

A
NEW VISION
FOR
CARIBBEAN HEALTH

CARIBBEAN COOPERATION IN HEALTH PHASE II

**A
NEW VISION
FOR
CARIBBEAN HEALTH**

CCH SECRETARIAT



May 1999

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INTRODUCTION

Countries in the Caribbean share a similar history in the development of their health systems. They have often cooperated to deal with many of the challenges to health which they have had to confront. However, there is need for even greater collaboration and cooperation among the countries of the Region, given the increasing threats to the economies of these countries and the presence of newly emerging and re-emerging problems in the health sector. Efforts, therefore, have to be focused not only on the fight against disease, but on promoting healthy lifestyles, protecting the environment and increasing the capacity of the health sector to provide quality services and value for money.

The concept of the Caribbean Cooperation in Health (CCH) Initiative was introduced in 1984 at a meeting of the former CARICOM Conference of Ministers responsible for Health (CMH). The CMH saw this as a mechanism for health development through increasing collaboration and promoting technical cooperation among the countries in the Caribbean. The Initiative, in which seven (7) priority health areas were identified, was adopted by the CMH and approved by the Heads of Government in 1986. An evaluation of the initiative (1992-94), found that the priorities identified ensured that activities were focused in areas critical to improving health status in the region. Overall it was established that the initiative was beneficial to Caribbean countries.

In 1996, the CMH mandated a re-definition and re-formulation of the CCH initiative for the period 1997-2001. A wide cross section of national and regional professionals in health and planning from 19 member countries met in Port-of-Spain in July 1997 to re-program the initiative. The meeting selected eight (8) health priority areas, recommended strategies for implementation and identified some areas of common concern which required joint action. The recommendations of that meeting, which were approved by CMH in 1997, form the basis of this current phase of the initiative.

VISION FOR HEALTH

The initiative promotes health as that state of well being which goes beyond the absence of disease and includes the mental, spiritual and emotional health. In addition, it recognizes that the factors affecting health go far beyond the ambit of the health sector and encompasses the physical and social environment, individual's genetic makeup and lifestyle. Thus interventions for improved health must include education for healthy life choices and skills, food security, satisfactory housing, access to potable water supplies and proper disposal of waste.

In the Caribbean the debate on health will be expanded from health sector reform to health reform in which greater focus is placed on the intrinsic value of health as a resource for sustainable human development. It is one of the four (4) pillars of the people-centered development implicit in the CARICOM Charter for Civil Society, along with

education, wealth and the freedoms associated with democracy. Further as the Caribbean seeks to maximize tourism as one of, if not the key engine for economic development, the health sector will strengthen the partnership with the tourism and hospitality sectors and play a significant role in making the Caribbean a safe destination.

CCH seeks therefore to contribute to the vision that

“In the new millenium, Caribbean people will be happier, healthier and more productive, each respected for his/her individuality and creativity and living more harmoniously within cleaner and greener environments.”

WHAT IS THE NEW CCH?

The CCH is a mechanism through which Member States of the Caribbean Community

- Collectively focus action and resources over a given period towards the achievement of agreed objectives in priority health areas of common concern.
- Identify the approaches and activities for joint action and/or Technical Cooperation among Countries (TCC) in support of capacity-building for the achievement of the objectives.

The purpose of CCH is to encourage countries to develop and implement programs which focus action and resources on priority health issues of common concern to the Caribbean community, with particular consideration given to vulnerable groups. In other words,

“Caribbean countries helping themselves and one another to improve opportunities and systems for health in the Region.”

GOAL OF CCH

The goal of CCH is

To improve and sustain the health of the people of the Caribbean:
Adding Years to Life and Life to Years for All.

This goal reflects the Caribbean’s commitment to increasing equity in, and for, health within and among countries.

PARTICIPATING COUNTRIES

The countries participating in the initiative are Antigua and Barbuda, Anguilla, The Bahamas, Barbados, Belize, Bermuda, the British Virgin Islands, the Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, Saint Lucia, St. Vincent and the Grenadines, St. Kitts and Nevis, Suriname, Trinidad and Tobago and the Turks and Caicos Islands. The integration movement has necessitated the re-definition of the Caribbean to include countries other than the English-speaking territories. Therefore selected countries will be invited to participate in specific projects of CCH-II as appropriate.

BENEFITS OF THE NEW CCH INITIATIVE

Countries participating in the initiative will:

- Access, mobilise and optimise national and external resources to address selected health issues.
- Jointly identify and implement, appropriate and sustainable projects and programs in collaboration with regional institutions.
- Share expertise and experience with other Caribbean countries especially in addressing similar problems. Professionals in any one country will be less isolated and better able to develop partnerships with colleagues in neighbouring countries.
- Create mechanisms for sustained involvement of relevant social partners.
- Reduce costs by pooling ideas and resources so that countries will benefit from economies of scale.
- Contribute to regional integration in a meaningful way in the health sector.

REGIONAL HEALTH PRIORITY AREAS

- 1 HEALTH SYSTEMS DEVELOPMENT**
- 2 HUMAN RESOURCE DEVELOPMENT**
- 3 FAMILY HEALTH**
- 4 FOOD AND NUTRITION**
- 5 CHRONIC NON-COMMUNICABLE DISEASES**
- 6 COMMUNICABLE DISEASES**
- 7 MENTAL HEALTH**
- 8 ENVIRONMENTAL HEALTH**

PLANNING PROCESS

Regional and national consultations were held to identify the priority issues related to each of the areas and to develop goals, objectives and indicators for resolving them over the next five (5) years. The goal indicators reflect achievement of improved health status and/or decreased health risks. Responding to the consensus that CCH should provide a framework/protocol to assist national planning, the objectives and indicators at that level are directional and indicate key achievement or strategic action required in the system to improve the situation.

The Logical Approach to project and program design was applied by all planning teams with a view to identifying clearly the outputs at national and regional levels required for improved health systems or situations. Available data from the Health Conditions of the Caribbean and the Caribbean Regional Health Study were used as far as possible to guide the setting of realistic targets thereby increasing probability of achievement within the timeframe.

HEALTH PROMOTION – STRATEGY FOR IMPLEMENTATION

Health Promotion has become essential in a changing Caribbean. Over the last forty years non-communicable diseases, violence and the “new” sexually transmitted diseases have gained priority ranking over other infectious diseases as the major causes of mortality in the Caribbean. Lifestyles and environmental hazards are major contributing factors.

In times past, a focus on a curative approach to health care was fueled by the discovery of antibiotics. Cost effective technologies and interventions like immunizations and pure water supply yielded massive returns in the treatment of communicable diseases. The prevention and control of chronic diseases, on the other hand, pose different and major challenges. Prominent among them are the costs of medication, hospitalization and long-term treatment and the difficulty in persuading individuals to change their behaviour. It has become evident that a broader approach to the problem of chronic diseases and the protection of health is required.

Health promotion is the approach that best achieves this goal. In its widest perspective, it treats health as a primary tool in human and economic development, focusing on public policies conducive to prevention of disease and on promotion of well being and productivity. At an individual and community level, dynamic health education, augmented by multi-sectoral action, enables people to control and modify personal practices and living conditions that improve their health.

In CCH II the six (6) strategies of the Caribbean Charter for Health Promotion are applied, as appropriate, to all priority areas thus utilizing Health Promotion as a strategic approach to health development. The strategies are :

- Formulating healthy public policy
- Reorienting health services
- Empowering communities to achieve well being
- Creating supportive environments
- Developing/increasing personal health skills
- Building alliances with special emphasis on the media

CRITICAL SUCCESS FACTORS

1. Long term and sustained commitment of countries as indicated by :
 - Using the regional priorities and objectives to guide national planning and to produce reliable health data collected in a timely manner
 - Supporting the role of Chief Medical Officers as the national CCH Coordinators
 - Involving and communicating with key stakeholders at national and regional levels
 - Participating fully at all levels of CCH
 - Providing guidance, direction and relevant information to the CCH Secretariat
2. A proficient Secretariat
3. Greater attention to communication among countries and between countries and key stakeholders including the Secretariat.
4. Ongoing monitoring and evaluation with timely reprogramming of objectives and/or strategies for implementation.
5. Use of CCH as a common agenda for health in the Caribbean by all collaborating institutions and donor agencies and countries

THE FUTURE

The new CCH initiative will ensure that activities are focused in areas critical to improving health status in the region. In addition it will also more actively involve all the countries of the Caribbean, and regional and international institutions and agencies, in a dynamic communications network dedicated to improving health in the region. CCH II signals the redefinition and reorientation of health; seeks to expand commitment to health; and to include other sectors as participants and partners.

MANAGEMENT OF CCH-II

In order for CCH-II to have greater reach, impact and success than the first Initiative had, countries have seriously reflected on the initiative and made firm commitments to ensure that it is sustainable.

It is important to ensure that ownership of CCH remains with the participating countries and that CCH itself represents a synergy of cooperating rather than competing interests. It should be noted that great care was taken to ensure that all countries and sectors were represented in the conceptualization, design and development of this phase.

Chief Medical Officers have a critical leadership role as CCH coordinators or persons responsible for steering and managing CCH-II at the national level. To facilitate this, they will:

- Organize coordinating mechanisms at the national level.
- Increase networking among CMOs and with the CCH Secretariat
- Participate in the annual regional meetings of CMOs to, inter alia, monitor CCH-II.
- Produce national progress reports on CCH-II and annual CMO/MOH reports in a timely manner.

National program managers (focal points) in each of the eight priority areas have been identified and together with the Chief Medical Officers (CMOs) of each country, form the basic building blocks of the cooperative mechanism.

The Coordinating Mechanism described below supports the national efforts at regional level.

CCH COORDINATING MECHANISM

The coordinating mechanism is composed of

1. The Caucus of Ministers responsible for Health, a sub-committee of COHSOD, ultimately responsible for guiding the implementation of CCH-II.
2. The Steering Committee comprising the Executive Committee of the CMOs; Regional Focal Points for the priority areas drawn from CEHI, CAREC, CFNI, CHRC, UWI and PAHO; and representatives of the CCH Secretariat. The CCH Secretariat, which manages the administrative functions of CCH, comprises the CARICOM Secretariat and the Office of Caribbean Program Co-ordination, PAHO/WHO.

The Steering Committee will meet twice a year and its functions are:

- Supporting and facilitating the implementation at national level including identification of solutions to common problems identified in implementation.
- Promoting and facilitating technical cooperation within and among countries, agencies, institutions and organizations in the public, private and voluntary sectors.
- Mobilizing resources.
- Monitoring and evaluating CCH.

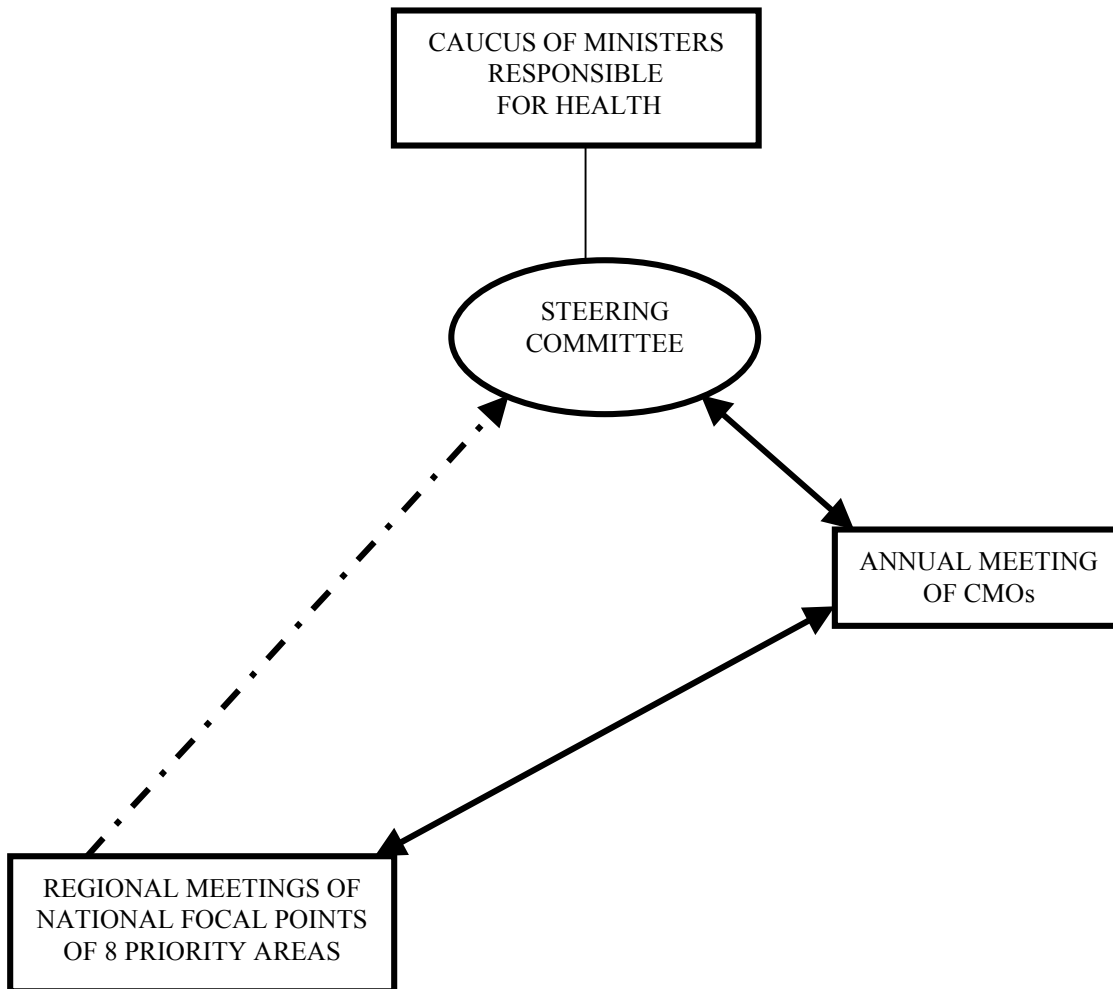
3. The Regional Focal points will have responsibility for:
 - Promoting, facilitating and guiding countries in developing plans, policies, programs and projects to achieve the national goals set in the priority areas.
 - Assisting in building capacity for the implementation of CCH-II at national level including project design and other resource mobilization skills.

4. The CCH Secretariat will hold formal meetings at least 3 times per year and will :
 - Develop an annual workplan for review by the Steering Committee.
 - Prepare an annual report on CCH for COHSOD and disseminate same to all stakeholders.
 - Maintain a database for monitoring the initiative.
 - Assist in resource mobilization.
 - Implement a communications strategy.
 - Design common formats for country reports on CCH-II and monitor implementation on an ongoing basis.
 - Arrange for conduct of evaluations at strategic intervals.

In support of the above the CCH-II monitoring mechanism will build on the successes of programs in which national program managers have been identified and assigned responsibility for planning programs, coordinating implementation and reporting directly to regional counterparts on a regular basis. The programs include Maternal and Child Health, Expanded Program of Immunization and Nutrition. CCH National Focal Points responsible for priority areas will meet regularly (annually or every two years) to evaluate activities of previous periods and develop future work plans. These meetings are important for identifying the strengths and challenges of individual country programs and promoting TCC or joint action as a strategy for achieving objectives.

Governments will need to commit resources to guarantee that regular meetings are held in all priority areas.

CCH REGIONAL COORDINATING MECHANISM



COMMUNICATIONS STRATEGY

In developing the second phase of the Caribbean Cooperation in Health Initiative (CCH-II), it was emphasized that greater attention must be paid to communications. This is necessary in an effort to disseminate information about CCH and its benefits, especially its contribution to improvement of the health and quality of life of Caribbean people.

