient information and which allows for information sharing among health care providers and toward universal health coverage. This means that a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services should be within reach for all Jamaicans in line with their needs.

Ultimately, outcomes are to include earlier pick up of non-communicable diseases with routine screening; earlier initiation of treatment, including lifestyle modifications; in addition to improved management through electronic access to health records, diagnostics and therapeutic services; and a joined-up health system.

Also anticipated is improved compliance with treatment through improved community services, identifying and managing barriers to treatment as well as a motivated and skilled workforce enabled by increased access to mentoring, supervision and continuing education.

Innovation is a requirement to safeguarding the best possible health outcomes for Jamaicans using the public health system; and this is embodied in the Primary Health Care Reform for Jamaica.



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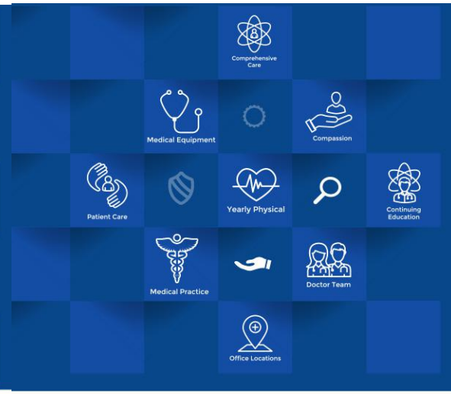
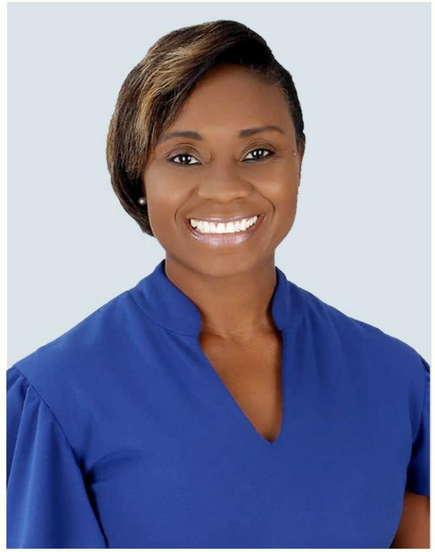



From the prevention and care management of non-communicable diseases to ensuring continuity of care during a pandemic or in the event of a natural disaster, the Primary Care Reform Plan 2021-2030 is designed to help Jamaica deliver on the best available quality of care to the population.

Its provisions put primary care as the first point of contact and at the core of the health system, through the integration of primary and secondary care facilities – including public health departments, diagnostic and therapeutic sites and hospitals. Its provisions also enable collaboration among health teams, as well as between public and private partners.

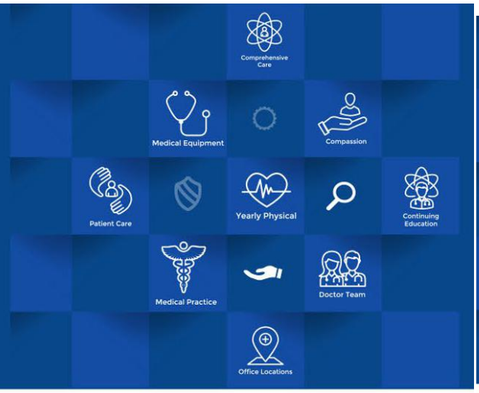
In this way, the health system becomes more responsive to the needs of vulnerable populations, including the chronically ill and disabled, persons with mental illness, the elderly, as well as low-income and/or homeless individuals. Further, it brings us closer to providing access to health services for all, when and where they need it, and without financial hardship.

With the triple threat of communicable diseases, non-communicable diseases and climate change, it has never been more important to reform the primary care system in order to support resilience. This includes the enhanced capacity to not only handle current and emergent health problems, but also to provide needed oversight for people as they progress along the life course. This plan is, therefore, as welcomed as it is timely.



The Hon. Juliet Cuthbert-Flynn
**State Minister**
Ministry of Health & Wellness

# MESSAGES




Mr. Dunstan Bryan
**Permanent Secretary**
Ministry of Health & Wellness

The reform of primary health care has never been more important than as Jamaica seeks to build back better with the realities of the COVID-19 pandemic, and accelerate progress toward universal health coverage.

The Ministry of Health & Wellness is, therefore, pleased to present this new plan for Primary Health Care Reform, which plots a course to health system resilience that is 'paved' by the creation of a network of reorganised health facilities; the integration of an information systems for health; and new policies and programmes that help to retain and attract talent into the public health sector.

The plan also supports collaboration between public and private partners that enables the delivery of the highest level of population and individual care services across the life cycle, and which is the best investment that can be made in the human capital of any society: good health.



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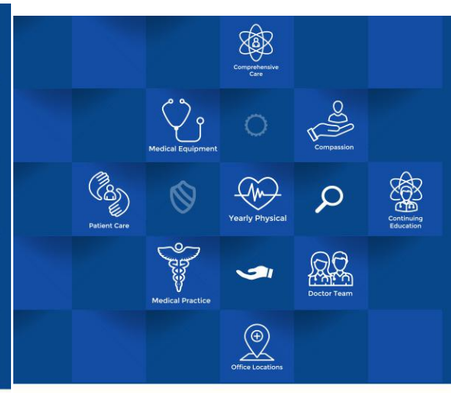



Jamaica's health system has a strong foundation in primary health care. Over the last 4 decades since Alma Ata, Jamaica has gone through a demographic and epidemiological transition that has created new demands in primary health care. The goal for universal access and universal health coverage can only be achieved through building on the existing foundation to ensure that the changing demands for health services are met by an upgraded and responsive primary health care system.

The reform of primary health care for Jamaica will see changes in infrastructure, human resources and a change to a patient centric, integrated model of care. This is no easy task and will be implemented over the next ten years in keeping with the Ministry of Health and Wellness's 10 year strategic plan. This reform will revolutionize the health care landscape and is expected to have a great impact on morbidity and mortality for many years to come.

It has been my greatest pleasure to review Jamaica's rich primary health care history and the works of several public health stalwarts in writing this document. What is presented incorporates the ideas of many and is the collective vision for primary health care in Jamaica. The engineering of this change will require commitment from all stakeholders.

Dr. Jacquiline Bisasor-McKenzie
**Chief Medical Officer**
Ministry of Health & Wellness

# ACKNOWLEDGEMENTS

This document represents the vision of the health sector for primary health care and will be implemented over the next ten years. I want to acknowledge the persons that contributed to the discussion and those that contributed material for inclusion. The micro-plans that will follow will document the further contributions from all areas covered in primary health care.

| | |
|---|---|
| **Mr. Everton Baker** | Environmental Health Unit, MOHW |
| **Dr. Karen Webster – Kerr** | National Epidemiologist, MOHW |
| **Dr. Simone Spence** | Health Promotion & Protection Branch, MOHW |
| **Dr. Nicole Dawkins-Wright** | Emergency Disaster Management Branch, MOHW |
| **Dr. Naydene Williams** | Health Services Planning & Integration Branch, MOHW<br>Nutrition Unit, MOHW |
| **Dr. Irving McKenzie** | Chief Dental Officer, MOHW |
| **Mrs. Patricia Ingram- Martin** | Chief Nursing Officer, MOHW |
| **Dr. Michelle Roofe** | Health Informatics, MOHW |
| **Ms. Joi Chambers** | Adolescent Health, MOHW |
| **Prof. Denise Eldemire Shearer** | Mona School for Aging, UWI |
| **Dr. Melody Ennis** | Family Health Unit, MOHW |
| **Dr. Kevin Goulbourne** | Mental Health Unit, MOHW |
| **Mr. Nicholas Ford** | Physiotherapist, MOHW |
| **Mrs. Dyer Mcken** | Radiographer, MOHW |
| **Dr. Dingle Spence** | Palliative Care |

*Dr. Jacquiline Bisasor-McKenzie*

Dr. Jacquiline Bisasor-McKenzie
**Chief Medical Officer, Ministry of Health & Wellness**



MINISTRY OF HEALTH & WELLNESS

# PRIMARY HEALTH CARE REFORM FOR JAMAICA

## 2021 - 2030

# EXECUTIVE SUMMARY

**1** Though there have been several attempts at reform in primary health care since 1978, the organization and scope of primary health care services have remained the same despite changing needs of the population. Improvements to the health system have focused on development and expansion of hospital services. New and expanded primary care centres have been constructed over the years but there has been no implementation of an overarching system approach to the improvement of primary health care in Jamaica. A review of the system now has taken into consideration the demographical and epidemiological transition that has occurred since 1978.

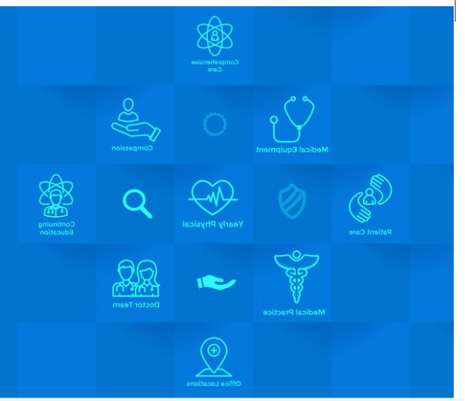
**2** Despite a geographical distribution that allows for access and a structural framework that is conducive to integration of health services, the seamless movement of patients, continuity of care and sharing of information has not been achieved. Over time there has been a change in the needs of the population as well as advances in medicine and medical technologies. This reform seeks to improve the existing system by incorporating strategies for integration, and, developing mechanisms to coordinate health care services in the public and private sectors.

**3** Jamaica's Primary Health Care Reform 2021-2030, will through the network of facilities ensure delivery of population based and individual care services, allow for access to the services by all the population and the delivery of service that meets the needs of the population at the different life stages and will facilitate escalation of services through horizontal and vertical integration. Integration of services does not only refer to integration of clinical services but must also ensure that there is feedback from clinical treatment sites to drive prevention and health promotion programmes in all primary health care programmes.

**4** The reason for the need for change in the organization of primary health care services and the expanded scope of services is the evolutions that have occurred in the health needs of the population. The epidemiological and demographic profiles have gone through transition phases with the result being a shift to non-communicable diseases being the leading cause of deaths and the elderly population have increased as life expectancy has increased. The management of diseases have evolved, and several scientific advances made where early interventions improve morbidity and mortality rates. Also, the environmental impact of climate change and socio-economic factors are impacting more on disease causation and outcomes.



EXECUTIVE SUMMARY




**5** A necessary part of this Primary Health Care Reform is the recognition that primary health care services include both population services and individual care services. Individual care services include curative or treatment services that is the first or primary level of clinical care. Population health services and the first (primary)level of clinical care services are different streams of services included in the overall scope of primary health care. The primary care clinical services are the first line of clinical services in the continuum of primary-secondary-tertiary levels of clinical care. Adequate clinical supervision of the first tier of clinical services have been lacking and is a critical part of ensuring comprehensive quality care.

**6** The scope of primary health care in this reform will be expanded for both population health and individual health care services. The priority programmes of the Ministry of Health as documented in the Ten Year Strategic Plan are within the scope of primary health care and it is therefore imperative that Primary Health Care Reform prioritizes these programmes and that the health care system is well developed to deliver on these priorities. Primary health care provides opportunities for disease prevention and health promotion as well as early detection of disease and is not just about treating common ailments. Population services encompasses programmes that manages the health of the population and focuses on prevention and monitoring. These include Environmental health, Monitoring and Surveillance, Health Promotion and Education, Emergency Disaster Management, Social Intervention programmes. Individual care services encompasses programmes that manage the individual and includes Maternal and Child Health, Treatment of specific illnesses, Sexual and Reproductive Health, Oral Health, Mental Health and Substance Abuse and also programmes that cater to the care of specific groups such as Adolescent Health and Elderly Health. While there is no demarcating line between health services, it is important that adequate resources are provided for both clinical care and other public health programmes.

**7** The population is encouraged to enter the health system through the primary care centres from birth. Preventative and Curative services are organized using the Life Stage approach to ensure that all persons who encounter the Health System at whatever stage of the Life cycle will benefit from a comprehensive package of services that is applicable to their stage in life. This package is also determined by the epidemiological profile of the community. The service revolves around the client, their immediate and future needs, and links them to services seamlessly, utilizing developed information systems, thereby encouraging compliance. The package is developed to ensure that the needs of the following age groups are addressed: Fetus – Maternal Care – Pregnancy, Infant, Child, Adolescent, Adulthood- (Gender) Health, Adulthood-Elderly Health. The implementation plan will include the training of staff in the new approach to service delivery. A change management will be developed in Phase 1 of implementation.

# EXECUTIVE SUMMARY

8 The Redesigning the Health System in Jamaica was described by Goffe and McCartney from as early as 2004. A subsequent version of the document, Redesigning of Jamaica's Primary Care System and Services was produced and approved for implementation by Cabinet in 2016. Both documents proposed the reorganization of health centres into Community, District, Parish and Comprehensive centres instead of Type 1-5 health centres previously described in the Primary Care Perspective. The implementation of the primary healthcare reform in the framework of the Ten-Year Strategic Plan (2021-2030) will see three levels of health centres established.

There will be three categories of Health Centres that will replace the existing five categories: Community, District/Parish (The service offered is at the District level but this may be the Parish Health Centre), Comprehensive/Parish (The service offered is at the Comprehensive level but this may be the Parish Health Centre)

A basic suite of services will be routinely offered at each health centre type with the Community Health Centre providing more reliable services that meet the needs of the population. Acute and Chronic care for Communicable and Non communicable diseases will be available at all health centre types with more comprehensive services being offered at the higher levels. The implementation plan will see the assessment and upgrading of health facilities to meet the service needs of the population.

9 The success of this programme is dependent on a supply of health care workers to provide the designated services. This expansion of services in the primary care centres will see new and upgraded professionals in Primary Care. The ***Medical Staff Policy and Procedures Manual*** will be reviewed to reflect this. The implementation plan will see the development of a Human Resources for Health Plan for Primary Health Care. This will be done with the development of Micro Plans for each service, the staff requirements, organizational plan for each service and facility and the conducting of a gap analysis exercise. The expansion of scope and the documentation of the organizational structure in the health departments and regional offices where all programmes are managed will also result in an increased demand for skilled staff. New strategies for engagement of health care workers will be developed.

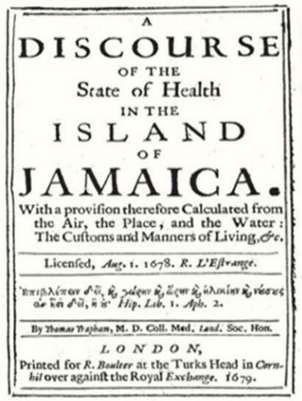
There is also need for supporting policies for governance, expansion of workforce and an integrated health service network that allows movement of patients through all levels of the system, sharing of information and movement of staff between primary and secondary care.

[1]Goffe & McCartney: Redesigning the Health System in Jamaica; A proposal. 2004. Revised 2004,2005,2006,2008
[2]Goffe. Redesigning of Jamaica's Primary Care System and Services 08.01.14
[3]Cabinet Approval 2016



# CHAPTER 1
## BACKGROUND & INTRODUCTION

The health system in Jamaica had its birth in the colonial period and its history is embedded in the plantation system. Estate based services and military based services were the main means through which health care was delivered. These catered minimally to the slaves and when the first public hospital, the Kingston Public hospital was established in 1776, it was for whites only. After the abolition of slavery, several social changes occurred that triggered development of the health system. No provisions though were in place for the free slaves generally. This led to increase in outbreaks of communicable diseases such as cholera and yellow fever.


A
DISCOURSE
OF THE
State of Health
IN THE
ISLAND
OF
JAMAICA.
With a provision therefore Calculated from the Air, the Place, and the Water: The Customs and Manners of Living, &c.
Licensed, Aug. 1. 1678. R. L'Estrange.
Hip. Lib. 1. Aph. 2.
By Thomas Trapham, M. D. Coll. Med. Lond. Soc. Hon.
LONDON,
Printed for R. Boulter at the Turks Head in Cornhil over against the Royal Exchange. 1679.

With the appointment of Governor Sir John Grant after the dismissal of Governor Edward John Eyre in 1865, the development of an organized health system began. This saw the enactment of the Public Health Law in 1867 and later resulted in establishment of the Island Medical Services or the Central Board of Health in 1875.[5]

Most development in the health sector occurred after World War I in response to the high infectious disease mortality rates. The Rockefeller Foundation was asked to assist with the control of hookworm, tuberculosis, malaria and yaws. Its recommendations led to the growth of public health programmes (eg. environmental health, public health nursing, community midwifery) alongside community-based curative services run by hospitals.

The most significant period of development occurred in the 1970s when the various vertical programmes were integrated into the current primary care system. Jamaica contributed to the development of the World Health Organization's Alma Ata Declaration on Primary Health Care, tabling the "Jamaican Perspective on Primary Health Care" which set out its goal that all citizens should be within 10 miles walking distance of a primary health care facility. [6]

The Primary Care perspective sets out how primary health care was to be structured, organized and delivered in the 1970's. Several gaps were identified at that time including inadequate human resources and an information system that would allow timely reporting and responsiveness. These gaps remain and have prevented the achievement of the full potential of the system described.

At the close of the twentieth century, the health reform process led to the development of Regional Health Authorities that were aimed at integrating the management of primary and secondary care, under four Regional Boards of Health. This has led to a change in the role of the central Ministry of Health to one of governance, policy making, setting standards and regulations, and monitoring and evaluation of the quality of health care.

[5] Campbell,A.(2018)The Jamaican Public Health System from the 17th -21st Centuries
[6] Moody,C. (1978) Primary Health Care: The Jamaican Perspective

BACKGROUND & INTRODUCTION

# CHAPTER 2

## AN INTEGRATED HEALTH SERVICE DELIVERY NETWORK

Though there have been several attempts at reform in primary care since 1978, the organization and scope of primary health care services have remained the same despite changing needs of the population. Improvements to the health system have focused on development and expansion of hospital services. New primary care centres have been added and health centres have been expanded but there has been no implementation of an overarching system approach to the improvement of primary care in Jamaica. A review of the system now must take into consideration the demographical and epidemiological transition that has occurred. While the definition remains for the most part the same, the reorganization, strengthening and broadening of services is critical to deliver the health care that is now needed by the general population.

