Primary Health Care and Local Health Systems in the Caribbean

PAN AMERICAN HEALTH ORGANIZATION

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Pan American Sanitary Bureau, Regional Office of the
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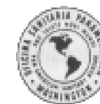

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Preface

Regular access to health services continues to be unavailable to vast segments of the population in many countries of the Americas, and the ongoing economic crisis has aggravated this situation by further constraining resources available to the health system. To fulfill the growing needs of the population, countries must use their health sector resources in the most efficient possible way.

The fact that the health status of the people of the Caribbean area has shown favorable trends, reflects the commitment made by leaders to the primary health care approach as the means of achieving universal health coverage. Gains have been made in such areas as disease control, and in the improvement of the health of communities through the encouragement of the planning process. However, despite important efforts made in this direction, situations of poverty and inequity persist.

Governments must continue to promote community participation in health at all levels, utilizing local health systems. Such systems must bring together all existing health resources in a given area, so that they can be used more effectively and be tailored to local conditions. Above all, the local health system must establish and foster a relationship of mutual responsibility with the population it serves. It can promote more active participation of the population in health promotion and in the delivery of services, and also assures the social and administrative accountability that is so essential for achieving efficient and effective services. By expanding collaborative efforts, progress in the strengthening of health systems can be made. Such collaboration is the aim of the Caribbean Cooperation in Health initiative, which provides the proper framework for implementing needed activities.

In November 1988 the Workshop on Primary Health Care and Local Health Systems, sponsored by the Pan American Health Orga-

nization, World Health Organization, UNICEF, and the Secretariat of the Caribbean Community, was convened in Tobago to provide a forum in which health care specialists could appraise progress made thus far in the implementation of primary health care and local health systems in the Caribbean subregion. It is hoped that by presenting the proceedings of the Workshop in this volume, a contribution will be made to the further development of primary health care in the Region and to strengthening the resolve of leaders in their efforts at attaining health for all.

Carlyle Guerra de Macedo
Director, Pan American
Sanitary Bureau

Introduction

Since the international community first made its commitment to implementing primary health care as the means of attaining health for all by the year 2000, there has been intensive dialogue and exchange of experiences regarding the formulation of policies and plans that will lead to the realization of a level of health permitting all citizens of the world to lead socially and economically productive lives. As countries move from the formulation phase to the complex tasks of implementation, the need to evaluate unique characteristics and demands of individual communities and their populations becomes more apparent.

In order to evaluate the progress made in achieving the implementation of the primary health care approach in the Caribbean, the Primary Health Care/Local Health Systems Workshop was convened from 7–11 November 1988 at the Mt. Irvine Hotel in Tobago. The workshop was organized jointly by the Pan American Health Organization (PAHO), World Health Organization (WHO), United Nations Children's Fund (UNICEF), and the Caribbean Community (CARICOM). The objectives of the workshop were:

- To review the progress made in implementation of the Strategy and Plan of Action developed for the Caribbean in Saint Lucia in June 1981;
- To evaluate the present state of development of local health systems in the countries of the subregion, and the influence of this development on the implementation of primary health care;
- To achieve consensus on subregional strategies for the further development of local health systems in the future implementation of primary health care.

Collected in this volume are the presentations made by those attending the Workshop; recommendations made to Governments of

the subregion; and the Declaration of Tobago, which was adopted by the participants to underline their commitment to primary health care. Certain documents basic to the definition of primary health care and local health systems have been reproduced in the annexes. Among others, these include an extract from the action plan developed at Saint Lucia in 1981; recommendations made at the 1988 meeting held at Riga, USSR; and priorities for action to support the development of local health systems as set forth in Resolution XV of the XXXIII Directing Council of PAHO in 1988. Also included in the annexes are statements made during the opening ceremony of the Workshop, the list of participants, and schedule of activities.

Representatives of the sponsoring organizations and health care specialists participated in group discussions focusing on: the current status of primary health care in the Caribbean; the use of local health systems as a means for implementing the primary health care approach; and the implications of the economic crisis in the Caribbean for the health care sector. These discussions resulted in recommendations to the Governments of the subregion regarding actions to be taken for the further implementation of primary health care.

The status of implementation

The focus of discussion on the first day of the Workshop was the status of primary health care implementation in countries and territories of the Caribbean. The 25-point action plan that was developed at the Primary Health Care Workshop in Saint Lucia in 1981 (see Annex 5) was the tool used to monitor the progress made.

It was reaffirmed during the group discussions that the primary health care approach is the appropriate strategy for improving the health status of the Caribbean people, and has been instrumental in improving health indices. Achievements have been made by many countries in the areas of disease surveillance, immunization, maternal and child health care, and the extension of coverage to broader segments of the population. The management of drug supplies has improved significantly with the establishment of the Eastern Caribbean Drug Service.

While regional indicators have shown favorable trends, there remain pockets of underserved populations. In many countries there has been less achievement than expected in the areas of intersectoral coordination, community participation, the development of health information systems, and the shift of resources to the primary health care level.

Local health systems

The means for moving from the realm of planning to that of implementing primary health care is through developing local health systems, which serve well-defined populations within certain administrative and geographical boundaries. Various degrees of autonomy govern these systems, but the principles guiding these systems should be equity, efficiency, and efficacy. The functioning of these systems is dependent on the coordination and cooperation of health-related activities and of other sectors that influence the social development of a community. The advantages of such an approach and the challenges posed in creating effective community participation in the Caribbean were addressed during the second day of the Workshop. Some of the observations made and recommendations that resulted from group discussions are outlined below.

Local health systems that vary depending upon size, geographical distribution, terrain, and population structure exist in all countries or territories of the Caribbean subregion. In-depth analysis of the characteristics of each country should be considered in adapting the local health system strategy to each national situation.

The local health system is seen as a management instrument with the capacity for planning, programming, and monitoring. It should be responsible for data collection and collation, and preliminary data analysis within a nationally organized and standardized health information system. It should also promote operational research and provide more useful epidemiological profiles.

The system should be able to facilitate the identification of local resources to assist with the maximization and achievement of health and health-related goals.

Implications of the economic crisis on health care

The economic crisis that is occurring in the Caribbean was analyzed by workshop participants, and they emphasized the fact that health operates within, and is constrained by, the socio-economic climate that exists in a country. Evidence was presented showing that the economic crisis has led to increased unemployment, a widening gap in

the standards of living of different segments of society, a reduction in access to adequate health care, and deterioration in nutritional status and living standards of mothers and children, the poor, and the aged.

In economies of the Caribbean where little or negative economic growth has occurred, efforts have been made to restructure government deficit financing through reduction in government expenditure. This structural adjustment has had both negative and positive impacts on primary health care, which were discussed by the participants. Negative aspects included: the increasing dissatisfaction among health personnel which has led to the emigration of already scarce manpower resources; the shortage of medical supplies, including essential drugs; and the introduction of user charges at a time of high unemployment which has resulted in limited access to, and less equity in, the delivery of health care.

Indirect benefits to the social sector brought about by structural adjustment include the potential for the following: improved management systems, rationalization of resources resulting in greater efficiency, reassessment of priorities and practices in delivery of health care, the optimal use of private sector resources, development of appropriate indigenous technology, the application of the "risk" approach to health care, and examination of alternative financing for health care services.

A strong case was made for renewed efforts in maintaining the level of public health expenditure in order to improve, or at least maintain, the productive capacity of the labor force. Policy makers should consider carefully the health implications of structural adjustment policies being pursued to obviate any erosions in gains already made in health status.

Caribbean Cooperation in Health

Workshop participants agreed that the Caribbean Cooperation in Health (CCH) initiative, coordinated by CARICOM and PAHO, is important to the Caribbean community at this time since it has the capacity to lessen the negative impact that structural adjustments will have on the health sector. In addition to attracting foreign resources, CCH has the capacity to maximize national resources, especially funds from non-governmental organizations (NGOs), to help in streamlining the national budget for health, to make effective and efficient use of regional resources through technical cooperation among developing countries (TCDC), to facilitate the sharing of technical information, and to promote retention of scarce manpower resources.

It is imperative that Ministries of Finance, which are responsible for the negotiation of external loans, and ministries and departments responsible for external technical cooperation, be intimately involved in the development of the CCH. Participants also stressed that projects introduced into the health service should be integrally coordinated into the total health care system.

Declaration of Tobago

The Declaration of Tobago, adopted by Workshop participants for consideration by Ministers of Health of the Caribbean Community, emphasizes the necessity for mobilization, support, and commitment of leaders at all levels in strengthening the primary health care approach, and for facilitating the attainment of health for all.

Part I. Implementation of Primary Health Care in the Caribbean

Primary Health Care—Caribbean Update

MERVYN U. HENRY[1]

Introduction

In 1978 representatives of independent CARICOM Member States participated in the historic international Conference in Primary Health Care held at Alma-Ata, USSR. That Conference drew up the fundamental principles of primary health care and embodied them in the declaration of Alma-Ata. It was agreed that urgent national and international action was needed to translate these principles into dynamic practical programs.

Subsequently, the World Health Assembly (WHA) at its 32nd meeting in Geneva approved the universal goal of Health for All by the Year 2000, a strategy that should be implemented through primary health care. At its XXVI Meeting in Washington, D.C., the Directing Council of PAHO approved the goal and strategy as recommended by WHA, and it was at this stage that Caribbean Ministers responsible for health requested PAHO, UNICEF, the University of the West Indies (UWI), and the United States Agency for International Development (USAID), among others, to assist in examining the implications for the Caribbean and to develop a Caribbean Strategy for Primary Health Care.

A workshop was duly convened in Saint Lucia in 1981 and attended by representatives from 18 Caribbean governments. The Caribbean Strategy for Primary Health Care was developed at this workshop, and was approved by the Conference of Ministers of Health which met in Belize two months later.

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This paper is the result of visits made in August 1988 to Anguilla, Barbados, Grenada, and Saint Lucia, with the purpose of evaluating and updating the status of primary health since 1981.

Findings and Observations in Four Countries

Eighteen countries have adopted the principles and philosophy of primary health care as originally elaborated at Alma-Ata in 1978 and subsequently approved by the World Health Assembly, the Directing Council of the Pan American Health Organization, and the Caribbean Conference of Ministers of Health in Belize in 1981.

In keeping with the principles of social justice, it was affirmed that health services should be extended to all citizens, especially vulnerable groups such as mothers and children, the elderly, and the disabled. They agreed on the program elements which would constitute the minimum primary health care package. Underlying the implementation of all the programs would be principles of equity, intersectoral coordination, community participation, and research and technology.

In the implementation of the primary health care strategy, most countries studied found it necessary to convene a national intersectoral workshop—some quite early within the period, others much later. One country is making plans to convene its first national intersectoral workshop. It may be deduced that countries holding national workshops gained earlier national consensus on how to proceed in the implementation of the strategy.

Of the countries visited having fully developed their first national health plans, Saint Lucia has already developed its second plan, while Barbados and Grenada are now updating their original plans. Anguilla is preparing its first draft plan based on recommendations from its first intersectoral workshop.

Although no senior official had been designated Primary Health Care Coordinator in the countries visited, responsibility for primary health care has been assigned implicitly or explicitly to the Permanent Secretary, Chief Medical Officer, or Health Planner. In all cases nurses have been involved in the delivery of primary health care (whether in immunization, gastroenteritis control, nutrition, antenatal, intrapartum or postnatal care), and the head of the community nursing services has therefore had a key role to play.

In some countries, restructuring has taken place at a central level

within the Ministry. For example, in one country an early development was the establishment of the Primary Health Care Intersectoral Committee which, while under the chairmanship of the Minister of Health, included sectors other than health, and met monthly. This committee was advisory to the Minister.

A parallel development within that country's Ministry was the establishment of a Planning, Monitoring, and Evaluation Committee under the chairmanship of the Director of Planning. This Committee met weekly and was mainly responsible for the day-to-day management of primary health care. There is a large measure of consensus that these committees have been very effective in promoting the implementation of primary health care.

In one country, the planning unit was strengthened to enable it to perform the functions of promoting and monitoring the implementation of primary health care.

Another development was the establishment of the post of Senior Medical Officer for Maternal and Child Health and Family Planning who was reported to by the Director of the Bureau of Health Education and Nutrition, a newly established unit. This development clearly indicates the elements of primary health care that are receiving increased attention of the Ministry. It is much too early in the life of that model to attempt any assessment of the impact.

Other aspects of the managerial process have been receiving attention with varying degrees of success. For example, with respect to the development of information systems some countries have devoted much time and effort to programming on a local level. It is not clear that the effort has been sufficiently sustained to have achieved national coverage, and there may well be some retrogression. However, in view of the fact that in some countries (Barbados and Saint Lucia) plans are advanced for computerization of data, it is important that a maximum and uniform effort be made in countries to allow for the collection and analysis of comparable data. At present, it would appear that information on surveillance of communicable diseases, immunization, and antenatal care is satisfactory, while information on nutrition and environmental health is inadequate.

The concept that use of district health teams is the best method of bringing a wider spectrum of skills to bear on the health problems of the community was fully endorsed by all the countries visited. Problems which could not be dealt with by the community or the health center would be referred to the next level of care.

In some countries district health teams functioned for a time and

functioned well. But transfers in staff and shortages of personnel caused the system to falter. The need for aides and auxiliaries did not receive unqualified acceptance, and the family nurse practitioner, who provides essential care in many countries, is still in need of legitimization in some countries. With respect to referrals, community nurses were loud in their criticism of lack of reciprocation by their colleagues at the secondary level—while patients from the community are always referred to the next higher level with the required health information, too often patients return to the community without appropriate information for the health officials at the community service level.

Having recognized the need to have well-trained personnel to implement their health programs, countries have invested their own resources, and utilize the resources of agencies in human resource development. In this context, the countries have collectively pressed into service a wide variety of auxiliary personnel—the family nurse practitioner, medex, dental nurse, primary care nurse, community health aide, environmental health aide, and veterinary public health assistant—who have contributed to the extension of services at a cost the community can afford.

Nevertheless, most countries are still without a comprehensive manpower policy that would address, *inter alia,* needs assessment, training programs that would result from dialogue between ministries of health and education, recruitment policy and practice, and manpower utilization.

Over the years, the patient has complained bitterly about the non-availability of drugs prescribed by the physician; in addition, costs have been escalating at a fairly rapid rate. Since 1986, thanks to the efforts of the East Caribbean Drug Scheme, as well as the past efforts of PAHO and CARICOM, the countries of the Organization of East Caribbean States (OECS) have cooperated in producing and utilizing an essential list of drugs. There is improved drug supply management so that the availability of drugs to the patient has increased while unit costs have decreased. More use is made of the Caribbean Regional Drug Testing Laboratory for quality control. It should be noted that the performance of the Barbados Drug Service is such that it has long been recognized as a WHO Collaborating Center.

One country spoke with pride about its capability in biomedical equipment maintenance as a result of program support provided by the United States National Institutes of Health (NIH) and Project

Hope. It is possible that the full potential of this program is not being utilized and personnel specifically trained to respond to national and regional needs are currently responding merely to national needs.

Program expansion in nearly all countries visited has been most evident in immunization, but most countries have made conscientious efforts to increase general health sector coverage. Two countries (Grenada and Barbados) are developing community mental health programs while another (Saint Lucia) has pioneered the development of community-based rehabilitation.

Many countries endeavoured to expand and upgrade services by refurbishing old health centers or constructing new ones. One country (Saint Lucia) was assisted by a grant from the Kellogg Foundation, while another country received a loan from the Inter-American Development Bank (IDB) to build and furnish several polyclinics from which it was intended that both government and private sector practitioners would provide service to members of the public. This concept is still under review. One country (Barbados) has just completed the first phase of modernization of its geriatric hospital.

In many of the smaller countries, it is the norm for the Permanent Secretary to have responsibility for more than one Ministry, and as such could be considered to be the embodiment of intersectoral coordination. Nevertheless, with one exception, good examples of intersectoral coordination were not found in the countries visited. In one case, where the practice of monthly intersectoral meetings has fallen into abeyance, staff would clearly be delighted if the practice were resumed as they were convinced of its usefulness. Of great interest is the fact that in Grenada, the Food and Nutrition Council, chaired by a representative of the Ministry of Agriculture, is quite functional and provides a good example of intersectoral coordination.

In another country there are regulary scheduled meetings of Permanent Secretaries in what is designated a Planning and Priorities Committee; the Ministries of Health and Agriculture cooperate in an Animal and Human Health Project with special reference to zoonosis control and meat inspection, while the Ministries of Health and Welfare cooperate in care of the elderly and the underprivileged.

Good examples of community participation were not easily recalled by persons interviewed. However, one senior Public Health Inspector who had organized several district health committees islandwide in Saint Lucia, succeeded in getting one committee to cooperate

in a vector control program which resulted in reducing the *Aedes aegypti* index from 33% to 6%. This program was given two successive WHO Awards of US$10,000 for program implementation.

Also in Saint Lucia, in a very depressed area with poor environmental health conditions, the community, the private sector, and government cooperated in a program to relieve the environmental situation. The program was successful, a much healthier environment was created, and as a result of a community training program, the ratio of environmental workers in that community has been increased from 1:10,000 (environmental health officers per person) to 1:50 (environmental health aides per person). In that country too, the community awarded the Prime Minister a check for EC$1.0 million toward the construction of a new hospital.

With respect to research and technology, some countries participated in a collaborative project entitled "Community-based Study on Utilization and Coverage of Health Services." The results are being reviewed to ensure their application to improvement of health care delivery. Saint Lucia participated in a study on community-based rehabilitation and pioneered the introduction of the program both locally and in other countries of the subregion. That country also collaborated with UWI in a pilot project on primary health care. The experience gained is being utilized in other primary health care programs on the island.

In Barbados, research is proceeding on a community mental health program to ascertain the best method of meeting the needs of the country.

Financing of health care is mainly through general revenue, and countries have allocated between 10–16% of national budgets to health. In the face of escalating health costs, and competing demands on shrinking national budgets, countries are exploring additional sources of revenue. Various types of user-charges are now in place for diagnostic laboratory and radiological services, inpatient care, drugs, deliveries, etc. In Saint Lucia, wherever new health centers are constructed, health care committees that include community organizations are established and are involved in the management of the center, contributing to its financial support. Some countries have introduced a health levy or a health surcharge which may or may not be earmarked for the health sector. Some countries are considering some form of national health insurance. In CARICOM countries social security systems do not currently deliver health care. Capital programs require extrabudgetary support through grants or loans.

The situation outlined thus far in the four Caribbean countries and territories studied is summarized in Table 1.

Achievements Since Implementation of Primary Health Care Strategies

It is against this framework of health systems that primary health care programs have been implemented in many countries of the Caribbean. In the field of health education, much emphasis was placed on the training of personnel and the establishment of health education units within ministries of health.

The PAHO adviser, on his arrival in the Caribbean in 1967, found services staffed by only 7 health educators; by 1985 there were 155 positions established in 16 countries. The added impetus from Alma-Ata resulted in the establishment of six units within ministries of health after 1978. Only one of the smaller countries does not yet have a post of health educator.

Program support has been given by PAHO in the areas of immunization, nutrition, maternal and child health, chronic diseases, drug abuse, and environmental health. However, more use should be made of the print and electronic media for education.

In the East Caribbean countries, there has been some success in modifying the curriculum of primary schools to facilitate increased health education. Workshops have been held for teacher training.

Technical advice on the formulation and implementation of national nutrition programs is made available through the Caribbean Food and Nutrition Institute. Through the promotion of breast feeding and education programs for feeding the weaning age group, and through dietary counseling to pregnant and lactating women, there has been a marked decrease in the problem of malnutrition. With the introduction of oral rehydration therapy, a similar decrease in mortality and hospital admissions for gastroenteritis has occurred. However, in the present economic climate nutrition surveillance is being intensified.

The routine distribution of iron and folic acid in antenatal clinics has much reduced the incidence of anemia in pregnancy, while iron therapy is recommended for other forms of iron deficiency in women.

Except in a few countries—Jamaica, Grenada, and Dominica being the outstanding exceptions—there has been little progress in the

TABLE 1. Findings on primary health care in selected Caribbean countries

	Anguilla	Barbados	Grenada	Saint Lucia
Managerial process				
Health for all/ primary health care policy	+	+	+	+
Health plan	Being drafted	Being revised	Being revised	Revised
Intersectoral workshop	+	Planned	+	+
Restructuring of Ministry	In process	+	+	+
Information system	Needs strengthening	Being computerized	Needs strengthening	Being computerized
District health teams	–	–	↓	↓
Referral system	±	–	–	–
Manpower policy	Training	Training	Training, use of auxiliaries	Training, use of auxiliaries
Essential drugs	±	+	+	+
Maintenance	–	+	+	–
Primary health care				
Expansion of services	+	+	+	+
Intersectoral coordination			+	
Community participation	–	–	–	+
Research and technology		+		+
Financing	General revenue, user charges	General revenue, user charges, health levy	General revenue, user charges	General revenue, user charges, health care committee

establishment of food and nutrition councils to assist in the formulation and monitoring of national food and nutrition policy.

Much work has been done on dietary counseling and developing guidelines and manuals for the prevention and treatment of obesity, diabetes, and hypertension. Guidelines for medical practitioners have also been completed. The use of press releases, radio shows, and television has resulted in increased consumer awareness on nutrition. Training programs have been carried out for food service supervisors, community nutrition workers, and dietetic interns; input on nutrition has also been provided to update the nursing curriculum.

In the field of environmental health, the major problems remain those that derive from the absence of a reliable potable water supply and inadequate systems of disposal of excreta and solid waste. While the larger territories can negotiate loans with funding agencies, no such avenue currently exists for the smaller independent territories which must depend on grant funds from friendly governments. This situation is being addressed with the assistance of the Caribbean Development Bank.

One of the major recent successes was a training-delivery project—the Caribbean Basin Water Management Project. Through this technical cooperation among developing countries (TCDC) project, which was originally funded by the Canadian International Development Agency (CIDA), training manuals were developed and lower level water authority personnel were trained utilizing the principles of appropriate technology. This project received international recognition, is now fully funded by governments, and is executed by the Caribbean Development Bank. It receives some financial assistance from CIDA and technical assistance from PAHO.

Other important achievements include the development of the Caribbean Environmental Health Strategy, the recent signing (1988) of the agreement to establish the Caribbean Environmental Health Institute, and the establishment in Antigua of the Pan-Caribbean Disaster Prevention and Preparedness Project.

In the field of maternal and child health, the Caribbean Community Maternal and Child Health Strategy, which was developed in 1975, was updated and reorganized in 1983 in a way that reflects the fundamentals of the primary health care approach. The key indices—infant and maternal mortality rates—show favorable trends with only one country having an IMR in excess of 35.

One key area of concern is now perinatal morbidity and mortality, commonly associated with low birth weights, often in turn associ-

ated with very young mothers. Family planning and family life education programs have therefore been strengthened.

With four of the six immunizable diseases (poliomyelitis, diphtheria, pertussis, and tetanus), as well as malnutrition largely under control, and with mortality and hospital admissions from gastroenteritis much reduced as a result of oral rehydration therapy, increasing attention is now being paid in some countries to previously underrecognized issues of child abuse and child neglect and consideration is being given to providing the required services in this area.

In the field of disease control, national epidemiologists have been trained and designated for almost all countries, efficient surveillance systems have been established, and referral and advisory links with the Caribbean Epidemiology Center have been strengthened. Diagnostic laboratory services in the less developed countries were also improved.

With control established over the immunizable diseases and a changing demographic pattern, the major disease threats are now from diabetes mellitus, hypertension, and cancer, while drug abuse, sexually transmitted diseases (including AIDS), and traffic accidents are inflicting an increasing toll on the society in general and most specifically on its youth.

Aedes aegypti control programs are still unsatisfactory; malaria can be found in the continental territories of Belize and Guyana.

The OECS has cooperated in the development of the East Caribbean Drug Scheme, which has resulted in marked improvement in the drug supply situation in those countries. There is currently renewed interest in participating in the CARICOM bulk purchasing scheme which would require development of and adherence to an essential list of drugs as well as improvement in drug supply systems.

Information on regional indicators for the four countries visited can be found in Table 2.

Conclusions and Recommendations

Primary health care concepts are well accepted by countries in the Caribbean. Greatest enthusiasm for primary health was found among those personnel who have had the most exposure to the concepts and have been most involved in their implementation at the national level. The converse is also true.

Where political will was strongest and was effectively communi-

TABLE 2. Primary health indicators for selected countries and territories

Country	Life expectancy (years)	Mortality rate		Immunization coverage[b]					Low birth weight	Access to potable water	Sanitary excreta disposal	Solid waste disposal
		Infant[a]	1–4 years	Year	DPT	Polio	Measles	BCG				
Anguilla	70	18.6	—	1986	88%	85%	65%	100%	5.6%	90%	96.5%	50% of households surveyed
Barbados	70	18.7	0.5	1987	79%	68%	85%	—	16%(1981)	100% (92% piped to houses)	100%	Sanitary landfill, pulverization plant satisfactory
Grenada	65.5	21.2	—	1987	80%	81%	77%	—	5%(1974–1975)	75%	85%	Dumpsite management, vehicle maintenance unsatisfactory
St. Lucia	71	20	1.1	1987	85%	86%	81%	89%	8.6%(1985)	85%	70%	Roadside dumping, dumping management unsatisfactory

[a] Per 1,000 live births.
[b] Percentage of children fully immunized before reaching age of 1 year.

cated to field staff, programs have been most vibrant. Any waning of enthusiasm resulted in a negative effect.

The value of national intersectoral workshops has been proven in facilitating cross-fertilization of ideas, creating involvement of health-related sectors, and acting as a springboard for program implementation. Countries may wish to consider the desirability of convening occasional national intersectoral workshops to monitor progress with program implementation, or at least to consider the advantages of resuming intersectoral meetings where these are in abeyance.

One of the basic tenets of primary health care is intersectoral coordination. Ministries of health must make greater efforts to identify the benefits to be derived from intersectoral coordination and must be prepared to take a leadership role in its promotion.

There is no substitute for health plans. Countries should seek PAHO's support in having them finalized as soon as possible.

Some aspects of the managerial process which need urgent attention include manpower policy, information systems, and maintenance of biomedical equipment.

Community participation must continue to be emphasized. In this connection there should be more dialogue with professional medical, nursing, environmental, and pharmaceutical associations. Dialogue and discussion should also be pursued with other nongovernmental organizations and with women's groups, since these are organizations that are often very active in or willing to promote primary health care.

Standardization of nutrition surveillance records is an urgent requirement so that comparative data on nutritional status in the Caribbean might be more readily available.

Although the need for ministries of health to become more cost-conscious cannot be denied, and countries need to explore the mobilization of additional sources of local revenues, the fear has been expressed that the imposition of charges for drugs in chronic disease programs (e.g. diabetes, hypertension, and cancer) will be counterproductive and lead to diminished standards of patient care.

Due to current resource constraints, countries need to keep their health indicators under constant surveillance to avoid any retrogression in gains made.

Agencies should continue to assist countries in the implementation of environmental health programs, especially to extend the availability of a potable water supply, to facilitate sewering of cities and

urban fringes, and to develop a satisfactory solid waste disposal system.

The experience in primary health care of many senior policy makers in the ministries of health in the Caribbean is such that more use can be made of them as consultants by international agencies.

Some countries have built, are building, or are about to build new hospitals. It is therefore most timely to consider the role of hospitals in primary health care.

Primary Health Care in Guyana and Trinidad and Tobago

CLAUDETTE HARRY-ASHLEY[1]

In preparation for this Workshop, the status of the implementation of the primary health care strategy and action plans in Guyana and in Trinidad and Tobago was evaluated. Interviews were held with staff of the Ministries of Health in both countries in August/September 1988. The situation in these countries was found to be remarkably similar.

There are some areas of deficiency according to the evaluation instrument,[2] as outlined below, but this does not necessarily indicate areas of deficiency in the implementation of the primary health care strategy.

- Although a central planning unit seems to be the preferred option for the incorporation of individual plans into national plans, formulation of health policies and plans are still essentially carried out by the Ministry of Health. The intersectoral committee option seems to be reserved for certain specific areas.
- Community participation as an organized activity and community involvement in training programs, and in planning and implementation of programs, still need much work and commitment. The difficulty seems to lie in the development of mechanisms to ensure this activity.

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[2] The evaluation instrument used was the 25-point action plan adopted at the 1981 Primary Health Care Workshop held at Saint Lucia.

- Manpower policies are urgently required, particularly in the light of the present manpower shortages which seem to be increasing steadily in both countries.
- Development of research and appropriate technology is another area of weakness. This should probably be an activity implemented at the regional rather than national level.

Details of the situation within each activity category in the two countries follow.

Implementation of Action Plan for Primary Health Care in Trinidad and Tobago

Formulation of policies and plans

At the present time no intersectoral mechanism exists for the formulation of national health policies. However, the Ministry of Planning and Mobilization is the central point at which all Ministries' plans are evaluated, approved, and incorporated into the macro-economic plan. Intersectoral committees exist for the formulation of policies and plans in specific areas, e.g., nutrition.

A country health plan, including statements on policy has been developed. This comprehensive plan has been incorporated into the macroeconomic plan, and covers the period 1987–1991. It includes a built-in system of evaluation and feedback strategies. The National Health Plan encourages the primary health care approach and covers 11 priority areas including environmental health, maternal and child health, food and nutrition, and dental health, among others. The plan incorporates strategies for implementation.

Planning and programming have been instituted at the county level. The intention is to apply this at the district level but thus far it has only been tried on a pilot basis at a few health centers.

Very little progress has been made in the area of shifting resources to primary health care. A major reason for this difficulty is that the servicing of secondary and tertiary care facilities must be continued.

Community participation

Active community participation has increased, particularly at the intermediate level. Some local authorities have established health

committees. The most active community participation, however, is through nongovernmental organizations, and in 1985 a workshop was held for NGOs involved in health care to determine their role, particulary their involvement in chronic disease programs.

There is no written policy on community participation. However, the Ministry of Community Development, Welfare, and Status of Women are jointly sponsoring a Consultation on Community Participation aimed at reviewing the role of village and county councils in community participation. County consultations were held between March and May 1988, and a national consultation, with health sector representation, will be held in September 1988 to bring together the recommendations made during the county discussions. It is hoped that guidelines on community participation will be forthcoming following the national consultation.

Management

Much attention has been paid to management, particularly at the county level. A programming manual was prepared in 1984 and updated in 1986. A workshop was held in 1986 to review information systems and supply management. Personnel management and supplies management manuals are in the process of being revised.

Facilities, supplies, and equipment

Health facilities, together with equipment and supplies were listed prior to 1985. Until now, the health centers and supplies have been adequate for the implementation of primary health care. There is a general feeling, however, that there is a need to make laboratory facilities available in a few strategic areas.

A national formulary does exist and consideration is now being given to the preparation of a list of essential drugs.

The installation of an effective supplies management system has been addressed. In 1985 a National Hospital Management Committee, responsible for the storage and distribution of drugs and other supplies was established. The system has improved greatly since that time.

Manpower policy

There is no written document on manpower policy, but manpower needs have been addressed in the national health plan. The

availability of manpower is very changeable, and the situation is presently being reviewed with the aim of making recommendations on new categories of personnel required to adequately service the system. Personnel management policies were included in a health infrastructure document produced in 1986.

Training programs

There have been on-going training programs for county health teams since before 1983. Health center staff and other persons are occasionally included.

Health information

A health information system has been developed, but not specifically for evaluation of the plan to implement primary health care. The system can, however, provide information on what is happening in this area.

Training

Community leaders are involved in county health team workshops, but there are no programs aimed specifically at the training of these leaders.

Research

A health research committee has existed since prior to 1982, and was recently reactivated. This committee, however, is used more for the evaluation of research proposals than for the promotion of research and development of appropriate technology.

Financing

A review is being undertaken at the national level of the financing of the health services.

Implementation of Action Plan for Primary Health Care in Guyana

Formulation of policies and plans

No intersectoral mechanism exists in Guyana for the formulation of national health policies. Within the Secretariat of the State Plan-

ning Commission, there is a unit responsible for the health sector which ensures the incorporation of the health plans into the national development plans.

