Approaches to primary health care in the Commonwealth Caribbean

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BACKGROUND

The Commonwealth Caribbean comprises many English-speaking countries widely scattered in the middle America region from the Commonwealth of The Bahamas in the north to the Republic of Guyana in the south; and from Belize in the west to the Leeward and Windward Islands chain in the east, Barbados being the most easterly island. Though it represents a relatively small landmass, the countries extend over a considerable segment of Western Hemisphere, from $1^\circ$ to $10^\circ$ north latitude and from $57^\circ$ to $90^\circ$ west latitude. Several of the countries are over 1,000 miles apart; the total population is about 5 million, of which Jamaica alone has about 2 million scattered over an area of 4,411 square miles; and more than half the population lives in rural areas.

HEALTH PROBLEMS OF THE COMMONWEALTH CARIBBEAN COUNTRIES

Poor environmental sanitation is one of the most important health problems resulting in an incidence of communicable diseases in the region. Mothers and children under 15 years of age make up 65 per cent of the entire population and rates of illness and death in this group are high. Sexually transmitted diseases, diabetes, hypertension, mental illnesses, and dental diseases are some of the important problems in the forefront. There is lack of knowledge and of a sense of responsibility and participa-

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2 Deceased. See p. 248.
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tion in community health. Moreover, there are serious weaknesses in the management of health services, in the availability of trained staff, and in the supply and maintenance of health care facilities.

Up to about two decades ago, the infant mortality rate, which is a good index of the health of the community, was on the order of 100 infant deaths per 1,000 live births in many of the Eastern Caribbean Islands, e.g., St. Vincent, 132 (1960); Montserrat, 114 (1961); Dominica, 116 (1961); St. Kitts-Nevis-Anguilla, 101 (1961); and Saint Lucia, 103 (1962). Around that time, there was a great thrust for the improvement of health care for children. The Faculty of Medicine, University of the West Indies (UWI), and Pan American Health Organization/World Health Organization (PAHO/WHO) worked closely with several governments. By 1964, infant mortality rates were reduced to 75 in St. Vincent and less than 60 in all the other islands. In Saint Lucia, the infant mortality has fallen steadily over the years, reaching 42.7 in 1970 and about 20 in the late 1970s.

Life expectancy is considerably lower than in North America, ranging from 52 years in Montserrat to 69 years in Barbados, with an average of 61 years. The death rates for children 0-4 years of age range from 35 per 100,000 in Barbados to 598 per 100,000 in St. Vincent.

Average per-capita expenditure for health care is very low in comparison to that of the United States. Compounding the problem is the fact that even if the dollar resources were available, human resources, particularly physicians, are not and will not be available in sufficient numbers to serve adequately the population. The doctor population ratio ranges from 1.8 in St. Vincent and Dominica to 5.8 in Barbados per 10,000 population, with uneven distribution with respect to urban and rural areas.

PRIMARY HEALTH CARE APPROACH

The Director-General of World Health Organization, Dr. Halfdan Mahler, while addressing the Thirty-second World Health Assembly in May 1979, stated that the historic Declaration of Alma-Ata in 1978 had made it clear that primary health care is the key to attaining an acceptable level of health for all by the year 2000.

In order to attain "Health for All by the Year 2000" in the Caribbean with the inadequacy and uneven distribution of various health profes-
sionals, the utilization of existing auxiliaries and new categories of health workers is imminent. Even though the term "primary health care" is new and widely used at present, the concept is very old in the Caribbean. The University of the West Indies, an academic center for tertiary education serving 14 different governments of the English-speaking Caribbean, through the Department of Social and Preventive Medicine (DSPM), has, over the years, been involved in several outreach training programs in the area. The Department has not only initiated collaborative projects and programs between the UWI and other agencies in service to governments and communities in the region, but also pioneered innovative programs in community health and primary health care. Salient features of various projects in the Commonwealth Caribbean will be discussed.

