WORKING for HEALTH in the CARIBBEAN

PAHO/WHO SUBREGIONAL COOPERATION STRATEGY • 2016-2019

Pan American Health Organization

World Health Organization
REGIONAL OFFICE FOR THE Americas

WORKING for HEALTH in the CARIBBEAN

PAHO/WHO
SUBREGIONAL COOPERATION STRATEGY
2016-2019

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TABLE of CONTENTS

TABLE of CONTENTS *(continued)*

MESSAGE from the DIRECTOR of PAHO

Dr Carissa Etienne
Director, Pan American Health Organization

The Pan American Health Organization/World Health Organization (PAHO/WHO) is the specialised international health agency working to improve and protect people's health. PAHO/WHO has a long-standing role in undertaking technical cooperation (TC) with Caribbean Member States in fighting communicable and non-communicable diseases and their causes; strengthening health systems, including information systems; and responding to emergencies and disasters.

This Subregional Cooperation Strategy (SCS) reflects the work that PAHO/WHO will undertake over the period 2016-2019 in the Caribbean subregion, in collaboration with Member States of the Caribbean Community (CARICOM), the CARICOM Secretariat, and other key partners. It complements the Organization's country level work and aligns with the vision of the PAHO Strategic Plan 2014-2019, adopted by Member States at the 52nd Directing Council in September 2013.

The SCS comes at a key juncture, as it was developed in tandem with several frameworks for addressing subregional and national health and development agendas, including the Sustainable Development Goals (SDGs), the CARICOM Caribbean Cooperation in Health Phase Four (CCH IV), and the United Nations (UN) Multi-Country Sustainable Development Framework (MSDF) for Caribbean countries. The MSDF recognises health as one of the core pillars in a joint UN agency approach to implementing the SDGs in the Caribbean.

The year 2016 marks the transition from the Millennium Development Goals (MDGs) to the SDGs, and PAHO/WHO's SCS is not only responsive to SDG 3, "Ensure healthy lives and promote wellbeing for all at all ages" but also provides a framework to contribute to the other SDGs. PAHO/WHO TC strategies at the country level are guided by national planning frameworks and the national health agenda. Similarly, the SCS is guided by the main subregional agenda for health – the CCH. CARICOM is in the process of finalising the CCH IV, 2016-2025, and the PAHO SCS was developed alongside this health agenda to ensure alignment with it. The SCS complements CCH IV's focus on the production of Regional Public Goods and approaches that benefit all Caribbean countries without requiring significant individual national investments. These RPGs include: health information systems (including disease surveillance), regulatory systems for pharmaceuticals, and models for health-in-all-policies, whole-of government, and whole-of-society approaches to non-communicable diseases.

PAHO/WHO recognises the significant public health gains realised through joint collaboration and coordination in the Caribbean, as well as the threats that the subregion faces, comprising, as it does, Small Island Developing States with vulnerable economies prone to disasters and economic turmoil. This challenges the vision of universal access to health and universal health coverage that Member States have endorsed.

The SCS was developed with all levels of the Organization, Member States, and CARICOM and its institutions, particularly the Caribbean Public Health Agency (CARPHA). PAHO/WHO will make every effort to ensure its implementation and looks forward to working with Caribbean governments, subregional stakeholders, and international partners to improve the health and well-being of the peoples of the Caribbean.

ACKNOWLEDGEMENTS

The PAHO/WHO Subregional Program Coordination, Caribbean (SPC-CRB) acknowledges with gratitude the invaluable contributions of the following persons, organisations and agencies to the development of this Subregional Cooperation Strategy:

- Ministries of Health in Caribbean countries
- The CARICOM Secretariat, especially the Health Development Programme
- The Caribbean Public Health Agency (CARPHA)
- UN agencies, funds and programmes working in the Caribbean
- Other key development partners working in the sub-region
- The SPC-CRB technical and administrative teams
- All PAHO/WHO Representatives and Country Teams working in the sub-region
- Entities at PAHO Headquarters, including Technical Departments and Units, the Office of Country and Subregional Coordination, and the Office of the Director
- The Department of Country Cooperation and Collaboration with the UN, WHO, Geneva
- Dr D Beverley Barnett, Consultant, and all others who contributed to the drafting and finalisation of the Strategy
- Ms Carol Williams Mitchell for the editing of the Strategy

The development of the Caribbean Subregional Cooperation Strategy was led by Jessie Schutt-Aine, Subregional Program Coordinator. The Subregional team comprises, Eldonna Boisson, Disease Surveillance and Epidemiology Advisor; Casimiro Dias, Health Systems and Services Advisor; Sandra Jones, HIV/STI, TB and Viral Hepatitis Advisor; Elisa Prieto, Non-communicable Diseases and Mental Health Advisor; Adrianus Vlugman, Water Sanitation and Environmental Health Advisor; Alexandra Vokaty, Veterinary Public Health Advisor and Erica Wheeler, Human Resources for Health Advisor.

The time taken to respond to requests for information and to provide feedback on drafts of the document, given busy schedules and other commitments, is much appreciated.

We look forward to the continued involvement and participation of all in the implementation and monitoring of the SCS, and its contribution to the health of the Caribbean people.

LIST of ACRONYMS and ABBREVIATIONS

ACS	Association of Caribbean States
ACTI	Association of Caribbean Tertiary Institutions
ACTO	Amazon Treaty Cooperation Organization
ADH	Adolescent Health
AIDS	Acquired Immune Deficiency Syndrome
ALBA	Bolivarian Alliance for the Peoples of Our America
AOSIS	Association of Small Island States
ART	Antiretroviral Therapy
BFHI	Baby-Friendly Hospital Initiative
BIREME	Latin American and Caribbean Centre for Health Sciences Information (PAHO)
BMCs	Borrowing Member Countries
BPOA	Barbados Plan of Action
BWP	Biennial Work Plan
CAHFSA	Caribbean Health and Food Safety Agency (CARICOM)
CAF	Development Bank of Latin America
CAMC	Caribbean Association of Medical Councils
CARICOM	Caribbean Community
CARIFORUM	Caribbean Forum
CARPHA	Caribbean Public Health Agency
CAP	Caribbean Association of Pharmacists
CAT	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CBS	Case-based Surveillance
CCCCC	Caribbean Community Climate Change Centre
CCH	Caribbean Cooperation in Health
CCHD	Cooperation among Countries for Health Development
CCPR	International Covenant on Civil and Political Rights
CCS	Country Cooperation Strategy
CCU	Department of Country Cooperation and Collaboration with the UN (WHO)
CDB	Caribbean Development Bank
CDC	Centres for Disease Control and Prevention (US)
CDEMA	Caribbean Disaster Emergency Management Agency
CED	Convention for the Protection of All Persons from Enforced Disappearance
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CERD	International Convention on Eliminating All Forms of Racial Discrimination
CESCR	International Covenant on Economic, Social, and Cultural Rights
CFNI	Caribbean Food and Nutrition Institute
CHA	Department of Communicable Diseases and Health Analysis (PAHO)
CHAMDS	Caribbean Health and Ageing Minimum Data Set
CKLN	Caribbean Knowledge and Learning Network
CMCA	Common Multi-Country Assessment (UN)
CMU	Department of Communications (PAHO)
CMW	International Convention of Protection of the Rights of All Migrant Workers and Members of Their Families
COFCOR	Council for Foreign and Community Relations (CARICOM)
CO	Country Office
COHSOD	Council for Human and Social Development (CARICOM)
CONSLE	Council of Ministers Responsible for National Security and Law Enforcement (CARICOM)
COTED	Council for Trade and Economic Development (CARICOM)
CPD	Continuing Professional Development