Intersectoral committees exist for the formulation of policies and plans in specific areas of nutrition. At various times a food and nutrition council within the State Planning Secretariat, and an intersectoral committee for non-formal nutrition education under the auspices of the Ministry of Health have functioned.

An overall health policy in support of primary health care was enunciated in 1982. The Ministry of Health monitors implementation of its health programs on a quarterly basis, and particular attention is paid to the areas of maternal and child health, nutrition, and environmental health, among others. However, this evaluation is not specifically aimed at implementation of the approved regional strategies.

A planning and programming process was developed in 1982 and instituted in 1983. This process is now being utilized at the health center level.

A comprehensive health plan that was scheduled for completion in 1987 has now been re-scheduled for completion in 1989. A health planner has been identified and discussions about establishing a planning unit is in progress.

Although the progressive shift of resources toward primary health care started in 1982, no completion date can be given for this activity.

Intersectoral cooperation is an ongoing activity. Although not specifically aimed at primary health care, it does take place at the regional level.

Community participation

Community involvement exists only in very specific areas, such as in the selection of candidates for training as community health workers, and, on an *ad hoc* basis, the building and refurbishing of health facilities. Some local authorities have health committees, but many of these are non-functional. A priority activity for 1989 is the re-establishment of local health committees which are to be attached to health centers.

Although a written policy on community participation exists, there is still no established mechanism to facilitate it. A short-term consultant was requested from PAHO to investigate the possibilities of such participation.

The examination of the existing health care system was started in 1978, and is considered to be an ongoing activity.

Management

A planning and programming process has been instituted, and a supply management manual has been developed and put into use. Monitoring and evaluation of the management system is carried out on a quarterly basis.

Health information

The health information system has been reviewed on several occasions, and an attempt is being made to streamline this system. The possibility of setting up epidemiological statistical units in each region is under discussion.

Facilities, equipment, and supplies

The necessary facilities, equipment, and supplies to implement primary health care in Guyana have been listed since 1984. A standard list of drugs, including essential drugs was developed in 1982. This has been revised, and a new formulary is to be published in 1988. Although a supplies management system has been in operation since 1983, this has been more effective for non-drug items. Some problems still exist in the drug distribution system.

Manpower policy

Work on the development of a manpower policy was started in 1985, but has not yet been completed. Restructuring of ministries, redesignation of responsibility for manpower planning, and delay in appointment of staff have slowed completion of this activity.

Training

Training programs for personnel working in primary health care have been ongoing for some time in both basic and continuing education. Personnel working in other health service related agencies are included in some of these programs.

Since 1984 no training programs have been held for community

leaders. However, in 1988 captains of villages in malarious areas were trained in the prevention and control of malaria.

Health development and research

Although regional health management teams exist, community health development teams still do not. The formation of such committees is being encouraged, particularly in the hinterland areas of Guyana.

Financing

A review of alternative methods of financing was carried out in 1987 at the national level.

Primary Health Care in Antigua and Barbuda and Dominica

C. ETIENNE[1]

At a Primary Health Care Seminar held in Saint Lucia in June 1981, a strategy and plan of action for implementation of primary health care in the Caribbean was adopted. Countries in the area have since implemented this 25-point action plan to varying degrees. Aspects of this plan were used as an evaluative tool in the following review of the status of implementation of primary health care in Antigua and Barbuda and Dominica.

Antigua and Barbuda and Dominica have several distinguishing features which influence health care delivery. Antigua and Barbuda have a combined area of 176 square miles and an estimated population of 81,000. Rainfall is low, and there are frequent periods of drought. Tourism is the mainstay of the economy. The road network is well-developed, and while there is no organized public system, all areas in Antigua are readily accessible by transport.

Dominica is a mountainous island covering an area of 289 square miles. The population of 80,000 live in small villages scattered along the coast. Rainfall is relatively high, and agriculture (mainly bananas) is the most important contributor to the economy. Most villages are accessible by motor vehicles, but the rugged terrain hinders ready transport.

Dominica suffered a major hurricane in August 1979 which destroyed or damaged most health facilities. This presented a unique opportunity for the reorganization of the health system, and empha-

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sis was placed on development of the primary care sector. The budget address in 1982 clearly stated the Government's commitment to the primary health care approach. Several Dominicans have been trained at the highest level for management of the primary health care system.

The Government of Antigua defined its health policy in 1984 with a stated commitment to primary health care. This commitment is, however, not reflected in budgetary allocations or in the health sector. The planning and managerial process is deficient, and there is a need for urgent assessment and reorientation of the health sector.

Implementation of the Action Plan in Antigua and Barbuda

In Antigua, in March 1986, a national intersectoral workshop on primary health care was conducted. An outcome of that workshop was a plan of action for the implementation of primary health care in Antigua, and a planning committee was formed. Due to the absence of a health planner and lack of commitment on the part of the central Ministry of Health staff, the planning committee remains nonfunctional, and the action plan has not been implemented.

At the highest level, the Cabinet reviews health issues and influences health policy, but there is no established intersectoral mechanism for the formulation of national health policy. In 1984 the Government published its health policy in support of primary health care, and stated its commitment to all national, regional, and international activities necessary to achieve health for all by the year 2000. However, there is as yet no national strategy for the implementation of the primary health care approach. The community nursing service is well-oriented in its thinking, and is committed to the primary health care approach. Regional strategies have been used to guide maternal and child health activities. The maternal and child health manual, which incorporates these strategies, was introduced in late 1986.

Planning and management

There is no formalized planning process, and efforts to secure PAHO technical assistance in this area in 1985/86 proved unsuccessful. An in-depth assessment of the existing health care system preliminary to the preparation of a health plan is needed and is scheduled for 1989.

The health management system is rudimentary. *Ad hoc* meetings are called by the Minister with the Permanent Secretary, Chief Medical Officer, Principal Nursing Officer, and the Matron and Superintendent of District Nurses. These meetings are, however, not specific to primary health care. There is no managerial process to ensure planning, programming, implementation, and evaluation.

Resource allocation

Resource allocation favors the further development of the secondary care hospitals at the expense of primary health care. Since 1976 the budget available for primary health care has remained at an average of 40% of the total. Capital expenditures in recent years have been mainly centered at Holberton Hospital. Personnel and supply allocation also favor hospital services.

Community participation

Neither a written policy on community participation nor national guidelines have been prepared. Health committees have been accepted as the main mechanism to foster community participation. Several health committees were formed as early as 1981, but only four are now functioning effectively. It is hoped that with the establishment in 1988 of district councils, community participation in health, and intersectoral coordination at the peripheral level can be enhanced. Programs for the training of community leaders have not been initiated and need to be considered.

Manpower

There is no manpower policy, stated or otherwise. An urgent need exists for personnel trained at the management level of primary health care. Community nurses have benefited most from training programs at both the local and regional levels and such programs, designed to meet the needs of primary health care, are ongoing. The regional training courses for community nurses have been attended by family nurse practitioners, public health nurses, community nurses, public health inspectors, and dental auxiliaries.

There has been no training for district medical officers. Following the establishment of the model health district in 1988, the first health team was formed. Difficulty was experienced in inducing other

health workers to meet regularly with nurses and to form a cohesive team. Attempts to incorporate representatives from other sectors were unsuccessful. At present, health teams are principally nursing teams.

Facilities and supplies

The island has been divided into six nursing and medical health districts, each comprised of a main health center and satellite clinics. There has been no inventory of facilities needed for the effective delivery of primary health care. New facilities have been provided largely in response to demands by political representatives. Health facility needs for St. John require urgent assessment.

A list of necessary supplies and equipment for the functioning of the model health district was prepared in 1984. In each health district, the public health nurse updates equipment and supply needs for nursing activities.

In August 1988 a list of drugs, representing an initial cautious attempt at rationalization, was completed. The list is very liberal and drugs are listed as vital, essential, or necessary. Further rationalization of a drug formulary is expected to take place, but no target date has been set for this activity.

The drug and supply management system can be immensely improved in terms of inventory control, purchasing practices, financing, and distribution. Central purchasing was introduced in 1985. A management committee, consisting of the Permanent Secretary, Chief Medical Officer, Purchasing Officer, Accountant General, and Accounts Officer, was appointed to control expenditures on drugs and supplies in 1988, but is now nonfunctional. Consideration is now being given to participation in the Organization of Eastern Caribbean States drug service, which would foster rationalized drug selection, improve purchasing practices, and strengthen the local drug management system.

Health information system

A health information system to support the implementation of primary health care is being developed. This process was initiated in 1986, and data forms, supported by a manual, were introduced in all health centers in 1988. The first quarterly report utilizing data collected from the system is currently being compiled. The system is as yet geared only to the support of maternal and child health activities, clinic activities for adults and the elderly, and chronic diseases. The system benefits from the services of a well-trained health statistician and from PAHO assistance.

Legislation

Health laws and regulations date back to colonial days in Antigua and Barbuda. A program for their update is necessary.

Research and appropriate technology

There is no established committee to promote research and appropriate technology. Individuals such as the Principal Nursing Officer and Health Statistician have stated their interest in research. In 1983 Antigua participated in the regional community bases survey in health services utilization.

Regional cooperation

The Ministry of Health supports and attends regional workshops, meetings, and seminars which are aimed at the review of alternative methods of financing the health sector.

Implementation of the Action Plan in Dominica

The implementation of the primary health care approach in Dominica was facilitated by a hurricane in 1979, which severely damaged all health facilities and affected health care delivery. This presented a unique opportunity for Dominican nationals and aid agencies to restructure the health delivery system. A rehabilitation committee was formed in 1979, following the hurricane, and was later broadened to include heads of departments and to function as a planning committee.

A health sector assessment was commissioned in 1980 with PAHO technical advice. The deficiencies in the system were highlighted. These included the maldistribution of resources, fragmentation at the district level as a result of vertical lines of command, and the ill-definition of district boundaries. The decision was made by the planning committee to adopt the primary health care approach, and the drafting of plans for restructuring began. Health districts were de-

fined, and levels of care established. The health team concept was accepted, and composition and functioning of health teams were determined. The first health team was formed in 1981, and by the following year, all district teams had been formed. These teams were comprised of all health workers assigned to, and working within, a health district (including the driver, cleaner, and yardman). Community organizations and other sectors were not given representation on the team, but they worked closely with health teams.

The Cabinet of Ministers was involved in the process and kept adequately informed by the Minister of Health and the planning committee. Health policy determination and plan formulation occurred simultaneously.

A detailed inventory of facilities, supplies, and equipment was taken with PAHO assistance in 1981. Location and distribution of facilities in each district, including staffing and equipment, were determined.

Intensive planning activities occurred in the fiscal year 1980/81. Overall health policy in support of primary health care was finalized in 1982 and presented in the Prime Minister's budget address for that year. A national intersectoral workshop was conducted in November 1982 during which the draft health plan was presented. This three-day workshop was attended by community workers and representatives of local organizations, government sectors, and nongovernment agencies, along with foreign aid donors and agencies. The health plan was adopted with few amendments to cover the period 1982–1987. Objectives were clearly defined and priorities stated, but the required financial resources for implementation were not computed.

Strategy

The focal strategy for implementation of primary health care in Dominica was decentralization. This was introduced in 1982, and continues to be developed. Health care delivery was guided by manuals on environmental health and maternal and child health that were distributed in 1981. These manuals incorporated approved regional strategies and approaches.

Management

With reorganization, vertical lines of command were removed, and a management team was established in each district, consisting of the District Medical Officer, Family Nurse Practitioner, Public Health Nurse, and either the Environmental Health Officer or Pharmacist. The District Medical Officer was the designated leader. Local programming was established in all districts by 1983.

Technical supervisors were included in a central technical committee with responsibilities for program formulation and for the provision of management support to the newly formed teams. Monitoring programs is the day-to-day activity of technical heads of departments, and is supported by in-depth quarterly evaluative reports. Annual assessment and evaluation commenced in 1983 with participation from peripheral workers and the central technical committee for the review and reestablishment of norms, standards, and goals.

Resource allocation

Significant maldistribution of financial resources, manpower, supplies, and drugs existed prior to 1981. Capital expenditures from 1981–1987 were largely focused on primary health care. Following decentralization, district health budgets were established in 1983, and district teams were allowed some control of these budgets.

Community participation and intersectoral coordination

Community participation and intersectoral coordination components of the primary health care approach have been the least explored and least implemented in Dominica. At the highest level, the Cabinet reviews and approves health policy. The Ministry of Health has worked closely with the Economic Development Unit since 1981, with an officer of that department participating in planning activities. Workshops held in 1982 and 1988 to review plans were attended by most sectors.

The Food and Nutrition Council is the best working example of intersectoral coordination. Intersectoral cooperation is informal, but well-developed on the periphery.

Structured community involvement and participation commenced in 1981 in the village of Laplaine with the formulation of the model health district. A detailed policy on community participation with guidelines for implementation was included in the 1982–1988 Health Plan. Formation of health committees was the mechanism established to facilitate and foster community involvement and partici-

pation. The health education unit was given the responsibility of supporting this activity. A total of 36 health committees have been formed.

A review of the status and functioning of health committees was conducted in 1984. This included an islandwide survey of health committee members, health professionals, and community members. The results of the study were presented at a two-day intersectoral workshop in 1985. The recommendations made there have not been implemented.

Extensive training of community leaders was conducted at the local level, with funding from the International Planned Parenthood Federation. Participants included village councillors, teachers, agricultural extension officers, and leaders of sporting, cultural, religious, and other local organizations.

Drugs and supplies

Efforts to decide on a list of essential drugs commenced in 1980. Drugs were categorized by first- and second-line. A list of drugs and supplies for use by each district nurse was finalized in 1981. The initial list was subjected to further rationalization by the Central Drug Committee, which was formed in 1981. The first formulary was published in 1984 and is continually updated. A reprint is expected in 1989.

The management system at Central Medical Stores, the central purchasing unit, was strengthened by the appointments of a chief pharmacist and a supply manager in 1982. Utilizing USAID funds and the expertise of management sciences for health, the management system was revolutionized. This resulted in improved purchasing practices, stock control, and peripheral distribution.

To facilitate purchasing and the prompt reimbursement of supplies, a revolving drug fund was established in 1983. District facilities and hospitals were allocated drug budgets in 1984 from which drugs were purchased from the Central Medical Stores. Computerization of the system in 1983 facilitated stock control and purchasing.

Manpower

A manpower policy has yet to be developed within the Ministry of Health. An evaluation exercise was conducted in December 1987. A new category of worker, the primary care nurse, was introduced and

trained specifically to deliver primary health care. Innumerable workshops and seminars were organized throughout the health districts for all categories of workers. These supported the developments within the system, including team-building exercises, management, and supervision.

Health information system

With PAHO assistance, the development of a health information system commenced in 1981 and was fully introduced in all health districts in 1982. It supports the function of planning, programming, implementation, and service delivery in monitoring and evaluation. A revision of the system was conducted in 1987, also with PAHO assistance.

A major weakness of the system lies in the non-inclusion of the secondary care level.

Research and appropriate technology

No committee has been designated to promote this activity. However, operations research and community surveys are frequently conducted.

Legislation

Legislation is generally outdated and irrelevant to the present system. Regulations to allow the full functioning of nurse practitioners and dental auxiliaries were passed in 1983. A new Mental Health Act was passed, and an AIDS bill was approved in 1987. The Public Health Act is currently under review.

Health care financing

Dominica participates in regional reviews of alternative methods of financing the health sector. A cost-sharing scheme was introduced in 1985, involving Social Security and individual patients.

Regional cooperation

The Ministry of Health cooperates with other Ministries of Health and agencies to promote the implementation of primary

health care. The Certificate Course in Community Health was hosted in Dominica in 1985, utilizing expertise from the Ministry of Health and the primary care system for field experience. Regional training workshops have been hosted on topics including drugs and medical supplies, supervision and management, and family planning management. Dominican health workers assist other countries within the Region in health team development, family planning training, evaluations, and reviews. Dominica is an active member of the Organization of East Caribbean States drug service.

Primary Health Care in the British Virgin Islands and Montserrat

LOWELL LEWIS[1]

Status of Implementation of Primary Health Care in the British Virgin Islands

The British Virgin Islands is one of the four dependent territories of the United Kingdom in the Caribbean. About 12,000 people live on this archipelago of islands, rocks, and cays, which cover a total of 59 square miles and lie about 60 miles to the east of Puerto Rico. The healthy subtropical climate and many sheltered beaches have helped to make the British Virgin Islands a major tourist resort.

The Minister of Health is responsible for all matters relating to health services. He is one of four elected Ministers who make up the local government, responsible for policy and the general direction of the nation.

The health status of the British Virgin Islands is relatively good. In 1986 the neonatal mortality rate was 20 per 1,000 live births, and the crude death rate was 6.25 per 1,000 population. The major causes of death were heart disease, cerebrovascular illness, and carcinoma.

In addition to the hospital and government clinics, a private hospital and seven private medical practices serve the population. In 1986 there were 1,014 persons treated as inpatients. The six leading causes for hospitalization were: complications from pregnancy; diabetes mellitus; arthropathies; diseases of the esophagus, stomach, and duodenum; hypertensive disease; and diseases of the urinary tract.

[1] Director of Health Services, Ministry of Health, Plymouth, Montserrat.

Recruitment of trained health personnel has become a problem due to the continuing migration of young British Virgin Islanders to the United States. Most foreign staff come from Jamaica and the other East Caribbean Islands, but several vacancies in the health system usually remain unfilled.

A good infrastructure has been established, with good roads, improving water, sewage and refuse disposal services, and readily available sea and air transport to and from the British Virgin Islands.

Primary health care programs are considered a priority by the Ministry of Health, but there are reservations by some staff who are of the opinion that emphasis on primary health care distracts from a total development of health care services, and that the primary health care strategy may not be the most appropriate for the British Virgin Islands.

Not many persons interviewed were familiar with the 25-point action plan developed at the 1981 primary health care workshop in Saint Lucia, but the process of development of health services that has taken place over the last 10 years coincides closely with the strategies set out in that plan.

A national intersectoral workshop was conducted in the early 1980s, but no intersectoral mechanism for the formulation of national health policies and plans has been established. The Minister of Health is eager for input from the Departments of Agriculture, Social Services, Tourism, and Labor, and supports the idea of intersectoral cooperation of health planning.

The annual health reports for 1980 to 1985 presented policy statements in support of primary health care. The priorities in health care coincide with the regional priorities of environmental health, maternal and child health, food and nutrition, and dental health. Some effort is being made to incorporate the planning process at all levels of the health service. A detailed five-year health plan was prepared in 1983, and most of the objectives of this plan have been achieved. The health department has begun preparation of a new five-year plan.

Several of the health officials interviewed were of the opinion that there has been no shift of resources in the direction of primary health care, and that there has been no restructuring prompted by the regional primary health care plan. However, the existing district clinic service and health education program ensure that a significant proportion of resources have traditionally been allocated to the primary health program.

The existing management system allows a satisfactory level of planning, program implementation, and monitoring of health services. However, evaluating mechanisms were not identified.

The facilities necessary to allow the implementation of primary health care have been present in the British Virgin Islands since before 1980.

The British Virgin Islands has joined the East Caribbean drug service, and has accepted their new formulary for regular use. The supplies management system is good.

A manpower policy is represented by the approved list of established and non-established workers.

There are no specific programs for the training of community leaders, and no primary health care community health development teams. However, much of the training of health personnel encompasses aspects of the regional primary health program.

Although there are neither written policy nor guidelines on community participation, a high level of volunteer activity by the Red Cross, the Mental Health Association, and church groups ensure that community participation in health care takes place.

There is no committee to promote the development of research and appropriate technology.

The British Virgin Islands has undertaken a critical review of the financing of health services, and most of the existing health legislation is being reviewed and updated.

The British Virgin Islands actively participates and supports the primary health care activities of the CARICOM States and Secretariat, and the primary health program of PAHO/WHO. The health care system of the British Virgin Islands has been developed appropriately. The imminent establishment of an intersectoral group and increased community participation is expected to allow further progress toward achieving the objectives of the primary health care concept.

Status of Implementation of Primary Health Care on Montserrat

Montserrat is one of four United Kingdom dependencies in the Caribbean. It is 39.5 square miles in size, and situated 26 miles to the southwest of Antigua. Just under 12,000 people live on this rugged, mountainous, volcanic island. The major industrial activities are centered around agriculture, tourism, and construction. In addition,

there are small-scale operations involving electronics assembly, garment manufacture, woodworking, and handicrafts.

Internal affairs of the Government are the responsibility of the elected Executive and Legislative Councils, while external affairs and defense are conducted by the Government of the United Kingdom.

The health of the population of Montserrat is relatively good. In 1987 the infant mortality rate was 28.2 per 1.000 live births (the mean rate for 1983–1987 was 17.0); the crude death rate was 10.5 per 1,000 population. The principal causes of mortality were cerebrovascular accident, heart disease, hypertension, malignant neoplasms, pneumonia, and other respiratory diseases. Hypertension and diabetes mellitus are very prevalent.

Most activities of the Ministry of Health are organized through working committees, and there is an attempt to incorporate the planning process at all levels of the health services. A draft list of health programs has been in circulation since 1985, but no comprehensive health plan has ever been prepared. District clinic services, health education, and encouraging community participation are priorities of the Health Department. The management system allows planning, programming, implementation, monitoring, and evaluation of services. However, staff shortages do not allow these activities to be done as promptly and as efficiently as desired.

The facilities needed for the implementation of public health care are present, and a national drug formulary has been in use since 1986. The supplies management system requires more staff and more money in order to function more effectively.

While there is no written policy or guidelines, community participation does occur throughout the island. There are primary health care committees in each of the three districts. Activities of these committees are coordinated by the Public Health Nurse for each area. Numerous health-related activities are organized by the Red Cross, Old People's Welfare Association, Family Planning Association, St. John's Ambulance Brigade, church groups, and service clubs. There have been weekend camps and workshops for the training of community leaders.

Research committees supervise three ongoing research projects in the areas of intestinal parasite control, developmental screening, and mosquito transmission of diseases.

The Ministry of Health is presently planning a change in the financing of health services. New legislation includes regulations for

district health services, and for the control of food, drugs, and cosmetics.

Montserrat actively participates in and supports the primary health care activities of the CARICOM States and Secretariat, and the primary health care programs of PAHO/WHO.

The Health Department and Ministry of Health are fully committed to primary health care and have made every effort to implement all the components of the regional 25-point action plan. A multisectoral workshop in 1985 was promptly followed by establishing an intersectoral National Primary Health Care Committee, which was chaired by the Minister of Health.

The current draft health plan lists the following policies:

1. To further organize the health care system utilizing the primary health care approach;
2. To provide comprehensive integrated services which are affordable, which allow for active community participation, and which utilize multidisciplinary approaches;
3. To refine current strategies for health care delivery.

Primary health care is a priority of the Government of Montserrat, but there is a need for more public education and community participation. An increased input of resources and a slowing of the emigration of trained persons are also needed to allow full implementation of an effective primary health care program.

Part II. Development of Local Health Systems

Current PAHO/WHO Policies and Strategies to Achieve Health for All—Local Health Systems

José María Paganini[1]

The current policies and strategies of the World Health Organization (WHO) and the Pan American Health Organization (PAHO) for achieving the goal of health for all by the year 2000 have come about as a result of a series of decisions made in the Region of the Americas beginning in the 1960s.

International Participation in Establishment of Primary Care Strategies

In 1961 the First Health Plan for the Americas was defined, wherein the Punta del Este Agreement identifies the health sector as both the object and the subject of development. The governments of the Region set their objectives and goals for the decade by adopting the Ten-Year Health Plan for the Americas in 1972. In 1977 the World Health Assembly (WHA) defined thé goal known as "Health for All by the Year 2000," which is to achieve for all world citizens a health level that would allow them to lead socially and economically productive lives. In that same year, the Meeting of Ministers of Health of the Americas identified primary care as the basic strategy for achieving health for all.

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In 1978 in Alma-Ata, USSR, the International Conference on Primary Health Care was convened under the sponsorship of WHO and UNICEF. It was asserted at Alma-Ata that primary health care, as a central function of the national health system and as an integral part of social and economic development, is the key to achieving health for all by the year 2000.

Since its first formulation, the concept of primary health care has progressed continually, so it is necessary to clarify its current status. Primary care is a global strategy for comprehensive health system development. It is a strategy which, when applied to the present health system and its future development, leads to very important structural changes.

The strategy includes the following components:

- The health system is viewed as a component of social development and an instrument of social justice.
- All populations are covered with no restrictions whatsoever; that is, the principle of universality is applied.
- The issues of the economic, cultural, and geographical accessibility of the most needy are addressed, applying the principle of equity.
- The community plays a fundamental role in decision making regarding its own health care and its active participation in the entire system.
- Extension of health services coverage and environmental improvement are considered to be fundamental. These include: development of intersectoral articulation; development of research and appropriate technology, human resources, and the availability and production of supplies and equipment; establishment of national financing systems for the sector; and reorientation of international cooperation.

Once the basic components of the strategy of primary care have been defined, the following nine essential elements of action can also be specified:

1. Health education
2. Promotion of food supply and proper nutrition
3. Adequate supplies of pure water and basic sanitation
4. Maternal and child care, including family planning
5. Immunization
6. Prevention and control of endemic diseases

7. Appropriate treatment of chronic diseases and accidents
8. Promotion of mental health
9. Provision of essential drugs

The strategic components of primary care and the essential elements listed above exemplify the new approach and change in the structure of the health system.

In 1979, the world's governments approved the Alma-Ata Declaration and the Strategy of Health for All by the Year 2000. In 1980, with the participation of the governments of the Americas, PAHO defined the Regional Strategies for Health for All by the Year 2000.

In 1981, the Directing Council of PAHO adopted the Plan of Action for Implementation of the Regional Strategies. This plan includes the minimum goals and the regional objectives, as well as the actions that the Governments of the Americas and PAHO should carry out in order to achieve health for all by the year 2000. Agencies such as the Organization of American States (OAS) and the Economic Commission on Latin America and the Caribbean (ECLAC) have adopted this proposal and included it in their plans of work.

In September 1986, the XXII Pan American Sanitary Conference, made up of health authorities from all the countries of the Region of the Americas, emphasized the need for all countries of the Region as well as for PAHO to give priority to health infrastructure development through decentralization. Three programming priorities were defined in the document "Orientation and Program Priorities for PAHO During the Quadrennium 1987–1990":

- Development of the health services infrastructure with emphasis on primary health care;
- Attention to health problems present in vulnerable human groups with specific programs implemented through the health services system; and
- Management of the necessary knowledge to accomplish the two preceding priorities, in accordance with a management strategy for optimum utilization of PAHO/WHO resources.

In addressing the development of health infrastructure, the above-mentioned document on programming priorities states that in order to achieve equity, efficiency, and effectiveness in health actions, and to ensure that services are available for the entire population through broad application of the strategy of primary health care, it

will be necessary to implement more effective planning methods to develop the services, and to improve their management to reflect local programming needs. These are objectives that can be achieved through effective political and administrative decentralization.

At its September 1988 meeting, the XXXIII PAHO Directing Council approved Resolution XV and Document CD33/14, which establish the need to support the development of local health systems as a basis for the reorganization and reorientation of the health sector.

Social and Economic Impact on Health Systems

What is the reason for this renewed interest in decentralization and local health systems? It is possible to mention some factors that might explain renewed interest in finding a development strategy of health infrastructure based on the decentralization and local health systems.

The economic crisis had its inception at the beginning of the 1980s and continues to affect most countries in the Region. We should remember that from 1981 to 1986, per capita GNP in the Region of the Americas declined 8% (ECLAC data) to its 1977 level—a setback of nearly 10 years. The persistence and depth of the crisis is a matter of serious concern; in 1986, 12 countries of the Region continued to show a decline in their growth rates. According to the Inter-American Development Bank, the accumulation of capital fell from a positive average annual rate of 7.3% during the 1970s, to a negative average annual rate of 4.5% during the period 1981–1986. This has resulted in a steady decline in the creation of new employment and a comparable rise in the rates of unemployment and underemployment, along with an estimated 15% deterioration in the real value of wages. Here, too, the figures have declined to the levels attained during the 1970s.

The problem of the economic crisis cannot be discussed without mentioning the external debt. The Latin American and Caribbean nations had a debt of more than US$382 billion in 1986. To most countries this has meant a debt service payment of between 35% and 40% of their export gains. This led to the paradoxical situation of poor countries transferring resources (amounting to US$130 billion in 1982) to rich countries.

The effects of the crisis are evident throughout the Region and the social sectors are the most severely affected. The problems confronting the health sector and the health services are dependent on the socioeconomic situation described above. Budgetary limitations, low wages, the inability of the most disadvantaged populations to pay for services, and the limitations of critical investments are obvious consequences of this crisis.

In addition to the economic crisis, the explosive increase in population—from 370 million in 1980 to a predicted 600 million by the year 2000—brings about problems such as rapid urbanization (by the year 2000, 75% of the population will be living in cities), the increase in the population of elderly persons and the resultant increase in chronic diseases, the persistence of diseases specific to underdevelopment, such as the infectious and the parasitic diseases, and the increased demand for technologies that cannot always be justified. All of these factors working together complete the picture of the situation confronting most of the health services of the Region today.

Finally, there are also problems internal to the health infrastructure itself, which may be summed up as the steady or increasing lack of effectiveness and efficiency in health services operation. The Latin American and the Caribbean countries invest around US$40 billion per year in the health sector (an annual average of US$100 per inhabitant). It is estimated that approximately 25%, or US$10 billion, of this amount is wasted through inefficiency in the operation of health services.

It can be concluded that the health systems are currently faced with serious problems which are rooted in the socioeconomic situation, and others which grow out of weaknesses in the organization and administration of the health services themselves. An estimated 135 million people in the Region, approximately one-third of the population, do not have adequate services.

The magnitude of the current challenge is clear. While facing a very difficult external situation, the health services must achieve coverage for an estimated 135 million people, and in addition must be prepared to serve the 160 million who will be added to the Region's population by the end of the century.

The Challenge of Decentralization

It is clear that the solutions for the health sector must come from a change in the overall socioeconomic situation of the Region. In ad-

dition, the health sector must contribute its own solutions to solve some of the sector's internal problems and to face the current crisis.

The organizational restrictions in the overall conduct and in the technical-administrative management of the health sector that contribute to a lack of equity, efficiency, and effectiveness in the services, as well as a decline in quality, should be solved. Among these technical and administrative limitations is excessive centralization in management that prevents the local health systems from developing a level of responsibility that will allow them to resolve their populations' health problems. Analysis of this excessive centralization has increased due to recent democratization of several countries of the Region, and calls for the social sectors and the health services, in particular, to provide an immediate response to the demand for increased participation and social justice, and to find better solutions to the problems of health and disease.

These sociopolitical, demographic, epidemiological, and financial factors justify the decision of the governments of the Region to renew their search for an organizational response to the challenges that currently confront the health systems. It is in this respect that decentralization and local health systems become the linkage for the reorientation and reorganization of the sector through increased development of the local health systems.

On this subject, Dr. Carlyle Guerra de Macedo, Director of the Pan American Sanitary Bureau, stated:

> There are common elements to any national strategy, and outstanding among them is decentralization. In fact, universal experience points toward the excessive centralization and lack of coordination as fundamental factors in the inadequate operation of the health services and the inefficiency of present systems. It is, therefore, essential to promote the necessary reorganization toward an effective decentralization, thus ensuring the required coordination. The establishment and strengthening of the local health systems, serving specific populations within defined geographical areas, should provide a basis for redesigning and developing the health system at all care and administration levels. Decentralization, then, does not imply the division of the health systems, but it encourages a cooperative interaction of its components which energizes all in relation to one essential objective: health for all.
>
> A local health system must bring together all the existing resources in a given area so that they will be used more effectively and be adapted to the local reality. And above all, a local health system must establish a relation of mutual responsibility with the population it serves. This relationship is the key to adequate and efficient operation

> as it creates the appropriate conditions for the technical-administrative programming and evaluation and for the social evaluation through true community participation. Achieving decentralization is, however, a very complex task. Beyond its technical and administrative characteristics, it implies a change in the distribution and exercise of power, which demands a firm political will and commitment without hesitation *(1)*.