DEVELOPMENT OF APPROPRIATE TECHNOLOGY

Concept

One of the most serious problems identified in the organization and management of the health services is the lack of adequate health care to reach the majority of the population, a primary reason being the absence of qualified and professional staff. It is therefore necessary to make sure that the staff available is properly utilized and that efforts are made to increase health service manpower. In the Caribbean, it is in this context that an attempt is being made to develop newer categories of health workers and of health manpower oriented toward learning a technology appropriate to the conditions in which they are to work, so as to adapt their roles and functions and provide quality health care within the limited resources.

The programs developed, and being developed, to attain this objective in the Caribbean are:

1. Development of newer categories of health workers:
   (a) basic health care worker—community health aide,
   (b) intermediate health care worker—nurse practitioner.
2. Education and training of allied health personnel.
3. Development of primary health care physicians.
DEVELOPMENT OF NEWER CATEGORIES
OF HEALTH WORKERS

Development of the Basic Health Care Worker—the Community
Health Aide Pilot Projects

As a direct result of the philosophy of the Department of Social and Preventive Medicine "to help persons to help themselves," the idea of developing community health aides was born. In 1967 an experimental pilot community health aide training program in the DSPM was initiated and made possible through a Milbank Memorial Fund Faculty Fellowship grant with the overall aim of preparing persons (volunteers) of limited formal education to work as auxiliaries, namely, "community health aides" (CHAs) on a health team under the supervision of established health professionals such as public health nurses, public health inspectors, district midwives, social workers, community development workers, and others.

The broad areas of function envisaged were:

(i) To assist the trained nurse in some of the duties which by virtue of tradition she had been called upon to perform but which could be carried out as well by less skilled persons, thereby releasing the trained nurse to apply her knowledge and skills in a wider and more productive manner.

(ii) To recognize the significance of important signs and symptoms of illness, viz., rising temperature or increasing pulse rate, and to take the necessary action, i.e., to report or refer to the appropriate authority.

(iii) To be a link or "bridge" with the community and the health department—to bridge the cultural and communication gap.

In this pilot project, originally 11 candidates from the Hermitage/August Town communities, to which the Community Health Center of the Department of Social and Preventive Medicine provides services, were selected. The training was conducted in two parts. Part I was an introductory four-week course, after which eight candidates were selected for Part II, which lasted three months, to give greater depth to knowledge in practical work in clinics and in the field. Even though there was no commitment to provide paid employment at the completion of the training, all eight community health aides have been employed and later, in 1970, they rotated through various departments of the hospital to gain more experience. Very good reports were received from members of the health team who supervised and directed the CHAs' work. A manual for com-
Community health workers was also prepared, using the lectures and demonstrations of the course.

As a result of the Department's pilot program, a joint project by the Jamaica Ministry of Health and Environmental Control, Cornell Medical College, New York, and DSPM was developed for another experimental training course for community health aides in the rural area of Elderslie, Parish of St. Elizabeth, Jamaica. The results of these two projects encouraged the Ministry to train and employ a larger number of these aides to work as members of the health team.

**Implementation of the Community Aide Program, County of Cornwall**

During the latter part of 1972, 262 aides were trained and appointed in two western parishes of Jamaica—Hanover and St. James—where child health problems, especially malnutrition, were of a serious magnitude.

In the County of Cornwall, the CHA is integrated into the health team in all areas. In the clinics, she is utilized in record-keeping, i.e., plotting Gómez Charts, filing, and recording simple information on admission of patients, for simple dressings, etc. They assisted in nutrition screening sessions, in food demonstrations for mothers of malnourished babies, and in vision screening under the supervision of eye specialists.

**Expansion of CHA Program on an Island-wide Basis in Jamaica**

On the basis of the positive results of the pilot projects and the Cornwall project, the Ministry of Health of Jamaica decided to employ CHAs in all parishes throughout the country in the extension of health service coverage at the primary care level. It was estimated that approximately 2,000 aides would be required for a population of 2 million—a target ratio of 1:1,000. The area covered by each CHA would be within a radius of three miles. As of 1979, there were over 1,200 CHAs working in the Government's health services.

A "Community Health Aide In-Service Training Manual and Practical Guide" was developed in association with the DSPM in 1976.

