FIFTH REPORT
of the Joint Select Committee on Ministries, Statutory Authorities and State Enterprises
(Group 1)
on
THE ADMINISTRATION AND OPERATIONS OF THE MINISTRY OF HEALTH WITH SPECIFIC FOCUS ON PRIMARY HEALTH CARE

Ordered to be printed with the
Minutes of Proceedings and Notes of Evidence

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PARL. NO. 14/5/14
# Table of Contents

**THE COMMITTEE**
- Establishment .................................................. 1
- Membership ......................................................... 1
- Secretarial Support .............................................. 2
- Powers ............................................................... 2
- Background ......................................................... 3
- Objectives .......................................................... 3
- Conduct of the Inquiry .......................................... 3

**THE EVIDENCE**
- Primary Healthcare Overview ................................ 8
- Organization and Management of Primary Health Care Services ........................................ 8
- The National Health Service .................................. 10
- Strategies for Strengthening Primary Health Care Services .............................................. 11
- Budgeting Procedures employed by the RHAs .......... 13
- Eastern Regional Health Authority .......................... 14
- North Central Regional Health Authority .................. 15
- North West Regional Health Authority ...................... 16
- South West Regional Health Authority ....................... 17
- Annual Service Agreement ..................................... 19
- Constraints in the RHAs ......................................... 27
- Mechanisms to deal with Complaints in the Health Sector .................................................. 28
- Patients’ Bill of Rights ............................................ 30
- Quality Management in the Health Sector ................. 30
- Human Resource Issues .......................................... 32
- Human Resource Planning for the Public Health Sector .................................................. 33
- Scholarships .......................................................... 46
- Public Oral Health Care Services ............................. 48
- Public Health Care in Schools .................................. 51
- RHAs Facilities and Property Management arrangement and guidelines ............................ 53
Procurement in the MOH ................................................................. 54
Effective, preventative maintenance for equipment .................................. 56
Status of unused exercise equipment ......................................................... 59
Management of Drugs ........................................................................ 61
Infant Mortality Rate ........................................................................... 68

OBSERVATIONS/FINDINGS ..................................................................... 78
RECOMMENDATIONS ........................................................................... 81
APPENDIX I .......................................................................................... 86
APPENDIX II ......................................................................................... 91
THE COMMITTEE

Establishment

In pursuance of the directive encapsulated at section 66 of the Constitution of the Republic of Trinidad and Tobago, the House of Representatives and the Senate on September 17, 2010 and October 12, 2010 respectively, agreed to a motion, which among other things, established a Joint Select Committee to inquire into and report to Parliament on Ministries with responsibility for the business set out in the Schedule as Group 1, and on the Statutory Authorities and State Enterprises falling under their purview with regard to:

- their administration;
- the manner of exercise of their powers;
- their methods of functioning; and
- any criteria adopted by them in the exercise of their powers and functions.

The business, as well as the entities which fall under the purview of the Committee are attached as Appendix I.

Membership

The current membership of the Committee is comprised as follows:

- Mrs. Corinne Baptiste-Mc Knight - Chairman
- Prof. Harold Ramkissoon - Vice-Chairman
- Mrs. Carolyn Seepersad-Bachan, MP
- Mr. Emmanuel George
- Mr. Ganga Singh¹
- Dr. Delmon Baker, MP
- Mr. Jairam Seemungal, MP
- Ms. Stacy Roopnarine, MP
- Mrs. Christlyn Moore²
- Dr. Amery Browne, MP
- Mrs. Patricia Mc Intosh, MP
- Mr. Faris Al-Rawi

¹Mr. Ganga Singh replaced Mrs. Verna St. Rose-Greaves with effect from October 16, 2012.
²Mrs. Christlyn replaced Mr. Danny Maharaj with effect from October 16, 2012.
Secretarial Support

Secretarial support for the Committee is provided as follows:

- Mrs. Lily Broomes - Secretary
- Ms. Khisha Peterkin - Assistant Secretary
- Ms. Sheranne Samuel - Assistant Secretary
- Mrs. Katharina Gokool-Mark - Graduate Research Assistant

Powers

Standing Orders 71B of the Senate and 79B of the House of Representatives delineate the core powers of the Committee which include *inter alia*:

- to send for persons, papers and records;
- to adjourn from place to place;
- to appoint specialist advisers either to supply information which is not otherwise readily available or to elucidate matters of complexity within the Committee’s order of reference; and
- to communicate with any other Committee of Parliament on matters of common interest.
INTRODUCTION

Background
Primary Health Care (PHC) is one of the most integral aspects in any Health Care System. Essential basic Health Care Services that are impartially accessible and cost-effective is imperative to achieving a successful Health Care System.

Too often though, PHC Services are limited by insufficient resources such as staff, facility equipment and medical supplies that plague the Health Care System.

Increasingly, it is recognized that without adequate delivery of PHC services a crisis of an insalubrious state can occur since it is the underlying foundation to a healthy population.

Accordingly, your Committee considered an inquiry into the administration and operation of the Ministry of Health (MOH) with specific focus on PHC.

Objectives
Your Committee identified the following as the primary objectives of the inquiry:

- To determine the progress made in filling the numerous vacancies in the health sector, at the PHC level;
- To ascertain what measures have been put in place for the improvement of the physical infrastructure of PHC facilities; and
- To determine the progress made in the realignment or strengthening of the vertical services/ national programs.

Conduct of the Inquiry
The Committee conducted three (3) public hearings with representatives of the MOH on the following dates:

1. Friday April 15, 2011;
2. Friday January 20, 2012; and
As part of the preparatory work for this meeting, the inquiry objectives of your Committee were communicated to the Ministry to solicit initial written responses. These responses were used as the basis for supplementary questioning pursued at the hearing.

At these hearings, the MOH was represented by the following officials:

<table>
<thead>
<tr>
<th>Name</th>
<th>Portfolio</th>
<th>1st Hearing Friday April 15, 2011</th>
<th>2nd Hearing Friday January 20, 2012</th>
<th>3rd Hearing Friday March 16, 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Sandra P. Jones (replaced by Ms. Antonia Popplewell w.e.f. Friday January 20th 2012)</td>
<td>Permanent Secretary</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mr. Asif Ali</td>
<td>Director Finance &amp; Accounts</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>Dr. Anton Cumberbatch</td>
<td>Chief Medical Officer</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>Dr. Randolph Phillip</td>
<td>County Medical Officer, St George West</td>
<td>✓</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Dr. Andrea Yearwood</td>
<td>Director Health Policy, Research &amp; Planning</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Dr. Rohit Doon</td>
<td>Advisor, Health Promotion, Communication &amp; Public Health</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
</tr>
<tr>
<td>Ms. Claudine Sheppard</td>
<td>Chief Executive Officer (Ag.) NWRHA</td>
<td>✓</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Ms. Judith Baliram-Ramoutar</td>
<td>Chief Executive Officer, NWRHA</td>
<td>x</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mr. Anil Gosine</td>
<td>Chief Executive Officer (Ag.) SWRHA</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ms. Kirlyn Archie-Lewis</td>
<td>Chief Executive Officer (Ag.) ERHA</td>
<td>✓</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Ms. Stacy Harricharan</td>
<td>Chief Executive Officer, ERHA</td>
<td>x</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mr. Collin Bissessar</td>
<td>Chief Executive Officer (Ag.) NCRHA</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
</tr>
<tr>
<td>Mr. Reynold Bedeau</td>
<td>Advisor, Health Sector Reform</td>
<td>✓</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Mr. Reynold Koylass</td>
<td>Project Manager, Project Management Unit</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Dr. Kevin Antoine</td>
<td>County Medical Officer (Ag.)</td>
<td>✓</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Approval Status</td>
<td></td>
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<tr>
<td>-----------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Harry Singh</td>
<td>County Medical Officer, St George Central, NWRHA</td>
<td>✓   ✓   ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Larry Chinnia</td>
<td>Primary Care Physician II NCRHA</td>
<td>✓   x   x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr. Akenath Misir</td>
<td>Executive Medical Director SWRHA</td>
<td>✓   ✓   x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Shevenand Gopiesingh</td>
<td>Executive Medical Director (Ag.) SWRHA</td>
<td>x   ✓   ✓</td>
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<td></td>
</tr>
<tr>
<td>Dr. Lester Goetz</td>
<td>Medical Director (Ag.), SWRHA</td>
<td>x   ✓   ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Harry Smith</td>
<td>County Medical Officer of Health, St George West, NWRHA</td>
<td>x   ✓   ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Olalekan Fagobola</td>
<td>County Medical Officer of Health, Nariva/ Mayaro, ERHA</td>
<td>x   ✓   ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Raveed Khan</td>
<td>Primary Care Physician, ERHA</td>
<td>x   ✓   ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary Care Physician II/Administrative (Ag.) Arima Health Facility, NCRHA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Mariyam Richards</td>
<td>Primary Care Physician (NCRHA)</td>
<td>x   ✓   x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Rodney Ramroop</td>
<td>Executive Medical Director</td>
<td>x   ✓   x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Yvonne Lewis</td>
<td>Director, Health Education Division</td>
<td>x   ✓   ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Chandradai Harry</td>
<td>Director Finance and Accounts (Ag.)</td>
<td>x   ✓   ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Brian Armour</td>
<td>Project Manager, HIV/AIDS Coordinating Unit</td>
<td>x   ✓   ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Jennifer Andall</td>
<td>Manager, Health Sector Human Resource Planning and Development</td>
<td>x   x   ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Bhabie Roopchand</td>
<td>Legal Adviser</td>
<td>x   x   ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Sherron Ahye-Romeo</td>
<td>Director, Human Resources, Ministry of Health</td>
<td>x   x   ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Adesh Sirjusingh</td>
<td>Administrator, Clinical Service, ERHA</td>
<td>x   x   ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Suresh Pooran</td>
<td>Medical Chief of Surgery/Director of Health</td>
<td>x   x   ✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr. Keith Beharry</td>
<td>Manager, Hospital Administration</td>
<td>x   x   ✓</td>
<td></td>
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</tr>
</tbody>
</table>

The draft of this Report was considered and approved with specified amendments at the meeting of the Committee held on April 5th, 2013.
The Minutes of the meetings of the Committee with regard to the inquiries are attached as *Appendix II*.

The Notes of Evidence of the hearings are attached as *Appendix III*. 
### ACRONYMS & ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATNs</td>
<td>AIDES TO NURSES</td>
</tr>
<tr>
<td>CFNI</td>
<td>CARIBBEAN FOOD AND NUTRITION INSTITUTE</td>
</tr>
<tr>
<td>CMU</td>
<td>CONTRACT MANAGEMENT UNIT</td>
</tr>
<tr>
<td>CNCD</td>
<td>CHRONIC NON- COMMUNICABLE DISEASES</td>
</tr>
<tr>
<td>COSTAATT</td>
<td>COLLEGE OF SCIENCE, TECHNOLOGY &amp; APPLIED ARTS OF TRINIDAD AND TOBAGO</td>
</tr>
<tr>
<td>ELPT</td>
<td>ENGLISH LANGUAGE PROFICIENCY TESTING</td>
</tr>
<tr>
<td>IEC</td>
<td>INFORMATION, EDUCATION AND COMMUNICATION</td>
</tr>
<tr>
<td>MOH</td>
<td>MINISTRY OF HEALTH</td>
</tr>
<tr>
<td>MOPSD</td>
<td>MINISTRY OF THE PEOPLE AND SOCIAL DEVELOPMENT</td>
</tr>
<tr>
<td>MPA</td>
<td>MINISTRY OF PUBLIC ADMINISTRATION</td>
</tr>
<tr>
<td>MTEST</td>
<td>MINISTRY OF TERTIARY EDUCATION AND SKILLS TRAINING</td>
</tr>
<tr>
<td>NACC</td>
<td>NATIONAL AIDS COORDINATION COMMITTEE</td>
</tr>
<tr>
<td>NICU</td>
<td>NEONATAL INTENSIVE CARE UNIT</td>
</tr>
<tr>
<td>PAHO</td>
<td>PAN AMERICAN HEALTH ORGANIZATION</td>
</tr>
<tr>
<td>PCAs</td>
<td>PATIENT CARE ASSISTANTS</td>
</tr>
<tr>
<td>PHC</td>
<td>PRIMARY HEALTH CARE</td>
</tr>
<tr>
<td>POCT</td>
<td>POINT OF CARE TESTING</td>
</tr>
<tr>
<td>RFPs</td>
<td>REQUEST FOR PROPOSALS</td>
</tr>
<tr>
<td>RHA</td>
<td>REGIONAL HEALTH AUTHORITY</td>
</tr>
<tr>
<td>UN</td>
<td>UNITED NATIONS</td>
</tr>
<tr>
<td>UWI</td>
<td>UNIVERSITY OF THE WEST INDIES</td>
</tr>
<tr>
<td>WHO</td>
<td>WORLD HEALTH ORGANIZATION</td>
</tr>
</tbody>
</table>
THE EVIDENCE

Based on the areas detailed in its inquiry outline, the Committee was provided with the following information by Ministry of Health Officials.

Primary Healthcare Overview

The MOH seeks to provide and ensure equitable access to comprehensive PHC Services through a network of integrated, collaborative and intersectoral programmes targeted at improving the quality of life and extending the life of the nation’s population. Some PHC strategies are identified through key activities, such as:-

- Health promotion;
- Health education;
- Disease prevention;
- Monitoring of health risks; and
- Risk reduction.

These activities are executed with the assistance of dedicated units such as the Health Education Division, the Public Health Inspectorate, the National Surveillance Unit and other vertical units.

Legal Framework of Public Health

PHC in Trinidad and Tobago was initially governed by the Public Health Ordinance which was enacted in 1917 and later revised in 1950. However, the Act has now become obsolete and its replacement, a revised Public Health Act is being considered to include provisions that will address all of the essential public health functions to which the MOH is entrusted.

Organization and Management of Primary Health Care Services

Primary Healthcare Services in Trinidad and Tobago are organized in a seamless system of healthcare programs that target specific populations. The management of the PHC system has been shared between the MOH through its vertical programmes and services and the Regional Health Authorities (RHA’s) (as sanctioned by the Health Sector Reform Program (HSRP) in Trinidad and Tobago since early 1990’s, through its community/primary health services.
The MOH relies on the network of Health Centres and District Health Facilities strategically located throughout Trinidad and Tobago which is managed by the RHA’s, the private sector and the NGO community to provide Public Health Care services. These facilities are constantly upgraded and reformed both at the health technology level and the service provision level to keep pace with the expressed needs of respective communities and best practices in the delivery of PHC services. Currently, there are seven (7) District Health Facilities, two (2) Enhanced Health Centres and seventy eight (78) Outreach and Health Centres.

Some staff at the MoH were reassigned to the RHAs to efficiently deliver services. This arrangement affords the MOH the time to attend to policy making and planning activities. These include activities which are vital for an effective PHC strategy, the organization and management of vertical programmes and services and the integration of these services into the RHA PHC delivery structure.

The MoH ensures by way of Vertical Services and National Programmes that critical public health services are made available to the public, such as, health education, food safety, immunization, blood transfusion and control of acute infectious diseases. The MoH has retained control of the administration of thirty-one (31) of these broad-based units called National Vertical Services and twelve (12) Special Programmes, as indicated hereunder:

**Table B**

<table>
<thead>
<tr>
<th>NATIONAL VERTICAL SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Insect Vector Control Division</td>
</tr>
<tr>
<td>2. Queen’s Park Counselling Centre and Clinic</td>
</tr>
<tr>
<td>4. Chemistry, Food and Drugs Division</td>
</tr>
<tr>
<td>5. Drug Inspectorate Division</td>
</tr>
<tr>
<td>6. Health Education Division</td>
</tr>
<tr>
<td>7. Dental Services</td>
</tr>
<tr>
<td>8. Medical Library Services</td>
</tr>
<tr>
<td>9. Trinidad Public Health Laboratory</td>
</tr>
<tr>
<td>12. School Of Nursing, General Hospital, Port of Spain</td>
</tr>
<tr>
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</tbody>
</table>
Over the years, the range of services offered through PHC Services have been improved with the introduction of the tobacco control legislation, risk reduction by screening and tobacco control clinics to prevent smoking. Other services that have assisted in improving PHC include Home Health Care Services where District Health Visitors and Medical Officers visit homes, a “passport” where members of the public are invited to health centres to get their screens done as well, health care personnel visit work sites to screen for blood pressure, HB1c and Cholesterol etc.

The emphasis in the Health Care Policy is prevention. However, along with that strategy is risk reduction which involves the identification of segments of the population that may be at risk and the strategies to deal with the problem e.g., the results of two (2) surveys employed to identify the percentage of overweight children were found to be alarming since the rate had increased. The risk reduction strategy in this case indicated that obesity and a lack of exercise can lead to hypertension and diabetes. As such, schools were targeted in collaboration with the Ministry of Education to promote the right mix of school nutrition and exercise as an intervention before a health problem arises.

**The National Health Service**

The MoH is also seeking to reform the health financing system through the development of a National Health Service. The National Health Service (NHS) as a financing mechanism is the proposed vehicle through which citizens can benefit from universal access to an essential basket of health services, including oral health services to citizens through either public or private health providers.
The government proposes to retain financial responsibility for the system in the initial stages but consideration could be given to the introduction of external contributions as the system matures.

**Strategies for Strengthening Primary Health Care Services**

To strengthen PHC Services the MoH proposes the decentralisation of National Programmes such as National Tuberculosis Control and, Hansen Disease Control Programmes etc. by integrating them into PHC Services and through the Expanded Programme on Immunisation (EPI) services through:

- Introduction and reintroduction of vaccines;
- Vaccination campaigns in the community;
- Placing greater focus on Health Promotion, Disease Prevention and Personal Responsibility;
- Administrative support and capacity building for the Primary Health Care (PHC) programmes;
- Strengthening surveillance;
- Health networking and improving the health management information system;
- IEC activities;
- Building an effective referral and clinical pathways;
- Standardization of clinical practice through development of clinical guidelines, treatment algorithms for Chronic Non-Communicable Diseases (CNCD) and standard operating procedures/manuals;
- Introduction/ reintroduction of programmes essential to address the needs of special target and at-risk groups.

**Plans to combat Chronic Non-Communicable Diseases**

The MOH has developed a structured plan “Campaign of Fighting the Fat “to address the issue of CNCDs. The Ministry has been collaborating nationally with the RHAs, regionally with CARICOM, the Caribbean Food and Nutrition Institute (CFNI) and the Pan American Health Organization (PAHO) and internationally with the World Health Organization (WHO). A number of approaches were undertaken to combat CNCDs such as conducting surveys to assess the status of the population’s health, identify risk areas and chart data by means of surveys.
Millennium Development Goals (MDGs)

The Millennium Development Goals (MDGs) developed by the United Nations (UN), are the main goals to be achieved by 2015 that will respond to the world's main development challenges. Trinidad and Tobago is fully committed to the Millennium Development Declaration of UN. The declaration sets forth key inter-connected and mutually reinforcing development goals as the global agenda for development in the 21st century. As such, the following Millennium Development Goals (MDGs) related to Maternal and Child Health were highlighted:

- Goal 4: Reducing Child Mortality and;
- Goal 5: Improve Maternal Health.

Regional and International strategies for PHC

Integrated prevention is the recommended strategic approach to reduce risk factors for multiple CNCDs.

- Pan American Health Organization (PAHO) aims to improve the health status of populations by reducing risk factors associated with CNCDs.

- Caribbean Cooperation in Health

The Caribbean Cooperation in Health (CCH) is a mechanism developed for Caribbean Community (CARICOM) Member States to collectively focus action and resources towards the achievement of agreed objectives in priority health areas of common concern and to identify approaches and activities for joint action and/or technical cooperation among countries. CCH phases I (1993) and II (2000) are now completed and have been evaluated. CCH phase III has been developed by Caribbean Member States and includes each of the key priorities of the Caribbean Commission on Health and Development Report.

- CARICOM Heads of Government Summit and Declaration on CNCDs

On Saturday 15 September 2007, the Heads of Government of CARICOM convened in Port-of-Spain, Trinidad and Tobago for a Regional Summit on CNCDs, under the theme, Stemming the Tide of Non-Communicable Diseases in the Caribbean. The Summit
culminated with the signing of a Declaration by the Heads of State which re-affirmed the recommendations of the Caribbean Commission on Health and Development and declared support for, *inter alia*, initiatives and mechanisms aimed at strengthening institutions for implementation of agreed strategies for the reduction of CNCDs.

