ジャマイカ国
南部地域保健強化プロジェクト
事前調査団報告書

平成9年4月

国際協力事業団
医療協力部

ジャマイカ国
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序　　文

ジャマイカ国は、人口約 250 万人を有し、近年の人口増加率は 1.0%（1980～1996 年平均)、乳幼児死亡率は 10/1000 出生（1996 年)、出生時平均余命 74 年（1996 年）とこれら指標は比較的高い水準にあるといえます。

子供ワクチン接種プログラムの進展に伴い、ポリオは根絶され、ジフテリア、百日せき、麻疹等小児感染症の件数も 1990 年代に激減しました。しかし、高齢化及び生活様式の変化に伴い、高血圧症、糖尿病をはじめとする生活習慣病が増加しています。

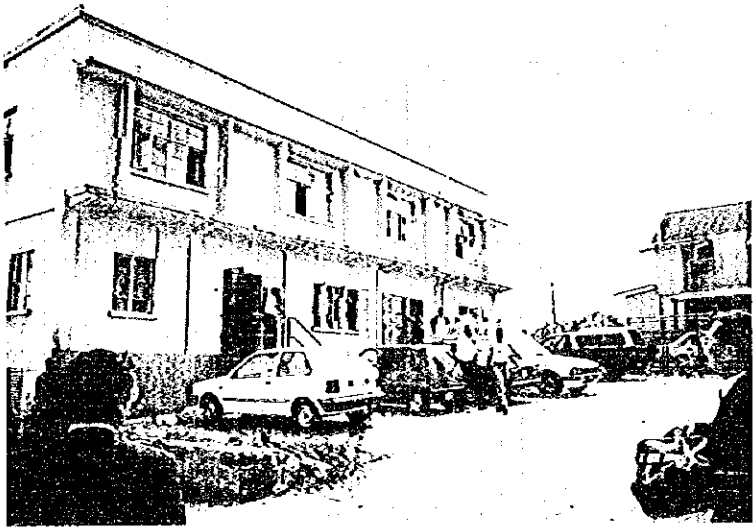
同国政府は、保健医療政策のなかで社会的・経済的弱者を主要な対象としたプライマリー・ヘルスケア（PHC）の充実に重点を置いており、保健医療行政の地方への権限委譲をはじめ、地方保健の強化に努めていますが、人口の 40%以上が居住する首都圏とそれ以外の地域における保健サービスの格差は著しくなっています。

かかる状況から、同国政府は、保健医療面で他の地域より遅れている南部地域において、地域住民の健康状態を改善すべく、わが国に対しプロジェクト方式技術協力を要請しました。この要請を受けて、国際協力事業団は、実施の可能性について調査すべく、平成９年４月７日から同年４月 20 日までの日程で、弘前大学医学部教授　三田禮造氏を団長として事前調査団を派遣しました。

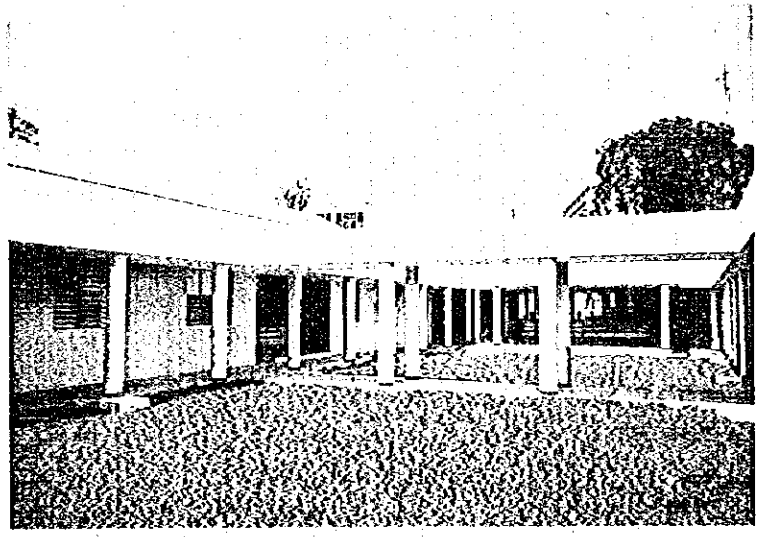
本報告書は、この調査の結果を取りまとめたものです。ここに、本件調査にご協力いただきました関係各位に対しまして、深甚なる謝意を表しますとともに、本プロジェクト実施に向けて、今後ともご指導、ご鞭撻をお願い申し上げます。

平成９年４月

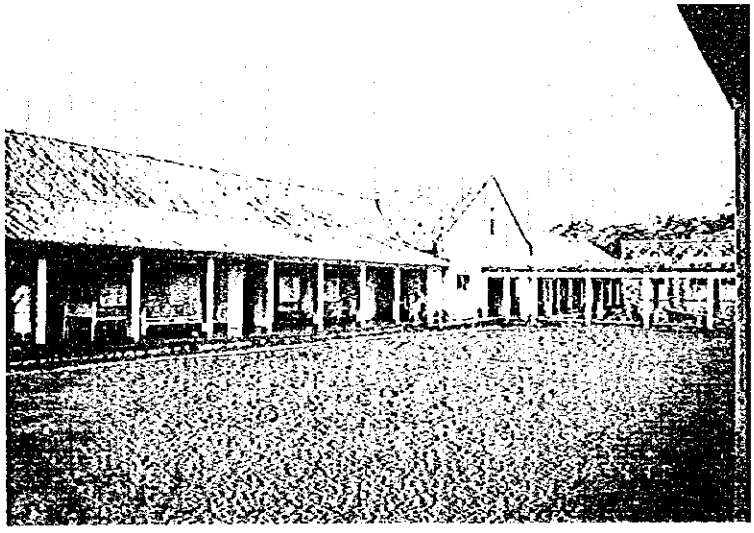
国際協力事業団
理事　小澤　大二



マンチェスターパリッシュ
タイプⅡのヘルスセンター
(PRATVILLE HEALTH
CENTRE)



マンチェスターパリッシュ
タイプⅣのヘルスセンター
(建設中)



クラレンドンパリッシュ
タイプCの病院
(THE PERCY JUNIOR
HOSPITAL, SPALDING)

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1．事前調査団の派遣

1－1　調査団派遣の経緯と目的

（1）派遣の経緯

ジャマイカは 1994 年の世界銀行推計によれば、人口が約 250 万人、1 人当たりの GNP が 1,380 ドルの低位中所得国であり、また国連開発計画（UNDP）の人間開発指標（HDI）においては、ミディアム（中位開発状況）HDI 国と位置づけられている。

しかし、同国全人口中、46%の 112 万人が地方に居住し、その地方人口の 80%（約 90 万人）が、UNDP の基準から程遠い栄養不良、感染症等の罹患状況から脱却できない状態（絶対的貧困）に置かれている。特に、都市部と地方、公共部門と民間部門との間の格差が拡大しており、医療分野では、公共地方病院における基礎的医療資機材の不足、看護体制の不備、医療従事者の海外流出等、人材不足から生じる医療サービスレベルの低下が著しく、貧困層は十分な医療サービスを満足に受けられない状況にある。

ジャマイカ政府は、医療行政の地方権限委譲をはじめ地方保健の強化に努めているが、財政的な制約から拠点となる保健センター等の機能拡充が困難な状況にあり、十分な進展がみられていない。

かかる状況から、同国政府は、保健医療面で他の地域より遅れている南部地域において、地域住民の健康を改善すべく、わが国に対しプロジェクト方式技術協力を要請越した。

＊「ジャマイカ国感染症基礎調査団」派遣：1995 年 4 月 10 日～5 月 9 日

＊「保健開発計画専門家」派遣：1996 年 2 月 12 日～2 月 26 日

（2）派遣の目的

①ジャマイカ側の要請内容を確認するとともに、現在の保健医療システムの現状を調査し、わが方の協力の可能性を検討する。

②ジャマイカ側のプロジェクト執行体制及びジャマイカ側が負担すべき事項（予算、カウンターパート（C/P）の配置、施設等）を調査し、協力計画を策定する。

③上記を踏まえ、実施段階におけるプロジェクトの枠組みについて日本・ジャマイカ双方で合意を形成し、これを議事録に盛り込んで署名交換を行う。

1－2　調査団の構成

	担当	氏名	所属
団長	総括	三田　禮造	弘前大学医学部公衆衛生学講座教授
団員	寄生虫学	神谷　晴夫	弘前大学医学部寄生虫学教室教授
団員	保健医療	高嶋　一敏	弘前大学生涯学習教育研究センター助教授
団員	協力計画	平井　利奈	国際協力事業団医療協力部医療協力第二課職員

1－3　調査日程

日順	月日	曜日	移動及び業務
1	4／7	月	出　発　11：00　東京発（NH-010）→10：30　ニューヨーク着
2	8	火	移　動　10：45　ニューヨーク発（AA-645）→15：26　キングストン着 17：30　日本大使館表敬訪問
3	9	水	09：00　保健省表敬訪問 09：30　保健省での協議・日程等打合せ
4	10	木	09：00　企画庁表敬訪問 10：30　保健省プライマリー・ヘルスケア（PHC）関係者ミーティング出席 13：30　保健省中央プロジェクト局表敬訪問
5	11	金	移　動　→マンデビル 10：30　南部保健機関担当者との協議 11：00　保健医療機関視察
6	12	土	09：00　協力隊員との打合せ 移　動　→キングストン
7	13	日	資料整理
8	14	月	09：00　保健医療機関視察 16：00　PAHO/WHO 表敬訪問
9	15	火	09：00　USAID 表敬訪問 10：30　加島書記官との打合せ 午　後　団内打合せ
10	16	水	午　前　団内打合せ 14：00　保健省との協議
11	17	木	午　前　団内打合せ 14：00　UNICEF 表敬訪問
12	18	金	09：00　保健大臣表敬訪問 09：30　保健省にてミニッツ署名 10：00　企画庁にてミニッツ署名 11：00　日本大使館報告 移　動　17：00　キングストン発（JM-0017）→21：50　ニューヨーク着
13	19	土	移　動　12：15　ニューヨーク発（NH-009）→
14	20	日	帰　国　14：50　成田着

1－4　主要面談者

(1) ジャマイカ側

1) Ministry of Health (保健省)

Dr. Peter Phillips	Minister of Health (保健大臣)
Dr. Barry Wint	Chief Medical Officer (医療審議官)
Dr. Winston Wryte	Acting Medical Doctor (Temporary Permanent Secretary)
Dr. Eva Lewis-Fuller	Principal Medical Officer (PHC)
Dr. Deanna Ashley	Principal Medical Offier (Secondary Care)
Ms. Margaret E. Lewis	Health Planner, Central Project Unit
Ms. Ivy Limonius	Director, WISPH
Mrs. Eileen Bernard	ADNS
Ms. Claudette Hemmings	Deputy Director
Mrs. Reneta McNab	Nursing Supervisor (PHC)
Dr. Marion Bullock-Ducasse	Senior Medical Officer (Health)
Mrs. Kathleen Rainford	Director, Nutrition Division
Dr. Margaret Robinson	Senior Medical Officer (MCH)
Mr. Peter Knight	Coordinator, VPMr
Mr. Benjamin Brown	Quarantine Officer
Mr. Sydney Erwin	Acting Coordinator (HD/TB)
Mr. Ransford Clarke	Rep. Epi Unit
Mr. Ambrose Fuller	Dep. DPHIS (Ag)
Mr. Laurie Watson	DPHIS
Mr. Donovan Brown	Administrator

2) Planning Institute of Jamaica (企画庁)

Mr. Winston Anderson	Director, Technical Cooperation and Regional Planning Division
Miss Pauline Morrison	Unit Manager, Bilateral Programme

3) Southern Area Health Administration (南部地域保健事務所)

Dr. Beverley Wright-Wilson	Senior Medical Officer (Health)
Ms. Doreen Laurence	Acting Senior Secretary
Mr. James Taylor	Senior Contact Investigator
Ms. Yvonne Pitter	Senior Public Health Nurse (CN3)

Ms. Myrtle Bryan	Epidemiology Officer
Ms. Sandia Chambers	Parish Administrative Officer
Ms. Pauline Brown	Senior Public Health Nurse
Ms. Laurett Wright	Regional Dental Auxiliary Coordinator
Mr. Egbenl G. Campbell	Reg. PHI
Dr. Michael Goombs	Medical Officer (Health), Manchester
Mr. Heather Wood-Mullings	Health Education Officer, Manchester
Mr. V. Ebanks	Acting Parish Administrative Officer, St. Elizabeth
Mr. D. Scott	Administrative Officer, Clarendon

4) Pan American Health Organization/WHO（全米保健機構）

Dr. Richard Van West Charles	Representative in Jamaica

5) UNICEF（国連児童基金）

Mr. Durvan Patric	PHC Officer

6) USAID（米国国際開発庁）

Dr. John R. Swallow	Director, Office of General Development
Ms. Grace-Anne Grey	Project Specialist, Family Planning Initiative Project
Ms. Lynne Lewis	Technical Advisor, AIDS, Health Sector Initiative Project, Family Planning Initiatives
Ms. Marsha Rigazio	Project Specialist, AIDS/STD Project

(2) 日本側

1) 在ジャマイカ日本国大使館

大久保　基	特命全権大使
伊藤　絢子	参事官
加島　章好	一等書記官

2) 青年海外協力隊（JOCV）事務所

金山　昌功	所長
小中　隆文	調整員
宮本　則子	調整員

3) 協力隊員

後藤　彰宏	電子機器
畔柳　良江	看護婦

2．要請の背景及び内容

(1) プロジェクト名称

「ジャマイカ国南部地域保健強化プロジェクト」(仮称)

(2) 対象地域

南部保健管区（クラレンドン、マンチェスター、セント・エリザベス）

〔南部地域総人口 56 万 4,000 人：クラレンドン 23 万 6,000 人、マンチェスター 17 万 8,000 人、セント・エリザベス 15 万人〕

(3) 相手国実施機関

保健省（南部地域保健事務所）

(4) 要請の背景

1) 北米に近いこともあり、高度医療の導入が進んでいる一方で、政府の保健政策は社会的・経済的弱者を主要な対象とした PHC の充実に重点を置いている。

2) 地方分権化政策の下では、地域の行政組織のレベル強化により、技術支援、人材養成、インフラ整備という課題を達成する必要がある。

3) 南部地域は保健医療面において他の地域より遅れていることから、保健システム改善のための組織強化を図る必要がある。

(5) プロジェクト目標

1) 上位目標

これまで以上に質の高い PHC サービスを享受することにより、南部地域の住民の健康状態が改善される。

2) プロジェクト目標

・効果的な統合保健サービスを実施するための、南部地域の行政（組織）能力の向上。

・現在及び今後の保健医療ケア・サービスの需要に応じた保健計画を実施するための、各管区の運営能力の向上。

・コミュニティーや家族レベルで健康維持が図れるよう、各管区の地域住民に対する保健教育能力の強化。

・各管区において、より効果的な疾病予防・疾病対策プログラムの運営能力の向上。

3）活動内容

①運営管理

・プロジェクトの管理・調整のための技術面及びロジスティックス面での支援。

・計画・予算・会計システム及び保健医療物品の需給、調達、在庫管理、配給の各計画の向上。

・以下を対象とした、地域及び管区のための情報管理システムの改善及び構築。

－保健情報と医療記録、管理情報と患者管理等の情報システムの構築。

－臨床部門と管理部門との間での連結システム（サブシステム）の構築。

－一次医療と二次医療の連絡体制強化への支援。

・職員への動機づけや監督指導を含めた地域及び管区レベルでの人材育成。

・地域及び管区における規範や基準の確立と策定計画の質的向上。

・資機材の活用・維持管理と資産管理。

②健康増進・健康教育

・健康増進のために以下の活動を行う。

－南部地域及び各管区の健康増進戦略への参画。

－各分野（精神衛生、栄養、歯科、体力向上、服薬、性とリプロダクティブヘルス、小児介護）を対象とした健全なライフスタイル推進のための健康教育。

－疾病予防活動及び慢性病対策活動へのコミュニティーの参画推進。

－計画推進のためのマスメディア活用。

－視聴覚教材の開発。

③疾病予防・疾病対策プログラム

・重要疾病のハイリスク患者の同定、把握。

・上記疾病のモニタリング及びコントロールの向上と、重要疾病予防の目標決定。

・効率的・効果的な連携システムの向上と、一次・二次レベル間の患者の円滑な輸送システムの強化。

・調査活動による重要疾病のモニタリングとコントロール機能の強化。

3．協力分野の現状と問題点

ジャマイカ保健省は PHC 分野における問題点として、①財政的制約があること（保健医療分野の予算の大きな割合は、都市部医療施設で実施される救急医療部門にあてられている）、②公共施設と民間施設、都市部と地方との格差が大きいこと、をあげている。また、高齢化に伴う高血圧症、悪性新生物が増加している一方、乳幼児死亡率及び妊産婦死亡率は依然として高いこと、HIV／エイズの増加が新たな問題となっていることを指摘していた。