**Utilization of CHA in other Commonwealth Caribbean Territories**

The training and utilization of CHAs in Jamaica were presented at a workshop in Saint Lucia in November 1976 on Alternatives in the Delivery of Health Services, and discussed as a case study. The workshop was

CHAs trained at the Barbados Nutrition Center are carrying out their functions in Barbados and St. Vincent. Antigua is one of the islands whose health personnel showed an early interest in having this new category of worker, and trained their first group of CHAs in the early part of 1977 (including one for Barbuda and one for Anguilla). By 1978, the program was implemented in Saint Lucia, Grenada, and Dominica. A CHA training program is being planned for Belize and other territories in the Commonwealth Caribbean.

A report on the status of utilization of CHAs was made to the Technical and Scientific Committee of the Health Ministers’ Conference held in Barbados in 1978. In the final report of the Fourth Meeting of the Conference of Ministers Responsible for Health in the Caribbean (Saint Lucia, July 1978), Resolution 31 recognized the significance and usefulness of community health aides in relation to the extension of coverage of the health services and recommended “that each member country consider carefully the training and utilization of this category of health worker within its health team.”

Assessment of the Community Health Aide Program in Jamaica and Antigua was carried out in 1978-1979 by the DSPM, with support from the International Development Research Center (IDRC) of Ottawa, Canada. This evaluation revealed that in general the CHA program was very useful as the aides have an important role to play in reaching the more difficult residents of the communities.

The list of CHA duties include the teaching of simple health facts, advice on nutrition, first aid, simple nursing care, encouragement and advice on immunization against infectious diseases, motivation and referral of clients to family planning, antenatal and child health clinics, assistance to PHNs in the clinics, advice to diabetics and hypertensives, advice to householders on sanitation measures, and generally to inform the community of the services that are available through the Health Department.

*Development of Intermediate Health Care Worker—The Nurse Practitioner Philosophy*

Experience is indicating that staffing health centers in the usual pattern, where the doctor is expected to be the main provider of health care, is simply not possible where resources are limited. It is probably not the best method of utilizing highly trained and scarce personnel. Instead, the
primary health care needs of the people can be met by a health team which includes health workers with different levels of skills. Thus, there is clearly a need for a health worker who has clinical skills intermediate to those of a doctor and a nurse.

In the Caribbean, a nurse is, in many instances especially in rural areas, called upon to perform duties beyond the scope of her formal training for which she has no legal protection or recognition. Thus, the idea was developed of teaching the nurse practitioner to assume additional clinical and diagnostic skills and assigning her more responsibilities in the care of patients.

The nurse practitioner is trained to work independently of, interdependently with, and complementary to the physicians and other members of the health team with clearly defined limits of activities.

**Genesis of the Nurse Practitioner Program in Jamaica**

Nurse practitioner programs have been in existence in the United States and Canada for a number of years. An experience with nurse practitioners in family practice based on the Burlington randomized trials in Canada served to support the success of the nurse practitioner program, which was described as the expansion of the role of registered nurses.

In Jamaica, the project was started in July 1977, sponsored jointly by the Ministry of Health and Environmental Control, the Advanced Nursing Education Unit (DSPM, UWI), and Project HOPE, with an aim of developing programs that will prepare senior professional nurses as family nurse practitioners and pediatric nurse practitioners.

The family nurse practitioner stream of the program was the larger component since it was recognized that this category of health worker would be able to meet most of the needs of primary care for residents of the Caribbean communities.

The pediatric nurse practitioner stream was considered necessary as children under 15 years of age comprise as much as 45 per cent of the country's population.

The curriculum of the one-year course for the family and pediatric nurse practitioners is organized as follows:

A. Core Curriculum, 6-8 weeks' duration. Courses are given in psychology, sociology, epidemiology, problem-solving. The emphasis is on history-taking and physical examination.
B. Didactic, 20-22 weeks' duration. The streams are divided for the major portion of this section of the curriculum. Lectures and practicals on pathophysiology of organ systems as well as diseases of these systems of the body.