CMOs will be encouraged and supported to implement national communication strategies, taking advantage of the capacity and expertise in the CARICOM Secretariat and PAHO, and of the partnership of the CCH Secretariat with the Caribbean Broadcasting Union (CBU) and the Caribbean News Agency (CANA). The communication strategy will include but not be limited to the following:

1. Wide dissemination of the CCH document and associated reports.
2. Development of a logo to be used by all countries, facilitated by the production of logo stickers.
3. Production of publicity material - posters, brochures and exhibitions about CCH - targeting the many publics in and outside of the health sector.
4. Production and dissemination of news releases and features for all media.
5. Involvement of journalists in ongoing dialogue on health and environment issues and on the progress of CCH. The CCH Secretariat will collaborate with the evolving Health Journalist Network and use UWIDEC and other distance communication technologies to hold regional teleconferences at least twice a year.
6. Use of web sites - information related to CCH available on the CARICOM and PAHO/CPC web sites until a primary web site is established.

HEALTH SYSTEMS DEVELOPMENT

Strengthening of health services in general deals with improving the institutional capacity to manage and develop health systems to meet the demands of changing epidemiology, emerging technologies and resource constraints. More specifically it looks at the inputs to the systems i.e. human, financial and material resources; how these are organized and managed in order to address the health problems in any particular country; and how they are distributed (e.g. rural vs urban) and utilized (e.g. by different socio-economic groups) as important determinants of “equity” of access to the health services. Underpinning this priority area therefore, is a clear realization that the way the health sector is organized and functioning in each country has to change through a process of health sector reform in order to meet these challenges of the present and the future.

Human resource development has been identified as a separate priority area for this initiative and this section will therefore address in particular how the services are organized and financed with special emphasis on: the leadership role of the Ministries of Health (Headquarters); the issue of quality improvement; and the production and use of information in decision making at all levels. In addition the continuing priorities of maintenance of plant and equipment, disaster management - in particular preparedness and mitigation - and drug management are included.

All of this must be achieved during a period of reorientation of the health sector toward health promotion and strategies to adopt this approach are included for each of the sub priority areas, guided by the Caribbean Charter on Health Promotion.

These are areas where there is significant potential for cooperative action between the countries and at the end of this section some suggested opportunities for joint action are included. This list is by no means exhaustive but it is hoped will generate ideas for further projects and initiatives.

SUB-PRIORITY AREAS

REORGANIZATION OF HEALTH SYSTEMS

FINANCING HEALTH SERVICES

QUALITY ASSURANCE

INFORMATION SYSTEMS

MAINTENANCE AND ASSESSMENT OF TECHNOLOGY

DISASTER MANAGEMENT

DRUG MANAGEMENT

OVERALL GOAL AND INDICATORS

GOAL

Health systems reformed to improve efficiency, effectiveness and quality of services delivered to the total population.

INDICATORS:

1. In 50% of countries, consumer surveys indicate increased satisfaction with hospital and primary care services between 2000 and 2004.
2. Mechanisms to ensure access to an agreed package of services for selected chronic diseases (nationally defined) for all residents, operational in all countries by 2008.
3. The costs of hospital services increased by no more than the national annual cost of living index beginning no later than 2003.
4. In all countries, budgetary review process is informed by analysis of performance and outcome indicators of health services and programs by 2003.
5. Down-time of at least 30 items of critical and essential equipment (selected nationally by health managers) reduced by 20% between 1999 and 2004.
6. Essential health services operational within at least 8 hours of natural disaster or as soon as feasible and victims of disaster managed adequately in the pre-hospital and hospital phases.
7. Mechanisms in place in all countries to make available and affordable a safe supply of vital and essential drugs for nationally defined priority health conditions by end 2003.
8. Common/shared services in at least one specialty/sub-specialty area established by end 2003 among selected countries.

RE-ORGANIZATION OF HEALTH SYSTEMS

PRIORITY ISSUES

1. Inability of the Ministry of Health Headquarters to assume the leadership role in responding to or addressing effectively changes in the health profile and the wider environment.
2. Limited capacity and mechanisms for involvement of community in the organization and management of health systems.
3. Inefficient and ineffective management systems.

OBJECTIVE 1

Reform of the Ministry Headquarters initiated.

INDICATORS

- 1.1 By 2000, all countries would have re-defined the roles and functions of the Ministry of Health headquarters, in keeping with the steering role of Ministries agreed to at the regional level; new policy document including a revised organizational chart disseminated throughout the Ministry of Health.
- 1.2 By 2003 all countries would have had job descriptions revised as required, to support the reform process and at least 50% of newly-defined posts for headquarters filled.

OBJECTIVE 2

Capacity for training health and community workers for joint management of health systems strengthened.

INDICATORS

- 2.1 By 2003, curricula of formal training programs at national and regional levels modified to include community development.
- 2.2 In at least 60% of countries, in-service programs to train health managers to work with communities established by 2000.
- 2.3 By 2003, at least 50% of countries would have instituted training programs for community leaders to identify and relate health issues to their living conditions.

OBJECTIVE 3

Mechanisms to foster interaction between health workers and communities developed.

INDICATOR

- 3.1 By 2003, at least 50% of countries have formal mechanisms for involving community participation including the private sector and NGOs.



RE-ORGANIZATION OF HEALTH SYSTEMS

OBJECTIVE 4

Structure, resources and systems in place for improved management.

INDICATORS

- 4.1 By 2003, all countries will have revised legislative and administrative arrangements to delegate authority for day-to-day operations from headquarters and to match levels of authority with that of responsibility and accountability for production of services at institutional and community levels.
- 4.2 By 2003, in all countries, at least 80% of staff with management responsibilities trained to apply the principles of management.
- 4.3 By 2003, at least 50% of countries will have developed management systems (plans, procedures and protocols) to manage utilization of resources and report on performance and outputs and/or outcomes on an annual basis.



RE-ORGANIZATION OF HEALTH SYSTEMS

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Enactment of legislation and/or formulation of policy document which elucidates the revised role of the Ministry of Health headquarters.

Public Sector reform to facilitate changes in the health systems.

Mechanisms for community participation developed, formalized and implemented.

Policies to support the critical role of health in development and shift from sickness to wellness model.

RE-ORIENTING HEALTH SERVICES

Strengthening of team at headquarters to examine the structure and carry out new and/or revised roles.

Involvement of new cadres to cater to the changing needs.

Development of systems for monitoring performance of MoH-H/Q leadership.

Training of health workers to interact with the community.

Client oriented services with health promotion as the priority strategy. System becomes performance driven within a culture of accountability.

EMPOWERING COMMUNITIES

Support for community leaders to be advocates and bring health issues to the fore.

Involvement of communities in the management of the health system at all levels.

Training of community leaders to interact effectively with the health systems.

Education of the community and provision of opportunities in the management and planning process for community involvement.

Participating in the shift from the sickness to the wellness model.

CREATING SUPPORTIVE ENVIRONMENTS

Supporting leadership in the private sector and Principals in schools to promote health strategies e.g. healthy work places and healthy schools.

Public sector reform programmes in place (with mechanisms to facilitate transfer of staff etc.).

DEVELOPING PERSONAL HEALTH SKILLS

Enhancing the capacity of health workers to provide personal health skills programmes.

Evaluation of education projects to facilitate acquisition of personal skills in addition to health information.

BUILDING ALLIANCES

Support from all social partners: private and public sectors, trade unions, political parties, media houses.

Improved collaboration with Community Development officers, social scientists and universities.

Using communication and media strategies to inform public of health issues, policies and plans.

Information on actions toward preventive and protective measures on various health issues.

Guidelines for public sector personnel for dealing with the media.

FINANCING HEALTH SERVICES

PRIORITY ISSUES

1. Inefficiency in allocating funds and in utilization of resources.
2. Failure to mobilize potential and available financial resources.
3. Unknown costs of health services.

OBJECTIVE 1

Financial management systems improved.

INDICATORS

- 1.1 Financial management and information system revised in all countries to facilitate unit costing of a range of primary and secondary services at least annually by 2003.
- 1.2 All countries will demonstrate evidence of mobilization of additional financial resources for health services by 2001 and greater autonomy for the management of resources by institutions or unit community services by 2003.
- 1.3 In all countries there will be evidence of improved allocation and utilization of funds to reflect policy priorities of health promotion and disease prevention between 1999 and 2003.



FINANCING HEALTH SERVICES

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Pursuing policies that will increase funding available for health to 5% of GDP.

Promoting shifts in the allocation for both existing and new resources to be spent on preventive services and health promotion.

RE-ORIENTING HEALTH SERVICES

Decentralising management and budget responsibilities.

Creating a culture of cost consciousness.

EMPOWERING COMMUNITIES

Educating the community on the cost of health care and engaging them in priority setting and selection of financing options.

CREATING SUPPORTIVE ENVIRONMENTS

Retaining user fee revenue within the collecting facility; adjusting fee levels to keep up with inflation and enacting legislation and/or regulation.

DEVELOPING PERSONAL HEALTH SKILLS

Supporting community-based organizations, NGOs and others which focus on cost effective promotion of healthy life styles (diet, exercise, substance abuse, AIDS prevention, etc) and of self care.

BUILDING ALLIANCES

Strengthening the alliance between the mass media and health interest groups toward successful communication of health promotion and preventive activities.

Social marketing of health-related policies that promote efficient use of health resources and also alliances between health and pharmaceutical and equipment suppliers.

Establishing alliance with tertiary institutions (regional and extra regional).

QUALITY ASSURANCE

PRIORITY ISSUES

1. Not enough attention being paid to quality issues in the management of the health services.
2. Norms and standards do not exist for health service delivery.

OBJECTIVE 1

Quality Improvement adopted as part of the management process.

INDICATORS

- 1.1 All countries will have demonstrated quality initiatives and functioning teams in at least two levels of the system by end of 2003.
- 1.2 All countries will have identified a focal point for "Quality" by end of 2000.

OBJECTIVE 2

Norms, standards and systems for delivery of quality services established at all levels.

INDICATORS

- 2.1 All countries will have relevant documentation of norms and standards in at least three selected areas (at managerial and operational levels) by end of 2000 and establish systems to monitor the performance of the health sector in these three areas.
- 2.2 All countries will have developed a Charter of Patients' Rights and Responsibilities to be displayed at key points of patient contact by end of 2000.
- 2.3 All countries will have mechanisms within all levels of the system to investigate citizens' complaints by end of 2003.

OBJECTIVE 3

Legislative/regulatory mechanisms to facilitate quality of care monitoring in place.

INDICATORS

- 3.1 All countries will be participating in the approved common mechanisms for the registration of professionals by 2003.
- 3.2 All countries will have agreed to mechanisms to apply Caribbean standards for secondary and tertiary care institutions in the public and private sectors by 2001 and initiated mechanisms to apply same nationally by 2003.
- 3.3 All laboratories in the public and private sector will be participating in the regional accreditation process for laboratories by 2003.
- 3.4 All countries have access (cost effective and timely) to laboratory diagnosis for investigation of at least vaccine preventable diseases; food-borne, water-borne and vector-borne diseases; and HIV, common STDs, and tuberculosis by end 2003.
- 3.5 All countries will have established at least a national ethical committee by the end of 2001.



QUALITY ASSURANCE

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Public sector reform initiatives to include quality.

Establishing Accreditation and Registration Boards/Councils and systems with norms and standards.

Advocating for the establishment of National Quality Councils.

RE-ORIENTING HEALTH SERVICES

Developing education programmes to foster a culture of quality at all levels of the system.

Incorporating Quality Improvement in management training programmes.

Developing protocols for management at all levels of the system and services.

Establishing and/or strengthening quality teams.

Empowering Communities

Establishing complaint mechanisms at all levels of the system and ensuring that complainants receive feedback on any action taken.

Establishing Boards and/or Committees with citizen representation.

Educating the public on the Charter of Patients' Rights and Responsibilities.

CREATING SUPPORTIVE ENVIRONMENTS

Working with the private sector and NGOs to foster acceptance and implementation of norms and standards.

BUILDING ALLIANCES

Encouraging the media to act as advocates for quality.

Collaborating with training institutions and professional organizations.

INFORMATION SYSTEMS

PRIORITY ISSUES

1. Inadequate and incomplete data and data analysis for managing resources, evaluating quality and monitoring health trends.
2. Planning and decision making not information based.
3. Lack of Information Systems and Information Technology (IS/IT) plans.

OBJECTIVE

Countries will provide resources for and implement plans and systems which produce information on a timely basis for planning and managing health systems.

INDICATORS

- 1.1 All countries will have available an annual CMO/MoH report including as a minimum the agreed format by June 30 each year, starting 1999.
- 1.2 All countries will be able to provide core data indicators annually and the latest year for which indicators are reported should not be more than two years prior to publication.
- 1.3 Each country will have trained and/or recruited personnel responsible for coordinating the production and dissemination of information and facilitate the utilization of information in at least the central level at the Ministry of Health by 2003.
- 1.4 Information System and Information Technology (IS/IT) plan to support hospital objectives and national health system developed and implemented and at least one report on implementation, disseminated to key managers in each country by end 2000.
- 1.5 Database of services and technologies available in the Caribbean region made accessible to all countries by end 2000.
- 1.6 All laboratories testing for HIV, common STDs, and tuberculosis in both the public and private sectors have in place laboratory information systems which meet the minimum regional standards and generate data required for surveillance and public health action.



INFORMATION SYSTEMS

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Fostering open communication, sharing information inter-sectoral and intra-sectoral and with the public.
Policies to promote easy access of individuals and families to computers.

RE-ORIENTING HEALTH SERVICES

Training health care providers to analyse and use information.
Focusing on performance indicators, outcomes and quality of services.

EMPOWERING COMMUNITIES

Disseminating epidemiological and treatment information to community-based organizations, NGOs and other public sector agencies about health problems of their specific geographic area.
Providing statistical information such as years of useful life saved through the use of seat-belts, instituting breathalyser testing, cessation of smoking initiatives to create the necessary policy environment for addressing the problem.

CREATING SUPPORTIVE ENVIRONMENTS

Recognition of the broad range of skills, maintenance and equipment required for health information systems.

MAINTENANCE AND ASSESSMENT OF TECHNOLOGY

PRIORITY ISSUES

1. **Poor recognition of the value of effective maintenance to the integrity of the health systems.**
2. **Inadequate/inappropriate management of the maintenance function at health facilities (plant, building and equipment).**
3. **Inappropriate procurement practices.**

OBJECTIVE 1

Increased understanding of the value of effective maintenance demonstrated by allocation of resources.


INDICATORS

- 1.1 All countries will allocate no less than four per cent of recurrent health expenditure for management of maintenance functions by end 2003.
- 1.2 Levels of posts in the maintenance departments upgraded and staff appropriately trained to meet competencies of revised posts by end 2001.

OBJECTIVE 2

Countries will implement/strengthen systems procedures and standards to upgrade programmes for maintenance of buildings, plant and equipment in their major institutions.

INDICATORS

- 2.1 All countries will have implemented a maintenance programme for buildings, plant and equipment of all health facilities by end 2003.
- 2.2 All countries will have preventive maintenance schedules and work order systems in place at major hospitals and institutions by end 2001.
- 2.3 All countries will have defined critical, essential and necessary equipment at all levels of the health system by end of 2000 and have in place user/technician in-service training programmes for all new equipment by end 2002.
- 2.4 All countries will have current inventory of plant and equipment by end 2002.
- 2.5 All countries will implement maintenance information systems providing regular reports on work orders, status of equipment and execution of service contracts in major institutions by end 2003 

MAINTENANCE AND ASSESSMENT OF TECHNOLOGY

OBJECTIVE 3

Countries will implement equipment procurement policies and procedures that will involve all interested parties and will include national and regional standardization.

INDICATORS

- 3.1 All countries will have documented revised equipment purchase policies and procedures to ensure that equipment purchased is in line with institution's development plan by end 2001.
- 3.2 All countries will have planned equipment replacement programmes for major and fixed items of equipment for each institution/health facility by end 2000.
- 3.3 Sub-regional technology assessment scheme including sub-regional database on performance of selected equipment in the Caribbean, established and accessible to all Ministries of Health by end 2002.

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Adopting and applying the CUBIC building code (or its equivalent).

Promoting modern approaches to budgeting that will allow planned capitalisation of equipment and maintenance budgets.

RE-ORIENTING HEALTH SERVICES

Establishing policies and procedures for maintenance and repair of plant and equipment in health facilities.