かかる状況の下、同国保健省は高額な医療費を要する質の高い医療サービスを受けられない貧困層を対象とした PHC の強化を図るため、地方への権限委譲をはじめとする保健医療制度の改革を実施している。その一環として、1997 年３月に保健医療サービスの地方分権化を目標とした「国家保健サービス法」が制定された。同法の施行によるメリットとしては、サービス供給の公平化、資源の有効活用、コミュニティーの参画があげられている。

ジャマイカの 13 パリッシュは４つの保健地域に分割されているが、南部保健地域はそれらの中で人口が多く（ただし、首都キングストンを含む南東部地域を除く）、また予防接種率等の保健指標が低いことから、今回要請の対象地域に選定されたとの説明がなされた。また、南部地域保健事務所関係者との意見交換の際、同地域では生活習慣病（成人病）が重要な問題であることを確認した。

さらに今回、保健医療施設の視察及び関係者との意見交換を踏まえ、わが方が確認した問題点は次のとおりである。

（1）保険・医療制度の不備

1）保険制度の不備

2）保健医療従事者の不足

公共保健医療施設における保健医療従事者は、給与や労働条件の問題から定着率が悪く、米国をはじめ外国で出稼ぎをしている。このような人員不足は外国人によって補われている。JOCV も例外ではなく、マンパワーとして役務提供せざるを得ない状況にある。そのため同病院への隊員派遣を見送る予定とのことであった。

3）保健医療施設の非効率性

各パリッシュは人口規模によりさらに保健地区（Health District）に分けられており、各地区ごとにヘルスセンターが設置されている。各ヘルスセンターは規模及び機能により、以下の３つのタイプに区分される。

・タイプⅠ：助産婦１名及び地域保健補助員（Community Health Aid）２名からなり、母子保健、栄養、家族計画、予防接種にかかるサービスを提供している。約 4,000 人の地域住民を対象としている。

・タイプII：タイプIのスタッフ及び機能に加え、Public Health Nurse 及び Public Health Inspector が常駐し、同地域のタイプIのヘルスセンターを訪問する。医師、Nurse Practitioner、薬剤師の定期訪問を受けることになっている。約1万2,000人を対象としている。

・タイプIII：タイプI、IIのスタッフ及び機能に加え、医師及び Nurse Practitioner が常駐している。

このほか、タイプIIIにパリッシュの保健医療計画を管理する部門が付設されたタイプIVがある。調査団のマンデビル訪問時には同タイプのセンターが建設中であった。

しかし、ヘルスセンターの数、配置状況、各センター間の関係という観点から、PHC システムは効率的に機能していないように見受けられた。また、今回の協力の中心となり得るタイプIIIのヘルスセンターについては、施設の規模の違いこそあれ、医薬品及び機材の不足等の点ではキングストン、マンデビルとも状況は同様であるとの印象を受けた。同センターでは公衆衛生活動に加え、診療行為も行われており、この点において、本プロジェクトを実施する際には十分検討する必要がある。

(2) 統計情報不足

1) 保健管区事務所の情報管理体制不備

各パリッシュのデータは中央に提出され、保健管区事務所で管理されていない。コピー機、コンピューターの不備もその一因にあげられるが、情報の集中管理及びその活用の重要性を認識してもらう必要がある。

2) 国際機関への依存性

国際機関はコンサルタントの活用により、独自にデータを収集している。

(3) 疾病構造

1) 生活習慣病

2) 性感染症 (STDs)

首都キングストン周辺には売春婦 (Commercial Sex Worker) が多い。感染経路は異性間、特に複数パートナーとの性行為による。近年では HIV／エイズの増加が深刻な問題となっている。

(4) その他

1) 検診：組織的な検診体制は整備されていない。

2) 教育：学校レベルでの健康教育活動は十分でない。

(5) 他の援助機関の動向

PAHO、UNICEF、USAIDにおいて、現在実施中、また今後実施予定の活動内容につき説明がなされた（表3－1参照）。

1) PAHOは予防接種活動に加え、環境保健（給水やトイレへのアクセス改善）に関連したプロジェクト等を実施している。

2) UNICEFはPHCの次の分野においてプログラムを実施している：予防接種、感染症、健康教育、母乳保育、母性保護。

3) USAIDは現在3つのプロジェクトを実施しているが、今後カリブ地域への協力を減少したいという意向があり、他のドナーの協力を期待しているように見受けられた。

表３－１　他の援助機関の動向

機関名	内　　容
UNICEF (1997～2001)	〈プログラム１〉Social Policy and Planning for Children and Women 目標：(1) 児童と女性のための国家行動計画（NPA）及び女性と児童に関する国家政策・計画を効果的に実施するために、政府の計画策定能力を向上する。また、特にハイリスク地域における女性と児童の状況のモニター、評価を行う。 (2) 児童の発展とジェンダーの関係を妨げる要因に関する地域住民の意識レベルを向上する。また、個人、コミュニティー、国家レベルにおける児童の権利発展を奨励する。 予算：2,596,000 米ドル プロジェクト１：Social Policy, Planning and Monitoring ２：Advocacy and Social Mobilization
	〈プログラム２〉Basic Education and Early Childhood Development 上位目標：NPA の目標（特に貧困家庭の０～12 歳児のための基礎教育の質の向上）を実施することにより、５カ年教育計画を支援する。 予算：3,250,000 米ドル プロジェクト１：Improving Learning Achievements ２：Infant and Child-Centered Learning -Curriculum and Teaching Environment -Community and Home-Based Learning ３：Parenting for Learning Empowerment
	〈プログラム３〉Child and Youth at Risk 目標：(1) 児童、特に危機的状況にある児童及び 10 代の青少年の保護権を促進する。 (2) 危機的状況にある児童及び 10 代の青少年の状況を改善し、既に困難な状況にある人々を更正する。 (3) 実施機関が包括的な家族ケアサービスを提供することを可能にする。 予算：3,090,000 米ドル プロジェクト１：Promoting Protection Rights of Children Project ２：Children and Teenagers At Risk Project

機関名	内　　容
UNICEF	〈プログラム４〉 Decentralized Community Development for Children 目標：選定されたコミュニティーの児童の生存、発展、保護を改善するために、統合化及びターゲット化を通じて UNICEF のプログラムの効果を最大限にする。 予算：3,594,000 米ドル プロジェクト１：Health and Nutrition Promotion ２：Children and Youth At Risk ３：Capacity Building for Community Empowerment
USAID	〈プロジェクト１〉 Health Sector Initiatives Project (HSIP) 目標：ヘルスケアにかかるコストの財政負担の拡大及びヘルスケアの質の改善。 予算：5,000,000 米ドル 期間：1989 年７月～1997 年７月 実施機関：MOH/HSIP Project Management Unit 〈プロジェクト２〉 AIDS/STD Prevention & Control Project 上位目標：HIV 感染数及び STD の発生数、有病数の増加率の減少。 目標：ターゲットグループのハイリスク行為の減少。 予算：10,115,000 米ドル 期間：1988 年８月～2001 年８月 実施機関：Epidemiology Unit, MOH 〈プロジェクト３〉 Family Planning Initiatives Project (FPIP) 目標：(１) 人口関連の国家開発目標を支援するため、家族計画サービスの質と量を最大限にする。 (２) 国家家族計画システムのプログラムの効率性及び持続性を増大する。 予算：7,000,000 米ドル 期間：1991 年７月～1998 年７月 実施機関：National Family Planning Board

4．相手国のプロジェクト実施体制

1997 年３月に「国家保健サービス法」が制定され、下記の事項について影響が及ぶことが予想される。

・実施機関の組織
・プロジェクトの組織及び関係機関との組織関連
・プロジェクトの予算措置
・建物・施設等計画
・カウンターパート（C/P）配置計画

現時点における確認事項は以下のとおりである。

（1）相手国受入機関は保健省であり、実施機関は南部地域保健事務所となる。保健省次官がプロジェクト全体の責任を負うこととなるが、南部地域保健事務所のシニア・メディカル・オフィサーがプロジェクト運営管理の責任者となる。また、同事務所は保健省のプライマリー・ケア局が統括しており、同局局長（Principal Medical Officer）がプロジェクト実施上の一責任者であることが望まれる。

（2）プロジェクトの予算措置については、当方から説明を行ったところ、長期調査の際に先方負担内容及び金額を提示してもらえば、確保するよう努めたいとのことであった。なお、会計年度は日本と同様である。

（3）既存の施設の機能強化を図るため、プロジェクト実施のために施設の建設の必要性はない。ただし、専門家執務室の確保については先方に申し入れたところ、現在検討中との回答が得られた。

（4）C/P については、地方分権化の過渡期にあるので、保健省及び南部地域保健事務所の両方に配置してほしい旨を申し入れた。しかし、C/P となり得る行政官は同時に病院に勤務する医師でもあり、フルタイムの配置が困難であるとのことから、さらに検討を要する。

〈参考〉（附属資料（2）参照）

「国家保健サービス法（The National Health Services Act）」1997 年３月制定

1）“The Hospital Public Act”（1947 年 12 月）の廃止

①保健大臣が委員会（Hospital Board）のメンバーを任命、委員会の機能（権限、

義務）定義、資金分配、公共保健施設の会計準備、監査管理を行う。

②各管区における公衆衛生システムに関する決定は、保健省を通じて行われる。

2）目標

①保健サービスの地方分権化

②各地域の自治

③保健サービスの効率性の向上、運営管理の改善

3）実施機関

4地域（西部、南西部、南部、北東部）に各地域保健事務局（Regional Health Authority）を設立。

4）組織

①保健大臣

全プログラムの政策立案、モニタリングに対して責任を負う。

②事務局（Authority）

スタッフの任命後、大臣からの最終的な承認を得る。

政府や他の資金援助機関（Funding Agency）により供給される資金や資源の分配や調整、保健省への会計報告に対して責任を負う。

③地域局長（Regional Director）、管区長（Parish Manager）

事務局により任命される。

日常の運営管理、地域の保健サービスのための戦略、運営計画の開発に対して責任を負う。

5．総括（相手国側との協議結果）

今次調査団は時間的制約から、詳細な活動内容についての確定まで至らなかった。しかしながら、今後協力を実施するうえで必要な事項を確認するため、長期調査員派遣を含めた、当方からのミニッツ案に合意が得られた。

また、当方からはプロジェクト方式技術協力及び負担事項につき説明を行ったのに対し、先方からは予算、C/P 確保等についての質問がなされた。それに対して、具体的負担内容に関してさらに説明を行ったが、フルタイムの C/P 配置については、なお検討が必要であると思われる。

なお、先方のプロジェクト方式技術協力に対する理解不足、保健医療体制の地方分権化、要請書の提出遅延による時間的制約のため、ミニッツに先方負担事項を含めるには、さらに十分な討議が必要と判断し、盛り込むまでには至らなかった。

他方、長期調査においては、プロジェクトの効果をあげるため、PHC サービスのモデルとなり得るディストリクトを選定することを提案した。これに対し、先方からはディストリクトは小さい単位であるため、可能であれば、南部地域の３パリッシュのうち１つを選定したいとの要望が出された。この要望に伴い、ミニッツでは、当初のディストリクト（District）からターゲット・エリア（Targeted Area）に変更した。

（1）プロジェクト名称

「ジャマイカ国南部地域プライマリー・ヘルスケアサービス改善プロジェクト」

（2）上位目標

質の高い PHC サービスを享受することにより、南部地域の住民の健康状態が改善される。

（3）プロジェクト目標

南部地域各管区の以下の能力が向上、強化される。

①効果的な PHC サービスを提供するための行政・組織能力。

②地域住民の現在及び今後の需要に応じた PHC サービス（生活習慣病をはじめとする疾病予防・対策を含む）を実施するための運営能力。

③個人・家族・コミュニティーレベルで健康増進が図れるための健康教育能力。

（4）プロジェクト期間

討議議事録（R/D）で定められた日から５年間。

(5) 日本側のとるべき措置

①専門家の派遣

② C/P の受入れ

③機材の供与

(6) プロジェクトの運営管理

①保健次官がプロジェクト実施に対して全責任を負う。

②医療審議官がプロジェクト運営管理面の責任を負う。

③南部地域保健事務所シニア・メディカル・オフィサーがプロジェクトの技術面及び運営面の責任を負う。

(7) 長期調査

プロジェクト計画を作成するため、長期調査員を派遣する。調査内容は下記のとおりである。

①詳細な活動の明確化。

② PHC サービスのモデルとなり得る、適当なターゲット・エリアの選定。

③その他（必要に応じて）。

また、今後のスケジュールとして、1997 年 8 ～ 9 月に長期調査を実施し、その結果を踏まえて 1997 年度中に実施協議調査団を派遣する予定であることを先方に説明し、了承を得た。

6．協力実施上の提言

6－1　技術協力の妥当性

先方からの要請内容は広範囲に及んでおり、わが方としては費用対効果の観点から全分野への協力は困難であることから、対象の絞り込みが必要であることを先方に申し入れた。

現時点においては、詳細な協力計画は策定されていないが、基本的には地方における PHC の質的向上を目標とすることで双方とも合意している。

同国政府の保健医療政策のなかでも、PHC は優先度の高い活動項目になっている。PHC の充実により、公共施設と民間施設、都市部と地方との格差が是正されるとともに、費用対効果の高い保健医療サービスがコミュニティーレベルにおいて実施可能となる。したがって、同分野に対する協力は、同国の社会開発目標に整合するほか、地域住民に対する裨益効果が高いと思料され、その協力の必要性は高いと判断し得る。

6－2　協力実施にあたっての留意事項等

（1）問題点

①社会構造の相違

②保険制度の相違

③医療体制の相違

④資料の不備

⑤疾病構造の相違

（2）留意事項・課題

①対象の決定（地域の設定、対象領域の設定）

・生活習慣病の管理システムの構築

・健康診査体制の確立

・栄養指導

②協力体制

③社会生活上の問題点

ジャマイカにおけるプロジェクト方式技術協力は本案件が２件目であるが、保健省にとっては初めてである。実施機関となる南部地域保健事務所では、日本の技術協力に対する理解が不十分であるため、さらに説明する必要がある。しかし、各機関の援助を調整する企画庁の担当者は技術協力のスキームを十分理解しており、今後同担当者にも適宜フォローしてもらう必要がある。

現在、ジャマイカでは前述の PAHO、UNICEF、USAID のほか、ドイツ、イタリア、EU 等のドナーが援助を実施している。同機関は十分な経験及び情報を有しており、本プロジェクトを実施していくうえで、情報交換の場をもつことは有益である。

供与機材の選定は、維持管理及び保守の観点から、現地調達及び第三国調達の可能性を含めて行われることが必要である。その際、既にマンデビル病院で活動している機材保守の協力隊員から関連情報を入手することが有用である。

現在、地方分権化が進行中であり、プロジェクトへの影響も予想されるところ、相手国側関係機関と密接に情報交換し、進捗状況を確認する必要がある。

ジャマイカでは海外流出による人材の不足から、専門家に対しても協力隊員同様、マンパワーとしての役務提供が期待されるであろう。わが方としては、相手側の自助努力を促し、C/P を確保・定着させるよう努力する必要がある。