In this statement, Dr. Macedo clarifies the elements of a process that is already underway in most countries of the Region. It is not a question, therefore, of forgetting the past or neglecting positive experiences, but rather of reviving an old concept which for a number of reasons was not completely applied.

Local Health Systems

It is not possible to define all the characteristics of local health systems, since each country has its own definition, based on specific historical, political, and administrative determinants. However, the Region as a whole has already identified certain characteristics that are basic to the development of these local health systems.

In the document entitled "Development and Strengthening of Local Health Systems in the Transformation of National Health Systems" (CD 33/14), PAHO introduced the following for consideration by the Member Countries:

- A local health system constitutes a proposed division of the work of the national health systems based on geographical and population factors in urban or rural areas.
- This population and geography-based proposal is influenced by the needs of the population defined in terms of harm and risks.
- The responsibility of the local health systems is to provide care for individuals, families, social groups, communities, and the environment, by coordinating the resources available in the health sector as well as extrasectoral resources and by facilitating social participation.
- Local health systems can integrate health resources, including hospitals, health centers, and health posts, to create a network of interrelated services with levels of care that meet the health needs of the population.

- Local health systems are a fundamental part of the national health systems, which serve to introduce vitality and indicate new directions. Therefore, local health systems should be viewed as the basic organizational units of a larger body that is fully articulated into the national health systems.
- Community participation that grows out of a relationship of mutual responsibility is of fundamental importance to the development of the local health systems.
- The size of local health systems varies in accordance with the situation of each country, but it is desirable to attain an operative level that reaches at least the second level of complexity, combined with an efficient use of resources.
- Local health systems provide the setting for closer articulation of the programs that are developed to serve the needs of the population within the structure and operations of the existing installed capacity.
- In addition to the technological capacity that will provide the strength to resolve the health problems in their areas of operation, local health systems should also possess adequate technical-administrative capacity in the areas of planning, administration, information, and epidemiology, along with a core of adequately trained human resources.

The following definition of the district health system was adopted by the WHO Global Program Committee in 1986:

> A district health system based on primary health care is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private, or traditional. A district health system, therefore, consists of a large variety of interrelated elements that contribute to health in homes, schools, work places, and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic, and logistic support services. Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative, and rehabilitative health activities. *(2)*

Formulation of Integrated Health Programs

In view of the above, local health systems should therefore be considered to be a fundamental strategy for reorganizing and reorienting the health sector based on the strategy of primary care in order to achieve equity, effectiveness, and efficiency.

Local programming using the risk approach is an essential component of this concept. It calls for organizing and integrating programs and activities for care of individuals, families, the community, and the environment in a coherent, harmonious, and logical fashion so as to reflect the true needs of the population.

Implicit to any definition of local health systems and local programming, therefore, is the attempt to go beyond isolated efforts. The idea is to pursue activities aimed at specific populations, arranged by age groups, pathologies, or particular preventive or curative actions, in a unified effort by the entire health system to organize its resources and tasks so that they answer the true needs of the population and address its principal health risks. It is an integrating approach both conceptually and operationally.

Local programming must also be flexible so that it can respond to continuously changing epidemiologic and social needs as evaluated in terms of equity, effectiveness, and efficiency of the services. For this reason, it should not be confused with certain practices in the local services wherein, under the name of local programming, proposed activities in the area of standards of care are carried out in isolated fashion, often without any allowance for either integration or ongoing evaluation. Local programming, as needed for the development of local health systems and the reorganization and reorientation of the sector, calls for far-reaching methodological and conceptual changes in most current programming practices in the services. It will be necessary to explore more global approaches with greater flexibility, such as strategic situational planning, so that, while remaining operational, there can be a qualitative improvement in the programming strategies in the services.

This is a priority area for research in health services; however, the necessary changes cannot wait. Accumulated experience makes it possible to define certain essential conditions or prerequisites to direct the reorganization of the sector. The first is an adequate and clear definition of health policy that does not simply establish the existence of the local health systems, but rather grants them real power to implement government health policy.

This definition of policy should be communicated and respected by all levels of the health system. This will mean making some changes, including altering the roles of the central levels, which should support the development of local health systems without creating parallel or "vertical" organizations in each area of interest. The tasks of producing, researching, and standardizing information should not be organized or divided in the same way as the task of conveying knowledge to the population. When conducting research and producing information, it is acceptable to divide the work according to disciplines or specializations. However, when relaying knowledge, the work should be arranged according to the needs of the population, so that it will be possible to define comprehensive actions to resolve the specific sets of health problems found among the most neglected members of society. Despite the fact that these concepts may, in principle, appear to be very simple and well-accepted, the tasks involved constitute one of our greatest challenges. It will be necessary to make substantial changes in the way that health actions are defined, programmed, and carried out. We must move away from the classical division of tasks according to disciplines or specializations, and instead move toward integrated actions aimed at specific sets of problems.

At the same time that the political and conceptual aspects of the role of the central levels are being redefined, the approaches to the financing and allocation of the budgetary resources must be reformulated as well. The allocation of funds at the central level according to "vertical programs" or pathologies must be replaced by budgetary allocations to the local health systems so that they may carry out integrated health activities in the populations they serve. Changing allocation by pathology to allocation by population will make it possible to set priorities in relation to the health needs and risks of the specific populations within each local health system.

These changes in the policy as well as the technical-administrative role of the central levels should be complemented by such development in the local health systems. Local health systems should not be seen as the passive receivers of the health programs defined at other levels, but rather as the true agents in the integration of all medical and socio-epidemiological knowledge oriented toward the actual needs of the population. The operational and conceptual weakness of local health systems is one of the reasons why the programs originated at other levels are carried out at the local level without the necessary integration.

Local health systems, with the participation of all health personnel and the community, can serve to integrate this knowledge. Thus the local health system becomes a "melting pot" that receives information from the different disciplines and specializations and then processes it in relation to the needs of the population, the operational strategies, the availability and types of resources, and the epidemiological profile of the population, including its main health risks. This combined information from various fields and disciplines is then transformed into comprehensive actions oriented toward health promotion, disease prevention, cure, and rehabilitation, as well as toward the environment.

A View of the Future

These political, conceptual, and operational definitions must be accompanied by development in two fundamental areas. One of these is research to evaluate ongoing experiences and to facilitate the creation of new approaches and methodologies; the other is continuous training for all health personnel and the community in order to give them the necessary technical knowledge and awareness of their joint responsibilities in achieving HFA/2000.

The efforts to decentralize and develop local health systems as a strategy for reorganization and reorientation of the sector need to be accompanied by scientific participation to create and renew policies, concepts, and methods.

Since research topics arise from real situations and related problems, it is possible to make a first approximation of the areas to be addressed based on some recent documents and ongoing experiences in the Region.

The first topic to be considered should be the appropriate size of local health systems: How can equity, efficiency, and effectiveness be achieved within a territorial unit? What units of care should be established and at what level of complexity? How is it possible to achieve a balance between geographical accessibility and the minimum resources needed to ensure quality, efficiency, and regularity of care? It is evident that there is no single answer to these questions since each country is influenced by different political, administrative, and sociodemographic factors.

Proposed research can facilitate decision making in this area. To address the above topic as well as issues of decentralization and cen-

tralization, research should also be conducted on the appropriate balance between the strategies defined at the central level of the health services, and the possibility of adopting these strategies to resolve specific problems at the local level.

Balance and coordination between central and local strategies should also be developed within the local health systems. Another important area of research should examine such questions as: How can health care activity be achieved so as to avoid division by disciplines and specializations? How can the quantity, type, and distribution of existing resources be adapted on a joint and coherent basis to resolve the priority problems of the population?

This area of research is also related to the topic of coverage of the services. How could current concepts of coverage that measure the activities of the services be made to reflect actual coverage, wherein each person, family, or population group has the security of having been allocated sufficient human and technological resources to provide comprehensive health care? How can individuals receive and utilize these resources in accordance to their needs for health promotion and disease prevention, cure, and rehabilitation? This new approach to population-based and integrated coverage is related to the issue of equity and the establishment of priorities for populations at risk.

In addition to epidemiological and population-based health services research, there are other research areas having to do with the specific structure and internal management of the health systems. The various established technological approaches and care models should be evaluated in terms of their achieved effectiveness and efficiency as well as their capacity to resolve health problems of the population through a network of services that are articulated and structured according to levels of complexity, and that share joint responsibility for a given population group.

Continuous training of all the members of the health team should be accompanied by research that develops and evaluates methods for facilitating the educational process. The nature and organization of human resources in a decentralized decision-making situation, as well as the level of commitment to the proposed transformations, merit examination.

There are clearly many other possible research areas that could be explored. It should be noted that health services research needs to be an essential component of any process of reorganization and reorientation in the health sector so that, in each case, the relationship between the proposed reorganization and the equity, effectiveness, and

efficiency achieved may be evaluated. Despite its importance, research should not delay or limit the action, but rather should serve to motivate and support any urgent decisions that must be made in order to solve pressing health problems.

We are challenged to act and to reflect on these issues as we work together in approaching the goal of health for all by the year 2000.

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Evaluation of the Status of Local Health Systems Development in Select Caribbean Countries

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Introduction

Local health systems may be defined as the basic organizational units that interlock into a much broader, more comprehensive national health system. While the latter determines policy for national health development, and coordinates the health system, the former should be the focal point for peripheral planning, management, and implementation of the primary health care strategy. The development of local health systems, with emphasis on primary health care, is expected to facilitate transformation of national health systems in such a way as to ensure greater equity in health status between the different population subgroups of countries.

The proposal to transform national health systems was initiated at the XXII Pan American Sanitary Conference in September 1986 in Resolution XXI, which also established priority programs for the Pan American Health Organization. If pursued, these priorities should help the subregion meet the goals set for Health for All by the Year 2000.

This report falls within the mandate of that Resolution and sup-

Note: This paper is a condensed version of Dr. Bowen-Wright's *Final Report for Evaluation of Local Health Systems Development in the Caribbean Subregion*, prepared for the PAHO/WHO Office of Caribbean Program Coordination, Barbados, October 1988.

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ports the objectives of the WHO/PAHO/CARICOM initiative for Caribbean Cooperation in Health (CCH). The commissioning of this report reflects in part the response of the CCH initiative, and particularly that of the PAHO/WHO Office of Caribbean Program Coordination (CPC), to assist in furthering the process of local health systems development in the countries of the Caribbean. Information derived from this evaluation could set the stage for further interventions, strategies, and activities, many of which might be implemented through CCH.

The methodology for this evaluation involved literature research and field visits. In order to standardize data, an evaluation instrument was designed in preparation for visits to six select Caribbean countries. On those visits, interviews were conducted with a variety of officials of local and national health authorities. The visits afforded an opportunity to gather microdata on local health systems that were not always available in national and international health documents. The author was able to see and experience local health systems development, and to appreciate the difference between stated intentions and actual implementation.

Background Information

Recent evaluations on progress made toward Health for All by the Year 2000 in the Caribbean and Latin America indicate that much needs to be done to achieve the set goals. In this Region, an estimated 700,000 deaths which occur annually could be prevented with effective public health measures and application of the primary health care strategy. This situation underlines the urgency of implementing the programming priorities defined by the XXII Pan American Sanitary Conference in 1986 *(1)*. Those priorities for 1986–1990 are:

Development of the health services infrastructure with emphasis on primary health care;
Attention to the priority health problems of vulnerable human groups, through specific programs implemented under the health services system;
The process of administration of the knowledge needed in order to carry out the two preceding activities, in accordance with the management strategy for optimum utilization of PAHO/WHO resources.

These priorities influenced the nature of the indicators used in this evaluation of the development of the local health systems in the Caribbean.

The primary health care strategy

Primary health care should not be confused with service delivery of basic health care at the community level. It is an expensive, but very cost-effective approach to maintaining health status and bringing equity in health to all countries, but to developing countries in particular, over the long-term.

Primary health care must be supported by a reliable information system which supports planning, monitoring, evaluation, and replanning. More importantly, these data are the basis for shifting and/or redeploying resources within the national health system to promote primary health care through development of local health systems.

Local health systems development

The characteristics of the local health systems will differ from country to country as each fashions them to suit particular demands. However, the fundamental principles to be applied to develop such systems will be similar. These should include: (a) a move away from vertical schemes of management which will lead to decentralization and delegation of management to the implementation at the community level of the national health system; (b) service provided to identified population groups or a defined geographical catchment of population; and (c) a management system at the local level. Such management should also seek to coordinate actions (inter- and intrasectoral coordination) to be taken by different sectors in the promotion of health for the defined population groups to be served. A local health system should also have structures developed to facilitate social participation.

Based on the above, examination of an effective local health system should demonstrate the following 10 aspects *(1)*:

1. Reorganization of the central level to ensure that clear policies are in place to guide the local health system;
2. Decentralization of controls and delegation of actions to appropriate local levels;
3. Strengthening of administrative capacity at the local level to support (2) above;

4. Intrasectoral cooperation within the health sector and intersectoral interaction with other sectors, e.g. education, agriculture, and water agencies;
5. Development of a network of local health facilities, well linked to the central and higher levels of care, with interaction between different levels;
6. Adjustment of financing mechanisms to give some financial autonomy at the local level;
7. Presence of structures to support social participation—these could be formal and/or informal;
8. Integration at the local health system level of preventive and control programs;
9. Training of the work force in health (not only in medical care);
10. Ongoing research to promote changes in approach and intervention for better health care delivery.

Current Status of Local Health Systems in Select Caribbean Countries

Evaluation process

The evaluation process, a valuable management tool, should be based on careful assessment and critical appraisal of given situations which should give rise to sensible conclusions and *useful proposals for future action*. The process is never intended to pass judgment on those responsible for policy and implementation.

Throughout the process, suitable indicators—preferably measurable—should be used. It must be realized, however, that some health activities have no suitable or measurable indicators. Hence, pertinent questions need to be asked concerning the activities to be evaluated. These considerations guided the approach to evaluating and comparing health systems development.

Objective indicators

Table 1 reveals that the availability of recent, well-standardized information is generally lacking, making comparisons within the Caribbean subregion difficult. Second, with the exception of life expectancy, some countries will not meet the goals set for the year 2000. Finally, the data on neonatal death rates, stillbirth rates, and maternal mortality rates, which are very sensitive indicators, are even more

TABLE 1. Trends in international health indicators for select Caribbean countries in 1985 and 1986 and comparison with goals set for Health for All by the Year 2000

Country	Health indicators (per 1,000 population)										
	Infant mortality rate	Neonatal death rate	Stillbirth rate	Death of children age 1–4 years	Maternal mortality	Live births per 1,000 women	Natural increase	Crude birth rate	Crude death rate	Life expectancy (years)	Population size
Jamaica	27	NR	NR	3.0	1.0	100	17.4	23.1	6	70	Large and diverse ethnic groups
Cayman Islands	11	8.3	2.8	0.6	2.7	63	12.5	16	6	75	Small and diverse ethnic groups
Bahamas	25	16	NR	NR	0.9	19	1.9	24	6	70	Small but homogeneous
Turks and Caicos Islands	32	15	32	2.0	0	122	NR	29	10	NR	Very small, homogeneous
Belize	23	NR	NR	1.7	NR	NR	NR	35	5	71	Small population and diverse ethnic groups
St. Kitts and Nevis	40	29	14	1.6	1.9	110	NR	23	11	70	Small and homogeneous population
Goals set for HFA 2000 (PAHO)	30	—	—	2.4	—	—	—	—	—	70	Cultural norms may impact the goals negatively or positively

Note: NR = not retrievable.

revealing. They speak to the quality of care being given in the maternal and child health programs with primary health care—a priority area in the Caribbean for at least the last 10 years.

In the Caribbean much attention has been given to coverage, and corresponding figures are impressive. If goals are to be realized and further improvements made, the local health systems need further strengthening. For example, qualitative indicators, and not just traditional quantitative data, should be closely monitored. Relative to maternal and child health programs, information gleaned from microdata suggests that attention should be given in the following three areas:

Linkages. The quality of maternal and child health at the level of the local health systems will only improve significantly if resources are optimally maximized so as to improve care for high-risk mothers and infants at the higher levels of care within the systems.

Transport/communication. Transportation and communication are generally inadequate within local health systems, so need to be improved.

Protocols. Procedural manuals, norms, and standards need to be updated and/or developed, where none exist. This would minimize the incidence of mismanagement of patients being cared for at an inappropriate level within the local health system.

The data presented in Table 2 represent other objective indicators that speak to the realities of health status at the community and national levels. Some, such as the prevalence of diseases preventable by immunization, will reflect the quality of the EPI program. They also give indications as to infrastructure in place at the local level to support EPI in the context of primary health care.

The data suggest that some infrastructure is in place to support EPI. The prevalence rates of diseases preventable by immunization were in keeping with the generally high coverage rates. However, some data must be interpreted with caution as they perhaps represent underreporting and/or misdiagnosis, for example, in the case of measles and pertussis.

Field visits to selected countries revealed the precariousness of the cold chain in many. It is not surprising, then, that sporadic out-

TABLE 2. Prevalence of diseases preventable by immunization per 1,000 population in selected Caribbean countries, 1985–1986

Country	Polio	Diphtheria	Pertussis	Tetanus	Measles (rubeola)	Tuberculosis
Jamaica	0	.003	.008	0	.01	.004
Cayman Islands	0	0	0	0	0	0
Bahamas	0	0	0	0	NR	NR
Turks and Caicos Islands	0	NR	NR	NR	NR	NR
Belize	1	NR	NR	NR	NR	NR
St. Kitts and Nevis	0	0	0	0	5	0

Note: Field visits to Bahamas and Turks and Caicos Islands may have yielded more data since examination of mortality and morbidity statistics at local level often yielded information not available in national and international documents of the countries included in this table.

breaks of some EPI diseases have occurred over the last decade (1978–1988), and, as indicated in Table 2, occasional outbreaks of poliomyelitis and measles were still occurring in 1985 and 1986 despite improvement in coverage of the target population.

Subjective indicators

In an attempt to evaluate developments at the local level, certain non-objective indicators were used. These were not measuring a specific level of performance but could substitute for a more objective type of measurement. For example, the continuing occurrence of typhoid may be a proxy for water quality and/or excreta disposal facilities. Using this approach, correlations were made and conclusions drawn. Data regarding integral elements of the local health systems are presented in Table 3.

When national data of select countries are examined, the high prevalence rates for some communicable diseases such as leptospirosis suggest an unsatisfactory status of solid waste disposal and animal health. In four countries visited, this situation was observed. Similar reports have been received from other country officials interviewed. This is an area that CCH might seek to address though a subregional project, as it seems to be a problem in almost all local health systems. In the countries visited, there was no evidence to support the existence of infrastructure (either in terms of equipment or enough trained personnel) to execute efficient and effective solid waste management.

TABLE 3. Occurrence of select communicable diseases in data reviewed for 18 Caribbean countries (1982–1986)

Disease	Number of countries	Percentage of countries	Remarks
Typhoid	4	22	Many countries have not had any cases in the past 10 years
Dysentery	0	0	This should be viewed with caution, as it may be recorded as a diarrheal disease
Leptospirosis	10	55	Suggests need for rodenticide program and surveillance of animal vectors
Dengue	5	27	The figure should be viewed cautiously as based only on virology confirmation
Diarrheal diseases (excluding dysentery) 0–5 years old	18	100	This suggests that more research needs to be done on the pathophysiology of the disease to be able to improve intervention
Hepatitis	6	33	Typhoid is being eradicated, so Hepatitis A may be the new indicator for water quality

The health information system at the local level must be strengthened. Many data are being collected at the local level, some accurate and very meticulous. However, at the local level health workers need more training to use the data. This would motivate them to utilize data collected for planning, monitoring, and evaluating at the local level. More importantly, the skill would help them to develop a more critical eye for data and improve capability for analysis.

Comparative Performance of Caribbean Countries in Local Health Systems Development (1981–1987)

As mentioned previously, there are 10 basic aspects of an effective local health system. In her evaluation of development in 1981, Moody focused on what she termed infrastructure *(2)*. She summarizes as follows: "Infrastructure involves the identification of the levels of care to be given, the places from which it will be given, the people who will give it and the support services required." The indi-

cators she used to assess infrastructure development, and which will be used here to facilitate comparison, were:

(a) Coverage
(b) Population ratio
(c) Accessibility
(d) Levels of care
(e) Personnel
(f) Communication and transport
(g) Support (management) systems
(h) Finance

Indicators for infrastructure development

(a) *Coverage*

While not all 18 of the Caribbean countries studied were visited, indications from documentation suggest that in over 75% of countries, coverage of the population approaches 100%. In those not achieving 100%, the problem lies in inadequate support systems to execute coverage. For example, in two countries studied in detail, technology reminiscent of developed countries exists on the main islands and in main urban centers, but indicators such as infant mortality rate and maternal mortality were vastly different in the rural areas. This was a direct result of inadequate transport, communication, and capability to deploy personnel to the rural areas/islands. Unfortunately, in the seven years since Moody's evaluation, changes have been only modest and even very marginal in some countries. Adequate physical facilities exist and levels of care have been determined in almost all countries of the subregion.

(b) *Population ratios*

More than half of the countries studied have given consideration to the population size that each category of personnel should serve. Consequent to the critical manpower shortage being experienced in some territories, ratios developed in 1981 have had to be revised and manpower is still lacking. Consideration needs to be given to the wider use of auxiliary health workers where necessary, and especially at the periphery.

(c) *Accessibility*

As Moody said in 1981, "our countries are not flat pieces of paper—there are hills, valleys, rivers, seas, and bush." This has limited the accessibility to care, although sufficient facilities exist and at relatively short distances. It is not surprising that the small flat islands tend to have the best coverage figures. The second constraint to use of the local health system is ignorance, for whatever reason. Hence, over 75% of countries still have not realized the goal of most pregnant women presenting for care in the first trimester. Support for health education and health promotion to improve access to local health systems is still desirable for almost 100% of countries.

(d) *Levels of care*

In over 75% of the countries, levels of care have been determined. In some countries, especially the largest (both geographically and demographically), more than one level exists within the local health system.

Primary care is as good as the supports available at the secondary/tertiary level. Therefore, these levels of care also need to be determined and must interlock with the appropriate level in primary care.

Difficulties still experienced at specific levels relate to inadequate referral systems, records, and transfer of information between levels. Also, clear definition of activities to be executed at the different levels with supporting protocols is lacking in many countries.

(e) *Personnel*

Three areas of deficit in personnel that represent constraints to development of the local and national health system are as follows:

- Span of control of an estimated 75% of national administrators is too wide; they have no time to guide the development of the local and national systems;
- Manpower is not consistently being developed to meet the needs and to match resources of the country;
- Career structures for all categories of primary care workers have still not improved markedly since Moody's assessment in 1981.

(f) *Communication and transport*

Only an estimated 5% of countries did not have communication/transport difficulties; of the remaining 95% some had major problems with the above systems. This may not improve until sectoral links strengthen, and/or alternative financing for health becomes a reality in the Caribbean.

(g) *Support system*

Drugs, sundries, and stationery supplies as well as maintenance of equipment and facilities were listed in this category by Moody. Essential drug lists, international assistance, change in attitude regarding care of equipment, and appropriate drug prescription habits were proposed in her assessment *(2)*. Some strides have been made in this area—an estimated 70% of countries have drug lists. But basic equipment is still lacking or inadequately maintained in many countries. The issue of systems will have to be tackled at the subregional level, perhaps through CCH.

(h) *Finance*

The capital and recurrent costs of establishing local health systems are not modest. Many countries have not been able to afford the minimum of US$100 per capita per year as recommended by WHO. Situational analysis in the few countries to which field visits were made suggests that with better management structures and systems in place, greater benefits could be derived for the money being spent on health care in the Caribbean.

Major Issues and Implications for Development

The short- to medium-term success of local health systems development, and its subsequent impact on primary health care and improved health status, will be directly related to the expediency with which certain issues are addressed. These issues revolve around health policies, program planning at the local level, strengthening infrastructure, and developing more effective structures for social participation.

A demographic review of the region showed a situation generally similar to that in 1978 (with some changes in the 65+ age group). The Caribbean population still tends to be young, with high dependency ratios. This suggests that programs under primary health care such as maternal and child health, nutrition, and family planning will remain priorities for at least the next decade.

The change in the elderly population may appear small percentage wise, but when expressed in absolute numbers, the burden to the individual territories will be great and costly. Except for new emphasis on chronic disease services, neither literature research nor field visits

yielded information to suggest that the Caribbean is seriously preparing geriatric supports for the elderly.

Women are emerging as a very vulnerable group *(3)*. Relative to developments in other programs, however, little seems to be taking place for women outside of programs for maternal and child health and the elderly. This issue must be addressed as women's life-styles are changing drastically and rapidly.

Management systems

Management is used here in the widest sense to include operational tactics and administration. For management to be more effective, and for a maximum use of resources in a period of low per capita expenditure on health in many Caribbean territories, systems need to be in place. This issue must be urgently addressed and given equal attention to that being given to the clinical aspects of service delivery.

Manpower development

Literature research indicated that not more than an estimated 50% of countries had clear policies for manpower planning and development. Where policies did exist, they were sometimes inappropriate for the situation of the 1980s. Hence, in some of the larger territories there was a gross undersupply of nurses, who are the backbone of primary health care. On the other hand, some of the small territories lacked the expertise of a resident pediatrician and/or mental health specialist, but sometimes did have one or more of another category of specialist for a very small population, or specialists in areas not identified as high priority (such as general surgeons).

Resource mobilization

The capability to access external funding was found to be lacking or minimal in many territories. In at least two territories GNP had declined between 1978 and 1988, and per capita spending on health was reduced. It will, in some cases, take political will to institute cost recovery schemes, an issue that cannot be ignored for much longer.

Social participation

Social participation can be a powerful tool for resource mobilization at the local level. It can also be an adjunct to improve service

delivery where community members volunteer their skills in areas such as record-keeping, simple tasks such as infant weighing, infant feeding, and ORS programs. Vector control, chronic disease contol, and the EPI can be community-based if people are empowered with knowledge regarding actions to take. The impression of this consultant was that as a strategy for improved health status, social participation is being only minimally explored.

Research

Traditionally, research has been conducted at the level of the tertiary institutions of the subregion and/or through special agencies such as the Caribbean Epidemiology Center (CAREC) and Caribbean Food and Nutrition Institute (CFNI). Such research has been more basic or academic. However, much more health service or operational research is needed to address problems in health services development, especially at the local level.

It was noted that in the larger, more developed countries (particularly Barbados and Jamaica), much research was in progress or had been accomplished. This has resulted in interventions that impacted positively on worker productivity, optimal benefits from expensive drugs, and other such areas of health services development.

Conclusions, Recommendations, and Strategies for Further Development of Local Health Systems

The consultant recognizes that it was difficult to make objective judgments in all areas, so some subjectivity enters into these conclusions. Difficulty was experienced in assessing the impact of CCH on programs and priorities in the area, and in determining how CCH had provided support or had an impact on the countries. It was only evident in two areas, those being essential drugs, and maternal and child health programs. This may be due to the design of the evaluative instrument and/or due to the persons interviewed and to the lack of specific information in the literature. Notwithstanding, it is hoped that this section will prove useful to PAHO (and CPC in particular) in programming for the quadrennium 1990–1993.

PAHO/CCH

While know-how in maternal and child health, nutrition, and vector control will certainly be in demand in the coming decade, new types of expertise are needed. For example, computer specialists, health economists, and management specialists (including financial systems personnel) will be required.

PAHO tends to use large numbers of physicians as administrators of country programs. If physicians will continue to be used, they must also be management specialists or have management specialists on their staff. Such managers should be systems oriented rather than having only traditional "administration experience."

The computer has come of age and with this has come a widening interest by the health scientist in policy problems and systems. This "systems-approach" allows for decision making in a coherent fashion without generalizations based on limited experience *(4)*. Where resources are dwindling, it is this approach that will facilitate greater output from the same dollar, which sometimes has less purchasing power.

Recommendations

Management infrastructure. Strengthen management at the level of local health systems by institutionalization of systems which should include: personnel management; supplies management (inclusive of drugs and all sundries); maintenance management (both for physical facilities and equipment); financial management (inclusive of performance, rather than consumptive type, budgeting initiatives); transport management; health information management; and inter- and intrasectoral linkages (inclusive of effective referral system).

Manpower development. A rational manpower development and utilization policy should be pursued for the subregion, including incentives to attract trainees and to curb attrition where it exists.

Resources. More resources need to be made available to the health sector, especially for local health systems.

Social participation. Such participation needs to be developed in an organized fashion vis à vis the present *ad hoc* initiatives.

Research. Case loads of health professionals at the service delivery points should be reduced by more rational uses of manpower to allow research initiatives where health professionals are so inclined.

Subregional strategies

Because of the similarities of needs and deficiencies in the many territories, strategies should address problems common to subgroups within the subregion.

Resource mobilization strategies. Collective resource mobilization through strategies such as CCH will address the need for added resources in the sector. External assistance through bilateral and multilateral schemes is also an alternative. Finally, governments of the subregion must now consider cost recovery schemes within the health sector to supplement inputs from general revenue.

Training strategies. The PAHO Fellowship scheme can be used to address the imbalances in manpower availability. It could support in-country training as well as external training, and address priority needs as well as supporting auxiliary training schemes.

Health promotion strategies. More aggressive pursuit of these strategies could be accelerated by incorporating nongovernmental and private voluntary organizations.

Community mobilization strategies. This strategy could be used to support resource mobilization, to facilitate social participation, and to promote health education.

Operational research strategy for service delivery. Such a strategy would address vulnerable groups such as women, and improve continuing problem areas such as high perinatal mortality.

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Intersectoral Coordination for Primary Health Care

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All countries of the Caribbean accepted the Alma-Ata Declaration (1978) of Health for All by the Year 2000. In order to operationalize the tenets of Alma-Ata, certain of the following assumptions must be made:

- Health for All by the Year 2000 is an achievable goal;
- Primary health care is the strategy for achieving this goal;
- The inter-disciplinary, inter-sectoral, community-oriented approach is the medium.

At the Primary Health Care Workshop in Saint Lucia in 1981, primary health care in the Caribbean context was seen to include "those services that can be provided to all the population at the most peripheral community and practical levels. It is the entry point into the health care delivery system."

At the community level, primary health care integrates promotion, prevention, early detection, healing, reduction of disabilities, rehabilitation, and community development activities. It should encompass the totality of humans in their environment, taking into account their social, economic, and political well-being.

Primary health care requires the mobilization of available community resources. It forms an integral part of any country's health care system and of overall social and economic development. It must be at a cost that the country and community can afford with full participation.

One of the objectives stated at the Saint Lucia Workshop in 1981

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was "to provide coordination with other sectors of the development strategy such as central planning, education, agriculture, water supplies, community development and communication. . . The need for devising a system for the coordination of these activities at the community level was also recognized."

Thus, there is the realization that health cannot be achieved by the health sector alone, but that there must be systematic interdependence fuelled by national political will, and by coordination of the health sector with relevant activities of other social and economic development sectors.

In 1980, the PAHO/WHO Caribbean Program Coordinator supported coordination when he stated that primary health care must be an integral part not only of the health system, but of overall social and economic development.

There is general agreement that primary health care represents a multidisciplinary approach by health and other sectors, and involves active participation of members of the community in determining their health care needs and priorities, and in solving these needs. Further, it refers to a social strategy that has implications for linkages and resource allocation between the several areas required to improve the community's standard of living. Development of health can no longer be viewed as a result of purely medical measures. It is an essential component of the socio-economic system, and combines a number of political, social, economic, and other measures.

The major thrust of health providers is that health delivery must be equitable, efficient, and effective, and should reach those most in need. Hence, the primary health care approach, with the community deciding on their own health, is a desirable strategy.

