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UNCLASSIFIED

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DEPARTMENT OF STATE  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
Washington, D.C. 20523

*Duplicate*

PROJECT PAPER

CARIBBEAN REGIONAL

BASIC HEALTH MANAGEMENT TRAINING

LAC/DR:78-21

Project Number:538-0019

UNCLASSIFIED

AUG 29 1978

**ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR (LAC)**

**FROM:** LAC/DR, Marshall D. Brown

**Problem:** Authorization of a \$1.8 million grant (\$200,000 in Fiscal Year 1978) to finance the Basic Health Management Training Project in the Caribbean Regional Program.

**Discussion:** The purpose of the Project is to strengthen the managerial capacity of personnel at all levels of the Ministries of Health in seven Eastern Caribbean Less Developed Countries (LDCs) and Barbados. The systems for health care delivery in the Eastern Caribbean are patterned after the standard industrialized model of hospital-based, physician-provided services. This model is proving to be a costly drain on severely constrained budgetary and human resources of the island economies. In most of the countries expenditures for health comprise a substantial proportion - 15 percent or more - of operating and capital budgets. The number of available staff is insufficient relative to the tasks at hand, while personnel costs absorb some 60 percent of recurrent budgets. Thus, priority must be given to improving the organization and efficiency of the existing health resources.

This Project will assist the island governments to improve the organizational structure of their health delivery systems and to better manage existing resources. A grant will be provided to the Caribbean Community (CARICOM) Secretariat to finance training, technical assistance, and special management activities for the participating islands. Four training modules will be developed and implemented in the areas of basic management, team building and teamwork, middle management tools, and program design and implementation. Technical assistance to complement the training packages will be provided in four primary areas: health planning, organizational assessment and analysis, development of model district health teams, and management information systems. In addition, Management Resource Centers will be established in each island health ministry, and conferences, workshops and inter-island exchanges will be provided as follow-on to the training and technical assistance activities. The CARICOM Secretariat will contract for experts to implement the Project activities.

The total Project cost is \$2.3 million over a three-year period. A.I.D. will contribute \$1.8 million for training, technical assistance, some equipment and materials, and additional staff support for CARICOM to direct the project. The participating countries will provide some \$470,000 and CARICOM some \$56,000 of in-kind support to the Project. Since this is a regional program, Section 110(a) of the FAA does not apply and no minimum host country counterpart contribution is required.

The Project was not included in the FY '78 CP since it was identified subsequent to preparation of the FY '78 budget. An Advice of Program Change was forwarded to Congress and the waiting period expired on August 29, 1978. An Initial Environmental Examination was prepared and a Negative Threshold Decision was approved on July 27, 1978. The Working Group on Human Rights and Foreign Assistance approved this Project in its June 16, 1978 meeting.

The LAC Bureau's Development Assistance Executive Committee reviewed the Project and recommended approval on June 9, 1978 subject to certain revisions of the Project Paper. The revisions have been incorporated in the Project Paper.

Under the Project, A.I.D. will finance a small amount of commodities - a maximum of \$125,000 -- to support training activities and the management resource centers in the participating countries. The commodities to be procured are printed teaching materials such as books and journals, light office equipment, and office supplies. The majority will be procured locally or from neighboring islands. Direct imports from outside the Region will be small. A minimal amount of office equipment, including a photo copier, a heavy-duty stapling machine, and pamphlet files, may be procured from the U.S. These commodities will cost between \$15,000-\$25,000. All shipments for this Project are expected to be substantially less than a trailer or container load. A review of shipping service to the Eastern Caribbean shows that U.S. flag carriers provide service only to three of the eight participating countries (Antigua, Barbados, Dominica, Grenada, St. Kitts-Nevis, St. Lucia, Montserrat, St. Vincent) and only on a full "Truck or Trailer Load" (TL) or "Full Container Load" (FCL) basis. No U.S. flag carrier service at all is available to five of the participating countries. Consequently, it is safe to conclude that no direct U.S. flag carrier service to the eligible countries is available for the type of shipments expected under the Project. The small value and size and the scattered geographic nature of the shipments, furthermore, offer insufficient inducements for U.S. flag shippers to provide special services for Project shipments. SER/COM has the authority to determine that U.S. flag service is not available for the type of shipments required under the Project. A determination of non-availability is signified by SER/COM's concurrence below.

In addition, A.I.D. financing of shipping costs on A.I.D. Geographic Code 935 carriers will be authorized under this Grant. As discussed above, the small islands of the Caribbean are not regularly serviced by U.S. flag carriers. Furthermore, the small volume and small dollar value of the shipping transactions and, therefore, of the shipping fees does not make it worthwhile for U.S. shippers to provide special service to the Region. A review of shipping service to the Eastern Caribbean shows that no A.I.D. Geographic Code 941 flag carriers provide regular, direct service to the seven countries participating in this Project. Consequently,

the interests of the U.S. are best served by permitting financing of transportation services on ocean vessels under flag registry of Code 935 countries. Pursuant to Delegation of Authority No. 40, and redelegation No. 40.01, SER/COM has the authority to approve shipments on non-U.S. flag carriers for transportation costs of up to \$250,000. Approval of a waiver to authorize A.I.D. financing of shipping costs on A.I.D. Geographic Code 935 carriers for this Project is signified by SER/COM concurrence below.

Recommendation: That you sign the attached Project Authorization for the Basic Health Management Training Grant.

**DEPARTMENT OF STATE**  
**AGENCY FOR INTERNATIONAL DEVELOPMENT**  
WASHINGTON, D. C. 20523

**ASSISTANT  
ADMINISTRATOR**

**PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS**

Name of Entity :	Caribbean Community Secretariat
Name of Project:	Basic Health Management Training
Project Number :	538-0019

Pursuant to Part I, Chapter 1, Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize a Grant to the Caribbean Community Secretariat ("CARICOM") of not to exceed One Million United States Dollars (\$1,000,000) (the "Authorized Amount") to help in financing certain foreign exchange and local currency costs of goods and services required for the project as described in the following paragraph. The project consists of a Regional Health Management Training program provided through CARICOM designed to enhance the managerial capacity of personnel of the ministries of health in each of the participating governments, thereby improving the health status of the target population through more effective use of budgeted funds (the "Project"). The Project will consist of the following general categories of assistance: (i) training; (ii) technical assistance; (iii) material resources; and (iv) special activities.

I approve the total level of A.I.D. appropriated funding planned for the Project of not to exceed One Million Eight Hundred Thousand United States Dollars (\$1,800,000), Grant funded, including the Authorized Amount, during the period FY 1978 through FY 1981. I approve further increments during that period of Grant funding up to \$800,000, subject to the availability of funds in accordance with A.I.D. allotment procedures.

I hereby authorize the initiation of negotiation and execution of the Project Agreement by the officer to whom such authority has been delegated in accordance with A.I.D. regulations and Delegations of Authority, subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

I. Source and Origin of Goods and Services

Except for ocean shipping, goods and services financed by A.I.D. under the Project shall have their source and origin in the United States or in the participating member countries of CARICOM. Ocean shipping financed by A.I.D. under the Project shall be procured in countries included in A.I.D. Geographic Code 935.

II. Conditions Precedent to Disbursement (Other than for Technical Assistance)

Prior to any disbursement, or the issuance of any commitment documents under the Project Agreement, other than to finance technical assistance, CARICOM shall furnish to A.I.D., in form and substance satisfactory to A.I.D.:

- (i) A written plan for the hiring and scheduled placement of the staff required for the Project;
- (ii) With respect to Project activities in any eligible CARICOM member country, a written statement from the Government of such country setting forth:
  - (a) the name of the individual appointed to serve as Project Coordinator for the duration of the Project;
  - (b) a policy statement, issued by such Government through the Ministry responsible for health, authorizing supervisors to make every effort to release staff to participate in Project activities; and
  - (c) an agreement providing the appropriate Government inputs identified equal to those in the Project Paper; and
- (iii) A plan of activities for 1978 and 1979 which shall incorporate the Grant authorized hereunder.

III. Covenants

Except as A.I.D. shall otherwise agree in writing, CARICOM shall covenant to:

- (i) submit for A.I.D. approval any Grant-financed contract which exceeds \$5,000;
- (ii) provide a written commitment stating that every effort will be made to secure funds from regular budgetary sources to support continuation of core staff and activities following termination of the A.I.D. contribution;
- (iii) provide a yearly plan of activity for 1980 and 1981 in a timely fashion, which shall be satisfactory in form and substance to A.I.D.;
- (iv) maintain and support health programs which develop regional unity and better utilize existing resources;
- (v) agree that funds made available under the Project shall be utilized for financing and technical assistance activities only in the following countries: Antigua, Barbados, Belize, Dominica, Grenada, St. Kitts-Nevis-Anguilla, St. Lucia, Montserrat and St. Vincent; and
- (vi) establish an evaluation program as part of the Project, which shall include, during implementation of the Project and at one or more points thereafter:
  - (a) evaluation of progress toward attainment of the objectives of the Project;
  - (b) identification and evaluation of problem areas or constraints which may inhibit such attainment;
  - (c) assessment of how such information may be used to help overcome such problems; and
  - (d) evaluation, to the degree feasible, of the overall development impact of the Project.

Clearance:

GC/LAC, JLKessler SJK Date 8/21  
LAC/CAR, AFunicello AF Date 8/21/78  
LAC/DR, MHoffman MH Date 8/21/78  
LAC/DR, RGomez R Date 8/21/78  
LAC/DR, MBrown MB Date 8/29  
SER/COM, WSchmeisser WS Date 8/22

Richard W. Vaeley  
Assistant Administrator  
Bureau for Latin America and  
the Caribbean  
August 29, 1978  
Date  
GC/LAC, G... Inter:lb:8/21/78

AGENCY FOR INTERNATIONAL DEVELOPMENT  
PROJECT PAPER FACESHEET

1. TRANSACTION CODE  
A ADD  
C CHANGE  
D DELETE

PP  
2. DOCUMENT CODE  
3

3. COUNTRY/ENTITY RDO/C  
CARIBBEAN REGIONAL

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0

5. PROJECT NUMBER (7 digits)  
538-0019

6. BUREAU/OFFICE  
A. SYMBOL LA  
B. CODE 05

7. PROJECT TITLE (Maximum 40 characters)  
BASIC HEALTH MANAGEMENT TRAINING

8. ESTIMATED FY OF PROJECT COMPLETION  
FY 81

9. ESTIMATED DATE OF OBLIGATION  
A. INITIAL FY 78  
B. QUARTER 4  
C. FINAL FY 80 (Enter 1, 2, 3, or 4)

10. ESTIMATED COSTS (\$1000 OR EQUIVALENT \$1 - )

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. P.C.	C. L.C.	D. TOTAL	E. P.C.	F. L.C.	G. TOTAL
AID APPROPRIATED TOTAL	350	650	1000	590	1210	1800
(GRANT)	350	650	1000	590	1210	1800
(LOAN)						
OTHER U.S. 1.						
OTHER U.S. 2.						
HOST COUNTRY					468	468
OTHER DONOR(S) CARICOM					57	57
TOTALS	350	650	1000	590	1735	2325

11. PROPOSED BUDGET APPROPRIATED FUNDS (\$1000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH CODE		E. 1ST FY 78		H. 2ND FY 79		K. 3RD FY 80	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) PH	501-S	560		1000		400		400	
(2)									
(3)									
(4)									
TOTALS				1000		400		400	

12. IN-DEPTH EVALUATION SCHEDULED

A. APPROPRIATION	N. 4TH FY		O. 5TH FY		LIFE OF PROJECT	
	P. GRANT	Q. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN
(1) PH					1800	
(2)						
(3)						
(4)						
TOTALS						1800

MM YY  
12 79

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

14. ORIGINAL AND COPY CLEARANCE

15. DATE DOCUMENT RECEIVED IN AID-W OR FROM AID-A DOCUMENTS, DATE OF DISTRIBUTION

SIGNATURE  
Theodore T. Foley

TITLE  
Acting AID Affairs Officer

DATE SIGNED  
05/30/78

MM DD YY  
06/01/78

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#### GLOSSARY

1. Abbreviations
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PROJECT COMMITTEE

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Approved by:

Theodore T. Foley  
Acting AID Affairs Officer  
Regional Development Office  
Caribbean

PART I - PROJECT SUMMARY AND RECOMMENDATIONS

- A. Face Sheet. See preceding face sheet for summary of fiscal data.
- B. Recommendations. The Regional Development Office/Caribbean (RDO/C) recommends authorization of grant financing of \$1,800,000 for a Basic Health Management Training Program to be implemented by the Caribbean Community Secretariat's (CARICOM) Health Section.

Annex AI - 1 contains CARICOM's letter requesting this assistance.

- C. Description of the Project. The recommended \$1.8 million grant will finance a coordinated regional effort to develop and implement a training system which will upgrade and expand the skills of the Islands'\* Ministries of Health employees and the training of community health aides.

As requested by the member Governments and confirmed by the findings of the AID Health and the Project Development Teams the project includes:

- 1. a) In-Territory Basic Management skills training of approximately 700 persons with separate modules for top, middle and line managers.
- b) Team building, with particular emphasis on teamwork at the district level.
- c) Operational management tools and techniques for middle management.

\* Antigua, Barbados, Dominica, Grenada, St. Kitts-Nevis-Anguilla, St. Lucia, Montserrat and St. Vincent.

2. Fifty-six (56) months (X months per island) of specialized technical assistance. The technical assistance will be coordinated and timed to reinforce training inputs. Areas include, but are not limited to: organizational analysis, health planning, project design (specifically of model district health projects) and information system development.
3. Special Activities, include regional workshops of conferences on key issues of common interest such as diffusion of ideas, coordination of resources, primary health care, the district team concept and issues in management and implementation. Special yearly workshops for Project Coordinators will focus on planning, implementation and evaluation.
4. A Management Resource Center will be established on each island and will receive continuing inputs through the Health Section of the CARICOM Secretariat.

#### D Project Goal and Purpose

1. A socio-economic goal of the RDO/C program is to improve the health status of the inhabitants of the Eastern Caribbean and Belize. Intermediate to that goal is this projects sector goal in enhancing the health status of the people of the Windward and Leeward Islands and Barbados in the CARICOM region.

The project as developed is in tune with the RDO/C Interim Strategy Paper of April, 1978 which assigns a moderately high priority to development assistance in the social sector of health. This paper also outlines AID's strategy for the Caribbean Regional programs' emphasis and need to strengthen key regional institutions and the encouragement of common efforts and cost sharing at the social levels.

2. The purpose of this project is to enhance the managerial capacity of personnel of all levels within the Ministries of Health of the Leeward and Windward Islands and Barbados and secondly to expand CARICOM's abilities to coordinate Regional Health Programs.

This purpose is supportive to President Carter's statement on International Health on May 2, 1978 which was partially

based on the following principles:

"--Developing nations can eventually meet their own health needs if we assist them in strengthening their institutions and building their own health systems.

-- Community based primary health care, including the use of community resources and the training of appropriate health personnel as near as possible to where they will deliver services, is the most effective means of achieving the standard of health we desire for all people."

Fulfillment of this purpose will increase the efficiency and effectiveness of the delivery of health care to the islands' populations, thus facilitating the achievement of the sector goal of improved health status.

#### E Summary Findings

The Basic Health Management Training Grant is feasible, needed and ready for implementation. The Project Committee, with the advice of various Island Governments and the implementing Agency CARICOM find the project financially, technically, economically and socially sound. The proposed project represents a unified approach to health training through a regional institution capable of administering the program.

Further, the RDO/C strongly recommends that this and all assistance for institution building and/or social sector activities be on a grant basis to help alleviate the inability of the small island governments to service debts.

Summary Financial Plan. The total cost of the Project is \$2,325,000 of which AID is providing \$1,800,000, CARICOM is providing \$56,800, and Island Governments \$468,200. The activities under the Project will be implemented over three years (36 months) from the date of signing of the project agreement. The Project Assistance Completion Date (PACD) will be 3½ years from the date of signature. The CARICOM and Island contribution to the Project represents a portion of the total staff time and resources which will be allocated to the specific activities under this Project. The financial plan for the Project indicating budgetary allocation and project elements to be subcontracted are shown in the following tables:

SUMMARY FINANCIAL PLAN

(US \$ 000)

SOURCE	AID GRANT	CARICOM	ISLANDS	TOTAL
TRAINING	518.6		301.9*	820.5
TECH. ASST.	520.7	24.0*	-	544.7
COMMODITIES	125.8	27.0	120.0	272.8
IMPLEMENTING AGENCY SUPPORT**	445.4	-	-	445.4
SUB TOTAL	1610.5	51.0	421.9	2083.4
INFLATION FACTOR***	128.0	5.8	46.3	180.1
CONTINGENCY FACTOR****	61.5	-	-	61.5
TOTAL	1800.0	56.8	468.2	2325.0

\*Estimates of in-kind support to the project, includes facility allocation.

\*\*Inputs are calculated to include project specific salaries, travel and per diem of essential members of the CARICOM staff.

\*\*\*Inflation factor = 14% of project estimated costs in year 2 plus 20% of costs for Year 3 (source: Central Bank of Barbados, RDO/C)

\*\*\*\*Contingency Factor = approximately 3% of total AID input plus rounding.

PROJECT ELEMENTS TO BE SUBCONTRACTED

	YEAR 1	YEAR 2	YEAR 3
<b>Commodities</b>	(No subcontract responsibility)		
<b>Salaries</b>			
1 Full Time (12p.m.) Trainer/ Mgt. Sp.) Package A delivery CARICOM based	50,000		
<b>Training Labor - short-term</b>			
Package A - 24 p.m.	197,600		
Package B - 3 p.m. (6 day wk)		33,000	
Package C - 8 p.m. (6 day wk)		48,000	
<b>Technical Assistance Labor</b> (not as part of training package)			
56 p.m.	217,308 (22 p.m.)	122,633 (18 p.m.)	100,100 (16 p.m.)
<b>Travel</b>			
Package A - 7 round trips	6,090		
Package B - 3 round trips		2,610	
Package C - 5 round trips		4,350	
Technical Assistance	5,850	4,950	3,150
<b>Per Diem</b>			
Package A - trng.	28,600		
Package B -		4,235	
Package C -		12,320	
Technical Assistance	26,217	22,642	17,875
<b>Yearly Sub-Total</b>	531,665	254,740	121,125
<b>Inflation</b>		+14%	+20%
<b>Yearly Adjusted Sub-Total</b>	(1) 531,665	(2) 290,404	(3) 145,350

**F Project Issues**

1. The degree to which participating Governments will increase their staff and pay salaries during the training period.
2. Whether a separate regional training institution should be established for an on going program.
3. The suitability of CARICOM for project implementation and contracting.

## PART II - PROJECT BACKGROUND AND DETAILED DESCRIPTION

### A Rationale of the Project

#### 1. Regional Setting.

The Leeward and Windward Islands and Barbados exhibit a duality of health conditions which are neither completely characteristic of either the economically developed or the developing societies of the world. On the one hand, average life expectancy in the region exceeds 60 years of age, and the major causes of death are cardiovascular diseases, stroke, neoplasms, hypertension, and diabetes, all of which are major causes of death in the United States and the other highly industrialized countries. However, on the other hand, the greatest killers of children under the age of five are gastroenteritis, respiratory diseases, and malnutrition, all of which are specific causes of death associated with less developed status.

In many respects, the Eastern Caribbean may be at an important crossroads in the continuing improvement of health status of its populations. Mortality and morbidity statistical patterns indicate consistent improvement over the past 20 years. Yet, the potential for regression exists. The vectors for dengue fever and yellow fever continue to flourish on many of the islands, many of the water supply and sewage disposal systems are either inadequate or antiquated, rapid population growth threatens to imbalance the precarious relationship between the islands' ecosystems and progressive socio-economic development, and the accelerating cost of health services endangers the ability of the population to receive adequate care. All of these negative conditions are amenable to remedial action, if strong political, economic, and administrative energy is directed toward the crux of these problems.

A key factor underlying current health efforts in the Caribbean is the pattern of health care delivery. The organization and staffing of health services falls into both the public and private sectors, although the relative strength of each sector varies considerably from island to island. In the majority of the islands, the

two sectors overlap or are tightly fused. Medical doctors commonly work in the public sector for a limited number of hours and then concentrate on their private practices.

In the public sector, the organization of services commonly follows a generic British colonial pattern depicted in Figure 1.

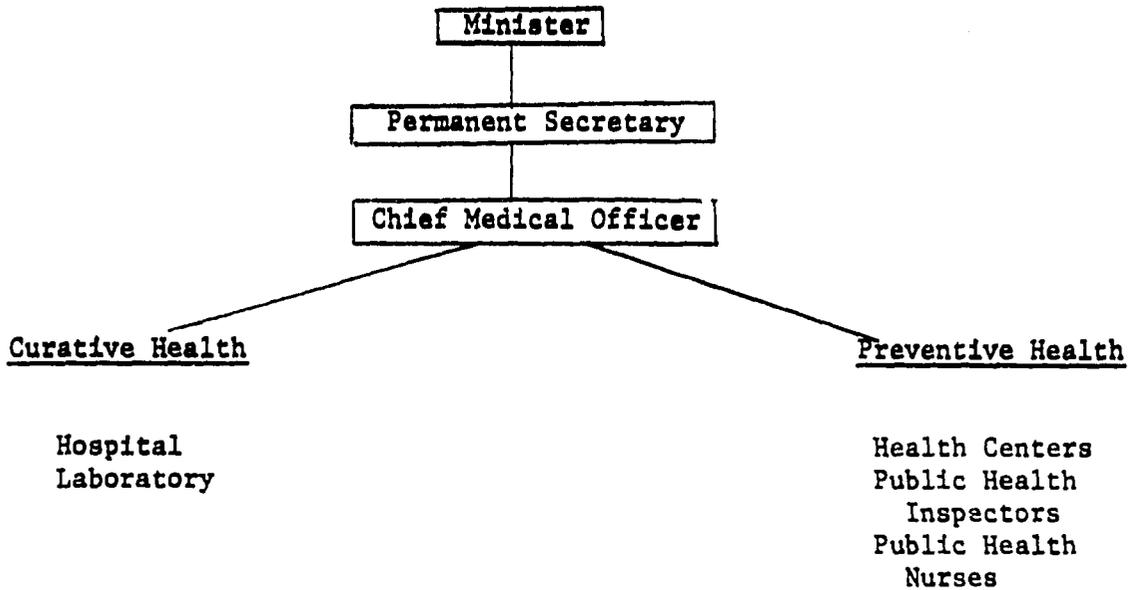


FIGURE 1

The line of authority goes from the Minister through the Permanent Secretary (PS) to the Chief Medical Officer (CMO) who is responsible for the technical guidance of all curative and preventive health activities of the government. The curative services include hospital and related support operations and generally account for approximately 50-75 percent of the total governmental budget for health. Preventive services are channeled through two mechanisms: one is a network of health centers staffed regularly by public health nurses and periodically by doctors, and the second is the environmental health and sanitation activities of the public health inspectors.

In theory, the curative and preventive arms of the government health system are intended to be closely linked under the coordination of the CMO. In fact, each side tends to work independently and at times in conflict with the other. Furthermore, within the preventive services arm, the vertical lines of services (medical, nursing, public health inspection) tend to be solidly distinct, with minimal coordination among the three.

Despite a growing policy level commitment to comprehensive, primary health services aimed at target population most at risk, the systems for health care delivery in the Caribbean continue to be patterned after the standard western model of hospital-based, physician-provided services. As is the case throughout the developing world, this model is not only inappropriate to the health needs of the majority of the populations, it is a costly drain on the severely constrained budgetary and human resources of these island economies. In most of the Eastern Caribbean, expenditures for health comprise a substantial percentage - 15 percent or more - of operating and capital budgets. Moreover, although in many islands the number of available staff may be considered insufficient for the tasks to be accomplished, personnel costs absorb between 50 and 70 percent of recurrent budget. Thus, at present, there is little room either for expansion of the total health budget or for increasing the numbers of staff. Alternatively, the appropriate and feasible course of action lies in improved structuring of the health delivery system and in better management of existing resources.

## 2. Regional Health Policies

Since 1969, Ministers Responsible for Health, representing all governments of the CARICOM region, have been meeting to examine their common problems and to prepare programs of regional cooperation. The current position of the Conference of Ministers Responsible for Health (CMRH) is perhaps best set forth in the "Draft Declaration on Health" prepared for the Third Conference of Ministers Responsible for Health, held June 28-30, 1977, and subsequently adopted by the CMRH\*.

\* A copy of this document and other relevant CMRH documents can be found in Annex A IV 2.

The CMRH has identified 14 principal health issues, which have been "screened" against the following criteria:

- a) The magnitude of a given problem;
- b) Its social and economic importance; and
- c) Its susceptibility to preventive and remedial measures.

Applying these criteria, the CMRH has determined that the first order of priority should be accorded to the more dynamic and creative management of the health services. CMRH draft documents emphasize that the major impediments to the delivery of appropriate health services to the underserved lie in the allocation of current resources, in the structure of the island health systems, in the internal processes of those structures, and in the poor development of managerial capabilities of existing personnel.

Indicative of these problems is the fact that only St. Lucia, Dominica, St. Vincent, and Barbados have written and ratified health policy statements. None of the island governments has a formal health plan. On the surface, even in the absence of a written health policy, the member governments espouse the regional health policies and priorities articulated by the CMRH. However, with the exceptions noted above, these regional policies have yet to be translated into island-specific policy statements. Furthermore, despite the expressed desire to implement a team approach and to decentralize comprehensive primary-level curative and preventive care, the de facto "plans" reflected in the health budgets continue to give priority to hospital-based curative care. In short, the island governments have not been able to formulate or carry out specific programs for management improvements that would facilitate the kinds of appropriate health systems envisioned.

#### B Relationship with Other Donors

AID's involvement in the health sector in the Commonwealth Caribbean is a recent event, and it must necessarily be seen within the overall context of the United States' regional development assistance strategy.\* In response to the renewed

\* For further elaboration of this strategy, see the Draft Interim Strategy Paper, Regional Development Office/Caribbean, April, 1978.

interest in the Caribbean, AID began systematically to assess the development assistance needs and opportunities in health as well as in other sectors. During 1977, a comprehensive background study was completed by the Office of International Health, DHEW\*\* and a Health Sector Survey Team toured the area. Health Management Development has not been an area of other donor development and assistance. From evaluation of CIDA's 1978 Projects, there appears a sharp decline in assistance to the health sector on a regional or bilateral basis. After intensive discussions with health personnel of Barbados, Grenada, St. Vincent, St. Lucia, Antigua, Montserrat, St. Kitts-Nevis-Anguilla, and with coordination of officials of CARICOM, CIDA, PAHO and UNDP, the Survey Team recommended that priority programmatic assistance should focus on the improvement of planning and management capabilities of the health sector.\*\*\* The enhancement of planning and management is seen as fundamental to the creation of a firm infrastructure base for the future development of health programs.

\*\* Caribbean Health Sector Study, Laskin, et.al., Volumes I and II.

\*\*\* For detailed discussion of these points, please see the Report of the Caribbean Health Survey Team, November 1977, AID, Washington, D.C. and Annex A II 2.

### PART III - PROJECT DESCRIPTION

#### A Goal and Purpose

The goal to which this project contributes is the improvement of the health status of the inhabitants of the Regional Caribbean, specifically the Leeward and Windward Islands and Barbados. Full goal achievement may be verified to the extent that, by 1985: (1) infant mortality will decrease by 10%; (2) the incidence of gastroenteritis in children will decrease by 10%; (3) the percentage of preschool children demonstrating signs of protein-calorie malnutrition will decrease by 20%, and (4) the coverage of preschool children for basic immunizations will increase to 75%. Exact attainment of these percentages may be difficult and any improvement can be considered significant to the sector. Goal achievement will be measured periodically using data from special studies conducted by the Health Division of the CARICOM Health Secretariat (CHS) and by statistical trends reported in the countries' Annual Health Reports.

The purpose of this project is to enhance the managerial capacity of personnel at all levels of the Ministries of Health on each of the participating islands. With an increase in managerial knowledge and skills, desired health programs will be administered in a more efficient and effective manner. It is assumed that there exists a positive relationship between the delivery of health services and the improvement of health status. Therefore, the enhancement of the ability of an organization and its personnel to choose, allocate and direct resources will serve to strengthen and intensify the effect of that relationship.

The Conference of Ministers Responsible for Health has mandated the Health Section of the CARICOM Secretariat (CHS) to mobilize and coordinate efforts to achieve regional health objectives. Because of AID's policy to work through existing regional institutions and given the congruence of CHS mandate with project purposes, the strategy adopted for this project is to funnel resources and activities through CHS, with the aim of having island-specific impacts. Achievement of the project purpose will be manifested through the improvement of certain key managerial practices and the institutionalization of management mechanisms in each of the target Health Ministries.

A secondary purpose is to expand CARICOM's coordination ability among and within the region. The usage of CHS as the implementing Agency will provide expanded contacts and a basic form of regional health service.

**B Inputs and Outputs**

1. Increased knowledge and use of management concepts and skills by personnel at all levels of the health system;
2. Improved teamwork, both vertically and horizontally, throughout the health organizations of the islands, particularly in relation to multi-disciplinary district health teams;
3. Improved use of operational tools of management by mid-level personnel in the Ministries of Health;
4. Enhanced ability of top and mid-level health managers to plan, design, implement, and evaluate health sector programs;
5. Implementation of a sector-wide health planning process in six countries;
6. Operation of effective information systems in all of the countries; and reinstitutionalization of annual reporting;
7. Improved coordination of internal and external resources within the islands; and
8. The Health Division of the CARICOM Secretariat will have an ongoing operational capacity to coordinate and support health management activities and resources of the region.

Verification of the successful attainment of these ends will rely on island government documents and reports, such as the Annual Health Report, revised health plans, annual budget estimates, organization charts and on the monthly reports issued by the CHS for this project. Further details are contained in the Evaluation Plan in Section V B of this Project Paper.

The proposed activities fall into four general categories under which the 12 specific outputs cluster. These categories are:

- a. Training
- b. Technical Assistance
- c. Material Resources
- d. Special Activities

All of these proposed activities evolved from intensive discussions with health leaders on each of the islands, and the project content reflects the collaborative style of the design methodology.\*

### Training

Four training modules will be designed, tested and delivered to health personnel on the islands. These modules are: (a) basic management; (b) team building/teamwork; (c) operational management tools for middle managers; and (d) program design and implementation.

Package A, Basic Management. - This package reflects the identified need for exposure of all levels of health personnel within the Ministries of Health of the islands to basic management concepts, techniques and skills. Approximately 700 individuals on the eight islands will be trained. Since this package provides the primary foundation for increased development of managerial concepts and skills, all training cycles will be completed within the first year of the project. Each module is composed of three basic elements which correspond to the type of personnel who will be participating in the training cycle. The first module is aimed at the top level managers and will include introduction of the basic management model\*\*, the tools of decision-making (problem solving, leadership skills and managerial styles), the planning process (plan development), and change-techniques, consequences and measurement. The second element will be for middle managers and will include an introduction to the basic model of management, planning and creative problem solving, resource identification allocation and utilization, group dynamics, conflict resolution, introduction to team build, supervision and motivation, and task management. The third element, aimed at line personnel will also include an introduction to the basic management model, development of the concepts of change agency, the concepts of motivation - groups - and introduction to team building and interpersonal communications. Common to all elements will be the development of the basic management model and understanding of how the

\* For further discussion of the design process, See Annex A II 1

\*\* See Technical Feasibility for a brief discussion of the definition of management and management model. See Annex A III 3 for further detail on content of project activities.

managerial, behavioral and change processes related to one another. Each training cycle will require five days. Five additional days -- three for pre-training preparation and two for post-training appraisal -- will also be required for each island.

Required AID inputs for Package A include 48 person-months for trainers/management specialists, travel and per diem, and training materials. Each island will provide one to two months of Project Coordinator time, training space and participant time.

Package B, Team Building/Teamwork. - All of the islands identified as a priority problem area the inability of personnel within the health organization to work together as a team. Problems of conflict management and resolution, role definition, motivation, and communications were all manifested to the Project Design Team. These problems exist up and down vertically through the system as well as horizontally. Although representatives of all levels of the health organization will be included in one segment or another of this training, the major concentration will be on the district field workers/district field team.

