

## **ACHIEVING MILLENNIUM DEVELOPMENT GOALS IN JAMAICA: PRIMARY HEALTH CARE BASED APPROACH**

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**Objective:** To strengthen the idea that Primary Health Care Based approach is the way to go in attainment of MDGs specifically related to health in Jamaica in 2015 (focusing on MDGs 4, 5 and 6).

**Methodology:** The Ministry of Health Annual reports, Western Regional Health Authority (WRHA) Annual reports and the International and national documents/reports about MDGs were reviewed. And the performance of the Ministry of Health and Western Regional Health Authority were analysed against the MDGs 4, 5 and 6.

**Results:** Since the implementation of abolition of user fees policy, there was a substantial increase in the utilization and demand of all services at the public health facilities in WRHA. The increased demand put the tremendous pressure on the system and the quality of services delivery was negatively impacted by the lack of necessary resources. In Jamaica the available data indicates that although some progress was made over the years in relation to the MDGs 4, 5 and 6, the progress is very slow.

**Conclusion:** The Alma Ata Declaration of 1978 endorsed the PHC as the key strategy for the achievement of Health For All (HFA) by 2000. It is clear to us that the Health For All 2000 (HFA 2000) was not achieved. However, Jamaica had made significant improvements in some aspect of health indicators and the PHC strategy remains very relevant for the country to move forward. The analysis shows that the potential for the PHC to improve the functioning of health systems has not been fully utilized and that there are opportunities today, which can be used for further improvements in health system goals.

## **ACHIEVING MILLENNIUM DEVELOPMENT GOALS IN JAMAICA: PRIMARY HEALTH CARE BASED APPROACH**

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### **Introduction**

An important milestone in the development of PHC for Jamaica followed the World Health Assembly in 1977, which put forward the vision of “Health for All by the year 2000.” The following year, the Assembly stated that PHC should be the means of achieving the goal and convened the historic PHC Conference in Alma Ata, Soviet Union. It was there that the declaration of Alma Ata and the development of the PHC programme were stated as a priority for all governments. For Jamaica, this was a strategic time as Jamaica was already engaged in developing her PHC programme and took advantage of the request for submission to the Alma Ata Conference to document what the plans for the country. To quote Dr. Christine Moody<sup>1</sup>, one of the leading PHC practitioners in Jamaica, “It spurred us to clarify our thoughts and produce a document which served not only as our submission to Alma Ata but also as a guide for the development of our services at home.” **Primary Health Care –the Jamaican perspective** as the document was called became the guideline for the development of the PHC programme and continued to be the foundation for emerging models. The document was prepared by the then team to take an active lead in the Alma Ata Conference and in framing the declaration of Alma Ata.

Primary Health Care in Jamaica is seen as “essential health care...at a cost, the country and the community can afford, using methods that are practical, scientifically sound, and socially acceptable”. It was established and formulated to focus on disease prevention and promotion of health within the population by bringing health services to them. As it received worldwide acclaim in 2001, a study published in the British Medical Journal ranked Jamaica’s eighth (8<sup>th</sup> of thirty-two (32) countries in providing good quality care at low cost to the population)<sup>2</sup>. Over the years Jamaica maintained a relatively good standard of health, and some selected health indicators could even be matched with developed countries like the United States of America.

### **Millennium Development Goals (MDGs)**

The Millennium Development Goals and targets were adopted by 189 countries, including Jamaica at the Millennium Summit held in 2000. The United Nation Declaration of 2000, framed

in the broader policy context of development sought to proffer the Millennium Development Goals (MDGs) of which three of eight goals were related to health and the environment (Table 1). It is well recognized that this requires a PHC approach<sup>3,4</sup> and herein lies the challenge to scale up PHC so as to realize the MDGs towards a better life for the people of Jamaica within the global context.

