G R E N A D A

THE ORGANISATION OF PRIMARY CARE

Virginia Morley

Camberwell Primary Care Development Project
Dept. of General Practice Studies
King's College School of Medicine & Dentistry

Safder Mohammed

Health Unit, London Borough of Haringey

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Thanks are also due to St. George's Medical School for giving us accommodation during our time on the island. We were sorry not to have had the opportunity to meet with Dr. Geoffrey Bourne, Vice Chancellor, who died shortly before our study began.

In particular, we are grateful to the Ministry of Health in Grenada for their time and permission to undertake this study, especially Dr. Murray, Mrs. Perrotte, and the staff of the medical stations and health centres who were very generous with their time.

Background

Grenada is the most southerly of the Windward Islands and is situated 90 miles off the coast of Venezuela in the eastern Caribbean. It comprises three islands, Grenada, Carriacou and Petit Martinique. From north to south, Grenada is about 21 miles, and east to west about 10 miles, with a population of nearly 100,000. 47 per cent of the population are under 15 years of age, giving Grenada one of the youngest populations in the Caribbean. The majority of Grenada's population lives at subsistence level and there is high unemployment, poverty and outward migration.

Politically, Grenada has undergone substantial changes since independence from Britain in 1974. The People's Revolutionary Government from 1979 to 1983, led by Maurice Bishop, developed strong links with Cuba. Since the American invasion in 1983 the government has established strong ties with the USA and Canada, and these countries remain their principal benefactors.

Many people living on Grenada seem to rely heavily on financial help from relatives living abroad. The island also appears to depend on a growing tourist trade, again, principally from the United States.

Grenada's economy is based on agriculture and its principal exports are cocoa, nutmeg, mace and bananas. Additional crops include sugar cane, coconuts and citrus fruit. Whilst we were there, many people referred to the potential in developing exports of exotic fruit, such as papaya, avocado and mango, all of which grow in abundance. Other than locally grown produce, however, food is almost all imported and relatively expensive.

Grenada is volcanic and covered in dense forest. Although distances are relatively small, this can be deceptive as transport and access to various parts of the island is difficult. Road-building and improvements only seem to occur where grants from overseas have supported them. Some of the roads are very poor and, during the rainy season, become pitted and inaccessible. It can take up to an hour and a half to make a less than twenty-mile journey. Public transport is also infrequent and unpredictable. A private system of "reggae" buses has emerged, which now provides the main passenger road transport. Our conversations with local primary health care staff seemed to imply an increasing number of road accidents, and seat belts are not compulsory by law.

Whilst we were there, water was plentiful and of drinking quality all over the island, although often from standpipes in the street. During the dry season, however, we understood that water can be in very short supply and is limited in certain areas of the island to a number of buckets per day per family. In addition we understood there to be an increasing level of pollution in rivers and streams which are a main source of water for washing.

We understood both from the PAHO (Pan American Health Organisation) documentation and also from government officials we spoke to, that an increasing number of deaths are from heart disease, reflecting an increasingly westernised disease pattern. Chronic diseases such as hypertension and diabetes are common, and it would seem largely managed within the primary health care system. PAHO figures also show a life expectancy for women of 67 years, for men 64 years, with an infant death rate of 21 per 1000 live births.

Reasons for Undertaking the Study

1. To study and document the present patterns and organisation of primary care services in Grenada. In particular, interest will be focussed on the essential relationship between the different professionals providing primary care and the different agencies, whether private or public, involved in the planning, organisation and delivery of primary care services.

2. To gain a greater understanding of the problems experienced by Afro-Caribbean people in the UK in utilisation and uptake of primary care services, and so assist the development of a more appropriate and responsive primary care service in Camberwell and the UK.

3. To utilise experience of development work in primary care in the UK to highlight possible areas for Grenadian developments in primary care.

Methodology

This report is based on informal discussions undertaken with officials of the Ministry of Health and with nursing fieldworkers in Grenada during August and September 1988. It is intended to reflect the informal approach adopted and the preliminary nature of the work we were able to do. Access to interview staff took longer to negotiate with officials at the Ministry than we had hoped. Once permission had been granted by the Ministry, visits to the clinics were not without difficulties.