Approximately 135 top, middle and line-level personnel will be exposed to this training. Package B will be delivered in the second year of the project and each cycle will be five days in duration.

AID inputs will include eight person-months for trainers, travel and per diem, and training materials. Island inputs will include Project Coordinators' time, training space, and participants' time.

Package C, Middle Management Tools. - This package will focus on training 224 mid-level health personnel in the concepts and techniques of "people management" and in the development of task and operational management tools. Under "people management", the subject matter will concentrate on supervisory techniques, such as interviewing skills, coaching, routine follow-up and follow-through, and on interpersonal communication and conflict resolution.

Task and operational skills to be taught include time management, cost-saving concepts and techniques, techniques for

task planning and implementation, reporting, written communication skills, and organizational charting.

Each training cycle will consist of ten working days to be offered at the end of the second and beginning of the third year. Total AID inputs include about 16 person-months for trainers, travel and per diem, and training materials. Host island inputs, as in Package A and B, will include Project Coordinators' time, training space, and participants' time.

Package D, Program Design and Implementation. - This training package reflects the identified need to develop specific skills and techniques for program and project development, design and implementation. In other words, many people in the Health Ministries felt they did not know how to translate policy into specific field activities. Participants in these training sessions will include 125 top and selected mid-management personnel. The specific content of this package will stress the development of goals and objectives, the identification of strategies, the scheduling of activities by time, the development of a work plan, monitoring and reassessment and/or evaluation, budgeting and resource management, and mobilization of internal and external resources. Package D will be delivered in the third year. Total time per cycle will be five days per island.

Since the Project Coordinators will actively participate in the delivery of training for this package, it is estimated that total AID input will only require 2.5 person-months of trainer time, travel and per diem, and training materials. Host countries will provide space and participants's time.

#### Technical Assistance

All of the island governments identified the need for technical expertise and assistance. Specific and immediate needs lie in the areas of health planning, organizational analysis, development of model district health teams, and information systems. Other types of technical assistance required are more discrete (and therefore cannot be readily clustered) and the duration and timing of their provision can only be defined as this project unfolds. Therefore, a total of 56 months of technical assistance will be provided, 32 months of which will be assigned to the four primary clusters and 24 months assigned to a "pool". This "pool" will offer the flexibility necessary

to enable the project to respond to the changing needs of CARICOM and the island health systems. Examples of assistance to be provided include budgeting techniques, alternative health financing mechanisms, and special studies (e.g. intersectoral coordination). A more complete listing of the types of technical assistance envisioned can be found in the Implementation Process section and Annex A III 1 of this paper.

Timing of island-specific technical assistance has been synchronized to maximize the complementary linkages with the training packages. CARICOM's TA package will be developed during project implementation.

With regard to the four primary clusters of technical assistance, the following points should be noted.

#### 1. Health Planning

The CARICOM Ministers of Health have reaffirmed several times the need to develop a health policy statement that provides a meaningful set of guidelines for the preparation of health sector plans. In addition, they have stressed the importance of evolving a health sector plan within a systematic planning process. While all of the countries have taken steps in these directions, the following have given this priority attention and have requested technical assistance: Dominica, Grenada, St. Vincent and Antigua. This project will finance ten person-months of health planning assistance in the first year of the project so that these islands can restructure their planning processes and begin to develop health sector plans which can be used as models for the other CARICOM members.

#### 2. Organizational Assessment and Analysis

While all of the governments are cognizant of the need for systematic organizational assessment and analyses, the following five attach an extremely high priority to this activity: Dominica, St. Kitts-Nevis, St. Lucia, St. Vincent and Montserrat. Each will initially receive one person-month of technical assistance in organizational analysis. Additional time may be provided from the "pool" of technical assistance. Specific organizational concerns include role definition, lines of authority, conflict resolution, and communications throughout the organization. Prior to the conclusion of this project, it is expected that these

five countries will have completed an in-depth assessment and analysis of their health management systems and initiated major efforts toward structural improvement.

### 3. Design and follow-up of Model District Health Teams.

Three of the countries, St. Lucia, Dominica, and Antigua, expressed a strong desire to move forward on the development of a district health team that would be multi-disciplinary in composition and would include the community. The absence of such a team at the periphery of the health system is currently one of the major impediments to task delegation and to more cost effective allocation of health resources. The health management project proposes to support the development of the district team concept by the provision of nine person-months of technical assistance for project design and periodic follow-up and evaluation. Moreover, this ties into the training package (B) which focuses on teamwork and team-building. In order to adequately support the development of a district health team in Dominica, special circumstances must be recognized and dealt with. The problems of infrastructure pose serious constraints to the successful implementation of any outreach program in this country. Therefore, the project proposes to provide two vehicles and specific types of equipment for the model districts identified so that the district team concept will not flounder through lack of necessary resources.

### 4. Management Information Systems

All of the governments have expressed concern about the inadequacy of their Management Information Systems. Of course the need for timely and accurate information for planning and program development is obviously linked to the other activities envisioned under this project. Therefore, eight person-months of technical assistance will be offered to the islands throughout the life of this project. One specific output will be the reinstitution and upgrading of the Annual Health Report and support of CARICOM's Information Delivery System.

### Material Resources

In order to support the previous activities and to provide a permanent facility for future reference, a Management Resource Center will be established within the Health Delivery Organization on each of the islands. This Management Resource Center will contain basic books on management and related subjects, appropriate journals,

specified articles and/or monographs, and sample management tools that have been selected and distributed by the CARICOM Secretariat's Health Section. These resources will be available through a check out system which will be centrally designed but island implemented in coordination with the CARICOM Information System.

Other commodities, such as office equipment to be provided by the project, related to the development of the project management unit within the executing agency.

As noted earlier, because of its rough terrain, inadequate transportation infrastructure, and its desire to develop a model district health team, two vehicles will be consigned to the Ministry of Health in Dominica to ensure organizational communication and managerial control. Fortunately, the other islands have adequate or superior transportation infrastructures.

AID inputs for commodities for the three-year life of the project total \$125,800. See Annex A II 3.

#### Special Activities

A series of special activities, mainly conferences and workshops, will take place throughout the life of the project. The intention is to reinforce the importance of key management issues, to maintain enthusiasm for the project by top-level personnel, and to provide a regional forum for inter-island management information exchange.

Specific activities include:

- a. Conferences and workshops for top-level personnel, including Ministers, on basic management concepts, the Annual Health Report, the coordination of internal as well as external resources for the region, and progress reports of this project;
- b. Workshops for the Project Coordinators to develop the project's work plan, to design and test training curricula, and to assess the progress of the project to date, particularly with regard to specific requests from the countries for training and technical assistance. These workshops will also ensure that Project Coordinators are clearly aware of their role in project implementation and evaluation.
- c. A one-week workshop on the district health team concept;
- d. Inter-island exchanges for 32 individuals from the Islands' Health Ministries in order to facilitate diffusion of ideas and experiences; and

- e. The establishment of a centralized system for the identification and coordination of health resources within the region.

The executing agency (CARICOM) will be the primary coordinating mechanism for the implementation of these activities. AID inputs for Special Activities will only total approximately \$111,475, accounting for travel, per diem, and conference facilities.

#### The Role of Women in the Health Management Project

The Project Design Team observed that women, in their roles as Ministers, nurses, and civil servants, were in many cases the most receptive to the need to change the management system within the health services. Nurses provide the primary contact point for the delivery of health services to the community and their involvement in the substance of the project is absolutely vital to the successful completion of the project purpose. Because the project focuses on the development of managerial skills at all levels of the health system, particularly at middle and line levels, women will comprise a large component of the training participants.

## PART IV - PROJECT ANALYSIS

### A. Social Analysis

#### 1. Social Landscape

Island specific evaluations (See Annex AII-2\*) were prepared for each of the Government Health Delivery Agencies to identify specific social relationships that occur in their management systems. Each territory represents a different complex bureaucratic or autocratic society that is hampered by a shortage of trained and utilized management skills.

The rapid decline of the European presence (within a space of 10 years for most of the LDCs) has truncated the social organization and left a leadership and political vacuum. Moving to fill this void have been West Indian senior level civil servants, prestige professionals (doctors and lawyers) and a few businessmen and school teachers. While they share ethnicity, ambition and upward mobility, they have not shed some of the negative management practices growing out of their long colonial history.

Because the islands are small, both in territory and population, the various sections which make up society -- family, social relations, business, politics -- tend to overlap one another. It is not uncommon for a government official to hold a number of key positions, inside and outside of the government. How this affects the conduct of social affairs and this project is not fully understood; however, selections of the key project coordinators based upon familism or political favoritism would be a detriment to the project. "Politics" is a rather new element in the LDCs, since until recently this social arena was limited to a small elite associated with the colonial government. Political competition is having a profound effect upon internal as well as external relationships, and will have an exceedingly complex effect on this project. The colonial relationship of the health system, if continued, is restrictive to the team-building and management required for successful health system delivery.

Although there are evidences of divisive "politics" on some of the islands, and even the most mundane take on a political cast, the past system of constitutional government prevails and the legal system remains strongly in place. The feelings of insularity and independence prominent throughout the LDCs will be used as a tool in this project in development of "island specific" training while maintaining the purpose of management skill expansion.

\* Additional island reports and comments are available in the RDO/C office.

## 2. Beneficiaries

### a. Ultimate Beneficiaries

The ultimate beneficiaries of this project are people in the lower income groups of the region. They will receive the advantages of improved health services that result from an upgraded management.

A prime indicator of the dimensions of poverty in the eastern Caribbean is per capita income. Although not conclusive, available data suggest that the average per capita GDP for the area is \$US 340 - ranging from a high of \$540 in Montserrat to a low of \$225 in St. Vincent. With the exception of Haiti these represent the lowest income levels in Latin American/Caribbean region. Moreover, available information indicates an extreme degree of inequality among income levels and best estimates place over one-half of the population of the territories below an income level of \$US 200.

The effect of the tenuous income situation is evident from Table 1, Underemployment Index. As can be seen in the 1973 July-August period, unskilled laborers had to work between 2.68 and 7.72 days to purchase a specified food basket. The data further demonstrate that the mean for the LDC territories was 4.23 work days which was considerably higher than the 2.38 MDC mean. The specified food basket consists of the following items: 4 lbs of rice; ½ quart of cooking oil; 1 dozen eggs; 2 lbs of frozen chicken; 3 lbs of salt cod; 2½ lbs of white sugar; 5 lbs of ripe bananas; 1 lb of onions; and 2 packs of cigarettes.\*

Table # 1

#### Underemployment Income Index

<u>Country</u>	<u>Work Days</u>
Antigua	2.68
Dominica	3.74
Grenada	4.28
Montserrat	3.68
St. Kitts	7.72
St. Lucia	4.27
St. Vincent	4.89
ECCM Mean	4.23
CARIFTA's MDC Mean	2.38

Infant and childhood mortality and malnutrition levels provide a further indication of the conditions of poverty in the LDCs. As can be ascertained from Table #2, the infant mortality rate for the eight

\* Source: World Bank Caribbean Regional Study, Vol. VII, 1975

territories is 30% higher than in the MDCs (supplementary information points out that infant mortality rates are four times as high as in Sweden). In addition the childhood malnutrition index, measured in terms of percentage of children under five years of age weighing less than 75% of the age specific "standard weight," is 14 times greater in the LDCs than in Sweden. Although the malnutrition means appears to be slightly lower in the LDCs as compared to the MDCs, it is assumed that the data does not accurately reflect the situation. There are indications that the mean would be significantly higher if information from Grenada and Montserrat were available.

Table # 2

	<u>Mortality</u>		Childhood
	<u>Infant 1/</u>	<u>Child 2/</u>	
Antigua	38	n.a.	2.3
Dominica	56	27	8.4
Grenada	34	32	n.a.
Montserrat	38	34	n.a.
St. Kitts	59	12	18.3
St. Lucia	42	n.a.	14.0
St. Vincent	45	n.a.	26.5
ECCM Mean	52	26	13.9
CARIFTA			
MDC Mean	39	29	15.0

1/ Number of deaths among infants under one year of age per 1,000 live births during 1972

2/ Number of deaths among children one to four years of age per 10,000 children in that age group during 1972

b. Direct Beneficiaries

The direct beneficiaries are the health personnel of the region who will be the recipients of management training. These will include both professionals (mid-level managers, doctors, nurses) and para-professionals (health inspectors, auxiliary nurses). Through innovative training it is believed that functional harmony and teamwork can be developed that will articulate new social responsibilities in the structural composition of the individual islands' bureaucracies.

Achieving such a change is not without potential pitfalls. Installation of a new management system that alters existing roles and responsibilities must be done in a fashion which is sensitive to the culturally defined system currently in place. Needless to say if such sensitivity is required concerning the installation of a new management system, it is likewise necessary in the design of the training program which will bring the new system about. For example, the trainees include people of distinct socioeconomic groups who have occupational roles with different statuses. This presents a potential

**constraint to training activities. Will high status medical doctors agree to participate with low status auxillary nurses? Will the auxillaries be inhibited by the presence of doctors or Ministry managers.**

Similarly, technicians within the health sector (doctors, nurses) may have a different view of the bureaucratic process than do the manager -- a possibility which has direct implications for not only the composition but also the content of training activities. Finally, the roles of the personnel in the current system with respect to the ultimate beneficiaries and towards each other may inhibit a radical change -- again an issue which relates directly to the composition of management training activities.

In short, health must be treated in "whole terms," taking into account the totality of management systems, environment, lifestyles, social fundamentals and more efficient usage of health care facilities. Development of human resources through the behavioral elements -- management style, motivation, leadership -- at all levels of management -- top, middle, and line -- and functional activities -- medical, nonmedical, administrative, and especially at the delivery point -- district or clinic levels will be stressed.

While the design of managerial improvement for each island health unit differs, there are some basic commonalities and assumptions. The entire regional health system needs management strengthening; personnel will experience on-island training in fundamental as well as specialized management subjects. Although multiple approaches will be employed to enhance the conditions of the health team in each of the LDCs, the principal leverage in this project will be the strengthening of an overall management awareness. This will involve building in each island government the capacity to identify problems and take constructive action in their solution. In management terms, this means an enhanced capacity to formulate health policies and plans, translate these into budgets and priority resource allocations, and implement and carry out program activities including evaluation and monitoring. To build such a capacity requires the acceptance of substantially different "images" of organizational patterns and practices. From top to bottom it will be necessary to view organization as some kind of "organic" whole, rather than the prevalent "deterministic" model which is commonplace in island organizations. The team rationale and approach is a means of positive reinforcement and constant infusion of new ideas and techniques of professional behavior and attitudes to reach and solve "old and established" health problems.

Building further within the comprehensive health system framework, the trainees will view the importance of health as a product of a cluster of management elements. With growing nationalism, this can be an opportunity to capture released social energies to build viable local institutions, with a sense of local pride and achievement. New possibilities exist to modify undesirable lifestyles and socio-environmental conditions as they pertain to the general state of local health conditions.

## B Financial Analysis

### 1. Expenditure Plan

The project would run three years within a disbursement plan as shown in the following table:

#### PROJECTION OF EXPENDITURES BY FISCAL YEAR

(US\$ 000 or EQUIVALENT)

FISCAL YEAR	AID GRANT		ISLANDS* L/C	CARICOM* L/C	TOTAL		GRAND TOTAL
	FX	L/C			FX	L/C	
1978	350	650.0	-	-	350	650.0	1000.0
1979	160	235.5	291.6	34.0	160	561.1	721.1
1980	80	135.0	130.3	17.0	80	282.3	362.3
INFLATION FACTOR	-	128.0	46.3	5.8	-	180.1	180.1
CONTINGENCY	-	61.5	-	-	-	61.5	61.5
<b>TOTAL</b>	<b>590</b>	<b>1210.0</b>	<b>468.2</b>	<b>56.8</b>	<b>590</b>	<b>1735.0</b>	<b>2325.0</b>

\* Includes in-kind support

In the third year, the Islands will begin to provide larger portions of the training costs (package training D) which provides a budget base and organizational background for follow-on funding to maintain and expand the training element of the project. The evaluation plan will determine the necessity of longer training programs on a continuing basis upon completion of the project.

A contingency factor of \$61,500 has been applied to provide funds for commodities or services not foreseen at the present but which may be required for the successful implementation of the project. The inflation factor has been applied using RDO/C standards as are estimated for the next three years.

## 2. Viability

It has been determined by RDO/C, the Health Evaluation Team and the Project Committee that there is no direct revenue producing results from this project but rather the strengthening of the training organization and serviceability of the health delivery systems for the Islands. The strengthening of these services will result indirect savings and improved services to the target group.

As is discussed in the interim strategy paper, one of the organizations suggested to receive AID support is CARICOM. As a result of this project, although not measurable in financial terms, CARICOM is expected to gain in stature and experience within the organizational framework of the islands.

Since 1973, the overall trend in island budget support for health services in the region has been increasing. The following chart shows the target group's past history of per capita health service funding:

### PER CAPITA GOVERNMENT EXPENDITURES FOR HEALTH SERVICES (\$US)

	<u>C/Y</u>	<u>1973</u>	<u>1974</u>	<u>1975</u>	<u>TREND</u>	<u>ADJUSTED TREND</u>
ANTIGUA		21	26	24	D	D
BARBADOS		43	46	54	U	D
DOMINICA		13	20	15	D	D
GRENADA		12	16	19	U	EQUAL
MONTSEERRAT		29	40	50	U	EQUAL
ST. KITTS/NEVIS		16	19	21	U	D
ST. LUCIA		11	12	16	U	D
ST. VINCENT		10	17	14	D	D

Note however, these trend figures do not reflect a true picture of the value of the service per capita delivered. The upward trends are only "keeping up with the economy". For example in 1973 a dollar of service was just that but in 1974, due to the oil crisis, that same expense provided only 75% of the service and in 1975, after reevaluation of the E.C. \$ to the U.S. \$, the costs brought only 60% of the original services. Taking this into account the adjusted trend is equal or down for all the islands. As a result

of this project the trends and levels will not change of major consequence, but rather the efficiency of these services and their coordination will be improved.

### 3. Cost/Effectiveness Analysis

Assuming that the per capita government expenditures for health services in the target island's remains an average of U.S. \$26 and that this value will be more effectively utilized after training; a factor can be assigned to reflect this increased utilization. If this factor was as low as three percent, the annual savings (as represented by more efficiency) would be minimum of (\$ 78 x 781,400) \$609,000. If improved training and information systems reached the expected improved and proficiency level of eight percent; efficiency savings over the next three years would be 5 million dollars. This gives a per capita estimated savings of \$2.08 per year from an associated investment of \$.99 per year.

From analysis of the following Table the package development and training of the target group will have direct cost of \$1.2 million or \$1,028 per trainee. This cost is considered reasonable and low if related to costs of other training alternatives. Approximately 1316 work days will be spent in conferences and work shops; again at a low cost \$94 per work day for value received.

The expansion of CARICOM's resources and improvement of the central co-ordination of the Governments' health programs in available information, modeling design and implementation is expected to be major output at a cost of \$678 thousand. These inputs can be identified in further development and expansion of health policy statements for the islands.

Another important activity will be the creation of eight Health Management Resource Centers, one for each of the participant Islands to provide on going training and information to the target group.

**COSTING OF PROJECT OUTPUTS/INPUTS 1/**

<u>PROJECT INPUTS</u>	<u>PROJECT OUTPUTS</u>												<u>TOTAL</u>
	<u>2/</u> 1.1	2.1	3.1	4.1	5.1	6.1	7.1	8.1	9.1	10.1	11.1	12.1	
AID GRANT	521.8	295.2	51.9	102.8	5.6	50.0	40.0	67.7	45.0	303.0	16.0	111.5	1610.5
ISLANDS		131.5	24.5	42.4	24.5	10.0	10.0	10.0	10.0	99.0	48.0	12.0	421.9
CARICOM	18.0					6.0	7.0	7.0	7.0	6.0			51.0
<b>TOTAL</b>	<b>539.8</b>	<b>426.7</b>	<b>76.4</b>	<b>145.2</b>	<b>30.1</b>	<b>66.0</b>	<b>57.0</b>	<b>84.7</b>	<b>62.0</b>	<b>408.0</b>	<b>64.0</b>	<b>123.5</b>	<b>2083.4</b>

1/ Inflation and Contingency Factors are not included.

2/ Refer to Logframe for numeric identification.

#### 4. Implementing Agency Analysis

The Caribbean Community Secretariat (CARICOM), created in 1973, is one of the principal administrative organs of the Caribbean Community in the field of functional cooperation.

The Health Secretariat of CARICOM, the implementing unit of this project, is an emerging regional agency with considerable potential, as demonstrated in its past programs and actions. While it has sufficient resources to carry out its present function and activities, as noted in the PP, additional resources from this project will be necessary to enhance the agency's capacity to perform. The inputs are considered minimal in comparison to the outputs and will be institutionalized with CARICOM's resources pattern before the end of the project's life.

As background to this section, it should be noted that the Chief of the CARICOM Health Section accompanied the AID Project Design Team on its visit to seven of the eight islands and participated in the data collection exercise and the final preparation of the Project Paper.

The current capabilities of CARICOM have been analyzed by the Project Committee. It is RDO/C's conclusion that CARICOM is capable of expanding its operations sufficiently to carry out the planned activities.

A condensed summary of CARICOM's CY 1974-77 Balance Sheets is shown below in U.S.\$ equivalents:

<u>SOURCE OF FUNDS</u>	<u>1974</u>	<u>1975</u>	<u>1976</u>	<u>1977 (UNAUDITED)</u>
Contribution from Governments	145,983	179,872	146,059	133,419
Income & Expenditures				
Surplus/(Deficit)	<u>13,594</u>	<u>(51,535)</u>	<u>710</u>	<u>7,613</u>
	159,577	128,337	146,769	141,032
	<u>          </u>	<u>          </u>	<u>          </u>	<u>          </u>
<u>FIXED ASSETS</u>	108,541*	107,542*	130,641*	139,095*
<u>CURRENT ASSETS</u>	197,555	176,867	155,251	283,967
<u>CURRENT LIABILITIES</u>	146,519	156,072	139,123	282,030
<u>NET CURRENT ASSETS</u>	<u>51,036</u>	<u>20,795</u>	<u>16,128</u>	<u>1,937</u>
	159,577	128,337	146,769	141,032
	<u>          </u>	<u>          </u>	<u>          </u>	<u>          </u>

Note: No provision is made in CARICOM's Financial Regulations for depreciation.

It is the opinion of the PP Committee that CARICOM will be able to effectively discharge their responsibilities in development and monitoring of the project as the planned management staff additions are completed; i.e. increasing the health staff: Project Manager, Administrative Assistant, Staff Trainer, two stenos and one contract trainer. The infrastructure of CARICOM is in place and is expected not to have difficulty controlling the funds provided by this project. CARICOM worked from a deficit income position in 1975 to a surplus level during the past two years. Information received from CARICOM does not provide a budget breakdown for 1978 but it is understood to provide sufficient funds to carry out those programs of interest to AID. The general outlook for 1978 is good, with contribution levels approximating those of 1976-77 and some possibilities of supplements to income during the year from other donor agencies.

## C Technical Analysis

### 1. Administrative Feasibility

The Caribbean Commonwealth (CARICOM) Secretariat, located in Georgetown, Guyana, shall be the executing authority for this project. The Health Section of CARICOM will serve as the administrative unit within the Secretariat responsible for project implementation. Project activities specified in the detailed description shall be carried out in the Windward and Leeward Islands and Barbados under project-specific cooperative arrangements to be concluded between CARICOM and the participating governments. The Regional Development Office/Caribbean of AID will be the Agency's administrative unit responsible for project monitoring and coordination.

CARICOM Secretariat: Description and Administration Capability. Since AID has no bilateral relationships with any of the participating governments under this project, and consistent with Congressional mandate to utilize existing regional institutions in implementation of Agency activities, the CARICOM Secretariat has been selected as the executing authority for this project.

The CARICOM Secretariat was established in 1973 by a treaty signed by the heads of government of the English-speaking Caribbean area, including each of the island governments participating in this project. Under provisions of the treaty, CARICOM is charged with responsibility to identify, promote and support functional cooperation in areas of common concern, specifically including health.\* Thus a firm legal basis exists to justify selection of CARICOM as the executing authority for this project, and it is anticipated that the project can be effectively accomplished within the existing legal structure.

While CARICOM, as a regional institution, has experienced difficulties in effecting coordination in the areas of economic and trade cooperation, particularly following the

\* Brief history and description of the mandate, functions and administrative organization of CARICOM will be found in Annex A IV 1.

oil crisis of 1974, health has continued, since the inception of CARICOM, as a viable area of functional cooperation and the activities of the Secretariat's Health Section continue to enhance CARICOM's role as a regional coordinating body.

The organization chart of the CARICOM Secretariat is shown in Annex A IV - 1 of this Project Paper. Of the five divisions reporting directly to the Secretary-General of CARICOM, three are of particular concern to this project: The Functional Cooperation Division, which includes the Health Section; the Legal Division; and the General Services and Administration Division, which includes the accounting function.

#### CARICOM's Health Section Capacity

Current and ongoing functions of the Health Section are described in detail in Annex A IV - 1. With regard to this project, it is of particular importance to note that these mandated functions include implementation of resolutions of the Conference of Ministers Responsible for Health; preparation of programs of regional cooperation in priority problem areas; and provision of advisory services to individual countries. Thus, the role of the Health Section, as the administrative unit within the CARICOM responsible for implementation of this project, is firmly consistent with the ongoing functions and responsibilities of the Section. Further, two factors underscore the appropriateness of selecting the Health Section for this role: (1) The Conference of Ministers has specifically selected this project's focus -- health management -- as a priority problem area in the region; and (2) the Health Section's understanding of and commitment to this project has been ensured by the consistent collaborative participation of the Chief of the Health Section, both during the study carried out by AID's Health Survey Team in October 1977 and throughout the project design phase, during which the Chief of the Health Section accompanied and worked closely with the Design Team. It is expected that the Chief of the Health Section, who has served in this capacity for the past

six and half years (as of April 1978), will continue in the assignment beyond the life of this project.

By virtue of its mandated role with regard to cooperative health activities in the region and through the energetic, experienced and highly respected leadership of its Chief, the Health Section has established direct, frequent and continuous contacts with the island governments, with members of the target populations (Ministry personnel at all levels), as well as with numerous regional and international agencies, institutions and organizations.

In order to ensure that the existing capabilities and functions of the Health Section are not jeopardized by the additional burdens of project activity, as well as to ensure the timely and effective management of the complex set of activities to be carried out under this project, enhancement of the Health Section's capacity will be required. Specifically, it is recommended that AID inputs provide for a Project Manager, one (1) Management Trainer, one (1) Administrative Assistant and two (2) clerk-typists to comprise the project staff within the Health Section. Specific functions of these personnel are described in Annex AIII 2, CARICOM Staff functions. To ensure that the capacity to provide health management training and technical assistance is institutionalized within the Health Section, it is further recommended that CARICOM be encouraged to seek budget support from its regular sources to establish a post for a Health Management Training and Technical Assistance Advisor upon completion of the AID project.

The Chief of the Health Section, who reports directly to the Secretary-General of CARICOM, will serve as Project Director, devoting ten percent of his time to the related oversight and coordinating responsibilities. The Project Manager will report to the Chief of the Health Section/- Project Director. The role of the Project Manager is critical to the success of this project, as he or she will be the focal point for coordination of all project activities. It is essential that the Project Manager be a strong individual with background in both management and health and with demonstrated experience and skill in actual management of complex activities. It is believed that an individual with the appropriate background and skills can be located and recruited from within the CARICOM region and that every effort should be made to do so, given the strong preference indicated for employment and

utilization of regional personnel. The prestige and visibility of CARICOM's Health Section will enhance feasibility of recruitment, although the requirement that the Health Section's Project Staff reside in Guyana may necessitate special salary benefits provisions. The Project manager will identify support T.A. required by CARICOM from the "pool" for successful implementation of the project and ongoing skill training.

The heavy workload anticipated in connection with coordination and management of project implementation will require the full time effort of the Project Manager (although, particularly in the second and third years, the individual may be engaged in actual delivery of training and technical assistance). For this reason, and because design and delivery of training constitutes a key component of project activity, it is recommended that a full-time Management Trainer be engaged as a member of the Health Section's core project staff reporting to the Project Manager. The role of this "Staff Management Trainer" will be particularly critical to ensure continuity among sequential training activities which build upon one another over the three year life of the project and which, as described below, will involve participation of subcontractor trainers.

It is anticipated that identification and recruitment of a Management Training Specialist from within the region may pose a somewhat greater problem than recruitment of a Project Manager. There are individuals in the region with qualifications in health management who possess teaching experience. It will, however, be more difficult to locate individuals who are skilled and experienced in providing short-term, high-participation training of the type envisioned for this project. Nevertheless, the preference for regional personnel, the necessity that training modalities be developed under supervision of an individual fully cognizant of the historical and cultural realities of the region, and the even greater difficulties which may be anticipated in recruiting a person from outside the region to serve out a three-year assignment argue for active recruitment from within the region. As a last resort, a qualified teacher of health management from within the region may work on-the-job to develop skills in short-term, high participation training through collaboration with a subcontractor-trainer of appropriate background during the first year of the project.

A number of regional resources exist which may not only serve as recruitment sources for an appropriate staff trainer, but may also represent potential subcontracting institutions. These include the health management faculty at the University of West Indies, management experts with health training experience within the private sector (e.g. the Barbados-based management training group (BIMAP), regional management consultant groups, the Management Institute in Trinidad, as well as other organizations active in the region.

#### CARICOM's Legal and Administrative/Accounting Capacity

CARICOM's ability to select, award and administer sub-contracts with both regional and U.S. - based organizations rests not only on the Health Section but also on the legal and administrative capacity within the Secretariat itself. The CARICOM Legal Division has a staff of five lawyers and has regular and extensive contacts with regional institutions and international organizations, such as IDB, PAHO, CIDA and CDC for whom CARICOM has served as an executing agency.

In addition, the Finance and Administrative Section of the General Services and Administration Division has a staff of seven accountants. A copy of the Secretariat's financial regulations governing accounting procedures is on file in RBO/C Offices.

CARICOM has recently served or is serving as executing agency for several projects funded by major international donors. These projects include contracts with the following:

- o The United States Government through the Center for Disease Control (CDC) for U.S. \$330,000 for epidemiological surveillance.
- o JNDP for U.S. \$2 million (with counterpart contributions of EC \$1.25 million) for agriculture.
- o Canadian International Development Agency (CIDA) in the amount of Canadian \$600,000 for technical training of health personnel from CARICOM member countries.
- o CIDA in the amount of Canadian \$60,000 for development of a regional drug policy.

Under the CDC and CIDA contracts mentioned above, CARICOM has experience in the letting of subcontracts (to CAREC and to the Pan American Health Organization). The Secretariat's legal and accounting capacity to undertake the letting of subcontracts has been recognized by international agencies such as CIDA and UNDP, and authority to subcontract has been granted to CARICOM under existing contractual arrangements with these organizations. Under CARICOM's recognized capability to do so, the executing agency will be granted authority by AID to solicit, select and administer subcontracts for training and technical assistance under this project. To ensure effective geographic coordination and to minimize diffusion of accountability, maximum responsibility for project activities, including control over subcontractors, is to be vested in CARICOM. AID will reserve approval on all contracts over \$5,000.

CARICOM has no prior experience in AID contracting and RDO/C and AID/W will provide orientation of CARICOM staff to AID host-country contracting and subcontracting procedures. CARICOM may also require assistance from AID in identification of suitable available mechanisms for soliciting subcontractors from U.S. organizations. This initial investment of orientation effort will build into CARICOM an ongoing capacity to serve as an executing agency for additional AID and other donor regional projects.

## 2. Environmental Analysis

An initial environmental examination was prepared by the Project Committee and is attached as Annex A I 6. RDO/C is proposing a negative determination.

