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Chapter 1 : Latin America and the Caribbean | Where We Work | U.S. Agency for International Developme

Get this from a library! The Caribbean state, health care, and women: an analysis of Barbados and Grenada during the period. [Patricia Rodney] -- This book makes a comparison of the health policies in Barbados and Grenada during the period as they relate to working-class women.

Follow us on Twitter! Despite the global financial crisis, the region averaged a three percent annual increase in economic growth between and Health indicators have greatly improved in the region: Political advances have been notable, as well: While these are impressive gains, the region still faces significant challenges. Latin America and the Caribbean continue to have some of the highest rates of income inequality in the world and economies have slowed. Severe, chronic drought threatens lives and livelihoods. Regional progress in health masks inequalities between and within countries. Worsening citizen security, fueled by a violent transnational drug trade, is hindering growth and undermining democratic institutions in parts of the region. Climate change poses risks, especially in Central America and the Caribbean. And some countries are restricting political rights. Economic and political stability in the Western Hemisphere are vital for the United States. Drug trafficking and violence that afflict our southern neighbors can penetrate our borders and impact U. Latin America and the Caribbean are also important and growing markets for American companies--a quarter of U. We Are Working to Make a Difference In LAC, USAID helps to make the United States and the Western Hemisphere more peaceful, secure, and prosperous by strengthening the capacity of governments and private entities to combat crime, improve governance, address climate change, and create an economic environment in which the private sector can flourish and create jobs. Our programs in LAC help to generate economic prosperity, reduce crime and violence, support civil society, defend universal rights, and protect the environment. Government agencies, civil society, the private sector, development banks, and international organizations to help achieve enduring results. We are dedicated to crafting and executing programs that strengthen the LAC region as a whole while meeting the diverse long- and short-term needs of individual partners in the region. Across the region, we are: Encouraging job creation, strengthening small- and medium-sized businesses, and promoting agricultural advances; Creating safe urban spaces, supporting community policing, educating vulnerable youth, and strengthening justice systems; Supporting the efforts of civil society groups and political leaders to protect and defend universal rights such as freedom of expression; and Helping countries to protect natural resources and adapt to changing climate patterns. Improvements in security, governance, and prosperity in Central America, particularly the Northern Triangle countries of Honduras , Guatemala , and El Salvador ; Programming that helps the people and government of Colombia to promote economic prosperity, improve the living conditions of victims of violence and vulnerable groups, and promote respect for human rights; and Advances in long-term reconstruction and development, economic growth and job creation, health care and education services, and municipal governance in Haiti in the wake of the devastating earthquake.

Chapter 2 : The Caribbean Public Health Agency (CARPHA)

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Nielson Find articles by Anders L. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited. The major objectives of this study were to evaluate the existing primary health care service provisions in the public and private sector and utilization of the services, and to assess the existing manpower and material resources. Data were collected through interviews with the primary health care providers. Data were also collected from the records maintained at the polyclinics and the Ministry of Health Statistics. An analysis and discussion of all the available data was conducted to develop a comprehensive primary health care service utilization and resources inventory at the polyclinics. Similar data were collected from the primary care providers in the private sector. In the public sector, there are 8 polyclinics that provide primary health care to the children. All the polyclinics have immunization services and curative acute care. Some of the polyclinics have a range of services, including dental care, eye care, and rehabilitative care services that common to both adults and children. In the private sector, primary health care is delivered through the 76 private office and of the individual physicians and 11 grouped private practices. All of the private offices and group practices have curative acute care for children and some of the offices have immunization services. In the public sector, The corresponding figures in the private care settings were The findings demonstrate the complimentary role of the public and the private sector in the primary health care of children in this country. While the private sector has a major role in the curative acute care of children, the public sector plays a pivotal role in the immunization services. There is a comprehensive publicly funded tax-funded and delivered health care, including the primary health care and tertiary health care at the hospital, prescription drugs and some dental care. The relative role of the public and the private health care providers in the primary health care of children in this country has never been explored. In this operational research study, we critically examine the available resources in the public and the private primary health facilities in this country. We describe the utilization of the public and the private facilities by the children of this country including the demographics of the children utilizing the public primary health care facilities as well as the profile of the presenting illnesses. The report highlights the strength and challenges of public funded and the private health care provisions. These information will be necessary for making any policy decisions for further strengthen the public primary pediatric care in this country. METHODS The majority of the data for this paper was drawn from the reports of a professional consultancy service commissioned by the Ministry of Health MOH , Government of Barbados to strengthen the primary health care for the children at its health centers â€" the polyclinics. As a part of this initiative, a need assessment survey of all the polyclinics across this country was undertaken. The major objectives of this need assessment were to evaluate the existing health care service provisions and its utilization and to assess the existing manpower and material resources at these Polyclinics. Data were also collected from the private sector primary care setting which included private offices of individual or group of doctors. Data from emergency care settings of both the public sector and the private sector were excluded. All of data pertained to the year Data collection involved multiple methods and used multiple sources. The lead consultant visited all of the polyclinics and met individually as well as collectively with the medical and the nursing staff at the polyclinics. The Medical Officer of Health and the Senior Public Health Nurse, who are responsible for the overall management of the 8 polyclinics in this country were interviewed using a semi-structured questionnaire. Several open ended questions were used to facilitate open discussions on the various issues in the context of pediatric services at these polyclinics. Interviews covered all aspects of the pediatric primary care delivery and the existing infrastructure for the delivery. A total of 36 physicians and 41 nurses were interviewed in 8 sessions. Data on service utilization was collected form the annual reports form the polyclinics. Doctors engaged in private practice and who provided primary care were