Firstly, many of the clinics are quite inaccessible by public transport and telephone lines were frequently not working. In practice, this meant that we arrived at a time we hoped staff would be willing to talk to us. Overall, this worked well and allowed us time to make observations, although it meant that we were limited in the numbers of clinics we were able to visit.

In addition, we had intended to use tape recordings during interviews. It was clear at the first interview that this was unacceptable. Very few of our interviewees had been interviewed at all before about their work and many of the nurses were hesitant at potentially being seen to criticise their employers. Interviews were therefore recorded through detailed note-taking.

The irregularities of the transport system meant it was essential to hire a car in order to get around the island. The length of time it took to get from one part of the island to another also meant we concentrated on clinics based in the southern part of Grenada. It should therefore be noted that the picture presented here reflects that part of the island, although it may be an indicator of areas of interest in further work needed across the island as a whole.

Overall, we interviewed a variety of officials from the Ministry of Health and voluntary organisations, together with one district medical officer, one family nurse practitioner, one public health nurse, six district nurses, and five nursing aides.

The Ministry of Health

The provision of health services in Grenada is the responsibility of the Ministry of Health. The current Minister of Health, Housing, Physical Planning and Women's Affairs is Mr. Danny Williams.

Written material produced by the Ministry of Health was hard to come by during our stay and was restricted to the annual reports to his constituents produced by the Minister. His newsletter, issued at the end of each year, outlines the Ministry's main achievements over the last year, and looks forward to 1988, stressing the need for "additional facilities at the hospital and more and better equipment and more specialists". The emphasis of this document had little to do with primary care.

Emphasis within the Ministry during our stay focussed upon the rebuilding of acute psychiatric services, as the previous psychiatric hospital had been damaged during the invasion in 1983. There has also been considerable emphasis placed on the implementation of an HIV/AIDS strategy recommended by WHO and this has evidently stretched the limited resources of the Ministry. The government also expressed concern about the development of services for drug abuse and alcoholism.

Discussions with officials at the Ministry made limited references to targets in primary care such as "Health for all by the year 2000". The major health strategy which we saw was produced by the People's Revolutionary Government in 1981 and this is still in circulation within the Department.

Hospital Services

Acute medical care on Grenada is provided in 2 hospitals on the main island. There is a small hospital on Carriacou although services on offer there are very limited and patients in need of acute services are usually transferred to Grenada by boat or plane. The range of specialities on offer is limited and, as with primary care, a private system of acute services is available through insurance, whereby patients are flown either to other islands, in particular Trinidad, or to the United States.

Please see attached map for siting of hospitals, health centres and medical stations.

Primary Health Care Services

Primary health care in Grenada is provided free of charge, by a range of medical and nursing staff based in 6 health centres and 14 medical stations across the country. 40 doctors work in the community in Grenada, and 10 act as District Medical Officers for the government. The health centres form a focal point for these primary health care teams, led by 7 Family Nurse Practitioners and 7 Public Health Nurses.

Within the health centres, a District Medical Officer (DMO) is usually available each morning to see 'sick' people and offer treatment. During these morning sessions, any DMO may see as many as 55 people between 9.00 a.m. and 12.30 p.m. Medical stations, however, only have a DMO once a week on a set day. These morning sessions are run on a walk-in, wait-your-turn basis, and so patients often wait a considerable time before being seen. In all the stations and centres, we observed very limited waiting space, and many people often stood or sat on the floor inside.

Problems occur in the stations where, if for any reason the DMO is not able to attend the session. This necessitates patients either going to one of the health centres some distance away often by public transport, or returning to see the DMO the following week. Treatment in terms of prescriptions is obtained from the dispensary which is on the health centre or medical station premises. The pharmacist is available on the morning the clinician is working. We understood from Project Hope staff that negotiations are under way to gain standard and regular supplies of drugs, but we were also made aware that supplies were often limited. Whilst drugs for common conditions did not appear to be overly expensive, we understood 'new' drugs could often be both prohibitive in price to some patients and only available intermittently.

Medical services in primary care are also provided via a private fee-paying system of family practitioners. These, particularly in the rural areas, we understand, are often the same practitioners who in the mornings provide a public service, and who go to their own premises in the afternoons to provide private services. Our access to family practitioners and clinicians during our time on Grenada was very limited. This was because, when we were in the centres or stations, they were usually running sessions and immediately having finished, would leave the building. Whilst we clearly would need much more evidence, we would suggest there is scope for improving the relationship between DMOs and their nursing colleagues.

