PAHO/WHO EASTERN CARIBBEAN COOPERATION STRATEGY 2006-2009: PAHO/WHO's Medium Term Cooperation Strategy For Barbados and Member Countries of the Organization of Eastern Caribbean States

September 2005

Prepared by the Office of Caribbean Program Coordination
Pan American Health Organization
Regional Office of the World Health Organization

Vision

Office of Caribbean Program Coordination

Our vision is to be:

Country focused
Productive and
Committed

while working together for
a healthy Caribbean.

Pan American Health Organization
Office of Caribbean Program Coordination
Barbados

Mission

Working with Caribbean governments and other partners to sustain and advance national, regional and global health and development.

Pan American Health Organization
Office of Caribbean Program Coordination
Barbados

ABBREVIATIONS & ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CARIFORUM	Caribbean Forum of African, Caribbean and Pacific (ACP) States
CCA	Common Country Assessment
CCC	Caribbean Council of Churches
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention
CDB	Caribbean Development Bank
CDERA	Caribbean Disaster Emergency Relief Agency
CEHI	Caribbean Environmental Health Institute
CFNI	Caribbean Food and Nutrition Institute
CFPA	Caribbean Family Planning Associations
CHRC	Caribbean Health Research Council
CIDA	Canadian International Development Agency
CRDTL	Caribbean Regional Drug Testing Laboratory
CROSQ	Caribbean Regional Organisation for Standards and Quality
DFID	UK Department for International Development
ECLAC	Economic Commission for Latin America and the Caribbean
FAO	Food and Agriculture Organization of the United Nations
FTC	French Technical Cooperation
GFATM	Global Fund to Fight Aids, Tuberculosis and Malaria
HIV	Human Immuno-deficiency Virus
IICA	Inter-American Institute for Cooperation on Agriculture
ILO	International Labour Organisation
ITU	International Telecommunication Union
MDGs	Millennium Development Goals
NGOs	Non-Governmental Organizations
OECD	Organisation for Economic Co-operation and Development
OECS	Orgnisation of Eastern Caribbean States
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership Against HIV/AIDS
PRSP	Poverty Reduction Strategy Paper
SWAp	Sector-Wide Approach
TC	Technical Cooperation
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNEP	United Nations Environment Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNGASS	United National General Assembly Special Session on HIV/AIDS
UNSRT	United Nations SubRegional Team
UPU	United Postal Union
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

In 2002 the World Health Organization (WHO) announced the introduction of the Country Focus Initiative (CFI) using the country cooperation strategy (CCS) as the nationally agreed framework, to focus the work of WHO in the countries it serves. The CCS combines a realistic assessment of a country's needs with subregional, regional, and global priorities.

At the end of 2003, the Pan American Health Organization, Regional Office of the World Health Organization (PAHO/WHO), approved an initiative for the development of a cooperation strategy for 10 countries in the eastern Caribbean namely: Antigua & Barbuda, Barbados, Dominica, Grenada, Saint Lucia, St Kitts & Nevis, St Vincent & the Grenadines and the three United Kingdom Overseas Territories (UKOTs) of Anguilla, British Virgin Islands, and Montserrat.

The multicountry Eastern Caribbean Cooperation Strategy (ECCS), as it is called, was developed through a consultative process involving representatives from the public sector and non-governmental organizations from all the Eastern Caribbean countries including development partners serving this group of countries. The ECCS was formulated on the opportunities arising from the confluence of (a) the needs, interests and expectations of the countries, focusing on their health and development challenges; (b) PAHO/WHO's policy framework; and (c) the work of development partners in health. The resulting draft strategy was presented to the above groups and its further development was facilitated by two sets of consultations with the Ministers of Health to get their agreement on the elements needed to enhance the country presence of the organization. The ECCS will guide the PAHO/WHO technical cooperation programs designed to support the countries in meeting health and development challenges.

Health and development issues and challenges

Through the consultation process the countries identified their key issues and challenges, which fall into four broad areas:

- Strengthening leadership for national health development;
- Strengthening health system infrastructure;
- Assessing and responding to vulnerability;
- Addressing specific priority health conditions.

Development financing

With the national incomes of these countries in the upper middle and higher income groups, the flow of official development assistance has decreased significantly. Traditional donors have increasingly restricted their involvement in health to the area of HIV/AIDS; and have directed most funding towards regional institutions.

Critical issues and challenges in development financing relate to the need to strengthen national:

- capacities to develop, manage, and evaluate investment plans to address their health priorities,
- mechanisms to manage externally provided resources

Strengths and Weaknesses

Starting in 1951, with the creation of a Zone Office in Venezuela, PAHO's program of cooperation to the Caribbean predates statehood of any of the countries. This arrangement was succeeded in 1978 by the establishment of the Office of Caribbean Program Coordination (OCPC) in Barbados. The consultations with national representatives and development partners revealed that PAHO is perceived as a reputable organization and a source of credible, independent and objective perspectives on health matters and is valued by national agencies as the preferred source of technical cooperation in health. Of special value were PAHO/WHO's role in information; its access to health-related experiences; its support for research; its ability to form effective partnerships; its support to subregional organizations and professional groups; and its promotion and support of technical cooperation among countries (TCC).

Weaknesses identified include the lack of a physical presence in all but one Eastern Caribbean country; administrative systems that are bureaucratic and relatively inflexible; limited technical and financial resources for follow-up; poor communication and weak monitoring and evaluation of implementation and impact of its programs.

Strategic agenda and direction

The strategic agenda reflects choices relating to those aspects of the countries' total work for health development, which PAHO/WHO is best placed to support. It addresses the individual and collective needs of the countries, including health and development challenges, and takes into account collective agreements for joint action and the Organizational strategy for greater country focus.

The strategic directions delineate the actions that the Organization should follow in order to make a difference in the health situation of the Eastern Caribbean. Based on the situation analysis, the WHO corporate strategy, the PAHO Strategic Plan 2003-2007, as well as global, regional and subregional collective agreements, the following five strategic directions are identified:

I. Enabling the health systems to ensure equitable access and improve quality of services.
II. Strengthening public health leadership.
III. Reducing preventable mortality, avoidable morbidity, and disability in priority health areas.
IV. Reducing vulnerability and threats to health arising from environmental and economic causes, including natural and other hazards.
V. Enabling optimal use of global, regional, and subregional collective agreements for national health development.

Implementation of the ECCS

Implementation of the ECCS demands immediate adjustments which allow for a dedicated team for the ECCS comprising a PAHO/WHO Representative for the Eastern Caribbean (PWR-EC), core technical team of Technical Advisors (ECTT), and 6 Country Program Officers (CPOs). The ECCS requires that the newly recruited CPOs are to be based in the countries being served (on a shared basis), and so will need close supervision initially. They will also need efficient communications with the remainder of the ECCS team based at OCPC. The skills mix of the

ECTT mirror the functional areas of the ECCS and comprise health systems development; health policy and services; epidemiology and health situation analysis; non-communicable disease and mental health; family health; environmental health, disaster mitigation and response; and HIV/AIDS. The role and level of collaboration with the Caribbean Environmental Health Institute (CEHI) will be strengthened to support TC in basic environmental sanitation. While each country budget will support the costs of a CPO and contribute a fixed percentage to the general operating expenses of the OCPC, the post costs for the ECCS remain a component of the CAR subregional budget.

The ECCS does not detail the TC to be provided through the subregional program by CAREC, CFNI and the OCPC which are currently undergoing a review, although the ECCS does not envision that their roles will change significantly. However it is anticipated that the OCPC will host the ECCS team and provide administrative support. It is expected that some technical competencies not available through the ECTT will be available to the countries through the subregional and regional programs e.g. communicable diseases/ risk reduction; media communication and advocacy; human resources for health; health information systems; environmental protection; veterinary public health; and disaster mitigation and response. Conversely there are some competencies which the subregional and regional levels will supplement even though available within the ECCT e.g. Mental Health, HIV/AIDS, Chronic Diseases.

The Regional Office will provide support in revising basic agreements with countries and the Memorandum of Understanding with CEHI; approving the post descriptions and refining the shared administrative arrangements. Ultimately, the approval of the arrangements, budgets, policies and technical support must be obtained from the Regional Office. The assistance of the Regional Office will be needed for the resource mobilization, information management and communication needs of the CPO in order to support enhanced TC.

The physical, administrative and policy changes necessary for implementation of the ECCS proposals need the support of the regional and global offices. The ECCS is expected to be operational by the start of the new biennium in January 2006.

SECTION I

1 INTRODUCTION

At the World Health Assembly in 2002, the then Director General of the World Health Organization (WHO), Dr Gro Harlem Brundtland announced the organization-wide Country Focus Initiative (CFI). The CFI envisaged a range of organizational changes within WHO with the aim of improving the organization's performance at country level, through:

- Extending the use of country cooperation strategies
- Improving the core competencies and capacity of country teams
- Enhancing integrated programmatic and technical support to country activities from regions and headquarters in response to the country cooperation strategies
- Enabling effective operations in WHO country offices
- Collecting and collating country-specific information and intelligence
- Improving WHO's working relationship with organizations of the United Nations system and development partners

The CFI became organizational policy and the country cooperation strategy (CCS) the framework, agreed with national authorities, to focus the work of WHO in and with the country in the medium term. The strategy combines realistic assessment of a country's needs with subregional, regional, and global priorities. The result is an agreed statement on how WHO will mobilize and prioritize the use of its resources within the country, whether these resources come from the country program, the regional office, headquarters or other sources, including WHO collaborating centres. The resources are not only applied to in-country action, but also used to facilitate action by the country in specific subregional, regional, or global collective agreements.

At the end of 2003, the Pan American Health Organization, Regional Office of the World Health Organization (PAHO/WHO), approved an initiative for the development of a cooperation strategy for Barbados and the countries belonging to the Organization of Eastern Caribbean States (OECS)[1], hereinafter referred to as the Eastern Caribbean Cooperation Strategy (ECCS). The purpose of the ECCS is to guide the technical cooperation (TC) provided by the entire WHO system. It would be the first of its kind developed for a group of countries. The objectives, however, remain the same as those of the CCS.

The Eastern Caribbean Cooperation Strategy (ECCS)
The ECCS provides the vision and blueprint for TC between the entire PAHO/WHO system and the Eastern Caribbean[2] for the period 2006-2009. More specifically, the ECCS will incorporate

[1] In 1981, seven Eastern Caribbean countries signed the Treaty of Basseterre establishing the Organization of Eastern Caribbean States (OECS). At present the OECS comprises Anguilla, Antigua & Barbuda, British Virgin Islands, Dominica, Grenada, Montserrat, Saint Lucia, St Kitts & Nevis, and St Vincent & the Grenadines. Anguilla, British Virgin Islands, and Montserrat are United Kingdom Overseas Territories (UKOTs).
[2] For the purposes of this document, the Eastern Caribbean comprises the following 10 countries: Anguilla, Antigua & Barbuda, Barbados, British Virgin Islands, Dominica, Grenada, Montserrat, Saint Lucia, St Kitts & Nevis, and St Vincent & the Grenadines.

the TC provided through the Office of Caribbean Program Coordination (OCPC), the Caribbean Epidemiology Centre (CAREC), the Caribbean Food and Nutrition Institute (CFNI)[3], PAHO HQ Washington and WHO HQ Geneva. The ECCS will also complement TC with the French Departments in the Americas (FDAs)[4].

The ECCS focuses on health-related priorities common to the countries, which the Organization is best placed to address and which are consistent with its strategic goals. It outlines an approach to working with national counterparts, government agencies, non-governmental organizations and other development partners, while harmonizing the internal organizational mechanisms to provide seamless technical cooperation in the countries in question.

The ECCS is meant to assist these countries in their national health development and contribute to the achievement of the various global, regional, and sub-regional initiatives, as defined by the goals agreed in the Millennium Declaration (MDGs) and other international development conferences, the Caribbean Cooperation in Health (CCH), the follow-up to the Caribbean Commission on Health and Development (CCHD), and the OECS Development Strategy. A challenge is to customize the MDG targets to the Caribbean subregional situation, where some, such as in maternal mortality and education, have already been met, but related issues remain. The ECCS will form the health contribution to the United Nations Development Assistance Framework (UNDAF) for the Eastern Caribbean countries.

Process

The ECCS was developed through a consultative process involving representatives from the public sector and non-governmental organizations from all the Eastern Caribbean countries. The process was led by a team that comprised representatives from WHO at the global, regional, subregional, and country levels.

Three consultations, held in Antigua and Barbuda, Barbados, and Grenada, sought to present the objectives and principles of the ECCS; identify the most important health and development issues and challenges; and obtain the perspectives of the participants on the role and effectiveness of PAHO/WHO. Consultations were also held with development partners serving this group of countries to determine their programs and their views on the comparative advantage of PAHO/WHO.

A second round of consultations and discussions was convened to present the draft strategy to a cross section of national participants, who, in turn, were responsible for coordinating the national reviews in their respective countries. Presentations on the draft strategy were made to development partners and a special session was held with the OECS Ministers of Health to review the strategy and obtain their feedback on the proposals. The OCPC staff, as key stakeholders in the process, participated in two consultations held specifically to keep them abreast of developments.

[3] CAREC and CFNI are the two specialized PAHO sub-regional centers in the Caribbean.
[4] The FDAs comprise French Guiana, Guadeloupe nd Martinique.

The ECCS was developed taking into consideration (a) the needs, interests and expectations of the countries, focusing on their health and development challenges; (b) PAHO/WHO policy framework; and (c) the work of development partners.

