

**Determining the Feasibility and Potential
Scope of Integration of
Reproductive Health (FP/MCH/STI/HIV)
Services, Using
Portland and St. Ann's Bay as Pilot Sites**

Study Report

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1 Introduction

1.1 Background

In response to the 1994 International Conference on Population and Development (ICPD), Jamaica's Ministry of Health (MOH) prepared a Strategic Framework for Reproductive Health within the Family Health Programme 2000-2005. One purpose of the Strategic Framework is to bring the main components of reproductive health together into an integrated plan to guide central, regional and parish office strategies and activities to improve reproductive health. Provision of reproductive health through integrated services is reiterated in the 2000 Annual Report of the Ministry of Health.

One of the recommended activities related to integration listed in the Strategic Framework is to, "review resource requirements for integration of Family Planning (FP) and STI/HIV/AIDS¹ services and make a policy go/no go decision." To assist the MOH in this activity, The POLICY Project is funding a project to assess the feasibility of integrating family planning/maternal and child health (FP/MCH) and STI/HIV services in two areas of Jamaica: the parish of Portland and the St. Ann's Bay Health District in the parish of St. Ann. Portland was chosen to be able to look at an entire parish health system. St. Ann's Bay was chosen because it is located close to one of Jamaica's major tourist centres (Ocho Rios) and is home to residents who work in the tourist industry, including on cruise ships, and is therefore likely to have relatively higher rates of STIs than Portland.

The project aims to develop a consensus on potential models of integration for the two areas in Jamaica. The project includes studies to identify the costs of the interventions and operational policy barriers² to integration of FP/MCH and STI/HIV/AIDS service delivery. Based on the studies, the project also aims to help develop operational policies to facilitate integration of these services.

It is intended that the experience gleaned in this project will be used to guide integration approaches for other parishes. It should be useful to donors and country programme policy makers and programme managers as they make decisions on integration of reproductive health services.

In analyzing the current provision of RH services, it was evident that there are many examples of integration that are already occurring within the region. However, based on extensive meetings at the central level and within the North East Regional Health Authority (NERHA), a number of potential interventions related to integration have been proposed that could further enhance current integration efforts. These interventions are

¹ Sexually Transmitted Infections / Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome

² Operational policies are the rules, regulations, codes, guidelines, procedures, and administrative norms that governments use to translate national laws and policies into programmes and services. Cross, H, K. Hardee, and N. Jewell. 2001. Reforming Operational Policies: A Pathway to Improving Reproductive Health Programmes. POLICY Occasional Paper No. 7. Washington, DC: The Futures Group POLICY Project.

categorized under seven main headings: Training, Screening, Increasing Access in Health Centres, Patient Education, Outreach, STI Diagnosis and Treatment, and MIS. The interventions are summarized in Table 1.1. Interventions are common for both areas. Details about each of the interventions are included in the results section.

Table 1.1 Integration Interventions Proposed for St. Ann’s Bay Health District and Portland Parish
Training
Training-1 (Train staff on holistic approach)
Screening
Screening-1 (Use of a common checklist for FP/ antenatal/STI)
Increasing Access in Health Centres
Access-1 (Reduce special clinics/all services offered more often)
Access-2 (Extend evening hours St. AB Health Centre/ Buff Bay Hospital)
Access-3 (Operationalise an appointment system)
Access-4 (Hire an additional physician each for Runaway Bay–Type II centre and for Portland)
Access-5 (Hire an additional public health nurse each for St. AB and Portland)
Access-6 (Hire one pharmacist each for St. AB and Portland)
Access-7 (Options for salary supplement to attract staff to rural areas)
Access-8 (Survey of facilities for renovation needs for privacy)
Access-9 (Survey equipment needs in Types I/II centres)
Access-10 (Reach men through child health visits)
Patient Education
Patient education-1 (Assessment of need for new/revised IEC materials to support counselling)
Patient education-2 (Equipment for expanded health promotion in centres)
Outreach
Outreach-1 (Better supervision for CHAs to do outreach work)
Outreach-2 (Provision of limited FP counselling/condom promotion/referral for other FP by Contact Investigators)
Outreach-3 (Increase peer educators linked to VCT)
STI Diagnosis and Treatment
STI-Referral-1 (Strengthen STI referral from Types I/II to Types III and IV, including system for forms)
STI-Referral-2 (STI referrals to physicians/nurse practitioners rather than Contact Investigators)
STI-Fees-3 (Examine fee schedule for STIs)
STI-Treatment-4 (Modification of STI protocol)
MIS
MIS-1 (Tracking system to synchronise MCSR data and CI data)

1.2 Objectives

The purpose of this component of the project is to assess the feasibility of various interventions related to integration, both operationally and from the perspective of providers and clients.

The specific objectives are:

- To identify and analyse operational barriers, including operational policy barriers, to integrating services;
- To propose means of overcoming the operational and policy barriers identified;

- To assess managers' and providers' views on the proposed interventions and to propose means of overcoming the barriers identified; and
- To assess client reactions to the integration interventions.

Resource constraints to programme integration have been assessed in a costing study conducted separately, but in conjunction with this study. The purpose of the costing component is to assess the cost of each intervention to allow the MOH to make an informed decision regarding adoption of each intervention. The specific objectives are:

- To identify the appropriate inputs for each intervention;
- To identify the quantity of each input needed for each intervention;
- To calculate the unit cost for each input; and
- To calculate the cost for each intervention based on identified inputs and unit costs; and
- Conduct sensitivity analyses where appropriate.

The methodology used to estimate the cost of the interventions is the following:

- Resources required to implement the intervention were identified with key stakeholders from Portland, St. Ann's Bay and NERHA.
- Specific inputs needed for each resource were then identified.
- Unit costs for each of the inputs were then obtained from the financial office at NERHA. They provided the unit costs for equipment, drugs, salaries, utilities and consultants.
- Intervention costs - unit costs were multiplied by the number of required inputs to obtain the total cost of the intervention.
- Sensitivity analyses were carried out where appropriate

The cost for each intervention is included within the text and can also be found in Appendix D. The assumptions used to cost the interventions can be found in Appendix E.

A cost-effectiveness analysis was conducted for one of the interventions – the STI – Treatment-4 (Modification of the STI protocol). The results of this analysis is presented under separate cover.

2 Approach

The study included three main components:

- Review of programme documents;
- In-depth interviews with programme managers and providers; and
- Focus group discussions with Community Health Aides (CHAs) and clients/potential clients (adult females, adult males, young females and young males in both urban and rural areas of St. Ann's Bay and Portland).

Details of the specific activities undertaken during the study are presented below:

2.1 Project Start-up

The start-up phase involved meetings between representatives of POLICY and KPMG to clarify requirements. Based on the preliminary discussions held during the week of June 16, 2003, the critical stakeholders to be interviewed for the project were identified, and a preliminary work plan was prepared.

The list of stakeholders interviewed is presented in Appendix A.

2.2 Design of Data Collection Instruments

POLICY and KPMG worked together to design the data collection instruments, integrating information previously compiled by Futures and its partners on potential barriers to the implementation of the models of integration.

Programme Managers and Providers

The questions were aimed at eliciting respondents' opinions on the feasibility of the models of integration, as well as their knowledge of the operational policy issues that would have to be addressed for effective implementation of the models. Based on the range of interventions and the cross-section of respondents, a draft "master questionnaire" for programme managers was developed (questionnaires available on request). Pilot interviews were then conducted with the Executive Director of the National Family Planning Board and the Regional Technical Director of NERHA. Feedback from these sessions was incorporated in the master questionnaire for programme managers, from which the relevant questions were selected to develop individual questionnaires for each type of manager.

The master questionnaire for managers was then adjusted as appropriate to develop a master questionnaire for providers, from which the relevant questions for each provider type were identified, and questionnaires were developed for each type of provider, with the exception of the Community Health Aide.

Based on the relatively large number of Community Health Aides to be consulted, the focus group discussion format was selected, and a focus group discussion guide was developed to explore the issues relevant to this group.

Clients and Potential Clients

A master client focus group discussion guide was developed to elicit client and potential client reactions to the basic and enhanced models of integration. This served as the basis for developing individual focus group discussion guides for each category of client.

2.3 Data collection and review

Review of Programme Documents, Including Operational Policy Documents

The review of documents was conducted prior to designing the interventions and questions for managers and providers.³

In-depth Interviews with Programme Managers, Providers and Other Key Stakeholders

KPMG conducted in-depth interviews with programme managers at the central MOH level and with managers and providers in NERHA, St. Ann's Bay and Portland. Data collection took place from December 2003 through June 2004. Questionnaires for the managers and providers are available on request.

When reading the results section of the report, it is important to note that, in the interest of time, some respondents were not asked all of the questions. To administer the entire questionnaire to all respondents would have taken a few hours of each respondent's time. From master manager and provider questionnaires, which were administered to a smaller number of respondents, individual questionnaires were adapted according to position and knowledge of aspects of the programme and services related to the various interventions.

Programme managers and providers were interviewed to elicit their views on the extent to which the interventions listed in Table 1.1 would work in St. Ann's Bay and Portland and the barriers that might be encountered in implementation. A total of 64 interviews were conducted (Table 1.2). Twenty nine interviews were conducted with managers, 32 with providers, and three with others (see Appendix Table A.1). No one refused to participate in the survey – in some cases the positions were vacant. The research team originally intended to interview ten nurses in Portland. However, only two individuals in this category are currently assigned to the parish in primary care. According to an

³ See Betty Butler Ravenholt. 2003. "Description of Delivery of Reproductive Health-Related Services Through the Primary Care Systems in the Parish of Portland and the St. Ann's Bay Health District." The Futures Group, POLICY Project.

assessment conducted for this project, “It appears that Registered Nurses are found primarily, if not exclusively, in hospitals and private medical practices.”⁴

Table 1.2 Distribution of Interviews with Managers and Providers

	MOH Central Office	NERHA	Portland	St. Ann’s Bay	Total
Programme Managers	12	9	4	4	29
Providers			21	11	32
Other			2	1	3
Total	12	9	27	16	64

Note: These numbers do not include the FGD conducted with six CHAs in St. Ann’s Bay and 10 CHAs in Portland.

Focus Group Discussions with Clients

Focus group discussions were held with clients/potential clients in urban and rural areas, to get their reactions to the proposed models of integration and to understand their preferences vis-à-vis the integration of FP/MCH and STI/HIV/AIDS services. Clients’ perceptions of stigma within the health care system and among providers and other clients were also explored (Client FGD guides are available on request). A total of 16 focus groups were conducted as shown in Table 1.3:

Table 1.3 Distribution of Focus Group Discussions with Clients/Potential Clients (Number of participants in parenthesis)

Group	St. Ann’s Bay Urban	St. Ann’ s Bay Rural	Portland Urban	Portland Rural
Adult males ages 25-49	1 (6)	1 (5)	1 (4)	1 (4)
Adult females ages 25-49	1 (6)	1 (6)	1 (6)	1 (6)
Young males ages 16 -24	1 (6)	1 (6)	1 (4)	1 (5)
Female youths ages 16 - 24	1 (5)	1 (6)	1 (6)	1 (6)

Age. For purposes of the FGD, youth was defined as ages 16-24 (16 being the age of consent in Jamaica), and adult was defined as ages 25 - 49.

Urban vs. rural. Clients living in the towns of St. Ann’s Bay and Buff Bay and Port Antonio (in Portland) were considered “urban,” while those living outside those towns were considered “rural.”

⁴Betty Butler Ravenholt. 2003. “Description of Delivery of Reproductive Health-Related Services Through the Primary Care Systems in the Parish of Portland and the St. Ann’s Bay Health District.” The Futures Group, POLICY Project.

Characteristics of the Managers and Providers

The managers have been working in their current jobs for an average of 4 years, with a range between less than one year to 16 years. Providers have been working in their current jobs for an average of 14 years, with a range of one year to 39 years. Managers had spent an average of 15 years working in public health. Providers had spent an average of 19 years in the field of public health, with a range of one year to 40 years.

3 Summary and Recommendations

This study has assessed the feasibility of a number of interventions related to integration of family planning, maternal health and STI/HIV services in the parish of Portland Parish and the St. Ann's Bay Health District. The findings of the study, combined with the cost information, provide the Ministry of Health, NERHA and the parishes with information on how to move forward with the components of integration that make sense for the parishes.

Table B.1 (in Appendix B) summarizes the findings related to each intervention, including the strength of agreement that the intervention is important, views on the likelihood that the intervention would be undertaken within two years, the policy changes, if any, that would need to be undertaken, the barriers to making the change and the level of government (Central MOH, NERHA and Parish) and other organizations (e.g. the NFPB, professional organizations or unions) that would be involved in making the change. While the respondents, both managers and providers, considered many of the interventions important, many were dubious that the interventions would be undertaken within a two-year time frame.

Reasons for Doubting that Integration Interventions would be undertaken Within Two Years

Reasons for being pessimistic about the interventions actually being undertaken were generally related to funding and the length of time it takes for changes to be made in the ministry. One manager noted, *"Everything in the Ministry takes 10 years."* Another added, *"We have to get the lessons learned and those kind of issues have to be widely accepted and a policy decision has to be made which is all literally time consuming,"* There was little consensus on what level of the health system would be involved in initiating and approving the changes investigated in this report. For each intervention, there were discrepancies as to whether the Central MOH, NERHA or the parish would be primarily responsible for making the changes. It is likely that this confusion results in a lack of initiative in the system regarding making changes to policies, procedures, and services. One manager explained, *"I think it may be a little beyond the Ministry of Health."* Parishes have little direct authority to make the changes suggested. *"At the end of the day the region has the purse string."*

Managers and providers were concerned that lack of staffing could hamper efforts to implement some interventions. One manager said, *"All this programme is very well and good but it's the same two little hands out here working."* Another manager said that the government's policy of giving long periods of leave, including department leave makes it difficult to ensure coverage for existing services, let alone any extended services. Other reasons for questioning the likelihood of interventions being undertaken included the need for:

- Clarity on policy change steps and which operational policy categories it would take (e.g. respondents noted the MOFP as being involved in policy changes on

staffing. Also, while the MOH maintains facilities; the Ministry of Lands owns the property).

- Champions for each intervention. *“There is no champion; there’s nobody who is held accountable for it.”*
- Policy dialogue with MOFP to get resources (resources consistently mentioned as an issue)
- Collaboration (e.g. integration of messages)

Not all of the suggestions made would require additional resources. For example, CHAs indicated that they would appreciate getting recognition and thanks for their work. Providers made a plea for making even small changes in work settings to improve the work environment (providers had several complaints about the shape some facilities are in). For example, some providers asked for a fan for their health centres.

Clients’ Reactions to Integration Interventions

Clients were enthusiastic about integration, and had positive reactions to most of the interventions, including:

- The appointment system (to not waste so much time sitting in the health centre)
- Extending clinic hours (some said early hours would also be welcome)
- Renovating clinics for privacy (although they said confidentiality is equally important for clients who don’t want everyone to “know my business”). For example, a lot of stigma is attached to “Room 7” in which STIs and HIV are diagnosed. One client explained, *“That room there, just bad.”*
- Having equipment and educational videos in clinics (soap opera style videos, or edutainment [incorporating educational material into entertainment], would be welcome)
- Using a self-screening checklist (some people would use and those who would not use it should for the sake of their health)
- Being reached with integrated messages by CHAs, Contact Investigators and Community Peer Educators. Young people especially are hungry for information about reproductive health, STIs and HIV
- Men being reached through child health visits (some men might be too busy and want to get through quickly, but others would welcome the opportunity to talk with a provider and get a brochure)

- Being seen the same day they are referred for an STI (to find out the same day if something is seriously wrong or not and reduce the risk of infecting others)
- Answering questions on a consolidated screening checklist (some clients might not want to answer, but they should be asked in case there are issues they hadn't thought of that should be addressed)

Clients were confused about the intervention to reduce special clinics. Many indicated that they worried about worse crowding in the clinics, not realizing that by having all services offered more often, crowding should be reduced. Still, while some clients welcomed the idea of not having to make multiple trips to the health centre, other clients said they thought the current system of special clinics was okay. Clients were not asked about some interventions, such as the STI diagnosis and treatment protocol that is still theoretical, and the revised MIS system that does not affect clients directly.

Rankings for Integration Interventions

Based on the findings from the study, the interventions have been grouped in four categories as shown in Tables B.2, B.3, B.4, B.5 and B.6 – best bets, second best bets, third best bets, long shots and one intervention in a special category. The best bets are interventions with the strongest agreement on importance and likelihood of implementation within two years.

See Appendix D for the costs of the interventions.

Best bets include:

- CIs provide limited FP counselling
- Sending CHAs to spend more time in the community with integrated outreach
- Sending STI referrals to Physicians and Nurses rather than Contact Investigators (this change is already underway)
- Strengthening the STI referral system
- Reaching men through child health visits
- Providing more integrated IEC materials
- Implementing an appointment system

Second best bets include:

- Purchasing TVs and VCRs for health promotion

- Training providers on a holistic approach
- Renovating facilities for privacy
- Hiring additional staff
- Introduce Mobile Teams Type I
- Developing an integrated screening checklist
- Extending evening hours in Types III and IV health centres
- Purchasing new equipment for Types I and II health centres

Third best bets include:

- Consolidating STI data (MIS)
- Reducing special clinics (Type IV)
- Introduce Mobile Teams Type II and Type III

Long shots include:

- Incentives to recruit and retain staff in rural areas
- Increasing the number of Community Peer Educators
- Modifying the fee system for STI referrals and contacts

Special category: This intervention was ranked very high in importance, but respondents were not asked about the likelihood of adoption within the next two years. In fact, there are many policy and program issues that need to be addressed before this intervention could be implemented.

- Modify the STI protocol for Types III and IV health centres (when tests are ready)

A cost effectiveness analysis was conducted on this intervention and can be found under separate cover.

Tables B.2 through B.6 in Appendix B are offered for discussion among stakeholders about whether integration is desirable and feasible and if so, which interventions to pursue and in which order.

4 Findings

4.1 Training Staff on the Holistic Approach

Background

The majority of potential interventions to increase integration have a component related to training. The following relates to the overall need for staff to reorient their thinking regarding serving the “whole” client, whatever the client needs might be. Other proposed interventions require various types of training for different levels of healthcare providers and relate specifically to clinical information or counselling needed for that particular provider. See the matrix on page 17 that shows the interventions by function and also shows which interventions include a training component.

Current Situation: Providers in all categories perform various forms of integration to a greater or lesser degree. One provider states that she treats her patients in a holistic manner regardless of the reason the client came to the clinic. If the client came for FP services, she will counsel them regarding safe sex, dual protection, STIs and also encourage them to have a pap smear. She will give the client a pap smear even if it is not the specified day when pap smears are given. Other providers only give the services designated by the particular specialized clinic conducted for that day.

Proposed Change: Regardless of what changes are made in the current health care system regarding enhanced integration of RH services, all staff need to be trained to provide services to clients in a holistic fashion to the extent possible. The staff need to be taught to view integration as an essential part of the services offered, not an “add-on” to what they are currently doing. They need to be sensitized to viewing the client as the centre of and the focus for combined services. True integration includes combining or joining services together as a strategy to provide a more complete package for the client. Ideally the training sessions should include participants from every provider category to foster the idea of a team approach to providing information and services to clients. Each provider type will be able to bring perspectives to the training that will enhance learning and interaction. By having all provider types together, communication among all providers can be enhanced. Attitudes regarding joint training will be determined during the provider attitude survey to be conducted by a local research organization.

The training should also include: human sexuality, human relations and adolescent reproductive health needs. The training in human sexuality should be explicit and practical, using appropriate anatomical models and audiovisuals. Time should be allowed for discussion of the psychological aspects of sexuality with special emphasis on the Jamaican setting. Also information should be provided regarding the benefits of HIV/AIDS prevention through the circumcision of males.

A major component of the training should be on counselling. All clients, whether presenting primarily for FP, HIV/AIDS, PMTCT, MCH, VCT or STI, should be offered integrated preventive STI/HIV/FP education. (See intervention on Screening in Section 4.2). All counselling should be consistent with existing VCT protocols. Counselling

techniques targeting specific groups such as men, women or adolescents should be addressed. Issues to be included in the training will also be identified during the research study planned for determining the service providers' willingness and ability to provide integrated services. In addition, specially selected supervisors should be trained in all aspects of the integrated service so that they can be responsible for coordinating future update training. Also, when feasible, the training could be offered to private sector physicians working in the parishes.

Anticipated Resource Requirements: Training for all staff – curriculum development, materials, trainers' salaries, training site costs, residential training off site. Impact indicators should be designed for the training.

Costs: J\$2,196,455 to J\$3,280,966 to conduct training for 130 staff members (See Appendix E)

Study Findings on Training-1

Agreement that Staff Require Training in Holistic Care for Clients

Eighteen of the 20 programme managers (90.0%) strongly agreed or agreed that regardless of what changes are made in the current health care system towards enhanced integration of reproductive health services, all staff should be trained to provide services to clients in a holistic fashion to the extent possible (Table T-1.1). Two managers, one at the central and one at the regional level, disagreed that providers need training in the holistic approach. Technical managers were somewhat more likely than administrative managers to say that providers need training on the holistic approach (92.3% compared to 85.7%). All of the 24 providers strongly agreed (37.5%) or agreed (62.5%) that providers should receive training in the holistic approach.

Table T-1.1. Level of Agreement that Providers Should be Trained in the Holistic Approach to Family Planning, Reproductive Health, and STI/HIV/AIDS, Among Managers

Level of agreement	Number	Percent
Strongly agree	10	50.0
Agree	8	40.0
Disagree	2	10.0
Total	20	100.0

Topics to be Included in Training on Holistic Care for Clients

Managers and providers agreed on the range of topics to be included in the holistic training approach, as shown in Table T-1.2. In addition, various managers and providers listed a number of other topics that could be included in the training.

Table T-1.2. Topics that Should be Included in Training on a Holistic Approach to The Components of Reproductive Health, such as Family Planning, Maternal and Child health and STI Screening, Diagnosis and Treatment (In percent)

Topic	Managers (N=17)	Providers (N=24)
Risk of both unintended pregnancy and disease transmission with unprotected sex	100.0	100.0
Human sexuality including psychological aspects of sexuality	88.2	95.8
Sexuality, gender and relationships within the Jamaican context	94.1	91.7
The reproductive health needs of men	94.1	100.0
The reproductive health needs of adolescents	94.1	100.0
Reproductive health and rights	100.0	100.0
Providing quality care to clients	100.0	100.0
Other social vulnerabilities and reproductive health/STI/HIV	NA ¹	100.0
Other topics (see list below)		

Note: Training should be provided at the appropriate level, by provider type. This training would be in addition to technical training on the components of reproductive health (including FP, MCH, STI and HIV/AIDS).

¹Due to a coding error, the responses for the managers for this topic could not be tallied.

Other topics, mentioned each by one manager or provider, included guidelines for provision of reproductive health care to adolescents, HIV/AIDS, Infection control, principles of health promotion, the relationship between general health and the reproductive health of males, sexuality in the general context, use of the morning after pill, abortion and the dangers of abortion, cancer screening for men and women, better parenting, healthy lifestyles, child abuse, anti-violence, customer service, support groups for persons with different diseases or conditions, support during pregnancy, rights of the client, sociology, counselling, psychology, communicating with persons of different backgrounds, and mental health.

Barriers to Training on a Holistic Approach

Eight of 12 managers who were asked (mostly technical managers from the Central MOH Office and the Regional Level) listed potential barriers to training, including:

- Difficulty in getting approval from the MOH
- The fact that there is limited training time available and this training would increase the length of time required for training

- The challenge of organising training so that everyone gets trained at different times
- The limited availability of qualified tutors
- People’s perception of what they need to know
- The process of curriculum change and influencing decision makers
- Providers were not asked about barriers to training.

Offices Responsible for Developing Training Curricula

According to the 10 managers who responded, eight listed the central office, seven NERHA and five the parish as responsible for developing the curricula (Table T-1.3). Three managers listed other organizations that would be involved in developing the curriculum for the training, namely the NFPB and the school of nursing. The Continuing Education Unit of the MOH indicated that it could play a role in the training, but that it was currently understaffed and had other priorities to tend to. However, the Continuing Education Unit could play a role in teaching and in developing materials.

Table T-1.3. Which Office(s) Is/Are Responsible for Approving the Training on a Holistic approach

Level	Number	Percent
Central MOH only	1	10.0
MOH and NERHA	1	10.0
NERHA only	1	10.0
NERHA and Parishes	1	10.0
Parish only	0	0.0
MOH, NERHA and Parishes	3	30.0
MOH and other organizations (UWI, School of Nursing, NFPB)	2	20.0
All three levels and other (School of Nursing)	1	10.0
Total	10	100.0

Policy Changes Needed to Implement Holistic Training

Most respondents indicated that no policy changes would be required to implement training on the holistic approach to client care. One manager noted that,

“In terms of the policy changes, it needs some policy to say if you are going to work in that particular area – the whole business of reproductive health – these are the basic requirements that you would need to become qualified [entry level qualifications to the area] as well as curricula that

they would use at the training institutions to ensure that the curriculum involves all holistic training.”

There is a need to convince training schools to include this training. Some respondents indicated that training already incorporates a holistic approach. *“I wouldn’t see any policy change needed there because that is the way we have been directing our patient care, isn’t it?”*

Perceptions of Likelihood of MOH Provision of Training on the Holistic Approach in the Next Two Years

There were mixed views regarding the likelihood of providing training on the holistic approach within the next two years (Table T-1.4). Of the 16 managers who responded, two indicated that it was highly likely (12.5%), eight that it was likely (50.0%), and five that it was unlikely (31.3%) that the MOH would provide training in the holistic approach to providers over the next two years.

Table T-1.4. Likelihood that a System for Training on the Holistic Approach will be Set Up in the Next Two Years, According to Manager

Likelihood	Number	Percent
Highly likely	2	12.5
Likely	8	50.0
Unlikely	5	31.3
Don’t know	1	6.3
Total	16	100.0

One manager explained:

“If you’re going to do it in regions, you’d probably first have to do a training of trainers so that everybody in all the regions are saying the same thing....so I see it as unlikely within the next two years, but I don’t think it is something impossible. We need coordination of efforts and to have the right people in place.”

One manager indicated that he/she was not sure and another indicated that this is already in progress.

“It has started, actually. It has started. ... The need also has been highlighted by many to have cross trained health care workers – family planning, STIs, safe motherhood. And there is also the desire from health care workers as well. And also it’s a paradigm shift from higher levels from WHO.”

Another respondent noted the challenge, saying “You’re talking about 10,000 providers out there.”

However, others indicated that:

- It is a low priority
- There are financial constraints. *“I think that it is something that should be done...the end result will be cheaper than we are doing now, because we’ll have people who are more rounded. But the cost of actually getting there...would be prohibitive....I think it would take more than two years.”*
- There is no ownership of the process. *“There is no champion; there’s nobody who is held accountable for it....The only way it is going to succeed is if it becomes...an indicator [of] success.”*

4.2 Screening

4.2.1 Development and Use of a Common Checklist for FP/ Antenatal/STI (Screening-1)

Background

Current Situation. When a patient comes into a particular facility, depending on the reason for the visit, the provider will ask a series of questions regarding the reason the client has come to the clinic. For instance, whether the client is coming for family planning, antenatal, STI or some other reason, there will be relevant questions asked of the client with the appropriate counselling provided. There are various checklists used by the provider for each of these various reproductive health issues.

Proposed Change. Ideally, for good integration of services, one comprehensive checklist for obtaining information should be used. Based on the answers to the checklist, appropriate individualized counselling could be provided for those infected or in need of contraceptive method-related treatment. A consultant could look at the current situation with regard to the various checklists to determine if the protocols could be combined in such a way to foster integration. It may be that the current protocols are sufficient, but someone needs to investigate the situation and make a determination whether changes should be recommended. The checklist would be used in all facilities for FP/MCH/STI screening.

Anticipated Resource Requirements. The fee for a consultant to study the situation and make recommendations; one week consulting fee. After the tool is developed, training for all provider staff needs to take place especially with regard to the appropriate counselling required. As with Training 1, (Section 4.1), this training could be offered to private sector providers when feasible. (This training could be a major sub-component of the training described under Training-1).

Costs: J\$205,066 to J\$559,107 to develop and print checklist (See Appendix E)

Findings for Screening-1

Opinion on Merging the Screening Checklists for Reproductive Health Care

Thirteen of the 16 managers who were asked (81.3%) agreed or strongly agreed that the screening checklists for reproductive health care should be merged to more fully integrate reproductive health care⁵. They thought that it would be possible (Table S-1.1). Among the 26 providers asked, 73.1% agreed or strongly agreed about the use of an integrated screening checklist.

Table S-1.1. Level of Agreement on Merging the Screening Checklists for Family Planning, Reproductive Health Care and STI/HIV

Level of agreement	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	4	25.0	7	26.9
Agree	9	56.3	12	46.2
Neither agree nor disagree	2	12.5	2	7.7
Disagree	1	6.3	5	19.2
Total	16	100.0	26	100.0

Willingness of Staff to Administer a Merged Checklist

Eleven of the 14 managers asked (78.6%) think that staff in health facilities would be willing to administer an integrated checklist. The response from providers was even more positive, as 23 of the 25 respondents (92%) indicated that they would be willing to administer an integrated checklist. Providers anticipated several advantages of using a merged checklist, including easier and earlier detection and treatment of all reproductive health issues, and reduced paperwork and use of stationery.

Willingness of Clients to Answer Questions on a Merged Checklist

Fourteen of the 15 managers asked (93.3%) felt that clients would be willing to answer questions on the integrated checklist, and 13 (86.7%) thought the integrated checklist would make it easier to meet their needs. Twenty-two of the 25 providers asked (88%) also agreed that clients would be willing to answer questions on the integrated checklist. Many clients, both male and female, also indicated that they would be willing to answer questions on an integrated checklist, and thought it would allow the providers to provide better care. However, some clients said that some people would not answer the screening

⁵ Providers noted a number of checklists that they currently use to screen clients, including: Docket Jacket (for first visit only), Patient Health Profile; Individual health continuation sheet; Medical Record; A piece of paper General Visit; STI; STI Score Sheet; STI Syndromic Treatment Record; Special Form for STD Specifics (risk assessment etc., lab request form); HIV/AIDS Confidential Forms; Risk Assessment Scoring Form; Maternal Care Record; Antenatal/Postnatal Form; Family Planning; Child Health Record.

checklist or that some people might lie. Some indicated that some clients may object to the use of an integrated checklist because:

- Clients are shy
- Clients are concerned about privacy and the number of people who have access to the information in their docket
- Clients may be concerned that more time would be required to administer the longer checklist
- Some clients would want to have their primary complaint dealt with more quickly.