Access for most patients getting to a centre or station is either by bus or on foot. Most of the buildings are sited on or near main roads, although we would suggest access for some patients, particularly the elderly and women with young children, who are a major client group, may be difficult. We also felt that a large part of the nursing time was spent doing home visits and this may have been due to the inaccessibility of the clinics although, again, this would need further investigation.

The major part of the primary health care service, however, in preventive health care, is provided by nurses.

Family Nurse Practitioners

Family Nurse Practitioners are relatively new to the organisation of primary care and all those working in Grenada were trained at the University of the West Indies, Jamaica. As a group, they provide a planning role in detailing the main variations of the population within their catchments i.e. the elderly, the young, etc., identifying needs within these groups and developing programmes of care to work towards meeting these needs. They prescribe a limited range of medication and repeat prescriptions, although it is clear that this may have been a source of friction within primary care teams, particularly with doctors and pharmacists. They work from a model of the extended role of the nurse involving diagnosis, treatment and prevention. In theory, we understood they have a major role to play in encouraging new ideas and/or ways of working with the primary care team and for introducing ideas to the team. One example of this was at St. Davids Health Centre, where the Family Nurse Practitioner stimulated local community involvement in establishing a Diabetic Association. As a Family Nurse Practitioner interviewed said: "It (the role) is intended to promote holistic care which will be better for the patient".

Whilst working based in the health centres, it is clearly the intention that these be 'mobile' posts frequently out in the community and at medical stations. In practice, however, this may not always be the case. During our interviews with members of the primary health care team, Family Nurse Practitioners were stressed as a liaison point for all members of the team in the broadest sense, including Ministers of religion, school teachers, environmental health officers and social workers. Managerially they work in tandem with public health nurses and are accountable to the chief nurse for the community.

They also take on particular areas of responsibility and in one health centre, we observed a Family Nurse Practitioner alone, running a specific paediatric clinic, dealing with problems ranging from scabies to skin problems, gastroenteritis, and respiratory tract infections.

Campaigns such as those designed to improve the uptake of rubella immunisation have been instigated from the Ministry of Health, although often led by the Family Nurse Practitioners. Annual 'Health Fairs', lasting up to a week, often with a health promotion focus, involve all staff members and very positively encourage the public to take part in health events.

Public Health Nurses

In many aspects of their work, Public Health Nurses fulfil a similar role to Health Visitors in the UK. Much of their work is involved with maternal and child health, in addition to reporting and following up contagious diseases. They are managerially responsible to the Chief Nurse and are responsible for both District Nurses and Nursing Aides in the primary care team. They work based in the health centres.

In this primary role as managers within primary health care teams, they are responsible for collating information and records for monitoring purposes and submission to the Ministry of Health.

District Nurses

There are currently 35 District Nurses on Grenada responsible for the activities of the 44 Nursing Aides working with them. District Nurses are based in health centres and medical stations, but seem to come into their own in the medical stations where, it would seem, they run the primary health care service.

Most medical stations were run on a session planned basis for clinics, such as hypertension, diabetes, ante natal, post natal, family planning, dressings. These clinic sessions took place during the morning, and most were booked on an appointments basis. The afternoons were kept for home visiting and getting records up to date. It seems District Nurses have considerable discretion as to how they wish to run their clinics and design of the week. In addition, they also have discretion as to how they develop a policy around a particular clinic. For example, some District Nurses said that people wouldn't inject their own insulin, and so patients were required to come to the medical station, whilst in other areas individual patients did their own injections and so attended less frequently.

In addition, some District Nurses commented that the stigma of patients attending a well-publicised family planning clinic was still too great and so were within the normal appointments for the week as a whole, whilst others had set times and clinic sessions. Similarly, as qualified midwives, they have discretion as to the numbers of home births they wish to be involved in.

Observations and comments suggested that the bulk of DNs' work focussed on chronic disease, maternal and child health, and dressing wounds. We were surprised, whilst observing in clinics, how many accidents occurred, often resulting from machete or cutlass injuries, as well as dog bites and burns. Throughput of patients for dressings was constant in nearly all of the stations that we visited.

Together with Nursing Aides, District Nurses also undertake home visiting to patients. Most District Nurses appeared to be working one-to-one with patients, although several expressed a wish to run ante natal and other group work. They often said they felt limited by availability of educational material and also in the suitability of accommodation for such group meetings.