The definition of primary health care developed for Jamaica in the 1970s is still relevant today:

***Primary health care includes those services that can be provided to all the population at the most peripheral and practical level and should be considered the entry point into the health care delivery system.***

***Primary health care integrates at the community level promotion, specific prevention, early detection, curative, reduction of disabilities, rehabilitation, and community development activities.***

***It should encompass the total picture of man and his environment. Primary health care requires the mobilization of available community resources especially those that have remained untapped.***

***In a well-integrated system of health care delivery, the primary level increases the accessibility to the other levels of care to those who need it through its screening function .*** [7]

[7] Moody,C. (1978) Primary Health Care: The Jamaican Perspective



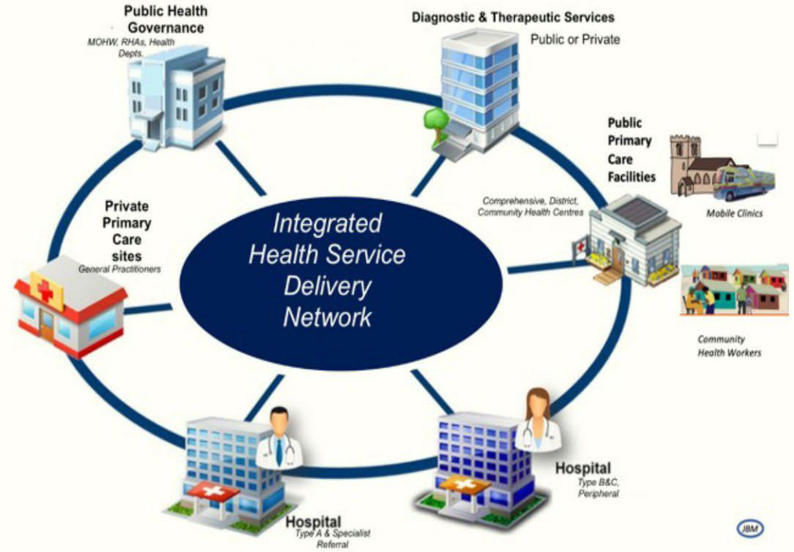


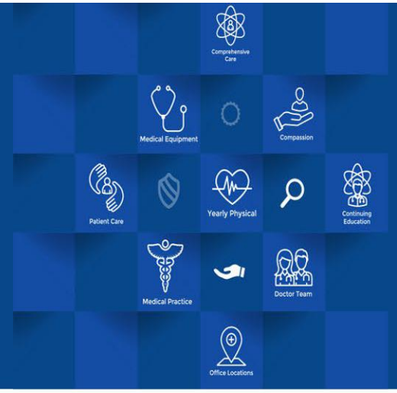

Figure 1: Integrated Health Service Delivery Network

The reorganization of primary health care services at this time must ensure that the Jamaican health system delivers comprehensive, integrated, and continuous health services through an Integrated Health Systems Network. Integrated Health Service Delivery Network (IHSDN) can be defined as “a network of organizations that provides, or makes arrangements to provide, equitable, comprehensive, integrated, and continuous health services to a defined population and is willing to be held accountable for its clinical and economic outcomes and the health status of the population served. [8]

The management and delivery of health services will provide a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation, and palliative care services, through the different levels and sites of care within the health system, according to the needs throughout the life course. [9]

[8] Shortell SM et al. Building integrated Systems: The Holographic Organization. Healthcare Forum Journal 1993;36(2):20-6

# AN INTEGRATED HEALTH SERVICE DELIVERY NETWORK


AN INTEGRATED HEALTH SERVICE DELIVERY NETWORK

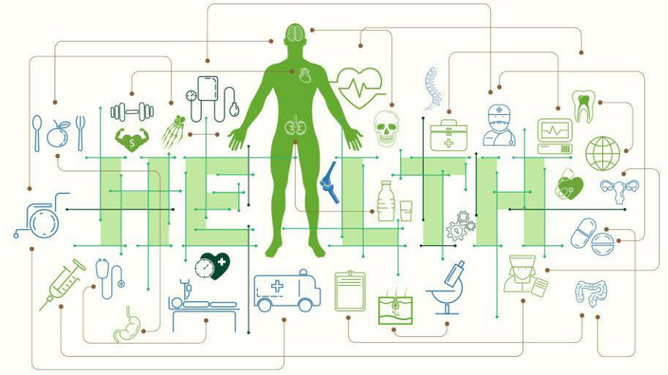
The model for primary health care (PHC) service that characterizes the Jamaican Health system has been seen as a best practice and was highlighted at the Alma Ata Conference in 1978 [10] and again at the 40th Anniversary of the Alma Ata Declaration at Kazakhstan in 2018 [11] . This model includes a system of interlocking public primary care centres called health centres that places the health centre close to the population allowing that no one should have to travel more than 10 miles to reach a health centre. There are five levels of health centres (Type 1 to 5) and there is an increasing range of services offered at the higher levels. It also includes a health department from which the public health care services are managed and coordinated.

The island is divided into 13 health departments and 63 health districts so that there is a dedicated set of staff that are responsible for the health outcomes of the district and the parish. Despite a geographical distribution that allows for access and a structural framework that is conducive to integration of health services, the seamless movement of patients, continuity of care and sharing of information has not been achieved. Over time there has been a change in the needs of the population as well as advances in medicine and medical technologies. This new model seeks to improve the existing system by incorporating strategies for integration, and developing mechanisms to coordinate health care services in the public and private sectors.

Various attempts have been made across the world to improve the primary level of care. Central to efforts to strengthen PHC is the development of models of care that promote a comprehensive vision of PHC. This includes ensuring that population-based services are adequately prioritized and that there is good coordination between public health and the first level of care. The Jamaican model of Primary health care prioritizes and coordinates both population-based services and individual care services. The public health department located in each parish is the hub of population services and the coordinating and monitoring centre for individual care services delivered at the health centres.

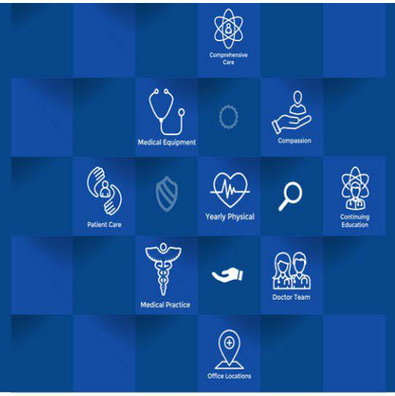
[9] Renewing Primary Health Care in the Americas. No. 4. Integrated Health Services Delivery Network
[10] McCaw-Binns A, Moody CO. The development of primary health care in Jamaica. West Indian Med J. 2001 Sep;50 Suppl 4:6-10. PMID: 11824020.
[11] WHO/HIS/SDS/2018.28






For individual health care services, the health system is to be reoriented to ensure that primary health care is both the first point of contact and the core of the health system, linked to all other levels of care and services. The health centre is the centre that offers the first level of clinical care as well as other individual care services. Other primary health care functions are also based at the different levels of health centres. Health centres will be classified as community, district and comprehensive health centres. The next levels of clinical care are in the hospitals. Hospitals are classified according to the complexity of services offered from Type C to A with Type A offering the most complex services. The first contact occurs from the development of the fetus in antenatal clinics and continue through the life stages from childhood to adulthood. As an individual's health needs change, there should be access to all primary health care services including prevention and early detection programmes, through horizontal integration of all service delivery sites. As the demands for secondary and tertiary care becomes evident, there should be seamless transition afforded by vertical integration of the different levels of health service delivery. Vertical and horizontal integration of services will require that the health centres and hospitals are linked through information systems management that allows the seamless flow of patients from one service delivery site to the next.

The delivery of primary health care that is continuous, comprehensive, coordinated, and people-centered has been facilitated by entrusting the health of defined geographical communities to specific teams assigned to the health districts and regions. Strategies are developed to ensure that primary health care is involved in addressing both existing and new health problems and has an oversight role for patients progressing along the pathways of the life stages as well as the pathway of a particular clinical condition. The coordination of services will be an important inclusion in the primary health care reform. To ensure comprehensiveness, where feasible the first level of care needs to take responsibility for managing chronic and noncommunicable diseases (including mental health) and associated factors across the continuum of care, including prevention, promotion, treatment, rehabilitation, and palliation. This includes the extension of primary healthcare, through programmes that support home health care and self-care . [12]


AN INTEGRATED HEALTH SERVICE
DELIVERY NETWORK

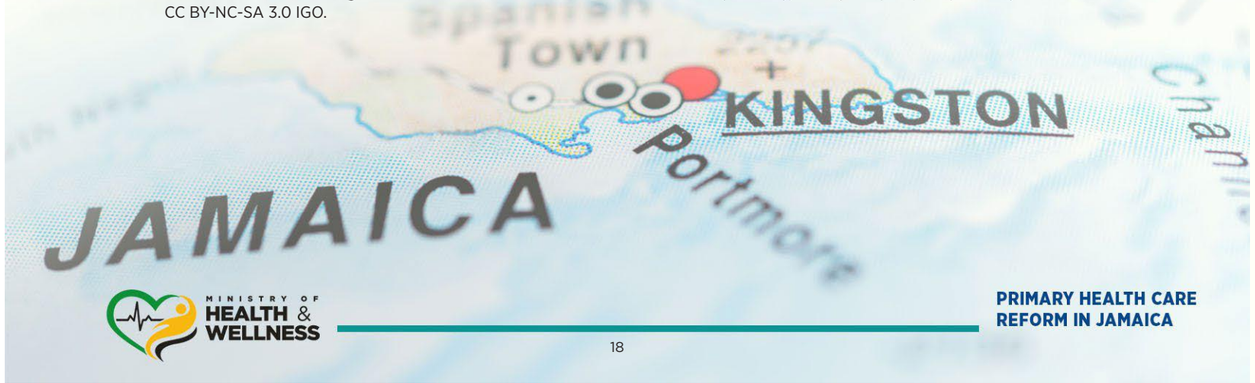
## ROLE OF PRIVATE SECTOR

Jamaica's strategy for delivering primary care to the population has been centered around the public facilities and utilization of health centres for primary care and hospitals for secondary care. Private primary and secondary care centres are utilized by the population. However, the cost of health care is a barrier to access to a large section of the population and the provision of government funded services is relied upon by many.

Strategies implemented in different countries include (1) delivery of primary care services in hospitals in out-patient clinics or through the emergency departments (2) a reliance on private practitioners to provide primary care services to the population. The success or failure of the different strategies lie in whether barriers to access are created by the different models of service. Geographical access to care in Jamaica is assured by division of the country into health districts and the provision of health centres in all health districts. Centralization of care to hospitals would create transportation barriers and would prevent timely access to care. Due to low insurance coverage and large out of pocket expenditures, health expenses pose a significant threat to the well-being of many. Government funded facilities therefore remain a critical part of the landscape for the Jamaica to achieve universal access to care.

In this Primary Health Care Reform, both public and private facilities for primary care are utilized. Jamaica's Primary Health Care Reform 2021-2030, through a network of public and private facilities ensures delivery of population based and individual care services, allows for access to the services by all the population and allows for delivery of service that meets the needs of the population at the different life stages and allows for escalation of services through horizontal and vertical integration.

[12] A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF); 2018 (WHO/HIS/SDS/2018.15). Licence: CC BY-NC-SA 3.0 IGO.





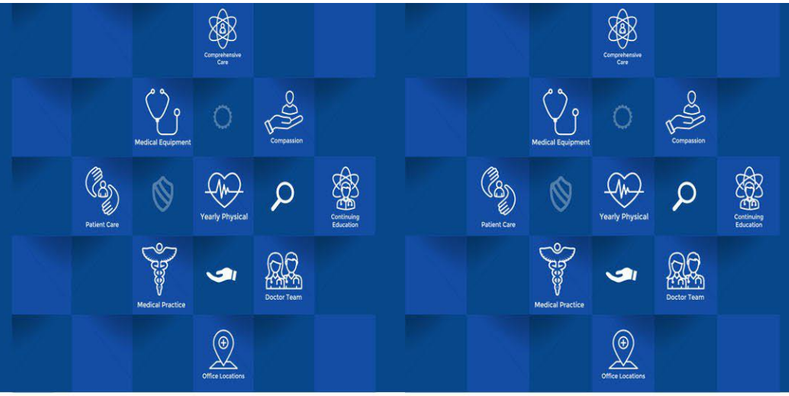

The private sector plays an important role in all health systems and in some countries provide the majority or all individual care services. The integration of private providers in the service delivery network will allow for capture of the true demand and supply of health care services and allows for better planning and policy making. Primary care services provided by private providers must align with services in the public sector and governance arrangements must be put in place to facilitate monitoring and reporting. Public facilities must also improve in the areas of customer service, patient confidentiality and patient participation in their management.

Private providers may independently carry out services with introduction of requirements for reporting or there may be purchase of services by the government with clear conditions for engagement. There are different types of legal arrangements that can be put in place including public ownership of clinics with private management, using public financing to support private activities and full-scale privatization of some health services. Different arrangements may be used simultaneously to achieve a certain level of care.

In countries where private providers provide all or most of the care, there is an almost 100% coverage by voluntary private insurance or mandatory national insurance. Systems are usually in place in these countries to regulate the private sector to ensure adherence to appropriate standards of care. The engagement and integration of the private sector about quality care will be a bold step in primary health care reform in Jamaica. Approaches will be adopted that promote their participation in planning, training, and monitoring.

Jamaica is moving towards a national insurance for health services. Mandatory national insurance could provide a basic package of care decided on by national authorities, but patients can access other care using private insurance. The proportion of medical care that is provided by voluntary private insurance vs mandatory national insurance will depend on financing that is available from public sector and other sources of income.

For Jamaica, a primary care model now must allow for changes in the future that may see a National Health Insurance that allows all the population access to a basic package of care that can be achieved through private or public facilities. The model must also allow for the evolution of the service over time with regards to proportion of persons who access care in the public health centre or the private health centre. The new model takes into consideration that all 63 health districts must be served by primary care sites, all persons must have access regardless of whether they have health insurance, and at each level, service must be comprehensive and of high quality. It also takes into consideration that there must be a framework that allows for delivery of population or public health services as well as the individual services in different settings. The Primary Health Care Reform 2021-2030 is therefore an improvement on the existing model using the public health centre network as the backbone of the service delivery in primary health care with allowances for inclusion of other strategies for service delivery.




AN INTEGRATED HEALTH SERVICE DELIVERY NETWORK

## SERVICE DELIVERY NETWORK

The proposed network will have the attributes of a PAHO/WHO defined IHSDN. It will link the public health department, the primary care service delivery sites, and the hospitals. There will be a broad range of health facilities for primary health care that will include the coordinating centre for population health services and clinical services that is the Parish Health department, and the service delivery sites which will include diagnostic and therapeutic centres. For treatment and prevention services, the public health centres will be upgraded to provide more comprehensive services and public/private partnerships will allow for private primary care physicians to be engaged thus making a comprehensive set of services more widely accessible to the population. Also, community engagement and involvement will be provided through community health workers and special clinics through mobile services. Health care will be provided in different settings including homes, schools, workplace and community. At the first level of care, the health centres will cover the entire population and will integrate and coordinate with the higher levels of care to meet most of the population needs.

The first level of care will not be limited to the delivery of basic health services at the health centres, but multi-disciplinary teams will be engaged to include specialists from different disciplines who will provide health services at the primary level. Care will be patient centered, meaning that it will take into consideration the physical, mental, emotional, and social dimensions of the person throughout the life course. The development of a Chronic Care Model will create an organizational approach to caring for people with chronic diseases in the primary care setting utilizing community resources, health system resources, care delivery systems and a clinical information system that will allow for patient self-support and informed decision making.

Specialized services will be delivered at the most appropriate location and not be confined to hospitals. The utilization of specialists from hospitals to support a more resolutive care at the primary level will be a part of this integrated service. Access to patient information and appointment systems at different sites will enable the seamless flow of patients from one service delivery site to the next. This will prevent duplication of effort and resources and result in cost saving and better management of resources.

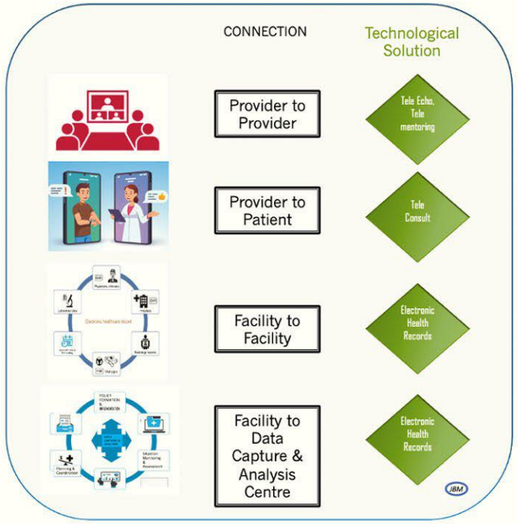



***Figure 2:*** *Health Technologies for Primary Health Care*

The government of Jamaica will look at ways to ensure a sufficient, competent, and committed workforce through the exploration of new policies and strategies to retain health care workers. Adequate funding and financing will be essential for the delivery of this model. Primary health care reform will complement the Secondary Care reform and together will constitute the Integrated Health System Delivery Network for Jamaica. The reorganization of health centres and health departments is outlined in this document as well as the services offered and the strategies for providing the workforce needed. Inherent to these descriptions will be the mechanisms and methods for coordinating and integrating care.

## INFORMATION SYSTEMS

Critical to the process of integration is a Health information System that will facilitate mechanisms to coordinate care throughout the health service continuum. Provider to provider communication for better patient management and continued medical education, provider to patient connection for improved continuity of care and decrease in overcrowding and long waiting times, facility to facility connection for coordination of health services and improved access to information and facility to coordinating and monitoring site for timely data capture and analysis are all areas that will require technological solutions that will be the supporting framework for the integration of services.

# CHAPTER 3

## RATIONALE FOR REORGANIZATION OF SERVICES & EXPANDED SCOPE

The reason for the need for change in the organization and scope of primary health care services and the expanded scope of services is the evolutions that have occurred in the health needs of the population. The epidemiological and demographic profiles have gone through transition phases with the result that non-communicable diseases are the leading cause of deaths and the elderly population have increased as life expectancy has increased. The management of diseases have evolved, and several scientific advances made where early interventions improve morbidity and mortality rates. Also, the environmental impact of climate change and socio-economic factors are impacting more on disease causation and outcomes.

The primary health care service has to change to meet demands of the new and evolving diseases caused by the cultural, environmental, social and economic changes and the proportionate needs of different age groups as well as keep up with medical and technological advances.

The Primary Care Perspective set out in 1978 how the Primary Health Care Network was to be organized. At that time, major driving issues included the occurrences of vaccine preventable diseases and other infectious diseases such as gastroenteritis and respiratory illnesses and sexually transmitted diseases such as syphilis.

In the 1960s, Jamaica was in the early stages of a demographic transition. With the improvement of health status of the population, death rates from communicable diseases decreased and there was an increase in birth rates [13] . The role of the midwife was expanded in the 1970s to provide quality maternal and child health services to the rural areas that were underserved by medical personnel. Many admissions to hospitals for deliveries were for normal deliveries while many deliveries [14] were happening in the communities with late or no presentations of pregnancy related illnesses. Non-communicable diseases such as Hypertension and other cardiovascular diseases were identified as common cause for admissions but were not the major focus at the time. The primary care network was organized to allow for no person travelling more than ten miles to access service. The thrust for adequate care for the pregnant woman, the young child and the prevention of infectious diseases especially Gastroenteritis, Respiratory illnesses and vaccine preventable illnesses was translated into an emphasis on the first line of service being Maternal and Child Health (MCH) services. The MCH clinics (Type 1 and Type 2 Health Centres) were positioned to be close to the patient to improve morbidity and mortality in these patient groups. These represented the largest numbers of health facilities.