The countries of the Eastern Caribbean are being challenged to increase their accountability; report on the progress of commitments made at various global, regional, and subregional fora; institute sustained mechanisms to monitor and evaluate the impact of interventions and investments and ensure that inequities are reduced. The ECCS will guide the PAHO/WHO TC program to support the countries in meeting these challenges.

SECTION 2

2 EASTERN CARIBBEAN HEALTH AND DEVELOPMENT CHALLENGES

2.1 The macro-picture

The countries of the Eastern Caribbean stretch from Grenada in the south to the British Virgin Islands in the north. Barbados is the most easterly island in the Caribbean chain and, though not a member of the OECS, shares a history of collaboration with these countries. The geographical proximity of these countries has facilitated collaboration in several aspects of social and economic development. In the health sector, Barbados is utilized by the Eastern Caribbean as one of the primary locations for both formal and informal referral services, and is a source of technical support in specified areas. The geographical proximity of two of the FDAs (Guadeloupe and Martinique) and some of the Netherland Antilles allows these islands to play similar roles for neighbouring Eastern Caribbean countries.

Barbados facilitates the cross-border movement of persons within the sub-region by serving as a transportation hub for many of the Eastern Caribbean countries. It also functions as the host country for the majority of the offices of the development partners that serve the Eastern Caribbean. Several of these agencies are currently either reviewing their future program of technical cooperation with the sub-region or finding mechanisms to foster greater coordination among themselves to ensure maximum utilization of resources.

The Eastern Caribbean countries share several characteristics. They are all Small Island Developing States (SIDS) and have democratic systems of government based on the Westminster Parliamentary Model. They participate in various administrative and political structures and alliances, e.g. the Caribbean Community (CARICOM) and the Association of Caribbean States (ACS). In addition, they enjoy a relatively stable social and political environment.

In 2003, the population in the countries ranged from 4,300 in Montserrat to 269,000 in Barbados. The United Nations Development Program (UNDP) stated in its 2004 Human Development Report that none of the Eastern Caribbean countries had Human Development Index (HDI) values below the middle group. With overall ranges between 29 (Barbados) and 95 (Dominica), three countries - Barbados, St Kitts and Nevis, and Antigua and Barbuda - fall in the high human development group. Most countries, with the exception of Grenada, recorded higher levels of economic activity in 2004 compared to 2003. Anguilla, Saint Lucia, and Antigua & Barbuda recorded growth rates in excess of 5%, and Anguilla led the group with an impressive annual growth of 12%. This increased economic activity was underpinned by improvements in tourism, construction, financial services, and a general upturn in the global economy.
However, the countries of the Eastern Caribbean also have relatively high levels of public debt, ranging from 14.0 in Anguilla to 170.2% in St. Kitts and Nevis during the period 2003-2004. Antigua & Barbuda, Dominica, Grenada, and St Kitts & Nevis are among the ten most indebted of

the emerging market economies.[5] In many of the countries, economic growth has not been sufficient to sustain real per capita income since the mid-1990s and there is marked economic vulnerability. The six independent OECS countries are now ranked among the top 16 most indebted economies in the world, and all have public debt higher than the Eastern Caribbean Central Bank fiscal benchmark for public sector debt of 60% of GDP.[6] .Several of the countries exhibit significant levels of inequity and are at risk of losing the achievements that resulted in the relatively high HDI ranking. According to the criteria used by some development agencies, the countries are generally ineligible for most kinds of Official Development Assistance (ODA).

Poverty levels in most of the countries are high, mainly among the rural population and affecting female headed households disproportionately. Generally speaking, the countries lack national plans, policies, and programs which address equity and poverty reduction. The contribution of agriculture to Gross Domestic Product (GDP) has been declining for several years, and the decline reflects diseconomies of scale and unwillingness on the part of developed countries to continue extending preferential trade benefits to Eastern Caribbean countries in the present era of global trade liberalization. Sugar and bananas, the main agricultural exports have been severely affected by the changing conditions of trade. In a move to diversify their economies to reduce dependence on traditional agricultural exports, most countries are turning to service industries such as tourism, offshore financial services and telecommunications.

Tourism has become the mainstay of many of these economies. However, the industry's performance has been hampered by unfavourable economic conditions, natural disasters, and heightened concerns about travel following the events of 11 September 2001 in the USA. Despite these challenges, most countries still recorded growth in stay-over arrivals in 2003. Furthermore, tourism is expected to continue to benefit from the Eastern Caribbean's image as a safe destination. The high level of travel in and out of the region exemplifies the issue of an increasingly borderless world. From a public health perspective, it also exposes the region to the risk of importation of new or re-emerging infectious diseases.

Unemployment has traditionally been high in the Eastern Caribbean. National rates ranged between 9.8% and 21% in 2004[7]. More men participate in the labour force than women who, with young people, account for most of the unemployed. It is important to note that the unemployment rate in youth has been reported as twice that of adults but with the same differences between men and women. While reliable data on the informal sector are not readily available, its role in providing employment is estimated to be significant. More women than men have worked in the informal sector but this trend seems to be changing.

The public sector is the largest employer in the Eastern Caribbean. To improve efficiency and deliver better service, all countries have embarked on public sector reform programs with the assistance of CARICOM and with international donor support. However, countries so far have not reduced the size of their public sector workforce.

[5] Source: ECLAC. Economic Survey of the Caribbean 2003-2004
[6] Source: World Bank Report (2005). Towards a New Agenda for Growth: Organization of Eastern Caribbean States.
[7] CDB Annual Report 2004.

There is at least compulsory primary education in all Eastern Caribbean countries. Despite this, some countries have an increasing number of out-of-school children aged 5-12 years. Literacy rates are high, ranging between 86.6 % and 98% in 2000. However, these rates do not reflect functional literacy; moreover countries use different definitions, different terminologies, and different target populations when conducting literacy surveys.

2.2 Vulnerability to disasters

The seven independent Eastern Caribbean countries are members of the Alliance of Small Island States (AOSIS). This Alliance was formed to call international attention to the special characteristics of small island states and to make a case for them to be accorded special treatment in their relations at bilateral and/or multilateral levels. Issues facing Small Island States include climate change, natural and environmental disasters, waste management, coastal and marine resources, freshwater, land resources, and security.

In terms of natural disasters, hurricanes, earthquakes, and volcanic eruptions pose the most serious threats to the Caribbean, with the potential to cause extensive damage, injuries and deaths. Health facilities are frequently impacted by natural hazards, often leading to loss of health service infrastructure. Principal disasters during the period 1997-2004 were the Soufriere Hills volcanic eruption in Montserrat (1997) and severe hurricanes in 1998, 1999, 2002 and 2004.

In many countries, disaster management is moving towards a comprehensive preparedness response and mitigation approach. Governments have institutionalized national plans to reduce the impact of emergencies and disasters, covering crisis management, disaster assessment, relief operations, public information, and liaison with non-governmental organizations. However, there is urgent need in most countries to develop a comprehensive health disaster plan that addresses natural, technological, and man-made disasters (including bio-terrorism).

2.3 Health Profile

The Eastern Caribbean countries are undergoing a demographic transition due to a rise in life expectancy, a fall in infant mortality, emigration of young people, and immigration of older people. These countries also have low fertility rates. Life expectancy at birth rose from 68.1 years (1980-85) to 71.5 years (1995-2000), with women on average living three to four years longer than men. CAREC estimates that by 2025 the elderly (>60yrs) will constitute 17.1% of the Caribbean population, up from the 2003 level of 9.9%. This, together with changes in lifestyles, will continue to alter the demand for health services.

The number of live births in 2002 ranged between 55 (Montserrat) and 3,816 (Barbados) and totaled 13,723 across the Eastern Caribbean. With a total of 5 deaths in the Eastern Caribbean related to or associated with pregnancy in 2002, the maternal mortality ratio was 36.3 per 100,000 live births. The average infant mortality rate across the Eastern Caribbean was 15.3 per 1000 live births, ranging from 0 in Montserrat to 31.2 in the British Virgin Islands. The perinatal mortality rate was 22 per 1000 live births. Following the trend over the last decade, trained personnel attended more than 90% of deliveries in 2002. However, further challenges related to quality of care, remain to be addressed regarding maternal mortality. Country-specific rates are to be taken with caution, as in countries with small populations; a few events can skew the rate.

The Eastern Caribbean has seen a shift in the epidemiological disease pattern. Chronic non-communicable diseases such as heart disease, stroke, diabetes, hypertension and cancers have become the main causes of morbidity and mortality and represent major economic burden on the health care delivery system. A mortality trend analysis in Eastern Caribbean countries for the period 1985-2000 showed that non-communicable diseases (NCDs) accounted for the four leading causes of death in 1995, and the five leading causes in 2000. Of note is diabetes, which climbed from the fifth leading cause of death in 1985 to third place in 1990 and 1995 and climbed further to second place in 2000. Over the same period, the leading sites for mortality from cancer were the prostate, digestive organs and peritoneum, female breast, and stomach.

Major risks to health in the region are unhealthy eating habits, physical inactivity, obesity, tobacco and alcohol use, unsafe sexual practices, violence and accidents and inadequate utilization of preventive health services. There is an apparent increased appreciation for the value of health and healthy lifestyles by individuals and civil society, but an integrated public health approach to risk factor control is lacking.

Notwithstanding the predominance of the chronic non-communicable diseases, the countries of the Eastern Caribbean face an unfinished agenda in relation to communicable diseases. In the Eastern Caribbean, HIV/AIDS constituted the eighth leading cause of death in 1995 and 2000. While there is no indigenous malaria transmission in the Eastern Caribbean, dengue and dengue hemorrhagic fever have increased in recent years due to high mosquito vector levels. The number of reported dengue cases has increased between the years 1990 (46 cases) and 2003 (3,643 cases). Ensuring adequate vector control continues to be a challenge for the health authorities, as the vector population remains intimately linked to inadequate sewage facilities and solid waste management.

Inadequate wastewater disposal facilities in low-income areas, combined with poor solid waste management and increased pollution of coastal waters, represent the most critical health threat associated with environmental conditions in the Eastern Caribbean. In addition, while the countries enjoy a relatively high coverage of pipe-borne water, there are still occurrences of water-related diseases, in some cases related to poor water quality management.

Despite considerable under-reporting of foodborne diseases, available data show an increasing incidence, which is linked to the proliferation of food preparation by different sources, poor habits of food handlers, and the emergence of Salmonella enteritis. Between 1995 and 2002, there were several reported episodes of food-related illnesses in the Eastern Caribbean countries, affecting the travel and tourism industry, the mainstay of the countries' economies.

The improvement in child health is reflected in the elimination of, most serious childhood infectious diseases, due to effective immunization programs. Indeed, the CARICOM has led the world in the eradication of polio and measles, and in 2003, immunization coverage was above 95%. However, it is important to guard against complacency and sustain the gains made. Data collected by the CFNI (1990-1999) have shown a systematic increase in the rate of childhood obesity in all countries and a decrease in child under-nutrition in all countries except one.[8]

[8] Obesity data (1990-1999): Dominica (6.0% - 9.7%), St. Kitts (7.1% -10.6%), St Vincent (6.9% - 7.2%). Prevalence of overweight and obesity in children - 9.7% (Dominica, 1999), 10.6% (St Kitts, 1999), and 7.2% (St Vincent, 1998).
Under five children with under nutrition showed a decrease for: Antigua - 1.8 % (1996) to 1.5% (1999), Dominica - 1.9% (1990) to 0.9% (1999), Grenada - 4.3% (1997) to 2.8% (1998), Saint Kitts - 8.5% (1990) to 4.4% (1999). However, St. Vincent data showed an increase from 4.3% (1991) to 5.9% (1999).

Youth development in the Eastern Caribbean is affected by several factors including early sexual initiation, increasing HIV/AIDS prevalence, sexual and physical abuse, school dropout, unemployment, crime, violence, and substance abuse – all resulting in considerable though (not quantified) losses to society.

Teenage pregnancy is a major problem, as evidenced by the high fertility rates for this age group. The consequences include school dropout, under-employment, and unemployment, more often in the lower-income sectors. While all countries provide family planning services, in surveys 40% of girls and 50% of boys reported not having access to contraceptives at first sexual intercourse[9].

The Caribbean Adolescent Health Survey (2000), which included six Eastern Caribbean countries, indicated that 17% of adolescent male and 15% of adolescent female respondents had experienced physical abuse; the figures for sexual abuse were 11% (females) and 9% (males). The survey affirmed that urgent attention to injuries is needed on grounds that they are preventable and the health and social costs incurred by morbidity and disability are significant.

The same survey indicated that 11% of adolescents had ever used cigarettes, 46% alcohol, 6% marijuana and 1% cocaine (2000). The Global Youth Tobacco Survey (GYTS), undertaken during the period of 1999-2002 among 13-15 year old schoolchildren in 12 Caribbean countries (which included eight Eastern Caribbean countries) indicated that the prevalence of current smoking among 13-15 year old students ranged from 5.2% to 16.3%.

There are few population-based epidemiological studies related to mental disorders in the Eastern Caribbean. Prevalence estimates appear not to differ significantly from those in other parts of the Americas or in Europe.

In the Eastern Caribbean, women assume a larger overall burden for cancers, with breast and cervical tumors tend to occur at an earlier age than in areas outside the Caribbean. Although diabetes-related mortality is increasing among men, the disability-adjusted life years lost among women are still substantially higher. Suicide rates and mortality rates for lung and stomach cancer are higher in men than women.