Establishing policies for basic and specialized medical equipment training.

Establishing policies for purchasing of plant and medical equipment.

Determining appropriate knowledge and skills requirement for maintenance personnel.

Training equipment users in use and maintenance of equipment.

EMPOWERING COMMUNITIES

Including communities in the design and planning of facilities and providing opportunities in relation to maintenance of building and equipment especially in the primary care services.

CREATING SUPPORTIVE ENVIRONMENTS

Fostering relationships with the private sector including NGOs, to improve plant and medical equipment in health facilities.

DEVELOPING PERSONAL HEALTH SKILLS

Training health workers in measures to protect themselves and patients from hazards.

Training clients in the use and maintenance of medical equipment.

BUILDING ALLIANCES

Working with the private sector to train maintenance personnel.

Using the media to sensitise the public about selection, cost and utilization of plant and medical equipment.

DISASTER MANAGEMENT

PRIORITY ISSUES

1. Low priority given to comprehensive disaster preparedness planning and regional levels.
2. Mitigation measures not incorporated in design of new facilities and not systematically planned for existing facilities.
3. Emergency Medical Services (EMS) inadequate.

OBJECTIVE 1

Health sector capacity to reduce the impact of disasters improved and/or strengthened.

INDICATORS

- 1.1 All countries should have comprehensive health disaster plans addressing natural, technological and man-made disasters by end 2001. These plans should be tested and updated every two years thereafter.
- 1.2 All countries will have allocated resources (human and financial) to establish a health disaster management programme by end 2001.
- 1.3 Regional health disaster plan to include regional approach for response, evacuation, treatment and supply management developed by end 2002.
- 1.4 All countries will have implemented at least basic mitigation measures as per Caribbean health facility standards in their main referral hospitals by end 2002.
- 1.5 In all countries EMS upgraded to (a) respond in a timely manner to at least 80% of calls and patients in emergency rooms within nationally defined targets and (b) manage emergency procedures in the pre-hospital phase.



DISASTER MANAGEMENT

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Promoting policies to update and enforce Caribbean Uniform Building Code (CUBIC) and legislation for land use.

Review of the definition of essential services related to disasters.

RE-ORIENTING HEALTH SERVICES

Promoting mitigation measures for essential health facilities.

Establishing health disaster programmes with senior staff leadership.

Upgrading emergency medical systems with emphasis on pre-hospital care.

EMPOWERING COMMUNITIES

Inclusion of health related issues as part of community disaster preparedness, NGOs and private sector activities.

CREATING SUPPORTIVE ENVIRONMENTS

Health disaster plans integrated into national and regional plans including arrangements for relief supplies, staff and mass casualty events.

Policies and procedures that facilitate early mobilisation of key health staff.

Promoting supportive legislation to maximise the use of EMT skills.

DEVELOPING PERSONAL HEALTH SKILLS

Promoting first aid and CPR training for the public.

BUILDING ALLIANCES

Working with all sectors and agencies in national and regional disaster response framework.

DRUG MANAGEMENT

PRIORITY ISSUES

1. Potential cost benefit of joint procurement not realized.
2. Few countries have adequate capacity for drug registration and quality control.
3. Inadequate drug management information.
4. Inadequate consumer protection against inappropriate drug advertising practices.

OBJECTIVE 1

Efficient and effective mechanisms for joint procurement, registration and utilization of drugs established.

INDICATORS

- 1.1 Number of countries (a) participating in a joint procurement initiative and (b) implementing policies for generic drugs increased by end 2003.
- 1.2 All countries will have updated legislation or policies and supportive laboratory facilities for effective monitoring of drugs to be registered and/or in use by end 2003.

OBJECTIVE 2

Systems for appropriate drug utilization improved.

INDICATORS

- 2.1 All countries will have mechanisms for at least annual updated national formularies and/or Essential Drug lists by end 2000.
- 2.2 All countries will have initiated the conduct of annual drug utilization reviews by end 2003.

OBJECTIVE 3

Capacity for increasing consumer awareness of risks in the inappropriate use of drugs (conventional and alternative therapies) increased.

INDICATOR

- 3.1 All countries will have client advocacy and educational programmes (hot lines, poison centres) for appropriate use of drugs and health promoting products by end 2003.



DRUG MANAGEMENT

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Developing and/or reviewing legislation for drug procurement, testing and registration.
Developing policies on interaction between health workers and the pharmaceutical companies.

RE-ORIENTING HEALTH SERVICES

Developing a Vital, Essential and Necessary (VEN) drug list with costing.
Development of protocols for distribution, use and prescribing of drugs.
Conduct of routine drug utilization reviews.

EMPOWERING COMMUNITIES

Educating the public about drug policies and the appropriate use of drugs including alternative therapies.
Educating the public on generic drugs.

CREATING SUPPORTIVE ENVIRONMENTS

Working with Pharmacy Associations in educating the public on pharmaceutical issues including how to critically assess drug advertisement.
Providing the environment and human resources to facilitate patient education at time of dispensing of drugs.

DEVELOPING PERSONAL HEALTH SKILLS

Developing the skills of pharmacists to better inform the public on drug issues.
Developing the skills of pharmacists for independent action.

BUILDING ALLIANCES

Collaborating with the media, pharmaceutical industry and practitioners of alternative medicine.

OPPORTUNITIES FOR JOINT ACTION

REORGANISATION OF HEALTH SYSTEMS

- Joint training of leaders of health systems.
- Sharing “best/worst” practices.
- Development of Caribbean indicators to monitor status determinants.

FINANCING OF HEALTH SERVICES

- Regional Health Insurance Scheme.
- Shared/joint services.
- Documenting and sharing best practices.
- Common costing methodology.
- Training of personnel in health economics and health financial management.

QUALITY ASSURANCE

- Development of Caribbean accreditation/registration systems in consultation with regional professional bodies.
- Caribbean programme for joint training.
- Development of protocols.
- “Caribbean Institute for Quality Improvement”.

INFORMATION SYSTEMS

- Sustainable health informatics training.
- Development/implementation of specific CCH-II Information System.
- Creating a regional health network (through the Internet) for key health managers.
- Updating of CMO Report template.

MAINTENANCE AND ASSESSMENT OF TECHNOLOGY

- Common training of technical and health staff in public and private sectors.
- Development of regional capacity for training in equipment maintenance and biomedical engineering.
- Fostering of inter-Caribbean collaboration in shared equipment services.
- Sharing of protocols, guidelines, service contracts etc.
- Creation of database on Caribbean experiences with equipment and suppliers.

DISASTER MANAGEMENT

- Train and maintain regional health response teams
- Common systems for post-disaster relief supplies management (SUMA) and training of regional SUMA team.
- Inter-country agreements for first response and shared/joint post-disaster services .
- Establish common standards and competencies for emergency medical technicians and other first responders.

DRUG MANAGEMENT

- Expansion of the pooled procurement of drugs.
- Review and strengthening of quality control mechanisms.
- Common legislative framework for drug registration etc. (adaptation by countries).

HUMAN RESOURCE DEVELOPMENT

The health sector in all countries in the Caribbean is faced with two major challenges, namely the provision of equitable access to quality health care services and the reduction or control of increasing costs of health care services. Most countries have responded to these challenges by embarking on a diversity of reform processes which involves a health care system oriented towards primary care; centered on people; focused on quality, sound financing and accountability; and geared to explicitly defined targets for improved health.

The special meeting of the Ministers Responsible for Health in April 1997 recognized the strategic importance that human resources play in achieving the objectives of the reformed health system. Additionally, the priorities for Human Resource Development (HRD) were identified in the areas of planning, management, training and performance monitoring.

Thus, the HRD Program for the Caribbean region is designed to focus specifically on:

- Manpower analysis and allocation of adequate numbers of appropriate categories of health workers;
- Development of an educational policy on functional, interdisciplinary training for health professionals;
- Establishment of a mechanism and standards for registering health practitioners and accrediting health programs; and
- Strengthening of regional educational institutions.

SUB-PRIORITY AREAS

INFORMATION FOR HUMAN RESOURCE DEVELOPMENT (HRD)

HUMAN RESOURCE MANAGEMENT

HUMAN RESOURCE PRODUCTION (TRAINING)

MONITORING PERFORMANCE OF HEALTH PROFESSIONALS

OVERALL GOAL AND INDICATORS

GOAL

Adequate/appropriate manpower available to support the reformed health system.

INDICATORS

1. Selected health professionals will be free to practise concurrently and support shared services in several CARICOM countries by end 2004.
2. Adequate manpower available in the Caribbean to support at least three selected new areas (oncology, gerontology, occupational health, occupational therapy, speech therapy) by end 2005.
3. At least 60% of unit/department/program heads demonstrate competencies in managing human resources in accordance with international human resources standards by end 2003.
4. In at least two countries, Health Sector Reform initiatives will demonstrate approaches to integrating the practice of traditional and alternative medicine by end 2003.

INFORMATION FOR HUMAN RESOURCE DEVELOPMENT (HRD)

PRIORITY ISSUES

1. Inadequate data for human resource planning and management nationally and regionally.
2. Absence of up to date information on the types, content and cost of available training programs for health professionals in the region.

OBJECTIVE 1

Effective Human Resource Management Information System operational at national and regional levels. (Culture of planning for HRD at Ministries of Health promoted and strengthened.)

INDICATORS

- 1.1 Information systems able to produce reports on at least the current human resource situation by institution, geographic area, programmes, and categories and professional skills by age, established in at least 60% of countries by end 2002.
- 1.2 Information on available training programs in health will be electronically accessible to all countries by end 1999.

HEALTH PROMOTION STRATEGIES

RE-ORIENTING HEALTH SERVICES

Modernization of health information system for HRD (use of electronic data collection and analysis).

Evidence-based practice in HRD.

Regional database for HRD.

Timely sharing and exchange of human resource information among countries.

Introducing the use of benchmarking of HR data.

Creating home-page for available training programs in health.

EMPOWERING COMMUNITIES

Training community leaders and allowing participation in the planning process.

CREATING SUPPORTIVE ENVIRONMENTS

Promoting the culture of planning for human resource development.

Providing resources to support a functional health information system.

DEVELOPING PERSONAL HEALTH SKILLS

Training in HR planning software.

BUILDING ALLIANCES

Collaboration with HR stakeholders: Ministries of Health (MoH), Ministries of Education (MoE), CARICOM, universities, tertiary level institutions (TLIs), private sector.

HUMAN RESOURCE (HR) MANAGEMENT

PRIORITY ISSUES

1. Lack of clearly articulated and documented policies and procedures on Human Resource Development.
2. Antiquated approaches to HRD management.
3. Inadequate institutional capacity to manage critical human resource functions in Ministries of Health.

OBJECTIVE 1

Infrastructure for modern approaches to HR management established.

INDICATORS

- 1.1 By end of year 2000, 50% of countries will have modernized the infrastructure for HRD management, which includes but is not limited to:
 - revision of organizational structure;
 - increase in quality and quantity of staff;
 - introduction of contemporary procedures for performance appraisal;
 - inclusion of team work among the criteria for staff selection.
- 1.2 All countries will have:
 - written national policies identifying appropriate mix of manpower and defining the roles that different categories of health and related personnel would play in the health care system; and
 - maintain current strategic plan for provision and/or production of identified manpower needs by end 2000.
- 1.3 Selected managers trained in the area of human resource management in all countries by end 2002.

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Policies and guidelines for HR management.

Introduction of policies supportive of the improved HRD management.

RE-ORIENTING HEALTH SERVICES

Decentralization of HR functions.

“Wave” approach to HR programs e.g. models of good HR practice in one country will be introduced in another country.

EMPOWERING COMMUNITIES

Increasing public awareness on HRD issues.

CREATING SUPPORTIVE ENVIRONMENTS

Civil service mentoring of HRD personnel at MoH.

DEVELOPING PERSONAL HEALTH SKILLS

Training and competencies in HR management.

BUILDING ALLIANCES

Working with Public Service, MoH, CARICAD, PAHO, universities, NGOs.

HUMAN RESOURCE PRODUCTION (TRAINING)

PRIORITY ISSUES

1. Absence of institutional capacity to accredit health training programs and institutions.
2. Weak planning mechanism - inadequate dialogue between critical stakeholders in health and education sectors for planning of health training programs at national and regional levels.
3. Personnel need to improve competencies to integrate health promotion and other current strategies and approaches into existing delivery programs.
4. Lack of training programs in new areas of need.
5. The need to strengthen the capacity of teaching institutions to employ modern technologies to achieve increased cost effectiveness and wider coverage.

OBJECTIVE 1

Capacity of countries to respond effectively and efficiently to training needs improved.

INDICATORS

- 1.1 Regional accreditation mechanism approved by the CARICOM Heads of Government will have defined the process for accreditation of selected health training programs by end 2003.
- 1.2 Planning for new regional health training programs would include documented needs assessment, inputs from critical stakeholders and sustainability analysis by beginning 2000.
- 1.3 By the year 1999, assessment of regional training needs in new areas will be completed and programs, in at least 2 areas, developed and initiated by mid-2003.
- 1.4 The cost-benefit ratio for two active programmes would have been improved through employment of new educational technologies and changes in curriculum design by end 2003.

HUMAN RESOURCE PRODUCTION (TRAINING)

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Endorsing CARICOM policy on shared services.

Framework for cost benefit analysis (CBA) and cost effective analysis (CEA).

Studies to assess impact of training program.

RE-ORIENTING HEALTH SERVICES

Training-practice partnership.

Broad-based multi-sectoral alliance for HRD.

Value for money criteria in training of human resources.

Harmonization of training curricula.

Rationalization of training programs.

Interactive and multimedia approach to teaching.

Developing core skills and competencies for different categories of health professionals.

EMPOWERING COMMUNITIES

Partnership between MoH and MoE.

Consumer involvement in health needs identification.

Soliciting experience of consumers in the use of non-traditional practitioners.

CREATING SUPPORTIVE ENVIRONMENTS

Technical assistance and provision of resources.

Collaborating with media to open public debate on the role of non-traditional health workers.

BUILDING ALLIANCES

MoH, MoE, PAHO, CARICOM, public.

MONITORING PERFORMANCE OF HEALTH PROFESSIONALS

PRIORITY ISSUES

1. Absence of mechanisms for common registration of health professionals and absence of standards for monitoring performance (except nursing).
2. Absence of a process to register and monitor performance of new (non-traditional) categories of health professionals.

OBJECTIVE 1

System to facilitate reciprocity of registration of health professionals and practitioners of alternative medicine among CARICOM countries developed.

INDICATORS

- 1.1 Standards and common mechanism for registration of physicians operational in the English-speaking Caribbean by end 1999.
- 1.2 Mechanism for common registration of at least two other health professional groups will be developed by end 2003.
- 1.3 Regional standards and process for registering and monitoring new (non-traditional) categories of health professionals developed by year 2003.

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Initiative on free movement of skills.

Approval of the Caribbean Medical Council (CMC) by Ministers of Health.

RE-ORIENTING HEALTH SERVICES

Performance improvement methodology in health care service delivery.

EMPOWERING COMMUNITIES

Information on registered health practitioners available to consumers.

CREATING SUPPORTIVE ENVIRONMENTS

Caribbean Medical Council (CMC) approval.

BUILDING ALLIANCES

Working with CARICOM, PAHO, national medical councils, universities. Alliance among national and regional professional organizations.

FAMILY HEALTH

Concern about the health of mothers and children has been a priority for Caribbean health services for over 50 years. Despite these efforts, there remain the growing and widespread problems of child abuse and neglect throughout Caribbean society which require urgent attention. There is also the need to accelerate the development of appropriate preventive, educational and rehabilitative services relating to children with disabilities. Another long-standing problem is asthma in childhood, a critical respiratory disorder in Caribbean children, requiring specific approaches and practices for its prevention and treatment.

In more recent times, attention has shifted to an approach which considers the health of the family unit in the Caribbean. This shift in focus has brought about a situation whereby countries in the region are using the life cycle approach to deal with population groups, such as infants, young children, adolescents, adults, and the elderly. There is, however, a need to concentrate attention on some areas. In the new CCH greater attention will be paid to services for adolescents and the elderly, while continuing to address an expanded MCH service which includes reproductive health.