identified form the listing of the registered medical practitioners in this country. Data form the private sector primary care providers were collected by telephonic call to the offices. The data collected from the polyclinics included the data on the available resources such as the number of physicians and nurses attending to children, availability of other support medical team such as nutritionist, physiotherapist, speech therapist, psychologist, and medical social workers. Data were also collected on the available services in term or curative care services, preventative care services, and rehabilitative services. A number of available hours available for these services were also collected. A third category of collected data included service utilizations such as number and demographics of children attending the well-baby and immunization clinic, acute care clinic and any follow-up clinics. Profile of the diagnosis for the children attending the polyclinics was also collected. An analysis and discussion on all the available data was conducted to develop a comprehensive community health care service utilization and resources inventory, to identify the needs in the priority area for improving and strengthening the primary pediatric care at the polyclinics. Total available professional manpower hours were calculated using the following formulae: Associations between categorical variables will be assessed for statistical significance by Chi-square test. A P value of 0. In the public sector, there are 8 polyclinics and 2 satellite health centers spread across the length and breadth of this island state that provide primary health care to the children as well as the adults of this country. The polyclinics have a range of services including well child health clinic, antenatal clinic, and the general practice clinics for both the children and the adults , whereas the satellite centers only have general practice clinics with limited services for both the children and the adults. In the private sector, primary health care is delivered through the 76 private office 57 GPs and 19 pediatricians of the individual physicians and 11 9 GPs and 3 pediatricians grouped private practices. Table 1 shows the range and the quantity of primary health care services for children that are available in the public sector at the polyclinics and the satellite centers and in the private sector in Barbados. These clinics are managed by the Public Health Nurses and provide immunizations covered under the expanded immunization program as well routine growth and development assessment for children under 5 years. Although, the GP clinics attend to both adults and children, there is a dedicated physician for children. Other services include dental services and eye care services that also serves all ages. Rehabilitative services such as physiotherapy, occupational therapy, and speech therapy are available at two of the polyclinics on three-half days a week at each. There are no dedicated follow-up clinics for chronic diseases in children except for an asthma clinic at one of the polyclinics. All of the polyclinics have a public pharmacy for dispensing medications prescribed by the physicians at the polyclinics free of any charges. None of the polyclinics have laboratory support for routine investigations. Whenever an investigation is necessary on a patient attending the polyclinics, then sample is collected and sent to the laboratory attached to the publicly funded QEH. Analysis of the records showed that on an average Available physicians and service utilization for the primary health care of children in the public sector and the private sector in Barbados is shown in Table 2. Of the medical doctors providing direct clinical care in the community in this country, Of the , estimated acute care visits from children to the primary care settings in Barbados, Only follow-up service available and utilized in the primary care settings were those for asthma at one of the polyclinics in the public sector and amounted to visits for the year Table 2 Open in a separate window Profile of the clients visiting the primary care settings of the public sector and the private sector is shown in Table 3. In the public sector, 21, In the private sector, Similar data were available from the public sector. Table 3 Profile of clients visiting the primary health care settings of the public sector and the private sector in Barbados Open in a separate window The diagnoses profile for the children seen at the primary care setting of the public and the primary sector is shown in Figure 1. Although the asthma 4.

Chapter 3 : Caribbean Women's Health Association (CWHA) | Women's Health Services

After analyzing the state in capitalist societies through a review of the literature, Dr. Rodney shifts her focus to the state in the periphery, and the evolution of public health care systems (PHC) there.

Investing in Contraception and Maternal and Newborn Health, This fact sheet presents estimates for of the contraceptive, maternal and newborn health care needs of women in developing regions, critical gaps in service coverage, and the costs and benefits of fully meeting these needs. Corrected December 6, As of , 1. About half of them million women want to avoid a pregnancy; of this subset of women, about three-quarters million are using modern contraceptives Figure 1. Yet million women of reproductive age in developing regions who want to avoid pregnancy are not using a modern contraceptive method. This includes million who use no method of contraception and 59 million who rely on traditional methods. These women are considered to have an unmet need for modern contraception. Their number has decreased from million in , as modern method use has increased. Of the million women who give birth each year in developing regions, many do not receive essential maternal and newborn health care. There are wide disparities in maternal and newborn health care across regions. Disparities among countries in contraceptive and maternal and newborn health care follow economic lines. In , an estimated , women in developing countries will die from pregnancy-related causes, and 2. Most of these deaths could be prevented with full access to certain vital services: Benefits of modern contraceptive use Current modern contraceptive use prevents an estimated million unintended pregnancies annually among all women of reproductive age in developing regions. If all unmet need for modern contraception were satisfied in developing regions, there would be approximately a three-quarters decline in unintended pregnancies from the current 89 million to 22 million per year , unplanned births from 30 million to seven million per year and induced abortions from 48 million to 12 million per year. The health benefits of preventing unintended pregnancies would be substantial. Compared with the current situation, fully meeting the unmet need for modern contraception would result in an estimated 76, fewer maternal deaths each year Figure 4. Preventing maternal and newborn deaths Maternal and newborn health care, by which we mean services that cover pregnancy and its outcomes live birth, miscarriage, stillbirth or abortion , currently prevents , maternal deaths and 1. If full care for all pregnant women and newborns were combined with full provision of modern contraception to women who want to avoid pregnancy, maternal deaths would drop from , to 84, per year, and newborn deaths would drop from 2. Barriers to the provision of accessible and acceptable care must be tackled. These include policy restrictions, shortages of trained health personnel, poor-quality services, lack of outreach to marginalized groups of people, and social and economic factors that prevent people from obtaining or using needed services. Significant investment in contraceptive services and maternal and newborn health care is needed. Governments, donors, NGOs, households and individuals all need to contribute to closing the funding gap to improve and expand services. Investing in contraceptive services and maternal and newborn health care together, rather than in maternal and newborn care alone, saves money and has a larger impact in preventing deaths and improving the health and well-being of women and their families. Overview of study To help decision makers evaluate the investments needed in developing regions, these estimates show the need for and costs and benefits of sexual and reproductive health services in two key areas: The estimates build on prior Adding It Up reports that provided estimates for , , and The estimates draw on new survey data and the most recent information on population and births, maternal mortality ratios, newborn mortality rates, maternal and newborn cause-of-death distributions, estimates of induced abortion and unintended pregnancy, guidelines for contraceptive and maternal and newborn health services, estimates of health worker salary costs, and commodity and supplies costs. Where relevant, we adjusted estimates to pertain to the reference year. The estimates include a limited subset of the services covered in the report; they do not include services to prevent mother-to-child transmission of HIV, to protect the health of pregnant women living with HIV, or to treat STIs among women of reproductive age. Estimates of abortion assume no change in the safety of abortion provision. Cost estimates in U. Direct costs are those related to personnel time, commodities and supplies for contraceptive services and maternal and newborn medical care, and