## 3. Technical Feasibility

The salient features of the "technology" or methodology to be utilized in this project may be characterized, in summary, as follows:

1. Heavy emphasis is placed upon on-site, short-term training of a relatively large number of existing health personnel (over 700 different people) in generic management skills, using high-participation training methodologies.
2. Provision has been made for technical assistance to complement and reinforce training activities by providing specialized expertise to assist islands in the practical application of generic management skills to real and immediate problems.

3. A Management Resources Center will make presently unavailable resource materials readily accessible to all levels of health personnel.
4. Regional Workshops and other Special Activities will provide for an exchange and dissemination of ideas, experiences and methodologies on topics of common concern.

#### D Economic Analysis

It has not been possible to analyze this project on the basis of a quantified judgement of its effect on the economies to the project target group. The economic benefits obtained from training can be traced only after implementation and evaluation. The array of unquantified economic benefits, as against the costs of doing the training, as reviewed in the financial section, qualify the project as cost effective and economically justified for AID purposes.

Historically, economic analyses for health projects have been made on the reduction of hospital occupancy, improved nutrition, less work absence and improved infant mortality. All of these could be economically addressed as the result of training. These issues are secondary to making the Island Governments health dollar go further and the effect can only be estimated at the present time.

A regional overview reflects that the CARICOM member countries currently participate in a modest degree of monetary cooperation through mutual consultation on exchange rate matters but this cooperation does not transfer to such applications as health appropriations and budgets. Each island is autonomous in application and assignment of budgetary emphasis. The available per capita GNP in 1976 for the target group was 633.

Average Government Health expenditure is 4% of the GNP.

In recent years, recurrent budget expenditures have exceeded recurrent revenue in most countries, in several instances by more than 20%. The true recurrent budget deficit would be greater, or government services less, if it were not for the presence of numerous foreign financed experts, professionals and volunteers, many of who perform functions or fill positions that would normally be filled by salaried government employees.

The simple deficit, however, is demonstrated in the following table for 1976, in E.C. \$ millions:

	<u>Revenue</u>	<u>Expenditure</u>	<u>Deficit</u>
Antigua	29.5	38.3	8.8
Dominica	17.6	22.8	5.2
Grenada	28.6	34.2	5.6
St. Kitts	19.0	26.2	7.2
St. Lucia	33.1	32.9	.2
St. Vincent	21.3	25.3	4.0

**This deficit is financed through domestic sources (treasury bills, overdrafts and other borrowing) and external budgetary assistance, primarily from the U.K.**

The AID contribution represents a marginal economic input into program effort in comparison to the total investment by the LDCs and the Health Secretariat. The strategy is that the grant of \$1.8 million spread over eight different island governments for a three year period will stimulate their health systems to utilize more effectively present levels of resource inputs and hence achieve enhanced economic outputs.

In addition, it is anticipated that the AID contributions will accelerate the institutionalization process(es) for the conduct of regional activities -- thus making it possible to capitalize on economies of scale and comparative economic advantages that otherwise would not be available.

Through the AID contribution, the economic planning process will be enlarged and strengthened in the health area and this in turn will effect the larger planning efforts of each LDC. Key decision makers will be able to more effectively analyze their resource allocation problems within the terms of welfare or social efficiency functions, an important aspect seldom practiced in today's management health and related resource matters.

Out of this kind of planning exercise should emerge a "real" capacity to manage better the health sector, including the widening of options such as contracting for

health services and mobilizing the energies of community groups and associations on specific health problems. Target groups will be better served and at lower costs, and health activities costed-out making it possible for the first time to prioritize program goals. Only a few of these kinds of decision making and management practices are now taking place, and none of them in a satisfactory manner. (Additional comments and models are on file RDU/C.

## PART V - IMPLEMENTATION PROCESS

### A. Administration of Project - Relationships and Functions.

Annexed to this section are: Staff and Implementation Functions of CARICOM; a listing of scheduled activities, organized chronologically by program "package" or type of activity; and a Gantt-type graphic showing the occurrence of project elements over time. See Annex III.

#### 1. CARICOM Secretariat, Health Section

For reasons discussed in the Project Analysis Section, the Caribbean Community (CARICOM) Secretariat, will be the executing agency for this project. Responsibility for project implementation will be vested in the Health Section of the Functional Cooperation Division of the Secretariat. The Chief of the Health Section will devote ten percent of his time to overseeing this project and coordination with other CARICOM initiatives in health. In the process of implementing this project, the Health Section will:

1. Continue to identify and define problems in the area of health management.
2. Prepare the project work plan and ensure its timely implementation.
3. Schedule and coordinate logistic activities.
4. Design curricula for the various training modules.
5. Determine appropriate mode of response to specialized technical assistance requests from island governments and provide positive reinforcement to the islands by ensuring the rapid deployment of technical assistance.
6. Integrated project activities with other health activities as well as with activities of other sectors in the region.
7. Maintain an active system of communication with the participating governments and local Projects Coordinators as well as key agencies and institutions, e.g., PAHO and regional educational institutions.

8. Report periodically on the project to the Health Ministers Conference and carry out the decisions of the Conference pertaining to and consistent with this project.
9. Assemble basic materials for "Management Development Resource Center" (library, etc.) and collect and disseminate supplementary materials to establish a center in each country.
10. Develop and maintain a system to identify personnel of the region with special skills related to health.
11. Conduct periodic evaluation of project activities.

In order to implement this project, the Health Section will require additional staff to be provided through AID inputs for the life of this project, including (1) Project Manager; (1) Management Trainer; (1) Administrative Assitant; and (2) Clerk-Typists. The specific duties of these persons are in Annex III 2.

## 2. Island Government Responsibilities

CARICOM will request, and it will be island government responsibility to provide:

1. Designation of a Project Coordinator to serve 50% time for the life of the project. The project coordinator will be the "life-line" of the project for the future. The skills developed by this key person will be held by on-island personnel for transfer to others upon completion of the project and beyond. Due to the sensitive and valuable nature of this position, selection of an adaptive, professionally skilled, and experienced person will be essential. These experiences will be used by the Island Governments when assigning these positions and previewed during the evaluation of the project. The Project Coordinator should be prepared to: coordinate with CARICOM project staff on finalizing curriculum design; coordinate scheduling of training activities on his/her island; ensure the execution of logistical arrangements for training, including selection, authorized release and registration of trainees; transportation; account for such project funds as may be released to the islands (e.g. per diem and travel for trainees); establish lines of communication for Government approval of specific requests to CARICOM for technical assistance; ensure that timing, roles and duties of technical assistants are clearly understood by all parties concerned; and participate in delivery of training Package D and in health management development project evaluation.

2. Issuance of a "training policy statement" (or its equivalent) to supervisors within the Ministries responsible for health encouraging authorized release of selected personnel for Health management development training activities.
  3. Ratification of expected island government inputs, as reflected in the budget of this Project Paper. It should be noted that only those inputs deemed to be within the capacity of all island governments have been included as "island inputs". These include the provision and salaries of Project Coordinators (50% time) and trainees, provision of space for training, the Management Resource Center (library room) and selected materials. Some islands have requested an honorarium for the Project Coordinator; however, since it is not provided for by AID inputs, this point should be clarified and agreed upon during project implementation.
3. Agency for International Development
- Specific AID tasks include:
1. Orientation of CARICOM personnel (existing and new project staff) to AID procedures and regulations; ongoing interpretation of these during implementation.
  2. Specification of information required of CARICOM by AID for project monitoring; verification (by inspection) that appropriate records and other information systems are established and maintained; execution of project monitoring.
  3. Participating in project evaluation activities as appropriate.
  4. Assistance to CARICOM regarding mechanisms for sub-contractor selection, particularly for U.S. - based organizations.
  5. Give guidance to CARICOM in procurement of commodities for the project office and activities.
  6. Coordination of health management development project activities with other AID health initiatives, as appropriate.

## B. Evaluation Plan

The Evaluation Plan for this project will attempt to deal with three inter-related, but discrete, factors of evaluation: process measurement; identification and measurement of intervening variables; and impact assessment. The combination of these three factors provides a significantly clear understanding of project impact, the means by which it was effected, and the relative importance of the different causative elements - whether inherent or exogenous to the project itself. Moreover, the three factors answer the basic questions of effectiveness, significance, and efficiency.

### Baseline Data Collection

The first phase of this evaluation will be the mobilization and collection of baseline data. In order to be able to measure project-induced changes and consequences, pre-implementation conditions must be known. These conditions include variables directly related to the project and contextual/intervening variables within which the project must operate. Specific inherent conditions of this project are management knowledge, skills, and attitudes; organizational structure and process; and institutional norms. Intervening variables relate to political climate, economic development, financial stability, and many other factors.

In order to begin to identify and sort out the various elements of this project, the Project Manager will be responsible for developing a conceptual evaluation model for which necessary data can be collected and evaluation instruments designed. Once the instruments are developed, the island-specific Project Coordinators will gather the information on their respective islands.

### Process Measurement

Evaluation of the project process will be ongoing and will be the responsibility primarily of the Project Manager, Core Staff Trainer, and Project Coordinators. Each training package has build-in time for island-specific evaluations of the training activities. Therefore, information on the number of cycles and the number and type of participants will be readily available and can be correlated with baseline data on management practices.

Much of this information is readily available and will not require a great deal of baseline analysis or research.

An intangible, but perhaps most vital aspect of the project will be the changes in management knowledge, attitudes, and practices (KAP) of Ministry personnel on each of the islands. As part of the baseline data collection effort and before the initiation of project implementation, a sample KAP survey of health personnel will establish the current status of management concepts and skills prevailing at different levels of the Ministry. The sample should be large enough to permit retrospective identification of two populations among the KAP respondents: those who receive training and those who do not. The identification and follow-up of these populations will permit correlation with training, intergroup comparisons, and measurement of diffusion effects (e.g. how many nontrainees are aware they work with persons who were trained and do they see effects of training?).

Underlying both the tangible and intangible impacts is the question of cost. Therefore, cost information will be included within the baseline data and will be correlated with specific project outcomes and processes (cost-effective analyses).

#### Intervening Variables

The environment within which the project is carried out is vitally important to the success and impact of the project itself. Such variables as economic development, financial stability, and political environment will contribute directly to program outcomes, although they are not under the control of the project. Within the development of the conceptual model for this evaluation, these factors will be identified and monitored periodically throughout the life of the project by the Project Manager, the Project Coordinators, and RDO/C. The primary mechanisms for collection of these data will be KAP surveys, statistical indicators provided by the island governments, and information provided by donor agencies such as CDB, IBRD, and PAHO.

Midway through the life of the project, the Project Coordinators will meet with the Project Management Staff to assess the progress of the project. At that time, preliminary evaluations can be made on the utilization of technical assistance, acquisition of commodities, and completion of the training cycles. In addition, the Annual Conference of Ministers Responsible for Health will provide a forum for continuing feedback from the Ministers and Permanent Secretaries on the progress of the Project.

#### Impact Assessment

This project will have short-term and long-term impacts. Short-term impacts will be the development of health plans, structural changes within the Ministries, the re-institution of Annual Health Reporting, and changes in knowledge, attitudes, and practices of management by the health personnel of the Ministries. Long-term impacts include a significant contribution to improved health conditions and more rational allocation of scarce resources.

Measurement of these impacts fall into two categories: tangible and intangible. The tangible impacts can be examined by asking questions concerning the:

- The Health agencies' effective utilization and assessment of indicators contained in CHATCOM's Annual Health Report;
- Formulation of a national health policy statement and implementation of this policy through the delivery of Health Services;
- Actual delivery of Health Services included in the budgets;
- Effectiveness of the health planning process: i.e., determination that planning by a specific Ministerial unit is directly related to the delivery of Health Services;
- Assumption that modification of attitudes through training is taking place and is leading to a more effective organization;
- Utilization of monthly health reports from the field to the central level to provide more efficient Health Services.

**Evaluation Time-Table**

The attached activities evaluation plan provides a proposed schedule of events through the life of the project. Responsibility for implementation of this schedule will rest with the Project Manager. A final report, including an assessment of the project's impact and costs, and recommendations for future programming, will be delivered to RDO/C within six months of the end of the project.

EVALUATION TIME-TABLE

C/Y

TIME ACTIVITIES	1978		1979				1980				1981			
	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Development of Conceptual Model	█	█												
Design of Evaluation Instruments		█												
Orientation of Project Coordinators		█												
Collection of baseline data		█	█	█										
KAP Survey			█	█							█	█		
Annual CMRH	█				█			█	█			█	█	
Mid-point Assessment								█	█					
End of project data collection												█	█	
Final report													█	█

**C Conditions and Covenants**

In addition to the usual covenants and conditions, the Project Committee recommends that the Loan Agreement contain the following:

**Source and Origin of Goods and Services**

Goods and services financed by AID under the Grant shall have their source and origin in the United States and CARICOM member territories except as AID may otherwise agree in writing.

**Conditions Precedent to Disbursement Other Than for Technical Assistance**

Except as AID may otherwise agree in writing, prior to any disbursement or to the issuance of any commitment documents under the Project Agreement to finance other than technical assistance, CARICOM shall furnish to AID, in form and substance satisfactory to AID:

- (i) A written plan for the hiring and scheduled placement of the staff required for the project;
- (ii) Prior to initiation of project activities in any eligible CARICOM member countries, CARICOM will secure a written statement from each Government giving:
  - (a) the name of an individual appointed to serve as Project Coordinator for the duration of the project;
  - (b) a policy statement, issued by the Government through the Ministry responsible for Health, authorizing supervisors to make every effort to release staff to participate in project activities;
  - (c) an agreement providing the appropriate Government inputs identified equal to those in the Project Paper; and
- (iii) A plan of activities for 1978 and 1979 which shall incorporate the AID Grant.

**Special Covenants**

CARICOM, except as AID shall otherwise agree in writing, shall covenant to:

- (i) submit for AID approval any grant-financed contract which exceeds \$5,000;
- (ii) provide a written commitment stating that every effort will be made to secure funds from regular budgetary sources to support continuation of core staff and activities following termination of the AID contribution;
- (iii) provide a yearly plan of activity for 1980 and 1981 in a timely fashion, which shall be satisfactory in form and substance to AID;
- (iv) maintain and support health programs which develop regional unity and better utilize existing resources;
- (v) agree that funds made available under the Project shall be utilized for financing and technical assistance activities only in the following countries ("Eligible Countries"): Antigua, Barbados, Belize, Dominica, Grenada, St. Kitts-Nevis-Anguilla, St. Lucia, Montserrat and St. Vincent; and
- (vi) establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will include, during the implementation of the Project and at one or more points thereafter:
  - (a) evaluation of progress toward attainment of the objectives of the Project;
  - (b) identification and evaluation of problem areas of constraints which may inhibit such attainment;
  - (c) assessment of how such information may be used to help overcome such problems; and
  - (d) evaluation, to the degree feasible, of the overall development impact of the Project.

**D Waivers**

To permit more efficient and timely implementation of the project the following waivers of AID regulations are requested:

- (i) waiver of 50-50 shipping requirement;
- (ii) authorization of AID financing of shipping costs on AID Geographic Code 935 carriers when U.S. carriers are not available; and

Cable Address:  
CARIBBEAN GUYANA  
P.O. BOX 607

ANNEX A

CARIBBEAN COMMUNITY SECRETARIAT

Third Floor, Bank of Guyana Building,  
Avenue of the Republic,  
Georgetown,  
Guyana.

ALL COMMUNICATIONS SHOULD BE  
ADDRESSED TO THE SECRETARY GENERAL

Dear Mr. Staman,

I have been much encouraged by the reports about informal discussions that have been taking place in recent months between officials of this Secretariat on the one hand and officials of AID on the other.

The strengthening of the management of health services is a matter to which the CARICOM Ministers of Health attach great priority and the visit of the AID Mission to Barbados and the Leeward and Windward Islands in order to see what assistance could be given towards the achieving of the objective is therefore very welcome.

The purpose of this letter is to confirm that I shall very much appreciate the cooperation of AID in devising measures to ensure the type of health management in these countries that will provide clear, visible and resolute attention towards the goals determined by the Governments.

Please accept the assurances of my highest consideration.

BEST AVAILABLE COPY

Mr. Thomas Staman,  
AID Affairs Office,  
Regional Development  
Centre,  
Georgetown,  
Guyana.

97/59/3

6 April 78

Dear Mr. Valdez:

I am writing to let you know of my appreciation of certain activities of the Agency for International Development among the so-called Less Developed Countries of the Eastern Caribbean in the area of management of health services.

In particular, I refer to the work of a Project Design Team which visited the Area during the month of March and was accompanied by the Chief of the Health Section of this Secretariat. The reports that I have received show that this is an activity of far-reaching significance to the people of the Area, particularly because of the concept of management upon which the Team has based its project design. I understand that this concept addresses - among other problems of management - what comes to me to be a fundamental issue in the delivery of health care in the Caribbean, namely, primary health care taken by health teams to the very periphery of the system, reaching the most vulnerable groups, namely, the poor, those living in rural areas, young children and mothers.

I look forward to seeing the project document that emerges from the Team's work, and you may rest assured that the Secretariat will play its appropriate part in implementing such a project.

Please accept the assurance of my highest considerations.

Yours sincerely,

Acting Secretary-General

Mr. A. Valdez  
Assistant Administrator  
Bureau for Latin America and the Caribbean  
Agency for International Development  
Washington, D.C. 20523  
U.S.A.

*With the Consent of the*

*Secretary General*

*Caribbean Community Secretariat*

BEST AVAILABLE COPY

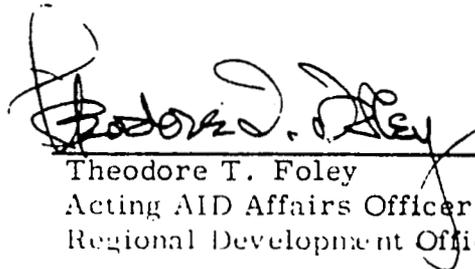
ANNEX AI - 2

CERTIFICATION PURSUANT TO SECTION 611 (e) OF THE  
FOREIGN ASSISTANCE ACT OF 1961, AS AMENDED

**SUBJECT:** CARIBBEAN REGIONAL - Capital Assistance -  
Basic Health Management Training Grant

I, Theodore T. Foley, as Acting AID Affairs Officer of the United States A. I. D. Regional Development Office, Caribbean, having taken into account, inter alia, the maintenance and utilization of projects in the Caribbean Region previously financed or assisted by the United States, do hereby certify that in my judgement the Caribbean Community Secretariat has both the financial capacity and the human resources to maintain and utilize effectively the proposed Basic Health Management Training Grant.

This judgement is based primarily on the facts developed in the Project Paper for the proposed Grant of \$1.8 million and A. I. D. 's Health Team analysis and evaluation of the Caribbean Regional health needs.



Theodore T. Foley  
Acting AID Affairs Officer  
Regional Development Office/Caribbean

05/30/78

Date

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5C(1) - COUNTRY CHECKLIST

Listed below are, first, statutory criteria applicable generally to FAA funds, and then criteria applicable to individual fund sources: Development Assistance and Security Supporting Assistance funds.

A. GENERAL CRITERIA FOR COUNTRY

1. FAA Sec. 116. Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the Department of State determined that this government has engaged in consistent pattern of gross violations of internationally recognized human rights?
 

Yes, This grant is being made for Basic Health Management Training of all levels to increase utilization of services to the target populations.
2. FAA Sec. 481. Has it been determined that the government of recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the U.S. unlawfully?
 

No.
3. FAA Sec. 620(b). If assistance is to a government, has the Secretary of State determined that it is not controlled by the international Communist movement?
 

There is no evidence that the Caribbean governments are controlled by the international Communist movement.
4. FAA Sec. 620(c). If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or contested by such government?
 

There is no evidence of any such debt owed to a U.S. citizen by a contributing Caribbean government.
5. FAA Sec. 620(e) (1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?
 

There is no evidence that any such action has been taken by a contributing Caribbean government.

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6. FAA Sec. 620(a), 620(j), App. Sec. 503. Is recipient country a communist country? Will assistance be provided to the Socialist Republic of Vietnam, Cambodia, Laos, Cuba, Uganda, Mozambique, or Angola? No.
  7. FAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression? No.
  8. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction, by mob action, of U.S. property? No.
  9. FAA Sec. 620(l). If the country has failed to institute the investment guaranty program for the specific risks of expropriation, inconvertibility or confiscation, has the AID Administrator within the past year considered denying assistance to such government for this reason? Not applicable.
  10. FAA Sec. 620(o); Fishermen's Protective Act; Sec. 5. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters,
    - a. has any deduction required by Fishermen's Protective Act been made? Not applicable.
    - b. has complete denial of assistance been considered by AID Administrator?
  11. FAA Sec. 620(q); App. Sec. 503. (a) Is the government of the recipient country in default on interest or principal of any AID loan to the country? (b) Is country in default exceeding one year on interest or principal on U.S. loan under program for which App. Act appropriates funds, unless debt was earlier disputed, or appropriate steps taken to cure default? The Caribbean Community Secretariat is not in default on interest or principal on any AID loan covered by this Act.
  12. FAA Sec. 620(s). "If contemplated assistance is development loan (including Alliance loan) or security supporting assistance, has the Administrator taken into account the percentage of the country's budget which is for military expenditures, the amount of foreign exchange spent on military equipment and the amount spent for the purchase of sophisticated weapons systems?" (An affirmative answer may refer to the record of the taking into account, e.g.: "Yes as reported in annual report on implementation of Sec. 620(s)." This report is prepared at the time of approval by the Administrator of the Operational Year Budget. Not applicable.

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Upward changes in the Sec. 620(s) factors occurring in the course of the year, of sufficient significance to indicate that an affirmative answer might need review, should still be reported, but the statutory checklist will not normally be the preferred vehicle to do so.)

13. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?
14. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget?
15. FAA Sec. 620A. Has the country granted sanctuary from prosecution to any individual or group which has committed an act of international terrorism?
16. FAA Sec. 666. Does the country object, on basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. there to carry out economic development program under FAA?
17. FAA Sec. 669, 670. Has the country, after August 3, 1977, delivered or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards? Has it detonated a nuclear device after August 3, 1977 although not a "nuclear-weapon State" under the nonproliferation treaty?
18. FAA Sec. 901. Has the country denied its citizens the right or opportunity to emigrate?

No such action has been taken by a contributing Caribbean government.

No contributing Caribbean government nor the CARICOM is in arre on its U. N. obligations.

No contributing Caribbean government has granted sanctuary to an international terrorist.

No. The CARICOM does not discriminate on the basis of race, religion, national origin or sex.

No contributing Caribbean government is engaged in such activities.

No Caribbean government has taken such action.

## B. FUNDING CRITERIA FOR COUNTRY

### 1. Development Assistance Country Criteria

- a. FAA Sec. 102(c), (d). Have criteria been established, and taken into account, to assess commitment and progress of country in effectively involving the poor in development, on such indexes as: (1) small-farm labor intensive agriculture, (2) reduced infant mortality, (3) population growth, (4) equality of

The CARICOM has established and followed both its own and AID criteria to involve and support small farm labor-intensive production, equitable income distribution, unemployment of rural and urban poor and reduction of infant mortality.

b. FAA Sec. 104(d)(1), If appropriate, is this development (including Sahel) activity designed to build motivation for smaller families in programs such as education in and out of school, nutrition, disease control, maternal and child health services, agricultural production, rural development, and assistance to urban poor?

c. FAA Sec. 201(b)(5), (7) & (8); Sec. 209; 211(a)(4), (7). Describe extent to which country is:

- (1) Making appropriate efforts to increase food production and improve means for food storage and distribution.
- (2) Creating a favorable climate for foreign and domestic private enterprise and investment.
- (3) Increasing the public's role in the developmental process.
- (4) (a) Allocating available budgetary resources to development.
- (b) Diverting such resources for unnecessary military expenditure and intervention in affairs of other free and independent nations.
- (5) Making economic, social, and political reforms such as tax collection improvements and changes in land tenure arrangements, and making progress toward respect for the rule of law, freedom of expression and of the press, and recognizing the importance of individual freedom, initiative, and private enterprise.
- (6) Otherwise responding to the vital economic, political, and social concerns of its people, and demonstrating a clear determination to take effective self-help measures.

d. FAA Sec. 201(b), 211(a). Is the country among the 20 countries in which development assistance loans may be made in this fiscal year, or among the 40 in which development assistance grants (other than for self-help projects) may be made?

e. FAA Sec. 115. Will country be furnished, in same fiscal year, either security supporting assistance, or Middle East peace funds? If so, has Congress specifically authorized such use of funds, or is assistance for population programs, humanitarian aid through international organizations, or regional programs?

Not applicable.

- (1) A number of Caribbean regional institutions (e.g. the University of the West Indies, the CDB, and the Caribbean Agricultural Research and Development Institute), as well as the National Governments in the Region, are carrying out programs aimed at increasing food production and improving facilities for food storage and distribution in the Region.
- (2) In general, while governments in the Region are currently seeking greater control over their own natural resources, the climate for foreign and domestic private enterprise and investment in the Region is favorable.
- (3) Development programs in the Region, both the national and regional level, are generally aimed at increasing the public role in the developmental process.
- (4)a. The Caribbean territories have been allocating considerable available budgetary resources to both national and regional development.
- b. Military expenditures by the National Governments in the Region are minimal.
- (5) Caribbean territories are making progress toward respect for the rule of law, freedom of expression and of the press, and recognition of the importance of individual freedom, initiative and private enterprise, as evidenced by the absence of press and other censorship and the encouragement of initiative and private enterprise in agriculture, industry, and housing. Some progress is being made in political reforms such as tax collection improvements and land tenure arrangements.
- (6) The current efforts being made by the Caribbean territories towards economic cooperation and integration are indicative of their determination to take self-help measures.
- (d) The Caribbean Region is among the 20 countries eligible to receive development assistance loans in this fiscal year.
- (e) No.

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2. Security Supporting Assistance Country Criteria

a. FAA Sec. 502B. Has the country engaged in a consistent pattern of gross violations of internationally recognized human rights? Is program in accordance with policy of this Section?

The Caribbean governments have not engaged in gross violations of internationally recognized human rights.

b. FAA Sec. 531. Is the Assistance to be furnished to a friendly country, organization, or body eligible to receive assistance?

Yes.

c. FAA Sec. 533(c)(2). Will assistance under the Southern African Special Requirements fund be provided to Mozambique, Angola, Tanzania, or Zambia? If so, has President determined (and reported to the Congress) that such assistance will further U.S. foreign policy interests?

Not applicable.

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

No commodities are to be granted in this project.

e. App. Sec. 113. Will security assistance be provided for the purpose of aiding directly the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?

No

f. FAA Sec. 620B. Will security supporting assistance be furnished to Argentina after September 30, 1978?

No.

5C(2) PROJECT CHECKLIST

Listed below are, first, statutory criteria applicable then project criteria applicable to individual fund category for criteria applicable only to loans; and

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT.

1. App. Unnumbered; FAA Sec. 653(b); Sec. 671  
 (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project;  
 (b) Is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that figure)
2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?
3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?
4. FAA Sec. 611(b); App. Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per *the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973?*
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project?
6. FAA Sec. 209, 619. Is project susceptible of execution as part of regional or multi-lateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. If assistance is for newly independent country, is it furnished through multi-lateral organizations or plans to the maximum extent appropriate?

The Project was included in the FY 1979 Congressional Presentation at \$840 thousand. Congress will be notified of the proposed increase to \$1.8 million before the grant is authorized.

Yes.

Not applicable.

Not applicable.

Yes. The Caribbean Regional AID Affairs Officer's Certification is included in the Project Paper.

Project is regional in nature and will be executed on a regional basis.

7. FAA Sec. 601(a); (and Sec. 201(f) for development loans). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

Not applicable.

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

Private U. S. firms will be invited to bid on the training services contracts to be financed under the loan.

9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

Not applicable

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency and, if so, what arrangements have been made for its release?

No.

11. ISA 14. Are any FAA funds for FY 78 being used in this Project to construct, operate, maintain, or supply fuel for, any nuclear powerplant under an agreement for cooperation between the United States and any other country?

No.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(c); Sec. 111; Sec. 281a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production, spreading investment out from cities to small towns and rural areas; and (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions?

The project will stimulate health action in rural areas through its training programs for all levels of management and will increase the utilization of governments allocated health funds which benefit the poor.

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b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: [include only applicable paragraph -- e.g., a, b, etc. -- which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.]

- (1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;
- (2) [104] for population planning or health; if so, extent to which activity extends low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and poor;
- (3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;
- (4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:
  - (a) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;
  - (b) to help alleviate energy problem;
  - (c) research into, and evaluation of, economic development processes and techniques;
  - (d) reconstruction after natural or manmade disaster;
  - (e) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;
  - (f) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

Project is designed specifically to improve the management abilities of the personnel in the Health delivery systems of the Caribbean Region.

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(5) [107] by grants for coordinated private effort to develop and disseminate intermediate technologies appropriate for developing countries.

c. FAA Sec. 110(a); Sec. 208(e). Is the recipient country willing to contribute funds to the project, and in what manner has or will it provide assurances that it will provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

d. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?

e. FAA Sec. 207; Sec. 113. Extent to which assistance reflects appropriate emphasis on: (1) encouraging development of democratic, economic, political, and social institutions; (2) self-help in meeting the country's food needs; (3) improving availability of trained worker-power in the country; (4) programs designed to meet the country's health needs; (5) other important areas of economic, political, and social development, including industry; free labor unions, cooperatives, and Voluntary Agencies; transportation and communication; planning and public administration; urban development, and modernization of existing laws; or (6) integrating women into the recipient country's national economy.

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

As a Regional Project Section 110(a) does not apply.

No.

The project supports extensive training in local management in development of training programs through regional programs directed at staff expertise in health management.

Basic health management training is a response to the regions needs and desires and permits the utilization of the Region's intellectual resources in the form of technicians who will assist CARICOM in project development, monitoring and continuance.

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g. FAA Sec. 201(b)(2)-(4) and -(8); Sec. 201(e); Sec. 211(a)(1)-(3) and -(8). Does the activity give reasonable promise of contributing to the development: of economic resources, or to the increase of productive capacities and self-sustaining economic growth; or of educational or other institutions directed toward social progress? Is it related to and consistent with other development activities, and will it contribute to realizable long-range objectives? And does project paper provide information and conclusion on an activity's economic and technical soundness?

Yes.

h. FAA Sec. 201(b)(6); Sec. 211(a)(5), (6). Information and conclusion on possible effects of the assistance on U.S. economy, with special reference to areas of substantial labor surplus, and extent to which U.S. commodities and assistance are furnished in a manner consistent with improving or safeguarding the U.S. balance-of-payments position.

The proposed grant will have a negligible effect on the U.S. economy.

## 2. Development Assistance Project Criteria (Loans only)

a. FAA Sec. 201(b)(1). Information and conclusion on availability of financing from other free-world sources, including private sources within U.S.

Not applicable.

b. FAA Sec. 201(b)(2); 201(d). Information and conclusion on (1) capacity of the country to repay the loan, including reasonableness of repayment prospects, and (2) reasonableness and legality (under laws of country and U.S.) of lending and relending terms of the loan.

Not applicable

c. FAA Sec. 201(e). If loan is not made pursuant to a multilateral plan, and the amount of the loan exceeds \$100,000, has country submitted to AID an application for such funds together with assurances to indicate that funds will be used in an economically and technically sound manner?

Not applicable

d. FAA Sec. 201(f). Does project paper describe how project will promote the country's economic development taking into account the country's human and material resources requirements and relationship between ultimate objectives of the project and overall economic development?

Not applicable.

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e. FAA Sec. 202(a). Total amount of money under loan which is going directly to private enterprise, is going to intermediate credit institutions or other borrowers for use by private enterprise, is being used to finance imports from private sources, or is otherwise being used to finance procurements from private sources?

Not applicable.

f. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

Not applicable.

3. Project Criteria Solely for Security Supporting Assistance

a. FAA Sec. 531. How will this assistance support promote economic or political stability?

Not applicable.

b. FAA Sec. 533(c)(1). Will assistance under the Southern African Special Requirements Fund be used for military, guerrilla, or paramilitary activities?