**Budgeting Procedures employed by the RHAs**

The Ministry currently employs the ‘Zero Based’ method of budgeting. No consideration of roll over funding from the previous year is allowed when using this method. However, there are plans to adopt a new method: activity based budgeting in the near future. The Ministry has engaged consultancy services in preparation for this shift in budgeting. The budgeting procedure used by the respective RHAs is listed out in Table C below:

### Table C

<table>
<thead>
<tr>
<th>RHA</th>
<th>BUDGETING PROCEDURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Regional Health Authority</td>
<td>The ERHA uses both the Incremental method and Zero Based method when preparing its budget</td>
</tr>
<tr>
<td>North Central Regional Health Authority</td>
<td>The Budgeting procedure used by the NCRHA is that as contained in the Authority’s Board approved Financial Policies and Procedures Manual</td>
</tr>
<tr>
<td>North West Regional Health Authority</td>
<td>The Authority prepares its annual budgetary estimates using the Zero Line Item Based Method. Therefore, there is no roll over for each line item as aligned to the Common Chart of Accounts to the next financial year.</td>
</tr>
<tr>
<td>South West Regional Health Authority</td>
<td>The SWRHA uses the output budget methodology to cost the 2010/2011 budget as of October 1st 2010</td>
</tr>
</tbody>
</table>

The following Pie charts represent Budgetary Allocations illustrating the amount spent on administrative expenses in the RHAs:
Eastern Regional Health Authority

Table D

<table>
<thead>
<tr>
<th>Expenditure Items</th>
<th>FY 11/12 Allocation</th>
<th>% Allocated</th>
<th>Actual Expenditure Oct 11 - Mar 12</th>
<th>% Year to date Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel Expenditure - Note 1</td>
<td>176,648,145</td>
<td>77%</td>
<td>89,141,903</td>
<td>75%</td>
</tr>
<tr>
<td>Utilities - Note 2</td>
<td>5,775,000</td>
<td>3%</td>
<td>2,944,755</td>
<td>2%</td>
</tr>
<tr>
<td>Maintenance - Note 3</td>
<td>4,392,000</td>
<td>2%</td>
<td>2,207,376</td>
<td>2%</td>
</tr>
<tr>
<td>Contract Services - Note 4</td>
<td>16,705,435</td>
<td>7%</td>
<td>13,649,619</td>
<td>11%</td>
</tr>
<tr>
<td>Other Goods and Services - Note 5</td>
<td>2,690,000</td>
<td>1%</td>
<td>1,228,262</td>
<td>1%</td>
</tr>
<tr>
<td>Administrative/Operating Cost - Note 6</td>
<td>23,789,420</td>
<td>10%</td>
<td>9,798,619</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Total Budgetary Allocation FY2011/2012</strong></td>
<td><strong>230,000,000</strong></td>
<td></td>
<td><strong>118,970,534</strong></td>
<td></td>
</tr>
</tbody>
</table>

Note:
Administrative/Operating Cost Include: Rent of Accommodations, rental of equipment, Materials & Supplies General Material & Supplies Medical, Insurance, Minor Equipment, Books & Periodicals, Health Promotions Meeting & Conferences, Other Admin Exps, Staff Benefits, Food Supplies, Unclaimed Bodies, Special Projects, Bank Charges & Interest
North Central Regional Health Authority

Figure 2
NCRHA Budgeted Expenditure for FY 2011

NCRHA: Pie Chart Showing FY 2011 Budgeted

Key
- Plant Fuel (Boiler)
- Security Services
- Rep & Maint -
  - Vehicle Operating Costs
  - Rent & Accommodation
  - Rent Equipment (Other)
  - Advertisements
  - Health Promotion
- Meeting & Conference Expenses
- Communication/Telephone
- Stationery & Supplies
- Licenses & Subscriptions
- Rent & Accommodation
North West Regional Health Authority

Note:

Table E

<table>
<thead>
<tr>
<th>Administrative Expense</th>
<th>38,456,623</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overtime</td>
<td>14,519,302</td>
</tr>
<tr>
<td>Others Expenses</td>
<td>547,024,075</td>
</tr>
<tr>
<td>Total Allocation</td>
<td>600,000,000</td>
</tr>
</tbody>
</table>

Figure 3

NWRHA

Table F

<table>
<thead>
<tr>
<th>Administrative Expenses</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Benefits</td>
<td>900,000.00</td>
</tr>
<tr>
<td>Meetings</td>
<td>75,000.00</td>
</tr>
<tr>
<td>Training</td>
<td>380,049.00</td>
</tr>
<tr>
<td>Postage</td>
<td>2,000.00</td>
</tr>
<tr>
<td>Bank Charges</td>
<td>20,000.00</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>510,000.00</td>
</tr>
<tr>
<td>Other Administrative Expenses</td>
<td>1,301,604.00</td>
</tr>
<tr>
<td>Patient Transport</td>
<td>10,000.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,198,653.00</strong></td>
</tr>
</tbody>
</table>
South West Regional Health Authority

Table G

<table>
<thead>
<tr>
<th>Analysis of Expenditure for 2010/2011</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actual Cost 2010/2011</strong></td>
<td></td>
</tr>
<tr>
<td>Personnel Costs (Net of Overtime)</td>
<td>562,604,999</td>
</tr>
<tr>
<td>Overtime</td>
<td>10,024,663</td>
</tr>
<tr>
<td>Medical &amp; Pharmaceutical Costs</td>
<td>129,863,04</td>
</tr>
<tr>
<td>Other Health Care Costs</td>
<td>18,513,649</td>
</tr>
<tr>
<td>Property &amp; Plant Expense</td>
<td>51,455,588</td>
</tr>
<tr>
<td>Administration Expenses</td>
<td>59,540,432</td>
</tr>
<tr>
<td></td>
<td><strong>832,002,345</strong></td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td>690,292,087</td>
</tr>
<tr>
<td><strong>Administrative Expenses</strong></td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td>4,721,157</td>
</tr>
<tr>
<td>Office Supplies</td>
<td>3,398,719</td>
</tr>
<tr>
<td>Depreciation</td>
<td>32,249,177</td>
</tr>
<tr>
<td>Bank Charges &amp; Interest</td>
<td>1,492,441</td>
</tr>
<tr>
<td>Vehicle Cost</td>
<td>3,090,676</td>
</tr>
<tr>
<td>Rent</td>
<td>3,434,502</td>
</tr>
<tr>
<td>Professional Dev. &amp; Legal Fees</td>
<td>1,907,395</td>
</tr>
<tr>
<td>Minor Equipment &amp; Furnishings</td>
<td>433,794</td>
</tr>
<tr>
<td>Other Administrative Expenses</td>
<td>16,508,142</td>
</tr>
<tr>
<td>Electrical Services</td>
<td>6,900,921</td>
</tr>
<tr>
<td>Water Services</td>
<td>956,532</td>
</tr>
<tr>
<td>Repair &amp; Maintenance</td>
<td>10,281,746</td>
</tr>
<tr>
<td>Security</td>
<td>16,382,783</td>
</tr>
<tr>
<td>Cleaning</td>
<td>4,369,340</td>
</tr>
<tr>
<td>Other property &amp; Plant</td>
<td>4,868,695</td>
</tr>
<tr>
<td></td>
<td><strong>110,996,020</strong></td>
</tr>
</tbody>
</table>
Output Budgeting in the RHA’s

The MOH is embarking on coordinating the efforts of the RHAs to implement output budgeting by the year 2013. Monthly meetings were held with the Chief Financial Officers of the RHAs. Plans are on schedule to achieve this goal by reproducing output budgeting as adopted by the South West Regional Health Authority (SWRHA), learning from the experience of the SWRHA while taking into consideration the challenges faced towards ensuring better utilization of resources and to provide a clear direction.
Annual Service Agreement

The Annual Service Agreement (ASA) between the MoH and the RHAs is part of the budgeting and planning cycle of the Ministry. The MoH uses the ASA as a planning tool to direct resources towards programmes and to ensure the planning and resource allocation processes are linked to results. It also serves as an accountability instrument, as it identifies the specific issues and performance targets for which RHAs are accountable. The ASA arrangement was implemented in all RHAs for the first time in 2010/2011 and quarterly reports were submitted on each RHA which were assessed. An annual review at the end of fiscal year 2010/2011 was completed and the results revealed there was variable performance across the RHAs. A description of the ASA planning cycle is shown in Figure 1 below for fiscal 2011/2012:

Performance targets in the RHAs

The Quality Performance Targets identified in the ASA FY 2010/2011 were as follows:
1. Reduce unscheduled admissions for same day conditions by 50%;
2. Reduce infection rate in NICU by 70%;
3. Reduce complaints about laboratory service by 60%;
4. Reduce average waiting time for histology reports to 3 weeks;
5. Reduce adverse events in Obstetrics by 80%;
6. All referrals for malignant conditions seen within 7 days;
7. Surgeries for malignant conditions performed within one month;
8. All high-risk antenatal clients referred to specialist clinics for management from their first visit.

Performance is measured against what is stated in the Annual Service Agreement. The RHAs were required to submit a number of reports to the MoH at various intervals which allowed the Ministry to assess their performance with respect to:

i) meeting their agreed undertaking; and

ii) meeting the key performance indicators set out in the agreement.

A summary of the reports and the frequency of submission as required of each RHA are shown in Table 1.

<table>
<thead>
<tr>
<th>Reports</th>
<th>Frequency</th>
<th>Due date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary ASA Quarterly Progress Report</td>
<td>Quarterly</td>
<td>14 days after end of Quarter</td>
</tr>
<tr>
<td>Quality Quarterly Reports</td>
<td>Quarterly</td>
<td>14 days after end of Quarter</td>
</tr>
</tbody>
</table>

Based on the data submitted in the various Reports, the Ministry conducted quarterly performance assessment of each RHA.

The following are the performance targets of the RHAs identified formed the basis for the quarterly reports submitted to the MoH by the RHAs:-

T1    Reduce the number of infections in the Neonatal Intensive Care Unit (NICU) by 70%.
T2    Reduce the no. of complaints about laboratory services by 60%.
T3    Reduce waiting time for Medical reports to 2 weeks
T4    Reduce waiting time for histology reports to 3 weeks
T5    See all referrals for malignant conditions within 7 days
T6    Perform Surgeries for malignant conditions within one month
T7  Ensure that all high-risk ante-natal clients are referred to specialist clinics for management from first visit

T8  Reduce adverse events in Obstetrics by 80%

The information presented at Tables 2 – 5 shows each RHAs performance based on the quarterly reports submitted to the Ministry by the RHAs. The ASAs were signed at the end of the first Quarter 2011 and so there was no first Quarter data for analysis. Targets that were met were identified in bold and underlined:

<p>| TABLE 2  |
| EASTERN REGIONAL HEALTH AUTHORITY  |</p>
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Q2 Mar 2011</td>
</tr>
<tr>
<td>T1</td>
<td>No. of infections in the NICU</td>
<td>NA</td>
</tr>
<tr>
<td>T2</td>
<td>No. of complaints about laboratory services</td>
<td>0</td>
</tr>
<tr>
<td>T3</td>
<td>Average waiting time for Medical reports</td>
<td>2 weeks</td>
</tr>
<tr>
<td>T4</td>
<td>Average waiting time for histology reports</td>
<td>4 weeks</td>
</tr>
<tr>
<td>T5</td>
<td>Average length of time taken to see referrals for malignant conditions</td>
<td>7 days</td>
</tr>
<tr>
<td>T6</td>
<td>Average wait time to perform surgeries for malignant conditions</td>
<td>5 weeks</td>
</tr>
<tr>
<td>T7</td>
<td>% of high-risk ante-natal clients referred to specialist clinics for management from first visit</td>
<td>ND</td>
</tr>
<tr>
<td>T8</td>
<td>No. of adverse events in Obstetrics</td>
<td>2</td>
</tr>
</tbody>
</table>

NA = Not applicable. There is no Neonatal Intensive Care Unit (NICU) in this Region
ND= no data provided
Table 3

**NORTH WEST REGIONAL HEALTH AUTHORITY**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1</td>
<td>No. of infections in the NICU.</td>
<td>Q2 Mar 2011: 0, This data is not presently collected</td>
</tr>
<tr>
<td>T2</td>
<td>No. of complaints about laboratory services.</td>
<td>0</td>
</tr>
<tr>
<td>T3</td>
<td>Average waiting time for Medical reports.</td>
<td>12 days</td>
</tr>
<tr>
<td>T4</td>
<td>Average waiting time for histology reports.</td>
<td>3 days</td>
</tr>
<tr>
<td>T5</td>
<td>Average length of time taken to see referrals for malignant conditions.</td>
<td>7 days</td>
</tr>
<tr>
<td>T6</td>
<td>Average wait time to perform surgeries for malignant conditions.</td>
<td>2.5 weeks</td>
</tr>
<tr>
<td>T7</td>
<td>Percentage of high-risk ante-natal clients referred to specialist clinics for management from first visit.</td>
<td>ND, No data was captured during this period</td>
</tr>
<tr>
<td>T8</td>
<td>No. of adverse events in Obstetrics</td>
<td>0</td>
</tr>
</tbody>
</table>

ND- no data provided
Over the past two years, The NWRHA had zero complaints regarding Laboratory Services reported through the Client Feedback System. On analysis this may be for a number of reasons:

- The absence of a Laboratory Client Feedback System (rolled out to doctors, nurses and other internal staff who would be able to identify shortcomings as the primary users of the Lab).
- The fact that patients, though experiencing a delay in service as a result of untimely laboratory reports, may not be aware of the reason for the delay (they may also be unaware due to their medical condition (ICU Patients).
- Patients unaware of the Client Feedback System.
- Patients who choose not to complain (personal preference).

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Q2 Mar 2011</td>
</tr>
<tr>
<td>T1</td>
<td>No. of infections in the NICU</td>
<td>19 (SFGH)</td>
</tr>
<tr>
<td>T2</td>
<td>No. of complaints about laboratory services</td>
<td>No Complaints</td>
</tr>
<tr>
<td>T3</td>
<td>Average waiting time for Medical reports</td>
<td>4 months (SFGH)</td>
</tr>
<tr>
<td>T4</td>
<td>Average waiting time for histology reports</td>
<td>6 weeks -3 months</td>
</tr>
<tr>
<td>T5</td>
<td>Average length of time taken to see referrals for malignant conditions</td>
<td>7days</td>
</tr>
<tr>
<td>T6</td>
<td>Average wait time to perform surgeries for malignant conditions</td>
<td>2 months</td>
</tr>
<tr>
<td>T7</td>
<td>%. of high-risk ante-natal clients referred to specialist clinics for management from first visit</td>
<td>13.6%</td>
</tr>
<tr>
<td>T8</td>
<td>No. of adverse event in Obstetrics</td>
<td>4</td>
</tr>
</tbody>
</table>

In the SWRHA the recurrent complaints consists of the long waiting times for Histology reports and the placement of lab reports in the patient’s notes. However, the recent addition of a full time Pathologist is expected to improve the situation. Additionally, the presence of Lab Information System (LIS) of some of the wards is expected to assist with the availability of prompt results to patients and the placement of reports on patient’s notes which in itself is a collaborative effort among the Nurses, Interns and Clerks.
The Point of Care Testing (POCT) in the Emergency Department has assisted tremendously to reduce complaints about long wait times. A Suggestion Box was also placed in the Lab to receive feedback.

Table 5

North Central Regional Health Authority

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qu. 1</td>
<td>No. of infections in the NICU</td>
<td>47&lt;sup&gt;a&lt;/sup&gt; 11 8 8 6 7 16</td>
</tr>
<tr>
<td>Qu. 2</td>
<td>No. of complaints about laboratory services</td>
<td>Chag. – 2 Arima – 0 MHWH – 1 EWSMC – 16 Chag. – 2 Arima – 1 MHWH – 2 EWSMC – 25 Chag. – 1 Arima – 0 MHWH – 3 EWSMC – 17 Chag. – 0 Arima – 0 MHWH – 0 EWSMC – 15 Chag. – 0 Arima – 0 MHWH – 0 EWSMC – 14 Chag. – 0 Arima – 1 MHWH – 1 EWSMC – 17</td>
</tr>
<tr>
<td>Qu. 3</td>
<td>Average waiting time for Medical reports</td>
<td>EWSMC: average waiting time approx. 30 working days MHWH: 10-14 working days. Chaguanna: average waiting time 1 month Arima: 3 – 4 weeks EWSMC: average waiting time approx. 30 working days MHWH: 10-14 working days. Chaguanna: average waiting time 1 month Arima: 3 – 4 weeks EWSMC: average waiting time approx. 30 working days MHWH: 10-14 working days. Chaguanna: average waiting time 1 month Arima: 3 – 4 weeks EWSMC: average waiting time approx. 30 working days MHWH: 10-14 working days. Chaguanna: average waiting time 1 month Arima: 3 days EWSMC: average waiting time approx. 30 working days MHWH: 10-14 working days. Chaguanna: average waiting time 1 month Arima: 3 days</td>
</tr>
<tr>
<td>Qu. 4</td>
<td>Average waiting time for histology reports</td>
<td>Wait time at EWSMC: 3-4 months Wait time at MHWH: 2 months Wait time at EWSMC: 12 months Wait time at MHWH: 2 months Wait time at EWSMC: 12 months Wait time at MHWH: 2 months Wait time at EWSMC: 12 months Wait time at MHWH: 2 months Wait time at EWSMC: 12 months Wait time at MHWH: 2 months</td>
</tr>
<tr>
<td>Qu. 5</td>
<td>Average length of time taken to see referrals for malignant conditions</td>
<td>EWSMC: *1 week MHWH: approx. 1 week EWSMC: *1 week MHWH: approx. 1 week EWSMC: *1 week MHWH: approx. 1 week EWSMC: *1 week MHWH: approx. 1 week EWSMC: *1 week MHWH: approx. 1 week EWSMC: *1 week MHWH: approx. 1 week EWSMC: *1 week MHWH: approx. 1 week</td>
</tr>
<tr>
<td>Qu. 6</td>
<td>Average wait time to perform surgeries for malignant conditions</td>
<td>EWSMC: High priority cases seen within approx. 1 month EWSMC: High priority cases seen within approx. EWSMC: High priority cases seen within approx. EWSMC: High priority cases seen within approx. EWSMC: High priority cases seen within approx. EWSMC: High priority cases seen within approx. EWSMC: High priority cases seen within approx.</td>
</tr>
</tbody>
</table>
5th Report of the Joint Select Committee on Ministries, Statutory Authorities and State Enterprises (Group 1)

Level of Services

The 2010/2011 recurrent budget allocation to the RHA was based on the target that the range and volume of services provided will be similar to those provided in 2009, subject to the specific changes. Table 6 outlines RHAs Services delivered in 2009:

Table 6

<table>
<thead>
<tr>
<th>Eastern RHA</th>
<th>Primary Care Attendances</th>
<th>82 705</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Outpatient/Ambulatory Attendances</td>
<td>25 832</td>
</tr>
<tr>
<td></td>
<td>SGH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Inpatients</td>
<td>8 251</td>
</tr>
<tr>
<td></td>
<td>SGH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total A&amp;E Attendances</td>
<td>76 051</td>
</tr>
<tr>
<td></td>
<td>SGH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MAYARO DHF</td>
<td></td>
</tr>
<tr>
<td>North West RHA</td>
<td>Primary Care Attendances</td>
<td>170</td>
</tr>
<tr>
<td></td>
<td>Total Outpatient/Ambulatory Attendances</td>
<td>130</td>
</tr>
<tr>
<td></td>
<td>POSGH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Radiotherapy Centre</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>POSGH</td>
<td>18 164</td>
</tr>
<tr>
<td></td>
<td>St Ann’s Hospital</td>
<td>44 539</td>
</tr>
<tr>
<td></td>
<td>St James Medical Complex – Gerontology</td>
<td>2 138</td>
</tr>
<tr>
<td></td>
<td>- Physical Med</td>
<td>27</td>
</tr>
</tbody>
</table>
The service targets identified in the RHAs for the period of the Annual Services Agreement of 2010/11 were:

**Table 7**

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Target Details</th>
</tr>
</thead>
</table>
| Maternal and Child Health – Immunization | 95% immunization coverage of children 0-4 years with vaccines against poliomyelitis, diphtheria, pertussis, tetanus, hepatitis B, haemophilus influenzae type b, measles, mumps, rubella and yellow fever, delivered in accordance with the current immunization schedule.  
- 85% attendance rates for infants <1year (including Health Visitor Contacts). |
Table 8 below illustrates some of the constraints experienced by the following RHAs:

**Constraints in the RHAs**

<table>
<thead>
<tr>
<th>REGIONAL HEALTH AUTHORITY</th>
<th>CONSTRAINTS</th>
</tr>
</thead>
</table>
| Eastern Regional Health Authority | - Reduced funding to conduct health care service delivery.  
- Unavailability of contractual agreements for preventative maintenance and servicing of vital equipment, medical, technological and otherwise.  
- Insufficient nursing staff/medical staff to adequately conduct services at both primary and secondary health care levels.  
- Staff residing at distant areas for example Siparia, Cunupia, Barackpore.  
- Aging staff.  
- The need for additional staff with post basic training and younger nurses to be trained in areas such as Trauma and Midwifery. |
| North Central Regional Health Authority | - The shortage of technical Human Resource staff including pharmacists, radiographers and Medical Laboratory Technicians.  
- The need to revise the methodology currently employed to deliver healthcare based on the current needs of the population such as opening hours, days of clinics, structure of clinics etc. |
| South West Regional Health Authority | - Insufficient Funds.  
- Absence of Maintenance Personnel to some facilities.  
- Lack of additional transportation. |
Mechanisms to deal with Complaints in the Health Sector

- All RHAs have a system for receiving complaints (suggestion boxes, customer relations officers (CROs), emails, letters to the editors of newspapers etc.).
- The RHA’s are outfitted with a Quality Risk Management Department at the executive level at all the main hospitals. There are also positions of Quality Coordinators who are also present throughout the Primary Health Care areas, Customer Services Officers and Monitoring Officers.
- Complaints at the institutions are entertained by Ground Officers who investigate them. Complaints requiring high level interventions are dealt with by a sub-committee of the Board called the Quality of Risk Management Committee consisting of the Medical Chief of Staff and key officers of the relevant institutions.
- The Ministry of the People and Social Development also engages in treating with complaints from citizens in the Health Sector.
- Additionally, the MoH has its own unit which deals with customer relations and customer complaints as well as a Quality Directorate Unit.

Primary Health Care Appointment System

The Block Appointment System was introduced in Primary Care Facilities as well as Hospital Out-Patients’ Facilities as a pilot project to ease the long waiting time to see doctors. Other measures to address the issue include a fax system of referrals between the Primary Care and Outpatients clinic with appointment date and time returned via fax to the respective health facility.

Computerization of systems in the Health Sector

The status of the computerization of systems in the Health Sector is outlined in table 9 below:

<table>
<thead>
<tr>
<th>REGIONAL HEALTH</th>
<th>STATUS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>AUTHORITY</th>
<th>Presently awaiting the networking aspect which would lead ultimately to better management of patient care and records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Regional Health Authority</td>
<td>Presently awaiting the networking aspect which would lead ultimately to better management of patient care and records</td>
</tr>
<tr>
<td>North Central Health Authority</td>
<td>Presently awaiting the networking aspect which would lead ultimately to better management of patient care and records</td>
</tr>
<tr>
<td>North West Regional Health Authority</td>
<td>The Ministry commenced a project and continuous meetings are held with the Authority. The following is the implementation plan for the project:</td>
</tr>
<tr>
<td></td>
<td><strong>Stage</strong></td>
</tr>
<tr>
<td></td>
<td>Planning</td>
</tr>
<tr>
<td></td>
<td>Workflow and process analysis</td>
</tr>
<tr>
<td></td>
<td>System Installation</td>
</tr>
<tr>
<td></td>
<td>Staff Training</td>
</tr>
<tr>
<td></td>
<td>Conversion</td>
</tr>
<tr>
<td></td>
<td>Preparation for go-live date</td>
</tr>
<tr>
<td></td>
<td>Go-Live</td>
</tr>
<tr>
<td></td>
<td>Lessons Learned</td>
</tr>
<tr>
<td>South West Regional Health Authority</td>
<td>Completed the installation of structured cabling at all SWRHA facilities. Replaced computers which were at the end of their life cycle. Installation of additional computers throughout the facilities based on need. Upgraded and replaced SWRHA’s servers.</td>
</tr>
<tr>
<td></td>
<td>✓ SWRHA has a computerized Financial System, PACS, LIS, and Radiology System.</td>
</tr>
<tr>
<td></td>
<td>✓ A Patient Registration System has been in operation since 2007. It is now being replaced by the ADT Forms applications. SWRHA is piloting the ADT Forms in A&amp;E at San Fernando General Hospital.</td>
</tr>
<tr>
<td></td>
<td>✓ The Surgical Waiting List has been implemented at SFGH. However, the system falls short in creating reports needed.</td>
</tr>
<tr>
<td></td>
<td>✓ Two (2) IT staff members are currently being trained in Advanced Excel to assist with the reporting for Surgical Waiting List.</td>
</tr>
<tr>
<td></td>
<td>✓ Injury Surveillance is currently deployed at SFGH. IT will be rolled out to the other DHFs and AHPF within the next three months.</td>
</tr>
<tr>
<td></td>
<td>✓ The three CMOH offices, the District Health Facilities and Area Hospital Point Fortin have metro connectivity to SWRHA with access to e-mail, internet and the financial system at their locations.</td>
</tr>
<tr>
<td></td>
<td>✓ SWRHA’s IT Department is in the process of planning adopt the new network installed which will allow for connectivity on the wards and</td>
</tr>
</tbody>
</table>
Patients’ Bill of Rights
The MoH is in the process of drafting a ‘Patient’s Bill of Rights’ wherein a system will be created for patients to have the authority to voice complaints and have them resolved outside of the court system similar to that of the Police Complaints Authority. The Patients’ Bill of Rights will codify the rights found in the document called the ‘Patients Charter of Rights and Obligations’ and will amend or increase those rights in accordance with the Ministry’s policy regarding the rights of a patient.