### **Relation between PHC, Health Systems and the MDGs**

The MDGs represent specific measurable goals of the health outcomes that result from all health related activities. These health activities are carried out within the health system which consists of all activities whose primary aim is to promote, restore or maintain health. Through the declaration of the Americas on the renewal of PHC, countries of the Americas committed to “concentrate efforts and advocate that the health organization of each country reorients its models of management, organization, financing, and care toward the development of health systems based on PHC that make it possible to contribute with other sectors to a comprehensive and equitable human development, addressing effectively, among other challenges, the development goals of the Millennium Declaration, the unfinished agenda, and the new health-related challenges<sup>4</sup>”.

### **JUSTIFICATION**

As we learned from the history, the epidemiological approach, PHC based approach; and prevention and promotion of health along with curative to diseases yielded a major success. The new centuries, however, bring new challenges, which are undermining the effectiveness of PHC based approach to diseases in Jamaica. They can be categorized into three groups.

- (1) **Within the Health System:** The weaknesses in PHC infrastructures such as funding to public health programmes, shortage of key staff leads to the weakness in leadership and his team, lack of essential tools to perform diseases screening and fragmented Health Information System.
- (2) **Diseases and demographic changes:** The high prevalence of HIV/AIDS, an aging population, high prevalence of Intentional and Unintentional injuries, epidemiological transition from infectious diseases to non communicable diseases and gradually declining the coverage in immunization against vaccine preventable diseases are the current and constant threats to the health and well-being of all Jamaican today. In addition emerging and reemerging infectious diseases such as dengue fever, leptospirosis and malaria are testing country's public health care system specifically PHC services.
- (3) **Factors outside the health care system:** Global economic crisis, natural and manmade disasters, climate change, and crime and violence both directly and indirectly impacted on health of the population and health care system.

In the meanwhile there is a shift of focus from preventive and promotive approach to curative approach. And much of the available resources are being put on specialist's services that are based in hospitals. This compromises the concept of "PHC services are entry of care for population".

### **Now more than ever**

The Government of Jamaica implemented the abolition of user fees policy in 2008. This implementation saw increased utilization of all services in the government health facilities especially in health centres throughout Jamaica compared to previous years. That was when gaps and major challenges which existed years long were exposed to public, politicians and academic communities. And there has been increased call for strengthening of all aspects of PHC services.

Primary Health Care is founded on the concept that health is a fundamental human right and the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. The Primary Health Care (PHC) movement began with a WHO Executive Board study in 1973 that identified widespread dissatisfaction of ordinary people with their health services, both in developed and developing countries. The study made a case for a complete revision of the way health services were viewed and organized. A WHO/UNICEF study in 1974 entitled "Alternative approaches to meet basic health needs in developing countries" introduced and defined PHC for the first time as "a health approach, which integrates at the community level all the elements necessary to make an impact on the health status of the people. Such an approach should be an integral part of the health care system<sup>5</sup>". The Alma Ata Conference in 1978 endorsed Primary Health Care as the key strategy for implementation by all countries of the world in order to improve the health status of the people and lead to the achievement of Health for All (HFA) by the Year 2000. Although many countries including Jamaica did not achieve HFA in the year 2000, there are renewed efforts at the global and Latin America and the Caribbean level to put health back to the forefront of the development agenda.

In the meanwhile all countries around the world including Jamaica are negatively impacted by the global economic crisis. This means that it is going to be very hard for the Government of Jamaica to maintain a reasonable financial support to the health sector while we have already committed to fulfill achieving MDGs in 2015. This forces policy makers and health managers to find new strategy to achieve stated goals. It is well recognized that PHC based approach is required to achieve these goals <sup>4,5</sup>. To this end, the declaration of the Americas on Renewing Primary Health Care<sup>5</sup> was framed by countries of the region and Jamaica was involved in developing the declaration.

## OBJECTIVE

To provide evidence that Primary Health Care Based approach is the way to go in attainment of MDGs specifically related to health in Jamaica in 2015 (focusing on MDGs 4, 5 and 6).