information and counseling associated with these services. Indirect costs, also known as program and systems costs, are those related to program management, supervision and training of personnel, monitoring and evaluation, human resources development, transport and telecommunications, health education, outreach, and advocacy, infrastructure improvements, and health management information and commodity supply systems. The estimates are based on data for countries or territories, and estimates presented here for Asia include countries in Oceania. Changes were made to correct errors in the coverage of contraceptive and maternal health services and the calculation of cost estimates in Adding It Up: Investing in Contraception and Maternal and Newborn Health, For details, see the errata at the end of the online supplementary tables addingitupsupplementary-tables. Acknowledgments This fact sheet is published as part of the study, Adding It Up: The research team is led by Jacqueline E. The views expressed are those of the authors and do not necessarily reflect the positions and policies of the donors.

Chapter 4 : Economy of the Caribbean - Wikipedia

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The most important index of the health conditions in any community is the infant mortality rate. The mortality data indicate that at least one to two in every 10 infants died before the age of one year in the colonial territories of the British West Indies. The majority of these children died from nutritional, diarrhoeal, and respiratory diseases. Poverty was the primary cause. Jamaica ranked second when compared to the rest of the British West Indies territories in Public-health Legacy After emancipation in , as the plantations closed down, worsening social conditions led to massive epidemiological crises in Jamaica. The ex-slaves built their shacks on marginal hillside lands characterised by improper disposal of human and solid waste, the absence of pit latrines, the absence of potable water supply, and the presence of faecal contamination in bushes, rivers, and streams from which they collected water for domestic supply. The inevitable consequences were outbreaks of cholera in , which caused 32, deaths; a smallpox epidemic in ; and epidemics of typhoid fever and cholera, again in , resulting in deaths of a quarter of the population of Kingston. By , conditions were so poor that it led to the Morant Bay Rebellion, the recall of the governor, and the institution of a Royal Commission. Strategic response The response of the colonial government to address the health situation was the promulgation of the Public Health Law, the introduction of the Local Parish Board of Health, and an expanded district public-health system which is part of our legacy to this day. The building of the Bellevue Hospital for the custodial care of the mentally ill roaming the streets in every parish was the expected outcome of an emancipated people burnt out by decades of poverty, hunger, and a sense of hopelessness. Greater emphasis on public health, better roads, safer water supplies, the enactment of quarantine measures, and the provision of dispensaries occurred throughout Jamaica. People, irrespective of income, were able to obtain drugs and medical supplies. The Kingston Dispensary was opened in By , the 14 parishes were divided into 40 medical districts and 35 district medical officers were allocated to 14 parishes. A number of sugar estate hospitals, closed prior to emancipation, were reopened and placed under the administration of the district medical officers. Although this health response by the colonial government was a strategic necessity and was in keeping with the current epidemiological trends, the measures were not sufficient to address the root causes giving rise to the worst health conditions of the time. Riots, rebellion, and healthcare in the watershed of The restlessness of the populace as a result of the poor social and economic conditions led to riots, rebellions, and social instability throughout the British West Indies. The popular uprisings were so serious as to demand the intervention by the Crown of another Royal Commission - the Moyne Commission - in This commission arrived at a number of conclusions: Housing accommodation for the poorer people in the West Indies is generally deplorable and general sanitation is primitive. Much ill-health arises from poverty - poverty of the individual, of the medical departments, and of governments. Much ill-health is of a preventable nature and much arises from ignorance. The high rate of illegitimacy combined with large families and a lack of parental responsibility are serious factors in health. The cure of disease has received much more attention than its prevention. Little improvement in the health of the people is expected no matter how extensive the hospital facilities are. This will continue until such defects are remedied. Relatively too large a proportion of the available funds and medical efforts is expended on curative medicine and too little on prevention. There is neglect of rural districts in favour of the urban areas. The creation of at least one school of hygiene with the training of auxiliary medical personnel is recommended. The centralisation of medical institutions for the training of all classes of medical personnel is recommended. The reorganisation of the medical services for the better balance between preventive and curative medicine is recommended. A minimum of 10 per cent of the national Budget should be spent on health-care services. With limited resources, the housing stock for Jamaicans, including the poor, has moved from less than 4, houses in years , to approximately , houses in 50 years, or approximately 20 times more houses in half the period of time when compared with the legacy period