4. Additional Criteria for Alliance for Progress

[Note: Alliance for Progress projects should add the following two items to a project checklist.]

a. FAA Sec. 251(b)(1), -(8). Does assistance take into account principles of the Act of Bogota and the Charter of Punta del Este; and to what extent will the activity contribute to the economic or political integration of Latin America?

Not applicable

b. FAA Sec. 251(b)(8); 251(h). For loans, has there been taken into account the effort made by recipient nation to repatriate capital invested in other countries by their own citizens? Is loan consistent with the findings and recommendations of the Inter-American Committee for the Alliance for Progress (now "CEPCIES," the Permanent Executive Committee of the OAS) in its annual review of national development activities?

Not applicable.

5C(3) - STANDARD ITEM CHECKLIST

Listed below are statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by exclusion (as where certain uses of funds are permitted, but other uses not).

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed?
 

U.S. small business will be ensured the opportunity to participate in the furnishing of goods and services under the loan.
2. FAA Sec. 604(a). Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him?
 

Yes.
3. FAA Sec. 604(d). If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the U.S. on commodities financed?
 

Yes.
4. FAA Sec. 604(e). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity?
 

Not applicable.
5. FAA Sec. 608(a). Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items?
 

Yes.
6. MMA Sec. 901(b). (a) Compliance with requirement that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent that such vessels are available at fair and reasonable rates.
 

The grant agreement will require maximum usage of U.S. flag vessels to the extent that such vessels are available.
7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis? If the facilities of other Federal agencies will be utilized,
 

Technical assistance for the project will be grant-financed and will be provided by individuals or firms on a contract basis. The facilities or personnel of other Federal agencies will not be used.

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are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

International Air Transport. Fair Competitive Practices Act, 1974

Yes.

If air transportation of persons or property is financed on grant basis, will provision be made that U.S.-flag carriers will be utilized to the extent such service is available?

#### B. Construction

FAA Sec. 601(d). If a capital (e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest?

Not applicable.

FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

Not applicable.

FAA Sec. 620(k). If for construction or productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million?

Not applicable.

#### Other Restrictions

1. FAA Sec. 201(d). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?

Not applicable.

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

Yes.

3. FAA Sec. 620(h). Do arrangements preclude promoting or assisting the foreign aid projects or activities of Communist-Bloc countries, contrary to the best interests of the U.S.?

Yes.

4. FAA Sec. 636(i). Is financing not permitted to be used, without waiver, for purchase, long-term lease, or exchange of motor vehicle manufactured outside the U.S. or guaranty of such transaction?

Yes.

Part I

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Will arrangements preclude use of financing:

- a. FAA Sec. 114. to pay for performance of abortions or to motivate or coerce persons to practice abortions, *to pay for performance of involuntary sterilization, or to coerce or provide financial incentive to any person to practice sterilization?*
- b. FAA Sec. 620(g). to compensate owners for expropriated nationalized property?
- c. FAA Sec. 660. to finance police training or other law enforcement assistance, except for narcotics programs?
- d. FAA Sec. 662. for CIA activities?
- e. App. Sec. 103. to pay pensions, etc., for military personnel?
- f. App. Sec. 105. to pay U.N. assessments?
- g. App. Sec. 106. to carry out provisions of FAA Sections 209(d) and 251(h)? (transfer to multilateral organization for lending).
- h. App. Sec. 112. *to finance the export of nuclear equipment, fuel, or technology or to train foreign nationals in nuclear fields?*
- i. App. Sec. 501. to be used for publicity or propaganda purposes within U.S. not authorized by Congress?

ANNEX A1 - 4

PROJECT AUTHORIZATION AND REQUEST  
FOR ALLOTMENT OF FUNDS

NAME OF ENTITY:: Caribbean Community Secretariat  
NAME OF PROJECT: Basic Health Management Training  
PROJECT NUMBER : 538-0019

Pursuant to Section 104(b) of the Foreign Assistance Act of 1961, as amended, I hereby authorize a grant to the Caribbean Community Secretariat (CARICOM) of not to exceed one million eight hundred thousand United States Dollars (\$1,800,000) the "authorized amount" to help in financing certain foreign exchange and local currency costs of goods and services required for the project as described in the following paragraph.

The project consists of a Regional Health Management Training program designed to enhance the managerial capacity of personnel through intervention and coordination of CARICOM of the ministries of health in each of the participating governments and thereby improve the health status of the target population through more effective usage of budgeted funds.  
(Here inafter referred to as the "project".) The Project will

consist of the following four general categories of assistance:

1. Training
2. Technical Assistance
3. Material Resources
4. Special Activities

I approve the total level of A.I.D. Appropriated Funding planned for this project of not to exceed one million, eight thousand United States Dollars (1,800,000) of which will be Grant funded, including the funding authorized above, in accordance with A.I.D. programs during the period FY 1978 through FY 1981.

I hereby authorize the initiation of negotiation and execution of the Project Agreement by the officer to whom such authority has been delegated in accordance with A.I.D. regulations and Delegations of Authority subject to the following essential terms and covenants and major conditions; together with such other terms and conditions as A.I.D. may deem appropriate:

- a) Source and Origin of Goods and Services

Goods and services financed by A.I.D. under the Grant shall have their source and origin in the United States and CARICOM member territories except as A.I.D. may otherwise agree in writing.

b) **Conditions Precedent to Initial Disbursement**

Prior to any disbursement or to the issuance of any commitment documents under the Project Agreement, CARICOM shall furnish to A.I.D., in form and substance satisfactory to A.I.D.:

- (i) a legal opinion of the General Counsel of CARICOM or other legal counsel acceptable A.I.D. to the effect that the Project Agreement has been duly authorized and/or ratified by the Board of Directors of CARICOM and executed on its behalf and that it constitutes a valid and legally binding obligation of the Caribbean Community Secretariat in accordance with all its terms; and
- (ii) a certified statement of the name of the person(s) authorized under the Project Agreement to act as CARICOM's representative under the Agreement with authenticated specimen signatures of said representatives.

c) **Conditions Precedent to Disbursement Other Than For Technical Assistance**

Except as A.I.D. may otherwise agree in writing, prior to any disbursement or to the issuance of any commitment documents under the Project Agreement to finance

other than technical assistance, CARICOM shall furnish to A.I.D., in form and substance satisfactory to A.I.D.:

- (i) A written plan for the hiring and scheduled placement of the staff required for the project;
- (ii) Prior to initiation of project activities in any eligible CARICOM member countries, CARICOM will secure a written statement from each Government giving:
  - (a) the name of an individual appointed to serve as Project Coordinator for the duration of the project;
  - (b) a policy statement, issued by the Government through the Ministry responsible for Health, authorizing supervisors to make every effort to release staff to participate in project activities; and
  - (c) an agreement providing the appropriate Government inputs identified equal to those in the Project Paper.
- (iii) A plan of activities for 1978 and 1979 which shall incorporate the A.I.D. Grant.

d. **Special Covenants**

**CARICOM, except as A.I.D. shall otherwise agree in writing, shall covenant to:**

- (i) submit for A.I.D. approval any grant-financed contract which exceeds \$5,000;
- (ii) provide a written commitment stating that every effort will be made to secure funds from regular budgetary sources to support continuation of core staff and activities following termination of the A.I.D. contribution;
- (iii) provide a yearly plan of activity for 1980 and 1981 in a timely fashion, which shall be satisfactory in form and substance to A.I.D.
- (iv) maintain and support health programs which develop regional unity and better utilize existing resources;
- (v) agree that funds made available under the Project shall be utilized for financing and technical assistance activities only in the following countries ("Eligible Countries"): Antigua, Barbados, Belize, Dominica, Grenada, St. Kitts-Nevis-Anguilla, St. Lucia, Montserrat and St. Vincent.
- (vi) establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will include, during the implementation of the Project and at one or more points thereafter:

- (a) evaluation of progress toward attainment of the objectives of the Project;
- (b) identification and evaluation of problem areas of constraints which may inhibit such attainment;
- (c) assessment of how such information may be used to help overcome such problems; and
- (d) evaluation, to the degree feasible, of the overall development impact of the Project.

a. Waivers

The following waivers of A.I.D. regulations are hereby approved:

- (i) waiver of 50-50 shipping requirement;
- (ii) authorization of A.I.D. financing of shipping costs on other A.I.D. Geographic Code 935 carriers when U.S. carriers are not available; and
- (iii) waiver of marking requirements on small value or off the shelf procurements.

LOGIC FRAMEWORK

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATOR	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal:</p> <p>The broader objective to which this project contributes is to enhance the health status of the people of the Windward and Leeward Islands sub-region in the CARICOM region.</p>	<p>Measures of Goal Achievement:</p> <p>Decreased infant mortality by 10%.</p> <p>Decreased incidence of gastroenteritis in children by 10%.</p> <p>Decreased number of preschool children demonstrating malnutrition to 20%.</p> <p>Increased coverage of immunization of preschool children to 75%.</p>	<p>Annual Health Reports and special studies conducted by C/H/S.</p>	<p>Assumptions for achieving goal targets:</p> <p>That Governments have a strong commitment to the improvement of the health status of the population.</p> <p>That available statistics are reasonably accurate.</p>
<p>Project Purpose:</p> <p>To improve the management and performance of personnel at all levels within the health sector in the Windward and Leeward Islands sub-region, and to expand CARICOM's Health coordination abilities and relationships among and within the region.</p>	<p>Conditions that will indicate purpose has been achieved:</p> <p>1.1 Project status.</p> <p>1.1 Increased knowledge and use of management concepts and skills by all levels of the health system in the Region.</p> <p>2.1 Teamwork will be improved throughout the Islands' Ministries of Health and CARICOM particularly in relation to multidisciplinary Regional Health Teams.</p> <p>3.1 Improved use of operational tools of management by mid-level personnel within the Ministries of Health.</p> <p>4.1 Enhanced ability of top and mid-level health managers to plan, design, implement and evaluate health sector programs.</p> <p>5.1 A sector-wide health planning process will be in place in 6 countries.</p> <p>6.1 Effective information systems will be operating in all of the countries and annual report-</p>	<p>1.01 Reports of Project Coordinators and C/H/S. KAP baseline and follow-up.</p> <p>4.01 Project document, implementation plans, and Annual Health Report health budget.</p> <p>5.01 Health plans and health budget.</p> <p>6.01 Monthly health reports and Annual Health Reports.</p>	<p>1.001 Governments appoint and support project coordinators and that Governments continue their commitment to the CHKH resolutions which affords health management a top priority.</p>

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATOR	LOGIC FRAMEWORK MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>7.1 Improved coordination of internal and external resources within the Leeward &amp; Windward Islands &amp; Barbados and C/H/S.</p> <p>8.1 The CARICOM Health Secretariat will have an ongoing operational capacity to coordinate and support health management activities of the region.</p>	<p>7.01 C/H/S monthly reports and Annual Health Reports.</p> <p>8.01 End-of-project evaluation.</p>	<p>Assumptions for achieving purpose:</p> <p>8.001 CARICOM will remain a viable organization.</p>

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LOGIC FRAMEWORK

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATOR	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs:	Magnitude of Outputs:		Assumptions for achieving outputs:
1. Curriculum design for management training.	1.1 4 Training packages/modules designed and tested a. Basic mgt. b. Team building/teamwork c. Operational mgt. tools for middle managers d. Program design and implementation	1.01 Curriculum materials	1.001 Technology is available to put together a curriculum package.
2. Training for all levels of health personnel in basic management.	2.1 700 top, mid, and line level personnel in health sectors trained in basic management.	2.01 Register of participants and certificates of completion.	2.001 Each country continue its commitment to the project and releases its employees for training.
3. Training for all levels of health personnel in teamwork and team building.	3.1 135 top, mid and line level personnel in the health sectors trained in teamwork and team building.		
4. Training for mid-level health personnel in operational tools for management.	4.1 225 mid level personnel in the health sectors trained in operational tools for management.		
5. Training for top and mid level health personnel in techniques of program design and implementation.	5.1 125 top and mid level personnel in the health sectors trained in techniques of program design and implementation.		
6. Country health policy statements and health sector plans.	6.1 Every country will have developed a health policy statement defining its priorities and 2 countries will have produced a comprehensive health sector plan, including budget and implementation plan.	6.01 Health policy statements and plans.	

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NARRATIVE SUMMARY	LOGIC FRAMEWORK		IMPORTANT ASSUMPTIONS
	OBJECTIVELY VERIFIABLE INDICATOR	MEANS OF VERIFICATION	
Inputs:	Magnitude of Outputs:		Assumptions for achieving outputs:
Organizational analysis of the structure, process, and behavior of the Ministry of Health.	7.1 Organizational analyses will be carried out in 5 countries.	7.01 Reports and recommendations from organizational analyst.	
Design and follow-up of model district health teams.	8.1 Projects for model district health teams in 3 countries will be designed and progress reports produced.	8.01 Project design documents, and progress reports.	8.001 Governmental support for model district health teams is unrelenting.
Design and implementation of health information systems and Annual Health Reports.	9.1 Information systems will be designed and implemented in 8 countries and Annual Health Reports will be produced within 6 months of the end of the year.	9.01 Annual Health Reports.	
A mechanism for the identification and coordination of health resources in the region.	10.1 A central coordinating system will be established in the C/H/S which relates to each of the 8 island governments.	10.01 C/H/S monthly reports and catalogue of external resources.	
Management Resource Center	11.1 A management resource center will be established in each of the 8 countries.	11.01 By observation.	11.001 Space is made available for center
Conferences and Workshops a. Annual Health Report b. Coordination of External Assistance c. District health team concept	12.1 Special Training Activities to be conducted: a) 3 Workshops (1 per year & immediately preceding b) CMRH) on Annual Health Reports and Coordination of External Assistance. c) A one week regional conference on the progress of the institution of the district health team.	12.01 a. C/H/S monthly reports and documents from CMRH b. c. Proceeding of regional conference	12.001 Top level personnel are available to attend.

LOGIC FRAMEWORK			
NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATOR	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
d. Exchanges	d. 16 individuals within health sector will spend 2 months in a work/exchange program in another country within the Eastern Caribbean and that 16 other individuals will spend 2 weeks visiting another country within the Eastern Caribbean.	12.01 d. Trip reports and travel documents	12.01 d. Two people from each island or available and willing to participate in the exchange.
e. Management Workshop with Ministers	e. 1 annual 2-day workshops with Ministers responsible for health.	e. Proceedings for workshops	e. Availability and willingness of Ministers to attend.
Project Inputs: See budget for detailed listing of AID, CARICOM and host country inputs.			

INITIAL ENVIRONMENTAL EVALUATION

PROJECT: Basic Health Management Training  
GRANT: \$1.8 million  
CARIBBEAN REGIONAL

Impact  
Identification  
and  
Evaluation

Impact Areas and Sub-Areas

A. LAND USE

1. Changing the character of the land through:

- a. Increasing the population \_\_\_\_\_ N \_\_\_\_\_
- b. Extracting natural resources \_\_\_\_\_ N \_\_\_\_\_
- c. Land clearing \_\_\_\_\_ N \_\_\_\_\_
- d. Changing soil character \_\_\_\_\_ N \_\_\_\_\_

2. Altering natural defenses \_\_\_\_\_ N \_\_\_\_\_

3. Foreclosing important uses \_\_\_\_\_ N \_\_\_\_\_

4. Jeopardizing man or his works \_\_\_\_\_ N \_\_\_\_\_

5. Other factors

\_\_\_\_\_  
\_\_\_\_\_

B. WATER QUALITY

1. Physical state of water \_\_\_\_\_ N \_\_\_\_\_

2. Chemical and biological states \_\_\_\_\_ N \_\_\_\_\_

3. Ecological balance \_\_\_\_\_ N \_\_\_\_\_

4. Other factors

\_\_\_\_\_  
\_\_\_\_\_

N - No environmental impact  
L - Little environmental impact  
M - Moderate environmental impact  
H - High environmental impact  
U - Unknown environmental impact

**C. ATMOSPHERIC**

- |                          |   |
|--------------------------|---|
| 1. Air additives _____   | N |
| 2. Air pollution _____   | N |
| 3. Noise pollution _____ | N |
| 4. Other factors _____   |   |
| _____                    |   |
| _____                    |   |

**D. NATURAL RESOURCES**

- |  |   |
|--|---|
| 1. Diversion, altered use of water _____       | N |
| 2. Irreversible, inefficient commitments _____ | N |
| 3. Other factors _____                         |   |
| _____  |   |
| _____  |   |

**E. CULTURAL**

- |  |   |
|--|---|
| 1. Altering physical symbols _____       | N |
| 2. Dilution of cultural traditions _____ | N |
| 3. Other factors _____                   |   |
| _____                                    |   |
| _____                                    |   |

**F. SOCIOECONOMIC**

- |  |   |
|--|---|
| 1. Changes in economic/employment patterns _____ | N |
| 2. Changes in population _____                   | N |
| 3. Changes in cultural patterns _____            | L |
| 4. Other factors _____                           |   |
| _____  |   |
| _____  |   |

**G. HEALTH**

- |   |         |
|---|---------|
| 1. Changing a natural environment _____   | N _____ |
| 2. Eliminating an ecosystem element _____ | N _____ |
| 3. Other factors _____                    | _____   |
| _____                                     | _____   |
| _____                                     | _____   |

**H. GENERAL**

- |                                 |         |
|---------------------------------|---------|
| 1. International impacts _____  | N _____ |
| 2. Controversial impacts _____  | N _____ |
| 3. Larger program impacts _____ | N _____ |
| 4. Other factors _____          | _____   |
| _____                           | _____   |
| _____                           | _____   |

**I. OTHER POSSIBLE IMPACTS (not listed above)**

_____	_____
_____	_____
_____	_____

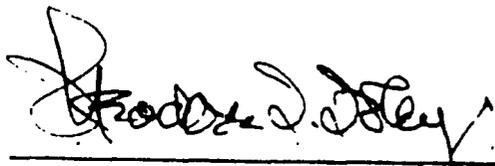
## II DISCUSSION

As this project is directed only at training, there is no environmental impact with one slight exception. That exception is change in cultural patterns. The change that is sought by the training process is one that will positively affect the relationship of health care providers with each other and with the community. The training will include working as a team and in eliciting community participation, both of which are not presently part of the cultural pattern.

As this impact on the culture is positive and will not cause familial or other societal disruptions, the overall environmental impact of the project is negative.

## III ENVIRONMENTAL ACTION RECOMMENDED

It is recommended that a negative determination be given to this project. The proposed action is not an action which will have a significant effect on the human environment and therefore, is not an action for which an Environmental Impact Statement or an Environmental Assessment will be required.

  
\_\_\_\_\_  
Theodore T. Foley  
Acting AID Affairs Officer

ANNEX AII - 1

PROCESS DESCRIPTION

INTRODUCTION

On January 26 and 27, 1978 the Design Team (Garth Jones, Sharon Stanton Russell and Scott Loomis) attended briefings in Washington, D.C. with Barbara Sandoval, LA/DR and Jerry Gower of the Caribbean Regional Office. The history of the health management project, its political context, and parameters of the Project Paper form and content were reviewed.

The Team then drafted a memorandum (copy attached) to Dr. Philip Boyd, Chief of the Health Section of the CARICOM Secretariat. Principally, the memorandum requested that the islands be contacted and asked to formulate working groups of 5-6 members to participate in the design process with the Team during its visit. Additionally, in view of the facts that (1) the project is AID's first health initiative in the region; (2) it was not feasible for an AID representative to accompany the Team and (3) CARICOM had been selected as the implementing agency for the project, the Team strongly urged that a representative of the CARICOM Health Secretariat accompany them. This memorandum was transmitted to Dr. Boyd early in February and the requested arrangements were subsequently completed by the Health Section.

Briefing meetings with the CARICOM Health Secretariat were held at Georgetown, Guyana on February 23, 24, and 25. Mr. Loring Waggoner, of AID's Regional Development Office/Caribbean joined the Team in these discussions to clarify AID policies. In addition, the Team met together with Dr. Boyd and Mr. Waggoner and representatives of the Pan American Health Organization: Mr. Miguel Segovia, Mr. Peter Carr and Dr. Henry. These discussions focused on the nature of PAHO's work in management within the Caribbean Region and on AID's planned areas of activity.

Further discussions were held on February 27 and 28 in Barbados and RDO/C, where the Team was briefed by AID's Acting Regional Representative; Mr. Tom Stuman, Mr. Ted Foley and by the Embassy's Political Officer,

Mr. Doug Koeleamay. The Team also met with Mr. Neil Carefoot, PAHO's Act: Country Representative to discuss his organization's recent and planned programming in the region and to describe the mission of the Design Team. On March 1 the team embarked on the actual on-island project design process. In all islands with the exception of Grenada, the Team was accompanied by Dr. Philip Boyd, of CARICOM's Health Section. In Dominica, Mr. Waggoner RDO/C (who was on the island pursuant to other business) was able to participate with the Team in one discussion session. In each island the Design Team's request that a local working group be convened had been carefully followed. Typically, each working group was comprised of the Permanent Secretary for Health, the Chief Medical Officer, the Principal Nursing Officer, the Chief Sanitarian, the Hospital Administrator and the Matron and Public Health Nurse, although this composition varied somewhat from island to island. From time to time, representatives from the Ministry of Finance and the Public Service Commission attended the sessions. In some cases an initially large group formed smaller working groups. In every island, with the exception of Antigua and St. Lucia, initial and concluding sessions were attended by the Minister Responsible for Health and in every case except Antigua the Ministers were fully briefed by the Team as to the shape of the project envisioned by the joint working group. The actual design process on each island took place over 2-1/2 days. Although at the time the memorandum to Dr. Boyd was drafted, it was not certain that an island working group could be engaged for the entire period of the Team visit, in fact the island groups worked consistently with the Design Team throughout the process.

#### PROCESS DESCRIPTION

Typically the Design Process followed the eight sequential steps outlined below:

1. Parameters of the project established
  - a. U.S. Government
    - i. Size of grant
    - ii. CARICOM executing authority
    - iii. Affects majority poor
    - iv. Managerial Improvement

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\* See Itinerary attached.

- b. CARICOM
  - i. Improvement health management high priority
  - ii. See CARICOM section for more details
  
- c. Host Government
  - i. On-island training preferred
  - ii. See individual island reports for more details
  
- 2. Definition of Management
  - a. Development of management models
  
- 3. Identification of Problems/Issues
  
- 4. Setting of Goals and Objectives
  
- 5. Identification and Selection of Strategy Options
  
- 6. Provisional Implementation Plan
  
- 7. Resources
  - a. Planned island inputs
  - b. Planned project inputs
  - c. Other planned donor inputs
  
- 8. Presentation to Health Minister
  
  
- N.B. This process was followed in all islands except Barbados. For description of Barbados, see island report.

The Design Team carried an easel, newsprint, colored marking pens and masking tape which were used to "post" or record visually the "output" of the sessions.

In the opening session, the Team verbally explained the purpose of the mission, stressing the focus on design of a specific project. A newsprint sheet showing the items included under (1) in the above outline provided the group with a visual outline of the presentation's content. Members of the island working groups then generally presented a review of current programs and activities as well as priorities. In many cases, materials which had been prepared for the Team's arrival were distributed. Invariably, island working group questions during this opening session focused on the definition of management. These questions led into joint formulation of an Agenda covering steps 2 through 8 above for subsequent meetings. The Agenda was posted on newsprint for reference.

In order to provide a basis for discussion of the definition of management, the team prepared the management model depicted in Figure 1. Once posted on the wall, this model served as a catalyst for focused identification of specific problems and issues. At this stage the Team members served as facilitators to the group. Members of the island working groups identified problems: Team members asked specific questions until a precise statement of the problem was obtained, whereupon the stated problem was posted (written on the newsprint). In this manner a list of 15-20 key problems was elicited\* and the surrounding discussion provided the Team with a great deal of insight concerning the root causes of the expressed problems. In subsequent sessions the Team utilized the islands' problem list as a basis for eliciting statements of goals and objectives from working group members. Members themselves then identified strategy options (training, technical assistance, tec.) and suggested specific content elements and modes of implementation which the Design Team posted and added to as appropriate. The Team then prepared a time-line for the life of the project and, with working group members, developed a sequence of project activities. In the final stages of discussion the Team outlined categories of resource inputs and the working groups identified those which are locally available and other related inputs which are anticipated from other donors.

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\*The most frequently mentioned problem areas identified are listed in Figure 2.

ITINERARY

February 24-26 - Georgetown Guyana

Briefing Meetings with CARICOM Health Secretariat

Dr. Philip Boyd - Chief of the CARICOM Health Section  
Loring Waggoner - AID Regional Development Office/Caribbean  
Miguel Segovia; Peter Carr; Dr. Henry - Pan American  
Health Organization

February 27-28 - Bridgetown, Barbados

Briefing Meeting, AID Regional Development Office

Thomas Stuman - AID Affairs Officer, RDO/C  
Ted Foley - AID Loan Officer, RDO/C  
Doug Koelemay - U.S. Embassy Political Officer  
Neil Carefoot - PAHO Acting Country Representative

MEETINGS WITH ISLAND WORKING GROUPS:

(See Island Reports, Annex g, for list of participants.)

March

1-4	Grenada
4-7	St. Vincent
8-11	St. Lucia
12-14	Dominica
15-17	Montserrat
18-21	Antigua
22-24	St. Kitts
25-31	Bridgetown, Barbados <u>Presentation of Project Paper for Review</u> - AID RDO/C

In a final session with the Minister Responsible for Health, the design process as recorded on the newsprint was reviewed and the provisional implementation plan and island resource inputs carefully outlined. The provisional nature of this design was stressed. In point of fact, however, the remarkable consistency in the nature of the problems identified in the strategy options and in the proposed activities was such that the final design reflected in the Project Paper will be quite congruent with island expectations.

The Design Team synthesized the individual island design processes into a final comprehensive design during the period of time in Antigua and St. Kitts, and subsequently in a final week of activity in Barbados (ending March 31, 1978). RDO/C and LA/DR comments on review of the first draft of this document and further elaboration of the design were incorporated in a second draft prepared in April, 1978 at Columbia, Maryland. The third and final draft was completed in Columbia and submitted to LA/DR on May 5, 1978.

February 2, 1978

DRAFT

MEMORANDUM

TO: Dr. Phillip Boyd

FROM: Westinghouse/OIH Project Design Team  
Dr. Garth Jones, Chief of Party,  
Public Administration Advisor  
Ms. Sharon Stanton-Russell, Project Manager,  
Training and Manpower Development Advisor  
Mr/ Scott Loomis, Office of International Health, DHEW,  
Health Planner

The Project Design Team has been meeting in Washington, D.C. January 26 and 27 for briefing and predeparture planning. We are taking the opportunity afforded us by the courtesy of two people who are departing for Guyana this weekend, to send you this draft memorandum. Barbara Sandoval of AID/W has reviewed our memo and a copy will be forwarded to the USAID Regional Office in Barbados.

We have reviewed a number of documents, including the Caribbean Health Study of May 1977, the Report of the Caribbean Health Survey Team which visited the region in October, 1977, and the terms of reference for our own team, which are contained in the Work Order (a copy of which is attached). Based upon our review of these documents and upon our discussions during this two day period, we believe it would be of value to set forth

herein for your consideration our understanding of the background and purposes of our impending visit to the region and a proposed course of action for accomplishing those purposes.

It is our understanding that the CARICOM Health Secretariat will be in contact with officials of the islands concerning our impending visit. If you are in agreement, we believe it would be fruitful for all parties concerned if the contents of this memorandum be shared with those officials.

Below are noted some of the specific purposes, understandings, proposed activities of the project design team and its work relationships.

1. The activities of our project team are a "follow-up" to the visits in October, 1977, by the study team which included Barbara Sandoval, Jerry Gower, Jim Doster, Scott Loomis, Steve Lucas, and Julie Weissman.
2. The end-project of our team's activities, as specified in our terms of reference (The Work Order) is a Project Paper. This is a planning document to be developed in full collaboration with the host governments. When approved by CARICOM and the Agency for International Development (AID), the Project Paper will enable the allocation of funds to implement the project design specified therein. For your reference, a copy of the guidelines for preparation of the Project Paper are attached.

3. The specific project which our team will be engaged in designing with the participating governments represents a "first initiative" by AID in the field of health in the Caribbean region. Because this is a first initiative, and because of its discrete focus (as described below), there may be a number of problems in the health area which will not be fully addressed by this project design. However, we believe that the activities to be carried out under this project will lay a firm basis for other projects in health which may be undertaken by the islands in the future in collaboration with AID or possibly even other donor agencies.
4. Based upon the agreement of the CARICOM Health Ministers Conference that management of health activities is a priority issue for member governments and based upon the discussions, analyses, and conclusions of the Study Team during October, 1977, visits to the region, and consistent with recommendations of the Pan American Health Organization, the focus of the project which we are undertaking to design with host governments is Health Management Development.
5. As a working definition of management, the team proposes to

use the definition formulated in a recent United Nations Report:\*

"Management is guiding human and physical resources into dynamic organization units that attain their objectives to the satisfaction of those served and with a high degree of morale and a sense of attainment on the part of those rendering the service."

Our team will propose methods and techniques which can be developed in order to enable host government personnel to make more efficient use of available resources in their application to identified health problems and needs. Some of the health related methods and techniques which might be developed under this project include: program planning, program management, personnel administration, supply and logistics management, equipment and facilities maintenance, reporting and record keeping, financial management and budgeting, human resource development, program documentation and evaluation, as well as policy formation and decision making.

6. The project design team hopes to work in closest possible collaboration with host government officials in each island to identify the problem areas most amenable to Health Management Development intervention, to select two or three

\*Development Administration, Current Approaches and Trends in Public Administration for National Development (United Nations Publications, Sales No. E. 76, I.I.H.I, 1975), p. 12.

priority areas to be addressed under this project, then to formulate the specifics of the proposed project. In order to accomplish this in a collaborative and timely manner, the project design team now proposes the following course of action:

- a) Following our initial meetings with you on February 24 and 25, and with the USAID Mission in Barbados, the team will proceed with a series of 2 1/2 day meetings in each island.
- b) We are suggesting that, prior to our arrival, the CARICOM Health Secretariat initiate in each island the host government's selection of 4 to 6 key officials to participate with the project design team in a "project design working group meeting" to last, at a minimum, one day. We would suggest that the selected officials include individuals who 1) will represent their governments, with authority to plan such a project, and 2) will have major responsibility for policy setting and implementation of the project. For example, a working group may consist of the Minister of Health or designee; the Permanent Secretary; the Chief Medical Officer; and a representative of the Ministry of Finance and Budget-- in addition to the project design team members.

c) During the first day of the teams visit, we would propose that the working group meet in an intensive session in which the following agenda would be carried out:

1. "Brainstorming" with Project Design Team members serving as facilitators and resources to the group, officials will list a number of problem areas amenable to intervention through health management development.
2. "Why are there Problems": The working group will then explore the specific manifestations and underlying causes of the health management related problems.
3. "Statement of Objectives": The group will then select 2-3 priority problems to be addressed under this project and formulate objectives for the project.
4. "Strategy": The group will then formulate a strategy of action which can be articulated as a specific design for this project. Specific elements of project design which are to be identified in the project paper include:  
The scope, goals, purposes, inputs and outputs of the project; special conditions, implementation arrangements; the wording of contracts to be financed; end of project status and "milestones" of goal attainment. It may readily be seen that these elements

presume a fair degree of specificity. For example, "inputs" must be specified, including the numbers and types of personnel to be trained in health management techniques, their salaries, host government-approved per diem rates for trainees, host government contributions, such as training facilities, conference space, coordinating personnel--and the "fair market value" of such contributions.

- d) During the second day of our visit, the project team proposes to take the results of the working group session and prepare a memorandum of agreement in principle on design of the project. If host government members of the working group are available on the second day, the team would welcome their participation.
- e) At the end of the second day or on the morning of the third day, the project design team will present the draft paper to designated host government officials for review, amendment, and ratification.
- f) It is the project design team's understanding that, in the actual implementation of the Health Management Development Project, the CARICOM Health Secretariat will serve as the coordinating body, to receive AID funding and that CARICOM/Health may then, in turn contract with

independent contractors, agencies and/or individuals to assist in implementation of the project. If you are in agreement, we feel it would be helpful for host government officials to understand this proposed relationship from the outset and prior to the design team's arrival. Further, the design team would consider it ideal, if possible, that a member of CARICOM/Health accompany the team and participate in the working group activities defined above. The design team will be working during the last week of our visit in Barbados to finalize the Project Paper. We would deem CARICOM/Health participation during that week to be of particular importance.