### Specific objectives:

1. To describe the current status of Ministry of Health's performance against MDGs (focusing on MDGs 4, 5 and 6)
2. To examine strengths and weaknesses of the current approach **in areas of quality, accessibility, availability and acceptability** in relation to achieving MDGs in Western Regional Health Authority (focusing on MDGs 4, 5 and 6)
3. To make specific recommendations / new strategies using PHC based approach that helps to attain MDGs in Jamaica in 2015 (focusing on MDGs 4, 5 and 6)

## METHODOLOGY

**Ethical consideration:** Permission was sought from the Chief Medical Officer, Ministry of Health Jamaica to conduct the project. Approval was also sought from the Regional Director, Regional Technical Director Western Regional Health Authority (WRHA) to conduct this project in the Region.

**Location:** The National Health Service Act which took effect in 1997 and the Government of Jamaica's Health Reform Programme which saw the decentralizing of health service delivery in Jamaica. Under decentralization, the management of delivery of health services shifted from central government (Ministry of Health) to four semi-autonomous bodies – the Regional Health Authorities (RHAs). RHAs have responsibility for the operation and management of health services within a defined geographic area.

This study was done using all available data of the Ministry of Health and the Western Regional Health Authority. The Western Region of the island occupies portions of the northern and southern coasts and the entire western coastline. Included are the parishes of Trelawny (874.6 km); St. James (549.9 km); Hanover (450.4 km); and Westmoreland (867.4 km). The area has mostly calm, clear seas and white sand beaches, backed by flat, raised plains and coral reefs. Home to the island's second airport and teeming with beaches, hotels and guest houses, the area serves as the tourist mecca of Jamaica. The parishes are variable in size ranging from Hanover with a population of 66,825 to St. James with a population of 174,631 (Population Census - April 2001). The total population of the parishes and Region (based on the 2001 Census) and available public health facilities are shown below in Table 1.

**Table 1: Population of Parishes of Western Region**

PARISH	POPULATION	Health facilities	Percentage of Jamaican
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	<b>CENSUS 2001</b>	<b>(Public)</b>	<b>Population</b>
<b>Westmoreland</b>	138,452	1 – Type B Hospital 20 – Health Centres	5.3
<b>Hanover</b>	66,825	1 – Type C Hospital 19 – Health Centres	2.6
<b>St. James</b>	174,631	1 – Type A Hospital 24 – Health Centres	6.7
<b>Trelawny</b>	72,816	1 – Type C Hospital 19 – Health Centres	2.8
<b>WRHA</b>	<b>452,724</b>		<b>17.4</b>

**Data collection:** the following secondary data were requested, reviewed and analysed.

- 1) Ministry of Health Annual reports
- 2) Western Regional Health Authority Annual reports
- 3) International and national documents/reports about MDGs

### **Study period**

The study period was from May 2010 to November 2010.

### **Limitations:**

- 1) Given the relatively short study period and availability of data, all required data were not available to review. Based on the historical reports, all regional health authorities' performances were relatively similar in many ways and in many indicators. The author, therefore, assumed that the results and recommendations of this study can be applied to the whole country. In addition all indicators related to MDGs 4, 5 and 6 were not available at the regional level.
- 2) The formula for selected indicators used to describe in this paper are based on locally acceptable / used calculations. And only public sector data were included in respective calculations.

## **RESULTS**

### **MDG 4 and Jamaica**

**Under Five Mortality Rate (5MR):** Between 1993 and 2007, the under 5MR declined from 29.5 per 1, 000 to 25.4 per 1,000 live births. If we are to achieve the under 5MR of 19.6 per 1,000 in 2015, we must improve management of acute respiratory tract infection and prevention and control of poisoning and injuries, which are the leading causes of mortality in children under 5 years in Jamaica.

**Infant Mortality Rate (IMR):** The IMR declined from 24.4 per 1,000 in 1990 to 21.3 per 1,000 in 2007 (Table 3a), this represents 12.7% decline in the 17-year time frame. Since the target is to reduce the IMR by two thirds (16.2 per 1,000), a decline of 12.7% between 1990 and 2007, can be regarded as slow progress. It must be noted that compared to other countries in the region, the relatively low Jamaica IMR requires an increasing institutional, technical and financial efforts. Risk factors directly related to sexual and reproductive health such as perinatal conditions associated with prematurity, children of teenage mothers, children born after a previous birth (short birth interval) and HIV/AIDS has contributed to the slower reduction in the IMR.