Their relationships with other team members seemed to depend on whether they worked in a medical station or a health centre.

In medical stations they were isolated on a day-to-day basis from other nursing and primary care colleagues, and described the monthly primary care meeting as:

> "going round in circles"
>
> "being too big"
>
> "not talking about things relevant to me"

They also reported frustration at constantly being required to go to the health centres to speak to Public Health Nurses, rather than the Public Health Nurses coming to them. In health centres, however, most District Nurses reported getting on well with Public Health Nurses and Family Nurse Practitioners.

Nursing Aides

Nursing Aides worked closely with District Nurses often within the medical station where they act both as receptionists and nurses. For example, in ante natal clinics, they would supervise the waiting area, weigh women in the waiting area as they arrive, take their blood pressure, test urine, etc. All these activities took place very publicly. They are also very involved in doing dressings, as people walk in off the street with both cuts and burns.

It would seem that the nursing aides do the bulk of the regular visits to people at home, following up non attendance for immunisation at the clinic, and carrying out injections for diabetics.

We understood that Nursing Aides are recruited from particular localities in order that they work locally, the intention being that they are very much a local resource and a very visible part of the primary health care team.

Health Education

Whilst on the island, we regularly tuned into local radio and listened to the bulletins put out by the Health Education Service. These consisted of short messages about 'not leaving children alone', 'immunisation and vaccination', 'physical abuse of children', 'diet' and 'AIDS'. Many of these messages could be considered to have moral overtones about what is considered to be correct behaviour.

We noted with interest, whilst visiting medical stations and health centres the variety of locally produced poster displays on mental health, diet, smoking, worms, family planning, AIDS, anaemia, flies, rats and garbage, taking care of wounds, and breast feeding. We felt these local initiatives were both positive and very relevant.

Information for Health Planning

We understood from the Ministry of Health that great efforts were being made in liaison with Project Hope to computerise relevant statistics collected through the primary health care system for use in future planning and development of services. However, we found these statistics relatively inaccessible and the only ones listed here which we felt relevant to our study were those relating to immunisation and vaccination. We were very impressed by the levels of uptake reported through the statistics available although these figures are dependent on the availability of vaccine and no data whatsoever is available for private injections given in family practice. It is compulsory for children attending school to be fully immunised.

The link between the availability of statistical information and its use in planning services was unclear and needs further investigation if the statistics available are to be made of good use.

Childhood Immunisation 1983 - 1987

Year	Diphtheria	Polio	Measles
1983	68	72	11
1984	76	75	31
1985	61	77	49
1986	98	92	62
1987	80	81	77

Source: Ministry of Health, Grenada 1988

In-Service Training

All the staff to whom we spoke reported having attended seminars or workshops on AIDS in the recent past.

Others had attended a variety of workshops on counselling, family planning skills and family life education. Many commented very positively about the University of the West Indies Distance Training Package Link-up System, which allows a two-way link-up by video between the islands, and lectures presented in Jamaica can therefore be heard and discussed within the islands.

Many also said that they would very much welcome a planned programme of education over the next year.

Inter-Sectoral Collaboration

We had hoped to look more closely at how departments within the government inter-related around health issues. In particular, we were keen to look at the effective links between public health, for example, environmental health supervision of the water supply, and statutory health service provision. This reflects on the differences between local authority held responsibilities for health in Britain, and district health authority responsibilities. We did not do this, basically due to a shortage of time. However, a particular observation of interest to the UK was that environmental health officers are based within health centres and are considered to be a major part of primary health care teams, following up cases of hepatitis, etc. We found this a very positive part of the primary care structure.

Premises

All of the centres and stations we visited were long, oblong buildings with access through the front, broader side of the building. One observation was that the walls within the building did not go up to the roof in order to allow air to circulate. This meant, however, that those in the waiting area, usually immediately adjacent to the consulting room, could often hear the consultation. In addition, particularly in those buildings which were relatively new, and brick built, the heat could be excessive during the middle of the day, and fans had not yet been installed. This means patients often stand around outside rather than sitting inside.

We observed some premises in use beyond what could be reasonably considered as an adequate life of the building. Several stations reported concerns about vandalism and also about parts of the building being hazardous to clients. Whilst some live-in accommodation had been provided on medical stations, in three premises nurses had refused to live in the accommodation provided as it was said to be inadequate.