8. Participating host governments may wish to know the time frame of the Health Management Development Project: The Project Paper will be completed in late March or early April 1978. AID administrative actions will then follow; "start-up" of the Health Management Development Project itself is expected to occur not later than January 1979.
9. It would be extremely helpful if an individual from each host government could be designated as project team's contact person. We would hope to be advised of names and roles of such persons during our meeting with you February 24 in Georgetown.

10. Also, at our meeting with you in Georgetown, we would like to discuss in further detail the anticipated role of CARICOM Health in the Health Management Development Project and the Health Secretariat's anticipated needs to carry out this role

**ISLAND REPORTS**  
**ANTIGUA**

The draft Management Project which was submitted by Antigua identified Maternal and Child Health and School Health Programs as health priority areas. Maintenance of equipment and facilities, and supply management were identified as the two most important administrative functions requiring attention. Although a draft health policy statement had been prepared in 1975, it had not been updated or submitted to the current government.

However, Antigua was a participant in the decision which identified management as a priority health issue for the CARICOM Health Ministers Conference. Moreover, a PAHO pilot management program was initiated on the island last year. The Ministry intends to establish the proposed pilot project in a selected health district in order to provide an experiential base for wider implementation and diffusion of health services. A multi-disciplinary approach to implementation is envisioned, with emphasis to be placed on strengthening the project's administrative component to be responsive to local needs.

The Design Team identified several management issues which focused in the areas of leadership, communications, planning and policy making, management styles, roles and responsibilities, resource organization, and attitude toward change. Constraining factors to project implementation were also noted. These included lack of effective leadership, minimal understanding of management styles, roles and responsibilities, and planning and policy-making. The absence of team work and the vertical organization of the Ministry were also seen as hindrances. Only one top official within the Ministry of Health has had formal training in management. This individual would be the appropriate choice for the position of Project Coordinator.

Priority issues identified by the Ministry were: (1) policy formulation and decision making; (2) program planning, documentation, management, and evaluation; (3) human resources development; and (4) records and reports.

Specific objectives for accomplishing the project goal of increasing the health care systems' effectiveness were stated as follows: (1) to develop the managerial and administrative skills of health administrators; (2) to promote the use of the interdisciplinary team approach to developing and operating the health care system; (3) to increase the effectiveness of the MCH and school health programs.

Antigua's draft Management Plan also set forth an abbreviated work plan for carrying out these objectives.

CONTACT SHEET - ANTIGUA

<u>Name</u>	<u>Title</u>
Mr. E. T. Heny*	Permanent Secretary, Ministry of Home Affairs and Labor
Dr. C. Lake*	Medical Advisor
Dr. A. I. Boyd	Chief Medical Officer
Mr. D. O. Marde*	Hospital Administrative Secretary
Mrs. H. Richardson*	Principal Nursing Officer
Mr. P. Boyd*	

\*working group participant throughout

## DOMINICA

The health policy statement for Dominica stresses the need for a broad inter-sectorial approach to health. The health plan is part of the larger national development plan for the island. Working group participants were responsive and enthusiastic about the prospect of developing managerial skills and the health team concept through the project. Several individuals had been trained in mid-level and supervisory management; nursing leadership appeared to be particularly strong.

Many of the constraining factors dealt with the natural environment of Dominica and the past failures of the administration of the health care services. Transportation, and thus communication, is extremely difficult due to the nature of the island's terrain and its lack of infrastructure. The brain drain is a continuing problem. Dominicans felt the need for additional trained personnel in nearly all functional areas.

The collaborative working group identified a number of key issues and problem areas, including: (1) lack of community involvement; (2) lack of organization and coordination at the district level; (3) managerial styles; (4) program planning, prioritizing, and implementation; (5) resistance to change; (6) lack of public awareness; (7) conflict resolution; (8) communication; (9) retention of personnel; (10) lines of authority and role definition; (11) motivation and discipline; (12) financing; (13) development of managerial and supervisory skills; (14) development of career and training plans.

The goal of the project was set forth as follows:

Effective coordination and guidance of the health system at all levels in order to improve health standards of the population of Dominica.

Specific objectives included: (1) development of a national health plan; (2) improvement of managerial skills of primary care providers and others as appropriate; (3) development of a health team; (4) development of a top-level leadership team; and (5) provision of adequate equipment, maintenance and supplies.

CONTACT SHEET - DOMINICA

<u>Name</u>	<u>Title</u>
Mr. Bannis	Minister of Home Affairs, Health and Welfare
Mr. O. Symes*	Permanent Secretary, Ministry of Home Affairs, Health and Welfare
Dr. B. Sorhando*	Obstetrician/Gynecologist
Mr. R. Riviere*	Hospital Administrator
Ms. A. Thomas*	Nursing Superintendent
Mr. L. LeBlanc*	Chief Public Health Inspector
Mr. E. Richards*	Acting Matron
Ms. J. Astaphan*	President, Dominican Nursing Association
Ms. P. Frompton*	Deputy Permanent Secretary, Ministry of Home Affairs, Health and Welfare

\*working group participant throughout

Prior to initiation of the project, the newly formed leadership team would begin development of a national health plan. During the project's first year, a Management Resource Center would be developed, technical assistance provided in health plan development, and the health team(s) selected and trained in various behavioral processes and techniques. In the second year, team training would continue, and top to mid-level personnel would receive training in managerial and behavioral skills. An evaluation would be undertaken at the end of the second year to determine third-year needs.

## GRENADA

Discussions of the working group initially centered upon project parameters and the development of a management model to assist in problem definition. Management process problems, i.e., organization, decision-making, planning and control -- were found to underlie the more highly categorical management problems which were first identified. The Design Team noted that several group members were familiar with principles of planning, project design and managerial style; furthermore, a number of individuals had pursued advanced training in health management and planning and thus could be utilized as local resources able to provide continuity to the project (an important consideration). The collaborative effort was met with enthusiasm and a high degree of participation. The group process was well received and serves as a model for proposed training methodologies. No written health policy or recent plan currently exists in Grenada: this was felt to reflect difficulties in making the leap from planning to implementation.

The collaborative working group identified the following areas of priority to be addressed by the project:

- (1) Development of skills in interpersonal relations and group work;
- (2) Personnel motivation;
- (3) Development of organization, planning and decision-making skills for mid-level personnel;
- (4) Fundamental understanding of the principles and techniques of planned change.

Two project goals were formulated: strengthening of management capabilities by improving personnel skills; and enhancing managers' ability to understand and plan change processes and to apply appropriate strategies for change. The project design reflects these goals via a progression of training in fundamental management skills to a mix of training and technical assistance in principles and techniques of management both within and outside the MOH.

CONTACT SHEET - GRENADA

<u>Name</u>	<u>Title</u>
Mr. H. Preudhomme	Minister of Health and Housing
Mr. W.E.E. Thomas*	Permanent Secretary, Ministry of Health & Housing
Mr. C. L. Robinson*	Senior Assistant Secretary, Ministry of Health & Housing
Dr. L. M. Comissiong*	Chief Medical Officer
Dr. F.C. Alexis*	Medical Officer of Health
Mrs. T. Augustine*	Chief Nursing Officer
Dr. G. Clarke*	Psychologist, Ministry of Health & Housing, and Ministry of Education
Mr. B. Phillips*	Acting Chief Technical Officer, Ministry of Health & Housing
Mr. J. Beggs	Hospital Administrator, Ministry of Health & Housing
Mr. A. C. Redhead*	Health Education Officer, Ministry of Health & Housing
Mr. G. Brathwaite	Senior Assistant Secretary, Ministry of Planning

\*working group participant throughout

## MONTSERRAT

Montserrat's firm commitment to a multidisciplinary team approach in the areas of program planning, service delivery and community participation was at the forefront of discussion. Also expressed were the needs for various on and off-site training options, and technical assistance in the areas of health planning, proposal preparation, and organizational analysis. No health plan or policy currently exists; however effective leadership at the top-middle management level combined with personal motivation and a spirit of cooperation among the various service levels are viewed as facilitating factors. Although there exist no local institutional resources for management development, a number of health service personnel have been exposed to and trained in management principles and practices.

The following problems and issues emerged as a result of collaborative discussions between the Design Team and local working group:

- (1) Non-relevance and inapplicability of international agency operational standards;
- (2) Health service users and providers not brought together in the planning process; different perceptions of needs;
- (3) Lack of coordination among health system services due to poor communication;
- (4) Lack of opportunity for mid-level personnel to acquire additional professional knowledge and expertise;
- (5) Motivation/morale problems related to remuneration and other reward and incentive factors;
- (6) Human relations problems viewed as major target for management development;
- (7) Skill development by mid-level personnel is needed in the areas of time management, work scheduling, and prioritization; management personnel must develop skills in task organization and delegation.

The agreed-upon goal for the health management project was set forth as follows:

To strengthen the management process of the Montserrat health system in order to improve the quality of health for all, with special priority to the poor and underserved.

Specific project objectives were:

- (1) Development of overall health policy and plan;
- (2) Improvement in management knowledge, attitudes, skills and practices of top, middle and line-level health personnel;
- (3) Strengthening of team approach to health care organization and service delivery;
- (4) Improvement of health management capability in identification and coordination of resources;
- (5) Improvement in organizational structures' appropriateness to desired functions and processes.

CONTACT SHEET - MONTSERRAT

<u>Name</u>	<u>Title</u>
Mrs. M. Tuitt	Minister of Health
Dr. Wooding*	Chief Medical Officer
Dr. V. Buffong*	Chief of Dental Services
Miss F. Daley*	Hospital Matron
Mr. Fairer*	Hospital Administrator
Mr. Lynch*	Public Health Inspector
Mr. Lee	Deputy Financial Secretary
Mr. Walker*	Acting Permanent Secretary

\* working group participant throughout

ST. LUCIA

Numerous documents had been compiled by the St. Lucia working group for review by the Design Team. Among these were a proposal for health management training and technical assistance, and status reports on various managerial tasks such as budgeting, planning, and evaluation. These reports had been prepared with assistance from PAHO, and responsibility for implementation of recommendations had already been vested in local department heads. The health management T and TA proposal prepared by St. Lucia included long-term and immediate objectives and the following brief statement with regard to management problems: "The management problems affecting the health services are well known. They have been thoroughly studied by the Ministry jointly with PAHO/WHO. There is no need for more diagnosis." Nevertheless, the Design Team felt that a closer examination of these problems was necessary. The collaborative effort resulted in identification of the following problems and issues: (1) handling individual needs versus organizational demands; (2) personnel motivation; (3) departmental organization/reorganization; (4) conflict management; (5) decision-making; (6) decentralization of authority and responsibility; (7) organization of service delivery; (8) community-level leadership and task management skills; (9) change processes; (10) task delegation; (11) inter-departmental coordination and cooperation.

Of particular interest was the recurrent theme of the need for a team approach. This was further emphasized in St. Lucia's own proposal for implementing a multi-disciplinary team approach to health services delivery on the island. This proposed Model Services Project would be designed and implemented by St. Lucians and, as such, would be independent of the AID/CARICOM project, although the latter would serve to complement the former. Thus, the Design Team's identification of enabling and constraining factors were applicable to both projects. Constraining factors included: the vertical structure of the Ministry and minimal amplification of the team approach concept. Major facilitating factors are the support of the project concept by the Conference of Ministers, and St. Lucia's interest in training community health aides despite a perceived reluctance on the part of the community to accept non-physician providers. Moreover, St. Lucia has a national health policy which has been

approved and ratified by the government. Some position descriptions and work procedures have been prepared with PAHO assistance, and a government - appointed training committee has already projected future training needs. The island also has facilities available for training. Several top-level personnel who have been exposed to management concepts could serve as project resources.

Project objectives as set forth by the collaborative working group were (1) to enhance district level personnel managerial capabilities; (2) to improve motivation; (3) To enhance the capability of personnel to select and implement change strategies; (4) To provide a system whereby the optimum amount of staff time can be focused on health problems; (5) To initiate development of health delivery teams at the local level; (6) To design and implement decentralized delivery of health services.

CONTACT SHEET - ST. LUCIA

<u>Name</u>	<u>Title</u>
Mr. Fitz Louisy*	Permanent Secretary for Health
Ms. M. Louisy	Health-Nutrition Educator
Mr. Lee	Hospital Administrator
Mr. R. Rene *	Sanitary Engineer/Chief Public Health Inspector
Ms. M. Niles*	Nursing Superintendent
Mrs. B. Lambert	Matron
Dr. Popovic*	Acting CMO
Mr. John Compton	Premier
Mr. J.R.A. Bousquet	Minister Responsible for Health

\*working group participant throughout

## ST. VINCENT

On October, 1977, the Health Survey Team identified "weak management" as the primary obstacle to attaining stated local government objectives. St. Vincentians themselves felt that the absence of a National Health Plan was a major contributing factor to this problem. Major themes which emerged in the collaborative discussion centered around St. Vincent's preference for utilizing local, rather than regional, training institutions; the on-going problem of intersectorial coordination and control; and the need for additional community-level paraprofessionals. The lack of financial resources was also viewed by Ministry leadership as a primary constraint to effective service delivery. Most management training of health personnel had occurred outside of the organizational confines of the Ministry of Health: however, a small cadre of individuals in public service has had exposure to management concepts. A major constraining factor was the inability to identify a local candidate to assume the position of Coordinator for the Project.

The collaborative working group identified the following areas requiring attention:

- (1) Behavioral processes - communication; leadership and motivation;
- (2) Techniques of basic management and change;
- (3) Organization and methods -- task and role definition

The stated project goal was to establish an integrated health delivery system with managerial capability to mobilize and utilize all available resources for the provision of comprehensive health care services to all of the people of St. Vincent.

In conjunction with the foregoing, specific project purposes were formulated:

- (1) To develop the capability to define and clarify roles, responsibilities, and functional authority;
- (2) To develop leadership skills;
- (3) To develop program design skills;

- (4) To develop communication, reporting, and dissemination skills and methods;
- (5) To familiarize personnel with the planning process and its utilization.

The first year of the project is designed to focus upon the development of management concepts, with concentration on behavioral processes. Specialization in management processes will follow in the second year. The third year will be preceded by a project evaluation in order to retain program flexibility, and basic management skills will be reinforced during this period.

CONTACT LIST - ST. VINCENT

<u>Name</u>	<u>Title</u>
Mr. R. Russell	Minister of Health
Mr. O. Cuffy*	Acting Permanent Secretary, Ministry of Health
Mr. J. McBride*	Hospital Administrator
Dr. G. J. Cordice	Senior Medical Officer and Chief Medical Officer
Mrs. I. Young	Assistant Secretary, Ministry of Health
Mr. M. Dellimore*	Training Section, Service Commission Department
Mr. M. Scott*	Acting Deputy Financial Secretary, Ministry of Finance
Mr. Thomas	Chairman, Public Service Commission

\*working group participant throughout

ST. KITTS/NEVIS

The problems and issues addressed by the Design Team are applicable only to the Island of St. Kitts, since Nevis was not represented in the working group.

The first issue to be addressed by the collaborative working group was the definition of management, particularly as it applied to health and the proposed project. The group then went on to identify the various priority problems and issues that were to be addressed. These consisted of the following: (1) the need for defined priorities incorporated within a policy statement; (2) Image, rewards, and incentives; (3) Insufficient community public health orientation of hospital-trained nurses; (4) Organizational and staff communications; (5) Leadership; (6) Continuity; (7) Antiquated legislation; (8) Control of resource allocations; (9) Lack of planning process.

Two project goals were formulated: to contribute toward the development of an organizational system within the Ministry of Health that could serve as a model for other Ministries or sectors; and to create a health team at the district level. Project objectives were stated as follows:

- To improve leadership/supervision
- To improve lines of authority, communication, and role definition
- To redefine the role of public health nursing
- To facilitate the modernization of health legislation
- To strengthen the Ministry of Health to gather, assess, and interpret information for improved planning, program development, and budgeting

Major themes throughout the discussion were the desires for on-site training and long-term technical cooperation. A comprehensive organizational analysis of the Ministry of Health will be the first element of the project, followed by training in district team-building and teamwork for all levels of the Ministry. An information/communication system will also be developed. On-island training for top, middle and some front-line

personnel will take place during the third year and will focus on strategic planning and tactical program design.

Two major constraining factors were identified by the Design Team: the lack of communication between the Permanent Secretary and his staff; and the political power exerted by the Medical Superintendent. The team was hard-pressed to identify any enabling factors. Other donor activity is minimal, and local management resources appear to be severely limited.

CONTACT LIST - ST.KITTS/NEVIS

<u>Name</u>	<u>Title</u>
Mr. Bryant*	Minister of Education and Health and Social Welfare
Mr. Riberiro*	Permanent Secretary
Dr. Baldacci*	Chief Medical Officer
Mr. Warner*	Chief Public Health Inspector
Dr. Sebastian	Medical Superintendent
	Hospital Matron
Ms. M. Byron	Director of Nursing Training*
Ms. Dulaney	Chief of Public Health Nursing*
Mr. Woods	

\*Working group participant throughout

BARBADOS ISLAND REPORT

Initial meetings with members of the Ministry of Health in Barbados were held on February 28, 1978. In attendance at the meeting were Sharon Ressel and Scott Loomis of the Design Team, Loring Waggoner of RDOC, Mr. Howell, Permanent Secretary for Health of Barbados, Mr. Cortez Nurse, Senior Health Planner, and Ms. Hurley, Health Planner.

At this initial meeting, the background and purpose of the Design Teams' forthcoming effort were discussed, together with background concerning other anticipated AID initiatives in the region. While it was clearly expressed that AID and the Design Team would welcome Barbados' participation in this project, it was also recognized that Barbados enjoys a set of conditions which make it distinct from the Windward and Leeward Islands.

Against this background, the Barbados team discussed recent developments on the Island pertaining to health management. Specifically, the Design Team was advised that the accounting firm of Peat, Marwick and Mitchell, based locally in Trinidad, had conducted a comprehensive management study and only recently delivered recommendations for improvement of the health services. Specifically, this study produced an organizational structural analysis based upon which the Ministry of Health has devised its own interim organizational structure. In 1976, after initiation of the Peat, Marwick and Mitchell study, Barbados made a political commitment to move toward institution of a national health service by 1980. For this reason, and by no fault of the organization involved, the recommendations made in the Peat, Marwick and Mitchell study have not been precisely applicable to the evolving requirements of the Ministry of Health, as it prepares for national health service.

Thus a need for identification of the organizational implications of national health service remains. In addition, several other potential areas for assistance were identified by the Barbados team:

- New appropriate job descriptions for health workers
- Manuals of procedure for each division within the Ministry
- Team management and human relations
- Program budget management
- Day to day supervision.

At the conclusion of this initial session, Barbados requested that a subsequent meeting be held following the Design Team's visit to the Windward and Leeward Islands. Accordingly, the Design Team members Jones and Russell, together with Dr. Philip Boyd of CARICOM, met again in Barbados with members of the Ministry of Health, on March 28, 1978.

Present at that meeting were, Mr. Alwin Howell, Permanent Secretary for Health, Dr. Harney, Chief Medical Officer, Mr. Allison Daniel, Senior Assistant Secretary, Mr. Cortez Nurse, Chief Health Planner, Miss Hurley, Health Planner.

At the outset of this second meeting, Dr. Boyd outlined the design process which had taken place in the Windward and Leeward Islands, and described as well, the project which had emerged. The Barbados team reiterated again, that the government is moving rapidly toward institution of a national health service. Further developments towards this end were then explained. The IDB will be funding construction of an expanded system of polyclinics, one of which is already in operation in the Island. An IDB Study to begin in June of 1978 will further identify all management aspects to be effected by the polyclinic system expansion.

In view of the considerable amount of technical assistance which Barbados has received in the health management area over the past several years, the government expressed only qualified interest in the T.A. activities of the AID/CARICOM project. However, it expressed very great interest in the management training aspects, particularly with regard to the basic management, team concept, and supervision aspects of the training envisioned. Furthermore, Barbados strongly supported the concept of on-island training, and expressed the greatest reservations concerning overseas training and the poor diffusion effects to be achieved by that training mode. The Ministry of Health as a training unit and an O. and M. unit, which, it was said, might profitably participate in the management training activities.

The team concept described was of particular interest, since the polyclinic system is predicated on a team approach to the delivery of health services. Based upon this expression of interest then, it was concluded that Barbados does choose to participate in the AID CARICOM project, as outlined in the project paper.

ANNEX A II - 3PARTIAL LISTING OF CARICOM  
PROPOSED COMMODITIES**Estimated Costs**

15,000	1 Photocopy with Duplex
1,000	1 Duplicating Gestetner/Roneo (Service Available)
2,000	2 Electric Typewriter at US\$1,000 ea.
1,500	10 Filing Cabinet s (Not Available Locally) at \$150
750	150 Pamphlet Files Cardboard (Vertical) (Not available locally)
20,000	2 Railroad cars of Paper (Serious shortages in Guyana) at 186 for 500 sheets
7,000	Postage, Cable and Telephone
50	Heavy Duty Stapling Machine (Not available locally)
50	Heavy Duty 3 Hole Punch
150	50 Looseleaf Binder at \$3
500	Folders, Hanging Files Frames and Folders
300	Calculators: 1 Tape Type Desk Top at 200 4 Hand Type at 25

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 US\$ 61,800

62,000

IMPLEMENTATION PLAN  
SCHEDULE OF ACTIVITIES

1978

Grant Agreement signed with CARICOM(AID and CARICOM)

Orientation of CARICOM, legal and financial staff and Chief of Health Section to AID procedures (AID with CARICOM)

Solicitation of subcontractor prequalification statements; selection of qualified organization and solicitation and review of final bids (CARICOM with AID)

Procurement of office equipment and supplies and management resource center materials.

1979

Jan. Feb. Development of comprehensive project work plan. (Project Staff).

IMPLEMENTATION PLAN

Training Modules

PACKAGE A

1979

2/15 - 3/15	Design and testing of Package A - Basic Management Training
3/16 - 4/15	Team 1 - Top, mid and line cycles - Grenada
3/16 - 4/21	Team 2 - Top, Mid 2 line cycles - Dominica
4/16 - 5/15	Team 1 - Top, mid and line cycles - St. Vincent
4/22 - 5/21	Team 2 - Top, mid and line cycles - Antigua
6/1 - 6/30	Team 1 - Top, mid and line cycles - St. Lucia
6/7 - 7/15	Team 2 - Top, mid and 2 line cycles - Montserrat
7/1 - 8/15	Team 1 - Top, 2 mid, and 2 line cycles - Barbados
7/16 - 8/15	Team 2 - Top, mid and line cycles - St. Kitts
9/1 - 9/21	Team 1 - Mid and 2 line cycles - Grenada
9/1 - 9/21	Team 2 - Mid and 2 line cycles - Antigua
9/22 - 10/15	Team 1 - Mid and 2 line cycles - St. Vincent
9/22 - 10/15	Team 2 - Mid and 2 line cycles - St. Kitts
11/1 - 11/21	Team 1 - Mid and 2 line cycles - St. Lucia
11/22 - 12/31	Team 1 - 2 mid and 2 line cycles - Barbados

PACKAGE B

1980

1/1 - 1/15	Design and testing of Package B
1/16 - 1/31	Grenada
1/22 - 1/31	St. Vincent
2/1 - 2/7	St. Lucia
2/8 - 2/23	Dominica
3/1 - 3/7	Antigua
3/8 - 3/15	Montserrat
3/16 - 3/31	St. Kitts
4/7 - 4/21	Barbados - 2 cycles

INFLUENZA VIRION PLAS - COND'N

PACKAGE C

1980

5/1 - 5/15	Design and testing of Package C
5/16 - 5/31	
6/1 - 6/15	St. Vincent
6/16 - 6/30	St. Lucia
7/15 - 7/31	Dominica
8/1 - 8/15	Antigua
8/16 - 8/30	Montserrat
9/1 - 9/15	St. Kitts
10/1 - 10/31	Barbados - 2 cycles
11/15 - 11/31	Grenada
12/1 - 12/15	St. Vincent
12/16 - 12/31	St. Lucia

1981

1/15 - 1/31	Antigua
2/1 - 2/15	St. Kitts
2/16 - 2/28	Barbados

PACKAGE D

1981

3/15 - 3/31	Design and testing of Package D
4/1 - 4/7	Grenada
4/8 - 4/15	St. Vincent
4/16 - 4/21	St. Lucia
4/22 - 4/30	Dominica
5/1 - 5/7	Antigua
5/8 - 5/15	Montserrat
5/16 - 5/21	St. Kitts
5/22 - 6/30	Barbados

Planning1979

5/1 - 6/30	Grenada
6/1 - 7/31	Antigua
7/15 - 9/15	St. Vincent
9/1 - 10/31	Dominica
9/21 - 11/20	Montserrat

Organizational Analysis1979

2/1 - 2/28	St. Lucia
3/1 - 3/31	Dominica
7/21 - 8/20	St. Vincent
9/21 - 10/20	Montserrat
10/21 - 11/20	St. Kitts

Model District Health Teams1979

2/1 - 2/28	Antigua - Project Design
3/1 - 3/31	St. Lucia - Project Design
4/1 - 4/30	Dominica - Project Design

1980

5/1 - 5/31	Antigua - Mid-project assessment and refinement
6/1 - 6/30	St. Lucia - Mid-project assessment and refinement
7/1 - 7/31	Dominica - Mid-point assessment and refinement

1981

10/1 - 10/31	Antigua - End-of-project evaluation
11/1 - 11/30	St. Lucia - End-of-project evaluation
12/1 - 12/31	Dominica - End-of-project evaluation

Information Systems1979

9/15 - 10/15	Barbados
11/15 - 12/15	Antigua

IMPLEMENTATION PLAN COND'T

Information System

1980

1/1 - 1/31	Dominica
2/15 - 3/15	St. Lucia
4/15 - 5/15	St. Kitts
6/15 - 7/15	Grenada
7/16 - 8/15	St. Vincent
9/15 - 10/15	Montserrat

"Pool" T.A.

1979

3/21 - 4/20	St. Kitts
5/7 - 6/6	Barbados

1980

1/15 - 2/15	St. Kitts
2/1 - 3/31	Grenada
6/1 - 7/31	Barbados
9/1 - 9/30	St. Lucia
10/15 - 11/15	Montserrat
11/16 - 12/15	St. Kitts
12/16 - 1/15	Barbados

1981

2/1 - 2/28	Montserrat
3/1 - 3/31	Antigua
4/1 - 4/30	St. Kitts
5/15 - 7/15	St. Vincent
8/1 - 6/30	St. Lucia
7/21 - 9/20	Grenada
9/1 - 9/30	Montserrat
10/1 - 11/30	Barbados
10/1 - 10/31	St. Vincent
11/1 - 11/30	St. Kitts

Planning1979

5/1 - 6/30	Grenada
6/1 - 7/31	Antigua
7/15 - 9/15	St. Vincent
9/1 - 10/31	Dominica
9/21 - 11/20	Montserrat

Organizational Analysis1979

2/1 - 2/28	St. Lucia
3/1 - 3/31	Dominica
7/21 - 8/20	St. Vincent
9/21 - 10/20	Montserrat
10/21 - 11/20	St. Kitts

Model District Health Teams1979

2/1 - 2/28	Antigua - Project Design
3/1 - 3/31	St. Lucia - Project Design
4/1 - 4/30	Dominica - Project Design

1980

5/1 - 5/31	Antigua - Mid-project assessment and refinement
6/1 - 6/30	St. Lucia - Mid-project assessment and refinement
7/1 - 7/31	Dominica - Mid-point assessment and refinement

1981

10/1 - 10/31	Antigua - End-of-project evaluation
11/1 - 11/30	St. Lucia - End-of-project evaluation
12/1 - 12/31	Dominica - End-of-project evaluation

Information System1979

9/15 - 10/15	Barbados
11/15 - 12/15	Antigua

## SPECIAL ACTIVITIES

ANNEX III-1

Page 7 of 7

Initial and On-going	Development of Management (Library) Resources Center Packages and dissemination.
July - 31, 1978	2 week session for Country Project Coordinators on orientation to proposed Work Plan and development of Package A curriculum.
July, 1979	1 day workshop preceding annual CMRH on The Annual Health Report.
July, 1979	1 day workshop preceding annual CMRH on coordination of external resources.
July, 1979	2 day workshop with Ministers on managerial concepts.
Feb., 1980	1 week conference concerning implementation of Model Health teams, relevant management issues, and relation to primary health care.
May, 1980	1 week seminar with project coordinators on mid-project evaluation.
July, 1980	1 day workshop preceding annual CMRH on The Annual Health Report.
July, 1980	1 day workshop preceding annual CMRH on coordination of external resources.
July, 1980	2 day workshop with Ministers on managerial concepts.
July, 1981	1 day workshop preceding annual CMRH on The Annual Health Report.
July, 1981	1 day workshop preceding annual CMRH on coordination of external resources.
July, 1981	2 day workshop with Ministers on managerial concepts.

ANNEX AIII - 2

STAFF AND IMPLEMENTATION FUNCTIONS OF CARICOM

The full-time Project Manager to be hired under the terms of this grant will have executive responsibility for project implementation. The Project Manager should possess qualifications in health and management, but above all, must be a strong individual with demonstrated experience in the management of complex activities. It is of particular importance that he or she be someone belonging to the Caribbean region. Specifically, the Project Manager will:

1. Provide liaison between Health Management Project headquarters at CARICOM Health Secretariat and the Project Coordinators on each island.
2. Coordinate and control project activities to ensure their timely execution in appropriate sequence.
3. Participate with the staff Management Trainer and subcontract personnel in preparation of curriculum and materials for training modules; ensure coordination with and involvement of island Program Coordinators with regard to curriculum, ensuring that curriculum elements address objectives of the project and identified problems.
4. Oversee and coordinate activities of subcontractors.

5. Review and ratify qualifications of subcontractor experts proposed to provide technical assistance to assure the appropriateness of their skills and of the timing of their activities. Prepare scopes of work for technical experts and evaluate their performance.
6. Plan and coordinate arrangements for Special Activities with participating island government officials and related institutions (e.g. Conference of Ministers Responsible for Health).
7. Maintain continual review of project expenditures and deliverables (including data required by AID for contract/project monitoring); provide technical coordination between CARICOM and AID as authorized by Project Director/Chief of Health Section.
8. Prepare evaluation plan and data collection instruments and coordinate execution of evaluation including data analysis and development findings and recommendations.
9. Supervise Administrative Assistant in the execution of logistical arrangements pertaining to travel of project personnel, facilities for special activities, collation and dissemination of training materials, and routine communications.
10. Select, supervise procurement and disseminate information to comprise Management Resource Centers (libraries) for each island.

The Management Trainer on CARJCOM's core project staff will have specific responsibility for training activities to be implemented.

He or she will:

1. Design, test and revise (as necessary) training curriculum and materials for Packages A,B,C and D (training modules);
2. Ensure continuity among elements in each successive package;
3. Specify roles and specific tasks for subcontractor trainers and supervise and coordinate training teams;
4. With Project Manager, collaborate with island Project Coordinators concerning curriculum content, selection of trainees and coordination of logistical requirements for training activities;
5. Participate as Team Leader in delivery of training packages;
6. Maintain appropriate records concerning training activities;
7. Provide follow-up technical assistance as appropriate;
8. Participate in project evaluation activities, with special responsibility for training evaluation.

The Project Administrative Assistant will be responsible for coordinating staff support for the implementation of project activities.

Tasks will include: routine execution of project logistical details including travel and accommodations arrangements; arrangements pertaining to facilities and services for special activities; collation and distribution of materials and communications to support project activities; maintenance of files, records and inventories pertaining to equipment, supplies, and materials procured and/or developed; supervision of office equipment maintenance; and direct supervision of two Clerk-Typists.