[13] Primary Care: Jamaica's perpective
[14] Primary Care: Jamaica's perpective





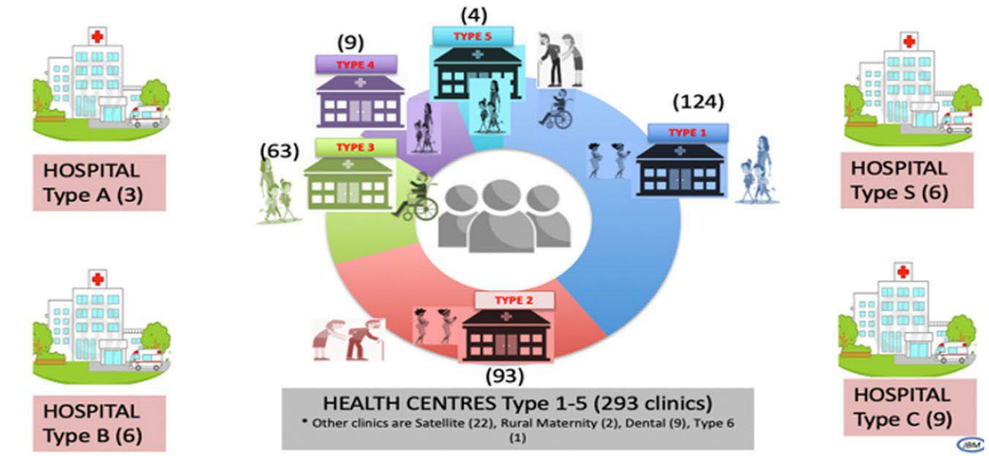
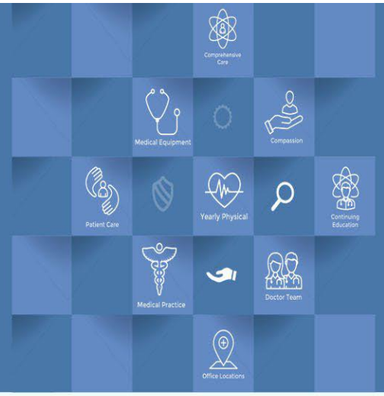



***Figure 3:*** *Overview of Public Health Care facilities*

At the turn of the twentieth century, Jamaica's epidemiological profile is marked by a declining burden of communicable diseases and a considerable increase in non-communicable diseases. Recent national surveys among adults 15-74 years of age show an upward trend in the prevalence of overweight and obesity, hypertension, and diabetes. Currently, 1 in 2 Jamaicans are obese, 1 in 3 have hypertension and 1 in 8 have diabetes. [15]

Jamaica is currently at an advanced stage of the demographic transition.[16] It has a declining 0-14 age group and an increasing working age group and dependent elderly population. The aging of the Jamaican population has implications for chronic disease prevalence and management and utilization of health services.

[15] The Jamaica Health and Lifestyle Survey 2016-2017
[16] Economic and Social Survey of Jamaica (ESSJ), Planning Institute of Jamaica 2019




RATIONALE FOR REORGANIZATION OF SERVICES & EXPANDED SCOPE


Jamaica is currently at an advanced stage of the demographic transition . It has a declining 0-14 age group and an increasing working age group and dependent elderly population. The aging of the Jamaican population has implications for chronic disease prevalence and management and utilization of health services.

In 2016, NCDs accounted for 12,577 or 68.4 per cent of all deaths (18,373) five years and older in Jamaica. Between 2010 and 2016, the number of deaths due to NCDs increased by 21.6% (from 10,344 in 2010 to 12,577 in 2016). [17]

With these numbers, we are compelled to make changes to improve early detection and management of new and established diseases, particularly since our youth, the future of our society, have not been spared. Obesity in students 13-15 years old, for example, increased by 68.3% from 6% in 2010 to 10.1% in 20173. The economic impact is significant, with losses associated with NCDs and mental health conditions projected at US$18.45 billion between 2015 and 2030 [18] .


[17] Ministry of Health & Wellness, NCD Unit
[18] The economic burden of noncommunicable diseases and mental health conditions: results for Costa Rica, Jamaica, and Peru. David E. Bloom , Simiao Chen , and Mark E. McGovern



One of the main challenges for the Jamaican health sector is therefore 1) to prevent early onset of NCDs by addressing four preventable risk factors that determine NCDs (i) use of tobacco; (ii) excessive alcohol consumption; (iii) unhealthy diet; and (iv) sedentary lifestyles; [19] and 2) for people with NCDs, to improve the quality of care [20] and prevent premature NCD related deaths (population younger than 65). Evidence shows that this is possible with chronic care models based on strong primary health care services.

Jamaica, in fact, faces a triple burden of disease: Communicable disease, non-communicable disease and Disasters. A renewal of the Primary Health care services now must, while retaining the emphasis on Maternal and Child Health and Communicable diseases, focus on the prevention and treatment of NCDs, and build resilient health systems that can stand up to emerging and re-emerging diseases, natural disasters, and climate change.

## INDIVIDUAL CARE SERVICES

Health facilities that provide individual care services must be so positioned to provide geographical access and also ensure that comprehensive quality services are provided that meets the needs of the population served. The Type I health centre is staffed with a midwife and community health aides. Their responsibility is to deliver Maternal and Child Health, Family Planning, Nutrition counseling and Immunization. The Type II health centre offers these services and additionally a public health nurse and a public health inspector are stationed there. A nurse practitioner (NP) or a physician visits these centres from once or twice per month in some areas to once or twice per week in others.

Patients with complaints related to chronic diseases as well as acute illnesses in communities served by these health centres will have to travel further to access medical care at the time of need or wait for the scheduled visit of the medical team.

[19] WHO. From burden to “best buys”: Reducing the economic impact of NCDs in low and middle-income countries. WHO 2011.
[20] Jamaica has problems with the quality of some health care services. For example, maternal mortality is still quite high (over 100 deaths per 100,000 live births) despite almost universal coverage of birth attendance by skilled personnel.

# RATIONALE FOR REORGANIZATION OF SERVICES & EXPANDED SCOPE


The Type 111 health centre has a doctor or nurse practitioner stationed there. Some however do not offer services for five days per week as the medical staff serves several facilities and therefore move from one health centre to a next several times for the week. This limits the quantity and quality of care and detracts from the team approach to serving the needs of the individual and the community. It also affects the continuity of care as the patient sees a different health care worker each time they visit.

At present, there are 315 functioning health centres in 63 health districts. Seventy-six or 24% of health centres are designated Type 3 to Type 5. Only these health centres are equipped to provide curative or treatment services. In practice, 52% of existing primary care facilities provide some curative services and 18% offer this service daily.

Each Health district serves more than twenty thousand persons and 20% of health districts have no health centre that offers curative services five days per week.

| | # Health Districts or Zones | # Of Functioning Primary Care Facilities | # Health Centres that offer Curative services 5 days/week | # Health Centres that offer Curative services >3 days/ wk | Number of Health Centres that offer any Curative Services | # Health Districts with no health centres offering curative services daily |
|---|---|---|---|---|---|---|
| SERHA | 14 | 95 | 29 | 37 | 54 | 3 |
| SRHA | 21 | 74 | 6 | 15 | 40 | 5 |
| WRHA | 16 | 79 | 13 | 18 | 45 | 4 |
| NERHA | 12 | 78 | 12 | 12 | 31 | 1 |
| Totals | 63 | 325 | 60 | 82 | 170 | 13 |
| % | | | 18% | 25% | 52% | 20% |

**Table 1: Distribution of Curative Services (Not including Type 6 Centres)**

As a result, the population seeks health services at hospital emergency departments that are open reliably twenty-four hours each day. This has contributed to increased morbidity and mortality because of delay in accessing services, overcrowding of hospital emergency departments, increase admissions, longer hospital stays and patient and staff dissatisfaction and low morale.



RATIONALE FOR REORGANIZATION OF SERVICES & EXPANDED SCOPE


There has generally evolved a lack of confidence in the health centres as they have not been able to deliver the quantity and quality of services demanded by the population. This is particularly so considering increased access to health information and greater awareness of health-related rights [21]. Even at treatment centres the focus is on the immediate problem and not the client.

The offering of reliable treatment services for the management of the patient along the entire life course, the management of Chronic Non-Communicable Diseases and its complications and the linkages to care are now key drivers that must be included in the plan for renewal of primary care services. The services must be near where persons live and work and must allow for continuity of quality, comprehensive care by a dedicated team of health professionals. In the Primary Care Reform, 130 health centres will be designated Comprehensive, District and Community Health Centres. These health centres will provide health promotion, prevention, and treatment services for communicable and non-communicable diseases. This will allow the population to have access to these services within the 10-mile radius of their home.

## POPULATION SERVICES

The delivery of core public health functions need to be organized to include new categories of workers to provide a range of public health services and continued support for community programmes. Environmental Health remains a priority area for the Health Ministry. Jamaica has experienced Chikungunya, Zika and Dengue Virus Disease epidemics between 2015 and 2019. The country has also faced the threat of Ebola Virus Disease and reemergence of Malaria and Yellow Fever in the region as well as other vaccine preventable diseases regionally and globally. Occupational Health and Food Safety are areas that remain of high importance.

There is far greater need for health promotion and education and for social interventions to decrease the incidence of diseases and poor outcomes, many of which relate to persons not taking responsibility for their own health outcome and the health of their relatives.

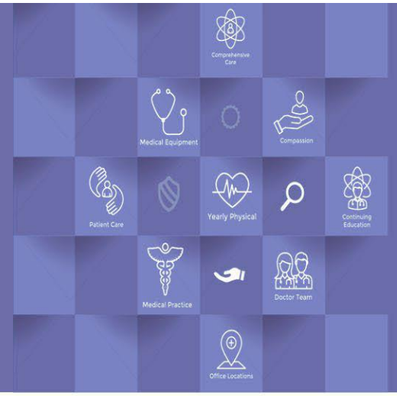
With increased globalization, Jamaica faces the threat of emerging and reemerging diseases. Jamaica has a robust surveillance plan already in place and a renewal of primary care must improve the capacity of the health system to detect, report and respond to events. The recent threat of Measles and the ongoing threat of Yellow Fever and Malaria from within and without of the region makes this more urgent.

The continued exposure to climate change and increasing natural disasters and the management of the health impacts must also be considered in the delivery of primary health care. With the continued threat of disasters, coordination and disaster risk management programmes must percolate through the entire health system to ensure that the health system is resilient and able to recover early from disasters.

The Primary Care Reform 2021-2030 provides a renewed focus on primary health care and a reorganization and expansion of scope of services to meet present demands.

[21] Integrated Health Services Delivery Network

# CHAPTER 4
# SCOPE FOR PRIMARY HEALTH CARE IN 2021-2030 REFORM


SCOPE FOR PRIMARY HEALTH CARE IN 2021-2030 REFORM

Over the last forty years, there have been changes in the services offered in primary health care in Jamaica. Some changes developed out of a need or an opportunity in one geographical area and while necessary have not yet been incorporated into the formal policies of the Ministry. Other areas of need have been identified coming out of the epidemiological and demographic transitions that is taking place in Jamaica. The scope of primary health care has been reviewed and is a major feature of the primary health care reform.

The priority programmes of the Ministry of Health as documented in the Ten-Year Strategic Plan are within the updated scope of primary health care and it is therefore imperative that Primary Health Care Reform emphasize these programmes and that the health care system is well developed to deliver on these most important concerns. Primary health care provides opportunities for disease prevention and health promotion as well as early detection of disease and is not just about treating common ailments. [22] The following are the population services and individual care services that will make up the scope of primary care in Jamaica:

| | | |
|---|---|---|
| **Environmental Health** | **Maternal & Child Health services** | **General Curative Services- Emergency, Acute & Chronic Treatment including Pharmaceuticals** |
| **Monitoring & Surveillance** | **Oral Health** | **Programmes for Management of Specific NCDs** |
| **Health Promotion & Education** | **Substance Abuse & Treatment** | **Programmes for Management of Specific CDs** |
| **Emergency & Disaster Management** | **Adolescent Health** | **Rehabilitative & Palliative Care** |
| **Nutrition Services** | **Gender Health** | **Ophthalmology –DR Screening, Visual Acuity testing** |
| **Social Intervention Programmes** | **Elderly Health** | **Audiometry - Screening** |
| **Sexual & Reproductive Health Services** | **Mental Health** | **Diagnostics Services: Radiological & Laboratory** |

Colour Codes : Grey = Established Programmes, Green = Programmes that have started without formal establishment, Orange = New Programmes to be established as part of the new Primary Care Model.

[22] The world health report 2008: primary care now more than ever. World Health Organization 2008



The expanded scope takes into consideration that primary health care is provided in different settings. Traditional service delivery sites provide for a more extensive lay out of staff and equipment to provide comprehensive services. However, for a variety of reasons, many persons do not access these services and this results in late diagnosis and suboptimal follow up for chronic diseases. This increases the burden of disease in the country with impact on the productive sector, the health system and the social support systems. Primary care reform will increase the scope of primary health care and provide more opportunities for access to these services through mobile and community services.

## PRIMARY HEALTH CARE SETTINGS

Primary Health Care is provided in different settings that the population live, work, and play as well as in the traditional health care settings. The health department and public and private health centres are traditional health care settings. Mobile services as well as the community health outreach programmes will provide additional health settings in home, work and communities.

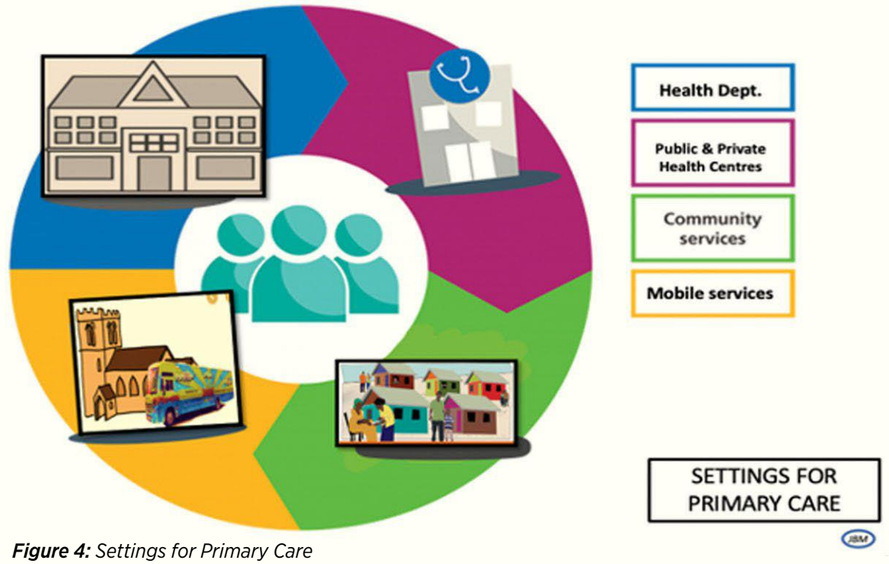



***Figure 4:*** *Settings for Primary Care*


SCOPE FOR PRIMARY HEALTH CARE IN 2021-2030 REFORM

## HEALTH CENTRES

Treatment, Screening, and preventative services as well as health promotion and education are offered in the health centres where there are health care providers and support services stationed with the required resources to cater to large numbers of persons. Health centres are positioned to provide services close to where persons live to make access easier and allow for continuity of care.  To increase access, private health centres are captured in the Primary Health Care Reform 2021-2030.

Some services that are required by some members of the population, require specialized equipment or personnel that cannot be duplicated in every health centre. These specialized services will be provided in the larger Comprehensive and District health centres.

The health centres are also the hub from which the environmental services are coordinated and delivered.

## MOBILE SERVICES

To improve access, mobile units may bring the service to the community. Services such as Oral Health and Mental Health will be facilitated in this way through continuation and enhancement of existing community-based programmes.

## COMMUNITY SERVICES

Continuity of care outside of health facilities, in the communities, enhances patient compliance and improve management. Some patients are unable to access care outside of their homes and their vulnerabilities increase if left untended. The Community Health Worker is a key participant in the delivery of health care services to vulnerable populations in their communities. The Community Health Programme is to be enhanced and expanded in the Primary Care Reform 2021-2030.

The development of a Chronic Care Model for Jamaica will enhance community engagement and facilitate continuity of care by linking patients and families of patients who are informed and motivated to a health system that is organized to provide support for the patient in the community through community and facility-based teams utilizing a well-developed health information system. Resources within the community form part of this support and the support teams are trained and prepared to monitor, aid decision making and render assistance.

## HEALTH DEPARTMENTS

The health department is the hub of the primary health care network. All primary health care programmes are coordinated from the health department and core public health functions such as environmental health management, monitoring and surveillance, emergency disaster management, health promotion and education and social intervention programmes are coordinated, managed and implemented from the health department. Information feeds into the health department from all the branches of primary health care and activities are planned and coordinated at this level to meet the changing demands of the population. Information that shapes and guides policy decisions are uploaded to the Regional Health Authorities and the Ministry of Health and Wellness.

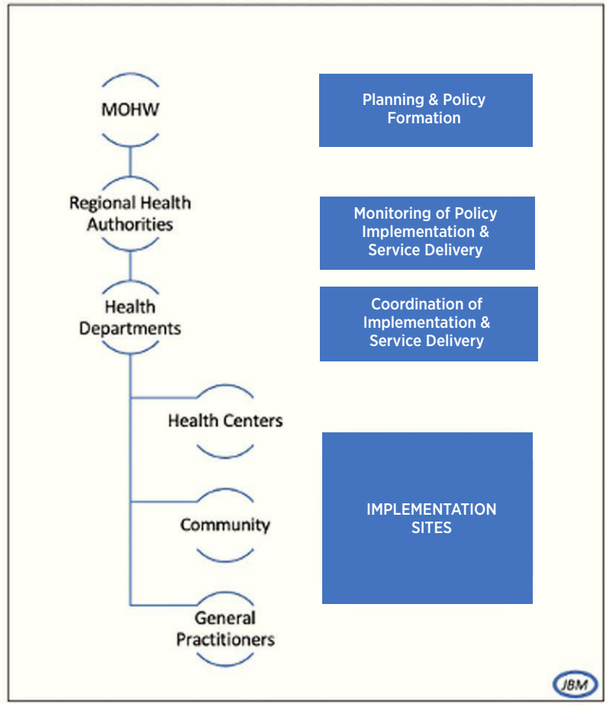



***Figure 5:*** *Organization of Health Services*


SCOPE FOR PRIMARY HEALTH
CARE IN 2021-2030 REFORM

## REGIONAL HEALTH AUTHORITIES

The Regional Health Authorities are responsible for delivering health services to the population according to the health ministry's policies and programmes. They provide administrative oversight for the parishes to ensure that services are being delivered proportionately and efficiently to meet the needs of the parish. The RHAs, through its surveillance and monitoring functions, have an overall view of the needs of the population of the region and the health services within the region. It also has direct access to the central ministry and plays a critical role in contributing to the policy and planning process of the health ministry.

For the most efficient use of resources, service delivery sites are positioned to ensure sustainability as well as access. The RHAs have a coordinating role to ensure that services within the region and services that are only available outside of the region are accessible to all the population in a timely manner.



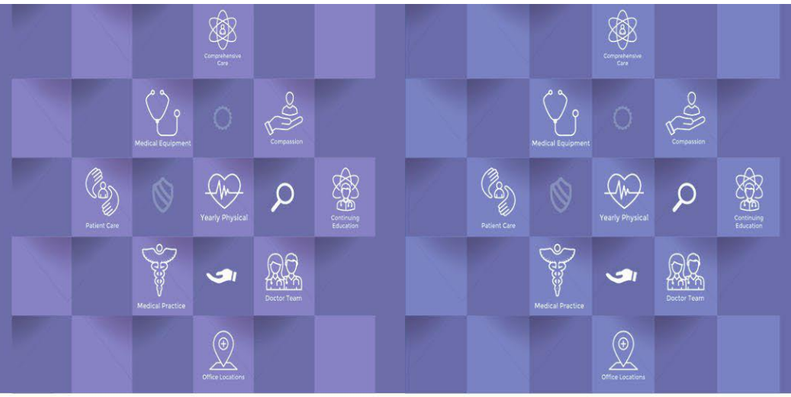
## PRIMARY CARE SERVICES

### 1. CURATIVE OR TREATMENT SERVICES

The first or primary level of clinical care is often referred to as Curative or treatment services in Jamaica. These services are individual care services and are the commonest reason why a member of the population interacts with the health system. It focuses on the individual and navigates towards treatment of specific illnesses or conditions. Over the years, the delivery of primary care services has emphasized maternal and child health services and treatment of specific communicable and non-communicable diseases with great impact in the reduction of maternal, neonatal, infant and under five mortality rates as well as a decline in the incidence of many communicable diseases. Despite interventions, there has been a steady rise in the incidence of non-communicable diseases (NCDs) and the complications associated with them. The Primary Health Care Reform will prioritize increasing and integrating strategies for management of NCDs in the health centres and in the community. Curative or treatment services in the past have focused on therapeutic and diagnostic aspects of medicine. However, with a shift from disease centric to patient centric care, treatment services must refocus on the full spectrum of management of the patient from health promotion and prevention to diagnosis and care of specific illnesses. In this way, prevention and early detection will play an important part in decreasing the burden of disease.