Women tended to say that since they are already sexually active, the questions are not too sensitive. One adult woman from rural Portland explained, *“We are all woman, so we have to know how to face nuff things.”*

A young woman in urban St. Ann’s explained that she would be willing to be asked the questions on the integrated checklist. *“Yeah, it is good, you know, because sometimes there are certain things that we might not take into consideration, but if asked, you know, we’ll consider we answer it, so, I think it’s good when we’re being asked more questions.”*

Men were less certain about the integrated screening checklist. Young men in rural St. Ann’s Bay said that some would answer and others would not. Those who would not, *“don’t wanna talk about their sex life, sex life, and stuff.”* Another young man in the group said,

“Well, some would listen. It would actually go to the mood that they’re, you’re, the setting of the place, probably if the person is nice to you, and right, you’d actually open up to that person. But if it was more like a serious type person, probably they wouldn’t.”

A young man from urban St Ann’s Bay said that clients should be asked integrated questions. *“If you go about family planning thing and they ask you about sexually transmitted diseases, they have a right, because they want to know how you react, if you a cheat, if you a cheat, or watch and come, and whatever.”*

A young man from Portland said,

“To ask some more questions. I mean, I never been in one where they ask questions before, but sometimes them just maybe hurry up things just to get to somebody else, and them no really ask enough questions or some questions that would point you in the right direction.”

An adult man from Portland said he doubted that men would answer, saying that they would not want to have to think about the responses, *“a no everybody brave enough fi really, like ‘How much woman you having sex with without condom?’ And you seh like, one, two or three.”*

Barriers to Merging Checklists

The views of managers were almost evenly split regarding the existence of barriers to merging the existing checklists, as eight (47.1%) of the 17 who were asked thought there would be barriers, and nine (52.9%) said there were none. Barriers identified included:

- The time required to administer the checklist
- Resistance to change
- Resistance to additional work among health care providers
- The need to print new forms
- The need for a consistent format for Monthly Clinical Summary Report (MCSR) reporting.

Providers were also concerned that there may be inadequate staff to administer the longer checklist and that clients may be unwilling to provide the additional information. They also expressed concern about ensuring confidentiality of the information recorded.

Procedures for Obtaining Approval to Merge Checklists

Thirteen of the 15 managers who were asked thought that the central level would be involved in approving the merging of the checklists (Table S-1.2). Only nine thought the region would be involved, and only four thought the parish would be involved. One respondent also noted that the unions and professional associations may also play a role.

Table S-1.2. Office(s) Responsible for Approving Merging of Checklists for Reproductive Health

Level	Number	Percent
Central MOH only	6	40.0
MOH and NERHA	3	20.0
NERHA only	2	13.3
NERHA and Parishes	0	0.0
Parish only	0	0.0
All three levels	3	20.0
All three levels + professional unions	1	6.7
Total	15	100.0

The following responses reflect the differing views on this issue. One regional manager thought that the Central MOH level would not need to be involved, saying that merging checklists is “*not a policy issue, therefore decision can be taken in the Region. We can finalise a list in the Region and use it.*”

Another manager, from the central level, described a process with significant involvement at the Central MOH level:

“We don’t approve a checklist until we have developed something and tested it. First, we decide it’s something we want to do. Check with the regions. We want to see where we can feasibly test it. Then we get a small working group together, sit down and look at the development of the integrated checklist. Then we implement it and test it in different types of settings. Because we’d have to use big clinics, small clinics, rural clinics, urban clinics. You find the methodology and the evaluation assessment criteria, etc. Run it for ‘X’ months; see how it works, do the analysis, get the results. Once you have that, then you would go through the technical review process and the findings with the CMO, and with a recommendation. Yes, it makes sense, no it doesn’t make sense. If it makes sense, then it’s taken to Policy Directorate level after that and ultimately put into policy.”

Likelihood of Merging Screening Checklists within the Next Two Years

Eight of the 14 managers (57.1%) who were asked thought it likely or highly likely that the checklists would be merged within the next two years (Table S-1.3). However, of these, only one thought it would be highly likely. Three respondents thought it would be unlikely. One thought it was a low priority, while the other two thought the time frame was too short, as illustrated by the following response:

“... We have now pilot programme in one, in one or two parishes... so we have to get the lessons learned and those kind of issues have to be widely accepted and a policy decision has to be made which is all literally time consuming, even though we are a technical field. I don’t mean that not to happen but I am just saying it’s unlikely in the next two years. It may take more than twenty-four months.”

Table S-1.3. Likelihood of Merging Screening Checklists Within the Next Two Years

Level	Number	Percent
Highly likely	1	7.1
Likely	7	50.0
Unlikely	3	21.4
Highly unlikely	0	0.0
Don’t know	3	21.4
Total	14	100.0

4.3 Increasing Access in Health Centres

4.3.1 Reducing Special Clinics (Access-1a) and Having All Services Offered More Often and Using Mobile Teams (Access-1b).

Background

Current Situation. Both parishes designate certain “clinic days” for family planning, ante-natal, post natal, STIs, child health and medical/curative in facility levels from Type I to Type IV. On these clinic days, only the designated services are offered to clients. This vertical provision of services mitigates the potential of integration of services. In some facilities, there is an attempt to schedule certain clinics on the same day such as post natal and family planning or family planning and STI. This practice facilitates some form of integration but it appears that more could be done.

Proposed change. To the extent possible, the number of special clinic days should be reduced in all facilities and combined services should be offered such as ante-natal, post natal, and FP on each of the days the provider attends the facility. The ability of the parishes to do this will be based on the number of providers that are available and the number of facilities needing to be served. (Access-1a)

In both parishes, one possibility could be to form a mobile team of healthcare providers that would visit Type I, II and/or III facility sites. The team could be composed of a physician/nurse practitioner, midwife, pharmacy tech., lab technician, cashier etc. This team could provide all health care services to clients. Essential medical supplies and medications would be transported with the team. (Access-1b)

Anticipated Resource Requirements. Potentially no extra costs for Type IV facilities, but transportation cost for mobile teams to Type I-III facilities.

Costs: J\$188,188 (See Appendix E)

4.3.1.1 Study Findings on Access-1a (Reducing Special Clinics)

Opinion on Eliminating Special Clinic Days and Offering All Services on the Same Day

Some managers⁶, particularly those at the Central MOH Level appeared uncomfortable with the premise that on special clinic days only the designated services are offered to clients.

“The thing is that it’s not a ‘either/or’ situation. So none of these work in that way. The core of the Maternal & Child Health Services is to have the family planning accessible on any day of the week... sometimes you need

⁶ An attempt has been made in some cases to distinguish between the responses of managers who are in administrative vs. technical positions; however due to the small number of cases in this study, it was not possible to distinguish responses according to administrative vs. clinical training.

to run special clinics; that's a given. But the antenatal clinic, when you assess the woman, the woman, based on the assessment, may have something which is related to STDs ...if the woman comes on any day, she's supposed to also be able to get the service... the woman who comes and says: "I'm out of pills and I want some more pills", must be able to get her pills any day. But if she needs a pelvic examination and [the Midwife] is tied up doing something else, she may need to come back, or wait. The principle, ...should be, always to provide, given the resources available, as much as possible, an integrated care to the individual. But you may have to have special times and special days for certain types of services."

However, the majority of the 21 managers and 25 providers who were asked, agreed that to the extent possible, the number of special clinic days at Types I, II and III health facilities should be reduced and combined services should be offered such as antenatal, post natal, and family planning on each of the days the provider attends the facility (Table A-1.1, A-1.2 and A-1.3). A higher percentage of providers (64%) than managers (57%) indicate that special clinics in Type III centres should be reduced.

Table A-1.1. Agreement on Eliminating Special Clinic Days and Offering All Services on the Same Day in Type I Facilities, According to Managers and Providers

Response	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	6	28.6	5	20.0
Agree	6	28.6	10	40.0
Neither agree nor disagree	3	14.3	4	16.0
Disagree	6	28.6	6	24.0
Total	21	100.0	25	100.0

Table A-1.2. Agreement on Eliminating Special Clinic Days and Offering All Services on the Same Day in Type II Facilities, According to Managers and Providers

Response	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	5	23.8	3	12.0
Agree	8	38.1	12	48.0
Neither agree nor disagree	1	4.8	2	8.0
Disagree	7	33.3	8	32.0
Total	21	100.0	25	100.0

Table A-1.3. Agreement on Eliminating Special Clinic Days and Offering All Services on the Same Day in Type III Facilities

Response	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	7	33.3	7	28.0
Agree	5	23.8	9	36.0
Neither agree nor disagree	1	4.8	2	8.0
Disagree	8	38.1	7	28.0
Total	21	100.0	25	100.0

Providers were also asked their opinion on eliminating special clinic days at Type IV facilities. The majority of respondents (53.8%) were in favour of this, but a significant proportion (42.3%) disagreed (Table A-1.4).

Table A.1.4. Agreement on Eliminating Special Clinic days and Offering All Services on the Same Day in Type IV Facilities, According to Providers

Response	Number	Percent
Strongly agree	7	26.9
Agree	7	26.9
Neither agree nor disagree	1	3.8
Disagree	11	42.3
Total	26	100.0

Note: One respondent in Portland indicated that she was not familiar with Types I-III, and therefore she only responded for Type IV, resulting in 26 respondents for Type IV while there are 25 respondents for Types I-III.

Managers were not asked about Type IV facilities.

Clients had mixed reactions about eliminating special clinics. Some were opposed to eliminating special clinic days and many were concerned about the possibility of crowding at an integrated clinic.

“You feel more comfortable if everybody come for the same thing. Like all pregnant women today, you feel comfortable, because everybody pregnant today.” [St. Ann’s Bay Females – Adult Rural]

“Well, I don’t think it would be a good idea...because it would be too crowded.” [St. Ann’s Bay Males – Youth Rural]

“That would be too stressful...because the amount of people that you have to deal with, you know. Too much havoc... We are not out of the area.... If you have to bring your baby tomorrow, and you have to come today, you

come today, and tomorrow you bring your baby.” [St. Ann’s Bay Females – Adult Urban]

“Well, to tell you the truth ‘bout Port Antonio now. You know you deh pon the sea front, right? And most Port Antonio man kind of show off. Them no go a clinic. Every man a hold them own money, the go a doctor... For from some people a pass and see you a clinic, them a go sey you either have AIDS, or you have gonorrhoeah, or you have some disease, that’s why you deh a clinic, or a sore foot.... So me no really use the health centre.” [Portland Males – Adult Urban]

Others felt it would be more convenient and less expensive, but expressed concern about having sufficient staffing in place.

“Yeah, ‘cause maybe we wouldn’t have to have so much visit, cause I mean, if you go there on a Tuesday, maybe you haffi go back pon a Wednesday, coulda just do it on the one day. Personally me never go a the scheme, but me carry my step daughter, and me haffi go more than one day.... From you go and you get through the same day. Not a problem. It’s the going back and the going back that we can’t manage.” [Portland Males – Youth Rural]

“It would save them the travelling because they can use the one in a them community... ‘cause all of them offer the same thing...It would a more cheaper...like how the fare raise now... Because if you don’t have to leave from Runaway Bay come a St. Ann’s Bay, that a cost you eighty dollars...” [St. Ann’s Bay Men – Youth Urban]

“Well, financially it would assist because clients, they wouldn’t be paying fares especially if they were out town.... and of course, time as well....The disadvantages lie if you don’t have sufficient doctors or nurses to deal with the situation, because then you’ll have a longer time to stay with one client.” [St. Ann’s Bay Males – Adult Urban]

“You could have it for one day, ‘cause for people who going to work, it’s difficult to get two days off to come to the clinic. But in that case, they would need to have more employees. Instead of one nurse doing all the babies, you probably could have four or so nurses doing the babies, and another two nurses probably doing the mothers....Because I’ve been here until four, and it’s just the babies that they’ve taken care of, and that time they probably close at 5:30, so it’s not much time to deal with so many persons.” [St. Ann’s Bay Females – Adult Urban]

Perceived Barriers to Reducing the Number of Special Clinic Days

One of the main concerns among both providers and managers was the level of staffing required to operate combined clinics (Table A-1.5). Seventeen of the 20 managers who were asked (85%) identified staffing as a barrier. Only four managers (all technical

managers) thought that policy changes might be needed to reduce special clinic days in order to offer all services more often. Other factors included culture, inadequate equipment and laboratory facilities, the location of the centres and transportation, and the number of clients.

Table A-1.5. Perceived Barriers to Reducing the Number of Special Clinic Days, According to Managers

Level	N = 20	Percent
Policies	4	20.0
Procedures	4	20.0
Staffing	17	85.0
Facilities	8	40.0
Other	9	45.0

One manager from the Central MOH Level explained why she disagreed with eliminating special clinic days for the Types II and Types III as follows:

“We have very limited staff, and the staff that provide these services are like the Midwives and the Public Health Nurses. For management of STIs for example, we don’t have doctors at a Type I health centre; we don’t have nurse practitioners. Types II don’t have them there all the time either. And the Types III will have them, but they tend to focus on curative. Now for example, if you talk about reproductive health you have to consider the other services - like immunization that’s offered. Because it’s the same staff. If you are going to say every single day, all the services should be provided by the same staff, then it’s going to include other services outside of reproductive health that must be available all the time. For immunization for example, there are certain vaccines that once you open them, you must use them up within six hours; and if we’re going to have a system where any day, every day people will come, we’re going to have a lot of wastage. For logistics, when you’re doing Family Planning you have to be handling speculum; it’s a dirtier thing when you’re doing vaginal exams and stuff. Yes, we have hand-wash basins etc., but if you’re going to be doing that and then turn around and taking a newborn and giving vaccines and stuff, logistics – it is going to be hard. The documentation is different, the kind of attention that needs – it’s going to be difficult. If we had adequate staff that you could have some devoted to a combined thing... okay you look after the baby, you look after it probably could work but, given our current resources....Getting rid of the special would be ideal, but I don’t agree that it can work.”

Providers from both parishes expressed similar concerns about the implications for staffing of reducing special clinics in order to provide all services more often. Providers in St. Ann’s Bay said:

“I would disagree for Type I and II. Staff would be burdened. Based on the present staffing situation if all services are offered on a same day the client come in then the staff will be burdened to offer that service. You find that you probably have one Nurse working in a Type I to offer all that care would be almost impossible but if staff is improved then fine.”

Providers in Portland said:

“... for [Types] III and IV which has a larger clientele, I don’t think that we should reduce the special visits, [because they have a larger clientele] and the same amount of staff.”

“Too many patients one time when you not going to have the staff to deal with so many persons...Because of that you’re going to have a longer working period and they going to start quarrelling.”

“There is a larger population and for the inflow of clients, presently you would not have enough staff to cope with that volume of work. We don’t have the accommodation even for the waiting area will be too small. There are times when the same nurse who does the prenatal that the same who does the child health and family planning.”

Offices with Authority to Reduce the Number of Special Clinic Days and Offer Combined Reproductive Health Services

Thirteen of the 19 managers who were asked thought that the Region would be involved in the process of authorising the reduction in the number of special clinic days (Table A-1.6). Nine thought the MOH would be involved and only eight thought the parish would be involved. Among those eight managers, five or 27.3 percent of all managers sampled thought that the parish itself had authority to reduce the number of special clinic days on its own, and that the five included respondents from the central level, regional level and both parishes.

Table A-1.6. Offices With Authority to Reduce the Number of Special Clinic Days and Offer Combined Reproductive Health Services

Level	Number	Percent
Central MOH only	1	5.3
COH and NERHA	6	31.6
NERHA only	4	21.0
NERHA and Parishes	1	5.3
Parish only	5	26.3
All three levels	2	10.5
Total	19	100.0

Likelihood of Reducing the Number of Special Clinic Days in All Facilities and Offering Combined Reproductive Health Services within the Next Two Years

Despite the fact that the majority of managers and providers agreed that, to the extent possible, special clinic days should be reduced, only nine of the 20 managers (45%) who were asked thought it likely or highly likely that this would be implemented within the next two years (Table A-1.7).

Table A-1.7. Likelihood of Reducing the Number of Special Clinic Days in All Facilities and Offering Combined Reproductive Health Services Within the Next Two Years

Response	Number	Percent
Highly likely	2	10.0
Likely	7	35.0
Unlikely	5	25.0
Highly unlikely	1	5.0
Don't know	3	15.0
No response	2	10.0
Total	20	100.0

4.3.1.2 Study Findings on Access-1b (Using Mobile Teams)

Opinion of Using Mobile Teams of Providers to Reduce the Number of Special Clinic Days in Types I, II and III Health Facilities

There was confusion among the respondents about the meaning of this intervention which was intended as: “In both parishes, one possibility could be to form a mobile team of healthcare providers that would visit Type I, II and/or III facility sites. The team could be composed of a physician/nurse practitioner, midwife, pharmacy tech., lab technician, cashier etc. This team could provide all health care services to clients. “Essential medical supplies and medications would be transported with the team.” (see Section 4.3.1) While the parishes currently have staff to travel from higher-level health centres to Types I and II health centres, the team concept for the proposed intervention would be to have a larger roster of health care staff, including a physician/nurse practitioner, etc as noted above, travel in mobile teams. The proposed intervention did not include purchasing a special vehicle such as mobile clinic van to transport the team.

The confusion about this intervention was evident in responses from some managers, who said a system of mobile teams currently exists. One manager indicated that:

“Again, there are mobile teams, because outreach clinics are held. In terms of some of these smaller type centres, we don't have the full-time staff that's most typical, and what happens is they are covered from the

next level centre. I am aware of these too, there are some communities that don't have a health centre and mobile teams are what they depend on for some of these services."

However, the majority of managers who were asked agreed with using mobile teams to reduce the number of special clinics in Type I facilities, but disagreed with this model for Type II and Type III facilities (Table A-1.8, A-1.9 and A-1.10). On the other hand, the majority of providers agreed with the mobile model for all three types of facilities, although more providers agreed for Type I (20 of 27 or 74.1%) than for Type II (18 of 27 or 66.7%) and Type III (17 of 27 or 63%).

Table A1.8. Agreement on Using Mobile Teams to Reduce the Number of Special Clinic Days in Type I facilities

Response	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	7	35.0	5	18.5
Agree	11	55.0	15	55.6
Neither agree nor disagree	0	0.0	1	3.7
Disagree	2	10.0	6	22.2
Total	20	100.0	27	100.0

Table A-1.9. Agreement on Using Mobile Teams to Reduce the Number of Special Clinic Days in Type II facilities

Response	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	2	10.0	3	11.1
Agree	6	30.0	15	55.6
Neither agree nor disagree	4	20.0	2	7.4
Disagree	8	40.0	7	25.9
Total	20	100.0	27	100.0

Table A-1.10. Agreement on Using Mobile Teams to Reduce the Number of Special Clinic Days in Type III facilities

Response	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	1	5.0	3	11.1
Agree	3	15.0	14	51.9
Neither agree nor disagree	3	15.0	3	11.1
Disagree	13	65.0	7	25.9
Total	20	100.0	27	100.0

Recommended Providers for Mobile Teams

Several respondents indicated that a Family Nurse Practitioner could travel with the team instead of the Physician. Suggestions for other members of the mobile teams included: Contact Investigators, clerical officers such as Cashiers or Record Clerks, Public Health Inspectors, Pharmacists, Laboratory Technicians and Health Educators.

Offices with Authority to Approve the Use of Mobile Teams

Fourteen of the 19 managers asked (73.7%) indicated that the Regional Authority would participate in the authorisation process whether as the sole authority (6 or 31.6%), in conjunction with the Central MOH Level (5 or 26.3%) or in conjunction with the Parish (3 or 15.8%) (Table A-1.11). Only seven (36.8%) of the respondents thought that the Central MOH Level would be involved in the approval process, and of these, only two (10.9%) thought that they would have sole authority. Only four respondents (21.1%) thought that the Parish would be involved in the approval process, and only one, a manager at the Regional level, thought that the Parish would have authority to approve the use of mobile teams without involvement of other levels.

Table A-1.11. Offices With Authority to Approve the Use of Mobile Teams

Level	Number	Percent
Central MOH only	2	10.5
MOH and NERHA	5	26.3
NERHA only	6	31.6
NERHA and Parishes	3	15.8
Parish only	1	5.3
All three levels	2	10.5
Total	19	100.0

Perceived Barriers to Forming Mobile Teams to Reduce the Number of Special Clinic Days

All fifteen managers who were asked indicated that staffing is a barrier to forming mobile teams (Table A-1.12). Forty percent each also noted procedures and facilities as barriers. Around one quarter (26.6%) noted policy as being a barrier.

Table A-1.12. Perceived Barriers to Forming Mobile Teams to Reduce the Number of Special Clinic Days, According to Managers

Level	N = 15	Percent
Policies	4	26.6
Procedures	6	40.0
Staffing	15	100.0
Facilities	6	40.0
Other	9	60.0

The majority of the “other” responses (6 of 9) or forty percent of the fifteen managers who were asked, indicated that transportation would be a barrier, and four (26.6% of the total sample) identified funding as a barrier.

It is obvious from the following quotes that there was confusion about the term “mobile teams.” The proposed intervention did not include the idea that the medical team would use a special vehicle like a mobile clinic van to travel to the health facilities.

Managers at the Central MOH Level said of mobile teams:

“In many instances, it won’t make sense. You need to have adequate transport. Transportation is a major issue. The amount of time you spend on the road; number of hours. Sometimes you actually spend more time on the road going to the place, than actually in the clinic seeing the patients. Now that can’t make sense either. Certain things you’re going to have to refer a better location where you can... if you’re not set up. So as I said, it depends on what you’re trying to do. Routine services for a population of 20,000 or 15,000 people, or 10,000 people, I cannot see mobile being effective. Because our same people need to see other problems that the people are facing, not just this.”

“Again, if it is mobile, where they go from place to place, if they’re going to function outside of a clinic that is already set up; for example, if you’re going to insert IUDs, you need certain facilities. So if the health centre has that, fine. Other than that, is it going to be a mobile unit like the Colgate, where they could provide the services from inside that unit? So to me, the barriers would be the transportation in terms of how you decide – is it that the staff drive their own cars to the site, or they go together? If you’re going to have separate teams, we have to make sure that they are adequately trained to provide all the services. In terms of procedures, again to decide what services going to be provided, how to do it, how you’re going to do it on a mobile unit, documentation – where you put the patients’ documents. The records must reside at a particular centre and which one will it reside at.”

“Staff inadequacy – that’s the first one. Staffing. I think second is the money. And if you’re talking about mobile teams, certainly you’re talking about the availability of transportation. And that is also a barrier.”

Managers at the Regional level had similar reactions regarding mobile teams:

“The barriers are financial resources to acquire the vehicle, and staffing...a mobile team, the vehicle, much like an ambulance, is an extension of the hospital. When you’re in an ambulance, you’re simply in a mobile portion of the hospital, and the mobile team is for the similar service.”

“... if we got a little bit more sophisticated, and we had a proper vehicle, the road conditions most of the times does not facilitate the, you know, like the mobile trucks, you know which is completely equipped? I’ve seen that, but it is not ideal for where it is, where the mobile team would go, it would be a place that is a straight road like here, and the accommodation and space and things might be here. But where it might be needed, up in hills, maybe the vehicle can’t go there because of the road conditions, and that sort of thing.”

Likelihood of Using Mobile Teams to Reduce the Number of Special Clinic Days within the Next Two Years

Of the twenty managers who were asked, only half thought it likely or highly likely, that the use of mobile teams would be implemented within the next two years, compared to five who said it was unlikely or highly unlikely (Table A-1.13).

Table A-1.13. Likelihood of Using Mobile Teams to Reduce the Number of Special Clinic Days Within the Next Two Years

Response	Number	Percent
Highly likely	2	10.0
Likely	8	40.0
Unlikely	4	20.0
Highly unlikely	1	5.0
Don’t know	2	10.0
No response	3	15.0
Total	20	100.0

4.3.2 Extend Evening Hours St. Ann’s Bay Health Centre and Buff Bay Hospital (Access-2)

Background

Current Situation. St. Ann’s Bay Health Centre, Portland Health Centre and Buff Bay Community Hospital are currently open five days a week during the day. Clients come early in the morning and stay until they are served. They may not be served for several hours. Currently, nursing services are offered during extended hours at the Buff Bay Community Hospital, however, employed individuals, unless they are severely ill, often cannot devote so much time to obtaining health services. This situation is especially negative to men who seek health care.

Proposed Change. St. Ann’s Bay Health Centre could extend the clinic hours and offer services two evenings a week in order to make it more convenient for employed people (especially men) and to offer services to people who would otherwise use the St. Ann’s Bay Hospital emergency room. The medical officer indicated that this could be done without a significant increase in staffing. The services offered would be comprehensive and integrated with no specialized clinic being held. It would be a true primary care, integrated service.

In Portland Parish, the Port Antonio Health Centre and the Buff Bay Hospital could also extend the clinic hours and offer services two evenings a week.

Anticipated Resource Requirements. Provider time could be staggered (flex-time) so that a physician would still only work an 8 hour day. Some over-time salaries would have to be paid for additional staff such as a CHA, midwife or public health nurse, cashier, and a security guard. Also a pharmacist or pharmacy technician could be present or they could prepare pre-packaged medicines for use in the evening clinic if a physician were present or if the policy changed regarding allowing medications to be prescribed by nurse practitioners. Utility costs would also increase.

Costs: J\$1,524,848 (See Appendix E)

Study Findings on Access-2

Opinion on Extending Clinic Hours in Some Facilities

The majority of 17 managers and 32 providers who were asked, expressed agreement with extending clinic hours in some facilities (Table A-2.1). However, providers appeared to be less enthusiastic than managers, as only 68.7 percent or 22 of 32 providers agreed or strongly agreed, compared to 82.4 percent or 14 of the 17 managers. Only five (15.6%) of the providers strongly agreed, compared to eight (47.1 %) of the managers, and five (15.6%) of the providers disagreed, while no managers disagreed.

Table A-2.1. Agreement That Clinic Hours in Some (Type IV) Facilities Should Be Extended to the Evening

Response	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	8	47.1	5	15.6
Agree	6	35.3	17	53.1
Neither agree nor disagree	3	17.6	5	15.6
Disagree	0	0.0	5	15.6
Total	17	100.0	32	100.0

The idea of extending health centre hours appears to be more popular among managers attached to Portland, while it is more popular among providers in St. Ann’s Bay. In Portland, two of the four managers who were asked strongly agreed and two agreed, while in St. Ann’s Bay, of the four managers who were asked, none strongly agreed, one agreed, and the remainder constituted the three “neither agree nor disagree” responses in the entire sample of managers. Among providers, 81.8 percent or nine of the 11 respondents in St. Ann’s Bay agreed or strongly agreed (Table A-2.2). In Portland only 61.9 percent or 13 of the 21 providers agreed or strongly agreed, and four (19%) disagreed. Only one (9.1%) disagreed in St. Ann’s Bay.

Table A-2.2. Agreement of Providers that Clinic Hours in Some (Type IV) Facilities Should be Extended to the Evening, by Parish

Response	St. Ann’s Bay		Portland	
	Number	Percent	Number	Percent
Strongly agree	3	27.3	2	9.5
Agree	6	54.5	11	52.4
Neither agree nor disagree	1	9.1	4	19.0
Disagree	1	9.1	4	19.0
Total	11	100.0	21	100.0

The idea of extended hours also received favourable responses among clients in both parishes, but some expressed concern about having adequate staffing arrangements in place to avoid overextending the staff. In Portland, clients said:

“Maybe if you work during the day, you will have time to go in the night.”
[Females – Youth Urban]

“Definitely... It depends on the time that you had to come to clinic and depends what time you get the vehicle or etcetera....Even the pharmacy can be open little

later. Because I guess is two o'clock it lock. So if it can lock say five, or five-thirty, it more better." [Females – Adult Rural]

"It wouldn't be a bad idea; it would be a good idea....As long as they have enough workers. Because they don't have enough workers and the same workers have to be working late, and they have to go home and do their business, they are going to be tired next day." [Females – Adult Urban]

"No man nah go nowhere a evening you know. Rum we start drink them hours deh." [Males – Adult Urban]

"Nuff young man might be ashamed [shy] of what they coming to deal with, so they would probably come later." [Males – Youth Urban]

Clients in St. Ann's Bay said:

"The working class people, persons, rather, they would have instead of going somewhere else, they can just go to the clinic and it would be cheaper ... Instead of going to the private doctor at the time they might get off work, you can just go to the health centre" [Females – Youth Rural]

"Yes, it would be more convenient for people who is working and have to leave work certain time... But then, the staff probably would be stressed, unless you gonna have a rotation." [Females – Adult Urban]

"I like that. It would be easier for like people who are working late. You know you come off at work at four, four thirty, five... then you have a better chance of catching the clinic one time. It would be good, a long time they could have done that. All you do is, you have shifts... workers if them tired, you have a next person to work. Or you may be tired, yes, and confused, because you working with so many people from the morning if you went. So therefore, it better if you do shift also, better for you... because some workers argue in the clinic...Do a shift." [Females- Youth Urban]

"If it go till eight o'clock, the only reason, you nuh have to rush, go kill off yourself when it full up during the day. You just wait till evening kinda come down more easier, because who was there in the day would be gone.... So, it would be more easier.... And some people might have things doing in the day... Can make it in the evening still, can't make it in the day." [Males – Youth Urban]

Responsibility for Approving Changes to Clinic Hours

Fourteen of the 15 managers who were asked (93.3%) indicated that the Regional Office would be involved in approving having clinic hours extended in the evening (Table A-2.3). Of these, only four (26.7%) thought that the Central MOH would be involved in the approval. Only one respondent, at the Regional Level, indicated that the decision could be taken independently at the parish level, indicating:

“That is a local initiative. It really doesn’t have anything to do with the national [or] the regional perspective. It has to do with a local decision where the staff would come together and look at the services offered, look at the user rate of the facility and look at the clientele, and determine if the community would be better served by having extended services for clients in the afternoon.”