**Immunization:** The immunization coverage to measles increased from 74% in 1990 to 87.2% in 2007 while the target is 100%. A decline of approximately 1% between 2000 and 2006 is a cause for concern. A severe shortage of Public Health Nurses, Midwives and Community Health Aides in some parishes, some schools accepting children without full immunization, crime and violence in some communities and young parents who have never seen these preventable diseases and do not take their children for vaccination when they are otherwise well are issues affecting low coverage.

### **MDG 5 and Jamaica**

The availability of accurate and consistent measurement of the MMR data due to unresolved data management issues is affecting the monitoring of maternal mortality in Jamaica. Reduction in maternal mortality has been affected by low coverage of women who initiate care in the first trimester of pregnancy, increase prevalence of anaemia in pregnancy and increase in the indirect cause of death due to high prevalence of hypertension and diabetes and HIV/AIDS while direct obstetric complications remain high. Pre-teen and teenage girls are considered a vulnerable group, especially the risk of contracting HIV/AIDS, due to transactional sex, gender-based violence, forced sex and sex with older HIV infected male partners. And the progress of MDG 5 is further hampered by the severe shortage (estimated 47% shortage) of in the cadre of midwives in the country due to migration. The shortage has severely impacted on the service provision of family and reproductive health on the field. Although reduced significantly in 2002, the adolescent fertility rate is still high. The National Family Planning Board has been doing a tremendous job over the years which saw the unmet need for family planning declined from 16.1% in 1989 to 8.5% in 2002.

### **MDG 6 and Jamaica**

Jamaica is making a significant improvement in tackling HIV/AIDS epidemic; however, sustainability of the progress is threatened by the financial commitment by donors due to the global economic crisis. Based on the Ministry of Health data the primary mode of transmission of HIV infection is through heterosexual sex (71%). And the main reported risk factors for HIV/AIDS infection are multiple sex partners (approximately 80%), a history of STIs (51%), sex with sex workers (24%), men who have sex with men (14%) and crack/cocaine use (8%).



Despite the evidence, there are factors that impede the epidemic. They are (a) the gap between knowledge about HIV, which is high, and the consistent practice of safe sex illustrates the difficulty in inducing behavioral change (b) the discrimination practised by members of the society and particularly health workers against PLWHA (c) deficiencies in the care and support of HIV infected persons and affected families, including access to social services, community care and institutional care of incarcerated persons in the correctional services. Malaria was reintroduced in 2006 but quickly contained. However, changes in the environment, lack of financial support for the vector control programme threatened the current status of malaria free Jamaica. Tuberculosis is not regarded as a threat to Jamaica at this time.

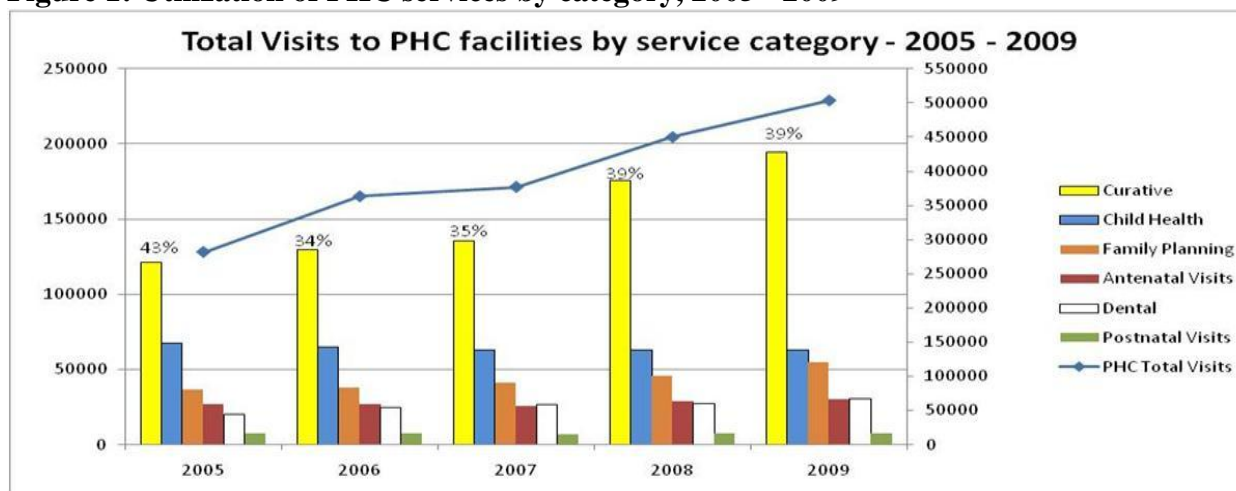
## Western Regional Health Authority's performance