C. Clinical, practical period: 20-24 weeks.

Phase I—Clinical practice in primary care and hospital settings (12-14 weeks' duration).

Phase II—Clinical practice in the primary care setting. Nurse practitioner will be assigned (8-10 weeks' duration).

In the selection for training, nurses are chosen mainly to serve in rural areas where they settle in and are apt to return. Established primarily in rural settings, the nurse practitioners work with a physician who has been identified for support and referral purposes.

A study carried out in 1979 to determine the attitudes of doctors, public health nurses, and health center nurses toward the nurse practitioner shows that this category of worker reduces the physicians' work load and is considered useful to the health care system.

Since 1977, 14 pediatric and 50 family nurse practitioners (a total of 64) have been trained; an additional 14 are currently receiving training. In Belize, one family nurse practitioner has been trained and two other nurses are now in training.

*Development of Nurse Practitioners for Eastern Caribbean Islands (1979)*

A project of continuing and post-basic education in advanced family health nursing for the Eastern Caribbean Islands of Antigua, Barbados, Dominica, Grenada, Montserrat, St. Kitts-Nevis-Anguilla, Saint Lucia, and St. Vincent is in operation to prepare family nurse practitioners. The project is funded by the United Nations Fund for Population Activities (UNFPA), and is executed by PAHO/WHO with project headquarters at the nurses' hostel, Kingston, St. Vincent, and Grenadines, West Indies.

This program has been developed in modules which are divided into units offering theoretical and clinical learning. The program lasts ten months, 66 per cent of which is clinical practice and 34 per cent didactic. Of this time, ten weeks have been allocated to a supervised practicum. This project is being developed since nursing personnel are responsible for primary care in most of the islands of the Commonwealth Caribbean,
often without formal preparation for this role in patient assessment and management.

Theoretical and clinical practice is offered under the direction of nurse practitioners, doctors, pharmacists, nutritionists, laboratory technicians, dentists, and epidemiologists. The first program, which trained 12 family nurse practitioners, was completed in 1980.

EDUCATION AND TRAINING OF ALLIED HEALTH PERSONNEL

In 1969, the Caribbean Health Ministers' Conference focused attention on the shortage of health personnel as being one of the more important single factors impeding delivery of health care in the Caribbean territories. Hence, the project for education and training of allied health personnel (PETAHP) in the Commonwealth Caribbean was established at the request of 14 Caribbean governments. It is executed through PAHO/WHO with financial grants from the United Nations Development Program, the United Nations Children's Fund, and the Canadian International Development Agency. The project started functioning in July 1975; its headquarters are in Bridgetown, Barbados, and its five regional centers are located in Barbados, Guyana, Jamaica, Trinidad and Tobago, and the Bahamas.

The objectives of the project are:

1. To improve the quality of life in the English-speaking Caribbean by ensuring the supply of personnel adequately and appropriately trained to meet the manpower needs of the health services of the region.
2. To reduce reliance on more expensive extraregional programs for the preparation of allied health personnel.
3. To promote the health team concept by developing integrated training programs relevant to the needs of the area and as a permanent feature of vocational and professional education in the region.
4. To optimize the use of physical and human resources within the region.

In the process of attaining the objectives, the project is attempting to fulfill the training needs of the Caribbean Governments in the development of health personnel, such as public health inspectors (basic level), health records/statistics personnel, laboratory technicians, pharmacists, dietetic technicians, community nutritionists, food service supervisors,
dental auxiliaries, and physiotherapists. The project also supports post-

basic level education such as Diploma in Community Health, and the

training of tutors in administration in various fields.

DEVELOPMENT OF PRIMARY HEALTH CARE PHYSICIANS

The Caribbean Health Ministers' Conference (1976) resolved that the

Faculty of Medicine, as a matter of urgency, should review its medical

educational programs in order to produce physicians who are committed
to providing health care for the people of the Caribbean. As a result of de-
cisions of various committees and the workshop on medical education

held in May 1977, the new curriculum of the UWI Medical Faculty was
implemented in October 1978 as a 1-3-2 scheme. Thus, the preclinical
period is for one year, followed by three clinical years and two of preregis-
tration with community health being an integral part of the new curricu-

lum starting with year 1 and extending throughout the training.