LIST of ACRONYMS and ABBREVIATIONS *(continued)*

CPP	Caribbean Pharmaceutical Policy
CRC	Convention on the Rights of the Child
CRIP	Caribbean Regional Indicative Programme
CRMA	Caribbean Regional Midwives Association
CROSQ	CARICOM Regional Organisation for Standards and Quality
CRPD	Convention on the Rights of Persons with Disabilities
CRS	Caribbean Regulatory System
CRSF	Caribbean Regional Strategic Framework (on HIV and AIDS)
CSC	Office of Country and Subregional Coordination (PAHO)
CSEC	Caribbean Secondary Education Certificate
CSME	CARICOM Single Market and Economy
CSO	Civil Society Organisation
CXC	Caribbean Examinations Council
CYDAP	Caribbean Youth Development Action Plan
DaO	Delivering as One
DFATD	Department of Foreign Affairs, Trade, and Development (Canada)
DFID	Department for International Development (UK)
DOTS	Directly Observed Treatment Short Course
DUI	Driving under the influence
ECCs	Eastern Caribbean Countries
ECCB	Eastern Caribbean Central Bank
ECLAC	Economic Commission for Latin America and the Caribbean (UN)
EDF	European Development Fund
EH	Environmental Health
EI	Elimination Initiative (for the Vertical Transmission of HIV and Congenital Syphilis)
EmONC	Emergency Obstetric and Newborn Care
EMTCT	Elimination of Mother-to-Child Transmission
ENHR	Essential National Health Research
EPA	Economic Partnership Agreement
EPI	Expanded Program on Immunization
EPHF	Essential Public Health Functions
ERP	Department of External Relations, Resource Coordination, and Partnerships (PAHO)
ESAVI	Events Supposedly Attributable to Vaccination of Immunisation
EU	European Union
EVD	Ebola Virus Disease
FA	Focus Area
FAO	Food and Agricultural Organization
FCTC	Framework Convention on Tobacco Control
FDA	Food and Drug Administration (US)
FGL	Department of Family, Gender, and Life Course (PAHO)
FNS	Food and Nutrition Security
GBV	Gender-based Violence
GDP	Gross Domestic Product
GEF	Global Environment Facility
GEI	Gender Equality Indicators (Model)
GF	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GNI	Gross National Income
GPW	General Program of Work (WHO)
HCC	Healthy Caribbean Coalition
HDI	Human Development Index
HDR	Human Development Report
HiAP	Health in All Policies
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HoE	Health of the Elderly
HPS	Health Promoting Schools
HPV	Human Papilloma Virus
HRH	Human Resources for Health

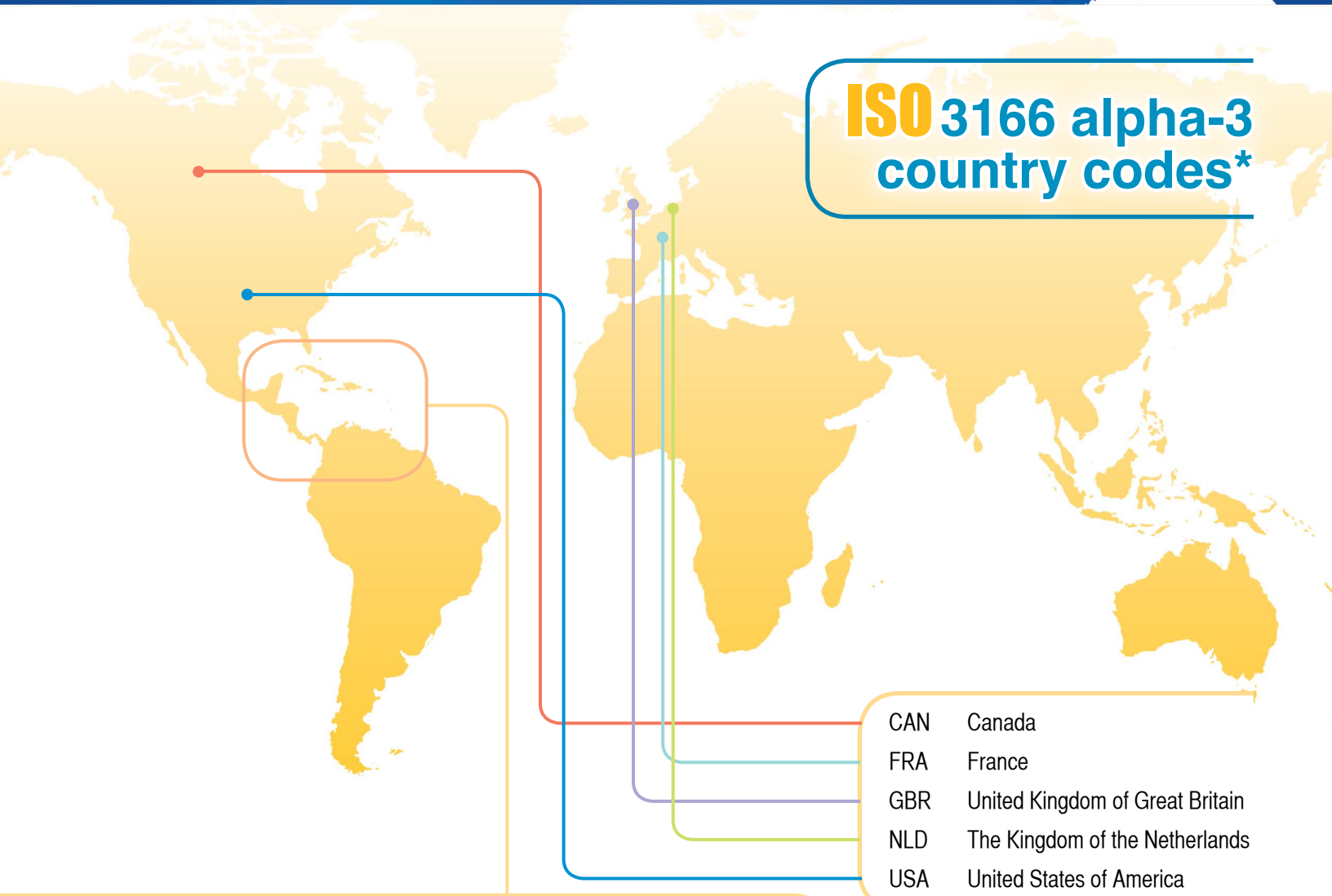
LIST of ACRONYMS and ABBREVIATIONS *(continued)*

HSS	Department of Health Systems and Services (PAHO)
ICT	Information and Communication Technology
IDB	Inter-American Development Bank
IDI	ICT Development Index
IGA	Inter-governmental Agreement
IHP	International Health Partnership
IHR	International Health Regulations (2005)
IICA	InterAmerican Institute for Cooperation on Agriculture
IMF	International Monetary Fund
IMPACS	Implementation Agency for Crime and Security (CARICOM)
IPHL	Integrated Public Health Laboratory
ITU	International Telecommunications Union
JANS	Joint Assessment of National Health Strategies
LQMS-SIP	Laboratory Quality Management Systems Stepwise Improvement Process
MDG	Millennium Development Goal
MSDF	Multi-country Sustainable Development Framework (UN)
mhGAP	Mental Health Gap Action Programme
MoH	Ministry of Health
MMR	Maternal Mortality Ratio
MMR1/2	Measles, Mumps and Rubella
MSI	Mauritius Strategy for Further Implementation of the Program of Action for the Sustainable Development of SIDS
MSM	Men who have Sex with Men
NCDs	Non-communicable Diseases
NGO	Non-governmental Organisation
NHA	National Health Authority
NHI	National Health Insurance
NHPSP	National Health Policy, Strategy or Plan
NMH	Department of Non-communicable Diseases and Mental Health (PAHO)
NTD	Neglected Tropical Diseases
OAS	Organization of American States
OCPC	Office of Caribbean Program Coordination
OCM	Outcome
ODA	Official Development Assistance
OECC	Office for Barbados and Eastern Caribbean Countries (PAHO)
OECS	Organisation of Eastern Caribbean States
OIE	World Organization for Animal Health
OS	Other Sources (PAHO Program Budget)
OSH	Occupational Safety and Health
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership (for HIV)
PBP	PAHO Budget Policy
PCV	Pneumococcal Conjugate
PED	Department of Emergency Preparedness and Disaster Relief (PAHO)
PEPFAR	President's Emergency Program for AIDS Relief (US)
PHC	Primary Health Care
PHEIC	Public Health Emergencies of International Concern
PITC	Provider-Initiated Testing and Counselling
PMA	Performance Monitoring Assessment
PMTCT	Prevention of Mother-to-Child Transmission
PNIG	Population Nutrient Intake Goals
POSD	Port of Spain Declaration (on NCDs)
PPE	Personal Protective Equipment
PWR	PAHO/WHO Representative
RB	Regular Budget (PAHO)
RDCS	Regional Development Cooperation Strategy
REDD	Reducing Emissions from Deforestation and Forest Degradation