The findings of recent school-based studies on adolescent health have shown that a high percentage of in-school youth is sexually active; that they have multiple sexual partners at an early age; that 50% of them do not use any contraceptives; and that many of them do not worry about HIV/AIDS. In recent years, school drop-out rates in the Caribbean have increased and efforts focused on in-school youth will not reach the out-of-school youth. Services for adolescents therefore should be comprehensive and should focus on improving knowledge and behavior of adolescents in reproductive and sexual health issues for both in-school and out-of-school youth.

It is estimated that the Caribbean will continue to experience absolute and relative increases in the elderly population in the period 1950-2025 and for the Caribbean the elderly population, which constituted approximately 4.3% in 1950, will increase to 10.4% by the year 2025. There is a general lack of specific health policies, plans and programs on the care of the elderly and development of such policies requires urgent attention if the solutions to these problems are to be found.

SUB-PRIORITY AREAS

REPRODUCTIVE HEALTH

CHILD HEALTH

ADOLESCENT HEALTH (ADH)

HEALTH OF THE ELDERLY

OVERALL GOAL AND INDICATORS

GOAL:

Health and the quality of life of selected vulnerable groups in the population improved.

INDICATORS:

1. National maternal mortality rates would be no higher than the Caribbean targets agreed to or defined in 1999, by end 2003.
2. Mortality rates due to Asthma reduced by at least 50% of the 1996 level in at least 8 countries, by end 2003; and reduce asthma morbidity, as measured by a reduction in asthma hospitalisations per 100,000 pop. by at least 10% of the 1998 level by end 2008.
3. By end 2003, the perinatal mortality would have declined by at least 10% of the 1997 level and at least 80% of children entering primary schools (5 years old) would have been immunised and screened for developmental disabilities in accordance with national schedules.
4. At least 5 countries would have programs in which at least 50% of children identified as neglected or physically or sexually abused receive physical and mental evaluation by end 2003, with appropriate follow-up as a means of breaking the inter-generational cycle of abuse.
5. The proportion of adolescents with healthy behaviours increased by end 2009:
 - Delayed initiation of the use of tobacco, alcohol and illegal drugs - no more than 5% of adolescents between ages 16 and 18 years should report having 4 or more drinks at any one time and ever used tobacco or illegal drugs.
 - Postponement of the onset of sexual activity - no more than 20% of adolescents report having ever had sex before the age of 15 years.
 - Early involvement in exercise - a lifetime physical activity. The proportion of children and adolescents who engage in vigorous activity that promotes the maintenance of cardio-respiratory fitness, 3 or more days per week for twenty or more minutes per occasion increased to 75%.
6. The proportion per 1,000 persons 65 years and older who have difficulty in performing 2 or more personal activities decreased between 2000 and 2010.

REPRODUCTIVE HEALTH

PRIORITY ISSUES

1. Inadequate quality and coverage of Reproductive Health Care services especially for adolescents and men.
2. Poor identification of high risk problems in the perinatal period.
3. Poor application of standards of maternal care.

OBJECTIVE 1

The quality, availability, accessibility and appropriate use of Reproductive Health Services improved. (* See also sections dealing with Adolescent Health, Communicable and Chronic Non-Communicable diseases).

INDICATORS

- 1.1 By end 2000, all countries would have determined reasons for low attendances at antenatal and post-natal services in keeping with the established Caribbean norms and standards (ref. Caribbean MCH Strategy) and would have introduced appropriate interventions by end 2002.
- 1.2 Caribbean standard protocols for identification and management of high risk pregnancies in use in all facilities and personnel certified in neonatal resuscitation in all referral institutions by end 1999.
- 1.3 All public primary care facilities would provide Family Planning services for adolescents, men and women and full range of services available through the NGO sector and/or tertiary institutions by end 2001.

REPRODUCTIVE HEALTH

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Development of policies and programs on Reproductive Health rights and gender issues.
Introduction of public health legislation to facilitate HIV/STD testing in all pregnant women.
Adopting the policies re the International Code on Marketing of breast Milk Substitutes.
Reviewing and updating laws on abortion.

RE-ORIENTING HEALTH SERVICES

Training of health workers.
Ensuring greater access to services.
Removing barriers to quality Reproductive Health care e.g. reduce waiting times at clinics.
Introduction of perinatal registration system.

EMPOWERING COMMUNITIES

Promoting policies for Reproductive Health education for students in schools.

CREATING SUPPORTIVE ENVIRONMENTS

Working with NGOs to increase awareness of reproductive health rights and gender issues.

DEVELOPING PERSONAL HEALTH SKILLS

Educating women on reproductive rights and their role in ensuring improved Reproductive Health.

BUILDING ALLIANCES

Collaborating with the media, Ministry of Education re Family Life Education.

CHILD HEALTH

PRIORITY ISSUES

1. Not enough progress made in breast feeding practices and the management of common childhood diseases e.g. ARI/Asthma.
2. The need to pay greater attention to new programmes e.g. prevention of developmental and other disabilities and prevention of child abuse and neglect.
3. The need to strengthen information systems to capture relevant data to facilitate planning and programming.

OBJECTIVE 1

Capacity of countries to consolidate gains made in child health and to address new issues strengthened.

INDICATORS

- 1.1 All countries will have developed and implemented programmes to address child abuse and neglect, using the inter-sectoral approach by end 2003.
- 1.2 All countries will have breast feeding promotion programs documented and functioning by end 1999.
- 1.3 At least 80% of health staff in primary and emergency care services and at least one teacher in 50% of primary and secondary schools trained in the use of protocols for identification and early treatment of ARI/Asthma by end 2002.
- 1.4 All countries should have developed multi-sectoral programmes (in at least health, education, social services) for the prevention and early detection of developmental and learning disabilities by end 2003.
- 1.5 Simplified Perinatal Care Records (SPCR) in use nationally and perinatal information analysed annually by institutions by end 2003.

CHILD HEALTH

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Introducing breast feeding policies for HIV and HTLV-1 positive mothers.

Developing policies to decrease air pollution.

Developing policies to allow teachers and day care providers to make basic interventions for children who become ill at school.

RE-ORIENTING HEALTH SERVICES

Introduction of standardised perinatal guidelines in health facilities.

Training staff in the use of data for management.

Ensuring that staff are competent to manage child health issues.

EMPOWERING COMMUNITIES

Training local NGOs to take leadership and advocacy roles in child health issues.

Training parents in early stimulation techniques.

Educating parents and teachers in the identification and reduction of environmental triggers for asthma.

CREATING SUPPORTIVE ENVIRONMENTS

Establishing day care facilities at the work place to facilitate breast feeding and bonding.

Employers to facilitate attendance of parents at child health clinics.

Creating smoke free environments in homes and the work place.

DEVELOPING PERSONAL HEALTH SKILLS

Educating asthma patients on identification of personal triggers for asthma attacks.

Educating children on the awareness and preventive actions required to protect themselves.

BUILDING ALLIANCES

Strengthening linkages with churches and other organizations to decrease spouse abuse, child abuse and violence in homes.

Collaborating with the MoE and the social services in developing comprehensive programmes in child abuse.

ADOLESCENT HEALTH (ADH)

PRIORITY ISSUES

1. Lack of national ADH plans and a comprehensive approach to ADH services for youth in and out of schools.
2. Initiation of unhealthy behaviours including early sexual activity, drug abuse and poor dietary habits.

OBJECTIVE 1

Plans for comprehensive, client-oriented services for adolescents developed and capacity to implement these services strengthened.

INDICATORS

- 1.1 All countries would have analysed the health and social needs of youth in school (Caribbean Adolescent Health Survey) by end 1999 and out of school youth by end 2001.
- 1.2 National youth/adolescent health plans developed using the WHO/GRID methodology in at least 50% of countries by end 2002.
- 1.3 At least 3 demonstration centres for comprehensive adolescent/youth services operational in the English-speaking Caribbean by end 2002.
- 1.4 Regional training programmes for ADH established by 2003 and national parenting programmes implemented/strengthened in all countries by end 2002.
- 1.5 Health and Family Life Education (HFLE) programmes incorporated into primary and secondary schools' curricula nationally by end 2001.

ADOLESCENT HEALTH (ADH)

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Advocating for remedial and special educational policies and programmes to decrease school drop-out rates.

RE-ORIENTING HEALTH SERVICES

Modifying clinical guidelines to address health issues of youth.

Training leaders in the health sector on strategies for working with the youth.

Equipping health workers to assist in the training of youth in life skills.

Developing effective health promotion programmes to reduce adolescent risk behaviours.

Develop health information system to capture appropriate information on adolescent health needs.

EMPOWERING COMMUNITIES

Working with parent groups, PTAs, etc. to strengthen communication with children and adolescents.

Developing methods and linkages with the community to reach “hard to reach” young people (including males) and those who are not in schools.

Creating Supportive Environments

Working with other sectors and agencies to develop recreational opportunities for the youth.

DEVELOPING PERSONAL HEALTH SKILLS

Developing and/or strengthening peer counselling programmes for young people.

Developing and/or strengthening parent-to-parent programmes to support child and adolescent rearing.

BUILDING ALLIANCES

Collaborating with the media, Ministries and agencies responsible for youth and child services.

Working with Ministries of Labour, vocational training institutions and the private sector to increase job skills and opportunities for the youth.

HEALTH OF THE ELDERLY

PRIORITY ISSUES

1. Low priority given to programmes for the elderly.
2. Limited information on the health issues and needs of the elderly.
3. Inadequate preparation by individuals for growing old and health care workers, family and community inadequately prepared to meet the needs of the elderly.

OBJECTIVE 1

To develop and initiate comprehensive programmes to promote and protect the health and well-being of the elderly.

INDICATORS

- 1.1 National plan for Healthy Aging developed or issues on aging addressed in national and or social development plans in all countries by mid-2000, utilizing approaches consistent with the 1998 Caribbean Charter on Health and Aging.
- 1.2 Health Focal points, multi-sectoral monitoring/steering mechanisms and evidence of resource mobilization for implementation of the Healthy Aging plan identified in all countries by end 2000.
- 1.3 Caribbean regional indicators on Health and Aging developed by end 2000, and national information systems in all countries modified where necessary by end 2002.
- 1.4 Training programs for health care workers, individuals and community care-givers on the aging process, and/or health needs of the elderly, and/or approaches to health care for the elderly instituted in all countries by end 2001.

HEALTH OF THE ELDERLY

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

- Developing and strengthening policies on aging.
- Developing Bill of Rights in support of the elderly.
- Adopting the Caribbean Charter on Health and Aging (when approved).

RE-ORIENTING HEALTH SERVICES

- Sensitising health workers about the special needs of the elderly.
- Strengthening PHC services targeted at the elderly.
- Establishing norms and standards for institutional care of the elderly.

EMPOWERING COMMUNITIES

- Sensitising community groups (including youth groups) about the special needs of the elderly.

CREATING SUPPORTIVE ENVIRONMENTS

- Working with care givers to ensure that standards of care are being met.
- Supporting activities to commemorate International Year of Older Persons (1999) and World Health Day 1999
- (theme “Active Ageing Makes a Difference”).

DEVELOPING PERSONAL HEALTH SKILLS

- Preparing adults for healthy aging.
- Educating elderly on ways to maintain and improve their health.

BUILDING ALLIANCES

- Collaborating with government organizations, NGOs and media.

OPPORTUNITIES FOR JOINT ACTION

REPRODUCTIVE HEALTH

- Collaboration with UWI, Mona in training in Fertility Management.

CHILD HEALTH

- Development of early stimulation projects involving NGOs and communities.
- Collaboration between countries and CAREC in the Global Asthma Initiative.
- Development of protocols for management of child health issues and information.

ADOLESCENT HEALTH

- Development of Adolescent Health guidelines.

HEALTH OF THE ELDERLY

- Development of regional core data indicators.
- WHO Collaborating Centre, UWI, Mona to take the lead in this sub-priority area.

FOOD AND NUTRITION

Traditionally, where energy intake is concerned, the Caribbean's main concern has been under-nutrition, resulting in Energy Protein Malnutrition (EPM) which accounts for unacceptably high rates in some vulnerable groups in the region. In CCH-II, mapping of high-risk areas will be an important strategy to target interventions. For the past few decades, however, there has been an increase in the prevalence of obesity, principally in adults, but also to some extent in adolescents and infants. With this increasing prevalence of obesity we observe the concomitant increase in nutrition-related chronic diseases such as diabetes mellitus, hypertension, heart attacks, stroke and some forms of cancer.

In the region, food production has long been surpassed by consumption and today the countries depend to a large extent on food importation. In fact, most of the energy and protein requirements are fulfilled by importation of raw or processed foods or food components. The region has a mere 6 million people yet we spend over 1.5 billion US dollars each year on food imports.

Most English-speaking Caribbean countries are progressively moving away from regulated markets involving direct state intervention in food marketing activities and price controls on basic foodstuffs to more liberalized marketing systems. The creation of the World Trade Organization (WTO) in 1995 substantially affects international trade in agricultural products which is an important aspect of the food security problem.

In CCH-II, food security will therefore emphasize how food and nutrition policies overlap with many other sectors - health, trade, agriculture and education. A wide spectrum of players needs to be involved because food security is an integral part of a process of nutrition and health development.

Thirty years ago food security in the Caribbean may have been conceived mainly as a supply problem i.e. attempting to increase the availability of various foods. Now, with availability of calories and protein much in excess of average requirement, the focus of food and nutrition security must include issues of cost-efficient food distribution and consumer education to achieve nutritional adequacy at the household level.

In CCH-II, policies on food security will strive to fulfill population nutrient goals. The approach is to identify the level of population intakes that, for the population as a whole, will lead to a low risk of inadequacy and a low risk of excess. The determination of food goals needs careful analysis as it must relate to the agricultural policy and economic opportunities in each specific country. Governments that take diet-health relationships seriously can make considerable savings in health expenditures.

Iron deficiency anemia remains a problem especially in pregnant women and pre-school and school aged children. This has been attributed to inadequate iron intake and to poor absorption. CCH-II will intensify efforts within the strategy of iron supplementation, diet modification and iron fortification to reduce the prevalence of anemia in the region.

SUB-PRIORITY AREAS

NUTRITION-RELATED DISEASES

HUMAN RESOURCE DEVELOPMENT

NUTRITION PROMOTION & INFORMATION

DISSEMINATION

SURVEILLANCE

FOOD SECURITY

OVERALL GOAL AND INDICATORS

GOAL

Safe food made accessible to the most vulnerable population groups and the nutritional status of selected groups in the population improved.

INDICATORS:

1. Mechanisms established in all countries to ensure that persons living below the poverty line spend less than 25% of their income to obtain a nutritionally adequate basket of food, by end 2003.
2. Prevalence of obesity (BMI>30) among the persons aged 35-64 years reduced by at least 3% of 1997 level and baseline established for persons between the ages of 12 to 15 years by end 2003.
3. Prevalence of anaemia in pregnancy reduced by 10% and, in children less than 15 years, by 12% between 1997 and 2003.
4. Under-nutrition weight for height (W/H) Z-score for children under 5 years reduced by 50% of 1997 levels by end 2003.
5. Exclusive breastfeeding at three months increased by 30% of 1997 rates by end 2003.
6. Number of outbreaks of food-borne diseases reduced to less than 50% of the 1997 levels in all countries by end 2003.

NUTRITION-RELATED DISEASES

PRIORITY ISSUES

1. Lack of strategic multi-sectoral plans and policies to combat the deficiency diseases and the multi-factorial problems of obesity and nutrition-related chronic diseases.
2. Insufficient attention to the causes of persistent anemia.
3. Inability of vulnerable groups to obtain continuous supplies of a nutritionally adequate and safe diet.

OBJECTIVE 1

Plans, policies and guidelines in place and mechanisms to monitor their implementation functional.