The Primary Health Care Reform will see a three-dimensional approach to expansion of treatment services with (1) more points of care, (2) increase in services and (3) improved quality of services.


***Figure 6:*** *Three dimensions of improved care*




SCOPE FOR PRIMARY HEALTH CARE IN 2021-2030 REFORM

**More points of care** will be accessible to the population. Treatment services will be offered at 130 community, district, and comprehensive health centres daily. This will allow clients to access consultation with a physician of family nurse practitioner reliably for acute or chronic complaints daily closer to their homes. In addition, the Ministry of Health and Wellness will partner with private providers to provide care to the population. These measures will reduce the number of clients who would usually bypass the primary care centres to make their way to hospitals for service.

The range of treatment services includes health promotion and management of the client at each stage of the life cycle and management of acute and chronic manifestations of communicable and non-communicable diseases. For some disorders there are specific treatment programmes that are monitored centrally.

These include Diabetes, Cardiovascular Disease, Cancers, some Respiratory illnesses, Rheumatic Fever/ Rheumatic Heart Disease, Sickle Cell Disease, HIV/STI/TB among others. The delivery of care to these special groups will be integrated into the general offerings at all health centres. This will serve to destigmatize some illnesses and will ensure that all health care providers are equipped to manage all type of cases. The implementation of electronic health records will allow for timely reporting on caseloads and treatment indicators needed to monitor these programmes. It will facilitate analysis and feedback that will allow for identification of challenges and appropriate interventions.

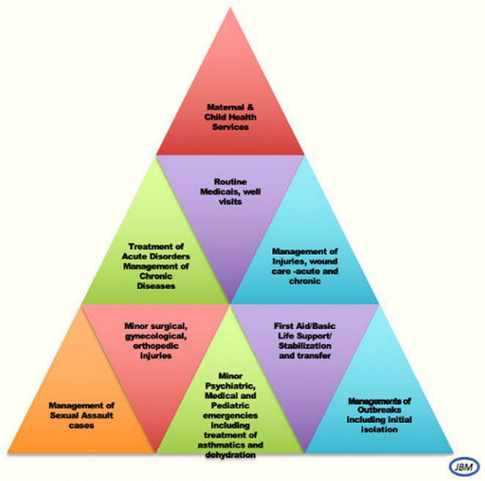



***Figure 7:*** *Treatment services at Primary Care Centres*



**More services will be offered.** Health Promotion and education, screening and prevention are integrated in treatment services and are offered to clients who will visit the health centres for acute or chronic disease care. As such, well visits and routine medicals will form a part of the services offered. Special needs of populations will be addressed through new clinics. These clinics are not disease specific but will bring under one umbrella sectors of the population that have similar health care needs and will coordinate their care ensuring that this care is integrated into the different treatment and support services offered. These special clinics include adolescent health, elderly health, and gender health. In addition, new services such as rehabilitative and palliative care, Ophthalmological and audiometric screening will be offered. Specialist clinics will also be available in district and comprehensive health centres to address more complicated cases.

**Service will be of improved quality.** Treatment services will be supported by a well-equipped qualified health workforce that will include family medicine physicians and specialists in areas determined by the needs of the population. Opportunities will be created through telemedicine conferences, tele-mentoring to provide support to physicians and other health care providers and ensure continued medical education as well as contact with specialists. The quality of services will be monitored locally as well as by the Regional Health Authority and the central Ministry.

## 2. ENVIRONMENTAL HEALTH SERVICES

Environmental Health is the area of public health that is concerned with controlling the factors of the natural and built environment that may affect human health. The condition of the physical environment; safe water, clean air, safe food, healthy workplaces, safe houses, suitable means of excreta disposal and safe communities all contribute to good health.

# SCOPE FOR PRIMARY HEALTH CARE IN 2021-2030 REFORM


SCOPE FOR PRIMARY HEALTH CARE IN 2021-2030 REFORM

**The primary programmes delivered under the environmental health services are as follows:**

### 1. WATER SAFETY & WASTE WATER MONITORING

a. Drinking water ( universal access to potable water by 2030)
b. Recreational water
c. Waste water

### 2. FOOD SAFETY & PROTECTION

a. Food Handling Establishments
b. Tourism Establishments
c. Licensing of Food Handlers
d. Inspection of Imported Foods
e. Meat Inspection

### 3. INSTITUTIONAL HEALTH

a. BPOs
b. Nursing Homes
c. Infirmaries
d. Prison & Lock Ups
e. Schools
f. Emergency Shelters

### 4. PORT HEALTH AND QUARANTINE

a. Ensure ports are not promoting entry of vectors or diseases into the island
b. Protection of environment from aircrafts and ships (International Convention
c. Compliance with IHR

### 5. VECTOR CONTROL

a. Entomological monitoring
b. Rodent Control
c. Community, Port & Hospital surveillance

### 6. OCCUPATIONAL SAFETY AND HEALTH

a. Indoor Air Quality
b. Ambient Air Quality (Outdoor)
c. Hazardous Substances
d. Site Inspections
e. Infection Prevention and Control




**In addition the Environmental Health team is responsible for carrying out the following activities:**

## EPIDEMIOLOGICAL INVESTIGATIONS

The EH team is a critical part of the rapid response team in each parish that investigates outbreaks and institute prevention and containment actions. It works in tandem with the Surveillance and Monitoring arm and the rest of the health system in responding to recurrent, new and re-emerging diseases and is instrumental in bringing these events under control.

## ENVIRONMENTAL HEALTH EDUCATION

The environmental team carries out a critical role in its routine duties of educating the population on environmental issues. This is an essential part of the preventative role that the service plays and many hours are spent in the field and in the formal setting raising awareness and stimulating behaviour change.

## ENFORCEMENT OF PUBLIC HEALTH ACT & REGULATIONS

The environmental health team is also responsible for the enforcing of the Public Health Act and its Regulations. Reports made of breeches to these legislations are investigated and actions taken to correct the breech.

## SUB DIVISION & DEVELOPMENT PLANS

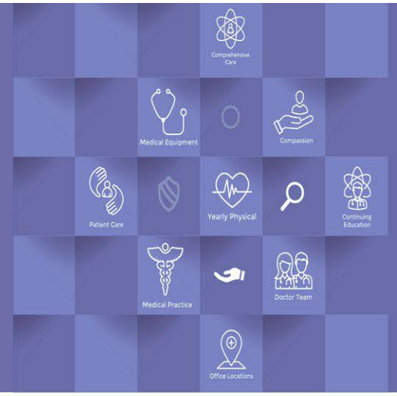
The environmental health team has a role to play in ensuring sustainable urban and rural development. Sub Division and Development Plans are reviewed for compliance with the Public Health Act and Regulations in particular respect to management of waste water and sewerage and other environmental hazards.For this, 9 lots and under processed by health departments; over 9 lots and large subdivisions processed by Environmental Health Unit at the Ministry of Health and Wellness.

## GENERAL SANITATION

The monitoring of general sanitation is contributed to by all the programmes and activities of the environmental health team. The monitoring of communities and town centres is part of the routine activities carried out. Stakeholder collaboration with local authorities is an integral part of ensuring a safe environment.

## ENVIRONMENTAL DISASTER PREPAREDNESS MANAGEMENT

The environmental health team also plays an active role in disaster preparedness management and response.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The World Health Organization (WHO) estimated that in 2012, approximately 12.6 million people died as a result of living or working in unhealthy environments. This is nearly 1 in 4 of total global deaths. These were all preventable deaths and it is deduced that by focusing on reducing environmental risk factors a significant burden of disease can be prevented.

With improved environmental health outcomes, there is expected to be better health, reduced morbidity and mortality attributable to environmental health factors, better quality of lives, improved longevity, enhanced productivity and greater development of the country.

The programmes and structure for the delivery of this critical primary health care service must therefore be strategically (effectively and efficiently) organised to deliver on its mandate.

The Environmental Health Unit at the central level has the responsibility to develop and monitor programmes that are implemented at the peripheral level.  The Parish Health Department with oversight from the regional level is the coordinating centre for environmental health activities. Activities are carried out from the health departments and from the health centres.

## 3. MONITORING AND SURVEILLANCE PROGRAMME

Surveillance is a core public health programme and is one of the Essential Public Health Services or Functions. The National Epidemiology Unit at the Ministry of Health is the Policy setting unit for surveillance. The National Surveillance manual  outlines the various programmes. The programme managers at the health department and staff at the service delivery sites are responsible to ensure that data is inputted, and timely notifications are done. This process requires staff at the Regional and Parish levels for monitoring, reporting, investigation, and analysis.

[23]MOH National Surveillance Manual for Jamaica 2009



## 4. HEALTH PROMOTION AND PREVENTION

Health Promotion is one of the essential Public Health Services or Functions. Health promotion cuts across all health programmes and its key goal is to improve health literacy of the population through enabling, motivating, and advocating for health promoting policies and actions. Policy initiatives are developed at the central level. The health promotion team at the health department is guided by the priority programmes of the Ministry of Health and seeks to increasing the degree to which individuals and communities have the capacity to obtain, process and understand the basic health information and services needed to make appropriate health decisions.

People need to acquire the knowledge, skills, and information to make healthy choices, for example about the food they eat and healthcare services that they need. They need to have opportunities to make those choices. And they need to be assured of an environment in which people can demand further policy actions to further improve their health. [24]

The health promotion team utilizes multiple stakeholders and community participation to get health messages across to the population. Activities are carried out in health facilities and in community outreach programmes. These require a dynamic and well-resourced team to make the desired impact.

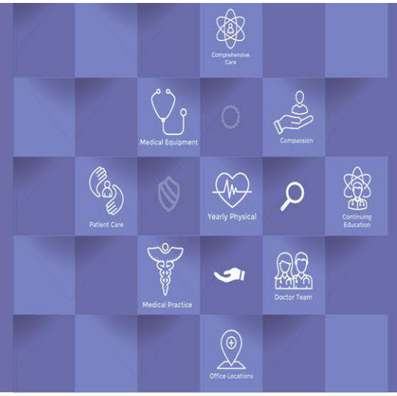
## 5. EMERGENCY & DISASTER MANAGEMENT

Reduction of the impact of emergencies and disasters in health is the 11th essential public health function described by PAHO/WHO. Emergency and disaster management is a priority area for the World Health Organization and special emphasis has been placed on interventions in small island developing states like Jamaica.

Jamaica faces a triple burden of health issues: Communicable Diseases, Non-Communicable Diseases and Disasters. It is vital that at the Regional and Parish Level that the planning and coordination of activities to mitigate the effects of disasters are given priority. The activities of the Parish Disaster Committee and the Parish Emergency Operations Centre must be ongoing to ensure that preparatory and response activities are coordinated and joined up with the activities of the regional and central organizing units.

The national programme has been robust over the years and must now be integrated into local programmes at the regional and parish level. A programme of work for emergency and disaster preparedness and management is to be developed for implementation at the local level. This is to be managed from the health department.

[24]WHO. Health Promotion. https://www.who.int/healthpromotion/en/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## 6. NUTRITION SERVICES

Nutrition and Dietetic Services form a core component of health care delivery having roles in preventive, risk reduction and treatment modalities. Nutrition services are related to, inter alia: Maternal and Child Health; Teen/ Adolescent; Chronic Diseases including HIV/AIDS; Medical/Surgical (Bariatric, Chronic Kidney Disease, Crohn's Disease, Ulcerative Colitis, Diverticular Disease).

***Nutrition Clinics*** are held in all health centre Types. Regular clinics will be scheduled in Comprehensive, and District Health Centres and clinics will be held in Community Health Centres based on the need for the service. In addition, Nutrition and Dietetic Staff participate in various clinics that are held at health centres.

### a. Maternal and Child Health

The focus in these interactions is related to healthy diets to support the development of the foetus and maintain the health of the mother during the first half of the first critical 1,000 days of human life. Anaemia and chronic diseases in pregnancy are also priority areas that are addressed. Children with growth challenges related to their nutritional status, usually stages of undernutrition or overweight and obesity are referred to Nutrition Clinics. Children with growth challenges related to medical diagnoses are also seen, for instance, prematurity, cerebral palsy and Down Syndrome.

### b. Teen/Adolescent Health

***Adolescent Clinics*** are held on specific days where Adolescents access predetermined services that include Nutrition. If further interventions are required, these individuals are then referred to the scheduled Nutrition Clinics as part of Maternal and Child Health.

### c. Chronic Diseases

Attendance at ***Chronic Disease Clinics*** is by referral. These clients receive medical nutrition therapy to assist in management of their conditions, which for the most part includes Diabetes, Hypertension and Cancers. As HIV/ AIDS is now classified as a chronic condition, clients with HIV exposure are either seen at ***Treatment Sites*** or in the Chronic Disease Clinics. Visits are also made to ***Specialist Clinics*** (Chemotherapy, Radiation, Pain) where group nutrition education sessions are facilitated.

### d. Medical/ Surgical

***Medical/Surgical Clinics*** are held for clients who are referred with a variety of medical/surgical conditions. In this setting, clients' nutritional status is augmented in either direction in preparation for surgery. Post-surgery clients are also seen.



**THE NUTRITION TEAM ALSO CARRIES OUT VARIOUS OUT-REACH ACTIVITIES SUCH AS:**

I. School visits
II. Early Childhood Institutions visits
III. Workplace Monitoring
IV. Home Visits

Caregivers are counselled on how to improve the nutritional wellbeing of their infants and young children. In some instances, ***home visits*** are required to facilitate a comprehensive situational analysis and provide practical guidance. More recently support services include ***Infant and Young Child Feeding Support Groups*** which include community members who have been trained to assist caregivers with overcoming challenges at the community level. Regular meetings are facilitated to assess effectiveness and provide guidance.

## 7. MATERNAL & CHILD HEALTH & FAMILY PLANNING SERVICES

These areas are key primary care programmes that provide the indicators that health systems are measured by. Jamaica has maintained a strong programme over the years and all health centres will offer these services.

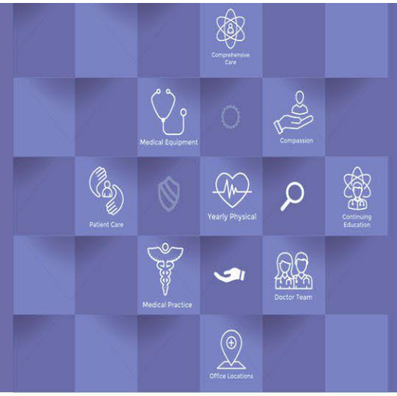
The maternal health programme is geared at: 1) ensuring that all pregnant women have access to quality care throughout their pregnancy, thus reducing morbidity and mortality from pregnancy-related conditions, 2) decreasing the incidence of unplanned pregnancy through the provision of technical information, education and counselling to couples in order to facilitate informed and voluntary decisions about fertility, 3) reducing the total fertility rate to 2.0 and 4) reducing the incidence of and mortality from cervical cancer through early detection and treatment of pre-cancerous changes.

The child health programme is to ensure holistic development of infants and young children through the protection and promotion of wellness in all aspects of their lives, utilizing the involvement of the family unit, health care team and wider community.

The focus is on early childhood development, nutrition, immunization, identification, and treatment of neuro developmental disorders and early stimulation.

**THE CHILD HEALTH PROGRAMME IS ALSO RESPONSIBLE FOR THE MONITORING OF THE FOLLOWING CHILDHOOD ILLNESSES:**

- Undernutrition in collaboration with the Nutrition Unit
- Acute Gastroenteritis/Diarrhoea
- Acute Respiratory Infections (ARI) and Asthma implemented in collaboration with the Chronic Disease Prevention and Control Unit
- Rheumatic Fever/Rheumatic Heart Disease
- Sickle Cell Disease (New Programme for 2019)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## 8. ADOLESCENT HEALTH

Adolescent Health is a priority Programme that is supported by a National Strategic Plan for Pre-adolescents and Adolescents 2011-2016 and subsequent plans. The Health Promotion Strategies developed by the World Health Organization are employed in programmatic activities. These are:

- Creating a supportive environment
- Building partnerships
- Reorienting the health services
- Capacity building
- Formulating health public policy

The goal is to improve Adolescent Health in primary care by providing quality health care delivery services for the adolescent through an integrated approach encompassing preventive, promotive, protective, curative, and rehabilitative activities. This will take place in adolescent health clinics in the district and comprehensive health centres.

The Ministry of Health and Wellness (MOHW) will through the primary care model assure that adolescents and pre-adolescents receive the highest possible quality of services (health education, counselling, preventive, diagnostic and curative) from service providers island wide. Ten standards and thirty- seven criteria were developed as a guide for assuring quality services to adolescents. These standards and criteria are to be implemented in adolescent clinics island wide. Adolescents can access care on designated days at these clinics, however adolescent services are not limited to only clinic days but can be accessed through the daily treatment services.

The Teen Hub: The Teen Hub is an example of creating a supportive environment. The first teen hub was established in 2017 in the Transportation Centre in Halfway Tree to provide a dedicated space for adolescents. It is considered a non-traditional access point whereby adolescents can access health, educational and social services. These services include:

- Health fairs
- Skills training
- Pregnancy screening
- HIV counselling and tests for adolescents 16 years and above
- Mental health screening, counselling, and referrals
- Assistance with homework and school-based assessment preparation
- Weekly visits by mental health and oral health professionals

**More teen hubs will be established in other parishes as part of the primary care landscape.**



## 9. MEN'S HEALTH

A comprehensive programme for men's health will be developed. The physician is required to ensure that at each client encounter the areas identified for intervention are discussed and the appropriate interventions and referrals are made.

## 10. WOMEN'S HEALTH

A comprehensive programme for women's health will be developed. The physician is required to ensure that at each client encounter the areas identified for intervention are discussed and the appropriate interventions and referrals are made.

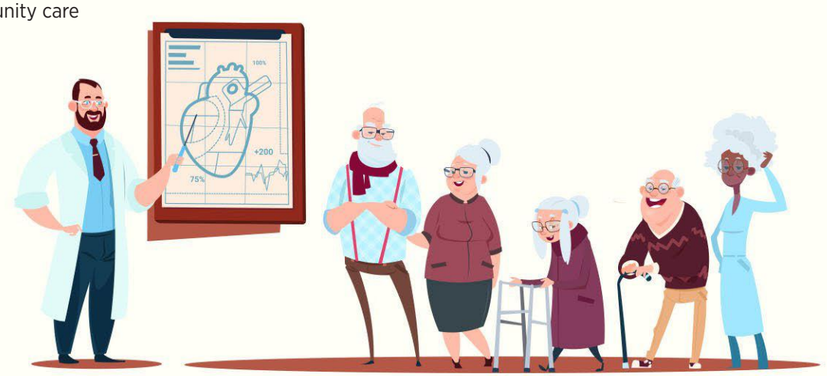
## 11. ELDERLY HEALTH

There is a need for specialized focus on the health care of older persons given the country's ageing population, the Sustainable Development Goals (and by extension those of Vision 2030), and the special health needs of the older population.