During the last two decades, intentional and unintentional injuries have emerged as significant areas of concern in Eastern Caribbean countries. Males are at 3-5 times higher risk of death from all categories of injuries due to external causes for the Caribbean region as a whole, with motor vehicle accidents ranking as the first cause of death in the 15-24 age group and homicide/assault ranking as the third leading cause of death in the 25-44 year age group.

2.4 Health Sector Development

The relationship between health and development has been recognized at the level of the CARICOM Heads of Government who, in the 2001 Nassau Declaration, stated that "the health of the Region is the wealth of the Region". The important role of health in development has also been affirmed in the OECS Charter and Development Strategy and has been highlighted in the Report of the Caribbean Commission on Health and Development (CCHD), 2005. The Caribbean Charter for Health Promotion, to which the Eastern Caribbean countries subscribe, also recognized

[9] The State of Eastern Caribbean Children, United National Children's Fund, 1998.

this relationship by noting the links among prevailing health issues, behaviours, and the socio-economic environments in which people live, work and play. The UN Subregional Common Assessment (SRCA) recognizes the commonalities among the Eastern Caribbean countries and will inform a common UNDAF for Barbados and the OECS.

The countries have all committed to sub-regional, regional, and international collective agreements addressing health. However, there has been poor integration and implementation of these at country level. One example of this is the Framework Convention on Tobacco Control (FCTC), which has been signed by all the countries, but which has not been ratified by any country. Additionally, there are inadequate national mechanisms in place to coordinate multiple agreements. The UN and InterAmerican systems recognize the need to assist the countries to address the MDGs in a manner that is tailored to the specific situation, which differs in several respects from other subregions in the Americas.

During the period 2001-2002, each of the Eastern Caribbean countries undertook a national assessment of the effectiveness of the Ministry of Health in carrying out its role of protecting the health of the public. Eleven Essential Public Health Functions (EPHFs)[10] were assessed to set a baseline for improving public health leadership practice throughout the health system. The results indicated satisfactory performance in only one of the functions "Reducing the Impact of Emergencies and Disasters in Health". Very weak performances were identified in "Quality Assurance in Personal and Population Based Health Services" and in "Public Health Research". In relation to public health research, the assessment showed little or no allocation of resources to this function by Ministries of Health and poor linkages with the educational institutions to influence their research agendas. In addition, there was insufficient basic public health research and mechanisms for evaluation and analysis.

With respect to quality assurance, weak areas were improving and evaluating user satisfaction, technology management and assessment, and the application of evidence-based decision-making.

The issue of human resources for health remains a critical one, with insufficient personnel, inadequate quality of the work force, and problems with retention of trained personnel. Skill shortages exist in a many professional areas including nursing, epidemiology, biostatistics, health informatics, environmental health, nutrition and certain medical/health specialties, including mental health. Due to the generally small numbers, in many instances, staff must function in multiple areas and there are often situations where the loss of one person means the loss of a unit. The situation is compounded by challenges concerning migration of skilled staff to North America, the United Kingdom, and other countries in search of better compensation, conditions of work, and professional challenges. There is aggressive recruitment of Caribbean nurses by North American medical institutions.

Other human resource challenges include regulation of health professionals, harmonization of training programs, high costs of training outside the individual countries and the sub-region, lack of human resource plans, and inadequate performance management systems. The situation has led to the conclusion that increasing the public health workforce and building leadership capacity are critical elements needed to address the health challenges facing Eastern Caribbean countries.

[10] The Essential Public Health Functions were developed by the World Health Organization, the Centers for Disease Control and Prevention, and the Pan American Health Organization.

Offshore medical schools and, more recently, nursing schools, have been established in some of the Eastern Caribbean countries. Some of the host countries have recognized that their power and capacity are often not sufficient to negotiate these ventures to ensure that they benefit adequately from the arrangements.

In the Eastern Caribbean countries, the main source of health financing is through the public purse. The CCHD has recommended that countries should aim to spend 6% of GDP on health, however the average spending on health is less; and ranged (2002) from 2.7% to 4.34% of GDP[11]. Per capita health expenditure (current US$) in 1999, ranged from $1,162 in British Virgin Islands to $154 in Grenada. Most of the countries have introduced user fees for a range of services. While user fees have the potential to increase revenue collected, gains accrued from this mechanism may be offset by decreased access for those unable to afford set prices. Often, private insurance companies are subsidized by the public sector because the latter does not have a well-defined system to bill and collect payment due from the insurance companies when services are rendered by public providers.

Information on health expenditure is crucial for the development of health financing policy. National Health Accounts are important tools for countries in the design of financial reforms and the analysis of current health services provision. In addition, they provide an important baseline against which to evaluate changes in the system in terms of equity, access and overall efficiency. Countries are currently implementing different financing approaches, and almost all have conducted studies towards the institutionalization of a National Health Insurance Scheme. However, many have encountered challenges in implementation.

The countries, in general, have weak information systems. They suffer from lack of, or incomplete, data; lack of timely and accurate data; and less-than-optimal use of available data for analysis and decision-making. An important area for improvement is the coordination between various departments to ensure streamlining of, and taking action on, the data e.g. between epidemiology and environmental health for dengue control.

The higher cost of telecommunications services, compared to the US and Latin America, impacts negatively on accessibility and connectivity, including internet and web-based services and information. Yet, there is enormous potential for the use of modern information and communication technology, which, combined with a trained workforce, could improve the quality, collection, analysis, and use of information to improve the health of the people of the Eastern Caribbean.

Inadequate mechanisms exist for social participation in health. There are several non-governmental organizations (NGOs) which are interested in selected priority health issues, especially the NCDs and HIV/AIDS.

The health systems in the Eastern Caribbean countries are adapting to the challenges associated with changes in health financing, in the utilization and demand for health care, and in the delivery of health services. One success is the OECS Pharmaceutical Procurement Services (OECS/PPS), through which the countries collectively purchase pharmaceuticals and selected medical supplies and benefit from economies of scale. Consideration is being given to expanding the range of items procured. Access to specialist services, including renal dialysis and cancer treatment, is also under active consideration by neighbouring countries as another potential area for collective action. It is

[11] Source: World Bank Report (2005). A time to choose: Caribbean Development in the 21st Century.

expected that the health sector reform process which most countries are undergoing will provide opportunities for varied and innovative interventions that will address the weaknesses identified in the health and health-related sectors.

2.5 Critical health development issues and challenges

Key issues and challenges for the Eastern Caribbean countries identified through the consultation process are consistent with the priorities suggested in the health situation analysis. These issues and challenges are:

1. Strengthening leadership for national health development
   - Articulating the health perspective in the transformation of national economies to meet the challenges of the global economy
   - Ensuring that health expenditure as percentage of Gross Domestic Product is at least 6%, as recommended in the report of the Caribbean Commission on Health and Development
   - Integrating and implementing global, regional, and sub-regional collective agreements at country level
   - Strengthening inter-sectoral action for health
   - Strengthening national mechanisms to coordinate multiple agreements
   - Strengthening the capacity of the countries to negotiate with external partners
   - Developing, implementing, and evaluating national plans, policies, and programs addressing equity and poverty reduction, including the MDGs.
   - Increasing attention to governance, management, and information
   - Encouraging the adaptation of the public health system to the health promotion approach

2. Strengthening health system infrastructure
   - Updating legislation and regulation, and strengthening enforcement
   - Improving mechanisms for social participation in health
   - Enhancing quality assurance and performance management
   - Defining and establishing appropriate financing mechanisms
   - Strengthening human resource development and management, including issues of retention and migration
   - Strengthening information systems to provide data to plan strategic interventions
   - Enhancing dissemination of health information
   - Conducting basic public health research and developing mechanisms for evaluation and analysis
   - Applying a systems approach to ensure sustainability

3. Assessing and responding to vulnerability
   - Developing/strengthening hazard management and disaster mitigation and response
   - Strengthening surveillance and public health systems for emerging and re-emerging diseases and other public health risks
   - Promoting environmental protection, development, and sustainability
   - Institutionalizing an integrated public health approach to risk factor control

4. Addressing specific priority health conditions
   - Non-communicable diseases: diabetes, cardiovascular diseases, and cancer; obesity and its co-morbidities
   - Communicable diseases – HIV/AIDS, dengue, food borne diseases, and vaccine preventable diseases
   - Violence and injuries - traffic accidents and homicides
   - Mental disorders and substance abuse
   - Family health, including child development, youth health, healthy ageing, and gender aspects of health

SECTION 3

3 COOPERATION AND PARTNERSHIPS FOR NATIONAL HEALTH DEVELOPMENT

3.1 Overall trends in development aid/financial flows

The countries entered the 21st century in relative prosperity, with all of the seven economies classified (by the World Bank)[12] in the upper middle income group. The Gross National Income (GNI) of two of the UKOTs, fall within the range of the upper middle income economies and while the economy of the third falls within the high income range. In 2002-03, development aid inflows to the Eastern Caribbean countries averaged 4% of GDP, having peaked at an average of 12% of GDP in the early 1980s and fallen to 5% of GDP by the mid 90s.

Data from the World Bank and the Organisation for Economic Cooperation and Development (OECD) reveal that with the decrease in Official Development Assistance, these countries have increasingly relied on private credit and foreign direct investments (FDI). The territories have been very successful in attracting private FDI with well-developed financial service sectors whereas the other countries have relied more on private credit at non-concessionary rates.

The traditional bilateral development agencies supporting the countries include the Canadian International Development Agency (CIDA), the United Kingdom's Department for International Development (DFID), the French Technical Cooperation (FTC), the German Technical Cooperation Agency (GTZ), the Government of The Netherlands, and the United States Agency for International Development (USAID). However, these partners now only provide assistance through the subregional level (OECS/CARICOM/CARIFORUM), except in the case of humanitarian (post-disaster) needs. The main multilateral financial and intergovernmental agencies, including the European Commission (EC), World Bank (WB), InterAmerican Bank (IDB), and Caribbean Development Bank (CDB), assist at both levels.

All the independent Eastern Caribbean countries have bilateral agreements with Cuba, which increasingly provides technical assistance in health services, human resources for health, and equipment and supplies. Cuba also serves as a referral centre for clinical care, as do Barbados, Jamaica, Trinidad & Tobago, Venezuela, Guadeloupe and Martinique.

Their membership in international organizations makes these countries attractive for bilateral assistance and collaboration with non-traditional partners. The main new non-traditional government sources of assistance include China, Nigeria, and Taiwan, China which provide specific project-related financial, material, and technical assistance in health. Since the late 1970s, significant health-related private sector investment has been realized with the establishment of off-shore schools (medical, veterinary and more recently nursing) in all islands except Anguilla and Barbados. This has occurred on a bilateral basis, and appears to occur outside of any well-defined investment strategy on the part of the host governments.

As traditional development partners and agencies refocus their priorities for assistance outside the subregion, the availability of financing has negatively affected the continued large-scale involvement

[12] The World Bank classifies all World Bank member countries (184), and all other economies with populations of more than 30,000(208 total). An upper middle income economy has a GNI of $3,256 – $10,056 and a high income with a GNI of $10,066 or more.

of NGOs in the subregion e.g. the World Council of Churches through the Caribbean Council of Churches. Some new NGOs e.g. the William J Clinton Foundation have provided assistance with the countries' responses to HIV/AIDS.

Indirect financial flows are associated with the migration of health personnel (especially nursing) across and away from the region. This migration, though not large in absolute numbers, removes a significant proportion of the human resources for health from originating countries. A few of the Eastern Caribbean countries especially the UKOTs are attractive to health personnel from other islands. Though not quantified, it is estimated that significant levels of remittances are made to the domestic economies of the source countries.

3.2 Major external agencies active in the health sector

HIV/AIDS and Health Sector Reform (HSR) are the two primary areas of support. Support for the latter comes through a combination of loans and technical cooperation grants to national authorities in selected countries. French technical cooperation has provided support for the OECS HSR program. Support for HIV/AIDS comes from multiple sources and targets mainly subregional capacity-building programs that aim at strengthening national program delivery. The GFATM also supports HIV/AIDS care and treatment programs in the independent OECS countries. The World Bank has established a special portfolio of loans to support HIV/AIDS and has completed negotiations with Barbados, Grenada, St Kitts & Nevis, Saint Lucia and St Vincent & the Grenadines.

Table 1 summarizes the activities of the major development agencies in health.