６－３　残された調査課題（長期調査項目）

・プロジェクト実施体制

・ジャマイカ側負担事項

・協力計画

附　属　資　料

（1）相手国側実施体制

① 保健省組織図

② PHC 組織図（管区レベル）

③ プロジェクト組織図（ジャマイカ側）

④ プロジェクト組織図（日本側）

（2）国家保健サービス法

① REPORT ON THE NATIONAL HEALTH SERVICES ACT OF MARCH, 1997

② THE NATIONAL HEALTH SERVICES ACT, 1997

③ THE HOSPITALS (PUBLIC) ACT

（3）ミニッツ

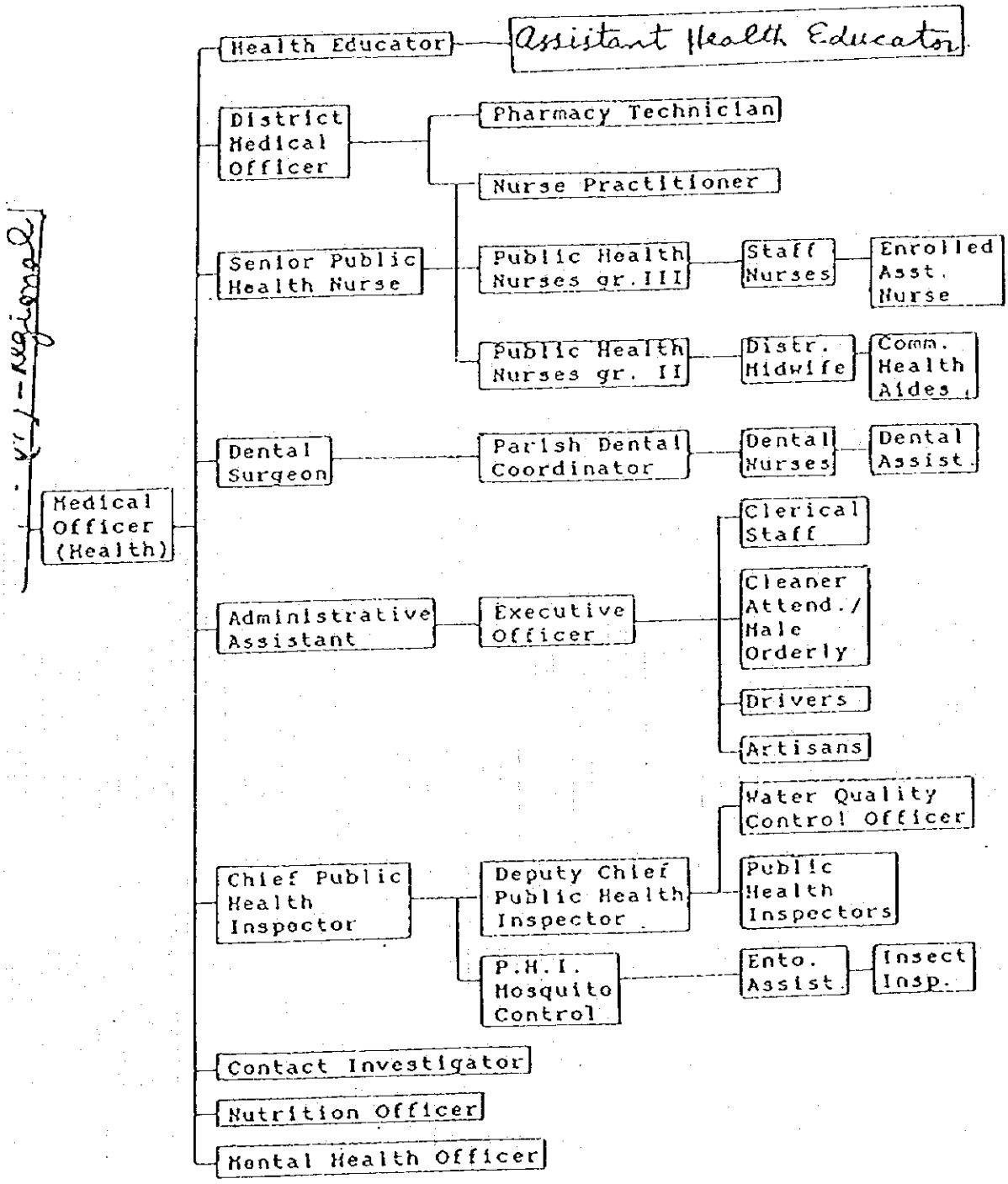
（4）保健省 PHC 関係者ミーティング席上配布資料
(OHP シートを含む)

（1）相手国側実施体制

① 保健省組織図

② PHC組織図（管区レベル）

Primary Health Care — Parish level



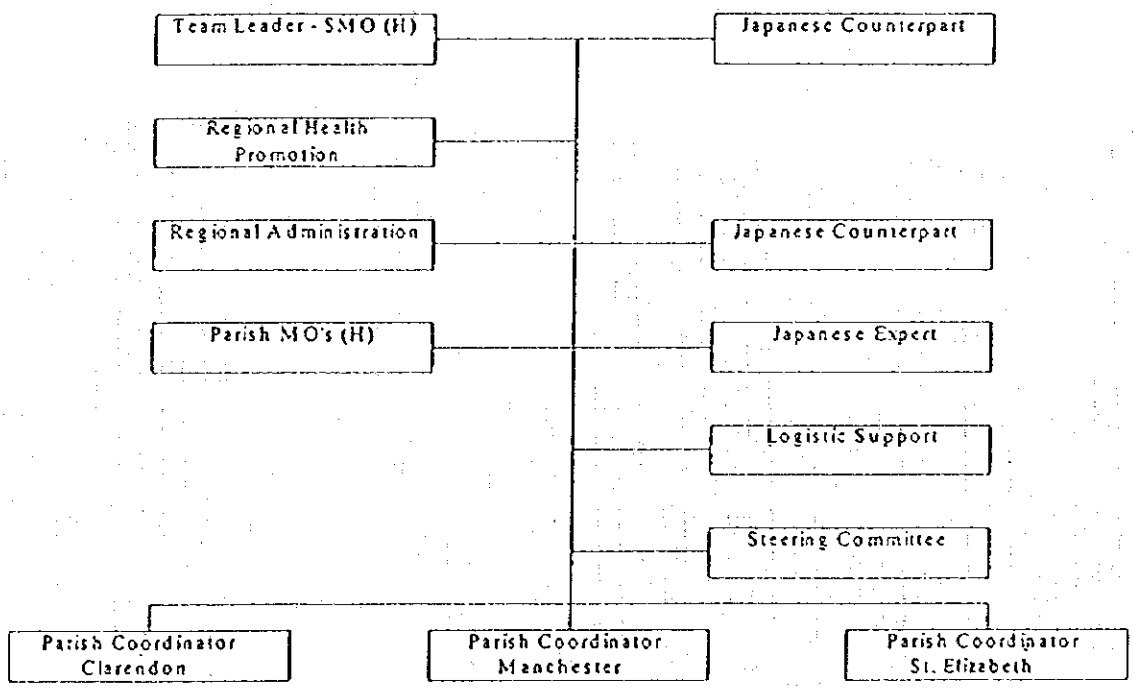
③ プロジェクト組織図（ジャマイカ側）

ORGANIZATION AND MANAGEMENT OF PROJECT

The relationship of the Southern Region to the central level demonstrated by Appendix 3.

Project Management Organogram

Diagram I

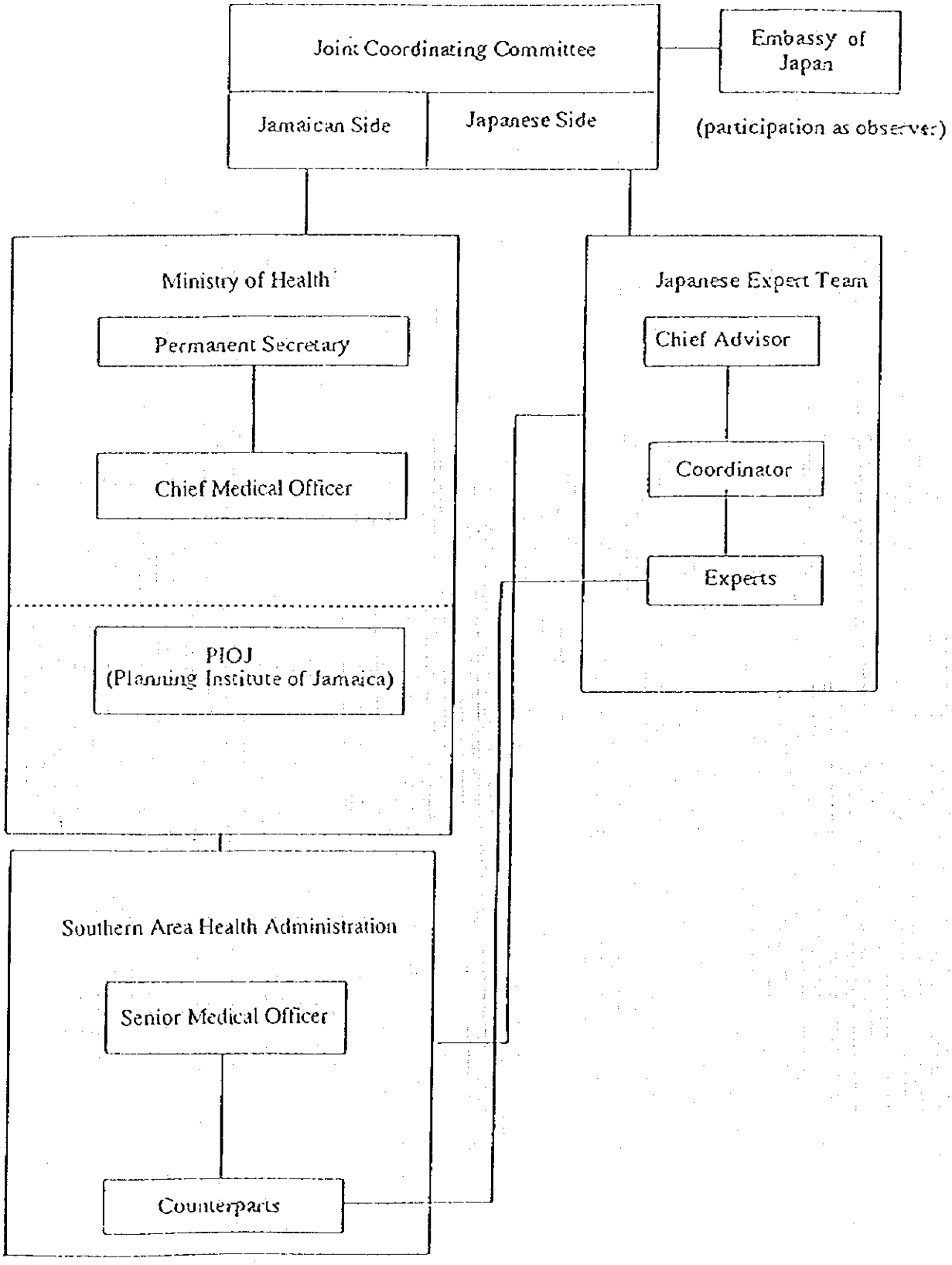


The Steering Committee Members are as follows:

- Regional Public Health Inspector
- Regional Nurse
- Regional Mental Health Officer

Appendix III

④ プロジェクト組織図（日本側）



(2) 国家保健サービス法

① REPORT ON THE NATIONAL HEALTH SERVICES ACT OF MARCH, 1997

REPORT ON THE NATIONAL HEALTH SERVICES ACT OF MARCH, 1997

The National Health Services Act passed in March 1997 to repeal the Hospitals Public Act, aims to rationalise the Public Health system island-wide in a move to make it more efficient and cost effective. The memorandum of objects and reasons states,

> "The decentralisation of the management of all health services is being actively pursued by the Ministry of Health in an effort to promote efficiency in the administration of health services island-wide."

Under this New Act four Regional Authorities will be set up in four regions island-wide to manage the public health service. The coordinated regions include Western (Trelawny, Westmoreland, St. James, Hanover), South-east (St. Thomas, Kingston, St. Andrew, St. Catherine), Southern (Clarendon, Manchester, St. Elizabeth) and the North-eastern region to include St. Ann, Portland and St. Mary.

The objective of the Programme being to decentralize the health services, making each region more autonomous, bringing the health services towards greater efficiency and better management. The Ministry will therefore become responsible for policy-making and monitoring of the overall programme. In effect the authorities will be set up as the implementation mechanism operating in a framework provided by the Ministry of Health.

As stated in the Act each Authority through a Broad of Directors, will appoint their own staff, gaining final approval from the Minister in charge. A Regional Director and a Parish Manager will be appointed by each Authority and will be responsible for the day-to-day administration and the development of strategic and operational plans for the health services in their region.

The Authorities therefore will operate as statutory bodies, responsible for the dispensing and regulating of funds and resources supplied by the government or any other funding agency, making timely reports to the Ministry of Health. As stated in the Act (No. 11 subsection 3),

> "...So soon as the accounts of an Authority have been audited, the Authority shall send the statement of its accounts.... To the Minister together with a copy of any report made by the auditors on that statement or on the account of the Authority..."

The Authorities will regulate all public health facilities including public health clinics, infirmaries, hospital and equipment as well as instigating a restructuring drive for personnel in the health system.

The Bill already approved and signed by the Governor-General, will become fully operational in approximately three months, since already staff is being recruited. The National Health Services Act a part of the continued effort of the government to rationalise the public sector, to bring more local participation into the decision-making machinery and to therefore eventually improve the service delivered by the public sector. By decentralising into four regional authorities government feels it will be able to deliver a more efficient service, because decisions concerning a particular region could be made by the people who know most, those that are there.

Under the previous Act, the Hospitals Public Act the Ministry appointed, defined the functions of the board, disseminated funds and governed the preparation , audit and inspection of the accounts of the various public health facilities island-wide. Under that scheme every decision concerning the public health system in each parish had to be made through the Ministry of Health, often delaying the decision-making machinery therefore not allowing for expediency and efficiency.

In concluding the major aims of the National Health Services Act are:

1. With Authorities being given the autonomy to access loans from funding agencies if it so needed, it is hoped that they will be able to improve their service to public and strive to be more efficient and cost-effective.
2. The aim of decentralisation is to improve and reduce delays in the decision-making machinery which often times not cause further problems. The aim is to get those who are affected most into the decision-making process, the feeling being that they must know best.
3. The process is part of the Governments continued aim to rationalise the public sector.

② THE NATIONAL HEALTH SERVICES ACT, 1997

THE NATIONAL HEALTH SERVICES ACT, 1997
(Act of 1996)

ARRANGEMENT OF SECTIONS

A BILL

ENTITLED

AN ACT to Repeal the Hospitals (Public) Act and to provide for the establishment of regional health authorities to administer the nation's health services and facilities and for matters connected therewith or incidental thereto.

[ ]

BE IT ENACTED by the Queen's Most Excellent Majesty, by and with the advice and consent of the Senate and House of Representatives of Jamaica, and by the authority of the same as follows:—

Short title and commencement.

1. This Act may be cited as the National Health Services Act, 1997 and shall come into operation on a day to be appointed by the Minister by notice published in the *Gazette*.

Interpretation.

2.—(1) In this Act—

"appointed day" means the date appointed by the Minister under section 1;

"Authority" or "regional health authority" means an Authority established by a scheme made under section 3;

"functions" includes powers and duties;

First Schedule.

"public health facility" means any facility specified in the First Schedule;

"public health service" means any service which is provided, whether directly or indirectly, by public health personnel in the fulfilment of their official duties, and includes services offered by public health facilities for research, monitoring, regulatory or promotional activities or for the reception or treatment of persons suffering from illness;

"region" means the area specified in a scheme establishing an Authority as the area within which each Authority administers the delivery of public health services;

Second Schedule.

"regional hospital" means any hospital specified in the Second Schedule.

(2) The Minister may, from time to time by order, amend the First and Second Schedules.

Schemes of establishment and management of regional health authorities.

3.—(1) The Minister may, from time to time, prepare a scheme or schemes for the establishment and management of one or more regional health authorities.

(2) Every such scheme shall—

(a) provide for—

(i) the establishment and functions of the Authority;

(ii) the appointment of members of the Authority and their tenure of office;

(b) define the parishes or parts thereof which comprise the region to be administered by an Authority;

(c) provide for the application of the funds of the Authority;

(d) provide for the duties and responsibilities of staff of the Authority;

(e) provide for such other matters as the Minister may consider expedient or necessary for giving effect to the purposes of this section.

(3) Every scheme prepared under this section shall be subject to negative resolution.

Appointment of Regional Director, Parish Manager and employees.

4.—(1) An Authority—

(a) shall appoint, at such remuneration and on such terms and conditions as it thinks fit—

(i) a Regional Director for the region for which that Authority is responsible; and

(ii) a Parish Manager for each parish within that region;

(b) may appoint and employ at such remuneration, and subject to such conditions as it thinks fit, such other officers, employees and agents as it thinks necessary for the proper carrying out of its functions under a scheme:

Provided that—

(a) no salary in excess of the prescribed rate shall be assigned to any post without the prior approval of the Minister; and

(b) no appointment shall be made to any post to which a salary in excess of the prescribed rate is assigned without the prior approval of the Minister.