INDICATORS

- 1.1 In all countries, national Food and Nutrition Plans updated to a) incorporate contribution of agriculture, health, trade and education sectors; b) link to national development policies and strategies; and c) include measurable population food and nutrition goals by end 2001.
- 1.2 Policy makers in at least 15 countries made aware of the economic benefits of interventions to combat nutritional problems by end 2002.
- 1.3 In each country, mechanism for multi-sectoral monitoring of implementation of plans established by end 2001 and meeting at least once per year thereafter.
- 1.4 Dietary guidelines for the Caribbean developed and disseminated to all countries by end 2003.

OBJECTIVE 2

Projects to reduce anaemia and obesity developed and implemented.

INDICATORS

- 2.1 Barriers to effective preventative and therapeutic iron supplementation researched and programs aimed at reducing the prevalence of anaemia in pregnancy developed and/or refined and executed in three (3) selected countries by end 2003.
- 2.2 Multi-sectoral, health promotion initiatives to reduce availability and consumption of saturated fats; increase the consumption of local fruits and vegetables, ground provisions and legumes; and introduce scientifically-based exercise programs in public and private institutions designed and initiated in at least 2 countries by end 2003.

(See complementary indicators in Chronic Non-Communicable Diseases section).

NUTRITION-RELATED DISEASES

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Ensuring firm political commitment to promote nutritional well-being as part of national research and development plans.

Altering regulations and policies that impact negatively on consumer food choices particularly in relation to food prices and low quality food items in order to encourage more nutritionally beneficial diets.

RE-ORIENTING HEALTH SERVICES

Establishing or strengthening regulatory bodies to develop, support and monitor dietary guidelines.

Strengthening institutional structures with attention to management to cope with multi-sectoral aspects of nutritional diseases.

EMPOWERING COMMUNITIES

Providing incentives to those who promote healthy diet and exercise habits.

Involving community groups in all aspects of nutrition improvement programs and supporting community initiatives.

CREATING SUPPORTIVE ENVIRONMENTS

Promoting and launching healthy eating and exercise programs at work-sites, training institutions and communities.

Sensitising public and private sector managers to the economic benefits of a healthy work force.

Organising NGOs and health clubs to promote and practise healthy lifestyles.

DEVELOPING PERSONAL HEALTH SKILLS

Development of advocacy and evaluation skills of key managers and community leaders.

Development of low fat cooking skills of homemakers.

Using a mix of media and face-to-face strategies to enable clients to manage diseases.

BUILDING ALLIANCES

Developing or strengthening food and nutrition coordination committees with Education, Trade, Agriculture and other related sectors.

Supporting organizations that promote physical activities and sports.

Developing awareness in these organizations about the importance of diet in enhancing physical activities and sport.

HUMAN RESOURCE DEVELOPMENT

PRIORITY ISSUES

1. Insufficient number of qualified health care professionals to impact on nutrition-related problems.
2. Roles of nutritionist and dietitians in health care teams not universally understood and not clarified in health sector reform initiatives.
3. Ministry of Health capacity to monitor food safety has not kept pace with growth in food processing and hospitality sectors.

OBJECTIVE 1

Human resource needs for the provision of adequate nutrition services determined, and implementation initiated.

INDICATORS

- 1.1 Needs assessment of nutrition and dietetic professionals required at specified levels within the public and private sectors of the health system completed in all countries by end 1999.
- 1.2 In each country, roles, responsibilities and method of functioning of all categories of nutrition-related professionals documented by end 1999.
- 1.3 Common standards for practice of professionals in nutrition-related areas developed and adapted or adopted by at least 75% of countries by end 2003.
- 1.4 In all countries, number and quality of nutrition-related professionals in the public sector strengthened in accordance with plan by end 2003.

OBJECTIVE 2

Selected persons trained and capacity of selected health training programs to provide graduates with required skills in nutrition counselling improved.

INDICATORS

- 2.1 Over the period 1999-2002, at least 100 community-based persons trained each year in basic and/or intermediate skills and knowledge of the relationship between diet, exercise and chronic diseases.
- 2.2 Regional programs for production of physicians, public health nurses and health educators evaluated against standard competencies related to managing diet, exercise and disease using the health promotion process (KAP studies and course evaluations) by mid-2002.
- 2.3 Curricula and methods of teaching in relevant regional training programs upgraded to address deficiencies identified in evaluations by end 2003.

HUMAN RESOURCE DEVELOPMENT

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Developing policies to attract persons into related professional areas.

Enabling effective registration and monitoring of performance at national and regional levels.

RE-ORIENTING HEALTH SERVICES

Focus on diet and lifestyle in community health care.

Preparing health care personnel with adequate knowledge in food, nutrition and health.

Incorporating nutrition personnel in PHC management team.

EMPOWERING COMMUNITIES

Training of NGOs to help lead the health promotion action on healthy lifestyle.

Educating families in healthy eating and exercise programs.

Public information training and recruitment opportunities.

CREATING SUPPORTIVE ENVIRONMENTS

Funding for training and continuing education.

Ensuring appropriate salary levels for professionals.

Inclusion of pre-requisite topics in secondary school curriculum and conducting wide range of nutrition training in education, trade, agriculture and health sectors.

Career development opportunities.

DEVELOPING PERSONAL HEALTH SKILLS

Encouraging staff to act as role models for healthy lifestyle.

Individuals accepting responsibility for continuing education.

Ensuring that all nutrition workers are computer literate.

BUILDING ALLIANCES

Developing linkages with NGOs, work-sites and community groups.

Strengthening alliances with regional training programs including those with distance education capacity in order to improve food and nutrition modules.

NUTRITION PROMOTION AND INFORMATION DISSEMINATION

PRIORITY ISSUES

1. Inappropriate mix of dissemination strategies to reach stakeholders in public and private sectors.
2. Lack of consistent, credible, relevant and scientifically based health and nutrition messages.
3. Inadequate counselling by health team.
4. Infrequent evaluation of promotion or education initiatives.

OBJECTIVE 1

Nutrition communication and information strategies implemented in support of nutrition promotion programs.

INDICATORS

- 1.1 Information, Education and Communication strategies for improving nutrition-related behaviours of selected population groups and in support of national food and nutrition goals defined and disseminated to stake-holders in all countries by end March 2002.
- 1.2 Regional nutrition/education strategy defined and disseminated to stakeholders by mid-2002.
- 1.3 Selected manuals, journals, newsletters and books written/updated by CFNI and disseminated to identified clients in all countries over the period 1999-2003.

NUTRITION PROMOTION AND INFORMATION DISSEMINATION

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Ensuring that the public is aware and convinced of the benefits of healthy dietary practices.

Financial dis-incentives for unhealthy foods.

Policies to protect health of children.

RE-ORIENTING HEALTH SERVICES

Conducting multi-disciplinary training work-shops so that all partners of the health care team provide consistent advice to clients.

Provision of space for client counselling and exhibitions in health facilities.

Ensuring budget allocation for communication strategy and related training.

EMPOWERING COMMUNITIES

Promoting community participation given that their knowledge and actions are driving forces for behavioural and social change.

Encouraging vegetable gardening.

Educating the public on how to use nutrition labels.

CREATING SUPPORTIVE ENVIRONMENTS

Improving school and office lunch programs as well as providing facilities for physical exercise.

Promotion of direct access to nutritionist services.

Nutrition information at time of choice in restaurants and supermarkets/groceries.

DEVELOPING PERSONAL HEALTH SKILLS

Ensuring that each individual knows his or her nutrition profile and has plans on its improvement and maintenance.

Development of life-time exercise skills in adolescents and to be conducted at least 3 times per week.

Ensuring that individuals are knowledgeable about the nutritional value of foods often eaten.

BUILDING ALLIANCES

Ensuring that the private sector is aware of the relationships between health, agriculture and food.

Encouragement of corporate sponsorship of nutrition messages.

Support of health promotion programs in supermarkets/groceries

Strengthening links between the media and the nutrition and health sectors to ensure appropriate information is received by all stakeholders.

SURVEILLANCE

PRIORITY ISSUES

1. Routine data analysis limited to children and pregnant women.
2. Available information not effectively used to inform policy decisions and programme planning.

OBJECTIVE 1

More effective nutrition surveillance in place.

INDICATORS

- 1.1 Regional electronic nutrition information database, including indicators of nutritional well-being to inform and monitor social development, established and accessible in all countries, including nutrition coordinators, by end 1999.
- 1.2 Food and nutrition surveillance information systems, producing at least annual reports of individuals and groups at risk of, and actually suffering from, the most prevalent nutrition-related diseases established in at least five (5) countries by end 2000 and in all countries by end 2003.

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Policy of national decision-making on food and nutrition based on surveillance data.

Policy to increase public access to data.

Provision in Budget for surveys.

RE-ORIENTING HEALTH SERVICES

Increase in the perception, knowledge, demand for information, and technical capability of staff to improve health services.

Capture collected data to provide surveillance of adults.

EMPOWERING COMMUNITIES

Inclusion of communities in the planning of nutrition information.

Provision of feedback information to the community in user-friendly manner.

CREATING SUPPORTIVE ENVIRONMENTS

Conducting workshops and other participatory activities to demonstrate the value of the cycle of data collection-decision making-feedback-data collection, etc.

Provision of training at various levels on the variety of communication methods using various sources of information.

Improving access to computers for health care workers.

BUILDING ALLIANCES

Collaboration with general practitioners and nutritionists in private sector.

Building alliance with media and using other avenues to increase understanding and facilitate dialogue on nutrition situation.

FOOD SECURITY

PRIORITY ISSUES

1. Lack of a comprehensive programmes on food security.
2. Lack of an effective mechanism to monitor foods to assure minimum acceptable levels of food quality: surveillance systems rudimentary and laboratory capacity inadequate.
3. Food handlers and the community not adequately trained.
4. Inadequate legislation, regulation and standards for monitoring safety/quality of imported and exported foods.
5. Nutritionally-appropriate foods too expensive for many people.

OBJECTIVE 1

Food security plans developed and infrastructure for implementation established.

INDICATORS

- 1.1 Strategies to modify the food production and consumption profile, in order to prevent obesity and other nutritional disorders and ensure sustainable food security, developed in each country by end 2003.
- 1.2 Regional technical support unit to facilitate institutional linkages and ensure complementarity of national and international actions established by end 2002, and annual reports disseminated to all countries thereafter.

OBJECTIVE 2

National systems to ensure safe food available for local consumption and export.

INDICATOR

- 2.1 Legislation, regulations and standards in all countries by end 2001, in keeping with PAHO/FAO Caribbean model.



FOOD SECURITY

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Promotion of a culture of consumer protection and establishment of legislation to protect the consumer from unsafe, low quality and mis-labelled foods.

Ensure action to secure food supplies which will improve nutritional status and public health - including “buy local” culture and vegetable house gardens.

RE-ORIENTING HEALTH SERVICES

Strengthening the infrastructure for monitoring food safety and quality control.

Ensuring that public health teams understand approach to food safety.

Review functional relationship of nutrition services as part of Health Sector Reform.

Establishment of a multi-sectoral food and nutrition coordinating mechanism to ensure complementary actions.

EMPOWERING COMMUNITIES

Educating the community on how to be watchdogs for food safety including how to interpret expiry dates.

Informing the public of which establishments have not met standards.

Addressing gender-related issues on the basis of efficiency.

Participation of local groups to ensure that the technologies and other initiatives promoted meet their requirements as users.

CREATING SUPPORTIVE ENVIRONMENTS

Promoting the use of attractive local foods which are safe and tasty.

Ensuring that nutritional and hygiene aspects are included in the manufacture and processing of foods; promotion of effective labelling.

Improving safe food preparation and display in the work-site, with street vendors and in institutions.

Promotion and stimulation of agricultural investments, employment opportunities and income generation.

Ensuring a user-friendly process for registration of food handlers.

DEVELOPING PERSONAL HEALTH SKILLS

Establishing training programs for food producers and processors to ensure that food industry quality control systems comply with the laws and standards.

Learning how to produce a vegetable garden within local conditions, in schools or through clubs.

Multi-media programs on basic process to ensure safe production of meals at home.

BUILDING ALLIANCES

Linking with the private sector in the development and manufacture of healthy and nutritious foods.

Collaboration with CAREC and CFNI to develop monitoring programs for food-borne diseases.

Enhancement of the institutional linkages among CFNI, UWI, CNIRD, IICA, CARDI and NGOs.

Harmonisation and promotion of initiatives at the local, national and regional levels.

OPPORTUNITIES FOR JOINT ACTION

NUTRITION-RELATED DISEASES

- Regional approaches to data gathering (common protocols and sharing of analytical capacity):CNCD risk factor surveys in Caribbean population; food consumption pattern and lifestyle studies.
- Sharing of national experiences in planning process (bilateral TCC, regional scientific fora).

HUMAN RESOURCE DEVELOPMENT

- Distance education utilizing resource persons from across the region.
- Common mechanism for registration and performance standards.
- Capacity building through sharing of experiences and skills in the region.

NUTRITION PROMOTION & INFORMATION DISSEMINATION

- Common curricula for training programs across the region for doctors, nurses etc.
- Regional social communication programs

SURVEILLANCE

- Common definitions and core data set; sharing of software
- Shared regional database

FOOD SECURITY

- Establishment of regional indicators and regional monitoring network.
- Model legislation and regulations
- Ensuring/establishing regional nutritional and quality criteria for imported foods as part of trade policy.
- Sharing experiences and laboratory capacity.
- Model food safety training program with audio-visual aids; regional process for certification of trainers.

CHRONIC NON-COMMUNICABLE DISEASES

Chronic, non-communicable diseases (CNCDs) are the main causes of death, disability and illness in the Caribbean. Data from the Caribbean Epidemiology Centre (CAREC) indicate that between 1980 and 1990 the three leading causes of death in the region, in order of rank, were ischaemic heart disease (due to narrowing of the blood vessels supplying the heart), followed by cerebrovascular disease (stroke), diabetes mellitus (DM), other heart disease and hypertension (high blood pressure).

Diabetes and hypertension contribute significantly to heart disease and stroke and diabetes is a major cause of admissions to hospital, kidney failure, blindness and limb amputations which are not due to injuries. It therefore affects not only quality and length of life but also has enormous economic costs. Direct costs of hospitalization and clinic care constitute an increasing burden which countries can ill afford.

Breast and cervical cancers are the leading causes of death from cancer in women and prostate cancer is the leading cause of cancer deaths in men. Cervical cancer is a sexually-transmitted disease which can be prevented not only through changes in sexual behaviour, but also through screening of women at risk to detect and treat pre-malignant changes.

Most Caribbean countries are increasingly concerned about the toll which injuries take on the health of their populations. Though intentional injuries (violence) constitute a major health problem, unintentional injuries (accidents), particularly motor vehicle accidents, are also a significant public health issue. Intentional injuries will be dealt with as part of the mental health aspect of CCH-II, but it was thought that unintentional injuries would be best included with CNCDs.

Many of the strategies for the prevention and control of CNCDs involve those outlined in the Caribbean Charter for Health Promotion, which are appended to each sub-priority area. The strategies are of particular importance in fostering behaviour change, the adoption of healthy lifestyles and the formation of partnerships for health. Such partnerships involve public sectors other than Health, Non-Governmental Organizations (NGOs) and the private sector.

Countries must be aware that there are no “quick fixes” for CNCDs. Their effective prevention and control require long-term commitment of adequate resources and the planning, implementation and evaluation of programs that will achieve the goal despite changes in social, economic and political environments.

SUB-PRIORITY AREAS

PLANNING AND INFORMATION SYSTEMS

RISK FACTOR PREVENTION AND CONTROL

SCREENING

QUALITY OF CARE

OVERALL GOAL AND INDICATORS

GOAL

Morbidity and mortality from selected CNCDs and unintentional injuries decreased.

INDICATORS:

1. Mortality from the following reduced in at least 20% of countries over the period 1990-2005:
 - Hypertensive disease and ischaemic heart disease by at least 15%.
 - Diabetes mellitus by at least 10%.
 - Invasive cervical cancer by at least 20%.
 - Breast cancer by at least 10%.
 - Prostate cancer by at least 5%.
 - Unintentional injuries due to motor vehicle accidents by at least 10%.
2. Amputations in persons with diabetes reduced by at least 10% in at least 30% of countries over the period 1990-2005.
3. Hospital admissions for cerebrovascular accidents reduced by at least 10% in at least 20% of countries over the period 1990-2005.