of colonial governance in Jamaica. Squatting is a deterrent to building a stable and secure family and to enabling responsible parenting. Affordable housing is the best way to build healthy families, develop a sense of personal pride, a culture of responsible parenting, and healthy lifestyles in communities. All governments have continued this policy in collaboration with the University of the West Indies and non-governmental organisations. At present, Jamaica boasts state-of-the art reproductive-health services at the University Hospital of the West Indies and in the public and private sectors. A number of these services have been assessed to be globally competitive in both cost and quality. The rate of population increase in Jamaica has been reduced to acceptable levels as a result of this very important programme. When these advances are coupled with continued advances in the reproductive rights of women, the future looks very bright for Jamaica over the next 50 years. The new law negated the notion of illegitimacy and gave legitimacy to the child born out of wedlock; the right of inheritance and, therefore, a legal right of attachment to his family; and a sense of identity and inheritance. Equal pay for equal work of women, increasing the possibility of the child receiving an improved nutritional status. Maternity leave with pay enabled women to retain their job while breastfeeding. The pregnant woman was viewed by industry as a liability in the working environment. The risk of malnutrition in children was mitigated both by the reality of greater job security of the mother and the provision of breastfeeding. Mass nutrition education emphasising breastfeeding. Complete immunisation of infants and children from communicable diseases. Fluoridation programme for the prevention of dental caries in children. Mother and child antenatal and postnatal programmes. Community participation through the development of community health committees. The foundations of universal access to free basic health care to all the population at the community level in Jamaica. The foundation for the eradication of preventable communicable diseases in Jamaica. Mass breastfeeding and mother-and-child nutrition programmes. Primary health care was the platform for building the national preventive health strategy. The training of several new categories of health workers facilitated the rapid expansion of primary health care to the rural parishes. Rapid expansion of mother and child antenatal and postnatal clinics had a profound effect on the infant mortality rate. The value of communities being allowed to participate in community health action was demonstrated in the mass aedes egypti control programme in the epidemic of dengue fever in The epidemic was controlled in six weeks, a record for control programmes at the time. The primary health-care programme has been in existence for over 30 years and has made a profound impact on the control of immunisable diseases, doubling the rates of immunisation between and It did so by introducing a policy of beginning immunisation at six weeks rather than three months. This set the stage for introducing compulsory immunisation as a prerequisite for entering primary school. Communicable diseases such as measles, mumps, rubella, polio myelitis, tetanus, small pox, tuberculosis in children and the seasonal outbreaks of gastroenteritis have been relegated to becoming diseases of the past in Jamaica. Birth of Community Mental Health The colonial government had a policy of custodial care for psychiatric patients at the Bellevue Hospital. There were over 3, mentally ill patients who were locked down in the institution, existing under inhumane conditions. The results of a peer review study by Dr Wendel Abel et al in revealed: As a result, the country has developed a more accessible mental health service; the number of patients treated in the community has doubled over the past decade, and 67 per cent of inpatients are now treated outside of the mental hospital; and there has been a reduction in the population of the mental hospital". Governments since Independence have displayed a remarkable sense of unity of purpose in the management of the health sector by their consistency and continuity of health programmes and policies of their predecessors. This is a very important pre-condition for sustainability and successful health outcomes. Any growth in the economy over the next 50 years can only be sustained if the inter-connected triad of human health, environmental and climate-change impact, and natural-disaster prevention and management is taken into account. Policymakers at all levels of Government, as well as the private sector, continue to ignore this fundamental developmental triad at their peril. The relationship between the pride of home ownership, marriage, nuclear-family development, responsible parenting, and enabling healthy lifestyles in all its forms, was never a core value in pre-Independent Jamaica. This relationship, more than any other, represents the essence of present and future attempts at developing a culture of healthy lifestyles, which is the defining culture for nation building and sustainable growth and development in a

brutally competitive globalised world. Send feedback to editor gleanerjm. Jamaica continues to celebrate 50 years of Independence. We have achieved a lot. However, there is much work left to be done if we are to progress as a country. The Next 50 Years, a special Gleaner series, will spotlight some of the challenges we must fix in the coming years. We want to hear from you. Email us at editor gleanerjm.

Chapter 5 : Trinidad and Tobago - HEALTH AND WELFARE

This book gets to the core of socio-economic health care policies in Barbados and Grenada, revealing their strengths and weaknesses, and includes well researched suggestions for improvements.

Addressed to an immigration attorney and copied to Human Rights Watch, the letter detailed conditions at the jail, including obstacles to medical care, and summarized some of the responses the women received when they pressed for needed care: Medical care that is provided to us is very minimal and general We have no privacy when our health record is being discussed ICE is not here to make you feel comfortable Mi casa no es su casa. Our living situation is degrading and inhuman. Most immigration detainees in the United States are held as a result of administrative, rather than criminal, infractions, but the medical treatment they receive can be worse than that of convicted criminals in the US prison system. Deaths in custody attributed to egregious failures of medical care have received prominent media attention and a University of Arizona study in January described failures of medical care for women detained at facilities in that state. Underlying the individual stories of abuse and mistreatment is a system badly in need of repair, recent reforms notwithstanding. This report, based on interviews with women detainees, immigration officials, and visits to nine different facilities in three states, addresses one important component of the needed change: As detailed below, we found that ICE policies unduly deprive women of basic health services. And even services that are provided are often unconscionably delayed or otherwise seriously substandard. The detained population on any given day is now over 29, nationwide, up almost 50 percent from ICE holds the majority of them in state and county jails contracted to provide bed space and other basic custodial services, including medical care. As civilâ€”not criminalâ€”detainees, these individuals have no right to be provided an attorney by the government while it holds them for an uncertain period pending the outcome of their immigration case. Every one of these individuals has health care rights and needs. Unfortunately, the system for providing health care to detained immigrants is perilously flawed, putting the lives and well-being of more and more people at risk each year. These women include refugees fleeing persecution, survivors of sexual assault, pregnant women, nursing mothers separated from their children, patients detained amidst treatment for cancer, and many more women who have needs for basic medical care. Many women in the United States continue to struggle with finding ways to access basic medical care. But for the thousands of women in immigration detention, there is only one way to get a Pap smear to detect cervical cancer, undergo a mammogram, receive pregnancy care, access care and counseling after sexual violence, or simply obtain a sufficient supply of sanitary pads: In custody without other options, women receive care through ICE or are forced to go without. We met women who were denied gynecological care or obtained it only after many requests, including a woman who entered detention shortly after receiving news of an abnormal Pap smear. She told detention authorities that her doctor instructed her to get Pap smears every six months, but after 16 months in detention and many requests, she had still not gotten a Pap smear. We met women who were refused hormonal contraceptives during detention, including one who had inflamed ovaries and endured excruciating, heavy periods when the detention facility refused to provide her the birth control pills prescribed to manage her condition. We met women who, according to standards of medical practice in the United States, should have received mammograms, including one woman who had breast cancer surgery before detention and was instructed to get mammograms every six months. Due for her six-month check-up when she was detained, she waited four months for her first mammogram during detention, and did not receive another in her remaining 12 months there. We met women who complained of inadequate care during pregnancy, including one diagnosed with an ovarian cyst threatening her five-month pregnancy shortly before she was detained. Her doctor said the cyst should be monitored every two to three weeks, but during her stay in detention of more than four weeks, she was never able to see a doctor. We met women who had to beg, plead, and in some cases work within the facility just to get enough sanitary pads not to bleed through their clothes, and one woman who sat on a toilet for hours when the facility would not give her the pads she needed. Certain themes arose again and again in our interviews and demand attention. Detained women did not have accurate information about available health services. Care and treatment were