A basic Health Services Package for the elderly is defined and is a minimum collection of essential health services that are available and accessible to them. These are age dependent and geared at promoting health and restoring and maintaining maximum function.

**The comprehensive care for older persons will include:**

- health promotion and prevention
- treatment services that address multiple morbidity and the geriatric syndromes
- palliative care
- coordination and continuity between all levels of care (primary, secondary, and tertiary)
- community care



# SCOPE FOR PRIMARY HEALTH CARE IN 2021-2030 REFORM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Care will be organized around the three levels of Health centres. **The Community Health Centre** is critical to effective elder care and the following services will be deliberately integrated in the routine activities of the staff stationed there.

***• HEALTH PROMOTION / EDUCATION***

The following health promotional activities are included and will target the elderly person and their caregivers and be provided in community and health facility settings:

o low impact physical activity

o nutrition counselling

o discussions on diabetes, hypertension, breast self-examination, Pap smear

o hygiene practices, self-care, sexual health, oral and prostate health

o promotion of mental health – targeting loneliness, retirement, and loss of independence

***• PREVENTION***

o Non communicable disease self-management and monitoring

o Breast self-exam

o Detection of Hypertension and Diabetes

o Fall prevention

o Cancer screening services

o Prostate, Cervix, Breast and Colon

***• SERVICES***

o Vital checks: BMI, temperature, respiratory rate, random blood glucose, pulse, weight and height, waist circumference and urine dipstick

o Acute and Chronic Disease management

o Foot care and joint care

o Immunization

o Wound care (basic)

o Support group

The home visiting programme is executed from this level and should embrace the team (PHN's, FNP's, RN's and the MO) approach although the primary persons interfacing at the home level will be the community health aids. ***Home visits should include:***

- Vitals check
- Foot care
- Nutrition counselling
- Pharmacy pick up and drop off services
- Caregiver education and support



The District and Comprehensive health centres will have elder clinics with dedicated staff to ensure comprehensive assessment and coordination of care for the elderly through the routine clinics. Once weekly clinics is being proposed for selected comprehensive and district facilities.

***ADDITIONAL PREVENTION STRATEGIES AT THE DISTRICT AND COMPREHENSIVE HEALTH CENTRES SHOULD INCLUDE:***

- Cholesterol monitoring
- Cognitive screening
- Full geriatric assessment
- Monitoring and Coordination of care
- Depression screening
- Oral health including periodontal care
- Ophthalmology screening (cataract, glaucoma)
- Pain management
- Balance and Coordination
- Advance wound care
- Pharmacy
- Laboratory
- Social services referrals

***IN ADDITION TO WHAT IS OFFERED AT THE COMMUNITY AND DISTRICT LEVELS THE COMPREHENSIVE CENTRES SHOULD OFFER:***

- rehabilitation services
- physiotherapy services
- quarterly stroke camps
- amputation clinics
- palliative care
- identification and referral to PATH/NIS or Poor Relief, SDC and Faith Based Organization), Social workers, JADEP and NHF
- development of care plans in conjunction with the hospitals and share with colleagues at the community and district levels
- combined review of selected geriatric cases by primary and secondary care team using the ECHO platform



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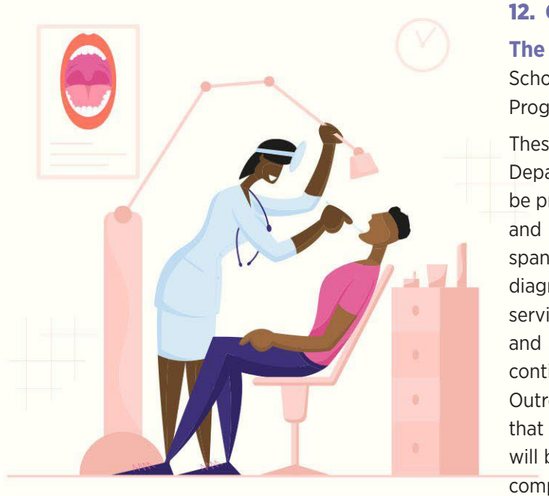

## 12. ORAL HEALTH SERVICES

**The Oral health programmes in Primary Care are:**
School- Oral Health Programme, Community Oral Health Programme, Special Oral Health Needs Programme.

These programmes are coordinated from the Parish Health Department and the Regional Health Authority. Services will be provided at the Comprehensive and District Health Centres and will include comprehensive collaborative care that will span emergency care, Screening and Prevention activities, diagnostic, rehabilitative and curative services. Where dental services exist at community health centres, this will continue, and services will be scaled up or down as indicated by the continuous monitoring of oral health needs in the community. Outreach services will be provided by the mobile dental service that will be stand-alone units that will serve remote areas. It will be staffed from the corresponding community, district, or comprehensive health centre.

The School Oral Health Programme is carried out from on-site locations at some schools and by the mobile dental services. The list of oral health services to be provided under the three main programmes are:

- Examination & Charting
- Sealants
- Fluoride Varnish
- Restorations
- Extractions
- Prophylaxis with or without topical fluoride
- Health Education & Promotion
- Basic Orthodontics
- Denture Services
- Screenings: Basic Periodontal Examination, Oral Cancer Screening and Caries Risk Assessment
- Periodontal Scaling
- Periodontal Surgery
- Surgical Extractions
- Diagnostic procedures to include Biopsy, Blood studies, Radiology
- Integrated Oral Disease Prevention Module
- Trauma Management
- Pain Management



## 13. OPHTHALMOLOGY

The services provided in primary care will be screening for Visual acuity, Diabetic Retinopathy and Glaucoma. This service will be provided in some District and Comprehensive centres. Opportunities for treatment must be expanded as screening services are introduced. A school programme for screening is to be considered to ensure early detection and treatment of visual defects.

## 14. AUDIOMETRY

There is an increase in demand for this screening service and this will be developed in the Comprehensive health centres. Opportunities for treatment must be expanded as screening services are introduced.

## 15. COMMUNITY MENTAL HEALTH

The Mental Health Service in Primary Care seeks to provide equitable, integrated, comprehensive, community based mental health services which are affordable, acceptable, available, and accessible to the people of Jamaica, while at all times respecting their human rights and adhering to evidence based practices. Consequently, such services are geared towards meeting the holistic needs of persons living with mental illness and their families in their own communities or as close to the community as possible.

**The services provided are:**

- Assessment and Management of patient (Medical and Nursing)
- Psychological Assessment and Therapy
- Social Investigation and Intervention
- Occupational Assessment and Therapy
- Outpatient clinic management
- Psychiatric Emergency & Crisis response
- Assertive outreach for Homeless Mentally Ill Patients
- Home Visits
- Forensic assessments and management

Mental Health services will be provided routinely at the Comprehensive and District Health Centres and through the visiting mobile community mental health teams who will provide emergency response as well as deliver outreach services. There will be established satellite clinics and outreach services as dictated by the needs of communities.

Persons will be referred to the Mental Health Service through direct referrals from members of the health care team in all health facilities (public or private) and indirect referrals from schools, children services, Police/Correctional Services, other institutions and agencies, NGOs, relatives and concerned citizens.



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## 16. DIAGNOSTICS: RADIOLOGY SERVICES

The introduction of basic radiology services at the primary level of care will allow easier access to Imaging. With these examinations being facilitated at a designated primary care site, patients will be able to have diagnoses and treatments done sooner. Removing the primary care patients from the hospital setting, will allow quicker turnaround times for those patients needing to move to the next tier in the system of care and build patient confidence in the primary care system.

Diagnostic requests will be written by registered practitioners in the health centre for patients needing imaging. Access to services by private patients must also be considered. Discharged hospital patients may also be given referrals for imaging as outpatients.

Patients requiring ultrasound examinations will require appointments in most instances except for emergency cases such as doppler ultrasounds for deep vein thrombosis.

Special imaging procedures such as Computed Tomography Scans (CT) and Magnetic Resonance Imaging (MRI) will not be offered routinely in primary care. However, this will be subject to review as demand increases and resources become available.

Initially, imaging services will be available in each Regional Health Authority (total of four, location to be decided) with four additional locations eventually added. Plain radiographs and Ultrasound are the initial services to be offered. These facilities will be within proximity or at the Comprehensive Health Centers. Consideration will be given to Mammography as resources allow.

## 17. DIAGNOSTIC SERVICES: LABORATORY

A determined range of Point of care tests will be offered at the Community Health Centre. Sample collection and testing will occur at the designated District and Comprehensive Health centres for routine haematology and clinical chemistry. Sample collection will be done for other laboratory services, and these will be transported to the hospital laboratory for processing.



## 18. PHYSIOTHERAPY

Physiotherapists have an essential role in the Primary Care setting. In the context of Primary Health Care, the role of the Physiotherapist is varied and continues to expand. This role includes diagnosis and treatment of acute and chronic conditions within the scope of practice, management of patients with chronic disease, education in diseases of self-management, participation in health promotion, wellness and injury prevention initiatives, and the provision of education to and consultation with other health care professionals.

The physiotherapy service will be based at the Comprehensive Health Centre. The initial implementation will commence at four (4) Comprehensive Health Centres (one in each Region ) and will target patients with non-communicable diseases, persons identified from the Referral Pathways and Transfers / Referrals from Physiotherapy Departments.

The referral pathway to the Physiotherapy Service at the Comprehensive Health Centre would originate from the following sources:

**The referral pathway to the Physiotherapy Service at the Comprehensive Health Centre would originate from the following sources:**

- Regional Hospital.
- Parish Hospital.
- Community/District Hospital.
- Transfer from a Physiotherapy Department at a Type A, Type B, Type C or Specialist Hospital.
- Health Centres

The physiotherapist will also visit Community and District Health Centres for scheduled appointments. During these engagements, the Physiotherapist would screen, educate, and advise persons depending on their diagnosis, impairment or disability. Where applicable, a referral would be made to the nearest Comprehensive Health Centre for any additional / appropriate intervention.

To serve the wider population at the Community level, a Community Engagement Plan would be promulgated. This would include participation in Health Fairs at Churches / Schools / Community Centres and regular home visits. A robust ***Visiting Service*** will be implemented to serve persons who have difficulties accessing a Service Centre.

## 19. PALLIATIVE CARE

The WHO defines palliative care as the prevention and relief of the physical, psychological, social and spiritual suffering of patients and their families facing life-threatening illness.

The Primary Health Care Reform will integrate evidence based, cost effective and equitable palliative care services across the continuum of care, and with emphasis on primary care including community and home-based care.

The same infrastructure and human resources that provide primary care in the Primary Care network will also provide basic palliative care services; similarly, efforts to implement community based palliative care will strengthen primary care.

Palliative care aims to improve the quality of life of patients, their families, and their caregivers. This care is provided for all patients from the point of diagnosis through end of life and into bereavement. To meet this objective, palliative care


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services will be integrated across the entire healthcare system, ranging from basic palliative care interventions provided by community nurses and primary care doctors caring for patients in their homes, through to specialist level programs based within regional hospitals.

Appropriate referral systems to support providers with less training with access to support and consultation and a pathway for bidirectional patient referrals will be put in place. Patients treated in hospitals will have a pathway to return to their community when possible. Patients, who are able to return home for end-of-life care, must be referred to the Palliative care clinic as well as to their local primary care provider. This type of care is to be extended out to all those needing care in the community, including patients suffering from complications of other NCDs as well as those with cancer. The Palliative Care Clinic will thus be in a position to coordinate and monitor care and ensure that appropriate follow up occurs.

In the Primary Health Care Reform, Palliative Care services will be coordinated from the comprehensive health center. The staff will include a Medical Officer (MO) with dedicated time to palliative care, full-time Registered Nurses (RN) and Community Health Aides (CHA) with dedicated palliative care hours as well as the part time services of counselor or trained chaplain.

**Responsibilities in primary care will include:**

- o Home visits for patients with palliative care needs (primarily CHAs with RN support)
- o Follow up and coordination of care through both physical visits as well as telephone communication utilizing the workforce in community, district, and comprehensive health centres
- o Conduct outpatient clinics for patient with palliative care needs
- o Conduct regular palliative care education sessions for staff in their facility and across their region
- o Provide education and support programs for the family and caregivers of their home-based care patients
- o Deliver community-based palliative care education programs

## 20. SPECIALIST CARE

**Specialist care is to be provided by doctors employed in primary care and in hospitals. The specialist clinics to be provided are:**

- o Internal Medicine General
- o Pediatrics General
- o High Risk Antenatal Clinic
- o Cardiology
- o General Surgery
- o Dermatology
- o Consideration for Nephrology and Haem/Oncology with further development of the service and resources

The list of Specialist Services will be reviewed periodically, and new services added based on epidemiological trends and the demand in specific areas. Specialists will also provide consultations through telemedicine and tele-mentoring for family physicians in community and district health centres.

Coordination of clinics and rostering of continuing medical education programmes will be provided by a Family medicine coordinator in the Comprehensive Health Centre. The specialist services will be dictated by the epidemiological profile of the community.



## 21. PHARMACEUTICAL SERVICES

Pharmacy services are provided in all Comprehensive and District Health Centres and in some Community Health Centres. Drugs are also available to clients through a Public Private Partnership with Private pharmacies. Drugs that are provided are listed in the MOHW's Vital, Essential and Necessary (VEN) Drugs publication. Pharmacy services include dispensing of drugs, counselling, and health promotion and education. Regional Pharmacists who are based at the Regional Office are responsible for monitoring and ensuring that pharmaceutical needs are met and that the service is of high quality and responsive to changes in the health situation of the country. They are also responsible for regulatory affairs within the Region they serve and for the monitoring of the points of entry with regards to items regulated under the Food and Drug and Dangerous Drug Acts.

## 22. SEXUAL AND REPRODUCTIVE HEALTH SERVICES

**Sexual and Reproductive Health Services in Jamaica are comprised of the following six components:**

- Family Planning
- Maternal and Neonatal Health
- Reproductive Organ Cancer specifically cervical cancer
- Reproductive tract infections focusing on sexually transmitted infections
- HIV and AIDS
- Adolescent sexual and reproductive health

These components are provided through the Maternal and Child Health Programme, the Adolescent Health Programme and the HIV/STI Programme at the primary care facilities. These services are offered at all levels of health centres. Family Planning Clinics are held in all health centres and counselling and contraceptive methods are offered. Referral to comprehensive health centres or hospitals for some contraceptive methods or reproductive health procedures are streamlined in all parish health networks.

Counselling for contraceptive methods start in the antenatal clinics and continue in the post-natal clinics. Screening for STIs as well as cervical cancer also takes place. Contraceptive methods are offered, and appropriate referrals are made where necessary.

The integration of sexual and reproductive health (SRH) and HIV services with the goal of maximizing coverage and health outcomes for the client and optimizing the use of scarce resources takes place in the primary care setting. SRH including family planning (FP) services is integrated into HIV counselling and testing programmes, into prevention of mother to-child transmission services, or into care and treatment programs. HIV testing, prevention, and counselling is added to existing FP, maternal-child, or primary health care services. SRH and HIV services are made available in the same location during the same visit and perhaps by the same provider. Services are also be linked by referring a client from one service to another.

Counselling and treatment are also offered in Adolescent Health Clinics.

## 23. SOCIAL INTERVENTION PROGRAMME

Health is affected by several factors outside of the health system. Access to food, housing, transport, physical and mental support are all factors that influence well-being and ability to achieve good health. Within any good primary care system, there must be the ability to address these social barriers to health if a patient centered, whole person approach is to be achieved.

The engagement of social workers as part of the community health workforce is essential to providing comprehensive care. A programme is to be developed for implementation at the community level to ensure that the social determinants of health for especially the vulnerable populations are addressed.

*The overview of this programme is to be included in this document when complete.*

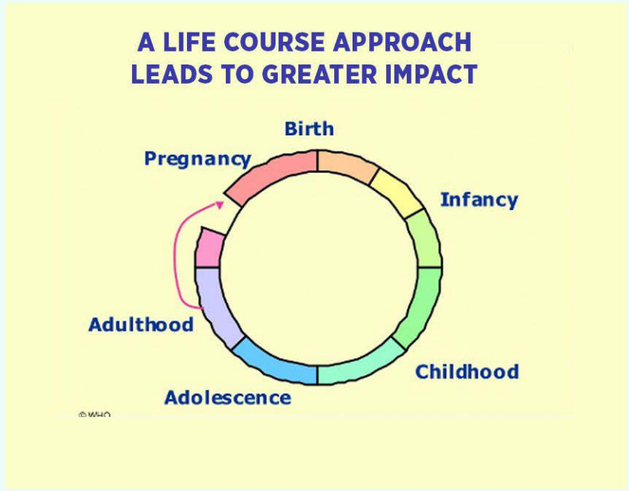
## IMPLEMENTATION

The completion of the Micro Plans for each service is to be completed in Phase 1 of the implementation plan. This is critical to understand the resources that are needed and to further inform the Human Resources Plan, the Training Plan, and the overall budget.





***Figure 8:*** *Life Course Approach (WHO)*




The population is encouraged to enter the health system through the primary care centres from birth. Preventative and Curative services are organized using the Life Stage approach to ensure that all persons who encounter the Health System at whatever stage of the Life cycle will benefit from a comprehensive package of services that is applicable to their stage in life. This package is also determined by the epidemiological profile of the community. The service revolves around the client, their immediate and future needs, and links them to services seamlessly, utilizing developed information systems, thereby encouraging compliance.

**The package is developed to ensure that the needs of the following age groups are addressed:**

- Fetus – Maternal Care - Pregnancy
- Infant
- Child
- Adolescent
- Adulthood- (Gender) Health
- Adulthood-Elderly Health

# LIFE STAGE APPROACH TO HEALTH SERVICES


LIFE STAGE APPROACH TO HEALTH SERVICES

The life cycle approach will ensure that each person presenting to the health system at whatever stage of the life course is offered the basic set of services shown in Table 4 that is applicable to their life stage.Client contact comes at acute care visits, chronic care visits, screening visits and when clients access special services. At all encounters, the stage of the life course is considered, and appropriate health promotion & education delivered and referral to appropriate services made.

The health care provider is to educate the client on the services offered, provide health information on the services, and link the client to the service through an appointment system. A care coordinator, at each visit is to ascertain if the client has obtained services previously prescribed, discuss results and follow up and ensure that the client is educated re appropriate checks for age or as indicated.

Referrals for consultations or emergency treatment will be handled in the same way, with the client linked to the service through an appointment system. Feedback is provided from the consultation point and the primary care provider can view results, management, and recommendations.

In this way, the service will transform to a client centric service that is connected at all levels and addresses both preventative and curative needs of the population. In the first phase of implementation of the reform, a detailed change management plan is to be prepared to sensitize, educate, prepare, and rally support of health care workers and the general population for the new approach to primary health care.