### Accessibility

#### Abolition of User fees

Since the implementation of abolition of user fees policy, there is a substantial increase in the utilization and demand of all services at public health facilities in Western Regional Health Authority (WRHA). Using 2007 as a base year it is observed that utilization of diagnostic services such as laboratory and Radiology increased approximately 18 % in 2008 and 37 % in 2009 over 2007. For therapeutic service (Pharmacy) increased utilization was 28 % in 2009 over 2007. More dramatic utilization is observed in Primary Health Care health centres curative visits, 30% and 44% in 2008 and 2009 respectively over 2007 (Figure 1). For hospital Accident and Emergency department visits the increased utilization was noted to be 14% in 2008 and 13% in 2009 compared to 2007 (Table 2). The change in utilization pattern put tremendous pressure on the whole health system in terms of human, material and financial resources.

**Figure 1: Utilization of PHC services by category, 2005 - 2009**





**Table 2: Service Utilization comparison between Emergency Dept visits and Health Centres (Curative) visits from 2005 – 2009, WRHA**

Service	% Change in 2008 (Base year 2007)	% Change in 2009 (Base year 2007)
<b>Laboratory (WRHA)</b>		
# of test	+ 28%	+ 46%
<b>Radiology (WRHA)</b>		
# of patients served	+ 7%	+ 25%
# of examination	+ 9%	+ 28%
<b>Pharmacy (WRHA)</b>		
# of patients	NA	+ 28%
# item prescribed	NA	+ 42%
# item dispensed	NA	+ 41%
<b>Casualty Visits (Hospitals)</b>		
CRH	+ 14%	+ 13%
Sav Hospital	+ 8%	- 3%
Falmouth Hospital	+ 21%	+ 25%
Noel Holmes Hospital	+ 15%	+ 22%
	+ 15%	+ 26%
<b>Curative visits (PHC)</b>		
St James	+ 30%	+ 44%
Westmoreland	+ 32%	+ 55%
Trelawny	+ 28%	+ 38%
Hanover	+ 34%	+ 37%
	+ 22%	+ 63%
Out Patient Department visits (Hospitals)	+ 26%	+ 34%
Admissions (Hospitals)	+ 10%	+ 12%

### Availability

- (i) Availability of diagnostic tools and other basic items in PHC– major challenge as some essential items such as ECG machines and basic lab diagnostic services which are not readily available.
- (ii) Since the implementation of abolition of user fees there are increased incidents (both reported and not reported) of health care workers who are being abused both physically and verbally. Among other things the current physical structure is not conducive for staff to avoid unnecessary confrontation. Almost all of our health centres were built years ago and some of them are battered by severe weather especially hurricanes.
- (iii) Availability of ambulance and utility vehicles in PHC– for continuation of care some patients are required to transport to nearest health centres or hospitals. And utility vehicles are needed to carry out programmes such as vector control, immunization, and health promotion etc. The current situation needs urgent attention.