Table A-2.3. Office(s) Responsible for Approving Changes to Clinic Hours

Level	Number	Percent
Central MOH only	0	0.0
MOH and NERHA	3	20.0
NERHA only	7	46.7
NERHA and Parishes	3	20.0
Parish only	1	6.7
All three levels	1	6.7
Total	15	100.0

Policies and Procedures and Other Factors to be considered in Extending Working Hours

One of the major issues in extending clinic hours appears to be the implications for staff working hours and the possible need to renegotiate the working hours outlined in union agreements, if a shift system were to be introduced. Otherwise, one respondent indicated that:

“There are no policies that need to be changed for that. ... in the Western region, we established them in Lucea, Green Island and Sandy Bay - Type IV and Type III locations... We got into trouble with money. Because we’d have to pay session fees to staff who stayed four hours after five [o’ clock]. So that was the only problem.”

Security and staffing also appear to be major concerns, as six of the seven managers who were asked indicated that security would have to be considered and five of seven (71.4%) noted staffing as an issue (Table A-2.4).

Table A-2.4. Factors to be Considered in Extending Opening Hours of the Health Centre

Level	N=7	Percent
Security	6	85.7
Cost	5	71.4
Staff	5	71.4
Other	2	28.6
No response	1	14.3

Professional Associations' Rules Regarding Extended Working Hours

Eight of the nine managers who were asked believed that the rules or constitutions of providers' professional associations allow members to work extended hours (Table A-2.5). The majority of the 24 providers asked (75%) agreed. Only two providers, both physicians, indicated that the rules do not allow members to work extended hours. It should be noted that a total of six physicians were interviewed, of which three indicated that the rules do allow members to work extended working hours. One did not know.

Table A-2.5. Do the Rules or Constitutions of Health Providers' Professional Associations Allow Members to Work Extended Hours?

Response	Managers		Providers	
	Number	Percent	Number	Percent
Yes	8	88.9	18	75.0
No	1	11.1	2	8.3
Don't know	0	0.0	3	12.5
No response	0	0.0	1	4.2
Total	9	100.0	24	100.0

Staff Opinion on Working Extended Hours

Eight of the nine managers who were asked did not feel that any category of staff would object to working during evening clinic hours (Table A-2.6). Only one respondent, a regional manager, felt that some categories of staff may object, but did not identify any specific category. Other respondents indicated that objections would more likely occur on an individual basis, due to possible conflicts with an individual's personal circumstances or commitments.

Managers' views are consistent with the response of providers, as 78.1 percent or 25 of the 32 who were asked, indicated that they would not object to working during evening clinic hours. Only four providers (12.5%) indicated that they would object to working evening hours, as they had other commitments in the evening or interests to pursue after normal working hours. However, it should be noted that the seven (21.9%) who objected or were undecided, included physicians, midwives, public health nurses and pharmacists, all specialized categories that are likely to form a core part of a late shift team, with limited staffing available for substitutions.

Table A-2.6. Would Staff Object to Working During Extended Evening Hours?

Response	Managers		Providers	
	Number	Percent	Number	Percent
Yes	1	9.1	4	12.5
No	8	72.2	25	78.1
Don't know	0	0.0	3	9.4
No response	0	0.0	0	0.0
Total	9	100.0	32	100.0

Providers' attitudes appear to be fairly consistent across the two parishes, but a relatively higher percentage of providers in Portland than St. Ann's Bay indicated that they would object to working during extended evening hours (Table A-2.7).

Table A-2.7. Providers' Objection to Working During Extended Clinic Hours by Parish

Response	St. Ann's Bay		Portland	
	Number	Percent	Number	Percent
Would object	1	9.1	3	14.3
Would not object	10	90.9	15	71.4
Don't know	0	0.0	3	14.3
Total	11	100.0	21	100.0

Overtime Pay vs. Flexible Schedule

The majority of managers who were asked (9 of 11) felt that providers would prefer to receive overtime pay to working on a flexible schedule (Table A-2.8). The provider responses confirmed that the majority (59.4%) would prefer to receive overtime pay. However, a significant proportion (31.3%) indicated that they would prefer to work on a flexible schedule. One respondent cited the example of a Type II facility in St. Mary:

“that offered those kinds of services [family planning, immunization] ... They went up until about 8 o'clock at night. But one of the things that prevented the services from continuing was the ... financial aspect of it, where persons are required to be paid for sessional hours, and so funding became a problem, as that could not continue.”

Table A-2.8. In Working the Evening Shifts, Would Providers Prefer to Operate on a Flexible Schedule or to Receive Overtime Pay?

Response	Managers		Providers	
	Number	Percent	Number	Percent
Flexible schedule	1	9.1	10	31.3
Overtime pay	9	81.8	19	59.4
Don't know	1	9.1	2	6.3
No response	0	0.0	1	3.1
Total	11	100.0	32	100.0

Providers' preference for receiving overtime pay was fairly consistent across the two parishes, 54.5 percent of respondents in St. Ann's Bay and 61.9 percent in Portland would prefer to receive overtime pay (Table A-2.9).

Table A-2.9. Providers' Preference for Working on a Flexible Schedule or Receiving Overtime Pay if Working Extended Hours

Response	St. Ann's Bay		Portland	
	Number	Percent	Number	Percent
Flexible schedule	4	36.4	6	28.6
Overtime pay	6	54.5	13	61.9
Don't know	1	9.1	1	4.8
No response	0	0.0	1	4.8
Total	11	100.0	21	100.0

Likelihood of Implementing Extended Clinic Hours within the Next Two Years

Some respondents noted that extended clinic hours have already been implemented on a small scale. However, only 50 percent of the ten managers who were asked thought it likely or highly likely that clinic hours would be extended into the evening to improve access to integrated reproductive health services within the next two years (Table A-2.10). The remainder thought it unlikely, or did not know, as they felt that the cost of overtime pay, limited staff availability and possible objections from unions might present obstacles.

Table A-2.10. Likelihood of Implementing Extended Clinic Hours Within the Next Two Years

Response	Number	Percent
Highly likely	2	20.0
Likely	3	30.0
Unlikely	1	10.0
Highly unlikely	0	0.0
Don't know	4	40.0
Total	10	100.0

4.3.3 Need to Operationalise an Appointment System (Access-3)

Background

Current Situation: Currently there are no appointment times set for individual clients to be seen by a service provider at health facilities in both parishes. As stated in Access-2 (extended evening hours), clients come early in the morning to health facilities and stay until they are served. They may not be served for several hours. Employed individuals, unless they are severely ill, often cannot devote so much time to obtaining health services. Also, clients from other health facilities that are referred for STI diagnosis and treatment cannot arrange for an appointment time. According to the FBA Study, 2001, STI clients report that they are generally satisfied with the services provided but say that waiting times are too long.

Proposed Change: Both parishes could explore the option of setting up an individual appointment system starting initially in the Type III & IV facilities. Adopting such a system would help facilitate access to these types of facilities by clients. It would assist in strengthening the referral system between Type I & II facilities to Type III & IV facilities (See Referral-1, strengthening STI referral). In those Type I & II facilities that have telephone service, the referring provider could actually help the client set up an appointment time, or the client could more easily call the facility and know that they will be seen at a stated time and not have to wait for hours to be served. In order for this system to work, the providers would need to be disciplined and be at the facility on time and adhere to the working hours of the facility. In addition, a media campaign targeted to clients attending the facilities would have to be conducted to raise awareness regarding the new system.

Anticipated Resource Requirements: Procedures for operationalising the appointment system would have to be written; provider and ancillary staff would have to be trained and sensitized to the new system of appointments. Costs associated with a media campaign.

Costs: J\$1,052,472 to J\$4,327,501 to write procedures, conduct training and carry out media campaign (See Appendix E)

Study Findings on Access-3

Support for an Appointment System

Managers and providers were overwhelmingly in favour of an appointment system, and felt that clients would also prefer such a system, which they anticipated would result in reduced client wait times (Table A-3.1). Fourteen of the 19 managers (73.7%) and 24 (80%) of the 30 providers agreed or strongly agreed. The managers expressed stronger agreement (52.6%) than the providers (30%) regarding the importance of setting up an appointment system.

Several providers expressed concern about the wait times currently experienced by clients, noting that *“when they come in and can’t get through they are miserable”* and one provider in Portland observed that *“right now we have quite a few patients who prefer to go to private doctors because they can’t wait so long.”*

It was felt, however, that a benefit to the current system was that *“...if you want to do public education on all of them (the clients) you just use that opportunity to do a public thing.”*

If an appointment system was to be put in place, one manager felt that a campaign of public education would need to precede its introduction to prepare clients to accept it.

Providers in Portland and St. Ann’s Bay were equally likely to prefer an appointment system. Among the managers, administrative managers were more likely to agree that an appointment system is needed. Among managers, the strongest agreement was at NERHA and the weakest agreement in St. Ann’s Bay.

Table A-3.1. Agreement that An Appointment System Should be Set Up in Types III and IV Health Centres, According to Managers and Providers

Agreement	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	10	52.6	9	30.0
Agree	4	21.1	15	50.0
Neither agree nor disagree	2	10.5	2	6.7
Disagree	3	15.8	4	13.3
Total	19	100.0	30	100.0

Potential Barriers to an Appointment System

Only four providers were opposed to an appointment system, raising concerns about the adequacy of staffing levels, and the potential difficulties if clients do not arrive at the appointed time. The managers shared concerns of the providers regarding the adequacy of staffing for this system and the failure of clients to comply with the system. One manager in Portland noted that the reason is *“Cultural. What happens, most persons in*

Jamaica are accustomed to getting out of their beds early and coming to a health centre.”

Other potential barriers to instituting a patient appointment system included:

- **Staff resistance**
Staff resistance could be due to culture, unwillingness or inability to organise the system, or having other commitments in the evening. A Manager from St. Ann’s Bay contended that *“certain hours people programme their minds that they’re coming out and they have to go back and to go to the children, and to get them home from school”*
- **Limited availability of transportation for staff and clients**
A Manager from St. Ann’s Bay noted *“because some of them live in remote areas and if they have the transportation leaving at a certain time, then they are forced to come at that time, whether they get a one o’clock or two o’clock appointment.”*
- **Limited access to telephones**
A Manager from St. Ann’s Bay commented that, *“a lot of people who are in need of primary health care do not have access to telephones, which is usually the means by which you would make an appointment ...It wouldn’t make sense coming to the health centre to make an appointment, as that would defeat the whole purpose. So the appointment system would basically be restricted to a certain category of people, whereby the health facilities are there for the public in general”*
- **Resistance by clients who are accustomed to attending the health facility from early in the morning**

This may be a result of their living in remote areas and having limited transportation, as well as limited communication to allow them to set appointments. One Manager from Portland explained, *“Sometimes the patients are accustomed to a certain system, so it’s going to take a little time to get them used to coming at a certain time. Depending on the area they are coming from, sometimes it might be a regular transport that leaves at that time so they have to catch the transport to come down. They prefer to come from early and it and wait all day.”*

- **The current system of giving out limited numbers of tickets**
The current “ticket” system leads clients to believe that they need to be at the facility early or they will not receive service. This system will be difficult to dispel among clients.
- **Conflict with the current system of group counselling, e.g. VCT for PMTCT, which is a staff resource efficient approach**

Provider Preference for an Appointment System

Twelve of the 18 programme managers (66.7%) when asked, thought that providers in types III and IV facilities would prefer a system with appointments (Table A-3.2). The others thought that providers may prefer to continue with the current system as the change may require greater punctuality, and some providers want to leave early in the evenings. One programme manager expressed the need for ‘follow through’ if such a system is instituted, indicating that sometimes things start “...and there isn’t the continuity, because you start off well, and then the staff member doesn’t follow, leaves the service and you can’t continue...so it has to go with change about the staff as well.” The manager anticipated provider acceptance of an appointment system because it would facilitate “crowd control.”

Among the 29 providers asked, 24 (82.8%) said they would prefer a system of appointments for Types III and IV health facilities (Table A-3.2). One provider from Portland explained the rationale for an appointment system, saying it would be “more comfortable for the patients. The patients don’t have to spend long hours here.” Another provider from Portland expanded on the idea of reducing waiting time, saying, “You don’t have this crowd of clients in clinic, which I think poses a fire risk, and a noise hazard. And it assumes right now that the client has nothing better to do but to stay at the clinic and wait ‘til six.” A provider from St. Ann’s Bay indicated that an appointment system would help clients because “Clients, like all of us they have their work so that they know that they have an appointment and they can ask for a specific appointment time so they can plan their work around the appointment. Right now [clients] have to take a day.”

Only two providers said they would not like a system of appointments and one nurse from Portland said the appointment system should be a block system whereby the patients are given a two-hour block in which to come to the clinic.

Table A-3.2. Providers' Preference for An Appointment System in Types III and IV Health Centres, According to Managers and Providers

Agreement	Managers		Providers	
	Number	Percent	Number	Percent
Yes	12	66.7	24	82.8
No	1	5.6	2	6.9
Don't know	4	22.2	3	10.3
No response	1	5.6	0	0.0
Total	18	100.0	29	100.0

Barriers to an Appointment System

The few managers and providers who did not think providers would want a system of appointments indicated that clients might not show up on time, and that such a system would require a change in work habits, that there might be insufficient staff, some consultations or treatments might take longer than others and that an appointment system might result in fewer clients being seen.

Client Preferences for an Appointment System

Most clients agreed that clients would prefer an appointment system, *“so long as they understand”* the system, according to a woman from rural Portland. They welcomed the possibility of not waking up at 5:00 am in order to queue for a number and not needing to spend the whole day at the clinic waiting to be seen. Some clients were concerned that the system should be flexible to handle emergencies. A young man from St. Ann's Bay suggested having some providers deal with appointments and others with emergency cases. *“...you can have three, four doctor deal with appointment, and you going to have like two a deal with emergency.”* Some suggested setting appointments for certain days of the week rather than every day.

Office Responsible for Developing the Policies and Procedures for an Appointment System

Among the 18 managers asked, five each said that the central MOH office with NERHA and NERHA alone had responsibility for changing policies and procedures related to an appointment system (Table A-3.3). Four others said the parish had the responsibility, while two indicated that NERHA and the parish shared responsibility. One manager indicated that only the Central MOH Office would be involved, while one indicated that all three levels shared responsibility in addition to the relevant professional associations and councils, and that the councils would also have to impress on their members to accept it, and there would also need to be education of clients within the communities. One programme manager did not feel that this was a policy barrier or required a policy

decision, but related to a Regional decision related to the cost of changing the STI referral system.

Table A-3.3. Which Office(s) Is/Are Responsible for Approving the Policy on STI Referrals Being Seen the Same Day

Level	Number	Percent
Central MOH only	1	5.5
MOH and NERHA	5	27.8
NERHA only	5	27.8
NERHA and Parishes	2	12.3
Parish only	4	22.2
All three levels and professional organizations	1	5.5
Total	18	100.0

Policy and Procedure Changes that Would be Needed to Implement an Appointment System

Respondents suggested:

- A written policy would be needed in order to institute an appointment system
- One respondent suggested that the Medical Records area may be assigned responsibility to set appointments
- Signage – signs that say clinics open 8:30 – 4:30 would have to be changed to say come by appointment
- Ensure that the system can still accommodate emergencies
- Implications for opening hours and working hours and related human resource issues including implications for implementation of a shift system or payment for sessional hours

Steps to Ensuring No Staff Shortages

Managers made the following suggestions for ensuring that staff would be available for appointments:

- Additional staff. Recruit part-time people for a shift system, such as retirees, institute a substitution programme
- Implement sanctions for not following guidelines
- Develop a schedule for staff in conjunction with the appointment system.

- Integrate primary and secondary staff
- Introduce incentives

One manager said that ensuring staffing “*Cannot be done now.*”

Likelihood that a System of Appointments Will be Set up within the Next Two Years

Thirteen of the 18 managers who were asked (72.3%) thought it likely or highly likely that an appointment system would be introduced within the next two years, as studies have shown long waiting times in the health facilities (Table A-3.4). It was also felt that the NERHA management has been proactive to ensure that high quality service is provided. However, others expressed concern that there are unlikely to be sufficient financial resources, and one manager at the regional level felt that this is not a priority.

Table A-3.4. Likelihood that An Appointment System in Types III and IV Health Centres Will Be Set Up in the Next Two Years, According to Managers

Response	Number	Percent
Highly likely	3	16.7
Likely	10	55.6
Unlikely	2	11.1
Highly unlikely	1	5.6
Don't know	2	11.1
Total	18	100.0

4.3.4 Hiring Additional Staff (Access 4-6)

Background

Access 4-Current Situation for Physicians: Currently Runaway Bay is the only Type II facility in the St. Ann’s Bay Health District. A physician attends this facility one day a week to provide curative care. Therefore, the potential for comprehensive integrated care is limited because of the unavailability of a health care provider who can deliver a broad range of services.

Proposed Change (St. Ann’s Bay): According to the medical officer for the district, if another physician could be hired (preferably a Jamaican), Runaway Bay could be staffed three days a week by a physician. Because of the additional time spent in the clinic, the physician could provide comprehensive, integrated services and operate as a true primary health care centre, treating not only curative clients but also all reproductive health clients with the aid of a nurse/midwife. The physician could spend the other two days reaching

out to the community with various health promotion activities designed to inform and to attract clients to the health facility.

Proposed change (Portland): If an additional physician could be hired in Portland, Type II facilities as well as the mobile teams described in Access-1, Section 4.3.1 (Eliminate special clinics) could have better coverage.

Anticipated Resource Requirements: The salary and benefits accorded two physicians.

**Costs: J\$3,796,192 for two physicians (one in St Ann’s Bay and one in Portland)
(See Appendix E)**

Access 5-Current Situation for Public Health Nurses: Currently, St. Ann’s Bay Health Centre has two physicians, one family nurse practitioner and one midwife present five days a week. An additional physician is there four days a week. The centre offers specialized clinic days for family planning, antenatal care, child health and STIs.

Proposed Change (St. Ann’s Bay): As stated above in the section on Physicians, the medical officer for the district states that if one more physician could be hired, not only could the Runaway Bay facility have extra coverage, but St. Ann’s Bay Health Centre could also have a sufficient number of health care providers available to offer true comprehensive, integrated services. In addition, if one more public health nurse could be hired, the specialized clinic days could be reduced or eliminated except perhaps for the child health clinic because of the protocols relating to immunization. One nurse could deal with postnatal, FP and pap smears every day and one nurse could deal with antenatal clients. In this way, any client could be served for any condition or type of service they are seeking on any particular day. It could also potentially alleviate some of the crowding that is occurring now with patients all coming to the health centre early in the morning for the specialized clinic day. The health centre could also try to set up stated appointment times for clients to come to be served. (See Access-3, appointment system, Section 4.3.3).

Propose Change (Portland): If an additional public health nurse could be hired in Portland, Type II facilities as well as the mobile teams described in Access-1 (eliminate special clinics) could have better coverage.

Anticipated Resource Requirements: The additional resources are stated under Access-4 above (two additional physicians). Also the salary and benefits accorded to two public health nurses.

**Costs: J\$2,874,860 for two public health nurses (one - St AB and one – Portland)
(See Appendix E)**

Access 6-Current Situation for Pharmacists: Currently there is only one Pharmacist in the St. Ann’s Bay Health District. Her time is shared with other districts and she therefore spends only two days a week in St. Ann’s Bay Health Centre. This restricts the

ability of clients to obtain their medications from the health centre. She does occasionally pre-package medications especially for the treatment of STIs, but this activity is not consistent. On days when she is not there, the providers write prescriptions that must be filled at a local private pharmacy. Depending on the type of drug, this could be a difficult burden financially for the client. In addition there is also a shortage of pharmacy personnel in Portland Parish.

Proposed change (St. Ann’s Bay): If a pharmacist or pharmacy technician could be employed, the person could cover the three days in the health centre when the pharmacist is not there and then spend two days at Runaway Bay during the time the physician is there, as described in the preceding section on Physicians.

Proposed Change (Portland): If a pharmacist or pharmacy technician could be employed, the Port Antonio Health Centre could have better coverage also.

Anticipated Resource Requirements: The salaries of two full-time pharmacists or pharmacy technicians.

**Costs: J\$2,757,952 for two pharmacists (one - St AB and one -Portland)
J\$1,399,222 for two pharmacy technicians (one - St AB and one – Portland) (See Appendix E)**

Study Findings on Access- 4-6

Agreement on the Need to Hire Additional Staff

Among the 14 managers who responded, seven (50.0%) strongly agreed and three (21.4%) agreed that the regions should hire additional staff for health facilities in order to improve client access to reproductive health services. Technical programme managers were more likely to agree with the proposal to hire additional staff than administrative managers. Six of the 10 technical programme managers strongly agreed (60.0%) and three agreed (30.0%), whereas one of four administrative managers (25.0%) strongly agree, three neither agree nor disagree (50.0%) and one disagreed (25.0%) with the hiring of additional staff.

The majority of providers who responded were in favour of hiring additional staff. Of the 29 providers who responded, 55.2 percent strongly agreed, 37.9 percent agreed, and 3.4 percent each were either neutral (neither agreed nor disagreed) or disagreed with the hiring of additional staff for health facilities to improve access to reproductive health services (Table A-4-6.1).

Table A-4-6.1. Agreement on the Hiring of Additional Staff Within the Region to Improve Access to Reproductive Health Services, According to Managers and Providers

Level	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	7	50.0	16	55.2
Agree	3	21.4	11	37.9
Neither agree nor disagree	2	14.3	1	3.4
Disagree	2	14.3	1	3.4
Total	14	100.0	29	100.0

Offices in Charge of Approving the Hiring of Additional Staff

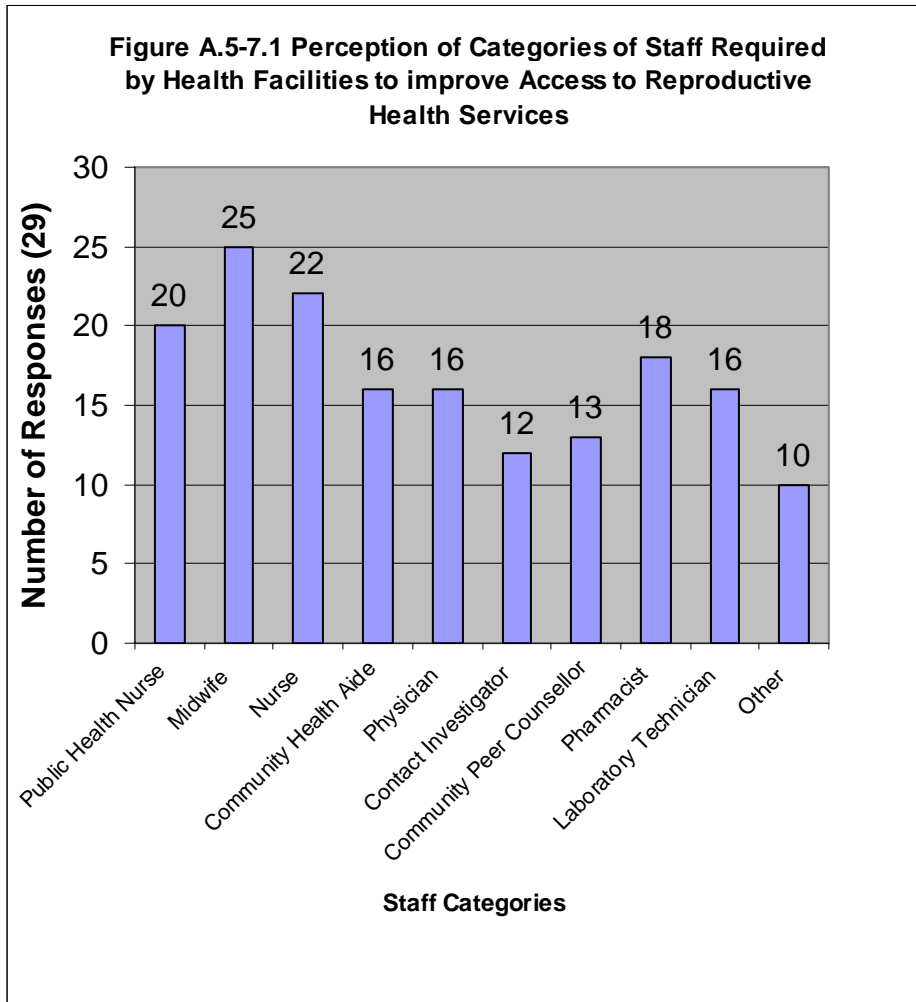
Diverse responses were received from 13 programme managers regarding which offices were in charge of approving the hiring of new staff. Three respondents considered it the sole responsibility of NERHA, three the joint responsibility of the Central MOH Office and NERHA, two the responsibility of MOH, NERHA and Ministry of Finance & Planning (MoFP) and another two the responsibility of the MoFP (Table A.4-6.2.). In all, 62 percent (8 of 13) said that NERHA would be involved in some capacity in the approval for hiring additional staff.

Table A-4-6.2. Offices in Charge of Approving the Hiring of Additional staff

Level	Number	Percent
Central MOH only	1	7.7
NERHA only	3	23.1
Parishes only	1	7.7
MOH and NERHA	3	23.1
NERHA and Parishes	1	7.7
MOH, NERHA, other –	2	15.4
MoFP	2	15.4
Other – MoFP only		
Total	13	100.0

Providers' Perceptions of Categories of Staff Health Facilities Needed in Order to Improve Access to Reproductive Health Services

The 29 providers responding identified Midwives, Nurses and Public Health Nurses as the staff categories most needed by their facilities in order to improve access to reproductive health services. Within the category “other,” porters and clerical workers were the most frequently named staff category.



Policy Restrictions in Hiring Categories of Staff

Respondents particularly noted policy barriers to hiring additional Contact Investigators (5 of 12 or 58.3%), Community Peer Counsellors (5 of 12 or 58.3%) and Community Health Aides (5 of 12 or 58.3%). Fewer than half of the respondents of the 10-12 managers who responded for each type of staff –(see Table 4-6.3) indicated that there were policy barriers to hiring other types of staff, including Physicians, Nurses, Midwives, Pharmacists and Laboratory Technicians.

Managers explained that the government-established cadre that determines the number of posts available in each institution and consequently determines budgetary allocations for salaries, limits the number of personnel they are able to employ. The cadre was identified as the primary policy restriction in hiring the following categories of staff (Table A.4-6.3).

Table A-4-6.3. Managers' Perspective on Policy Restrictions in Hiring Staff

Staff Category		Policy restriction	
		Number	Percentage
Public Health Nurse	(N=12)	5	41.7
Midwife	(N=12)	5	41.7
Nurse	(N=12)	5	41.7
Community Health Aide	(N=12)	7	58.3
Physician	(N=12)	5	41.7
Contact Investigator	(N=12)	7	58.3
Community Peer Counsellor	(N=12)	7	58.3
Pharmacist	(N=11)	4	36.4
Laboratory Technician	(N=10)	4	40.0

Policy Changes Required to Facilitate the Hiring Additional Staff

Seven of 11 managers who responded recommended that the policy on the cadre of posts in the MOH be revised. Three managers suggested an increase in the cadre, which they thought should be determined by benchmarking staff requirements against population size. According to one manager, persons are currently employed on a sessional basis if a post number is not available.

A recent decision by the MoFP to freeze hiring in the public sector has also affected the MOH's ability to recruit needed personnel. The MoFP therefore must approve contracts for the hiring of additional staff.

Other Barriers to Hiring Staff

Table A-4-6.4 below highlights a number of non-policy related barriers to hiring additional staff in the region. Most respondents noted that a shortage of qualified applicants was the main factor that hampered their ability to hire Public Health

Nurses (86.7%) and Midwives (80.0%). A high percentage of respondents (86.7%) thought competition from overseas was also affecting the pool of qualified Registered Nurses from which the MOH could hire. Some 73.3 percent of respondents believed that physicians were unwilling to work in rural areas and intimated at some physicians' preference for secondary care assignments over primary care and a shortage of housing as other reasons for the MOH's inability to recruit Physicians in sufficient numbers.

Nearly three-quarters (73.3%) of respondents also indicated that the Ministry lacked the ability to pay market salaries and benefits for Pharmacists and over two-thirds indicated that the MOH faced competition from local organisations, e.g. private pharmacies. Among the other barriers mentioned in respect of the recruitment of Pharmacists in

NERHA was their tendency to migrate to Kingston or other urban centres where they could avail themselves of opportunities for further studies. Housing was noted as an “other” barrier for eight of the nine categories of staff.

Table A.4-6.4 Managers’ Perception of Barriers to Hiring Staff, by Category of Staff and Barrier (n=15)

Staff Category	Cadre exhausted	Competition from overseas	Competition from local organisations	Shortage of qualified applicants	Unable to pay market salaries and benefits	Unfavourable working conditions	Unwillingness to work in rural areas	Other (specify)
Physician	40.0	26.7	46.7	40.0	40.0	40.0	73.3	Housing, shortages in primary care
Public Health Nurse	20.0	53.3	33.3	86.7	20.0	20.0	6.7	Housing
Registered nurse	20.0	86.7	40.0	60.0	26.7	20.0	26.7	Housing
Midwife	26.7	46.7	26.7	80.0	20.0	20.0	6.7	Housing and training
Pharmacist	20.0	33.3	66.7	53.3	73.3	26.7	40.0	Exodus to Kingston, studies
Lab Tech	26.7	13.3	33.3	20.0	40.0	26.7	13.3	Housing
Community Health Aide	46.7	0.0	0.0	6.7	6.7	13.3	6.7	Housing; ability to train & employ; need to re-evaluate their role
Contact Investigator	40.0	0.0	13.3	26.7	0.0	6.7	0.0	Housing; absorption capacity
Community Peer educator	20.0	0.0	0.0	13.3	20.0	0.0	0.0	Housing; inability to create posts

Note: Barriers noted by more than 40% of respondents are highlighted.

Perceptions of Likelihood that Additional Staff will be Hired within the Next Two Years

Respondents had mixed views regarding the likelihood of the MOH hiring additional staff for health facilities to improve access to reproductive health services within the next two years. Of the 13 managers who responded, three indicated that it was highly likely, four that it was likely, four that it was unlikely one that it was highly unlikely and another did not know (Table A.4-6.5). Thus, 53.9 percent of respondents thought it highly likely or likely that the Ministry would hire additional staff over the next two years.