The intersectoral approach must therefore involve coordination of policy, planning, technical/institutional and community activities. A listing of various sectors that are involved are listed below:

Ministry of Health (lead sector)
Planning and development
Environment
Agriculture
Housing
Education
Community development
Women's affairs
Foreign affairs

In addressing intersectoral coordination at the 1981 Workshop, Philip Boyd noted "that the coordination of the work of the numerous contributing sectors was the inescapable responsibility of the Ministry of Health." To be effective, political goodwill and commitment are essential to any attempt at operationalizing primary health care and intersectoral coordination. This commitment should not, however, stop at the level of the Ministries of Health of Member States or the Pan American Health Organization Directing Councils, but should be agreed to, at a minimum, by National Cabinets and, if possible, at the parliamentary level in countries of the Caribbean.

Primary health care strategy envisages a system in which activities undertaken by each component are fully coordinated with the others. Achieving this would require effective planning and efficient management. Having obtained political commitment, appropriate policies should be prepared for the national governments and should seek to include activities of the Carribbean that impact not only on peoples of one country, but of the entire Caribbean. Accordingly, the 1981 Workshop in Saint Lucia saw the planning process as one of developing policies that would reflect the following fundamentals of the primary health care approach:

(a) Extension of coverage of health services to the entire population;
(b) Intersectoral coordination;
(c) Community participation;
(d) Progressive shift of resources in the direction of primary health care.

The Final Report of the Workshop, in noting that implementation would not be easy, stated that each country would have to develop strategies that take into account constraints and obstacles as well as factors facilitating implementation.

Recognizing that a healthy population is indispensable to social and economic development, it is essential that planning components of intersectoral coordination include the widest representation by planning sections/divisions.

Writing in 1987, Robert M. Solow, the Nobel Laureate in Economics, saw the role of science in creating wealth by providing a foundation for technology and industry. In the same way, science and technology could facilitate health development and improvement of the economic sector. The involvement of planning divisions would ensure the integration of the health plan within the overall plan of the government or region.

The finance departments should ensure that health, which in terms of allocation of resources is regarded as the stepchild of most governments, receive adequate finances since it provides the fuel, that is, the human resources, for economic development.

Environmental portfolios must ensure that a sustainable environment is maintained and that proper sanitation, waste management, and potable water supplies are provided for all levels of the population.

The agriculture departments in many countries have already begun implementing the activities of the Regional Food and Nutrition Strategy (1980) which has as its objectives, *inter alia*:

(1) Increased production in the food sector;
(2) Improved distribution of appropriate food to nutritionally at-risk groups;
(3) Reduced incidence of nutrition-related diseases;
(4) Improved maternal and child health status.

Provision of basic shelter is an ineluctable component of primary health care. It is recognized that more than 50% of the world's population live in inadequate shelters—a figure that is close to the regional situation. It is thus mandatory that planning and coordination processes address this area of priority.

Health education and health promotion must be constant themes in public policy since both are concerned with improving the quality of peoples' lives. People must be given the resources and information to make healthy choices. This involves an understanding of the responses of different social groups.

The Liverpool Declaration on the Right to Health (1988) states "that the starting point in changing life-styles is to recognize that to a considerable extent health depends on the political, social, cultural, economic and physical environment." The Declaration affirms that it is first necessary to "provide opportunities and develop capacities for adopting healthy life-styles."

The integration of women into this process is crucial for its success since mothers are important in inculcating proper behavior in their children, in modulating their behavior, providing for their nutrition, and in control of their environment. In short, their influence on the social, political, environmental, and planning spheres of the nation is immense.

Health for all cannot be achieved without participation of all. An important element in becoming healthy is taking control over one's

life. This has to be done by empowering people with a voice in the decisions that affect their health. Modalities for achieving this would include:

(i) Opening up the membership of all bodies and at all levels that take decisions within the public sector. This may necessitate passage of legislation to involve full participation;
(ii) Decentralizing management structures.

Not least among the coordinating division is that of foreign affairs, which should seek international cooperation by opposing the export of unhealthy products and by resisting the import of practices, goods, and services harmful to the health of the people.

Regional institutions, namely, the University of the West Indies, the University of Guyana, the Caribbean Agricultural Research and Development Institute (CARDI), the Caribbean Agricultural and Rural Development Advisory and Training Service (CARDATS), and the CARICOM Secretariat must encourage relevant research to achieve health for all.

As the Caribbean area adjusts to the impact of structural adjustment, and seeks to work within the framework of the new international economic order and technical co-operation, the need for the community to be pro-active in planning for their own health is heightened. The call for decentralization of health systems and wide representation from sectors such as education, agriculture, health, planning, and finance, and from agencies that train health workers, becomes more urgent.

Given goodwill and commitment, health for all, utilizing as its strategy primary health care, is achievable by the year 2000.

New Models in Health Care

CAROL COLLADO[1]

Introduction

When one is thinking of creating something that will change the status quo, it is well to ask why.

The search for new models in health care responds to various influences of the present situation.

The economic crisis which affects the majority of the countries affects all sectors, but in particular the social sectors, and amongst them, health. Having "to do more with less" has become the rule of thumb, not the exception in the health sector. When combined with the increasing population in the majority of countries, the problems of providing safe, efficient, and accessible care to all become staggering.

In view of this challenge faced by health providers, in 1978 the governments of the world united to approve the goal of Health for All in the Year 2000. Revisions of accomplishments since then have demonstrated the mobilizing power of this idea, although they have also shown that progress has not been all that was originally hoped.

Primary health care was adopted as the strategy to implement health for all and defined as follows:

> . . .essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. *(1)*

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Unfortunately, in many areas primary health care was interpreted only as an extension of services at the first level of attention. This resulted in an attempt to allocate resources at a peripheral level while allowing the quality of care to worsen in the secondary and tertiary care centers. Paradoxically, the hoped for effect at the primary level also fell short of expectations so that presently we find health care delivery which is inefficient at best and in many cases deficient. This calls for a new plan—one which will help to define goals and then to choose amongst alternatives and manage the processes of change involved.

Local health systems have been conceived as a way in which the primary health care concept can be operationalized. The primary health care ideas as implemented through local health systems should include all of the aspects necessary to put this idea into practice. They have been identified as follows:

- Reorganization of the central level in order to ensure the guidance of the sector and the development of local health systems;
- Decentralization and deconcentration;
- Social participation;
- Intersectoral action;
- Adjustment of financing mechanism;
- Development of a new health care model;
- Integration of prevention and control programs;
- Strengthening of administrative capacity;
- Training of the work force; and
- Research *(2)*.

In particular, this presentation will discuss the aspect of "new models"; however, it will be evident that there exists an interrelatedness within all of the elements.

Before discussing some different issues, elements, possible results, and evaluation questions that local health systems provoke, it is helpful to state two important underlying assumptions which exercise an influence in the developmental possibilities of local health systems:

- The idea of local health systems is based on a concept of health which is amplified and goes beyond the absence of illness as its basis to include other facets of human development and well-being;
- Local health systems are based on a firm belief in the appropriateness of the democratization of health, a concept which includes the demystification of knowledge surrounding health as well as participative leadership development with shared responsibilities. This of course implies the elimination of the dependency role of the user/client/community.

Planning Local Health Systems—Issues

Due to the different historical, political, technical, administrative, geographical, demographical, and cultural characteristics of each country/region as well as the resources that may be available, it is evident that the development of new models of health care systems will mobilize all of the creative potential of the persons involved. Decisions will be made according to local realities and the appropriateness of the elements being examined to the overall goals.

That is to say: *there are no formulas,* no absolute answers, no boxes to fill in order to develop new models. Each new system will be a product of the particular situation in which it is being developed, as well as the needs of the population and the number, type, and capabilities of the resources available. That having been said, there are, however, a number of issues which must be examined, positions taken, and conflicts resolved in order to establish the foundations of this new model.

1. *What type or degree of autonomy will this local health system enjoy?*

Evidently, the structure of the situation vis-à-vis the overall health sector, and the predominant mode of governance will be important to consider here. Also coming into play would be the possibilities of this local health system to mobilize financial aid and other resources from outside sources (e.g., extrabudgetary funds for special programs, the incorporation of nongovernmental agencies into the work plan, the use of volunteer groups). At stake in the discussion of autonomy is the question of leadership and decision making: Who will control the financial process? Who will dictate the program priorities and norms? How will the locally made decisions interface with the central structure and other local health systems?

2. *What balance can be brought about between the curative focus and prevention and health promotion?*

Beginning with a concept of health which is amplified, illness cannot be the only concern of the health system. Presently, the population uses the health service based on illness, and even the preventative aspects such as environmental sanitation and vaccines are considered as less important by the community and often also by the health providers. New relations of cooperation will need to be designed and experimented with to permit an integral view of health which expands to include life-style and cultural influences on health behaviors and social determinants of health, amongst others.

3. *Will this system have a passive or an active role in terms of providing services?*

Present practices for initiation of contact between the population and the system place the responsibility principally on the shoulders of the community. Contact is made because the person seeks assistance due to a health problem. Local health systems must decide on this issue as services are planned. Will activities be developed "in house" for those who seek attention or will they occur in various different settings with the system seeking out nontraditional and potential users in different sites, such as the workplace?

4. *Will the focus of the health care system be predominantly individual, or will it concentrate on a broader base for its design?*

In the majority of the health care systems today, including those which are more directly involved with the community, an individual-based focus predominates. Care organized in this form often fails to create an impact in terms of overall population health status. Without losing the potential for humanistic care which individually focused attention has, how can the local health system be focused so that a change is noted? Answers may be found in different approaches to planning goals and organizing services such as the risk-based ap-

proach, or through other means that fit the local situation and its population.

5. *How will community participation be achieved?*

Entire treatises have been written on this question. Old habits are difficult to break, however, and if localized health systems are to include community participation, much will be needed in the area of changing the relations between the population and the system. Suffice it to say that the search for adequate participation of the base community is a fundamental part in the design of any local health system. It might be added that the idea in theory is not a difficult one to embrace but that operationalization of this concept is difficult. All the more reason that it becomes an issue to be discussed and approximated in the development of local health systems.

6. *What measures must be incorporated in this "new" design to assure intersectoral cooperation?*

A basic element of putting into practice an amplified version of health is that the health sector alone cannot resolve the situation. It is therefore fundamental to incorporate ways in which education, science and technology, and local governmental and nongovernmental organizations will participate in the search for ways to improve the health of the population. Means must be found for both fluid communication and shared development.

7. *What will be the role of the hospital in the system?*

At the very least, in the development of local health systems an adequate and efficient system of referral and counter-referral must be designed. In many situations, however, depending on the availability of other facilities, the hospital may be the most adequate base for community outreach programs, or for the health education base. Answering this question involves the rethinking not only of the role of the hospital but the reevaluation of the system's goals and an adequate distribution/redistribution of resources according to priorities and choices made.

8. *What part will technology play in the system; will it be determinant, will it be developed in a parallel form with the system, or will it be developed in response to the system's needs?*

The role of technology is often underestimated or seen as being outside of the system. However, in many instances it is a determining factor in the development of new services and the distribution of resources. There are three possibilities open to a developing local health system. One would be to allow technology to be a driving force in the design of the system. Another would be to isolate technology from the system and to allow it to develop separately. It can be noted that when this has been attempted, technology often enters the system in a back-door fashion. The third and most rational, but often most difficult as well, would be to utilize or develop appropriate technology along with the design and development of the system as a whole.

9. *How will work be divided? What are the most appropriate roles for the different members of the health care team?*

Evidently, a new concept of health, along with new systems of managing services in local health systems, will have effects on the personnel involved. Distribution, utilization, and development of personnel must be taken into consideration as well. An important aspect to be considered is how to effectively design a system which encourages health personnel to work effectively as a team—internally and with the community.

Elements of Health Care Models

After having examined the issues above which give rise to some philosophical and policy decisions, one can look more closely at the operational questions of the design of local health systems. For purposes of further discussion the elements of health care models can be grouped under three broad headings: organization (structure), delivery (the functional process of developing services), and resources.

Once again, there are more questions to be asked in this process of development of new models than ready answers. Those must come as a result of local planning and design. The following is only a partial listing of some questions regarding each element that could provide a

point of entry into the changes toward new models of health care systems in accordance with the goals of health for all.

Structure/organization

What is to be the degree of autonomy enjoyed at each level (of care, of services, and of the system)? The question of autonomy has been examined in terms of the system in general in a previous section of this paper. It is, however, valid at each level of the system, and should be foreseen in the design.

How can meaningful communication be ensured among the different elements of the health care system? In order for a system to function as such, means must be developed to provide for sharing of information and feedback on developments, as well as other aspects that permit fluidity and provide continuity of care.

Can a system be devised in which administration becomes a means to an end and not the end itself? Unfortunately, bureaucracy has a habit of being self-perpetuating, often to the point of obscuring the original intent of the system. In many health services today, for example, the paperwork and not the client has become the most important aspect of the health worker's functions. Management of the system must be designed in such a way so as to keep in mind the eventual goals of better health.

How can the productive sector for health manpower be incorporated into efforts to increase health for the population? Over the past century, the separation of education from service in the health sector has become an institution. The unfortunate result of this is that the formative centers have become isolated and in many instances extremely theoretical and removed from reality. This results in the production of personnel who, only with difficulty, find their places in the system. Another problem that the lack of coordination between the two sectors produces is the concentration of the educational institution in the production of personnel only, without harnessing its potential and resources toward the development of new answers to delivery of care and the design of appropriate systems.

Are we using the available demographic and epidemiological data appropriately to structure the system? Although often the information available is not of the quality desired, it does provide a starting point. However, even the information available is not being utilized as a basis for programming. Policy decisions and autonomy are related to programming, but it is also imperative to develop the habit of investigation and local information utilization if local health systems are to achieve success.

Can a team approach to health care be implemented? While much has been written in support of a team approach to health care, it is the exception to find a group well integrated and functioning in the health sector. Much less is the possibility of finding such a group which has been able to incorporate the community into its decision making, implementation, and evaluation. It is important to assess local possibilities and build this element into the structure of new systems so that functioning becomes easier.

Function/delivery

By what process will policy be decided? Since policy will determine in large measure what priorities will be, and the way in which the system will function, one of the fundamental questions will be regarding the policy process. Who will participate and from which levels and disciplines? What will be the participation of the community? How will the policies be communicated and how will these policies be translated into quality care? These are but a few of the questions that must be asked.

Who defines the local health system priorities? Although general policies will give certain ideas regarding program implementation, a time will come in which more specific and individualized decisions will have to be made to assure that the system remains relevant to the needs of its population. Who will be involved in this?

Can continuity of care be guaranteed within the system's functioning? One of the unfortunate effects of present delivery systems is the atomization of care and its episodic nature. As new systems evolve, decisions will be made regarding their mode of functioning. In order to support the goal of health for all, continuity must be implemented.

Are reasonable goals and priorities established as a means of designing health care delivery systems? The key question here is "reasonable." It is easy when attempting to implement new models to fall into the trap of illusion that everything can be ideal. The planning process is very important in the setting of goals and priorities which can be met. Otherwise, the personnel and community will become disillusioned and frustrated, causing a backlash against the system.

What role will international resource organizations play in defining policy and functions of local health systems? This element is once

again related to the question of autonomy. If local health systems define priorities, and adapt or define policies with the population's needs in mind, then resources are sought in light of their programs. If, on the other hand, resources are implemented without a masterplan, the availability of resources is often what determines policy and priority, and not the population's needs.

How can health education, operational research, and information management be incorporated in the local health systems? The three activities listed are fundamental for the effective and efficient operation of any system. Whether responsibilities will be integrated into those of all personnel and programs, or managed by specialized persons, is a local decision. In either case provisions must be made so that these functions are seen as important elements.

What quality controls are inherent to the system's functioning? This is almost a self-evident element of the design of any system. Evaluation has always been considered important. It is necessary, however, in the development and implementation of new models based on a new amplified concept of health, to give thought to the design of new indicators. These will assist in the evaluation of impact, behavioral changes, and other aspects of health which are not readily apparent in the morbidity and mortality statistics currently in use.

What is the function of supervision within the system? Here, there are two aspects to consider: one is the role which supervision is seen to play within the system, and the other is how to facilitate the inclusion of that role in the functional design. Although much lip service has been given to the need for supervision, many times this activity has been given low priority in the allocation of resources (time, transportation, etc.). In other cases it has become an exercise in control without the corresponding activities in development which are part of supervision.

Who is accountable? This is an obvious but difficult question. Bureaucracies are famous for creating elaborate mechanisms where accountability falls through the cracks. In order for personnel to take pride in what they do, it is important for them to be accountable for their portion of the system. Impersonalization of the system which is the antithesis of accountability is a danger. In assigning functions, this must be an element of consideration.

Resources

When, how, and to what degree will the community assume self-reliance in health? The question of how to mobilize the community and its resources to achieve a positive valoration for health is complex. It involves situating the local health system in the particular socio-economic, political, and cultural context or contexts that operate. As with other elements discussed, there is no one answer. Even within a local health system one community may be more disposed to assume responsibility and mobilize their resources than others. In either case, the design of a new model of health delivery—called local health systems—must provide for community participation growing toward self-reliance.

How is the organization/concentration of resources to be decided? The answer to this question evidently lies with the policies and priorities of the local health system and the social context in which it is immersed. There may be pressing cultural, technical, economic, or political reasons, however, that require adaptations of general policies within local health systems. The deployment of personnel to cover a health post in a rural area, for example, will not make the system work unless the infrastructure permitting adequate provision of supplies and supervision is established. Transportation questions may influence this deployment as well.

What is integration of teaching and service? As stated before, educational institutions have a grand potential which has not been harnessed in improving services. Services likewise can contribute greatly to making education more relevant. The combined efforts of both sectors can be put in motion to benefit both education and service. Exploring possibilities for collaboration locally may lead to innovations in the design of local health services.

How is technology utilized? Technology can be examined not in terms of its basic relation to the system, as was discussed previously, but in terms of its relationship to the people of the system, both the caregivers and the users. Is technology to be used to supplement or substitute personnel? What effects will that have on usage of services? Are provisions adequate for personnel development when new technology is introduced? These and other questions must be answered and the decisions foreseen in any planning for local health systems.

Are there rewards within the system which stimulate the contribution of all participants? This question has to do with aspects such as fair pay for work, adequate working conditions and incentives for a job well done, among others. Stimulated workers produce far better results than those who are often absent or who, when they come, perform as mere robots without being inspired to participate in the change process.

To which sector of the population does the system respond in

terms of resolving health problems? This perhaps delicate question is one that has numerous implications. If, for example, the local health system tries to compete with the private sector in the provision of high technology attention, then the obvious conclusion is that it is directing its services toward a small percentage of the overall population. Given the fact that few, if any, local health systems can count on unlimited resources, weighing the scale in favor of some programs and priorities will almost inevitably take some resources away from another sector.

By what means is leadership incorporated into the system's functioning? By whom may it be exercised? One of the first questions that would have to be answered in this respect is: What is leadership? Does it depend on authority given by position, by competence, or by other factors? Studying this question can lead to new possibilities for enhancing the system's functioning.

What is the orientation of a continuing/permanent educational plan for personnel? Is there an educational plan in place for the system and for what purpose is it used? Can it be designed so that it furthers the aims of improving services, assists in the development of the individual worker, and promotes community maturation in health?

What Can Be Achieved

Planning new models is evidently an all-encompassing venture but the results can be exciting. The goal of health for all can be closer with equity, effectiveness, efficiency, and community participation! Although different, the models would have certain common characteristics:

- The creation of a "culture" of primary health care (values, attitudes);
- An increase in self-responsibility for health;
- A positive impact on the social change required for reaching health for all;
- The production, exchange, and utilization of locally gathered information as a basis for decision making;
- Instruments that facilitate quality, integral, community-based care;
- Programming/planning and strategy development based on priorities and policies formulated and/or adapted at the local level;
- The rational distribution and maximum utilization of resources;
- Adaptability; and
- The democratization of health.

Evaluation

Just as the models themselves are "new" with a "new" health focus, it is important to recognize that measures for evaluation will also need to enter into the change process. Traditional indicators will be able to tell only part of the picture of the communities' health. New ways of looking at the impact of the local health care system will have to be developed. New concepts of health and community participation will demand their inclusion in evaluative efforts. It is through the process of developing criteria, examining results, and using this information to modify and improve, that the "new" models will grow and truly move toward the achievement of health for all.

Examples of Some Models

The following examples of models that have been initiated from different starting points may be useful:

A political decision to decentralize decision making in one country (Guyana) led each region to form a locally elected council. This council has autonomy for budget preparation, management of resources, setting of priorities, and intersectoral coordination, among other activities. In health, the use of locally produced information has led to adaptation of norms, redistribution of resources, and motivation of personnel, and has had a measurable impact on identified health problems in the area.

A restructuring of organization, function, and personnel occurred as a result of a project in Palmatitla, Mexico, that was designed to *incorporate research* as a key element in the local health system. Results included motivation of personnel, increased utilization of services by the community, community involvement in health activities, and a high degree of accountability.

A *hospital* in San Ramón, Costa Rica, became a *focal point* for

the development of a local health system after a national reorganization which separated hospital and community services. An organized community protest created a special situation in which hospital and community services in this instance became one system.

The *redistribution of personnel* and functions in the system in an effort to provide continuity of care from the community to tertiary level initiated the change process in Maribor, Yugoslavia. Community nurses, who are the first level personnel, were assigned to assist 2–3 days each week in outpatient consultations and to visit hospitalized persons from their assigned areas. Individuals and families are given appointments except in emergencies, when they can be seen as outpatients by their neighborhood nurse. Results included increase to 95% coverage in immunizations, fewer missed appointments, better coverage of priority programs, and others. The implementation of this system brought out the importance of referral–counter-referral activities.

A ***university-based research initiative*** in Santander, Colombia, stimulated the priority of programs over ownership. In this local health system at least four different health providers, each with its own policies and norms, attended certain sections of the community. A *political agreement* was reached which permitted the integration of the different providers into one model that was able to cover a much greater proportion of the community. As might be imagined the political, economical, and technical difficulties were staggering, but in the interest of quality care they were overcome and the results have been impressive.

There are many more examples. Most demonstrate that the hardest part is beginning. There are, however, many ways to begin. As these examples have shown, the element of leadership is important.

Challenge of the Future

One of the essential elements in the development of models is the human factor. It has been said that health workers are disenchanted and even demoralized. Ways must be found to increase motivation within this group. Internal motivation, derived from responsibilities executed, from excellence and pride in a job well-done, and from the feeling of satisfaction that comes from full utilization of skills, must be cultivated at all levels. Means for externally reinforcing motivation must be looked at as well. Work conditions, praise from

others, job classifications, and promotions are just a few. If the system is to be developed as "new," then its health personnel must be motivated and committed to it—the challenge is there.

It is vitally important to examine the role of the health care workers as leaders in catalyzing this process of change. They must be able to comprehend and communicate this new vision of health and of the local health systems as means to achieving health for all. They have roles in the definition and application of policy, management of data, identification of critical areas, the motivation of others, and in the management of change. They have made a commitment to the community in the search for well-being, and they are willing to take the risk!

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Part III. Economic and Social Determinants of Health Status

Economic Crisis in the Caribbean and Its Implications for Social Services

COMPTON BOURNE[1]

All signs indicate that the English-speaking Caribbean is at a critical point in its post-independence history. One detects this not only from economic indicators, migration statistics, and evidence of social disorder, but also from a widening atmosphere of confusion, uncertainty, and even despair among much of the area's population. The thoughts and energies of every segment of the population need to be directed to the task of national revitalization and development. It is therefore encouraging that this body of health officials and medical practitioners has sought to acquaint itself with the nature, extent, and implications of the current economic crisis in the Caribbean.

The Economic Crisis

With few exceptions, CARICOM economies have performed poorly thus far in the 1980s. In seven countries, real economic growth as measured by the average annual percentage change in inflation-adjusted gross domestic product per capita was negative between 1980 and 1985. In four other countries, economic growth rates were less than 2%. The member countries of the Organization of East Caribbean States (OECS) appear to be somewhat of an exception, with positive economic growth rates of 2.7%, 4%, and 6% being recorded for Dominica, St. Vincent and the Grenadines, and Antigua and Bar-

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buda, respectively. However, there is a fragility to the recent economic prosperity of those economies, resting as it does on the weakness of the U.S. dollar relative to the pound sterling (in which banana export prices are denominated) and on capital inflows of questionable stability. A strengthening of the U.S. dollar, or tighter controls on capital outflows from the main source countries, can quickly impair their balance of payments and economic growth performance.

The economic crisis is also manifest in much higher rates of unemployment now than during the first half of the 1970s. In 1985, for instance, open unemployment rates were between 15% and 25% in several CARICOM countries. The incidence of unemployment is particularly acute among females and among persons of both sexes in the 15- to 25-year category.

One consequence of high levels of unemployment and slow or negative economic growth is a substantial reduction in living standards. The well-being of Caribbean peoples has also been compromised by substantial emigration of highly skilled and educated persons.

An evident feature of deep economic recession is the rise in inequality of income opportunities and wealth, and unequal access to those commodities and services provided on a commercial basis. In cases where public provision of those items or public subsidies of private supply have been severely reduced in response to fiscal stress, persons with low income bear the brunt of the system-wide deterioration in the standard of living.

There is no question, therefore, that CARICOM countries are confronted by a major development problem. The urgency of the problem is intensified by projected labor force growth well in excess of incremental labor demand on recent best-case scenarios and present production technology. In effect, "business as usual" policies will not be sufficient to avert an unemployment problem of major proportions.

Contributory factors

Much of the current crisis is due to structural changes in the world economy and to global economic recession, Caribbean adaptation to which has been minimal and slow. The following structural factors are likely to be of lasting significance. First, changes in production technology and in the nature of commodities erode the long-term international demand for the traditional agricultural and mineral product exports from the Caribbean. Ready examples are the development of synthetic raw materials, energy-substitution, and corn-based sweeteners. Second, international consumption patterns have been changing in ways that necessitate the production of new commodities and services and the cessation of production in declining areas. Third, shifts in the geographical distribution of income and wealth have altered the relative importance of traditional export markets and signal the need to penetrate new ones, especially in the Pacific and Latin America. Fourth, the development and spread of electronics-based production technology, such as computer-aided design and management, has globalized production and reduced the appeal of low wage rates to foreign investors. Fifth, the trends in international financial markets are adverse to developing countries, particularly in relation to their access to concessionary financing.

While not downplaying the impact of international economic conditions, it should be appreciated that Caribbean economic policies and economic management are a large part of the problem. Fiscal operations resulting in chronically large deficits and high average rates of personal income taxation have undermined financial stability, especially with respect to foreign exchange and the foreign exchange rate, and have discouraged private initiative. There is widespread misallocation of resources, and resource inefficiency in both private and public sectors. Countries have persisted too long and too zealously with inward-looking strategies that recognize the importance of international trade, finance, and technology transfers. At the regional level, policies have been competitive rather than complementary and mutually supportive. Economic weaknesses have also been aggravated by a marked deterioration in political values and political practices which have had alienating and demoralizing effects on the peoples of several Caribbean countries.

Social Sector Implications

An appropriate development strategy for CARICOM countries would involve attention to the achievement of international competitiveness. It would include the establishment of new trade and finance relationships, and the strengthening of existing ones. It would also require improvements in export marketing and export financing systems.

The social sector should be a central element in this development

strategy, for human resources is the key to successful development. Scientific skills for technology acquisition and development, international marketing capability, entrepreneurial skills in commodity production and service industries, and work effort and productivity, are all facets of human resource availability and quality. The social sector makes its contribution to economic development through improvement of human resources in several ways: health care and nutrition affect physical capacity; education and training develop intellectual and technical attributes; and the provision of the mix of services bears directly on the psychological dimension of human beings.

There is considerable cause for concern regarding trends in the social sector. Government expenditures in constant prices (i.e. in real terms) have slackened in most countries and have even decreased in a few countries. Of particular interest to this audience would be illustrations about the trend in recurrent expenditures on health services in two cases. In Barbados, expenditures in current prices increased from Bds$50.1 million in 1980 to Bds$92.2 million in 1987. However, expenditures actually stagnated (still in current prices) in the vicinity of Bds$90 million between 1985 and 1987. Adjusting for inflation, health expenditures in real terms rose by 20% between 1980 and 1987, and have declined by 5% during the last three years. In Trinidad and Tobago, recurrent expenditures on health increased from TT$523.6 million in 1983 to TT$563 million in 1987 in current prices, i.e. by a mere 7%. In real terms there was a 26% decrease in recurrent health expenditures.

The trends in real expenditures may be used as a rough indicator of trends in supply, allowing, of course, for improvement in efficiency and for qualitative changes. These trends indicate that public provision of social services has decreased. Since the State is not the only supplier, there is the possibility that the private sector partially compensates for the deficiency in public provision of services. However, one should be careful not to exaggerate the practical significance of this possibility. The State is the major, and sometimes the predominant, supplier of most basic social services. Furthermore, the cost of privately produced social services severely limits access by low income persons, particularly in times of stagflation.

Deterioration in the social services sector has to be taken seriously partly because the initial situation was not particularly impressive. Crude indicators of health and nutrition on a national average basis show considerable improvement during the 1970s and the 1980s. Infant mortality, for instance, has been halved within the last 25 years.

However, the limited access of some income groups and in certain geographical regions, and problems of quality of service detract from the favorable impression conveyed by national average health and nutrition indicators. In the field of education, a substantial proportion of the secondary school age cohort fails to obtain places in schools in several countries (e.g. Jamaica 42%, Trinidad and Tobago 30%), while only a small proportion of the population has access to higher education.

Policy Issues and Choices

The CARICOM countries must squarely confront the policy issues and choices occasioned by the fiscal crises being experienced. Among these are the question of whether to encourage and rely upon private provision, and whether to engage in substantial cost recovery through charges on users of publicly provided services.

There is a strong preference on the part of international donors and foreign aid agencies for user charges, i.e. prices set at levels which susbstantially recover costs or generate profits, and for private, commercial production and supply of social services that have traditionally been provided by public sector agencies. This preference obviously constrains public policy in countries reliant on foreign financial assistance.

Several fundamental considerations should inform policy choice. One is the relative magnitude of the net benefits to individuals and institutions and the net contribution of the services to the well-being of the community as a whole. The greater is the latter, and the stronger is the vested interest of the State in ensuring the supply of the service at affordable charges. Another consideration is the ability of users to pay. Related to this is the question of social justice. Exclusion for reasons of income may conflict with precepts of social justice. It is not at all clear what maxims can be developed for the social sector in general or for any particular social service. One approach might be to adopt the policy of subsidized public provision for persons at the lower end of the income scale and private, commercial provision at the upper end of the income scale. For obvious reasons, such as information deficiencies, political considerations, and costs of enforcement, schemes based on discrimination among users are difficult to operationalize successfully.

Conclusions

This address has sought to introduce medical practitioners and health officials to the seriousness of the economic crisis in the Caribbean area and to its implications for the social sector of which they are a vital part. It is hoped that all will appreciate that much has to be done at the policy level and has to be done with an acute sense of urgency. A few underlying policy issues have been identified. It is worth stressing that the fundamental trade-off is between economic efficiency and cost-recovery on one side and social justice on the other side. Achieving an acceptable balance is not an easy task, but it must be attempted.

Social Determinants of Health Status: New Challenges for the Primary Health Care System

ELSIE LE FRANC[1]

The adoption of the primary health care approach demands that greater attention be paid to the social determinants of health status. The emphasis on disease prevention and health promotion means that social communication techniques need to be developed and perfected for both the transmission of health messages and for the alteration of attitudes and values concerning health practices, and the concept of health itself.

The primary health care approach was perhaps in large measure stimulated by the clear recognition that most of the major communicable diseases were avoidable if only significant improvements were made in the conditions usually associated with *poverty*. One unfortunate consequence, therefore, of the way in which the concept developed has been the stubborn perception that primary health care is for the poor.

Recent trends in the pattern of illness in the Caribbean region show that the diseases that are now the major causes of mortality and morbidity are also avoidable, or at least manageable. They are avoidable or manageable because, apart from the association between age and certain types of illnesses, they are closely related to life-styles and social behavior—especially those usually associated with urbanization and socioeconomic development. Consequently, the issue can no longer be one simply of changing ideas and values, or even of removing poverty and its causes, but more generally of discovering and un-

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derstanding those structural factors and social processes that make this or that group more or less susceptible to this or that group of diseases.