### Acceptability

### **Service available Vs Service expectation**

- (iv) Some studies done in the Caribbean (unpublished papers) suggested that there is a common believe among general public that “hospital is the only place where everything gets done”. We need to educate general public about “service available versus the service expectation” at the different facilities. In the meanwhile we must strengthen existing referral system between facilities so as to smoothen the flow of patients from one facility to another. Recent times our casualty departments were filled with non emergency patients. Since abolition of user fees, we encouraged clients with non emergency to visit health centres and we have made some progress in this regard. Unfortunately current resources and status of PHC are ready to receive their demand.

### **Quality**

#### **Health promotion approach (Primary and Secondary Prevention Approach)**

- (v) Due to severe resource constraint **screening** programme for preventable diseases (treat appropriately if detected in the early stage) such as breast cancer, cervical cancer, colon cancer, prostate cancer (still controversial) and Chronic Non Communicable Diseases (CNCD) which are highly prevalent in Jamaica, are not implemented effectively and efficiently.
- (vi) While we continue to analyse the process indicators such as the number of visits, tests performed etc., there is a need for evaluation of outcome indicators, particularly quality of care in our system.

### **DISCUSSION and RECOMMENDATION**

In Jamaica to realize a health system that is based on the PHC approach to the achievement of stated MDGs 4, 5 and 6 the current health system must be strengthened. And our discussion and recommendations focused on the main functions of a health system<sup>5</sup> (a) organization of health care delivery (b) health financing and (c) creating resources for health and (d) governance of health.

#### **(a) Organization of health care delivery**

To improve the health status of population and achieving MDGs in Jamaica, the health services provided have to be technically appropriate, of good quality and acceptable to the communities that are to use them. Therefore, investing in first level of service, PHC service is essential with appropriate referral linkage to the higher level of care / levels. The health team concept must be strengthened with reevaluation of the effectiveness of “linkage system” which already exists in the Jamaica health system. To realize effectiveness of service delivery at the PHC level it is also required to provide required health infrastructure (Health Information System, diagnostic and screening capabilities, friendly health centres and buildings, proper transport system, adequate

medicines supply) and appropriate human resources (nursing, medical, community health workers, etc).

### **Community participation**

One of the principals in PHC is (active) community participation. "Community participation is an educational and empowering process in which the people, in partnership with those who are able to assist them, identify the problems and the needs and increasingly assume responsibilities themselves to plan, manage, control and assess the collective actions that are proved necessary."<sup>5</sup> It is well recognized that community participation is one of the most important supportive activities for achieving MDGs in 2015. In Jamaica the lesson learned during the malaria outbreak in 2006 clearly demonstrated that over the years active community participation becomes weak and in some instances non existence. During the peak of the malaria outbreak, health providers had to request permission from the community so called area leaders to carry out vector control activities and screening of persons for malaria during early case findings and appropriate treatment activities. The trust between community and health care providers was broken. It is compounded by the establishment of informal communities throughout Jamaica. As described in a local newspaper "It is a failing. The local authority has failed in that way and we have ended with 754 large settlements accommodating near a third of our population, the absence of basic amenities such as streetlights and roads in the informal communities had made these communities a special challenge for the police in terms of easy access, especially at nights. Furthermore, the absence of specific addresses and sound social structures had made the areas quite attractive to criminals"<sup>6</sup>. Based on the lesson learned, with collaboration with other governmental, non governmental agencies / Ministries and private sector organizations, we have to rebuild the "community". The District Health Team in which community members, local political leaders and health team members are members should be strengthened. Their capacity to contribute effectively to the implementation of health programmes, oversight utilization of resources for health and development of appropriate health intervention at the community must be strengthened as well.

### **(b) Health financing**

The Jamaica health sector is expected to face challenges, especially in financing as country's debt increases, impact of the natural disaster on health infrastructures, and negative growth in the agricultural sector. Against this background appropriate utilization of the available fund is essential. To provide quality health care to population is not cheap. Jamaica fully implemented abolition of user fees in 2008. The policy saw an increase utilization of services. However, sustainability of this policy is now threatened by financial constraint of the country and is threatening the future of sustainability of abolition of user fees policy is in danger. We, therefore, recommend that;

- 1) funding should be aligned with the current epidemiology profile of the country. Emphasis should be placed on conditions and illnesses with high mortality and morbidity of the population.
- 2) donors should scale up their support to the health sector in line with international agreements and commitments like the PHC, MDGs, the G8 Summit at Gleneagles and the 2005 World Summit. Donor programmes should be closely aligned and harmonized with government priorities, policies, institutions and management arrangements in line with the Paris Declaration.
- 3) the Government of Jamaica must ensure that funding for PHC is increased.
- 4) the Government of Jamaica must also ensure that funding for social safety nets, e.g., PATH is properly maintained so that the welfare of poor is protected.