LIST of ACRONYMS and ABBREVIATIONS *(continued)*

RELACSIS	Latin American and Caribbean Network to Strengthen Health Information Systems
RENR	Regional Examination for Nursing Registration
RFNSP	Regional Food and Nutrition Security Policy
RHA	Regional Health Authority
RNIs	Recommended Nutrient Intakes
RTI	Road Traffic Injuries
SAICM	Strategic Approach to International Chemicals Management
SAMOA	SIDS Accelerated Modalities of Action
SARI	Severe acute respiratory infection
SCS	Subregional Cooperation Strategy
SICA	Central American Integration System
SIDS	Small Island Developing States
SDGs	Sustainable Development Goals
SL	Strategic Line
SNS	Strengthening the National Health System
SP	Strategic Priority
SPC-CRB	Subregional Program Coordination, Caribbean
SPS	Sanitary and Phytosanitary
SRH	Sexual and Reproductive Health
STEPS	Stepwise Approach to NCD Risk Factor Surveillance
STI	Sexually Transmitted Infections
TC	Technical Cooperation
TCC	Technical Cooperation among Countries
TechPharm	CARICOM Expanded Technical Advisory Committee on Pharmaceutical Policy
TWG	Technical Working Group
UAH-UHC	Universal Access to Health and Universal Health Coverage
UNASUR	Union of South American Nations
UNDP	United Nations Development Programme
UNEP	United Nations Environment Programme
UNFCCCUN	Framework Convention on Climate Change
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNITAR	United Nations Institute for Training and Research
USA	United States of America
USAID	United States Agency for International Development
UWI	University of the West Indies
VCT	Voluntary Counselling and Testing
VH	Viral Hepatitis
WHA	World Health Assembly (WHO)
WHO	World Health Organization
WHO-AIMS	WHO Assessment Instrument for Mental Health Systems

ISO 3166 alpha-3 country codes*



CAN	Canada
FRA	France
GBR	United Kingdom of Great Britain
NLD	The Kingdom of the Netherlands
USA	United States of America

AIA	Anguilla
ATG	Antigua and Barbuda
ABW	Aruba
BHS	The Bahamas
BRB	Barbados
BLZ	Belize
BMU	Bermuda
CYM	Cayman Islands
CUB	Cuba
CUW	Curaçao
DMA	Dominica
DOM	Dominican Republic
GUF	French Guiana
GRD	Grenada
GLP	Guadeloupe
GUY	Guyana
HTI	Haiti
JAM	Jamaica
MTQ	Martinique
MSR	Montserrat
PRI	Puerto Rico
KNA	St. Kitts and Nevis
LCA	Saint Lucia
VCT	St. Vincent and the Grenadines
SXM	Sint Maarten
SUR	Suriname
TTO	Trinidad and Tobago
TCA	Turks and Caicos Islands
VGB	British Virgin Islands
VIR	US Virgin Islands

** Available at http://www.iso.org/iso/country_codes, accessed 29 March 2016*

LIST of TABLES and FIGURES

EXECUTIVE SUMMARY

The Subregional Cooperation Strategy (SCS) for the Caribbean, 2016-2019, of the Pan American Health Organization/World Health Organization (PAHO/WHO) sets out the issues, strategic priorities and outcomes that the organisation's technical cooperation (TC) in the sub-region will address for the stated period. The subregional level of TC complements country and regional TC, focusing on the production of subregional public goods that contribute to the achievement of the health and development objectives of PAHO/WHO's Member States. These objectives are aligned with national priorities at country level. In addition, they are articulated in the health agendas of the inter-governmental integration mechanisms to which the Member States belong, and in their international agreements and commitments in health.

The development of the SCS comes at an opportune time, enabled by: the close of the previous SCS 2010-2015 and the Caribbean Cooperation in Health, Phase III (CCH III), the Caribbean Community's (CARICOM's) health agenda, to which the SCS responded; the guidance provided by the CARICOM Strategic Plan 2015-2019; the formulation of CCH IV; the finalisation of the United Nations (UN) 2030 development agenda and the Sustainable Development Goals (SDGs), the successors to the Millennium Development Goals (MDGs); the start of implementation of the PAHO Program Budget 2016-2017 and planning for the 2018-2019 cycle, both of which make operational the 2014-2019 PAHO Strategic Plan and WHO General Program of Work.

In the Region of the Americas, though the Caribbean is the smallest sub-region, compared with Central America, South America and North America, it is recognised worldwide for its diversity and its beauty. Its status as a premier tourist destination often masks the vulnerability of the Small Island Developing States (SIDS) that comprise the majority of its countries and the persisting inequities that form roadblocks to the sub-region's sustainable development. External factors and natural or man-made disasters can wreak havoc on the Caribbean's fragile economic, social and political environments, putting in jeopardy, or reversing, the gains in health and other areas made by the sub-region.

Many of the gains have been achieved through collective action by Caribbean countries to address their common priorities, coming together in political integration mechanisms, exemplified by CARICOM and the CCH. Though CARICOM and the Organisation of Eastern Caribbean States (OECS) are the main integration mechanisms in the Caribbean, individual countries belong to several others as they seek to partner with countries in other sub-regions to address common issues and share expertise, experiences and lessons learnt.

The SCS 2016-2019 was formulated based on an analysis of the sub-region's political, macroeconomic and social context; health and development issues; health status of the population and health systems; the strategic priorities for CCH IV and existing subregional policies, strategies and plans; development cooperation, partnerships and the contribution of the sub-region to the global health agenda; and the strategies, leadership priorities, outcomes and core functions set out in the PAHO Strategic Plan 2014-2019, as well as the organisation's cooperation over the past SCS cycle. Input for the SCS was also obtained from key stakeholders, including PAHO/WHO Member States in the Caribbean; UN and other development partners, including civil society representatives; and PAHO/WHO technical staff at national, subregional, regional and global levels of the organisation.

The five **CCH IV Strategic Priorities** are:

1. Health systems for universal health coverage
2. Safe, resilient and healthy environments to mitigate climate change
3. Health and well-being of Caribbean people throughout the life course
4. Data and evidence for decision-making and accountability
5. Partnerships and resource mobilisation for health

EXECUTIVE SUMMARY *(continued)*

The **Strategic Priorities and Focus Areas of the SCS** are aligned with the CCH IV Strategic Priorities, and are summerised below.