As noted in the Project Analysis Section of this paper, CARICOM will require subcontractor assistance in implementing project activities. A summary budget showing the effort to be subcontracted may be found in Table 1. Specific personnel and tasks to be provided through subcontractual arrangements are:

1. Twelve (12) person-months of a Management Trainer to serve during the first year of project life, to be based in the CARICOM Health Section office (project headquarters) in Georgetown, Guyana.

The long-term subcontractor trainer will participate in the design and testing of curriculum modules, and will lead one team in the delivery of Package A/Basic Management Skills Training. The subcontractor's long-term trainer should be carefully selected to ensure she/he possesses skills which will complement those of the staff trainer. Reasonable qualifications may include: Master's level degree in management (e.g. MBA, MPA or adult education with management focus); experience in working with health personnel and governmental entities; and experience in delivery of short-term, high participation, skills-based management training.

In view of anticipated difficulties in locating certain training skills within the Caribbean, it is expected that the subcontractor trainer should also possess demonstrated skills in behavioral aspects of management training, such as group work, interpersonal communications, and leadership. Familiarity and working knowledge of experiential/laboratory training modalities is highly desirable; willingness to train the the staff trainer in these modalities may be required.

2. Twenty-four (24) person-months of short-term management training specialists labor for participation in delivery of Package A/Basic Management Skills during year 1. As will be seen in the Implementation Plan, Attachment B at the end of this section, Package A will be delivered by two teams operating simultaneously. One team will be headed by the CARICOM staff trainer, the other by subcontractor's long-term trainer. The 24 months of short-term training specialist effort must be provided by a minimum of two persons, one to work with each team. Seven (7) "training trips", each including several islands and lasting approximately 2-3 months

will be required to deliver Package A. Thus, a maximum of seven different short-term trainers may be considered, although the fewer different trainers involved, the greater the continuity and cohesion. Qualifications and skills required of the short-term trainers for Package A are similar to those required for the long-term trainer, although consideration must be given to the "mix" and complementarity of skills. Each Basic Management Team should include training specialists with skills in decision making/problem solving; leadership and managerial styles; planning (generically); change techniques, consequences and measurement; resources identification, allocation and utilization; group dynamics; conflict management; supervision and motivation; team building; and task and time management. Adequate time provision has been made for orientation of short-term trainers and their integration into the training team.

3. One Management Training Specialist for three person-months in Year 2 to participate in the design and delivery of Package B/Team Building and Team Work. In addition to demonstrated background and experience in training for team work, this specialist should be familiar with patterns of relationship among health personnel and the community. She or he should also possess skills in effecting goal and objective setting, role definition and conflict management. The subcontract specialists will work with and be immediately responsible to the CARICOM staff trainer. Three "training trips" of approximately one month each (six-day work week) are envisioned.
4. Eight (8) person-months Management Training Specialist labor in Year 2 (extending into Year 3) to participate in the design and delivery of Package C/Middle Management Tools. Specialists should demonstrate skills to train in specific task and operational management tools including time management, costing, cost-saving principles and techniques; graphic tools for task planning and implementation (e.g. flow charts, time lines); techniques for determining resource requirements and allocation; reporting and written communication skills; organization charting; supervisory techniques (e.g. interviewing, follow-up/follow-through). Five "training trips", involving six-day work weeks are anticipated. Subcontract training specialists will work with and be responsible to the CARICOM staff trainer.

5. A total of 36 months of technical assistance specialist labor will be provided through subcontractual arrangements. Specific types of technical assistance which can be anticipated at this time include:

- 10 person-months in health planning and plan development;
- 5 person-months in organizational analysis;
- 9 person-months in model rural/district health team planning and implementation;
- 8 person-months in information systems; and
- 24 person-months of technical assistance\*to be distributed flexibly over the life of the project in response to changing island needs. Types of technical assistance to be provided from this "pool" include: budgeting; additional organizational analysis (particularly to mesh structure and function); preparation of project documents; alternative health services financing; legal expertise to assist in drafting revision of legislation which affects structure and function of health services; evaluation (e.g. of island model district team projects); and special studies (e.g. feasibility of intersectoral coordination mechanisms). Subcontract short-term technical assistants will be approved by the Project Director and Project Manager, and will be immediately responsible to and work from task descriptions prepared by the latter.

The above-mentioned personnel and tasks to be implemented through subcontractual arrangements can be subcontracted separately (by task and level of effort) or as a package. While a profusion of subcontractual relationships would impose an undue administrative burden on CARICOM's project, legal and financial staffs (as well as on AID monitors), careful consideration should be given to use of several selected subcontractors. A number of regional (Caribbean) organizations (such as those listed in the Administrative feasibility section) may have the capacity to respond to solitations for some, but not all of the tasks to be subcontracted. Similarly, minority and/or small business organizations based in the U.S. may have partial but not total response capability.

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\*It may be highly desirable that CARICOM retain a portion of the technical assistance time and budget to let out under personal services agreements.

TRAINING PACKAGES  
PACKAGE A

Training

PACKAGING OF PROGRAMME ELEMENTS: On-Island

Title: Basic Management

<u>TRAINING</u>	<u>MANPOWER REQUIREMENTS</u>	<u>COMMODITIES</u>
<p>1. Basic Mgt. Module-Top 5 days.</p> <ul style="list-style-type: none"> <li>- Basic Model</li> <li>- Decision making tools (problem solving)</li> <li>- Leadership skills and managerial styles</li> <li>- Planning process (plan development)</li> <li>- Change - Techniques, consequences &amp; measurement.</li> </ul>	<p>2 Trainers and Project Coordinator</p>	<p>Reading Kit #1 Hand-outs #1</p>
<hr/> <p>Participant evaluation, management assessment and plan.</p>		
<p>2. Basic Mgt. Module-Mid 5 days.</p> <ul style="list-style-type: none"> <li>- Basic Model</li> <li>- Planning &amp; creative problem-solving - resource I.D., allocation &amp; utilization</li> <li>- Group dynamics - conflict resolution - intro to team building</li> <li>- Supervision &amp; motivation</li> <li>- Task Management</li> </ul>	<p>2 Trainers and Project Coordinator</p>	<p>Reading Kit #2 Hand-outs #2</p>
<hr/> <p>Participant evaluation, management assessment and plan</p>		
<p>3. Basic Mgt. Module-Line 5 days.</p> <ul style="list-style-type: none"> <li>- Basic model</li> <li>- Change agency</li> <li>- Motivation - Groups - intro to team building</li> <li>- Interpersonal communication</li> </ul>	<p>2 Trainers and Project Coordinator</p>	<p>Reading Kit #3 Hand-outs #3</p>
<hr/> <p>Participant evaluation, management assessment and plan</p>		

PACKAGE A

4. Preparation and Appraisal on Island 5 days 2 Trainers and Project Coordinator Easel, paper, pens

PACKAGE A = 1 month/island 2 p.m./island X 8 = 16 p.m.  
1 month = Training Design/Curriculum Develop. X 2 = 2 p.m.  
18 p.m.  
PROJECT COORDINATOR = 1 p.m. X 8 = 8 p.m.  
26 p.m.

## PACKAGE B

TrainingPACKAGING OF PROGRAM ELEMENTS: On-IslandTitle: Team Building/Team WorkTRAININGMANPOWER  
REQUIREMENTSCOMMODITIES

Team Bldg./Team Work

2 Trainers &  
Project Coordinators

Handouts &amp; Kits

- one day, top, middle, line  
in selected district:  
directly related  
Overview

- days 2 & 3, selected  
district only.
- Goals & objectives setting
- Role definitions & community,  
group and association linkages
- Conflict Management and  
Resolution

- day 4, re-assemble management  
lines, levels, top, mid. line  
and district

- What district needs from top  
and mid levels (implication  
for Supervision)

- day 5, Appraisal - Pre and Post

---

Easel, paper, pens

5 days = week

Project	2 p.wks x 8 = 16 p.weeks = 4 p.m.	(5 p.m.)
Coordinator	1 p.wk X 8 = 8 p.week = <u>2 p.m.</u>	
		6 p.m.
	4 p.wks - Training Design	<u>1 p.m.</u>
		7 p.m.

PACKAGE C

Training

Title: MIDDLE MANAGEMENT TOOLS: TRAINING      On Island

TRAINING CONTENT

Mpwr

COMMODITIES

1. Task and Operational Mgt. Tools

- Time Mgt.
- Costing & Cost Saving Concepts & Techniques
- Techs for task planning & implementation (e.g. flow charts, time lines) determining resource reqs and allocation
- Reporting, written communication skills
- Organization charting

Handouts & Kits

2. People Management

- Supervisory Techs (e.g. incl. interviewing skills, "coaching" routine follow-up/follow thru
- interpersonal communication \_\_\_\_\_ (2 Trainers)  
10 days | CARICOM  
1 Island

Training: 2 Trainers X 8 islands X 10 days " 8 p.m. ( 2 X 4 mos)

PACKAGE D

Training

PACKAGING OF PROGRAM ELEMENTS      On Island

Title: Program Design and Implementation

TRAINING

MANPOWER

COMMODITIES

- Preparation Program:

Goals & Objectives

(justification)

Schedule, activities by  
time, work plan, monitoring  
and reassessment & evalua-  
tion.

Budgeting & resource Mgt.

Mobilization of internal &  
external resources

1 Trainer and  
Project Coordinator

Handouts & Kits

Clientele: Top and selected  
mid-mgt.

Deliver on Request  
Specific Island

(time 2 - 5 days)

Summary Cost:

1 year External Trainer  
Project Coordinator

1 p.wk./island X 8 = 8 p.wks = 2 p.m.

1 p.wk/island X 8 = 8 p.wks = 2 p.m.

4 p.m.

<u>ISLAND</u>	<u>IMPLEMENTATION YEAR</u>		
	<u>1</u>	<u>2</u>	<u>3</u>
GRENADA	PAC. A	PAC. B, C	PAC. D
ST. VINCENT	PAC. A	PAC. B, C	PAC. D
ST. LUCIA	PAC. A	PAC B, C	PAC. D
DOMINICA	PAC. A	PAC. B, C	PAC. D
MONTSERRAT	PAC. A.	PAC. B, C	PAC. D
ANTIGUA	PAC. A	PAC. B, C	PAC. D
ST. KITTS	PAC. A	PAC. B, C	PAC. D
BARBADOS	PAC. A	PAC. B, C	PAC. D

TECHNICAL ASSISTANCE

- |        |  |  |
|--------|--|--|
| 4 p.m. | 1. - Organizational Assessment and Analysis  | - St. Vincent,<br>St. Lucia, Dominica,<br>Montserrat |
| 8 p.m. | 2. - Planning - Process and Development of Plan-   | Montserrat, St. Vincent<br>Grenada, Dominica         |
| 6 p.m. | 3. - Project Design, Implementation and<br>Evaluation for Team-Based District Health   | - St. Lucia, Dominica                                |
| PAHO   | 4. - Supply and logistics system Management<br>(Conference/workshop for storekeepers<br>to develop curriculum for supply manage-<br>ment training) | - Grenada, Dominica                                  |
| 8 p.m. | 5. - Information system development<br>Periodic reporting  | - All islands  |
| PAHO   | 6. - Equipment and maintenance - CARICOM<br>PAHO   | - Antigua, Montserrat,<br>St. Kitts                  |
| PAHO   | 7. - Resource Allocation and Budgetting  |  |

TOTAL = 26 p.m.

SPECIAL ACTIVITIES

ACTIVITY	PARTICIPANTS	LOCATION & TIMING
1. 1 day Workshop on Annual Health Report	P.S. & C.M.O. (16) CARICOM	1 day before CMRH
2. 1 day Workshop on Coordination of Approach to External Assistance	P.S. & C.M.O. (16) CARICOM	2 days before CMRH
3. 3 day Conference on Implementation of Alma Ata (USSR) Resolutions on Primary Health Care/District Health Team Concept	Selected from all levels from top to community CARICOM	1980 Conf. in CARICOM
4. 1 Workshop/yr. - Year 1 - General Project design & implementation. Work plan & curriculum for PAC. A - Implication for each island.  Year 2 - On-going review of training & preparation for end-of-yr. evaluation  Year 3 - Review of evaluation results and planning of 3rd year activities	Project Coordinators & CARICOM MGT. STAFF	Location: LDC-rotation  1st Quarter 1979  2nd Quarter 1980  1st Quarter 1981
5. 2 day Workshop on Health Mgt. project progress and evaluation of results to date. Feedback on future activities	P.S. & C.M.O & Project Coordinator (24) CARICOM	1st Quarter 1981
6. Inter-country/island exchange focusing of selected topics, e.g. health teams, model district delivery projects, planning, etc. Attachments - 1-3 months Observational tours 1-2 weeks	To be selected. All levels eligible 2/island for attachment = 16 2-month period Housing provided. CARICOM-subsistence & Travel 2/island for touring=16 CARICOM-travel & per diem	1981

CARICOM ACTIVITIES/RESOURCES

I. Program Coordination and Management (Executing Activities)  
(Integrate project activities with those of island governments and Caricom Health Secretariat and within region)

Activities

1. Project Reporting and Evaluation
2. Seeking/Mobilization Donor Assistance
3. Conference/Training Sessions Planning/Special Activities
4. Technical Assistance Planning
5. Communication - Island governments and key agencies Institutions - UWI and University of Guyana
6. Assures Project Review Ministerial Conferences/ Related Ways. Carry out Ministerial instructions
7. Rescheduling/Replanning work Activities.

Resources

Core Staff

- Project Manager  
Knowledge, Management, Training Health (MBA/MPA-type) Caricom Recruit
- Adm. Assistant  
(executive ability - transportation arrangements, newsletter format and materials production, record keeping)
- Stenographers (2)

Trainers

- 3 Trg + TA each of 3 years
- One long term Caricom (3 years)\*  
Contractor for 2 yrs, regional person (direct hire) for 1 yr.
- One FTE short term (3 years)
- (One year - last year open either continuance Long Term or Caricom)

Resources

II. External Resources

Develop mechanism to identify resources in relationship program needs. Institutional capacity.

III. Management Resource Center

Collect, distribute materials and studies. Library development, newsletter.

IV. Special Skills Identification

Develop and maintain a system.

Planning activities in several health areas are inseparably linked with the management process and organization means should be developed/strengthened to move these forward.

### Training Package

The choice of on-site (on island) training of large numbers of existing personnel is dictated by several considerations. First, existing personnel are the focus of this management skills development effort because addition of new personnel with adequate skills is out of the question. Indeed, it is because increases in budgetary as well as other resources, are not feasible that achievement of greater productivity through improved management of existing resources is so critical to these island health systems.

Secondly, with regard to the choice of on-site training: on virtually every island, several key Ministry personnel at both top and mid levels have already been sent on scholarship to advanced training and/or to a number of regional workshops which have included selected topics related to management of health services. While this has created a small pool of energetic health professionals who see the importance of better management and who possess some tools to implement that vision, these trained personnel must return to work with colleagues (at all levels) who lack even minimal exposure to basic management concepts. This lack of exposure to and understanding of management concepts. This lack of exposure to and understanding of management inheres at all levels of the governmental health system, but is particularly acute at mid and lower levels in the organization. Furthermore management problems are manifest not only among those involved in "housekeeping functions" (such as logistics, supply and maintenance) but also among those engaged in the provision of direct services. The sheer number and interdependency of personnel requiring management skills training off-island, at some central regional location.

Furthermore, the practice of sending a few personnel off-island for training at existing institutions has, in the view of virtually every working group involved in design of this project, served to exacerbate the "brain drain" (largely to the benefit of the more developed countries of the region). It is also noteworthy that many personnel at the mid and lower echelons of the health system lack the requisite levels of educational attainment to gain admittance to those few regional institutions which offer any training in management.

Finally, and perhaps the most critical factor determining selection of the "on-site, large number of participants" training option is the fact that many of the management problems identified inhere in the day-to-day interactions among personnel who work together. The island working groups were unanimous in requesting that training be on-site and involve as many participants as possible. This alternative offers the greatest potential for spread effects by providing a common base of knowledge, terminology and methodology.

Because of islands' governmental health systems are relatively small, it will be feasible to provide management skills to a large proportion of existing personnel by employing repeating cycles of short-term training. Cycles must be kept short and must involve a maximum of 15 persons at a time to avoid intolerable disruptions of service.

It should be noted that, with the exception of a small private consulting group operating on Dominica, there are no local management trainers in the Windward and Leeward Islands.

The relatively good transportation and telecommunications systems among, as well as within, the participating islands make the strategy of fielding training teams from Guyana logistically feasible. This alternative has the further advantage of facilitating coordination between training and other project activities which will emanate from project headquarters and encourages consistency and economy in the use of support services.

The focus of training content on generic management skills and the choice of a high participation training modality are the direct result of the design process conducted on each island (see Annex A II-1 for further description). The following is a listing of the most frequently mentioned problem areas as a result of the island studies:

Lack of community participation

Decision-making based on hard data rather than political consideration.  
Techniques for decision-making

Resistance to change

Conflict resolution

Communication - vertically and horizontally

Retention of personnel - rewards, incentives and professional growth

Lines of authority

Role definition

Motivation/discipline

Planning and control

Areas of responsibility - clarification of functional authority

Follow-through

Report preparation

Organizational structure and process

Mobilization of resources - external/internal

Means of effecting change

Manuals

International standards of operation

Time mgt., work scheduling, and setting priorities, organizing, delegation of tasks

Individual needs vs. organizational demands

Decentralization of authority

Integrated services at district

Development of leadership and task mgt. skills at community level

Intersectorial coordination

Interpersonal relations

Methods of diffusion - ideas, policies, etc.

Operating within resource constraints

First, it is clear that, in the past, "Management" and management training have been conceived in terms which are at once too broad and too narrow. Thus, on the one hand, the management function is understood by those who have had some management training to include "allocation of resources" or "the implementation of policy directives", but their preparation has seldom addressed the practical steps required or tools available to apply these concepts. On the other hand, in other methodological approaches, "management" has been so deeply couched in a professional or para-professional context (e.g. ward management for nurses, water systems management), that personnel are unable to transfer the generic management principles to other applications or to colleagues who have not had such opportunities for exposure.

The high degree of receptivity accorded to the generic management model, together with the nature of the problems which surfaced and the reflections of island working group members on alternative training content and methodology all support the appropriateness of training in generic management skills. Furthermore, the island working group were unanimous in recommending the high-participation training modality and the success of such a modality in the design process itself (even given that personnel of quite different rank and status were involved) confirmed its feasibility. In addition, this content and training modality has proven to be particularly well-suited for use with groups of adult individuals who have varying levels of educational attainment.

The methods recommended for use in this project have been in use for over 30 years in the U.S. and U.K. The National Education Association was active as early as 1947 in identifying the need for educational modalities particularly suited to adults and particularly for application in management training and other work-related settings. Major U.S. corporations including Exxon, TRW and Proctor and Gamble regularly use these methodologies in management training. Short term, high participation management training of work groups has also been applied in the public sector for a number of years (e.g. City of San Diego). The body of knowledge developed out of application of this methodology in the United Kingdom through the work of Tavistock and other institutes has demonstrated its feasibility in British-type cultural systems.

Despite real variations from island to island in a range of situational characteristics, the commonality of the management problems identified is striking, thus further supporting the use of modular training "packages".

The role of the island Project Coordinators, while important for all elements of this project, is key to the training activities. As noted in the Implementation Plan, the Coordinators will be specifically responsible for the "advance work" on each island, including arrangements for facilities, identification and release of trainees and arrangement of their transportation and accommodations. The feasibility of having project coordinators execute the important functions envisioned for them is contingent upon: (1) compliance by the governments with the request that a project coordinator be designated; and (2) selection of individuals who possess the managerial skill, the organizational standing and the interest to carry out these functions over the life of the project.

A similar point must be made with regard to this project's role in the development of model district health teams. The development of such teams depends not only on training and technical assistance inputs for this project, but also on the mobilization of political will and continued commitment on the part of the several islands wishing to undertake the model team approach. These islands will have to take certain actions, such as designation of model districts, issuance of relevant mandates or directives and, in some cases, ratification of changes in legislation to permit reorganization of tasks and functions.

#### Technical Assistance

Technical assistance has been selected as an element of this project because it constitutes an appropriate means of responding to specific, individual island needs. In addition, there are certain management problems which cannot reasonably be addressed through management skills training of the types included under this project. For example, specialized expertise is required to conduct needed analyses of organizational structure and function in several of the islands. Such requirements are variable and episodic. While these skills may be desirable as a permanent feature of the organizations

involved, they do not warrant an alternative mode of meeting such needs at this time (e.g. by sending an individual for specialized training off-island). The Design Team found it to be a commonly held view that, particularly in sensitive areas such as organizational analysis, the findings and recommendations of an outsider are frequently more effective in catalyzing change than the equally well-formulated views of an insider.

Technical assistance activities have been time-phased to reinforce the effects of training and to assist key personnel in applying newly learned management skills to identified problems of concern.

#### Management Resources Centers

The Management resources center element has been selected to fill a glaring gap in on-island resources for self-instruction in management. The interest in such materials is high. The variable levels of educational attainment will mean that texts, articles and materials will have to be carefully selected to ensure adequate provision is made for materials suitable to persons of a variety of backgrounds and capabilities. It will be important to ensure that the centers are established and maintained in a location and a manner which will facilitate ready access by all types of health personnel. Special steps may have to be taken to "advertise" the existence and content of the Center. Potential spread effects exist if (as was discussed on several islands) the Centers' resources are also utilized as curriculum materials in nursing education and as part of ongoing in-service training programs.

All islands have agreed to make available space and appropriate support services (e.g. clerk to maintain inventories and logs of resource materials).

#### Special Activities

Special Activities, including a number of regional workshops and seminars, have been included in order to facilitate inter-island exchange of ideas and methodologies which are of common interest and about which the governmental health system personnel (particularly at the operating levels) have a great deal to learn from one another. (The organization and implementation of the model district health teams represents only one of several such topics.) Care will have to be exercised to ensure that mid and lower level personnel are, in fact, included in these events, since opportunities to travel to such regional activities appear to be highly coveted.

It is believed to be of particular importance that the element on "Management for Ministers" be incorporated as part of the Annual Conference of Ministers Responsible for Health. It was found in a number of instances that lack of clarity at the top about the appropriate functions and principles of good management, as well as about the appropriate functions and principles of good management, as well as about the management implications of policy decisions, contribute substantially to a number of the problems identified.

The Caribbean Community Secretariat, located in Georgetown, Guyana, and headed by a Secretary-General is the principal administrative organ of the Caribbean Community which was established by a Treaty signed by Heads of Government of the English-speaking Caribbean Area.

The Community, established in 1973, is a sequel to the Caribbean Free Trade Association (CARIFTA). Prior to CARIFTA, there existed a political federation of all the States in the Community except Guyana and Belize. The Federation broke up in 1962.

The period following the break-up of the Federation was marked by the attainment of independence of Jamaica and Trinidad and Tobago in 1962, and Guyana and Barbados in 1966. During the period up to the early 1970's, some unsuccessful attempts at political union were made such as the Federation of the Eastern Caribbean, the Federation of the Little Eight, the Federation of the Little Seven and the unitary statehood between Grenada and Trinidad and Tobago. The main force behind the integration process during this period was the Heads of Government Conference which first met in Trinidad and Tobago in 1963.

The first CARIFTA (Caribbean Free Trade Association) Agreement between Antigua, Barbados and Guyana was signed in 1965. It was soon followed in 1968 by the CARIFTA Agreement which included Antigua, Barbados, Guyana, Trinidad and Tobago, and later Dominica, Grenada, St. Kitts-Nevis-Anguilla, St. Lucia, St. Vincent, Jamaica, Montserrat and Belize. CARIFTA, being an instrument of economic and not political integration, faced the serious problem of having to incorporate countries with unequal levels of development. Accordingly, a set of special measures in favour of the so-called Less Developed Countries - Antigua, Dominica, Grenada, St. Kitts-Nevis-Anguilla, St. Lucia, St. Vincent, Montserrat and Belize - was adopted. CARIFTA's main achievements have been the dismantlement of tariffs among its members and the establishment of foundations for an eventual common external tariff.

In 1969 the Caribbean Development Bank was created and finally the Caribbean Community Treaty (CARICOM) came into effect on 1 August 1973 with the More Developed Countries as signatories: Barbados, Guyana, Jamaica, and Trinidad and Tobago, the four independent countries at that time. Belize, Dominica, Grenada, Montserrat, St. Lucia and St. Vincent signed the Treaty on April 17, 1974 and became full members of the Community on 1 May 1974.

Antigua and St. Kitts-Nevis-Anguilla joined the Treaty later. Surinam and the Netherlands Antilles have been given what is known as "Liaison Status".

#### THE STRUCTURE AND FUNCTIONS OF THE CARIBBEAN COMMUNITY

The Heads of Government Conference is the supreme organ of the Community and determines its general policy. As such it exercises final authority over all aspects of the Community, including Institutions of the Community, except for "Associate" Institutions such as the University of the West Indies and the Caribbean Development Bank. Subject to the broad general authority of the Conference, the Common Market Council, controlling the affairs of the Common Market, is the next most important organ of the Community. The Institutions of the Community comprise Standing Ministerial Committees dealing with matters such as Finance, Agriculture, Health, Education, Labour, etc.

CARICOM has three areas of activities:

1. Economic integration through the Common Market;
2. Common Services and functional cooperation;
3. Coordination of foreign policy among the independent countries.

Through the Common Market, CARICOM aims at achieving:

- (a) a free trade area (nearly completed under CARIFTA);
- (b) common external tariff (already implemented between the four LDCs as from 1 August, 1973);
- (c) coordination of national economic policies and national development planning, including agriculture, industry and natural resources;
- (d) common policies towards third countries in areas such as trade policy, foreign investment, double taxation agreements, etc., and
- (e) special measures for the LDCs with respect to industrial and agricultural production, trade, finance and intra-regional technical assistance.

In the field of functional cooperation, the following are some of the main areas:

Education and Training  
Health ...  
Intra-regional Technical Assistance  
Harmonisation of Laws  
Mass Communications and Broadcasting  
Meteorology  
Shipping and Air Transport  
Culture ...  
Enhancing the Role and Status of Women  
Tax Administration  
Industrial Relations

The Caribbean Community Secretariat with its Headquarters in Georgetown, Guyana, is the administrative organ of the Community and Common Market. It has three functions: it services the implementation of the Caribbean Community Treaty, including that Treaty's Common Market Annex; it also serves as Secretariat for all the Institutions and some of the Associate Institutions described above.

The Secretariat has a Secretary-General, a Deputy Secretary-General, and a staff of economists, administrators and technicians which at present numbers approximately 60.

#### FINANCING OF THE SECRETARIAT

The Heads of Government Conference approves the budget annually and the Secretariat is financed by contributions from Member States of the Community. Under CARIFTA it was known as the Commonwealth Caribbean Regional Secretariat (CCRS). Aggregate expenditure of the Secretariat is shown below for 1969-1974:

<u>Year</u>	<u>US\$ (Approx.)</u>
1969	200,000
1970	300,000
1971	300,000
1972	460,000
1973	650,000
1974	800,000

Contributions by Governments are in the following proportions:

Jamaica	37.50
Trinidad	27.50
Tobago	9.50
Guyana	12.50
Bahamas	6.00
Antigua	.95
St. Kitts-Nevis- Anguilla	.95
St. Lucia	.95
St. Vincent	.95
Grenada	.95
Dominica	.95
Belize	.95
Montserrat	.35

#### STAFF STRUCTURE

The Staff Structure is set out in the organisational chart attached as an Appendix.

Secretariat staff are assigned general duties in accordance with the dictates of the Heads of Government Conference and no attempt is made to allocate and record time spent in the pursuit of any particular function.

#### ACCOUNTING PROCEDURES

There are two sources of funds:

1. Contributions by Member States
2. Grants by international and extra-regional organisations for financing specific functions of the Secretariat.

The financial year is the calendar year. The annual accounts are audited by a firm of Public Accountants appointed by the Secretary-General with the approval of the Common Market Council of Ministers. The present auditors are Messrs. Thomas, Stall & Co., 5 America Street, Georgetown. Final audited accounts are submitted annually to the Common Market Council of Ministers.

All expenditure is recorded against heads of expenditure approved by the

Council of Ministers (on behalf of the Heads of Government Conference).

Payments in excess of \$25 are made by cheque.

All payments must be supported by authorized orders and cheques are

signed by two senior officials. Normal source records (such as books of original

entry) are kept. Standard financial control procedures (bank reconciliations,

control accounts, etc.) are applied. A copy of our financial regulations is

attached.