## BASIC SET OF SERVICES OFFERED AT EACH LIFE STAGE

| SERVICE | Pregnant mother | Infant & Child | Adolescent | Adulthood | Elderly |
|---|---|---|---|---|---|
| TREATMENT SERVICES | Acute and chronic disease management & Referral as appropriate<br><br>Well visits | Acute and chronic disease management & Referral as appropriate<br><br>Well visits (school medicals) | Acute and chronic disease management & Referral as appropriate<br><br>Well visits (Annual Checkup)<br><br>Adolescent Health Clinic for coordination of care | Acute and chronic disease management & Referral as appropriate<br><br>Well visits (Annual Checkup) | Acute and chronic disease management & Referral as appropriate<br><br>Well visits (Annual Checkup)<br><br>Elderly Health Clinics for coordination of care |
| MATERNAL CARE | Antenatal, Intra-natal, Post Natal<br><br>Home delivery<br><br>Domiciliary services | (If indicated – HIGH RISK CASES)<br><br>Appropriate linkage to social services | Antenatal, Intra-natal, Post Natal<br><br>Appropriate linkage to social services | Antenatal, Intra-natal and Postnatal Care,<br><br>Pre-pregnancy counseling for select groups<br><br>Home deliveries | - |
| IMMUNIZATION | Age-appropriate immunization | Age-appropriate Immunization | Age-appropriate Immunization | Age-appropriate Immunization | Age-appropriate Immunization |
| GROWTH & DEVELOPMENT | (Growth Monitoring will be a part of antenatal care offered) | Age-appropriate growth and development screening and management | Age-appropriate growth and development screening and management | - | Age-appropriate growth and development screening and management |
| SEXUAL & REPRODUCTIVE HEALTH | Counseling & Education, Family Planning, STI/HIV Management, Risk Assessment, PMTCT | Counseling & Education as indicate.<br>Appropriate interventions | Counseling & Education, Family Planning, STI/HIV Management, Risk Assessment, Prevention of Sexual Abuse & Violence | Family Planning, STI/HIV Management, Risk Assessment, Menopause & Andropause Management | STI/HIV Management, Risk Assessment, Menopause & Andropause Management |

LIFE STAGE APPROACH TO HEALTH SERVICES

## BASIC SET OF SERVICES OFFERED AT EACH LIFE STAGE

| SERVICE |  Pregnant mother |  Infant & Child |  Adolescent |  Adulthood |  Elderly |
|---|---|---|---|---|---|
| NUTRITION | Nutrition & Breast-Feeding promotion, growth monitoring and counseling | Nutrition & Breast-feeding promotion, growth monitoring and counseling | Nutrition Assessment & Management<br><br>Healthy eating to prevent overweight & Obesity | Nutrition Assessment & Management | Nutrition Assessment & Management |
| SCREENING & PREVENTATIVE MANAGEMENT: COMMUNICABLE & NON-COMMUNICABLE DISEASES | Risk factor Screening, Prevention and Management<br><br>NCD Screening<br><br>Sickle Cell Disease screening | Risk factor Screening, Prevention and Management<br><br>NCD Screening | Risk factor Screening, Prevention and Management<br><br>NCD Screening | Risk factor Screening, Prevention and Management<br><br>NCD Screening<br><br>Screening for Cancers | Risk factor Screening, Prevention and Management<br><br>NCD Screening<br><br>Screening for Cancers |
| ORAL HEALTH | For the pregnant mother | Screening<br>Preventive care (sealant application)<br>Education and promotion<br>Extractions and fillings | Screening<br>Preventive care (sealant application)<br>Education and promotion<br>Extractions and fillings | Screening<br>Preventive care (sealant application)<br>Education and promotion<br>Extractions and fillings | Screening<br>Preventive care (sealant application)<br>Education and promotion<br>Extractions and fillings |
| OPHTHALMOLOGY | Screening for visual disabilities | Screening for visual disabilities<br><br>*Newborn screening in selected conditions<br><br>*Part of well visits for school medicals | Screening for visual disabilities | Screening for visual disabilities<br><br>Diabetic Retinopathy, Cataract, Glaucoma | Screening for visual disabilities<br><br>Diabetic Retinopathy, Cataract, Glaucoma |
| AUDIOMETRY | Screening for hearing disabilities for the newborn as indicated | Screening for hearing disabilities | Screening for hearing disabilities | Screening for hearing disabilities | Screening for hearing disabilities |
| MENTAL HEALTH | Social risk assessment<br>Screening & Education of mother for Substance Abuse<br>Depression screening | Social risk assessment<br>Mental Health assessment to include:<br>Developmental Disorders,<br>Cognitive Impairment<br>Substance Abuse Disorder<br>Mood Disorders<br>Psychotic Disorders,<br>Suicide Prevention | Social risk assessment<br>Mental Health assessment to include:<br>Developmental Disorders,<br>Cognitive Impairment<br>Prevention of Alcohol, Tobacco & other Substance Abuse Disorder<br>Mood Disorders, Psychotic Disorders<br>Personality Disorders,<br>Suicide Prevention | Social risk assessment<br>Mental Health assessment to include:<br>Cognitive Impairment<br>Substance Abuse Disorder,<br>Mood Disorders<br>Psychotic Disorders<br>Suicide Prevention Personality Disorders | Social risk assessment<br>Mental Health assessment to include:<br>Cognitive Impairment<br>Substance Abuse Disorder,<br>Mood Disorders<br>Psychotic Disorders<br>Suicide Prevention<br>Nuero-psychiatric Disorders |
| PALLIATIVE CARE | | As needed | As needed | As needed | As needed |
| REHABILITATIVE CARE | | As needed | As needed | As needed | As needed |
| HEALTH PROMOTION COMMUNITY & ENVIRONMENTAL HEALTH | Home assessments<br><br>Health Education & Promotion for diseases or events of Public Health Interest | School health<br><br>Health Education & Promotion for diseases or events of Public Health Interest | School health<br>Health Education & Promotion for diseases or events of Public Health Interest | Worker's Health<br>Occupational Health<br>Health Education & Promotion for diseases or events of Public Health Interest | Home assessments<br>Health Education & Promotion for diseases or events of Public Health Interest |

TABLE 4: **BASIC SET OF SERVICES TO BE OFFERED TO EACH LIFE STAGE**



# CHAPTER 6
## REORGANIZATION OF PRIMARY CARE SERVICES

The first level of clinical care and other individual primary health care services are offered in public health centres and private offices across Jamaica. The Primary Health Care Reform visions the transformation of the first or primary level of care into a more reliable comprehensive and quality service that is accessible to all the population.

***The Redesigning the Health System*** in Jamaica was described by Goffe and McCartney from as early as 2004[25]. A subsequent version of the document, ***Redesigning of Jamaica's Primary Care System and Services***[26] was produced and approved for implementation by Cabinet in 2016[27]. Both documents proposed the reorganization of health centres into Community, District, Parish and Comprehensive centres instead of Type 1-5 health centres previously described in the Primary Care Perspective. The implementation of the primary healthcare reform in the framework of the Ten-Year Strategic Plan (2021-2030) will see three levels of health centres established.

**There will be three categories of Health Centres that will replace the existing five categories:**

- **Community**
- **District/Parish (The service offered is at the district level, but this may be the Parish Health Centre)**
- **Comprehensive/Parish (The service offered is at the Comprehensive level, but this may be the Parish Health Centre)**

A basic suite of services will be routinely offered at each health centre type with the Community Health Centre providing more reliable services that meet the needs of the population. Acute and Chronic care for Communicable and Non communicable diseases will be available at all health centre types with more comprehensive services being offered at the higher levels.

The Clinical services will be coordinated through a Clinical Coordinator based in the Comprehensive health centre and the other public health programmes are managed directly from the Health department with general oversight for all programmes by the Medical Officer of Health for the Parish.

At least one Comprehensive Health Centres will be present in each Region.

[25]Goffe & McCartney: Redesigning the Health System in Jamaica; A proposal. 2004. Revised 2004,2005,2006,2008
[26]Goffe. Redesigning of Jamaica's Primary Care System and Services 08.01.14
[27]Cabinet Approval 2016


REORGANIZATION OF PRIMARY CARE SERVICES

| PRIMARY CARE PERSPECTIVE 1978 | GOFFE MCCARTNEY 2004 | PRIMARY CARE MODEL IMPLEMENTATION |
|---|---|---|
| **Type 1 Health centre** is the smallest Unit of Health care serving no more that 4000 persons. It is staffed by one midwife and at least two Community Health Aides whose responsibility are to deliver basic maternal and child health, nutrition, family planning and immunization services. | The function of the **Community Health Centre** is to provide appropriate quality service by involving and working very closely with the community which it serves. It is intended that Community Health Centres will provide non-curative care and disease prevention activities.<br>The population to be served is up to 10,000 persons. | This **Community Health Centre** would meet a wider range of health needs including Maternal and Child Health as well as Curative or treatment and disease preventative services for a wide range of illnesses including the Non communicable diseases that are now the leading cause of morbidity and mortality in the country.<br>It will serve up to 20,000 persons and its staff will visit several satellite clinics in the communities that it serves. |
| **The Type 2 health centre** has the staff and functions of a Type 1. In addition, there is a public health nurse and public health inspector stationed there. There will also be a resident staff nurse who can treat common illnesses. The doctor and FNP visit on a regular basis. This health centre serves about 12000 persons through its Type 1 health centres. | | |
| **The Type 3 health centre** is the headquarters for the district and will serve up to 20,000 persons through its Type 1 and 2 health centres. The doctor and FNP will be based here. | Each Health District will have a **District Health Centre** where the doctor will be based full-time supported by other curative staff as is defined by the Ministry of Health Norms and Standards. The population served is 30,000 – 60,000 persons.<br>The District Health Centre forms the main port of call for the people entering the Primary Health Care system for treatment and should be able to deal with most of the conditions from which they suffer. As such the Doctor or Nurse Practitioner will remain at the District Health Centre if some curative coverage is extended to a Community Health Centre. | |
| **The Type 4 health centre** administers the health programme of the parish. It offers the same service as the Type 3 but the Medical Officer of Health and other parish staff are based there. It is on the hospital compound to enable access to diagnostic services and these health centres are only to be in Cornwall County. | The **Parish health center** will be based at the Parish central township, if possible, near the Parish hospital. It will cover a population of 30,000 - 60,000 persons.<br>A Parish Health Centre will offer full time medical, dental, and pharmaceutical services.<br>The vision is to have these Health Centres open to offer extended services beyond normal working hours.<br>Essential to attaining the level of utilization expected of a facility of this type is the presence of a full-time Pharmacist, Pharmacy Technician, and the appropriate supply of drugs.<br>Such a centre should also have a laboratory service able to process basic laboratory examinations as necessary for the various primary health programmes. | **The District Health Centre** offers the next tier of service. This health centre will provide the same services as the Community Health Centre but will also provide a higher level and range of services for a population of up to 40,000 persons from the communities served by its feeding CHCs. The number served will vary from parish to parish. Some DHCs will serve up to 80,000 persons. The DHC will have full time medical, dental and pharmacy services as well as have laboratory support and other diagnostic and screening services. The DHC will have visiting clinical specialists. The specialist service provided will be dependent on demographics and epidemiology of the area served. |
| **The Type 5 health centre** are comprehensive health centres and are only to be in the Parishes of Kingston and St. Andrew and the Spanish Town and Portmore areas of St. Catherine. | The **Comprehensive health center** will be sited in densely populated urban areas serving a population of 60,000 and greater. It is proposed to be open from 8:00 am to 8:00 pm daily.<br>They will give a variety of services daily and certain more specialized services on a regular but less frequent basis. | The **Comprehensive health center** will be sited in densely populated urban areas serving a population of 60,000 and greater. It is proposed to be open from 8:00 am to 8:00 pm daily.<br>It will provide all the services of the District Health Centres. They will give a variety of special services daily and certain more specialized services on a regular but less frequent basis. |

**Table 5: Comparison of three Primary Health Centre Interventions for Jamaica**

## HEALTH CENTRES FOR PRIMARY CARE MODEL

### The Community Health Centre

The Community Health Centre serves a population of up to 20,000. This health centre type will provide an upgraded service to several communities previously served by Type 1 or Type 2 health centres. The range of services has been expanded due to the changing demands that have arisen out of the change in demographics and epidemiology in Jamaica. Services previously provided at the Type 1 and 2 health centres will continue to be provided. The health centre will now routinely provide daily treatment services for acute and chronic complaints due to non-communicable diseases (NCDs) and communicable diseases. The rise in NCDs including hypertension, diabetes, cancers, and trauma has resulted in a flood of persons seeking care in hospitals because of not being able to access care at the health centre nearest to their homes. Where the hospital is not easily accessible, delays to care have caused worsening conditions and outcomes.

Enhancing and expanding services at the first level of care in the community health centre will improve access to care for NCDs. A higher level of staff and the support by specialists at the other tiers of the health centre network will ensure that a more comprehensive and resolutive service is offered. Infrastructure changes will be made to support the upgraded service.

The Community Health Centre will provide the core services of Curative medicine, Maternal and Child Health, Wound care daily while some services such as Nutrition, Environmental Health, Mental and Oral Health services will be scheduled as indicated by population needs.

Maternal and Child Health Clinics and Treatment (Curative) Clinics are to be held daily. Walk ins and appointments are seen. Walk-ins are triaged and seen based on priority level. At each interaction, regardless of presenting complaint, the stage in the life course is considered and patient education and management is offered. Priority screening services, specialist referrals and diagnostic and therapeutic services are to be offered/scheduled and the patient directed to the facility where the service is to be obtained. Clinics for added services are scheduled and walk-ins and appointments will be seen.

Difficult cases or cases requiring Specialist attention are referred to the Specialist Clinics at the District or Comprehensive Health Centres for a management plan to be crafted and the opportunity for discussion is provided to the health care provider at the most basic level of care. This service will not only provide a higher level of service but also is a means of ensuring continued medical education and mentoring for health professionals.

# REORGANIZATION OF PRIMARY CARE SERVICES


REORGANIZATION OF PRIMARY CARE SERVICES

Outreach programmes are to be carried out in the communities served by the Community Health Centre by the Community Health Aides, Public Health Nurses and Physicians stationed there. Public health programmes such as Environmental Health Programmes are coordinated at the health department and will utilize staff from various centres within the parish for implementation across communities. The implementation of the Chronic care Model will link patients in their community to health care professionals and services providing more opportunities for control of chronic diseases in difficult cases and reaching many who would have been lost to follow up.

The outreach programmes are organized from the level of the Community Health Centre and the District Health Centre that oversees the Community Health Centre. Outreach programmes are also planned for special services.

| **COMMUNITY HEALTH CENTRE LIST OF SERVICES** |
|---|
| • Maternal Care (Family Planning, Antenatal, Intra-natal, Postnatal Care) |
| • Child Health (Immunization, nutrition, Child growth and development monitoring and counseling) |
| • Wound dressing |
| • Health Promotion and Health Education – Physicians and Nursing personnel stationed at these sites to provide health promotion and education material and activities including community sensitization. |
| • Community Outreach programmes – Community Health Aides guided by Public Health Nurses to benefit from training to increase monitoring of Non-Communicable Diseases so as to ensure continuity of care at all levels of health system |
| • Home visiting – Curative and Preventative visits to those that cannot easily access care. Satellite Outreach centres and mobile clinics to be the spokes of the central hub of health care. |
| • Screening for Prioritized Non-Communicable Diseases to be carried out in routine and planned visits. |
| 1. Diabetes |
| 2. Hypertension |
| 3. Cervical Cancer |
| 4. Breast Cancer |
| 5. Prostate Cancer |
| • Chronic Non Communicable Disease Management |
| • Communicable Disease management (including HIV/STIs) |
| • Management of ambulatory patients for acute and chronic complaints |
| • Routine well checks and medicals |
| • Referrals to appropriate services |
| • Emergency Services |
| 1. First Aid, Minor Trauma |
| 2. Minor surgical emergencies including abscesses, lacerations |
| 3. Minor medical emergencies |
| 4. Minor OBGYN emergencies |
| 5. Stabilization & Transfer |
| • Basic POC laboratory service |
| 1. Urine protein and urine glucose and by Test Strips |
| 2. Blood Glucose by Glucometer |
| 3. Pregnancy Tests |
| 4. Urinalysis |

**Table 6: Community Health Centre –List of services**

# REORGANIZATION OF PRIMARY CARE SERVICES


REORGANIZATION OF PRIMARY CARE SERVICES

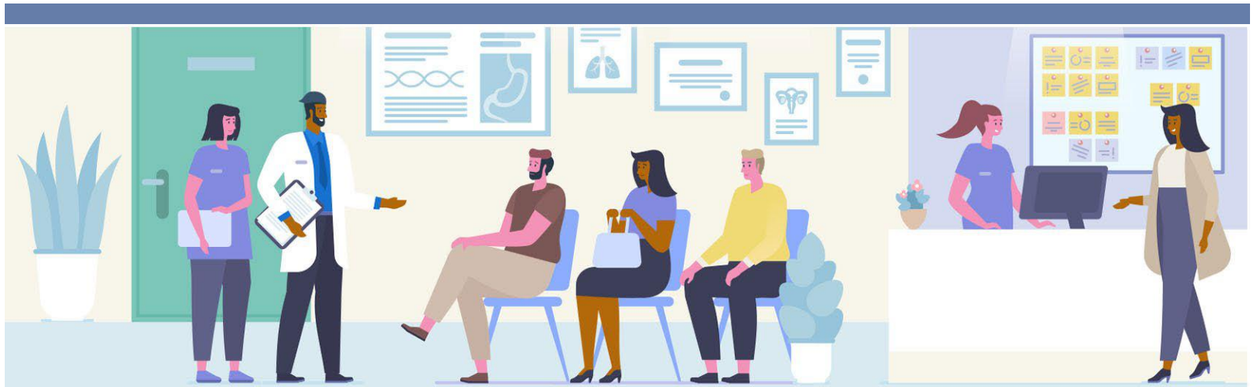
## THE PRIVATE COMMUNITY HEALTH CENTRE

Universal access seeks to ensure that all persons have access to care for preventative care, acute care, chronic care and rehabilitative or palliative care. The integration of private providers into the overall public health system is considered as one way of increasing access and ensuring that all persons who access health care are considered in enumerating the burden of disease and in guiding policies and programmes that benefit the population on a whole. The Primary Care Reform will seek to ensure that the entire population is reached through the community level of care.

Private General Practitioners will be engaged as part of the community level care. Each private general practice would be seen as a private community health centre and offer at minimum, the same package of primary care services. The General practitioner in private practice however would now be guided by the public health system and expected to offer the same comprehensiveness of care along the life cycle. The public health system will support the private practitioner through a continuing education programme involving all community health centres, a field officer to provide updates and monitoring, provision of supplies at a reduced or no cost to encourage private patients to access these services eg. Family planning and immunization.

This pool of Private community health centres and public community health centres will increase access to all citizens.

A system for monitoring of private community health centres will be implemented from the parish Health department. The Public Health centre and private health centres within its vicinity will form a cluster. A field officer will be assigned to this cluster for monitoring purposes. The district health centre will be the referral point for several clusters of community health centres including the private community health centre.



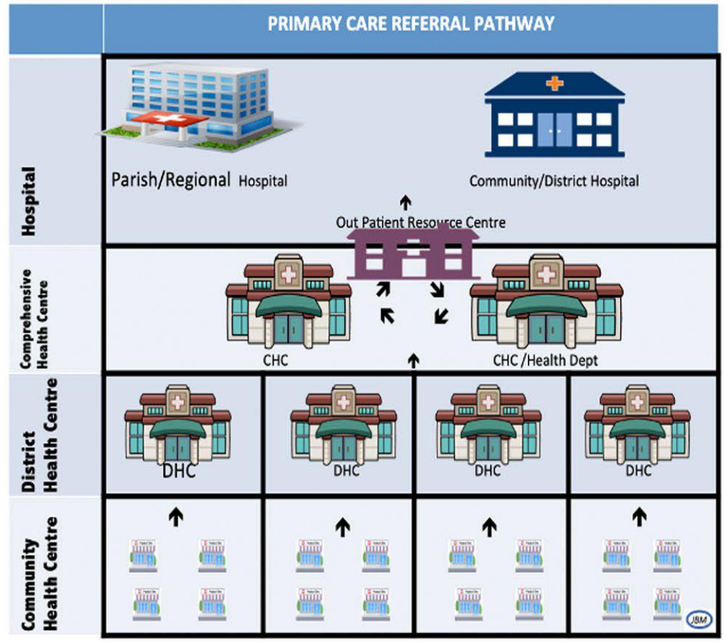


## THE DISTRICT HEALTH CENTRE

The District Health Centre (DHC) offers the next tier of service. This health centre will provide the same services as the Community Health Centre (CHC) but will also provide a higher level and range of services for a population of up to 40,000 persons from the communities served by its feeding CHCs. The number served will vary from parish to parish. In the more populated parishes of St. Catherine and Kingston & St. Andrew some DHCs will serve up to 80,000 persons.