Table 1: Health-related development assistance of donor agencies

Agencies	Recipient Countries	Key programs in Health	Comments
Caribbean Development Bank (CDB)	CARICOM-wide and individual countries	Health & poverty studies Review of CARICOM Health Institutions Development of national strategic health plans (Grenada & St Kitts & Nevis) Health infrastructure projects Disaster mitigation and response	CDB's relationship to the Inter-American Development Bank (IDB), allows the CDB to act as executor of funds made available to OECS member states Provides grants and loans
Canadian International Development Agency (CIDA)	CARICOM-wide OECS	HIV/AIDS through CAREC, PANCAP; CFNI; and two NGOs (CCC, CFPA) Social development & environmental management/ climate change	CIDA has no bilateral country programs, and works through sub-regional institutions (OECS & CARICOM). Collaborative arrangements with USAID
Government of Cuba	All independent countries	Technical assistance, health personnel Health infrastructure Clinical services and Patient referral and treatment Training/fellowships	The degree of assistance has increased significantly over the period
Department for International Development (DFID) United Kingdom	CARICOM-wide OECS	HIV/AIDS	PANCAP OECS Regional Coordinating Mechanism for HIV/AIDS Global Fund activities
European Union (EU)	Barbados	Sector- wide support to health sector reform.	First application of the sector-wide approach in the Caribbean. Demands strategic alliance with
	Saint Lucia	Health sector reform	

Agencies	Recipient Countries	Key programs in Health	Comments
	Antigua & Barbuda, Dominica, Saint Lucia and St Vincent & the Grenadines	Health Infrastructure Inter-country project in demand reduction for drugs	the other development partners
	CARICOM-wide	Through the CAREC laboratory strengthening project	
	CARICOM-wide	Through CDERA, strengthening disaster response	
French Technical Cooperation (FTC)	Six OECS countries	Health sector reform (OECS) HIV/AIDS/STI (CAREC) Epidemiology (CAREC)	Financial resources, personnel and technical assistance.
Inter-American Development Bank	Barbados	Health Sector Rationalization.	Channels assistance to the Eastern Caribbean countries through the CDB
Inter-American Institute for Cooperation on Agriculture (IICA)	Barbados and the OECS member states	Food safety	Has a physical presence in each of the independent OECS countries
United States Agency for International Development, USAID and CDC	Barbados & the OECS Member countries	HIV/AIDS (through CAREC; PANCAP; CHRC; Coalition of National AIDS Program Coordinators and NGOs).	Has an umbrella MOU with CARICOM. Uses MDG and UNGASS as guiding frameworks for action
FAO	CARIFORUM	Food Security	
UNICEF	Works at subregional and country levels	HIV/AIDS Immunization Health & Family Life Education School health	
UNDP	Works at subregional and country levels	HIV/AIDS Poverty eradiation Disaster management and the environment Drugs & crime	Supporting the donor coordination group
UNIFEM	Works at subregional and country levels	Gender-based violence and HIV/AIDS	
UNFPA	Works at subregional and country levels	Reproductive health and HIV/AIDS	Regional office based in Jamaica.
World Bank	Barbados, Grenada, Saint Lucia, St Kitts & Nevis and St Vincent & the Grenadines	HIV/AIDS loans and grants	
Global Fund	CARICOM OECS	HIV/AIDS	Anguilla, British Virgin Islands and Montserrat are not direct beneficiaries

3.3 Mechanisms for coordination

There are multiple mechanisms for aid coordination. At the national level, the responsibility for aid coordination lies within the Ministries of Finance, through Development Units and the Public Sector Investment Programmes. Following the devastation of hurricane Ivan in 2004, Grenada established an Agency for Reconstruction and Development, which now manages and coordinates all the aid for development and reconstruction. The EC has National Authorising officers in each country, related to the Ministries of Finance. Some development agencies have project officers in countries.

The UN Subregional Team (UNSRT), covering Barbados and the countries of the OECS and comprising ECLAC, FAO, ILO, ITU, PAHO/WHO, UNDP, UNODC, UNESCO, UNICEF,

UNIFEM, UNFPA and UPU, is coordinated through Office of the UN Resident Coordinator located in Barbados. All agencies but ECLAC, ILO, UNESCO, UNFPA, and UPU are resident in Barbados. The UNSRT recently updated the SRCA for Barbados and the Eastern Caribbean, which is being used to inform the revision of the UNDAF for Barbados and the Eastern Caribbean 2005-2009. The UNDAF for 2002-04 was closely linked to the OECS Development Strategy, which, with the OECS Development Charter, provided a framework for donor assistance. Several agencies and donors confirmed their use of the MDGs and UNGASS as guiding frameworks for their support.

The UNSRT has organised donor coordination groups comprising UN agencies and development partners working with the Eastern Caribbean, the most visible being the Eastern Caribbean Donor Group for Disaster Management. A theme group for HIV/AIDS for the Eastern Caribbean has been established, but, due to the wide physical dispersion of the countries, coordination has been a challenge to successful action at the country level. Ad hoc working groups and collaborative groupings have been set up based on thematic approaches.

The countries benefit from resources mobilized through CARICOM and the OECS. The unique situation of Anguilla, the British Virgin Islands, and Montserrat has called for special arrangements with the UK government and the European Commission for support to allow the participation of the UKOTs in externally funded projects of the OECS or CARICOM (e.g. the DFID-funded HIV/AIDS project and the EC-funded laboratory strengthening project).

At the CARICOM level, a formal agreement with development partners called the Pan Caribbean Partnership (PANCAP) guides and coordinates the responses to HIV/AIDS in addressing components of the Pan Caribbean Strategic Framework for HIV/AIDS 2001-2005. The PANCAP Regional Coordinating Mechanism has representation from all countries. There is also a regional coordinating mechanism for the GFATM HIV/AIDS project for the OECS countries. The Caribbean Disaster Emergency Response Agency (CDERA) coordinates emergency disaster relief across CARICOM and there is a Memorandum of Understanding between CDERA and PAHO for coordination of the health component of the disaster response. The Barbados-based Caribbean Forum for Development (CFD), successor to the Caribbean Group for Cooperation in Economic Development (CGCED) since 2000, has been identified to serve as a coordinating mechanism for many of the multilateral financial institutions and agencies. The CDB serves as the CFD Secretariat.

The health-related institutions of CARICOM - the Caribbean Environmental Health Institute (CEHI), the Caribbean Regional Drug Testing Laboratory (CRDTL), and the Caribbean Health Research Council (CHRC) - are partners, collaborators, and beneficiaries in the subregional health initiatives. They form a vital link in the chain of technical cooperation among countries and between countries and aid agencies. All of these institutions work within the CARICOM governance structure and, in the case of health, link to the Council of Human and Social Development (COHSOD) for policy direction.

Membership in the Commission for African Caribbean and Pacific states (ACP) and CARI-FORUM groups allows dialogue with, and assistance from, the EU as related to the specific EU-ACP agreements e.g. Cotonou.

3.4 Critical issues and challenges for coordination and partnerships

It is evident that donors are increasingly restricting their involvement in health to the area of HIV/AIDS; are attracted to strengthening regional institutions, with the expectation that these, in turn, will support national institutions and program; and have increased their use of civil society and non-governmental counterparts to deliver their programs, adding to the complexity of arrangements. Often there is lack of communication and subsequent duplication of efforts.

Critical issues and challenges are:

1. Strengthening development partner investment in health
   - Establishing the case for additional resource mobilization in support of national health development in upper middle income countries
   - Expanding the scope of development partner involvement in health to priority areas other than HIV/AIDS
   - Pooling of development partner resources for institutional strengthening, rather than implementation of isolated projects
   - Implementing agreements for integrated systems for monitoring and evaluating the use of development partner resources

2. Strengthening the capacity of countries to develop, manage, and evaluate investment plans to address their health priorities, including use of the plans in negotiation with development partners

3. Strengthening national mechanisms to manage externally provided resources
   - Improving the countries' capacity to negotiate with the subregional institutions that are provided with development partner funds
   - Enhancing government collaboration with civil society and non-governmental counterparts to ensure that these counterparts are working within the framework of the national investment plan
   - Improving the capacity of the country to demonstrate the impact of "non-action" in priority areas

SECTION 4

4 PAHO/WHO CURRENT COOPERATION

4.1 Brief historical perspective

PAHO founded in 1902, is one of the oldest international public health agencies in the world. PAHO is recognized both as the specialized health agency in the InterAmerican System and the Regional Office for the Americas of the World Health Organization.

There is a long history of PAHO involvement in the Caribbean, since Zone Offices were created in 1951, before any of the territories had gained their independence. The Zone I office in Caracas, Venezuela, had the responsibility for technical cooperation with the Caribbean Territories. In the 1960s, as the countries became independent and formally joined PAHO as individual sovereign states, the role of the Zone Offices changed.

In 1978 the OCPC was established in Barbados in recognition of the commonality of health problems in the Eastern Caribbean. The similarity of health systems originated in the common historical development and the long standing tradition of collaboration in health among these countries. Many of the resources were transferred from Caracas. The OCPC is the largest multi-country office in the PAHO system.

The PAHO/WHO program of TC with countries of the Eastern Caribbean is administered mainly through the OCPC and two sub-regional[13] specialized centres, CAREC, located in Trinidad & Tobago, and the CFNI, located in Jamaica, with an office in Trinidad & Tobago.

The OCPC houses a complement of technical staff[14] to implement the PAHO/WHO TC program in the Eastern Caribbean, the three FDAs and, for selected program areas, in the wider English-speaking Caribbean. The OCPC also functions as the co-secretariat of the CARICOM Caribbean Cooperation in Health (CCH), the Secretariat of the CCHD, and serves as PAHO/WHO's liaison with various subregional institutions, including the CARICOM Secretariat, the OECS Secretariat, the Caribbean Development Bank (CDB), and the University of the West Indies (UWI). Additionally, the office has the responsibility for conducting subregional health situation analyses and promoting coordinated program development.

The multi-tier, multi-country, multi-lingual functions of the OCPC result in a complex operating environment for TC. Further, the increase in the number of institutions and agencies operating at the subregional level makes coordination more challenging and demands an appropriate administrative structure.

CFNI was established in 1967 to develop and promote a regional approach to nutritional issues in the Caribbean. The mission of CFNI is to co-operate technically with member countries to strengthen their ability to analyze, manage, and prevent the key nutritional problems, and to

[13] Within the Caribbean, these centres are referred to as "regional" to reflect their CARICOM-wide remit. The core budget for these centres is provided by quota contributions from Member States and from PAHO resources.

[13] There are technical advisors in the following areas: Chronic Disease & Mental Health; Communication & Media; Entomology (vacant); Environmental Health; Epidemiology; Disaster Management (vacant); Family, Reproductive and Oral Health; Health Education & Health Promotion; Health Information Systems; Health Financing & Health Planning; Human Resource Development (Inter-country, vacant); and Veterinary Public Health.

enhance the quality of life of the people through the promotion of good nutrition and healthy lifestyle behaviors. CFNI's programs are thus aimed at ensuring food security and combating nutrition-related problems such as obesity, chronic diseases, iron deficiency anaemia, and under-nutrition.

CAREC came into existence in 1975 after the endorsement by the 1973 Caribbean Health Ministers' Conference, held in Dominica. From its inception, CAREC was able to build on the strength of its foundation institution, the Trinidad Regional Virus Laboratory, which at that time enjoyed strong ties with research agencies. CAREC's mission is to improve the health status of Caribbean people by advancing the capabilities of member countries in epidemiology, laboratory technology and related public health disciplines through technical cooperation, service, training, research and a well-trained motivated staff.

CAREC's initial focus was on infectious diseases, but it has broadened the scope of its activities over the years to encompass surveillance of injuries, food-borne diseases and chronic diseases. However, HIV/AIDS accounts for the major portion of CAREC's activities, supported in large part by international partners.

4.2 The Office of Caribbean Program Coordination

The vision of the OCPC is to be country focused, productive and committed while working together for a healthy Caribbean. The staff of the OCPC have defined its mission as follows: working with Caribbean governments and other partners to sustain and advance national, regional and global health and development.

4.2.1 Key areas of work

The OCPC's technical cooperation with the countries of the Eastern Caribbean countries and the FDAs is currently designed and implemented through individual country programs, each country having an average of three individual projects. Exceptions are the three UK Overseas Territories (UKOTs) and the FDAs, which each share a single program. Additionally there is a joint extra budgetary project to support Health Sector Reform in the independent OECS Member States, which is funded by the Government of France.

Twenty-two (22) projects are being implemented through the TC program for 2004-2005. They cover the following areas:

1. Health systems and services development, with a primary focus on health sector reform to ensure universal access to integrated, equitable and sustainable health systems, and the promotion of effective health input into social, economic, environmental, and development policies.
2. Family and community health, with emphasis on maternal and child health; the promotion of mental health; and healthy growth and development.
3. Disease prevention and control, addressing communicable diseases; non-communicable diseases; and healthy lifestyles and social environment.
4. Environmental health and disasters, addressing the promotion of safe physical environments; disaster preparedness, management and response; vector control; and food safety.
5. Health promotion and social communication, where these cross- cutting approaches are used to address the more specific program areas.

4.2.2 Financial resources

The financial resources available to support the OCPC's TC during the 2004-05 biennium amount to approximately US$9.3 million, of which $4.3 million are staff costs. Approximately 87 % of the resources come from the regular budget (See Table 2). There are additional in-kind contributions from Barbados, the host Government, and the French Government.

Table 2 Financial Resources Budgeted to OCPC for 2004-2005 inclusive of country allocations

Source	Amount in US$
Regular budget	8,050,229
Other sources	1,210,347
Total	**9,260,576**

These funds are programmed through the country program budgets and a subregional program budget. The latter is used to support the Eastern Caribbean and other subregional Caribbean programs. Traditionally, the relative share of the costs of maintaining the PAHO/WHO's technical staff dedicated to serving the Eastern Caribbean has not been included in the quantified resources allocated to each country budget. However, the staff have estimated that 70% of their working time is used in serving the needs of the Eastern Caribbean and the FDAs.

Except in the case of Barbados and the FDAs, other related costs to support TC, (e.g. for travel and the cost of locally recruited staff) are not allocated through the country budgets, but are taken from the subregional budgetary allocation. Over the past two biennia, an attempt was made to accommodate the increasing costs of general operating expenses (GOE), and an average contribution of 8% (range 3% to 15%) of the budget for each country was dedicated to the GOE of the OCPC.