(2) For the purposes of this section, the prescribed rate means five hundred thousand dollars per annum or such higher rate as the Minister may, from time to time, by order, prescribe.

(3) The Governor-General may, subject to such conditions as he may impose, approve the appointment of any officer in the service of the Government to any office with the Authority and any officer so appointed shall, while so employed, in relation to any pension, gratuity or other retiring benefits and in relation to the other rights as a public officer, be treated as continuing in the service of the Government.

(4) It shall be lawful for the Authority, with the approval of the Minister—

(a) to enter into arrangements respecting schemes whether by way of insurance policies or not; or

(b) to make regulations,

for pensions gratuities and other retiring or disability or death benefits relating to members and employees of the Authority, and such arrangements or regulations may include provisions for the grant of benefits to the dependents and legal personal representatives of such members or employees.

Responsibilities of Regional Director and Parish Manager.

5.—(1) A Regional Director appointed under section 4 (1) (a) (i) shall be responsible for—

(a) the day-to-day administration of the business of the Authority;

(b) directing and controlling the development of strategic and operational plans for health services in the region;

(c) the provision of guidance in administrative and policy matters to Parish Managers within the region;

(d) the coordinating of activities of—

(i) all public health facilities in the region; and

(ii) such other agencies as may be responsible for the delivery of health services within that region;

(e) the review and appraisal of all projects for the divestment of medical and non-medical services in the region;

(f) the preparation and submission of financial reports to the Authority and the Minister on a timely basis;

(g) such other duties as may from time to time be specified by the Authority.

(2) A Parish Manager appointed under section 4 (1) (a) (ii) shall be responsible for—

(a) accounting for expenditure of monies allocated for the delivery of public health services in the relevant parish;

(b) directing and controlling the development of strategic and operational plans for health services in that parish;

(c) managing the delivery of public health services in accordance with government policies and regulations; and

(d) such other duties as may from time to time be specified by the Authority.

Funds of Authority.

6. The funds and resources of an Authority shall consist of—

(a) such sums as may be provided annually for the purpose in the Estimates of Revenue and Expenditure of the Island;

(b) such sums as may be allocated from time to time to the Authority from loan funds;

(c) sums borrowed by the Authority for the purpose of meeting any of its obligations or discharging functions; and

(d) revenues from charges imposed by the Authority in respect of public health services provided by it;

(e) all other sums or property which may in any manner become payable to or vested in the Authority in respect of any matter incidental to its functions.

Application of revenues.

7. The revenues of an Authority shall be applied for the purposes authorized by this or any other law in relation to the functions of the Authority.

Borrowing powers.

8.—(1) Subject to subsection (2), an Authority may borrow sums required by it for meeting any of its obligations or discharging any of its functions.

(2) The power of an Authority to borrow shall be exercisable only with the approval of the Minister responsible for finance, as to the amount, as to the source of borrowing and as to the terms on which borrowing may be effected.

(3) An approval given in any respect for the purposes of this section may be either general or limited to a particular borrowing or otherwise and may be either unconditional or subject to conditions.

Power to invest moneys.

9. All moneys of an Authority not immediately required to be expended in the meeting of any of its obligations or the discharge of any of its functions may be invested in such securities as may be approved either generally or specifically by the Minister and the Authority may, with the approval of the Minister, sell all or any of such securities.

Guarantee by Minister of borrowings by Authority and repayment of sums issued to meet guarantees.

10.—(1) With the approval of the House of Representatives the Minister responsible for finance may guarantee in such manner and on such conditions as he may think fit, the repayment of the principal and interest on any authorized borrowings of the Authority.

(2) Where the Minister responsible for finance is satisfied that there has been default in the repayment of any principal moneys or interest guaranteed under the provisions of this section, he shall direct the repayment out of the Consolidated Fund and assets of Jamaica of the amount in respect of which there has been such default.

(3) The Authority shall make to the Accountant-General, at such times and in such manner as the Minister responsible for finance may direct, payments of such amounts as may be so directed in or towards payment of any sums issued in fulfilment of any guarantee given under this section, and payments of interest on what is outstanding for the time being in respect of any sums so issued at such rate as the Minister may direct, and different rates of interest may be directed as respects different sums and as respects interest for different periods.

Accounts and Audits

11.—(1) Each Authority shall keep proper accounts and other records in relation to its business and shall prepare annually a statement of accounts in a form satisfactory to the Minister being a form which conforms with established accounting principles.

(2) The accounts of each Authority shall be audited by an auditor appointed annually by the Authority and approved by the Minister.

(3) So soon as the accounts of an Authority have been audited, the Authority shall send the statement of its accounts referred to in subsection (1) to the Minister, together with a copy of any report made by the auditors on that statement or on the accounts of the Authority.

(4) The auditor's fees and any expenses of the audit shall be paid by the relevant Authority.

(5) The Auditor-General shall be entitled at all reasonable times to examine the accounts and other records in relation to the business of each Authority.

Annual report.

12.—(1) Each Authority shall, within six months after the end of each financial year, cause to be made and transmit to the Minister a report dealing generally with the activities of the Authority during the preceding financial year, and containing such information relating to the proceedings and policy of the Authority as can be made public without detriment to the interests of the Authority.

(2) The Minister shall cause a copy of the report together with the annual statement of accounts and the auditor's report thereon to be laid on the Table of the House of Representatives and the Senate.

Regulations.

13.—(1) Subject to the provisions of this Act, the Minister may make regulations generally in respect of public health facilities, and such regulations may relate generally to all public health facilities or to any particular health facility.

(2) Without prejudice to the generality of subsection (1), regulations made under this section may provide for—

(a) the admission into, the treatment at, and the discharge from, any public health facility of any person or class of persons;

(b) fixing the dues to be paid in respect of persons obtaining medicines or surgical appliances at, or receiving attention or treatment, in any public health facility;

(c) the establishment of Codes of Discipline for regional health authorities;

(d) the regulation and constitution of Hospital Management Committees, Parish Committees or any other Committee appointed pursuant to this Act;

(e) any other matter that is relevant to the delivery of public health services.

Liability for expenses, etc. of seaman.

14. Every Master and every consignee of a vessel from which any seaman, (not being a deserter from his vessel) has been received into any public health facility, shall be liable for the expenses and fees arising therefrom and, in case of death, for the funeral expenses of such seaman.

Expenses of paupers in public health facilities.

15. All expenses arising from—

(a) the provision of public health services in respect of a pauper sent from any parish by the Parish Council of that parish (or other public entity responsible for his care) for treatment in any public health facility and the cost of returning him to his parish when discharged; or

(b) his funeral in the case of death,

shall be defrayed from the funds of the parish from which he was so sent.

Recovery of fees.

16. Any fees arising from the provision of public health services and any funeral expenses incurred in connection with the burial of any person who has died in a public health facility may be recovered without limit of amount, as a civil debt in the Resident Magistrate's Court in the parish in which the public health facility which provided the service is situated.

Transfer of officers to Authority.

17.—(1) Subject to the provisions of this section, on the appointed day—

(a) an Authority may accept the services of any person who, immediately before that day was the holder of a post constituted under the Civil Service

Establishment Act in a public hospital as defined in this section or in a Health Department, as the case may be; and

(b) any such person (in this section referred to as an "officer") shall be deemed to be seconded from the service of the Government to the service of the Authority.

(2) The Governor-General may at any time determine the secondment of an officer.

(3) The Authority may, within twelve months from the appointed day give to any officer in its employment by virtue of subsection (1) notice in writing—

(a) offering the officer employment on such terms as the Authority shall specify; or

(b) of the intention of the Authority to request the Governor-General to determine the officer's secondment.

(4) The Authority shall not offer employment to any officer except on terms and conditions not less favourable than those enjoyed by the officer in his substantive post at the date of that offer.

(5) During the period of secondment an officer may elect by notice in writing to the Chief Personnel Officer to apply for a post in a Regional Authority.

(6) When an officer accepts an offer of employment made pursuant to this section, his service with the relevant Authority shall be deemed to have commenced and his service with the Government, subject to section 4 (3), to have ceased at the date on which he accepts the offer.

(7) For the purposes of this section and section 20 "public hospital" means—

(a) any clinic, dispensary or institution (other than Bellevue Hospital or the Hansen Home) for the reception or treatment of persons suffering from illness or requiring medical care; or

(b) any maternity home, convalescent home or rehabilitation centre,

maintained by the Government.

Repeal of Hospitals (Public) Act.

18. The Hospitals (Public) Act is hereby repealed and is hereinafter referred to as the repealed Act.

Savings.

19. Where in any written law there is a reference to a Management Scheme under the repealed Act, or to any employee thereunder, the reference shall be construed as a reference to a Scheme under this Act or an employee under that Scheme.

Vesting of assets and transfer of liabilities.

20. Upon a day to be appointed by the Minister by notice published in the *Gazette* (hereinafter referred to as "the vesting day") there shall be transferred to and vested in the Authority named in the notice by virtue of this section and without further assurance, all such assets and liabilities as may be specified in the notice being—

(a) property of the Government vested in the Commissioner of Lands or the Accountant-General, as the case may be, and occupied, utilized or enjoyed by a public hospital named in that notice;

(b) debts owing to the Government by virtue of the operations of the public hospital referred to in paragraph (a);

(c) any liabilities of any such public hospital.

FIRST SCHEDULE (Section 2)

PUBLIC HEALTH FACILITIES

— Clinics
— Convalescent Homes
— Dispensaries
— Drug Windows
— Health Centres
— Health Departments
— Laboratories
— Maternity Homes
— Medical Rehabilitation Centres
— Pharmacies
— Public Hospitals

SECOND SCHEDULE (Section 2 (1))

REGIONAL HOSPITALS

— Cornwall Regional Hospital
— Kingston Public Hospital
— Mandeville Hospital
— St. Ann's Bay Hospital

Passed in the House of Representatives this 25th day of February, 1997.

CARL MARSHALL,
Speaker.

MEMORANDUM OF OBJECTS AND REASONS

The decentralization of the management of all health services is being actively pursued by the Ministry of Health in an effort to promote efficiency in the administration of health services islandwide. The management of health services delivery will be decentralized from the Ministry's headquarters in Kingston to four regions throughout the Island.

This Bill therefore seeks to repeal the Hospitals (Public) Act, which dealt specifically with the individual hospitals within parishes, and introduce new provisions for the management of all public health facilities on a regional basis, and to make other changes consequent upon the restructuring of health care administration.

The Bill provides *inter alia*, for the establishment and management of regional health authorities and the appointment of Regional Directors, Parish Managers, officers, employees and agents by the Authority.

PETER PHILLIPS,
Minister of Health.

A BILL

ENTITLED

AN ACT to Repeal the Hospitals (Public) Act and to provide for the establishment of regional health authorities to administer the nation's health services and facilities and for matters connected therewith or incidental thereto.

As passed by the Honourable House of Representatives.

PRINTED BY JAMAICA PRINTING SERVICES (1981) LTD.,
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THE HOSPITALS (PUBLIC) ACT

Cap. 150. Act 20 of 1963.

[30th December, 1947.]

1. This Act may be cited as the Hospitals (Public) Act. Short title.

2. In this Act— Interpretation. 20/1963 S. 2.

"functions" includes powers and duties;

"public hospital" means—

(*a*) any clinic, dispensary or institution (other than Bellevue Hospital or the Hansen Home) for the reception or treatment of persons suffering from illness or requiring medical care; or

(*b*) any maternity home, convalescent home or rehabilitation centre,

maintained by Government.

3.—(1) The Minister may, from time to time, prepare a scheme for the management of one or more public hospitals. Schemes of management of public hospitals. 20/1963 S. 2.

(2) Every such scheme shall—

(*a*) provide for the constitution of a Hospital Board;

(*b*) provide for the appointment of members of such Board and their tenure of office;

(*c*) define the functions of such Board;

(*d*) make such provision as may be expedient for empowering such Board to appoint committees and specify the matters to be referred to them;

(*e*) provide for the responsibility for funds that are made available to such Board;

(*f*) provide for preparation of accounts and audit inspection of such Board;

(g) provide for the responsibilities for the staff;

(h) define the functions of the Minister in relation to such Board;,

(i) provide for such other matters as the Minister may consider to be expedient or necessary for giving effect to the purposes of this section.

(3) Every scheme prepared under this section shall be subject to affirmative resolution.

Regulations. 20/1963 S. 2.

4.—(1) Subject to the provisions of this Act the Minister may make regulations generally in respect of public hospitals, and any such regulations may relate generally to all public hospitals or to any particular public hospital.

(2) Without prejudice to the generality of the power contained in subsection (1), regulations made under this section may provide for---

(a) the admission into, the treatment at, and the discharge from, any public hospital of any person or class of persons;

(b) fixing the hospital dues to be paid in respect of persons obtaining medicines or surgical appliances at, or receiving attendance or treatment in, any public hospital.

Liability for hospital dues, etc., of seaman.

5. Every Master and every consignee of a vessel from which any seaman, not being a deserter from his vessel, has been received into any public hospital shall be liable for the hospital dues and, in case of death, for the funeral expenses of such seaman.

Expenses of paupers in public hospital.

6. The hospital dues in respect of a pauper sent from any parish of this Island by the Parish Council of such parish for treatment in any public hospital, and the cost of returning him to his parish, when discharged, or his funeral expenses in case of death, shall be defrayed from the funds of the parish from which he was so sent.

[The inclusion of this page is authorized by L.N. 450/1973]

7. Any hospital dues owing in respect of attendance at or treatment in any public hospital and any funeral expenses incurred in connection with the burial of any person who has died in a public hospital may be recovered in the Resident Magistrate's Court of the parish in which the public hospital is situated without limit of amount by proceedings in the name of the Attorney-General. Recovery of hospital dues, etc. 20/1955 S. 4.

8. All moneys received under this Act or any regulations made under this Act shall be paid into the Consolidated Fund. Hospital dues to be paid to Consolidated Fund.

[The inclusion of this page is authorized by L.N. 450/1973]

(3) ミニッツ

MINUTES OF DISCUSSIONS
BETWEEN
THE JAPANESE PRELIMINARY STUDY TEAM
AND
THE AUTHORITIES CONCERNED OF THE GOVERNMENT OF JAMAICA
ON
THE JAPANESE TECHNICAL COOPERATION
FOR
THE PROJECT FOR IMPROVEMENT OF PRIMARY HEALTH CARE SERVICES
IN THE SOUTHERN REGION OF JAMAICA

The Japanese Preliminary Study Team (hereinafter referred to as "the Team") organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA") and headed by Dr. Reizo MITA, Professor, Department of Public Health, Hirosaki University School of Medicine, Japan, visited Jamaica from April 8 to 18, for the purpose of making the study on the proposed technical cooperation for the Project for Improvement of Primary Health Care Services in the Southern Region (hereinafter referred to as "the Project").

During its stay in Jamaica, the Team exchanged views and had a series of discussions with the Jamaican authorities concerned.

As a result of the study and the discussions, the Team and the Jamaican authorities concerned came to an agreement on the matters referred to in the document attached hereto.

Kingston, April 18, 1997

三田禮造

Dr. Reizo MITA
Leader,
Preliminary Study Team,
Japanese International Cooperation Agency (JICA),
Japan

Mr. George Briggs
Permanent Secretary,
Ministry of Health,
Jamaica

Mr. Winston Anderson
Director,
Technical Cooperation and Regional Planning Division,
Planning Institute of Jamaica,
Jamaica

ATTACHED DOCUMENT

1. NAME OF THE PROJECT

The Project for Improvement of Primary Health Care Services in the Southern Region of Jamaica

2. OVERALL GOAL OF THE PROJECT

To improve the health status of the population of the Southern Region by increasing access to quality primary health care services.

3. PURPOSE OF THE PROJECT

To improve and strengthen the following capacities:

(1) the administrative/organizational capacity to provide an efficient primary health care services of acceptable quality.
(2) the operational capacity to implement the primary health care services to meet the existing and future demand of the population, including illness prevention/intervention activities such as those for lifestyle diseases.
(3) the health promotion/health education capacity to empower individuals to take responsibility for their own health, that of their family and community.