The DHC will have visiting clinical specialists. The specialist service provided will be dependent on demographics and epidemiology of the area served and will be decided by the Ministry of Health and Wellness in conjunction with the RHA. Patients can be referred from the CHC for specialist care as well as for other services not provided at CHC.

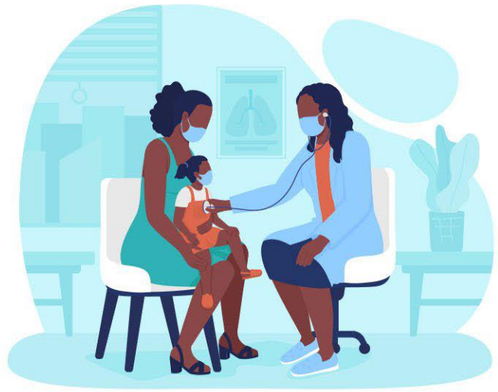
***Figure 9:*** *Primary Care Referral Pathway*



# REORGANIZATION OF PRIMARY CARE SERVICES


The package of services at the DHC is focused on both preventative and curative health services as well as core public health services such as Environmental Health. All services provided at the Community Health Centre level will also be offered at the District Health Centre. More services will be offered, and more specialized staff will be based at this clinic.

The full package of services to be offered at each DHC is influenced by the proximity of a Comprehensive Health Centre and/or a hospital and the population of the district served.



Maternal and Child Health Clinics, Treatment (Curative) Clinics and Dental Clinics are held daily. Walk ins and appointments are seen. Walk-ins are triaged and seen based on priority level. At each interaction, regardless of presenting complaint, the stage in the life course is offered.

Priority screening services, specialist referrals and diagnostic and therapeutic services are to be offered/scheduled and the patient directed to the facility where the service is to be obtained.

Clinics for Special services such as Mental Health, Nutrition, Palliative, Rehabilitative are scheduled, and walk-ins and referrals are seen on an appointment basis.

Specialist Clinics such as Internal Medicine, Pediatrics, OBGYN and General Surgery are held weekly, and clients are seen by appointment. Difficult cases are referred to the Specialist for a management plan to be crafted and the opportunity for discussion is provided to the health care provider on site on acute or chronic cases. This service will not only provide a higher level of service but also be a means of ensuring continued medical education and mentoring for health professionals.

Cases referred from the Community Health Centres and Community Outreach programmes are seen, and feedback provided to the referring facility. Documentation of services provided and recommendations because of a referral should be made for patients returning to the Health Centre after being referred to other facilities.

*The list of services is shown in Table 7.*



REORGANIZATION OF PRIMARY CARE SERVICES



## THE COMPREHENSIVE HEALTH CENTRE

The Comprehensive Health Centre is the major referral centre for primary care services. Specialist services and programmes for continued medical education will be offered through a combination of specialist run clinics and telemedicine. The mix of staff and services at this level of primary care centres will allow for more resolution of problems at the primary care level resulting in decreased complications of chronic diseases and decreased referrals to secondary care with a projected overall impact of decreased morbidity and mortality.

The development of Health Information Systems and Internet and Intranet connectivity will allow for communication and feedback at all levels of the health system. More diagnostic and therapeutic services will be available on site and off site through real and virtual integration. Special services such as Social Work, Rehabilitative and Palliative services will be introduced to address the increased need. More direct and interactive access to advanced therapeutic services is to be afforded to increase accessibility and compliance with treatment.

In some regions a main outpatient resource centre, with access to diagnostics by primary care patients will be a part of the network, although this may not be present at the location of the Comprehensive Health Centre.
The Comprehensive Health Centre will provide the range of services as the District Health Centre as well as additional specialist and diagnostic services. Specialists engaged in Primary Care and Secondary Care will provide services at the Comprehensive Health Centre and Outpatient Resource Centre.

*The services to be provided at the health centres are included in Table 7.*

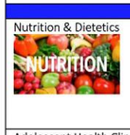
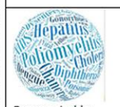

REORGANIZATION OF PRIMARY CARE SERVICES

## OUTPATIENT RESOURCE CENTRE

The Outpatient Resource Centre is a major addition to the primary care network that will facilitate the integration of services and increase access to what was previously considered hospital services. The Centre will be near the Parish hospital and the Comprehensive Health Centre. This facility will house specialist clinics, diagnostic services, and therapeutic services. Staff from the hospital will provide services in dedicated time for primary care. This centre will be a hub for technology driven continued medical education through tele-consulting and tele-conferencing.

## IMPLEMENTATION

Primary healthcare facilities are to be upgraded to meet the requirements of the services offered. Each type of health centre will have a minimum requirement for spaces required to function optimally. Phase 1 of implementation includes a gap analysis of all primary care facilities. Facilities will be ranked according to the complexity and cost of intervention required. Construction will take place in phases over ten years.

| Name of Clinic | Service Offered | Service Location | Staff Required HCW | Target Population |
|---|---|---|---|---|
| **ROUTINE SERVICES** | | | | |
| Maternal & Child Health   | Immunization, Child growth & Development monitoring<br>Early Childhood stimulation<br>Family Planning, Antenatal, Postnatal | Community HC MCH Clinic<br>District HC MCH Clinic<br>Comprehensive HC MCH Clinic<br>Community Outreach<br>Community & Home Visits | Medical Officers<br>Public Health Nurses<br>Midwives<br>Registered Nurses<br>Health Educators<br>Nutritionist<br>Community Health Aides<br>Social Workers | Children<br>Reproductive Age women |
| CURATIVE OR TREATMENT CLINICS — Non-Communicable Disease   | Education<br>Screening<br>Monitoring<br>Treatment of Acute & Chronic conditions | Community HC<br>District HC<br>Comprehensive HC<br>• Curative Clinics (Acute & Chronic care)<br>• Screening Clinics<br>Community Outreach<br>Community & Home Visits | Medical Officers<br>Registered Nurses<br>Health Educators<br>Nutritionist<br>Physical exercise Coordinators<br>Public Health Nurses<br>Community Health aides<br>Social Workers | All Age groups |
| Communicable Disease   | Education<br>Treatment of acute and Chronic conditions<br>Contact tracing | Community HC<br>District HC<br>Comprehensive HC<br>• Curative Clinics (Acute & Chronic care)<br>• Screening Clinics<br>Community Outreach<br>Community & Home Visits<br>Health Department | Medical Officers<br>Registered Nurses<br>Health Educators<br>Medical Officers (Health)<br>Public Health Nurses<br>Public Health Inspectors<br>Vector Control Workers<br>Contact Investigators<br>Community Health aides<br>Social Workers | All age groups<br>Adolescents<br>Adult |
| Oral Health   | Preventive care<br>Rehabilitative care<br>Oral Cancer Screening<br>Periodontal care for Diabetic patients<br>Periodontics<br>Endodontic<br>Prosthodontics<br>Forensic odontology<br>Orthodontics | Daily Clinics- District, Comprehensive Health Centres<br>Mobile Clinics – Communities<br>Outreach Programmes<br>(Highlighted service at COMPREHENSIVE HEALTH CENTRE ONLY) | Dental Surgeon<br>Dental Auxiliaries (Dental Nurses and Hygienists)<br>Dental Technician | All Age groups |
| Mental Health   | Acute and Chronic Psychiatric evaluation, monitoring, treatment<br>Counselling, Behavior therapy<br>Social intervention<br>Child Guidance<br>Child and Adolescent Mental Health<br>Community Mental Health and Counseling | Daily Clinics- District, Comprehensive Health Centre – MH, CG, Occupational therapy Clinics<br>Weekly clinic visits-Community Health Centre- MH & CG Clinics<br>Community Outreach—<br>Community & Home Visits | Medical Officers<br>Mental Health nurse<br>Psychiatrist<br>Psychologist<br>Community Mental Health Officer<br>Social Worker<br>Child Guidance Counsellor<br>Occupational therapist | |
| **SPECIAL CLINICS** | | | | |
| Nutrition & Dietetics   | Education: Group & Individual sessions<br>Counselling & Monitoring<br>Integrated management | Daily Clinics – District, Comprehensive Health Centres – walk-ins & Referrals<br>Weekly visits – Community Health Centres – walk-ins and referrals<br>Outreach programmes | Nutritionist<br>Assistant Nutritionist | All age groups |
| Adolescent Health Clinic  | Counseling, Screening<br>Safe Space<br>Computer Centre | District, Comprehensive Health Centre- scheduled<br>Community Health Centre – scheduled | Social Worker<br>Mental Health Officer | Adolescent |


REORGANIZATION OF PRIMARY CARE SERVICES

| | | | | |
|---|---|---|---|---|
| Gender Health | Counselling<br>Special gender related services<br>Pathways to care<br>Sexual and reproductive Health- FP, Menopause mgmt., STI/HIV, Risk Assessment<br>NCD- Risk factor prevention /Lifestyle modification, smoking cessation<br>Screening for Cancers, Social risk assessment | District, Comprehensive Health Centre- Scheduled<br>Outreach Clinics | To be decided | Adult |
| Elderly Health | Counselling<br>Special services, Pathways to care<br>Nutrition, NCD- Risk factor prevention/Lifestyle modification, Screening for Cancers, palliative care menopause management<br>Rehabilitation services, Social Risk assessment | District, Comprehensive Health Centre- Scheduled<br>Outreach Clinics | To be decided | Elderly |
| Environmental Health | Food Handlers Clinic | District Health, Comprehensive Centres – Scheduled<br>Community Health Centres- Scheduled | Public Health Inspector<br>Public Health Nurse | Adults |
| **SPECIALIST CLINICS** | | | | |
| Specialist Clinics | Referrals<br>Continuing Medical Education<br>Telemonitoring<br>High Risk Antenatal Care | District, Comprehensive Health Centre – scheduled<br>Outreach to Community Health centres | Specialists:<br>Internal Medicine<br>Pediatrics<br>OBGYN<br>Dermatology<br>Cardiology<br>Nephrology | All ages |
| **DIAGNOSTICS & THERAPEUTICS** | | | | |
| PHARMACY SERVICES | Chronic Disease drugs<br>Acute Care Drugs | District, Comprehensive Health Centre<br>Mobile Units to Community Health Centres | Pharmacist<br>Pharmacy Technicians | Referred Services<br>All Ages |
| LABORATORY SERVICES | Urine protein, glucose and WBCs by Test Strips<br>Blood Glucose by Glucometer<br>Blood Glucose-HbA1c<br>Pregnancy Tests<br>HIV/Trust Tests<br>Cholesterol test<br>CBC and BUN, Creatine & Electrolytes<br>Full range of Lab. Services offered in conjunction with hospital services. | Community, District, Comprehensive Health Centre<br>(Some services at COMPREHENSIVE HEALTH CENTRE ONLY) | Medical Technologist<br>Laboratory Technical Assistant | Referred Services<br>All Ages |
| DIAGNOSTIC SERVICES & SCREENING | ECG<br>Obstetric Ultrasound<br>Dental X-rays<br>Plain X-rays<br>Ophthalmology<br>Visual acuity<br>Glaucoma<br>Diabetic retinopathy screening<br>Audiometry testing | District, Comprehensive Health Centre<br>(Some services at COMPREHENSIVE HEALTH CENTRE) | Radiographer<br>ECG technicians<br>DR Screeners, Graders | Referred Services<br>All Ages |
| Rehabilitative Care | Physiotherapy<br>Counseling | COMPREHENSIVE HEALTH CENTRE<br>OUTREACH TO District Health Centre<br>Community Outreach-- Home Visits | Physiotherapists<br>Rehabilitation trained Nurses<br>Community Health Workers | All Age groups |
| Palliative Care | Education<br>Counseling<br>Wound Care<br>Symptom Relief<br>Stress Management | COMPREHENSIVE HEALTH CENTRE<br>OUTREACH TO District Health Centre<br>Community Outreach-- Home Visits | Community Health Aides<br>Multi-Disciplinary team: Palliative Care Specialist, Internist, Mental Health Professional | All Age Groups |

**Table 7: List of Clinics and Services at Each Health Centre Type**



## THE PUBLIC HEALTH DEPARTMENT

The public health department is the main operations centre from which services in the parish to provide the public health programmes are administered. The public health department is responsible to ensure that the policies and programmes of the Ministry, responsible for health, are carried out satisfactorily in the parish. They are therefore not only responsible for implementation at the local level but also for monitoring and reporting to the Ministry through the Regional Health Authority.

The public health team is so comprised to manage the treatment and preventative services at the health centres and to manage and operate preventative services from the health department ensuring that there is a coordinated and integrated approach.

The Parish Medical Officer of Health is the officer that has overall responsibility for primary health care programmes in the Parish. This officer supervises the Programme Managers, who are the technical officers with direct responsibility for the programme and ensures that there is coordination of activities.

**There are 9 main programme areas:**

- Epidemiology
- Health Promotion
- Disaster Management
- Environmental Health
- Curative or Treatment services
- Maternal and Child Health Services
- Mental Health
- Oral Health
- Social Intervention

Depending on the size of the parish and the workforce some functions may be grouped under one programme manager.

## OTHER PRIMARY CARE FACILITIES

Community Hospitals, Satellite Clinics, Dental Clinics and Rural Maternity Centres have been a part of the primary care landscape for several years.

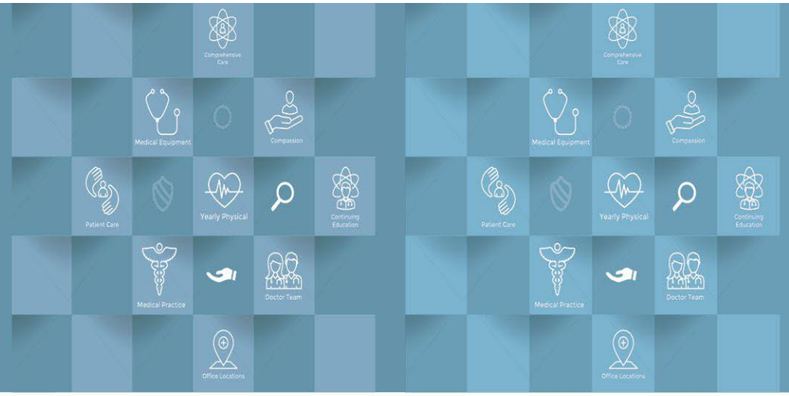
Satellite Clinics are outposts from which the staff from the Community or District Health Centres can provide a scheduled service based on specific needs of the population served.

Dental Clinics have developed in some communities and as part of outreach of non-health-based organizations. Many of these are funded by the parent entity or sponsors and are staffed by the public health workforce. They increase access to oral health services and will be evaluated over time. Dental services will be offered at District Health Centres and Comprehensive Health Centres. Mobile services will extend into high demand and remote areas to ensure that there is access to all.

The Community Hospitals provide similar service as the Comprehensive Health Centres; however, there is a ward dedicated for the delivery of maternity clients. Patients can also be admitted for 24hours observation. These facilities will be upgraded to ensure that they offer the full suite of comprehensive clinic services. The Community Hospital overall will function as a Comprehensive Type Health Centre, a rural maternity centre with a 24 hour urgent care service.

Stand Alone Rural Maternity Centres will continue to function and perform only normal deliveries.

# CHAPTER 7
## HUMAN RESOURCES




The success of this implementation of the primary health care reform is dependent on a supply of health care workers to provide the designated services. This will require an in-depth review of the human resources requirement for all the services offered. Over the years, the workforce has expanded as the population served has increased, the programmes of work in each area have evolved and training institutions and the ministry have sought to fill the gaps created. With expansion of services, the primary health care workforce will embrace new cadres of staff for the delivery of services using the life course approach and who will commit to the integration of service delivery, the utilization of technologies and the continuing education required to deliver a comprehensive quality service. The Organizational structure and cadre of staff must now be aligned to the optimized service level.

Priority will be given to the development of a Human Resources Plan for Primary Health Care that gives full attention to Primary Heath Care needs and provides for the reorientation and training of Health Care Workers to fill the gaps that will be created by this redesign. It requires an increase in investment in the first level of care in order to improve response capacity, increase access and progressively expand the supply of services in order to meet unmet health needs of the population. This investment of funds should include an increase in employment options at the first level of care, attractive labor conditions and incentives to work in underserved areas.

The human resources changes will result in the consolidation of collaborative multidisciplinary health teams through strengthening of professional resources consistent with the community health profile and improved opportunities for sharing of information between the generalists and the specialists.





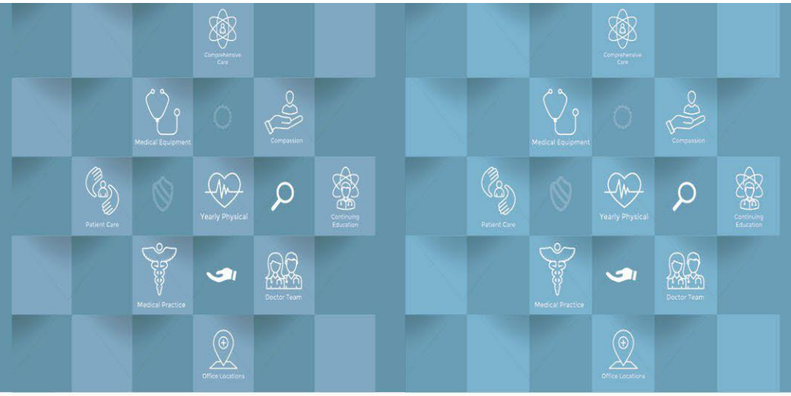

All services already offered and to be offered in Primary need to be revisited to determine the cadre of staff that is needed to serve the population. The following areas are to be covered in the first phase of implementation to ensure an organized approach to Human Resource development:

- Micro Plans for each area to be developed to outline the specific services offered and the cadre of staff needed to deliver the services.
- Organizational structure at each facility to be developed so that an adequately supervised and accountable workforce is in place.
- Training Plans for primary health care to be developed.
- Posts to be created.
- Updating of the Medical Officer Staff Policy

The provision for and management of human resources is a complex task and requires national level policy and planning for long term sustainable impact.
The following areas are to be addressed to enhance human resources for health for the renewed primary health care[28].

- Ensuring adequate numbers of staff
- Task Shifting
- Clinical Mentoring
- Supportive supervision
- Safe work environment
- Employee motivation and retention

[28]Operations manual for staff at Primary Care Centres. Chapter 9. Human Resources at https://www.who.int/hiv/pub/imai/om_9_human_resources.pdf




HUMAN RESOURCES

# Ensuring Adequate Number of Staff

There has been difficulty in attracting and retaining doctors in the rural health districts. To be able to staff the primary health care reform, new measures will have to be introduced. It is critical that the staff requirements for the model are established, there is expansion of recruitment, training, and creation of new posts.