Patterns of past expenditure of the country budgets reveal that training has traditionally consumed the largest chunk of expenditure. Resources expended in fellowships and training seminars accounted for between 24%-58% and 14%-33%, respectively, of the regular country budgets.

Table 3 Individual and multi-Country Budget Allocations 2004-2005 (US$000s)

Areas of Work	ANI	BAR	DOM	GRA	SAL	SAV	SCN	MULTI COUNTRY PROGRAM BUDGETS			
								ECA	FRG	CAR RB & TCC	CAREB
Communicable Diseases+	13.7 (9%)	2.7(0%)	17.1(7%)	5.5(4%)	14(9%)	3.2(2%)	12.6(8%)	8.1(3.2%)	23.4(11.9%)	25.8 (0.9%)	100.5(9.9%)
Chronic Diseases+	35(22%)	99(16%)	44.5(18%)	18.4(12%)	44.1(28%)		19(12%)	4.1(1.6%)		136.2(8.2%)*	42.8(4.2%)
Environmental Sanitation &Food Safety	14.2(9%)	51.9(8%)	14.4(6%)	18(12%)	5.9(4%)	5.9(4%)	8.5(6%)	16.2(6.4%)	24(12.3%)	40.2(2.5%)*	376(36.9%)
Child & Adolescent Health/ Gender Equity, women & Health	2.7(2%)		11.7(5%)	2.7(2%)	9.5(6%)	3.2(2%)		4.1(1.6%)		10.2(0.6%)	
Policy Making for Health & Development+	18.5(11%)	235(38%)	43.5(18%)	43.3(28%)	32.5(20%)	74.4(47)	48.6(36%)	140.8(30.6%)	49(25%)	42.8(1.6%)	248.4(24.3)
Human Resources for Health	62.6(39%)	60(10%)	82.6(34%)	52.5(33%)	42.8(27%)	58(37%)	60.6(38%)				27.4(2.7%)
Fellowships	*39.6(25%)*	*48(8%)*	*68(28%)*	*35(22%)*	*20.3(13%)*	*33(21%)*	*33.3(21%)*	79.3(31.1%)		4.5(0.3%)	
Emergency Preparedness		4.5(1%)	7.0(3%)								189.2(18.6%)
TCC to be defined										143.1(8.6%)*	
WHO's Core Presence in Countries	11.9(8%)	159.0(26%)	23.5(10%)	18.3(12%)	9.9(6%)	13.5(9%)	10.4(7%)	65.8(25.8%)	99.5(50.8%)	1269(90.8%)	35 (3.4%)
- GOE	4.5(3%)	75.8(12%)	8.1(3%)	5(3%)	4.5(3%)	4.1(3%)	4.5(3%)	40.1(15.2%)	18.5(9.4%)	327.5(23.4%)	
- Travel costs									58(29.6%)	364.3(26.1%)	
- Local Staff costs									23(11.7%)	542.5(38.8%)	
- Staff Development										20(1.4%)	
- Information systems & technology										10(0.7%)	
- Hospitality										5(0.4%)	
Total	**158.7**	**612.1**	**244.3**	**158.7**	**158.7**	**158.7**	**158.7**	**255.3**	**195.9**	**1,662**	**1,019.3**

+Communicable Diseases includes HIV/AIDS.
+Chronic Diseases includes Nutrition, Mental Health & Substance Abuse
+ Policy Making for Health & Development includes Organization and Management of Health Services; Health Financing & Social Protection; Knowledge Management and Information Technology.

Abbreviations

ANI: Antigua & Barbuda; BAR: Barbados; DOM: Dominica; GRA: Grenada; SAL: Saint Lucia; SAV: St Vincent & the Grenadines; SCN: St Kitts and Nevis; ECA: Anguilla, British Virgin Islands and Montserrat; FRG: French Departments in The Americas (French Guiana, Guadeloupe and Martinique); CAR: Multi-country projects cover all or some of the CPC countries as defined.
RB: Regular Budget; EB: Extra budgetary funds; TCC: Technical Cooperation between Countries; * TCC Regular Budget Funds.

4.2.3 Human resources

The OCPC staff members comprise:

- The Caribbean Program Coordinator (CPC), who is the credentialed PAHO/WHO Country Representative for all the countries covered by the Office; and who coordinates country programs for Barbados and the FDAs.
- The Program Officer for the Eastern Caribbean (POEC), who is responsible for the day-to-day coordination of the country programs, with the exception of Barbados and the FDAs,
- Twelve (12) International Staff[14] and 1 Public Health Expert assigned by the French Government
- Thirty-eight (38) locally recruited staff
    - 1 National Officer
    - 9 UN General Service (GS) positions
    - 1 National Professional
    - 14 CLT[15] positions
    - 1 bilingual secretary, and
    - 12 administrative support staff- including office assistants/secretaries, gardeners, drivers, messengers, domestic

The Government of Barbados contributes 12 of the personnel working in the office and the Government of France supports the bilingual secretary. The current organizational structure of the OCPC is attached at Annex 1.

4.2.4 OCPC partnerships

PAHO/WHO works with several partners in providing TC to improve the health of the people in the Eastern Caribbean. Some of these partners are mentioned below:

National governmental partners: PAHO's primary partner is the Ministry of Health/Department of Health. Other key governmental partners are the Ministries of Education, Agriculture, Social Improvement, Environment, and Community Development. More recently, partnerships with other sectors are being forged (e.g. the police, community colleges and other tertiary training institutions).

National non-governmental partners: While OCPC partners with some non-governmental organizations (NGOs) in providing in-country TC, others are beneficiaries of capacity building TC aimed at strengthening their health related roles. The Organization is currently working with nutrition councils, patient- and disease-related support groups, religious groups, and community groups. However, the mechanisms for collaboration with NGOs have not been systematized. As a result, expanding the Organization's partnerships with civil society organizations remains a challenge.

Subregional and International NGO partners: The OCPC collaborates with and supports the work of many CARICOM-wide professional bodies e.g. Regional Nursing Body (RNB); Caribbean Association of Medical Councils; and international NGOs such as the Red Cross all of which are represented on each island.

[15] Recruited under local conditions of employment.

Subregional intergovernmental and other partners: PAHO/WHO's two main partners within the subregion are the CARICOM and the OECS Secretariats and their health-related institutions, i.e., respectively CEHI and the PPS. The main health-related areas of work with CEHI are water management, waste management, chemicals management, occupational health, and climate and health. There are other health matters such as veterinary public health (zoonoses and food safety), in which there is collaboration between the OCPC and CARICOM institutions such as the CARICOM Regional Organization for Standards and Quality (CROSQ) and the Caribbean Regional Negotiating Machinery (CRNM). As previously noted, PAHO/WHO has a Memorandum of Understanding with CDERA.

The OCPC collaborates with the Caribbean Tourism Organization to promote tourism in health and health and tourism.

The OCPC has collaborated extensively with the OECS Secretariat in the area of environmental health management and with the PPS on drug utilization, the review of prescribing patterns, accessing anti-retroviral therapies, and other activities related to pharmaceutical management. Additionally, PAHO/WHO collaborates with the Caribbean Development Bank (CDB), which funded the Health and Poverty study for the CCH. The OCPC regularly contributes the health input to project assessments conducted by the CDB.

International development partners: The OCPC has established effective partnerships and collaboration with other UN agencies, regional organizations, and international development agencies, e.g. DFID, CIDA, Health Canada, and USAID. Partnerships are in the following areas:

- Health systems and services development, with DFID, USAID, and the Government of France
- Environment and disaster mitigation and response, with DFID, USAID, OFDA, CIDA, and the EC, including ECHO
- Disease prevention and control, with the Global Fund to fight AIDS, Tuberculosis, and Malaria
- Resource mobilization, with the Pan American Health and Education Foundation (PAHEF). This Foundation, housed in PAHO, Washington, D.C, has supported countries in resource mobilization from specific donors. The Foundation is currently managing a major radiological diagnostic project in one of the Eastern Caribbean countries.

The OCPC's UN and InterAmerican Systems partners in the social arena include the: FAO, ILO, IICA, UNAIDS, UNDP, UNFPA, UNICEF, and UNIFEM.

4.2.5 The coordinating role of the OCPC

The OCPC works closely with PAHO Washington, DC, PAHO specialized centres, and the country offices in the subregion to support activities in priority areas for health as identified by national governments of the Caribbean. The optimal level of planning and coordination between the OCPC and the other levels and parts of PAHO/WHO is yet to be achieved. This is so especially in light of the multi-tasking that needs to be done to serve the countries, and the limitations in capacity of the Member States themselves.

In the English-speaking Caribbean, PAHO/WHO has offices in The Bahamas, Belize, Guyana, Jamaica, and Trinidad and Tobago. There is also a PAHO/WHO office in Suriname, which, with the other offices and the OCPC, is involved in coordination of the planning of the Caribbean subregional programs. The PAHO/WHO Representative (PWR) Venezuela, whose office serves

The Netherlands Antilles, is also included. This coordination aims to identify commonalities, promote responsiveness to the changing needs of the countries, reduce duplication of activities, and maximize the Organization's technical resources for the Caribbean.

The mix of resources and organizational units in technical cooperation is often not seen by the countries as a timely and cohesive composite of the Organization. The success of the collaborative effort is challenged by the complexity of dealing with small populations in multiple countries. Communication needs to have adequate anticipation in terms of the time and resources required, so that agreed timetables can be adhered to.

4.3 Caribbean Food and Nutrition Institute (CFNI)

The CFNI's work with its Member States is programmed on a multi-country basis, which does not facilitate determination of the financial resources that have been allocated to its programs in the Eastern Caribbean countries.

CFNI has been involved in deliberations with the OCPC to develop its biennial work program, but has not been consistently involved in the development of the individual programs for the countries served by the OCPC, due to scheduling problems. Nevertheless, CFNI receives from the OCPC the nutrition-related TC requests from the countries and the country program budgets provide additional budgetary support for CFNI TC, as necessary.

The budget allocated to CFNI for technical cooperation in the biennium 2004-2005 totals US$2.99M, of which 85% represents PAHO/WHO regular budget funds, with the remainder from other sources. None of the CFNI's technical staff is based within the Eastern Caribbean, but they travel to each country on an as-needed basis. Overall, a strong operational partnership exists with CFNI in addressing nutrition-related issues and joint implementation has been successful in several areas, e.g. Childhood obesity, management of NCDs

4.4 CAREC

CAREC's work with its Member States is also programmed on a multi-country basis, which makes it difficult to determine the precise amounts of financial resources allocated to the Eastern Caribbean countries. Some difficulty has been experienced in the area of joint work with CAREC because of issues related to programming and coordination. However, there are ongoing efforts to achieve greater integration of technical cooperation, not only for the Eastern Caribbean countries, but also for the wider Caribbean.

CAREC's total operating budget for the biennium 2004-2005 is US$9.4M. The proportion originating from quota contributions and the PAHO/WHO regular budget is 16% ($1.5M) and resources from other sources total $7.8M (84%). Specific technical resources have been dedicated to some Eastern Caribbean countries, but this has been dependent on development partner support, especially for HIV/AIDS programs. UK DFID has provided an epidemiologist for the UKOTS and the French Technical Cooperation an epidemiologist for the OECS countries. These posts are not resident within the countries served, but are based in Trinidad & Tobago.

4.5 Other PAHO/WHO Centres

The Pan American Institute for Food Protection and Zoonoses (INPPAZ)

The OCPC has received support from INPPAZ in its TC with the Eastern Caribbean. INPPAZ has assisted in mobilizing regular internal resources of the Organization to strengthen basic components of food safety systems through projects on risk assessment, epidemiologic surveillance of food-borne diseases, and monitoring of microbiological and chemical contaminants. This collaboration has been extended to partnerships with CAREC, the Centers for Disease Control and Prevention (CDC) and WHO/HQ for improvement in specific surveillance activities such as the Global Salm-Surv (GSS) training program and the strengthening of inter-agency networking at the national, sub-regional, and regional levels.

Pan American Food-and-Mouth Disease Center (PANAFTOSA)

Collaboration with PANAFTOSA has been longstanding in matters related to the prevention and control of zoonoses such as rabies, brucellosis, tuberculosis, leptospirosis, and others, with special emphasis on coordination between health and agricultural sectors.

Latin American and Caribbean Center on Health Sciences Information (BIREME)

This centre in Brazil has provided TC for the development of the Virtual Health Library, in Barbados and the strengthening of the document centres including work with the UWI.

Pan American Center for Sanitary Engineering and Environmental Sciences (CEPIS)

There is a well-established relationship between CEPIS in, Peru and OCPC, and CEPIS provides special technical cooperation to the Eastern Caribbean countries as requested. There is a privileged relationship between CEPIS and CEHI on enhancing laboratory capacity and information systems

Latin American Center for Perinatology and Human Development (CLAP)

This centre in Uruguay has supported TC to enable the use of evidence based medicine in the area of perinatal health to improve the survival of infants and reduce further maternal mortality. The perinatal information system (SIP) developed by CLAP (2000) was customized for and is being adopted for use in the Caribbean.

Barbados Drug Service (BDS)

The Barbados Drug Service functions as the sole PAHO/WHO Collaborating Center in the Eastern Caribbean and has supported TC with other countries in the assessment and strengthening of pharmaceutical systems.

4. 6 PAHO/WHO's Strengths, Weaknesses, and Opportunities

The consultations with partners and national representatives indicate that PAHO is perceived as a reputable organization and a source of credible, independent objective perspectives on health matters. The Organization is valued by national agencies as the preferred source of technical cooperation in health. The support has been described as exemplary, especially on matters of policy formulation and advocacy.