4. DURATION OF THE PROJECT

The duration of the Japanese Technical Cooperation for the Project shall be five (5) years from the date determined in the Record of Discussions(R/D).

5. MEASURES TO BE TAKEN BY THE JAPANESE SIDE FOR THE PROJECT-TYPE TECHNICAL COOPERATION

The technical cooperation of the Project will be implemented through:

(1) Dispatch of Japanese experts
    a. Chief advisor
    b. Coordinator
    c. Experts in the field mutually agreed upon
(2) Acceptance of the Jamaican counterpart personnel for training in Japan
(3) Provision of equipment and materials

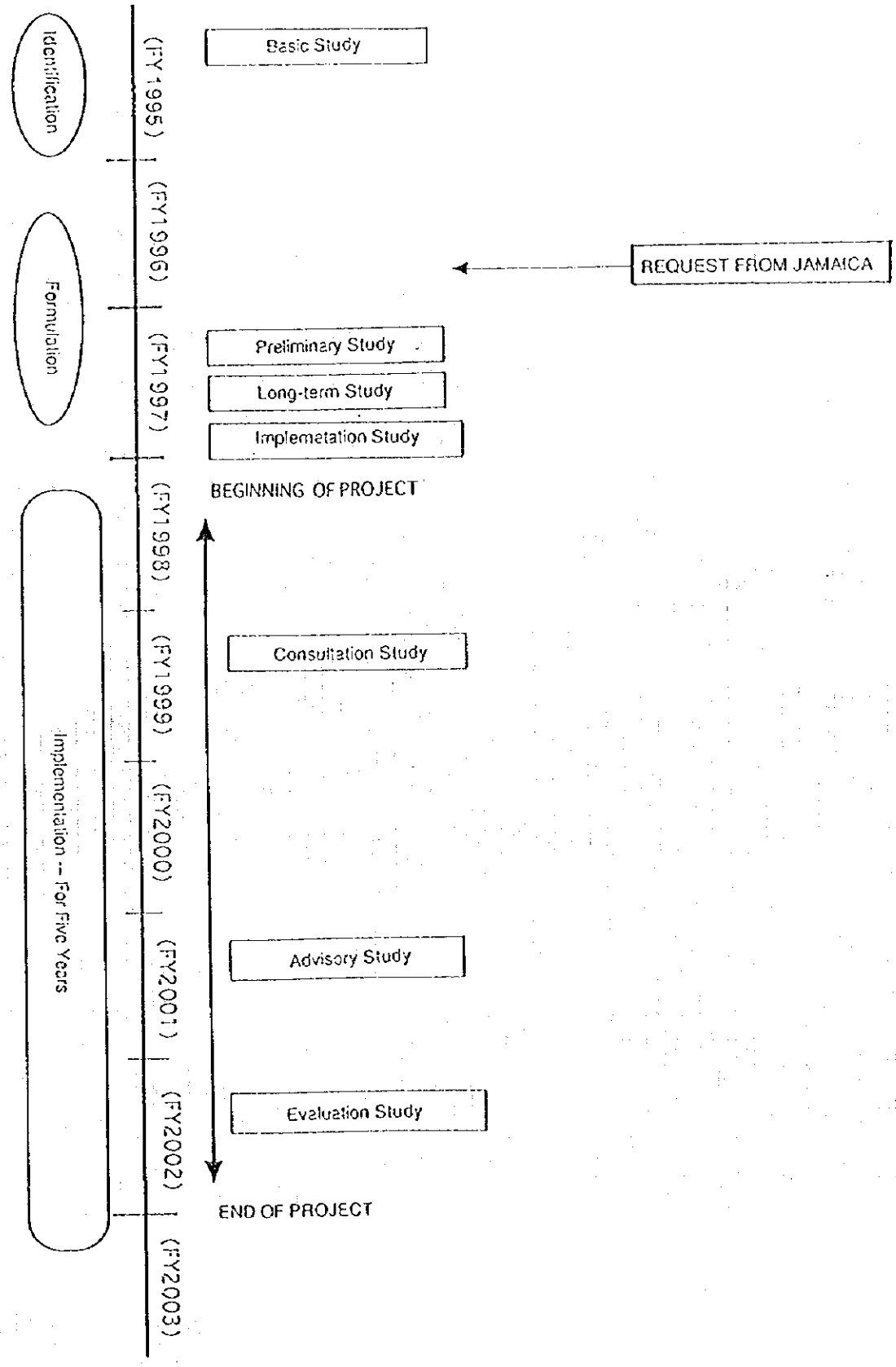
6. ADMINISTRATION OF THE PROJECT

(1) The Permanent Secretary,Ministry of Health, will bear the overall responsibility for the implementation of the Project.
(2) The Chief Medical Officer, Ministry of Health, will be responsible for administrative and managerial matters of the Project.
(3) The Senior Medical Officer (Health) of the Southern Area Health Administration, Ministry of Health, will be responsible for technical and operational matters of the Project.
(4) Other related personnel in the Southern Region should be selected as necessary for the smooth implementation of the Project.

7. THE LONG-TERM STUDY

The Team explained that the long-term study team will be dispatched to formulate a clear picture of the Project by:
(1) clarifying the detailed activities.
(2) selecting an appropriate targeted area, which can be a model of primary health care services.
(3) others mutually discussed as necessary.

IMPLEMENTATION MODEL FOR PROJECT



（4）保健省 PHC 関係者ミーティング席上配布資料
（OHP シートを含む）

NOTES OF PRIMARY HEALTH CARE STAFF MEETING

HELD MARCH 13, 1997

Present were:-

Dr. Eva Lewis-Fuller	Chairperson
Ms. Ivy Limonius	Director, WISPH
Mrs. Eileen Bernard	ADNS
Ms. Claudette Hemmings	Deputy Director
Mrs. Reneta McNab	Nursing Supervisor - PHC
Dr. Marion Bullock-DuCasse	SMO(H)-SP
Mrs. Kathleen Rainford	Director Nutrition Division
Dr. Margaret Robinson	SMO(H)-MCH
Mr. Peter Knight	Coordinator VPMr.
Mr. Benjamin Brown	Quarantine Officer
Mr. Sydney Erwin	Actg. Coordinator, HD/TB
Mr. Ransford Clarke	Rep. Epi Unit
Mr. Ambrose Fuller	Dep. DPHIS (Ag)
Mr. Laurie Watson	DPHIS

APOLOGIES

Mr. Trevor Castle
Dr. Bernard Sutherland

CALL TO ORDER

The meeting was called to order by the Chairperson at approximately 10:12 a.m.

Prayers were also offered by the Chairperson.

WELCOME

The Chairperson welcomed eyeryone. Special welcome was extended to Dr. Margaret Robinson, Acting Senior Medical Officer (H) -MCH; Mrs. Kathleen Rainford, Director, Nutrition & Dietetic Division, and Mrs Talita Fennell, Acting Assistant Director of Nursing Services.

AMENDMENTS

Page 3 Item 1.3.1	Line 1 - word to read "workshop"
Page 5 Item 2.3.1	Line 4 "Mycrobactrium"
Page 8	Meat and Other Foods Course - Line 1 to read "...The names of all applicants have been submitted ..."

REVIEW OF NOTES/INFORMATION SHARED

ACTION 1 Surveillance at Airports: A meeting was scheduled for April 1, 1997. Representatives from the Quarantine Division will be attending.

ACTION 2 Estimate on Cost to Repair WISPH Building: Ms Limonius stated that the building was assessed and an estimate is awaited.

ACTION 3 Workshop on Data Collection: Mr. Watson stated that discussions were held with the PWR/PAHO on the matter. The date for the workshop is to be arranged.

ACTION 4 Desalination Plant - Pedro Cays: Mr. Watson stated that specifications were obtainend. In terms of the cost , the size plant will have to be first decided..

- Re Markets - St. Catherine Mr. Watson stated that no further report was received on the fish vending area of the **Spanish Town Market.**
- The **Linstead Market** has been closed. However, consideration was being given for the market to be re-opened. Additional funding is needed to effect repair work to the meat vending section; the holding area for solid waste; and the leaking roof.
- The St. James Abbatoir - remains closed.
- Aircraft Spraying: Mr. Brown stated that information is still being sought on the exact location in Panama where the insecticide is to be obtained.
- Chicken Pox: Mr. Clarke stated that this would not be termed an outbreak ,

REPORTS

1. HANSEN'S DISEASE/TUBERCULOSIS CONTROL

Mr. Erwin reported:

1.1. Re: Hansen's Disease: Six (6) Dermatology Clinics were conducted in February, 1997. The number of clients seen and examined total 115. Two (2) HD patients were evaluated - one of whom had completed chemotherapy and put under surveillance,while the other resumed treatment. The latter patient had defaulted in December, 1996.The register shows 25 active cases i.e. 23 (92%) are multi-bacillary and 2 (8%) paucibacillary.

Supplies of Dapsone are available.

1.2 Re: Tuberculosis:Fifteen (15) suspected cases of Tuberculosis were reported for February, 1997, giving a cumulative total of 35 for 1997. Thirteen (13)suspected cases of TB had lab/radiographic investigations completed, 10 of which were confirmed, 3 discarded.

The cumulative total was 26. From that figure, 19 (73%) community case investigations have been initiated; 7 (27%) is pending. Of the 19 initiated 7 were completed while 12 were incomplete.

2 ENVIRONMENTAL HEALTH

Mr. Knight reported:

Veterinary Public Health

2..1.1. Milk Sanitation Programme: Routine collection, submission and analysis of milk samples for bacteriological and chemical examination continue. The non-participation of some parishes continue to deflect from the effective monitoring of the programme. Improvemennts noted in returns from Serge Island Dairy Processing Plant.Lab reports continued to show marked improvements also the physical infrastructure of plants. This is due to public health intervention at national and parish levels.
The St Catherine Health Staff conducted a one-day workshop for owners and dairy workers in the at Parish.

2.2. Mr. Watson reported on the following -

- Staff Changes in Inspectorate
- HEART/NTA - this initiative to be approved by HEART/NTA Board
- Healthy School Initiative - Concentrated effort is being made to obtain environmental health status reports on all unsatisfactory primary and all -age school

s.

- Italian Cooperation in Health - Phase 3 begins in April, 1997 and will comprise: Computer training, vector control, disaster preparedness,acquisition of computers and other office equipment, District Health Information System.

-

2.3. Parish Highlights

Mr. Fuller reported that activities were focussed on the agreed programme areas of -

- Food Safety
- Meat Inspection
- Water Quality including waste water
- Institutional Health - Work on lock-ups in Kingston & St. Andrew continues.
- General sanitation and dialogue has begun between At. Ann Health Department and UDC re sanitary condition at Faith's Pen Arcade and the Dunn's River Falls Resort

-

Vector Control -activities are still low-keyed due to lack of funds. Indices
Special allocation was made to St. Ann after submission of a "SOS" estimate.

- Port Health - Reports obtained indicated 73% compliance in aircraft disisection.
- Reports received from 11 health departmets.

2.4. Quarantine

Mr. Brown reported:

2.4.1 Airports

Norman Manley - Total number of direct flights 298 of which 73% were sprayed. 71% of the baggage compartment of such aircrafts were sprayed by the PHIs.

Donald Sangster - Total of 762 flights arrived and were sprayed (501 residual and 261 inflight).

2.4.2 Seaports

Vessels arrive in the folllowing ports -

Kingston Waterfront	156
Pt. Esquivel	7
Rocky Point	5
Pt. Kaiser	6
Pt. Antonio	17
Ocho Rios	21
MontegoBay	60

2.4.3 Other matters reported on were the issuing of 13 Deratting Exemption Certifictes; Food Inspection and Refuse Disposal. A total of 1,429 persons were put under surveillance from the Norman Manley Airport; 432 from Donald Sangster; 323 from Montego Bay Ship Pier and 2 from Ocho Rios.

2.4.4. Death on Board ship: Three (3) persons died on board ship. The bodies were all kept on board in the vessel in Montego Bay.

3. MATERNAL & CHILD HEALTH.

Dr. Robinson reported:

3.1.. Immunization The Epi Report for January - December, 1996 reveal coverage for under
1 year olds -

BCG	98.3%
OPV	91.9 % under 1 year old

OPV + DT 91.6%

Coverage for under 2 years old -
MMR/Measles coverage 99.3%

Targeted interventions are being proposed so as to increase immunization coverage in the parishes of, St. Elizabeth, St. Thomas , Trelawny, and KSA.

Other areas reported on included the Management of Vaccines; and Breastfeeding making all hospitals babyfriendly by March 1998, and the monitoring of the 1996 Babyfriendly- certified hospitals on a quarterly basis.

3.2 Children's Services

3.2.1 Ms. Hemmings reported that a meeting of Superintendents of Government Child Care institutions was held in February, 1997 to plan and set objectives for 1997.

3.2.2. Re Office Accommodation: Two (2) rooms have been secured at the Princess Margaret Hospital to house the office of the CSD in St. Thomas.

3.2.3 Re Health Care: Reports have been received that health care personnel now visit the child care institutions. Children'sOfficers in the parishes have been directed to make contact with SMOs(H) whenever necessary.

2.2.4. HIV/AIDS: Two (2) of the eight(8) confirmed cases of AIDS reported on previously have been retested and results are negative. Another child has also been tested negative.

A meeting is to be held with Dr. Figueroa, PMO (Epi) to discuss the proposed establishment of facility for children with AIDS.

3.3. Nutrition

Mrs. Rainford reported:

3.3..1 Nutritional Status of Young Children: Four (4) parishes - Kingston and St. Andrew, St. Thomas, St. Mary and St. Catherine had an average prevalence rate of 70% which is significantly above the national average. The remaining parishes with prevalence below the national average ranged from 1.9% to 5.4%.

In 1996 there was a 46.9% reduction in admission for malnutrition over 1993 figures. The 6 - 11 and 12-23 months age groups recorded the largest proportion of admissions for malnutrition - 49.4%.

Other areas highlighted were Supplementary Feeding; Iron Fortification of Cornmeal by Seprod ,and the appointment of a Nutritionist from the F.A.O. Office in Kingston to develop a progress report in collaboration with other relevant persons on the prevailing themes from the International Conference on Nutrition .

3.4. Nursing

Mrs. Fennel reported that the parishes continued their annual evaluation and review of activities and achievements of 1996, and goals and targets set for 1997.

Other areas reported on were - service delivery; staffing; transportation and poor working conditions.

WISPH

Ms. Limonius resprted that the programmes undertaken by the school were going on satisfactorily.

Recruitment Eighteen (18) applications for the Nursing Course were received. Interviews tobe held in April, 1997.

Meat & Other Foods Course

Sixteen (16) applications received. Interviews to be held.

Other highlights were on - Sports (scheduled for March 26, 1997)
- Stafling - Executive Officer recuperating after surgery
- Mrs. Thelwell-Reid still on leave.

5.. PROJECTS

Dr. Ducasse reported:

5.1 Chronic Diseases:The activities of the programme continue with emphasis on developing a comprehensive national programme, utilizing health promotion strategy..

5.4. Report - Annual Conference on Diabetes & Nutrition

The 3rd Annual Conference was held from February 27-March 2, 1997 at the Jamaica Grande Hotel, Ocho Rios. Sixteen (16) MOH staff members who were recommended by primary care and sponsored by PAHO attended. .

The main objectives wer to enable participants to discuss the ew classification of Diabetes Mellitus and the method of monitoring and to review the nutritional guidelines for diabetes management in infancy, adolescence and adulthood.

5.5. Emergency Medical Service (EMS) - programme continues to operate in four (4) sites in Western Jamaica. The fifth site in Phase 1, Lucea Fire Station, will be launched by June 1997.

5.7 Social Sector Development Project (SSDP) - Two (2) facilities still undergoing construction - Mandeville Type IVand Mocho Type 2, including 2-betroom staff quarters, are scheduled for completion in March and May, 1997, respectively.

5.8. Restoring Inner-City Society(RISE) Programme' Implementation continues in KSA. JS9.6 million has been approved for vector control,latrine construction and CHA training. whichh starts in April 1997..

5.9 Disaster Management Regular monthly meetings of the MOH Disaster Managment Committee and the Health Sub-Committee of the National Disaster Committee continued in February,1997. The emphasisfor the 1st quarter - Jan - March 1997 is safety in the workplace and home and a presentation on Fire Safety and Procedures for planning and holding a Fire Drill was done by the Jamaica Fire Prevention Services.