Supplies of Equipment

In all the clinics we visited, we asked both about the supply and availability of syringes and needles. The most common situation was that the supply was adequate to the health centres. The supply to the medical stations, however, was considerably less than satisfactory in many cases, and staff reported the shortages affecting their work. As one nurse we interviewed said:

> "I will now spend the rest of the day ringing round to get needles in order that I can do the child immunisations tomorrow morning".

On occasions, this had inevitably meant people attending the clinic and being sent away until supplies were obtained. Several of the staff, however, commented that the situation had improved, although they still lacked refrigeration facilities for storing vaccines, and sterilising equipment was rarely available.

Disposal of Clinical Waste

Concern was expressed by Ministry officials over the recent recommendation of WHO to stop using re-boilable syringes in the light of AIDS and HIV. The introduction of vacutainers was considered to be of concern as managers were unsure of how competent the nurses were in using these new-style needles. The recent changes to use disposable syringes also presented a new problem, the disposal of the syringes.

In most cases, used syringes were being stacked loose in cardboard boxes and stored within the medical stations. In a number of instances nurses referred to them being dropped down pit latrines. Most of the nurses we spoke to reported that they were waiting for a collection service to be established, but were not sure when this would start.

Discussion

Our trip to Grenada was both enjoyable and fascinating. Whilst both our time and resources were limited, this small and incomplete study offered us a range of opportunities previously not available to us.

Our perspective of the patterns and organisation of primary care services was restricted to publicly available documents produced by the Ministry of Health and interviews with essentially junior members of the primary care and nursing teams.

We feel, however, that it is still possible to make key observations relating to primary care. For example, we feel there is considerable unfulfilled potential within both family nurse practitioners and public health nurses in generating, motivating and supporting other team members in their work. This relates in very practical terms to the lack of transport available to these nurses, but also that the transport issue remains unrecognised and unacknowledged within the organisation as a whole. The other, and perhaps more fundamental area for development, lies in the potential for management training and supervision of these nurses in supporting their staff to implement innovations and changes they themselves may wish to make. In addition, the further development of primary care teams, to include District Medical Offices and Environmental Health Officers should not be underestimated if Grenada is to take on such major challenges in public health as HIV and AIDS. Clearly, resources will need to be made available to do this either within existing budgets of the health service, aid from abroad, or economic developments within Grenada which will allow for a greater spending on health. Whilst this is a gross over-simplification of a very complex economic problem, it remains an area deserving greater attention. A wider study of the organisation of primary and secondary care in Grenada, taking into account health in the private sector, as well as examining resource allocation within the public sector, would obviously need to be undertaken if these statements are to be supported.

As individuals working and committed to working within the NHS, it was interesting to see how the experience of black people using primary care in Grenada could potentially influence their use of services in the UK. Again, our data in supporting these comments is limited. Expectations of services appears to be low. Patients often wait between two to three hours to be seen by a clinician and regularly are sent away, or to another health centre. The very brief consultation, rarely lasting more than a few minutes and, it would appear, commonly resulting in a prescribed treatment, reflects a position that was common in Britain in the 1950s and 60s. In addition, clinic times within the station or health centre appeared to be rigid, and essentially treatment-oriented. For example, the diabetic clinic was primarily one of medical review, insulin injections, urine-testing, etc. They appeared to be very limited in areas of health promotion and prevention. Again, the individual consultation as the norm, as opposed to a group focus, suggested a treatment-oriented approach.

We feel the distinction made between the public and the private systems, particularly in the doctor-led part of primary care is important. Frequent comments were made to us about the public service being a second-rate system. Again, one could surmise these

perspectives may alter the potential patterns of use of the private and the public system in the UK by black people, although our data was very limited in this area and a further study would be necessary to support such statements.

Overall, we feel our experiences in the UK were important in highlighting the current strengths and weaknesses in parts of the primary care system we observed. Firstly, we saw very positive commitment among individuals and groups of nurses to a greater involvement of the public and local communities in their future health service. We also felt the enthusiasm of the nurses to take up available education and training programmes was very encouraging.