This is an area of inquiry that, while fairly well explored in other societies, is relatively new in the Caribbean. As of now, there are many questions and very few answers. The complexities and peculiarities of the Caribbean do not make the task any easier. As will be seen shortly, although still an area of developing societies by most standard criteria, illnesses usually associated with poverty tend to account for almost as many of the years of potential life lost (YPLL) as do those due to illnesses usually associated with development. For example, a recent review of the health situation in Jamaica *(1)* showed that from a group of 133 selected causes of death, the estimated total YPLL before age 65 in 1981 was approximately 104,000, and that deaths from gastrointestinal and respiratory infections were responsible for 30% of the YPLL. Given underreporting rates of up to 54% in the case of infant deaths *(2, 3)*, this figure is likely to be much higher. At the same time, the reviewers estimated that the chronic diseases account for approximately 25% of YPLL.

The economic difficulties and policy responses of the 1980s have only served to bring these complexities more sharply into focus, and to make even more urgent an understanding of the relationship between illness patterns and socioeconomic growth and development. It may be generally expected that an economic recession will in all likelihood lead to deterioration in a society's health status. Where cutbacks in the expenditure on health and other social services follow as part of an attempt to correct or cope with the recession, it might be anticipated that there will be a negative impact on health status. Not only is the health delivery system affected, but the fall in income and consumption patterns must eventually take a toll on health and nutrition. An examination of the economic and health situation of the CARICOM countries during the 1980s shows that while the expected correlation essentially obtains, there are some intriguing surprises.

Recent Economic and Health Trends in the CARICOM Countries

Any attempt at analysis of health trends in the Caribbean has to be preceded by a strong cautionary note about the generally poor quality of the data that are available—they are often incomplete if they exist at all. One of the principal causes of incompleteness is simple underreporting, for example, of infant deaths and communicable

diseases. The data are frequently not standardized, and the demographic data on which calculation of age-adjusted mortality and morbidity rates, for example, depend are often poor or nonexistent. Data are also inconsistent and conflicting from one agency to another, or from one report to another, within a particular territory. It is, therefore, very difficult to carry out the necessary analyses that are important to any attempt at theory building or even the establishment of simple cause and effect relationships. Keeping this major constraint in mind, it is nonetheless important to try to identify the dominant trends in the region over the past decade. These are:

(i) Chronic noncommunicable diseases have come to be the leading causes of morbidity and mortality. Today approximately 40% of the total mortality in the English-speaking countries of the Caribbean are due to cardiovascular diseases and diabetes *(4)*.

(ii) The incidence of communicable diseases that can be controlled by immunization has fallen to fairly insignificant proportions. The downward trends reported for other communicable diseases through the mid-1970s in most territories had, however, been reversed by the early 1980s. For example, viral hepatitis was increasingly reported in five of the territories; typhoid showed an upward trend in at least three countries; the number of tuberculosis cases rose in six territories; leptospirosis increased in Jamaica; in Trinidad and Tobago, the incidence of scabies rose by almost 100%. Perhaps the illness showing the most widespread and sharp increases was gastroenteritis, where at least 10 countries showed significantly increased rates.

(iii) Data that permit the mapping of trends in malnutrition are patchy, but what data are available suggest that the phenomenon is either on the increase or remains at stubbornly high levels. Where significant reductions have been achieved, as, for example, in St. Vincent and in Antigua, it is likely that success has been due to official intervention in the form of food supplements, rather than to any changes in conditions causing the problem.

(iv) Infant mortality rates, while falling in most of the territories, show no clear downward trend and have even increased in four and possibly five countries. At the same time, conditions originating in the perinatal period remain among the top five causes of death in five countries, and in at least four countries actually rose for the 0–1 year age group.

We found that there did not always seem to be a clear linear and

positive relationship between economic growth, increases in health expenditures, and health status. In 1981 the Caribbean Food and Nutrition Institute (CFNI) found that only three of the countries suffered any kind of aggregate food deficit, and in 1981 McIntosh similarly found that total food supply in Guyana was perfectly adequate *(5)*. This alerts us to the need to examine the impact of internal distribution structures, rather than overall growth rates only.

Looking at the region as a whole, the average rate of growth of GDP between 1980 and 1986 (at factor cost, constant prices) ranges from − 1.0% in Trinidad and Tobago and Guyana to 7.3% in Antigua and Barbados. From a more detailed examination of the performance during the 1977–87 period, it can be concluded that the best performers were St. Vincent, Bahamas, St. Kitts, Saint Lucia, and Antigua with rates of over 4%; followed by Montserrat, Grenada, and Dominica; Trinidad and Tobago, Guyana, and Jamaica had *negative* rates, or rates of less than 1%. While all the countries in the Caribbean were adversely affected in 1982, the least developed economies have shown quicker and stronger recovery, the most notable being Montserrat, Grenada, Antigua, Saint Lucia, and the Bahamas.

Examining the possible relationships between these trends, it is interesting to find that:

(i) While the health status has deteriorated in Guyana, Trinidad and Tobago, and Jamaica, it has also done so in the relatively stable and growing economies of, for example, Antigua, the Bahamas, Montserrat,[2] Saint Lucia, and St. Kitts.

(ii) The incidence of anemia (less than 10g/dl) has persisted at high levels, and has even increased in countries such as Guyana, Montserrat, Jamaica, and Dominica.

(iii) Obesity exists at significantly high levels in countries as diverse in social structure and economic performance as Barbados, Guyana, Saint Lucia, and Antigua.

Finally, when examining the relationship between health expenditure and health status, there seem to be two trends that require further analysis. First, although decreases in health expenditure are associated with notable increases in certain illnesses, increases in real per capita health expenditure can, in fact, have no apparent impact on

[2]Higher incidence rates of illness may be due to better reporting.

the process of deterioration, as in the case of Trinidad and Tobago. Second, the decline in health status seems to follow rapidly upon the economic decline—so rapidly in fact, as to call for an investigation not only of the fragility of the population's hold on good health status, but also of the real impact of the health service. We are already aware of the problems of excessive emphasis on drug therapy for the treatment of socially related illnesses. We were surprised at the finding of the nutrition survey in 1981 in Barbados, that only 11% of the population sampled had received health education from a clinic or doctor.

The major conclusion of this review is, perhaps, that far more attention needs to be given to the impact of the *internal* socioeconomic dynamics of the society. One of the cases currently under investigation through a random sample survey of households and their illnesses is that of Trinidad and Tobago. The following focuses specifically on the relationship between health status, education, and occupation in that society.

Social Influences on Health Status in Trinidad and Tobago

In Trinidad and Tobago, the illness pattern is similar to that found in most other Caribbean countries. The survey showed that arthritis, diabetes, health disease and hypertensive diseases were principal causes of morbidity, followed by diseases of the respiratory system, and accidents. The first four chronic illnesses accounted for approximately 45% of the morbidity reported. The prevalence rate for diabetes mellitus was similar to that found in the St. James, Trinidad, study but lower than that found for hypertension—a difference most likely due to a lack of awareness on the part of respondents.[3]

Chronic illnesses, of course, tend to increase with age; a breakdown of the health status of household heads only, by age category, reveals this trend. The breakdown also provides supporting evidence of the sex differential in illness patterns found in the St. James study, where for diabetes this differential was present at all ages, and in the 35–44 age group the rate for men was almost twice that of women *(6)*. Our Trinidad and Tobago study found that while for acute illnesses males tend to be more susceptible than females, men have fewer

[3]The survey was of individuals' knowledge or perception of their illnesses—it did not attempt to medically test anyone.

chronic illnesses only in the 20–29 year age category (see Table 1). When all types of illnesses are considered together, females lose their superior position and become equal to men between 40–49 years. After age 50 the percentage of women with no illness declines rapidly and at a faster rate than that of men.

For the total sample population, the broad picture is similar. With the exception of the 15–19 year age category, women are more likely to be ill. Further, it would appear that this sex differential is largely found among those with chronic illnesses. More women than men suffer from chronic illness at all ages, except among those aged 15–19 years, where women are in a slightly superior position, and among those in the 30–40 year category, where the sexes are roughly equal. The decline in health status as age increases is greater among women, so that among those aged 50 years and older, 42% of the women had a chronic illness as compared with 31% of men.

To be sure, a good deal of this can be related to the higher incidence of obesity among women—beginning even during the school years. However, to the extent that the burden of chronic noncommunicable disorders is "disproportionately shared between the sexes," that "females are carrying a much greater share of the load," and that the male:female ratio appears to be the *reverse* of that found in North America *(4)*, where obesity is also a major problem, then much closer examination of the *relative* importance of obesity, the character (rather than mere extent) of the involvement of females in the labor force, and types of family systems and relationships, is necessary.

There are also predictable associations between sanitary conditions and health status. The majority of respondents had access to adequate water and sanitary facilities: 65% had water piped into their homes; 91% had their garbage collected at the gate; and 65% had a water closet, while 32% had a pit latrine only. We found that those with access only to standpipes at some distance, and those who disposed of solid wastes through backyard burning, were more susceptible to disease. Thus, of those with a pit latrine, for example, 61% had had no illness in the preceding 12 months, as compared to 67% of those with a water closet. Similarly, of those burning garbage in the yard, 52% had experienced no illnesses, as compared to 65–86% for the rest of the sample. The differences become greater when only acute illnesses are considered.

The survey examined health practice awareness to determine whether this might have an independent and overriding effect on health status. It was interesting to find that although the large major-

Table 1. Health conditions of heads of households in Trinidad and Tobago, by age and sex (percentage distribution).

Age	Acute illness only		Chronic illness only		Chronic and acute		No illness		Total	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
15–19	—	—	—	100.0	—	—	100.0	—	100.0	100.0
20–29	11.9	7.4	9.0	3.7	—	—	79.1	88.9	100.0	100.0
30–39	9.6	8.3	9.0	13.9	0.6	—	80.8	77.8	100.0	100.0
40–49	8.3	2.0	17.9	23.5	1.3	2.0	72.4	72.5	99.9	100.0
50–59	7.7	15.2	25.4	30.4	3.8	10.9	63.1	43.5	100.0	100.0
60–69	13.4	9.3	31.1	34.9	7.6	9.3	47.9	46.5	100.0	100.0
70 +	5.4	5.0	41.1	57.5	3.5	5.0	50.0	32.5	100.0	

[a]This is a subsample of 691 males and 245 females; the total sample includes *all* household members.

ity of those interviewed knew the importance of good sanitation, hygiene, proper eating habits, regular check-ups, etc., it appeared to have little impact on their health status. That is, susceptibility to illness, either chronic or acute, did not vary noticeably with attitudes (see Table 2). To the extent that it did, the suggested explanation is that the onset of illness itself induced greater awareness of appropriate health practices. Thus, for example, those with chronic illnesses are more likely than those with acute illnesses to talk about proper eating

Table 2. Opinions of heads of households in Trinidad and Tobago regarding avoidance of illness, by health condition (percentage distribution).[a]

	Health condition				
Best way to avoid illness	Acute illness	Chronic illness	Acute and chronic	No illness	Total
Good sanitation and hygiene	10.8	20.6	3.7	64.9	100.0
Public/private spraying	8.0	16.0	8.0	68.0	100.0
Balanced diet/ proper eating habits	6.0	26.9	2.2	64.8	99.9
No smoking/ drinking, etc.	14.3	14.3	—	71.4	100.0
Better public education	7.7	23.1	—	69.2	100.0
Avoid environmental pollution	6.5	24.3	2.8	66.4	100.0
Regular check-up, good health	8.1	35.1	8.1	57.1	100.0
Practices prayers/faith[b]	22.2	—	—	77.8	100.0
"Prevention" (vague answer)	11.8	20.6	—	67.6	100.0
"Don't know"/can't avoid sickness	14.3	25.0	3.6	57.1	100.0

[a]This is a subsample of 954 individuals; the total sample includes *all* household members.
[b]Represents nine persons interviewed.

habits; those with acute illnesses were more likely to stress good hygiene. The only two exceptions were among those who abhor smoking and drinking, and those who fiercely believe in prayers and faith.

This apparent discrepancy between health awareness and health status stimulated even more interest in the relationship between level of education and health. Studies in other countries have found a more or less inverse relationship between socioeconomic status (using occupation as an indicator) and health status. In this context the influence of both occupation and education were considered. We are all familiar with the critical role that education plays, or is perceived to play, in the process of social mobility in the Caribbean region. Consequently, we felt that it might be useful to examine this variable both as a possible proxy for socioeconomic status and an indication of the levels of enlightenment or ability to receive and act upon health information.

Again, the findings were somewhat unexpected. The figures for the subsample are presented in Table 3 where it will be seen that those with a secondary level of education experienced the least illness in the reported period. Those with primary or no schooling enjoyed a health

Table 3. Level of education attained by heads of households in Trinidad and Tobago, by health condition (percentage distribution).[a]

	Health condition				
Level of education	No illness	With acute illness	With chronic illness only	Both chronic and acute	Total
No schooling	59.1	4.5	34.1	2.3	100.0
Primary school only	57.1	9.3	28.8	4.8	100.0
Junior and comprehensive secondary	82.5	4.2	13.3	—	100.0
Traditional secondary	78.2	10.2	10.9	0.7	100.0
Technical, vocational	74.7	12.7	10.5	2.1	100.0
College, professional and universities	57.6	15.3	22.0	5.1	100.0

[a]This is a subsample; the total sample includes *all* household members

status similar to those with a tertiary level of education. It is also interesting to note that those with very low levels of education were relatively free from acute illnesses but were more prone to chronic ones. The converse also holds: those with superior levels of education are more susceptible to acute illnesses than are the poorly educated, and less so to chronic illnesses. It is true that this correlation has not yet been controlled for age, but we are not inclined to think that it will significantly alter the picture. We believe that this correlation says less about the impact of education than it does about occupational and income variations that are implied, yet masked, by the patterns observed.

In correlating occupation and health status, the data suggest at least two possible conclusions. In looking simply at those individuals who do not suffer illness, the relationship is not a straightforward one: the high managerial and professional group were as illness free (73%) as the skilled manual workers (72%), and the unskilled manual workers and the unemployed were even more so (79–80%). Indeed, the healthiest group was the middle service group, comprised of secretaries, clerks, and sales agents. However, closer examination reveals that the occurrence of different types of illnesses complicates the picture. Individuals in the higher status occupational groups are more likely than are those in the lower groups to suffer from acute illnesses (15% and 11% compared to approximately 5–6% of the respective occupational categories).[4] On the other hand, there is a noticeable tendency for the incidence of chronic illness to increase as one descends the occupational ladder.

Controlling for sex confirms the earlier finding that females, regardless of their situation in life, are not as healthy as males. Females represent most of the unemployed in the sample (67%), but they are dominant in the lower managerial, professional, secretarial, and clerical categories. Yet with two possible exceptions, they are more likely to suffer from both acute and chronic illnesses.

Data presented in Figures 1–3 illustrate the relationship between health and occupation in all age groups. Controlling for age, the overall pattern is not significantly altered. It does indicate the likely reason for the generally superior status of that middle service, or the lower managerial, professional, secretarial, and clerical categories. They are

[4]This survey did not isolate the 0-4 year age group, and therefore did not focus on problems that may be peculiar to that group.

FIGURE 1. Percentage of adults in Trinidad and Tobago reporting no illness, by occupation and age.

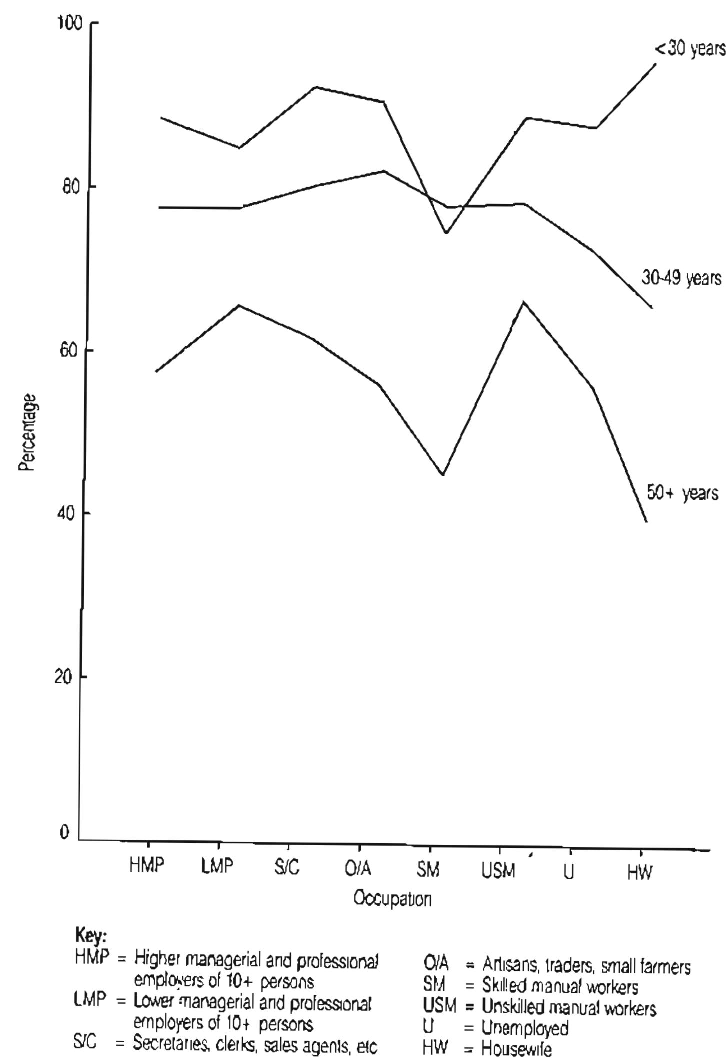


FIGURE 2. Percentage of adults in Trinidad and Tobago reporting acute illness, by occupation and age.

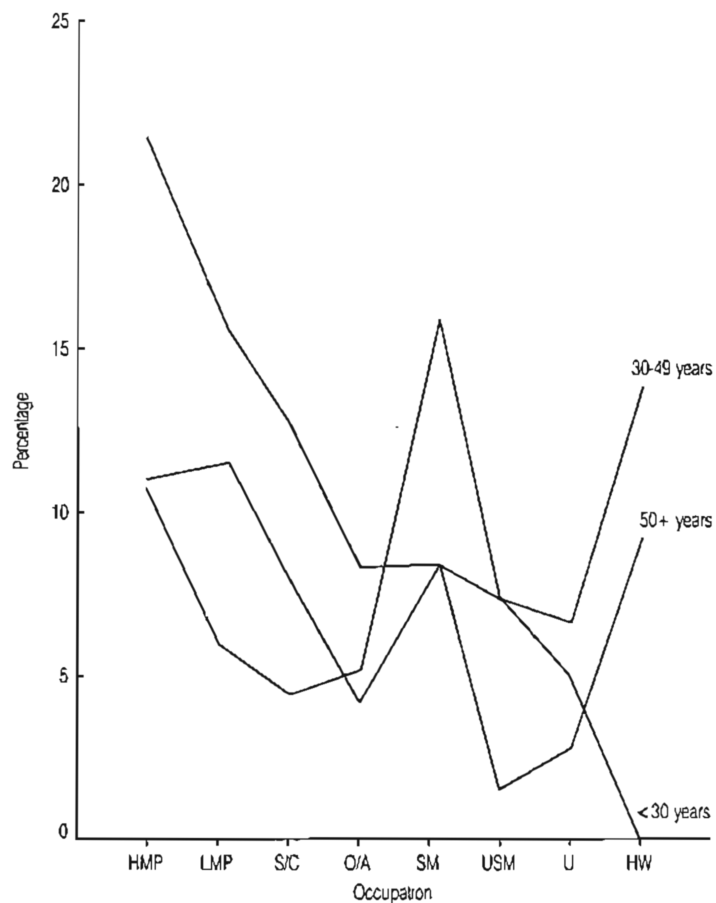
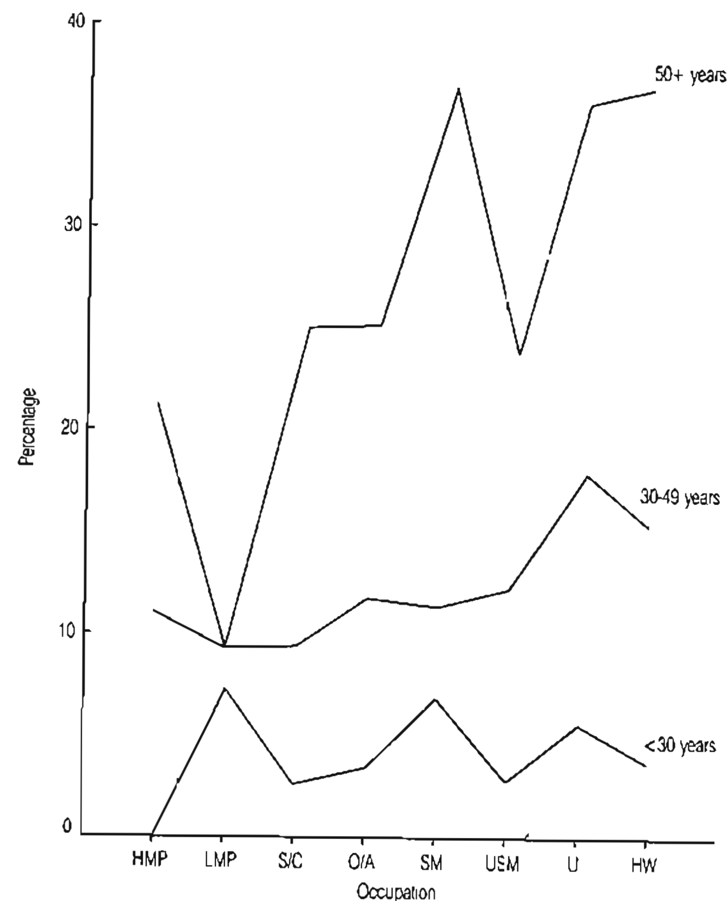


FIGURE 3. Percentage of adults in Trinidad and Tobago reporting chronic illness, by occupation and age.



the youngest group in the labor force while the higher managerial and professional category is, perhaps expectedly, the most mature group. Given this, it is interesting to note that for almost every age group over 20 years, the middle service group has the lowest incidence of chronic illnesses. At the same time, the unemployed, who have a fairly similar age distribution as do these "middle" groups, consistently have a higher incidence of chronic illnesses.

The general conclusions seem to be as follows: the overall relationship between occupation and health status is not as well defined as it might be, even though by age 30 the trend does begin to emerge. However, we think that one of the main reasons for this lack of clarity is the presence of opposing tendencies, whereby the incidence of acute illness tends to *fall* as socioeconomic status falls, but that of chronic illnesses *rises* as socioeconomic status falls. Finally, the housewife and the skilled manual worker appear to be in a class by themselves, in that they consistently have some of the highest frequencies of both types of illness.

If what we have so far been saying is essentially correct, then it raises a number of questions about what might be the appropriate response of a primary health care-oriented health delivery system to these new challenges. Any preventive/self-help system will, in all likelihood, discriminate against the poorer individuals in a society, unless ways are found to reach them. They do not, and are not inclined to, present at the health facility until there is little other choice. This is an orientation that is further reinforced by the relative absence of acute illnesses among poorer adults—they are, after all, the fittest, have survived the scourges of poverty, and are no doubt firmly convinced of their invincibility. The survey found that a significant number (37%) of the respondents never went for a check-up, the principal reason stated being "There is no need, because I'm not ill." Of those who did go, 55% did so occasionally, or went for a medical exam only. Those with chronic illnesses are the most frequent users of health services (73% compared to 69% of those with acute illnesses, and 55% of those with no illness). It may, therefore, be inferred that these kinds of visits tend to be for illness management rather than illness prevention, and are largely a function of the onset of an illness.

This being the case, the apparently higher incidence of chronic diseases among the lower status groups is sufficient cause for a review of the continuing preoccupation with drug therapy as the principal

method of disease control, and for careful consideration of increased privatization of the health delivery system.

In most of the Eastern Caribbean countries, the public sector is still largely responsible for the health delivery system. However, available data indicate growing private sector involvement, where most doctors straddle both sectors. Certainly for Trinidad and Tobago, our survey found that the majority of those interviewed consulted first with a private doctor. Further, those with chronic illnesses were more likely (61.4%) than those with acute illnesses (48%) to go first to the private physician. Those in this latter group tended to present as hospital outpatients or be immediately hospitalized.

It might be expected that long-term chronic illness management is costly. Does it follow, then, that the more socially disadvantaged are paying more for health care? This is a question that is still being explored, but which, unfortunately, will not be adequately answered with the kind of data we now have. However, the mere possibility that this is the case should be enough to encourage a greater sense of urgency among those who are trying to identify new and innovative ways to spend the health dollar more effectively.

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Part IV. The Declaration of Tobago

Declaration of Tobago

PRIMARY HEALTH CARE/
LOCAL HEALTH SYSTEMS WORKSHOP
MOUNT IRVINE HOTEL, TOBAGO
7–11 NOVEMBER 1988

The participants at the Primary Health Care/Local Health Systems Workshop (held in Tobago from 7 to 11 November 1988), representing Ministries of Health and Universities of the Commonwealth Caribbean, the Caribbean Community Secretariat, UNICEF, and PAHO/WHO, submit the following declaration for the consideration of Ministers of Health.

Declaration of Tobago

1. We *reaffirm* our commitment to health for all as a permanent goal for all the countries of this subregion up to and beyond the year 2000; and to primary health care as our strategy for its achievement.

2. We *consider* that the definitions of health for all and primary health care recommended by the June 1981 Caribbean Workshop on Primary Health Care are still appropriate to Caribbean needs and potential, and should be restated on this occasion.

> "*Health for All by the Year 2000*
>
> "Health for All by the Year 2000 in the Caribbean context is taken to mean much more than the absence of disease. It means that working people are fit and productive and are able to acquire and use new skills, that school children are fit and able to benefit from their education, and that their physical and mental development has not been permanently impaired by malnutri-

tion in infancy and early childhood. . . It means that health care is delivered by teams of well-trained and deeply committed health workers. It means that there is dynamic and creative management of the health services. It means, above all, that people have determined for themselves the most important community health problems and are actively involved in programs for solving them.

"*Primary Health Care (PHC)*

"Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development, in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community."[1]

3. We *endorse* the three basic concepts of the primary health care approach which were included in the revised Declaration on Health for the Caribbean Community, adopted by Ministers of Health at the Eighth Meeting of their Annual Conference held in Barbados in July 1982:

(i) Health is a fundamental right of every human being;
(ii) A government has a duty, on economic as well as on humanitarian grounds, to provide essential health care for *everyone* irrespective of ability to pay at the time of receiving attention;
(iii) Individual citizens—and the community as a whole—have a responsibility for their own health, not only in terms of habits and behavior, but in all aspects of health within their competence.

[1] CARICOM, "Primary Health Care Strategy and Plan of Action for the Caribbean," Workshop on Primary Health Care, Saint Lucia, 7–13 June 1981, p. 1.

4. We *emphasize*, however, that the PHC approach *must* pervade the entire health care system, and therefore should be fully integrated *at all levels*—including the secondary and tertiary.

5. We *note* that the PHC approach in the Caribbean has demonstrated its effectiveness in disease control, and improvement in community health status, *inter alia*, through encouragement of the planning process, and training/deployment of new cadres of health workers.

6. We *recognize* that despite this progress, some of the minimal targets of the 1981 Strategy and Plan of Action (the 25-point action plan) have *not* been met, especially in relation to:

- Community participation
- Intersectoral coordination
- Restructuring of the health care systems
- Development of management including health information systems to ensure proper planning, programming, implementation, monitoring, and evaluation
- Promotion of health systems research and innovation in appropriate technology

7. We *note* also that in almost all our countries many of the key indicators of health status have continued to show favorable trends. Nevertheless, we are *fully aware* that these national averages mask continuing problems in vulnerable groups, especially among the poor and disadvantaged. These differentials have been exacerbated by the socioeconomic crisis of the 1980s, and are as "politically, socially and economically unacceptable" today as they were at Alma-Ata in 1978. They bring into sharp focus the central issues of *social justice* and *equity*.

8. We *believe* that provision of health care of a *quality* and *level* that is appropriate to *need* can best be achieved through the development of *local health systems* within each country. Local health systems are an important mechanism for strengthening the primary health care approach, and for facilitating attainment of those critical targets in our Plan of Action which have still not been met.

9. We *note* that the fundamental tenets of local health systems development include:

- Decentralization/deconcentration
- Community participation/social mobilization
- Intersectoral coordination

- Adjustment of financing mechanisms
- Development of new care models
- Integration of prevention and control programs
- Strengthening of managerial capacity
- Training of the work force in health
- Research

and that application of the principles of local health systems will require complementary adjustment of the functions at the central level of the national health system; and redefinition of the role of the hospital.

10. We are *convinced* that continuing progress in improvement of the health of the Caribbean people will require mobilization, support, and commitment of *leaders* at all levels as advocates of health development.

11. We *urge* all health workers, nongovernmental organizations, the universities, the CARICOM Secretariat, PAHO/WHO, UNICEF, and all the agencies to rededicate themselves to achievement of health for all through primary health care, and to cooperative action through the CARICOM/PAHO Caribbean Cooperation in Health initiative.

Annexes

ANNEX 1

Work Program

Primary Health Care/Local Health Systems Workshop
Mount Irvine Hotel, Tobago
7–11 November 1988

Monday, 7 November 1988

08:30–10:00	Opening Session
	Introductory Remarks: Miriam Caesar Moore, Tobago House of Assembly G. Norris Melville, CARICOM Jane E. Haile, UNICEF
	Feature Address: Elizabeth Quamina, Ministry of Health, Trinidad and Tobago
10:00–10:30	Recess
10:30–11:30	Primary Health Care—Caribbean Update, by Mervyn U. Henry
11:30–12:45	Review of Primary Health Care by Groups of Countries, by Claudette Harry-Ashley, C. Etienne, and Lowell Lewis
12:45–14:00	Lunch
14:00–15:30	Group Discussion
15:30–15:45	Recess
15:45–17:00	Plenary: Group Reports/Discussion

Tuesday, 8 November 1988

08:30–09:30	Local Health Systems, by José María Paganini

09:30–10:00 Plenary Discussion
10:00–10:30 Recess
10:30–11:30 Local Health Systems in the Caribbean, by Carmen E. Bowen-Wright
11:30–12:00 Community Participation, by Jane Haile
12:00–12:30 Intersectoral Coordination, by G. Norris Melville
12:30–14:00 Lunch
14:00–15:30 Group Discussion
15:30–15:45 Recess
15:45–17:00 Plenary: Group Reports/Discussion

Wednesday, 9 November 1988

08:30–09:30 An Overview of the Socioeconomic Situation in the Commonwealth Caribbean: The Crisis and Its Implications for the Social Sector, by Compton Bourne
09:30–10:00 Plenary Discussion
10:00–10:30 Recess
10:30–11:30 Economic Analysis of the Health Sector: Implications for the Implementation of PHC/LHS, by Elsie Le Franc
11:30–12:00 Plenary Discussion
13:00–14:00 Lunch
14:00–15:30 Group Discussion
15:30–15:45 Recess
15:45–17:00 Plenary: Group Reports/Discussion

Thursday, 10 November 1988

08:30–09:15 New Health Care Models, by Carol Collado
09:15–10:00 Group Discussions
10:00–10:30 Recess
10:30–12:00 Group Discussions
12:00–13:30 Lunch
13:30–15:00 Group Discussions

15:00–15:30 Recess
15:30–17:00 Plenary: Group Reports/Discussion

Friday, 11 November 1988

08:30–12:00 Final Plenary Session
1. Consideration of Draft Final Report
2. Adoption of Final Report and Declaration of Tobago
3. Closing Remarks

ANNEX 2

List of Participants

Primary Health Care/Local Health Systems Workshop
Tobago
7–11 November 1988

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ANNEX 3

Presentations at Opening Ceremony of Workshop

Introductory Remarks
Tobago, 7 November 1988

Madam Chairperson, distinguished guests, I am quite pleased to bring you greetings on behalf of the Tobago House of Assembly on this historic occasion. I am informed that this is the first such Conference to be hosted by PAHO in Tobago.