Table A-4-6.5 Likelihood that the MOH Will Hire Additional Staff Within the Next Two Years

Response	Number	Percent
Highly likely	3	23.1
Likely	4	30.8
Unlikely	4	30.8
Highly unlikely	1	7.7
Unlikely	1	7.7
Don't know		
Total	13	100.0

One Regional manager indicated that NERHA was determined to increase the quality of care to its clients and thus would like to employ as many professionals as required. However, as indicated by many respondents, there are financial constraints and a shortage of applicants. Individuals terminating their contracts upon expiration of their bonds exacerbate this shortage of applicants.

4.3.5 Personnel Recruitment Incentives for Rural Areas (Access-7)

Background

Current Situation: Because of the rural nature of Portland Parish, it is difficult to attract and retain all level of staff within the health facilities from lab technicians to physicians. The problem of staffing in rural areas is a world-wide phenomenon and represents a barrier to access of health care for the rural population. Currently, Portland has several funded positions that are not filled- e. g. ten District Midwife positions. There are no incentives in place in the North East Regional Health Authority (NERHA) for recruiting and retaining healthcare staff.

Proposed Change: It is recommended that the NERHA explore various options for providing incentives to recruit and retain healthcare staff. Options that could be considered include: 1) fast-tracking the application process so that interested applicants could be on board faster; 2) offering free or subsidized housing; 3) offering assistance with moving costs; 4) offering to assist in finding housing; 5) paying school fees for the children of the staff; 6) after working for two years in a rural area, staff could receive advanced training paid by the MOH if they agree to return to work two additional years in the rural area; 7) other options to be determined.

Anticipated Resource Requirements: Varies depending on the types of incentives chosen.

Costs: J\$60,313 to J\$603,136 per person (See Appendix E)

Study Findings on Access-7

Level of Agreement that Providers Should Provide Incentives to Recruit and Retrain Health Care Staff in Rural Areas

Approximately half of the 13 managers (53.8%) and 18 of the 35 providers (51.4%) who were asked, strongly agreed that the regions should provide incentives to recruit and retain health care staff in rural areas (Table A-7.1). An additional 30.8% of managers and 42.9% of providers agreed that incentives should be used to recruit staff to rural areas. While the same percentage of managers and providers strongly agreed about the need for incentives to attract health staff to rural areas, the managers were more ambivalent about the need for incentives (15.4% neither agreed nor disagreed) than were providers (only 2.9% neither agreed nor disagreed).

Table A-7.1. Level of Agreement that the Regions Should Provide Incentives to Recruit and Retain Health Care Staff in Rural Areas

Level of agreement	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	7	53.8	18	51.4
Agree	4	30.8	15	42.9
Neither agree nor disagree	2	15.4	1	2.9
Disagree	0	0.0	1	2.9
Total	13	100.0	35	100.0

Level of Importance/Feasibility of Providing Incentives

Providers were asked to rate the level of importance of various incentives, while managers were asked to rate the level of feasibility. Table A-7.2 shows that providers consider the most important incentives for attracting staff to rural areas as help with locating housing, free and subsidized housing and free advanced training. Assistance with moving costs and school fees for children were considered of lesser importance to providers.

Table A-7.2. Level of Importance of Various Incentives, According to Providers (N=35)¹

Incentive	Level of Importance		
	Very	Somewhat	Not
Fast track the application process	51.4	42.9	5.7
Provide free or subsidized housing	68.6	22.9	8.6
Provide assistance with moving costs	38.3	38.2	23.5
Provide assistance with locating housing	71.4	22.9	5.7
Pay school fees for children of the relocated staff	25.7	34.3	40.0
Provide free advanced training	62.9	31.4	5.7
Other (see list below)			

¹ Note: The N for the assistance with moving costs was 34.

Sixteen respondents listed other incentives to recruit staff, including day-care, better work facilities, staff training on teamwork, giving staff a say, transportation, financial incentives, more leave, and making midwives travelling officers.

Other Ideas for Incentives

Providers had a number of other ideas for incentives that might attract staff to rural areas and retain them once there.

- Improving the work environment

Although not specifically asked, a number of providers mentioned that improving the working environment through upgrading facilities and training staff in teamwork and giving staff a say would also help to attract health care staff to rural areas. One provider in Portland said, *“It’s very important to have a good working environment.”* The provider continued, *“Make sure that the place that you are coming to is up to standard. Because sometimes you come and the place is a mess.”* Another provider from Portland said the Ministry is approaching the problem of staffing shortages in rural areas from the wrong perspective, saying, *“it is pointless spending the money on the staff, because staff are willing to work. But you go somewhere and there, the roof, there’s no bed, there’s no chair, there’s no room, there’s no light, there’s no water...it’s just you, the staff, and God. Truly.”* The provider continued, *“Improve the facility. You spend like a million dollars getting some Nigerian nurse to work in...and she’ll take one look and spin around and go straight home again. Because it is just so dilapidated.”*

- Transportation

Although not specifically asked, some providers, particularly in Portland, mentioned the need for transportation for work

The CHAs were asked separately about incentives to recruit staff to rural areas. The CHAs made similar suggestions in both parishes – mostly suggestions that would make their own jobs easier, such as recognition, transportation and even reinstatement of the MOH paying for uniforms.

- More pay, or “cash,” as one CHA answered in Portland.
- Recognition.

“Yes, I think – not the money so much. But, for example, we work in an area and like how we give like a long service award, you know. At least you feel that somebody recognizes that I am working. So it’s not the money so much as the recognition.” [St Ann’s Bay]

“Now we might just hear like, “Ladies, we are down this month on so and so,” you know, but we never told, “Oh, we are up this month on so and so.” [Portland]

- Uniforms

“Well, for right now, you know, we usually get uniforms from the government, and we were told that we won’t be getting anymore [it’s about two years now.] So we have to buy that from our pay.” [Portland]

- Housing – proper and affordable
- Transportation

“Some places you drive in rural – dark roads in Jamaica, you know. Proper roads and vehicles, to get out and come in to do things. They don’t want to stay there, so they don’t go there.” [St. Ann’s Bay]

- Facilities upgrade

“I think the only thing that could get me to come to Buff Bay is to give us a nice facility, open back the hospital, you know, if is even that to four or five beds to open it back and give us a decent building.” [Portland]

“We don’t even have a fan here.” [St. Ann’s Bay]

Feasibility of Instituting a System of Incentives to Recruit and Retain Staff in Rural Areas

The majority of the options suggested by managers were considered very or somewhat feasible, the exception being paying the school fees of the relocated staff, which 11 of the 12 respondents found to be not feasible (Table A-7.3). The managers were not as keen as staff on providing free or subsidized housing or on providing free advanced training, but were more inclined than staff to think about fast-tracking the application process.

Table A-7.3. Level of Feasibility of Various Incentives, According to Managers (N=12)¹

Incentive	Level of Feasibility		
	Very	Somewhat	Not
Fast track the application process	60.0	30.0	10.0
Provide free or subsidized housing	50.0	33.3	16.7
Provide assistance with moving costs	40.0	40.0	20.0
Provide assistance with locating housing	83.3	16.7	0.0
Pay school fees for children of the relocated staff	0.0	8.3	91.7
Provide free advanced training	41.7	50.0	8.3
Other (see list below)			

¹ Note: The Ns for fast track and assistance with moving costs were 10, as two respondents did not respond about those incentives.

Two managers had suggestions for other incentives, including providing career development opportunities and spending money on training and providing transportation.

Barriers to Introducing Incentives

The managers listed a number of barriers to introducing the incentives, including:

Fast track

- Bureaucracy due to wage freeze
- Culture
- Local capacity
- Need to look at eligibility for employment based on rules and regulations of various councils, and getting work permits (for persons from abroad)

Free or subsidized housing

- Approval from central authority and approval from the National Housing Trust for project money
- Money

Paying school fees

- Government policy
- Cost

Free advanced training

- Cost; lack funding
- Funds and access to training and the need for the service or skills
- No human resources management software to identify persons with ability

Offices in Charge of Approving the Use of Incentives

Eight of the 13 managers who were asked thought either the regional authority alone (4) or working in conjunction with the central ministry (4) would approve the use of incentives to recruit and retain staff in rural areas. One respondent said the responsibility was with the MOH and NERHA working with the Ministry of Finance and Planning. Only one manager thought that the parish would be in charge, in conjunction with the region. Two managers thought the Ministry of Finance and Planning would also have a role to play.

Table A-7.4. Which Office(s) Is/Are Responsible for Approving Use of Incentives to Attract and Retain Staff in Rural Areas

Level	Number	Percent
Central MOH only	1	7.7
MOH and NERHA	5	38.5
NERHA only	3	23.1
NERHA and Parishes	1	7.7
Parish only	1	7.7
MOH, NERHA and Parishes	0	0.0
MOH, NERHA and MoFP	1	7.7
MoFP, Compensation Division	1	7.7
Total	13	100.0

Likelihood of System of Incentives for Recruitment and Retention of Rural Staff Being Set up during the Next Two Years

Only 25 percent of the 12 managers who were asked thought it likely that a system would be introduced within the next two years to recruit and retain staff (Table A-7.5). Seven of the 12 managers (58.47%) thought it unlikely that such a system would be set up in the next two years.

Table A-7.5 Likelihood That A System Would be Introduced in the Next Two Years to Recruit and Retain Staff in Rural Areas

Level	Number	Percent
Highly likely	0	0.0
Likely	3	25.0
Unlikely	5	41.7
Highly unlikely	2	16.7
No response	2	16.7
Total	12	100.0

Two respondents, one at the central level and the other at the regional level, indicated that the Ministry would regard this as a national policy decision, with broader implications for civil service remuneration. A number of managers mentioned cost as a big factor. Furthermore, there is currently a government hiring freeze, so more effort has to go into justifying hiring. However, one manager indicated that “*there is a staffing crisis so it will be considered.*”

4.3.6 Renovate Facilities for Privacy (Access-8)

Background

Current Situation. In reference to Outreach 3, Section 4.5.3, the issue regarding the Voluntary Counselling and Testing (VCT) programme, it is essential that appropriate space is available in each of the facilities to properly counsel the clients and maintain confidentiality. Currently some of these facilities do not have separate offices needed to conduct confidential counselling to support the present programme being initiated).

Proposed Change. The facilities in St. Ann’s Bay Health District and Portland Parish need to be surveyed to determine which facilities need to be modified in order to conduct confidential counselling. (Constraint: some of the facilities are rented and not owned by the MOH.)

Anticipated Resource Requirements. Survey of all facilities with a plan that details the type of renovation needed; renovation costs.

Costs: J\$37,998 to develop and conduct survey of all facilities (See Appendix E)

Findings on Access-8

Opinion on Whether Facilities should be Renovated to Ensure Privacy and Confidentiality

Both managers and providers were overwhelmingly in favour of renovating facilities to ensure privacy and confidentiality, as shown in Table A-8.1, although the providers were

more ambivalent than the managers about renovation for privacy. Eighty-five percent of the 13 managers and 75 percent of the 24 providers strongly agreed that facilities should be renovated to improve privacy.

Table A-8.1. Opinion on Whether Facilities Should be Renovated for Privacy

Response	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	11	84.6	18	75.0
Agree	2	15.4	4	16.7
Neither agree nor disagree	0	0.0	2	8.3
Disagree	0	0.0	0	0.0
Total	13	100.0	24	100.0

Opinion on Whether Facilities have Sufficient Private Space for Counselling and Examination

Providers

Twenty-four providers were asked if they thought that the health facilities in their district have sufficient private areas for counselling and examination of patients. For Types I, II and III facilities, significantly more providers thought that facilities do not have sufficient private space, compared to those who thought that there is sufficient private space. The responses are shown in Table A.8.2.

Table A-8.2. Providers' Opinions on Whether Facilities Have Sufficient Private Space for Counselling and Examination of Patients

Response	Type I		Type II		Type III		Type IV	
	N	Percent	N	Percent	N	Percent	N	Percent
Yes	3	12.5	6	25.0	4	16.7	11	45.8
No	12	50.0	11	46.0	10	41.7	11	45.8
Don't know	6	25.0	0	21.0	6	25.0	2	8.3
No response	1	12.5	5	8.3	2	16.7	0	0.0
Total	24	100.0	24	100.0	24	100.0	24	100.0

One provider noted that even though the Type IV facility has a private area, that room is stigmatised because it is where STI (and HIV) diagnosis and treatment are done.

Clients

Many clients also felt that facilities did not provide sufficient private space to deal with their confidential issues. However, it was not clear that providing additional private space would encourage more people to use the centre. For example, some clients noted that even though private rooms were provided at the St. Ann's Bay Health Centre, they

still perceived a lack of privacy as the windows to the adjoining waiting area were kept open, and staff frequently entered the room during a private consultation without knocking. One woman from rural Portland explained why additional privacy would not encourage her to use the centre in her community: *“I wouldn’t even look at the privacy, it’s the services. They don’t offer all the services like the ones you get here [Port Antonio Health Centre].”*

On the whole, clients seemed less concerned about privacy than confidentiality.

“I don’t know about the others, but personally, I feel sometimes, the nurses, they, they chat too much. They don’t know how to keep things private, and it’s from a personal experience.... I feel, honestly, that majority of the time when things are not stressed confidential, it’s because of the nurses, or the people who, you know, you are expecting to keep your business private.”

“Sometimes, people might be, like go to the doctors, then after a while you hear it from another person’s, mouth...other than doctor. My girlfriend come to the doctor - surprising some of the things that she tell me. I wondering how she know all of that, it supposed to be nurse and the patient... So I’m not, I’m not saying that the person on the outside didn’t hear, but again, I’m not sure if the nurse is not the person leaking the information.”

“That room is all right, because... The reason why nuff people use Port Antonio clinic...because it more private and to them... now like say I am from Priestman’s River and nobody knows me from Priestman’s River, so I come to Port Antonio...”

Another phenomenon was that even with additional privacy, some men indicated that they would not consider attending the smaller centres. For example, when asked if they would use the centre at Lime Hall in St. Ann’s Bay if it were fixed up so that there is a private area, some men responded that:

“Most people prefer to go to the coast. Lime Hall have the pregnant woman and the baby and check up. A baby mother thing that.”

Offices Responsible for Approving the Renovation of Health Facilities

Only three of the 12 managers (25%) thought that the parish would be involved in approving the renovation of health facilities (Table A-8.3). Most (10 or 83.3%) thought that the Region would be involved in the process, while somewhat fewer (8 or 66.7%) thought that the central office would be involved. One manager explained:

“Sometimes the projects might come from the central body. Then the MOH might be directly responsible as they see fit. But, certainly in a decentralized structure, you cannot leave out the regions, because in the long run, they are the ones who are really responsible for service delivery.”

Table A-8.3. Offices Responsible for Approving the Renovation of Health Facilities

Level	Number	Percent
Central MOH only	2	16.7
MOH and NERHA	4	33.3
NERHA only	3	25.0
NERHA and Parishes	1	8.3
Parish only	0	0.0
All three levels	2	16.7
Total	12	100.0

MOH Policy for Renovating Health Facilities

It appears that the regions are directly responsible for the maintenance of their physical assets and equipment. The MOH has bodies to monitor and to inspect these facilities to ensure that there is a level of upkeep to these facilities. The Health Facilities Management Unit (HFMU) at MOH would basically periodically inspect and audit these facilities to ensure compliance with the standards. The HFMU may provide technical support to the Regions; however *“in a de-centralized mode, they should be responsible to carry out their own renovations...because technically, they are given the money.”*

There appeared to be no clear policy for renovating facilities not owed by the Ministry of Health. One regional manager explained:

“I can’t respond definitively on that one. Because in general, we don’t seem to do anything with ones that we don’t own – that would apply to private. We virtually don’t do anything to those. We depend on the owners to do some repairs on those facilities, because generally, we’re not spending money on property that we don’t own. Or we try not to.”

Barriers to Renovating Health Facilities

Ten of the 12 managers asked thought there would be barriers to renovating health facilities to provide private and confidential counselling, the main one being the financing requirements, particularly where this entailed spending money on non-MOH facilities (Table A-8.4). Limited availability of space was also identified as a barrier.

Table A-8.4. Barriers to Renovating Health Facilities, According to Managers

Response	Number	Percent
Yes	10	83.3
No	2	16.7
Don't know	0	0.0
No response	0	0.0
Total	12	100.0

Likelihood of Renovating Health Facilities within the Next Two Years

Fifty-four percent or just over half of the eleven managers interviewed thought it likely or highly likely that the facilities would be renovated within the next two years, and several indicated that this process has already begun (Table A-8.5). One manager from the Central MOH level noted that:

“There is a pressing need, because as I said, when we look at some of the statistics coming out we realize that we don't want it to become an epidemic. So whatever we need to do to get people to come in, to get people tested, to get people to practice safe sex we will do it; and we do have some funding for HIV programmes in the Region, through the World Bank and through USAID. So that's something that is likely to happen; very likely. We have annual budgets with these institutions, where we set out the programme for the year and they provide the funding. So, if we need to do that, certainly we could incorporate that into it.”

However, four (36.4%) thought it unlikely or highly unlikely, because of the financing requirements and the bureaucracy that would be involved in implementation.

Table A-8.5. Likelihood of Renovating Health Facilities Within the Next Two Years

Response	Number	Percent
Highly likely	2	18.2
Likely	4	36.4
Unlikely	3	27.3
Highly unlikely	1	9.1
Don't know	1	9.1
Total	11	100.0

4.3.7 Equipment Needs in Types I/II Centres (Access-9)

Background

Current Situation. Currently, some procedures cannot be offered because of the lack of necessary medical equipment in Type I and Type II facilities. Many of these facilities do not even have electricity or running water. For example, in the Steer Town facility, the midwife there is capable of inserting IUDs, but there is no examination table with stirrups available to perform the procedure. There is also inadequate lighting. Therefore, she has to refer the client to another facility.

Proposed Change. Appropriate equipment could be purchased to provide for expanded services at Type I and Type II facilities. A survey could be conducted of all of the facilities to see what essential equipment is missing that could help facilitate one stop service for the client and decrease the need for referral to another facility.

Anticipated Resource Requirements. A survey of St. Ann's Health District and Portland health facilities conducted to ascertain essential equipment needs; the cost of the identified equipment.

Costs: J\$57,901 to develop and conduct equipment survey of all facilities (See Appendix E)

Findings on Access-9

Experience with a Lack of Necessary Equipment

Providers were asked to describe their experiences regarding the availability of necessary equipment. In all, 16 of the 23 respondents (69.6%) indicated that they had had to refer patients to another facility because they did not have the necessary equipment or supplies to provide the standard services offered at their facility (Table A.9.1). There was a noticeable difference in the responses between the two parishes, as 50 percent of the eight respondents in St. Ann's Bay and 80 percent of the fifteen respondents in Portland indicated that they had had to refer patients to another facility because they did not have the necessary equipment or supplies to provide the standard services offered at their facility.

Table A-9.1. Providers' Responses When Asked if They Have Had to Refer Patients to Another Facility Because the Necessary Equipment Was Not Available to Provide the Standards Services Offered at Their Facility.

Response	Number	Percent
Yes	16	69.6
No	6	26.1
No response	1	4.3
Total	23	100.0

Providers were asked what type of equipment was consistently lacking that hamper the services they provide. In both parishes, CHAs indicated that they need scales.

“Right now, we need two scales ... a standing one and a baby scale ... it’s a long time – over twenty-seven years we are using the baby scale. When you try to move the pointers they stick, you have to lift up and draw.” [St. Ann’s Bay]

“We need scales, the scales, most of the time the clients complain that they carry the baby to somewhere and then they come, the weight is different. So we realize that sometimes the scale is the problem.” [Portland]

Other provider responses included:

St. Ann’s Bay

“An ultra sound machine, we need an ECG machine ...a cholesterol machine and that is so cheap, is only eight thousand plus [Jamaican] for one.”

“I don’t know if consistently, because we might have things out at various times but for example in Type II we would have like lack of nebulisation equipment, suturing equipment.”

“Adequate treatment, drug therapy for HIV/AIDS clients ... The clients come in here wanting the medication and it’s not available”

“We need something to sterilize our utensils...We never had one. Sometime we take to the Type IV.”

“We have to boil ours [utensils]; we have a big pot. Yes, we improvise, and we don’t have any running water inside. But as it is a rented place you know, we use the basic – soap and water we can have outside.”

“Some areas of family planning ... This is a government health centre so all they have is two brands of family planning pills and I think they have nearly 40 brands out there and one type of injection which is very poor. They need to have a choice of injection. They need to have female condoms. Every day they come and they ask and all they provide is the male condoms and one brand of course - the rough ones. Is only the government condoms. So, they need to do something about that.”

“We need filing cabinets for filing dockets. Sometimes, we have to put them in boxes.”

Portland

“Well, for Port Antonio here we will do well with a fetal monitor....”

“Sometimes we are out of things for dressing, I think mostly it’s just things for dressing so far.”

“At this health centre [Port Antonio Health Centre], I can’t think of anything right now, in terms of equipment.”

Procedure for Adding to List of Approved Equipment or Supplies for Types I or II Facilities

There were varied responses regarding the procedure for adding to the list of approved equipment or supplies in Type I or Type II facilities, as illustrated by some of the examples provided below.

Central MOH level:

“The procedure would be for the [Parish] Medical Officers of Health group who have the responsibility for the primary care system, to put a proposal up to their region, after a policy decision has been made at the Head Office. Again, it is not as simple as it sounds. The determination of the list is a response to the level of service that the staff at the centre has to do. Unless you’re going to change that, extending the services can mean either training the staff to provide additional services – and if you do that, then you can list supplies, and supplies don’t go by itself, that’s the point I’m trying to make. It’s linked to what that staff can do. A Type I, if it’s a midwife there, there are things she can do and things she can’t do, so it wouldn’t make sense giving her supplies for things she can’t do.”

“The Health Services Improvement team would state the nature of the services to be offered; they would look at what is needed in each of these institutions and then we would offer the technical specifications for those equipment, and if there is anything to be done about the layout or the design of the physical asset, that is where we come in. But the actual equipment needs for service delivery, the Health Systems Improvement Department operates.”

Regional level:

“I think what happens here is you need to redefine the service of the health centre, because a Type I health centre does X, Y and Z, and therefore the equipment is allocated based on the service that you’re offering. So, the first thing you do is to redefine the service and determine the additional equipment needed. Source the funding and acquire the equipment. Sometimes the funding is not out of your recurring budget, but sometimes from NGOs, sometimes it’s from friends of the hospital, and so on. We, for example, just expanded the maternity ward at, not ward, delivery room at Port Maria Hospital, as a gift from the Kiwanis. They funded it, found the contractor, came in, expanded the facility, and we getting two new delivery beds coming from the States from Kiwanis. So, you got the service, but somebody is funding it for you.”

Parish level:

“Depending on the cost of the equipment, if it is an equipment that will require significant amount of funding, say in excess of \$200,000, you have to go through the Procurements Department at the Regional Health Authority. Initiated in the parish, submitted to the Procurements Department of the Regional Office; Procurements Committee will have a meeting based on the availability of funding and can approve it based on the priority. Less than that, it is a Parish decision. We would have meetings with the relevant health care providers, prioritise the equipment to be purchased. Again, based on the availability of funding the equipment would be purchased.”

“Usually, we have a budget for the year and each area would identify the needs for that facility. It’s usually submitted to the Parish Manager and then they would seek – you have to have funding to buy the things that are needed. I think they [Parish Managers] have to submit [the budget] to the Region for approval at the regional level because they’re the ones who control the budget, more or less. Dependent on whether or not they have the money. Sometimes you order things and sometimes you might not get it for that year, or you might get a part and they tell you that they can’t supply you with any other. But in some cases, there are some things that Food for the Poor, depending on what it is, you might get some supplies from that organization.”

Offices Responsible for Approving and Implementing the Purchase of New Equipment and Supplies

All of the 14 managers who were asked indicated that the Regional Office would be involved in the approval and implementation of the purchase of new equipment or supplies for health facilities (Table A-9.2). Exactly half of them indicated that the Central MOH Level would also be involved in the process. Six (43.8%) thought that the Parish would participate in the process with other levels.

Table A-9.2. Office(s) Responsible for Approving and Implementing the Purchase of New Equipment and Supplies, According to Managers

Level	Number	Percent
Central MOH only	0	0.0
MOH and NERHA	4	28.6
NERHA only	4	28.6
NERHA and Parishes	3	21.4
Parish only	0	0.0
All three levels	3	21.4
Total	14	100.0

Factors to be Considered Before Obtaining Equipment or Supplies

The majority of the managers indicated that cost, security and maintenance would have to be considered before equipment or supplies could be obtained (Table A-9.3). While still a majority, only seven felt that availability was an issue. One manager indicated that: *“usually, the supplies are available but not the money.”* Other considerations include defining the expanded services, the technical specifications of the equipment, appropriate use of the equipment and identifying sources of funding other than the MOH.

Table A-9.3. Factors to be Considered Before Obtaining Additional Equipment or Supplies, According to Managers

Factor	N=13	Percent
Cost	12	92.3
Security	12	92.3
Maintenance	11	84.6
Availability	7	53.8
Other	7	53.8

Likelihood of Acquiring Additional Equipment and Supplies within the Next Two Years

Fifty percent or seven of the 14 managers who were asked felt it was likely or highly likely that the money would be spent to acquire additional equipment and supplies for Type I and II centres within the next two years (Table A-9.4). The others felt this was unlikely, highly unlikely, or did not know, and the majority of them (6) cited inadequate financial resources as the major constraint. Even the positive responses were qualified e.g. one respondent who thought it was highly likely confined her response to *“small equipment”*; another who thought it was likely, cautioned that this was so *“if they have the money”* and speculated that *“we might get the money from somewhere.”*

Table A-9.4. Likelihood of Acquiring Additional Equipment and Supplies Within the Next Two Years, According to Managers

Level	Number	Percent
Highly likely	2	14.3
Likely	5	35.7
Unlikely	4	28.6
Highly unlikely	1	7.1
Don't know	1	7.1
No response	1	7.1
Total	14	100.0

4.3.8 Reach Men through Child Health Visits (Access-10)

Background

Current Situation. Women access the public health facilities in both parishes more often than men. Contact Investigators in Portland report that 70-75% of their STI clients are female. It appears that men are treated for STIs in the private sector. Few, if any, men come to family planning clinics. When they do come to health centres for family planning related services, it is to pick up free supplies of condoms. To accommodate these male condom users, a box of condoms is placed at the registration desk in some centres so that the men can easily and quickly pick up several strips. However, there are a noticeable number of young fathers bringing their babies and young children to child health clinics in St. Ann's Bay. (This phenomenon is less noticeable in Portland but does occur.) If this trend continues and grows, it may provide an unexpected opportunity to reach men in a clinical setting with important health messages.

Proposed change. When the men bring children to the facility, they could potentially be reached in a low-key way by giving them “safe sex” brochures and perhaps having the Nurse/Midwife or CHA emphasizing one of the messages in the brochure. Men could also be encouraged to attend antenatal visits with their pregnant partners and could be counselled regarding safe sex practices.

Anticipated . Training of providers in counselling; brochures.

Costs: J\$1,299,966 to J\$2,131,691 to develop materials and conduct trainings on reaching men (See Appendix E)

Findings on Access-10

Opinion on Targeting Men Who Attend Child Health Clinics

Twelve of the 14 managers (85.7%) and 11 of the 14 providers (78.5%) who were asked, agreed or strongly agreed that when men bring children to a health facility, they could potentially be reached in a low key way by giving them “safer sex” brochures and perhaps having the Nurse, Midwife or CHA emphasize one of the messages in the brochure (Table A-10.1).

Table A-10.1 Agreement That Men Who Bring Children to Health Facilities Could Potentially be Reached in a Low Key Way with “Safe Sex” Messages

Response	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	8	57.1	8	57.1
Agree	4	28.6	3	21.4
Neither agree nor disagree	1	7.1	2	14.3
Disagree	1	7.1	1	7.1
Strongly disagree	0	0.0	0	0.0
Total	14	100.0	14	100.0

Clients had mixed views on how men would respond to being targeted in this way, as illustrated by the following responses from adult males in St. Ann’s Bay.

“With that question... it kinda hard, man, trust me, because say me come with my kid, and you a go tell me about safe sex, me nah go want hear about that...No, me a think about one next one. And after the next one, mi done know say no more after that because me done set my future say to, or plans to have four already. So as long as I have my two, mi nuh want nothing more. We can talk about that after. Me and the woman can talk about that after.”

“It should be a must that they have to listen because some men seems like they not seeing you well, or you never, you understanding about life, because them just get all a dozen children and they can’t even mind one, and you know?”

Young men from urban Portland agreed that men could be reached in health centres when they come with their children because,

“Because you already go through the process, you have your child, and you have to try to protect it. Just to even go through it in a way that you understand it more, that when your child grow up you can explain it to them. So that’s basically it.”

Possible Barriers to Targeting Men Who Attend Child Health Clinics

Respondents were unable to identify any policy directives that would be needed to ensure that men are targeted in this way. Eight of the 14 managers indicated that no policy change was required, as one indicated: *“health promotion is everyone’s role.”* However, possible barriers included the fact that men were often in a hurry to leave, the environment may not be conducive, and that women in the centres may object to the men receiving special attention, as illustrated by the following responses:

“The barriers...it’s just that most of the time when the men come, they are in a rush, and because they are few, I think sometimes the staff tend to...I would say single them out and give them a little special care...”

[Manager, NERHA]

“the Child Health Clinic may be a difficult environment, because parents may be agitated and children are screaming and don’t sit still.”

[Manager, NERHA]

“if you have printed material that is just a matter of handing it to them, there is no barrier. If you have to sit and talk with them when their mind is on their baby, and you’re going to talk about something else, then time might be a barrier.” [Manager, Central MOH Level]

“Women come for care for their children and a male comes in; because the health care provider wants to encourage this man to come and to continue to come, they will go all-out to look after this person. They may even see this person before they see the females, and they get very, very annoyed, they get aggressive ... they’ll say: “because this person is a man, I don’t see why you need to see him first, because all of us here for the same reason.” So I think the only barrier would be his fear of coming to the health facility because of the responses that he would get from persons in the community.” [Manager, NERHA]

Ten or 71.4 percent of the 14 providers who were asked indicated that men are usually in a hurry to leave, which made this the leading barrier identified by providers (Table A-10.2).