Community health is taught in an integrated approach by the Depart-
ments of Social and Preventive Medicine, Child Health, Nutrition, and
Psychiatry. In addition to lecture/discussion series, the curriculum con-
sists of clerkships of 10 weeks, 5 weeks and 5 weeks, respectively, in the
first, second, and third clinical years. The broad objectives outlined in the
report on the workshop in Teaching Community Health to Medical Stu-
dents at UWI, held in March 1978, emphasizes the acquisition of skills
that would be necessary for functioning at the primary health care level in
an urban area in the second clinical year, and in a rural area in the third
clinical year. After the first workshop in 1977, two more workshops were
held—one in January 1979 and the other in December 1980, to review the
curriculum. In the second preregistration year there will be a six-month
period in community health.

In addition, a three-year residency in family practice has been devel-
oped in order to prepare family physicians, and was initiated in July 1980
with the aid of a grant from the Kellogg Foundation.

DEVELOPMENT OF PRIMARY HEALTH CARE SERVICES

As early as 1970, a pilot project for the development of rural maternal

and child health services was started in the Parish of Portland, Jamaica,
with an expanded role of the district midwife who not only assumed
greater responsibility for antenatal care but also became fully involved in the total health program. Based on the Resolution 7 of the Fifth Caribbean Health Ministers’ Conference (1973), the strategy and plan of action to combat gastroenteritis and malnutrition in children under two years of age was developed in 1974. The areas of prominence were safe water supply, sewage and solid waste disposal, maternal and child health services, family planning, breast-feeding, supplementary feeding program, standardized treatment of malnutrition and gastroenteritis, and nutrition education in schools.

A strategy and plan of action to strengthen maternal and child health services in the Caribbean was formulated by the Technical Advisory Group of the Health Ministers’ Conference which met in Antigua in 1975.

Meanwhile, the World Health Assembly of 1975 accepted guidelines along which primary care services were to be developed. Since then and after the Declaration of Alma-Ata (1978), the various Caribbean Governments began planning their primary health care services based on the guidelines set forward.

PRIMARY HEALTH CARE IN JAMAICA

The structure and principles of primary health care delivery in Jamaica is a good example. Primary health care services are provided through health centers type 1, 2, 3, and 4.

Organization

At the central level, the primary care unit is headed by the Principal Medical Officer (primary care). The country is divided into 14 parishes and these are grouped into four regions, each being the responsibility of a Senior Medical Officer.

At the parish level, the medical officer of health and the parish level staff are responsible for the efficient and effective delivery of health care throughout the parish, maintaining technical standards and discipline. Each parish has been divided on a demographic basis into health districts with a population of 20,000. Each district is served by a series of interlocking health centers offering different levels of service.

Type 1 Health Center. Serves a population of up to 4,000. It is staffed by one midwife and at least two community health aides who will be respon-
sible for delivering basic maternal and child health, nutrition, family
planning, and immunization services, with a major educational compo-
nent.

Type 2 Health Center. Serves a population of 12,000 through a number of
type 1 health centers. It has the staff and functions of type 1, but in addi-
tion, a public health nurse and a public health inspector. They visit type 1
centers in the area. A resident staff nurse provides simple treatment for
common illnesses. A doctor and/or nurse practitioner and pharmacist
visit the center regularly.

Type 3 Health Center. Headquarters of a health district. Serves a popula-
tion of 20,000 through types 1 and 2 health centers. A doctor and/or nurse
practitioner are stationed at this center. Its functions are those of types 1
and 2. A higher grade public health nurse and public health inspector
provide administrative and supervisory functions.

Type 4 Health Center. Administers the health programs of the parish. Its
functions are similar to those of type 3 and it has a medical officer (health)
and parish staff.

Principles

Primary health care services are structured basically around three
maxims.

1. The services available at the type 1 health center are the basic mini-
imum which should be given to everyone in the country.