Funds received from international and extra-regional agencies are accounted

for separately in accordance with the purposes for which the funds are granted

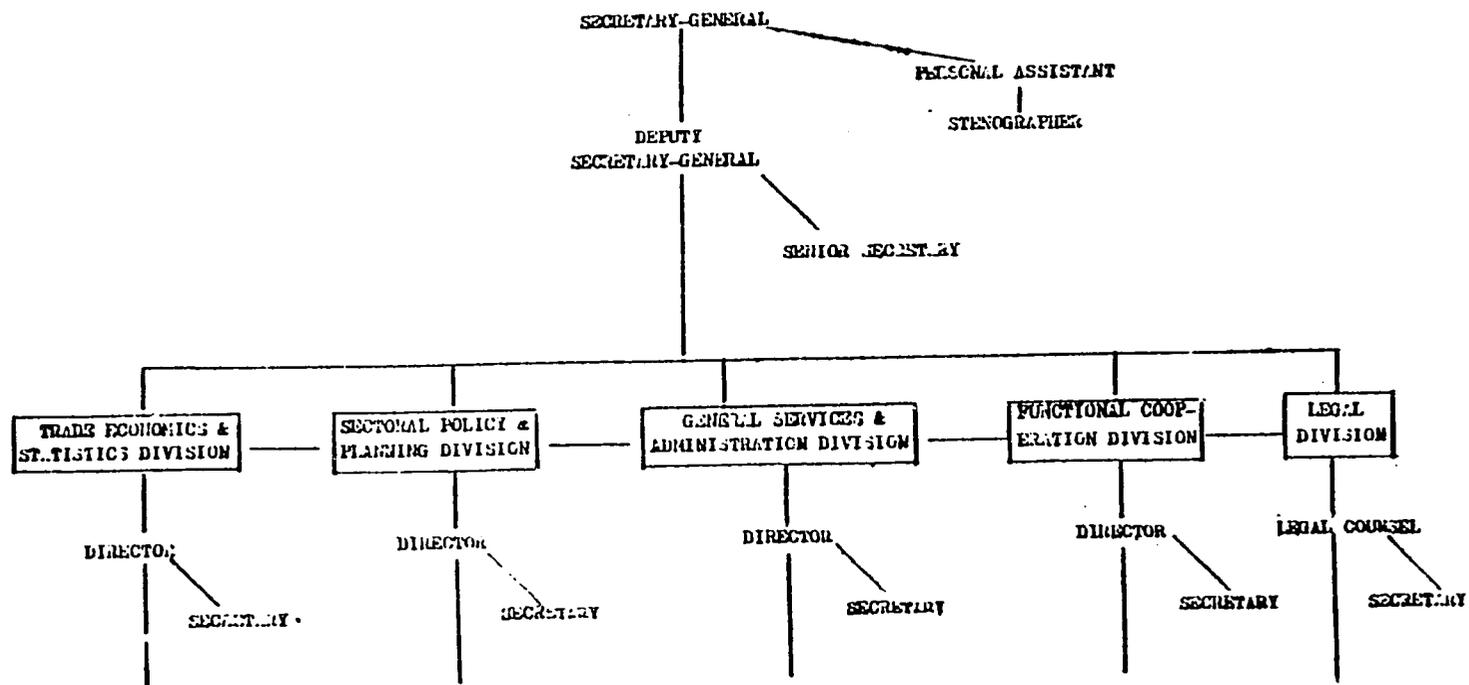
and the stipulations of the particular agreement under which an operation is

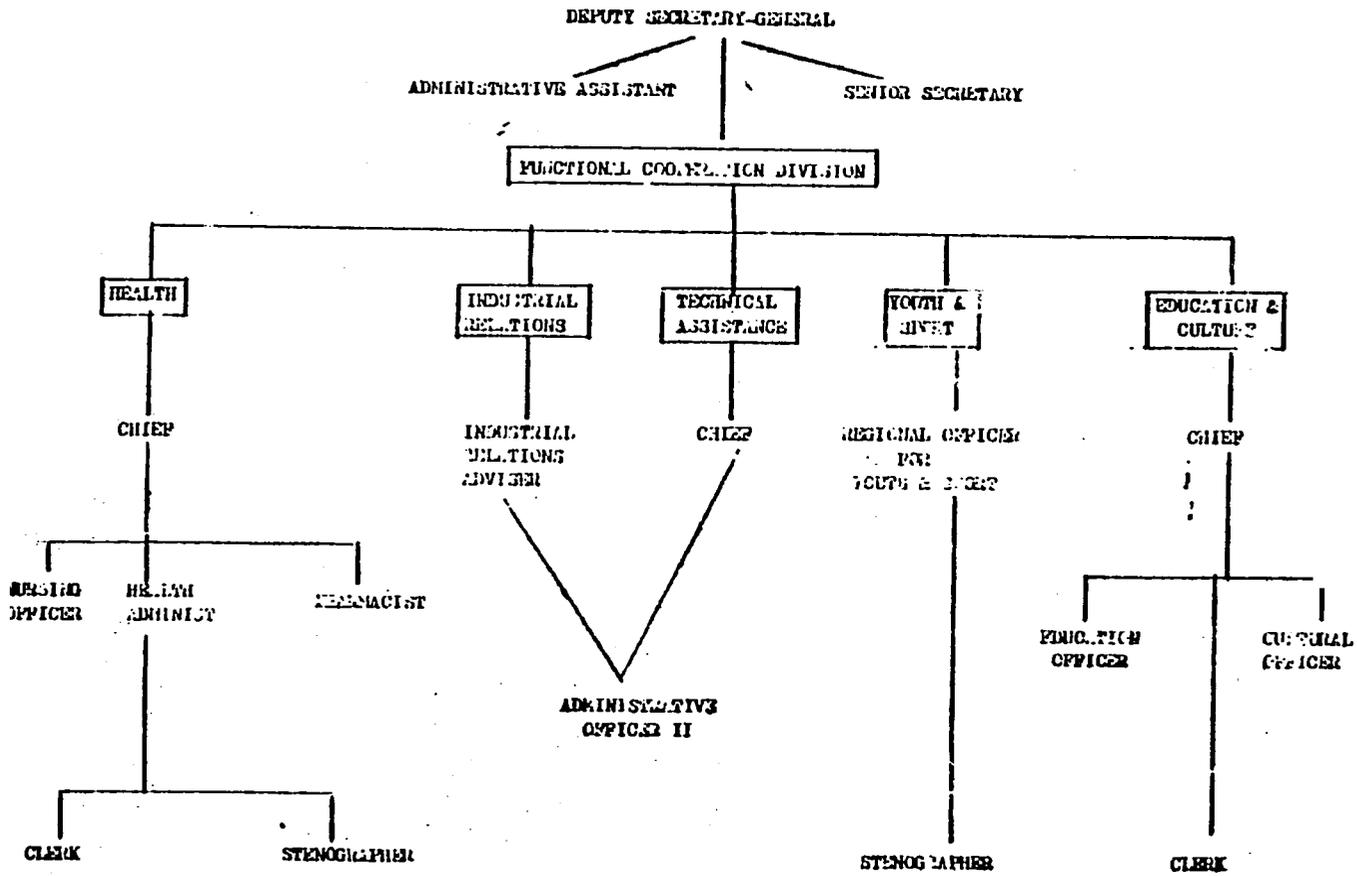
funded. A separate bank account is maintained for the Caribbean Health Ministers

Conference (an institution of the Heads of Government Conference).

CARIBBEAN COMMUNITY SECRETARIAT

ORGANISATION CHART





### HEALTH SECTION OF THE SECRETARIAT

The Health Section now carries out the following functions:-

1. Services meetings of the Health Ministers Conference in cooperation with other Secretariat staff members.
2. Implements resolutions of the Ministerial Conference.
3. Prepares, for the consideration of the Ministerial Conference, statements on regional health policy that include descriptions of the health problems, priorities and objectives.
4. Prepares or measures the preparation of programmes of regional cooperation in such priority problem areas as management; education; training and retention of health personnel; primary health care; health education and community participation; environmental health; food and nutrition, and maternal and child health.
5. Maintains a system of close cooperation, in the Secretariat as well as in the individual countries, with other sectors concerned with health, for example, central planning, education, agriculture, community development, housing, water supplies and waste disposal, as well as with the regional organizations of health professionals and voluntary workers.
6. Helps to maintain in the Secretariat and in individual countries an adequate system of health information that includes vital statistics and data relating to morbidity, health resources, health service activities and finance.
7. Reports to the Ministerial Conference, periodically as required, on the implementation of resolutions and stimulates the health administrations in the individual countries to report promptly on the health situation and health services.
8. Prepares and evaluates continuously the annual work programmes of the Secretariat in the health field.
9. Gives advisory services to individual countries on request.
10. Plays its appropriate part in the implementation of resolutions of the Conference of Commonwealth Health Ministers.
11. Works closely with other agencies: those assisting in the health field, e.g. PAHO/WHO, as well as those engaged in social and economic development in general, e.g., AID and UNDP.
12. Seeks and mobilises external aid.

ANNEX A IV - 2

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C A R I B B E A N            C O M M U N I T Y            S E C R E T A R I A T

THIRD CONFERENCE OF MINISTERS  
RESPONSIBLE FOR HEALTH

CMH 77/3/5

Frigate Bay, St. Kitts  
June 28-30, 1977

March 24, 1977

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DRAFT DECLARATION ON HEALTH BY CONFERENCE OF  
HEADS OF GOVERNMENT OF THE CARIBBEAN COMMUNITY

This Paper has been prepared in compliance with Resolution 19 of the Second Meeting of the Conference of Ministers responsible for Health, which reads in part as follows:

"REQUESTS the Secretary-General, taking account of previous decisions of the Ministerial Conference, to prepare a draft health policy for the Caribbean Community that would then be considered by the Conference of Ministers responsible for Health and, if the Conference so decides, to submit it to the Heads of Government Conference".

The contents of this Paper derive almost entirely from previous decisions of the Ministerial Conference but are also completely in harmony with the Sixth General Programme of Work (1970-1983), which was adopted by the Twenty-ninth World Health Assembly a year ago and circulated to all Governments.

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- B. THE PRIORITIES
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- E. OUR SPECIFIC OBJECTIVES
  - 1. The Development of Comprehensive Health Services
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CONCLUSION

DECLARATION ON HEALTH  
BY THE HEADS OF GOVERNMENT CONFERENCE

INTRODUCTION

The ultimate goal of regional cooperation in the Caribbean is the improvement of the living standards of the people.

The health of the people is a vital factor in their standard of life. It is at once a prerequisite and a goal of development.

We no longer view the health services as a complex of purely medical measures. They are an essential component of the socio-economic system and combine a number of political, social, economic and other measures which the society is using to protect and improve the health of every individual and of the community as a whole.

At a time of economic crisis, comprehensive social and economic planning is inescapable, but economic development, defined in terms of increase in per capita income, does not necessarily reach the most vulnerable groups in the population. Therefore, our development effort must give separate and special priority to health strategy, particularly designed to reach those who may have been by-passed by economic growth and are worst affected by economic recession.

Unprecedented scientific advance in recent times has placed in our hands many new tools that should be brought to bear upon the health problems of the people of the Community.

In the Caribbean Community health is geographically indivisible. That is to say, the achievements of any member country in the prevention and treatment of sickness are of value to all, and among the countries unequal development of health services is a common danger, particularly where communicable diseases are concerned.

It has become increasingly evident that the efforts of the individual countries are insufficient to deal adequately with such diverse issues as food and nutrition planning, the education and training of doctors, dentists and other health staff, epidemiological surveillance, and the cost and quality control of pharmaceuticals.

This is not to say that the national effort is of secondary importance. On the contrary, experience has shown that the principal determining factor in the development of national health services is dynamic and creative effort within the country itself.

We think it convenient to divide this Declaration into the following parts:

- A. The Principal Health Issues
- B. The Priorities
- C. Our General Purposes in Health
- D. Some Fundamental Principles that Guide Us
- E. Our Specific Objectives

One of the fundamental prerequisites for formulating a health policy is the careful and correct identification of the health problems.

We find that in the Caribbean Community as a whole the principal health issues are as follows:

1. The population of the Caribbean Community has continued to increase at about 2 per cent per annum. The crude birth rate has been declining steadily in nearly all the countries during the past ten years. There has also been a gradual decline in emigration as well as in infant mortality rates. The population of the Community is young, approximately 60 per cent being under 25 years of age.
2. Among the greatest causes of sickness and death are poor environmental conditions and the resulting communicable diseases, namely, gastroenteritis, dysentery and typhoid. The high rate of intestinal parasitic infestation among children is significant. Cholera remains a serious threat.
3. The chief dangers in the environment arise from insufficient and unsafe water supplies. Insanitary excreta disposal and poor food hygiene come next in importance. The other problems in the environment have a distinctly lower priority.
4. Mothers and children make up two-thirds of the whole population and have high rates of sickness and death. Services, including family planning, are inadequate in coverage and in quality.
5. Combined malnutrition and diarrhoeal disease in children under two years of age account for most of the deaths in this young age group, but also for one-fifth to one-third of deaths for all ages.
6. More than half of the children of the Caribbean Community under 5 years of age suffer from malnutrition and more than half of the households are not receiving their food energy requirements. This can only mean that large numbers of our citizens of all ages are unable to achieve their full potential because of malnutrition.

7. Twenty to thirty per cent of all deaths in the Caribbean Community are due to communicable diseases, and one-third of these deaths are due to diseases that could easily be prevented by immunisation.
8. The sexually transmitted diseases are on the increase. Tuberculosis remains a major problem, and so does leprosy.
9. Diabetes and high blood pressure are common and often undetected and uncontrolled until they give rise to grave complications that strike down adults at the height of their productive capacity.
10. Mental illness constitutes about one-half of the total volume of illness, and the mental health services are sadly deficient. Drug abuse falls under this heading, but in the Caribbean Community the most important drug problems are alcohol and tobacco smoking.
11. Diseases of the teeth and gums are universal, and the care of the mouth is seriously deficient. The dental services are largely given over to extractions and more needs to be done for prevention and conservation.
12. All the countries are infested with the mosquito that transmits yellow fever and dengue in populated areas. The virus that causes yellow fever is found in the forests of Guyana and Trinidad and nearly all the South American countries and could at any time spread through the Caribbean Community.
13. There is a lack of knowledge and of a sense of personal responsibility and community participation in health, and the majority of the countries do not have programmes in health education, which would remedy this state of affairs.

14. There are serious weaknesses in the management of the health services, in the availability of information about the health situation, in the availability of trained staff, in the relevance of training to the needs of the health services and of the people of the Caribbean Community, and in the supply and maintenance of health care facilities. The delivery and cost of health care have become serious problems. The health laws are out of date.

## B. THE PRIORITIES

In determining health priorities for the Caribbean Community, we have adopted as our criteria:

- a. the magnitude of a given problem
- b. its social and economic importance
- c. its susceptibility to preventive and remedial measure

Applying these criteria, we have arrived at the following determination of the priorities:

1. the more dynamic and creative management of the health services;
2. the education, training and retention of health personnel and especially those involved in the delivery of primary health care;
3. the health education of the public, with particular emphasis on the responsibility of the individual and active community involvement;
4. environmental health, with special reference to the quantity and quality of drinking water supplies and the sanitary disposal of human waste;
5. food and nutrition, and especially a programme that makes immediate provision for the needs of the vulnerable groups and, in the longer term, ensures that no citizen of the Community is prevented by malnutrition from achieving his full potential;
6. the health of mothers and children, with special reference to total coverage of maternal and child health care during pregnancy, childbirth and childhood.

### C. OUR GENERAL PURPOSES IN HEALTH

The ultimate purpose of our health policy is that the people of the Caribbean Community shall attain the highest possible level of health.

Recognising that health is a fundamental right of every citizen, we accept the need to work out a system under which all the people of the Community receive health care, irrespective of their ability to pay at the time of receiving attention.

But first we must enunciate our concept of health in the Caribbean context. We conceive of health as being not merely the absence of disease. We believe that it is much more. Our purpose is that the people of the Community shall be fit and productive and able to acquire and use new skills, that school children shall be fit and able to benefit from their education and that their physical and mental development shall not have been permanently impaired by malnutrition in infancy. Our policy is to provide the health services with dynamic and creative management, both technical and administrative. Our purpose is to eliminate the serious environmental health hazards in the Caribbean Community and to control the communicable diseases associated with that environment.

Recognising that the vast majority of people needing health care are to be found - not in hospitals or other institutions - but in the wider community, we shall place emphasis on community care.

We shall give even greater attention to prevention than to treatment. Our policy is to provide special care for all the mothers and children of the Caribbean Community. Our aim is that our people shall be emotionally well-adjusted, individually, in families and as a community, and free from dependence on alcohol or tobacco. Above all, we shall help our people to determine for themselves the most important health problems of the Community and to play their part in solving them; we are resolved to imbue each individual with a feeling of responsibility for making the changes in habits and behaviour that are needed to solve the health problems so that ultimately health in the Community will be achieved by the actions and efforts of the people themselves.

Each Member Government will work out a health system which is appropriate to its particular needs and potentials.

We shall seek health for our people, not only through the traditional types of health services, but also through social and economic development, including agriculture and general education.

Each Member Government will carry out a careful study of the existing health situation and select its own priorities.

We shall identify the constraints that are impeding the efficient operation of the health services and the achievement by our people of health in the broad sense in which it is conceived in this Declaration.

Each Member Government, and the Secretariat at the regional level, will make a continuous evaluation of the health situation and of our efforts from the very beginning and report promptly each year to the people of the country and the Community, respectively.

Each Member Government, and the Secretariat at the regional level, will prepare a plan of work for achieving our objectives in the shortest possible time.

D. SOME GUIDING PRINCIPLES FOR POLICY MAKERS

It is necessary to reaffirm certain fundamental principles, some already well known, that guide us in making this Declaration:

1. Increasing numbers of countries are including in their constitutions and statutes the principle that health is a fundamental human right.
2. The proposal of solutions for problems before the whole situation has been examined and the problems carefully identified remains a common phenomenon. Plans and programmes should be formulated not for problems seen in isolation but only after careful selection of priorities, careful definition of objectives, selection of efficient techniques, as simple and as inexpensive as possible, and the creation of good systems of information and evaluation.
3. The ultimate instrument for the delivery of health care is a comprehensive national health system or service. It is for each country to examine for itself whether and to what extent the principle of social security should be applied to the delivery of personal health care. Health being a fundamental right of man, capacity to pay at the time of receiving care should be totally irrelevant.
4. The promotion of health is dependent in large measure on other social and economic programmes, such as rural development, urban development, the more equitable distribution of wealth and food, general education and appropriate population policy. Since health is so closely linked with social and economic development, we need:
  - (a) to ensure that health considerations are properly taken into account - for example, by economic and other planning authorities - in programmes of agriculture, industrial and educational development, and
  - (b) to provide health care in close association

5. The obstacles to health will, for a long time to come, be economic rather than technical. This has obvious implications for those who operate the health services. It is more than ever necessary to devise programmes and techniques that are suited to countries with limited resources, to make more extensive use of community health aides and other auxiliaries, and to pool resources. Some of the health problems contributing most to sickness and death can be prevented by simple and inexpensive techniques applied through well-managed systems; immunisation is an example.
6. Adopting the basic objective of expanding the coverage of health services, we consider that the development of primary health care is an essential element in health policy. By such a policy some countries have converted an expensive service for a privileged few into a basic, adequate service for the people as a whole.
7. Health care for the community includes a wide range of services. To mention only a few: special care for mothers and children, including immunisation and family planning, safe drinking water supplies, health education and rehabilitation. Health care of such a varied character requires, besides the doctor and the nurse, a wide range of worker - the administrator, the school teacher, the environmental engineer, the health educator, the dental and other auxiliaries, the community health aide, and even - until she can be phased out in all the countries - the traditional birth attendant. Team work is therefore fundamental, and the new systems of education must prepare doctors and other health workers to be effective members of the team.
8. The drugs now available for medical care are numerous, complex, powerful and potentially harmful. They take up a large and increasing share of health costs. It is therefore essential to continue to develop and put into effect national and regional drug policies.

9. Health education, with emphasis on the responsibility of the individual and on active community participation, is an indispensable part of the health programme. ...
10. Priority in regional health programmes should be given to the so-called Less Developed Countries.
11. Within each country priority should be given to those who are most vulnerable or underserved, namely, the rural areas, the poor, young children and expectant and nursing mothers.
12. Fundamental changes are needed in the attitudes of doctors and other health workers - attitudes towards service in the Caribbean and especially in the rural areas as well as towards preventive and social action and the solution of the health problems. These changes in attitude require, for their part, fundamental changes in systems of education with respect to relevance to the needs of the health services and of the people of the Community.

## E. OUR SPECIFIC OBJECTIVES

It is convenient to arrange our specific objectives under the following headings:

1. The Development of Comprehensive Health Services
2. Health of Mothers and Children
3. Food and Nutrition
4. Communicable Diseases
5. Noncommunicable Diseases
6. Environmental Health
7. Supporting Services

### 1. The Development of Comprehensive Health Services

#### 1.1 Management

Organise in each country a comprehensive goal adapted to its particular needs and potential, with particular attention to the extension of coverage of the population.

*very definition* 1. Prepare in each country a health policy that includes the description of problems, the determination of priorities and the definition of objectives.

*process of health planning* 2. Strengthen the process of health planning.

*inclusion of health in socio-economic devel* 3. In order to reduce health hazards and increase health benefits, ensure the inclusion of the health components in socio-economic development and take part in such activities as urban planning, housing, agricultural development, industrial development, educational planning and social welfare.

*primary health care* 4. Make primary health care available to the whole population, ensuring that high-risk and vulnerable groups and those who are now underserved receive proper care, integrate this activity with other community development work such as agriculture, education, public works, housing and communications and carry it out at the most peripheral level of the health service by the most appropriate staff available, for example, community health aides.

/Strengthen ...

- info systems* 5. Strengthen in each country the system of health information, including vital statistics, medical records, morbidity statistics, statistics on health resources and statistics on health service activities and finances.
- admin reform* 6. Initiate the processes of administrative and institutional reform.
- programming* 7. Introduce or strengthen, as the case may be, programming in the following areas: services, infrastructure, resources (including external aid) implementation and evaluation.
- reporting, eval* 8. Procure prompt and systematic annual reporting by each Ministry of Health, utilising the agreed proforma.
- training* 9. Institutionalise for the Community as a whole a system of training in the management of health services.
- intersectoral Coord.* 10. Promote close cooperation of health services with all other sectors concerned with health promotion such as social welfare services, and set up intersectoral activities to improve, for example, the care of the aged, the prevention of disability and the rehabilitation of the disabled.

## 1.2 Health Manpower Development

Promote planning for and training of the various types of health staff making up health teams, imbuing them with the knowledge, skills and attitudes for carrying out health programmes and giving special attention to the training of staff for primary health care, such as community health aides.

Re-examine the education of medical, nursing and other health personnel in respect of relevance to the needs of the people of the Caribbean and to interrelationships within the health team and within the system of general education.

Promote curriculum development as well as evaluation with respect to basic and continuing education for all categories of health staff.

Arrange training in educational techniques for those responsible for training health staff.

Ensure optimum utilisation of staff.

Stimulate research to develop better understanding of the motivation of health workers in respect of service in the Caribbean Community and particularly in rural areas so as the better to appreciate their aspirations and provide them with suitable conditions of work and prospects for career development.

Review and revise the measures that are needed to combat the "brain drain" in the health professions.

Examine the feasibility of a system of regional nursing examinations.

Maintain a permanent mechanism of consultation between those who train health staff on the one hand, and the ministries who employ them, on the other.

Develop other mechanisms for evaluating the relevance of the educational processes to the needs of the health services and of the Caribbean people.

Involve the universities of the Region in the study of the health situation and the strengthening of the health services.

### 1.3 Facilities

Procure in each country the management of hospitals by qualified hospital administrators.

Explore the feasibility of a system of voluntary accreditation of hospitals as a means of raising the standards of care of patients.

Put into effect the regional programme for the maintenance of health care facilities and the setting up in Trinidad of a centre for training and advisory services in this field.

1.4 Finance

Seek and use all potential sources of funds for health programmes and health related activities, both national and regional.

Develop relationships with other agencies and obtain external assistance for health programmes, for the health component of development programmes, and for development programmes with identifiable effects on health, including community water supplies and systems of waste disposal.

1.5 Legislation

Implement the regional project for bringing up to date and harmonising the health laws of Member Countries.

1.6 Research

Cooperate with the Commonwealth Caribbean Medical Research Council to make research relevant to the needs and priorities of the people of the Community and to promote operational research, research into new methods of delivery of health care and increased productivity in the health sector, and studies on costs and financing.

2. Health Care of Mothers and Children

Reduce deaths and sickness among mothers and children, aiming ultimately at the total coverage of maternal and child health care during pregnancy, childbirth and childhood.

Put into effect in the Community as a whole and in each country the Strategy and Plan of Action for Strengthening the Maternal and Child Health Services (Document CNR 75/1/5, revised as PAHO Scientific Publication No. 325, 1976).

Apply the definition of the components of MCH Services set out in the Strategy.

Procure the designation by each Member Government of a person or group of persons to be responsible for the implementation of the Strategy.

Pay special attention to those measures which imply the economic use of resources, for example, the identification of high-risk groups, the utilisation of auxiliaries, breast feeding, immunisation, and health education, including family life education.

Procure the inclusion of family planning among the services provided, subject to the right of each Government to determine its own population policy.

Adopt the quantified targets set out in the Strategy.

Carry out the regional activities set out in the Strategy.

### 3. Food and Nutrition

Improve at once the quantity and quality of food taken by the vulnerable sections of the population, namely, small children, expectant and nursing mothers, and the poor.

Attain in the longer term a level of food intake that prevents any degree of malnutrition that impairs human well-being and productivity.

With these aims in view develop a multisectoral food and nutrition policy for each country and for the Community as a whole.

Continue the examination of the other implications of changing the name of the Regional Food Plan to Regional Food and Nutrition Plan.

With this in view adopt a triple approach to strategy:

- a. Rural development, with emphasis on productivity and the redistribution of income;
- b. Measures to improve the combination, quality and distribution of foods produced; and
- c. Health and related activities.

Develop veterinary public health services, with particular attention to the control of such important zoonoses as rabies, bovine tuberculosis, leptospirosis, brucellosis and equine encephalitis.

## 5. Control of Noncommunicable Diseases

### 5.1 Chronic Diseases

Develop programmes for the prevention and control of non-communicable diseases of major public health importance, such as diabetes, high blood pressure, heart disease and cancer.

### 5.2 Mental Health

Put into effect in each country a programme that is integrated within the general health service and includes the treatment of mental illness by psychiatrists at health centres, the maintenance of beds in general hospitals for the short-term treatment of mental illness, educational and other measures for prevention of mental illness, the control of alcoholism, tobacco smoking and other forms of drug dependence, and a serious attempt to change the attitudes of people towards mental illness in the direction of greater acceptance.

Provide orientation for health and social and other workers with respect to mental health problems.

### 5.3 Dental Health

Carry out as far as practicable the Strategy and Plan of Action for the Reform of the Dental Health Services, reported at the St. Lucia Workshop in May 1977 for the purpose of increased population coverage by the services, prevention of dental disease, conservation and restoration of teeth and dental health education of the Community, and to make provision for the training of dentists and dental auxiliaries within the Caribbean Community.

Adopt the quantified targets for nutrition set out in the Strategy and Plan of Action for Strengthening the Maternal and Child Health Services (Document CMH 75/1/5; revised as PAHO Scientific Publication No. 325, 1976).

#### 4. Control of Communicable Diseases

Develop programmes for the control of communicable diseases of major public health importance.

Expand the use of immunisation for the control of those diseases for which effective immunisation exists, designing such programmes as part of a primary health care policy.

Reduce mortality from measles, whooping cough and tetanus to 1.0 per 100,000 population by the immunisation of 90% of children under five years of age and, in the case of tetanus, the administration of tetanus toxoid to 60% of expectant mothers.

Reduce morbidity from diphtheria and poliomyelitis to rates of 1.0 and 0.1, respectively, per 100,000 population by adequate immunisation programmes directed to children under 5 years of age.

Reduce by 50% the rates of mortality from enteric infections.

Prepare and carry out in each country a programme for controlling the sexually transmitted diseases, adopting and adapting the model formulated in the Seminar held in Trinidad in May 1975.

Eradicate yaws.

Control leprosy and tuberculosis.

Eradicate malaria in the countries that are still infected and maintain the transmission-free status in the other countries of the Community.

Maintain the smallpox-free status of the Community by a system of surveillance.

Eradicate *Aedes aegypti* in the countries that are still infested and prevent the reinfestation of areas from which it has been eliminated.

## 6. Environmental Health

### 6.1 General

Carry out, as far as practicable, the recommendations of the Workshop on Environmental Health Strategy convened by the Secretariat in the second half of 1976.

### 6.2 Drinking Water Supplies

Provide piped water, safe for drinking, inside the house, for twenty-four hours a day, to every citizen in the Caribbean Community.

### 6.3 Excreta Disposal

Provide approved facilities for excreta disposal to every household in the Community.

### 6.4 Safety of Food

Develop food safety policies in each country and for the Community as a whole in order to prevent contamination and chemical or biological adulteration and thus reduce human illness and economic loss.

Stimulate awareness of the importance of food quality for the health of the consumer, promote health education programmes for the general public and for executives and other personnel in the food industry, emphasizing the need for strict observance of the rules of hygiene in food factories, warehouses, markets, shops, restaurants and houses and for accurate labelling of packaged foodstuffs.

### 6.5 Solid Waste

Procure the adoption by each country of a system of management of solid waste adapted to its needs, including efficient collection, treatment and disposal, improved by institutional development, the training of staff, educational work to obtain community participation and the necessary legislation.

#### 6.6 Pollution

Develop programmes for the early detection, prevention and control of pollution of air, water and soil (chemical, e.g., industrial waste; physical, e.g., radiation; biological, e.g., excreta).

#### 6.7 Housing and Human Settlements

Improve housing and health conditions in human settlements and promote the health and psycho-social aspects of town and country planning, attempting to prevent and solve the health problems of industrial development and urbanisation.

#### 6.8 The Health of Workers

Develop a programme, integrated within the general health services, to promote the health of the working population, control occupational health risks and procure the humanisation of work.

#### 6.9 Pesticide Control

Prepare a programme in each country and in the Community as a whole for pesticide control, enacting legislation, harmonising such legislation with that in the rest of the Community, and promote cooperation of the ministry of health with the ministry of agriculture and other agencies concerned with pesticide control.

#### 6.10 Traffic and other Accidents

In order to reduce the number of deaths and the amount of disability caused by traffic and other accidents, carry out a coordinated programme that takes account of the multiple nature of accident causes and the need for collaboration among various ministries such as the ministries of health, labour, transport and education.

#### 6.11 Disaster Preparedness

Procure the full participation of each health administration in national pre-disaster planning and preparedness in the health aspects.

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#### 6.11 Disaster Preparedness

Procure the full participation of each health administration in national disaster planning and preparedness in the health aspects.

## 7. Supporting Services

### 7.1 Nursing

Procure the setting up in each territory of a system of nursing in which the role of nursing, the categories and numbers of nursing staff and the education programmes required to achieve our objectives, are clearly defined.

### 7.2 Epidemiological Surveillance

Cooperating closely with the Caribbean Epidemiology Centre (CAREC), promote in the Community and in each country a system of epidemiological surveillance that guarantees prompt and adequate information on the incidence of diseases and the conditioning factors.

### 7.3 Laboratory Services

With a view to strengthening the diagnostic facilities both for clinical medicine and for community health, including food hygiene and veterinary public health, implement the project that emerges from the 1976 survey of the laboratory services of the Community.

Organise a regional service in forensic medicine.

### 7.4 Drug Policy

Make safe and effective drugs available at a reduced cost by:

bulk-purchasing through master-contract;

promoting the use of non-proprietary drugs;

compiling a list of basic and essential drugs and incorporating them in a Formulary;

restricting the importation and domestic production of drugs to those listed in the Formulary;

establishing a Regional Drug Testing Laboratory to monitor the safety and effectiveness of all drugs, and

removing import duty and other taxes from drugs used in the treatment of certain chronic diseases such as high blood pressure and diabetes.

### 7.5 Health Education

Prepare and put into effect in each country a health education programme that will help the people to determine for themselves the priority community health problems and acquire a feeling of responsibility for solving them, provide for the employment of an adequate number of professional health educators and for the inclusion of health education in the basic preparation of all health staff and its incorporation into each and every health programme.

## CONCLUSION

The usefulness of this Declaration must be judged in the final analysis by the extent to which our stated objectives are attained and, more especially, by the resulting measured improvement in the health of the people of the Community.

Under the Treaty establishing the Caribbean Community, the Secretariat is the principal administrative organ of the Community and the Secretary-General its principal administrative officer.

It is to the Secretary-General, therefore, and to the Secretariat that we assign the responsibility of taking, at the regional level, the action that must follow this Declaration.

This is not to say that we expect the Secretariat to play a passive role and await our guidance. It clearly has a leadership role to play in promoting the health of the people of the Community. It best performs this role by constant stimulation of thought and action in the field of health and by proposing new solutions for difficult health problems.

We urge all those, within the Caribbean Community and outside it, who are interested in promoting the health of the people and assisting us to attain the objectives that we have outlined, to collaborate with the Secretary-General and the Secretariat. Since health is inextricably linked with social and economic development this call is made, not only to PAHO/WHO and the other organizations of the United Nations system, but also to all other agencies concerned with social and economic development.

We call upon individual Member Governments to do their part, which is the most important of all.

ANNEX A IV - 2

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C A R I B B E A N      C O M M U N I T Y      S E C R E T A R I A T

THIRD CONFERENCE OF MINISTERS  
RESPONSIBLE FOR HEALTH

CMH 77/3/5

Frigate Bay, St. Kitts

June 28-30, 1977

March 24, 1977

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DRAFT DECLARATION ON HEALTH BY CONFERENCE OF  
HEADS OF GOVERNMENT OF THE CARIBBEAN COMMUNITY

This Paper has been prepared in compliance with Resolution 19 of the Second Meeting of the Conference of Ministers responsible for Health, which reads in part as follows:

"REQUESTS the Secretary-General, taking account of previous decisions of the Ministerial Conference, to prepare a draft health policy for the Caribbean Community that would that would then be considered by the Conference of Ministers responsible for Health and, if the Conference so decides, to submit it to the Heads of Government Conference".

The contents of this Paper derive almost entirely from previous decisions of the Ministerial Conference but are also completely in harmony with the Sixth General Programme of Work (1970-1983), which was adopted by the Twenty-ninth World Health Assembly a year ago and circulated to all Governments.

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### CONCLUSION

DECLARATION ON HEALTH  
BY THE HEADS OF GOVERNMENT CONFERENCE

INTRODUCTION

The ultimate goal of regional cooperation in the Caribbean is the improvement of the living standards of the people.

The health of the people is a vital factor in their standard of life. It is at once a prerequisite and a goal of development.

...  
We no longer view the health services as a complex of purely medical measures. They are an essential component of the socio-economic system and combine a number of political, social, economic and other measures which the society is using to protect and improve the health of every individual and of the community as a whole.

At a time of economic crisis, comprehensive social and economic planning is inescapable, but economic development, defined in terms of increase in per capita income, does not necessarily reach the most vulnerable groups in the population. Therefore, our development effort must give separate and special priority to health strategy, particularly designed to reach those who may have been by-passed by economic growth and are worst affected by economic recession.