The Organization offers multidisciplinary technical expertise, fosters international and inter-organizational linkages, and promotes inter-sectoral and inter-institutional actions. Feedback from

several partners has indicated the value placed on PAHO/WHO's role in information; its access to health-related experiences; its support for research; its ability to form effective partnerships; its support to subregional organizations and professional groups; and its promotion and support of technical cooperation among countries (TCC).

Weaknesses identified include the lack of a physical presence in all but one Eastern Caribbean country; administrative systems that are bureaucratic and relatively inflexible; limited technical and financial resources for follow-up; poor communication between the Regional Office and the field; inadequate assessment of the national technical capacity to implement BPB activities; and weak monitoring and evaluation of implementation and impact.

There are several opportunities to enhance and make more strategic PAHO/WHO's TC:

- The developments in telecommunication, with projected further reduction in costs, along with the increasing investment and liberalization in the information technology (IT) sector can lead to increasing efficiency of operation.
- Frameworks such as the Nassau Declaration and the implementation of the CSME along with the recommendations emanating from the CCHD report, as accepted by the CARICOM Heads of Government will enhance the role of health in development.
- The reorientation of cooperation from France related to the FDAs, and the Organization's re-thinking of its TC approach to the UKOTs and The Netherlands Antilles, can result in more effective partnerships.
- The Organization's managerial strategy of enhancing its country focus, including development of medium-term cooperation strategies, strengthening its country presence, decentralization, and building linkages with other development partners for the benefit of national health development.
- Implementation of the Regional Program Budget Policy, which has a specific subregional allocation that demands clearer definition of the subregional approach.

4.7 Key Issues and Challenges

PAHO/WHO's major challenges are:

- Definition of the most appropriate niche for its programs and interventions to add value in the countries.
- Promotion and advocacy to facilitate national and subregional acceptance of the more strategic and focused TC that is planned.
- Strengthening mechanisms to build alliances to work with the specialized Centres and with new partners in health for the benefit of the countries.
- Mobilization of resources to undertake interventions and assisting countries and institutions to effectively manage the resources that they mobilize.
- Devising and implementing strategies to mitigate the limited capacity and multi-tasking that exists in countries.
- Definition and implementation of managerial strategies and mechanisms to ensure integration of the strategic agenda into the Organization's planning, monitoring, and evaluation processes and instruments.
- Redefinition and improvement of managerial and administrative procedures at OCPC, CAREC, and CFNI to address the multiple levels of TC – national, Eastern Caribbean, and wider Caribbean, including strengthening of the coordinating role of OCPC, revision of

the organizational structures as necessary, and strengthening PAHO/WHO's country presence in the Eastern Caribbean.

- Strengthening infrastructure and achieving minimal operating security standards (MOSS) for OCPC, CAREC, and CFNI.

SECTION 5

5 WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

5.1 WHO Strategic Direction and Policies

WHO's broad strategic directions are set out in the General Programme of Work (GPW). The Tenth GPW is for the period 2002 to 2005, while the Eleventh GPW will cover the period 2006-2015. WHO remains committed to the vision that Health for All can become a reality in our lifetime and the 11th GPW will seek to address health as a centerpiece of the global agenda, as reflected in the Goals of the Millennium Declaration. The Organization will need to increase its foresight in order to address the rapidly changing and unpredictable future.

The directions for this period are:

- Enhancing global health security
- Accelerating progress towards achieving the Millennium Development Goals
- Responding to the increasing burden of non-communicable disease
- Promoting equity in health
- Ensuring accountability

Based on the strategic directions and identified priorities, six specific areas of work will be given greater emphasis and additional resources in order to achieve significantly improved expected results. These are: epidemic alert and response; making pregnancy safer; child and adolescent health; surveillance, prevention and management of chronic, non-communicable diseases; tobacco; and planning, resource coordination and oversight.

5.2 Regional Strategic Directions

PAHO promotes and coordinates efforts of countries in the Western Hemisphere to combat disease, lengthen life, and promote the physical, mental and social health of their people.

The Organization provides TC to 35 Member States in the Americas. It aims is to strengthen national and local health systems and improve the health of the peoples of the Americas, in collaboration with Ministries of Health, other government and international agencies, nongovernmental organizations, universities, social security agencies, community groups, and many others.

In support of the global thrusts, the Secretariat of the Regional Office of The Americas (PAHO/ AMRO), strives to be the catalyst for improvements in the conditions for health in the Americas. Its mission is:

> *To lead strategic and collaborative efforts among Member States and other partners to promote equity in health, to combat disease, and to improve the quality of and lengthen the lives of the peoples of the Americas.*

The following core values are reflected in the Secretariat's work, externally and internally:

- *Equity: Striving for fairness and justice by eliminating differences that are unnecessary and avoidable.*
- *Excellence: Achieving the highest quality in what it does.*

- *Solidarity: Promoting shared interests and responsibilities and collective efforts to achieve common goals.*
- *Respect: Embracing the dignity and diversity of individuals, groups and countries.*
- *Integrity: Assuring transparent, ethical and accountable performance.*

In order to address the changes in the environment for technical cooperation, the Secretariat has five (5) corporate objectives:

- Respond better to country needs
- Foster innovative modalities of TC
- Establish a Regional Forum
- Become a learning, knowledge-based Organization
- Enhance managerial practices.

In its Strategic Plan 2003-2007, PAHO/AMRO identifies the following 8 priority technical areas that are consistent with the WHO Strategic Directions formulated for the period 2002-2006:

1. *Prevention, control and reduction of communicable diseases*
2. *Prevention, control and reduction of non communicable diseases*
3. *Promotion of health lifestyles and social environments*
4. *Healthy growth and development*
5. *Promotion of safe physical environments*
6. *Disaster management*
7. *Ensuring universal access to integrated and sustainable health systems for individual and public health*
8. *Promotion of effective health input into social, economic, and developmental policies.*

These have all been identified as priorities for the Eastern Caribbean and PAHO/WHO will integrate and coordinate human, financial and other resources to support the countries in confronting the public health challenges ahead of them, addressing common priorities, while not neglecting national specificities. One of the ways in which the Organization proposes to enhance its country focus and strengthen its technical cooperation is through increased, direct interaction with countries. More of the Organization's resources (personnel) will be assigned to countries to facilitate a more timely and relevant response to the needs of the countries and their peoples thereby contributing to better health outcomes. Three inter-related principles of primary health care, health promotion and human rights underpin the technical cooperation, which aims to assist countries to meet the collective agreements to which they have committed themselves.

SECTION 6

6 WHO/PAHO'S STRATEGIC AGENDA: PRIORITIES JOINTLY AGREED FOR COOPERATION WITH THE EASTERN CARIBBEAN 2006-2009

The strategic agenda reflects choices relating to those aspects of the countries' total work for health development, which PAHO/WHO is best placed to support. It addresses the individual and collective needs of the countries and considers health and development challenges, and collective agreements for joint action, and the Organizational strategy for greater country focus.

6.1 Overview of the Strategic Directions

The strategic directions delineate the actions that the Organization should follow in order to make a difference in the health situation of the Eastern Caribbean. Based on the situation analysis, the WHO corporate strategy, the PAHO Strategic Plan 2003-2007, as well as global, regional and subregional mandates, the strategic directions (SD) are:

I. Enabling the health systems to ensure equitable access and improve quality of services.
II. Strengthening public health leadership.
III. Reducing preventable mortality, avoidable morbidity, and disability in priority health areas.
IV. Reducing vulnerability and threats to health arising from environmental and economic causes, including natural and other hazards.
V. Enabling optimal use of global, regional, and subregional collective agreements for national health development.

6.2 PAHO/WHO Functions in the Eastern Caribbean

The following functions, based on the WHO generic country functions, have been identified for PAHO/WHO in the Eastern Caribbean:

1. Building national and subregional capacity; catalysing adoption and adaptation of technical strategies; seeding large-scale implementation.
2. Providing specific policy advice; serving as broker; influencing policy, action and spending/investment in health.
3. Mobilizing resources and forging strategic partnerships.
4. Supporting research and development; monitoring health performance.
5. Information and knowledge sharing; providing generic policy options; standards; advocacy.
6. Supporting long-term implementation.

6.3 Strategic Directions

Strategic Direction I: Enabling the health systems to ensure equitable access and improve quality of services

This Strategic Direction is the most critical. Its emphasis will be on the review, design, development, and provision of support for appropriate, efficient, and effective interventions to meet the particular needs of the Eastern Caribbean in improving the performance of the health

systems and strengthening the Ministries of Health. Action will be taken to ensure a systems approach and sustainability of the various strategies and interventions.

Components of the Strategic Direction

- **Health planning –** PAHO/WHO will support capacity building in strategic planning, implementation, monitoring and evaluation of sectoral projects aimed at achieving efficiency, effectiveness, improved quality and sustainability of national health systems.
- **Health financing mechanisms** – PAHO/WHO will support decision-making regarding collective options for, and implementation of programs for universal access to quality care and to improve the allocative efficiencies of Eastern Caribbean countries.
- **Health Information Systems** – PAHO/WHO will support the development and implementation of plans to strengthen national health information systems.
- **Steering role of the Ministry of Health** – PAHO/WHO will continue to stress improvements in the performance of the EPHFs, with special focus on the following areas:
  - Human resources development, planning and management, with particular attention to renewal, staff performance management, retention, and migration;
  - Public health research to inform policy-making and to guide the development of interventions and evaluate their impact;
  - Quality assurance and systems performance management to improve the technical efficiency of the health sector;
  - Development and management of information systems to improve evidence based decision-making and management.
- **Equitable access to quality health services –** PAHO/WHO will support the identification and targeting of health inequities and inclusion of vulnerable groups to ensure equitable access to quality health services.

PAHO/WHO Functions

Priority actions will be:

- *Information and knowledge sharing; providing generic policy options; standards; advocacy.*
- *Building national and sub-regional capacity; catalysing adoption and adaptation of technical strategies; seeding large-scale implementation.*
- *Supporting research and development; monitoring health sector performance*.

Critical success indicators

1. Support provided for the development of national strategic health planning processes, to include intersectoral interdisciplinary collaboration as evidenced in up to date National Strategic Health Plans (NSHP) in 90% of countries by end 2008.
2. Development of appropriate health financing mechanisms and models supported at the national and sub-regional levels and shared with national counterparts by mid 2007.
3. Strengthened national health information systems evidenced through the timely production of information requirements and reports at the national level, increased capacity for use of information and evidence in decision-making at all levels
4. Support provided to disaggregate core data sets and include social and economic indicators as evidenced in the situation analyses produced by end 2007

5. Interventions aimed at strengthening of EPHF explicitly integrated to all NSHP as documented in the reassessment of EPHF conducted by end of the period in at least 70% of the countries.
6. Resources mobilised by end 2006 and information available by end 2007 to provide evidence for decision-making in monitoring the success of policy options for managed migration
7. Interface with international financial Institutions supporting health sector reform, from a technical perspective as indicated in reports of meetings and requests for technical inputs.

Strategic Direction II: Strengthening public health leadership

This Strategic Direction will focus on programs that build national capacity to promote the health and development agenda. It is intended to contribute to well-being and a reduction of health inequities through the development and implementation of healthy public policies, and a reorientation of the approaches to health delivery. It will place particular emphasis on the needs of vulnerable groups.

Components of the Strategic Direction

- **Building competencies for public health leadership –** The input of PAHO/WHO will focus on the identification, assessment, and training of potential leaders within and outside of the health sector and provision of assistance in the development of management programs that could be used for capacity building. Emphasis will be given to the determinants for health and health as a social and economic development issue, investment in health, and health system governance.
- **Public health policy, legislation, regulation and registration** – PAHO/WHO will develop, in collaboration with countries, model policies and legal instruments and support updating and implementation of structures for their enforcement.
- **Promoting intersectoral action to attain health goals –** PAHO/WHO will foster the use of empirical evidence and research for promotion of health and well being, including analysis of determinants of health, drafting public policies that contribute to health, and developing strategies for a sustained intersectoral approach.
- **Communication and advocacy** – PAHO/WHO will support the increased use of information, communication, and advocacy for health, working directly with the countries and their media to put health on the public agenda and promote social participation. Emphasis will be given to the sourcing and marketing of appropriate information packages for diverse audiences.
- **Reduction of health inequities –** PAHO/WHO will give emphasis to strengthening the analysis of inequities (including gender-related perspectives) and the role of social determinants of health to provide evidence for advocacy and intervention as part of the public health program.

PAHO/WHO Functions

Priority actions will be:

- *Building national and regional capacity; catalysing adoption and adaptation of technical strategies; seeding large-scale implementation.*

- *Providing specific policy advice; serving as broker; influencing policy action, and spending/investment in health.*
- *Supporting research and development; monitoring health sector performance.*
- *Sharing information and knowledge; providing generic policy options; standards and advocacy.*

Critical success indicators

1. Assessment of the gaps in competencies for public health conducted by June 2007 and design and promotion of training packages aimed at potential leaders in public health by end of 2008.
2. Evaluation of the policy and legal framework documented by end 2006 and plan of action for updating of draft new instruments and enforcement strategies designed by end 2007.
3. Identification and promotion of best practices and development of models to enhance intersectoral and social participation in health documented for Eastern Caribbean and shared by end 2009.
4. Capacity building for the development and implementation of IEC products and models for various audiences as evidenced by inventory of local products in use by end of 2007.
5. Model exercises and training materials to strengthen the capacity of the public health workforce to utilize the analysis of inequities and social determinants of health in planning and implementing health interventions developed and used for training in all countries by end 2009.