Permit me to express appreciation to PAHO/WHO for the tremendous work done in health promotion and disease prevention in the Caribbean Region. Your generous assistance to the governments I am sure is greatly appreciated. You no doubt are encouraged by the tangible evidences of the fruits of your labor.

It was only last week that you hosted a workshop on Caribbean diarrheal diseases at this venue. There were also participants from different parts of the world in attendance.

We feel deeply honored that you chose Tobago for these important conferences. It is indeed gratifying to know that we can provide the environment that is conducive to healthy deliberations, and to be able to contribute in a small way in making your task easier as you develop plans and programs for health in the region.

I must also specially recognize the presence of the representatives from UNICEF. Your contributions to the health and well-being of the children of the Region will go a long way in helping us achieve our goals for the year 2000 and beyond. We are recipients of your generosity and anticipate your continued support.

Gracing our presence today are participants from the CARICOM Region, the Cayman Islands, Turks and Caicos Islands, Suriname, the Bahamas, Anguilla, and the British Virgin Islands. A warm welcome is extended to you on behalf of the people of Tobago.

The focus during this seminar on Primary Health Care and Local Health Systems is very timely, given the present socio-economic climate of the Region and, to a larger extent, the developing world.

This is of even greater significance to us in the Tobago House of Assembly since we were given total responsibility for health in Tobago by the government last year. Even though there is ongoing collaboration and consultation with the Ministry on matters of health in Tobago, there is still need for greater development in our local health system.

Tobago is in a unique position to capitalize on any recommendations made by your team that are germaine to improvement in health delivery. Based on your criteria for achieving primary health care goals, we can say that we now possess the political will. The foundation is laid and the framework is in place. We are now in dire need of the building blocks so that the structure can take form.

I am confident that conferences such as these will assist us greatly as we strive towards improving our systems, which would result in better health care delivery to the people.

Your deliberations this week will no doubt produce the desired programs and approaches that will minimize the burdens now placed on the health systems—especially when viewed within the context of health for all by the year 2000 and a depressed socioeconomic climate.

As peoples of the Caribbean region we possess the resolve and determination. I have faith therefore in believing that we will rise to the occasion.

I await the outcome of this workshop so that we can utilize the information in our planning.

Ladies and gentlemen, I thank you.

MIRIAM CAESAR MOORE,
Tobago House of Assembly

When I began to gather my thoughts for this morning's ceremony I realized that it would be difficult to be profound or original on the subject of primary health care. In that realization I went back to the Joint Report prepared by WHO and UNICEF at Alma-Ata in 1978.

On rereading that document I was struck again by the profoundly revolutionary nature of the prescriptions outlined there; revolutionary in the sense that they overturn the established view of the patient as an ignorant, passive, and dependent object, dependent on and subordinate to the medicine, the hospital, and the doctor.

In the joint declaration of Alma-Ata there is also, of course, an important recognition that the health of an individual, a family, and a nation depends for the most part on factors outside the purview of the medical profession; and that whilst medical professionals are essential for treatment of ill-health, maintaining "wellness" requires a much broader and more holistic approach.

What can we say 10 years after Alma-Ata about our success in transferring our rhetoric from "paper to people" in the phrase of Dr. Tejada de Rivero?

What are the indications we should look for that the primary health care approach has taken root in a given country?

From my knowledge of the literature, as well as my direct experience with a number of primary health care systems in South and Southeast Asia, I would like to make a few observations on both the positive and negative features of implementation to date. I think it can be said that the most evolved primary health systems are to be found in those countries where decentralization of health care stems from urgent practical, as well as humanitarian, concerns. I am thinking, of course, of countries with large and scattered populations, low GNP/GDP, and high IMR where a large percentage of the population have little or no direct access to the medical services. In such a situation the training of multitiered cadre primary health care workers can indeed seem like the answer to a prayer.

There is often also—and we should be very frank—a strong element of passing the buck involved in generously devolving to the community the responsibility for the tasks which the professionals have failed to accomplish. We have many instances, and I am thinking particularly of Asia, where new bureaucracies of primary health care have been built, involving layers of intersectoral primary health care committees and armies of health care workers trained—usually rather briefly—to perform a battery of curative and promotive tasks at the community level.

I think we have sometimes become trapped by our own rhetoric. The building of more clinics and health posts outside the urban centers does not of itself indicate that we have extended the outreach of the center; we have, rather, truly involved and stimulated our consumer public. For me, the best indications that the primary health care approach has been implemented are the changes taking place in individual beliefs and behavior.

- Do people realize that the health of their bodies is their concern?
- Are people aware of how to maintain their health?
- Are they capable of simple self-cure for themselves and their children—or do they run for the doctor and the Kaopectate at the first sign of diarrhea?
- Do they know how to use the medical services that are available? Do they know what they can demand from the services and what they should refuse?

The implementation of primary health care also requires attitudinal and behavioral change in the medical profession: Are doctors treating their patients as whole human beings or as a series of symptoms to be quickly treated? Are doctors themselves promoting self-maintenance? Are doctors advocating health issues beyond the health sector by becoming more involved—for example—not only in advocating safe working conditions at the place of work, but also in day care centers so that women can practice what we preach?

Another indication of the adoption of the primary health care approach is the involvement of media of all kinds—human, electronic, and print in discussion of health issues. During the following days I am looking forward to hearing from all the participants what are the key primary health care issues to be addressed in the Caribbean. In many Caribbean countries the functions that have traditionally triggered the development of primary health care systems—geographical dispersion, lack of access to physicians, yawning cultural gaps between rural folk-culture and western-trained medical practitioners—are absent. Hence, not all the features of the classic primary health care system may be applicable here.

As a relative newcomer I have been struck by the dependence of the average person on doctors and clinics for treatment of even small ailments, and the often scanty knowledge of basic nutrition and health factors relating to self-maintenance. Here, as elsewhere, the key to implementation of primary health care would seem to be better communication and sharing of knowledge with the community.

In the Caribbean, unlike many other countries where we work, there exists tremendous capacity to promote better health. Newspapers, radio, and television are almost universally accessible—dynamic

NGOs and service organizations are a common feature, and the education system is all-embracing—indeed already incorporating health and nutrition issues into the curriculum in several countries.

As we move toward the fourth development decade and into the second decade of primary health care, I would like to reiterate here UNICEF's commitment to building a grand alliance with our sister agencies, with ministries of health, and with all other institutions and sectors who must be involved in achieving health for all.

Ladies and gentlemen, I thank you.

JANE E. HAILE
UNICEF, *Caribbean Area Office*

Feature Address

The Honorable Minister of Health, Dr. Emmanuel Hosein, has found it impossible to integrate our national airline timetable with his schedule for today. He realizes the importance of this meeting. As Chairman of the Caribbean Conference of Ministers of Health he looks forward to receiving the reports and recommendations emanating from this Workshop.

I welcome all participants from sister countries to Trinidad and Tobago on behalf of the Minister of Health. I can assure Ms. Miriam Caesar Moore we shall enjoy Tobago! It is now 10 years since Alma-Ata. On 12 September 1978, 134 nations and 67 organizations pledged their commitment to action to promote the health of all the people of the world. It was the birth of the health for all movement! The strategies to achieve this goal are enshrined in primary health care. The target date is fast approaching. Caribbean countries were represented at Alma-Ata and they have accepted the challenge. In 1981 in St. Lucia the 25-point plan was agreed upon setting clearly defined regional targets. Where do we stand now?

The advent of health for all has made a significant impact on fundamental concepts, and the progress toward equality has increased in momentum.

- There is political awareness and commitment by Ministers of Health for the concepts and goals of health for all, but by itself this does not carry us far along the road. Policies, budgetary allocations, organizational rearrangements, and strong managerial capabilities are required to provide continuous support for primary health care.
- Greater effort is being made to reach underserved populations—the elderly, the disabled with particular reference to the blind, and AIDS victims.
- Identification of target groups for education and service has begun—school populations, teenagers at work, and persons with, or at risk of developing, chronic diseases.
- A team approach to the delivery of health care has been accepted and put into effect, and new disciplines are joining the team. Social scientists are contributing to formulating solutions to health problems. Local health systems are being strengthened and program planning at local levels is being introduced.
- The importance of community acceptance and participation is being emphasized and encouraged.
- Increasing emphasis is being placed on encouraging personal responsibility for health and providing the necessary education to support that goal.
- More nongovernmental organizations are entering the health area and becoming partners in programs by actively participating in AIDS programs. Disaster preparedness pressure groups represent interests in particular diseases and in the management of projects.
- Training in management skills and the use of program planning have been identified as major areas for health manpower development.
- Intersectoral interaction has increased but is not yet accepted practice. There are now many intersectoral committees on health-related matters where other government agencies take lead roles and health sector representation is requested. This is a sign of increased awareness of "health." But health does not *have* to be boss!

In Trinidad and Tobago, the draft "Medium Macro Planning Framework" focuses on most of these issues in the chapter dealing with the health sector. But there are some recent disquieting trends, some of them felt acutely in Trinidad and Tobago, where the rapid economic recession has caused the imperative of adjustment to become a harsh reality within a short period.

As a consequence, new issues have assumed critical importance:

- Alternative means of financing health care, which in the Caribbean have been traditionally funded from general revenue;
- Decrease in per capita income has highlighted the health consequences of poverty and unemployment;
- The renewed battle for resources between maintaining primary health care priorities in the face of the demand for access to high technology medicine;
- The necessity for health education to enter the realm of the twentieth century and the mass media.

However, regretfully, the pace is slowing. The economic crisis has had a strong negative effect on the delivery of health care in the Caribbean. The social sectors are under severe strain as a result of budget cutbacks. Public health services are facing increasing burdens as people who used to pay for private health sector care turn to free services financed by general revenue. There is a danger of losing the headway made and falling back to the situation of 15 years ago.

The countries of the area, who have a long history of sporting, education, and family links, have come together through the economic and political grouping of CARICOM, and, in cooperation with PAHO, have presented the Caribbean Cooperation in Health initiative.

The six priority areas identified in the initiative are:

1. Environmental protection, including vector control;
2. Human resources development;
3. Chronic noncommunicable diseases and accidents;
4. Strengthening health systems;
5. Food and nutrition;
6. Maternal and child health and population activities.

There are indications, some very positive, that there are to be successful bilateral projects financed in these areas.

The great questions to be asked are: Will these projects be self-sustaining? Can they renew the momentum? Is this really the solution for us?

It is necessary, therefore, that we review critically our subregional 25-point plan and evaluate the primary health care strategy, and ask if we are placing the correct emphasis on its components. This Workshop should provide Caribbean Ministries of Health with a conceptual framework for thinking about the multiplicity of both new and old problems, and for guiding decisions about priorities and action with a special concern for equity in health. There is a disconcerting trend to discount investment in health in favor of economic improvement, and failure to recognize the importance of sustained social development as a contribution to long-term economic progress. There is a failure on the part of both politicians and their economic advisors to appreciate the fragility of the health situation in the Caribbean, where the balance in favor of healthy childhood is barely sustained, and can suffer as the price of certain food items increases by as much as a dollar! But health for all is a value issue—*all* children must be monitored, not some. *Equity* is our key word.

To achieve and sustain this ideal of equity requires constant surveillance—it is too easy to erode. There is need for enlightened leadership for health to ensure response where the greatest need is identified. The quality of leadership is critical and this potential will not be realized by pure chance. It is our solemn duty to take positive action to motivate and encourage new leadership at all levels and sectors—professional organizations, universities, NGOs, churches, and trade union communities—to bring their talents to bear on health developments. We have begun the task of informing and educating people to enable them to share in the opportunities and responsibilities, and to make decisions about their own health. But communities need a framework and a leadership in order to convert their aspirations for a healthy, productive life into a reality. Enhancing the health of communities should not cause fragmentation of the development process, and an integrated approach is essential if people are to obtain the support they need to reach their full potential.

Equity cannot be ensured without the use of simple indicators to measure progress—not only at the national macro level where vast discrepancies in equity of care can often be masked, but at the district level. Strengthening of management and evaluation capabilities in the district health system is a further step along the path to identifying and meeting the needs of disadvantaged groups.

It is at the district (or county) level that the greatest strides can be made in forging strong intersectoral linkages, and this has been illustrated in Trinidad and Tobago. However, one of the most difficult linkages to establish within our own health sector has been that of hospital linkages.

In basic terms we cannot put any more financial resources into health. Technology costs (including pharmaceuticals) are rising, while human resources are available, literate, and resourceful.

To adjust the balance between health costs and available resources, greater human efforts must be made at ensuring that individuals and communities stay healthy. The process must start before conception! We need to derive policies and strategies to meet this goal. The cost of technology has to be reduced—just as with time the "price of sale" has fallen! More research into "appropriate technology" is required.

I wish to thank PAHO/WHO and the Tobago House of Assembly for this opportunity to meet together in order to identify our problems and to derive strategies that will bring about solutions. A previous speaker stated that we have within the Caribbean a "tremendous capacity to promote better health." I agree and I am confident that we shall succeed.

ELIZABETH QUAMINA
Ministry of Health, Trinidad and Tobago

ANNEX 4

Recommendations of the Primary Health Care/ Local Health Systems Workshop

Tobago
7-11 November 1988

Participants of the Workshop, having reviewed progress in implementing the primary health care strategy;

Noting the achievements and shortcomings in the countries of the Caribbean,

Determined that the development of local health systems should now be the major initiative in all our countries, wish to make the following recommendations:

1. Governments of the Region should continue to give full commitment to the primary health care approach as the major strategy for the achievement of improved health status of the Caribbean.
2. Ministries of Health should take the lead role to promote intersectoral coordination as a major strategy for achieving the primary health care approach. Such promotion should take place at the highest political levels as well as throughout all levels of the public administration system.
3. A *sine qua non* of the primary health care approach is the acceptance of people of responsibility for their own health. In this regard Governments should take every step to promote community participation in health at all levels to the greatest degree possible, and in so doing utilize and build upon existing methods of community

participation, utilizing local health systems. At a minimum, such participation should be obtained in problem identification.

4. Many Governments of the Region already administer health services through local health systems of varying degrees of development. These systems should be further developed and strengthened as the major operational tactic for implementation of primary health care. These organizational arrangements would bring health workers in closer contact with the communities they serve and would facilitate and enhance community participation, intersectoral coordination, and accountability to the populations served.

5. All local health systems should establish closer linkages with nongovernmental organizations and community groups at the local level so as to ensure that the resources of these organizations are utilized for priority health problems identified with full participation of the community served.

6. In strengthening of the local health system special attention should be paid to the management process, including development of the health information system for defining and responding to health needs; to the planning, programming, budgeting, and evaluating process, and to the management of human resources within the context of achieving equity, efficiency, and effectiveness in the delivery of services.

7. The local health system should not be established in isolation, but should be integrated into the national health system with close linkage to the hospital services ensuring accessibility to services for populations served, based on health needs.

8. Given the negative impact that structural adjustment has had on social services, especially health, governments of the Region should be urged to consider and utilize Caribbean Cooperation in Health (CCH) as a major strategy for cushioning the negative impact. In addition to attracting foreign resources, CCH has the capacity to maximize national resources, streamline the national budget for health, and facilitate the effective and efficient use of national and subregional resources.

9. Governments of the Region are urged to consider more carefully than hitherto the health implications of structural adjustment policies being pursued. In this connection, Ministries of Health should take the lead to analyze the impact of such policies and to present the findings to relevant policy-makers to obviate any erosion in gains already made in health status of the Caribbean countries.

10. Alternative strategies of financing health care could have

considerable impact on the way health care is delivered within countries and should be critically examined, so as to ensure that equity is not compromised.

11. As an integral part of the training and preparation of health professionals, educational programs for such personnel should include a strong component of the primary health care/local health systems approach and there should be regular continuing education programs for health workers to ensure that they apply this new orientation and philosophy in the delivery of health services. PAHO/WHO should give full support to all such efforts.

12. PAHO and CARICOM should give priority attention in their technical cooperation programs to support Caribbean countries in their efforts to implement the primary health care approach, utilizing local health systems as the main tactic for reorientation of their health systems.

13. The CARICOM Secretariat should submit these recommendations to the next meeting of the Conference of Ministers Responsible for Health.

14. The Declaration of Tobago, which will be approved by participants at this Workshop, should be given the widest possible publicity throughout the Caribbean.

ANNEX 5

Extract from Strategy and Plan of Action for the Caribbean Community

At the Regional Workshop on Primary Health Care held in Saint Lucia from 7–13 June 1981, with the sponsorship of the CARICOM Secretariat, strategies and action plans for the achievement of primary health care were formulated and recommended for the Caribbean subregion. From these submissions, a "Primary Health Care Twenty-Five Point Action Plan" was derived. These strategies and action plans were approved by the Seventh Meeting of the Conference of Ministers Responsible for Health held in Belize in July 1981. At the Ninth Meeting of the Conference of Ministers Responsible for Health, held in Dominica in July 1984, the original target dates set for accomplishments were varied in accordance with the wishes of Member States. Following is the text of the 25-Point Action Plan with revised target dates.

25-Point Action Plan with Revised Target Dates

Preliminary

1. Conduct a national intersectoral workshop on primary health care (PHC) by 1984.

Policy

2. Establish an intersectoral mechanism at the highest level for the formulation of national health policies and plans by 1984.

3. Define overall health policy in support of primary health care by 1984.

Strategy

4. Prepare a strategy which will ensure implementation of the PHC approach and of already-approved regional strategies for environmental health, maternal and child health, food and nutrition and dental health, as well as programs in the other PHC areas by 1984.

Plans

5. Incorporate the planning process at all levels of the health service system by 1985.
6. Prepare a comprehensive health plan, integrated within the national development plan, with clearly defined objectives, priorities and resources and a built-in system of evaluation and feedback strategies, by 1985.

Activities

7. Begin at once:

   (a) the progressive shift of resources in the direction of PHC;
   (b) intersectoral cooperation at national and local levels; and
   (c) community involvement.

8. Examine the existing health care system and, where necessary, restructure it, adopting the PHC approach, by 1985.
9. Develop a management system which will ensure planning, programming, implementation, monitoring, evaluation, and updating of the PHC approach to ensure continuous responsiveness to changing needs, by 1985.
10. Prepare a written policy on community participation, including the establishment of the mechanism to facilitate it, by 1985.
11. List the facilities, including supplies and equipment, necessary for the implementation of PHC, by 1985.
12. Have a standard list of essential drugs in use by 1985.
13. Install an effectively functioning supplies management system, including drugs, by 1985.
14. Develop a manpower policy by 1985.

15. Initiate training programs to meet the needs of PHC and include personnel working in all the health-related sectors, by 1984.
16. Begin at once to develop a health information system that facilitates the evaluation of this Action Plan and complete it by 1985.
17. Write national guidelines on community participation and establish community mechanisms by 1985.
18. Initiate programs for the training of community leaders by 1984.
19. Field community health development teams that include all relevant personnel in all areas/districts by 1987.
20. Achieve active community participation at all levels by 1987.
21. Designate a small committee to promote the development of research and appropriate technology, by 1984.
22. Take part in a comprehensive regional review of alternative methods of financing the health sector by 1985.
23. Prepare a program of legislation designed to support PHC, by 1985.
24. Develop, with other Member States, the CARICOM Secretariat and other agencies, a mechanism to facilitate intercountry cooperation in the implementation of this Plan of Action, by 1984.
25. Take part, in close cooperation with the Secretariat and PAHO/WHO, in a work program to evaluate this Plan of Action, including the selection of indicators to measure impact, services, and the attainment of the targets listed in this section of the Action Plan, beginning immediately and ongoing.

ANNEX 6

Alma-Ata Reaffirmed at Riga: A Statement of Renewed and Strengthened Commitment to Health for All by the Year 2000 *

At the midpoint in time between the historic Alma-Ata Conference, in 1978, and the year 2000, a meeting was convened by WHO to review progress and problems experienced in pursuing the goal of health for all and to consider reassessments that might be necessary in order to proceed more effectively towards the goal of health for all by the year 2000, and beyond.

The meeting was held in Riga, USSR, from 22 to 25 March 1988, and brought together experts from all WHO regions as well as representatives of UNICEF, UNDP, and nongovernmental organizations.

The participants concluded that the health for all concept has made strong positive contributions to the health and well-being of people in all nations. Nevertheless, they noted that problems remain which call for increased commitment and action to ensure more effective implementation of primary health care.

They strongly reaffirmed the Declaration of Alma-Ata and called for the principles and spirit of health for all to be made a permanent goal by all countries.

*This statement was adopted by participants at the World Health Organization meeting "From Alma-Ata to the Year 2000: A Midpoint Perspective," held at Riga, USSR, 22–25 March 1988.

Introduction to the Actions at Riga

At the International Conference on Primary Health Care held in Alma-Ata in 1978 the nations of the world joined together in expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world.

These concerns, expressed at the World Health Assembly in 1977, were emphasized again in the Declaration of Alma-Ata which stated: that a main social target should be the attainment by all people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life; and that primary health care is the key to attaining this target as part of development in the spirit of social justice. It was also stated that health, peace, and development are intimately related to one another, and that each must be pursued and protected in the interests of the well-being of mankind.

The experiences of the Member States in health development over the 10 years since the Alma-Ata conference make it clear that the concepts and principles of health for all have provided the world with moral, political, social, and technical guidance that has enabled countries to deal forthrightly with the problems of inequity in health care and the ill health of their populations.

This period has also demonstrated the potential importance of political action in contributing to health for all, such as action to decrease military confrontations and reduce defense expenditure, improve trade and economic relations, and the efforts to help resolve the problems of external debt.

Most countries have made considerable gains in increasing the equity and effectiveness of health services and in improving the health and well-being of their populations, thus affirming the validity and strategies of WHO's goal of health for all. Some striking examples can be given of improvements in coverage, effectiveness, and quality of programs:

- Immunization rates in most countries of the world have increased from about 5% of children in developing countries in 1970, to more than 50% in the late 1980s;
- Decreasing infant, under-five, and maternal mortality rates are evidence of remarkable progress in many countries, whose under-five mortality rates have decreased by more than 50% since 1950;
- Many countries have based their national health policies on the concepts of health for all, emphasizing health promotion, including improvements in life-styles, and decentralizing initiatives to districts, cities, and local communities.

Despite widespread progress, it is evident that the gains have not been uniform, either between countries or within them. All countries recognize the need perpetually to fight against ill health even though the nature of health problems will change. Looking ahead to the turn of the century and beyond, it is clear that maintaining health and ensuring equity must be a permanent goal of all nations.

Moreover, a number of the least developed countries have made only very limited progress: their infant, young child, and maternal mortality rates and related morbidities remain unacceptably high. Projections of current trends to the year 2000 indicate that these mortality rates will persist at tragically high levels for many of those countries. For example, in many countries of Africa and Southern Asia mortality rates for children under five will still be well over 100 per thousand in the year 2000.

Health problems are also increasingly serious in large urban populations steeped in poverty.

Thus, health conditions in the least developed countries persist at levels that are so limiting and destructive of human potential and so contrary to the principles and intent of health for all, as to be unacceptable to the global community.

It is urgently necessary to recognize and acknowledge that many of the most serious health problems still remain largely untouched by development efforts. These residual problems, that contribute so heavily to the human burden of death and disability, sound an insistent call for careful assessment and more vigorous application of current approaches, as well as for new approaches—new research, new mechanisms, new partnerships, new resources—in order that these problems may be overcome.

The world is faced with variable progress in pursuit of the goal of health for all, remarkable gains by many countries, modest gains by others, and, for a tragic few, little progress at all. To address the range of persisting problems and to establish preparedness for problems that will emerge in the future, the following action must be undertaken:

The Permanence of Health for All

I. Maintaining health for all as a permanent goal of all nations up to and beyond the year 2000

Recommendation: Reaffirm health for all as a permanent objective of all nations, as stressed in the Alma-Ata Declaration, and establish a process for examining the longer term challenges to health for all that will extend into the twenty-first century.

It is clear that the principles and values contained in the Declaration of Alma-Ata that underlie health for all should be seen as having a permanent place in the responsibilities of nations with respect to the health of their peoples. No nation solves all of its health problems, and new problems continue to emerge in every country. These are biological and social realities of life.

In every nation there will be continuously changing patterns of health and disease, and always there is the national responsibility for dealing with those problems so as to safeguard the health of the people and ensure equity and promote a spirit of self-reliance.

The goal of the year 2000 continues to be a milestone of great significance. Associated with it are imperatives that identified targets be met in every country, but with particular emphasis on mortality and morbidity reduction in vulnerable groups in all countries.

At the same time, it is necessary to look over the horizon, beyond the turn of the century to the problems of that time, some continuing from the present, others emerging as entirely new. The capacity for dealing with those problems will be strengthened further between now and the year 2000. It is likely that a very important long-term contribution of the health for all movement will be to establish in every country, and in every community, an evolving capacity to deal with the health problems of that place and time.

Thus, the goal of HFA remains unchanged, but targets will shift from those suited to the decade preceding the year 2000 to those relative to future times and places. Key principles will remain—equity, effectiveness, affordability, community participation, intersectoral collaboration. Problems will change, as will the technologies and social and organizational mechanisms to grapple with them.

Here, at the midpoint between Alma-Ata and the year 2000, the goals of all nations should be:

To identify the critical challenges to be met between now and the turn of the century, and to make headway, even against the problems that have been most difficult to solve;

To lay the ground for the continuing work that must follow the turn of the century, heralding appropriate changes of strategy necessary to consolidate the pursuit of health for all beyond the year 2000;

To continue to recognize and affirm that health, peace, and development are intimately related to one another, and that each must be pursued and protected, in the interests of the well-being of mankind.

Intensifying Social and Political Action for the Future—Agenda 2000

II. Renewing and strengthening strategies for health for all

Recommendation: Each country should continue to monitor its own health problems and develop its own health strategies in the spirit of health for all. This will reveal its most pressing health problems and identify the most seriously underserved and vulnerable populations. Programs should be directed towards those populations in the spirit of equity, inviting their active participation in the development and implementation of the strategies.

It should be acknowledged and affirmed that the concept of Health for All by the year 2000, formulated at the World Health Assembly in 1977, and further elaborated at Alma-Ata in 1978, has provided the countries of the world with moral, political, social, and technical guidelines that have enabled and encouraged them to deal more effectively with the problems of health inequity and ill health of their populations.

In keeping with the goal of health for all, the majority of nations and regions have made substantial progress in dealing with their problems of inequity and ineffectiveness of health services, and have significantly improved the health of their populations. All nations should continue those efforts, and, in collaboration with each other and with WHO, should pursue further targets of improvement of the health of all their people so as to ensure that every citizen has the opportunity to live a socially and economically productive life. Such improvements should go beyond physical and mental illness to the

quality of life itself. Resources required to meet those targets should be identified and allocated accordingly.

In this spirit, special priority should be given to improving the health conditions of the poor and underserved, in the developed as well as the developing world, and in this way to reduce inequity. Steps should be taken to establish and pursue targets for reducing disparities in both health status and access to health services between disadvantaged population groups and the general population, for example, by reducing the differences from the national mean in under-five mortality rates, infant mortality rates, and maternal mortality rates.

It has to be re-emphasized that the concept of health for all has never included the simplistic notion that the world would ever be free of health problems. The purpose of health for all is to provide a conceptual framework for thinking about the multiplicity of problems, for guiding decisions about priorities and action with a special concern for equity in health, and for sharing experiences, problems, and ideas with other nations in order to promote health and reduce health inequities. It is recognized as well that both international and national policies must be adapted to local settings, where local people can bring about improvements in their own situations.

The procedures for monitoring and reporting on progress towards health for all are an important example of WHO support for sharing national experiences. They should be further strengthened to ensure that countries will benefit from each other's lessons and be inspired by examples of progress.

III. Intensifying social and political action for health

Recommendation: Intensify social and political actions necessary to support shifts in policy and allocation of resources required to progress toward health for all, including the involvement of other sectors, nongovernmental organizations, communities, and other interested groups. Seek mechanisms for promoting new partnerships for health among them and with governments.

Social and political action, both national and international, is imperative for progress in health development, not only to support the shifts in policy and support required to have a stronger impact on health, but also to enlist the participation of the wide variety of potentially interested parties—international organizations, nongovernmental organizations, universities, industry, student groups, individual citizens, health workers, and their associations—many of whom are waiting for indications of useful directions in which to apply their resources and energies. These should be true partnerships, with active sharing of ideas, resources, and responsibilities. The mass media should be used to inform others about the needs of health for all, and advocate efforts to meet them.

Political commitment is a prerequisite to progress toward health for all, but by itself may have limited practical value. Also vital are policies, which embody the commitment to work towards health for all; budgetary allocations, which are the litmus test of political commitment; structural rearrangements, which may be necessary for policy implementation; and strengthening of management, to progress towards targets and avoid excessive waste. In addition, assignment of strong leadership to key posts, and continuous support for primary health care at the district level, can help to ensure that effective services reach the periphery through planned programs rather than by only trickling down.

There is also an urgent need to challenge current international development philosophies that discount investment in health and other social sectors in favor of economic improvement only. Efforts should be undertaken to enhance the international climate for development support, including policies which focus on social equity rather than economic considerations alone, which recognize the long-term nature of social development, and which promote wider understanding and acceptance of the development process including respect for the people who are involved in its implementation. Economic policies should protect those who are most vulnerable and least able to protect themselves from economic penalties, and should recognize the contribution of social development to long-term economic progress. It is necessary to acknowledge that health is a fundamental right in addition to being a prerequisite to development.

National and international action is required to mobilize new resources and to create new mechanisms and new partnerships for health development, including joint mobilization of resources between health and other sectors. WHO should assume a leadership role in this effort by promoting debate and supporting initiatives on the feasibility of new approaches in favor of the most vulnerable groups.

A special effort should be directed toward enlisting joint efforts by major developed countries towards assisting the least developed countries. Savings achieved through reductions in arms expenditure would serve this purpose well.

IV. Developing and mobilizing leadership for health for all

Recommendation: Give strong emphasis in every country to developing and stimulating the interest and support of current and potential leaders in health and other sectors, at community, district, and national levels, in order to bring creativity, advocacy, commitment, and resources to bear on the challenge of health development.

Enlightened leadership for health for all is in short supply. Is it possible to achieve a major shift, in which those who can assume such leadership positions become more plentiful, rather than occasional, and in the front line, rather than only remote from need?

At its core, health for all is a value issue. But the problems it addresses are also quantitative—all people, not some. All children are to be monitored, not some. The impact of health for all must be quantitatively effective. The numbers of people who assume leadership roles for health for all must be quantitatively significant. Their influence must be pervasive.

But the quality of leadership is also vital. Those in positions where leadership is possible must understand the principles and imperatives of health for all, have a clear view of what is needed, what might be done to achieve it, how to function in their local situation to progress towards it, and how to mobilize others to join in working towards it.

There is a clear need for leadership in health and in other sectors at every level: in communities, where the need is for self-reliance; in nongovernmental organizations, where their flexibility and creativity can be brought to bear on problems of national interest; in universities, where their capacity for generating and trying new ideas and new programs can contribute to the effectiveness of health policies and services; in government, where the responsibility resides for reaching the poorest and most deprived, and where effective policies and programs in pursuit of health for all must be developed.

Ministries of Health must deal with multiple levels of policy formulation and resource allocation, including the parliament or its equivalent. Those in policy-making roles often need support in the form of policy-related research that will assist them in formulating strategy options. Managerial leadership is required, including the capacity to manage the changes that are vital for progress towards health for all. Leadership is needed to help redress the current imbalance between social and economic development.

There is a paradox about leadership. Formally trained and experienced leadership is in short supply, and often overused. At the same time, there are vast numbers with leadership potential who are untrained and inexperienced. Those already in leadership roles, often too few in number, need support, while at the same time training and experiential opportunities need to be created for others. Incentives need to be developed to help sustain those in leadership roles.

Beyond all else, leadership is to be people-centered—people leading people in order to benefit people. The ultimate impact is to be at the community level, where the need is the greatest and the opportunity to respond must be extended to those who are on the path towards self-reliance. Leadership formation must be a central theme in the larger scope of health manpower development.