often delayed and sometimes denied. Confidentiality of medical information was often breached. Women had trouble directly accessing facility health clinics and persuading security guards that they needed medical attention. Interpreters were not always available during exams. Security guards were sometimes inside exam rooms, invading privacy and encroaching on the patient-provider relationship. Some women feared retaliation or negative consequences to their immigration cases if they sought care. A few were not given the option to refuse medication or received other inappropriate treatment. Full medical records were not available when the detained women were transferred or released. Written complaints about medical care through facility grievance procedures went ignored. The list goes on. This may pose challenges, but they are not insurmountable. As this report details, ICE practice falls short of many of these standards. The revised ICE medical standard contains important improvements, but much more remains to be done to develop adequate policies, ensure their proper implementation, and open up the detention system to effective oversight. As a start, the government should take immediate steps to address the fundamental policy flaws that limit access to medical care for all immigration detainees. Convert the ICE detention standards, including the ICE medical standard, into federal administrative regulations so that they have the force of law and detained individuals and their advocates have recourse to courts to redress shortfalls in health care. Implement the recommendations of the UN special rapporteur on the human rights of migrants, including in particular the recommendations that ICE develop gender-specific detention standards with attention to the medical and mental health needs of women survivors of violence and refrain from detaining women who are suffering the effects of persecution or abuse, or who are pregnant or nursing infants. Establish a formal process for ICE officers charged with case management to coordinate with health services personnel to ensure that nursing mothers, pregnant women, and other women with significant health concerns are immediately identified and considered for parole. Finally, to meet its obligations and make real improvements in medical care for women in immigration detention, the government should aggressively pursue better implementation and oversight of its policies, beginning with the following steps: Conduct intensive outreach to facilities to ensure that both health professionals and security personnel are aware that the men and women in their custody are entitled to the same level of medical care as individuals who are not detained and assure health professionals that ICE and DIHS policies are intended to support and not inhibit their delivery of care consistent with standards of medical practice in the United States. Improve the current system for receiving and tracking complaints made by individuals in ICE custody. Ensure that all individuals receive notice of complaint procedures in their native languages and that they are informed of the availability of these mechanisms for addressing medical care complaints. Require detention facilities to provide regular reports to the DHS Office of the Inspector General detailing the number of grievances received regarding medical care and their disposition at the facility level. Methodology This report is based primarily on interviews conducted by Human Rights Watch in the United States in with individuals possessing direct knowledge of the medical care provided to women in immigration detention. Our research included consultations with legal and health service providers and immigration policy experts, and a review of relevant published materials. The research also included interviews with 48 women detained by Immigration and Customs Enforcement ICE 34 of whom were in detention when we interviewed them and 14 who had been detained for some period of time since the formation of ICE in ; 17 detention officials and health services administrators; and two off-site specialists contracted to provide prenatal and gynecological services to women in ICE custody. Human Rights Watch informed ICE of our intent to carry out this and two other research projects in February and entered into discussions with ICE officials regarding the parameters of our access to detention facilities. In selecting the facilities for this research project, Human Rights Watch sought to identify states with a high concentration of women in detention, examples of each of the types of facility referenced above, and local legal service providers and other partners able to identify women willing to talk about their detention experience. On the basis of these criteria, we identified ten facilities in Florida, Texas, and Arizona. While the bulk of the interviews for this report were conducted at detention centers between April 7 and May 2, , in accordance with the schedule of announced facility visits negotiated with ICE, Human Rights Watch arranged further interviews with women released from detention, community service providers, and local activists during the