Strategic Direction III: Reducing preventable mortality, avoidable morbidity, and disability in priority health areas

This Strategic Direction will concentrate on enhancing the use of epidemiological and other information for policy development and appropriate interventions oriented to prevention, with particular reference to the primary care level. Clear reference to gender issues in health will be included in each area.

Components of the Strategic Direction

- **Diabetes, cardiovascular diseases and cancer.** PAHO/WHO will focus attention on the implementation of CARLI[16] and provision of support to national health programs for prevention and control of non-communicable diseases. Epidemiological surveillance of the diseases and risk factors, as well as the evaluation of programs will be addressed.
- **Nutritional disorders, including obesity and deficiencies.** Through CFNI, the focus will be on epidemiological surveillance, research and program interventions.
- **Mental disorders and rehabilitation.** Emphasis will be given to the epidemiological surveillance of the disorders, policy and legislation aspects, monitoring, evaluation and research, suicide prevention as well as advocacy for the reduction of stigma and discrimination.
- **HIV/AIDS and other sexually transmitted infections (STI).** Through CAREC and OCPC, priority will be given to supporting the coordination, monitoring and evaluation of the national programs for epidemiological surveillance, management including diagnosis, care and treatment, and participation on the HIV/AIDS Theme groups and coordinating mechanisms. OCPC will support the implementation of the WHO 3x5 initiative.

[16] **Car**ibbean **Li**festyle **I**ntervention program, an initiative to plan, implement, and evaluate programs for non-communicable disease risk factors, throughout the health services.

- **Vaccine preventable diseases.** Through the regional program on EPI based at CAREC, priority will be given to planning, monitoring and evaluation of programs, epidemiological surveillance and technical guidance. PAHO/WHO will continue to procure vaccines for countries through the Revolving Fund.
- **Road traffic injuries.** PAHO/WHO will give priority to strengthening capacity to implement integrated responses, including epidemiological surveillance, revised legislation and an intersectoral approach to prevention at national level.
- **Violence, suicides and homicides.** Support to address injuries due to interpersonal, domestic and strangers' violence will be prioritized. Main attention will be given to epidemiological surveillance, and education and training especially at the school and at the community levels. An inter-sectoral and inter-agency approach will be emphasized.
- **Child health.** Priority will be given to the actions which improve childhood development, specifically school health and dental health, as well as actions which prevent perinatal mortality.
- **Youth health.** Actions to improve issues related to the physical, mental and social well being and the development of youth, including sexual and reproductive health will be prioritized.
- **Health and aging**. Priority actions will focus on policy development and appropriate service delivery for older persons.

PAHO/WHO Functions

Priority actions will be:

- *Information and knowledge sharing; providing generic policy options; standards; advocacy.*
- *Building national and sub regional capacity; catalyzing adoption and adaptation of technical strategies; seeding large scale implementation*
- *Supporting research and development; monitoring health sector performance*
- *Providing specific policy advice; serving as broker; influencing policy, action and spending/investment in health.*

Critical success indicators

1. Model policies to address non-communicable diseases and mental disorders and assistance to update national policies and plans supported in 90% of countries by the end of 2007
2. Promotion and preparation of a model questions for inclusion as health component in national Surveys of Living Conditions supported by end 2007.
3. Resources to conduct at least one survey of behavioral risk factors supported
4. Production of “popular version” of Caribbean health situation analysis and disease-specific situation analyses, e.g. EPI, HIV/AIDS by end 2007.
5. Collation and dissemination of lessons learned regarding successful interventions in at least one priority health area documented by end 2009.

Strategic Direction IV: Reducing vulnerability and threats to health arising from environmental and economic causes, including natural and other hazards

This Strategic Direction will focus on reducing the impact of environmental conditions that threaten the health and well-being of the public.

Components of the Strategic Direction

- **Disaster management.** PAHO/WHO will continue to place emphasis on reducing the impact of natural hazards/disasters, focusing on mitigation, and risk reduction in health facilities. A priority will be to assist countries in strengthening their plans and programs to make health facilities more secure, and the Organization will continue its critical role in coordinating the international health response and surveillance post-disaster.
- **Basic sanitation and environmental management.** PAHO/WHO will intensify collaboration with the CEHI to build national capacity for implementation of environmental risk assessment and for an effective response to environmental health challenges related to basic water and environmental sanitation.
- **Dengue.** PAHO/WHO will give attention to the epidemiological surveillance, the development and introduction of treatment protocols, external evaluation of the vector management programs, and public health research.
- **Food- and water-borne diseases.** PAHO/WHO will support interagency and inter-sectoral collaboration, prioritizing actions in food safety surveillance/HACCP[17], legislation and regulation enforcement.
- **Environmental protection**. PAHO/WHO will work with countries, and sub-regional and international institutions to strengthen national capacity in environmental health management; and the development of model policies, guidelines, and regulations that address common environmental health issues such as trade, port health, and occupational health etc.
- **International Health Regulations implementation**. PAHO/WHO will support national capacity building for the implementation of the IHR and responding to emerging diseases.

PAHO/WHO Functions

Priority actions will be:

- *Building national and sub regional capacity; catalyzing adoption and adaptation of technical strategies; seeding large scale implementation.*
- *Sharing information and knowledge; providing generic policy options, standards and advocacy.*
- *Mobilizing resources and forging strategic partnerships*
- *Providing specific policy advice; serving as broker; influencing policy, action and spending/investment in health.*

Critical success indicators

1. Negotiation and signing of a Memorandum of Understanding with CEHI by end of first quarter 2006 and, evaluation of the implementation of the MOU conducted by mid 2009.
2. Environmental impact assessment model developed and the application in a third of the Eastern Caribbean countries supported by end of 2009.
3. Relevant models and guidelines for updating environmental health policies, and procedures developed by the end of 2008.
4. Plan of action to assist with IHR implementation developed in collaboration with countries and other interested regional institutions by end of 2006.

[17] Hazard Analysis Critical Control Point

Strategic Direction V: Enabling optimal use of global, regional, and subregional collective agreements for national health development.

This Strategic Direction will focus on the contribution that health can make to the national development process and will support translation of collective agreements into action at the country level.

Components of the Strategic Direction

- **Stakeholder involvement**. PAHO/WHO will focus on the development of procedures for effective stakeholder consultations and mobilization of non-health partners.
- **Building alliances and partnerships**. PAHO/WHO will give priority to the networking with partners in the UN, OAS and other intergovernmental systems to promote and foster integrated and coordinated approaches for national health development.
- **Analysis of international agreements**. PAHO/WHO will monitor and analyze international development agreements and provide briefings on their implications for the relevant sectors in the countries. Demonstration of the links among the agreements will be important to allow the development of integrated policies and actions reflecting the international agreements and harmonization of national efforts for monitoring.
- **Analysis of options for investment in health**. PAHO/WHO will explore financial and technical resource mobilization opportunities.
- **International cooperation in health**. PAHO/WHO will support the development of national mechanisms to coordinate and negotiate international cooperation and resources for health. There will also be support for project design and management as appropriate for the national situation.

PAHO/WHO Functions

Priority actions will be:

- *Building national and subregional capacity; catalyzing adoption and adaptation of technical strategies; seeding large-scale implementation.*
- *Providing specific policy advice; serving as broker; influencing policy, action and spending/investment in health.*
- *Mobilizing resources and forging strategic partnerships*
- *Supporting research and development; monitoring health performance*
- *Information and knowledge sharing; providing generic policy options; advocacy.*

Critical success indicators

1. Enhanced collaboration between MOH and Ministry of Foreign Affairs.
2. Designated PAHO/WHO country program officers to coordinate technical cooperation in countries have received training in effective stakeholder networking by end 2007.
3. Strategy for mobilization of additional resources to support TC in IHR, NCD and MH defined by end of 2006.
4. Monitoring and evaluation of PAHO/WHO's support to national health development conducted in collaboration with national counterparts and other stakeholders by end of 2007.

SECTION 7

7 IMPLEMENTING THE ECCS: IMPLICATIONS FOR PAHO/WHO SECRETARIATS

This section describes the PAHO's capacity to implement the strategic agenda and the implications for the OCPC in terms of operational and organizational adjustments issues capacities including infrastructure, functions and resources. The implications for the rest of the Organization will be examined in terms of the support needed from and the interactions with the three levels, the WHO headquarters, AMRO/PAHO secretariat and the sub-regional centers.

7.1 Developing the capacity at the OCPC to implement the ECCS

The implementation of the ECCS is expected to begin at the start of 2006-07 biennium. Providing a country-focused approach for TC with the Eastern Caribbean from a physical presence based in one of the constituents is the driving force and a major challenge of this strategic agenda. The staff at the OCPC conceptualized the following definition of *enhanced PAHO/WHO country presence*: "the strengthening of the PAHO/WHO technical cooperation through increased direct interaction with countries. The aim is to intensify the response to the needs of the countries and their peoples thereby contributing to better health outcomes". The Ministers of Health of the Eastern Caribbean endorsed this definition[18]. In order to increase this direct interaction with countries, the OCPC will need to make immediate changes to the human resources and proposes establishing a dedicated (country) team to implement the ECCS in the Eastern Caribbean.

Immediate adjustments/ reprofiling the country team

The ECCS team will comprise a PAHO/WHO Representative for the Eastern Caribbean (PWR-EC) and a core technical team of Technical Advisors (ECTT) and 6 Country Program Officers (CPOs), the latter being based in the countries they serve. While the CPO for Barbados will serve Barbados on a full time basis, the CPOs for all other islands will be shared as follows:

- the CPO serving the UKOTS will be based in Anguilla
- the CPO serving the FDAs will be based in Martinique
- the CPO serving both Antigua & Barbuda and St Kitts & Nevis will be based in Antigua & Barbuda
- the CPO serving both Dominica and Saint Lucia will be based in Dominica
- the CPO serving both Grenada and St Vincent & the Grenadines will be based in Grenada.

The CPO will be a new category of personnel recruited and managed by OCPC to provide direct interface with countries. Ministers of Health have endorsed the proposal for shared CPOs and agreed on the importance of having (within the Ministry of Health in each country), a designated National Focal Point (NFP) to support the collaboration and coordination needed with the CPO to implement the ECCS. A job description for the CPO has been drawn up which outlines the skills needed such as generalist public health skills in epidemiology, health systems development (in

[18] Meeting of Ministers with PAHO/WHO Director and staff of OCPC held 13th April 2005.

particular the health planning aspects) and project management. A suggested job description for the NFPs was agreed with Ministers of Health. The new organizational structure of the OCPC is attached as Annex 2.

The functional areas to be addressed by the ECCS, have defined the competencies and skills mix of the ECTT, to comprise health systems development; health policy and services; epidemiology and health situation analysis; non-communicable disease and mental health; family health; environmental health, disaster mitigation and response; and HIV/AIDS. These skills will be available through 5 technical advisors based at the OCPC; while it is proposed that the technical capacity of CEHI be strengthened to provide the basic sanitation and environmental management, disaster mitigation and response. Short term expertise in HIV/AIDS will be supported at OCPC through the WHO 3 x 5 initiative.

The implementation of the ECCS will be on a multi-country basis, which will demand great efforts in coordination. The CPOs will need extensive training in, and orientation to the PAHO/WHO approaches and instruments. They will represent PAHO/WHO on the selection committees for fellowship awards. The CPOs will need close supervision initially, and with the remainder of the ECCS team based at OCPC, efficient communications with the OCPC and their respective countries will be essential. Reviews and assessments of the implementation will be at two levels initially at the country level followed by a multi-country review on a six monthly basis.

Financing the adjustments

With the exception of Barbados, the 2006-07 budgets for the Eastern Caribbean will benefit from an increase following the approval by the PAHO/WHO Directing Council (September 2004) of the revised regional budget policy to guide more equitable allocation of the organisation's resources. The cost of the CPOs (salary and travel costs) will be absorbed within the ceilings of each country's budget, assuming the projected budget level is maintained. The contribution of each country budget to the GOE of the OCPC will be increased (with the exception of Barbados) to 14% of the country budget allocation. The difficulty of supporting the post costs for the ECCS team in the country budgets was noted and it is recommended that, in the medium term, these costs remain as a component of the CAR subregional budget.

Administrative/Managerial support

The Eastern Caribbean country team will share physical space with the CAR subregional program, this will call for some physical restructuring of the OCPC; the details and cost of which are yet to be determined. The team will also share administrative arrangements of the OCPC, led by an Administrative Officer under the supervision of the CPC (See proposed organogram), which will provide on a shared basis registry, documentation and library services, general housekeeping maintenance and security services, corporate information systems, financial and other office management systems and personnel. While these arrangements will be made within the current budgets available, all vacant posts will need to be filled and the relationships and supporting procedures to be well defined. The proposal to enhance efficiency includes one new post of Program Assistant and realignment of the posts of Personnel Officer and General Services Supervisor.

Policy dimensions

The ECCS demands changes to existing basic agreements with countries and the introduction of agreements where none currently exist. The proposal to support CEHI to provide expertise in basic environmental sanitation and some disaster response needs to be guided by a Memorandum of Understanding. The relationships of the OCPO to the two subregional centers may be changed following the review exercise. Credentialing articles for the PWR-EC and the CPC in the subregional role will have to be developed. These will need close collaboration between the OCPC at the levels of the PWR-EC, CPC and the regional office.