V. Empowering people

Recommendation: Empower people by providing information, technical support, and decision-making possibilities, so as to enable them to share in the opportunities and responsibilities for action in the interest of their own health. Give special attention to the role of women in health and development.

Involvement of communities in primary health care in not an ethical nicety; it is a technical and social necessity. Key advances in health of communities depend on their decisions—about how they live, care for one another, and look after their environment. Important promotive, preventive, first aid, and rehabilitative actions can be undertaken by people in their own homes and communities. Services that are "delivered" from the outside will have limited effect unless fully understood, absorbed, and taken over by communities.

Health services should fully involve communities: in defining problems, about which communities often have intimate knowledge; in decisionmaking, in which communities have both a right and a responsibility; in financing, where community resources can be both essential contributions and a lever to ensure that the people's voice is heeded. Health services need to reach the home, family, and place of work, through local people trained in or near the community, to provide ready access to health assistance as required. Health personnel must learn how to organize and support community involvement.

The role of women in promoting healthy ways of life is essential. They need to be given opportunities for self-improvement and to contribute to the development and quality of life in their communities, including extending their activities beyond family life to policymak-

ing and implementation. Education alone may not suffice to put women in positions to take effective action—some degree of autonomy or independence is required for them to make decisions and take actions necessary to promote improvements in health for themselves and their families. Empowering women includes giving them control over their own lives, bodies, and family size.

Health is mainly determined in the home and the workplace, where families live and work in healthy or unhealthy ways, where behavior is influenced by family, neighbors, and fellow workers, and where decisions are made that affect every aspect of family health. People must be given information about their health and how it can be improved. For them to lack such knowledge leads to both dependency and ignorance, neither of which has a place in community development. People should participate in determining what kinds of information and education they need for their individual community development. The views of health professionals about community needs may conflict with people's perceptions—differences that require harmonization through better dialogue. Health services must help them to learn how to care for themselves.

The health of the family depends on the health status of all family members; the father and other members of the household should not be overlooked, even though priority is given to the mother and child. Attention to the others, as through assessing their health risks, also serves the interests of the mother and child, and supports the integrity of the family unit. Empowerment should go beyond mothers and fathers to their children, tomorrow's generation, who can be reached through schools and youth groups.

VI. Making intersectoral collaboration a force for health for all

Recommendation: Support the creation of sustained intersectoral collaboration for health by incorporating health objectives into sectoral policies and activating potential mechanisms at all levels.

It is widely recognized that health is not the concern of the health sector alone but is dependent on the actions of many social and economic sectors, both governmental and nongovernmental. Education for literacy, income supplementation, clean water and adequate sanitation, improved housing, ecological sustainability, food and other agricultural products, building of roads—all may have a substantial and synergistic impact on health. Nevertheless, few innovative examples exist of sustained intersectoral collaboration for health.

It is apparent that sectoral priorities and administrative structures usually preclude the sharing of ideas, joint planning, and collaborative action. This problem has been exacerbated by poor advocacy and lack of commitment to the ideas of intersectoral collaboration by the health sector itself.

At the very time when lack of resources for health is universally proclaimed as a most serious problem, it is neither rational nor defensible to ignore the potential of shared responsibility between sectors. Intersectoral collaboration must be made a force for achieving health for all.

Many practical possibilities for action exist. Identification of vulnerable groups and cross-sectoral assessment of their needs can provide the basis for collaboration at community level. Involvement in the process by people themselves adds to its effectiveness. Existing intersectoral mechanisms such as district development committees need to be further utilized by the health sector. This will require more effective advocacy on the part of health personnel in relating to other sectors. At the national level ways of strengthening sectoral policies need to be found so as to maximize the impact of health-enhancing actions whilst eliminating or reducing the impact of those that are harmful. The particular energies and interests of nongovernmental organizations may serve as important catalysts in all of these.

At all levels research jointly pursued by collaborating sectors can be an important tool for identifying ways of making intersectoral collaboration work.

Accelerating Action for Health for All—Agenda 2000

VII. Strengthening district health systems based on primary health care

Recommendation: Strengthen district health systems based on primary health care, as a key action point for focusing national policies, resources, and local concerns on the most pressing health needs and underserved people.

District health systems based on primary health care should be at the center of the health for all effort. Acceptance of primary health care is fairly general at policy levels, but implementation that achieves widespread coverage is often absent, especially in the least developed countries. The problem is only partly due to scarcity of resources. There are weaknesses in planning, management, financing and evalu-

ation capacities, and in training and providing effective support for personnel in field settings.

More attention needs to be given to strengthening health infrastructures. Given an effective infrastructure, primary health care programs can be added or deleted according to local need, targeted at specific problems. Emphasis should be on integrated or comprehensive primary health care, in contrast to selective or vertical structures, which often lead to overconcentration of limited resources on a few programs, and disruption of efforts to strengthen health systems based on primary health care as an integral part of community development.

A further deficiency is the inability and even disinterest in monitoring simple indicators of coverage and health status. These deficiencies result in systems that are blind to program impacts and powerless to correct drift or failure. Here is the heart of health for all's challenge—equity. Without a system design that can achieve coverage, without simple indicators to identify inequities and measure success or failure in dealing with them, without effective management, including a capacity for self-correction, without involving the community at all levels, equity becomes a lost hope.

Another weakness is the lack of supportive interaction between the district and higher levels of health services on the one hand, and with community-level activities on the other. Strongly centralized decision making discourages initiative at the periphery, while exclusive interest in health facilities and doctor-based services results in little support to community-level activities. Technical cooperation among developing villages (TCDV) can be encouraged through district health systems. To facilitate such activities, decentralization to district and community levels is essential.

The district is well suited to overcoming problems of health services in relation to community development, including: preparation of health personnel for effective functioning in district programs; management technologies; interaction with communities; and intersectoral working relationships.

Primary, secondary, and tertiary care levels of a health system involve vital interactions that are usually missing in health services, and the district health system is the ideal place to develop them. One of the most difficult linkages to establish among the levels of health services is between the front-line or district hospital and community-based primary health care. Maternity services, based in the community and backed-up by the front-line hospital, are one example of a challenge to primary health care that demands such effective linkages in order to save the lives of women with complications of pregnancy and delivery.

VIII. Planning, preparing, and supporting health personnel for health for all

Recommendation: Change educational and training programs for health personnel emphasizing relevance to health services requirements by locating learning experiences in functioning health systems based on primary health care. Provide strong moral and resource support for personnel, particularly those working in remote or difficult circumstances.

The deficiencies are deep and widespread—professionals inadequately trained to motivated to work where the needs are. Three aspects of health manpower development need emphasis:

- Recruitment and training are too often separated entirely from planning and utilization—a reason for WHO's emphasis on integrated health systems and manpower development (HSMD). But the integration must be more than a paper exercise; education and training should relate to and also take place in field settings where operational primary health care programs embody a large part of the desired manpower competencies. Training and uses of community and auxiliary level personnel need to be closely related to that of other health workers. Health manpower policies should be consistent with national health for all strategies.
- The preparation of health personnel needs to be strengthened in terms of relevance to health services and to people's health needs and demands, as in competency-based, community-oriented, team-focused learning experiences, and also in terms of educational methodologies, as in community-based, problem-oriented, student-oriented, self-learning experiences. More than academic jargon, these are key ideas in the interactions between education and function.
- Less well appreciated is the severe demoralization of health personnel in many field settings, particularly in more remote locations. The neglect and unresponsiveness of health services in this respect is consistent, widespread, and destructive. Neglect often leads to a sense of uselessness and lack of motiva-

tion, and, when such despondency occurs, loss of dependability and integrity are not far behind. Better management practices and personnel support systems could incorporate supportive policies, such as: incentives for exemplary work and assignment in hardship settings; amenities to improve the quality of family life; continuing education; and career development opportunities.

Universities and other training institutions have key roles to play in addressing these issues, by linking their educational, research, and services programs directly with national plans for health system and manpower development. Universities should be involved in community-based primary health care activities where various kinds of students can learn, as team members, how to address health and health system problems in community settings. Early exposure to community-based problems and to interactions of epidemiology and management can be emphasized. In these settings, students can also learn about the needs of field-based health personnel for support and professional encouragement.

Thus, the concept of health system and manpower development leads the university beyond the more traditional concept of the teaching hospital to a teaching health system. Through association with a functioning health system, the university has the opportunity for ensuring close relevance between educational preparation and national needs, and also for contributing to improvements in the field-based health services research.

IX. Ensuring the development and rational use of science and appropriate technology

Recommendation: Emphasize the applications of science and appropriate technology to the critical health problems that threaten populations in all parts of the world, and strengthen research capacities of developing countries, with emphasis on research aimed at improving the health of the most deprived people.

Science has much to offer health for all. Some problems call for most advanced scientific insight and methodologies almost on an emergency scale, as in grappling with the AIDS pandemic. There are other calls on science, some less dramatic, but no less important, for example, new applications of diagnostic methods that can be used even in remote locations. New vaccines will strengthen health services, and new techniques for the control of tropical diseases will ease the burden of suffering on countless lives.

However, the most serious deficiencies in improving health in developing countries do not relate to a shortage of technology, but to inadequacies of health system infrastructures and the high cost of making technology available to all in need. This fundamental deficiency is often compounded by the indiscriminate transfer of technology to developing countries. The result is the consumption of scarce resources which could be used more effectively in primary health care programs.

Technology assessment has an important place in assessing costs and impacts of alternative technologies. The costs of the transfer of technology may be more than that of the technology itself. Applying existing knowledge and technology when they are effective is an imperative first step. The utility of traditional versus modern technologies needs to be kept in view. Good maintenance can reduce overall costs and ensure reliable functioning of technologies. Educational methods are an important consideration in transferring appropriate technology from country to country and sector to sector.

Most problems of developing countries cannot be solved by indiscriminate technology transfers. Solutions must be developed on the spot, and capacity building in research is essential, based on a clear view of the range of technological choices involved, and a detailed knowledge of local research capacities. This is an ideal enterprise for North-South collaboration. Emerging needs for enhanced research capacity must be addressed in the context of extreme resource constraints and the search begun, nonetheless, for new resources, new mechanisms, and new partners. Operations research or health services research have great practical utility in dealing with problems at field level.

Attention should also be given to the ethical implications of advances in technology. When the technology is beneficial but costly, questions of equity and autonomy arise: who should benefit and who should be passed by, and what are the roles of individuals and communities in making such decisions?

Thus, a balanced strategy is needed for applying the benefits of science and technology to health worldwide. There should be strong support for the enhancement of scientific research and education in all countries. Continued global efforts should be directed towards

strengthening health research capacities of scientists from developing countries and their institutions, so they might collaborate in a global research network.

X. Overcoming problems that continue to resist solution

Recommendation: Establish priority programs aimed at overcoming serious problems where underdevelopment or disturbances of development are major contributing factors and progress has been very limited, such as high infant, child, and maternal mortality rates; substance abuse, such as tobacco and alcohol; and the imbalance between population growth and environmental and socioeconomic resources. Develop improved approaches through primary health care, emphasizing intersectoral action.

The most serious problems to be addressed between now and the year 2000 will be those which resist solution largely because of underlying conditions of severe underdevelopment, as in the least developed countries, or under conditions of long established patterns of personal and social behavior, as in developed countries. It is necessary to be clear, however, that the people are not the causes of these problems, they are the victims—of underdevelopment or "development-gone-wrong"—and solutions must address those development problems at their roots, and not simply blame people for circumstances the world has given them. Examples can be taken from both developed and developing countries:

Very high maternal and under-five mortality rates. Sixty-four countries with 40% of the world's population suffer more than 80% of the under-five deaths, and more than 90% of maternal deaths occurring in the world each year. These high death rates are embedded in the problems of underdevelopment—poverty, malnutrition, illiteracy, and contaminated environments—and remain unresolved in a large number of countries despite widespread knowledge of how to deal with the problems.

Underdevelopment, population growth, and environment. A number of developing countries face serious problems of socioeconomic underdevelopment: ineffective agricultural development, landlessness of populations, migration of rural populations to urban centers, poverty, weakness of health systems, including family planning services based on primary health care, and poor environmental health. These examples show the importance of a multisectoral approach to the solution of health problems on the part of national authorities and international organizations.

The expanding use of tobacco and its commercial exploitation. The continued use of tobacco in developed countries, and its expanding use in developing countries, with commercialization pursued in the face of irrefutable scientific evidence of human harm is an example of a global problem that calls for continued aggressive action to combat it at all levels: political, social, scientific, and economic.

Other examples can be given of problems embedded in the process of development in both developing and developed countries: alcohol and drug abuse; environmental pollution; enlarging and dependent aging population; unwanted pregnancies and illegal abortion.

Efforts to address these problems must be directed at the underlying problems of development. Primary health care, with its strong emphasis on intersectoral collaboration, provides avenues for addressing the problems. However, new approaches are also called for: new ways of analyzing the problems, new approaches to field-based research, new forms of interacting with other sectors, and new scales of action.

Special Priority Initiative in Support of the Least Developed Countries by WHO and the International Community

Recommendation: Establish a special international effort focused on the tragic circumstances of the least developed countries, especially those with markedly elevated infant, under-five, and maternal mortality rates, which will address specific obstacles to progress and will set targets to be reached by the year 2000.

While most countries have benefited from the health for all movement, a tragic residue suffering from death and disability is so extreme as to leave no doubt that they are being bypassed by even the barest of opportunities to progress toward some minimal levels of human dignity and well-being.

It must be appreciated that these nations are not the cause of these problems of development stagnation; rather they are the victims of it. They have been marginalized by it, and to a large extent they have been abandoned to it. The resources and processes involved in

international development have failed these people, and the health for all effort has thus far failed them as well.

In order to confront this unacceptable situation it is proposed that the World Health Assembly declare its commitment to helping these tragedy-ridden countries fully into the development process. This will require special and urgent priority on the part of WHO to support the poorest countries, particularly those with the highest infant, under-five, and maternal mortality rates. More extensive resources and stronger commitment than heretofore available are urgently needed.

The World Health Assembly should further undertake to monitor the outcome of this effort. The rate of progress should serve as an indicator of the effectiveness of the resolve of Member States in dealing with this most fundamental of challenges—countries which, without effective development assistance and collaboration, will likely slip further down the spiral of development failure.

ANNEX 7

Strengthening Primary Health Care *

Forty-first World Health Assembly
Agenda Item 12

The Forty-first World Health Assembly,

Recalling resolution WHA30.43 in which it was decided that the main social target of governments and WHO should be the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life;

Further recalling resolution WHA32.30 which endorsed the Declaration of Alma-Ata with its emphasis on primary health care and its integrated approach as the key to attaining health for all, and resolution WHA34.36 by which the Assembly adopted the Global Strategy for Health for All by the Year 2000;

Mindful of United Nations General Assembly resolution 36/43 which endorsed the Global Strategy for Health for All, urged all Member States to ensure its implementation as part of their multisectoral development efforts and requested all appropriate organizations and bodies of the United Nations system to collaborate with WHO in carrying it out;

Having considered the statement issued by a meeting in Riga, USSR in March 1988 to mark the tenth anniversary of the Declaration of Alma-Ata, known as "Alma-Ata: Reaffirmed at Riga";[1]

Recognizing that at this mid-point between the launching and the attainment of the goal of health for all by the year 2000, much

*Document WHA41.34.
[1]Document A41/19.

progress has been made by many countries in parallel with the evolution of their social and economic situation, but that there remain a considerable number of countries in which the health situation and the means for improving it remain highly unsatisfactory 10 years after Alma-Ata;

Convinced of the importance of district health systems for the optimal organization and provision of primary health care as an integral part of national health systems and of the global health system constructed primarily by countries themselves with appropriate support by WHO, and of the need for research and development as a vital step in fostering the development of such care;

Recognizing further that the active participation of the people and the communities and their contribution is essential to the attainment of the goal of health for all;

1. *Endorses* the statement "Alma-Ata: Reaffirmed at Riga," which emphasizes that the Declaration of Alma-Ata remains valid for all countries at all stages of social and economic development and that the application of its principles should therefore be maintained after the year 2000;

2. *Urges* all Member States:

(i) to increase their efforts to attain the goal of health for all by the year 2000 through health systems based on primary health care in line with the global, regional and national strategies to that end taking into account the statement "Alma-Ata: Reaffirmed at Riga";

(ii) to prepare for the continuation of these efforts beyond the year 2000 to ensure the maintenance and progressive improvements of the health of all their people;

3. *Thanks* all those multilateral and bilateral developmental agencies, nongovernmental organizations and voluntary and philanthropic bodies that have supported the struggle to attain health for all and appeals to them to continue and intensify this support;

4. *Calls on* the international community:

(i) to continue their support to the efforts of Member States in the development of health systems based on primary health care;

(ii) to take unprecedented measures to support the least-developed countries committed to improving the health of their people in line with the policy of health for all;

(iii) to support such efforts under the international coordination of the World Health Organization;

5. *Requests* the Regional Committees;

(i) to pay particular attention to the monitoring and evaluation of strategies for health for all with a view to identifying areas in which particular efforts are required and to taking appropriate action;

(ii) to report thereon to the Executive Board in conformity with the revised plan of action for implementing the Global Strategy for Health for All;

6. *Requests* the Director-General;

(i) to ensure the widest dissemination of this resolution and the statement "Alma-Ata: Reaffirmed at Riga";

(ii) to cooperate with Member States in the implementation of the recommendations made at Riga for accelerating progress towards Health for All by the Year 2000 paying particular attention to the problems that have hitherto resisted solution;

(iii) to intensify program activities of research and development on primary health care, including health services, within the existing organizational framework, with particular emphasis on:

(a) strengthening integrated health approaches and district health systems within the national context;

(b) the development and rational use of science and appropriate technology and their transfer among countries;

(iv) to secure resources from within the regular budget of the Organization and the continued mobilization of extrabudgetary resources as additional means for above program implementation;

(v) to ensure that the activities of the program and those of all other related programs give particular emphasis to supporting the least-developed countries;

(vi) to direct all programs of the Organization to increase their support to countries in strengthening the integrated approach and in research and development in primary health care with emphasis on strengthening district health systems;

(vii) to present to the Executive Board at its eighty-third session the proposed intensification of program activities of research and development in primary health care, including the feasibility of establishing a special program, and information on international support to the least-developed countries;

7. *Requests* the Executive Board:

(i) to intensify its monitoring and evaluation of the Global Strategy for Health for All, paying particular attention to supporting the countries in the strengthening of integrated approaches and to international support to the least-developed countries;

(ii) to report thereon to the World Health Assembly in conformity with the revised plan of action for implementing the Global Strategy for Health for All.

Fifteenth plenary meeting, 13 May 1988

ANNEX 8

The Development and Strengthening of Local Health Systems in the Transformation of National Health Systems *

I. Introduction

The fact that large sectors of the population in most of the countries of the Americas still do not have real access to health services and the fact that this deficit in coverage has occurred in the midst of a considerable constriction of the resources available for the sector pose a major challenge to the organizational and managerial capacities of the national health systems. It is for this reason that emphasis has been placed on the idea that, in order to reduce the effects of the economic crisis, it is of vital importance that the countries utilize their resources for comprehensive health service in the most efficient way possible and that, at the same time, there be an intense mobilization of national resources, supplemented by a mobilization of external resources in order to transform the health systems and thereby meet the growing needs of the population.

Recent evaluations carried out by the Governments on the progress made towards the goal of health for all by the year 2000 have revealed the complexity of the undertaking and the major efforts that

*Document CD33/14, presented to the XXXIII Meeting of the Directing Council of PAHO, 15 August 1988

still need to be made. As a result, it is necessary to intensify the analysis of the existing situation with a view to reorienting national and international resources with greater precision in order to translate political discourse into more effective and efficient concrete actions. Attainment of this goal will require very significant social and economic transformations, as well as a review of the orientation, organization, and administration of the national health systems. Each Government should undertake a careful analysis of the means and the sequence of actions needed to achieve these changes.

The transformation of the national health systems in the countries of the Region is necessary in order to respond to problems that impinge on their development, which include: a) the serious economic, political, and social crisis of the present decade; b) the insufficiency of institutional responses in the face of the growth and evolution of the problems confronting the health sector; c) the accumulated health debt, which translates into an accumulation of unsatisfied needs in the unprotected population groups; and d) the lack of equity, effectiveness, and efficiency in health actions.

Resolution XXI of the XXII Pan American Sanitary Conference defined the programming priorities for the quadrennium 1987–1990 on the basis of three areas:

- Development of the health services infrastructure with emphasis on primary health care;
- Attention to the priority health problems of vulnerable human groups through specific programs implemented under the health services system; and
- The process of administration of the knowledge needed in order to carry out the two preceding activities, in accordance with the management strategy for optimum utilization of PAHO/WHO resources.

In an effort to identify an approach that makes it possible to effectively advance in the development of that objective, it is considered that the strengthening and development of local health systems is an operational tactic suited for the application of the basic principles of the strategy of primary care.

Local health systems can provide a suitable environment for achieving social participation, intersectoral action, effective decentralization and control of decisions, and the use of more effective methods of planning and management in relation to the needs of each population group.

II. Current Situation

1. *Socioeconomic and political context*

In order to analyze the situation of the health sector in particular, it is indispensable to understand its relationship with the national economy, as well as the insertion of the Latin American and Caribbean economies in the world context.

The development models that prevailed in previous decades in this Region have led the Latin American and Caribbean countries to an extremely difficult situation that has been further aggravated in the 1980s. Of most paramount concern is the fact that formulas have not yet been identified for renewing the process of expansion of the productive bases, an indispensable element in order to eliminate underdevelopment and poverty.

The economic recession of recent years has detracted from the credibility of the political currents that were always associated with achieving goals related to growth, employment, and social development. The transnationalization of the economies on a worldwide scale along with the external debt have considerably restricted the scope and effectiveness of national policy instruments.

Fluctuations in the international market have also affected national economies in the form of worse terms of exchange with the more developed countries. The countries of Latin America and the Caribbean area are suffering from the consequences of the trade imbalances between the industrialized countries and the lack of coordination among those countries' policies. This limits access to markets and has an impact on financial currents.

These trends all share one unmistakable symptom: the Latin American debt crisis. Such a situation emphasizes the Region's structural insufficiency to sustain growth rates and the inability of the intersectoral structure to respond to the problem of underdevelopment.

Today, rather than transfer resources that would promote the formation of capital in Latin America and the Caribbean area, the industrialized countries are absorbing savings on a large scale. In 1987, more than US$28 billion was transferred out of Latin America and the Caribbean, and in the last five years the funds that were "lost," mainly on the payment of the accumulated external debt, totalled $130 billion.

With regard to the social situation, it is necessary to reexamine

the development strategies and to begin the search for new ways to promote economic growth without ceasing to respond to social demands, including those in the health area. The economic crisis has not only caused detriment to the well-being of vast sectors of the population, it has also limited the economic resources available for the public institutions that provide health services.

In the labor field, coexisting with the work force that is part of the modern sectors of the economy, there is now a population mass that is engaged in the so-called informal activities, especially in the urban fringes. At the same time, the modernization of agriculture and of the types of agricultural development, combined with ecological deterioriation, has caused an increase in the number of displaced workers, who are then forced to seek seasonal work or to migrate to the cities, where they are normally incorporated into the informal sector.

The process of urbanization has been rapid, and the differences in the levels of income and consumption of the various social groups have become more marked as well. Despite the growth of the per capita product in the Region, at present nearly one-third of the population is below the level of absolute poverty. This poverty is not distributed evenly within each country; rather it is concentrated in the most depressed areas, thereby aggravating the Regional disparities observed today in Latin America and the Caribbean.

In the face of the crisis triggered by the constraints of the prevailing economic models and aggravated by the magnitude of the external debt and by the world economic situation, the countries have defined adjustment policies in order to cope with this serious situation.

The search for equilibria in fiscal and monetary terms and in the balance of payments for the purpose of servicing the debt has resulted in many cases in increased unemployment and zero purchasing power for large sectors of the population. This is generating and aggravating situations of critical poverty and deteriorating the attention given to basic needs, especially in the neediest groups.

This same policy of adjustment in the economic area is felt as well in the social sector in the form of lower levels of investments and current expenditures, with the consequent effect on such basic services as health, housing, education, sanitation, and transportation.

In the health sector the impact of these adjustment measures has taken various forms: limited capital investments for key areas, such as basic sanitation and the maintenance and preservation of equipment and physical plants, and for the replacement of the minimum facilities necessary for providing care to marginal populations; limitations

for current expenditures, thereby affecting the normal operation of programs that address problems that are prevalent in the Region; and constraints that limit the administrative development of the sector and the training and development of personnel.

Another manifestation of the adjustment policies in the health sector is the concentration of resources in programs of action that focus on priority problems and that have greater immediate impact, as is the case of the immunization, child survival, or food supplement programs.

The constraints limiting the access of large masses of population to the health services thus have multiple and interrelated causes. Not only are there fewer opportunities for development, owing to high unemployment and the limited ability of the neediest population groups to pay for services, but the operation of the health system has deteriorated, as the result of inadequate investments, budget cutbacks for operating expenses, and low efficiency and effectiveness in management.

Consequently, such situations have aggravated the scenario of inequity in access to health services. There is a small fraction of population that has a high level of income and therefore has access to all the possibilities that private consumption can provide. Urban, and in some cases rural, workers attain an intermediate level of access using mixed schemes that involve resources from the State, the social security system, and direct payments to the private sector. Finally, there is a great mass of population in the informal sector—the displaced and marginal groups, both rural and urban—that is in a situation of extreme poverty. Their low levels of income increase their risk of disease and death; their basic needs, including health services, should be met by the State's health care systems, but these systems' response is increasingly insufficient, in quality and in quantity, in order to meet the growing needs of these groups.

It is evident then that most of the countries have accumulated an enormous social debt that is expressed in, among other things, relative differences in levels of health and in access to services. The economic crisis, the factors that gave rise to it, and the difficulties in recovering from it and adopting new models of development are the most important constraints limiting the possibilities for socioeconomic development. At the same time, they represent a challenge to seek a new balance between meeting the requirements of economic growth and meeting social demands, including those in the health sector.

Within this socioeconomic panorama it is important also to observe the role of the State. In the sphere of political organization, there has been a prevalence of models with concentrated power and concrete manifestations in the control of the sources of resources and in the overall decisions on economic and social policies. Administratively, there has been excessive centralization, which has reduced the capacity of the provincial and local levels of government to respond to the needs of their populations and severely limited the political participation of broad sectors of society.

At the same time, these constraints have contributed to a generalization of bureaucratic formats in the management of the public sector. The manifestations of inefficiency and lack of commitment to community interests have become frequent even in the health sector of many countries.

Even with the political and historical diversity that exists in most of the countries of Latin America and the Caribbean, the State should play a decisive role in the promotion and guidance of development. In addition to facilitating the growth of the productive infrastructure, mediating in conflicts of interest, and coordinating the operation of the economy, it should also play a key role in social development and services as a fundamental means of ensuring growth with equity.

In recent years, the Region has seen a trend toward changes in its formal political organization and these changes have opened the way for the establishment of Governments that are more committed to the needs of broad sectors of the population.

This is a situation, then, that requires new roads that combine economic growth with a social project that is geared toward greater equity, with more participatory forms of guidance, and in which the development of health plays a key role as a motivating element.

2. *Health situation*

In the Region of the Americas, as well as in the entire world, there is sufficient awareness of the special significance of the present stage of development of our societies and the projections of this situation for the coming years. We are witnessing, without a doubt, a rapid period of change that is producing an impact on all aspects of our lives as well as deep repercussions on the health situation and on the resources available for coping with it. An understanding of this process of change and the consequent adjustment of actions in the health sector and in society itself are an ineluctable responsibility if

the goal that has been set by the Governments is to be attained: to achieve health for all by the year 2000 with equity, effectiveness, efficiency, and participation.

As socioeconomic development progresses, changes occur in the health situation as well, both in the populations' profile of diseases and in the organization of the health systems that are to handle them.

Thus, there is an initial stage—in which there is a predominance of the infectious diseases linked with poverty, malnutrition, and precarious environmental health and personal hygiene—that would respond to greater availability of food, improved housing, higher literacy levels, and certain public health measures, particularly extended coverage of drinking water services, sanitation, and vaccination.

A predominance of cardiovascular diseases, cancer, strokes, mental problems, and other degenerative diseases, such as diabetes, characterizes what could be termed the second stage. The public health measures needed in the previous stage are assigned to the normative level and models of individual care now predominate as instruments for the prevention and treatment of this type of health problems. The development of expensive and complicated technologies for diagnosis and treatment contributes to the transfer of medical care from the physician's office to specialized hospitals. These technologies, when they are introduced to the market without adequate evaluation of their safety, efficiency, and effectiveness, or when they are used in excess, result in higher costs for the models of individual care, thereby further limiting the already poor access of the population to health care.

The third stage in the evolution of the health situation is characterized by a predominance of health problems caused by environmental exposure to a growing number of chemicals and other toxic substances. Also, modifications are observed in the social conditions of families, communities, and work that influence behavior and that are associated with violence, alcohol abuse, and drug addiction in epidemic proportions. The search for rapid economic development, without proper protection of the environment and the population, accelerates the occurrence of such health problems as occupational diseases, traffic accidents, and environmental pollution. Similarly, migration, unemployment, and the breaking up of families and communities are associated with a variety of disorders, such as alcoholism, violence, and promiscuity, each with its own physical, mental, and social repercussions. Higher life expectancies and the resulting in-

crease in the economically inactive populations, i.e., children and the elderly, add new dimensions to these problems. The problems generated by this stage pose the need to adapt health and sanitation services and systems so that they can focus their attention on health promotion and on the application of collective and individual preventive measures through effective commitment and coordination with other sectors.

The developed countries took more than a century to go through these three stages. The developing countries face the challenge of living with the three models simultaneously. In the poorer populations, which constitute the majority, there is a predominance of the first-stage problems; in better off populations, especially in urban areas, the second-stage problems are more common; while the large cities are already experiencing problems of the third stage as a result of the environmental and social deterioration that accompanies disorderly urban growth and unemployment.

This situation highlights the need to identify the differences that exist between various population groups. Hence, it is indispensable that the analysis of the health situation be carried out at the local level, broken down by type and level of risk for the prevalent kinds of harm and the accessibility of health and sanitation services. The need to know this situation at the local level is fundamental since national averages mask the specific problems of population strata and of certain regions that are in a relatively worse situation.

Most of the countries of Latin America and the Caribbean thus face a complex epidemiological picture, and consequently the measures for their solution are also complex. The economic and social crisis summarized in the previous chapter surely will require considerable creativity in order to cope with these problems appropriately with equity and efficiency.

3. *Situation of the health systems*

In response to this complex health situation and in accordance with the objectives and goals of Health for All by the Year 2000 and the strategy of primary care, the countries of the Region have begun to restructure and expand their health systems with a view to enhancing their equity, effectiveness, and efficiency. However, this process is far from achieving the expected results, in part because the health sector has to compete with other sectors for extremely limited financial resources, and in part because of limitations in the organization and administration of the sector.

The countries of Latin America and the Caribbean possess a total of some 15,000 hospitals with one million beds and 65,000 units for outpatient care. Regarding human resources, the work force in health is calculated to be around 2.6 million.

Most of the countries of the Region have a pluralist system of health care in which at least three subsectors can be identified: a) the public (or official) subsector, which is often organized into units having national, provincial, municipal, or other levels of jurisdiction; b) social security (also divided into different jurisdictions), which makes financial contributions and has its own installed capacity; and c) the private subsector, with a very broad gamut of modalities ranging from individual consultations with a professional to hospitals with the most modern health care technology.

The lines of responsibility and the relationships between these subsectors are complex and varied. The role of the Ministries of Health in their function of guiding the sector has been cut back. The social security subsector often does not benefit from sufficient coordination when it finances services that are provided by private and State establishments. Since in most cases there are no explicit mechanisms to orient the relationships between the subsectors, services are often, and unnecessarily, duplicated, patients are rejected, or, paradoxically, costly examinations that are not entirely without risk are repeated.