Quality Management in the Health Sector
- There are quality improvement departments in all the RHAs which deal with patient complaints and adverse events. The department conducts thorough investigations and suggests recommendations to the Quality Risk Management Unit a sub-committee of the Board of Directors (NWRHA) and to the Health Sector Quality Council (SWRHA).
- The Ministry utilizes a comprehensive quality standards and accreditation programme that highlights standards of procedures for primary health care systems as well as hospital systems and vertical services which are mandated to quality improvement.
- Each RHA has a Quality Unit led by a Quality Manager and audits are produced.
- The MoH provides standards and procedures developed by the Ministry and an Accreditation Standards Manual.
- The Ministry has been working diligently alongside the medical board to ensure that the quality of medical practice improves by assuring continuous medical education for revalidation of degrees.
- There is also a Health Sector Quality Council.
- RHA Performance Monitoring Teams have recently been added to the Ministry. The RHAs also have counterpart monitoring teams.
- Indicators inclusive of customer service indicators have been developed.
- A customer service or customer client feedback survey is also used to monitor quality in the RHAs by the quality department.
Table 10

Health Centres with 24 hour services

<table>
<thead>
<tr>
<th>REGIONAL HEALTH AUTHORITY</th>
<th>HEALTH CENTRE</th>
<th>HOURS OF WORK</th>
<th>OBSTACLES TO HAVING A HEALTH CENTRE IN A DISTRICT OPENED ON A 24HOUR BASIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NWRHA</td>
<td>St James District Health Facility - Accident and Emergency</td>
<td>8a.m.-9.p.m. 24/7</td>
<td>The matter is under review/discussion with the objective of selecting one Health Centre in a district to be opened on a 24 hour basis</td>
</tr>
<tr>
<td>NCRHA</td>
<td>St Joseph Enhanced Health Centre Arima Health Facility: - Accident and Emergency - General Practice Clinic Chaguana Health Facility: ▪ Accident and Emergency ▪ Radiology Department ▪ General Practice Clinic ▪ Laboratory (CBC &amp; Dengue Rapid)</td>
<td>8a.m.-10p.m. 24/7 8a.m.-8p.m. Mon-Fri &amp; 8a.m.-4p.m. on Weekends</td>
<td>The impediments to having a 24 hour health center service were identified as human resource deficits, questionable cost effectiveness for the anticipated low patient flow and security concerns that can deter both patient and staff</td>
</tr>
<tr>
<td>ERHA</td>
<td>Mayaro District Health Facility Rio Claro Health Centre Toco Health Centre</td>
<td>24/7 24/7 24/7</td>
<td>The Nariva/Mayaro district experiences staffing issues, a lack of infrastructure, ambulance services and equipment. Similarly, at the St Andrew/St. David district there is a lack of human resources, infrastructure, security, finance and accommodation for staff. Also, there is need for a proper implementation plan as well as a needs assessment survey to justify the need for a 24 hour service.</td>
</tr>
<tr>
<td>SWRHA</td>
<td>Couva District Health Facility Princes Town Siparia Point Fortin: Accident and Emergency San Fernando General Hospital: ▪ Accident and Emergency ▪ Radiology Services</td>
<td>24/7 24/7 24/7 24/7</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
Table 11
Facilities equipped with Standby Generators

<table>
<thead>
<tr>
<th>Regional Health Authority</th>
<th>Facilities equipped with Standby Generators</th>
</tr>
</thead>
</table>
| Eastern Regional Health Authority | - Sangre Grande Hospital  
- Toco Health Centre  
- County Health Administration Office St Andrews/St David  
- Cumana Health Centre  
- Rio Claro Health Centre  
- Mayaro District Health Facility  
- County Health Administration Office Nariva/ Mayaro |
| North Central Regional Health Authority | - St. Joseph Enhanced Health Centre- to preserve vaccines viability  
- Arima Health Facility- to preserve vaccines viability at A.H.F.  
- Blanchisseusse Health Centre to preserve vaccines viability only (lasts only 2 – 3 hours).  
- Chaguanas Health Facility to preserve vaccines |
| North West Regional Health Authority | - St. James District Health Facility  
- Morvant Health Centre  
- Oxford Street Health Centre  
- San Juan Centre(in procurement process)  
- El Socorro Health Centre(in procurement process) |
| South West Regional Health Authority | - Couva District Health Facility  
- Princes Town District Health Facility  
- Siparia District Health Facility  
- Area Hospital Point Fortin  
- San Fernando General Hospital |

Human Resource Issues
There exists a shortage of medical professionals e.g. doctors and nurses. As a result of the shortage of human resources overtime becomes necessary. However, some strategies that are being considered to address the deficiency consist of extensive planning, training, external and internal recruitment as well as the scholarships.
Table 12

Status of vacancies for doctors as at January 31, 2012 was as follows:

<table>
<thead>
<tr>
<th>Medical Doctors</th>
<th>SWRHA</th>
<th>ERHA</th>
<th>NCRHA</th>
<th>NWRHA</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant /Specialist Medical Officer</td>
<td>32</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>49</td>
</tr>
<tr>
<td>Registrar</td>
<td>65</td>
<td>11</td>
<td>42</td>
<td>13</td>
<td>131</td>
</tr>
<tr>
<td>House Officer</td>
<td>41</td>
<td>8</td>
<td>4</td>
<td>50</td>
<td>103</td>
</tr>
<tr>
<td>Primary Care Physician I</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Primary Care Physician II</td>
<td>22</td>
<td>10</td>
<td>6</td>
<td></td>
<td>38</td>
</tr>
<tr>
<td>Primary Care Physician III</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Medical Officer I</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Senior Medical Officer</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>171</td>
<td>39</td>
<td>61</td>
<td>71</td>
<td>342</td>
</tr>
</tbody>
</table>

The main shortages were specialists (inclusive of Registrars and Senior Primary Care Physicians) which accounted for almost 66% of these vacancies.

Human Resource Planning for the Public Health Sector
Health Needs Assessment
The last comprehensive Health Needs Assessment was conducted in 1994 under the Health Sector Reform Program. The MOH has been in the process of retaining technical assistance to undertake another National Health Survey which would form the first Phase of an updated National Health Needs Assessment. The systematic assessment usually involves three (3) components:

1. Conducting a National Health Survey to identify the specific health needs of the population
2. Performing supply side analysis which entails an inventory and analysis of data about the numbers, types and characteristics of available human and service resources.

3. Prioritization and rationalization where health and program priorities are identified and national health targets set given the above two components.

Additionally, Human Resources Health Studies are being conducted with the assistance of the RHAs to determine the mix of skills required to efficiently and effectively address the health needs of the population and to deliver the services required. These studies include:

- **Workload Indicator of Staffing Needs (WISN) Study**
  The main purpose of this study is to conduct an independent assessment of the existing staffing needs of public health institutions as they vary by facility type, size and by region.

- **The Manpower Requirements of Private Health Institutions**

- **A comprehensive Training Needs Assessment**

- **Development of Staff to Patient Ratios**
  A Discussion Paper has been drafted on Staff to Patient Ratios by the MOH. The draft is being considered by the RHAs and national staff to patient ratios will be finalized and hence forth used as part of the human resource planning process for clinical and allied staff.

- **Human Resource Planning and Development of the 10 year Manpower plan for the Health Sector**
  The Health Sector Human Resource Planning and Development Unit of the MOH has also developed a 3-5 year Manpower Plan for the Public Health Sector as an interim measure to the development of the 10 year Manpower Plan. The Ministry of Health and RHA plans to meet to begin making projections for the human resource needs over the next three (3) years.

**Training**

The MoH is in the process of undertaking the following initiatives with respect to training:
a. Collaborating with the Trinidad and Tobago Health Training Centre (TTHTC) to be the in-service training centre for the public health sector by offering programmes ranging from HIV/AIDS related training, training with respect to CNCDs, mental health and other qualitative courses such as management of diabetes, monitoring and evaluation and conflict management. These courses are either in the process of being developed or approval is being sought for their delivery.

b. Liaising with tertiary level institutions to expand the range of programmes offered and to meet manpower needs of the sector.

c. Exploring distance learning opportunities for example, expanding the use of telehealth/telemedicine modes in the MoH and RHAs.

d. Re-activating Staff Development Units at hospitals through the RHAs. Thus far, the North Central Regional Health Authority is active while the other RHAs are in the process of re-activating their units.

e. Training community nurses. District nurses are trained by the Ministry of Tertiary Education and Skills Training (MTEST), Schools of Nursing, (formerly under the domain of the MOH), while the District Health Visitors are trained by the University of the West Indies (UWI).

➢ In order to participate in the District Nursing programme, nurses involved in the programme are required to be trained in midwifery as prerequisite. However, while training in midwifery due to a shortage of midwives at various secondary (hospital) institutions, such nurses experience difficulty in being released to complete training in District Health Visiting.

➢ As such, there exists no cohort of District Nurses in training but a batch of thirty (30) persons are presently being trained as District Health Visitors at the University of the West Indies.

➢ Discussions were held with the MTEST, School of Nursing and COSTAATT to implement a direct entry midwifery programme to address the shortage. As such, COSTAATT began training nurses in midwifery in September, 2012. Currently,
there are sixty (60) registered nurses being trained in midwifery. Therefore, by July, 2013 there will be one hundred and twenty (120) or RN/Midwives.

- Other ongoing training consists of the Masters of Health Administration programme at the University of Trinidad and Tobago

**External Recruitment**

The MoH continues its recruitment from abroad to help meet the demand for public health care services. The first batch of thirty-seven (37) doctors and twenty-eight (28) nurses arrived from Cuba in November 2011. All these officers, with the exception of one (1) are still employed with the Ministry of Health. A second batch of sixteen (16) doctors and fifty-four (54) nurses arrived in the second quarter on June, 2012 while the last batch of eight (8) doctors and twenty-eight (28) nurses were recruited in November, 2012. Therefore, a total of one hundred and seventy one (171) health care professionals consisting of sixty-one (61) doctors and one hundred and ten (110) nurses from Cuba were employed in 2011-2012 by the MoH.

**Local Recruitment**

- **Auxiliary Staff:**
  - A strategy also being considered is to employ auxiliary staff such as Patient Care Assistants (PCAs) and Aides to Nurses (ATNs) as is done in other countries so nurses can concentrate on their nursing procedure.

- **Expansion of medical and allied programmes:**
  - Discussions with UWI and COSTAATT began in 2011 for the expansion of their medical and allied programmes.
  - UWI submitted a proposal for the accommodation and expansion of their specialist medical programme.
  - The MOH is also considering the requirements for such medical specialist trainees to be accommodated at the teaching hospitals, or at private hospitals which can be accredited as teaching hospitals.
  - COSTAATT as at November 16, 2012 had a total of one thousand, six hundred and fifty four (1,654) persons enrolled in their nursing programmes at their various campuses as follows:
Table 13

**Enrolment - Nursing Programmes – 2012/2013**

<table>
<thead>
<tr>
<th>Count of ID</th>
<th>DEPARTMENT</th>
<th>CAMPUS</th>
<th>PROGRAMME CODE</th>
<th>PROGRAMME</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nursing</td>
<td>City Campus</td>
<td>BGNU_AAS</td>
<td>Basic General Nursing</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BGNU_AS</td>
<td>Basic General Nursing</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BGNU_BS</td>
<td>Basic General Nursing</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BPNU_AAS</td>
<td>Basic Psychiatric Nursing</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BPNU_BS</td>
<td>Psychiatric Nursing</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td><strong>City Campus Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>91</strong></td>
</tr>
<tr>
<td></td>
<td>Port of Spain Nursing Centre</td>
<td></td>
<td>BGNU_AAS</td>
<td>Basic General Nursing</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BGNU_BS</td>
<td>Basic General Nursing</td>
<td>566</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BPNU_BS</td>
<td>Psychiatric Nursing</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td><strong>Port of Spain Nursing Centre Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>591</strong></td>
</tr>
<tr>
<td></td>
<td>Sangre Grande Campus</td>
<td>BGNU_BS</td>
<td>Basic General Nursing</td>
<td>106</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BPNU_BS</td>
<td>Psychiatric Nursing</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Sangre Grande Campus Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>107</strong></td>
</tr>
<tr>
<td></td>
<td>South Campus</td>
<td>BGNU_AAS</td>
<td>Basic General Nursing</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BGNU_AS</td>
<td>Basic General Nursing</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BGNU_BS</td>
<td>Basic General Nursing</td>
<td>619</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BPNU_BS</td>
<td>Psychiatric Nursing</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td><strong>South Campus Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>638</strong></td>
</tr>
<tr>
<td></td>
<td>St Ann's Nursing Centre</td>
<td>BGNU_BS</td>
<td>Basic General Nursing</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BPNU_AAS</td>
<td>Basic Psychiatric Nursing</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BPNU_BS</td>
<td>Psychiatric Nursing</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td><strong>St Ann's Nursing Centre Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>59</strong></td>
</tr>
<tr>
<td></td>
<td>Tobago Campus</td>
<td>BGNU_AAS</td>
<td>Basic General Nursing</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BGNU_BS</td>
<td>Basic General Nursing</td>
<td>155</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BPNU_BS</td>
<td>Psychiatric Nursing</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td><strong>Tobago Campus Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>167</strong></td>
</tr>
<tr>
<td></td>
<td>Trincity/East Centre</td>
<td>BGNU_BS</td>
<td>Basic General Nursing</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Trincity/East Centre Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

**Enrolment - Nursing Programmes – 2012/2013**

<table>
<thead>
<tr>
<th>Count of ID</th>
<th>DEPARTMENT</th>
<th>CAMPUS</th>
<th>PROGRAMME CODE</th>
<th>PROGRAMME</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nursing Total</td>
<td></td>
<td></td>
<td></td>
<td><strong>1654</strong></td>
</tr>
<tr>
<td></td>
<td>Grand Total</td>
<td></td>
<td></td>
<td></td>
<td><strong>1654</strong></td>
</tr>
</tbody>
</table>
Coming out of the total figure, twenty-nine (29) nursing students (10 new students and 19 re-sits) are presently being trained at the SWRHA/San Fernando while seven (7) employees of the NCRHA are enrolled at COSTAAT pursuing nursing.

- **Training to fill existing vacancies:**
  - In order to fill existing vacancies and in anticipation of further requirements the MOH is seeking to train and develop as well as offer scholarships and bursaries to train and educate persons in specific areas of medical expertise.
  
  - The MOH submitted a list of priority areas for allied health professionals to the Ministry of Public Administration (MPA) in the years 2010 and 2011.
  
  - In February 2012, the Ministry provided an updated list of needed medical professionals required over the medium term. The number of persons who have received training based on existing needs in the public health sector in the medical and allied fields was seven (7) (see Table 14 below for details).
Table 14

MINISTRY OF HEALTH
PROJECTION OF COMPLETION DATES OF RETURNING SCHOLARSHIP/FULL PAY
STUDY LEAVE RECIPIENTS

<table>
<thead>
<tr>
<th>No</th>
<th>Des</th>
<th>Sex</th>
<th>Name of Course of Study</th>
<th>Degree</th>
<th>Institution</th>
<th>Expected Date of Completion</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Dr.</td>
<td>M</td>
<td>Nephrology</td>
<td>Fellowship</td>
<td>University of Toronto, Canada</td>
<td>December 31, 2012</td>
<td>Request was made to NCRHA for employment of officer</td>
</tr>
<tr>
<td>2.</td>
<td>Dr.</td>
<td>M</td>
<td>Neurology</td>
<td>Fellowship</td>
<td>University of Calgary, Toronto, Canada</td>
<td>March 2014</td>
<td>2 yrs FPSL wef April 2012</td>
</tr>
<tr>
<td>3.</td>
<td>Dr.</td>
<td>M</td>
<td>Neonatal Medicine</td>
<td>Fellowship</td>
<td>University of Toronto, Canada</td>
<td>June 2014</td>
<td>2 yrs FPSL wef July 2012</td>
</tr>
<tr>
<td>4.</td>
<td>Dr.</td>
<td>M</td>
<td>Clinical Neurology</td>
<td>MSc</td>
<td>Institute of Neurology, University College, London UK</td>
<td>September 2013</td>
<td>1 yr FPSL wef September 2012 Officer received a Commonwealth Scholarship, Salary and applicable allowances paid by SWRHA. No expenditure incurred by MoH.</td>
</tr>
<tr>
<td>5.</td>
<td>Dr.</td>
<td>M</td>
<td>Cardiology</td>
<td>Msc</td>
<td>Canterbury Christ Church University England</td>
<td>October 2013</td>
<td>1 yr FPSL wef October 2012</td>
</tr>
<tr>
<td>6.</td>
<td>Ms.</td>
<td>F</td>
<td>Medical Laboratory Technology</td>
<td>BSc</td>
<td>University of Technology, Jamaica</td>
<td>August 2013</td>
<td>4 yr Scholarship wef August 2009</td>
</tr>
<tr>
<td>7.</td>
<td>Dr.</td>
<td>F</td>
<td>Radiation Oncology</td>
<td>Master of Medicine Degree</td>
<td>University of Cape Town, South Africa</td>
<td>March 2013</td>
<td>4 yr Scholarship wef March 2009. Processing a request for an extension from March 2013 to June 2013.</td>
</tr>
</tbody>
</table>

Nine (9) persons also received bursaries in areas of need from the Ministry to pursue medical and allied health programmes (please see Table 15 below).
Table 15

MINISTRY OF HEALTH
RETURNING BURSARY RECIPIENTS
FOR 2012

<table>
<thead>
<tr>
<th>No</th>
<th>Sex</th>
<th>Name of Course of Study</th>
<th>Degree</th>
<th>Institution</th>
<th>Expected Date of Completion</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>F</td>
<td>Medicine</td>
<td>MB MED</td>
<td>College of St. Benedict’s/St. John’s University USA</td>
<td>September 31, 2012</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>F</td>
<td>Clinical Psychology</td>
<td>PsyD</td>
<td>Nova Southeastern University</td>
<td>July 31, 2012</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>F</td>
<td>Clinical Psychology</td>
<td>PsyD</td>
<td>University of Denver</td>
<td>July 31, 2012</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>F</td>
<td>Optometry</td>
<td>BSc.</td>
<td>Cardiff University, UK</td>
<td>July 31, 2012</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>F</td>
<td>Medicine</td>
<td>MBBS</td>
<td>St. George’s University, Grenada</td>
<td>May 31, 2012</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>F</td>
<td>Medicine</td>
<td>MD</td>
<td>Howard (USA)</td>
<td>May 31, 2012</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>F</td>
<td>Counselling</td>
<td>MSc.</td>
<td>UWI (Mona)</td>
<td>May 31, 2012</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>F</td>
<td>Speech Therapy</td>
<td>BSc.</td>
<td>University of Reading, United Kingdom</td>
<td>September 2012</td>
<td>Awardee completed one year and changed University without prior approval. She was granted approval to serve obligatory service from March 2014 for monies expended on scholarship.</td>
</tr>
</tbody>
</table>

The number of persons who received training abroad was sixteen (16).

The RHAs also provided information on the number of persons who received training to fill vacancies as follows:

**Eastern Regional Health Authority**

In the ERHA, a total of 51 persons have received training to fill existing vacancies in the medical field and in anticipation of further needs (see Table 16 below).
Table 16

<table>
<thead>
<tr>
<th>POSITION/ TYPE OF OFFICER</th>
<th>TRAINING RECEIVED</th>
<th>INSTITUTE/ VENUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Health Visitor</td>
<td>4 Ultrasonography</td>
<td>COSTAATT and Michner Institute for Applied Arts</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>1 Ultrasonography</td>
<td>COSTAATT and Michner Institute for Applied Arts</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>1 Post Basic Training in Midwifery</td>
<td>School of Midwifery</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>5 Intensive Care Nursing</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>1 Operating Theatre</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>3 Trauma and Emergency</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>1 Cardiac Sonography Training</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>3 Midwifery Training Programme</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>1 Diploma in Ultrasound Science</td>
<td>College of Ultrasound Sciences</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>2 Bsc Oncology</td>
<td>UWI</td>
</tr>
<tr>
<td>Enrolled Nursing Assistant</td>
<td>4 General Nursing Programme</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Messenger I</td>
<td>1 General Nursing Programme</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Receptionist/Telephone Operator</td>
<td>1 General Nursing Programme</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Clerk I</td>
<td>1 General Nursing Programme</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Enrolled Nursing Assistant</td>
<td>1 BSc Nursing</td>
<td>COSTAATT</td>
</tr>
<tr>
<td>Enrolled Nursing Assistant</td>
<td>1 Associate in Science Degree in General Nursing</td>
<td>College in Science, Technology and Applied Arts of Trinidad &amp; Tobago</td>
</tr>
<tr>
<td>Enrolled Nursing Assistant</td>
<td>1 Scrub Technician</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Messenger I</td>
<td>General Nursing Programme</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Receptionist/Telephone Operator</td>
<td>General Nursing Programme</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Clerk I</td>
<td>General Nursing Programme</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Hospital Attendant I</td>
<td>Enrolled Nursing Assistant Programme</td>
<td>Ministry of Health</td>
</tr>
</tbody>
</table>
In the ERHA, a total of six (6) persons have received or completed training abroad.