**(c) Creating resources for health**  
**Human Resource in Health**

After thorough consultation with communities and professional associations, some health centres open for extended hours (8:00am to 10:00pm) to accommodate the demand of services. This works quite well for clients, but once again security for staff, staff burnout and lack of essential diagnostic tools threaten sustainability. The current cadre for various categories of staff for WRHA was established in 1960s. All categories described to have never reached to their full cadre during the last five (5) years' period. The main reasons are similar to that of other Caribbean countries. Health care providers, specifically doctors and nurses, midwives and pharmacists working at government health centres in Jamaica are under pressure to see patients at a faster pace than ever before especially since the abolition of user fees. This has added to the increase in patient demand and responsibilities and is profoundly unsatisfying for both patients and their doctors and nurses. Add to these difficulties are increasing administrative burdens, high living costs and disparities in remuneration between secondary (hospitals) and for primary care. Working in Primary Care is often seen as transitional with many of our doctors moving to other specialist areas, private practice, or they migrated especially to the United States of America. In Jamaica the basic salary for both PHC and hospital doctors are the same. The significant difference is hospital doctors have the potential to earn two or three times more than primary care doctors pursuant to sessional payment for overtime work. Most health care providers join the health care profession primarily because of a passion to serve, but for PHC to survive the disparities will have to be removed. Some models around the world, such as the Thailand Model, demonstrate this fundamental understanding in the remuneration of Primary Health Care Workers. There is presently no Primary Health Care specialization in Jamaica, although some physicians are qualified Family Medicine Practitioners. We, therefore, recommend that Ministry of Health collaborate with the University of the West Indies, Mona promotes career paths in PHC, for example, for doctors, nurses, pharmacists and medical technologists. All health professionals' courses should include a mandatory PHC as well as during the internship and

postgraduate period. Incentives for PHC staff such as the provision of housing within the close geographical location to health facilities should be considered as a significant attraction for health workers, especially in rural areas.

### **Skill mix / Task shifting**

Task shifting refers to the rational distribution of tasks among health workforce teams, with specific tasks moved from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make efficient use of the available human resources. Through the task shifting, the impact of health worker shortfalls may be mitigated and countries have the opportunity to build equitable and sustainable health systems.<sup>7</sup>

Jamaica embraced the concept of 'no highly qualified member of the health team should be routinely engaged in doing work that a less highly trained person could do' and Community Health Aides, Nurse Practitioners and Pharmacy Technicians were introduced to the PHC in 1970s. In the early 1970s, a randomized controlled trial was conducted in a primary care clinic in the southwestern Ontario city of Burlington, Canada. The study found that the use of NPs in a Family Planning practice is both safe and effective. It also found that in terms of cost to society, NPs represent substantial savings, hence it is also efficient<sup>8</sup>. However, such an innovation was not adopted widely in North America because participating physicians would suffer financial loss<sup>9</sup>. Although there is no study done in Jamaica about the effectiveness of health in both process and outcome indicators for those categories of staff, their positive contribution to PHC is not in question. However, evaluation of role and function of each category should be done. It is also time for to examine other areas where PHC could benefit from such an innovation such as environmental Health, community investigation of communicable diseases and Prevention and Control of Chronic Non Communicable Diseases.