2. "No highly trained person should spend time routinely doing tasks
that could be undertaken by a lesser trained person." This is the basis for
the development of newer categories of health workers such as CHA and
nurse practitioner, and also for the changing roles of the midwife and
other health workers.

3. "Health cannot be imposed on a community but the community
members must participate and decide to what extent they wish to improve
their own health." Toward this goal, the organization of a network of
health committees is underway.

Referral System

The referral system is an integral part in the delivery of primary health
care services. A two-way flow is expected to operate between the various
types of health centers with the support of existing secondary health care (general hospitals) and tertiary health care (regional hospitals) facilities.

Training

In-service training for all categories of staff in order to accept their changing roles in the newer strategies and in the development of health manpower is on a continuous basis.

Primary Care in Other Caribbean Territories

Since 1979 a project was started for the development of primary care services in the smaller territories of the Caribbean, funded by the U.S. Agency for International Development and administered through the Caribbean Community Secretariat. It aims to improve the management of health services and especially those involved in primary care of rural and underserved areas. The countries participating in this project are Antigua, Barbados, Belize, Dominica, Grenada, Montserrat, St. Kitts-Nevis-Anguilla, Saint Lucia, and St. Vincent. The project provides these territories with training, technical assistance, material resources, and special activities as requested by each country.

The project is expected to provide the following to each participating territory:

1. Training of top, middle, and line managers in basic principles of management, problem identification and problem-solving, supervision task management, and interpersonal communication. The training is arranged in the core module for all levels of managers and special modules to meet the needs of top, middle, and line managers.

2. Technical assistance in the development of primary care services of a health district through identification of health team and health problems using guidelines from the Declaration of Alma-Ata and adapting these to the conditions of each country.

3. Technical assistance and training for team building. This section of the project is geared to providing the primary health care team with the necessary skills for working with one other and with the community in the development of primary health care.

The project is funded for the period of three years, and it is hoped that it will provide the boost necessary for the development of primary care in the participating territories.
Other Programs

A project on family health care in the Caribbean was initiated in 1979 with an overall objective to increase the quality and quantity of trained health manpower at various levels with particular reference to the management and delivery of family-oriented health care. The project also aims to develop new approaches for obtaining effective community participation in the planning, implementation, and evaluation of these health programs. Special emphasis is given to the health needs of the adolescents and youth related to the reproductive behavior of this vulnerable group.

CONCLUSION

In the Commonwealth Caribbean, there are many activities directed toward “Health for all by the year 2000.” The primary care activities are designed not only to improve and diversify manpower resources, but also to provide management capabilities for the health services. As for manpower resources, training programs exist for the basic and intermediate health care worker, as well as physicians, at both the undergraduate and postgraduate levels.

The management capabilities for primary care are being developed on an in-service basis. All levels of health workers are considered important in these programs.

With the consolidated efforts of all these projects and programs, it is hoped that the current purpose of the World Health Organization’s “Health for all by the year 2000”, subscribed by the Governments of the Region through World Health Assembly and Conferences of Ministers Responsible for Health in the Caribbean, can be achieved.

SUMMARY

In this article, the authors present a brief review of the health problems of the Commonwealth Caribbean and of the primary care activities being implemented to solve them.

Special attention is given to programs which develop new categories of health workers and direct health manpower toward learning a technology appropriate to the conditions in which they work. These programs enable
the health worker and allied health personnel to adapt their roles and functions accordingly and thus provide quality health care within limited resources.

The main programs are: development of new categories of health workers such as the community health aide and the nurse practitioner; education and training of allied health personnel; and training of primary health care physicians.

An account is also given of primary health care in Jamaica and in the smaller territories of the Caribbean.

**BIBLIOGRAPHY**


Family Healthy Care in the Caribbean, July 1979-June 1982. UNFPA/PAHO/WHO. Prepared by the Department of Social and Preventive Medicine, University of the West Indies.


Muschett, P., and P. Desai. An Assessment of the Community Health Aide Programme in Antigua, W. I. Department of Social and Preventive Medicine, University of the West Indies.