6. Epi Update

Mr. Clarke reported :

Measles - To date (March 13) a total of 41 cases of suspected measles was reported from the parishes. Lab results indicated all beuing negative for measles and 18 cases (45%) positive for rubella. Sixteen (16) of the rubella cases were reported from Westmoreland and the other two (2) from Kingston and St. Andrew.

Typhoid - The occurrence of cases for 1997 reported

St. James 1 confirmed case (died)
St. Catherine 1 suspected
Westmoreland 2 suspected

Investigations are being carried out.

Fever A slight rise in the number of cases was seen in KSA, Hanover and Clarendon but the island profiled a declining trend.

Gastroenteritis - In the GE cases<5yrs. there was a significant increase in the number of cases reported from most parishes and in particular St. James and Manchester.A constant rise and fall persist in the > 5 age group. The rota virus has been isolated from specimens from KSA, St. James and Manchester.

7. General Update

Dr. Fuller reported on the following -

- Italian Health Project - activities are being re-instituted
- Opening of Porus Health Centre - 28/2/97
- Upcoming Annual Reviews - KSA held 12/3/97
- Appreciatioon was being shown to Mrs. Eileen Bernard who had retired in recent times. a gift was given her on behalf of the Primary Health Care Team.

8. NOTICES

1. Annual Hansen's Disease Workshop was held at the Terra Nova Hoted on February 26, 1997.
2. World TB Day - March 24, 1997. A number of activities have been planned and will be duplicated during World Health week - 1997
3. Epi Unit preparing draft presentation of diseased for exhibition and press release during World Health Week

ACTION SHEET

1.	To take forward the matter of procedure consumers to follow regarding faulty food items	Dr. Fuller/Mr. Watson
2.	To appraise Dr. Peters/Dr. Fuller on queries regarding the bruscellosis programme	Mr. Knight
3.	To prepare a report on the general status of incoming vessels	Mr. Brown

APPENDIX I

PRIMARY HEALTH CARE
SPECIFIC OBJECTIVES OF ACTIVITIES

1996/97

OBJECTIVES

1. OVERALL: To ensure that all primary care services are functional, accessible and equitable fo all

Specific Objectives:-

1. MANAGEMENT/COORDINATION AND BUDGET

i) To monitor the per caption US dollar allocation to Primary Health Care (PHC) over time and advocate for increased allocation to PHC (including family planning).

ii) To develop mechanisms for public/private collaboration in Primary Health Care.

iii) To ensure suitably trained technical staff are recruited, orientated and placed in key positions and locations.

iv) To strengthen communication, tehnical and managerial capacity at all levels.

v) To ensure that Primary Health Care Programmes undergo Monitoring and Evaluation cycle.

a) To hold and participate in at least one programme review/evaluation exercise in each parish during the year.

b) To hold and participate in PHC Senior Supervisory/ management meetings in order to monitor the programmes.

c) To institute a computerized Environmental Health System and review the present MCSRS a monitoring and evaluation tool.

d) To review some Primary Health Care indicators eg MCH, Women's Health, Family Health and improve their appropriateness and validity.

vi) To improve the Primary Health Care infrastructure so as to enhance the delivery of services

2. MATERNAL AND CHILD HEALTH/FAMILY PLANNING .

(i) Immunization

To achieve and maintain 100% coverage of children under one year old with the vaccines: BCG, DPT, OPV; for the under two year olds - 100% coverage with the MMR vaccine.

ii) ANTE-NATAL/INTRA NATAL CARE

To improve the quality and coverage of ante-natal and intra-natal care, in particular to

a)increase the proportion of pregnant women initiating ante-natal care by 16 weeks gestation (first tremester) from 20% to 80%.

b)To increase the average number of visits made by pregnant women to a health facility from 4 to 5.

c)To increase the coverage of pregnant women to receiving tetanus toxoid vaccination from 61% (1996) 80%.

d)To increase the proportion of pregnant women visiting health centres screened for Sphyllis from from 67% to 75%.

e)To increase home deliveries from 5% to 20%

f)To ensure that all newborns receive prophylactic (Silver nitrate) eye drops

(iii) POST NATAL

To improve post-natal coverage from 69.9% to 75% and acceptance of family planning methods by clients attending this service from 61.2% (1995) to 75%.

(iv) FAMILY PLANNING

To support and contribute to the increase in contraceptive prevalence rate (CPR) of 1% per annum in the 15-49 year age group (CPR now eestimated at 63.8% in 1993).

V NUTRITION

a)To increase fully breast-fed babies at six weeks old from 51.7% to 60%.

b) To implement Baby Friendly Hospital Initiative and certify 9 Hospitals (6 public and 3 private), then extend to other hospitals

c)To reduce iron deficiency ananemia in ante-natal mothers from 17% to less than 10%.

d)To reduce severe malnutrition to less than 0.3% of children under 3 years.

3 ENVIRONMENTAL HEALTH

i) To increase access to safe, potable water

ii) To improve food-handling practices and ensure that standards are adhered to by food establishments (restaurants, hotels, markets etc) to a level of 70%.

iii) To increase the proportion of satisfactory excreta disposal/latrine facilities fromm 55% to 70%.

iv) To monitor and seek to improve the health status of public institutions eg schools, Places of Safety, prisons and hospitals.

vi) To achieve and maintain an average Aedes Aegypti index of less than 5% generally and 0% at ports of entry - (i.e airports).

vii) To respond appropriately to all reported cases of malaria within 24 hours of notification.

viii) To monitor the implementation of the amended Quaratine Regulation regarding aircraft spraying.

4. CHRONIC DISEASE

i) To establish Registers in Types 3-5 health centres for diabetes and hypertension.

ii) To establish baseline and increase the proportion of diabetics and hypertensives who are controlled at clinic visits by 10%.

iii) To implement special health education/promotion intervention through the Chronic Disease Committee.

iv) To improve screening and monitoring of cancer prevalence and incidence, islandwide.

6. DIARRHEOAL DISEASE

i) To maintain the admission rate and case fatality rate to less than 1%.

ii) To increase access to Oral Rehydration Salt from 80% (for the under 5 year olds) to 100%

7. TUBERCULOSIS CONTROL

i) To develop and put in use a protocol for the management of Tuberculosis at all levels of health care.

ii) To initiate field investigation for 90% of under cases within 7 days of notification to Epidemiology Unit.

iii) To complete field investigations pertaining to 80% of the index cases within 6 weeks of commencing investigation.

8. HANSEN'S DISEASE

i) To increase case-finding by 20%.

ii) To initiate treatment of 80% of all Hansen's Disease cases before the occurance of deformities.

(iii) To achieve 80% drug compliance with multidrug therapy(MDT).

v) To increase staff awareness and attitude towards Hansen's Disease clients.

9. RHUEMATIC FEVER PREVENTION

i) To increase the penicillin prophylaxis coverage from 60% to 75% of rheumatic fever cases on register.

10. ADOLESCENT HEALTH

i) To designate Regional Focal Points for adolescent Health.

ii) Each parish to produce an Adolescent Health Plan of Action.

iii) Adolescent Health Policy to be finalized.

iv) To obtain intersectoral awareness and support for Adolescent Health.

11. DENTAL HEALTH

i) To increase dental health education in health centres, schools and communities.

ii) To increase the number of prevenitve procedures completed in dental clinics to 70,000.

iii) To monitor and support the maintenance of optimum fluoridation of salt.

12. CHOLERA PREVENTION

(i) To continue to increase the awarness, knowledge and involvement of community in Cholera Prevention and preparedness.

ii) To contribute to the improvement in sanitary status of the parishes through construction of latrines, toilets, public sanitary conveniences etc.

13. DISASTER PREPAREDNESS

i) To update parish disaster preparedness plans, including "call out" list.

ii) To conduct one disaster simultation excerise per Region per year.

iii) To have Parishes represented at all parish disaster committee meetings.

iv) To inspect and seek to improve all Disaster Shelters at least once per annum.

14. WOMEN/GENDER HEALTH AND DEVLOPMENT WHD/GHD

i) To sensitize senior directors and the political directorate re gender issues.

ii) To identify or re-confinn one focal point for WHD/ GHD in each Region.

(iii) To have each parish develop WHD/GHD plans

(v) To include gender-disaggregrated data collection system in the MCSR.

vi) To explore issues relating to men's health.

15 HEALTH EDUCATION/PROMOTION

i) To collaborate with the Bureau of Health Education in developing concepts and an approach to promoting healthy lifestyles.

ii) To revive community health committees and re-institute 50 such committees and/or subcommittees of other groups.

iii) To institute a healthy parish initiative using health promotion as the main strategy to improve health.

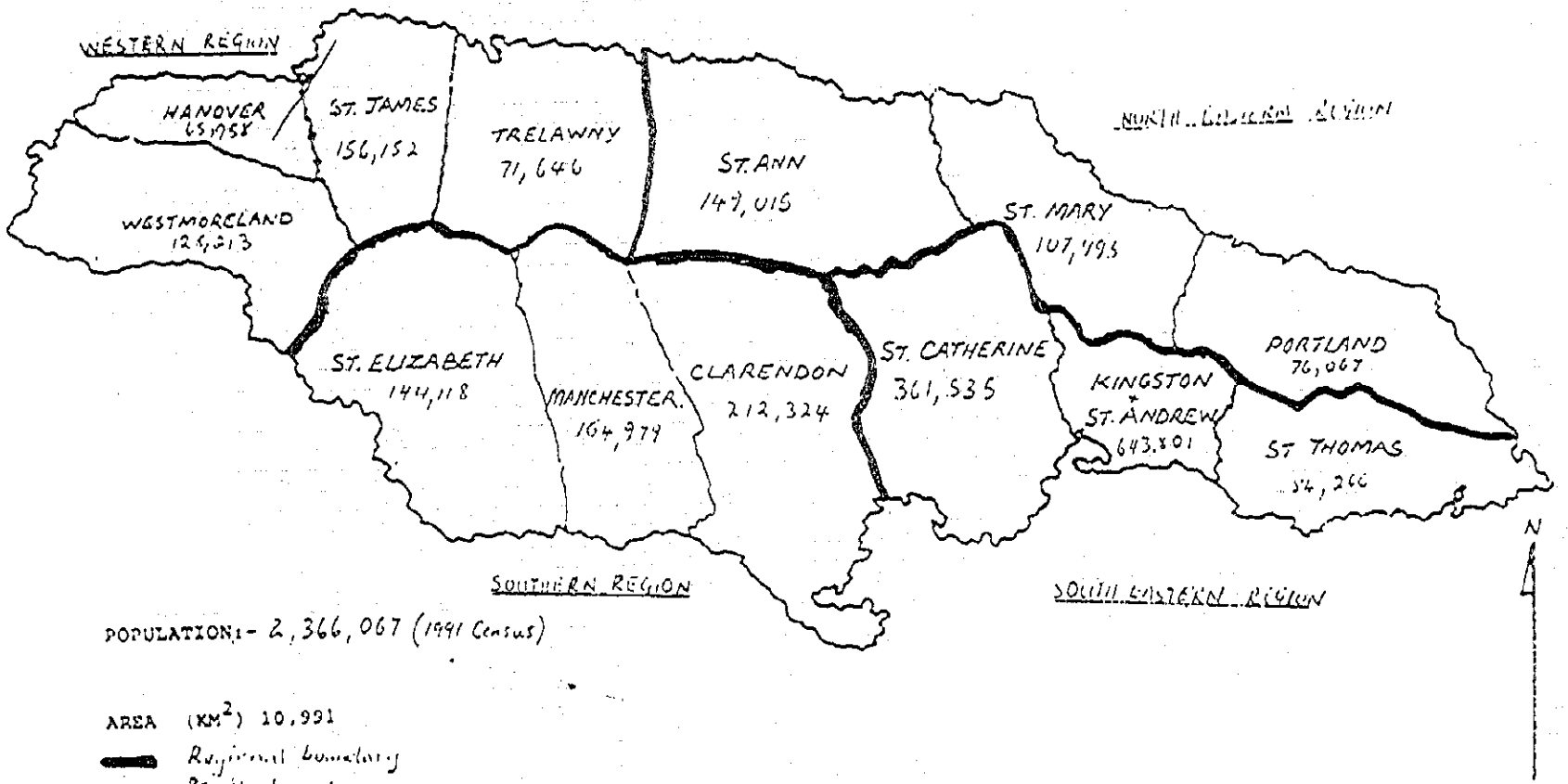
PRIMARY HEALTH CARE VISION

A SOCIETY IN WHICH ALL PERSONS PRACTICE HEALTHY LIFESTYLE IN ALL ASPECTS OF LIFE AND ACTIVELY PARTICIPATE IN THEIR OWN HEALTH CARE, SUPPORTED BY AN OPTIMALLY FUNCTIONAL PUBLIC HEALTH SYSTEM

THE PRIMARY HEALTH CARE MISSION

TO PROMOTE HEALTHY A LIFESTYLE , PREVENTION AND EARLY DETECTION OF DISEASES , PROVISION OF CURATIVE AND REHABILITATIVE SERVICES WHILE FACILITATING COMMUNITY PARTICIPATION AND INTERSECTORAL COLLABORATION. SERVICES ARE PROVIDED THROUGH A NETWORK OF FACILITIES AND EVENTS THAT ARE ACCESSIBLE, APPROPRIATE, COST-EFFECTIVE AND AFFORDABLE TO THE POPULATION.

MAP OF JAMAICA



POPULATION:- 2,366,067 (1991 Census)

AREA (KM^2) 10,991

Regional boundary

Parish boundary

DISTRIBUTION,NUMBER,PERSONNEL,CATCHMENT AREA,SERVICES PROVIDED AT ALL LEVELS OF THE PRIMARY HEALTH CARE SYSTEM

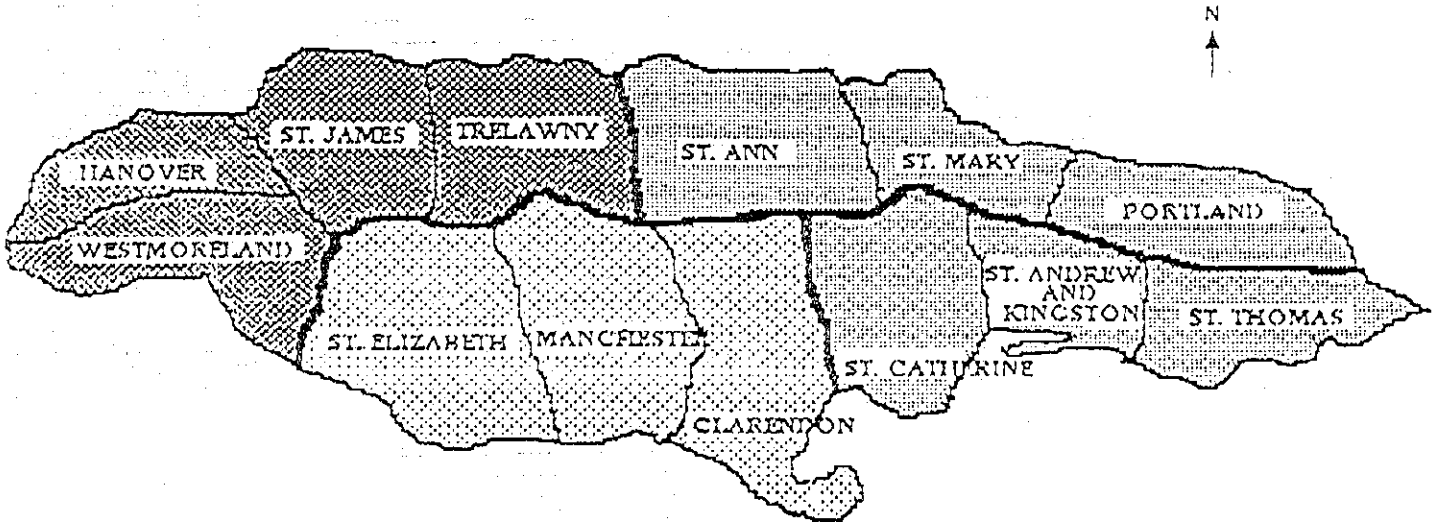
TYPE OF SERVICES HEALTH CENTRE	NO.	LEVEL OF PERSONNEL	CATCHMENT POPULATION	
TYPE 1	200	MIDWIFE 2 CHAs	4,000 -5000	MCH,HOME VISITS
TYPE 2	89	PHN, PHI,RN, VISITING DMO AND DENTIST DENTAL NURSE	10,000 - 12,000	CURATIVE, PREVENTIVE PROMOTIVE
TYPE 3	76	DMO, NP, DENTIST PLUS TYPE 2 SERVICE	12,000- 30,000	CURATIVE AND PREVENT.
TYPE 4	6	COMBINATION OF TYPE 3 AND PARISH OFFICE	PARISH	TYP3+ADMIN.
TYPE 5	3	FULL STAFF, VISITNG SPECIALISTS	DENSELY URBAN	COMPREH-ENSIVE SERVICE