The main area we felt needed more work was in encouraging the Ministry staff at all levels towards clearer aims within primary health care. No "mission" in primary care was identified during our time there. As much of Grenada's health development relies on external funding, it was felt likely that their priorities would continue to be set by other outside bodies, whether USA or WHO without some internal review mechanism for goal setting. In addition greater emphasis was needed in the continuing professional development of those nurses at senior levels. We also saw the need for developing multidisciplinary policies across Grenada in areas of common practice. For example, maternal and child health and chronic illness. This, we feel, would lead to a greater consistency in approach between localities, and a potential improvement in the quality of service on offer to patients.

It is important, we feel, to note, even in this final paragraph, that many of these areas we have identified need more work both in exemplifying areas in need of further study and in training and development work in areas such as goal setting and teamwork.

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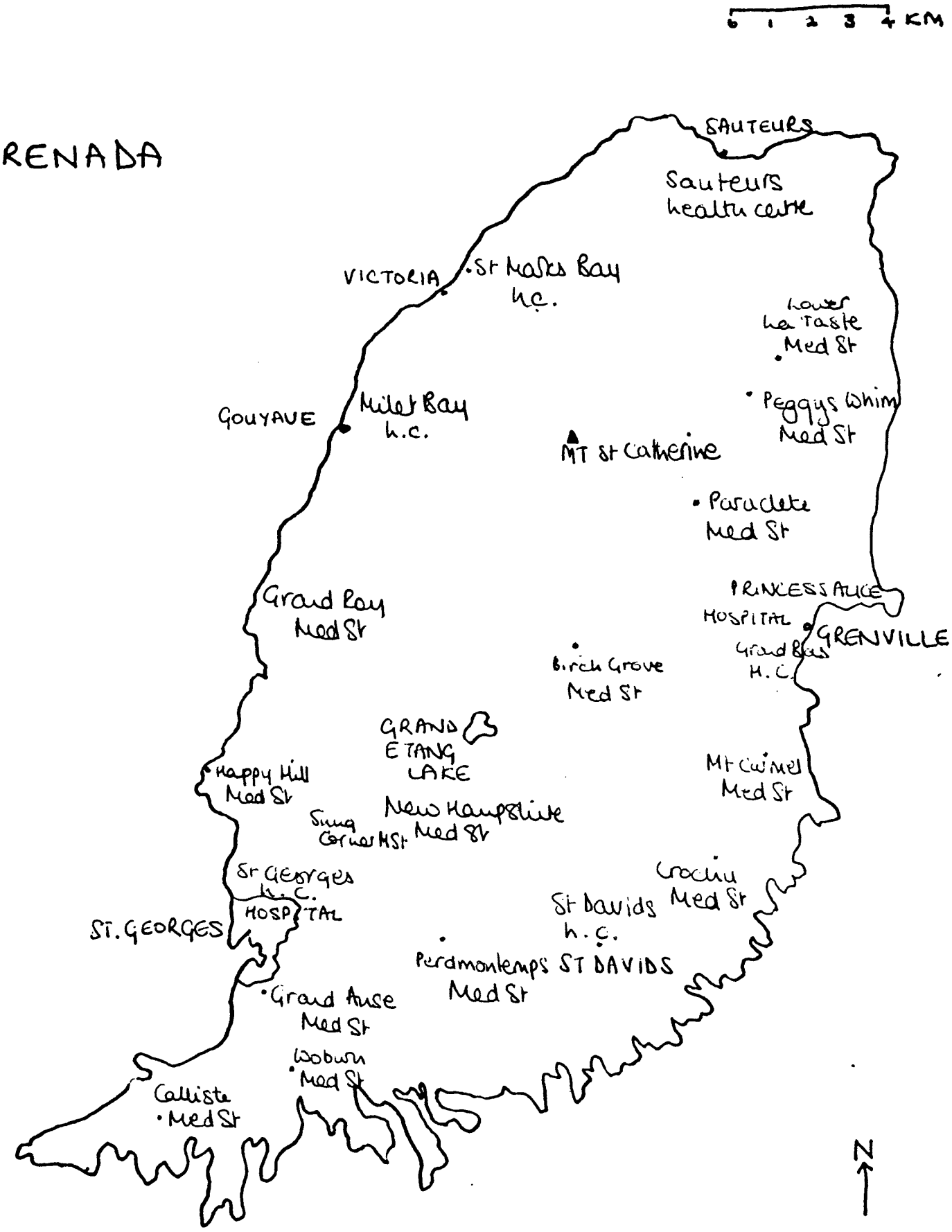
GRENADA