Strategic Priority 1: Universal access to health and universal health coverage

Focus Areas:

1.1 Review **health financing** – to develop and implement health finance reform

1.2 Increase **access to quality essential medicines and appropriate health technologies** with the establishment of the Caribbean Regulatory System (CRS)

1.3 Update, implement, monitor and evaluate the subregional **human resources for health (HRH)** Action Plan in collaboration with Member States, regional training institutions, professional associations and other relevant partners

1.4 **Promote the establishment of shared specialist referral centres** – Development of strategies to reduce barriers to the establishment of referral centres for complex tertiary care ("Centres of Excellence") in the sub-region

Strategic Priority 2: Safe, resilient and healthy environments to adapt to climate change and mitigate disasters

Focus Areas:

2.1 Provide standardised subregional models and strategies for **environmental health and sustainability** for improvements in water quality and quantity, sanitation and hygiene

2.2 Develop and implement measures to reduce **climate change impact on health,** with focus on vulnerable groups

2.3 Expand **disaster preparedness, mitigation and response** using the WHO Emergency Response Framework to cover all phases of the emergency management cycle

2.4 Enhance and assess implementation and impact of **Integrated Vector Management (IVM)** across the sub-region

Strategic Priority 3: Health promotion and disease prevention and control throughout the life course, including cross-cutting themes

Focus Areas:

3.1 Develop and implement policy, legislative and protocol frameworks for multi-sectoral action on the prevention and control of **non-communicable diseases (NCDs) and their risk factors, mental health, and violence and injury prevention**

3.2 Strengthen strategies to prevent and control priority **communicable diseases,** including HIV, vaccine-preventable diseases, emerging and re-emerging diseases, with emphasis on IHR (2005) implementation, food safety, the human-animal interface, and elimination of selected neglected diseases

3.3 Develop and implement tailored strategies to improve the **health of specific population groups** – women's, maternal, neonatal, infant, child and adolescent health, and the health of older persons, including health promotion and lifestyle interventions

3.4 Promote and foster multi-sectoral collaboration and Health in All Policies to address gender, equity, human rights, ethnicity and the **social determinants of health**

Strategic Priority 4: Health information systems and research

Focus Areas:

4.1 Strengthen **health information for equity and evidence-based decision-making** by establishing a regional clearinghouse for information on subregional health priorities, including the social determinants of health

EXECUTIVE SUMMARY *(continued)*

4.2 Identify areas and possible sources of financing for operational **research** into health systems in the Caribbean and develop relevant research guidelines and protocols

4.3 Establish a regional virtual platform for information-sharing and **knowledge management** to which Member States and key stakeholders have access

Strategic Priority 5: Partnerships, resource mobilisation and cooperation among countries for health development

Focus Areas:

5.1 **Facilitate Cooperation among countries for health development (CCHD**) to promote and contribute to South-South and triangular cooperation, in the framework of the 2013 PAHO Cooperation for Health Development policy

5.2 Strengthen **collaboration and resource mobilisation** with the UN system and with other traditional partners, and establish new partnerships

5.3 Develop and implement a **communication strategy** for the SCS and PAHO/WHO's TC, targeting a wide range of stakeholders

5.4 Ensure efficient and effective **program implementation, monitoring and assessment** of the SCS

The Strategic Agenda is mapped to the CCH IV Strategic Priorities, the relevant Outcomes of the PAHO Strategic Plan 2014-2019, and the SDG Targets, demonstrating the contribution that this level of TC will make to countries' achievement of their international commitments and advancement of their health development. The Strategic Agenda is also aligned with the outcomes of the UN Multi-country Sustainable Development Framework (MSDF) that is currently being finalised to guide the UN system's work with several countries in the Caribbean.

The success of PAHO/WHO's TC at subregional level depends heavily on partnerships and resource mobilisation, involving CARICOM and PAHO Member States; the CARICOM Secretariat; Caribbean regional institutions, including the Caribbean Public Health Agency, the Caribbean Disaster and Emergency Agency, the CARICOM Centre for Climate Change and the CARICOM Regional Organisation for Standards and Quality; civil society organisations; the private sector, as appropriate; other UN agencies; and international development partners.

Many frameworks for action in health and health-related areas exist at subregional, regional and global levels to effectively address the Strategic Priorities and Focus Areas of the SCS. Taking advantage of resource mobilisation opportunities and developing creative partnerships, including with non-health sectors and entities, will be essential in addressing risk factors and the social determinants of health, and ensuring that cross-cutting factors such as equity, ethnicity, gender and human rights are taken into consideration. Cooperation among countries and institutions, with other sub-regions, and with other WHO regions to share expertise, experiences, successes and lessons learnt, will be critical, facilitated by reliable, disaggregated health information and accessible information-sharing platforms.

Promotion of the SCS among PAHO/WHO Member States, PAHO and WHO entities and key external stakeholders, including the general public, is essential to encourage interest and "buy-in". The SCS document can be used to develop communication products that target various audiences. Participatory monitoring and evaluation of the Strategy, involving as many stakeholders as possible, will maintain their commitment.

Another critical success factor is the organisation's consideration of the implications of the SCS; though the PAHO/WHO Subregional Program Coordination entity for the Caribbean will lead and coordinate the implementation of the SCS, it is a "whole-of-organisation" strategy that demands the attention of relevant entities at all levels of PAHO/WHO. To this end, all applicable resources, systems and mechanisms at the organisation's disposal must be mobilised in support of the SCS.

CHAPTER 1 INTRODUCTION

The Pan American Health Organization (PAHO) is the specialised health institution of the Inter-American System and the Regional Office for the Americas of the World Health Organization (WHO).[1] The PAHO/WHO Subregional Cooperation Strategy (SCS) for the Caribbean 2016-2019, provides a medium-term strategic vision to guide the organisation's subregional level of technical cooperation (TC) in the Caribbean. The SCS is a framework for action at this level by the PAHO/WHO Secretariat as a whole, coordinated by the PAHO/WHO Subregional Program Coordination, Caribbean (SPC-CRB),[2] which led the development of the strategy.

The SPC-CRB (previously the Office of Caribbean Program Coordination, OCPC) was established in 1978 in Barbados to coordinate the organisation's TC with the Caribbean sub-region, in recognition of the common health issues in the sub-region, the similarity in historical development of the countries and their longstanding tradition of collaboration in health and other areas. The 2012 PAHO Budget Policy (PBP) reaffirmed the importance of the subregional functional level of TC that was officially approved in the 2004 PAHO Regional Program Budget Policy. This level of TC is defined as one in which "technical cooperation programs are aimed at meeting the needs of a group of countries in their pursuit of the subregional health development goals within the framework of the Organization's collective mandates".[3] The PBP also notes that "this approach of technical cooperation work supports the health agendas of the intergovernmental integration mechanisms". **This is an important distinction from the country and other functional levels[4] of TC.** In the Region of the Americas PAHO recognises four sub-regions: the Caribbean, Central America, North America and South America.

The SCS is the subregional counterpart of the PAHO/WHO Country Cooperation Strategy (CCS), which provides the framework for the organisation's work at country level, coordinated by the respective PAHO/WHO country offices. The SCS complements the CCSs of Caribbean countries, and, like the CCS, is an important instrument in the implementation of WHO reform. It is part of the WHO management reform area of "Support to Member States"[5], as it leads to the production of subregional public health goods that contribute to the achievement of national health development goals. The SCS will therefore be the framework for the development and/or adjustment of biennial work plans (BWPs) – PAHO/WHO's operational planning instruments – and will guide the allocation and mobilisation of relevant resources.

Since all of PAHO/WHO's TC is aimed at improving health in its Member States, the PBP makes the link between the subregional approach and impact at country level. The SCS identifies the strategic priorities and focus areas for PAHO/WHO's TC in addressing Caribbean subregional health priorities, based on:

- The health and development situation
- The work being done by other development partners and
- The organisation's added value and comparative advantage

The SCS emphasises interventions and initiatives that will add value to national, regional and global initiatives, rather than doing or duplicating what is better addressed at those levels.