The state health services in most of the countries of the Region are not able—in quality, quantity, or distribution—to meet the population's needs. The current economic crisis, along with the generation of greater demand, lower family incomes, proportionally lower public resources for the health sector, and the general constraints on health spending have been added to the problems facing the health services systems. The problem of the administrative systems has been aggravated, thereby hindering the rational, timely, and efficient use of resources and producing serious deficiencies in the operating capacity of the health and sanitation services. In this regard, the sector is facing enormous operational and managerial challenges.

Within the policies of adjustment to cope with the economic crisis, numerous countries have concentrated their resources on physical investments, especially at the peripheral levels, or on isolated actions to deal with pathologies or control specific risks.

Some experiences in the Region indicate the need for these pro-

posals to be part of a comprehensive plan for the development of the health infrastructure as a way to vitalize the process of transformation and strengthen the health activities by ensuring their continuity and efficiency.

In regard to the distribution of resources, the focus continues to be on large urban areas, and much of the expenditure on high cost technologies goes to making said technologies available to groups who are able to pay, leaving a clear majority of the population without coverage.

In relation to technologies, it was recognized in the past decade and based on the definition of the strategy of primary care that the application of technologies without adapting them to the needs, sociocultural levels, and life-styles of developing societies had led to inefficiency and inequity in the health systems. More than half way through this decade, the changes achieved, although they do represent important advances, had not yet produced any significant impact on the handling of health problems in the Region.

The performance of equipment and installations continues to be low, there is a lack of coordination between the various levels of care, operating capacity at the primary level is limited, and technological investments in highly complex equipment are excessive.

The sector's financial situation is another area of concern. Most of the countries in Latin America and the Caribbean fall below the world average (US$100 per capita per year) for government spending on health. Although the social security subsector has made important advances in its definition of policies as a contribution toward attaining the goal of health for all and allotting its important resources for health care, some structural constraints persist that limit the benefits of this important financial resource.

The lack of ongoing assessment vis-à-vis the ultimate objectives of the health systems is another limitation in their operation. Developing health systems that are adapted to the reality of each country implies the need for periodic evaluation of the level of health attained and not just the level of completion of activities.

Despite the express definitions of intersectoral action within the strategy of primary care, the prevailing development models in the health sector have led, on various occasions, to a failure to realize the potential of intersectoral action in controlling the socioeconomic and environmental determinants of disease: cooperation with other sectors, such as drinking water and sanitation, education, and agriculture, has still not been fully developed. This has special relevance for health promotion and actions for specific prevention of some prevalent problems.

The foregoing description summarizes structural and operational problems of the health systems that, when compounded by the countries' economic crisis, become even more difficult to solve. Ultimately, this means that broad sectors of the population in most of the countries of the Region have no real access to health and sanitation services. According to estimates on the level of coverage reached, of the total of 423 million inhabitants, some 130 million currently do not have regular access to basic health services. If we add the estimated population growth of 160 million people for the period 1986–2000, the total rises to some 290 million people for whom appropriate health care must be provided.

At present this is the most important challenge for the health systems of the countries of the Region. It means that these health systems, which in general have not yet been able to provide health care to the entire population with equity, effectiveness, and efficiency, should be reorganized and reoriented not only in order to maintain health care in the face of the crisis but also in order to cover the current gap and respond to the needs of caring for the increased population. This challenge, which began with the definition of the goal of health for all by the year 2000 on the basis of the strategy of primary care, has yet to be resolved.

However, the need for change in the health systems is not exclusively quantitative. Changing structures of morbidity and mortality, different demands in perinatal pathology and adolescent and workers' health, and the increase in the adult and elderly populations, combined with processes of accelerated and disorderly urbanization and changes in financial systems and the availability of new technologies, also require major qualitative changes in the health systems' operation and organization.

Proper administration of the health systems encompasses much more than the administration of the health services. It involves the complex process of establishing priorities, allocating resources, and carrying out activities based on the health needs of the populations to be served, taking into account their risks and the most appropriate technologies for their solution.

This capacity for planning and implementing strategies and programs in accordance with needs and available resources, as well as for evaluating the progress of actions and their results at the local level in

particular, is still very limited in most of the countries of Latin America and the Caribbean.

The crisis faced by the countries calls for urgent measures in all the social and economic sectors in order to identify viable solutions that attenuate the negative impact on the health and well-being of the population and contribute as well to finding suitable and equitable solutions for development.

It is necessary then that all the health resources, oriented by a well-defined national policy, respond in a comprehensive form to the changing and growing needs of the population.

III. Local Health Systems in the Transformation of the National Health Systems

In most of the countries of the Region, proposals have already been formulated for the political, technical, and administrative reorientation and reorganization of the health systems in keeping with the national contexts of social and economic development. Under this approach, decentralization and local development have been identified as suitable instruments within the processes of democratization and greater participation and social justice, as well as serving as a means to achieve equity, effectiveness, and efficiency in administrative management.

The proposal to reorganize and reorient the national health systems on the basis of the processes of decentralization and local development was initiated in Resolution XXI of the XXII Pan American Sanitary Conference in September 1986, which established the programming priorities of the Organization.

In response to this need to establish priorities for the development of health services infrastructure and to address priority problems and groups from the approach of the strategy of primary care, and in accordance with the mandate from the XXII Pan American Sanitary Conference, the present proposal has been drawn up with an eye toward the transformation of the national health systems through the development of local health systems and as an operational tactic in order to accelerate the application of the strategy of primary care and its essential components.

Bearing in mind the different historical, political, technical, and administrative characteristics of the countries, their size, and the distribution of their populations and resources, it should be acknowledged that the definition of "local health system" will differ from one country to the next and even from one region to the next. However, and in order to facilitate their development and evaluation, it is possible to identify some common characteristics that need to be taken into consideration in most of the cases.

Hence, as the capacity to analyze the health situation at the local level becomes more developed and as the resources for the production of services are identified and directly coordinated, it becomes possible to offer a better response to the health needs and problems of the population. Furthermore, the local health systems should move away from the vertical schemes of management in which the decision-making levels are located exclusively at the center of the structure and the periphery merely implements the standards and programs that emanate from the higher administrative levels. In this way, the proposal to develop local health systems will become a broad-reaching proposal for the reorganization and restructuring of the health sector as a whole.

The concept of local health systems can be defined by identifying various points of view that converge on a given purpose.

From the standpoint of developing the State, local health systems fill the requirement of decentralizing and deconcentrating the State apparatus in an effort to ensure greater democratization and efficiency. They should be viewed therefore as part of the process of democratic development which is under way in most of the countries of the Region. Hence, the local health systems can be defined on the basis of the political-administrative divisions of the State, independently of their denomination, e.g., municipality, canton, etc.

From the standpoint of community social development, a local health system presupposes the existence of an identified population that has an existing or potential capacity to act as a whole to the benefit of its collective health. In this case, a local health system should utilize the resources of the health sector and of other sectors involved in social development at the local level.

As was mentioned above, the health sector should follow, organize, and participate in these processes of local development. Therefore, the definition of local health systems, from the standpoint of the health sector, is geared to achieving greater adaptation and capacity of response to the changing and specific requirements of population groups affected by common socioeconomic, environmental, and epidemiological problems. This gives rise to a series of elements that are specific to the health sector and that can be observed in two comple-

mentary areas: on the one hand, the reorganization and reorientation of the sector's overall structure through the processes of decentralization and, on the other hand, the reorganization of the network of services within defined populations.

From the health sector's standpoint, a local health system is an integral part of the health sector that bears the characteristics of decentralization and deconcentration as defined by the State and that has the capacity to coordinate all of the existing health resources to form a network of services within a given population, be it urban or rural.

A local health system should also have a management structure that is responsible for the administration of the health actions in that particular population. This means having the capacity for direct administration of certain resources and coordination of all the social infrastructure assigned to health in a given geographical area, along with a structure capable of solving a significant proportion of the health problems of individuals, families, social groups, communities, and the environment in addition to facilitating social participation, all of this as an element of the national health system, to which it gives vitality and new direction.

The managerial level should assume responsibility, therefore, for the coordination of all the existing resources (hospitals, health centers and posts, water supply systems and other sanitation services, and extrasectoral resources) for a given population with a view to ensuring optimum utilization and adaptation to the local reality. Within this responsibility, it is of paramount importance to establish a relationship with reciprocal responsibilities for the population in regard to the development of health.

This relationship should be manifested in all aspects that touch on individual and public health, the definition of policies, establishment of priorities, the origin and distribution of resources, programming, execution, and evaluation, as well as individual and group behavior vis-à-vis the health-disease process. Since both the population and the territory to be served have been defined, it is possible to evaluate the actions that are carried out or that should be undertaken in order to respond to the local health needs.

Thus, a better definition of the population and territory that are to be covered and of the specific responsibilities of the services will promote more active participation of the population both in health promotion and in the delivery of services, two areas that require the support and follow-up of the community.

The formats and mechanisms of interaction between the population and the services, as well as the population's own behavior with regard to protecting its health and seeking solutions to its health problems, are fundamental components of the system. Naturally the social structure in support of health at the individual and collective levels is an essential element.

In light of the foregoing, it should now be clear that a local health system does not refer simply to a dividing up of the administrative tasks in the health sector or to a mere redefinition of the responsibility for health resources. Rather, in the context of the structural and democratic changes in the countries, they should promote the development of new forms of action that help to set up networks of comprehensive health services in coordination with effective community representation and participation, thereby becoming structures that are more sensitive to the needs of the population.

Local health systems should be viewed as the basic organizational units of a much broader, fully articulated structure—the national health system. That is to say, local health systems are the focal point for the peripheral planning and management of health services under the integrative and normative guidance of a national structure for coordination of the health system, which formulates overall policies and defines the systems of logistical, technical, and administrative support required for the execution of programs and the delivery of services at the local level. Within this national scheme, local health systems can serve as the base for the definition of regional health systems.

In relation to this, a topic of interest is the size or scope of the local health systems. As was pointed out above, there is no single formula for this. Their size will depend on the political-administrative contexts of each country as well as other factors, such as the country's size, population distribution, communications and transportation systems, the distribution, complexity, and operating capacity of the resources of the health sector, and the levels of technical and administrative efficiency.

As a result, although political-administrative divisions may be of use in defining a local health system, as is the case of municipalities in some countries, the aforementioned characteristics also allow for other solutions. Using this same approach, local health systems can also be defined by grouping municipalities or other political-administrative units together; in other cases, especially in urban areas, local health systems may cover a geographical or populational division within a given municipality.

In synthesis, the population covered by a local health system should not be so small that the system becomes inefficient nor so large that it impedes the proper control and coordination of the resources.

In addition, the development of health services at the local level should be done in coordination with the development and decentralization process involving other sectors, thus introducing the possibility of an intersectoral approach at the local level.

Bearing these points in mind, a local health system should: take into consideration the country's political-administrative structure; be defined for a given population; cover all the resources for health and social development existing in said space; respond to the processes of decentralization of the State and of the health sector to the needs of the population and to the structure of the health service network; and be organized in such a way as to facilitate the overall coordination of actions.

Finally, an important area of discussion will be the resources needed to promote and develop local health systems. In this respect it is necessary to stress that the emphasis on the process of change should focus on increasing effectiveness and on the rational use of available financial, technological, and human resources. Additional investment should be considered only after proper evaluation of the efficiency and efficacy of the use of existing resources. On the other hand, special consideration must be given to resources needed to strengthen managerial capacity and for proper manpower training.

IV. Aspects to be Considered for the Development of Local Health Systems

The development of local health systems cannot be approached in isolation. It was mentioned above that they represent the health sector's response to the processes of democratization and decentralization of the State. They also represent an internal response of the sector in an effort to achieve greater equity, effectiveness, and efficiency in its actions.

Based on this approach, it is possible to identify 10 fundamental aspects that need to be developed:

4.1 Reorganization of the central level in order to ensure the guidance of the sector and the development of local health systems

4.2 Decentralization and deconcentration
4.3 Social participation
4.4 Intersectoral action
4.5 Adjustment of financing mechanisms
4.6 Development of a new health care model
4.7 Integration of prevention and control programs
4.8 Strengthening of administrative capacity
4.9 Training of the work force in health
4.10 Research

4.1 *Reorganization of the central level in order to ensure the guidance of the sector and the development of local health systems*

The strengthening of the capacity and leadership of the central level is a fundamental aspect for guiding the processes involved in the development of local health systems.

As the regulatory entity of the sector, the Ministry of Health should have the capacity to orient the action of the rest of the institutions, organizations, and persons with respect to the Government's national health policy and the policies of socioeconomic development within the processes of democratization, decentralization, and deconcentration as defined.

Guidance of the sector should be accompanied by the development of leadership in health. For this, it is necessary to promote the development of human resources, including aspects of planning, training, and utilization of personnel (university leaders, upper-level staff from the Ministries of Health, social security institutes, and planning offices), and bearing in mind their impact and the outlook for the next 20 years as concerns health, labor, and education, while at the same time providing the essential elements for scientific handling of the strategy.

This regulatory function of sectoral guidance will guarantee the necessary cohesion in the development of local health systems, ensuring the redistributive capacity of the resources in order to satisfy the different needs of populations at greater risk by applying the principle of equity.

This guiding role of the health sector should also be manifested in the financing of the sector in order to coordinate all the financial resources and thereby ensure the proper operation of the local health

systems. Coordination and agreements with the social security system also play a key role in this strategy.

This proposal in no way implies any expansion of the central level; on the contrary, it requires a new orientation for greater administrative agility to provide assistance at the operational level. Nor does it mean a transfer of responsibilities without assuming ultimate responsibility for overall management, which should always remain at the central level.

4.2 *Decentralization and deconcentration*

In order to ensure the complete development of the local health systems, it is necessary to transfer areas of jurisdiction and decision-making powers to other levels of the national health system. This will involve aspects related to the decentralization and deconcentration of the State, in general, and of the health sector, in particular.

Decentralization and deconcentration are viewed as vitalizing elements for the development of local health systems, and their implementation should be consistent with the country's political-administrative organization. In this order of ideas, it will be necessary to analyze possibilities and identify the restrictive and facilitating factors that contribute to or inhibit the operation of these administrative processes.

Decentralization, as a social phenomenon, is essentially a political process that has legal and administrative manifestations and that is fed by economic, cultural, historical, and geographical processes. It is a proposal to change the use and distribution of power in the sector and in society.

In order for the process to be carried out, certain requirements need to be met, such as:

- A firm political decision to carry out the process effectively. Ideally, the decision should be made by the Government and apply to all sectors. However, the process can be carried out, although with greater difficulty, if the Government's decision is only sectoral;
- Transfer of the necessary political power from the central level, not only through legal and administrative provisions, but by effectively transferring the necessary financial, economic, human, technological, and other resources;
- Development of local political power, provided in part by the direct management of the resources (mainly financial and economic), but especially by the formation of a base of political support through the direct, active, and pluralist participation of community organizations;
- Development of the capacity to manage the delivery of services, including technical capabilities in the coordination of resources and in the definition, execution, and evaluation of health activities.

In regard to the strategies of application, it should be remembered that decentralization is a process that should be carried out in stages—under specially formulated strategies that are readjusted regularly—and on the basis of specific and well-defined elements, in accordance with a duly detailed program. Thus, for example, it is not enough to define the element that is transferred; it is also necessary to adapt it to the reality and possibilities of the decentralized area, to the desirability of the use of new technologies, and to the need for political support, and this requires making sure that the benefits of decentralization are visible.

Within the topic of the distribution of power and local responsibilities, there is also the strategy of deconcentration. This is understood to be a form of delegation of powers to different levels within a given organization, while maintaining the hierarchical dependency with the central level.

It is important to note, in regard to the aspects indicated, that some countries are undertaking processes of decentralization in some cases and processes of deconcentration in others. Now, although this trend is more common in administration than in technical areas, it represents an excellent opportunity for developing innovative schemes within the management process at the local level with a view to preparing concepts and methodologies for the tools that will provide better local operation of the health systems.

In any process of decentralization and deconcentration, it is also necessary to view centralization and concentration as harmonious forms of management that are not mutually exclusive but rather that complement each other. Taken together, these strategies form a dynamic and continuous process that occurs at each level of the organization. Within this process, there is consequently no one level that defines standards, strategies, and priorities and another level that carries them out. Rather each level assumes these responsibilities within a common line of action. Therefore, decentralization or deconcentra-

tion does not mean the division and/or atomization of the health system, nor should it be confused with the anarchic dissolution of the system. On the contrary, properly developed, they will strengthen the overall structure of the system by helping its constitutive parts to achieve their greatest operating capacity.

Centralization on the political and normative aspects should ensure as well a redistributive capacity throughout the system in order to prevent any growth or deepening of inequities between local health systems.

Both decentralization and deconcentration represent models of management that are linked to the effectiveness and efficiency of an organization; they should not be conceived as conflictive or exclusive. On the contrary, their timely and proper use can help to solve specific problems in health service organization, keeping in mind that the goal is to strengthen the health system and the operating capacity of the local levels.

The processes of deconcentration and decentralization that are implemented in the sphere of public administration have a decisive and determining impact on similar processes that are promoted in the health system. The existence or lack of government policies, decisions, and programs for administrative deconcentration and decentralization are external factors that do indeed affect the health system. When the public sector has limited control over these processes or weak levels of technical and legal implementation, it becomes an obstacle to any form of management of governmental services. Hence, the overall policies of governmental organization and the normative technical and legal framework are the main factors that affect the health system.

4.3 *Social participation*

The next key aspect in the development of local health systems is support for the processes of social participation. Motivating social participation and directing it toward health care requires flexible strategies that take into account the formal and informal groups and the sectoral institutions that are present in a given territory. It is necessary at the same time to promote coordination among these groups and institutions for the preparation and execution of specific proposals.

In order to achieve this, the strategy needs to allow for deliberation among the organized agents (community and institutional) on the health problems and ways of handling them. In addition, it should promote coordination between the various social agents regarding ways to improve health care, how this can be achieved, and commitments and responsibilities that need to be assumed. The processes of deliberation and coordination should be supported by ongoing consultation with the population through existing organizations in the local health systems.

In order to activate these processes, it is necessary to keep in mind the possibilities for deliberation and coordination in the communities and the possibility of expanding or opening new areas in which collective analyses and common programs can be carried out through participatory planning, as well as a continuous process of human resource development.

4.4 *Intersectoral action*

The development of intersectoral health policies as a basic element of the strategy of primary care should be implemented at the local level. Any effort with a broad approach in the area of health development will need to involve all the social and economic forces in order to ensure the collective well-being. Intersectoral action and social participation are thus two fundamental forces for the development of local health systems.

At the community level, the intersectoral approach should be expressed in the form of comprehensive care for basic needs, particularly of the large population groups that have less access to the benefits of development. At the national level, intersectoral action should be used to coordinate financial and any other type of resources with a view to satisfying basic needs. At both the local and national levels, it is necessary to view the development of health as an integral part of well-being, giving preference therefore to health promotion actions.

The proposal for intersectoral development is linked to the concept of healthy communities in which all the sectors contribute to achieve this social and economic goal.

4.5 *Adjustment of financing mechanisms*

The debate on the amounts to be assigned to health, sources of financing, and the distribution of resources should bear in mind the processes of local development and decentralization. This means that health funding should undergo not only quantitative changes but qualitative changes as well, focusing on support for specific actions

aimed at the decentralization of decisions regarding the use of alternative sources of financing and expenditure allocation mechanisms that are geared to guarantee comprehensive health care, including basic sanitation.

It will be necessary to change the traditional forms of distribution and control of financial resources in order to ensure that they are utilized with greater efficiency and that they respond to the needs of priority social groups.

The coordinated use of State funds provided by general revenue, as well as the different forms of social security and new forms of collecting and utilizing additional funds, should provide total coverage, giving priority to local health systems and population groups in greatest need.

4.6 *Development of a new health care model*

As was pointed out earlier, the development of local health systems should not be limited simply to a division of labor within a decentralized scheme of government. Rather, it should be a process of fundamental change in the technical procedures of service delivery, in the use of available technologies, in the integration of knowledge, in the way resources are used, and in how to ensure social participation. Based on these elements, a series of methodologies and basic principles can be defined in order to facilitate the development of these new health care models.

The development of local health systems should be based on an analysis of the health situation, a projection of knowledge about needs, and the identification and qualification of the conditions of risk in order to orient the definition of priorities, organization, and utilization of the available resources.

In order to facilitate local programming and the evaluation of health services, a local health system should be subdivided into the smallest possible geographical units of analysis, taking into account the characteristics of the health services structure and the distribution of the population groups.

The development of the local health systems' analytical capacity will help to better identify the information that is required and will permit increasingly pertinent and relevant analyses.

The activities of the local health systems should be organized with a view toward the entire population and its highest priority

needs, using a participatory process of programming that includes all the available resources and defines the activities to be carried out, the goals in terms of coverage and impact, and adjustments in accordance with periodic strategic evaluations.

Each family and population group should be assigned explicit health resources and personnel to provide them with care at either the institutional or community level through a network of coordinated services with the necessary levels of care in order to respond to the needs of the population.

In this way, the best format for coordinating all the existing resources—national, local, social security, and private—will be found in order to achieve a common action strategy.

An attempt should be made to maintain an overall approach in actions that are grouped in accordance with the set of problems of the population. These actions should be carried out comprehensively by the various categories of personnel, avoiding grouping by pathology or related programs.

The service network as a whole should assume responsibility for providing comprehensive care to the entire population. This means that the resources of the local health systems should find appropriate solutions either through their own installed capacity or through the development of the necessary interrelationships. The entire demand should be met and no request for care should be rejected.

In this topic, hospitals should be regarded as part of the local health systems. Upon being inserted into a local health system, hospitals undergo a change that affects all their services in one way or another. In addition to meeting the demand of the population in their area of responsibility, they should also work with the other services in the network, and this causes changes in the quantity and quality of services and makes it necessary to seek new forms of organization.

The health service should be organized with a view to bringing about a change in the population's epidemiological profile as concerns individual and collective health problems and risks. Hence, assessment of the impact and quality of care should be an ongoing activity.

The local health systems should implement, within their territory, processes of delegation of authority, decentralization, and concentration as a suitable means of distributing responsibilities and facilitating technical and administrative management.

4.7 *Integration of prevention and control programs*

The area of activity of the local health systems should provide an opportunity to combine the efforts of the community with those of the sector's resources in order to produce joint actions in health.

Thus, the development of health programs and their capacity of mobilization should be utilized to promote the development of the health infrastructure so as to be able to assign resources to the most socially relevant needs, as identified by a convergence of clinical knowledge, epidemiology, and administration.

Local health systems present more concrete possibilities for coordinating the development of programs that seek to meet the needs of the population within the structure and operation of existing installed capacity for the production of the necessary services. These ties can be activated more easily when the technical and administrative management process is part of the specific plan of the health system, i.e., when the local health problems are brought into as close contact as possible with the design of programs and the adjustment of the service organization.

The basic capacity of response of the resources that make up the service network should include the set of programs and activities that are defined for the solution of the community's priority health problems in order to respond to the health needs of the vulnerable human groups and to reorient resources toward the principal health problems at the local level.

4.8 *Strengthening of administrative capacity*

Concerning the development of the health systems' capacity of administration and management, it should be pointed out that the achievement of the goal of total coverage and health for all with equity and efficiency within the political-economic context of the countries depends for the most part on increasing the operating capacity of the health services and rationalizing health expenditures. The insufficient operating capacity of the services and unproductive expenditures are the result, in many cases, of deficient administrative and managerial systems, procedures, and practices.

The concept of management should be understood as an action that is aimed at optimizing resources in order to attain the objectives of the health institutions through a continuous process of planning, programming, organization, and coordination of resources for the development of actions, using an appropriate form of execution and with regular supervision, follow-up, and evaluation. This management process should receive input from the continuous flow of information which generates the knowledge that is needed for analyzing the situation and for making timely decisions in order of priority.

The local health systems should have an administrative capacity that permits adequate support for the delivery of services to the population in a given geographical area. This administrative capacity should be defined as the ability to fulfill some minimum requirements, such as:

a) A unit for technical and administrative guidance staffed with properly trained human resources and covering the general administration of services, while also handling the information system and providing support services;
b) An information system that collects data on the health situation and service delivery, incorporates the epidemiological and administrative analysis of that information, and utilizes the analysis in the management process;
c) A basic supply of physical resources and critical supplies for carrying out the activities mentioned above;
d) The capacity to execute and coordinate financial resources for the development of activities at the local level;
e) The capacity to coordinate health care activities with the process of community organization in order to promote health in the area.

4.9 *Training of the work force in health*

The challenge of attaining the goal of HFA/2000 poses, among other aspects, the need to promote studies and develop procedures geared to the optimum rational utilization of existing personnel by providing continued training to the human resources that are already part of the sectoral work force.

To achieve this, health personnel and the community need new processes of communication, integration, and collaboration that will be able to produce an impact on health problems, on their determining factors, and on community dynamics.

The magnitude of the challenge of reorganizing the infrastructure of the health sector basically through the development and strengthening of local health systems requires that, in order to in-

crease the effect of decentralization, the duties of the personnel be redefined, that mechanisms be implemented to link the personnel to the service system, and that personnel receive continued training and supervision in keeping with the comprehensive and strategic proposals that guide the new approach.

The local health systems need sufficiently qualified personnel to perform the tasks and responsibilities created by the reorganization. They also need a staff that is closely linked to the process of social participation, a process whose dynamics transcend the "institutionality" that is so deeply rooted in the health sector.

The dynamics that arise from the concept of local health systems require health agents who interact as teams that are closely linked to the context in which they operate. The values and customs of the population are key considerations that provide a framework for the activities of each and every one of the agents involved in the network.

The development of ongoing educational programs for health personnel will promote knowledge and the sensitivity of the staff to the problems and local health needs of the population. Closer contact between health personnel and the population should result in better information, greater exchange, and joint actions that are aimed essentially at promoting and developing social participation in the planning and administration of the health systems.

It is necessary that the process undertaken by the countries of the Region with reference to local health systems and decentralization receive support for the training of health workers. The incorporation of health personnel in educational activities at the Schools of Health Sciences should be promoted through education-service integration in the local health systems. It is also important to have, at the level of graduate studies and continuing education, programs for training the administrators of local health systems, epidemiologists, and highly qualified personnel in the guidance of the sector.

4.10 *Research*

Bearing in mind the need to continue and intensify the development of innovative models of health service at the level of the local health systems, research on health services should accompany—from the very beginning—the entire process of reorganization and reorientation of the sector through the development of local health systems.

In this way, studies on the local health systems will develop new operational models or their critical components and they will assess the level of equity achieved, effectiveness and quality, the coverage

obtained, the efficiency of the use of resources, as well as the degree of social participation obtained.

Research on the local health systems should be carried out in coordination basically with the providers of the services, the community, and the users, thereby enhancing the possibility that the results will be used to introduce corrective actions and, consequently, move a step closer to better health for the population.

V. Bases of a Plan of Action for PAHO Cooperation

The general guidelines for formulating a PAHO plan of action for the next years to support the Member Countries in their efforts to develop local health systems focus on three specific areas:

1. The collection, evaluation, and dissemination of national experiences in the development of local health systems;
2. Conceptual analysis and methodological development;
3. Support for the national processes of development of the local health systems.

In order to know the efforts of the countries in relation to the strengthening of local health systems, it is necessary:

a) To draw up an inventory of experiences identifying the efforts developed in the past and the experiences under way in all the countries;
b) To undertake a critical analysis of the experiences described in order to detect their virtues and problems;
c) To promote prospective field research on some selected experiences taking into account the structure, the processes, and the results of the local health systems. A comparison should be done of, among others, productivity, effective coverage, program development, the efficiency and effectiveness of services, and the participation and satisfaction of the population. The conceptualization and methodologies of research on health services should also be taken into account;
d) To continue and strengthen activities aimed at identifying the results obtained in the various countries.

Thus, there should be a regional awareness among the health workers, leaders in the health area, and political and administrative leaders, as well as in the community, in order to support and participate in this process.

The conceptual analysis and methodological development will be a consequence of the activity of collection and evaluation geared to obtain experiences on the approaches and methodologies utilized.

The collection and evaluation of experiences as well as the conceptual analysis and methodological development have to be expressly oriented to support specific activities at the national and local levels. Hence, the Organization's resources and cooperation at both the country and regional levels should focus on supporting the processes of transformation that are identified in the Region. This will require a joint interprogrammatic and interdisciplinary effort of all PAHO's areas and programs in order to facilitate the integration of actions for the achievement of a given objective.

It must be emphasized that the proposal for development of local health systems does not signify the substitution for or replacement of other strategies, nor of other programs of the Organization. On the contrary, it must be viewed as an essential means of facilitating the proper delivery of all health programs.

The programming of technical cooperation for the quadrennium should reflect this operational tactic as a crucial approach for implementing the priorities that have been defined for achieving HFA/2000.

The aspects to be considered for the development of local health systems described in point IV will be used to orient the cooperation activities and their possible openings in specific projects of work that identify the objectives to be attained, the mobilization of resources, and indicators for assessment. Special consideration will be given to the difficulties involved in achieving the proposed changes. Five specific issues have been identified as having to be addressed as first steps, namely, strengthening local planning and information systems; development of managerial capacity; social participation; overall leadership of the health sector; and the proper development of health manpower.

Resolution XV. Development and Strengthening of Local Health Systems in the Transformation of National Health Systems

The XXXIII Meeting of the Directing Council,

Having seen Document CD33/14, "Development and Strengthening of Local Health Systems in the Transformation of National Health Systems," Resolution WHA41.34 of the World Health Assembly, and the observations of the 101st Meeting of the Executive Committee;

Taking into account Resolution XXI of the XXII Pan American Sanitary Conference, which defined the orientation and programming priorities of PAHO for the quadrennium 1987–1990;

Recognizing the urgent need to accelerate the transformation of the national health systems in order to promote application of the primary health care strategy and to attain the goal of health for all by the year 2000;

Concerned about the constraints on the proper development of health care imposed by the present economic crisis and by limitations within the health sector itself;

Convinced that the challenge of improving the health of the neediest populations should be met, despite the crisis, with innovative measures for the structuring and administration of available resources;

Cognizant of the exercises already under way in most of the countries for transformation of the national health systems based on the development of local health systems as part of national decentralization and deconcentration processes; and

Agreeing that it is at the local level that policies and strategies for social development and health care can be implemented on the basis of social participation, intersectoral action, coordination of financial sources, and integration of programs,

Resolves:

1. To thank the Director for Document CD33/14, "Development and Strengthening of Local Health Systems in the Transformation of National Health Systems."
2. To urge Member Governments:
   a) To continue and strengthen their work of defining policies, strategies, programs, and activities for the transformation of national health systems through the development of local health systems;
   b) To ensure coordinated participation in the strengthening of local health systems by all government institutions responsible for the delivery of services, especially the social security administrations, and the international cooperation agencies;

c) In accordance with their institutional realities, to promote the notion of a program-level partnership between the public sector, nongovernmental organizations and the private sector;
d) To place special emphasis on the provision of resources and decentralization to strengthen the operating capacity of local health systems, and on specific programs for dealing with priority health problems;
e) To give special attention to the aspects cited in Section IV of Document CD33/14 as a response by the sector for the attainment of greater equity, efficiency, effectiveness, and participation;
f) To define and apply suitable indicators and processes for evaluating the development of local health systems and the progress made;
g) To promote research on health system services at the local level.

3. To request the Director:
a) To strengthen technical cooperation to the Member Countries so that resources will be mobilized for activities to transform national health systems and support priority programs through the development of local health systems and, particularly, to develop the planning process and information systems, administration, community participation, the leadership of the sector, and personnel training;
b) To encourage exchanges of experiences between countries and groups of countries as a form of technical cooperation among countries, and to disseminate among governments and local organizations the available information on advances in the development of local health systems and the transformation of national health systems;
c) To promote the coordinated participation of all health-related agencies, including those providing services, training human resources and pursuing research, and those for international cooperation;
d) To disseminate to the governments and their ministries and agencies the information available on methodological aspects and advances in the development of local health systems and the transformation of national health systems;

e) To support the monitoring of the evaluation of progress in the countries, and to include this topic in his annual reports during the present quadrennium (1987–1990).

(Adopted at the tenth plenary session, 30 September 1988)