0 1 2 3 4 KM
SAUTEURS
Sauteurs health centre
VICTORIA
St Marks Bay h.c.
Lower La Taste Med St
Peggys Whim Med St
GOUYAVE
Nilet Bay h.c.
MT St Catherine
Paradete Med St
PRINCESS ALICE HOSPITAL
GRENVILLE
Grand Bay H.C.
Grand Bay Med St
Birch Grove Med St
GRAND ETANG LAKE
Happy Hill Med St
Mt Carmel Med St
New Hampshire Med St
Sauteurs Corner Med St
St Georges h.c.
HOSPITAL
ST. GEORGES
Crochu Med St
St Davids h.c.
Perdmontemps ST DAVIDS Med St
Grand Anse Med St
Woburn Med St
Calliste Med St
N

APPENDIX II

Itinerary

5.8.88	Meeting Oswald Gibbs, High Commissioner to Grenada in Britain
7.8.88	Travel to Grenada
8.8.88	Arrive Grenada
10.8.88	Meeting Mrs. Perrotte, Chief Nurse Community, Ministry of Health
	Meeting Norton Noel, Minister of Labour, Social Services and Civil Aviation
11.8.88	Meeting Dr. Murray, Ministry of Health
	Meeting Everett Boyke, Permanent Secretary, Ministry of Health
15.8.88	St. Georges Esplanade Health Centre, St. Georges
16.8.88	St. Georges Esplanade Health Centre, St. Georges
	Meeting Angela Gittens, Information Officer, Ministry of Health
17.8.88	Grand Anse Medical Station
	Chronic Diseases Committee, Ministry of Health
18.8.88	Woburn Medical Station
	St. Davids Health Centre
19.8.88	Calliste Medical Station
	Eugene Gittens, Director, Grensave
	Meeting Dr. Clarke, Ministry of Health
22.8.88	Perdmontemps Medical Station
	St. Georges Health Centre
23.8.88	Family Nurse Practitioner and Public Health Nurses Meeting
	Health Education Department
24.8.88	Project Hope
	Woburn Medical Station
	Crochu Medical Station
	St. Davids Health Centre

Itinerary (Contd.)

30.8.88	Snug Corner Medical Station
	New Hampshire Medical Station
31.8.88	Carriacou
1.9.88	Meeting Rosie Bhola, Health Education Dept, Ministry of Health
	Happy Hill Medical Station
5.9.88	Meeting Dr. Murray, Ministry of Health

Grensave

This is a small voluntary organisation based in St. Georges, and funded essentially between Swedish and Canadian Save The Children Fund. Our interview with the Director stressed his commitment to targetting help to areas of greatest deprivation on Grenada, in particular to St. Andrews and St. Johns parishes. In these areas, they were already involved in major initiatives which we felt were relevant to the primary health care context on Grenada.

1. They have established two day care centres for pre-school children at minimal or no cost to parents. This provision was established mainly to support single-parent families.

2. They have established a youth centre for unemployed youths who have been encouraged to identify local priorities and act upon them. This group has also acted as a means of education for the youth about health, leadership, etc.

3. Grensave have started a venture to produce coconut oil. This is essentially a women's project, and is the first project with a potential for producing an income which could be ploughed back into the organisation itself. It provides both employment and a developed social network for the women.

Project Hope

Project Hope was started in 1983 after the American invasion to fill the vacuum left by the departure of the Cuban doctors who were then working in Grenada. It is a voluntary organisation under the auspices of the People to People Foundation in the USA.

In its first phase, we understand, it acted both to recruit DMOs, and fund hospital registrar training. There is now an attempt to recruit ex-patriates to return to Grenada fully trained.

During our interview with the Director of Project Hope he stressed the main focus of the project in developing a quality infrastructure for the development of health care, which would lead to cost-effective medical service.

In addition, the project has obviously been key in:

promoting links with other Caribbean islands in developing medical specialities;

developing medical records systems;

funding education through training nurse tutors;

developing community health/mental health workers linked with existing primary health care teams;

and developing and running seminars on a continuing education basis.

In addition, they have been very much involved in developing the new acute psychiatric service.

The project is due to end in 1990 although it is anticipated that the project will continue to act as a consultancy in Grenada after this time.