Unprecedented scientific advance in recent times has placed in our hands many new tools that should be brought to bear upon the health problems of the people of the Community.

In the Caribbean Community health is geographically indivisible. That is to say, the achievements of any member country in the prevention and treatment of sickness are of value to all, and among the countries unequal development of health services is a common danger, particularly where communicable diseases are concerned.

/It has ...

It has become increasingly evident that the efforts of the individual countries are insufficient to deal adequately with such diverse issues as food and nutrition planning, the education and training of doctors, dentists and other health staff, epidemiological surveillance, and the cost and quality control of pharmaceuticals.

This is not to say that the national effort is of secondary importance. On the contrary, experience has shown that the principal determining factor in the development of national health services is dynamic and creative effort within the country itself.

We think it convenient to divide this Declaration into the following parts:

- A. The Principal Health Issues
- B. The Priorities
- C. Our General Purposes in Health
- D. Some Fundamental Principles that Guide Us
- E. Our Specific Objectives

One of the fundamental prerequisites for formulating a health policy is the careful and correct identification of the health problems.

We find that in the Caribbean Community as a whole the principal health issues are as follows:

1. The population of the Caribbean Community has continued to increase at about 2 per cent per annum. The crude birth rate has been declining steadily in nearly all the countries during the past ten years. There has also been a gradual decline in emigration as well as in infant mortality rates. The population of the Community is young, approximately 60 per cent being under 25 years of age.
2. Among the greatest causes of sickness and death are poor environmental conditions and the resulting communicable diseases, namely, gastroenteritis, dysentery and typhoid. The high rate of intestinal parasitic infestation among children is significant. Cholera remains a serious threat.
3. The chief dangers in the environment arise from insufficient and unsafe water supplies. Insanitary excreta disposal and poor food hygiene come next in importance. The other problems in the environment have a distinctly lower priority.
4. Mothers and children make up two-thirds of the whole population and have high rates of sickness and death. Services, including family planning, are inadequate in coverage and in quality.
5. Combined malnutrition and diarrhoeal disease in children under two years of age account for most of the deaths in this young age group, but also for one-fifth to one-third of deaths for all ages.
6. More than half of the children of the Caribbean Community under 5 years of age suffer from malnutrition and more than half of the households are not receiving their food energy requirements. This can only mean that large numbers of our citizens of all ages are unable to achieve their full potential because of malnutrition.

7. Twenty to thirty per cent of all deaths in the Caribbean Community are due to communicable diseases, and one-third of those deaths are due to diseases that could easily be prevented by immunisation.
8. The sexually transmitted diseases are on the increase. Tuberculosis remains a major problem, and so does leprosy.
9. Diabetes and high blood pressure are common and often undetected and uncontrolled until they give rise to grave complications that strike down adults at the height of their productive capacity.
10. Mental illness constitutes about one-half of the total volume of illness, and the mental health services are sadly deficient. Drug abuse falls under this heading, but in the Caribbean Community the most important drug problems are alcohol and tobacco smoking.
11. Diseases of the teeth and gums are universal, and the care of the mouth is seriously deficient. The dental services are largely given over to extractions and more needs to be done for prevention and conservation.
12. All the countries are infested with the mosquito that transmits yellow fever and dengue in populated areas. The virus that causes yellow fever is found in the forests of Guyana and Trinidad and nearly all the South American countries and could at any time spread through the Caribbean Community.
13. There is a lack of knowledge and of a sense of personal responsibility and community participation in health, and the majority of the countries do not have programmes in health education, which would remedy this state of affairs.

14. There are serious weaknesses in the management of the health services, in the availability of information about the health situation, in the availability of trained staff, in the relevance of training to the needs of the health services and of the people of the Caribbean Community, and in the supply and maintenance of health care facilities. The delivery and cost of health care have become serious problems. The health laws are out of date.

### 9. THE PRIORITIES

In determining health priorities for the Caribbean Community, we have adopted as our criteria:

- a. the magnitude of a given problem
- b. its social and economic importance
- c. its susceptibility to preventive and remedial measure

Applying these criteria, we have arrived at the following determination of the priorities:

1. the more dynamic and creative management of the health services;
2. the education, training and retention of health personnel and especially those involved in the delivery of primary health care;
3. the health education of the public, with particular emphasis on the responsibility of the individual and active community involvement;
4. environmental health, with special reference to the quantity and quality of drinking water supplies and the sanitary disposal of human waste;
5. food and nutrition, and especially a programme that makes immediate provision for the needs of the vulnerable groups and, in the longer term, ensures that no citizen of the Community is prevented by malnutrition from achieving his full potential;
6. the health of mothers and children, with special reference to total coverage of maternal and child health care during pregnancy, childbirth and childhood.

C. OUR GENERAL PURPOSES IN HEALTH

The ultimate purpose of our health policy is that the people of the Caribbean Community shall attain the highest possible level of health.

Recognising that health is a fundamental right of every citizen, we accept the need to work out a system under which all the people of the Community receive health care, irrespective of their ability to pay at the time of receiving attention.

But first we must enunciate our concept of health in the Caribbean context. We conceive of health as being not merely the absence of disease. We believe that it is much more. Our purpose is that the people of the Community shall be fit and productive and able to acquire and use new skills, that school children shall be fit and able to benefit from their education and that their physical and mental development shall not have been permanently impaired by malnutrition in infancy. Our policy is to provide the health services with dynamic and creative management, both technical and administrative. Our purpose is to eliminate the serious environmental health hazards in the Caribbean Community and to control the communicable diseases associated with that environment.

Recognising that the vast majority of people needing health care are to be found - not in hospitals or other institutions - but in the wider community, we shall place emphasis on community care.

We shall give even greater attention to prevention than to treatment. Our policy is to provide special care for all the mothers and children of the Caribbean Community. Our aim is that our people shall be emotionally well-adjusted, individually, in families and as a community, and free from dependence on alcohol or tobacco. Above all, we shall help our people to determine for themselves the most important health problems of the Community and to play their part in solving them; we are resolved to imbue each individual with a feeling of responsibility for making the changes in habits and behaviour that are needed to solve the health problems so that ultimately health in the Community will be achieved by the actions and efforts of the people themselves.

/Esch ...

Each Member Government will work out a health system which is appropriate to its particular needs and potential.

We shall seek health for our people, not only through the traditional types of health services, but also through social and economic development, including agriculture and general education.

Each Member Government will carry out a careful study of the existing health situation and select its own priorities.

We shall identify the constraints that are impeding the efficient operation of the health services and the achievement by our people of health in the broad sense in which it is conceived in this Declaration.

Each Member Government, and the Secretariat at the regional level, will make a continuous evaluation of the health situation and of our efforts from the very beginning and report promptly each year to the people of the country and the Community, respectively.

Each Member Government, and the Secretariat at the regional level, will prepare a plan of work for achieving our objectives in the shortest possible time.

## D. SOME FUNDAMENTAL PRINCIPLES THAT GUIDE US

It is necessary to reaffirm certain fundamental principles, some already well known, that guide us in making this Declaration:

1. Increasing numbers of countries are including in their constitutions and statutes the principle that health is a fundamental human right.
2. The proposal of solutions for problems before the whole situation has been examined and the problems carefully identified remains a common phenomenon. Plans and programmes should be formulated not for problems seen in isolation but only after careful selection of priorities, careful definition of objectives, selection of efficient techniques, as simple and as inexpensive as possible, and the creation of good systems of information and evaluation.
3. The ultimate instrument for the delivery of health care is a comprehensive national health system or service. It is for each country to examine for itself whether and to what extent the principle of social security should be applied to the delivery of personal health care. Health being a fundamental right of man, capacity to pay at the time of receiving care should be totally irrelevant.
4. The promotion of health is dependent in large measure on other social and economic programmes, such as rural development, urban development, the more equitable distribution of wealth and food, general education and appropriate population policy. Since health is so closely linked with social and economic development, we need
  - (a) to ensure that health considerations are properly taken into account - for example, by economic and other planning authorities - in programmes of agriculture, industrial and educational development, and
  - (b) to provide health care in close association with other social services.

5. The obstacles to health will, for a long time to come, be economic rather than technical. This has obvious implications for those who operate the health services. It is more than ever necessary to devise programmes and techniques that are suited to countries with limited resources, to make more extensive use of community health aides and other auxiliaries, and to pool resources. Some of the health problems contributing most to sickness and death can be prevented by simple and inexpensive techniques applied through well-managed systems; immunisation is an example.
6. Adopting the basic objective of expanding the coverage of health services, we consider that the development of primary health care is an essential element in health policy. By such a policy some countries have converted an expensive service for a privileged few into a basic, adequate service for the people as a whole.
7. Health care for the community includes a wide range of services. To mention only a few: special care for mothers and children, including immunisation and family planning, safe drinking water supplies, health education and rehabilitation. Health care of such a varied character requires, besides the doctor and the nurse, a wide range of workers - the administrator, the school teacher, the environmental engineer, the health educator, the dental and other auxiliaries, the community health aide, and even - until she can be phased out in all the countries - the traditional birth attendant. Team work is therefore fundamental, and the new systems of education must prepare doctors and other health workers to be effective members of the team.
8. The drugs now available for medical care are numerous, complex, powerful and potentially harmful. They take up a large and increasing share of health costs. It is therefore essential to continue to develop and put into effect national and regional drug policies.

9. Health education, with emphasis on the responsibility of the individual and on active community participation, is an indispensable part of the health programme. ...
10. Priority in regional health programmes should be given to the so-called Less Developed Countries.
11. Within each country priority should be given to those who are most vulnerable or underserved, namely, the rural areas, the poor, young children and expectant and nursing mothers.
12. Fundamental changes are needed in the attitudes of doctors and other health workers - attitudes towards service in the Caribbean and especially in the rural areas as well as towards preventive and social action and the solution of the health problems. These changes in attitude require, for their part, fundamental changes in systems of education with respect to relevance to the needs of the health services and of the people of the Community.

## E. OUR SPECIFIC OBJECTIVES

It is convenient to arrange our specific objectives under the following headings:

1. The Development of Comprehensive Health Services
2. Health of Mothers and Children
3. Food and Nutrition
4. Communicable Diseases
5. Noncommunicable Diseases
6. Environmental Health
7. Supporting Services

### 1. The Development of Comprehensive Health Services

#### 1.1 Management

Organise in each country a comprehensive health service adapted to its particular needs and potential, with particular attention to the extension of coverage of the population.

*by definition* 1. Prepare in each country a health policy that includes the description of problems, the determination of priorities and the definition of objectives.

*ess of health planning* 2. Strengthen the process of health planning.

*need of health socio. econ. devel* 3. In order to reduce health hazards and increase health benefits, ensure the inclusion of the health components in socio-economic development and take part in such activities as urban planning, housing, agricultural development, industrial development, educational planning and social welfare.

*primary health care* 4. Make primary health care available to the whole population, ensuring that high-risk and vulnerable groups and those who are now underserved receive proper care, integrate this activity with other community development work such as agriculture, education, public works, housing and communications and carry it out at the most peripheral level of the health service by the most appropriate staff available, for example, community health aides.

/Strengthen ...

- info systems* 5. Strengthen in each country the system of health information, including vital statistics, medical records, morbidity statistics, statistics on health resources and statistics on health service activities and finances.
- admin reform* 6. Initiate the processes of administrative and institutional reform.
- programming* 7. Introduce or strengthen, as the case may be, programming in the following areas: services, infrastructure, resources (including external aid) implementation and evaluation.
- reporting coord* 8. Procure prompt and systematic annual reporting by each Ministry of Health, utilising the agreed proforma.
- training* 9. Institutionalise for the Community as a whole a system of training in the management of health services.
- intersectoral coord* 10. Promote close cooperation of health services with all other sectors concerned with health promotion such as social welfare services, and set up intersectoral activities to improve, for example, the care of the aged, the prevention of disability and the rehabilitation of the disabled.

## 1.2 Health Manpower Development

Promote planning for and training of the various types of health staff making up health teams, imbuing them with the knowledge, skills and attitudes for carrying out health programmes and giving special attention to the training of staff for primary health care, such as community health aides.

Re-examine the education of medical, nursing and other health personnel in respect of relevance to the needs of the people of the Caribbean and to interrelationships within the health team and within the system of general education.

Promote curriculum development as well as evaluation with respect to basic and continuing education for all categories of health staff.

Arrange training in educational techniques for those responsible for training health staff.

/Ensure ...

Ensure optimum utilisation of staff.

Stimulate research to develop better understanding of the motivation of health workers in respect of service in the Caribbean Community and particularly in rural areas so as the better to appreciate their aspirations and provide them with suitable conditions of work and prospects for career development.

Review and revise the measures that are needed to combat the "brain drain" in the health professions.

Examine the feasibility of a system of regional nursing examinations.

Maintain a permanent mechanism of consultation between those who train health staff on the one hand, and the ministries who employ them, on the other.

Develop other mechanisms for evaluating the relevance of the educational processes to the needs of the health services and of the Caribbean people.

Involve the universities of the Region in the study of the health situation and the strengthening of the health services.

### 1.3 Facilities

Procure in each country the management of hospitals by qualified hospital administrators.

Explore the feasibility of a system of voluntary accreditation of hospitals as a means of raising the standards of care of patients.

Put into effect the regional programme for the maintenance of health care facilities and the setting up in Trinidad of a centre for training and advisory services in this field.

1.4 Finance

Seek and use all potential sources of funds for health programmes and health related activities, both national and regional.

Develop relationships with other agencies and obtain external assistance for health programmes, for the health component of development programmes, and for development programmes with identifiable effects on health, including community water supplies and systems of waste disposal.

1.5 Legislation

Implement the regional project for bringing up to date and harmonising the health laws of Member Countries.

1.6 Research

Cooperate with the Commonwealth Caribbean Medical Research Council to make research relevant to the needs and priorities of the people of the Community and to promote operational research, research into new methods of delivery of health care and increased productivity in the health sector, and studies on costs and financing.

2. Health Care of Mothers and Children

Reduce deaths and sickness among mothers and children, aiming ultimately at the total coverage of maternal and child health care during pregnancy, childbirth and childhood.

Put into effect in the Community as a whole and in each country the Strategy and Plan of Action for Strengthening the Maternal and Child Health Services (Document CIH 75/1/5, revised as PAHO Scientific Publication No. 325, 1976).

Apply the definition of the components of MCH Services set out in the Strategy.

Procure the designation by each Member Government of a person or group of persons to be responsible for the implementation of the Strategy.

Pay special attention to those measures which imply the economic use of resources, for example, the identification of high-risk groups, the utilisation of auxiliaries, breast feeding, immunisation, and health education, including family life education.

Procure the inclusion of family planning among the services provided, subject to the right of each Government to determine its own population policy.

Adopt the quantified targets set out in the Strategy.

Carry out the regional activities set out in the Strategy.

### 3. Food and Nutrition

Improve at once the quantity and quality of food taken by the vulnerable sections of the population, namely, small children, expectant and nursing mothers, and the poor.

Attain in the longer term a level of food intake that prevents any degree of malnutrition that impairs human well-being and productivity.

With these aims in view develop a multisectoral food and nutrition policy for each country and for the Community as a whole.

Continue the examination of the other implications of changing the name of the Regional Food Plan to Regional Food and Nutrition Plan.

With this in view adopt a triple approach to strategy:

- a. Rural development, with emphasis on productivity and the redistribution of income;
- b. Measures to improve the combination, quality and distribution of foods produced; and
- c. Health and related activities.

Develop veterinary public health services, with particular attention to the control of such important zoonoses as rabies, bovine tuberculosis, leptospirosis, brucellosis and equine encephalitis.

## 5. Control of Noncommunicable Diseases

### 5.1 Chronic Diseases

Develop programmes for the prevention and control of non-communicable diseases of major public health importance, such as diabetes, high blood pressure, heart disease and cancer.

### 5.2 Mental Health

Put into effect in each country a programme that is integrated within the general health service and includes the treatment of mental illness by psychiatrists at health centres, the maintenance of beds in general hospitals for the short-term treatment of mental illness, educational and other measures for prevention of mental illness, the control of alcoholism, tobacco smoking and other forms of drug dependence, and a serious attempt to change the attitudes of people towards mental illness in the direction of greater acceptance.

Provide orientation for health and social and other workers with respect to mental health problems.

### 5.3 Dental Health

Carry out as far as practicable the Strategy and Plan of Action for the Reform of the Dental Health Services prepared at the St. Lucia Workshop in May 1977 for the purpose of increased population coverage by the services, prevention of dental disease, conservation and restoration of teeth and dental health education of the Community, and to make provision for the training of dentists and dental auxiliaries within the Caribbean Community.

Adopt the quantified targets for nutrition set out in the Strategy and Plan of Action for Strengthening the Maternal and Child Health Services (Document CMH 75/1/5, revised as PAHO Scientific Publication No. 325, 1976).

#### 4. Control of Communicable Diseases

Develop programmes for the control of communicable diseases of major public health importance.

Expand the use of immunisation for the control of those diseases for which effective immunisation exists, designing such programmes as part of a primary health care policy.

Reduce mortality from measles, whooping cough and tetanus to 1.0 per 100,000 population by the immunisation of 90% of children under five years of age and, in the case of tetanus, the administration of tetanus toxoid to 60% of expectant mothers.

Reduce morbidity from diphtheria and poliomyelitis to rates of 1.0 and 0.1, respectively, per 100,000 population by adequate immunisation programmes directed to children under 5 years of age.

Reduce by 50% the rates of mortality from enteric infections.

Prepare and carry out in each country a programme for controlling the sexually transmitted diseases, adopting and adapting the model formulated in the Seminar held in Trinidad in May 1975.

Eradicate yaws.

Control leprosy and tuberculosis.

Eradicate malaria in the countries that are still infested and maintain the transmission-free status in the other countries of the Community.

Maintain the smallpox-free status of the Community by a system of surveillance.

Eradicate *Aedes aegypti* in the countries that are still infested and prevent the reinfestation of areas from which it has been eliminated.

/Develop ...

## 6. Environmental Health

### 6.1 General

Carry out, as far as practicable, the recommendations of the Workshop on Environmental Health Strategy convened by the Secretariat in the second half of 1973.

### 6.2 Drinking Water Supplies

Provide piped water, safe for drinking, inside the house, for twenty-four hours a day, to every citizen in the Caribbean Community.

### 6.3 Excreta Disposal

Provide approved facilities for excreta disposal to every household in the Community.

### 6.4 Safety of Food

Develop food safety policies in each country and for the Community as a whole in order to prevent contamination and chemical or biological adulteration and thus reduce human illness and economic loss.

Stimulate awareness of the importance of food quality for the health of the consumer, promote health education programmes for the general public and for executives and other personnel in the food industry, emphasizing the need for strict observance of the rules of hygiene in food factories, warehouses, markets, shops, restaurants and houses and for accurate labelling of packaged foodstuffs.

### 6.5 Solid Waste

Procure the adoption by each country of a system of management of solid waste adapted to its needs, including efficient collection, treatment and disposal, improved by institutional development, the training of staff, educational work to obtain community participation and the necessary legislation.

#### 6.6 Pollution

Develop programmes for the early detection, prevention and control of pollution of air, water and soil (chemical, e.g., industrial waste; physical, e.g., radiation; biological, e.g., excreta).

#### 6.7 Housing and Human Settlements

Improve housing and health conditions in human settlements and promote the health and psycho-social aspects of town and country planning, attempting to prevent and solve the health problems of industrial development and urbanisation.

#### 6.8 The Health of Workers

Develop a programme, integrated within the general health services, to promote the health of the working population, control occupational health risks and procure the humanisation of work.

#### 6.9 Pesticide Control

Prepare a programme in each country and in the Community as a whole for pesticide control, enacting legislation, harmonising such legislation with that in the rest of the Community, and promote cooperation of the ministry of health with the ministry of agriculture and other agencies concerned with pesticide control.

#### 6.10 Traffic and other Accidents

In order to reduce the number of deaths and the amount of disability caused by traffic and other accidents, carry out a coordinated programme that takes account of the multiple nature of accident causes and the need for collaboration among various ministries such as the ministries of health, labour, transport and education.

#### 6.11 Disaster Preparedness

Procure the full participation of each health administration in national pre-disaster planning and preparedness in the health aspects.

## 7. Supporting Services

### 7.1 Nursing

Procure the setting up in each territory of a system of nursing in which the role of nursing, the categories and numbers of nursing staff and the education programmes required to achieve our objectives, are clearly defined.

### 7.2 Epidemiological Surveillance

Cooperating closely with the Caribbean Epidemiology Centre (CAREC), promote in the Community and in each country a system of epidemiological surveillance that guarantees prompt and adequate information on the incidence of diseases and the conditioning factors.

### 7.3 Laboratory Services

With a view to strengthening the diagnostic facilities both for clinical medicine and for community health, including food hygiene and veterinary public health, implement the project that emerges from the 1976 survey of the laboratory services of the Community.

Organise a regional service in forensic medicine.

### 7.4 Drug Policy

Make safe and effective drugs available at a reduced cost  
by:

bulk-purchasing through master-contract;

promoting the use of non-proprietary drugs;

compiling a list of basic and essential drugs and incorporating them in a Formulary;

restricting the importation and domestic production of drugs to those listed in the Formulary;

establishing a Regional Drug Testing Laboratory to monitor the safety and effectiveness of all drugs, and

removing import duty and other taxes from drugs used in the treatment of certain chronic diseases such as high blood pressure and diabetes.

7.5 Health Education

Prepare and put into effect in each country a health education programme that will help the people to determine for themselves the priority community health problems and acquire a feeling of responsibility for solving them, provide for the employment of an adequate number of professional health educators and for the inclusion of health education in the basic preparation of all health staff and its incorporation into each and every health programme.

## CONCLUSION

The usefulness of this Declaration must be judged in the final analysis by the extent to which our stated objectives are attained and, more especially, by the resulting measured improvement in the health of the people of the Community.

Under the Treaty establishing the Caribbean Community, the Secretariat is the principal administrative organ of the Community and the Secretary-General its principal administrative officer.

It is to the Secretary-General, therefore, and to the Secretariat that we assign the responsibility of taking, at the regional level, the action that must follow this Declaration.

This is not to say that we expect the Secretariat to play a passive role and await our guidance. It clearly has a leadership role to play in promoting the health of the people of the Community. It best performs this role by constant stimulation of thought and action in the field of health and by proposing new solutions for difficult health problems.

We urge all those, within the Caribbean Community and outside it, who are interested in promoting the health of the people and assisting us to attain the objectives that we have outlined, to collaborate with the Secretary-General and the Secretariat. Since health is inextricably linked with social and economic development this call is made, not only to PAHO/WHO and the other organisations of the United Nations system, but also to all other agencies concerned with social and economic development.

We call upon individual Member Governments to do their part, which is the most important of all.

ANNEX A V - 1

TABLE OF ABBREVIATIONS IN THE FP

CMRH	Conference of Ministers Responsible for Health
CHMC	Caribbean Health Ministers Conference (predecessor to CMRH)
CFNI	Caribbean Food and Nutrition Institute
CAREC	Caribbean Epidemiology Center
CARICOM	Caribbean Community
PAHO/WHO	Pan American Health Organization/World Health Organization
IDB	Inter-American Development Bank
CDB	Caribbean Development Bank
AID	Agency for International Development
UWI	University of the West Indies
IPPF	International Planned Parenthood Federation
BDD	British Development Division
CIDA	Canadian International Development Agency
UNDP	United Nations Development Programme
IBRD	International Bank of Reconstruction and Development (World Bank)

GLOSSARY OF HEALTH PLANNING

MANAGEMENT SYSTEM TERMS

<b>Accessibility</b>	A measure of the ability of an individual or group to obtain health care. Accessibility has geographic, financial, social awareness, and other components.
<b>Acceptability</b>	A measure of an individual's or group's overall assessment of the medical care available. Cost, quality, results, convenience, and provider attitudes are some of the things which might be appraised in such an assessment.
<b>Comprehensive Health Care</b>	Provision of the following services: health maintenance and prevention, primary care, specialty care, restorative care, health related custodial care.
<b>Consumer</b>	A resident of the health service area served by the agency who is a consumer of health care and who is not a provider of health care, and who is broadly representative of a social, economic, linguistic and racial populations geographic areas of the health service area.
<b>Consumer Participation</b>	Input from or participation of (1) users of the services rendered; (2) consumer advocates and advisaries of services provided or to be provided.
<b>Continuity of Care</b>	A characteristic of health care which is the result of a planned treatment program designed to treat the patients as a "whole" person and to provide a full range of services in a coordinated and integrated manner responds to the patient's needs.
<b>Disability</b>	Any limitation of physical, mental, or social activity of an individual as compared with other individuals of similar age, sex, and occupation.
<b>Facilities</b>	The site of the delivery of emergency, primary, secondary, or supportive health care services. Facility can be as small as a telephone operative referral service or as large as traditionally considered acute care facilities.
<b>Goals</b>	The highest attainable standard of health status and of health systems performance technically obtainable and consistent with the community ideals of health quality and service. Goals will have reached when the needs have been met.

Health Manpower	Those personnel who provide specified health services. Health manpower personnel may be defined as having special training and skills in assessing health problems, knowledge of health resources in circumscribed areas, or how to perform a specified array of preventive diagnostic, therapeutic, or rehabilitative procedures.
Health Manpower Ratio	The number of active members of a specific health care professions per 100,000 population or some other accepted ratio.
Health Status	The state of health of a specified individual group, or population. It may be measured with people's subjective assessment of their health or with indicators of mortality (death), morbidity or disability. Health status is an outcome measure for the effectiveness of the health care systems. All services, function, and resources in a geographic area intended to effect the people's state of health (boundaries of a health systems are arbitrary rather than absolute).
Health System	All services, functions, and resources in a geographic area intended to affect the people's state of health (boundaries of a health system are arbitrary rather than absolute).
Infant Mortality Rate	Rate of deaths of children under one year of age per 1,000 live births.
Length of Stay	The numbers of days of service rendered to an inpatient before discharged from an institution.
Need	Something or action which is essential, indispensable, required or cannot be done or lived without; a condition marked by the lack or want of some such thing or action. The presence or absence of a need can and should be measured by an objective criterion or standrad. Need may or may not be perceived or expressed by the person in need and must be distinguished from demands, expressed desires whether or not needed. Like appropriateness, need is frequently and irregularly used in health care with respect to health facilities and services and people. It is thus important to specify what thing or actions need is being considered, by what criterion the need is to be established, by whom, and with what effect.

## Concepts of Need and Demand

The concept of demand embodies health economics' most notorious misfit between theory and "reality". There are two primary objections to the concept: 1) it ignores "need" for services, and 2) it misrepresents the decision process which results in purchase of health services.

The concepts of "demand" and "need" provide two alternative methodologies to guide allocation of resources in the health sector. Allocation decisions must resolve two issues: whether resources shall be available, and how much.

The classical "demand" concept is intended as an "impersonal" indicator for both decisions. The existence and shape of a demand curve, interacting with supply, produces an equilibrium price for, and quantity of, resources for a particular good/service. Implicit in the concept is the rather whimsical notion that demand can be "withheld" by the buyer if the price is not right. The possibility that demand cannot or should not be withheld is a "normative" judgment not encompassed by the concept. Demand simply creates, and reflects, market conditions.

The concept of need, on the other hand, attempts to relate availability and quantity of health services to the personal attributes of "consumers", rather than to the "tastes and preferences" of "buyers". Age, sex, race, life style, education, and health status are seen as "predetermining" variables affecting individual behavior with respect to health services, regardless of income and price, and in a more compelling manner than "taste" implies. Need exists independent of the existence, or level of prices. Neither is it directly related to specific services which may be available in the market. Need may be satisfied in a number of alternative ways: a physician visit, home health care, emergency room treatment, the ministrations of a local faith-healer. Determinations of need can be highly subjective and are heavily influenced by cultural patterns and expectations.

An integrated theory of need and demand is a major challenge for both health care professionals and health economics. Sole reliance on demand to guide allocation of resources can result in the culturally unacceptable position that absence of demand justifies absence of supply. Given current values, demand is not a sufficient guide to whether services should be available. Sole reliance on need, however, requires social consensus concerning what is desirable. But even if this could be achieved, need is not precise enough to determine how

much services should be available. Both concepts must play a role in a resource allocation theory consistent with both traditional patient-oriented values and current conditions of increasing scarcity, inflation, and competing group goals.

The second problem with the traditional concept of demand is that it does not adequately account for the actual and well-known set of decisions which result in consumption of health care resources. Where classical demand relates a buyer directly to a seller, through the price of the offered good, demand for health services can be disaggregated into two components fairly independent of the other and even located in different persons.

First, an individual decides, or is brought involuntarily, to "enter the system". This decision is often suppressed by ignorance of "need for" or "desirability of" services, and distorted by an inability to judge the appropriateness or quality of services sought. This poor decision-making environment has long been protected by "professional ethics" which prevent dissemination of helpful information and enhance the mystical authority of the provider. Nevertheless, the individual generally controls, within the constraints of ignorance and except in comatose emergencies, entry into a system of service. Demand at this point can be measured, but it may be understated due to imperfect knowledge on the part of consumers.

Once "in" the system and face-to-face with a provider, the next phase begins. A highly trained provider, such a physician or nurse practitioner, determines which resources must be called upon to treat the presenting or suspected conditions. Utilization of resources is a matter of professional judgment over which the patient has little or no control. Price sensitivity becomes a remote determinant of consumer behavior.

#### Objectives

Specified results or consequences of activities to be obtained within a specific period. Objectives come from an expression of some attainment of goals defined in indicator levels achieved by a given time. Partial attainment is expressed by specifying the portion of total need, or by specifying component elements of the needs to be met by a target date.

<b>Preventive Services</b>	Health services which are designed to prevent the occurrence of an event of disease. Such services include immunization, chemoprophylaxis, contraception, nutrition education, control of environment to hazards, and other activities.
<b>Primary Care</b>	Basic or general health care. A primary care provider usually assumes responsibility for a patient in both health maintenance and therapy of illness.
<b>Provider</b>	<p>A provider is generally characterized as an individual who makes her or his living through the profession of health, i.e., has a fiduciary relationship to health care; or who holds a position of interest or trust on board or council having responsibilities for the provision of health care, or who is an immediate family member of an individual who is a provider. The following are examples of providers: physician, registered nurse, hospital administrator, hospital board member, spouse</p> <p>of a dentist or other health care provider, a person performing medical research, a public health sanitarian, an individual producing or supplying drugs.</p>
<b>Quality of Care</b>	An assessment of the adequacy of the physical condition of the health facilities, the training of the health staff, the availability and utilization of essential equipment, as well as a perceived satisfaction of services, among other things.
<b>Resources</b>	Health resources include health manpower and facilities used for the provision of health services in the total health care system.
<b>Risk</b>	Risk is a statistical term which is expressed in percentages or odds. In dealing with risk one does not profess to make predictions about individuals but about the likelihood of an event occurring in a population of given characteristics.
<b>Secondary Care</b>	Specialist services, inpatient care, including diagnostic and consultant services for patients referred by primary physician.
<b>Services</b>	The total spectrum of activities and procedures which promote, maintain, protect, preserve and restore physical and/or mental health and those which protect and improve features of the physical and social environment which are detrimental to the physical and mental health of the citizens.

Slot	A slot is equal to the number of units of service available (i.e., 2 people could fill one slot or 1 person could fill 2 slots).
Tertiary Care	Care for conditions occurring infrequently in a population, but requiring more technical capacity than secondary care.
Target Populations or Population at Risk	<p>For every statistical average reflecting a condition in the health field, or in any social field for that matter, there are a number of "populations" which contribute very unevenly to the average. Average annual income is a glaring example of an economic indicator which, if taken at face value, would conceal the wide spreading numbers and incomes between the poor and the rich. In order to improve the health conditions underlying a particular average, it is therefore necessary to subdivide the contributing "population" so that attention can be focused on that part of the population which is making the greatest adverse contribution to the average. This segment of total population we call a "population at risk" or "target population".</p> <p>When a population at risk is identified, it is necessary to spell out the characteristics of its profile, so that risk factors can be assessed.</p>
Unit of Service	Specified period of time or increment of service based on set criteria.

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