MAP OF JAMAICA

BY PARISH AND HEALTH REGION

WESTERN REGION				
PARISH	POPULATION (1994)	HOSPITALS		PRIMARY HEALTH CARE FACILITIES
		PUBLIC	PRIVATE	
TRELAWNY	74,300	1	-	21
ST. JAMES	168,200	1	2	26
HANOVER	66,900	1	-	19
WESTMORELAND	131,700	1	-	22

NORTH EAST REGION				
PARISH	POPULATION (1994)	HOSPITALS		PRIMARY HEALTH CARE FACILITIES
		PUBLIC	PRIVATE	
PORTLAND	78,900	1	-	21
ST. MARY	114,600	2	-	32
ST. ANN	155,700	1	-	22

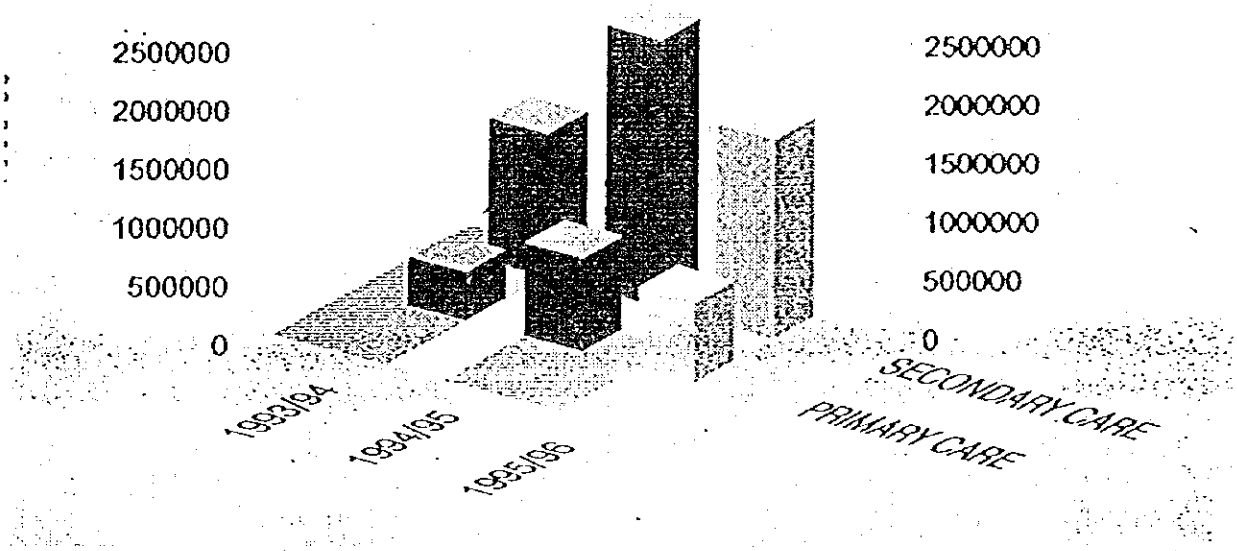


SOUTHERN REGION				
PARISH	POPULATION (1994)	HOSPITALS		PRIMARY HEALTH CARE FACILITIES
		PUBLIC	PRIVATE	
ST. ELIZABETH	147,100	1	-	30
MANCHESTER	176,400	1	1	28
CLARENDON	223,900	3	-	46

SOUTH EAST REGION				
PARISH	POPULATION (1994)	HOSPITALS		PRIMARY HEALTH CARE FACILITIES
		PUBLIC	PRIVATE	
ST. CATHERINE	374,300	2	-	26
ST. ANDREW & KINGSTON	707,100	8	6	49
ST. THOMAS	89,900	1	-	19

PREPARED BY : PLANNING AND EVALUATION UNIT, MINISTRY OF HEALTH
APRIL, 1996

ECURRENT BUDGET FOR RIMARY AND SECONDARY EALTH CARE.1993/94 -1995/96



STATUS OF EMPLOYMENT OF SELECT PRIMARY HEALTH CARE STAFF, ISLANDWIDE, SEPTEMBER 1995

CATEGORY	CADRE	IN POST	VACANCIES	
			NO	%
Registered Nurse(RN)	591	314	227	47
Midwives	382	152	225	59
Nurse Practitioners	68	60	8	12
Enrolled Assistant Nurse	84	55	29	35
Community Health Aide (CHAs)	563	790*	-	-
Public Health Inspector	451	280	171	38
Dentists	60	57	3	5
Dental Auxilaries	155	149	6	5
Health Educator	45	18	27	60
Medical & Public Health Doctors	102	85	17	17

*Excess of 227 CHAs employed compared with no of posts. A total of 1,200 posts for CHA is thought to be ideal for the country.

TABLE 6: REASONS FOR VISITS TO HEALTH CENTRES - 1991 - 1996

Year	Total Visits	Reasons for Visits as % of Total visit					
		Ante-Natal	Post - Natal	Child Health	Family Planning	Curative	Dental
		%	%	%	%	%	%
1991	1984774	8.3	5.7	19.4	17	39.4	10.3
1992	1932510	7.7	4.2	10.2	13	45.5	10.6
1993	1752956	9.6	4.9	19	11.7	44.5	10.4
1994	1688877	10	2.6	19.6	12.3	44	11.4
1995	1695287	9.5	2.5	19.2	11.3	44	11.4
1996							

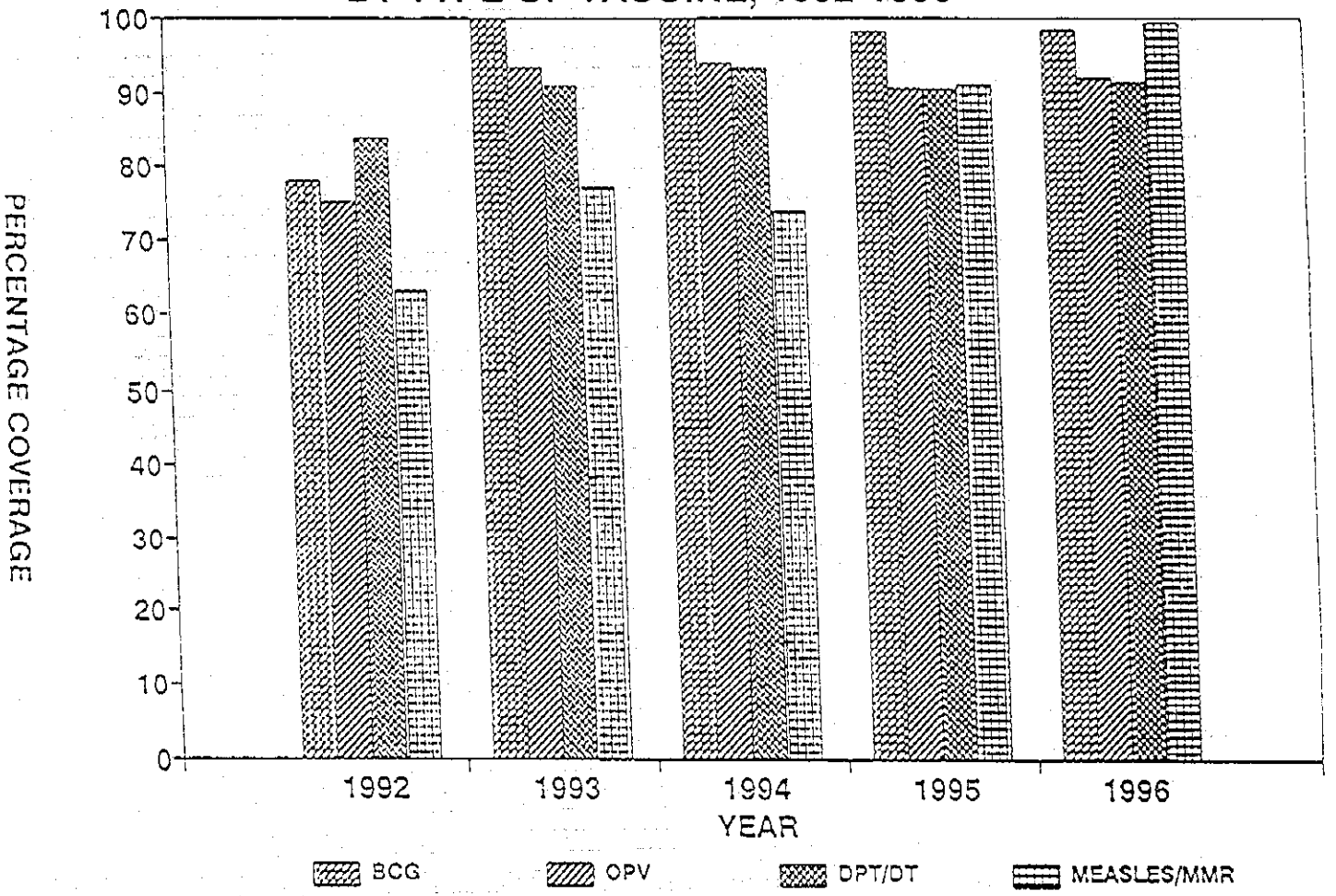
TABLE 7: REASONS FOR CURATIVE VISITS 1991 - 1996

Year	Total No Cur. Visits	Reasons for Curative Visits as % of Total									
		Diab.	Hypr	Resp	Mus/ Skin	STD/ PID Gyna	Dres etc	G E	Psy	Skin	Oth.
1991	905.860	5.7	14.5	8.9	7.3	8.6	30.8	1.5	1.6	5.4	32.0
1992	879,909	5.6	13.7	7.8	6.7	.9	29.5	1.9	1.4	5.6	32.6
1993	780,687	5.8	14.3	8.4	7	9	27.1	1.2	1.7	8.5	34.4
1994	743,495	6.3	14.9	6.4	7	9.7	25.4	1.6	1.9	8.5	33.2
1995	780,520	5.9	13.6	10.6	7.1	7.4	24.5	1.6	1.87	7.4	31.0
1996 (Proj)*	885,000 ?	6.5	14.9	11.0	7.3	9.5	25.6	1.9	1.9	8.2	30.2

IMMUNIZATION (%) COVERAGE
1992 - 1996

VACCINE	*1992*	*1993*	*1994*	*1995*	*1996*
DPT	*82.3*	*91*	*92.6*	*90.5*	*91.6*
OPV	*74.2*	*93.3*	*93.1*	*90.6*	*91.9*
BCG	*85.4*	*100*	*100*	*98.1*	*98.3*
MEASLES/ MMR	*63.3*	*72*	*82.4*	*91.1*	*99.3*

FIG. 1: % IMMUNIZATION COVERAGE
BY TYPE OF VACCINE, 1992-1996



Target group for BCG, OPV, DPT ------ 0 - 11 months Target group for Measles/MMR --- < 2 years ld