7.2 Implication for the collaboration with the sub-regional centers

Reprofiling of the subregional team(s)

One of the objectives of PAHO's revised regional budget policy is to provide greater definition of and support to subregional programming. The regional budget policy considers the expertise at CAREC, CFNI and the OCPC as components of the organisation's subregional response (program) and would seek more cohesion in the implementation of the subregional response (program). Currently all three components are subject to an internal review and the resultant recommendations will inform the future function, roles and relationships. In the interim, for the OCPC, the definition of the ECCS has demanded a separation of the subregional program of work and a reprofiling of the team. The OCPC proposal for the team to implement this subregional program comprises the CPC and technical advisors with the following competencies: communicable diseases/ risk reduction; media communication and advocacy; human resources for health; health information systems; environmental protection; veterinary public health; and disaster mitigation and response. Expertise in hospital management will continue to be accessed from a base in the Bahamas office.

Until further determination of roles, CAREC is expected to provide TC in communicable diseases, including HIV/AIDS; laboratory and epidemiology support; while CFNI will provide nutrition related TC. The OCPC team will provide streamlined communication between the regional level in respect of areas of TC /collaboration outside of the ECCS work plan; advocate for adequate resources (technical /financial) for a specific (CARICOM) subregional agenda; and as is done for other country offices, provide TC support in the Eastern Caribbean in the absence of that expertise in the ECTT e.g. veterinary public health. A collaborative approach to TC will also include the maintenance of close working arrangements with other partners outside of PAHO/WHO.

7.3 Implications for the AMRO/PAHO and WHO HQ

Specifically the Regional Office will provide support in terms of completing agreements with countries and CEHI; approving the post descriptions and refining the shared administrative arrangements. The Regional Office also has access to resources in change management which would minimize the stress which would normally accompany changes in the work environment as major as this separation of teams. There are some outstanding internal administrative and personnel issues which need to be addressed and settled prior to the implementation of the ECCS.

The assistance of the Regional Office will be needed for the information management and communication needs of the CPO in order to support enhanced TC.

The AMPES/OMIS system which currently comprises 8 BPB units for the Eastern Caribbean countries will need to be adapted to facilitate a multi-country approach to TC, while concurrently having the ability to report data about expenditure and implementation on individual country budgets in a shared arrangement. It is hoped that this will be possible for the start of 2006-07 BPB.

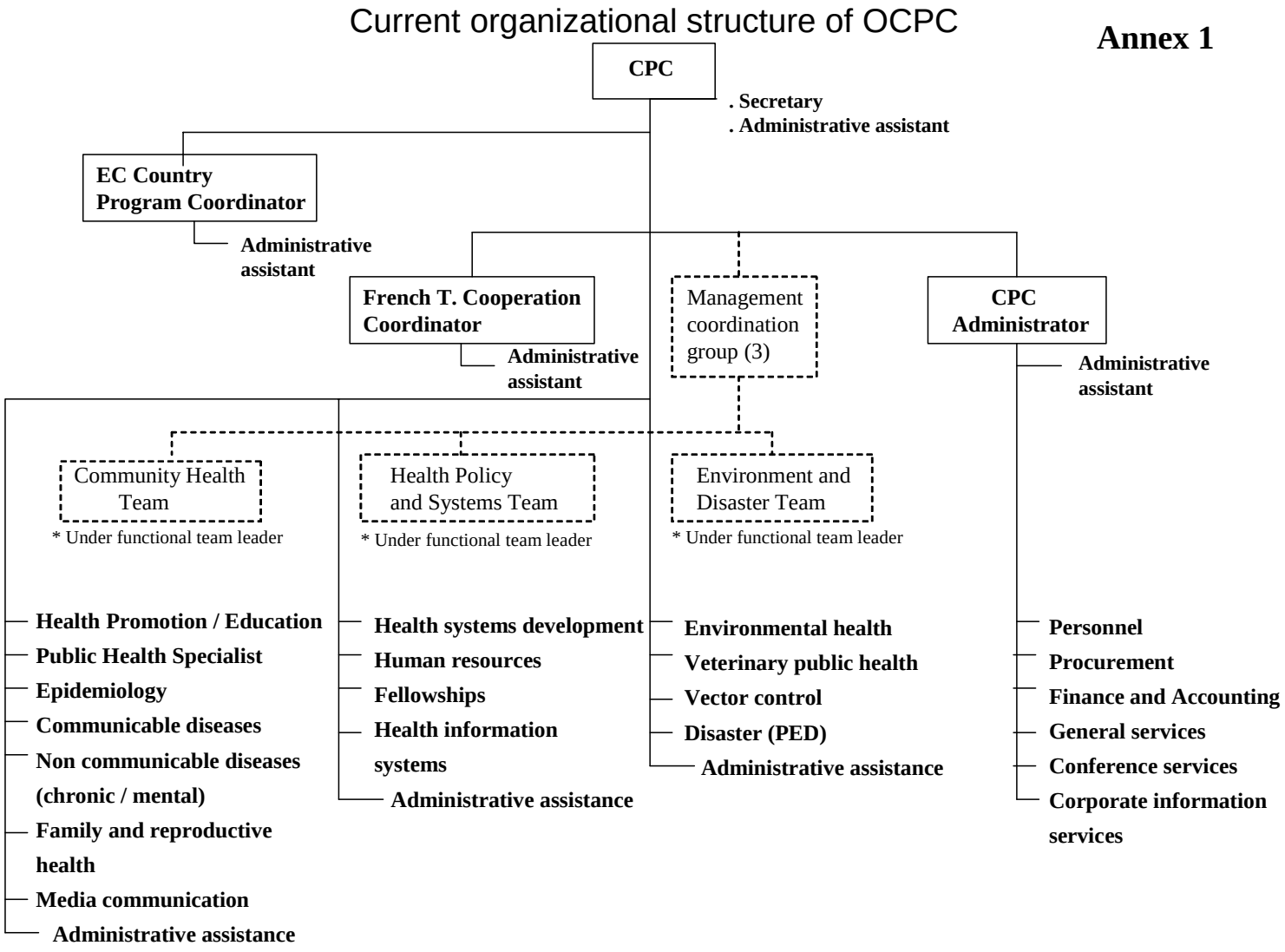
Ultimately the approval of the arrangements, budgets, policies and technical support must be obtained from the Regional Office. The ECCS workplan should allow a closer nexus with the regional program leading to strengthened /streamlined communication in support of the country programs. At the technical level, the regional and/ global offices are expected to provide direct extra support (technical/financial) where the skills base are absent/insufficient at the field level due to diseconomies of scale to address some issues such as: health financing; investment in health; updating legislation; international health regulations; response to emerging global threats like pandemic 'flu; trade and health; health protection and sustainable development; climate and health; HIV/AIDS; resource mobilization and building partnerships for health investment.

The physical changes needed to facilitate the ECCS proposals, need the support of the regional and global offices. Similar support is also needed in respect of the mandatory security recommendations for MOSS compliance.

Bibliography

1. A Portrait of Adolescent Health in the Caribbean: Pan American Health Organization, 2000
2. Area of Health Analysis and Information Systems, Health Situation in the Americas, Basic Indicators Brochure 2003. Pan America Health Organization.
3. Caribbean Development Bank, Annual Report 2003
4. Caribbean Epidemiology Center (CAREC)
5. Caribbean Food and Nutrition Institute (CFNI)
6. Country presentations at the Family Health Coordinators Biennial Meeting, Curacao, November 2003
7. Eastern Caribbean Central Bank (ECCB)
8. Health Conditions in the Caribbean, Pan American Health Organization, 1997
9. Human Development Report, United Nations Development Program, 2004
10. OECS Human Development Report 2002
11. Small Islands, Big Issues: Global Conference on the Sustainable Development of Small Island Developing States, Bridgetown, Barbados, 25 April - 6 May 1994
12. Sub Regional Common Assessment of Barbados and the OECS, UN Development System for the Eastern Caribbean, January 2002
13. The SIDS Program of Action, Agenda Twenty One, The Road to Johannesburg, United Nations Economic Commission for Latin America and the Caribbean, 2002
14. World Bank, (2001). The Health of Women in Latin America and the Caribbean, Levine et al,
15. World Bank (2005). "A time to Choose: Caribbean Development in the 21st Century", Report No. 31735-LAC, Washington DC.
16. World Bank (2005). "Organization of Eastern Caribbean States: Towards a New Agenda for Growth", Report 31863-LAC, Washington DC

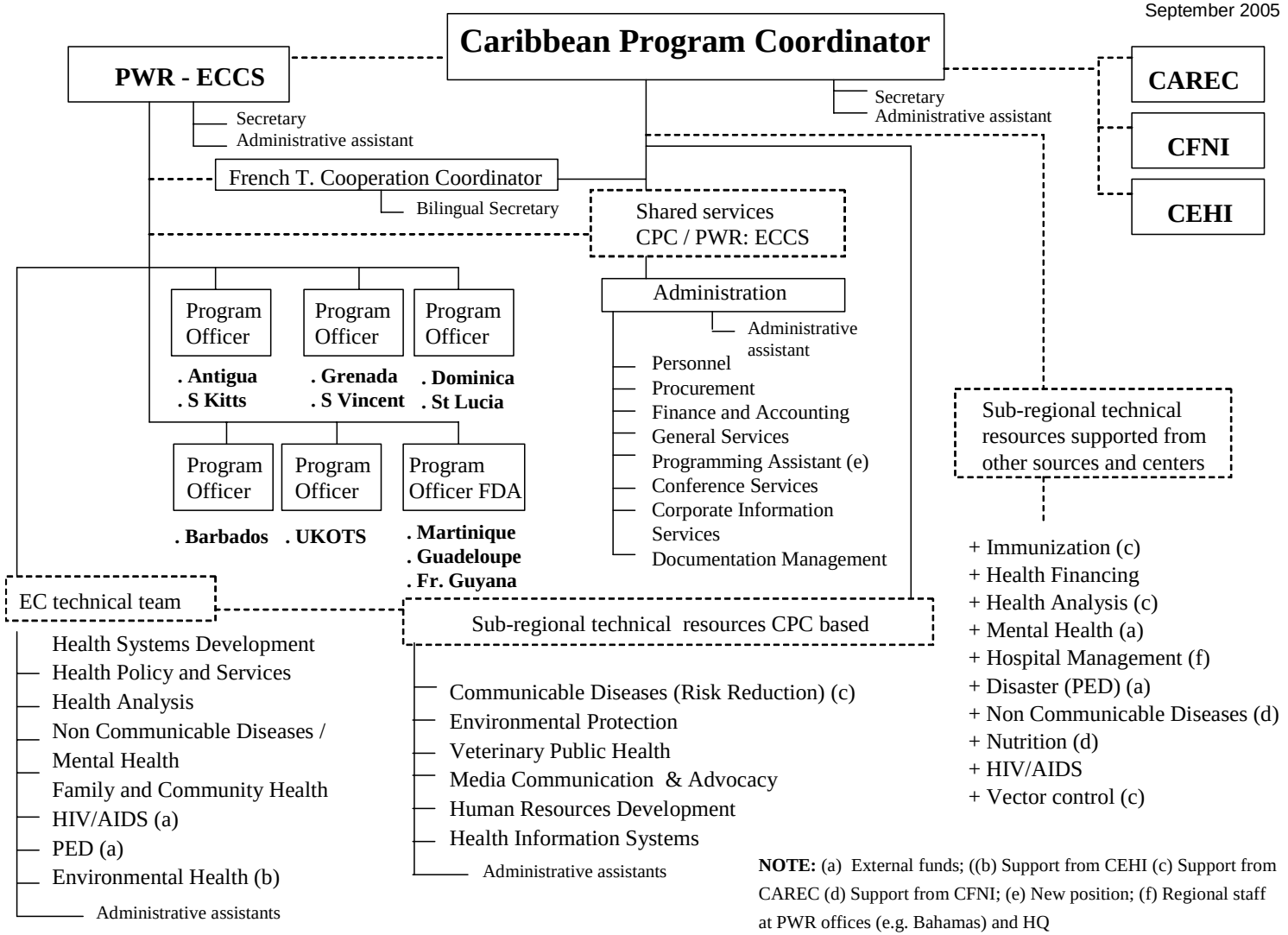
Annex 1


Current organizational structure of OCPC
CPC
. Secretary
. Administrative assistant
EC Country Program Coordinator
Administrative assistant
French T. Cooperation Coordinator
Administrative assistant
Management coordination group (3)
CPC Administrator
Administrative assistant
Community Health Team
* Under functional team leader
Health Policy and Systems Team
* Under functional team leader
Environment and Disaster Team
* Under functional team leader
Health Promotion / Education
Public Health Specialist
Epidemiology
Communicable diseases
Non communicable diseases (chronic / mental)
Family and reproductive health
Media communication
Administrative assistance
Health systems development
Human resources
Fellowships
Health information systems
Administrative assistance
Environmental health
Veterinary public health
Vector control
Disaster (PED)
Administrative assistance
Personnel
Procurement
Finance and Accounting
General services
Conference services
Corporate information services

CPC proposed functional arrangements to support ECCS 2006-2007

Annex 2

September 2005



NOTE: (a) External funds; ((b) Support from CEHI (c) Support from CAREC (d) Support from CFNI; (e) New position; (f) Regional staff at PWR offices (e.g. Bahamas) and HQ