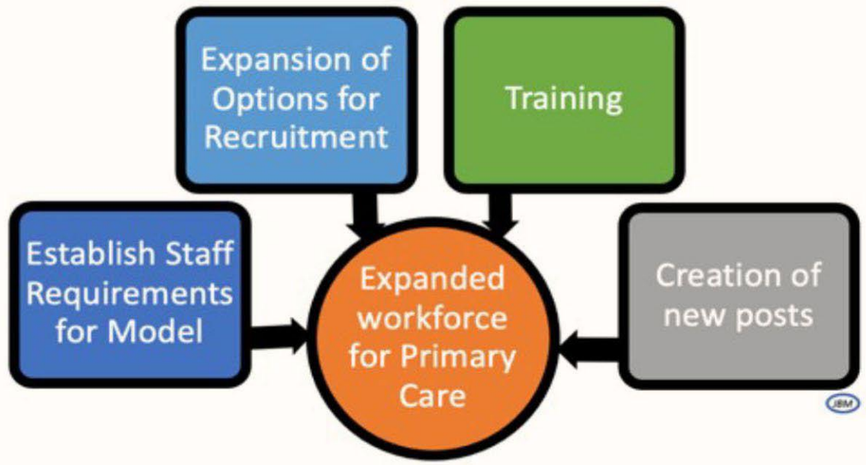



***Figure 10:*** *Expanded workforce for Primary Health Care*

## ESTABLISHING STAFF REQUIREMENTS FOR MODEL

The primary health care reform will require an expanded cadre of healthcare workers. The staffing requirements will be derived from the following documents that are to be completed in **Phase 1 of the Implementation Plan:**

a) A micro plan for each service is to be completed that will include the personnel required to carry out the tasks.

b) An organizational plan for each service will outline the reporting structure for each service.

c) An organizational plan for each facility will indicate the numbers and types of staff required.

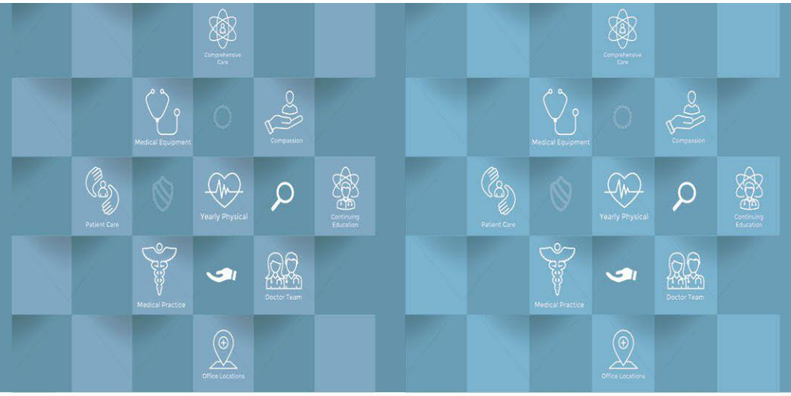
## EXPANSION OF OPTIONS FOR RECRUITMENT

Consideration is to be given to new positions and new types of employment to expand the work force.

### 1. Expanded Senior House Officer period

Expansion of the Senior House Officer programme to two years has the potential to immediately provide doctors to work in primary health care. The Senior House Officer (SHO) would be required to spend one year in primary care to qualify for post graduate training, employment in the government service or overseas training programmes funded by GOJ. Incentives such as training in the Diploma Programme in Family Medicine and employment and promotion on completion of the SHO programme must be considered for retention.

The SHO programme is still considered an extended training programme. To facilitate the learning process, although the Senior House Officers are to be posted at the Community Health Centre, they will rotate with more senior officers to always ensure senior coverage, the development of skills and the increase in knowledge that will benefit the physician and the patient.




HUMAN RESOURCES

Tele-mentoring, teleconferencing and the engagement in formal training programmes will add to the quality of care and the ability of the primary care centre to resolve clinical cases and to retain a competent level of staff.

The Policies and Procedures Manual for Medical Internship and Senior House Officer Programmes was revised in April 2015. As of the graduating class of June 2004, the Medical Internship porgramme was reduced from 18 months to 12 months. This was a decision taken by the Medical Councils in CARICOM following on the recommendation by the caucus of CARICOM Health Ministers that same year.

The SHO programme was introduced at the same time with the aim of providing a further period of clinical experience for new graduates. As well, it functions to enable them to hone their skills and broaden their experience before entering post graduate training or private practice. The programme is not mandatory but the successful completion of the SHO period is a requirement for permanent employment within the public health sector, entry into postgraduate training programmes at the University of the West Indies or Government sponsorship internationally.

Subsequent to discussions, a decision was taken that commencing with the cohort of 2014, the SHO programme shall include a mandatory six months in primary care.

Following on this, a further decision was taken to split the SHO period into three 4- month rotations and to have a mandatory 4-month rotation in primary care.

In order to provide a reliable work force, it is now being proposed to increase the SHO period to two years and to have a mandatory twelve months in primary care. The doctors would be fully registered and have one-year post internship exposure in hospital which would include a mandatory 4-month rotation in Accident & Emergency.

The skill set of the doctor coming into primary care will be increased. This will also result in an increased capacity of doctors choosing to go into private general practice, thus ensuring improved management practices in private community centres.

### 2. Specialists in Type C Hospitals

Consideration is to be given to the upgrading of the Type C Hospital. The Type C hospital is to be upgraded to offer the 4 basic specialties of Internal Medicine, General Surgery, Pediatrics and Obstetrics & Gynecology. New terms of engagement of the specialist in the Type C hospital will be explored to allow for coverage of primary care facilities. This may require a change in their compensation package and will require stakeholder consultation.

### 3. Nurses in Primary Health Care

There is a need for more specialist trained nurses in primary health care. Opportunities will be provided for all categories of staff including nurses to improve their skills to meet the needs of all areas in the new scope. Consideration is to be given to removal of the disincentives for nurses to enter primary health care.

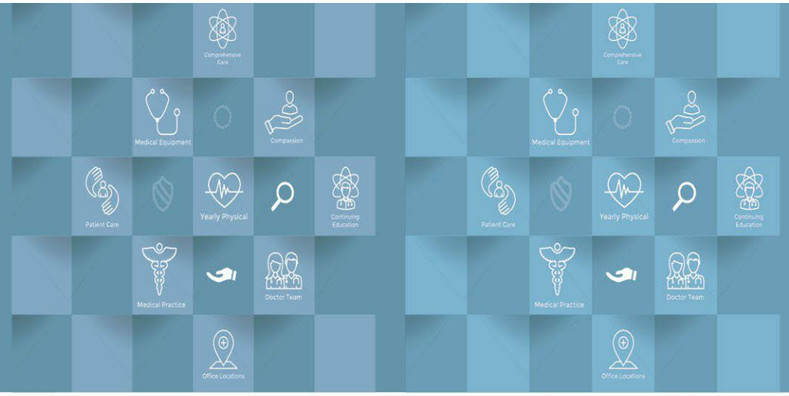
### 4. Other Health Care Workers

The expansion of some services e.g., Physiotherapy and the creation of some services e.g., Audiometry, diabetic retinopathy screening, will provide new options for professionals who have traditionally worked on secondary care and for different categories of workers in primary health care.

## TRAINING FOR REQUIRED SKILLSETS

The implementation plan for the primary care reform must include a substantial budget for training as new services are offered and existing services are expanded. There will be an assessment of the capacity of existing educational institutions as well as in-service training programmes to meet the demands of the new primary health care landscape.

Continued Medical Education (CME) through the ECHO programme will be expanded and optimized to sustain quality and comprehensive care.




HUMAN RESOURCES

## AREAS FOR CONSIDERATION INCLUDE:

### Post Graduate Programmes in Family Medicine

A higher quality of service is to be provided in the Primary care centres. This will require adequate supervision and a programme of continued medical education. The Family Medicine Physician is that higher trained physician who is trained to deliver services along the life stages incorporating health promotion, and treatment and preventative services and engaging the family and community in the management of the patient. Family Medicine Physicians will be needed at all district and comprehensive health centres. The FMP will provide oversight to the doctors at the Community health centres. The University of the West Indies through the Family Medicine Programme will be engaged to train doctors already employed in the health centres. This will be priority for the Ministry of Health's training programme over the next five years. This will be a "on the job" training programme. Training will also be offered at the Diploma level for those doctors who wish to enroll in a two-year programme allowing them to have a certification at the end of their time in primary care. The Diploma course for both Family Medicine and Emergency Medicine will be established.

### Clinical Specialists in Primary Care

In addition to the Family Medicine Physician, more expertise is needed in managing some chronic and acute illnesses. The doctor in primary care sees a wide range of illnesses and with basic training and limited oversight is expected to be able to stabilize acute illnesses, manage most cases, recognize difficult cases and refer appropriately for expert management. However, many doctors who end up in primary care have little experience and they are often left without appropriate supervision to manage on their own.

This has resulted in many illnesses being inadequately managed as procedures and protocols are not taught. This has contributed significantly to an increase in visits to the emergency room as clients are not confident in the care received and bypass health centres for emergency rooms. This has also contributed to doctors not wanting to work in health centres as there is no continuing education and they feel abandoned.

Specialists in Primary care is not new to our health system, but it has not become a part of the structure of our organization of primary care except for Mental Health. The renewed Model requires that Specialists be engaged as a means of attracting doctors to primary care, improving quality of care, and improving satisfaction for both the client and the health care provider.

Specialists in the major specialties of Internal Medicine, Pediatrics and OBGYN and Psychiatry will be needed in primary care and while their main stay will be at the Comprehensive Health Centre, they will provide clinics to the District Health Centres. These doctors will see cases by appointment, be available for discussion with junior doctors and provide structured continued education programmes for health care providers.

Areas of specialization with demand in primary care: Internal Medicine, Pediatrics, OBGYN, Psychiatry, Dermatology, Geriatrics and Palliative Care will also receive attention in the Ministry.



### Specialists in Public Health

This expansion of services in the primary care centres will see new and upgraded professionals in Primary Health Care.***Staff Policies and Procedures Manual*** will be reviewed to reflect this. This will require a higher level of training for public health practitioners who will be responsible to supervise and integrate a more diverse and highly skilled workforce. Specialist training at the doctoral level will now have to feature prominently in consideration for promotion. Consideration must be given to the doctoral programme (DrPH) being tailored to meet the needs of the public sector paying particular attention to the on the job training that is required to build experience.

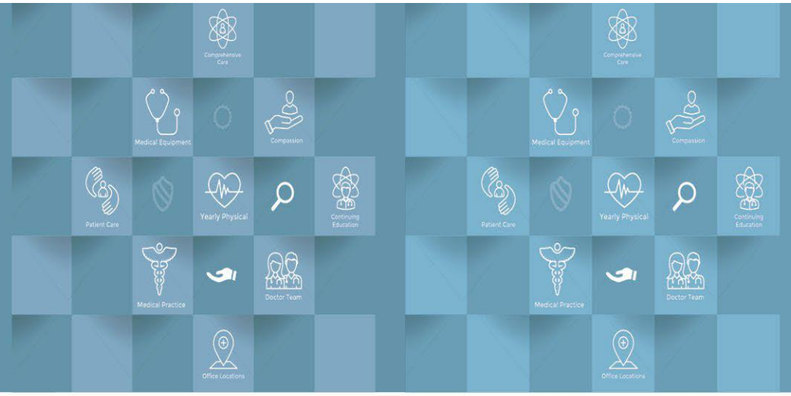
The Ministry of Health's training programme will also include training of health professionals to the DrPH level to ensure that there is the right set of skills to manage this workforce. The training programme for public health nurses and public health inspectors will also be supported as well as the Master's programme in public health for these categories of workers.

### Creation of New posts

All the health centres are functioning within their present level. Once the staffing requirements are finalized, new posts will have to be created. A gap analysis between existing posts, existing employments and post requirements for the primary care reform will be completed in the first phase of implementation.

The establishment and activation of posts will be done in a phased approach as the existing infrastructure allows and as services are expanded and new infrastructure is added. The Project Implementation team will have the responsibility to ensure that there is synergy between the different components of the project.

Expanded services at the 130 upgraded health centres daily will require new posts to be created in all areas. The new workforce for primary care for each professional group will be a priority of project implementation and will affect new budget requirements for the health sector for each year over the next ten years.




HUMAN RESOURCES

## Task Shifting

"Task shifting" is the reassignment of clinical and non-clinical tasks from one level or type of health worker to another so that health services can be provided more efficiently or effectively[29]. For example, when medical officers are in short supply, many services can be effectively shifted to non-physicians such as clinical officers and nurses, while maintaining quality. This increases accessibility of health services to the community.

At present, Jamaica faces a depletion of the nursing workforce. This is the greatest threat to the provision of quality health services. The Community Health Aides and Nurse assistants can be trained to perform a variety of basic nursing tasks that will allow health services to be provided to many more persons. The job descriptions descriptions and training for the Community Health Aide and the Patient Care Attendant are being revised to allow for this.

## Clinical Monitoring

Improving the numbers of doctors at health centres alone will not improve ethe quality of care. The change in modus operandi for service delivery with respect to the life stage approach, the patient centered approach and the implementation of the Chronic Care Model, the NCD Screening Guidelines and the programmes for continued medical education and mentoring will result in improved and enhanced patient management.

A clinical mentor is a clinician with experience and expertise who provides ongoing training and advice to clinical providers with less experience or expertise. The goal is to help the less experienced provider develop skills and experience, grow professionally, and provide higher quality care. Mentors meet regularly with the providers they are helping to review clinical cases, answer questions, problem-solve, and provide feedback and assist with case management.

[29]Task Shifting: What is Task Shifting and Why is it Needed? publichealthnotes.com



A clinical mentor is different from a supervisor, who has formal authority over a staff member and is responsible for evaluating performance. Mentors are instead more like a 'coach', who focuses on improving staff expertise, motivation, and confidence. In this network model of care, clinical mentoring at the health centre will be conducted through visits by clinical providers from the hospitals, and through ongoing teleconferencing where available.

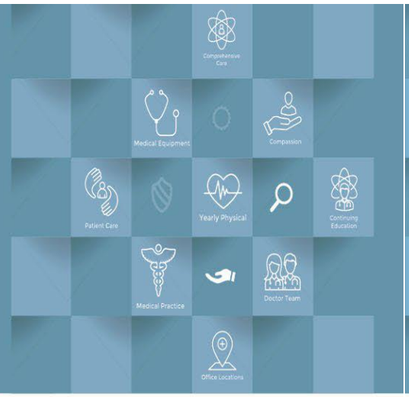
### The following is to be considered:

Specialists employed in Secondary care will dedicate four hours each week to the operating of clinics in the health centres. This will allow for integration of care. This will require re-orientation of doctors employed in hospitals to understand their role in preventative services in both screening and early expert management of disorders to decrease the burden on hospitals and the country in general. New areas such as Palliative Care and Geriatric Medicine will be added to the list of services offered and some areas such as Dermatology will be expanded.

The implementation plan looks at a Change Management Plan that will address potential barriers and increase awareness of all members of staff.

## Supportive Supervision

Supervision is a formal relationship of authority between a more senior ranking health worker and his or her subordinates. Supervisors can be located at the primary health centre or at a higher-level facility such as the parish health department. A supervisor is responsible for helping ensure that each staff member is providing adequate service delivery and is following health centre rules and policies.




Supervision does not mean finding 'fault'. Instead, supportive supervisors focus on making sure their staff has the training, mentoring, guidelines and tools, equipment and supplies and working conditions they need to perform the job effectively. It means assisting your junior staff to achieve goals, identify problems and challenges and together find solutions to problems. The supervisory relationship should be compassionate, supportive, and helpful. Good supervisors learn from their subordinates, adapt to their needs and should be open to suggestions.

In Phase 1 of the implementation plan, organizational charts for each facility and service will be completed. This will clearly establish reporting relationships and allow for increased efficiency.
Some areas of consideration are:

a) The establishment of the Family Medicine physician in primary care as the supervisor for clinical officers is key to providing supportive supervision and direction to the clinical staff.

b) The clear role of the Parish Medical Officer of Health as the lead administratively and technically in some areas.

c) The role of programme managers in specialist and special areas.

## Safe Work Environment

The implementation of the primary care reform will address infrastructure gaps in health facilities. Over the years, building expansion has not kept up with the growth in the workforce. As a result, many health care workers work in environments that are not conducive to personal health, confidentiality, and efficient use of time.

The safe work environment is key to ensure that workers carry out their functions satisfactorily. Attention to staff welfare as well as provision of personal protective equipment are measures that improve staff morale. The establishment of Occupational Health and Safety Clinics in the Comprehensive Health centres and the training of suitable staff to provide these services is a new area of focus in this model.



HUMAN RESOURCES


## Employee Motivation and Retention

There has been difficulty in attracting and retaining doctors in the rural health districts. To be able to staff the Primary Care reform, new measures will have to be introduced to incentivize jobs in rural areas. These include:

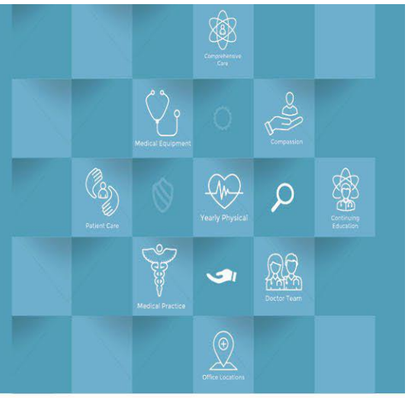
- Provision for accommodations
- Provisions for travelling
- Priority for training programmes

In addition, there are general measures that must be in place to keep staff motivated. These include:

- Ensuring staff are aware of their job descriptions
- Regular feedback to staff on job performance
- Fair and transparent opportunities for training
- Participation in decision making that affects job performance

The implementation plan will review opportunities for staff retention as well as ensure that there are processes that monitor the satisfaction and performance of staff ensuring a motivated workforce providing quality and comprehensive service.

# CHAPTER 8
## POLICY REVIEW




An overall assessment of present cadre of staff and the rules that govern their engagement is to be done to identify the gaps to fully implement the Primary Care reform. The broadening of the scope for primary health care and the changes in organization and cadres of staff required will have to be supported by changes in present legislation, policies, and practices. There is also need for supporting policies for an integrated health service network that allows movement of patients through all levels of the system, sharing of information and movement of staff between primary and secondary care. **Consideration is to be given to the following**:

**I.** The Primary Care Reform Implementation Plan will need to be approved as the way forward for Primary Health Care in Jamaica.

**II.** The Public Health Act should be reviewed to look at the role of the Local Board in the management of health services.

**III.** The Health Services Act needs to reflect the role of the Medical Officer of Health in management of the health services.

**IV.** The organizational structure in primary care will be changed to include new categories and levels of staff.

**V.** The cadre of health care professionals for Primary Care needs to change to reflect the new model.

**VI.** The Medical Staff manual will be reviewed to reflect the changes in categories and levels of staff.

**VII.** The Senior House Officer Programme will need to be reviewed.

**VIII.** The terms of engagement for Specialists in secondary care is to include service in primary care.

**IX.** The Medical Act and Pharmacy Act are to be reviewed to include oversight of telemedicine practices.

**X.** Policies that govern Private practice will need to be in place.

**XI.** Legislation that governs the use of technologies in health services and information systems for health will need to be drafted.

**Review of existing policies will start in Phase 1 of implementation.**



MINISTRY OF HEALTH & WELLNESS

# PRIMARY HEALTH CARE REFORM FOR JAMAICA

## 2021 - 2030

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