Table A-10.2. Providers Opinions on Possible Barriers to Reaching Men When They Come to Child Health Clinics

Possible barrier	N = 14	Percent
Men are in a hurry to leave	10	71.4
The environment has many distractions	7	50.0
The child demands the man’s full attention	6	42.9
Female clients object to men receiving special attention	5	35.7
Total	14	100.0

It should be noted that this does not include the responses of Community Health Aides, whose opinions were solicited in a focus group setting and therefore could not be included in the quantitative analysis. However, it was clear that CHAs were sensitive to the issue of impatience among male clients, as indicated by the following comments:

“Sometimes, some of them on hurry to get back to work, you know”

“When the fathers come, and I try to ask like the ladies, can you allow them to get through (to encourage them to come back), they don’t want to give them a chance.” “We don’t have that problem at our health centre. We will say that these three men are here and so or one man is here, can you give him the preference so that he can go in because maybe he have to get back to work. Now, when we work that out sometimes, you see the ladies now stay back and they will let the men come.”

“Long waiting. Some of them don’t wait long. And when they find themselves with a lot of ladies, you know... so we try to let... we try to always do them before, you know.”

Possible Ways to Reach Men with Sexual and Reproductive Health Messages Other Than When They Take Their Children to Health Facilities

Suggestions from providers of other possible ways to reach men with sexual and reproductive health messages included:

- Meeting them in the places where they socialize e.g. bars, football matches, barbers, youth clubs, church groups, dancehalls “go go” clubs. A CHA in St. Ann’s Bay commented *“[December was] AIDS week, and we went to a club, like the go-go place up there. And the women were there dancing, and do you know that the men were more focused than the ladies, and they were more cooperative than the ladies. Is when they saw the men coming in now with the condoms and do the exercise that we asked them to do, you see them taking it. So sometimes the men really cooperate.”*
- Establishing men’s clinics
- Focusing on reproductive health messages in schools

It was also noted that there may be a need to adopt different strategies for men of different ages, as illustrated in the following discussion with CHAs in St. Ann’s Bay.

“Sometimes like when the STI PC [Peer Counsellor] worker give a talk to like 30 persons at a curative clinic, they say “me done with that” or something like that, you know... Depends on the age of the men. Even the ladies too, say’ “me done with sex” or, you know, something; of course – how much times they say that! No, but sometimes they really say it. So, you know, the PC worker might feel – you know, and she doesn’t worry to give that talk then. No, we see that happen.”

Clients suggested reaching men with music and at times when they are not busy with work.

“If they have... a DJ would actually do ... sex and stuff. That would actually help, because most time persons ... young guys into music and stuff, so if there’s really a song that really inspire us how to take care of our self, we’d actually do it.”

“... keep something like a day when you know say the man them nah go busy ...like Sunday evening, like when they bathe and come out to relax.... And you know mostly on a Sunday is the most ...and they go out, go eat ice cream...”

Responsibility for Approving Reaching Men with Safe Sex and Other Appropriate Messages in Health Facilities When They Bring their Babies and Young Children for Care

The majority of the eleven managers who were asked (72.7%) indicated that the Parish has responsibility for approving reaching men with safe sex and other appropriate messages in health facilities when they bring their babies and young children for care. One of these thought that the NFPB would also play a role, along with the Parish. Only three (27.3%) thought that the Central MOH or the Region would have to be involved in the approval process.

Table A-10.3. Responsibility for Approving Reaching Men With Safe Sex and Other Appropriate Messages in Health Facilities When They Bring Their Babies and Young Children for Care

Level	Number	Percent
Central MOH only	0	0.0
MOH and NERHA	1	9.1
NERHA only	0	0.0
NERHA and Parishes	0	0.0
Parish only	8	72.7
All three levels	2	18.2
Total	11	100.0

Likelihood of Implementing Targeting of Men who Attend Child Health Clinics within the Next Two Years

Seventy-five percent or nine of the 12 managers who were asked thought it likely or highly likely that the MOH would implement such a programme within the next two years (Table A-10.4), citing the following reasons: it is part of the Strategic Plan, it is a high priority, it is easy to do, and the process has begun. However, there was one respondent, a key decision maker, who thought it unlikely *“because there are other priorities.”*

Table A-10.4. Likelihood of Implementing Targeting of Men Who Attend Child Health Clinics, Within the Next Two Years, According to Managers

Level	Number	Percent
Highly likely	4	33.3
Likely	5	41.7
Unlikely	1	8.3
Highly unlikely	0	0.0
Don't know	2	16.7
Total	12	100.0

4.4 Patient Education

4.4.1 Assessment of Need for New/revised IEC Materials to Support Counselling and Use of a Self-Administered Screening Tool (Patient Education-1)

Background

Current Situation: Health promotion and educational brochures are provided to the health district by the MOH in Kingston. Although some shortages have been reported by certain providers, it appears to be a distribution problem rather than a true shortage. It is a matter of ordering the appropriate number of materials and having them transferred to the parish. The health district Health Educator is in charge of ensuring that sufficient materials are ordered in a timely fashion and are available so that providers can hand them out to clients. It is not certain whether these educational brochures contain information in an integrated fashion or whether they should be revised to provide an integrated message.

Proposed change: A consultant could be retained to assess the need for new and/or revised IEC materials to support counselling and education in integrated FP/STI/HIV/AIDS services delivery. (P-1a)

In addition, a self-administered screening tool could be developed that focuses on risk factors related to STIs and HIV/AIDS. It could be a simple one-page questionnaire that asks less than 10 questions related to sexual behaviour. (It could be similar to the questions on the rapid risk assessment screening tool referenced in Treatment-1 in Section 3.5.4 and Screening-1 in Section 3.6.1). The directions could be, if you answer a certain way to a stated number of questions, you would be advised to seek the advice of your personal physician or the public health centre. The questionnaires could be handed out by CHAs, peer educators and even to clients sitting in the clinic. (P-1b)

The medical officer at St. Ann's Bay suggested that the materials be stored at the Region for more efficient disbursement to the parishes in the North East.

Anticipated Resource Requirements: – A consultant fee for one week to assess the need for developing new materials; if new materials are needed, there will be costs for development, testing and printing. Any new materials should take into consideration the

literacy level of the clients. In addition there will be costs associated with the development of the self-administered screening tool; testing of the tool; printing costs.

Costs: J\$566,948 to J\$791,918 to assess IEC materials and develop self-screening tool (See Appendix E)

4.4.1.1 Study Findings on P-1a (Integration of IEC Materials) Are Family Planning and STI Messages Sufficiently Integrated in Existing IEC Materials

Ten of 14 technical managers (71.4%) were of the opinion that Family Planning (FP) and STI messages were not sufficiently integrated in existing IEC materials. One of the 10 managers commented that “posters are currently unilateral that is, they send only one message.” Three technical managers (21.4%) at the Central MOH Office did not know whether FP and STI messages were sufficiently integrated in existing IEC materials. Similar results were seen among providers. Four of six providers (66.7%) who were asked did not believe the messages were sufficiently integrated, and only 33% believed that they were.

Suggestions for the Integration of Reproductive Health Messages

At the heart of integrating FP and STI messages is the need to have an impact on clients’ lifestyles by providing information on the risks of unprotected sex in a manner which is user-friendly, easy to assimilate and which enhances clients’ likelihood of using new information to govern decisions about their sexual practices. In order to have the desired impact on clients, such information must be pitched at the level of the target audience. Some clients in the target population have a low level of literacy and as such, integrating FP and STI messages will pose some challenge. Materials may have to be redesigned. As one programme manager put it, “*existing materials are written, way above the public’s head and almost all are foreign and need to be redone within the Jamaican context.*” It was also noted that whereas existing IEC materials facilitated increased *awareness of STIs* they did not communicate this information in a manner that improved clients’ *knowledge of STIs and FP.*

Eight of the 14 technical programme managers and all six providers provided ideas on how STIs and FP messages could be more integrated. With the exception of one provider who indicated that IEC materials could incorporate messages about dual protection and family planning, respondents did not specify what messages they would like to see integrated and the media through which to communicate these integrated messages. Suggestions made dealt instead with the presentation of current messages and outlined a basic methodology for addressing those issues.

Table P-1a.1 Suggestions on How Messages Could be More Integrated in IEC Materials

Issue	Suggestions
Content, language and context of IEC materials communicated above the level of target population.	<ul style="list-style-type: none"> • Review existing IEC materials • Ensure the language used in the presentation of materials is pitched to the educational level of the general public. • Ensure that illustrations/presentation media can be easily understood and that clients can relate to the information/material presented in the context of their own environment.
Concerns with the relevance of material	<ul style="list-style-type: none"> • Identify key or common messages that can be easily integrated • Ensure that the revision of IEC materials is a collaborative effort between health care providers and those who compose the material. • Use providers’ field experience as a guide to determine the relevance of certain information or illustrations to the target population in order to maximise the impact of the message. • Pre-test revised integrated material among target population to ensure that they understand the messages being conveyed before releasing them into general circulation.
Current materials convey unilateral messages	<ul style="list-style-type: none"> • Widen the scope of presentations and provide more information • “Find innovative ways to promote other [contraceptive] methods for persons in faithful relationships.” • Combine key messages and condense the information in integrated posters, etc. • Change the focus of presentations from a disease-centred to person-centred approach in order to improve knowledge of STIs and FP and to encourage behaviour modification among target groups. • Include the use of locally designed audiovisual materials and retrain staff in their use.

Possible Barriers to Integrating Messages

Nine of 10 technical programme managers interviewed indicated a number of possible barriers to integrating reproductive health messages. The most common responses among the nine managers were that the development of integrated messages is inhibited by literacy level of the public, donor agency stipulations and cost/lack of financial resources. Other possible barriers include:

- Pervasiveness of cultural myths and practices, and value systems
- Lack of human resource and time required to develop materials
- Number of messages that can be incorporated in a short brochure
- Policymakers lack of will, and lethargy in implementation
- Attitudes towards combining resources, as one programme manager indicated, “everyone wants to keep their own resources.”

Offices in Charge of Developing IEC Materials on Family Planning, Maternal Health and STI/HIV/AIDS

Three managers indicated that the MOH was responsible for developing IEC materials for family planning. One indicated that the MOH was responsible for the development of maternal health materials and two indicated that the MOH was responsible for the development of STI/HIV/AIDS. Overall results indicate that the central MOH head office was the sole office in charge of developing IEC materials on family planning, maternal health and STI/HIV/AIDS.

Perception of Likelihood of MOH Integrating Messages for Family Planning, Maternal Health and STI/HIV/AIDS within the Next Two Years

There was a general consensus among managers regarding the MOH’s likelihood of integrating messages on family planning, maternal health and STI/HIV/AIDS within the next two years. Of the 12 managers interviewed, two indicated that it was highly likely (16.7%) and eight that it was likely (66.7%) that the Ministry would integrate messages on family planning, maternal health and STI/HIV/AIDS within the next two years. The remaining two managers (16.7%) did not know whether the Ministry intended to integrate the messages in the next two years (Table P-1a.2).

Table P-1a.2. Likelihood that the MOH will Integrate Messages for Family Planning, Maternal Health and STI/HIV/AIDS in the Next Two Years

Level	N	Percent
Highly likely	2	16.7
Likely	8	66.6
Don't know	2	16.7
Total	12	100.0

Three managers mentioned that the integration of messages was currently being addressed and that it was part of the strategic framework and as such was a high priority issue for the Ministry.

4.4.1.2 Study Findings on P-1b (Self-Administered Screening Tool for Clients)

Probability of Female Clients Using a Self-administered Screening Tool

Four of eight providers (50.0%) thought that female clients would use a self-administered screening tool that would focus on risk factors for STIs and HIV and that would encourage them to seek attention from their healthcare provider if they were at risk. Among those providers, two of the eight were of the opinion that low literacy levels would prevent females from using the self-administered screening tool. Two respondents also thought the stigma associated with anything related to STI/HIV prevent females from utilizing the self-administered screening tool. The remaining four respondents did not believe that stigma associated with STI/HIV or low literacy would prevent females from using the form.

Female clients differed in their views of whether women would use a self administered screening checklist. One woman from rural Portland indicated that “*probably four out of ten*” would use it. Those not inclined to use it would be worried about putting personal information on paper and that they “*might not want to deal with the results,*” according to a young woman from urban Portland. Clients would be more inclined to use it if it were anonymous.

Young clients indicated that such screening checklists should be used. One young woman from urban St. Ann’s Bay explained,

“Yeah, it is good, you know, because sometimes there are certain things that we might not take into consideration, but if asked, you know, we’ll consider we answer it, so, I think it’s good when we’re being asked more questions.”

The Probability of Male Clients Using a Self-administered Screening Tool

Whereas one provider was unsure, three of six providers (50%) thought that male clients would use a self-administered screening tool that would focus on risk factors for STIs and HIV and that would encourage them to seek attention from their healthcare provider if they were at risk. Only two of the six providers felt that low literacy levels among male clients would prevent them from using self-administered screening tool (33.3%) and one felt that the stigma associated with STI/HIV would inhibit the use of the self administered tools. Other factors may influence men's disinclination to use the tool. Two respondents suggested that men were impatient and that most men were in a hurry.

Male clients were also inclined to agree with the use of a self-administered checklist, although literacy was noted as a concern. One young man from urban Portland said:

“Yeah, for some anyway, because you have to consider the people them whe really can't read, to answer the question them. Because right now, most young man, them really go school but for instance, them take up weed. Nuff of them smoke and them no really matter 'bout school, so you find some of them can't read. So them one deh you haffi really go to them verbal to get whe you want get through.”

Another young man added:

“Not saying can't read, but most of them cannot go, to read a question and to think about it before answering, that is a bit far for them youth, because some people can just read something and just tick without thinking what the question is about.”

An adult man from urban Portland said that not everyone would want to think about the questions on the screening checklist. He said, *“not everybody brave enough fi really, like “How much woman you having sex with without condom? And you seh like, one, two or three.”*

Feasibility of Distributing self-administered Screening Tools to Clients

Programme managers were asked their opinion on the feasibility of issuing self-administered screening tools that would focus on risk factors for STIs, HIV and unintended pregnancy and that would encourage women and men to seek attention from their health care provider if they had various risks. Providers were asked about the feasibility of issuing these tools in communities. Feedback from programme managers was mixed and somewhat unenthusiastic with respect to the use of a self-administered screening tool given out to clients by CHAs, CIs and Community Peer Educators. Only six of the 12 managers said clients would use the tool (Table P-1b.3). Four indicated that they did not know if clients would use the tool and two managers said that clients would not use it.

Table P-1b.3. Agreement on the Feasibility of Distributing A Self-administered Screening Tools for Client Use and Using it in the Community, According to Managers and Providers

Response	Managers		Providers	
	Number	Percent	Number	Percent
Yes	6	50.0	3	50.0
No	2	16.7	3	50.0
Don't Know	4	33.3	0	0.0
Total	12	100.0	6	100.0

Feasibility of Distributing Self Administered Screening Tools within Communities

The providers who were asked were also evenly split (3 of 6) on the feasibility of distributing a self-administered screening tool in communities (Table P-1b.2). The three providers who said it would not be feasible advised that clients might not use the instruments if left to complete them on their own. To emphasise the point, one provider gave the following example: *“sometimes we go out and we issue pamphlets just to reinforce the message, they won't fill it out if you just leave it there. Unless you fill it out they will just take it and that's it.”*

Providers, also cited low literacy and perception of the level of importance of the exercise as additional reasons why distributing the self administered screening tools in communities might not be feasible. Another of the three suggested that it might not be appropriate to visit homes in order to distribute these instruments but instead to go to a *“central area because the community may pass judgement as to why health persons are visiting someone's home.”*

Reason Why a Self Administered Screening Tool Would Not be Feasible

When asked why the distribution of a self-administered screening tool may not be feasible, two of five programme managers pointed to the low educational level of clients. Others indicated that it would be more effective if the screening tool were administered, as the instrument may not be taken seriously if left in the hands of the client. This was in keeping with the feedback received from providers.

Organisations or Offices Responsible for the Development or Supervision of the Development of a Self-administered Screening Tool

The 10 managers who responded had mixed views on which offices were in charge of developing, or supervising the development of a self-administered screening tool (Table P-1b.4). In general the majority said that the responsibility rested with central MOH office (30.0%) and MOH, NERHA and Parishes (30.0%). Two respondents also indicated that the National Family Planning Board, the Bureau of Health Education and

relevant international agencies are some of the other agencies which may also be involved in the development of a self-administered screening tool.

Table P-1b.4. Offices In Charge of Developing or Supervising the Development of a Self- administered Screening Tool

Level	Number	Percent
Central MOH only	3	30.0
MOH and Other	1	10.0
NERHA and Parishes	1	10.0
MOH, NERHA and Parishes	3	30.0
NERHA only	1	10.0
Three levels and other organizations (NFPB, Bureau of Health Education, relevant international organizations)	1	10.0
Total	10	100.0

Offices in Charge of Approving a Self-administered Screening Tool

The majority of 10 managers interviewed felt that the Central MOH Office was in charge of approving a self-administered screening tool (60.0%). Three respondents were of the opinion that central MOH office, NERHA and Parishes (30.0%) were in charge of approving a self-administered screening tool and one respondent thought the region was solely responsible (10.0%) (Table P-1b.5).

Table P-1b.5. Which Office(s) is/are in Charge of Approving A Self-administered Screening Tool

Level	N	Percent
Central MOH only	6	60.0
MOH, NERHA and Parishes	3	30.0
NERHA only	1	10.0
Total	10	100.0

Perceptions of Likelihood of MOH Approving and Developing of a Self-administered Screening Tool within the Next Two Years

There were mixed views regarding the likelihood of MOH approval and development of a self-administered screening tool advising clients to seek attention from their health care provider if they have certain risk factors within the next two years. Of the seven managers who responded, one indicated that it was highly likely, three that it was likely, two that it was unlikely and one did not know (Table P-1b.6.).

Table P-1b.6. Likelihood that the MOH will Approve and Develop Self-administered Screening Tools within the Next Two Years

Response	Number	Percent
Highly likely	1	14.3
Likely	3	42.9
Unlikely	2	28.6
Don't know	1	14.3
Total	12	100.0

4.4.2 Purchase TVs & VCRs for Health Promotion in Facilities (Patient Education-2)

Background

Current Situation. Currently, clients come to health facilities early in the morning, register for a clinic, or to see a specific health care provider, and then wait to be served. The client may be there for several hours waiting to be seen by a provider. Apparently, even if clients are given a time for an individual appointment such as for curative or dental, they still come early in the morning. It seems to be a cultural behaviour. On special clinic days such as antenatal, the nurse or midwife will conduct a special group educational session on various health topics before beginning to see individual clients. The rest of the time, the clients sit and wait to be served. This is a good time to educate them to various health issues including STIs, HIV/AIDS, safe sex practices etc. This can be accomplished by playing educational tapes on VCRs and TVs. According to the health district staff, many health education tapes are available and could be played. Currently there is a shortage of VCRs and TVs in the facilities.

Proposed Change. Equipment could be purchased in order to provide expanded health promotion information to waiting clients. It is recommended that the equipment be placed in Type III and above facilities.

Anticipated Resource Requirements. A survey needs to be done to determine how many VCRs and TVs need to be purchased; cost of the equipment and suitable grill work to help ensure that the equipment remains in the facilities.

Costs: J\$79,614 (See Appendix E)

Study Findings on Patient Education-2

Level of Support for Purchase of TVs and VCRs to Help Reach Clients with Health Promotion Messages

Both managers and providers are in strong favour of having the equipment at facilities to enable showing reproductive health-related tapes to clients. All of the providers and 94.8 percent of the managers strongly agreed or agreed that health facilities should have VCRs and TVs to show reproductive health related tapes.

Table P-2.1. Level of Agreement That Health Facilities Should Have TVs and VCRs in Order to Show RH-related Tapes

Level of agreement	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	14	73.7	21	77.8
Agree	4	21.1	6	22.2
Neither agree nor disagree	1	5.3	0	0.0
Total	19	100.0	27	100.0

- Some might want to watch soap operas instead

Virtually all of the managers and providers interviewed thought that clients would be receptive to having educational videos in clinics, although they predicted that some clients would want to take the opportunity to watch soap operas rather than health information videos. The clients – women, men and youth also liked the idea of having educational videos in the health centres, saying that most people would watch but that some would not. A rural woman from St. Ann’s Bay indicated, *“The persons that are interested would watch it, but the ones that are not interested wouldn’t.”* The client also agreed that many people would want to watch soap operas instead.

- We need the information

Many clients said that people need the information that the videos would provide, particularly young people. A woman from rural Portland said, *“There is young people that still don’t know about certain things, so if you could implement a system like this where you have televisions...I think a lot of people would find it interesting.”* A young man from rural Portland said that people are captive audience in clinics and that they would watch videos. *“Probably that would be the only time they really stop and watch it.”* At home they would change the channel.

- It has to be interesting

An urban woman from Portland said that the videos would have to be interesting. *“You will sit and watch it, but once it not interesting, you not going to sit and watch.”* A young man from urban St. Ann’s Bay indicated that whether or not people would watch the videos would depend on the topic and what they came to the health centre for. If they had come for something serious, the videos might be distracting. *“Like watching it and relax until your time comes, you know, you nah go really tormented and say, “Boy, mi can’t get through.” If you have a nice show to look pon, you a go feel comfortable...[but] it a drip [discharge], and*

them things, you can't go feel comfortable to watch TV, cause you want get through for that stop....Is like a distraction to me."

Factors that Need to be Considered in Purchasing TVs and VCRs

Managers listed three primary issues that need to be considered in purchasing TVs and VCRs, namely security and cost/maintenance (Table P-2.2).

Table P-2.2. Factors That Need to Be Considered in the Purchase of TVs and VCRs, According to Managers

Factor	Number	Percent
Cost	12	75.0
Security	16	100.0
Maintenance	8	50.0
Availability	1	6.3
Other	3	18.8
Total	16	

Percentages exceed 100% because multiple responses were possible.

- **Security**

Based on the responses of the 16 managers who were asked, security appears to be a major factor for consideration and was identified by all respondents. According to a programme manager from St. Ann's Bay, "*Security is the main thing, because most of what we had, they have stolen them – they break the health centres and they steal them. You know, security is – although we have grilled them.*"

- **Cost and maintenance**

Cost is also significant, and was identified by 12 managers (75.0%), followed by maintenance identified by eight managers (50.0%). One manager in Portland lamented "*They break down and you never get them back when you send them to the repair shop [due to lack of parts].... we had to purchase another television!*"

Availability does not appear to be considered a major problem, and only one respondent identified it as a factor. Other factors are clinic size and patient load, the fact that some facilities have no electricity and the effectiveness in achieving behaviour modification or change.

Offices in Charge of Approving and Carrying Through the Purchase of TVs and VCRs for Patient Education in Health Facilities

As with other interventions, there was no consensus on which office or offices would be in charge of approving and carrying out the purchase of the TVs and VCRs. The most

common responses among the 15 managers who responded were that the Parish was in charge (4) or that the NERHA was responsible (4). Three respondents suggested that both NERHA and the Parish shared responsibility, while two respondents noted that the responsibility fell with NERHA and the Ministry of Finance and Planning. One each gave responsibility to all three levels together, to the Central MOH and NERHA together. In all, 11 of the 15 respondents indicated that NERHA would be involved in approving and purchasing the equipment.

Table P-2.3. Which Office(s) Is/Are Responsible for Approving and Purchasing TVs and VCRs for Health Facilities

Level	Number	Percent
Central MOH only	0	0.0
MOH and NERHA	1	6.7
NERHA only	4	26.7
NERHA and Parishes	3	20.0
Parish only	4	26.7
MOH, NERHA and Parishes	1	6.7
NERHA and Ministry of Finance and Planning	2	13.3
Total	15	100.0

Likelihood that TVs and VCRs Will be Purchased in the Next Two Years

While the majority of managers (62.5%) thought it likely or highly likely that TVs and VCRs will be purchased for patient education within the next two years, nearly one-third (31.3%) thought it unlikely or highly unlikely that the purchase of this equipment would take place, mostly for cost reasons (Table P-2.4).

Table P-2.4. Likelihood That TVs and VCRs Will be Purchased for Patient Education Within the Next Two Years

Likelihood	Number	Percent
Highly likely	4	25.0
Likely	6	37.5
Unlikely	4	25.0
Highly unlikely	1	6.3
Don't know	1	6.3
Total	16	100.0

One manager from Portland was enthusiastic, saying, “*Highly likely, because we have been doing that. It is already being done.*” However, one Central MOH Office manager cautioned:

“that just focuses on the technology... what is even more basic than that is to have somebody who is motivated and trained to do it ... the important thing is that it is done in a discussion format, with question and answer and that kind of thing, and you can provide the A/V (audio/visual) aids to the person doing it, to the extent that you can afford ... you can be very effective in doing the other things, so when you jump to a VCR to go to every Type I health centre... So I agree, strongly agree it’s a good opportunity that health workers should seek to utilise and not miss. But to jump into just the technology – that’s just one aid. That’s not the important part of it.”

4.5 Outreach

Although the following proposed interventions are categorized under “Outreach”, they contain components related to supervision and training. The healthcare workers who are responsible for Outreach activities are in this category – Community Health Aides, Contact Investigators and Peer Educators.

4.5.1 Better supervision for CHAs to Do Outreach Work (Outreach-1)

Background

Current Situation: Currently, Community Health Aides (CHAs) are supposed to spend the majority of their time going out in the community, meeting with groups and conducting home visits with health promotion activities such as good nutrition, family planning, safe sex practices, encouragement of breast feeding, charting growth of newborns, promotion of healthy lifestyles etc. They are also supposed to assist in the follow-up of family planning “drop-outs” and clients identified as having special health problems. During these visits, they report that men are often in the home and it is a good opportunity to reach men with appropriate health messages especially regarding safe sex practices and condom promotion for dual protection. Their training has traditionally emphasized MCH/FP, not STIs. Their training includes 3 weeks of classroom instruction and three weeks “on the job” training. In addition, some of the CHAs are being trained in VCT.

It has been reported that their activities are being constrained by having to stay in the facilities often assisting with clerical activities such as pulling docketts due to shortages in administrative staff. The medical officer for St. Ann’s said that the CHAs assist the nurse in the specialized clinics, and while they are there, it is logical for them to pull docketts and do clerical work. In St. Ann’s facilities the Type I units have two CHAs – while one is in the clinic, one is supposed to be out in the community. In Portland Parish however, they are currently recruiting for more clerical staff to assist providers in various facilities. The medical officers in both parishes think that there may be two other reasons for the CHAs not being out in the community more. They say that the CHAs need better training in health promotion activities especially the concept of integrated activities and also better supervision. The work of the CHAs is currently being directed and supervised by the nurse or midwife assigned to the particular facility where the CHA is assigned.

Proposed Change: The supervision system in place for the CHAs needs to be strengthened by training the nurse/midwife supervisors in techniques to properly direct and evaluate the CHAs activities. The supervisors need to be more directive and give assignments to the CHAs and help them to target their work better. The supervisors also need to ensure that the CHAs are properly reporting their activities. The CHAs should be made aware of the issues of target-setting for monitoring and evaluation of the programme. For instance, one of the indicators the parish is evaluated on by the Regional Health Authority is the number of women breastfeeding exclusively. In order for the CHAs to assist in increasing the number of women breastfeeding, they need to know that there are a target number of women that need to be reached and that they are expected to do their part in reaching the target. The CHAs also need additional training in health promotion activities regarding reproductive health; protocols that address specific suggestions on how to deal with family planning clients' complaints regarding the current contraceptive used, as well as how to provide/suggest alternative methods in order to reduce discontinuation rates. Further training in STIs & HIV/AIDS prevention and an integrated approach is needed, particularly since they may be able to interact with men in the home and their communities who are reluctant to access services at the clinics. It is also recommended that an internal review be conducted by the two parishes to determine if more CHAs are needed to accomplish the work load.

Anticipated Resource Requirements: Training of CHAs in health promotion issues with regard to fostering integration; revision of the current supervision protocol; training for nurse/midwife supervisors in improving the supervision of the CHAs.

Costs: J\$341,375 to J\$547,044 to train CHAs and nurse midwife supervisors (See Appendix E)

Findings on Outreach-1

Can CHAs Take on More Responsibility and Would They be Willing?

All of the 17 managers and 24 providers strongly agreed (58.8% and 54.2%, respectively) or agreed (41.2% and 45.8% respectively) that CHAs should be more involved in outreach work to provide integrated reproductive health messages (Table O-1.1).

Table O-1.1. Level of Agreement that CHAs Could be Used to Provide Family Planning and Reproductive Health Information, in Addition to STI/HIV/AIDS, According to Managers and Providers

Agreement	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	10	58.8	13	54.2
Agree	7	41.2	11	45.8
Total	17	100.0	24	100.0

When asked if the CHAs would be willing to take on the work of outreach with integrated messages, nine of 10 managers agreed that CHAs would be willing to do so. The CHAs also agreed. CHAs in Portland said they already spend about three-quarters of their time in the field – one week a month in the clinic and the other three in the field. CHAs in St. Ann’s Bay also said their main job is visiting in the community, but that sometimes the amount of time they actually spend in the community depends on the health centre. One CHA in St. Ann’s Bay indicated that they should get more involved in integrated care because, *“They see us first, and we live – most of us live in our community.”*

Willingness of Female and Male Clients to be Reached by CHAs in the Field

All 11 managers who were asked indicated that women would be willing to be reached by CHAs and 10 of the 11 said men would also be willing to be reached by CHAs. Among the 20 providers asked, only three said they did not think that female clients would want CHAs to be involved in providing integrated outreach. Three others either did not know or did not respond. Among the 19 providers who responded, only one said men would not want to be reached by CHAs (four said they did not know and one did not respond).

The CHAs agreed that both females and males in their communities would be willing to be reached by CHAs. In terms of reaching males, some CHAs said it depends, as one CHA indicated *“on how you approach them.”*

- The lady in the blue dress

Some clients did not know who CHAs are until they were told that CHAs wear blue dresses. One rural woman from Portland said she sees a CHA *“once in a blue moon.”* CHAs were mostly equated with checking on babies in the communities.