PLANNING AND INFORMATION SYSTEMS

PRIORITY ISSUES

1. Inadequate epidemiological data (quantitative and qualitative) and surveillance systems.
2. Planning not information-based.
3. Lack of involvement of sectors other than Health and NGOs in planning and implementation of national programmes for CNCDs.

OBJECTIVE 1

Information and surveillance systems established.

INDICATORS

- 1.1 At least 80% of countries agree on minimum data set for selected CNCDs and/or injuries by end 2000.
- 1.2 At least 50% of countries initiate process, including commitment of resources, to establish relevant information and surveillance systems by end 2002.
- 1.3 At least 20% of countries outline plans for and initiate implementation of at least one specific registry for CNCDs and/or injuries by end 2003.

OBJECTIVE 2

Partnerships for planning and implementing CNCDs program developed.

INDICATOR

- 2.1 At least 60% of countries establish multi-sectoral body, including NGOs, in planning and implementation of national CNCD programmes by end 2003.

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Establishment of policies governing the operation of information systems.

RE-ORIENTING HEALTH SERVICES

Mobilization and allocation of resources for the establishment and maintenance of information systems.

BUILDING ALLIANCES

Involvement of NGOs in the operation of information systems.

Fostering greater appreciation of contribution of non-health sectors to health.

Involvement of social sector and program beneficiaries in program planning, implementation and evaluation.

RISK FACTOR PREVENTION AND CONTROL

PRIORITY ISSUES

1. Lack of organized programmes to facilitate the adoption of healthy lifestyles.
2. Insufficient attention paid to primary prevention (risk factor prevention and control) of CNCs and injuries by Ministries of Health and related sectors.

OBJECTIVE 1

Healthy lifestyle programmes developed and implemented.

INDICATORS

- 1.1 At least 50% of countries develop and implement healthy lifestyle programs at national and/or local level by end 2003.
- 1.2 At least 30% of countries enact anti-smoking legislation, including promotion of smoke-free environments and regulation of sale of tobacco to minors by end 2003.
- 1.3 At least 10 countries plan and implement surveys to determine contributing factors to motor vehicle accidents by end 2000.
- 1.4 At least 60% of countries draft legislation to prevent injuries secondary to motor vehicle accidents.

OBJECTIVE 2

Value of primary prevention appreciated by Ministries of Health.

INDICATOR

- 2.1 At least 60% of countries increase budgetary allocation for health promotion by at least 5% over 1997 levels by end 2003.

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Drafting of relevant legislation and policy for smoke-free environments, prevention of sale of tobacco to minors, and wearing of seat belts and helmets.

Formulating food security policies that protect cost of basic "basket" of healthy foods.

EMPOWERING COMMUNITIES

Public education programs.

CREATING SUPPORTIVE ENVIRONMENTS

Enactment and enforcement of legislation.

Creation of smoke-free environments.

DEVELOPING PERSONAL HEALTH SKILLS

Fostering attitudinal and behaviour change.

BUILDING ALLIANCES

Collaboration with other sectors, NGOs and the media.

SCREENING

PRIORITY ISSUES

1. Insufficient attention to secondary prevention of CNCs by Ministries of Health and related sectors.
2. Lack of organized screening programmes for selected CNCs.

OBJECTIVE 1

Screening programs targeting selected population groups developed.

INDICATORS

- 1.1 At least 50% of countries establish cervical cancer screening programs aimed at having at least 60% of women over age 40 have one Pap smear by end 2002.
- 1.2 At least 50% of countries develop and implement policies and protocols for screening first degree relatives of persons with diabetes by end 2000.
- 1.3 At least 50% of countries develop and implement public education programs promoting regular screening for breast and prostate cancers in keeping with international guidelines and practices by end 2000.
- 1.4 At least 50% of countries develop and implement continuing education programs encouraging health care providers to screen for hypertension as part of routine examination by end 2000.

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Drafting of policies to facilitate screening.

RE-ORIENTING HEALTH SERVICES

Education of health care providers and provision of infrastructure to facilitate screening.
Scheduling services for the convenience of the clients.

EMPOWERING COMMUNITIES

Public education programs on the value of early detection and treatment.

DEVELOPING PERSONAL HEALTH SKILLS

Education about self-examination, regular visits for screening and awareness of “warning signs”.

BUILDING ALLIANCES

Collaboration with NGOs, the media and private sector.

QUALITY OF CARE

PRIORITY ISSUES

1. Inadequate use of protocols and standards to facilitate quality care in CNCDS.
2. Unavailability and/or excessive cost of drugs.
3. Cost of diagnostic and treatment services increasing.

OBJECTIVE 1

Quality of care in selected CNCDS improved.

INDICATORS

- 1.1 At least 50% of countries develop and/or implement protocols for management of selected CNCDS by end 2000.
- 1.2 At least 50% of countries evaluate use of protocols, including assessment of client satisfaction, by end 2002.
- 1.3 At least 60% of countries implement at least one continuing education activity related to CNCDS per year for health care providers and/or others in health-related fields over the period 1999-2003.
- 1.4 At least 60% of countries plan and implement at least one self-help programme for persons with selected CNCDS by end 2001.

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Decision to adopt specific policies, protocols and standards.

Health Sector Reform to ensure health care financing package available for persons with CNCDS.

Policy on Essential Drugs.

RE-ORIENTING HEALTH SERVICES

Raising awareness of existence of specific policies, protocols and standards.

Training of health care providers in use of specific policies, protocols and standards.

EMPOWERING COMMUNITIES

Drafting and advertisement of charter of patient/client rights and responsibilities.

CREATING SUPPORTIVE ENVIRONMENTS

Health Sector Reform to ensure health care financing package available for persons with CNCDS.

DEVELOPING PERSONAL HEALTH SKILLS

Drafting and advertisement of charter of patient/client rights and responsibilities.

BUILDING ALLIANCES

Collaboration with private sector, professional associations and alternative medicine practitioners.

OPPORTUNITIES FOR JOINT ACTION

PLANNING AND INFORMATION SYSTEMS

- Facilitation of networking among, and institutional strengthening of, national and sub-regional NGOs.
- Standardization of data items and information systems.
- Development of disease registries with common minimum data set to allow comparison of data at regional level.

RISK FACTOR PREVENTION AND CONTROL

- Strengthening of Health Education Units through technical cooperation and sharing of expertise.
- Development of model legislation regarding prevention of injuries due to motor vehicle accidents.

SCREENING

- Formulation and adoption of sub-regional guidelines and protocols for screening.

QUALITY OF CARE

- Formulation and adoption of protocols and guidelines for quality care.

COMMUNICABLE DISEASES

During the period 1980-1994 morbidity due to communicable diseases in the Caribbean declined significantly as a result of expansion of those health services that offered interventions such as preventive immunisations; reduction in poverty, which allowed households to increase their consumption of safe and clean water; and increasing educational levels which facilitated individuals to apply new scientific knowledge to protect their own health as well as that of their families.

The most significant declines in morbidity and mortality due to communicable diseases have been recorded for the six target diseases of the Expanded Programme on Immunisation: poliomyelitis, diphtheria, pertussis, tetanus, measles and tuberculosis. This programme has been successful in achieving high vaccination coverage rates throughout the Caribbean and significant reduction in the incidence of these diseases. It is therefore necessary that all countries in the Caribbean continue to vaccinate their populations and maintain effective public health surveillance systems.

Tuberculosis has re-emerged as a major public health problem because of poverty, malnutrition, diminished control efforts, the HIV/AIDS epidemic and the emergence of multiple-drug-resistant strains of the causative agent (*Mycobacterium tuberculosis*). It is therefore necessary for countries to re-establish tuberculosis as a priority problem and allocate the necessary resources for its control. With the high case fatality rates associated with the HIV/AIDS epidemic and in the absence of any effective treatment or prophylaxis, it will be necessary for countries to strengthen epidemiological surveillance; create definitive programmes and policies on the care and support of persons with AIDS; and strengthen educational activities in an effort to modify behaviour in the population.

The prevention and control of communicable diseases in the Caribbean requires that CCH-II focus on food-borne, water-borne and vector-borne diseases; on vaccine preventable diseases - especially those which are not included in the existing schedules; and on STD/HIV/AIDS and tuberculosis.

SUB-PRIORITY AREAS

FOOD-, WATER- AND VECTOR-BORNE DISEASES

VACCINE-PREVENTABLE DISEASES

**(DIPHTHERIA, PERTUSSIS, TETANUS, POLIOMYELITIS, MEASLES,
RUBELLA, MUMPS, HEPATITIS B, HAEMOPHILUS INFLUENZA).**

STDs/HIV/AIDS AND TUBERCULOSIS

OVERALL GOAL AND INDICATORS

GOAL:

Mortality and morbidity for food-borne, water-borne and vector-borne diseases reduced; and the Caribbean region maintained free from polio and measles, and rubella eliminated.

INDICATORS:

1. Incidence of four tracer food-borne and water-borne diseases reduced by 50% of the 1997 level in all countries by end 2003.
2. In endemic countries the incidence of malaria reduced by 25% below the 1998 levels by end 2003, and in malaria-free countries zero cases of indigenous malaria maintained.
3. The regional incidence rate of dengue fever confirmed to no more than 50 cases per 100,000 population and case fatality rate of DHF should not exceed more than 5% in any country.
4. In all countries, elimination status of zero cases of indigenous polio maintained by end 1999.
5. No cases of indigenous rubella and congenital rubella syndrome occurring in any country by end 2003.
6. In all countries, elimination status of zero cases of indigenous measles maintained.
7. Prevalence of HIV infection among pregnant females 15-19 years in the region (a sentinel population) reduced by 30% below the 1997 levels by end 2003.
8. Incidence of urethral discharge and genital ulcers among males aged 15-49 years reduced by 20% below 1997 levels by end 2003.
9. Regional TB incidence rates reduced to no more than 5 cases per 100,000 population by end 2003.
10. Rate of reported vertical transmission of HIV reduced by 50%, as evidenced by a decrease in the number of HIV positive babies born to infected mothers by end 2003.

FOOD-, WATER- AND VECTOR-BORNE DISEASES

PRIORITY ISSUES

1. Weak and/or inadequate surveillance systems exist for food, water and vector-borne diseases.
2. Lack of a monitoring system for behavioural risk factor surveillance.
3. Continued occurrence of food-borne disease outbreaks in communities and institutions.
4. Increasing incidence of Dengue and Dengue Haemorrhagic Fever (DHF) in the Region with high case fatality rates.
5. Increasing incidence of malaria in malaria-endemic countries and outbreaks in non-endemic countries.

OBJECTIVE 1

Surveillance systems for food-, water- and vector-borne diseases strengthened.

INDICATORS

- 1.1 Prescribed protocols for surveillance of communicable diseases adhered to in at least 75% of countries by end 2000.
- 1.2 In at least 80% of countries, surveillance reports on the incidence of vector-related diseases analysed on a monthly basis with feedback to field units and to CAREC no later than one month after end of period by end 2001.
- 1.3 All countries implement appropriate clinical management protocols for DHF and DSS by mid-1999.

VACCINE-PREVENTABLE DISEASES

(diphtheria, pertussis, tetanus, poliomyelitis, measles, rubella, mumps, hepatitis B, Haemophilus influenza).

PRIORITY ISSUES

1. The Caribbean has registered success in the area of vaccine-preventable diseases, but there remain obstacles (psycho-social, cultural, economic and service-related) to universal coverage.
2. Limited capacity of health service to provide supportive programming and evaluation components e.g. IEC design, monitoring of impact and evaluation of behavioural interventions.
3. The need to ensure that social and political commitments continue to support and maintain protection of the individual against those diseases for which vaccines are available but not routinely included in schedules; financial resources required to implement CARICOMMinisters' declaration to eliminate rubella.

OBJECTIVE 1

Vulnerable populations immunised against selected vaccine preventable diseases.

INDICATORS

- 1.1 At least 95% EPI coverage achieved in all countries by end 2003.
- 1.2 All countries have in place for EPI a focal person; a plan that ensures access by all sectors of the population; and the resources to implement the plan by end 2003.
- 1.3 In all countries, Hepatitis B (HepB) and Haemophilus influenzae B (HiB) vaccines introduced into the public health immunization schedule by 2003.

OBJECTIVE 2

Compliance promoted by marketing, to all sectors of the population, the importance and cost-effectiveness of immunisation.

INDICATORS

- 2.1 In all countries, a marketing strategy for newly introduced vaccines developed, incorporated and implemented within national EPI plans by end 2003.
- 2.2 A sub-regional EPI marketing plan developed and implemented by end 2003.

OBJECTIVE 3

Reliable systems for safe delivery of efficacious vaccines to clients established and maintained,

INDICATOR

- 3.1 All countries attain and maintain full cold chain requirements by end 2003.



VACCINE-PREVENTABLE DISEASES

OBJECTIVE 4

Legislation to support the immunisation of vulnerable groups against vaccine preventable diseases enacted.

INDICATORS

- 4.1 All countries have updated legislation pertinent to the vaccine preventable diseases by end 2003.
- 4.2 All countries have reliable systems for safe disposal and destruction of used syringes, needles and vaccine vials by end 2003.

OBJECTIVE 5

Sensitive surveillance and control systems established and made operational.

INDICATORS

- 5.1 All countries adhere to prescribed protocols (for the reporting, investigation and control of vaccine preventable diseases) for surveillance of vaccine preventable diseases by end 2003.
- 5.2 All countries will have implemented a surveillance system for adverse events, supported by written guidelines, by end 2003.

STDs/HIV/AIDS AND TUBERCULOSIS

PRIORITY ISSUES

1. Inadequate surveillance systems for assessment of the burden of the communicable disease situation in countries.
2. Inadequate measures to assist/involve communities in disease prevention and control.
3. Inadequate advocacy.
4. Human and financial resources inadequate and/or poorly managed, utilised or distributed.
5. Unavailability of model treatment services.
6. Inadequacy of legislation to facilitate appropriate public health action and interventions.

OBJECTIVE 1

Health Information and Surveillance systems strengthened to generate data for public health action.

INDICATORS

- 1.1 In all countries, a quarterly epidemiologic review based on data generated by laboratories and epidemiology surveillance units produced, disseminated and utilised for public health decision-making by end 2003.
- 1.2 In all countries, a minimum of two national research projects related to either HIV, AIDS, common STDs or TB developed and executed by end 2003.

OBJECTIVE 2

Appropriate policies, regulations, and legislation to ensure effective disease prevention and control of HIV/AIDS/STDs and TB enacted and enforced.

INDICATORS

- 2.1 Legislation regarding confidentiality of health status information and the protection of human rights of persons infected and affected by AIDS enacted and promulgated in all countries by end 2002.
- 2.2 Legislation to regulate the establishment and functioning of clinical and public health laboratories enacted and promulgated in all countries by end 2002.

OBJECTIVE 3

Multi-sectoral collaboration between relevant agencies, (e.g. Ministries of Housing, Social Development, National Security, Finance and Health) enhanced in order to minimise the risks and impact associated with the occurrence of communicable diseases.

INDICATOR

- 3.1 Multi-sectoral mechanism (national AIDS committees including NGOs and PWAs) which reflects the expanded response required for the HIV/AIDS epidemic established in all countries by end 1999.



STDs/HIV/AIDS AND TUBERCULOSIS

OBJECTIVE 4

Availability and quality of diagnostic, clinical, preventive and support services for STDs/AIDS/HIV/TB and client accessibility to these improved.

INDICATORS

- 4.1 At least 75% of reported persons living with HIV/AIDS receive appropriate clinical management in accordance with UNAIDS standards for case management in all countries by end 2003.
- 4.2 At least 75% of reported persons living with HIV/AIDS and 50% of persons affected by HIV/AIDS receive supportive counselling by end 2003.