### **Public Health Leadership**

As described elsewhere in this paper PHC services already struggle with the institutional and financing challenges and face a shortage of the primary care physicians. Obviously, these challenges worsen when demand for service increases in response to the abolition of user fees. In addition the nature of organizational structure and its functions of PHC even make it harder for a person who leads the team and carries out its vision and mission. To meet these challenges Markuns et<sup>10</sup> al proposed a Five steps action (1) build horizontally and vertically integrated collaborations between academic medical centres and community health centers, (2) increase opportunities for trainees in underserved primary care settings, (3) offer leadership training for physicians committed to caring for the underserved, (4) create a national program to provide longitudinal training and mentorship for potential primary care physician-leaders, and (5) identify new funding mechanisms for medical education in community health centers.

### **Resource distribution**

Equitable distribution based on long term forecast of health infrastructure, including diagnostic equipment, appropriate transport and communication is the key. Capacity for appropriate running and maintenance of available infrastructure is crucial for efficient utilization of such resources. Provision of adequate quantities of effective and good quality essential medicines and health supplies cannot be overemphasized. It is important to streamline the various funding and logistical setups for essential medicines and supplies, including ART, treatment for opportunistic infection (OIs), vaccines and family planning supplies into a common framework to enable improvements in transparency, efficiency, equity and allow for building strong and sustainable institutions for the management of essential medicines and supplies in the country.

#### **(d) Governance of Health**

*Intersectoral collaboration / Health in All policy* – attainment of MDGs cannot be realized by health sector alone. Each sector must play its role and include health as part of its policy. For example, sector policy on HIV/AIDS will significantly reduce stigma and discrimination against employees with the diseases. Sadly most trade agreements are being signed / were signed with little or no consultation from health sector inputs.

*Sustain what we have achieved so far* – it is important for the GOJ to consolidate and maintain what the health sector has achieved so far in relation to some important health indicators such as immunization coverage, Infant Mortality Rate, reducing the prevalence of HIV/AIDS and malaria free status while recognizing the epidemic of non communicable diseases. It is widely believed that the existing regulations and laws in relation to health such as the Public Health Law and the Quarantine Act are outdated. The GOJ must therefore, ensure that these laws and regulations are reexamined and amended to effectively deal with the current environment.

*Public awareness* – this is an important area for the Ministry of Health and the GOJ to focus as there are many changes that country is embarking on in the health sector that general public should be aware of. The GOJ should plan and engage more with communities, different professional associations about the abolition of user fees policy implementation process, service availability at the different facilities, health awareness and taking charge of their health.

#### **CONCLUSION**

The Government of Jamaica is committed to achieving stated MDGs in 2015 despite all the challenges; the renewal of PHC is being adopted by all countries in the region, including Jamaica; the government of Jamaica is determined to sustain the abolition of user fees policy implemented in 2008; the global economic crisis which severely impacted the economic growth of the country and its ability to finance health sector while we need to maintain what we have achieved so far, thus call for new strategy; and decision makers, academia, John public and media are now paying serious attention on PHC in Jamaica.

There are overwhelming evidence and literatures, which support that the PHC based system is the way to go and this is clearly articulated by Pan American Health Organization, and World Health Organization. We now need to ask ourselves the following questions.

What does that actually mean to local politicians?

What does that mean to Managers / administrators?

What does that mean to clinicians working in hospitals settings?

**Are we all on the same**

**page?**

What does that mean to the Dean at medical school?

What does that mean to a medical student?

What does that mean to a student nurse?

In my humble opinion

Are we clearly communicated / articulated to our **colleagues** / managers who are in the position to make decisions? What if we all (health professionals across the board) are saying the same thing with very strong voice?

We must identify gaps in our system and fix them with decisive and strategic forward thinking. We must maintain and improve the quality by effective utilization of limited resources.

The Alma Ata Declaration of 1978 endorsed Primary Health Care as the key strategy for the achievement of Health For All (HFA) by 2000. It is clear to us that the Health For All 2000 (HFA 2000) was not achieved. However, Jamaica had made significant improvements in some aspect of health indicators and the PHC strategy remains very relevant for the country to move forward. The analysis shows that the potential for the PHC to improve the functioning of health systems has not been fully utilized and that there are opportunities today, which can be used for further improvements in health system goals.



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