Strategy and plan of action to combat gastroenteritis and malnutrition in children under two years of age. Proceedings of a Technical Group Meeting on Malnutrition and Gastroenteritis (St. Vincent, 8-11 January 1974).


University of the West Indies, Department of Social and Preventive Medicine. Report on Regional Seminar on Community Health Aide Training, 3-5 April 1978.
SISTEMAS DE ATENCION PRIMARIA DE SALUD EN LA MANCOMUNIDAD DEL CARIBE

(Resumen)

En este artículo, los autores hacen un breve análisis de los problemas de salud de la Mancomunidad del Caribe y de las actividades de atención primaria emprendidas para resolverlos.

Se concede especial atención a los programas conducentes al establecimiento de nuevas categorías de auxiliares de salud y a la orientación del personal en técnicas apropiadas a las condiciones de trabajo. Esos programas permiten al auxiliar de salud y al personal homólogo adaptar convenientemente sus cometidos y funciones, y prestar así una atención de calidad con recursos escasos.

Los principales programas son: formación de nuevas categorías de auxiliares de salud, por ejemplo, ayudantes de salud de la comunidad y enfermeras auxiliares de medicina; instrucción teórica y práctica de personal homólogo; y adiestramiento de médicos de atención primaria.

Por último, se exponen las actividades de atención primaria de salud en Jamaica y en otros países y territorios del Caribe.

CRITÉRIOS DA ATENÇAO PRIMÁRIA DE SAÚDE NA COMUNIDADE DO CARIBE (Resumo)

Os autores deste artigo passam em revista, em breve análise, os problemas de saúde da Comunidade do Caribe e as atividades primárias de saúde que vêm sendo desenvolvidas para resolvê-los.

Atentam especialmente para programas que preparam novas categorias de pessoal de saúde e orientam os recursos humanos em saúde para o aprendizado de tecnologias apropriadas às condições em que trabalham. Esses programas capacitam o profissional da saúde e o pessoal correlato a adaptar adequadamente suas atividades e funções e, assim, a prestar serviços de qualidade, apesar da limitação dos recursos.

Os programas principais referem-se a desenvolvimento de novas categorias de pessoal de saúde, como o auxiliar de saúde comunitária e a enfermeira prática; educação e treinamento de pessoal de saúde correlato; e treinamento de médicos em cuidados primários de saúde.

Os autores também descrevem o sistema de saúde ao nível primário na Jamaica e nos territórios menores do Caribe.
LES PROGRAMMES DE SOINS DE SANTÉ PRIMAIRES DANS LE COMMONWEALTH DES CARAÏBES (Résumé)

Les auteurs passent en revue les problèmes sanitaires du Commonwealth des Caraïbes, et les activités de soins de santé primaires visant à les résoudre.

Ils s’intéressent en particulier aux programmes qui développent de nouvelles catégories d’agents sanitaires et incitent la main-d’œuvre médico-sanitaire à apprendre une technologie appropriée aux conditions dans lesquelles elle travaille. Ces programmes permettent aux agents sanitaires et au personnel paramédical d’adapter leurs rôles et leurs fonctions en conséquence et de fournir des soins de santé de bonne qualité et dans les limites des ressources disponibles.

Les principaux programmes sont les suivants: mise au point de nouvelles catégories d’agents sanitaires, notamment l’aide soignant communautaire et l’infirmier, formation du personnel paramédical et de médecins de soins de santé primaires.

L’article rend aussi compte des soins de santé primaires en Jamaïque et dans les plus petits territoires des Caraïbes.

OBITUARY

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Dr. Esmond J. Garrett died in Jamaica on 18 July 1981. He was a Professor at the Department of Social and Preventive Medicine, University of the West Indies, Mona, Kingston, Jamaica, under Professor Kenneth L. Standard.

Born in Belize City, Belize, on 26 September 1946, Dr. Garrett graduated from the University of the West Indies with M. B. and B. S. degrees. In 1979 he received a certificate of “Teacher of Primary Health Care Worker” from the Liverpool School of Tropical Medicine, Liverpool, England.

This issue of Educación médica y salud presents two articles written with the participation of Dr. Garrett.