1 PAHO was established in 1902, WHO in 1948. As the WHO Regional Office in the Americas (AMRO), PAHO is often referred to as PAHO-AMRO, reflecting its dual identity.
2 The SPC-CRB is headed by the Subregional Program Coordinator, Caribbean.
3 PAHO. PAHO Budget Policy 2012, page 7. PAHO Document CSP28/7. Available at http://iris.paho.org/xmlui/bitstream/handle/123456789/4147/CSP28-7-e.pdf?sequence=1&isAllowed=y, accessed 25 October 2015.
4 The four functional levels are country, inter-country, subregional and regional.
5 WHO. Implementation of WHO reform, 2012: Report by the Director General. WHO Document EB132/5 Add.8, January 2013, page 8. Available at http://apps.who.int/gb/ebwha/pdf_files/EB132/B132_5Add8-en.pdf?ua=1, accessed 17 November 2015.

Major frameworks for determination of the strategic priorities and focus areas include:

- *The Caribbean Cooperation in Health (CCH)*, which is the health agenda of the Caribbean Community (CARICOM), the major political integration mechanism in the sub-region. The recommendations from the evaluation of CCH III, the third iteration of this agenda (2010-2015), informed the development of CCH IV, which will be presented to the CARICOM Council for Health and Social Development (COHSOD) for approval in September 2016
- *The CARICOM Strategic Plan 2015-2019,*[6] which includes among its six Strategic Priorities "Building Social Resilience – Equitable Human and Social Development", under which the strategy of "Advancing initiatives for health and wellness" is outlined
- Other applicable subregional development frameworks, including the *UN Common Multi-Country Assessment* and the *UN Multi-Country Sustainable Development Framework* for several Caribbean countries, currently being finalised
- The *Health Agenda for the Americas 2008-2017*, which includes nine Areas for Action[7]
- The *PAHO Strategic Plan 2014-2019*,[8] which is fully aligned with the WHO 12th General Program of Work (GPW) 2014-2019,[9] and which focuses on reduction of inequities. The Strategic Plan elucidates PAHO's six core functions,[10] four cross-cutting themes,[11] six categories,[12] thirty programmatic areas, nine leadership priorities[13] and eight key countries[14]
- The *2013 PAHO policy on Cooperation for Health Development in the Americas*,[15] which expands and makes more strategic the organisation's triangular cooperation mechanism of technical cooperation among countries (TCC), under a new cooperation among countries for health development (CCHD) structure
- The *Small Island Developing States (SIDS) Accelerated Modalities of Action (SAMOA) Pathway*, which resulted from the Third International Conference on SIDS, held in Samoa in September 2014[16]

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6 Caribbean Community (CARICOM). Strategic Plan for the Caribbean Community 2015-2019: Repositioning CARICOM, Vol. 2 – The Strategic Plan, July 2014. Available at http://caricom.org/jsp/secretariat/caribbean-community-strategic-plan.jsp, accessed 11 November 2015.

7 Strengthening the National Health Authority; Tackling health determinants; Increasing social protection and access to quality health services; Diminishing health inequalities among countries and inequities within them; Reducing the risk and burden of disease; Strengthening the management and development of health workers; Harnessing knowledge, science, and technology; and Strengthening health security. Available at http://new.paho.org/hq/dmdocuments/2009/Health_Agenda_for_the_Americas_2008-2017.pdf, accessed 30 November 2015.

8 PAHO. Strategic Plan of the Pan American Health Organization 2014-2019, September 2013, Official Document 345. Available at http://www.paho.org/hq/index.php?gid=14004&option=com_docman&task=doc_view. Accessed 20 October 2015.

9 WHO. Twelfth general program of work 2014-2019: Not merely the absence of disease. WHO 2014. Available at http://www.who.int/about/resources_planning/twelfth-gpw/en/, accessed 16 November 2015.

10 Providing leadership, engaging in partnerships; shaping research, stimulating and disseminating knowledge; setting norms and standards; articulating ethical, evidence-based policy options; establishing technical cooperation, building sustainable institutional capacity; monitoring health situation and trends.

11 Gender, equity, human rights, ethnicity.

12 Communicable diseases; non-communicable diseases and risk factors; determinants of health and promoting health throughout the life course; health systems; preparedness, surveillance, and response; corporate services/enabling functions.

13 Social determinants of health*/Health in All Policies; universal health coverage (UHC)*; non-communicable diseases (NCDs)*; International Health Regulations (IHR) (2005)*; priority communicable diseases; unfinished MDGs/SDGs*; information and evidence; knowledge and expertise sharing among countries; efficient and effective Pan American Sanitary Bureau (PASB). *Note*: * are also WHO leadership priorities; the 6th WHO leadership priority is access to essential medicines.

14 Bolivia, Guatemala, Guyana, Haiti, Honduras, Nicaragua, Paraguay, and Suriname.

15 PAHO. Policy on Cooperation for Health Development in the Americas. Document CD52/11. Available at http://www.paho.org/hq/index.php?option=com_content&view=article&id=8833&Itemid=40033&lang=en, accessed 26 October 2015.

16 United Nations (UN). Report of the Third International Conference on Small Island Developing States held in Apia, Samoa, 1-4 September 2014. UN, Document A/CONF.223/10, 2014. Available at http://www.sids2014.org/samopathway, accessed 5 November 2015. Sixteen Caribbean countries were represented at the Samoa conference: Antigua & Barbuda, The Bahamas, Barbados, Belize, Cuba, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, St. Kitts & Nevis, Saint Lucia, St. Vincent & the Grenadines, Suriname, and Trinidad & Tobago. British Virgin Islands, Curaçao, Montserrat, and Sint Maarten participated as observers, as did CARICOM and the OECS.

CHAPTER 1- INTRODUCTION *(continued)*

- The *Sustainable Development Goals (SDGs)*, approved at the UN Sustainable Development Conference in September 2015,[17] where SDG 3 is the "health goal". However, all of the other goals relate to health and its determinants, especially SDGs 2, 4, 5, 6, and 10. SDG 17, which addresses partnerships, is critical for the implementation of all the SDGs, including SDG 3

The SCS has six chapters, in addition to an Executive Summary and annexes:

Chapter 1: Introduction

Chapter 2: Health and development situation

Chapter 3: Review of PAHO/WHO's cooperation over the past SCS cycle

Chapter 4: Strategic Agenda for PAHO/WHO's cooperation

Chapter 5: Implementing the Strategic Agenda: Implications for the entire Secretariat

Chapter 6: Monitoring and evaluation of the SCS

The development of this SCS is timely, given the end of CCH III and the PAHO/WHO SCS 2010-2015 that responded to CCH III. It also dovetails with on-going WHO reform; the start of the BWP 2016-17 cycle in PAHO; initiation of planning for the BWP 2018-19 cycle; the formulation of the first UN MSDF for several Caribbean countries; and the approval of the new SDGs. The process was based on the *WHO 2014 Guide for the formulation of the WHO Country Cooperation Strategy*,[18] adapted as needed for the subregional approach. **The SCS development process is summarised in Annex A.**

17 UN. Transforming our world: The 2030 agenda for sustainable development. UN, 2015, Document A/RES/70/1. Available at https://sustainabledevelopment.un.org/post2015/transformingourworld/publication, accessed 16 November 2015.

18 WHO. Available at http://apps.who.int/iris/bitstream/10665/181038/1/ccs_guide_2014.pdf?ua=1&ua=1, accessed 26 October 2015.