- Eager for information

Most female and male clients agreed that they would be willing – and were in fact eager – to be reached by CHAs in the field. Men did not seem to be bothered about hearing about reproductive health, family planning and STI/HIV/AIDS from female CHAs. Clients explained that everyone should want to hear from CHAs about these issues, but that some people would not want to because, according to a urban woman from Portland, *“Maybe they are just ignorant because telling some people about certain diseases, they just don’t want to hear.”* Another urban woman from Portland added, *“Some people don’t feel that you should tell them what to do.”* A young man from urban St. Ann’s Bay said that if CHAs held group meetings, some people might not come out of ignorance or fear, but that he would. *“Me woulda go still, because it more, it better for you, you can learn nuff things.”* An adult man in rural St. Ann’s Bay agreed, saying, *“Me’d listen them, me’d listen them still.”* A young woman in rural St. Ann’s Bay said,

“If a nurse came at my house and talk to me about family planning, or HIV, whatever, I will surely interested to listen to what she has to say.”

- Fear of lack of confidentiality

Some clients worried about confidentiality in talking with a CHA in the community. A young woman from urban Portland said, *“Might be some people really can’t trust them.”* Another added, *“Maybe you can talk to them on the road, and when you come to the clinic, they might pass them and they will talk to somebody one of the co-workers, and say, ‘You know that girl there tell me something the other day!’ Right, you might have the fear that they might discuss it with somebody else.”*

- Saving a trip to the health centre

Some clients said that having CHAs to speak with in the community would save them a trip to the health centre. A young urban woman from St. Ann’s Bay said, *“Sometimes people nuh really have the money to go to the clinic, you know, nuh matter how small it is, so it would be good.”*

Obstacles to CHAs Taking on More Outreach Function

Managers and providers noted a number of obstacles to CHAs providing more outreach work, including:

- CHAs ability to handle confidential information
- The need to review the role, current job description and related policies
- Inadequate numbers, given the number and nature of other activities, *“For example, the immunization programme by itself is a big task, to look for a child who is not fully immunized, or the mother who did not come for her antenatal*
- Involvement in administrative functions in the clinic, which one respondent attributed to a lack of Records Officers
- CHA fear of walking alone in some areas due to the high crime rate
- The need for privacy to deal with some aspects of the STI or HIV issues
- Inadequate training of CHAs
- Inadequate knowledge of STDs

Training and Other Needs for CHAs

Most (93.3% of managers and 79.2% of providers) thought that CHAs could take on additional outreach work if they had additional training. Additional training needs suggested include:

- Basics of reproductive health, family planning and contraceptive methods, maternal and child health
- STDs, HIV/AIDS symptoms and home-based care
- Universal precautions and infectious diseases
- Confidentiality
- Communication, especially how to communicate to those of a low literacy level and how to use IEC materials such as charts, TV etc.; how to relate to people at all levels of society
- Integrated approach and holistic outlook
- Sex and sexuality
- Gender and relationships within the Jamaican context
- Adolescents and reproductive health
- Nutrition and immunization

The CHAs agreed that they need training in STIs and HIV/AIDS in order to provide more integrated outreach work. A CHA from Portland said that getting more training on HIV/AIDS is particularly important now so that they can meet the needs of HIV positive mothers and children, because *“we don’t know who is going to be born with it in this area. So I think we should be set up, they should set us up from now and [with] training.”* CHAs also noted that they needed more information about confidentiality related to HIV/AIDS. A CHA from St. Ann’s Bay explained, *“With the HIV thing, they are saying that should be confidential, it’s a delicate thing.”* CHAs listed other skills that would be useful in the community such as being able to give insulin injections.

Training for Supervisors to Better Direct CHAs

Managers indicated that supervisors need a variety of training to better supervise CHAs, including the integration process, evaluations, conflict resolution, supervision/supervisory management, monitoring, how to get feedback, how to deal with confidentiality, roles and responsibilities of CHAs and knowledge of the parish work plan and priorities.

Communicating Targets for CHAs

Targets for CHAs seem to be set in conjunction with their supervisors in terms of the needs within the community – how many pregnant or nursing women there are at the time, how many people with hypertension or diabetes, or how many students.

CHAs say they particularly watch out for teen mothers in the community since some of them have little idea how to care for babies. The CHAs indicated that they do not need to be given targets for breastfeeding, for example, because they already know from their training that the target is 100% - that all new mothers should be encouraged to breastfeed for the first four months. In Portland the CHAs indicated that targets are set by being assigned a number of households per day. One CHA indicated, *“so we have to give account for the ten each day, so we have a diary [that] we produce to them when they ask.”*

Some CHAs indicated that they have monthly meetings with their supervisors at which they discuss the month’s activities. One CHA from Portland explained that, *“If they have anything special to tell us, they will tell us.”*

The 10 managers who were asked also indicated that monthly meetings are held and that supervisors also visit CHAs during the month. Among the 22 providers questioned, 12 of each (44.4%) said supervisors have regular staff meetings and individual meetings with staff members and 10 (37%) said that supervisors provide written feedback to the CHAs.

Managers and providers listed a few ways to strengthen monitoring of CHAs’ work, including:

- Re-introducing special report forms and tracking systems
- Sharing statistics among supervisors
- Using flow charts to monitor and evaluate
- Providing transportation
- Providing educational materials
- Maintaining supervisory visits
- Having CHAs work in pairs
- Providing feedback, handouts, evaluation of what they are doing
- Giving positive reinforcement and reassurance that supervisors respect them and trust them to carry out their duties

Other than Strengthened Supervision and Additional training, Other Support Needed

Managers suggested that CHAs would need transportation, training aids and “*basic tools like literature, equipment etc....a demonstration kit, flashlight for physical examination for referral purposes, umbrellas.*”

Offices Responsible for Approving an Expanded and Revised Job Description for CHAs

It is not clear to managers which organizations or offices within and outside of the MOH, including the central, regional, and parish levels, would be involved in approving a revised job description for CHAs. Among the six managers who were asked this question, five indicated that the MOH would be involved, three mentioned NERHA and two mentioned the parishes (Table O-1.2).

Table O-1.2. Which Office(s) Is/Are Responsible for Approving the Policy on Revising the Job Description for CHAs

Level	Number	Percent
Central MOH only	3	50.0
MOH and NERHA	1	16.7
NERHA only	0	0.0
NERHA and Parishes	1	16.7
Parish only	0	0.0
All three levels and professional organizations	1	16.7
Total	6	100.0

Changes to Procedures Necessary to Support CHAs Doing More Integrated Approach

Managers suggested that the following changes would be necessary to support CHAs to take a more integrated approach:

- Hire additional staff
- Check logs or worksheets on a daily basis to ensure that they are doing what they are supposed to do
- Make changes in the curriculum for district midwives and nurses who work in health centres.

One respondent felt that the systems are in place, but are not being universally implemented. Another felt that the level of training of the CHAs coming in could be higher so that the understanding could be greater.

Likelihood of a System Being Implemented in the Next Two Years for CHAs to Get More Involved in Outreach Work to Promote Integrated RH Messages

Eleven of the 15 managers (73.4%) indicated that a system would be established in the next two years for CHAs to provide more outreach work focusing on integrated reproductive health messages (Table O-1.3).

Table O-1.3. Likelihood That a System Will be Instituted Within the Next Two Years for CHAs to Provide More Outreach with Integrated Messages, According to Managers

Response	Frequency	Percent
Highly likely	1	6.7
Likely	10	66.7
Unlikely	3	20.0
Don't Know	1	6.7
Total	15	100.0

Some managers indicated that this system should be “*Easy to implement,*” and that it is “*already being done, it just needs additional training and motivation,*” and that it is a “*priority for Portland.*” Others worried about the cost of training and the time for the process to take place. One manager said it would take place only if donors paid for the programme.

4.5.2 Contact Investigators Provide Limited FP Counselling/ Condom Promotion/Referral for Other FP (Outreach-2)

Background

Current Situation: Currently the contact investigators focus on diagnosing, counselling, treating STIs and going out into the community to do partner tracing and general STI/HIV education to individuals and community groups. They also encourage use of condoms and provide them to their clients in the clinic and in home visits. The contact investigator sometimes includes a discussion of FP issues with clients they are treating for STIs when information on FP is in the client record. The STI form that is filled out for the client has a section regarding contraception. The contact investigator sometimes refers clients to the FP clinics. However, FP counselling is not part of the routine procedure followed by the contact investigator and the number of referrals to FP clinics is less than the number of STI referrals to them from FP providers.

Proposed Change: To foster enhanced integration, contact investigators could provide limited FP counselling regarding methods, stress the use of condoms as a dual protection method and then refer clients who would prefer additional types of contraceptives to the appropriate facility/clinic.

Anticipated Resource Requirements: Training on contraceptive technology and counselling skills.

Costs: J\$132,891 to train contact investigators (See Appendix E)

Study Findings on Outreach-2

Agreement That Contact Investigators Should Provide Limited Family Planning and Referral

All 17 managers (52.9%) agreed or strongly agreed (47.1%) that to foster enhanced integration, Contact Investigators should provide limited family planning counselling and refer clients to family planning clinics (Table O-2.1). Among the three Contact Investigators asked, two strongly agreed and one agreed that Contact Investigators should provide some family planning counselling and refer clients to clinics.

Table O-2.1 Level of Agreement that Contact Investigators Should Provide Limited FP Counselling and Refer Clients to Clinics

Level of agreement	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	8	47.1	2	66.7
Agree	9	52.9	1	33.3
Total	17	100.0	3	100.0

Twelve of the 16 technical managers (75.9%) who were asked also thought that Contact Investigators would be willing to be more involved in outreach with integrated messages of STI/HIV, family planning and safe motherhood. However, one manager thought they would not be willing, and thought them to be “*very myopic i.e. limited in their scope and how they see reproductive health. They see it only in terms of STI.*” Another respondent added another dimension, noting that Contact Investigators currently “*have structured activities in terms of contact investigation for STI and HIV, and they do also counselling and they do also outreach programmes in risk reduction [and] educational activities. So they may not be inclined to add safe motherhood and family planning.*” All three of the contact investigators said they would be willing to provide outreach with integrated messages. A contact investigator from Portland said, “*I don’t think there should be any objection.*”

Fifteen of the 16 technical managers (93.8%) and all three providers who were asked felt that clients would be willing to receive information from Contact Investigators regarding family planning and safe motherhood in addition to sexually transmitted infections. A Contact Investigator from Portland said that clients would be willing to receive

information from Contact Investigators, “because they would have built up a rapport with the contact investigator.”

Most clients had not heard of Contact Investigators; however, they did not seem to have any objections to hearing about family planning from Contact Investigators.

What Would Contact Investigators Need to Provide Counselling on Reproductive Health?

All of the managers asked thought that the Contact Investigators would need training, 87.5% said they would need materials, and 81.3% mentioned that they would need supervision in order to provide expanding counselling (Table O-2.2).

Table O-2.2. Needs of Contact Investigators to Provide Counselling on Reproductive Health, According to Managers

Type of Support	Number	Percent
Training	16	100.0
Materials	14	87.5
Supervision	13	81.3
Transportation	1	6.3
Total	16	100.0

The types of training identified included:

- Contraceptive technology and family planning
- Antenatal care (but not enough to turn them into midwives).

Which Offices Would Approve an Expanded and Revised Job Description for Contact Investigators?

Eight of the 11 technical managers who were asked (72.7%) thought that the Central MOH Office is solely in charge of approving an expanded and revised job description for Contact Investigators (O-2.3). Three more thought that it is head office in conjunction with the region, parish or Ministry of Finance and Planning. One respondent also identified the Contact Investigators association as a major stakeholder, noting that: “it is difficult to add any kind of job function to this group. They have an association. That association also has a trade union ... So it’s very difficult. You can’t just add a job description, even a word, without their blessings.”

Table O-2.3. Offices With Authority to Revise Job Description of Contact Investigators to Provide More Outreach

Level	Number	Percent
Central MOH only	6	54.5
MOH and NERHA	1	9.1
NERHA only	0	0.0
NERHA and Parishes	0	0.0
Parish only	0	0.0
All three levels	1	9.1
NERHA and CI Association	1	9.1
Ministry of Finance and Planning	2	18.1
Total	11	100.0

Likelihood that a System will be Instituted in the Next Two Years for Contact Investigators to Provide More Outreach

Ten of the 11 managers asked believe that it is likely (72.7%) or highly likely (18.2%) that a system will be instituted within the next two years for Contact Investigators to provide more outreach with integrated messages on all aspects of reproductive health (Table O-2.4). One manager from the Central MOH Level explained:

“As much as possible, we are trying to incorporate reproductive health messages in HIV prevention or HIV prevention programmes. And we have also trained the CIs to work in counselling. So we are also in the process of reducing the clinical time. And then over the next two to three years, our goal is to have more of the health promotion programmes and counselling programmes. Therefore, there is good reason to believe that the MOH and other authorities will institute the system.”

Table O-2.4. Likelihood That a System Will be Instituted in the Next Two Years for Contact Investigators To Provide More Outreach With Integrated Messages

Response	Number	Percent
Highly Likely	2	18.2
Likely	8	72.7
Don't Know	1	9.1
Total	11	100.0

4.5.3 Increase Community Peer Educators Linked to VCT (Outreach-3)

Background

Current Situation: Currently Community peer educators work in STI/HIV-AIDS prevention and do not provide information on family planning. They make home and group visits -- including presentations at health centres on some family planning and antenatal clinic days -- and do what is called "condom demonstrations." They also go out into the community to speak with community groups and into school settings to educate people regarding HIV/AIDS. (Currently, they receive no (minimal amounts) transportation allowance to cover expenses.) They are an important link to adolescents and men in the community. The peer educators were originally funded through a USAID programme for HIV prevention. The funding for these positions is gradually being shifted to the responsibility of the parish in which they are assigned. There is currently only one peer educator in St. Ann's Bay Health District and four in the entire parish of Portland. With the current HIV/AIDS programme being funded through the World Bank, Voluntary Counselling and Testing (VCT) is due to be operationalised soon. The initial plan is that peer educators will have an important role in this programme by attending antenatal and STI clinics and giving a group presentation on VCT to the clients waiting to be served by the providers at the clinic. (Almost all of the providers are receiving training currently on VCT.) Then if a client is interested in VCT, the client will tell the provider when she/he is served and the provider will counsel the client.

Proposed Change: It is evident that more peer educators need to be hired in order to carry out VCT activities as they are currently planned. If there were more peer educators, outreach into the community to target youth and males could be increased. There is no provision for increasing the number of peer educators with the World Bank funding, therefore the parish will have to pay for the increased number needed. The peer educators could also provide information on family planning methods.

It is estimated that two more peer educators would be needed to serve the St. Ann's Bay Health District. This would make a total of three for the district. In order for Portland to have three peer educators in each district, five additional peer educators would need to be hired. The peer educators should also receive a higher transportation allowance to facilitate their work in the community. They currently receive a very minimal amount for transportation.

Anticipated Resource Requirements: The salaries of seven peer educators (two for St. Ann's Bay and five for Portland); transportation allowances; training for the current staff and additional staff on reproductive health issues including family planning; and training for the additional staff on STI/HIV/AIDS.

Costs: J\$2,280,546 to hire 7 new Peer Educators and train both new and existing Peer Educators in FP (See Appendix E)

Study Findings on Outreach-3

Can Community Peer Educators be Used to Provide Family Planning Information in Addition to STI/HIV/AIDS

The majority of technical and administrative managers (94.1%) and all of the providers thought that Community Peer Educators could be utilized to provide information on family planning methods in addition to STI/HIV AIDS (Table O-3.1). One respondent cautioned that this group had limited training and qualifications, and it would be too much work for them.

Table O-3.1. Agreement that Community Peer Educators Could be Used to Provide Family Planning and Reproductive Health Information, in Addition to STI/HIV/AIDS, According to Managers and Providers

Agreement	Managers		Providers	
	Number	Percent	Number	Percent
Yes	16	94.1	5	100.0
No	1	5.9	0	0.0
Total	17	100.0	5	100.0

Clients' Views on Being Reached by Community Peer Educators

Most of the clients said they would be willing to be reached by Community Peer Educators, although some expressed reservations about the group. One young woman from urban Portland remarked that Community Peer Educators do not always do what they tell others to do. *“They are telling them something, and they are not exactly doing what they are telling you. So maybe some [people] would not want [to listen to them].”* Some men in rural St. Ann’s Bay said that they might prefer to talk to a male Community Peer Educator. One young man in rural St. Ann’s Bay said that the right Community Peer Educators could be effective. *“Because if you like actually picked persons from a community who is like role model or person that looked to...I’d actually listen to that person.”*

Needs of Peer Educators to Provide Family Planning and Reproductive Health Information in the Community

The managers listed a number of needs of the Community Peer Educators. All of the managers identified supervision as a need for peer educators to get involved in providing family planning and reproductive health information in the community. Other needs listed included training and materials (91.7% each) and transportation (66.7%) (Table O-3.2).

Table O-3.2. Needs of Community Peer Educators to Provide Family Planning and Reproductive Health Information in Addition to STI/HIV/AIDS, According to Managers

Need	Number	Percent
Training	11	91.7
Supervision	12	100.0
Materials	11	91.7
Transportation	8	66.7
Total	12	100.0

Office Responsible for Approving the Hire of Additional Peer Educators

Two of the nine managers asked think the Central MOH Office is solely in charge of approving hire of additional community peer educators, while five think that NERHA is involved, either by itself (1), with the Central MOH (2) or with a Parish (1), or with both the MOH and a Parish (1) (Table O-3.3). Two respondents mentioned that other organizations would be involved, namely the NFPB and NGOs.

Table O-3.3. Offices With Authority to Approve the Hire of Additional Peer Educators

Level	Number	Percent
Central MOH only	2	22.2
MOH and NERHA	2	22.2
NERHA only	1	11.1
NERHA and Parishes	1	11.1
Parish only	0	0.0
MOH and Parish	0	0.0
All three levels	1	11.1
MOH and NGOs	1	11.1
NFPB	1	11.1
Total	9	100.0

Only four of the nine managers who were asked agreed with the estimates for the number of Community Peer Educators needed. The majority – seven of the nine – said they did not know enough about the peer education programme to say how many were needed.

How Could the Peer Education Programme be Financed?

The managers had a number of suggestions for funding the additional peer educators, including:

- GOJ central funding
- NGO funding

- Donor funding or grant allocation
- NERHA funds with assistance from USAID; would prefer USAID to sponsor fully for one year, and the region absorb thereafter, or share cost 50/50, or hire on part-time basis
- Submit a proposal to the National Health Fund for primary care and reproductive health

Likelihood of Seven More Community Peer Educators Being Hired in the Next Two Years

Only one respondent (9.1%) thought it highly likely that seven more community peer educators would be hired within the next two years (Table O-3.4). The majority of respondents (63.7%) thought it unlikely (45.5%) or highly unlikely (18.2%) mainly because of financial constraints.

Table O-3.4. Likelihood that the Relevant Organisation or Office of the MOH Will Employ Seven More Community Peer Educators Within The Next Two Years

Response	Number	Percent
Highly likely	1	9.1
Likely	1	9.1
Unlikely	5	45.5
Highly unlikely	2	18.2
Don't know	2	18.2
Total	11	100.0

4.6 Strengthening STI Diagnosis and Referral

4.6.1 Referral from Types I/II to Type III, Including System for Forms (STI Referral-1)

Background

Current situation. If clients seen in a Type I or II facility are suspected of having an STI, they are referred to a Type III facility for diagnosis and treatment. In both parishes, a triplicate copy, standard referral form is filled out by the referring provider. The referring provider keeps one copy and places it in the client's medical records. The other two copies are given to the client with instructions to go to the Type III facility and give the forms to the physician or contact investigator when the client is seen. The provider seeing the client in the Type III facility is supposed to fill out the form with information regarding the diagnosis and treatment of the patient, keep one copy for the medical records of the client and the third copy is supposed to be returned to the referring provider. The system for returning the third copy to the referring provider is not

consistent. Sometimes the patient is given the third copy to take back to the referring provider the next time the client goes to the referring facility. Sometimes the third copy is sent by the Type III facility to the referring facility by personnel visiting the Type I or II facility for other purposes or in the case of St. Ann's Bay, a regular delivery service is made to the Type I and II facilities. Midwives and nurses in outlying centres in Portland generally report that they do not receive direct feedback from their referrals of STI clients to the contact investigators. Some clients are lost because of the referral.

Apparently, even within Type III and IV clinics where there is always a physician or contact investigator in the clinic, referrals for STIs cannot always be seen on the same day. On days when the contact investigator is not there, the clinic can be so busy that the physician will not see the referred patient because the situation is not considered to be an emergency. So the client must either return and therefore, incur additional cost and time, or does not return and is potentially not treated.

Proposed change: The referral system needs to be strengthened between Type I and II facilities to Type III facilities and within Type III facilities. One recommendation for strengthening referral between the facilities could be a more systematic mechanism for transporting the referral forms. After the client has seen a provider in a Type III facility, the form should not be given to the patient to take back to the referring facility. Regular transport by the parish personnel should be used. St. Ann's Bay currently has containers where documents and supplies are placed to be sent out to the various facilities in the district. Portland could have a similar system. **(Referral 1a)**

Ensuring that clients referred actually go to the Type III facility for further diagnosis and treatment is more problematic. Since none of the facilities set appointment times for clients, and most Type I and II facilities do not have phone lines, the referring provider cannot make an appointment for the client. The client has to be proactive in seeking further evaluation.

Within the Type III facilities, providers need to be willing to see a suspected STI client on the same day that the person is identified by a nurse or midwife. This will require some training regarding the importance of seeing the client. **(Referral-1b)**

In addition private sector providers could be encouraged to participate in serving referred patients and also in returning the third copy of the referral form to the referring facility. **(Referral-1c)**

Anticipated: Training of relevant staff – providers (public and private); transport personnel.

Costs: J\$37,696 to train staff to see STI patients immediately and to handle referral forms differently (See Appendix E)

4.6.1.1 Study Findings for Referral-1a (Using the MOH Transportation System to Enhance Referral)

Agreement with Using the MOH Transportation System to Ensure that Referral Forms are Returned

Fourteen of 15 of the managers (93.3%) believe that the MOH transportation system could be used to ensure that the third copy of the referral form is sent back to the referring provider. One respondent in St. Ann indicated that there were not sufficient vehicles.

Table R-1a.1 MOH Transportation System Could be Used to Ensure 3rd Copy of Referral Form is Sent To Referring Provider

Response	Number	Percent
Yes	14	93.3
No	1	6.7
Total	15	100.0

The managers had a number of suggestions for ways of improving the referral system, including:

- Assigning someone in the Medical Records Office with responsibility for co-ordinating referrals
- Having someone, possibly the Public Health Unit, use the pre-numbering of the form to monitor and ensure that forms are sent back within established deadlines
- Taking advantage of set meeting dates when persons are travelling from different locations to a central location
- Sending the slips to a central point, such as the parish office, for dispatch to health centres
- Using a box like the one used in Port Antonio for blood results coming from different clinics
- Recording referrals in the appointment book and following up with the patient and the provider to find out what happened to the client
- Automating health centres
- Giving midwives motorbikes.

4.6.1.2 Study Findings on R-1b (Clients Referred for STIs Should be Seen the Same Day)

Agreement that Referred Clients Should be Seen the First Day

Among the 18 managers who were asked, 88.9% agreed or strongly agreed that clients referred for STI services should be seen by the Type III or IV health facility on the same day. Among the 25 providers who were asked, 96% strongly agreed or agreed. A higher percentage of providers than managers strongly agreed (56.0% compared to 38.9%).

Table R-1b.2. Agreement That Clients Referred for STI Treatment Should be Seen the Same Day, According to Managers and Providers

Response	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	7	38.9	14	56.0
Agree	9	50.0	10	40.0
Neither agree nor disagree	2	11.1	1	4.0
Total	18	100.0	25	100.0

One provider said that they are already seeing referrals on the same day. However, several barriers were identified:

- Inadequate numbers of clinical practitioners; high patient load (the main barrier mentioned)
- Trained providers might not be at the clinic that day
- Culture of organization not used to it
- Lack of pharmacy or laboratory services on that day; unavailability of medicine.
- Referring provider may not know which days specific clinics operate
- Distance between facilities and transportation problems
- Clients may not have money for transportation to referral centre
- Heavy case load
- Client concerns about privacy
- Clients may arrive too late; all appointments taken
- Clients do not always go for referrals

Clients' Views on Same-day Referrals for STIs

Clients like the idea of referrals for STIs being seen on the same day, mostly because they would want to know how serious the condition was for which they were referred. Urban women in Portland said, for example,

“It would be very good, because at least they would know. It would probably ease their mind whether they have a problem or not.... Cause maybe when you go home, you might change your mind and never come back.... And if it is the case where you are infected, it’s best to know early so...if there is treatment, it can be dealt with early.”

A rural woman in Portland agreed, saying, *“Because I’m so anxious to hear what it is, if it is good, or if it is bad.”* A young urban woman made a similar point, saying, *“It’s very important, you know, that you are seen on the same day. You know, just in case is something that you can spread you know. But the sooner the detection and cure, the better.”*

Offices in Charge of Approving a Policy for Ensuring that Clients Referred for STIs are Seen the Same Day at the Referral Facility

The 15 managers who responded gave a mixed picture of which offices were in charge of approving the policy on STI referrals being seen the same day (Table R-1b.3). The main responses were that the responsibility rests with NERHA and the parishes (4), with all three (3) and with the central MOH office (3).

Table R-1b.3. Which Office(s) Is/Are Responsible for Approving the Policy on STI Referrals Being Seen the Same Day

Level	Number	Percent
Central MOH only	3	20.0
MOH and NERHA	1	6.7
NERHA only	2	13.3
NERHA and Parishes	4	26.7
Parish only	2	13.3
All three levels	3	20.0
Total	15	100.0

4.6.1.3 Study Findings on R-1c (Involving the Private Sector in the Referral System)

Two-thirds (64.7%) of the 11 managers and 76% of the 25 providers who were asked agreed that private sector providers should be included in the referral system. Suggestions included:

- Sensitising providers and educating them through periodic meetings and other communications
- Having joint programmes or plans with some private providers to keep them abreast of current developments and trends in those programmes
- Targeting specific private doctors

Among the managers who disagreed or did not know, reasons given include:

- Inability to guarantee confidentiality of the receptionist in the private provider's office
- The fact that the public sector has responsibility for providing overall care, and might be perceived as shirking this responsibility

Client Views on Referral to Private Providers or Health Centres

Clients had varying opinions on the merits of referral to private providers compared to public sector health centres.

- Cost

Clients preferred referrals to MOH health centres for cost reasons and to private providers for privacy reasons. A woman in rural Portland said one has to go to services one can afford, even if the services are better elsewhere. *“The private doctor would we able to do better...but you have to...if you have a sickness...hang your cap where you can reach it.”*

- Privacy and confidentiality

While clients' opinions were mixed about wanting to be referred to the health centre or a private provider, most agreed that private providers offered more privacy and confidentiality. In part, health centres are more crowded. A young urban man from St. Ann's Bay explained, *“You see a man who would catch...any form of germs, and say him nuh want to go a clinic, because whole heap of people a go clinic.”* A sentiment expressed by women, men and young people in both parishes is that, *“In some clinics, you have some nurses that will talk.”* Such talk is less likely in private providers' offices, in part because, *“there is less trafficking in the doctor's office,”* according to an urban woman in Portland. A rural woman in St. Ann's Bay remarked, *“Only you and the doctor alone in there a go know what wrong.”*

- The stigma of “room 7”

Several groups mentioned that health centres have special rooms for STI diagnosis and treatment – they referred to “room 7,” which everyone knows is the STI and HIV room. A young urban woman from St. Ann said, *“That room there, just bad.”* Another young urban woman from St. Ann explained, *“Yeah, see the rooms down there are numbered. From them numbered, them know what you are going to do. And people stay down there and chat you.... So all them do is watch you and watch everybody.”* A young urban man from St. Ann’s Bay, referring to room 7, agreed, saying, *“me ‘fraid to go a number seven, because everyone down at the clinic know that when you go to number seven, a must one of dem dey something there, you know.”* Many people suggested that the room number designation be changed so that treatment categories are not revealed.

- Time and crowds

A young urban woman in Portland said that clients get better and more thorough treatment from private providers because they are not so rushed. *“Maybe you can talk to the private provider, you can get some counselling, but when you come at the clinic, you have to say okay then when I come and get through, I have to leave now because somebody out there is waiting and sometimes it’s full.”* A young man in rural St. Ann’s mentioned that private providers are less crowded. *“Some persons would rather go to the private doctor and just pay a big money, and just get their stuff over with quick. More than go in and you stand in a line, and you have thirty persons there for the same thing...”*

- Better treatment

Rural adult men in St. Ann’s Bay said they would rather be referred to private providers because they are not treated well in health centres. One man said that in the health centres the nurses are *“kinda harsh....Them say it’s a minor thing and...put on whatever and say’ if you see it again, you come back’ and, them don’t give you no real check-up.”*

4.6.2 STI Referrals Go to Physicians/Nurse Practitioners Rather than Contact Investigators (STI Referral--2)

Background

Current Situation: The Contact Investigator’s role is supposed to be primarily out in the community doing contact tracing, interviewing/investigation, case finding and outreach. Only 10% of the time is supposed to be spent on clinical care. At St. Ann’s Bay Health Centre and Port Antonio Health Centre, a contact investigator is in the clinic part time and in the community the other days. At least one physician and one nurse practitioner are in the health centre every day. Referrals for STIs are currently made to either the contact investigator or the physician depending on the day and which provider is available. The contact investigator is known by every client to be treating STIs and HIV/AIDS. Apparently, when a client is referred to the contact investigator, the client does not want to go in because of the fear of being stigmatized by other clients.

Sometimes the clients just walk out of the health centre rather than go into the STI room. As a result, they are lost to treatment, at least within the facility. They may go to the private sector, but their partners may never be traced or treated.

Proposed change: To the extent possible, referrals should go to the physician or nurse practitioner. In this way the reason for the client going to this provider is unknown as these providers treat all patients. This change also fits into the policy directives from the national MOH. The MOH wants the contact investigators to spend more time in the community and less time in a health facility doing the actual treatment of patients. The MOH wants a gradual shift away from the contact investigators to the physicians.

Anticipated: Potential training for Physicians and/or Nurse Practitioners in the ability to diagnose and treat STIs depending on the skill level of these providers. The training should be very practical and include “hands on” experience.

Costs: J\$265,850 to train physicians and nurse practitioners to treat STIs (See Appendix E)

Study Findings on STI Referral-2

Should Diagnosis and Treatment of STIs be Shifted from CIs to Medical Providers?