Table 17

<table>
<thead>
<tr>
<th>POSITION/ TYPE OF OFFICER</th>
<th>TRAINING RECEIVED</th>
<th>INSTITUTE/ VENUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Assistant</td>
<td>2 Enrolled Nursing Assistant Programme</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Dental Assistant</td>
<td>1 Enrolled Nursing Assistant Programme</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Radiographer</td>
<td>1 Ultrasonography</td>
<td>COSTAATT and Michner Institute for Applied Arts</td>
</tr>
<tr>
<td>Medical Officer I</td>
<td>1 Doctor of Medicine in Medical Microbiology</td>
<td>UWI, Mona</td>
</tr>
<tr>
<td>Pharmacist II</td>
<td>1 Bachelor of Science Degree in Pharmacy</td>
<td>UWI, St. Augustine</td>
</tr>
<tr>
<td>District Nurse</td>
<td>1 Diploma in District Health Visiting</td>
<td>UWI</td>
</tr>
<tr>
<td>Midwife</td>
<td>1 Diploma in District Health Visiting</td>
<td>UWI</td>
</tr>
<tr>
<td>Registrar (Medicine)</td>
<td>1 Cardiology Fellowship</td>
<td>NCRHA in Collaboration with John Hopkins University</td>
</tr>
<tr>
<td>Female Labourer</td>
<td>1 Social Work</td>
<td>COSTAATT</td>
</tr>
<tr>
<td>Clerk I</td>
<td>1 Assoc. in Applied Science Degree in Environmental Health</td>
<td>COSTAATT</td>
</tr>
</tbody>
</table>
The South West Regional Health Authority:

Table 18

<table>
<thead>
<tr>
<th>NO.</th>
<th>TRAINING PROGRAMME</th>
<th>POSITIONS OF PARTICIPANTS</th>
<th>NUMBER</th>
<th>DEPARTMENTS</th>
<th>DATE / PERIOD</th>
<th>TYPE OF AWARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Masters in Public Health at Johns Hopkins, USA</td>
<td>Primary Care Physician I</td>
<td>1</td>
<td>CMOH - Victoria</td>
<td>June 30, 2010 to May, 2011</td>
<td>Full Pay Study Leave (FPSL)</td>
</tr>
<tr>
<td>2</td>
<td>Fellowship in Cardiology with the Trinidad and Tobago Health Sciences Institute (TTHS)/ Johns Hopkins Medicine International</td>
<td>Registrar</td>
<td>1</td>
<td>GHSF</td>
<td>February 2010-February 2012</td>
<td>No Pay Study Leave (NPSL)</td>
</tr>
<tr>
<td>3</td>
<td>DM Programme in Neurosurgery at UWI, Mona, Jamaica</td>
<td>House Officers</td>
<td>2</td>
<td>Neurosurgery, GHSF</td>
<td>Eight (8) years</td>
<td>Full Pay Study Leave (FPSL)</td>
</tr>
<tr>
<td>4</td>
<td>Clinical Postgraduate Degrees in (1) Gastroenterology at Barts and the London School of Medicine and Dentistry &amp; (2) Dermatology at Cardiff University</td>
<td>House Officers</td>
<td>2</td>
<td>CDHF</td>
<td>January 28 to October 31, 2010 / January 26 to Nov 30, 2010</td>
<td>No Pay Study Leave (NPSL)</td>
</tr>
<tr>
<td>5</td>
<td>Elective in Emergency Medicine</td>
<td>Registrar</td>
<td>1</td>
<td>A &amp; E, GHSF</td>
<td>July 01 - August 12, 2010</td>
<td>Full Pay Study Leave (FPSL)</td>
</tr>
<tr>
<td>6</td>
<td>Trainer Cardiac Sonographer/Cardiac Ultrasound Training</td>
<td>Radiographers I and II</td>
<td>2</td>
<td>SFGH</td>
<td>w/e March 14, 2011</td>
<td>Full Pay Study Leave (FPSL)</td>
</tr>
<tr>
<td>7</td>
<td>DM in Pathology</td>
<td>House Officer</td>
<td>1</td>
<td>SFGH</td>
<td>Three (3) years from July 01st, 2011</td>
<td>Full Pay Study Leave (FPSL)</td>
</tr>
<tr>
<td>8</td>
<td>Diploma in District Health Visiting</td>
<td>Registered Nurses</td>
<td>5</td>
<td>Across SWRHA</td>
<td>August 29, 2011 to June 30, 2012</td>
<td>Full Pay Study Leave (FPSL)</td>
</tr>
<tr>
<td>9</td>
<td>MSc in Neurology at the Institute of Neurology, University College London, UK</td>
<td>Registrar</td>
<td>1</td>
<td>SFGH</td>
<td>September 24, 2012-September 23, 2013</td>
<td>Full Pay Study Leave (FPSL)</td>
</tr>
<tr>
<td>10</td>
<td>MSc. in Cardiology at Christchurch University in Kent, UK</td>
<td>House Officer</td>
<td>1</td>
<td>Emergency Department CDHF</td>
<td>October 08, 2012 to October 11, 2013</td>
<td>Full Pay Study Leave (FPSL)</td>
</tr>
<tr>
<td>11</td>
<td>On line Doctor of Physical Therapy Programme</td>
<td>Senior Physiotherapist</td>
<td>1</td>
<td>Physiotherapy Department, SFGH</td>
<td></td>
<td>Partial Award (50% sponsorship)</td>
</tr>
</tbody>
</table>
North Central Regional Health Authority

In addition several persons received skills enhancement training in the following areas/disciplines:

- Trauma & Emergency Nursing Education - 6 persons
- Antimicrobial Stewardship - 2 persons
- Sickle Cell Disease - 1 person
- Histocompatibility Specialist Course - 1 person
- Introduction to Infection Prevention & Control - 3 persons
- Advancement of Medical Instrumentation - 1 person
- Haemotology Analyser - 1 person
- SPSS Training, UWI - 20 persons
- Detection, Prevention, Corruption Procurement - 3 persons

Total - 38 persons

Training abroad

- Antimicrobial Stewardship - 2 persons
- Sickle Cell Disease - 1 person
- Histocompatibility Specialist Course - 1 person
- Introduction to Infection Prevention & Control - 3 persons
- Advancement of Medical Instrumentation - 1 person
  Total - 8 persons

- **Advertising to fill vacancies in the Public Healthcare System**
  - The RHAs have been advertising to fill vacancies that arose due to retirements and separation as a result of migration and abandonment. As such, the Ministry engaged in both local and international advertising to fill vacancies in 2009 and 2010.
  - The data revealed one hundred and sixty-three (163) appropriately qualified nationals in medicine, nursing, and allied health professions indicated their interest in filling the vacancies. Some applications received were transferred to the RHAs because of their authority to recruit in a timely manner.
  - The total number of responses received by the MoH from local and international advertising efforts to fill vacancies from 2010-2012 was eighteen thousand, nine hundred and twenty-five (18,925).
  - The ERHA, for the period 2010-2012 had a total of four thousand seven hundred and forty-three (4,743) persons expressing interest in filling vacancies in response to local and international advertising as shown below:

<table>
<thead>
<tr>
<th>Category</th>
<th>No of Applications Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>245</td>
</tr>
<tr>
<td>Para-Clinical</td>
<td>322</td>
</tr>
<tr>
<td>Managerial</td>
<td>1187</td>
</tr>
<tr>
<td>Administrative &amp; Auxiliary</td>
<td>2989</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4743</strong></td>
</tr>
</tbody>
</table>

- NWRHA had two hundred and ninety-seven (297) persons applying in 2010 and three thousand six hundred (3600) persons applying in the year 2011.
- SWRHA had a total of seven thousand eight hundred and twenty-two (7,822) persons willing to fill vacancies that were advertised during the years 2010, 2011 and 2012.
Five thousand, one hundred and seventy-eight (5,178) persons expressed interest in filling vacancies at NCRHA in 2010-2012.

**Scholarships**

In 2007 a training programme costing approximately 100 million was implemented. The programme involved the award of scholarships and bursaries in critical and medical nursing and other allied health areas. The RHAs identified the various areas where there were critical needs and recommendations were made in respect of the award of scholarships. The scholarships were advertised and successful health professionals were interviewed. Returning beneficiaries were obligated to engage the secondary health care system to allow other health professionals into the PHC system for example, Physician I and II while others will be utilized where shortages exists.

In light of chronic vacancies in the public health system for qualified medical and dental staff, it was proposed that any obscurities in the contracts offered to scholarship holders that may allow its exploitation ought to be dealt with, e.g. students being allowed to pay off their debt at the end of the study or delaying mandatory period of service in the public sector by furthering their studies.

The MoH suggested amendment be made to include a consignee who is willing to cover the cost of the investment of the students period of study should they fail to assume their period of service upon graduation. However, the MoH has not encountered any problems with scholars shirking their obligations to serve in the public sector. However, the MOH highlighted the need to have positions available in the RHAs in a timely manner in order to absorb the scholars.

**Challenge with absorbing returning scholars**

The MoH and the RHAs are not always in a position to immediately absorb the returning scholars. The MoH absorbs persons who were awarded a scholarship, bursary or given full pay study leave by the MoH/ RHA, upon return. However, it is not possible to immediately absorb persons who received an award of scholarship through the Ministry of Public Administration or otherwise.

The MoH is therefore seeking to address this issue and has since requested by letter dated June 1st, 2012 to the MPA, that in the future, information be provided on the award of
scholarship at the time the award is given and not during the year the person is due to complete the study programme. In this way, the necessary arrangements and planning can be made to ensure that positions are created for such persons to fill upon their return.

The RHAs positions with respect to absorbing scholars are as follows:

Table 20

<table>
<thead>
<tr>
<th>RHA</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ERHA</td>
<td>• The ERHA is able to absorb only those scholars whose area of study is in relation to the services offered by the ERHA.</td>
</tr>
<tr>
<td></td>
<td>• The employment of returning scholars would be based on the availability of positions and funding at the time of request by the MoH.</td>
</tr>
<tr>
<td></td>
<td>• In fiscal 2011/2012 the MoH enquired of the ERHA’s ability to recruit thirty-nine (39) returning scholars as such, the ERHA offered employment to fifteen (15) of these returning scholars.</td>
</tr>
<tr>
<td>SWRHA</td>
<td>• In order to employ scholars, further information on the area of study for each scholar, the number of scholars per area of study and the date of completion of study for each scholar is required.</td>
</tr>
<tr>
<td>NCRHA</td>
<td>• The NCRHA can absorb returning scholars once there are vacancies.</td>
</tr>
</tbody>
</table>

Registration of Doctors

Registration of Doctors through the Medical Board of Trinidad and Tobago is as follows:

- Graduates of St Georges University of Grenada – temporary and full registration (permanent) without graduates being subject to any examination. Full registration is granted only after three (3) years following graduation.
- Graduates of the University of the West Indies (UWI) are granted full registration following one year after graduation.
- Any nationality who is an American Board Certified Medical Graduates (not board eligible) is automatically granted full registration and is actually recognized as having “Higher Qualifications” (specialist in that field). Such Board Certification means having specialist qualification which includes a period of supervised training and an exit examination. Accordingly Board Certified persons are granted full registration with the Medical Council of Trinidad and Tobago which allows them to practice without supervision, i.e. as an independent medical practitioner.
● There were some instances where certificates and language of instruction were not in English however, this is being addressed through various embassies, the English Language Proficiency Testing (ELPT) and the Caribbean Association of Medical Councils.

Public Oral Health Care Services
The Department of Dental Services is presently a Vertical Program in the MOH. However, the provision of oral health services occurs in dental units at health centres that are equipped and maintained by RHAs. Public oral health care services are limited to provision of oral health care for children (ages 2-12 years) and the special needs population, with the provision of emergency/palliative care to the adult population. Dental care is offered to children by dental nurses and dentists.

Dental nurses visit schools, teach dental hygiene at schools and perform examinations and small fillings when necessary for students, while dental services for adults mainly entails extraction. There is need to expand the service to include dental education for adults. The use of X-ray machines are not required for children nonetheless, X-ray machines are necessary for adults.

Currently, there are fifty (50) Dental Nurses, forty-six (46) Dental Surgery Assistants and twenty-six (26) Dentists providing oral health care services at forty-seven (47) dental units throughout Trinidad and Tobago. Three (3) oral surgeons provide oral maxillofacial surgical services at three (3) hospitals in Trinidad and Tobago based on referrals from general dental practitioners.

Of the twenty-six (26) dentists providing public oral health services, twenty-four (24) have been appointed as Dentist I by the MOH, while two (2) are bonded to the Government of Trinidad and Tobago by virtue of scholarships to serve a four (4) year term at the Ministry, with a year of vocational service being counted as a year of service to the Government of Trinidad and Tobago. Upon completion of vocational training at the university the trainees will be appointed as Dentist I to the MOH. However, there is an option to repay the monies expended on scholarship winners.
Shortage of Dentist and Dental Technicians
Approximately one hundred and sixty (160) Dentists are required for patients 65+, special needs population, the children population aged 12-18 years and 10% of the adult population who might present emergency/palliative oral health care challenges. An estimated 34 dental nurses are required to treat patients 11 years and under. National tertiary level education institutions in the country have been engaged to train oral health professionals. To address the issue of the shortage, the RHAs are seeking to hire the required numbers of personnel from the best in the field as consideration would be given to the development of career pathways by offering opportunities for further education, professional development for staff and improved remuneration packages.

Oral Health Promotion
In addition to the provision of curative services to deal with the burden of oral disease that exists presently, the Department of Dental Services at the Ministry also recognizes the importance of oral health promotion and education in disease prevention. As such for fiscal year 2009-2010, two (2) oral health promotion campaigns were carried out and these campaigns supplemented the routine school oral health visits conducted by dental nurses throughout the year. The campaigns proved to be a success as a wide section of the population was accessed through health fairs and demonstrations as well as school programmes that allowed for oral health education. Similarly, for oral health month (2011) the department of Dental services initiated oral health screening for children at all custodial care institutions. The project would be followed up with the development of oral health protocols for these institutions that would allow for the improvement of the oral health status and maintenance for such a vulnerable group.

School Health Programmes
On January 30th 2012, the offices of Dental Nurses received approval for their inclusion under Part I of the Third Schedule of the Travelling Allowances Regulations, Chapter 23:50 for a period of two (2) years, after which further consideration of the continued scheduling would be made. This measure would facilitate the revitalization of the schools and community oral health programme which would involve oral disease prevention strategies such as education, screening, referrals for appropriate and timely treatment and management.
Monitoring of the Dental Programme
The dental programme is monitored by the County Medical Officer of Health or the Primary Care Managers in the RHAs to whom monthly reports are submitted. Similarly, a Dental Manager from the Ministry charged with responsibility for the whole programme is reported to so as to ensure that procedures and programmes are adhered to. The dental programme is coordinated at the policy and structural level from the Ministry. There is a cooperative relationship where the Dental Manager liaises with the RHAs, the County Medical Officer of Health, the General Manager of Primary Care and directly with dental staff to ensure the programmes delivery.

Dental Health Policies and Plans
The MOH developed a draft oral national health policy and plan in consultation with both internal and external stakeholders to develop and implement an efficient and effective oral health care service based on prevention and oral health promotion which is expected to be sustained in collaboration with the RHAs so that the following objectives can be achieved:

- Reduction of inequities in access to oral health services;
- Promotion of the coverage of the entire population; and
- Improvement of the efficiency of the overall healthcare system.

The documents are in the process of undergoing further ratification before its approval by the MOH.

A project forecasted for 2012 and 2013 entails a targeted dental service towards the elderly in Geriatric Homes, however, the project is awaiting approval and funding. Another important policy proposal is fluoridation of the water system as is the case in other countries to prevent dental caries. There are plans to train a new cadre of dental staff to support dental nurses and to increase the number of dental nurses. The Ministry is also exploring other categories of dental providers such as dental therapists, and dental hygienists to be implemented into the dental system. However, this requires legislative amendments.
Dental Health Issues

Meetings were held with the dental council and the matter of annual registration fee was under consideration to be increased. The Dental Council and all dentists were invited to a Breakfast Meeting with the Minister of Health to address the issue as well as other issues.

Status of unutilized dental equipment at some health centres:

Table 21

<table>
<thead>
<tr>
<th>RHAS</th>
<th>HEALTH CENTRE</th>
<th>STATUS OF UNUTILIZED DENTAL EQUIPMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Regional Health Authority</td>
<td>Rio Claro Health Centre</td>
<td>- All dental equipment are utilized with the exception of an Automatic X-ray developer due to a part to be replaced; procedures are done manually in the interim.</td>
</tr>
</tbody>
</table>
| North Central Regional Health Authority | Blanchisseusse | - Major structural adjustment to the building to accommodate a dental service is required. The equipment presently stored at the Caura Hospital was declared fully functional subsequent to inspection by the NCRHA Biomedical Department.  
- Installation of the equipment is on the way. |
| South West Regional Health Authority | San Raphael  | - There is no unutilized dental equipment at any of the facilities. There is a shortage of dental equipment as existing equipment is malfunctioning.  
- There are plans are to install x-ray machines at some of the health centres. |
| North West Regional Health Authority |                      | - The NWRHA is currently reviewing its dental services and anticipates at the end of the 2nd Quarter one or two sites will be fully functional with X-ray services included. |

Public Health Care in Schools

Dilapidated toilets at schools

Public Health Inspectors assess every school during the school vacation and submit a report on actions to be taken to ensure a functional environment for students. The toilet and water system are critical parts of the assessment.

Additionally, the Public Health Inspectorate of the MoH is mandated to visit every primary school at least every quarter per year and produce a report to the Executive of the Ministry
of Education and the relevant school supervisor informing of deficiencies and recommendations to address the deficiencies. Visits are also made to the schools to address complaints such as overgrown bush and hazard areas that allow for the breeding of mosquitos. Recommendations are submitted to the relevant authority for action if no action is taken by the school.

School Health Promotion Programmes

Health promotion programmes are used to dispense health information to educate the public on nutritional content of food.

The Ministry also collaborates with other health organizations in planning strategies for developing healthy public policies. As such, the creation of national nutrition and dietary guidelines is currently being undertaken in collaboration with the Caribbean Food and Nutrition Institute. A National School Health Policy was also developed in collaboration with the Ministry of Education to cover all aspects of health from infant to childhood with particular attention to adolescent health.

Health information is available on the MOH website and through the public media. Health programmes are held in primary schools and secondary schools. The MoH Health School Programmes consist of Hearing and Vision Screening delivery services which are piloted by School Health Screening Assistants (SHSA) employed and trained by the MoH, with addition training and certification in Health Screening Level II from the Technical Vocational Education Training system governed by the National Training Agency of Trinidad and Tobago (NTATT). These SHSA are assigned to the various counties under the RHAs.

Programmes in secondary schools are done mainly as a project throughout the entire school, (e.g. vision screening) upon request by a stakeholder, or upon request by the school’s principal (e.g. career guidance). In all cases the students receive the same benefits as those in the primary schools.

The aim of the screening is to identify potential hearing or visual problems children may have so that action can be taken to have early intervention and follow-up to ensure that appropriate investigation and care is given to every child identified with a potential or acute problem.
Parents are given prescriptions for children found with significant refractive errors, referred to an eyewear provider and asked to purchase the eyeglasses. A system of referral to a Medical Social Worker (MSW) is applied for a child whose parent is unable to afford the eyeglasses. Discussions with the MoPSD-SWD have been ongoing to ensure this process is expedited.

Direct supervision of hearing and vision screening is performed by the District Health Visitors (DHV), School Nurses (SN) and District Nurses (DN) and annual hearing and vision screening workshops for DHV, SN, and DN are conducted.

Audiometers used for hearing screening in the schools are calibrated by the School Health Programme annually to maintain functionality and status. New audiometers were purchased by the MoH and distributed to each county with the “Roll Out” of the School Health Project to the RHAs in July 2011. The vision screening equipment (Snellen Eye Charts) were also purchased by the MoH and handed over to the various counties. The RHAs will be responsible for purchasing screening equipment in the future.

Meetings are held with the Primary Care Nurse Managers (PCNM) of the counties under each RHA to monitor the implementation of the hearing and vision screening protocol. The screening outcomes are submitted to the MoH where data is collated, analyzed and status reports produced for the MoH and all stakeholders.

Over 100 community-based Medical Officers received updates on hearing and vision screening, and the management of children failing hearing and vision screening. With the protocol for vision screening approved, all health centres and medical facilities are supplied with copies.

RHAs Facilities and Property Management arrangement and guidelines
All RHAs encompass procedures for proper Facilities and Property Management as follows:

Facility and Property Management at the Eastern Regional Health Authority are conducted in accordance with the following:

- infection control standards manual
- the occupational safety and health standards
- housekeeping standards policy and procedures manual
Among other maintenance and management tasks at the North Central Regional Health Authority (NCRHA), a preventative and routine maintenance is the strategy employed on a daily basis which is performed by in-house staff, while jobs requiring intense skills are completed using small contractors or artisans from the community.

A Facilities Manager was recruited at the North West Regional Health Authority to provide Property/Facilities Management services throughout the North – West Region.

The South West Regional Health Authority utilizes a Property services Manual which is a revision of the Facility Manual compiled and published in November 1999. The Manual outlines the standard operating Procedures for the Property Services Department (PSD) to assist in the effective maintenance of the South – West Regional Health Authority Facilities and processes of the Property Services Department.

**Procurement in the MOH**

Procurement procedures over the past four years have incorporated tendering service contracts. A four year maintenance period has been adopted for fairly complex equipment such as bio-medical equipment.

The Ministry of Health has embarked on the following activities alongside the Regional Health Authorities in respect of its various procurement processes:

- Establishment of an Evaluation Review Committee within the Ministry requiring the RHAs to submit to the Ministry all procurement contracts tendered for goods and services in excess of $750,000.00 for approval prior to issue of the award. This involves the completion of an agreed procurement checklist by the respective RHA.

- Development of a Biomedical Engineering Policy and Procedures Manual in conjunction with the various RHAs towards the standardization of medical equipment maintenance management practices including procedure for procurement of new medical equipment.
The MOH seeks to work closely with all the RHAs towards the standardization of specialist type Request for Proposals (RFPs) and other procedural guidelines by offering technical assistance. The table below identifies various procurement procedures utilized by the RHAs:

### Table 22

<table>
<thead>
<tr>
<th>REGIONAL HEALTH AUTHORITY</th>
<th>PROCUREMENT METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Regional Health Authority</td>
<td>The process is guided by the MOHs approved Regional Health Authorities Financial Policy and Procedures and the Regional Health Authority Act</td>
</tr>
<tr>
<td>North Central Regional Health Authority</td>
<td>The process is guided by the MOHs approved Financial Policy and Procedures 2011.</td>
</tr>
<tr>
<td>North West Regional Health Authority</td>
<td>A Tenders Handbook created by the Authority and approved by its previous Board is applied.</td>
</tr>
</tbody>
</table>
| South West Regional Health Authority       | • Requisitions under $50,000.00 must be approved by the Head of Department  
• Purchases over $50,000.00 must be tendered for and managed by the Central Purchasing Unit or receive Board approval prior to issue of purchase order:  
• Departments prepare and submit requests to the CEO for approval which is then forwarded to the Infrastructure Committee (Board Committee) for approval of the Request for Proposal to be advertised for inviting bids  
• In the case of a selective tender the bidder must be identified with justification and approved by the Tenders Committee before invitation letters are issued  
• An evaluation team evaluates bids and makes recommendation to the Tenders Committee who approves/disapproves all decisions of the Infrastructure and Tenders Committees.  
• A technical person on the tender evaluation team ensures goods and services purchased meet the required specification and assists in allowing for objectivity in the evaluation process since all members must be in agreement before submitting the report to the Tenders Committee  
• Suppliers are pre-qualified for 2 years after which they become re-assured  
• Procurement policies and procedures allow for transparency and competitive bidding assist in ensuring value for money as well as purchasing items in bulk to benefit from supplier discounts.  
• Suppliers and items supplied must meet specified criteria inclusive of suppliers submitting mandatory document. |

**Contract Management Unit**

The Ministry proposed the establishment of a dedicated Contract Management Unit (CMU) – Health Services to operate within the MOH. Thus far, the MOH has completed a draft
position paper outlining the rationale and options for the structure, staffing and operations of the proposed CMU. Cabinet approval is being sought. The core responsibilities of the CMU would include:

- Quality assurance;
- Cost Accounting and Budget Management;
- Logistics and Materials Management Analysis;
- Project Management/ Contract/Performance Management;
- Communicating and Liaising with key stakeholders;
- Conducting Customer Satisfaction Surveys;
- Defining standards of practice and Good Governance;
- Due Diligence and Audits; and
- Reporting.