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CHAPTER 2 HEALTH and DEVELOPMENT SITUATION

2.1 Main health achievements and challenges

2.1.1 Political, macroeconomic and social context of the sub-region

2.1.1.1 Political

The Caribbean is an economically, environmentally, culturally, linguistically and politically diverse region, and one of the premier tourist destinations in the world. Caribbean countries share a history of colonialism, reflected in their language, architecture and culture; and include English-, French-, Dutch-, and Spanish-speaking countries, several of which also have a dialect or Creole language. Most are now independent states, with only a relatively small number remaining as Overseas Territories or Departments. In this document, the Caribbean refers to the following countries, with a total population of approximately 45 million:

- Independent states that are members of the British Commonwealth: Antigua and Barbuda, The Bahamas, Barbados, Belize, Grenada, Jamaica, St. Kitts and Nevis, Saint Lucia, and St. Vincent and the Grenadines
- Republics that are members of the British Commonwealth: Dominica, Guyana, and Trinidad and Tobago
- Other independent states: Aruba, Curaçao and Sint Maarten, formerly Kingdom of The Netherlands Overseas Territories
- Other republics: Cuba, Dominican Republic, Haiti and Suriname
- United Kingdom Overseas Territories: Anguilla, Bermuda, British Virgin Islands, Cayman Islands, Montserrat, and Turks and Caicos Islands
- Kingdom of The Netherlands Overseas Territories: Bonaire, Saba and Sint Eustatius
- French Departments in the Americas: French Guiana, Guadeloupe, Martinique and Saint Martin
- United States Overseas Territories: Puerto Rico and US Virgin Islands

Political systems in most English-speaking countries are governed by the principles of parliamentary democracy, based on the British Westminster System, with an elected head of state. The World Bank's 2015 classification of the world's economies,[19] based solely on gross national income (GNI) per capita, categorises most Caribbean countries as upper middle- or high-income, except for Guyana (lower middle income) and Haiti (low income). This classification is an important factor in the inability of many countries to access concessional funding for development projects on the international market and in the reduction of official development assistance. The classification and its consequences ignore the countries' vulnerability and challenges as SIDS:

- Single industry dependent
- Heavy reliance on food imports with risk of food insecurity

19 World Bank. New Country Classifications, 2015. Available at http://data.worldbank.org/news/new-country-classifications-2015, accessed 17 November 2015.

- Prone to the negative effects of climate change, including natural disasters
- Persisting inequities
- Susceptible to reversal of health and other development gains by external factors such as global food, energy and economic crises, and natural or man-made disasters

All the independent states listed above were represented at the 2014 SIDS conference in Samoa, in addition to the British Virgin Islands, Montserrat, CARICOM and the Organisation of Eastern Caribbean States (OECS), a measure of the importance that the countries and their major political integration mechanisms give to these challenges.

The UN Development Program's (UNDP's) Human Development Report (HDR) 2014[20] includes a 2013 ranking of Caribbean countries by Human Development Index (HDI). The HDI, based on life expectancy at birth, mean years of schooling, expected years of schooling and GNI per capita, puts most of the countries in the high human development category. Over the period 2009-2014, most countries declined in HDI ranking. However, it is worth noting that such rankings do not address quality and equity considerations. **Table 1 summarises selected development data for Caribbean countries** from the 2014 rankings in the Human Development Report 2015[21].

The main political integration bodies in the Caribbean are CARICOM and the OECS. However, individual countries are also members of several other political integration mechanisms, including the Caribbean Forum (CARIFORUM), the Association of Caribbean States (ACS), the Bolivarian Alliance for the Peoples of Our America (ALBA) and the Amazon Cooperation Treaty Organization (ACTO). The health development agendas or objectives of the integration mechanisms provide frameworks for technical cooperation at the subregional level; selected integration mechanisms are described below.

CARICOM

CARICOM, including the Caribbean Common Market, was established by the Treaty of Chaguaramas in 1973,[22] and its secretariat is located in Guyana. The Treaty identified three pillars for integration – economic integration, coordination of foreign policy and functional cooperation in areas such as health, education, culture and other areas related to human and social development. CARICOM's fifteen (15) Member States are Antigua and Barbuda, The Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica, Montserrat, Saint Lucia, St. Kitts and Nevis, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago. There are five (5) Associate Members – Anguilla, Bermuda, British Virgin Islands, Cayman Islands and Turks and Caicos Islands.

In 2001 the Revised Treaty of Chaguaramas re-established CARICOM, including the CARICOM Single Market and Economy (CSME). The CSME is meant to achieve sustained economic development based on international competitiveness, coordinated economic policies and enhanced trade and economic relations with other States. It will provide a larger market, taking advantage of greater economies of scale, stimulating increased competitiveness and increasing opportunities for investment.[23] However, there have been delays in the implementation of the CSME's five regimes – free movement of skills, free movement of goods, free movement of services, movement of capital and rights of establishment, though protocols are in place in several Member States for the free movement of some skilled persons, including university graduates.

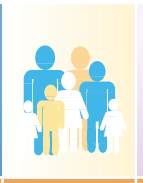
20 UNDP. Human Development Report 2014 – Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience. Available at http://hdr.undp.org/sites/default/files/hdr14-report-en-1.pdf, accessed 17 November 2015.

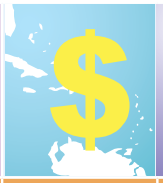
21 Human Development Report 2015: Work for Human Development. Available at http://hdr.undp.org/sites/default/files/2015_human_development_report_0.pdf, accessed 19 December 2015.

22 Information on CARICOM is available at www.caricom.org.

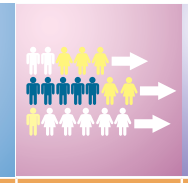
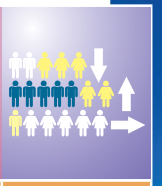
23 CARICOM. Strategic Plan for the Caribbean Community 2015-2019: Repositioning CARICOM, Vol. 1 – The Executive Plan, July 2014, page 14. Available at http://caricom.org/jsp/secretariat/caribbean-community-strategic-plan.jsp, accessed 11 November 2015.

Table 1. Summary of selected development data for Caribbean countries





Country	Population 2014	Economy classification (income level)	GNI per capita (US dollars)	Life expectancy at birth, total (years)	Dependency ratio 2013/2014 (per 100 working pop.)	School enrolment, primary (% gross)	Overall level of statistical capacity, 2015 (scale of 1-100)	Human Development Rank, 2013/2014	Change in HDI rank (2009-14)
Antigua & Barbuda	90,900	High	13,360 (2014)	76 (2013)	47/46	98 (2012)	NS	61/58	-6
Aruba	103,400	High	-	75 (2013)	44/44	104 (2012)	NS	NS	NS
The Bahamas	383,100	High	20,980 (2014)	75 (2013)	41/41	108 (2010)	NS	51/55	2
Barbados	283,400	High	14,960 (2012)	75 (2013)	49/50	105 (2011)	NS	59/57	-3
Bermuda	65,180	High	106,140 (2013)	81 (2013)	NS	86 (2013)	NS	NS	NS
Belize	351,700	Upper middle	4,350 (2013)	74 (2013)	60/58	118 (2013)	54.4	84/101	-7
British Virgin Islands*	29,564 (2013)	Not stated (NS)	29,564 (2013)	74 (2004)	NS	NS	NS	NS	NS
Cayman Islands	59,170	High	NS	NS	NS	NS	NS	NS	NS
Cuba	11.38 m	Upper middle	5,880 (2011)	79 (2013)	43/43	98 (2013)	NS	44/67	-14
Curaçao	155,900	High	-	77 (2011)	50/50	165 (2013)	NS	NS	NS
Dominica	72,340	Upper middle	7,070 (2014)	77 (2002)	NS	118 (2013)	52.2	93/94	-10
Dominican Republic	10.41 m	Upper middle	6,030 (2014)	73 (2013)	59/58	103 (2012)	78.9	102/101	0
Grenada	106,300	Upper middle	7,850 (2014)	73 (2013)	51/51	103 (2013)	51.1	79/79	NS
Guyana	763,900	Lower middle	4,170 (2014)	66 (2013)	55/53	75 (2012)	56.7	121/124	1
Haiti	10.57 m	Low	820 (2014)	63 (2013)	64/63	112 (1998)	47.8	168/163	-3
Jamaica	2.721 m	Upper middle	5,220 (2013)	73 (2013)	51/49	96 (2004)	77.8	96/99	-23
Sint Maarten	37,660	High	-	76 (2009)	NS	NS	NS	NS	NS
St. Kitts & Nevis	54,940	High	14,990 (2014)	71 (2002)	NS	85 (2013)	56.7	73/77	NS
Saint Lucia	183,600	Upper middle	7,080 (2014)	75 (2013)	49/48	100 (2007)	61.1	97/89	-5
Saint Martin	31,530	High	-	79 (2013)	NS	NS	NS	NS	NS
St. Vincent & the Grenadines	109,400	Upper middle	6,560 (2014)	73 (2013)	48/47	105 (2013)	55.6	91/97	-5
Suriname	538,200	Upper middle	9,470 (2013)	71 (2013)	52/51	113 (2013)	62.2	100/103	-5
Trinidad & Tobago	1.354 m	High	15,550 (2013)	70 (2013)	42/43	106 (2010)	56.7	64/64	-4
Turks & Caicos Islands	33,740	High	NS	NS	NS	90 (2005)	NS	NS	NS
US Virgin Islands	104,200	High	13,660 (1989)	80 (2013)	58/59	120 (1992)	NS	NS	NS