The majority of the 16 managers and seven providers who were asked were in favour of shifting the diagnosis and treatment of STIs from the Contact Investigator to the Physician and Nurse Practitioner, as shown in Table R-2.1. The managers (all but one, a technical manager) more strongly agreed with making the shift. Central MOH and NERHA managers were more likely than Parish managers to agree to the shift from CIs undertaking diagnosis and treatment to Physicians and Nurse Practitioners doing the work.

Table R-2.1. Agreement that Diagnosis and Treatment of STIs Should be Shifted from CIs to Physicians and Nurse Practitioners

Agreement	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	10	62.5	2	28.6
Agree	5	31.3	3	42.9
Neither agree nor disagree	1	6.3	1	14.3
Disagree	0	0.0	1	14.3
Total	16	100.0	7	100.0

Barriers to Shifting Diagnosis and Treatment of STIs from CIs to Physicians and Nurses

Managers noted a few barriers to shifting diagnosis and treatment of STIs from Contact Investigators to Physicians and Nurses, including:

- The most common response among the seven managers who noted barriers was inadequate number of clinicians, both Physicians and Nurse Practitioners. One manager noted the *“Clinical load for the physician at the clinic level. ... I’m sure they would take at least twenty to seventy patients from the CIs.”*
- Poor organization of the system to make the shift
- Under funding of the regions and lack of funding to employ more Primary Care Physicians
- Attitudes of Physicians and Public Health Nurses, clinical resistance
- Attitudes of CIs who see themselves as clinicians
- Reinforcing of new thrust to Triage Nurses and Medical Records Staff

Five managers indicated that there could be financial implications to this shift in responsibilities from CI to the physicians and nurse practitioners in that more medical personnel would be needed in clinics.

The majority of the 11 managers and the seven providers who were asked about the need for training said that Physicians would need additional training (90.9% of the managers and 57.1% of the providers). Of the managers and providers who were asked, most indicated that the nurse practitioners would need additional training (86.7% of the managers and 57.1% of the providers). According to the managers and providers, the types of training that the Physicians and Nurse Practitioners would need include:

- Diagnosis and management of STIs
- Diagnosis and treatment of the side effects of drugs
- Syndromic management
- Updates in case management and current treatment norms
- Clinical training

Would Nurse Practitioners not Being Able to Prescribe Drugs be a Barrier?

There were mixed views on whether Nurse Practitioners not being able to prescribe drugs would be a barrier to diagnosing and treating STIs.⁷ Among the 12 technical managers who were asked, five (41.7%) indicated that it would be an issue while seven (58.3%) said it would not be an issue (Table R-2.2).

Table R-2.2. Would Nurse Practitioners Not Being Able to Prescribe Drugs be a Barrier to Providing STI Services?

Response	Managers		Providers	
	Number	Percent	Number	Percent
Yes	5	41.7	2	28.6
No	7	58.3	5	71.4
Total	12	100.0	7	100.0

Suggestions for overcoming the barrier that nurses cannot prescribe drugs included:

- Changing MOH policy or relevant laws to give nurse practitioners the right to prescribe.
- Having pre-signed prescriptions. A Physician in Portland indicated, *“I think they are well trained and we just countersign the prescription and give it to them.”*

4.6.3 Modify Fee Schedule for STI Clients and Referrals (STI-Fees 3)

Background

Current situation. Current policy within both parishes regarding the collection of fees from clients is that fees are charged for the majority of services, including STI client visits and medications for treatment. Exceptions to this policy are made for the truly indigent and an assessment officer makes the determination whether a client can receive free service. Normally if an STI client is seen at a Type I or II facility, the client pays for the visit. When the client is referred to a Type III or IV clinic, the client pays again for service at the second facility.

Proposed change. In order to eliminate barriers to the diagnosis and treatment of STIs, the parishes could examine the fee schedule and consider not charging the referred STI client for the second visit within the parish.

Anticipated . Each parish may experience a decrease in revenues as a result of this policy change.

⁷ A circular was sent around in 1981 regarding Nurse Practitioners and prescribing certain drugs; however, the law was never enacted.

Study Findings on STI-Fees 3

Issue of Whether Referred Clients Are Charged Again at the Health Facility of Referral

Three of seven respondents (42.9%) indicated that clients referred from one health centre to another have to pay again at the facility of referral. One (14.30%) of the respondents said clients did not have to pay again, and three (42.9%) were not sure.

Modification of the Fee Schedule to Prevent Referred STI Clients from Paying Twice

There was agreement to strong agreement among eight of the 12 programme managers interviewed (66.7%) that the fee schedule should be modified so that clients referred from one centre to another for STI services are not charged for the referred visit (Table F-3.1). Providers were slightly less enthusiastic about changing the fee structure. Among 22 providers who were interviewed, more than half (59.1%) said they agreed or strongly agreed with modification of the fee schedule so that STI clients would not have to pay a second time. The viewpoint of one provider who strongly agreed was *“they should not be further charged for the same problem or service.”*

Table F-3.1. Modification of the Fee Schedule to Prevent Referred STI Clients From Paying Twice

Response	Managers		Providers	
	Number	Percent	Number	Percent
Strongly agree	5	41.7	7	31.8
Agree	3	25.0	6	27.3
Neither agree nor disagree	1	8.3	4	18.2
Disagree	3	25.0	5	22.7
Total	12	100.0	22	100.0

Likelihood of Clients Going to Referral STI Services if it were Free

Seven of the nine programme managers approached (77.8%) agreed or strongly agreed that *“clients would be more likely to go for referral STI services if they did not have to pay for the referred visit.”* Managers within the MOH and the NERHA were mainly the ones in agreement.

One of the remaining two managers neither agreed nor disagreed. The other, a technical manager, disagreed that clients would likely visit referral services if there were no cost, saying that clients should *“pay for certain things... This whole mentality of people should not pay for services, the giving free policy and that is why we are in the plight we are in now.”* The manager also said that if people had to pay for STI services they might be more likely to change their behaviour. *“When they start paying for it I’m sure that they*

will start to monitor their behaviour because they will realize that it is gonna be a cost to their behaviour.”

Barriers to Charging a Referred STI Client for the First Visit Only

Two of three managers, indicated that there are no barriers to “charging a client for only the first visit if he/she is referred for STI services.” Another manager indicated that he/she did not know if barriers exist. Three managers believed that there are some barriers to charging an STI client for only the first visit. One of the three commented “I would say the barriers mainly are the people in the system...You just have to sell the idea to them for them to see...Not the technical persons. But the managers whose business it is to collect funds. Not the Programme Managers, the Parish Managers.” Another manager said there was a need for an “administrative decision, some form of communication.” A third manager suggested that health centres would be in favour of continuing to charge as they need the funds to finance their operations (purchase drugs etc.).

Modifying the Fee Schedule so that “Contacts” Traced are not Charged for the Referred Visit

Four of the seven managers (57.1%) who were asked either agreed or strongly agreed that “the fee schedule should be modified so that “contacts” traced by contact investigators are not charged for the referred visit.” All four managers were technical managers, three of whom work at the MOH head office. Three managers disagreed that the fee schedule should be modified including two technical managers.

Table F-3.2 Modification of the Fee Schedule to Prevent Referred Contacts from Being Charged for Visit

Response	Managers	
	Number	Percent
Strongly agree	1	14.3
Agree	3	42.9
Neither agree nor disagree	0	0.0
Disagree	3	42.9
Total	7	100.0

Barriers to not Charging for STI Referral Visits by “Contacts” Traced by Contact Investigators

Responses varied among eight respondents who were asked to list the barriers to not charging for referral visits for STI services by “contacts” traced by contact investigators. For example, one individual said there would be no barriers, particularly since the norm is that persons who are unable to pay are still seen. A second person indicated that

financial constraints require that someone bears the cost of the service offered while a third said that not charging was an “administrative decision.”

Significance of the Financial Implications of not Charging for the STI Referral Visit

The six managers interviewed had different opinions on the question of how significant the financial implications of not charging for the STI referral visit would be. One person thought it would be very significant and another somewhat significant. Two others (33.3%), thought there would be no impact, while the final two persons respectively said don’t know or had no response.

Organizations or Offices Responsible for Approving Changes in Fee Structures and Protocols

A majority of the seven managers who gave an answer thought the MOH Head office was solely responsible for approving changes in fee structures and protocols (Table F-3.3).

Table F-3.3 Organization (s) or Office (s) Responsible for Approving Changes in Fee Structures and Protocols

Level	Number	Percent
Central MOH only	5	71.4
Central MOH and Parish	1	14.3
Other (Cabinet)	1	14.3
Total	7	100.0

Likelihood that within the Next Two Years Patients Referred for STI Services Will Not be Charged for the Referral Visit

The responses from twelve managers when asked about the likelihood that the relevant organization or office of the MOH will institute a system within the next two years by which patients referred for STI services are not charged for the referred visit seemed less than optimistic (Table F-3.4).

Table F.3.4. Likelihood that Changes in Fee Structure for Referred Clients from other Health Facilities Will be Approved within the Next Two Years

Level	Number	Percent
Likely	3	25.0
Unlikely	4	33.3
Highly Unlikely	1	8.3
Don’t Know	4	33.3
Total	12	100.0

Only three (25%) of the twelve managers thought it likely that the system would be implemented. The three respectively said:

“Getting the individual for STD early treatment also reduces the transmission to other people so definitely there is a cost benefit....It reduces the cost to the MOH of the service provided.”

“You have to take any barriers...that would cause them not to come in for treatment. Because if they’re not treated...it’s going to be worse for us and we’re going to have to spend more money as a country.”

“They [the MOH] are very concerned about the prevention and control of STIs.”

Five managers thought it unlikely (33.3%) or highly unlikely (8.30%). Some reasons advanced as to why it is unlikely that the MOH will institute a system whereby patients referred for STI services are not charged for the referred visit include:

“Financial situation. Even if MOH policy, regions wouldn’t implement”

“Perhaps a general change, but for this specific purpose, no”

“There will be a reduction in fee income. The MOFP is looking for additional not to reduce”

“Both policy and political decision”

The lone proponent of highly unlikely felt the *“focus is on increasing fee income.”*

The remaining four managers (33.3%) said they did not know. The number and percentage of responses are summarized in Table F-3.4.

Likelihood that within the Next Two Years “Contacts” Traced Will Not Be Charged for the Referred Visit

Three (42.9%) of seven managers felt it was likely that the relevant organization or office of the MOH will institute a system within the next two years by which contacts traced by CI’s are not charged for the referred visit (Table F-3.5). The rationale given by one manager who thought it likely that a no-charge system would be introduced for referral visits by traced contacts is that *“STI is a major risk factor, hands are being forced in that area.”* Two other managers felt that it was unlikely and the final two said they did not know.

Table F-3.5. Likelihood that Changes in Fee Structure for Referred Contacts Will be Approved Within the Next Two Years

Level	Number	Percent
Highly likely	0	0.0
Likely	3	42.9
Unlikely	2	28.6
Highly Unlikely	0	0.0
Don't Know	2	28.6
Total	7	100.0

4.6.4 Modification of STI Diagnosis and Treatment Protocol (STI Treatment-1)

Background

Current situation. Currently in the MOH system in Jamaica, clients who are suspected of having a sexually transmitted infection (STI) are referred to physicians and contact investigators by midwives or nurses based on the client's complaint of discharge or other complaint that sounds like a possible STI. The clients are diagnosed and treated by the contact investigator, physician, or nurse practitioner according to syndromic management protocols. However, syndromic management fails to identify and manage appropriately a proportion of women with cervical infections and it identifies a proportion as being infected when in fact they are not. Since the only patients referred for diagnosis in Jamaica are those that are symptomatic, it can be assumed that asymptomatic patients who have an STI are not identified and are therefore not treated. Most men with STIs are symptomatic, while the majority of women with STIs are asymptomatic. Many women presenting with discharge will not have an STI resulting in over treatment of this population. The prevalence of STIs in the population of St. Ann's Bay and Portland is not specific. If female has symptoms but no lesions use rapid tests for NG/CT and blood test for syphilis. Ideally known although an STI prevalence study may be conducted in the two parishes in the near future. A rapid test has been developed for Chlamydia and rapid test for gonorrhea is due to be released in early 2004.

Proposed change. As part of the strategy to integrate family planning with STI/HIV/AIDS services, an intervention is proposed to explore the possibility of modifying the protocol for detecting, diagnosing and treating STIs. (Show the decision tree to each provider and hand out the following protocol). The protocol would be as follows:

Option 1 Screen all individuals who present to clinics with signs and symptoms of infection with a risk assessment. If the female client has symptoms:

- a. Treat syndromically if it is "certain" she has an STI, e.g., an ulcerative lesion.
- b. If not, screen using the rapid tests.
- c. If the male has symptoms, treat syndromically.

d. Counsel everyone.

Option 2 Screen all individuals who present to clinics, with a risk assessment.

1. If the individual has symptoms regardless of risk:

a. If male, treat syndromically.

b. If female, treat syndromically, if it is "certain" she has an STI (e.g. ulcerative lesion)

c. If female has symptoms, but no lesions, use rapid tests for NG/CT and blood test for syphilis

2. If the female is at high risk and has no symptoms:

a. Screen using NG/CT rapid tests and blood test for syphilis. Treat if positive.

3. If female is at low risk and has no symptoms:

a. Randomly screen women using NG/CT rapid tests and blood test for syphilis. Treat if positive.

4. Counsel everyone.

Option 3 Screen all individuals who present to clinics, with a risk assessment.

1. If the individual has symptoms regardless of risk:

a. If male, treat syndromically.

b. If female, treat syndromically, if it is "certain" she has an STI (e.g. ulcerative lesion)

c. If female has symptoms but no lesions, test for NG/CT + Syph by obtaining specimens for lab testing. Treat if positive.

2. If the individual has no symptoms and is at high risk:

a. Screen for NG/CT + Syph by obtaining specimens for lab testing. Treat if positive.

3. If the female is at low risk and has no symptoms:

a. Randomly screen women for NG/CT + Syph by obtaining specimens for lab testing. Treat if Positive.

4. Counsel everyone.

(Refer to Appendix C for a flow chart that depicts the above treatment options.)

Resources required: All costs for the various scenarios listed above would have to be estimated to determine whether they are cost effective. Various assumptions would have to be made regarding the number of clients served, the percentage that will be positive for STIs etc. If feasible, the rapid risk test kits could be sold to the private sector physicians at the subsidized MOH prices.

(Costs associated with proposed protocols can be found under separate cover.)

Study Findings for Treatment

Level of Agreement that if Appropriate Rapid Tests and Lab Facilities were Available, the Proposed Protocol for STI Diagnosis and Treatment is Practical

The seven managers and 10 providers who responded to the questions on the proposed revised protocol for STI diagnosis and treatment were more likely to think that a revised protocol would be practical – as long as it was used in Types III and IV/V health centres (TR-1.1).

Table TR-1.1. Level of Agreement That if Appropriate Rapid Tests and Lab Facilities Were Available, the Proposed Protocol for STI Diagnosis and Treatment is Practical, For Types I through IV/V Health Centres, According to Managers (N=8)¹ and Providers (N=10) (In percent)

Level	Clinic Type			
	Type I	Type II	Type III	Type IV/V
Strongly agree				
Managers	14.3	28.6	25.0	50.0
Providers	30.0	30.0	50.0	60.0
Agree				
Managers	0.0	28.6	75.0	50.0
Providers	20.0	30.0	40.0	40.0
Neither agree nor disagree				
Managers	0.0	0.0	0.0	0.0
Providers	10.0	10.0	0.0	0.0
Disagree				
Managers	85.8	42.9	0.0	0.0
Providers	40.0	30.0	10.0	0.0

¹Note: The N for managers for Types I and II is 7

Reasons given by managers and providers for disagreeing that a revised protocol would be practical for Types I and II included:

- Lack of appropriate service providers (clinicians) (mostly commonly mentioned; listed by one provider in Portland as affecting Type III also)
- Inadequate infrastructure, including lab facilities (also commonly mentioned; listed by one provider in Portland as affecting Type III also)
- Low pick up rate, high cost for test and lab facilities
- Unavailability of a physician for anaphylactic reaction

- Inadequate privacy at most Type I health centres

Barriers to Implementing the Proposed Protocol for STI Diagnosis and Treatment

According to the managers and providers, implementation of a revised protocol for STI diagnosis and treatment would face a number of barriers.

Two barriers identified related to the tests themselves:

- The absence of a good, rapid and cheap test for the field (there is a good test for Chlamydia, but it is expensive)
- The need to evaluate protocol; need to define low/high prevalence; what STIs

Other barriers pertained to funding, staffing, infrastructure and logistics:

- Lack of trained staff, including lab/tech assistants (commonly mentioned)
- Need to have a physician present in case of reaction to drugs, e.g. penicillin
- Current resource constraints; lack of funding for the facilities to do the tests (commonly mentioned)
- The fact that the health system and whatever protocol is approved could not have an algorithm for one locality; it would need to be observed island-wide
- Insufficient or limited availability of drugs, reagents and equipment
- Inadequate laboratory/treatment facilities
- The tests would increase waiting time

One provider from St. Ann also mentioned the need for follow through if the system is changed. *“One of the barriers is to ensure that adequate supplies are always available because sometimes these things are started and then there is no follow through.”*

The Process for Approval of Use of the Rapid Tests for Chlamydia and Gonorrhoea in Jamaica

According to the eight managers who responded to this question, a feasibility study undertaken through the MOH Standards & Regulations Unit testing the test kits for utility in screening in the Jamaican population would need to be conducted to evaluate the protocol against the current gold standard. The results would be submitted to the National Public Health Lab in addition to others working on STI. The CMO and persons responsible for STIs would discuss the results and take a policy decision at that level. If the results are good the tests will be approved.

Obstacles to Getting Approval for the Use of Rapid Tests for Chlamydia and Gonorrhoea in Jamaica

Two of six managers who responded indicated that there were no obstacles to getting approval for the tests. The others listed the following barriers:

- The need for a policy decision to undertake the testing; red tape - passing from desk to desk, not getting consensus (mentioned at NERHA and Parish level).
- The need to have test kits available to do the evaluation, resources for evaluation and persons dedicated to do the survey; also need a reference lab to confirm the tests (mentioned at the central MOH level)
- Cost (mentioned at the central MOH level)

Length of Time Estimated to get Approval for Use of These Rapid Tests in Jamaica

The three managers who responded had different opinions on the length of time the approval would take, ranging from less than one year, to one year, to one and a half years.

Obstacles to Implementing the Option in the New Protocol for Detecting, Diagnosing and Treating STIs that Specifies Conducting Lab Tests, if Funding were Available to Equip Lab Facilities

Opinion was split on obstacles to implementing the option that included lab tests, given available funding; five of the 10 managers indicated that there would be obstacles and five could think of no obstacles.

Among those who thought there would be obstacles, the list was similar to obstacles listed above, including:

- The need to secure additional, adequately trained staff
- Limited cases in Portland (facilities would be best used at a regional referral centre, e.g. in St. Ann)
- The need to secure personnel for the lab, if this is not included in the funding.
- The need for laboratory sites and recurrent funding

Offices Responsible for Approving the Change in the New Protocol for Detecting, Diagnosing and Treating STIs

According to the nine managers who were asked, only two said the central MOH would not be involved in some capacity (the two indicated that NERHA and the parishes shared the responsibility) (Table TR-1.2). Three indicated that responsibility rested with the central MOH alone, two said the MOH and other organizations would be involved and one each said that the MOH/NERHA and the MOH/NERHA/Parishes shared responsibility.

Table TR-1.2. Which Office(s) Is/Are Responsible for Approving the Revised Protocol for STIs

Level	Number	Percent
Central MOH only	3	33.3
MOH and NERHA	1	11.1
NERHA only	0	0.0
NERHA and Parishes	2	22.2
Parish only	0	0.0
MOH, NERHA and Parishes	1	11.1
MOH and other organizations (Nursing Council and National Public Health Lab)	2	22.2
Total	9	100.0

Steps necessary to Approve and Adopt the New Protocol for Detecting, Diagnosing and Treating STIs

In terms of steps for approving and adopting the new protocol, one manager indicated that there was only one step – that the revised protocol be submitted for approval. Other suggestions included:

- Central MOH Level develops protocols, print protocols, disseminates in the field, trains staff and provides resources
- Once the evidence base and financial resources are approved by the Region and the Central MOH Level, local training is provided and implementation issues are addressed

Policies that Would Need to be Changed Associated with Approving the Protocol for Detection, Diagnosis, and Treatment of STIs

Two managers said that no policy change would be necessary, one added, “*as long as people do what they have to do*”

Others listed policies that would need to change, including:

- Protocol for management of STIs

- Pharmaceutical policies and procedures
- Policies for service including treatment protocol, user fees, training of staff on the algorithm (training policy would need to change from syndromic management only to add aetiologic management also)

Length of the Process to Approve and Adopt the Revised Protocol for Detection, Diagnosis and Treatment of STIs

Three of the six managers estimated that the revised STI protocol could be approved and adopted within a six month period (Table TR-1.3). Two others indicated that the process would take one or more years and one manager did not know.

Table TR-1.3. Estimated Length of Time Necessary to Approve and Adopt Revised STI Protocol, According to Managers

Length of time	Number	Percent
1-6 months	3	50.0
7-12 months	0	0.0
1-2 years	1	16.7
More than 2 years	1	16.7
Don't know	1	16.7
Total	6	100.0

4.7 Management Information System

4.7.1 Consolidating STI and FP Data (MIS-1)

Background

Current Situation: (Consolidated data on STIs) Currently there are a variety of statistical reports that record health service data. The MOH facilities throughout Jamaica are required to fill out the standard form – MCSR (Monthly Clinical Service Report). This report records all service data except for HIV/AIDS. For STIs the form contains a section to fill out on the categories “STD” and “PID”. This form contains client visit information, not individual cases. The number of client visits attributed to these diagnoses is for clients seen by healthcare providers other than the Contact Investigators. The Contact Investigators submit separate reports that detail the number of clients (cases) they see as well as the number of total client visits. Because there are two different reports instead of one regarding STI visits, the ability to accurately track visits and cases is problematic. Apparently there are no plans in the immediate future to design one reporting mechanism for tracking and recording STI service statistics.

Proposed Change: It is recommended that the two parishes design a simple tracking mechanism using the MCSR data and the CI data to determine how the two can be

synchronized. This could be done on Excel or Access to track the STI service statistics so that accurate data can be obtained.

Anticipated Resource Requirements: A staff member proficient in the use of financial software could set up the report. Someone needs to be trained to keep the report updated and distributed to appropriate staff.

Costs: J\$66,345 to J\$302,171 to develop STI tracking form and set up report (See Appendix E)

Study Findings on MIS-1

Agreement that MIS Forms Should be Consolidated

As indicated in Table MIS-1.1., the majority of the 13 respondents (61.5%) thought that the forms that Contact Investigators and other health care providers submit on STIs should be consolidated. However, one respondent objected, indicating that already too much time is spent filling in the Monthly Clinical Service Report (MCSR). One programme manager agreed that data should be consolidated in order to avoid “...inconsistency in the reports.” Another respondent was uncertain of the benefit of consolidating the reports, emphasizing that agreement would be contingent on maintaining “...the volume and the quality of the information...” and adding “...to the utility of the report.”

Table MIS-1.1. Agreement that An MIS System Should Consolidate data on STIs Submitted by CIs and Other Health Care Providers

Agreement	Managers	
	Number	Percent
Yes	8	61.5
No	1	7.7
Don't Know	3	23.1
No Response	1	7.7
Total	13	100.0

Obstacles to Consolidating MIS Forms

Programme Managers identified some possible obstacles to consolidating STI data with data provided in the MCSR. These included resources, the size of the form, need for a patient-based system and confidentiality.

“Resources. We have to have computers, to be computerised, to build web-based information systems. People have to be trained. We have to have database managers. Too many fragmented information systems we have now.”

“The size of the form – would be huge.”

“Manual systems are not case-based but based on workload. A Patient-based system is needed which would allow queries to be done.”

“Probably not all of us members of staff really should have knowledge. If we are going to consolidate the forms, it means that more people would have access to the information and that is really a delicate area.”

Offices Responsible for Changes in MIS Forms

Of the 11 respondents, six thought the Central MOH Office would be responsible for making changes in MIS forms if there was to be consolidation; two respondents thought this was the joint responsibility of the MOH and the Regional Office; two respondents thought all three levels – Central, Regional and Parish – were responsible, and one respondent felt that the Region alone had responsibility for making these changes (Table MIS-1.2). One respondent indicated that at the Central MOH level, the offices involved would be the Epidemiology Unit, the Health Promotion and Protection Division, and the Systems and Information Technology Unit.

Table MIS-1.2. Offices Responsible for Approving Consolidation of the MIS Forms

Level	Number	Percent
Central MOH only	6	54.5
MOH and NERHA	2	18.2
NERHA only	1	9.0
NERHA and Parishes	0	0.0
Parish only	0	0.0
All three levels	2	18.2
Total	11	100.0

Policy Changes Needed to Consolidate MIS Forms

Respondents were asked to comment on the policy changes that would be needed in order to consolidate the forms on STI reporting. Of the six Programme Managers who responded, four did not know what policy, if any, would need to be changed. Of the two Programme Managers who responded (one from Portland and the other from St. Ann’s Bay), one indicated that the process would require developing an implementation plan with various stakeholders at a national level rather than *“...for just this region when the entire country is being affected.”* The other manager indicated that *“...you have to integrate the service so that you can integrate or consolidate reporting.”*

Likelihood of Consolidating MIS Forms

Six of the 13 Programme Managers (46.2%) who responded felt that there was a likelihood of consolidating STI data with MCSR data within the next two years (Table MIS-1.3). Only one of those respondents said consolidating the MIS form was highly likely to happen. One respondent viewed this as part of the Ministry’s overall strategy for integration of services. Another respondent indicated that the process was already underway, “...especially for HIV and some data from the MCSR”, and yet another Manager indicated that “...a web-based STI/HIV database...is currently being built.” that would make consolidation of data highly likely.

One manager felt that it was unlikely that the forms would be consolidated within the next two years “...based on the fact that they were just recently revised...so it would be after the next two years.”

Table MIS-1.3. Likelihood That The Forms That CIs And Other Health Care Providers Submit On STIs Will Be Consolidated Within The Next Two Years

Likelihood	Number	Percent
Highly likely	1	7.7
Likely	5	38.5
Unlikely	2	15.4
Highly Unlikely	0	0.0
Don't know	4	30.8
No Response	1	7.7
Total	13	100.0

Appendix A

Actual People Interviewed

MANAGERS

Ministry of Health - Head Office (12)

Chief Medical Officer
Director Health Promotion & Protection
Director Family Health
Director of Human Resource
Chief Nursing Officer
Chief, Epidemiology & AIDS/HIV Unit
STI Consultant, MOH
Head -Standards & Regulations Unit
Senior Medical Officer- AIDS/HIV unit
Head - Maintenance Unit
Head - Continuing Education Unit, MOH
Executive Director, NFPB

NERHA (9)

NERHA Regional Technical Director
NERHA Regional Director
NERHA Finance Director
NERHA HR Director
NERHA MIS Director
NERHA Regional Programme Development Officer
NERHA Regional Behaviour Change Communication Officer
NERHA Regional Health Promotion Officer
Regional Nursing Supervisor

St. Ann's Bay (4)

Medical Officer of Health- St Ann
Parish Manager- St Ann
Parish Administrator - St. Ann
Senior Public Health Nurse- St Ann

Portland (4)

Medical Officer of Health- Portland
Parish Manager- Portland
Parish Administrator- Portland
Senior Public Health Nurse- Portland

PROVIDERS

St. Ann's Bay (12)

Public Health Nurse
Parish Midwife Supervisor
Midwife (2)
Nurse
Physician (2)
Contact Investigator
Community Peer Counselor
Pharmacist
Laboratory Technician

Portland (23)

Public Health Nurse (4)
Parish Midwife Supervisor
Midwife (2)
Nurse
Community Health Aide
Physician (4)
Contact Investigator (2)
Community Peer Counselor (2)
Pharmacist (2)
Laboratory Technician
Family Nurse Practitioner

OTHERS

St. Ann's Bay (1)

Registration Clerk

Portland (2)

Registration Clerk (2)

Appendix B

Notes to tables:

1. **Table B.1.** – This table summarizes the findings related to each intervention, including the strength of agreement that the intervention is important, views on the likelihood that the intervention would be undertaken within two years, the policy changes, if any, that would need to be undertaken, the barriers to making the change and the level of government (Central MOH, NERHA and Parish) and other organizations (e.g. the NFPB, professional organizations or unions) that would be involved in making the change. Please note the following explanations for some of the columns in the table:
 - a. The column marked “N” means the number of people who responded to the questions regarding the particular intervention. This number includes both managers and providers surveyed added together.
 - b. The columns of figures marked “Strongly agree/agree” and “Likelihood” are the percentage of people surveyed (column “N”) who agreed that the intervention was important and whether the intervention would likely be adopted within the next two years.
 - c. The columns marked “Policy Change Required” and “Main Barriers” are self explanatory.
 - d. The last four columns marked “Central, Regional, Parish, Other” include percentage figures regarding the responses of managers and providers surveyed regarding what level of authority could make the policy or program decision to adopt the intervention. You will note that these figures do not add up to 100% because the responses to the question had overlapping choices, such as “MOH and NERHA” or “NERHA and Parishes”.
2. **Table B.2.**-This table contains the interventions with the highest rankings (Best bets) regarding importance and the likelihood of being adopted within the next two years. They received a 70% or higher agreement on importance and likelihood of adoption. The interventions are listed in rank order within the table with the first intervention being ranked highest.
3. **Table B.3**-This table contains the interventions ranked “Second Best Bets”. They include interventions that received a percentage of 70% or higher on importance and 50-69% on likelihood of being adopted within the next two years. These interventions are also rank ordered with the highest ranked intervention listed first.
4. **Table B.4**- This table contains the interventions ranked “Third Best Bets”. They include interventions that received a percentage of less than 70% in importance and less than 50% in likelihood of adoption within the next two years. These interventions are also rank ordered within the group with the highest ranked intervention listed first.
5. **Table B.5.**-This table contains the interventions ranked at the bottom. Although these interventions received a high score for importance, they received a low score (25% or less) on likelihood of being adopted within the next two years.