same period. Our main method for reaching women willing to speak with us, whether currently or formerly detained, was through legal service providers, who discussed our project with women they identified as possibly having information relevant to our research. However, with more than 80 percent of individuals in detention unrepresented, many women were simply beyond our reach. Also, fear among women that speaking with us about detention conditions could adversely affect their immigration status led some to decline an interview. ICE had no input in identifying which women would be interviewed for this research. Shortly before the start of the first trip, ICE introduced a limit of 12 on the number of individuals in custody who could be interviewed, without indicating whether this limit applied per facility, per day, per state, or per Human Rights Watch project. Despite efforts to clarify this issue, the limit became a major impediment, as each ICE field office varied in its application of the limit set by headquarters, and none permitted us to interview more than 12 detained individuals per facility for all three projects. Further, the field offices imposed different requirements regarding the form in which the individuals, and sometimes their lawyers, were to demonstrate their consent to the interviews. They also required up to five business days notice for the list of interviewees, a particularly impractical demand given the transience of the immigration detention population. As noted above, of the 48 women who spoke with Human Rights Watch about their experience with medical care in immigration detention, 34 were in ICE custody at the time of their interview; the other 14, all of whom had been detained for some period of time since the formation of ICE in , had been released from custody and were living in the US. The length of time the women had spent in ICE custody varied considerably, from less than 24 hours to over two-and-a-half years. The backgrounds of the women interviewed also varied in terms of the length of time they had spent in the US, the manner in which they had come to be in ICE custody, and their countries of origin, although 29 of the 48 came from Latin America and the Caribbean. No one below the age of 18 was interviewed for this report, and the majority of the women were in their 20s or 30s. Human Rights Watch conducted an individual interview with each woman. With the exception of two, the interviews at detention centers took place in a room in which only the woman, the Human Rights Watch interviewers, and any interpreters were present. In two cases, the interviews were conducted in a corner of a large room in which other detained women were present but out of earshot. Human Rights Watch met with women who had been released from detention in a variety of locations selected for their comfort and privacy. The primary interviewers for this project were women; however, due to logistical constraints, a male colleague pursuing a separate line of research was present for several of the interviews. The interviews ranged in length from 15 minutes to almost four hours; most lasted approximately one hour. Interviews were conducted in English or in Spanish, and, in one case, in French. They began with a discussion of the purpose of the interview and an explanation that participation was entirely voluntary and could be stopped at any time. Where appropriate, Human Rights Watch attempted to provide contact information for other organizations offering legal, counseling, or social services. No one received or was promised any material compensation for their participation. To protect their privacy and alleviate concerns regarding retaliation, Human Rights Watch assured women that their real names and the potentially identifying details of their interview would not appear in this report. For this reason, the names of all women interviewed for this report have been replaced with pseudonyms in the form of names and initials which do not reflect real names and the exact date and precise location of the interviews have been withheld. Between December and May , the number of individuals in the custody of Immigration and Customs Enforcement on any given day shot up almost 50 percent, from 19, to 29,, [6] giving ICE the distinction of overseeing the fastest growing form of incarceration in the US. In fact, the proportion of the detention population made up by women increased from approximately 7 percent in to 10 percent in These include the passage in of the Illegal Immigration Reform and Immigrant Responsibility Act, which expanded mandatory detention during removal [15] proceedings for individuals convicted of certain crimes; [16] the events of September 11, , and the subsequent emphasis on border security and immigration law enforcement; the broader detention powers ushered in by the USA PATRIOT Act; [17] and an expansion in the use of expedited removal for undocumented individuals apprehended at a port of entry or within a certain distance of the border. Eight of the facilities used by ICE are service processing centers, 7 are contract detention facilities, and more than are state and county jails. To be

eligible to hold women, ICE facilities need only establish that they can maintain physical and visual separation of the sexes. Even though they constitute only 10 percent of the immigration detention population, women are spread out over plus facilities. However, 50 percent of the women detained by ICE are held in ten facilities, half of which are located in Texas. Further, alternative methods for ensuring that individuals appear for their immigration hearings and comply with the final rulings in their cases have proven successful, with supervised release programs reporting upwards of 90 percent of participants appearing for their hearings. The division is headquartered in Washington, DC, where the national office sets policy for the detention medical care system. However, of the more than facilities, DIHS personnel provide the on-site medical services at only 21, eight of which are service processing centers run by ICE. Under this regime, individuals detained by ICE should have access to the same level of care regardless of where they are held. In state and county jails, for example, the individuals held on behalf of ICE should have access to services necessary for meeting the ICE medical standard, regardless of the services available to the criminal population at the jail. Since the services available within individual facilities may vary, ensuring uniform access to services requires providing coverage for services in the community i. Where the on-site clinic is small, this may encompass almost all medical services. The TAR process is currently a major weakness in the system that can result in major delays or denials of necessary health care.

Chapter 6 : Review of health care in Jamaica | Lead Stories | Jamaica Gleaner

Read "The Caribbean State, Health Care and Women: Analysis of Barbados and Grenada During the Period, Women's Studies International Forum" on DeepDyve, the largest online rental service for scholarly research with thousands of academic publications available at your fingertips.

Natural resources[edit] By International standards, minerals most valuable on the international market are found in: Cuba , Jamaica , and Trinidad and Tobago. The resources that make significant contributions to domestic economies and regional job sectors include, but are not limited to: The attention by regional governments towards economic diversification in the early s is often associated with increased production in tourism , oil , and nickel , spurred by foreign investment in these primary industries. However, unlike many developed countries, this trend may be accounted for by a growing tertiary sector , as opposed to industrial growth except for Trinidad and Tobago and Mexico. Some of the associations representing the agricultural industry in the region are: From foundations built on the plantation economy , the Caribbean economy has always involved reliance on one or several export sectors. While numerous attempts at market diversification have been made, the struggle to develop the political and economic infrastructure necessary to successfully respond to market fluctuations, and loss of competitiveness, in key export sectors remains a struggle. Due to the lack of economic opportunity and low GDP per capita levels, Caribbean people are travelling in large numbers to developed countries. Globally, Grenada has the third highest percentage of emigrate at Kitts and Nevis is fourth at Most of these Caribbean emigrants are women. Now, it is the exportation of labor that is on the rise in the Caribbean. Caribbean women are migrating to developed countries for the opportunity to study particularly in nursing programs. Women in the Caribbean migrate in large numbers to developed countries such as the United States, Canada, the United Kingdom and France. These host countries have better education and resources that provide better health care knowledge and health care training. In these developed regions of the word, Caribbean women receive more on and off the job training as well. Educational opportunities for health care allow women in the Caribbean to receive advanced knowledge on nursing and their degrees are recognized in their host countries. With advanced education come more career opportunities. In the host countries, there is a lot of demand for healthcare workers, which means more job opportunities for the women. Caribbean women also emigrate in such large numbers to developed countries to earn higher pay. Income earned in host countries is usually enough for a female immigrant from the Caribbean to live off of and still send remittances back home. Additionally, the currencies from host countries have more purchasing power than the domestic currency in the Caribbean. Money being sent back to Caribbean countries allows for individuals to set up for retirement accounts and provide financial support to the families that the Caribbean women left behind. Disadvantages[edit] The labor exportation from the Caribbean to the host countries is offering education and employment opportunities to women, but is also limiting the opportunities for the Caribbean. The educated women who want to learn advanced skills and have the potential to make a difference in and on their home countries are travelling abroad, and in large part are staying abroad to take full advantage of the education and the economic prospects. The health care education systems and quality of health care declines because the participants are leaving. Guyana is one of the top 10 countries that export labor. Lately, however, there been serious deficiencies and neglect in the health care market due to Caribbean nurses staying abroad after pursuing their education. Guyana is one of the top countries to benefit from remittances from nursing labor. This dependence on the developed foreign economy leaves Guyana vulnerable to any changes or crashes that the developed country may face. The remittances that Guyana is receiving are helping to sustain the economy but also have the potential effect of really crippling it, if nurses lose their jobs or receive pay cuts and can no longer send back a hefty amount of remittances. Technology[edit] The Caribbean governments are increasingly looking at the need for digital communications networks to help economic growth.