Sources: Columns 2-8: World Bank. New country classifications, 2015. http://data.worldbank.org/news/new-country-classifications-2015, accessed 17 November 2015 and World Bank. Age dependency ratio (DR) % of working-age population. http://data.worldbank.org/indicator/SP.POP.DPND, accessed 9 December 2015. [DR = # persons <15 years old + # persons >65 years old/# persons 15-64 years old x 100].

Columns 9-10: UNDP. Human Development Report 2014 – Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience. http://hdr.undp.org/sites/default/files/hdr14-report-en-1.pdf,

**Data from UN Statistics Division http://data.un.org/CountryProfile.aspx?crName=British%20Virgin%20Islands, accessed 30 November 2015*

The CARICOM Strategic Plan 2015-2019[24] sets out six Strategic Priorities (SPs):

- *Building economic resilience*
- *Building social resilience*
- *Building environmental resilience*
- *Building technological resilience*
- *Strengthening the CARICOM identity and spirit of community*
- *Strengthening community governance*

Table 2 outlines selected Strategic Priorities and health-related strategies and issues from the CARICOM Strategic Plan.

Table 2. Summary of selected Strategic Priorities and health-related strategies and issues in the CARICOM Strategic Plan, 2015-2019

Strategic Priorities	Strategies	Issues
Building economic resilience	• Build competitiveness and unleash key economic drivers to transition to growth	• Food and nutrition security
Building social resilience	• Advance initiatives for health and wellness	• Development of a regional health insurance scheme with a basic package of services for NCDs, HIV treatment and mental health screening • Health education and prevention for NCDs and HIV • Prevention and control of pandemic diseases • Fostering an enabling environment and inter-sectoral actions
	• Advance human capital development: key skills, education reform and youth development	• Health literacy • Development of human resources for health
	• Mainstream inclusiveness in public policy	• Gender • Persons with disabilities • Older persons
	• Enhance citizen security and justice	• Social development • Crime and violence prevention
Building environmental resilience	• Advance climate adaptation and mitigation • Advance disaster mitigation and management, using an integrated risk management approach • Enhance management of the environment and natural resources	• Climate change adaptation • Disaster preparedness, risk reduction, mitigation and recovery • Environmental health and sustainability
Building technological resilience	• Bring technology to the people and transform them into digital citizens and digital entrepreneurs	• Health promotion and communication • Health information and knowledge management

24 CARICOM. Strategic Plan for the Caribbean Community 2015-2019: Repositioning CARICOM, Vol. 2 – The Strategic Plan, July 2015.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

Resolutions, policies, strategies and plans approved by the CARICOM COHSOD, the Council for Trade and Economic Development (COTED), and other CARICOM organs that relate to health, serve as important frameworks for subregional TC in health. They include the Caribbean Pharmaceutical Policy (CPP), Plans of Action for the Prevention and Control of NCDs, the Caribbean Youth Development Action Plan (CYDAP) 2012-2017 (draft), and the Caribbean Regional Strategic Framework (CRSF) on HIV and AIDS 2014-2018. CARICOM health-related institutions play critical roles in the implementation of the resolutions and policies, and include the Caribbean Public Health Agency (CARPHA), the Caribbean Community Climate Change Centre (CCCCC or 5C's), and the Caribbean Disaster Emergency Management Agency (CDEMA).[25]

CARICOM has sought to collaborate with other subregional integration mechanisms, such as the Central American Integration System (SICA), and a CARICOM-SICA Plan of Action was signed in Belize City in 2007.[26] The Plan includes health as an area for cooperation, focusing on NCDs and HIV, and joint arrangements for purchasing medication, in collaboration with PAHO/WHO. In June 2015, the Ministers of Foreign Affairs of CARICOM and SICA met and renewed their commitment to cooperation.[27]

CARIFORUM

CARIFORUM comprises fourteen CARICOM Member States (all states except Montserrat) and the Dominican Republic.[28] Its objectives are to manage and coordinate policy discussion between the Caribbean and the European Union (EU), and to promote integration and cooperation in the sub-region. The partnership operates under the CARIFORUM-EU Economic Partnership Agreement (EPA), which was signed in 2008 and facilitates trade in goods and services.[29]

OECS

The OECS,[30] which has its Secretariat located in Saint Lucia, comprises seven Member States and three Associate Members. Antigua and Barbuda, Dominica, Grenada, Montserrat, Saint Lucia, St. Kitts and Nevis, and St. Vincent and the Grenadines are Members. Anguilla, the British Virgin Islands and Martinique are Associate Members. The OECS was established in 1981 with the Treaty of Basseterre, and formed an economic union of Member States in 2010 with the Revised Treaty of Basseterre. The most well known institution of the OECS is the Eastern Caribbean Central Bank (ECCB), which manages the Eastern Caribbean Dollar, the official currency of all members except the British Virgin Islands and Martinique. Unlike CARICOM, the OECS does not yet have an official, published health agenda, but a Health Desk is being established and the Member States cooperate in specific health issues, such as HIV prevention and control, and for environmental and sustainable development. As SIDS with small land masses and populations, the OECS Member States are particularly vulnerable to food insecurity and the effects of climate change and natural disasters.

ACS

The ACS was established in 1994, with its Secretariat located in Trinidad and Tobago. It comprises twenty-five Member States and four Associate Members, with a mix of countries from across Latin America and the Caribbean. The Members are Antigua and Barbuda, The Bahamas, Barbados, Belize, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Saint Lucia, St. Kitts and Nevis, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, and Venezuela. The Associate Members are Aruba, Curaçao, France (on behalf of French Guiana, Guadeloupe, Martinique, St. Barthelemy and St. Martin), Sint Maarten and the Kingdom of The Netherlands (on behalf of Bonaire, Saba and Sint Eustatius). The ACS fosters "consultation, cooperation, and concerted action", and has identified five areas of concern: the preservation

25 Information on CARICOM institutions is available at http://caricom.org/jsp/community/institutions.jsp?menu=community, accessed 18 November 2015.
26 CARICOM-SICA Plan of Action, 2007. Available at http://www.caricom.org/jsp/secretariat/legal_instruments/caricom_sica_poa.pdf, accessed 18 November 2015.
27 CARICOM-SICA Joint Communiqué, 16 June 2015. Available at http://www.sica.int/consulta/documento.aspx?idn=95326, accessed 19 November 2015.
28 Information on CARIFORUM is available at http://www.caricom.org/jsp/community_organs/cariforum/cariforum_main_page.jsp?menu=cob, accessed 18 November 2015.
29 Information on the CARIFORUM-EU EPA is available at http://ec.europa.eu/trade/policy/countries-and-regions/regions/caribbean/, accessed 18 November 2015.
30 Information on the OECS is available at http://www.oecs.org/, accessed 18 November 2015.

and conservation of the Caribbean Sea, sustainable tourism, trade and economic external relations, natural disasters and transport.[31] The ACS has completed, or is implementing, several projects relating to disaster risk reduction.