**Effective, preventative maintenance for equipment**

A number of factors account for the downtime of equipment as follows:

- Age of equipment, particularly plant equipment at various facilities that require upgrade/ replacement. This also impacts on the availability of spare parts.
- Shortage of trained Biomedical Engineers and Technicians locally.
- Suppliers of some equipment do not have the necessary technical service staff to adequately maintain equipment that they sell.

To ensure for effective maintenance of equipment, all RHAs are provided with a budget to cover maintenance costs however; major equipment costs are dealt with by the Permanent Secretary.

The MoH provides funding through its capital development allocation for equipment replacement. As part of the RHAs reporting the MoH also requires that they be informed of any major equipment downtime and/or request for additional funding for maintenance.

The RHAs are responsible for the maintenance of its equipment installed within the various facilities. Each Regional Health Authority has a Biomedical Department and an Engineering Department with the responsibility for maintenance of both medical and plant equipment.
A Computerized Maintenance Management System was installed in certain RHAs to aid in the tracking, planning and monitoring of equipment maintenance. Also, Standard Operating Policies and Procedures for the maintenance of medical equipment have been developed.

All of the RHAs have challenges and problems in the area of maintenance and in some areas it is more difficult to attract and retain maintenance staff. The strength and capacity of the maintenance departments varies within the RHAs. The NCRHA has the most established biomedical and engineering departments of all the RHAs while the NWRHA has the most prevalent challenge of the RHAs that of having aged plant equipment at the POSGH.

The following table provides information on the responsibility of the RHA with respect of maintenance of equipment and the reasons why some equipment remain in a state of unrepair at the various RHAs:

<table>
<thead>
<tr>
<th>RHA</th>
<th>RHA AND EQUIPMENT MAINTENANCE</th>
<th>REASONS FOR BROKEN-DOWN EQUIPMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ERHA</td>
<td>The ERHA includes for all its equipment purchases, 1 yr. warranties and 4yrs extended warranties which include all parts and labor. Training is also included in the contract to ensure that the Biomedical Team can provide some level of support after the warranty period expires; alternative additional service contracts can be entered into with the providers of the equipment after the initial 5yr period has elapsed. Where suppliers are not performing their duties and the RHA has been unable to obtain the support required, the MoH can intervene on behalf of the RHA, in liaising with the supplier in an attempt to resolve the matter.</td>
<td>Equipment under warranty when broken down is covered by extended warranties. There may be delays due to the availability of necessary parts and the time requested for parts to be delivered if they are not readily available. Equipment not under warranty when broken down is assessed by the biomedical team to assess the extent of repairs required. If the repairs needed cannot be fully addressed by the Biomedical Team then the supplier of the equipment is contacted. The RHAs identified the funding required to implement Preventative Maintenance Programmes for all equipment identified as critical. As</td>
</tr>
</tbody>
</table>
| SWRHA | There are two maintenance systems to maintain and repair equipment:

1. Service Contracts—Several Service contracts for maintenance of elevators, imaging equipment, large air conditioning equipment and so on with the Supplier/Agents of equipment. In addition the RHA purchases extended warranty (3-5) years for some new equipment.

2. In-house maintenance—In-house engineering staff conduct scheduled preventative and corrective programmes for the equipment with the facilities of the RHA. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NWRHA</td>
<td>Presently there is no broken down maintenance equipment at the NWRHA. In the event of such, arrangements are made to have it repaired/replaced at the earliest convenience.</td>
</tr>
</tbody>
</table>
| | Equipment remain broken down because:
| | - Some obsolete equipment remain in operation for a prolonged period, as the replacement cost is beyond the available funding. Available spares for these equipment are difficult to source and downtime is increased.
| | - Local suppliers do not stock spares, as they should, and most spares have to be imported with consequent delays.
| | - The procurement process of the Regional Health Authority has a built-in delay, which adds to the total delays.
| | - Some of the in-house end users are not careful and cause damage to equipment.
| | - The RHA is challenged by the private sector to keep and retain skilled and experienced maintenance personnel (Biomedical Engineering). |
| | The NWRH’s responsibility with respect to maintenance is to maintain a pro-active approach towards equipment maintenance thus ensuring minimal downtime, reduced equipment replacement costs and by extension, optimal patient care.
| | Also to ensure that staff is properly trained and qualified to maintain equipment safely and competently.
| | The link between the NWRHA and the MOH allows for financial and technical assistance when needed in the areas of training and the |
| NCRHA | The purpose of the RHA is to ensure functionality and upkeep of equipment through planned processes.  
• The role with RHAs and MOH would be short term, medium term and long and the viability of certain equipment based on public needs and of course the application of funding. | In most cases parts are obsolete. Assessment is done on existing and future needs for the particular piece or pieces of equipment for its purpose. Most equipment are scheduled under a preventative maintenance scope. |

**Status of unused exercise equipment**

The exercise equipment at the North-West Regional Health Authority, Petit Valley Health Center is utilized in the programme “exercise by prescription” where patients are seen by the doctor and exercise programmes are prescribed. There are plans to expand the exercise programs which are scheduled to take place at four (4) new health centres. Similarly, at the ERHA there are wellness centres located at all the Health Centres with a wellness coordinator assigned to each wellness centre in addition to social workers and a
nutritionist. The wellness centres also offer life support programmes and smoke cessation programmes.

Some equipment has not been maintained at the ERHA. An audit was therefore conducted to assess the equipment available at the wellness centres and a preventative maintenance programme was implemented. Equipment at the health centres under the purview of the SWRHA is not in use. However, exercise programmes are available at most of the health centers. Table 24 below depicts the responsibility of the RHAs for use and maintenance of exercise equipment at their facility:

Table 24

<table>
<thead>
<tr>
<th>RHA</th>
<th>RHAS USE AND MAINTENANCE OF EXERCISE EQUIPMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ERHA</td>
<td>The RHA is responsible for use and maintenance of exercise equipment.</td>
</tr>
<tr>
<td></td>
<td>- In carrying out this responsibility, the RHA ensures that all equipment purchased, is of industrial quality and includes an adequate maintenance contract from the provider.</td>
</tr>
<tr>
<td></td>
<td>- The use of the exercise equipment, which are located at Wellness Centres, is monitored by the Wellness Centre Committee and the Wellness Centre Coordinator and the Biomedical Team conducts regular maintenance checks on these equipment. At the ERHA, an audit of the Wellness Centre equipment was conducted in fiscal 2011/2012.</td>
</tr>
<tr>
<td>SWRHA</td>
<td>The responsibility for the use and maintenance of exercise equipment encompasses three (3) separate departments:</td>
</tr>
<tr>
<td></td>
<td>- The Commissions and Projects department is responsible for distributing the exercise equipment.</td>
</tr>
<tr>
<td></td>
<td>- The District Health Visitors are responsible for the usage of the exercise equipment.</td>
</tr>
<tr>
<td></td>
<td>- The Engineering department is responsible for the maintenance of the equipment.</td>
</tr>
<tr>
<td>NWRHA</td>
<td>- Exercise equipment is utilized by the clientele of specific Health Centres as part of an &quot;Exercise by Prescription Programme&quot; and is coordinated by a trained nursing professional.</td>
</tr>
<tr>
<td></td>
<td>- The recruitment of a Wellness Coordinator is expected to enhance this programme. Equipment maintenance is coordinated by the Area Administrator in collaboration with the Biomedical Department according to supplier warranties.</td>
</tr>
<tr>
<td>NCRHA</td>
<td>- The use and maintenance of exercise equipment is the responsibility of the Wellness Coordinator. However, this post is currently vacant and therefore the responsibility lies with the Facility/Cluster Managers of the respective Primary Care Clusters.</td>
</tr>
<tr>
<td></td>
<td>- Nevertheless, we continue to monitor and evaluate the needs, both manpower and infrastructure, of our Health Centres and will respond appropriately based on the proper needs assessment reports provided by the key stakeholders.</td>
</tr>
</tbody>
</table>
Management of Drugs

Drugs for use in the Public Sector are selected by the National Drug Advisory Committee and its subcommittee, the Formulary/Essential Drug Committee. Drugs are selected based on Standard Treatment Guidelines, efficacy and Pharmacoeconomics that are placed onto the MoHs VEN list/Formulary and a yearly open tender is conducted for their purchase.

The National Insurance Property Development Company Limited (NIPDEC) manages the procurement, storage and distribution of pharmaceutical and non-pharmaceutical medical supplies on behalf of the MoH. NIPDEC’s Tender Policies and Procedures are utilized. Approximately seventy (70) pre-qualified local and foreign-based suppliers tender for the procurement of approximately eight hundred (800) pharmaceutical items fourteen (1400) non-pharmaceutical medical supply-items each year.

All drugs used in the public sector must be registered with the MoH’s Chemistry, Food and Drugs Division and must be listed on the National Drug Formulary which is periodically updated by a National Advisory Committee (chaired by the Chief Medical officer) and advised by a Formulary Committee.

Quantities for each item on the Formulary for the next fiscal year are required to be supplied by each RHA before the end of March to NIPDEC. NIPDEC aggregates the estimated needs, prepares a Tender Package and invites pre-qualified suppliers to bid for these items. After consultation with the RHAs and ratification from the MoH, NIPDEC awards contracts to successful tenders.

No new drug is required to be added to the current list of oncology drugs as these are sufficient for oncology. Three (3) times the amount of money was spent on drugs for oncology in relation to any other category of drugs in the years 2008/2009, 2009/2010 and 2010/2011.

Nonetheless, there is need to expand the list of analgesics available for treatment of pain. The MoH is working along with the relevant stakeholders e.g. Pharmaceutical Distributors to achieve this. However, there are obstacles, as the MoH does not directly import drugs for use in Trinidad and Tobago as drugs are imported via third party. Narcotics in particular as an international policy, must be sourced from a company that is registered with the Regulatory Authority in the country of origin. Presently, there are four (4) distributors
available and willing to deal in narcotics as opposed to the past where there existed over ten (10) suppliers which is the basis of the problem with sourcing.

The listed drugs in the public sector are almost always available and any stock outs are covered by ad hoc purchases until the situation is rectified by normal supplies. Procedures are in place for special permission to purchase drugs for unique patients provided that the drug is not listed.

On the other hand, in the private sector the availability of drugs is based solely on the patient’s ability to purchase. If a clinical need arises and the drug is not available, it can be imported once registered for use in Trinidad and Tobago and if not registered it can be verified clinically as being safe by special permission for its importation for the patient.

**Shortage of analgesics**

The analgesics used by oncology patients in the public sector are based on the WHO’s Pain Relief Ladder. The Ministry encounters problems with sourcing some drugs and the quantity of drugs that can be obtained. The challenges associated with “sourcing drugs” can be placed in one of three broad categories:

1. **Registration** - in order to register a drug it must be registered by law for use in Trinidad and Tobago. NIPDEC can only procure medicines that are registered by Chemistry Food and Drug Division (CFDD) for use in Trinidad and Tobago and it is this requirement that at times pose a challenge to sourcing medicines.

2. **Manufacturing** -
   a) Manufacturers of medicines have “minimum operational batch sizes” that would make production financially viable. There are instances when the required quantities are too small to meet this minimum threshold; when this occurs, all such small orders are aggregated into a viable batch size before production is commenced. E.g. Zidovudine Suspension. Cipla, India.

   b) Where the quantity ordered below the “minimum operational batch size” even when aggregated, and when the monetary value of the drug is low, the number of
manufactures of such a drug will fall dramatically until it is counter-balanced by demand. Obtaining such a drug becomes difficult because demand would now be high relative to the very scarce supply, assuming that there is still a supply. E.g. Coral Snake Antivenom. Wyeth United States of America.

c) There was a dramatic drop in the production of generic injectable (cancer) drugs as four of the largest Pharmaceutical Manufacturers- Hospira, Teva, Bedford and Sandoz were effectively forced to simultaneously take significant products off line in order to deal with FDA warnings.

As a result, production to these generic injectables dropped by 30% contributing to massive shortage. Therefore, with fewer firms making older sterile injectable drugs, there is a limited number of production lines that can make these drugs.

The raw materials suppliers are also limited in the amount of drugs they can produce due to capacity issues at their facilities. The small number of manufacturers and limited production capacity for older sterile injectables, combined with the long lead times and complexity of the manufacturing process for injectable drugs, results in the drugs being vulnerable to shortage. When one company has a problem or discontinues, it is difficult for the remaining firms to increase production quickly and a shortage occurs.

d) Shortages of Active Pharmaceutical Ingredients API, the raw materials for manufacturing, have reduced the number of product sources for injectable medicines. E.g Cogentin Injection.

3. **Supplier/Distributor**

a) Some suppliers/distributors consider the Caribbean market, let alone Trinidad and Tobago’s, to be too small to be worth their while and simply stop the distribution of the item to this region. E.g. Erythromycin Suspension.

b) The drug may be readily available however the value of the Tender Award is low and therefore makes the registration of the drug with the Chemistry Food and Drugs Division of the Ministry of Health (CFDD) uneconomical. E.g Chlorpheniramine Injection.
c) Worldwide shortage of drugs.

Table 25 below outlines the RHAs challenges with sourcing drugs:

Table 25

<table>
<thead>
<tr>
<th>RHA</th>
<th>CHALLENGES WITH SOURCING DRUGS</th>
</tr>
</thead>
</table>
| ERHA   | • All Drugs are supposed to be received from NIPDEC /C40\(^3\). However, over the years, the supply continues to be inadequate and erratic.  
• In the event that C40 indicates that they do not have a supply of a critically needed item, the item is purchased from the supplier. |
| SWRHA  | • All Drugs are supposed to be received from NIPDEC /C40. However, over the years, the supply continues to be inadequate and erratic.  
• In the event that C40 indicates that they do not have a supply of a critically needed item, the item is purchased from the supplier. |
| NWRHA  | • All Drugs are received from NIPDEC central stores, the department responsible for procurement. According to NIPDEC, shortages are experienced due to a number of problems:  
  - It is unprofitable for some manufactures to export to Trinidad especially for older drugs.  
  - There is no bid for a product.  
  - Manufacturers cannot supply.  
  - Late arrival into the country and additional late clearing at the docks.  
• The quantity ordered is seldom what is supplied. |
| NCRHA  | • NCRHA Pharmacy Services receive their supply of drugs from C-40 NIPDEC, based on a National Formulary. Drugs that are not on the National Formulary that are needed are approved via Regional Drug Committee.  
• The NCRHA has not had a consistent supply from C-40 which is mainly based on the apparent reason that international and local distributors cannot fulfill the demands of the RHA and that Food and Drug Registered suppliers of certain products are not available. |

\(^3\) C40 NIPDEC's warehouse building.
CDAP

All drugs inclusive of a basket of fifty-two (52) items to be used in the Chronic Disease Assistance Plan (CDAP) are registered before they are placed on the market. The Chemistry Food and Drugs Division (CFDD) is responsible for the quality of all drug products according to the Food and Drug Act and Regulations.

The requirements in the Regulation assure the identity, strength and quality of drugs. Any complaint or query made by any member of the public regarding the quality of any item on CDAP is investigated by NIPDEC and or the CFDD.

To facilitate this process and to make the data useable, NIPDEC is currently developing a simplified Adverse Drug Reaction and Quality form to be available online and at all pharmacies. This is required to ensure quality and safety of drugs.

Thus far, no drugs from CDAP have been removed by the CFDD after surveillance and testing. To ensure quality of the medicines at the private pharmacies, NIPDEC has two (2) field monitors who engage in site visits. The monitors ensure that no expired CDAP items are present or dispensed at the pharmacies, that the medicines are stored in a manner consistent with “Good Pharmacy Practice” and manufacturers guidelines and that a Pharmacist is on duty.

The CFDD is currently reviewing its processes and human resource capacity to improve the frequency of surveillance and monitoring. In addition, the MoH is in the process of undertaking an evaluation of the CDAP Programme for the period 2003-2009 to improve the programme’s overall performance.

National AIDS Coordinating Committee (NACC)

National AIDS Coordinating Committee was officially launched at the Office of the Prime Minister in March 2004 to lead a national multi-sectoral response to HIV. That Committee was terminated in March 2011, to be replaced by a Statutory Authority. Efforts are currently underway to establish a revamped Coordinating Unit in the Office of the Prime
Minister with the assistance of an inter-ministerial team comprising all the Ministers involved coordinating the national response to this pandemic.

**Other Issues**

**Shortage of doctors at the Health Centres in the constituency of La Horquetta/Talparo**

There is no shortage of doctors at the La Horquetta/Talparo district. A Medical Officer is present five days per week at the Centre while medical services are offered at the San Raphael Health Centre four (4) days per week and three (3) days per week at the Talparo Health Centre. Also, nursing services are accessible five (5) days weekly at the La Horquetta, San Raphael and Talparo Health Centres.

**Status of Public Health in the Laventille Area**

Several Public Health Inspectors are assigned to the Laventille area to perform routine inspection on a daily basis. Any issues arising from the inspection are reported to the County Medical Officers and the Regional Corporations. Public information is provided through Health Centres and Community Health Centres. Two health centres are located in the Laventille area; the Upper Laventille Health Centre and the Success Laventille Health Centre which are controlled by the County Health Administration. These centres offer an array of services such as General Practice, Antenatal Care, Chronic Eye Disease Care, Foot Care Programmes and Chronic Disease Management.

**The ratio of patients to health care providers in the area of Laventille.**

**Table 26**

<table>
<thead>
<tr>
<th>Days</th>
<th>Upper Laventille</th>
<th>Clinic</th>
<th>Success Laventille</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mondays</td>
<td>5</td>
<td>Antenatal</td>
<td>36</td>
<td>Antenatal</td>
</tr>
</tbody>
</table>
Staffing at the Health Centres:

Table 27

<table>
<thead>
<tr>
<th>TYPE OF STAFF</th>
<th>UPPER LAVENTILLE</th>
<th>SUCCESS LAVENTILLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Dentist</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>District Health Visitor</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>District Nurse</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Enrolled Nursing Assistant</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Patient Care Assistant</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Clerks</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 28

Palliative, Menopausal and Andropausal Care for Patients

ERHA
- At the Nariva/Mayaro district there is no palliative care for patients. The district requires further training for staff, additional infrastructure and additional Human Resource to implement these services in the district. On the other hand at the St. Andrew/St David there is an Oncology home-based programme which provides palliative care.
- Andropausal care is available at Rio Claro Health Centre, Mayaro District Health Facility and quarterly at Brother’s Road and Biche Wellness Centre.
- Counseling and Lectures are held at Health and Wellness Centers in Nariva/Mayaro and St Andrews/St. David
- There is no structured programme in place for Menopausal Care but lectures and counseling are available when required at the health and wellness centers.
- Cervical and Breast Screening are conducted at all Health Centres

NCRHA
- In 2009 a group of health care workers were nominated to attend a workshop on the
- At the Chaguanas Cluster an elderly support group meets at least twice per
### National Oncology Programme (NOP)

The National Oncology Programme (NOP) Home Care Guild facilitated by an Innovation Seeker attached to the Saint Elizabeth Health Care Centre, Ontario Canada where participants were introduced to a colleague interactive online learning solution software, “At your side” and completed an Introduction to Palliative Care online course. Due to the resignation of the then coordinator of the NOP the constraints imposed by this precluded the provision of palliative care services within the region.

- The group comprises approximately 45 persons and includes a mix of males and females over the age of sixty years.

### SWRHA

Every District Health Facility (Couva, Princes Town and Siparia) has an oncology clinic which also provides palliative care. This is supported by staff of the Community Liaison Unit (CLU). Plans are to launch the first dedicated Palliative clinic in Marabella.

- There are no structured clinics in the County of Victoria to deal with these conditions however, information is provided to clients and individual counsel and care is available when required.
- The Caroni South District through the Women’s clinic at Couva District Health Facility and Freeport Health Centre both offer menopausal care through Health education and Counseling, Breast Examination and Cervical screening.
- There is no schedule for andropausal care although some needs are met through outreach programmes/projects where screenings for blood, prostate, specific antigen and, direct digital rectal are performed.
- Examinations, health education and counseling are available.

### NWRHA

A Pilot project was instituted in St George Central in 2006 by Dr. Paul however, there is no support staff which coincided with a low level of interest in the programme.

### Infant Mortality Rate

PHC infant mortality rates have been reduced due to the elimination of diseases via immunization. The PHC system in Trinidad and Tobago allows for a range of maternal and child health services to be offered for free as well as free antigens (a substance that causes the immune system to produce antibodies) to be administered by district health nurses to the entire population. These services are offered through the RHAs at Health Centres, Mobile Clinics and at a higher level with greater diagnostics at District Health Facilities.
The MOH has taken steps to address the infant mortality rate by addressing the following aspects of maternal care, delivery and antenatal care. Table 29 below outlines the steps taken by the various RHAs to address maternal, delivery and antenatal care to lower the infant mortality rate:

**Table 29**

<table>
<thead>
<tr>
<th>RHA</th>
<th>STEPS TO IMPROVE MATERNAL, DELIVERY AND ANTENATAL CARE</th>
</tr>
</thead>
</table>
| ERHA   | 1. Antenatal care is provided by a physician, and also by a District Health Visitor in the primary care.  
2. Early registrations are encouraged and home visits are arranged for complicated cases.  
3. All clients are screened for diabetes, rhesus status, hypertension etc.  
4. Prompt referrals from primary care to secondary care, are effected for complicated cases to ensure expert opinion is sought to address any obstetric complications.  
5. Further home visits are carried out in primary care, by the District Health Visitor soon after mother and baby are discharged after delivery. |
| SWRHA  | 1. Decentralize the management and provision of antenatal care services in Trinidad and Tobago.  
2. Offer pre-pregnancy counseling clinics at the local Health Centres and improve peripheral service at the primary care facilities.  
3. Improve nursing, medical, auxiliary staffing. Increase senior staff.  
4. Provide additional equipment such as foetal monitors, foetal blood sampling machines, and disposable resuscitation equipment and scalp electrodes.  
5. Increase theatre services by ensuring that the D&C and Obstetric theatres are fully equipped andstaffed in order to be readily available at all times.  
6. Encourage Continuing Medical Education (CME) for all levels of staff.  
7. Conduct regular Audits and monitoring of “near misses” and adverse events in order to improve the level of care.  
8. Conduct on-going risk management training and workshops in order for staff to be continuously aware of all current protocols and procedures.  
9. Improve the neo-natal services by ensuring there is a ready supply of trained staff and appropriate equipment.  
10. Medical care of patients should be optimum and there should be no blame games as to avoid litigation.  
11. Ensure full implementation of the recommendations of the Bassaw Commission of Inquiry.  
12. Regular meeting should be held to discuss perinatal mortality and maternal deaths in order to develop protocols, policies and procedures to avoid repeat in adverse events.  
13. All protocols, policies and procedures should be regularly updated.  
14. Skills and drills seminars and workshops should be held regularly.  
15. Early Pregnancy Assessment Units (EPAUs) should be introduced in order to
identify any early problems and deal with these from the onset.