6. **Table B.6.**-This table contains the intervention of modifying the STI Diagnosis and Treatment. This intervention is in a special category. It is ranked very high in importance (95-100%) but the respondents were not asked about the likelihood of adoption within the next two years. In fact there are many policy and program issues that need to be addressed before this intervention could be implemented.

Table B.1 Summary of Agreement on Importance, Likelihood, Level, of the Programme Responsible for Making a Change, Policy Changes Needed and Main Barriers to Implementing Policy Changes, by Intervention

Intervention description and Table number	N	Percent		Policy change required	Main Barriers	Percent				
		Strongly agree/agree	Likelihood			Level involved in making policy/program changes				
						Central	Regional	Parish	Other	
Training										
Train Providers on holistic approach	T.1	44	95	63	None	<ul style="list-style-type: none"> ▪ Funding ▪ Logistics ▪ Training of trainers 	80	70	50	30
Screening										
Use common screening checklist	S.1	42	76	57	Feasibility testing; recommendation to CMO for use island wide	<ul style="list-style-type: none"> ▪ Time ▪ Resistance ▪ Need to print new forms 	87	60	27	0
Increasing access in health centres										
Reduce special clinics – Type I	A.1.1	46	59	45	Regional directive with MOH and Parish input	<ul style="list-style-type: none"> ▪ Staffing ▪ Crowding ▪ Facilities 	47	68	42	0
Reduce special clinics – Type II	A.1.2		60							
Reduce special clinics – Type III	A.1.3		60							
Reduce special clinics – Type IV	A.1.4	26	54	47	Regional directive with MOH and Parish input	<ul style="list-style-type: none"> ▪ Staffing ▪ Transportation ▪ Procedures ▪ Facilities 	45	84	32	0
Introduce mobile teams – Type I	A.1.8	81	50							
Introduce mobile teams – Type II	A.1.9	55								
Introduce mobile teams – Type III	A.1.10		45							

Table B.1 Summary of Agreement on Importance, Likelihood, Level, of the Programme Responsible for Making a Change, Policy Changes Needed and Main Barriers to Implementing Policy Changes, by Intervention

Intervention description and Table number	N	Percent		Policy change required	Main Barriers	Percent			
		Strongly agree/agree	Likelihood			Level involved in making policy/program changes			
						Central	Regional	Parish	Other
Extend evening hours in Type III/IV A.2	49	74	50	Regional directive with MOH and Parish input	<ul style="list-style-type: none"> Funding to pay staff overtime or sessional pay Staffing if flexible schedule Security 	27	93	33	0
Appointment system – Type III/IV A.3	49	78	72	Written policy needed from Region	<ul style="list-style-type: none"> Adequacy of staff Procedures Client compliance 	39	72	54	16
Hire additional staff A.4-6	43	86	54	Change in cadre; MOFP must lift its hiring freeze for needed staff	<ul style="list-style-type: none"> Funding Availability of applications willing to work in rural areas 	46	69	15	15
Incentives to recruit/retain staff in rural areas A.7	48	92	25	Approval from MOFP	<ul style="list-style-type: none"> Wage freeze Funding 	54	77	15	15
Renovate facilities for privacy A.8	37	94	54	No policy change needed for MOH facilities; MOH policy change on maintaining/renovating non-MOH property	<ul style="list-style-type: none"> Many facilities needing renovation are non-MOH properties Funding Small Facilities 	67	83	25	0
Purchase new equipment for Types I and II (16 of 23 providers (70%) had to refer patients to other facilities because of lack of equipment) A.9	14	NA	50	No policy change needed	<ul style="list-style-type: none"> Funding; cost Security Maintenance 	39	72	54	6

Table B.1 Summary of Agreement on Importance, Likelihood, Level, of the Programme Responsible for Making a Change, Policy Changes Needed and Main Barriers to Implementing Policy Changes, by Intervention

Intervention description and Table number	N	Percent		Policy change required	Main Barriers	Percent				
		Strongly agree/agree	Likelihood			Level involved in making policy/program changes				
						Central	Regional	Parish	Other	
Reach men through child health visits	A.10	28	82	75	No policy change needed; Parish can authorize change	<ul style="list-style-type: none"> Men in a hurry to leave clinic Environment not conducive 	20	20	67	7
Patient Education										
New/revised integrated IEC materials (10 of 14 technical managers agreed that FP and STI messages were not sufficiently integrated into current IEC materials.)	P.1a	12	NA	84	No policy change needed	<ul style="list-style-type: none"> Donor funding stipulations MOH funding Literacy level of public 	80	60	50	20
Development of a self-screening checklist for clients (9 out of 18 interviewed (50%) thought it was feasible)	P.1b	12	NA	33	No policy change needed	<ul style="list-style-type: none"> Which office to take lead? New; will people use it? 	90	40	30	0
Purchase TVs & VCRs for health promotion	P.2	46	98	63	No policy change needed	<ul style="list-style-type: none"> Funding Security Maintenance 	13	73	53	15
Outreach										
CHAs spend more time in community doing integrated outreach; supportive supervision for CHAs to do integrated outreach	O.1	41	100	73	Enforce the existing system through which CHAs are supposed to spend a significant portion of time in the community	<ul style="list-style-type: none"> Need more CHAs Training Client fears about confidentiality 	83	50	33	17

Table B.1 Summary of Agreement on Importance, Likelihood, Level, of the Programme Responsible for Making a Change, Policy Changes Needed and Main Barriers to Implementing Policy Changes, by Intervention

Intervention description and Table number	N	Percent		Policy change required	Main Barriers	Percent				
		Strongly agree/agree	Likelihood			Level involved in making policy/program changes				
						Central	Regional	Parish	Other	
CI's provide limited FP counselling	O.2	20	100	91	Revised job description by MOH	<ul style="list-style-type: none"> Potential resistance from professional association/union 	73	27	9	27
Increase number of Community Peer Educators	O.3	22	96	18	No policy change	<ul style="list-style-type: none"> Funding for hiring Training Supervision 	67	56	22	22
STI Diagnosis and Treatment										
Strengthen referral system for STI cases	R.1	43	93	NA	No policy change needed	<ul style="list-style-type: none"> Transportation Redesign forms 	47	67	60	0
STI referrals go to physicians instead of CI's	R.2	23	87	NA	May need to change law/policy to allow FNPs to prescribe	<ul style="list-style-type: none"> Staffing – Physicians, Nurses and Lab Technicians Funding 	NA	NA	NA	NA
Modify fee system for STI referral cases	F.3	34	61	25	MOH directive (with approval from MOFP?)	<ul style="list-style-type: none"> Loss of revenue 	86	0	14	14
Modify protocol for STI – Type I	TR.1	17	35	NA	CMO and National Laboratory to approve protocol	<ul style="list-style-type: none"> Decision to undertake testing of revised protocol Funding Approval to use rapid tests 	78	44	3	22
Modify protocol for STI – Type II	TR.1	17	58	NA						
Modify protocol for STI – Type III	TR.1	18	95	NA						
Modify protocol for STI – Type IV	TR.1	18	100	NA						

Table B.1 Summary of Agreement on Importance, Likelihood, Level, of the Programme Responsible for Making a Change, Policy Changes Needed and Main Barriers to Implementing Policy Changes, by Intervention

Intervention description and Table number	N	Percent		Policy change required	Main Barriers	Percent			
		Strongly agree/agree	Likelihood			Level involved in making policy/program changes			
						Central	Regional	Parish	Other
Consolidate STI data MIS.1	13	62	46	Decision by MOH; would national change be needed?	<ul style="list-style-type: none"> ▪ Need a computerized system ▪ Resources ▪ Need a patient-based system 	91	46	18	0

Table B.2. Best Bets: Integration Interventions Most Likely to Take Place in the Next Two Years (70% or higher agreement that the intervention is important and/or 70% or higher say likelihood is very high/high that the intervention will take place within two years) (Interventions are in rank order with highest listed first)

Intervention description and number			Actions needed*
1.	CIs provide limited FP counselling	O.2	<ul style="list-style-type: none"> ▪ Revise job descriptions (Central MOH level) ▪ Provide training
2.	CHAs spend more time in community doing integrated outreach; supportive supervision for CHAs to do integrated outreach	O.1	<ul style="list-style-type: none"> ▪ Enforce existing system ▪ Assess job descriptions for needed revisions (Central MOH level)
3.	STI referrals go to physicians instead of CIs	R.2	<ul style="list-style-type: none"> ▪ Ongoing initiative; continue to train Physicians and Family Nurse Practitioners. ▪ Assess the necessity and feasibility of changing the prescribing laws/policies for FNPs
4.	Strengthen referral system for STI cases	R.1	<ul style="list-style-type: none"> ▪ Issue directive from NERHA ▪ Develop procedures
5.	Reach men through child health visits	A.10	<ul style="list-style-type: none"> ▪ Develop materials; some training for staff
6.	New/revised integrated IEC materials	P.1a	<ul style="list-style-type: none"> ▪ Ensure collaboration among MOH Departments (FP, MCH, STI/HIV) (Central MOH level) ▪ Policy dialog with donors (to mix funding streams)
7.	Appointment system	A.3	<ul style="list-style-type: none"> ▪ Issue written policy/directive from NERHA ▪ Ensure staffing

*Policy issues are highlighted

Table B.3. Second Best Bets: Integration Interventions Second Most Likely to Take Place Over the Next Two Years (70% or higher agreement that the intervention is important and 50-69% or higher say likelihood is very high/high that the intervention will take place within two years) (Interventions are in rank order with highest listed first)

Intervention description and number			Actions needed*
1.	Purchase TVs & VCRs for health promotion	P.2	<ul style="list-style-type: none"> ▪ Locate funding for purchase and maintenance (NERHA) ▪ Ensure security
2.	Train providers on holistic approach	T.1	<ul style="list-style-type: none"> ▪ Locate funding for training ▪ Develop curricula ▪ Train trainers (TOT) ▪ Phase in in-service training ▪ Policy dialogue with pre-service training centres to incorporate training
3.	Renovate facilities for privacy	A.8	<ul style="list-style-type: none"> ▪ Locate funding (in collaboration with HIV/AIDS projects?) (NERHA) ▪ Make policy decision regarding renovating non-MOH properties
4.	Hire additional staff	A.4-6	<ul style="list-style-type: none"> ▪ Policy dialog with MOFP (NERHA) ▪ Get cadre extended, where needed ▪ Locate funding
5.	Introduce Mobile Teams – Type I	A.1.8	<ul style="list-style-type: none"> ▪ Funding for transportation ▪ Reallocate staff ▪ Develop procedures
6.	Use common screening checklist	S.1	<ul style="list-style-type: none"> ▪ Develop the checklist ▪ Pilot test the checklist ▪ Issue a directive from the Central MOH level on use of the checklist

Table B.3. Second Best Bets: Integration Interventions Second Most Likely to Take Place Over the Next Two Years (70% or higher agreement that the intervention is important and 50-69% or higher say likelihood is very high/high that the intervention will take place within two years) (Interventions are in rank order with highest listed first)

Intervention description and number		Actions needed*	
7.	Extend hours in Type III/IV	A.2	<ul style="list-style-type: none"> ▪ Issue directive from NERHA ▪ Conduct survey to establish utilization projects for cost efficiency ▪ Ensure staffing ▪ Revise scheduling ▪ Create new signage ▪ Organize security
8.	Purchase new equipment for Types I and II	A.9	<ul style="list-style-type: none"> ▪ Conduct inventory of needed equipment (NERHA) ▪ Locate funding for purchase and maintenance

*Policy issues are highlighted

Table B.4. Third best bests: Integration Interventions 3rd Most Likely to Take Place Over the Next Two Years (Fewer than 70% agree that the intervention is important and less than 50% say that the likelihood is very high/high that the intervention will take place within two year) (Interventions are in rank order with highest listed first)

Intervention description and number			Actions needed*
1.	Consolidate STI data	MIS.1	<ul style="list-style-type: none"> ▪ Provide a directive from the Central MOH level ▪ Redesign forms ▪ Investigate use of a computerized, patient-based reporting system
2.	Reduce special clinics – Types I-IV	A.1	<ul style="list-style-type: none"> ▪ Directive from NERHA ▪ Reorganize staffing schedule ▪ Provide public education on new system
3.	Introduce Mobile teams Types II and III	A.1.9-10	<ul style="list-style-type: none"> ▪ Funding for transportation ▪ Reallocate staff ▪ Develop procedures

*Policy issues are highlighted

Table B.5. Long shots: Integration Interventions Least Likely to Take Place Over the Next Two Years (fewer than 25% say that the likelihood is very high/high that the intervention will take place within two years) (Interventions are in rank order with highest listed first)

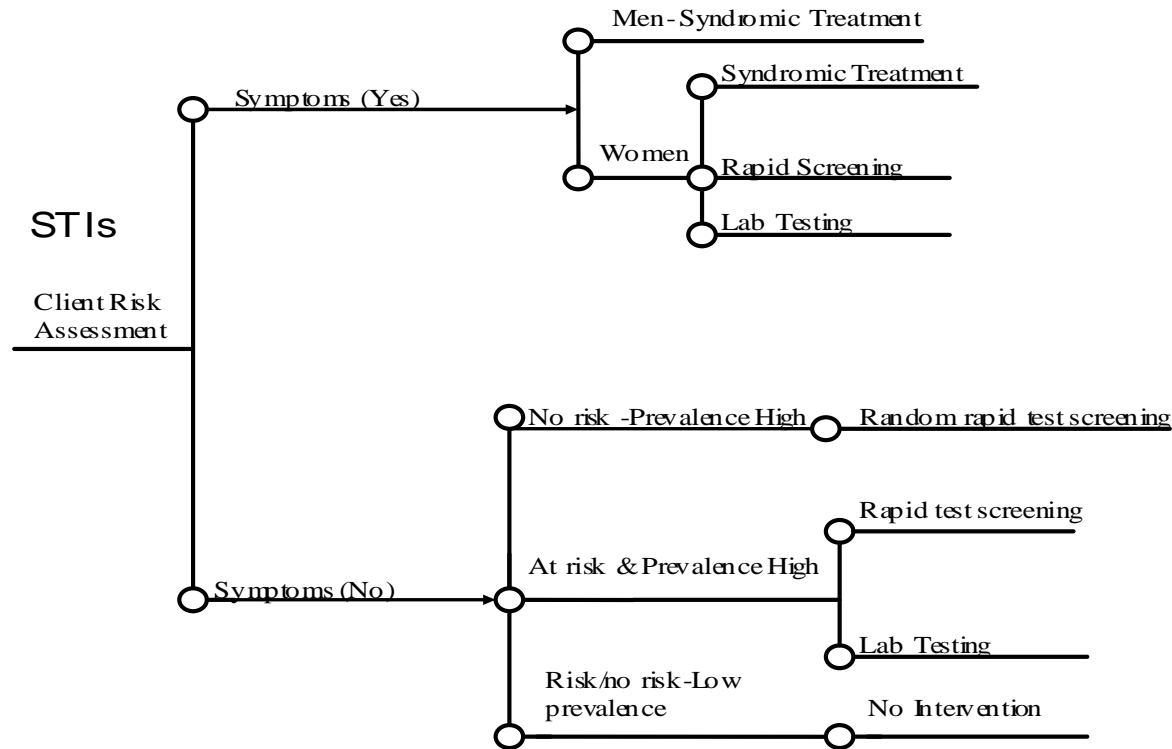
Intervention description and Table number			Actions needed*
1.	Increase number of CPEs	O.3	<ul style="list-style-type: none"> ▪ Locate funding to hire additional CPEs
2.	Incentives to recruit/retain staff in rural areas	A.7	<ul style="list-style-type: none"> ▪ Locate funding for the incentives
3.	Modify fee system for STI referral cases and contacts	F.3	<ul style="list-style-type: none"> ▪ Directive from Central MOH level ▪ Policy dialog with MOFP

*Policy issues are highlighted

Table B.6. Special Category: Integration Intervention not Likely to be Adopted within the Next Two Years, but considered very important		
Intervention description and Table numbers		Actions needed*
Modify protocol for STI – Types III-IV	TR.1.	<ul style="list-style-type: none"> ▪ Importance ranked high, but must wait until tests are available. ▪ Directive from Central MOH level to conduct feasibility testing of revised protocol

*Policy issues are highlighted

Appendix C



Appendix D

Estimated Costs of Interventions

Table D.1: Sorted in Rank Order within Each Category

No.	Intervention	Lowest Cost J \$ US\$1=J\$60.3136	Highest Cost J \$
Best Bets			
O-2	Contact investigators provide limited FP counseling	\$132,891	\$132,891
O-1	Better supervision for CHAs	\$341,375	\$547,044
STI-2	STI referrals go to physicians instead of Contact Investigators	\$265,850	\$265,850
STI-1	Strengthen referral system	\$37,696	\$37,696
A-10	Reach men through child health visits	\$1,299,966	\$2,131,691
P-1	Assessment of need for new/revised IEC materials	\$566,948	\$791,918
A-3	Appointment system	\$1,052,472	\$4,327,501
Second Best Bets			
P-2	Purchase TVs & VCRs for health promotion	\$79,614	\$79,614
T-1	Train staff on holistic approach*	\$2,196,455	\$3,545,140
A-8	Survey facilities for renovation-privacy issues**	\$37,998	\$37,998
A-4	Hire additional physicians	\$3,796,192	\$3,796,192
A-5	Hire additional public health nurses	\$2,874,860	\$2,874,860
A-6	Hire additional pharmacy tech	\$1,399,222	\$2,757,952
A-1.8	Introduce Mobile Teams - Type I	\$94,094	\$94,094
S-1	Use of a common checklist for FP/antenatal/STI	\$205,066	\$559,107
A-2	Extend evening hours in Type III/IV/session	\$1,524,848	\$1,524,848
A-9	Survey equipment needs**	\$57,901	\$57,901
Third Best Bets			
M-1	Consolidation of STI data	\$66,345	\$302,171
A-1	Reduce special clinics/all services offered more often (Type IV)	0	0
A-1.9-10	Introduce Mobile teams Types II and III	\$94,094	\$94,094
Long Shots			
O-3	Increase number of Peer Educators	\$2,280,546	\$2,280,546
A-7	Personnel recruitment incentives (per person)	\$60,313	\$603,136
STI-3	Modify fee schedule	NA	NA
Special Category			
STI-4	Modify protocol for STI detection, diagnosis and treatment	See cost effectiveness model-separate report	See cost effectiveness model-separate report

*The difference is the result of international versus Jamaican TA and residential versus non-residential training.

**A8 and A9 costs only include amounts for the surveys not the cost of renovations or cost of equipment.

Table D.2: Sorted by Cost

No.	Intervention	Lowest Cost J \$ US\$1=J\$60.3136	Highest Cost J \$
Best Bets			
STI-1	Strengthen referral system	\$37,696	\$37,696
O-2	Contact investigators provide limited FP counseling	\$132,891	\$132,891
STI-2	STI referrals go to physicians instead of Contact Investigators	\$265,850	\$265,850
O-1	Better supervision for CHAs	\$341,375	\$547,044
P-1	Assessment of need for new/revised IEC materials	\$566,948	\$791,918
A-3	Appointment system	\$1,052,472	\$4,327,501
A-10	Reach men through child health visits	\$1,299,966	\$2,131,691
Second Best Bets			
A-8	Survey facilities for renovation-privacy issues**	\$37,998	\$37,998
A-9	Survey equipment needs**	\$57,901	\$57,901
P-2	Purchase TVs & VCRs for health promotion	\$79,614	\$79,614
A-1.8	Introduce Mobile Teams - Type I	\$94,094	\$94,094
S-1	Use of a common checklist for FP/antenatal/STI*	\$205,066	\$559,107
A-6	Hire additional pharmacy tech	\$1,399,222	\$2,757,952
A-2	Extend evening hours in Type III/IV/session	\$1,524,848	\$1,524,848
T-1	Train staff on holistic approach*	\$2,196,455	\$3,545,140
A-5	Hire additional public health nurses	\$2,874,860	\$2,874,860
A-4	Hire additional physicians	\$3,796,192	\$3,796,192
Third Best Bets			
A-1	Reduce special clinics/all services offered more often (Type IV)	0	0
M-1	Consolidation of STI data*	\$66,345	\$302,171
A-1.9-10	Introduce Mobile teams Types II and III	\$94,094	\$94,094
Long Shots			
A-7	Personnel recruitment incentives (per person)	\$60,313	\$603,136
O-3	Increase number of Peer Educators	\$2,280,546	\$2,280,546
STI-3	Modify fee schedule	NA	NA
Special Category			
STI-4	Modify protocol for STI detection, diagnosis and treatment	See cost effectiveness model-separate report	See cost effectiveness model-separate report

*The difference is the result of international versus Jamaican TA and residential versus non-residential training.

**A8 and A9 costs only include amounts for the surveys not the cost of renovations or cost of equipment.

Appendix E

Training 1-Train staff on holistic approach

Costs: J\$2,196,455 to J\$3,545,140 to conduct training for 130 staff members

The cost difference is based on two factors, 1) international versus Jamaican technical assistance and residential versus non-residential training.

General Assumptions:

- 130 staff members will be trained
- Training will last 5 days

Assumptions J\$2,196,455:

- Assumes local Jamaican consultant and non-residential training
- Assumes five local round-trips for each trainee
- Assumes training will occur four times in different locations
- Assumes trainer incidental covers per diem and expenses.

Assumptions J\$3,545,140:

- Assumes international consultant and residential training
- Assumes training will be conducted four times
- Assumes first training conducted by international consultant and following three trainings conducted by local trainer

Screening 1- Use of a common checklist for FP/antenatal/STI

Costs: J\$205,066 to J\$559,107 to develop and print checklist

The cost difference is based on international versus Jamaican technical assistance

Assumptions J\$205,066:

- Training conducted as part of Training 1 activities or during monthly Parish meetings
- Assumes local Jamaican consultant

Assumptions J\$559,107:

- Training conducted as part of Training 1 activities or during monthly Parish meetings
- Assumes international consultant

A-1-Reduce special clinics/all services offered more often using mobile clinics in Type I, II & III facilities

Costs: J\$188,188

Assumptions:

- Covers cost of transportation and sustenance for 3 staff members to conduct a single mobile clinic (J\$ 3619 per single clinic)
- One mobile clinic conducted each week for one year
- Assumes that one half of clinics will be conducted in Type I facilities and one half will be conducted in Type II or III facilities (J\$ 94,094)
- No extra costs associated with reducing special clinic days in Type IV facilities

Access-2-Extend evening hours in Type III/IV St. AB Health Centre/Buff Bay Hospital

Costs: J\$1,524,848

Assumptions:

- Security light installation amortized over two years (104 weeks)
- One extended evening hour clinic per week in each parish for one year
- Sessional costs supplied by Finance Director of NERHA
- Sessional costs per parish (J\$7,331)

Access-3 Operationalise an appointment system

Costs: J\$1,052,472 to 4,327,501 to write procedures, conduct training and carry out media campaign (difference in cost due to use or non use of TV ads)

Assumptions: J\$1,052,472

- Local Jamaican consultant will write procedures for appointment system
- 200 copies of procedures will be printed
- Local Jamaican consultant will develop training materials
- Training will be conducted during monthly Parish meetings
- Local Jamaican consultant will develop radio
- Radio ad will air 40 times

Assumptions: J\$4,327,501

- Local Jamaican consultant will write procedures for appointment system
- 200 copies of procedures will be printed
- Local Jamaican consultant will develop training materials
- Training will be conducted during monthly Parish meetings
- Local Jamaican consultant will develop radio and TV ads
- Radio ad will air 40 times
- TV ad will air 5 times

Access-4 Hire an additional physician for both Runaway Bay–Type II centre and

Access-4 Hire an additional physician for both Runaway Bay-Type II centre and Portland

Costs: J\$3,796,192 for two physicians (one in St Ann’s Bay and one in Portland)

Assumptions:

- Medical Officer 3 top of grade used as baseline (2002 salary scale)
- Average increase of 11% per year between 2000 and 2002
- Applied 11% raise in 2003 and 2004
- Add J\$96,000 location allowance

Access-5 Hire an additional public health nurse each for St. AB and Portland

Costs: J\$2,874,860 for two public health nurses (one - St AB and one - Portland)

Assumptions:

- Baseline Public Health Nurse 7 – top of grade used as baseline (2002 salary scale)
- Raises between 1999 and 2002 averaged 5% per year
- Applied 5% raise in 2003 and 2004
- Tailoring allowance J\$34,736
- Rural incentive allowance J\$71,222
- Porterage allowance J\$3,684
- Traveling PHN allowance J\$62,280
- Supervision allowance J\$14, 446 (J\$56/day x 260 days)

Access-6 Hire one pharmacist/pharmacy technician each for St. AB and Portland

**Costs: J\$2,757,952 for two pharmacists (one - St AB and one – Portland)
J\$1,399,222 for two pharmacy technicians (one - St AB and one – Portland)**

Assumptions pharmacist:

- Baseline pharmacist level 4 top of grade (2002 salary scale)
- Average of 5% increase per year between 2000-2002
- Subsistence allowance J\$232,960 (J\$896 per 24 hour period x 260 days)

Assumptions pharmacy technician:

- Baseline pharmacy technician level 2 top of grade 2002 (2002 salary scale)
- Average of 5.4% increase per year between 2000-2002
- Subsistence allowance J\$232,960 (J\$896 per 24 hour period x 260 days)

Access -7 Options for salary supplement to attract staff to rural areas

Costs: J\$60,313 to 603,136

The cost difference is based on a low, medium or high amount depending on staff salary and could be anywhere along this continuum

Assumptions:

- The salary incentive is used to attract hard to find professionals such as pharmacists
- Not meant to apply to all staff
- Low range assumes J\$60,313 per person
- High range assumes J\$603,136 per person

Access-8 Survey of facilities for renovation needs for privacy

Costs: J\$37,998 to develop and conduct survey of all facilities

Assumptions:

- MOH Jamaican consultant from NE
- Assume 2 days to develop survey and 20 days to conduct survey

Access-9 Survey equipment needs in Types I/II centres

Costs: J\$57,901 to develop and conduct equipment survey of all facilities

Assumptions:

- MOH Jamaican consultant from NE
- Assume 4 days to develop survey and 30 days to conduct survey

Access-10 Reach men through child health visits

Costs: J\$1,299,966 to J\$2,131,691 to develop materials and conduct training on reaching men

Assumptions: J\$1,299,966

- Local Jamaican consultant to develop materials and conduct workshop
- Training is non-residential
- 130 staff from ST. AB and Portland will be trained
- Assumes no refresher training
- Brochure will be developed by local consultant
- 5,000 brochures will be printed

Assumptions: J\$2,131,691

- Training is non-residential
- 130 staff from ST. AB and Portland will be trained
- 1 one-day refresher training will be held
- Brochure will be developed by local consultant
- 10,000 brochures will be printed

Patient education-1 Assessment of need for new/revised IEC materials to support counseling

Costs: J\$566,948 to J\$791,918 to assess IEC materials and develop self-screening tool (difference in cost due to use of Jamaican versus international consultant)

Assumptions: J\$566,948

- 130 staff members will be trained
- Training on self-assessment tool will be done at monthly Parish meetings
- Jamaican consultant 15 person days
- Includes cost of printing self-screening tools
- Does not include development of new IEC materials

Assumptions: J\$791,918

- 130 staff members will be trained
- Training on self-assessment tool will be done at monthly Parish meetings
- International consultant 15 person days
- Includes cost of printing self-screening tools
- Does not include development of new IEC materials

Patient education-2 Equipment for expanded health promotion in centres

Costs: J\$79,614

Assumptions:

- Unit cost of VCR and TV includes cost of installing iron security cage around units (J\$19,903)
- Four facilities will be provided with equipment in Type III/IV clinics (two in each parish)

Outreach-1 Better supervision for CHAs to do outreach work

**Costs: J\$341,375 – J\$547,044 to train CHAs and nurse midwife supervisors
(difference in cost due to number of trainees)**

Assumptions J\$341,375

- Local Jamaican consultant to develop training materials and conduct workshop.
- All training is non-residential
- Three-day training for 30 CHAs to be held three times
- Three-day training for 10 nurse midwives to be held three times
- Assumes three round-trips for each trainee

Assumptions J\$547,044

- Local Jamaican consultant to develop training materials and conduct workshop.
- All training is non-residential
- Three-day training for 60 CHAs to be held three times
- Three-day training for 24 nurse midwives to be held three times
- Assumes three round-trips for each trainee

Outreach-2 Provision of limited FP counseling/condom promotion/referral for other FP by Contact Investigators

Costs: J\$132,891 to train contact investigators

Assumptions: J\$132,891

- Local Jamaican consultant
- Two-day training for 6 CIs
- Two one-day refresher trainings for 6 CIs
- All training is non-residential
- Assumes three round trips for each trainee

Outreach-3 Increase peer educators linked to VCT

Costs: J\$2,280,547 to hire 7 new Peer Educators and train both new and existing Peer Educators in FP

Assumptions:

- J\$1,548,400 cost of 5 new Peer Educators in Portland
- J\$619,360 cost of 2 new Peer Educators in St. Ann's Bay
- Two-day training for 7 new and 5 existing Peer Educators
- One one-day refresher training for all 12 Peer Educators
- All training is non-residential
- Local Jamaican consultant to develop training materials and conduct training

STI-Referral-1 Strengthen STI referral from Types I/II to Types III and IV, including system for forms

Costs: J\$37,696 to train staff to see STI patients immediately and to handle referral forms differently

Assumptions: J\$37,696

- 130 providers will be trained
- Training will take place during monthly Parish meetings or as part of the training 1 activity.
- Training will be conducted by local Jamaican consultant

STI-Referral-2 STI referrals to physicians/nurse practitioners rather than Contact Investigators

Costs: J\$265,850 to train physicians and nurse practitioners to treat STIs

Assumptions: J\$265,850

- Local Jamaican consultant will develop materials
- NE consultant will conduct training
- Three-day training conducted for 20 providers
- All training will be non-residential
- Round trips for three days for each trainee

MIS-1 Tracking system to synchronise MCSR data and CI data

Costs: J\$66,345 – J\$302,171 to develop STI tracking form and set up report

Assumptions J\$66,345:

- Training on the tracking form will take place during monthly Parish meetings by NERHA
- Local Jamaican consultant/s will develop STI tracking form and set-up reporting function

Assumptions J\$302,171:

- Training on the tracking form will take place during monthly Parish meetings by NEHRA
- International consultant/s will develop STI tracking form and set-up reporting function