OBJECTIVE 5

Committed decision makers and key influential persons at all levels of the society actively engaged in support of the prevention and control of HIV/AIDS/TB.

INDICATORS

- 5.1 STDs/AIDS/HIV/TB issues programmed for action in annual national budgets by the political leadership in all countries by end 2001.
- 5.2 In all countries, 40% of private sector organisations have HIV/AIDS work place policies established by end 2003.

OBJECTIVE 6

Individuals and communities, through education and other strategies, adopt preventive behaviour and be empowered as partners in care efforts for AIDS and TB patients.

INDICATORS

- 6.1 In all countries, the proportion of persons reported living with AIDS who receive care in the community increased by at least 10% above the 1999 level by end 2003.
- 6.2 The proportion of 15-19 year olds practising care-seeking behaviours that reduce the risk of STD/HIV infection increased by at least 30% above current 1997 levels by end 2003.
- 6.3 Thirty per cent (30%) of males aged 15-49 years reporting a decrease in non-regular sexual partners by end 2003.
- 6.4 In all countries, 75% of confirmed TB patients receive Directly Observed Therapy (D.O.T.S.) in the community and cured as evidenced by a test of cure at the end of treatment by end 2003.

OBJECTIVE 7

Strategy to facilitate behaviour change, screening and treatment related to decreased transmission of HIV and syphilis implemented.

INDICATORS

- 7.1 Condom usage with last non-regular sexual partner increased by 30% above current 1997 level by end 2003.
- 7.2 Syphilis testing of 85% of pregnant women undertaken twice during pregnancy in accordance with current Caribbean recommendations by end 2003.
- 7.3 At least 80% of syphilis positive pregnant seeking antenatal care and 60% of their sexual partners adequately treated by end 2002.

STDs/HIV/AIDS AND TUBERCULOSIS

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Existing legislation reviewed, updated and enforced.

Appropriate information dissemination technology and policies in place.

Institutional strengthening to manage programmes.

Adoption of the national plan for the prevention and control of STDs/HIV/AIDS by all key stakeholders.

RE-ORIENTING HEALTH SERVICES

Training and re-training of health care workers and allied personnel.

Improvement in collecting, analysing and disseminating information.

EMPOWERING COMMUNITIES

Developing self-help projects.

Establishing community organisations or mobilising existing community groups to deal with vector control.

CREATING SUPPORTIVE ENVIRONMENTS

Ensuring that infrastructure (laboratory facilities and quality control mechanisms) in place.

Introducing on site policies and programs at work sites.

DEVELOPING PERSONAL HEALTH SKILLS

Educating individuals about lifestyle choices.

BUILDING ALLIANCES

Close collaboration with community groups, trade unions, the media, NGOs, church groups.

MENTAL HEALTH

The importance of mental health has long been recognized by Caribbean governments and regional agreements on the principles of delivery of mental health services have been reached. Limited financial and human resources have prevented many of the mandates from being implemented but, with renewed recognition of the issues, new initiatives and strategies are being considered and implemented. CCH-II is such an initiative.

It is well recognized that mental disorders disrupt the life of the community and the individual but more data are needed on the epidemiology of these disorders, especially in populations such as the elderly, adolescents and children. Data are also needed on the influence of socio-economic and socio-cultural environments on mental health.

Important mental health issues in the region include policy, services, promotion, human resource development and legal issues, including patients' rights. Psychiatric institutions are still regarded as the centre of delivery of care though most are ill-equipped to offer therapeutic interventions other than custodial care. There is increasing emphasis on community mental health but further development of the infrastructure to ensure its effectiveness is needed.

Human resource development, tailored to the needs and capacity of the countries, needs to be addressed further in recognition that mental health care is best delivered through a team approach. Consumer issues and mental health promotion, including the development of vibrant Mental Health Associations, the acknowledgement of the patient as an integral member of the Mental Health Team and greater consideration of patients' rights, need more emphasis. Mental health promotion needs particularly to address removal of the stigma associated with mental illness and also associated with those who work with the mentally ill.

The maintenance of mental health must be approached in the same way as the maintenance of physical health. Primary prevention (dealing with risk factors), secondary prevention (early detection through screening, with appropriate treatment) and tertiary prevention (treatment and rehabilitation) all have a role to play in the prevention and control of mental illness. The development of comprehensive mental health programs is a priority and involves cooperation and collaboration with sectors other than Health, non-governmental organizations, the private sector, regional institutions and international organizations.

SUB-PRIORITY AREAS

**HUMAN RESOURCE DEVELOPMENT AND TRAINING
FRAMEWORK FOR DEVELOPMENT AND DELIVERY
OF MENTAL HEALTH PROGRAMS**

PREVENTION OF MENTAL HEALTH DISORDERS
(INCLUDING SUBSTANCE ABUSE, WITH EMPHASIS ON CHILDREN,
ADOLESCENTS AND FAMILIES)

**MENTAL HEALTH INFORMATION AND INFORMATION
SYSTEMS**

MENTAL HEALTH PROMOTION

**INTEGRATED COMMUNITY-BASED MENTAL HEALTH
SERVICES**

OVERALL GOAL AND INDICATORS

GOAL

Mental health infrastructure improved and mental health of Caribbean populations improved and maintained.

INDICATORS

1. Prevalence of at least 3 selected mental disorders, including substance abuse, reduced by 5% in at least 5 countries by end 2010.
2. Suicides reduced to no more than 7 per 100,000 in at least 5 countries by end 2008.
3. The proportion of persons with depressive disorders who obtain treatment in the primary care services increased by 4% between 1996 and 2004.
4. The number of persons over 18 years who seek help with personal and emotional problems in the Primary Health Care system (public and private) or through recognized counsellors increased by 5% by end 2010.
5. Length of stay at psychiatric hospitals reduced by 5% from 1997 levels in at least 3 countries by end 2001.

HUMAN RESOURCE DEVELOPMENT AND TRAINING

PRIORITY ISSUES

1. Planning for number and type of health professionals inadequate and priority not given to training or recruitment for appropriate “mix”.
2. Need to conduct cultural sensitivity training for those persons trained outside the region.
3. Minimal use of mental health professionals in expanded roles as practitioners, administrators and researchers.
4. Difficulties experienced by some countries in retaining and sustaining mental health professionals; and problems with increasing “burn-out” among those professionals.

OBJECTIVE 1

Mental health manpower needs determined and capacity for production of selected professionals increased.

INDICATORS

- 1.1 Assessment of mental health manpower needs conducted in all countries based on national definition of composition, roles and responsibilities of Mental Health Team by mid 2001.
- 1.2 Regional training program in at least one (1) new area established and approved by the Association of Caribbean Tertiary Institutions (ACTI) by end 2003.
- 1.3 Opportunities for continuing education and sharing of experiences at least once a biennium provided by regional professional associations and/or regional mental health NGOs by end 2003.

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Review/revision of policy to allow mental health team to function as required.

RE-ORIENTING HEALTH SERVICES

Review of manpower and skills

BUILDING ALLIANCES

Involve the Association of Caribbean Tertiary Institutions (ACTI).

FRAMEWORK FOR DEVELOPMENT AND DELIVERY OF MENTAL HEALTH PROGRAMS

PRIORITY ISSUES

1. Need for mental health Code of Ethics.
2. Few countries have mental health plans and these are seldom integrated into national health plans.
3. Mental health legislation antiquated with inadequate enforcement and utilization of what exists.
4. Inadequate consumer participation in mental health program planning, implementation and evaluation.

OBJECTIVE 1

Framework for implementation of modern practices related to mental health and psychiatry established in collaboration with community.

INDICATORS

- 1.1 Regional mental health Code of Ethics adopted or adapted by all countries by end 2001.
- 1.2 Comprehensive mental health plans, addressing promotion, prevention and treatment, including forensic psychiatry, developed and integrated into national health plans by end 2003.
- 1.3 At least one (1) NGO or professional association related to mental health included among partners with Observer Status to Council on Human and Social Development (COHSOD) by end 2000.
- 1.4 Multi-disciplinary, multi-sectoral Advisory Committee, including consumer representation, organized and meeting at least once a year to plan and evaluate mental health programs by end 1999.
- 1.5 Mental health legislation dating no earlier than 1985 enacted in at least 80% of countries by end 2003.



FRAMEWORK FOR DEVELOPMENT AND DELIVERY OF MENTAL HEALTH PROGRAMS

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Synthesis and adaptation of existing codes, professional codes of conduct and best practice guidelines.

Consultative process involving health professionals.

Appropriate policy changes to foster integration.

RE-ORIENTING HEALTH SERVICES

Education of health professionals on consumer rights.

EMPOWERING COMMUNITIES

Involvement of communities in the review process.

Organisational strengthening, training, provision of management skills.

Informing consumer of his/her rights.

CREATING SUPPORTIVE ENVIRONMENTS

Review of current status of legislation; recommendations for improvement.

Creation of climate that supports advocacy.

BUILDING ALLIANCES

Collaboration with other departments in the health sector.

Collaboration with other interest groups.

Increased collaboration between Ministries and NGOs.

PREVENTION OF MENTAL HEALTH DISORDERS

(including substance abuse, with emphasis on children, adolescents and families)

PRIORITY ISSUES

1. Need for coordination for prevention of mental health disorders.
2. Need for mental health component in many existing health and education services.
3. Few programs for early detection and intervention programs and inadequate mechanisms for referral among the sectors.
4. Epidemiology of increasing levels of violence, particularly among young males and within domestic relationships, unknown and little support for addressing psychological consequences.
5. Need to strengthen substance abuse prevention and control programs, including abuse of alcohol and prescription drugs.

OBJECTIVE 1

Critical components of national programs for early detection and prevention of mental health problems in specially selected groups functional.

INDICATORS

- 1.1 National mental health Coordinator formally designated in each country by mid-2000.
- 1.2 Regional guidelines and protocols for inclusion of Mental Health components in family and community health services adapted or adopted and implementation initiated in all countries by mid-2003.
- 1.3 Standardized instruments developed and used to screen children and adolescents for mental disorders as part of existing developmental screening programs in health and education sectors in all countries by end 2002.
- 1.4 Mechanisms for early detection and intervention for families at risk established in the community in collaboration with NGOs, and advertised through all media, in at least 5 countries, by end 2003.
- 1.5 At least one (1) staff person in 50% of primary schools and all secondary schools trained in counselling and mediation by end 2002.
- 1.6 Conflict resolution training available to all children between the ages of 10 and 15 years in 75% of countries by end 2002.

OBJECTIVE 2

Existing substance abuse prevention and control measures strengthened.

INDICATORS

- 2.1 Substance abuse prevention and control component included in national mental health plans of all countries by end 2000.
- 2.2 Programs planned for substance abuse prevention and control in selected populations, including children and young adults, in all countries by end 2000.



PREVENTION OF MENTAL HEALTH DISORDERS

(including substance abuse, with emphasis on children, adolescents and families)

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Review and/or revision of existing plans.
Use of research findings to inform policy.

RE-ORIENTING HEALTH SERVICES

Identification of a suitable locus to focus on mental health programs.
Re-orientation of Maternal and Child Health and Health and Family Life Education (HFLE) programs to reflect psycho-social concerns.
Public education targeting teachers and parents on how to recognise mental health disorders, and on re-training of health care workers.
Research and creation of appropriate instruments.
Development of research methodology and/or instruments.

EMPOWERING COMMUNITIES

Public education programs targeting groups.
Formation of support groups.
Training of mediators.

CREATING SUPPORTIVE ENVIRONMENTS

Appointment of focal point to whom people can relate and who can act as a resource.
Establishment of community norms.

DEVELOPING PERSONAL HEALTH SKILLS

Training of groups and individuals.

BUILDING ALLIANCES

Advocacy within the health sector and with the Ministry of Education.
Involvement of Ministry of Education, parents, teachers, media.
Collaboration with other sectors, including the media.

MENTAL HEALTH INFORMATION AND INFORMATION SYSTEMS

PRIORITY ISSUES

1. Need for comprehensive database on mental health needs, morbidity, treatment and outcomes.
2. Poor dissemination of mental health information at regional and national levels.
3. Epidemiology of selected priority problems in mental disorders unknown.

OBJECTIVE 1

Modern information technologies maximized to increase capacity of countries to analyze mental health data.

INDICATORS

- 1.1 WHO Global Mental Health Database data collection instrument adopted and/or adapted to develop standardised instrument for sub-regional database, with input from all countries by end 2000.
- 1.2 Instrument administered in at least 60% of countries and sub-regional database established by end 2001.
- 1.3 At least two multi-country research projects completed by end 2003, including one to elucidate the epidemiology of suicide.
- 1.4 Network of Mental Health Coordinators and/or mental health resource agencies, and/or individuals working in mental health established through electronic communication by end 2000.

HEALTH PROMOTION STRATEGIES

RE-ORIENTING HEALTH SERVICES

Development and/or strengthening of Essential National Health Research (ENHR).

Replication of ENHR survey of research institutions (done in Jamaica, Trinidad & Tobago, Curacao) in other countries.

BUILDING ALLIANCES

Collaborating with regional institutions.

MENTAL HEALTH PROMOTION

PRIORITY ISSUES

1. Information not analyzed and packaged to demonstrate to policy makers the impact of mental health and mental disorders on health and development.
2. Persistent stigmatization of persons with mental disorders by public in general and social partners including employers.
3. Need for greater appreciation by health professionals of the psycho-social contribution to the development and treatment of physical illnesses and assumption of responsibility by these professionals for the total management of the patient.

OBJECTIVE 1

Mental Health placed on agenda of policy makers and health workers sensitized to need to integrate mental health and the psychosocial aspects of physical illness in the management of patients.

INDICATORS

- 1.1 Cost-benefit studies (social and economic costs of mental disorders, cost-effectiveness of prevention and treatment of mental illness) conducted in at least three (3) countries by end 2001.
- 1.2 Presentation of results of cost-benefit studies on mental disorders made to: a) the CARICOM Council of Human and Social Development (COHSOD); b) national fora for social development in at least four (4) countries; and c) national and regional media, by end 2002.
- 1.3 Curricula of regional and national training programs for family practitioners, community and public health nurses reviewed and revised to provide skills for management of mental disorders and maintenance of mental health by end 2001.

HEALTH PROMOTION STRATEGIES

RE-ORIENTING HEALTH SERVICES

Research conducted by health economists in the region.

Increased focus of promotion/prevention, especially in mental health.

Re-training.

Greater emphasis on community mental health.

CREATING SUPPORTIVE ENVIRONMENTS

Determination of infrastructure needed to support community care.

BUILDING ALLIANCES

Media relations.

Cooperation among Ministry of Health, UNICEF, parents and teachers.

Involvement of NGOs, including church groups.

INTEGRATED COMMUNITY-BASED MENTAL HEALTH SERVICES

PRIORITY ISSUES

1. Primary Health Care Team not trained to identify and manage mental health disorders.
2. Need for integration of mental health services into general health care at all levels.
3. More community support services, including accommodation, needed to support de-institutionalization.
4. Need for comprehensive rehabilitation programs to allow individuals to achieve their maximum potential.

OBJECTIVE 1

Critical elements of comprehensive community-based mental health programs functional.

INDICATORS

- 1.1 Marketing strategy defined and brochures describing community-based services available in all public health centres and in 50% of general practitioners' offices by end 2002.
- 1.2 Services delivered by Mental Health Team, with documented policies and protocols for referrals, available in at least 50% of public health centres by end 2003.
- 1.3 Primary Health Care staff in 50% of health centers in all countries trained to use WHO International Classification Guidelines (ICD), adapted if necessary, to manage selected common mental health disorder, by end 2002.
- 1.4 Mechanisms to facilitate return of client to community, e.g. sheltered workshop and/or half-way house, available in at least one community in at least 50% of countries by end 2003.
- 1.5 Psychiatry beds/ward included in all acute care hospitals (national referral centres or hospitals with more than 200 beds) built after 1997 or renovated, by end 2003.
- 1.6 Regional standards for quality care in psychiatric in-patient services developed and adapted or adopted by all countries by end 2003.

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Provision of framework to mandate integration of programs.