16. Introduce feto-medicine clinics to identify the infants at risk so that appropriate action can be taken.

NWRHA

1. Monthly Maternal Morbidity and Mortality meetings are being held for over a year.
2. At these meetings, cases are presented and lively discussion occurs in an attempt to identify areas where patient management can be improved in order to reduce the incidence of adverse events. For example, the NWRHA had no maternal deaths for more than a year. The NICU staff is expected in the future to make presentations that highlight specific areas where modifications in maternal management may lead to improved fetal outcome.
3. Protocols have been produced on several topics in maternal patient management based on Royal College of Obstetrics and Gynaecology and NICE Guidelines, modified via internal audits and experience to be more relevant to our local circumstances. This is an ongoing process.
4. Improvements in the staff complement and distribution have recently been realized. These improvements include rotation of Obstetric House Officers and Interns through the NICU.
5. Improvements in equipment, including two new Ultrasound machines, one of which is dedicated to neonatal scanning and one to Obstetric and Gynaecological scanning, as well as a number of new fetal monitors, both for non-stress and cardiotocograph testing as well as hand held Doppler Machines. These machines play an integral and vital role in the assessment of fetal wellbeing, and greatly assist, for example in early detection cases where appropriate measures and interventions may prevent adverse fetal outcome.
6. Improvements in infrastucture, for example continuous refurbishment and upgrade of all floors in the Maternity building, including the installation of air conditioning units in all active wards, which not only enhances patient and staff comfort but is also expected to decrease both maternal and neonatal infection rates.
7. Pediatricians attend all emergency Caesarean Sections, as well as all deliveries, both normal (vaginal) and operative, where there is either evidence of fetal compromise or any condition where there may be increased fetal risk.
8. Well organized teaching and training programmes are in place aimed not only at medical students, but also at junior doctors in training for postgraduate qualification.
9. Antenatal services provided by Primary Health Care are only intended for low-risk pregnancies. High-risk clients are referred for hospital-based antenatal care in accordance with specific criteria. In order to support appropriate and timely referrals, a system of clinical audit should be instituted and continuous medical education for both medical and nursing professionals must be formalized. Additionally, the feasibility of the provision of specialist obstetric clinics at Local Health Centres is being explored as a means to decentralize this expertise.

NCRHA

1. An increase in bed space for the pregnant female is anticipated by the construction of two (2) new hospitals, one (1) at the Arima Health Facility as well as a new hospital in Central Trinidad.
2. These facilities would have antenatal clinics and ultrasound facilities and are capable of performing emergency Caesarian Sections, (Operating Theatres). This
means that more Specialist Obstetricians and Gynaecologists and Registrars in Obstetrics and Gynaecology are needed. This will lead to a decreased patient to doctor ratio which will decrease the infant mortality rate.
3. Antenatal beds should be available for those patients who develop complications during pregnancy, such as diabetes, high blood pressure, preterm labour, multiple gestation and antepartum hemorrhage. An adequate number of midwives would be needed for the antenatal wards, delivery room as well as the antenatal clinics in order to effectively deliver antenatal care, to recognize the high risk patient and to decrease the perinatal and infant mortality rate.
4. There would be an increased need for Pediatricians, and Neonatologists to provide services at these new institutions. In the interim the NCRHA has been providing a Specialist Antenatal Clinic to the Arima Health Facility to recognize the high risk patients so as to transfer these patients in a timely manner to Mt. Hope Women’s Hospital.
5. At the Mt. Hope Women’s Hospital new Antenatal as well as Neonatal Clinic Facilities are being constructed in order to accommodate a larger number of patients. A first stage room is being constructed to accommodate patients in early labour to avoid patients having to go back home to return later when they are closer to delivery.
6. This allows the patient to be monitored and abnormalities in labour to be recognized earlier.
7. Also an Operating Theatre in the Birth Department is being constructed so that patients can have faster access to surgery avoiding unnecessary delays which could lead to increased perinatal morbidity and mortality. A larger neonatal unit is being designed with the capability of performing pediatric surgery, with a capacity of being able to ventilate ten (10) babies at a time. Women in labour are being offered epidural anesthesia to eliminate the discomfort of labour pains and make the birth’s experience a pleasurable one.
8. The provision of immunization Clinics and Child Care Services in our Primary Health Care Centres would ensure a healthier infant and decrease the infant mortality rate.

Hospital Services

Backlog of Radiology Reports at the RHAs

The accumulation of Radiology Reports was reported as being in the thousands but this figure has since been reduced. University graduate radiologists were no longer granted employment as radiologists because they were receiving disbursements on par as doctors from the RHAs. This arrangement was revised to ensure that a more fairer and equitable system exists so that all doctors inclusive of university graduates were allowed contracts.
The RHAs identified the following as the main problems encountered with the timely output of Radiology Reports.

**Table 30**

<table>
<thead>
<tr>
<th>RHA</th>
<th>MAIN PROBLEMS WITH RADIOLOGY REPORTS</th>
<th>SOLUTIONS TO REDUCE BACKLOG</th>
</tr>
</thead>
<tbody>
<tr>
<td>ERHA</td>
<td>➢ insufficient qualified staff, ➢ insufficient administrative support staff and malfunctioning technology systems (Picture Archiving and Communications System – PACS). ➢ The ERHA is currently utilizing PACS to allow for remote access by Radiologists for the reading of Radiology Reports, outside of normal working hours. Once this system is functioning properly, the output of Radiology Reports would be greater.</td>
<td>➢ Hire more suitably trained Radiologists and to review the compensation package for Radiologists across the nation. An interim solution to address challenges in recruiting Radiologists would be to offer sessions for these Radiologists. ➢ implement compensation for backlog reporting; this is to be done to clear any current backlogs. Based on the premise that 6 CT, 4 Mammography, 10 General X-Ray and 10 Ultrasound cases can be reported during a normal workday (8am- 4pm), any backlog reports performed beyond this figure should constitute “overtime” as these reports will have to be accomplished outside normal working hours. In addition, payments would only be made once the daily quota for each doctor is exceeded. PACS is an information technology/information systems solution to the backlog of Radiology Reports. Remote access to a functioning PACS would facilitate the reading of Radiology Reports off site.</td>
</tr>
</tbody>
</table>
| NCRHA | ➢ The main problem with Radiology reports at EWMSC is the volume of imaging (CT, MRI, Ultrasound, Fluoro, Mammo) is not proportional to the amount of Radiologists on staff which is four (4). | ➢ To reduce the backlog the department is currently in on overtime drive where substantively at least 50% of outstanding reports have been cleared thus far.  
☐ Hire additional Radiologists  
☐ Have more reporting stations to
There is need for more Radiologists on staff.
For September 2012 the number of MRI and CT studies done totalled:
- MRI – 394
- CT – 1,860
- Four Radiologists cannot provide timely reports for such a volume

allow Residents to prepare preliminary reports
Continue the overtime sessions in the interim to assist in clearing outstanding reports

The waiting time for reports, especially CT scans depend on the number of Radiologists on staff.
Presently, there is need for more Specialists.

Increase the number of Radiologists.
Continuous overtime reporting is needed to reduce backlog. Scans are done twenty-four hours/per day, however reporting is only done from Monday – Friday 8:00 a.m. – 4:00 p.m. Radiologists can report these cases as extra duty and can be compensated at a rate consistent with their employment status. This is being worked on presently.

The reporting to transcription to collecting time is approximately two weeks and this is for elective cases.
The request to reporting time is usual one day in emergency situation and these are all in keeping with International standards.

Need for expansion of the Radiology department as there is limited space to accommodate the ultrasound machines.
Present CT scan machine is fully utilized, functional and overburden with request 24/7. We await the helium from abroad for the MRI machine.
Table 31

Status of Backlog of Radiology Reports at the RHAs

<table>
<thead>
<tr>
<th>Information requested</th>
<th>ERHA</th>
<th>NCRHA</th>
<th>NWRHA</th>
<th>SWRHA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No. of Backlog Reports</strong></td>
<td>no backlog of reports as at Tuesday April 10\textsuperscript{th}, 2012</td>
<td>5,766 cases</td>
<td>There are no backlogs of reports for General x-rays, Special examinations e.g. Bariums, IVPs, Ultrasound and Mammograms as well as no backlog of Pathology slides and tissue interpretation and reports. MRIs are not performed in the NWRHA</td>
<td>100 MRI cases</td>
</tr>
</tbody>
</table>
| **Method of Clearing exercise utilized** | a. House Officer and SMOs worked on the most outstanding reports after hours  
b. A total of 8 cases constituted one session of overtime which was paid as such  
c. The 8 cases was mandate to include at least 3 whole body scans  
d. The overtime sessions were paid along with the officers salary  
e. All overtime sessions were signed off and approved by the Head of the Department | Staff to be paid the following overtime rates:  
a. Consultants - $173/hr.  
b. Registrars - $136/hr.  
c. House Officers - $111/hr.  
An agreed number of (3) MRI cases (2 Brain, 1 whole body) per hour constitute the baseline. | External Radiologists were hired to treat with MRI cases. Other models were adopted to treat with backlog of CT cases which required performing actual examinations and producing reports. |
<p>| <strong>Length of time taken to clear reports</strong> | 3 months | 1 year | 1 month |
| <strong>Approximate cost of one years’ clearance</strong> | $1 - .5 M exclusive of cost of transcriptionists | $603,489.00 | $45,000.00 |
| <strong>Remarks on possibly</strong> | Currently the department is | The money used to clear the backlog can | Moneys spent on the backlog could |</p>
<table>
<thead>
<tr>
<th>diverting money spent on backlog to other areas</th>
<th>critically short staffed at 25% of its medical staff requirement therefore diverting of funds is not an option</th>
<th>be utilized to hire 3 additional Radiologists and furnish the department with 2 additional work stations for CT reporting.</th>
<th>be diverted to Training for Radiologists to read more difficult cases would diminish the need to hire external radiologists.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Backlogs other than radiology</td>
<td>No significant backlogs</td>
<td>-</td>
<td>1800 CT Scans expected to take 3-6 months to clear</td>
</tr>
<tr>
<td>A backlog in histology was reduced from 2,000 slides and 800 samples to 435 slides and 400 samples</td>
<td>The average turnaround time is 6-8 weeks for routine samples.</td>
<td>Stat sample take 72 hours</td>
<td>Approximate cost of clearing the backlog is estimated to be at the end of June 2012 at a cost of $50,000.00</td>
</tr>
</tbody>
</table>

**Impact of Trauma Cases in RHAs**

The increase in Trauma cases at the RHAs has resulted in longer waiting time for non-trauma patients. At the NWRHA particularly, the impact is as follows:

- Surgical wards become overcrowded and all intensive care beds are utilized, support services such as Radiology, Laboratory, Pharmacy and Dietician services are drained, and elective surgeries are forced to be cancelled.
- A shortage is manifested in medical, nursing, clerical and support staff as well as a shortage of surgical, medical, anesthetic and cleaning consumables.
- Items and projects are postponed as a result of finance having to be redirected to address trauma cases.
All elective surgical lists are affected owing to cancellations to facilitate trauma cases which are given priority. The main disciplines affected are General, Orthopedic and Neuro surgeries.

Consultations were held with some non-governmental organizations to decide on the best approach for the Ministry to adopt in order to provide psychological trauma services. There are plans to approach cabinet with a proposal to treat with the provision of psychological trauma services at various health facilities.

**Neurological Services**

The number of neurological cases is minimal in the ERHA however, at the EWMSC (NCRHA) there is a greater turnover which requires two lists per week rather than one list per week. All SWRHA neurosurgical patients are redirected to either NCRHA's EWMSC, NWRHA or sent to private institutions e.g. Community Hospital, since the SWRHA is unable to provide a neurological service. A minimum of two (2) to three (3) neurosurgeons will ease the situation. Thus far, scholarships were granted to two (2) doctors to pursue training in the neurology field in Jamaica. The NWRHA's Port of Spain General Hospital is the designated neurosurgery centre for Trinidad and Tobago placing a severe demand on its Intensive Care Unit (ICU).

**Cardiac Surgery Services**

Patients visiting health facilities under the ERHA in need of cardiac surgery are given the option to seek the services of a Private practitioner or are referred to the MoH. Patients visiting health facilities of the NCRHA are screened by cardiologists and medical social workers and placed on a list for surgery. Cardiologists determine the wait time and urgency of cases however, protocol with respect to referrals is being reviewed. At the SWRHA patients attending cardiology clinics are referred for Cardiac surgery depending on the urgency of their condition. Life threatening delays are prevented by adherence to guidelines and protocols. The NWRHA allowed for Open heart surgery to be conducted during the period June 22nd, 2007 to November 11th, 2011 at the main operating theatres at the Port of Spain General Hospital. Approximately one hundred and fifty (150) cases were treated and plans are to restart Cardiac surgery soon.
Details on District Visits programmes/schedules

All RHAs engage in home visits and have programmes in place to promote primary health care services apart from their regular clinic schedules. Statistics show that approximately 50% of the public do not utilize health centres and opt for health care from the private sector. The MOH through the RHAs seeks to tackle this problem through its outreach programmes.

EHS service

An Ambulance Act is proposed to deal with all pre-hospital care. Through the Act an Authority will be established with the responsibility for all ambulance services.
OBSERVATIONS/FINDINGS

The Committee recognizes and commends the MoH for its efforts to provide a quality Primary Health Care Service as part of achieving a “quality health care system”. However, it identified the following areas as worthy of further attention:

A. Shared Responsibility for Management of Health Services

The MoH controls the management of the PHC services to a large extent since it retains responsibility for the 22 vertical services which largely relate to public health matters. However, the facilities in which the PHC system are housed are the responsibility of the RHAs. This does not seem to be a very efficient arrangement especially in the absence of a stringent monitoring capacity within the MoH where the facilities management function of the RHAs does not appear to be well developed or very efficient.

B. Public Health in schools

In spite of the collaboration with the CFNI on the nutrition and dietary guidelines for schools and the surveys on global school health and youth tobacco, the volume of attention given to the promotion of public health in the nation’s schools was seen as insufficient.

In addition, the actual services which should be provided to primary and secondary school students are adversely affected by a critical shortage of School Nurses and Social Workers.

The Committee was dissatisfied with the fact that schools are visited by Public Health Inspectors only during the vacation period. It felt that continuous visits should be made to schools to monitor the environment in these institutions.

C. Patient’s Complaints

While work continues at a measured pace on the Patient’s Bill of Rights and the Patient’s Charter, shortfalls/ problems persist in many sectors of the system, to the detriment of the patients.
D. Radiology Services
The immediate problem of the backlog in this department was partially solved in a manner that resulted in a substantial number of old examinations remaining unprocessed. Since qualified staff in this area remains inadequate, a better solution needs to be adopted to provide for the timely processing of all CT scans and MRIs as the processing of these examinations is an essential prerequisite for proper diagnosis and treatment of ailments.

E. Dental Care
The MoH has commendable plans for expanding this service to secondary school children and the elderly in homes; due to the wide differential in earnings of professionals in the public and private sector. No progress has been made with the fluoridation of the water supply.

F. Wellness/Preventative Maintenance Programme
Many initiatives have been introduced in the roll out of this programme but much of the work in the fight against CNCDs is not well publicized:
  a. Fight the Fat Campaign
  b. Partners Forum
  c. Exercise by Prescription
But there are some glaring inefficiencies e.g. equipment not in use or in need of repair or underutilized by the public.

G. Financing of the RHAs
The Committee recognized that the insufficient current budgetary allocations to RHAs and the insufficiency in the expenditure inhibits them from performing optimally in the area of Primary Health Care.

H. Human Resource Issues
The acute shortage of medical and nursing staff severely affects the performance of the RHAs and MoH. It was established that there are no strategies in place to attract or keep staff. Consideration is being given to the introduction of new categories of allied health professionals (dialysis and scrub technicians) to provide specific technical services thus freeing scarce nursing staff to perform their professional functions. In addition, increased
use of the existing categories of auxiliary staff (PCAs and ATNs) to assist in non-technical is being pursued. These measures could have a positive effect on the conditions of service of nursing staff. Shortage of support staff in the Pharmacy, Physiotherapy, Radiography, Laboratory, Quality Control and Operations Departments also negatively affect the ability of these facilities to deliver service with dire consequences to the public.

I. Infrastructure
The Committee recognizes the dilapidated state of the infrastructure in many areas of the Health Sector and the lack of maintenance of equipment.

J. National AIDS Coordinating Committee (NACC)
The Committee noted that as an interim measure the MOH has been tasked to assume responsibility for some of the coordinating functions of the former National AIDS Coordination Committee (NACC) and has functioned in that capacity during the period 2011 to 2013, while all the appropriate units were redesigned and reformatted to fit the legislative framework that was being envisaged.

The Committee regrets the two-year hiatus in the operations of the NACC and urges the responsible authority to accelerate action to fully re-establish an official national HIV coordinating mechanism at an early date.
RECOMMENDATIONS

The Committee recommends that the MoH take action to address the following:

1. The Gafoor Report be revived, reviewed and its findings, most of which remain completely relevant, implemented. This report should also be published.

2. The Public Health Ordinance which is largely obsolete needs to be urgently updated and the RHA Act needs to be urgently revisited.

3. Maintain a more direct discourse with the RHAs to ensure the quality of the service. For this purpose the MoH should establish its capacity to oversee and coordinate the PHC services offered by the RHAs. This person/department will work closely with the RHA Primary Care Managers monitoring/evaluating the RHAs performance.

4. Public Health in Schools
   The MoH and the MoE should collaborate more strategically to promote the health of students in the nation’s schools. This objective should include the following:
   - Finalization of the CFNI nutritional and dietary guidelines and apply them to the school meal programme; and
   - Remove “sweet drinks” and/or carbonated beverages from government school compounds and reduce the sugar content in fruit juices which accompany school meals.
   - Ensure that an adequate supply of potable water is available in all schools.

   The MoH publish immediately, the Global School Health Survey and the global Youth Tobacco Survey.

   Mechanisms should be put in place to ensure that Public Health Inspectors continuously assess and monitor the toilets, food sold by private concessionaires and the school environment.

5. Patient Complaints
   - Accelerate the completion of the Patient’s Bill of Rights and Patients Charter
Consider the establishment of a Health Ombudsman to act as an independent overseer and provide the public with a channel to highlight grievances with the administration of public health care.

6. **Radiology Services**
Consider entering into arrangements with reputable overseas institutions to provide real time processing of MRI and CT scan reports.

7. **Dental Care**
Develop a National Dental Health Policy which would address inter alia the fluoridation of the water supply and expand dental services to all PHCS.

8. **Wellness/Preventative Maintenance Programme**
MoH should execute its Health Promotion and Health Education Programmes in collaboration with the Regional Corporations, Ministry of Sport and Ministry of Community Development. This collaboration should include the provision of personnel trained to deliver programmes which make optimum use of fitness equipment in PHCS as well as in the maintenance of that equipment.

9. **Financing of RHAs**
The Committee agreed that the MoH should match the estimates submitted for the RHAs to the quality and quantity of services required for the successful operation of the PHCS.

Provide adequate funding for County Medical Officer of Health to enable them to execute their programmes effectively.

10. **Human Resource Issues**
Immediate attention is required to filling existing vacancies for medical and nursing personnel. Accordingly, MoH should:

   a. Arrange for the timely integration of returning scholars into the health service;
b. Collaborate with TTRNC, TEST and other relevant agencies to complete the review of the hierarchy and classification of the nursing profession **before** the 2013 class of BSc Nursing graduates are qualified to practice;

c. Proceed urgently with the review of the nursing establishment with a view to deciding on:
   - the establishment of new categories of allied health professionals;
   - increasing the categories of auxiliary nursing staff; and
   - Address the recruitment and training of personnel as District Nurse and District Home visitor.

d. Confront the acute problems in the dental services among which are:
   - The emoluments which in the case of dentists are no way comparable to what would obtain in private practice.
   - In the case of nurses, dental assistants, and dental maintenance technicians, their salary when combined with their other conditions of service, (no travelling allowance and short staffing) results in a total take home pay that does not provide a reasonable/ decent living wage.

e. Provide security for nurses who do home visits in “hot spot” areas.

f. Facilities should be provided at all Centres to allow nursing personnel to change into uniform on the premises to obviate the possibility of cross contamination through commuting in uniform.

11. **Infrastructure**
   - To develop a national infrastructure improvement plan to address the inefficiencies in infrastructure within the health care system
   - Standardize the provision of service contracts for all major equipment
   - Provide comfortable seating accommodation for patients at all Health facilities should be made.

12. **AIDS Coordinating Committee**
    Work closely with the Office of the Prime Minister to ensure full re-establishment of a National AIDS Coordinating mechanism in the OPM in the shortest possible time.
13. Other

- Improve referral and follow up system between Primary and Secondary Health Care Systems.
- Institutionalize the training of staff in the proper use of equipment.
- Include the stocking/provision of spare parts in the procurement process.
- Monitor the provision of drugs by C40.
- Chemistry, Food and Drug Department to monitor the quality of CDAP drugs more closely.
- MoH should publish the result of the evaluation of the CDAP Programme.
- Standardize the protocols for Palliative, Menopausal and Andropausal Care across the RHAs.
- Standardize protocols for Maternal, Delivery and Antenatal Care across RHAs.
- Institute measures to improve the supply of medical social workers, laboratory technologists and technicians, nutritionists and health promotion specialists at PHCS.
- Accelerate the computerization of patient records.
- Improve ambulance services at health centers.
- Provide post-natal services at all health centres.
- DHVs to schedule visits to day care centres, nurseries, senior citizens’ homes, special homes for the physically and mentally challenged.
- All PHCSs must have detailed protocols to guide their handling of child abuse cases.