Chapter 7 : Womenâ€™s Struggles to Obtain Health Care in United States Immigration Detention | HRW

The mMOM project implemented an innovative, integrated mHealth program to improve the maternal, newborn and child health (MNCH) of ethnic minority women (EMW) in remote and mountainous areas of Thai Nguyen, Vietnam.

What are Health and Health Care Disparities? Health and health care disparities refer to differences in health and health care between population groups. Disparities in health and health care not only affect the groups facing disparities, but also limit overall gains in quality of care and health for the broader population and result in unnecessary costs. Addressing health disparities is increasingly important as the population becomes more diverse. What is the Status of Disparities Today? Many groups are at disproportionate risk of being uninsured, lacking access to care, and experiencing worse health outcomes. For example, people of color and low-income individuals are more likely to be uninsured, face barriers to accessing care, and have higher rates of certain conditions compared to Whites and those at higher incomes. What are Key Initiatives to Address Disparities? The Affordable Care Act ACA coverage expansions helped narrow longstanding disparities in health coverage for people of color and low income individuals. What is at stake for disparities Looking Forward? Although the ACA sharply reduced uninsured rates for people of color and low-income individuals, coverage disparities remain, and changing federal priorities could reverse recent progress reducing disparities. Continued enrollment efforts could further narrow coverage disparities, but the share of remaining nonelderly uninsured who are eligible for coverage varies by race and ethnicity. Moreover, recent reductions in funding for outreach and enrollment may limit continued coverage gains. Further, changing federal priorities could lead to coverage losses and other reverses in recent advances in reducing disparities. Health and health care disparities refer to differences in health and health care between populations. Health and health care disparities often refer to differences that cannot be explained by variations in health needs, patient preferences, or treatment recommendations. Health inequality and inequity also are used to refer to disparities. Individual factors include a variety of health behaviors from maintaining a healthy weight to following medical advice. Provider factors encompass issues such as provider bias and cultural and linguistic barriers to patient-provider communication. How health care is organized, financed, and delivered also shapes disparities. Social Determinants of Health Health and health care disparities are commonly viewed through the lens of race and ethnicity, but they occur across a broad range of dimensions. For example, disparities occur across socioeconomic status, age, geography, language, gender, disability status, citizenship status, and sexual identity and orientation. Federal efforts to reduce disparities focus on designated priority populations who are vulnerable to health and health care disparities, including people of color, low-income groups, women, children, older adults, individuals with special health care needs, and individuals living in rural and inner-city areas. Disparities also occur within subgroups of populations. For example, there are differences among Hispanics in health and health care based on length of time in the country, primary language, and immigration status. Disparities have been documented for many decades and, despite overall improvements in population health over time, many disparities have persisted and, in some cases, widened. Disparities in health and health care not only affect the groups facing disparities, but also limit overall improvements in quality of care and health for the broader population and result in unnecessary costs. Addressing disparities in health and health care is not only important from a social justice standpoint, but also for improving the health of all Americans by achieving improvements in overall quality of care and population health. Moreover, health disparities are costly. It is projected that people of color will account for over half of the population in , with the largest growth occurring among Hispanics Figure 2. There also are wide gaps in income across the population. Today, many groups face significant disparities in access to and utilization of care. People of color generally face more access barriers and utilize less care than Whites. For example, among nonelderly adults, Hispanics, Blacks, and American Indians and Alaska Natives are more likely than Whites to delay or go without needed care Figure 4. Moreover, nonelderly Black and Hispanic adults are less likely than their White counterparts to have a usual source of care or to have had a health or dental visit in the previous year Figure 5. Low-income individuals also experience more barriers to care and receive poorer quality care than high-income individuals.