RE-ORIENTING HEALTH SERVICES

Formulation of new job descriptions; re-assignment of responsibilities; re-training; and re-orientation of health providers.

Determination of consumer needs and implementation of recommended improvements.

EMPOWERING COMMUNITIES

Participatory methods.

ENVIRONMENTAL HEALTH

In 1979, the CARICOM Ministers Responsible for Health approved the Caribbean Environmental Health Strategy because of the need to remedy the environmental health hazards that threatened the population of the Caribbean. A key element of the strategy was the establishment of the Caribbean Environmental Health Institute (CEHI) which was founded in 1981.

The goals of the strategy included the supply of safe water and the provision of approved facilities for the sanitary disposal of liquid waste, excreta and solid waste; standards and criteria for the design of water supply and waste disposal systems; and the establishment of agencies to monitor and regulate environmental pollution.

Drinking water supply in the Caribbean demonstrates high coverage levels in terms of the percentage of the population with access to piped water. While there has been progress in water supply, there has very little progress with sewerage in that countries have not been able to expand the sewage disposal services. Although there are limited sewerage services, sanitation coverage is high, particularly through individual excreta disposal systems.

Approximately 5,000 tons of solid waste are generated daily in the Caribbean and in most of the countries it receives low priority when compared with other national needs. With the indirect health risks to the population because of poor solid waste management practices, it is important that the existing systems for the collection and disposal of waste be upgraded.

The CCH-II objectives and indicators as outlined will provide the basis for initiatives and programmes to improve environmental health in the Caribbean.

SUB-PRIORITY AREAS

VECTOR CONTROL

LIQUID WASTE AND EXCRETA DISPOSAL

SOLID WASTE MANAGEMENT

WATER QUALITY

WORKERS' HEALTH

OVERALL GOAL AND INDICATORS

GOAL

Selected community health conditions and environmental health risks reduced.

INDICATORS

1. By the year 2003, household and container indices reduced by 50% between 1998 and 2003.
2. By the year 2003, the number of outbreaks of food- and water-borne diseases from infectious agents and chemical poisoning reduced to less than 75% of 1999 level.
3. Reduced risk of solid waste-related contamination as measured by reduction of per capita waste produced daily by 10% between 1999 and end 2003 in 80% counties.
4. By 2003 at least 95% of urban and 80% of rural population have access to water that meets WHO quality standards or national standards, piped to or within 100 yards of each house.
5. By 2003, at least 80% of recreational water monitored in all countries meets WHO quality standards.
6. Reduction of human exposure to untreated liquid waste or excreta - by 2003, at least 85% of rural and 95% of urban population have access to and using appropriate sanitary facilities.
7. Work related deaths and number of sick-days related to work-related causes, including injuries reported by social security agencies, decreased by 10% between 1998 and 2003.

VECTOR CONTROL

PRIORITY ISSUES

1. Low levels of knowledge and inappropriate behaviour by households and community with respect to vector control.
2. Ineffective strategic management of vector situation and inadequate institutional capacity for surveillance of disease vectors.
3. Inadequate source reduction. Fogging costly and often ineffective.

OBJECTIVE 1

Community more aware of vector control strategies and demonstrate appropriate behaviour for integrated vector control.

INDICATORS

- 1.1 KAP studies indicate that by 2003 at least 90% of population knowledgeable of the *Aedes aegypti* mosquito and aware of critical factors which result in increased vector population.
- 1.2 Seventy five per cent (75%) of households using a checklist of habitats for managing the environment to protect against vector-borne diseases by end 2003.
- 1.3 Stored water sources/containers protected against mosquito breeding in at least 80% of households in all countries by end 2003.

OBJECTIVE 2

Vector control plans maintained current and capacity for monitoring vector distribution strengthened.

INDICATORS

- 2.1 Plans for integrated vector control updated annually at national and community-unit levels in all countries by end 2003.
- 2.2 At least 75% of countries have biological control programmes included as part of their integrated vector control strategies by end 2003.
- 2.3 In all countries, relevant vector indices analyzed quarterly and reports distributed to policy makers, community health teams and PAHO & CAREC by at least the end of the month after the period ends by end 1999.
- 2.4 In all countries monthly reports of disease incidence (including from sentinel physicians in the private sector) analyzed and disseminated to policy makers, community health teams and PAHO/CAREC by the 20th of the month following the end of the period by end 2001.

VECTOR CONTROL

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Review of public policies to emphasize community empowerment and involvement.
Rewards and penalty system established.

RE-ORIENTING HEALTH SERVICES

Decentralized health services to community level.
Integrated approach to vector control.

EMPOWERING COMMUNITIES

Training of community leaders and allowing participation in decision making process.
Establishment of community based groups and vigilantes.

CREATING SUPPORTIVE ENVIRONMENTS

Providing adequate resources and institutionalisation of competitions at national levels.

DEVELOPING PERSONAL HEALTH SKILLS

Adoption of health habits which support the suppression of vectors

BUILDING ALLIANCES

Collaboration with the media, NGOs, churches, service groups and healthy city projects.

LIQUID WASTE AND EXCRETA DISPOSAL

PRIORITY ISSUES

1. Lack of access and low coverage with technically appropriate facilities.
2. Inadequate capacity for monitoring, surveillance and management.
3. Inadequate policy and legislation for operations and monitoring.

OBJECTIVE 1

Plans and standards for increasing access to appropriate sanitary facilities developed.

INDICATORS

- 1.1 All countries would have plans for achieving targets for sanitary facilities including technical feasibilities and strategies for financing required investment by end 2001.
- 1.2 Standards for construction of sanitary facilities developed and available at all designated national outlets by end 2000.

OBJECTIVE 2

Capacity for monitoring, surveillance and management strengthened.

INDICATORS

- 2.1 Legislation of each country reviewed to ensure effective monitoring of compliance by operators with conditions of license by end 2001.
- 2.2 Ninety per cent (90%) of designated Environmental Health Officers (EHOs) in all countries trained and provided with resources to monitor efficiency and effectiveness of treatment plant operations by end 2003.
- 2.3 At least 80% of treatment plants in all countries managed by at least one trained/certified operator by end 2003.
- 2.4 All countries include analysis of treatment plant operations in annual community health reports by end 2002.

LIQUID WASTE AND EXCRETA DISPOSAL

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Incentives for construction of appropriate facility for lower socio-economic groups.
Environmental Impact Assessment (EIA) in all new projects as part of the planning process.

RE-ORIENTING HEALTH SERVICES

Health sector reform upgrades the level of functioning of EHOs to managerial level within the Ministry of Health.
Building capacity at periphery for decentralized health systems.

EMPOWERING COMMUNITIES

Provision of incentives and relevant information and education through community discussion.

DEVELOPING PERSONAL HEALTH SKILLS

Personal hygiene encouraged at schools and food handling establishments.

BUILDING ALLIANCES

Working with the media and with the legal systems to streamline efforts for compliance.
Joint training for hotel operators.

SOLID WASTE MANAGEMENT

PRIORITY ISSUES

1. Poorly informed public and inappropriate community behaviour.
2. Excessive waste generation.
3. Inefficient waste collection and inadequate and inappropriate disposal methods.

OBJECTIVE 1

Population educated and individual behaviours related to solid waste management modified.

INDICATORS

- 1.1 At least 50% of the population in each of ten (10) countries would have participated in national programs for recycling of household wastes by end 2003.
- 1.2 Ongoing education and incentive programmes for waste reduction, targeting the general public and the school population, introduced in all countries by end 2001.
- 1.3 In all countries, dump sites registered by community health teams reduced by 50% between 1999 and 2003.

OBJECTIVE 2

Systems for collection and disposal made more effective and efficient.

INDICATORS

- 2.1 In all countries garbage collection increased to at least once per week for all housing settlements and twice per week in urban areas by end 2003.
- 2.2 All countries would have appropriate disposal methods in operation with capacity to handle 100% waste generated on and off shore by end 2002.

SOLID WASTE MANAGEMENT

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Policies on waste minimisation and recycling.

Promoting public policies which facilitate the participation of the private sector.

RE-ORIENTING HEALTH SERVICES

Involvement of other health personnel in solid waste management issues.

EMPOWERING COMMUNITIES

Training of key community groups, e.g. stakeholders.

Promoting advocacy through the establishment of customer care hotline

CREATING SUPPORTIVE ENVIRONMENTS

Allocation of resources for the provision of reliable services

DEVELOPING PERSONAL HEALTH SKILLS

Promotion of good environmental practices, e.g. backyard composting

Teaching skills in handling storage and transportation of waste.

BUILDING ALLIANCES

Inter-sectoral collaboration, media and NGO involvement.

WATER QUALITY

PRIORITY ISSUES

1. Inadequate institutional capacity for surveillance.
2. Inadequate management of water resources.
3. Safe drinking water not universally accessible; quality of recreational water inadequately monitored and managed.

OBJECTIVE 1

Surveillance capacity and efficiency improved.

INDICATORS

- 1.1 One hundred per cent (100%) of public and community water supply monitored using WHO or national standards and reports disseminated to community health administrations in all countries by end 2003.
- 1.2 Ninety per cent (90%) of Environmental Health Officers trained to monitor water quality and all countries have timely access to the necessary laboratory facilities by end 2003.

OBJECTIVE 2

Water resources management plan developed and implemented.

INDICATOR

- 2.1 All countries would have developed strategies and protocols for maintaining the quality and quantity of key water resources by end 2003.

WATER QUALITY

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Development of standards and procedures for surveillance of water supplies.

Assessment of existing policies and legislation to ensure that necessary legal framework exists to protect and promote safe water for drinking and recreation.

RE-ORIENTING HEALTH SERVICES

Re-training of staff in surveillance of water supply including sampling, laboratory analysis, interpretation and analysis of data.

Creation of water quality control services in Ministries of Health and/or reinforcement of existing services.

EMPOWERING COMMUNITIES

Development of community surveillance skills

Increased awareness and community skills and basic management of water resources.

CREATING SUPPORTIVE ENVIRONMENTS

Standards for monitoring water quality.

Strengthening CEHI and CAREC

Use of appropriate technology to ensure that people have access to safe water.

DEVELOPING PERSONAL HEALTH SKILLS

Personal hygiene and training in basic water management under regular and emergency situations.

BUILDING ALLIANCES

Working with national laboratories, CAREC, CEHI, Ministry of Agriculture, NGOs and neighbourhood councils.

WORKERS' HEALTH

PRIORITY ISSUES

1. Inadequate workers health situation analysis. Lack of comprehensive multi-sectoral policies and legislation on Workers' Health.
2. Lack of sustained mechanisms for monitoring the implementation of national plans.
3. Inadequate capacity for implementing plans.
4. Lack of specific health sub-projects.

OBJECTIVE 1

Comprehensive Workers' Health plan developed, implemented and monitored.

INDICATORS

- 1.1 All countries would update the policy and plans related to workers' health every two years.
- 1.2 All countries would have reviewed and upgraded legislation in Workers' Health utilizing the model legislation developed by CARICOM by end 2003.
- 1.3 In each country, multi-partite group would report annually to relevant authorities on status of implementation of the Workers' Health Plan of Action by end 1999.

OBJECTIVE 2

Training programmes developed.

INDICATOR

- 2.1 At least two Occupational Health Training programmes for physicians and for environmental health officers established at regional training institutions by end 2003.

OBJECTIVE 3

Information systems strengthened.

INDICATORS

- 3.1 Occupational Safety and Health (OSH) clearing-house established at CEHI by end 2002.
- 3.2 Minimum data set and indices for surveillance of workers health in the Caribbean developed and their use initiated in all countries by end 2001.
- 3.3 Research on the status of the health of workers in the hospitality and informal sectors conducted by end 2003.



WORKERS' HEALTH

OBJECTIVE 4

Policies and programs related to health promotion in the work place developed.

INDICATORS

- 4.1 In at least ten countries, policies on HIV/AIDS at and PWAs in the work place developed and agreed to by tri-partite group by 2003.
- 4.2 Number of work places with at least 50 persons on staff and which have health promotion projects, increased in all countries between 1999 and 2003.

OPPORTUNITIES FOR JOINT ACTION

VECTOR CONTROL

- Development of public health programmes using short public service announcements and using popular theater.
- Strengthening of laboratory capabilities and developing partnerships with private laboratories.
- Establishment of regional database.

LIQUID WASTE

- Production of user-friendly guidelines and standards.
- Communication programmes.
- Updating environmental health legislation.
- Sub-regional training for environmental health officers.

WATER QUALITY

- Epidemiological research to correlate diarrheal disease and water quality.
- Implementation of water surveillance programmes based on successful experiences in other countries.
- Standardised procedures for laboratory techniques and quality assurance programme.
- Joint selection committees for water resources management at community and institutional levels both at the national and sub-regional levels.

SUB-PRIORITY AREA

FOOD SAFETY

OVERALL GOAL AND INDICATORS

GOAL

Control and prevention of food borne diseases.

INDICATOR

1. 50 % reduction of the 1997 levels of the food borne diseases by the year 2003.

FOOD SAFETY

PRIORITY ISSUES

1. Lack of surveillance and laboratory capability.
2. Inadequate training and education of food handlers and the community.
3. Legislation, regulation and standards for food safety/quality, including import and export foods.

OBJECTIVE 1

Strengthen surveillance and laboratory capabilities.

INDICATORS

- 1.1 By year 2003 25% of countries will establish a revised surveillance and outbreak investigation system that integrates laboratory control and EPI-data sources.
- 1.2 By end 2000 all countries will have laboratory capacity for the isolation of prevalent food borne pathogens.

OBJECTIVE 2

Appropriate education program for food handlers and the general public.

INDICATORS

- 2.1 Operation Manuals on food inspection developed and utilized in each country by 2003.
- 2.2 50% of food handlers trained in HACCP by 2003.
- 2.3 KAP survey conducted to assess consumer knowledge on food safety by 2003.

OBJECTIVE 3

Legislation/regulations to ensure food safety.

INDICATOR

- 3.1 By the year 2001 all countries will have revised and modernized their legislation and regulations in keeping with the PAHO/FAO Caribbean model legislation.

FOOD SAFETY

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

- Objective 1 Continued support for CAREC and other National Laboratories.
- Objective 2 Policy to introduce certification of food handlers.
- Objective 3 Develop food standards.

REORIENTING HEALTH SERVICES

- Objective 1 Outbreak investigation and survey skills developed.
Notification mechanisms improved.
- Objective 2 Improve access to new techniques, information and appropriate equipment and supplies.
- Objective 3 Continue consultative advisory.

EMPOWERING COMMUNITIES

- Objective 1 Training and education
- Objective 2 Educate the public to be watchdogs in food safety/quality issues.
- Objective 3 Education about the regulations and standards, including dissemination of information.

CREATING SUPPORTIVE ENVIRONMENT

- Objective 1 Modern lab facilities available.
Establish harmony between regulators and operators.
- Objective 2 Generate incentives for application of training in work places.
- Objective 3 Sensitize policy makers.

DEVELOPING PERSONAL HEALTH SKILLS

- Objective 1 Training in personal hygiene.
- Objective 2 Training of food handlers in food safety according to area's need.
- Objective 3 Train and educate about regulation and standards.

BUILDING ALLIANCES

- Objective 1 Collaboration with other Ministries (Agriculture, Trade, Tourism) and the private sector (National and Sub-regional Hotel Associations); CCF
- Objective 2 Collaboration with the media, community groups, NGO's, CHA and other allies.
Media involved in National Food Safety Committees
- Objective 3 Collaboration with all stakeholders.

OPPORTUNITIES FOR JOINT ACTION

SURVEILLANCE

Intercountry: Exchange of information

Attachment

Training of personal

Technical model

Institutional: UWI, CARICOM, Caribbean Development Bank (CDB), PAHO, private sectors, local organizations.

TRAINING

Intercountry: Net working

Attachments

Sharing information

Institutional: Caribbean Alliance for Sustainable Tourism (CAST), UWI, colleges, private sector, Caribbean Hotel Association (CHA), FAO, PAHO.

LEGISLATION

Intercountry: Exchange of information.