Source: Prepared by PIOJ from data provided by HEU, MOH

CASE DETECTION FOR AIDS AND TUBERCULOSIS

NUMBER OF CASES

YEAR	TUBERCULOSIS	AIDS
1990	110	62
1991	121	134
1992	111	100
1993	115	236
1994	109	359
1995	109	505
JUNE 1996	48	236

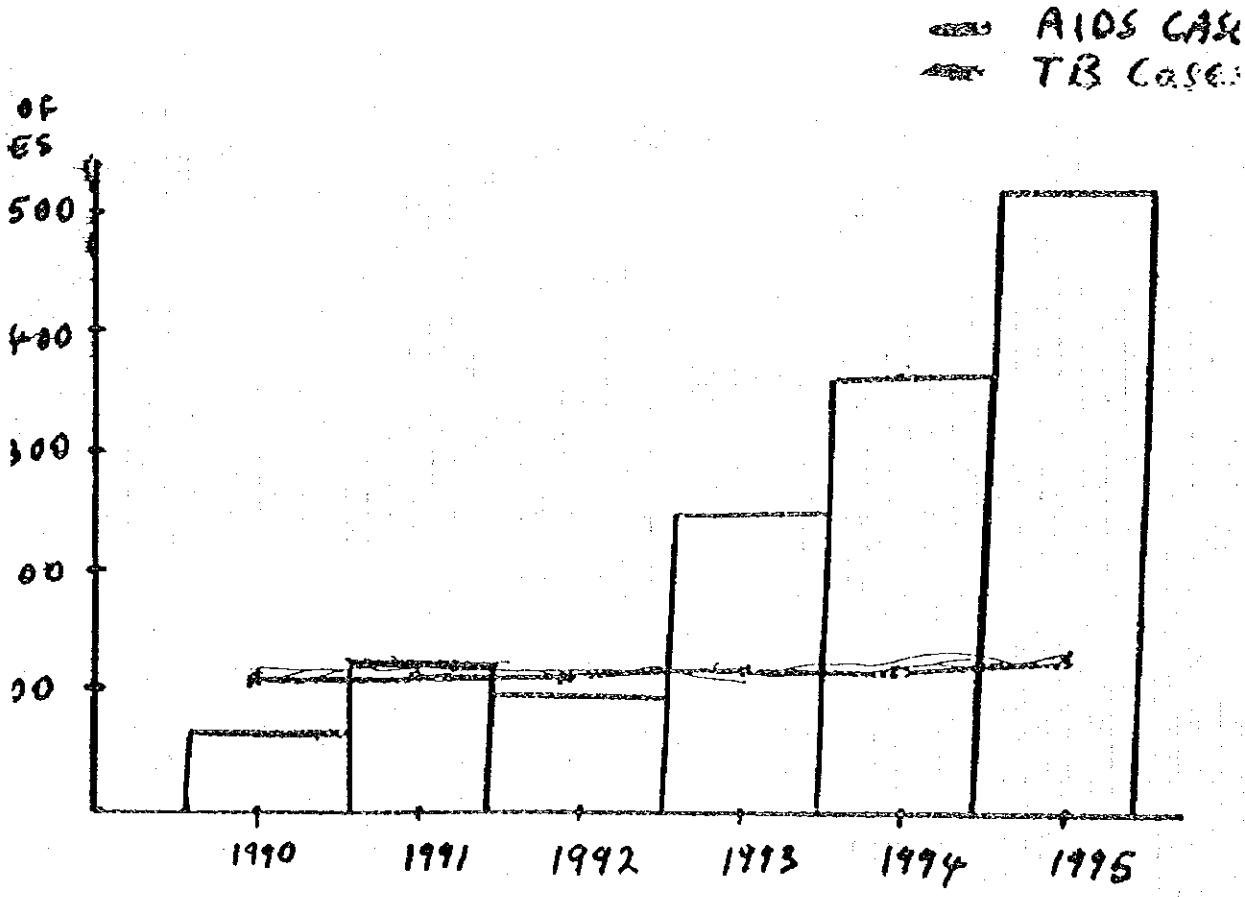


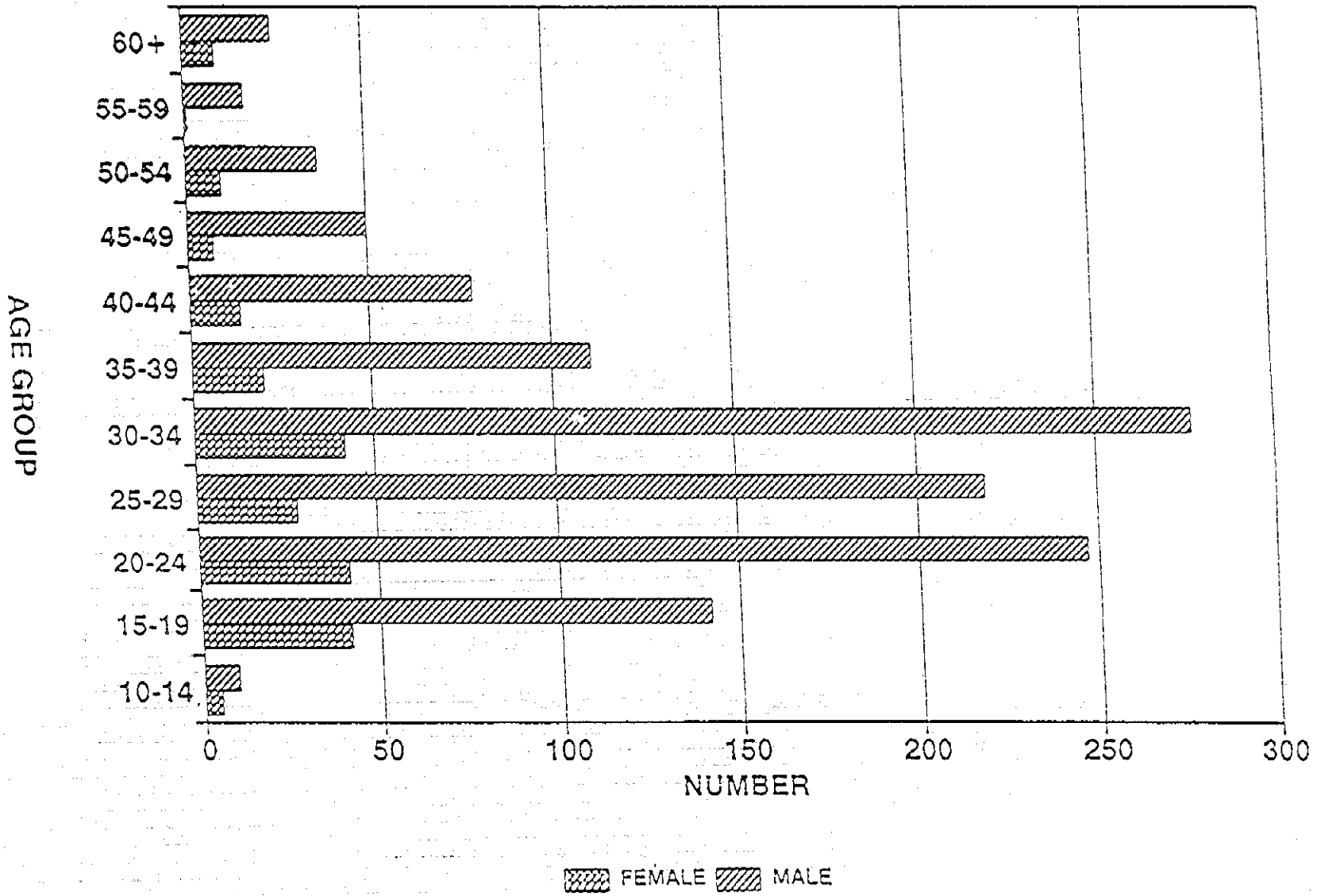
TABLE 3: CASE DETECTION OF TUBERCULOSIS AND AIDS 1985 - 1996

Disease	Year									
	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Tuberculosis	133	102	104	110	121	111	115	105	109	121
AIDS	32	30	64	62	134	100	236	359	505	527

TABLE 4: DETECTION OF TUBERCULOSIS/HIV CO-INFECTION - 1992 -1996

YEAR	NO. OF TB/HIV CO-INFECTION
1992	0
1993	5
1994	7
1995	7
1996	12

FIG22.2 AGE GROUP OF PERSONS WITH DRUG PROBLEM BY SEX



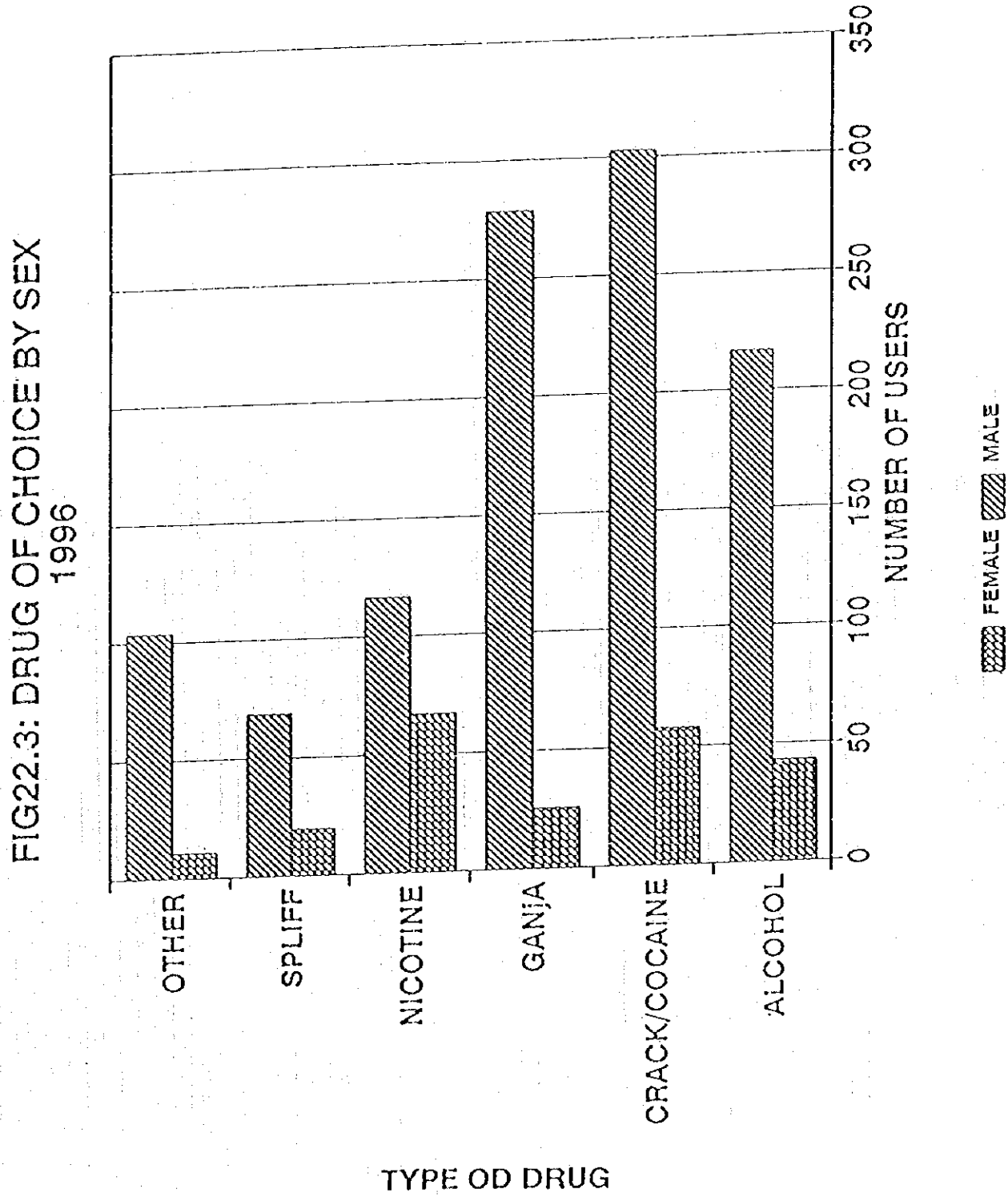


FIG22.3: DRUG OF CHOICE BY SEX
1996
OTHER
SPLIFF
NICOTINE
GANJA
CRACK/COCAINE
ALCOHOL
0
50
100
150
200
250
300
350
NUMBER OF USERS
FEMALE
MALE
TYPE OD DRUG

FAMILY PLANNING - 1995

- USE OF PILL - 17.5%
- DEPOPROVERA INJECTION - 64%
- FEMALE STERILIZATION - 5%
- MALE " - 5%
- IUCD - 8.6 %

1995

ACHIEVEMENTS OFTARGETS

- FIRST TRIMESTER - 24%
- NO. OF VISITS PER PREGNANCY - 80% 3-4
- TETANUS VACCINATION IN PREGNANCY - 76%
- WOMEN TESTED FOR SYPHILIS - 89.5%
- HOME DELIVERIES 27% -

FINDINGS OF THE WATER AND SANITATION MONITORING SYSTEM

RESEARCH
ISLANDWIDE

(WASAMS)

SAFE WATER

- ACCESS TO SAFE WATER BY 98% OF POPULATION IN URBAN AREAS

- ACCESS TO SAFE WATER BY 69% OF THE POPULATION IN RURAL AREAS

- AN AVERAGE OF 84% OF THE POPULATION ACCESS SAFE WATER

- 16% OR 401,569 PERSONS DO NOT HAVE ACCESS TO SAFE WATER

    - OF THIS A PROPORTION OF 12% ACCESS UNSAFE WATER
    - 4% DO NOT HAVE ACCESS TO ANY REGULAR SUPPLY OF WATER

FINDINGS OF THE WATER AND SANITATION MONITORING SYSTEM
RESEARCH
ISLANDWIDE

(WASAMS)

EXCRETA DISPOSAL

- EXCRETA DISPOSAL 94.7% OF THE POPULATION HAVE ACCESS TO SATISFACTORY EXCRETA DISPOSAL FACILITIES THAT HYGIENICALLY SEPARATES EXCRETA FROM HUMAN CONTACT

    - 10% OF THESE (MAINLY PIT LATRINES) USED BY 261,705 PERSONS NEED REPAIRS

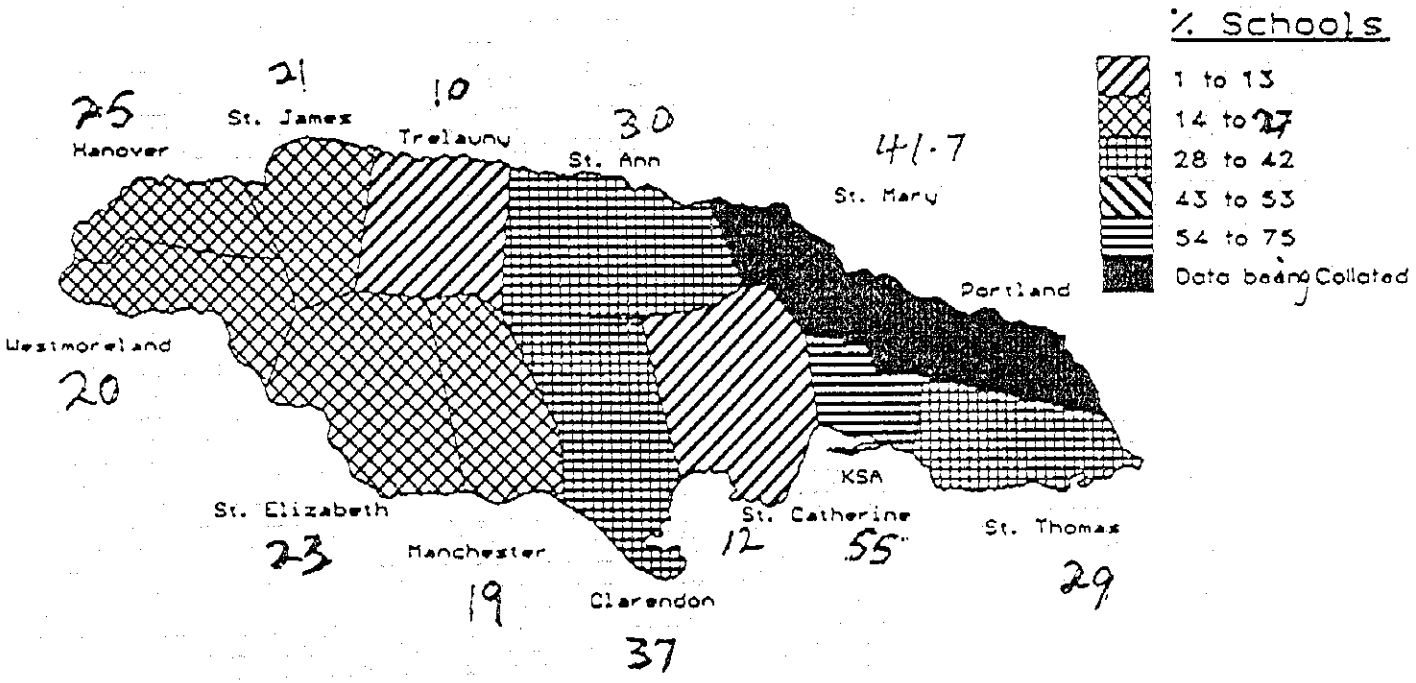
    - 5.3% HAVE UNSATISFACTORY FACILITIES

- 54% OF THE POPULATION IS SERVED BY WATER CLOSETS

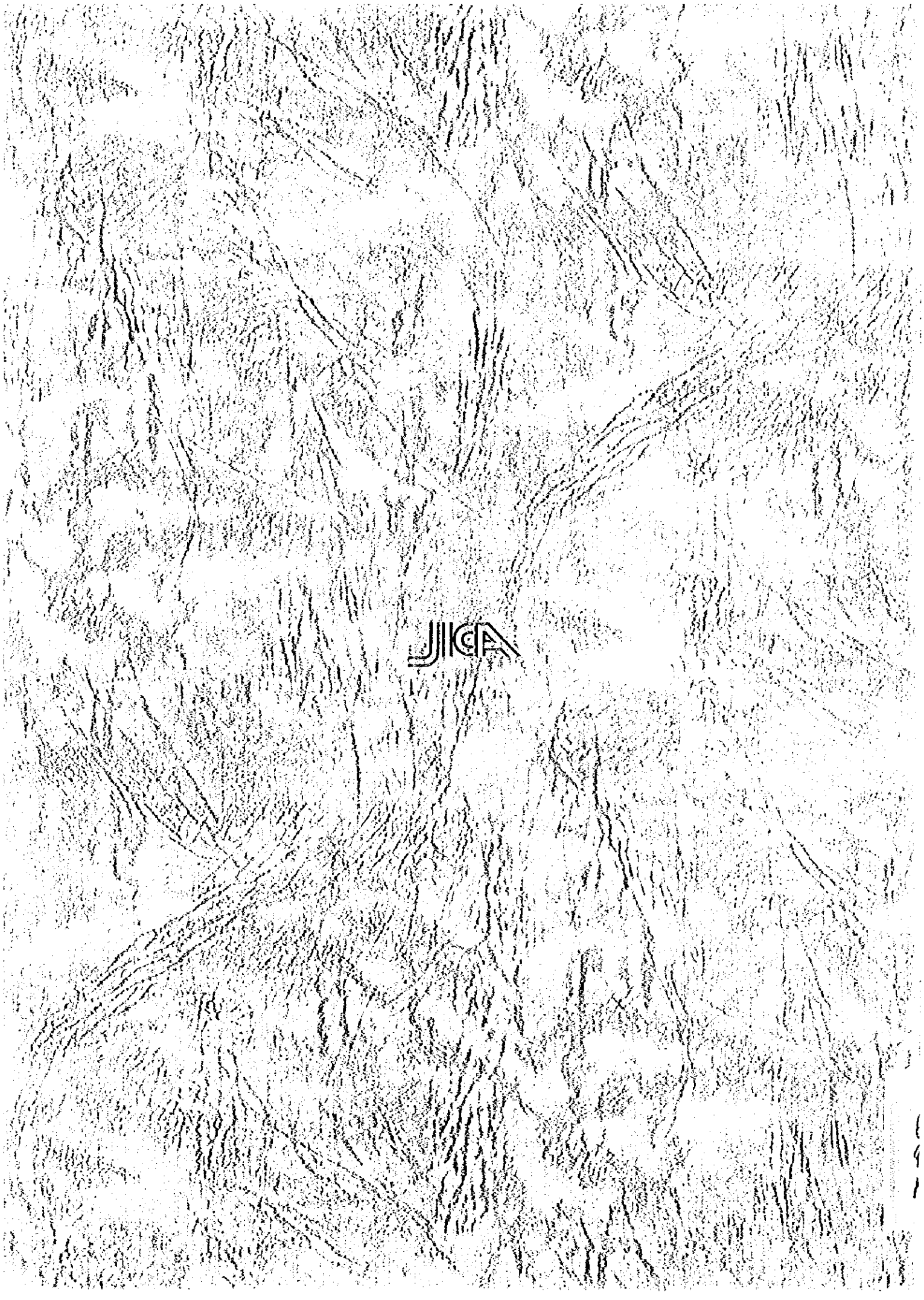
- 40% OF THE POPULATION IS SERVED BY PIT LATRINES.

JOINT EVALUATION REVIEW

Percentage of Schools with Un-Satisfactory Health Conditions



Joint Evaluation Review
PAHO/WHO and MOH Jamaica
Kingston, Jamaica W.I.
Nov 1988


JICA