For example, individuals living in rural areas have more limited access to private coverage compared to those in urban areas and face significant barriers to accessing care. For example, Blacks and American Indians and Alaska Natives are more likely than Whites to report a range of health conditions, including asthma, diabetes, and heart disease Figure 6. What are Key Initiatives to Eliminate Disparities? Significant recognition of health and health care disparities began over a decade ago with several landmark reports and the first major legislation focused on reduction of disparities. Soon after, the Institute of Medicine released two seminal reports documenting racial and ethnic disparities in access to and quality of care. Other ACA provisions explicitly focused on reducing disparities, such as creating Offices of Minority Health within HHS agencies to coordinate disparity reduction efforts. The ACA also promoted workforce diversity and cultural competence, increasing funding for health care professional and cultural competence training and education materials, and strengthened data collection and research efforts. In , the Department of Health and Human Services HHS developed an action plan for eliminating racial and ethnic health disparities. States, local communities, private organizations, and providers also are engaged in efforts to reduce health disparities. Through Racial and Ethnic Approaches to Community Health REACH grants funded by the Centers for Disease Control and Prevention, a number of states, local health departments, universities and non-profit groups implemented community-focused interventions to reduce specific neighborhood-based disparities. What is at Stake for Disparities Looking Forward? The ACA sharply reduced the uninsured rate for people of color and low-income groups, but coverage disparities remain. However, they still remain significantly more likely to be uninsured than Whites Figure 8. However, poor and near poor individuals remain more than twice as likely to be uninsured than those with higher incomes Figure 9. Uninsured Rates for the Nonelderly Population by Income, Continued efforts to enroll eligible individuals into coverage could contribute to further coverage gains and narrowing of disparities, but the share of the remaining nonelderly uninsured who are eligible for coverage varies by race and ethnicity. Compared to Whites, Blacks have a significantly higher share of nonelderly uninsured individuals that fall into the coverage gap that exists in the 17 states that have not expanded Medicaid. Consistent with immigrants accounting for large shares of uninsured Asians and Hispanics, nearly half of these groups remain ineligible for coverage options, limiting continued coverage gains that can be achieved through enrollment efforts for these populations. The ACA created Navigator programs to provide outreach, education, and enrollment assistance to consumers eligible for marketplace and Medicaid coverage and requires that they be funded by the marketplaces. Since taking office, the Trump administration has dramatically reduced funding for federal marketplace Navigators. The reductions in funding will likely lead to fewer enrollments and renewals in coverage, particularly among these groups, contributing to coverage losses that could reverse recent reductions in coverage disparities. Changing federal policy priorities could result in reductions in coverage and erode progress addressing coverage disparities. Although efforts to repeal and replace the ACA and cut federal financing for Medicaid failed in , proposals to reduce federal Medicaid funding may reemerge. Moreover, some states are implementing waivers to impose work requirements and other changes in Medicaid that could result in coverage losses. Reductions or limits in Medicaid disproportionately affect people of color and low income individuals and would widen coverage disparities by race and ethnicity and income. The implementation of work requirements may also disproportionately affect certain groups with lower rates of work like older adults, people with disabilities, and women. While health and health care disparities are commonly viewed through the lens of race and ethnicity, they occur across a broad range of dimensions and reflect a complex set of individual, social, and environmental factors. Disparities not only affect the groups facing disparities but also limit continued improvement in overall quality of care and health for the broader population and result in unnecessary costs. It is increasingly important to address disparities as the population becomes more diverse. For over the past decade, there has been increased focus on reducing disparities and a growing set of initiatives to address disparities at the federal, state, community, and provider level. However, changing federal priorities may lead to coverage losses that would reverse recent progress reducing health and health care disparities. Endnotes Definitions of health disparity differ. Department of Health and Human Services, April , http: For example, a health disparity, which typically refers to differences caused by social, environmental attributes, is sometimes

distinguished from a health inequality, used more often in scientific literature to describe differences associated with specific attributes such as income, or race. A health inequity implies that a difference is unfair or unethical. Olivia Carter-Pokras and Claudia Baquet.

Chapter 8 : Barbados Has A Well-Developed Health Care Infrastructure

Islamic State fighter acts dead to save his life during the clashes with the Syrian army State institution were forced to clash against each other during military regimes: Raza Rabbani.

The mortality rate had been reduced from The infant mortality rate for the same year was Life expectancy at birth in averaged Morbidity indicators also improved but were nevertheless below expectations. In only 60 percent of children one year of age and younger had been immunized against measles, poliomyelitis, diphtheria, pertussis, and tetanus. The implication of the deficient inoculation programs was evident in the 4. Despite the fact that 95 percent of the population had access to potable water in and percent was serviced by sanitary waste disposal, communicable diseases were still a problem. In dengue fever was endemic, venereal diseases were rampant, and tuberculosis was still a minor threat. As of , there were confirmed cases of acquired immune deficiency syndrome in Trinidad and Tobago, 93 resulting in death. Drug addiction and noncommunicable diseases were becoming increasingly prevalent in the late s. A government report named alcoholism as the most serious drug abuse problem and also pointed to a noticeable rise in the use of marijuana and cocaine. Abuse of other drugs, however, had not yet become a serious problem. Drug abuse in general, and alcoholism in particular, was considered a significant contributor to the relatively high incidence of motor vehicle fatalities and the increasing suicide rate. Cancer, hypertension, and heart disease were the most common noncommunicable health problems. The principal goal was to provide basic health care to all communities, utilizing a decentralized, public education format, and giving maternal and child health care priority status. In the s, the overall public health program was the responsibility of the Ministry of Health, Welfare, and Status of Women. It was divided into four divisions responsible for community services, environmental health, institutional health care, and epidemiology. Community services oversaw the primary curative and preventative , secondary hospitalization , and tertiary specialized and long-term community health service program. At the local level, each county had a medical officer responsible for the health care system, particularly primary health care. Primary health care revolved around the health centers located throughout the country. They provided outpatient services on a daily basis, which included the rotation of medical specialists. Public health nurses were also available to make house calls and visit schools. The health centers were the primary vehicles for extending the immunization programs. Secondary health care was available at eight district hospitals, as well as two large government hospitals in Port-of-Spain and San Fernando. Tertiary health care was available only in Port-of-Spain. The main facility was the Mount Hope Medical Complex, which housed a bed general-purpose hospital, bed pediatric facility, and bed maternity hospital. Other specialized facilities included the St. James Infirmary for geriatric, oncological, and physical therapeutic care. The total number of public hospital beds in was approximately 4,; there were 15 private health institutions that provided an additional beds. Private sector health services concentrated primarily on ambulatory care; some publicly employed physicians maintained separate private practices, however. In Trinidad and Tobago had 1, doctors, or a ratio of At the same time, there were dentists and 3, nurses, or ratios of 0. In spite of noted improvements in health care delivery, serious deficiencies were still evident in the late s. The ratio of population to health centers was twice as large as desired, requiring a long-term commitment to the construction of additional facilities. There was also a lack of critical medicines and trained medical personnel, particularly technicians. Physical facilities and equipment also required attention, as did the lack of dental care nationwide. The National Insurance Scheme acted as the equivalent of a social security system in the late s. Welfare disbursements went to public assistance programs, food stamps, and retirement pensions and played a small role in health care by providing compensation for injuries and diseases acquired on the job.