The Committee respectfully submits the foregoing for the consideration of the Parliament.
5th Report of the Joint Select Committee on Ministries, Statutory Authorities and State Enterprises (Group 1)

Sgd.
Mrs. Corinne Baptiste-Mc Knight
Chairman

Sgd.
Prof. Harold Ramkissoon
Vice-Chairman

Sgd.
Mrs. Carolyn Seepersad Bachan, MP
Member

Sgd.
Mr. Emmanuel George
Member

Sgd.
Mr. Ganga Singh
Member

Sgd.
Dr. Delmon Baker, MP
Member

Sgd.
Mr. Jairam Seemungal, MP
Member

Sgd.
Ms. Stacy Roopnarine, MP
Member

Sgd.
Mrs. Christlyn Moore
Member

Sgd.
Dr. Amery Browne, MP
Member

Sgd.
Mrs. Patricia Mc Intosh, MP
Member

Sgd.
Mr. Faris Al-Rawi
Member
APPENDIX I

BUSINESS ENTITIES
List of Ministries, Statutory Authorities and State Enterprises that fall under the purview of this Committee:

1. ARTS AND MULTICULTURALISM
   Carnival Institute
   Naparima Bowl
   National Academy for the Performing Arts (NAPA)
   National Carnival Commission of Trinidad and Tobago
   National Cultural Commission
   National Theatre Arts Company
   Queen's Hall Board
   Trinidad and Tobago National Steel Symphony Orchestra

2. ATTORNEY GENERAL
   Anti-Corruption Investigation Bureau
   Central Authority
   Council of Legal Education
   Environmental Commission
   Equal Opportunity Commission
   Equal Opportunity Tribunal
   Hugh Wooding Law School
   Industrial Court
   International Law and Human Rights Unit
   Law Reform Commission
   Tax Appeal Board

3. COMMUNICATIONS
   Board of Film Censors
   Caribbean New Media Group Limited (CNMG)
   Government Information Services Limited (GISL)
   National Broadcasting Network (NBN)

4. COMMUNITY DEVELOPMENT
   National Association of Village and Community Councils
   Village Councils
   Export Centres Company Limited

5. EDUCATION
   Local School Boards
   National Commission for UNESCO
   National Library and Information System Authority (NALIS)
   Education Facilities Company Limited
   National Schools Dietary Services Limited
6. ENERGY AND ENERGY AFFAIRS

Lake Asphalt of Trinidad and Tobago (1978) Limited
National Gas Company of Trinidad and Tobago Limited
National Quarries Company Limited
Petroleum Company of Trinidad and Tobago Limited (PETROTRIN)
Trinidad and Tobago National Petroleum Marketing Company Limited
Alutrint Limited
Alutech Limited
La Brea Industrial Development Corporation
National Agro Chemicals Limited
National Energy Corporation of Trinidad and Tobago Limited
NATPET Investment Company Limited
NATSTAR Manufacturing Company Limited
NGC NGL Company Limited
NGC Trinidad and Tobago LNG Limited
Phoenix Park Gas Processors Limited
Powergen
Trinidad and Tobago LNG Limited
Trinidad and Tobago Marine Petroleum Company Limited
Trinidad Nitrogen Company Limited
Trinidad Northern Areas Limited
TRINMAR Limited
TRINTOC Services Limited

7. ENVIRONMENT AND WATER RESOURCES

Institute of Marine Affairs (IMA)
The Environmental Management Agency
The Green Fund Advisory Committee
Water and Sewerage Authority (WASA)
—Water Resources Agency

8. FINANCE AND THE ECONOMY

Central Tenders Board
National Insurance Appeals Tribunal
National Insurance Board
National Insurance Property Development Company Limited (NIPDEC)
National Lotteries Control Board (NLCB)
Trinidad and Tobago Civil Aviation Authority
Trinidad and Tobago Unit Trust Corporation
Corporation Sole
Divestments
Investments
BWIA West Indies Airways Limited (New BWIA)
Caribbean Airlines Limited
First Citizens Holdings Company Limited
National Enterprises Limited (NEL)
Rum Distillers Limited
The Economy Sugar Manufacturing Company Limited
Trinidad and Tobago Forest Products Company Limited (TANTEAK)
Taurus Services Limited
Tourism and Industrial Development Company (TIDCO)
Trinidad and Tobago (BWIA International) Airways Corporation (Old BWIA)
Caribbean Investment Corporation
Trinidad and Tobago Development Finance Limited
Trinidad and Tobago Mortgage Finance Company Limited
Caribbean Development Network Limited
Caribbean Microfinance Limited
Colonial Life Insurance Company Limited (CLICO)
First Citizens Bank Limited (FCB)
First Citizens Mortgage & Trust Company Limited
First Citizens Investment Services Limited
Trinidad and Tobago Mortgage Agency Company Limited

9. FOOD PRODUCTION

Agricultural Society of Trinidad and Tobago
Caribbean Agricultural Research and Development Institute (CARDI)
Cocoa and Coffee Industry Board
Livestock and Livestock Products Board
Caroni (1975) Limited
National Agricultural Marketing and Development Corporation (NAMDEVCO)
Agricultural Development Bank
Caribbean Food Corporation
Sea Food Industry Limited

10. FOREIGN AFFAIRS

11. HEALTH

Boards regulating the Practice of Medicine and Related Professions
Children’s LIFE Fund Board of Management
Dental Council of Trinidad and Tobago
Drug Advisory Committee
Eastern Regional Health Authority
Emergency Medical Personnel Council of Trinidad and Tobago
Food Advisory Committee
Medical Council of Trinidad and Tobago
National Emergency Ambulance Service Authority
North Central Regional Health Authority
North West Regional Health Authority
Nurses and Midwives Council of Trinidad and Tobago
Opticians Council of Trinidad and Tobago
Pesticides and Toxic Chemicals Board
Pharmacy Council of Trinidad and Tobago
Princess Elizabeth Home for Handicapped Children
South West Regional Health Authority

12. HOUSING, LAND AND MARINE AFFAIRS

Estate Management and Business Development Company Limited (EMBD)
<table>
<thead>
<tr>
<th>5th Report of the Joint Select Committee on Ministries, Statutory Authorities and State Enterprises (Group 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land Settlement Agency</td>
</tr>
<tr>
<td>Sugar Industry Labour Welfare Committee</td>
</tr>
<tr>
<td>Housing Development Corporation</td>
</tr>
<tr>
<td>Urban Development Corporation of Trinidad and Tobago Limited</td>
</tr>
<tr>
<td>Community-based Environmental Protection and Enhancement Company Limited</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>13. JUSTICE</strong></td>
</tr>
<tr>
<td>Criminal Injuries Compensation Board</td>
</tr>
<tr>
<td>Legal Aid and Advisory Authority</td>
</tr>
<tr>
<td>Police Complaints Authority</td>
</tr>
<tr>
<td>Sentencing Commission</td>
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<tr>
<td><strong>14. LABOUR AND SMALL AND MICRO ENTERPRISE DEVELOPMENT</strong></td>
</tr>
<tr>
<td>Boilers Examiners Board</td>
</tr>
<tr>
<td>Cipriani College of Labour and Co-operative Studies</td>
</tr>
<tr>
<td>Friendly Societies</td>
</tr>
<tr>
<td>Minimum Wages Board</td>
</tr>
<tr>
<td>National Productivity Council</td>
</tr>
<tr>
<td>Occupational Safety and Health Authority</td>
</tr>
<tr>
<td>Registration, Recognition and Certification Board</td>
</tr>
<tr>
<td>National Entrepreneurship Development Company Limited</td>
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<tr>
<td><strong>15. LEGAL AFFAIRS</strong></td>
</tr>
<tr>
<td>Law Revision Commission</td>
</tr>
<tr>
<td>Rent Assessment Board</td>
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<tr>
<td>Prices Council</td>
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</tbody>
</table>
APPENDIX II
MINUTES OF PROCEEDINGS
MINUTES OF THE SIXTH MEETING OF THE JOINT SELECT COMMITTEE OF PARLIAMENT
APPOINTED TO INQUIRE INTO AND REPORT ON GOVERNMENT MINISTRIES (GROUP I), STATUTORY AUTHORITIES AND STATE ENTERPRISES FALLING UNDER THOSE MINISTRIES, HELD IN COMMITTEE ROOM 2, RED HOUSE, PORT OF SPAIN, ON FRIDAY, APRIL 15, 2011

PRESENT

Mrs. Corinne Baptiste–Mc Knight  
Prof. Harold Ramkissoon  
Mrs. Patricia Mc Intosh, MP  
Mr. Danny Maharaj  
Mr. Jairam Seemungal, MP  
Mr. Emmanuel George  
Ms. Stacy Roopnarine, MP  
Mrs. R. Nan Gosine - Ramgoolam  
Mrs. Carolyn Seeppersad–Bachan, MP  
Dr. Amery Browne, MP  
Mr. Faris Al-Rawi  

Ms. Khisha Peterkin  
Ms. Katharina Gokool - Mark  

Chairman  
Vice-Chairman  
Member  
Member  
Member  
Member  
Member  
Member  
Member  

Assistant Secretary  
Graduate Research Assistant  

ABSENT

Dr. Delmon Baker, MP  

Member  

OFFICIALS FROM THE MINISTRY OF HEALTH

Mrs. Sandra P. Jones  
Dr. Anton Cumberbatch  
Dr. Randolph Phillips  
Dr. Andrea Yearwood  
Dr. Doon  
Ms. Claudine Sheppard  
Mr. Anil Gosine  
Ms. Kirlyn Archie-Lewis  
Mr. Colin Bissessar  
Mr. Reynold Bedeau  
Mr. Asif Ali  
Mr. Reynold Koylass  
Dr. Harry Singh  
Dr. Keven Antoine  

Permanent Secretary  
Chief Medical Officer  
County Medical Officer, St. George West  
Director – Health Policy, Research & Planning  
Adviser Health Promotion Communications and Public Health  
Chief Executive Officer (Ag.), NWRHA  
Chief Executive Officer (Ag.), SWRHA  
Chief Executive Officer (Ag.), ERHA  
Chief Executive Officer (Ag.), NCRHA  
Adviser, Health Sector Reform  
Director of Finance & Accounts  
Project Unit Manager  
County Medical Officer of Health, St. George Central  
County Medical Officer, St. Andrew
COMMENCEMENT

1.1 The meeting was called to order at 9:42 a.m.

CONFIRMATION OF MINUTES (March 18, 2011)

2.1 The Committee considered the Minutes of the 5th Meeting held on March 25, 2011. There being no corrections or omissions, the Minutes were duly confirmed on a motion moved by Mr. Emmanuel George and seconded by Prof. Harold Ramkissoon.

MATTERS ARISING FROM THE MINUTES

3.1 The Chairman referred Members to the following matters arising from the Minutes:

- **Paragraph 3.1 on page 2:** The First Report was laid in the Senate on March 22, 2011 and in the House of Representatives on March 25, 2011.

  The Minister of Health was informed by letter dated March 29, 2011 of the requirements in the Standing Orders that a response to the Report should be tabled within 60 days of laying.

- **Paragraph 4.2 on page 2:** Written submissions were received from the following 5 persons:
  - Mr. Roy Mitchell- Principal Consultant, Executive Relationships Marketing
  - Ms. Petra Bridgemohan- Public Health Optometrist, ERHA
  - Mr. Kenneth Subran- Retired Public Officer
  - Mr. Nicholas Cumberbatch
  - Ms. Dianne Williams- Director, Mamatoto Mothers and Midwives Alliance of Trinidad and Tobago

PRE-HEARING DISCUSSIONS

4.1 The Committee discussed some areas of concern and agreed to the approach to be taken at the hearing.

4.2 The Committee agreed to invite Ms. Petra Bridgemohan, to an *in camera* meeting to make a presentation on optometry in the health care service, on a date to be determined.
OTHER BUSINESS

Next Inquiry Hearing

5.1 Members agreed that due to the public response to the inquiry into primary health care services that a second hearing would be held with officials on May 20, 2011. The hearing with the representatives of the National School Dietary Services Limited would be rescheduled to June 10, 2011.

Draft Second Report – Green Fund

5.2 It was agreed that Members would review the Draft within the next two weeks and submit comments to the Secretariat.

(The meeting was suspended and members proceeded to the chamber)

PUBLIC HEARING WITH OFFICIALS FROM THE MINISTRY OF HEALTH

re: Primary Health Care Services

6.1 The meeting resumed in the Parliament Chamber at 10:10 a.m. and introductions were made on both sides.

6.2 The Permanent Secretary was invited to make an opening statement. Members were informed of the efforts made by the Ministry to implement its Transformation Plan as it related to primary health care.

6.3 The following topics were discussed:

(a) Improvements made in the Health Sector

There has been an increase in life expectancy over the years and the number of services available to the public. As well as improvements in free child care services, infrastructure, i.e. health centres and district health facilities, weekend mobile clinics and the tobacco control clinics. These services have been measured against global indicators.

- The Ministry has been focusing on the preventative aspects of health care, in keeping with the global concept of risk reduction. Citizens were being encouraged to take charge of their health by having regular blood pressure, cholesterol and diabetes tests done.

(b) Recurrent Problems within the Ministry

- With reference to page 7 of the Report on the Commission of Enquiry into the Operation and Delivery of Public Health Care Services in Trinidad and Tobago (Vol. 1), the following recurrent problems were noted:
  i. a lack of comprehensive training programmes resulting in poor quality service, primarily at the primary health care level
ii. indiscipline among staff
iii. improper financial management
iv. inadequate policies regarding procurement of equipment and medical supplies
v. a lack of effective preventative maintenance programmes for equipment and health care facilities
vi. dilapidated toilets and kitchen facilities at many health care institutions

• Members were informed that training issues were being addressed at a cost of over $100 million. This involved the University of the West Indies (UWI) and the establishment of a Distance Learning Centre located at the South West Regional Health Authority and the award of scholarships and bursaries in critical areas of medical nursing and other health areas. Training programmes were also being developed at the University of Trinidad and Tobago (UTT) in Masters of Health Administration.

• The problem with staff indiscipline was aligned to the lack of a proper regulatory framework to treat with this prior to 2007.

• With the creation of the RHAs, there were public officers who did not migrate and as such there is a dual reporting. This problem is being addressed in the Transformational Plan.

(c) Sanitary Standards in Schools

• Public Health Inspectors are mandated to visit every school at least once in three months and to produce a report outlining recommendations for improvements needed in the areas of infrastructure and the school environment.

• These reports are forwarded to the Ministry of Education and the School Supervisors. However, it was noted that the recommendations are not often implemented.

(d) Health Promotion Programmes

• These programmes focus on educating the public on the nutritional content of food, especially fast food to help in making wiser food choices. The Caribbean Food and Nutrition Institute is currently developing National Nutrition and Dietary Guidelines.

• These programmes are advertised via (i) the use of mass media and (ii) the use of target groups e.g school health population; the maternal and child health population or the older persons health promotion.
(e) **Infant Mortality Rate**

- The infant mortality rate has steadily improved over the past 10 years from 21.1 per thousand in the year 2000 to 15 per thousand in 2009.

- The Ministry’s aim was to reduce that figure to single digits by 2020. This would require more investment into neonatal and antenatal care.

(f) **Life Expectancy Rate**

- On average, life expectancy in Trinidad and Tobago is 71 years compared to 83 years in Japan and 80 years in Canada.

- Male deaths, on average, occur seven years prior to female death and is attributed to (i) violence and (ii) HIV/AIDS infections. Another major factor is the failure to treat chronic diseases, since men tend not to seek medical attention, though they have higher consumption levels of alcohol and tobacco.

(g) **Staff Vacancies at the Regional Health Authorities**

- At present, there are 2,953 vacancies within the RHAs. This was attributed to a lack of tertiary level institutions to train the number of personnel required to fill the positions.

- In response, the Ministry was liaising with institutions such as COSTAATT in an effort to have such programmes introduced. In the interim, some of these posts have been filled by professionals from Cuba and the Phillipines.

(h) **Quality Management**

- The Ministry has a Quality Standard and Accreditation Programme which focuses on the standard of procedures in primary health care, the hospital system and in vertical services. There is a Quality Unit in each RHA with a mandate to provide continuous improvement qualities.

- The Ministry conducts quality standard audits at both public and private institutions in order to bring the health care system to an acceptable standard.

(i) **Community Dental Care**

- The Dental Plan is targeted at primary school children. Dental nurses visit schools to conduct examinations, checkups, minor fillings, if necessary, and provide dental education. The adult programme is limited to mainly extractions.
(j) **Public Health and Environmental Issues in Laventille**

- In Laventille, factors such as the demographics, location and crime have proven to be difficult for the Ministry. Health care is provided by two Health Centres located in Upper Laventille and Success Village. The services provided at these Centres include eye care chronic disease, antenatal care, general practice, foot care programmes and chronic disease management.

- Public Health Inspectors, in this area, conduct daily inspections and report issues to the County Medical Officers and the Regional Corporations.

6.4 The Officials were asked to provide the Committee with the following written information:

1. the budget preparation procedure used to determine the allocation of funds to the Regional Health Authorities (RHAs) and the areas of budgetary deficit;
2. the Annual Service Agreement between the Ministry of Health and the Regional Health Authorities for fiscal year 2011/2012;
3. details on constraints experienced by the Regional Health Authorities (RHAs), particularly at the South West Regional Health Authority (SWRHA);
4. details on the role to be played by the Ministry of Health with regard to the National AIDS Coordinating Committee (NACC);
5. the status of unutilized dental equipment at some health centres;
6. the ratio of patients to health care providers in the area of Laventille;
7. details of shortfall of human resource capacity collated by divisions;
8. what are the impediments to having at least one health centre in a district opened on a 24 hours basis, to ease the situation at the hospitals;
9. why dental health care service in the constituency of La Horquetta/Talparo, have been cancelled;
10. is there a shortage of doctors at the Health Centres in the constituency of La Horquetta/Talparo;
11. whether the procedures outlined in the report on the “Revised Principal Role of the Ministry of Health” have been implemented;
12. details on the child development aspect of primary care in relation to – ophthalmic, dental care; child pregnancy, child abuse protocols and infant care etc;
13. details on facilities/programmes that exist for the provision of palliative care;
14. details on menopausal and andropausal care;
15. details on district visit programmes/schedules; and
16. details on Facilities and Property Management arrangements and guidelines.

6.5 The Chairman indicated that given the depth of the topic under review, the Committee would meet again with the Officials from the Ministry on May 20, 2011.

6.6 The Officials from the Ministry were thanked for their attendance.
ADJOURNMENT

7.1 The meeting was adjourned at 12:22 p.m.

I certify that these Minutes are true and correct.

Mrs. Corinne Baptiste-McKnight

Chairman

Mrs. Lily Broomes

Secretary
PRESENT

COMMITTEE MEMBERS

Mrs. Corinne Baptiste–Mc Knight  
Prof. Harold Ramkissoon  
Mr. Emmanuel George  
Ms. Stacy Roopnarine, MP  
Mrs. Carolyn Seezersad–Bachan, MP  
Mr. Danny Maharaj  
Mr. Jairam Seemungal, MP  
Mr. Faris Al Rawi  
Mrs. Verna St. Rose-Greaves  
Dr. Amery Browne, MP

Chairman
Vice-Chairman
Member
Member
Member
Member
Member
Member
Member

ABSENT

Dr. Delmon Baker, MP  
Mrs. Patricia Mc Intosh, MP

Member (Excused)
Member (Excused)

SECRETARIAT

Mrs. Lily Broomes  
Ms. Sheranne Samuel  
Mrs. Katharina Gokool-Mark

Secretary
Asst. Secretary/Parliamentary Intern
Graduate Research Assistant

ALSO PRESENT

Officials from the Ministry of Health

Mrs. Antonia Popplewell - Permanent Secretary
Dr. Anton Cumberbatch - Chief Medical Officer
Mr. Asif Ali - Deputy Permanent Secretary (Ag.)
Dr. Andrea Yearwood - Director Health Policy, Research and Planning
Ms. Yvonne Lewis - Director Health Education
Ms. Chandradai Harry - Director Finance and Accounts
Mr. Ronald Koylass - Project Manager
Mrs. Judith Balliram-Ramoutar - Chief Executive Officer, North West Regional Health Authority
Mr. Anil Gosine - Chief Executive Officer, South West Regional Health Authority
Ms. Stacy Harricharan - Chief Executive Officer, Eastern Regional Health Authority
Dr. Akenath Misir - County Medical Officer of Health, St. George East
Dr. Shevanand Gopiesingh - Executive Medical Director (Ag.), South West Regional Health Authority
Dr. Lester Goetz - Medical Director (Ag.), South West Regional Health Authority
Dr. Harry Singh - County Medical Officer of Health, St. George Central, North West Regional Health Authority
Dr. Harry Smith - County Medical Officer of Health, St. George West, North West Regional Health Authority
Dr. Olalekan Fagbola - Chief Medical Officer of Health (Ag.), Nariva/Mayaro County, Eastern Regional Health Authority
Mr. Keith Beharry - Quality Manager, Eastern Regional Health Authority
Mr. Brian Armour - Programme Director HIV Unit
Dr. Mariyam Richards - Primary Care Physician II, North Central Regional Health Authority
Dr. Raveed Khan - Primary Care Physician II, North Central Regional Health Authority
Dr. Rodney Ramroop - Executive Medical Director, North Central Regional Health Authority

COMMENCEMENT

1.2 The meeting was called to order at 9:27 a.m. The Chairman welcomed Members and extended New Year greetings.

1.3 The following Members were asked to be excused from the day’s meeting:
• Dr. Delmon Baker, MP
• Mrs. Patricia Mc Intosh, MP

CONFIRMATION OF MINUTES OF THE EIGHTH MEETING (November 18, 2011)

2.1 The Chairman invited the Committee to consider the Minutes of the 8th Meeting held on November 18, 2011. There being no corrections or omissions, the Minutes were duly confirmed by a motion moved by Mr. Emmanuel George and seconded by Mr. Jairam Seemungal.

MATTERS ARISING FROM THE MINUTES

3.1 The Chairman referred Members to the following matters arising from the Minutes:

• Page 2 Paragraph 4.2 – Chairman stated the Committee will continue with the Ministry of Health today (January 20, 2012).

• Page 5 Paragraph 6.7 – The Chairman advised that additional information from the Ministry of Education and the National Schools Dietary Services Limited (NSDSL) has been received.
• **Page 2 Paragraph 4.1** – It was noted that the Third Report on Legal Aid and Advisory Authority was still outstanding. The comments of Mr. George was circulated, however, the Committee was not in position to examine said comments. The Chairman indicated that this will be on the agenda for the next meeting.

**OTHER BUSINESS**

**Meeting times**

4.1 Mr. Seemungal sought clarification on meeting times, whether it is 9:00 a.m. or 9:30 a.m. The Chairman confirmed that meeting starts at 9:00 a.m. and that it is determined by the agenda on the day.

**Pre-Hearing Discussions**

5.1 The Chairman asked Members if they were satisfied with the answers received from the Ministry of Health to questions posed by the Committee at the last hearing with the said Ministry.  
5.2 Professor Ramkissoon raised concerns about whether his questions had been answered and also how were written answers made public. Mr. Seemungal stated that he was not satisfied with the answers to his questions.  
5.3 The Chairman suggested that the Committee should start the inquiry by seeking clarifications to questions that were not suitably answered in the written submissions.

**Deliberations on next entities to appear before the Committee**

6.1 The Committee agreed that the National Carnival Commission (NCC) would be the next entity to be approached to appear before them. They would be followed by the Ministry of Education, however, the Committee asked that the Secretariat provide a full list of entities that fall under this ministry. The Committee will then decide at the next meeting which entities they will like to appear.

(The meeting was suspended at 9:43a.m. and Members proceeded to the J. Hamilton Maurice Room)

**EXAMINATION OF THE OFFICIALS FROM THE MINISTRY OF HEALTH (CONTINUED)**

**Re: Inquiry into the Administration and Operations of the Ministry of Health with particular focus on primary health care services**

7.1 The meeting resumed in the J. Hamilton Maurice Room, Mezzanine Floor at 10:17 a.m. and introductions were exchanged.

7.2 The Chairman invited the Permanent Secretary to give opening remarks. The PS then proceeded to outline the areas in which answers to additional questions were provided to the Committee.

7.3 The following topics were discussed:

**(a) Dental Care**

There is a policy for the provision of dental services in Trinidad and Tobago, with dental health care services being concentrated in the pediatric and children (up to age 13) age group. Related to this
there is a school dental health programme and primary health care dental services at health centres which target children. The bulk of these services are provided by dental nurses supported by dentists. The targeting of children ages 14–18 will require a change of regulations. Currently there is not an extensive dental health care programme for adults, only extraction services are provided. Any expansion of the present system will prove quite expensive and will require the engagement of private sector dentists and some form of insurance scheme.

There are plans for dental services to be provided to the elderly in homes, it is set to commence in the period 2012/2013. As part of the Ministry's preventive policy, Trinidad and Tobago will be required to engage in fluoridation of the water system. The Ministry also intends to train a new cadre of dental staff and increase the number of dental nurses.

The provision of dental care service to children does not require the use of X-rays. X-rays are required for the adult programme and X-ray units are now being installed as part of the routine range of dental equipment.

All RHAs have a biomedical department that handles maintenance. The cost of maintenance is included in their budgets. Only in the case of major equipment costs will the matter go to the Permanent Secretary.

A dental health education programme exists. Dental health education forms part of the duties of dental nurses. They visit schools and also invite children and parents to the clinics at specified times. This programme is monitored at two levels: at the level of the RHAs through reports to the County Medical Officer of Health or the Primary Care Manager and at the level of the Ministry through the Dental Manager. Reports are done on a monthly basis.

(b) Chronic Non-communicable Diseases

Chronic non-communicable diseases (CNCDs) are among the leading causes of death in Trinidad and Tobago. As such the Ministry has developed a structured approach to dealing with this issue. The social determinants of health and the various players involved have to be taken into consideration. There is also a need for persons to readjust their lifestyles and thus reduce the risk factors of CNCDs. It was revealed that as a society we overeat and there is a need for portion sizing.

Additionally, resources have to be diverted from chronic non-communicable diseases to violence and trauma.

With respect to CNCDs, Trinidad and Tobago has been working very closely with their partners locally, regionally and internationally such as the RHAs, Caricom, PAHO and WHO. The Ministry has undertaken a risk assessment to determine the risk factors for CNCDs. Based on a survey on body mass index (BMI) among children it was found that obesity levels stood at 25 per cent nationally, but when disaggregated by different counties, the percentage varies. As a result of this, the Ministry began working with the Caribbean Food and Nutrition Institute to develop nutrition and dietary guidelines for schools.

A risk assessment was done among the general population, using the step survey developed by PAHO. Among the findings: 55 percent of the population is overweight; nationally the population eats 0.9 fruits and vegetables while the recommended amount is at least 5. The Ministry has conducted the global school health survey and the global youth tobacco survey.
Cabinet has appointed the Partners Forum for action on chronic diseases. It aims to bring together different segments such as the Chamber of Commerce and the manufacturing sector. Trinidad and Tobago is the only Caribbean country to have the Partners Forum identified. Barbados is also working on salt reduction, however, they have not established a Partners Forum.

At a recent follow up meeting to the UN General Assembly on Chronic Diseases the issues of the reduction of hypertension and obesity and the elimination of salt and transfat from the diet were examined. The Minister of Health recently launched the “Fight the Fat” campaign to tackle obesity.

The CMO is of the view that “sweet” drinks should be removed from school compounds. For this to happen the Ministry would have to make a proposal to Cabinet for consultation and agreement and the articulation of a policy. The Ministry of Education will be responsible for implementing at schools.

The RHA’s outlined the exercise programmes they have initiated such as the “exercise by prescription” at the Petit Valley, Health Centre and advised how exercise equipment at health centres is used. Some of the equipment was not in use and required maintenance work. While some of it is being used by staff rather than the public. It was suggested that health centres be opened after 4 p.m. to allow for the use of exercise equipment.

(c) Annual Service Agreement

An annual service agreement (ASA) was signed last year and a review conducted regarding performance. Quarterly reports were done of the RHAs and performance was varied from quarter to quarter. A new web enabled, performance monitoring system has now been put in place.

(d) Budgeting and Quality of Service

Output budgeting is used by the SWRHA. A question was raised as to whether the other RHAs had intentions of adopting this type of budgeting.

The Permanent Secretary informed Members that there is a measure in place to monitor quality of care. There is a health sector quality council and RHA performance monitoring teams have recently been put in place by the Ministry. The RHAs are to have counterpart monitoring teams. Indicators have been developed, which is inclusive of customer service indicators. Also RHAs have been issued with a customer/client feedback survey. The Ministry expects to see the results of this initiative within a year.

The Ministry is also partnering with the Trinidad and Tobago Registered Nurses Association (TTRNA) to ensure that nursing care is of an excellent standard.

(e) Human Resource Issues

Previously there was not a clear understanding of the approved staffing structure at the RHAs and this led to a staffing and funding issue between the Ministry and the RHA. Discussions have been held to address this issue. The Ministry has embarked on the rationalization of the entire HR structure in the RHAs and at the Ministry.

Concerns were raised about the number of vacancies. With regard to training and development, the PS indicated that there is a problem in terms of the pace at which persons can be trained and integrated into the system, the example of nurses was given. Aside from training in the case of
nurses there is also the issue of nurses leaving, attracted by other countries. The CMO also spoke of acquiring additional persons to perform non-nursing functions so that nurses can concentrate on actual nursing procedure.

Mention was made of the agreement with the Cuban and Philippine Governments which are aimed at addressing shortages in the system. The use of information technology is another avenue, which would allow the health professional to work smarter and cover wider areas. Additionally, the health system globally is moving toward having additional types of people in the health system, technically trained to do specific things; for example dialysis technicians rather than dialysis nurses.

There are ratios for all categories of staff, the Ministry aims to determine how the current ratios can be utilized to deal with the range of expanding services. The use of information technology can be adopted to change the ratio of professionals to patients.

(f) Communication

Communication has to go beyond the MOH with regard to combating information in the media that may be erroneous and products that are falsely advertised. It would also require the modernization of the regulatory system especially as regards pharmaceuticals, herbal products and foods. The Ministry also needs to strengthen its internal regulatory system and a change in the law is necessary. The education system is also important in terms of enabling children to examine what is provided to them in the commercial world and making appropriate, informed choices.

(g) National AIDS Coordinating Committee (NACC)

The portfolio responsibility for the NACC rests with the Office of the Prime Minister; the Ministry of Health provides technical support and some coordination. The MOH has been working closely with the Office of the Prime Minister ensuring the coordination and reporting responsibilities. The programme of coordination has not stopped, in fact the Ministry continues to expand its role to ensure that patients are taken care of and the NGO system is examined.

There is a coordinating unit established at the Office of the Prime Minister and there is an inter-ministerial team. The unit at the Office of the Prime Minister is being reformed and redesigned to take into consideration legislation which can be expected within the next year.

(h) Radiology

Contracts have been signed with private firms to aid with the backlog of radiology examination reports. There is an audit process to ensure that the reports are correct before any payments are made.

The Executive Medical Director at the NCRHA indicated that there is a backlog of approximately 5000 MRI cases and 5000 CT cases as of six months ago. However, work is being done and this figure has since been reduced. It was noted that there are increased numbers of examinations, increased numbers of patients.

A waiting list initiative has been introduced and it has been deemed to be equitable as opposed to what obtained previously and both RHA and university doctors are benefitting.

7.4 The officials were also requested to forward documentation on the following: Output Budgeting
• Indicate if there is any intention on the part of other Regional Health Authorities (RHAs) excluding the South West Regional Health Authority (SWRHA) to adopt output budgeting and how soon.

• Is quality of service included when dealing with output budgeting?

**Annual Service Agreements**

• Provide data indicating whether RHAs have been meeting performance targets and to what extent.

• With respect to performance targets, what data is captured, how is it captured and when is it reported?

**Dental Care**

• Provide a current snapshot with respect to dental health care.

• The number of dentists who are bonded to the Government of Trinidad and Tobago by virtue of scholarships and their assimilation into the system; an example of the type of contract that is engaged between students on scholarship and the government.

**Human Resource Issues**

• Does the Ministry of Health (MOH) and by extension the RHAs have any solutions to address HR issues?

• Is the Ministry looking towards training and development, scholarships etc. to fill vacant positions?

**Procurement**

• The method utilized by the MOH and the RHAs with respect to procurement and getting value for money.

**Methodology**

• Explanation by the North Central Regional Health Authority (NCRHA) about the methodology referred to as a need of development. (see page 21 of Ministry’s response)

**Radiology**

• Contribution of the Executive Medical Director and Consultant Radiologist (NCRHA) re:
  1. The status of the thousands of radiology examination reports?
  2. The reason for the termination/suspension of the services of the university radiologist;
  3. The nature of the backlog clearing exercise; and
  4. How is the quality of those reports monitored?

**Training**

• The measures that have been put in place re: training since the enquiry on April 15th 2011 and the areas of focus.

• The systems/programmes that are in place by the Ministry of Health to ensure that community nurses are being trained effectively.

**Relationship between the public and private health sector**

• Whether the state should continue with a separate public health sector and a separate private health sector or should both public and private be merged and through what mechanism?

**Ministry of Health**

• The steps taken by the MOH to ensure that cheaper generic drugs in the Chronic Disease Assistance Programme (CDAP) are of an acceptable quality.

• When was the last Health Needs Assessment done by the MOH?

• In particular, whether there have been proper assessments and recommendations for an appropriate skills mix that is required to provide holistic health care?

• Provide information in terms of how the nursing shortage can be alleviated by bringing on more allied health professionals.
Patients Complaints
- Comment on a pilot project introduced that concerns the appointment system to ease the long waiting times to see doctors.
- The status with respect to the computerization of systems in the health sector.

Miscellaneous
- The need for a Health Complaint Authority similar to that of the Police and the requirements to have such an authority started.
- Provide a list of health centres that are currently opened on a 24hr basis.
- A list of the health facilities that are equipped with electric standby generators to preserve vaccines viability and in which centres are they used?
- Procedures that are in place to ensure that doctors and nurses are held accountable for the time spent at the health facilities.

7.5 The Chairman thanked the officials for their attendance, advised that they will be informed of the date of the next meeting. The officials departed.

NEXT MEETING

8.1 After some discussions, the Committee established that the next meeting will be held on Friday March 2, 2012 at 9:00 a.m. The Ministry of Health will return then.

ADJOURNMENT

9.1 The Chairman thanked Members and the meeting was adjourned to Friday March 2, 2012 at 9:00 a.m.

9.2 The adjournment was taken at 12:36 p.m.

I certify that these Minutes are true and correct.

Mrs. Corinne Baptiste-McKnight
Chairman

Mrs. Lily Broomes
Secretary

January 23, 2012
MINUTES OF TENTH MEETING OF THE JOINT SELECT COMMITTEE OF PARLIAMENT APPOINTED TO INQUIRE INTO AND REPORT ON GOVERNMENT MINISTRIES (GROUP I), STATUTORY AUTHORITIES AND STATE ENTERPRISES FALLING UNDER THOSE MINISTRIES, HELD IN IN THE ARNOLD THOMASOS ROOM (EAST), LEVEL 6, AND THE J. HAMILTON MAURICE ROOM, MEZZANINE FLOOR, OFFICE OF THE PARLIAMENT, TOWER D, THE PORT OF SPAIN IWFC, 1A WRIGHTSON ROAD, PORT OF SPAIN ON FRIDAY MARCH 16, 2012 AT 9:00 A.M.

PRESENT

COMMITTEE MEMBERS

Mrs. Corinne Baptiste–Mc Knight
Prof. Harold Ramkissoon
Mr. Emmanuel George
Ms. Stacy Roopnarine, MP
Mrs. Carolyn Seepersad–Bachan, MP
Mr. Danny Maharaj
Mr. Jairam Seemungal, MP
Mr. Faris Al-Rawi

Chairman
Vice-Chairman
Member
Member
Member
Member
Member
Member

ABSENT

Dr. Delmon Baker, MP
Mrs. Patricia Mc Intosh, MP
Dr. Amery Browne, MP
Mrs. Verna St. Rose-Greaves

Member (Excused)
Member (Excused)
Member
Member

PRESENT

SECRETARIAT

Mrs. Lily Broomes
Ms. Sheranne Samuel
Mrs. Katharina Gokool-Mark

Secretary
Asst. Secretary/Parliamentary Intern
Graduate Research Assistant

ALSO PRESENT

Officials from the Ministry of Health

Mrs. Antonia Popplewell
Dr. Andrea Yearwood
Ms. Yvonne Lewis
Ms. Chandradai Harry
Mr. Ronald Koylass
Dr. Rohit Doon
Mrs. Judith Balliram-Ramoutar

Permanent Secretary
Director, Health Policy, Research and Planning
Director, Health Education
Director, Finance and Accounts
Project Manager, Project Management Unit
Adviser, Health Promotion, Communication and Public Health
Chief Executive Officer, North West Regional Health Authority
Mr. Collin Bissessar  
Chief Executive Officer, North Central Regional Health Authority

Bhabie Roopchand  
Legal Adviser

Mr. Anil Gosine  
Chief Executive Officer, South West Regional Health Authority

Ms. Stacy Harricharan  
Chief Executive Officer, Eastern Regional Health Authority

Dr. Shevanand Gopiesingh  
Executive Medical Director (Ag.), South West Regional Health Authority

Dr. Lester Goetz  
Medical Director (Ag.), South West Regional Health Authority

Dr. Harry Singh  
County Medical Officer of Health, St. George Central, North West Regional Health Authority

Dr. Harry Smith  
County Medical Officer of Health, St. George West, North West Regional Health Authority

Dr. Olalekan Fagbola  
Chief Medical Officer of Health (Ag.), Nariva/Mayaro County, Eastern Regional Health Authority

Dr. Adesh Sirjusingh  
Administrator, Clinical Service, Eastern Regional Health Authority

Mr. Keith Beharry  
Quality Manager, Hospital Administration, Eastern Regional Health Authority

Mr. Brian Armour  
Programme Director HIV/AIDS Coordinating Unit

Dr. Raveed Khan  
Primary Care Physician II/Administrative (Ag.), Arima Health Facility, North Central Regional Health Authority

Dr. Rodney Ramroop  
Executive Medical Director, North Central Regional Health Authority

Dr. Surbash Pooran  
MCOS/Director of Health

COMMENCEMENT

1.1 The meeting was called to order at 9:45 a.m. The Chairman welcomed Members and suggested that Members proceed to the meeting with the Ministry of Health and then meet for fifteen (15) minutes as a committee after the investigation has concluded.

(The meeting was suspended at 9:47 a.m. and Members proceeded to the J. Hamilton Maurice Room)
EXAMINATION OF THE OFFICIALS FROM THE MINISTRY OF HEALTH (CONTINUED)

Re: Inquiry into the Administration and Operations of the Ministry of Health with particular focus on primary health care services

2.1 The meeting resumed in the J. Hamilton Maurice Room, Mezzanine Floor at 10:00 a.m. and introductions were exchanged.

2.2 The Chairman invited the Permanent Secretary to give opening remarks. The PS proceeded to outline the areas where answers to additional questions were provided to the Committee.

2.3 The following topics were discussed:

(i) **Health Complaints Authority**

- The mechanism in place at all RHAs to treat with complaints.
- There are Quality Risk Management Departments and Customer Relations Officers at all RHAs.
- Currently the MOH is in the process of drafting a Patients’ Bill of Rights. A request was made for detailed information on the Patient’s Bill of Rights.
- There is also the Patient’s Charter which is a policy document.

(ii) **24/7 Health Centres**

- NWRHA – The St. James District Health Facility is opened on a 24 hour basis while there are extended opening hours at other health facilities.
- NCRHA – The Accident and Emergency department at the Arima Health Facility and the Chaguanas Health Facility are open 24 hours. There are also general practice clinics which are opened for extended hours.
- ERHA – The Mayaro District Health Facility and the Rio Claro and Toco Health Centres are opened on a 24 hour basis.
- SWRHA – The District Health Facilities opened for 24 hours are those located in Princess Town, Siparia and Couva as well as the A & E at the Point Fortin Area Hospital. At San Fernando General Hospital 24 hour radiology services are available.
- Mr. Gosine assured that there are plans to enhance the general practice services available at the La Horquetta Health Centre.

(iii) **Radiology Reports**

- Not all RHAs have backlogs, however, where there are backlogs a method has been identified to deal with it.
- NCRHA staff will be utilized to clear the backlog in that region which stands at 5,766 for the period January 2011-2012. It is expected to be cleared within nine months to one (1) year. Overtime will be paid once stipulated work hours have been completed. Overtime rates are as follows:
  
<table>
<thead>
<tr>
<th>Position</th>
<th>Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>$173.08 per hour</td>
</tr>
<tr>
<td>Registrar</td>
<td>$136.48 per hour</td>
</tr>
<tr>
<td>House Officer</td>
<td>$111.06 per hour</td>
</tr>
</tbody>
</table>
Further information was requested on any significant backlogs that may exist with respect to radiology and other areas at the various RHAs.

(iv) Certification of Doctors

- The Parallel Medical Board was created as a result of the difficulty experienced with the certification and registration of foreign physicians by the Medical Board of Trinidad and Tobago.
- A certain degree of stringency and scrutiny was exercised and the doctors were confined to the public sector.
- In some instances e.g. the Cuban doctors, are employed for a specific period of time. The UN Volunteer System has been discontinued.
- The issue of St. George's medical graduates having to undergo supervision for an additional 2-3 years after their one year internship has been completed. There are several categories of doctors, depending on where qualifications were obtained, and a listing of traditional and non-traditional schools.
- It was stated that the Medical Board of Trinidad and Tobago is a separate entity and does not come under the control of the MOH.

(v) Scholarship

- Statistics show that the MOH has been able to retain scholars returning from abroad.
- The MOH has submitted a listing of specialist areas to the Ministry of Public Administration, where scholarships are required.
- Last year approximately ten (10) scholarships were offered in allied health care fields.

(vi) Human Resources

- An acute shortage exists in specialist areas within the RHAs.
- As at December 2011 there were approximately 234 specialist vacancies across the RHAs. This figure refers to current staff and does not include future projections.
- MOH started using the WHO Planning Tool in 2011 which was tailored to suit the needs of the MOH.
- There is a three year and ten year manpower plan in place. The 10 year plan relates to both the private and public sector.
- Due to staff shortages in the system overtime work is a necessity.

(vii) Oncology/Pain Management

- It is within the remit of the Drug Inspectorate Agency of the MOH to manage the process of the registration, importation, distribution and availability of analgesics.
- The importation and the amount of drugs that a country could import is controlled by a UN agency. This causes a delay if there is need for an increase in the drugs required.
- The private sector’s need for analgesics cannot be easily determined.

(viii) Dental Health Care
• There is a need to review and restructure the dental services; there is a plan to decentralize the service to the RHAs and also to introduce other categories of dental providers such as dental therapists and dental hygienists.
• Some legislative amendment is required.

(ix) **Trauma Services**

• The MOH intends to approach Cabinet with a proposal to treat with the provision of psychological trauma services at the various health facilities.

(x) **EHS Services**

• The MOH is working on legislation to establish an Emergency Ambulance Authority, which will be responsible for ambulance services.

(xi) **Annual Service Agreement**

• The first year the MOH implemented the ASA across the board was in fiscal year 2010/2011.
• Regions report on a quarterly basis and end of year baselines are established. NCRHA has assured that they have taken immediate steps to address the issue of missing data.
• The question of actual measurability was a problem and was suggested as a reason for the lack of data provision.
• The MOH intends to have training sessions with the various RHAs to train officers in data collection and collation.
• There is a need for improved and strengthened monitoring of services.
• At the SWRHA there is an overcrowding problem which contributes to increased rates of infections. Also, the average waiting time for surgeries has been extended since the RHA is dealing with up to 40% of cases coming from other regions.

(xii) **Procurement**

• The NCRHA has developed a Tenders’ Handbook
• The former Minister of Health had indicated that this Tenders’ Handbook would have been adopted by all other RHAs

(xiii) **Trinidad and Tobago Health Training Centre (TTHTC)**

• The TTHTC is a joint initiative between the MOH and the University of the West Indies.
• Currently the TTHTC is seeking to expand the range of training offered. The issue of accreditation will have to be considered.
• Presently service programmes are offered with a certificate of participation upon completion. Diplomas and degree programmes are handled by the UWI.

(xiv) **Health Needs Assessment**

• The last national health needs assessment was done in 1994 under the Health Sector Reform Programme.
• Needs assessments are carried out in different RHAs from time to time.
(xv) **Skills Mix**

- Work has commenced on the private health institution study and the staff-to-patient ratio.
- The innovation and introduction of technology requires constant review and update.
- The primary health care sector skills mix is already known.

2.4 **The officials were also requested to forward documentation on the following:**

**Bill of Rights**
- Provide information on the status of the Bill of Rights, what is being considered and what caveats are expected to be placed in it.

**Radiology**
- The estimated cost and time it will take to clear the backlog of reports.
- Could the money for the backlog clearing exercise be otherwise diverted into the existing structure?
- Is this a model which was proposed with respect to other backlog exercises?
- What is the approximate cost of the one-year clearance exercise at the NCRHA?

**Backlogs**
- Are there any significant backlogs in respect of diagnostics and other material areas? If so, state the areas and the cost to clear it.

**Oncology**
- The status of improving the quality of analgesics used in the public sector health care system.
- The approach used by the private sector with respect to oncology management.
- How are the drugs being procured for oncology management?
- Reasons preventing the expansion of the range of drugs that are currently in use.
- How are complaints of the private and public sector institutions relative to the shortage of drugs and the limited range of drugs being dealt with?
- What is the timeframe for improving this structure?

**Scholarships**
- Suggest whether there is a need to revisit/modify the contract to make it more rigid in order to better utilize returning scholars.

**Human Resources**
- State the current shortfall of doctors.
- How do the RHAs deal with disciplinary issues?
- Procedures that are in place to ensure that doctors and nurses are held accountable for the time spent at the health facilities.

**Registration of Doctors**
- The MOH’s perspective on the difficulties faced in the equality of treatment for the registration of doctors with respect to the medical board.

**Budgeting**
- By way of a diagram, (pie chart), show the percentage of the budget that goes toward administrative services at the RHAs.
- What is the expenditure in terms of overtime?

**Procurement**
• How does the MOH ensure value for money, monitoring of service and the maintenance of contracts?

Dental Care
• What are the plans for addressing the dental and oral healthcare needs of persons over the age of 18?
• State the deficiency with respect to the shortage of dentists and dental technicians and the approach being taken to alleviate the situation.

Hospital Services
• State the impact of the increase of trauma cases on available resources? How does it affect the provision of services in respect of non-traumas cases?
• Are the RHAs able to meet the demand on the current facilities and human resources for neurosurgery services?
• Are the MOH and the RHAs able to address the population’s need for cardiac surgery in a timely fashion or are there delays that can be potentially life-threatening?

Health Centres
• How many health centres have standby generators for the purpose of preserving vaccination medication and other medication which require refrigeration in the event of an electricity outage?

Annual Service Agreements (ASA)
• Provide a copy of the model ASA.

2.5 The Chairman thanked the officials for their attendance.

NEXT MEETING
3.1 The Chairman suggested that Members submit written comments regarding Mr. George’s submission on the Legal Aid Report by March 29, 2012 in order to finalize the report.

3.2 After some discussions, the Committee established that the next meeting will be held on Friday April 20, 2012 at 9:00 a.m. The National Carnival Commission (NCC) will be examined.

ADJOURNMENT
4.1 The Chairman thanked Members and the meeting was adjourned to Friday April 20, 2012 at 9:00 a.m.

4.2 The adjournment was taken at 12:12 p.m.
I certify that these Minutes are true and correct.

Mrs. Corinne Baptiste-Mc Knight

Chairman

Mrs. Lily Broomes

Secretary

March 23, 2012