ALBA

ALBA[32] was established in 2004 by then-Presidents of Venezuela and Cuba, respectively President Hugo Chavez and President Fidel Castro. ALBA has eleven Member States, listed in the order in which they joined the integration mechanism: Venezuela, Cuba, Bolivia, Nicaragua, Dominica, Ecuador, Antigua and Barbuda, St. Vincent and the Grenadines, Saint Lucia, Grenada, and St. Kitts and Nevis.

ACTO

ACTO[33] comprises eight countries: Bolivia, Brazil, Colombia, Ecuador, Guyana, Peru, Suriname and Venezuela. The Treaty was signed in 1978 and the Secretariat was inaugurated in Brasilia, Brazil, in 2002. ACTO is deeply concerned with conservation of the Amazon area and resources for the benefit of its people, especially its vulnerable populations, which include indigenous people. Programmes and projects to address forests, water, biodiversity and climate change are included in its activities.

Other Mechanisms

Other subregional integration mechanisms are:

- **The Union of South American Nations (UNASUR)**[34]
- **The Association of Small Island States (AOSIS)**[35]

Caribbean countries' membership in the plethora of integration mechanisms within the sub-region and across sub-regions can pose challenges to efficient, effective TC, especially when resources are limited. However, this "multiple membership" also provides opportunities for cross-fertilisation among subregional political integration mechanisms. The identification of common priorities across the integration mechanisms, communication at the political level, and sharing of knowledge, experiences and lessons learnt are critical strategies for effective subregional TC.

2.1.1.2 Macroeconomic

Caribbean economies share many of the characteristics of small States, with open and vulnerable economies, narrow resource bases, limited diversity in production, exports concentrated on a few products, thin markets and high transportation costs. Governments of Caribbean SIDS face considerable challenges in generating sustained economic growth rates and these challenges have been exacerbated by external shocks. These include the global financial crisis, energy price shocks, fluctuating commodity prices, the rising cost of external credit, the dismantling of preferential market arrangements for traditional agricultural commodities and the introduction of stringent market entry conditions, including sanitary and phytosanitary restrictions.[36]

As a result of the 2008-2009 global economic downturn, most Caribbean countries, dependent on tourism, services and commodity exports as their main income-earners, experienced slow or negative economic growth for several years. Between 2011 and 2012, the average debt burden decreased from 69.7% to 65.4% of Gross Domestic Product, but the high debt levels in many Caribbean countries

31 Information on ACS is available at http://www.acs-aec.org/index.php?q=about-the-acs, accessed 19 November 2015.
32 Information on ALBA is available at http://albainfo.org/, accessed 19 November 2015.
33 Information on ACTO is available at http://otca.info/portal/index.php?p=index, accessed 19 November 2015.
34 Information on UNASUR is available at http://www.unasursg.org/en, accessed 19 November 2015.
35 Information on AOSIS is available at http://aosis.org/, accessed 19 November 2015.
36 UN Economic Commission for Latin America and the Caribbean (ECLAC). Third International Conference on Small Island Developing States: Caribbean Regional Synthesis Report, August 2013, page 6. Available at https://sustainabledevelopment.un.org/content/documents/5164250Synthesis%20Report%20Final%2020%20August%202013.pdf, accessed 20 November 2015.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

limit their accessibility to further financing.[37] Remittances from the diaspora make significant contributions to the economies of many countries in the Caribbean. An increase in remittances after the 2008-2009 international financial crisis was primarily due to special transfers of resources to Haiti after the 2010 earthquake. Subsequently, there was zero growth until the second half of 2013, when they began to increase. In 2014, annual volume increased by 6.3% for a total of US$9.9 billion in remittances received.[38]

In its 2014 Annual Report,[39] the Caribbean Development Bank (CDB) noted that its Borrowing Member Countries (BMCs) reported overall economic growth for the fourth straight year. The CDB's 2014 Caribbean Economic Review and Outlook for 2015[40] noted the gradual recovery of the world economy and further slowing of inflation, and reported that 16 of its 19 BMCs experienced economic growth during the year, driven mainly by tourism and construction services. The improvement in the construction sector was linked to tourism development, driven by foreign direct investment inflows, though in some cases there was unanticipated reconstruction work following weather-related events.

Tourism is a key industry in the Caribbean, with around 35 million visitors per year. Cruise ship tourism has shown a high and steady rate of growth, though cruise ship visitor arrivals in individual ports have been more erratic.[41] Linkages with other services and sectors increase tourism's importance for the subregional economy, but there are several constraints, including low competitive ability on the international tourism markets and a mass-tourism industry focused on "sea-sun-sand", with a significant all-inclusive supply system that generally does not involve local communities, which results in limited benefits for national economies. There is also limited understanding among policy makers of tourism mechanisms and the industry's role in community development and poverty reduction. Diversification of the tourism product is important, perhaps through investment in the creative and cultural industries, especially since preliminary results of economic assessments of the subregional tourism sector in The Bahamas, Barbados, Montserrat and Saint Lucia have shown declining revenue. However, other important tourism destinations such as Cuba and the Dominican Republic have increased their tourist arrivals[42] and with the official thawing in relations between Cuba and the USA that occurred in 2015, tourist arrivals to Cuba are likely to further increase.

The 2015 CDB Economic Review and Outlook noted that:

- The fastest expansion rates in the sub-region were estimated for two of the more tourism-dependent economies: St. Kitts and Nevis, and Turks and Caicos Islands, each of which had accelerated growth of approximately 4%
- Despite on-going depletion of petroleum reserves (Belize and Suriname) and declines in gold and bauxite production (Guyana and Suriname), these countries showed improvements over 3%, led by construction and other services
- Haiti's performance fell slightly below 3%, mainly due to drought-related contraction in agricultural output, but was boosted by on-going post-earthquake reconstruction and to a lesser extent, tourism
- Moderate gains (1-3%) seen in Anguilla, Antigua and Barbuda, The Bahamas, Cayman Islands, Grenada and Montserrat, were linked to general improvement in tourism and, in all except Grenada, to construction

37 Ibid.
38 Maldonado R, Hayem, M. Remittances to Latin America and the Caribbean set a new record high in 2014, page 10. Washington, D.C.: Multilateral Investment Fund, Inter-American Development Bank (IDB), 2015. Available at http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=39619143, accessed 20 November 2015.
39 Caribbean Development Bank. 2014 Annual Report – Fuelling Sustainable Growth, Vol.1. Available at http://www.caribank.org/publications-and-resources/annual-reports, accessed 16 November 2015.
40 Caribbean Development Bank. 2014 Caribbean Economic Review and Outlook for 2015. Available at http://www.caribank.org/uploads/2015/02/CDB-2014-Caribbean-Economic-Review-and-Outlook-for-2015.pdf, accessed 16 November 2015.
41 UN ECLAC. Third International Conference on SIDS: Caribbean Regional Synthesis Report, August 2013, page 35. Available at https://sustainabledevelopment.un.org/content/documents/5164250Synthesis%20Report%20Final%2020%20August%202013.pdf, accessed 20 November 2015.
42 Ibid.

- Dominica and Jamaica experienced relatively modest increases of just under 1%, but these still represented improvements, compared with 2013
- There were some exceptions to the on-going recovery:
    - Trinidad and Tobago's economy slowed considerably to record modest growth in 2014; operational challenges and the significant fall in oil prices suppressed petroleum output, driving a decline in the mining and quarrying sector
    - Barbados and the British Virgin Islands (BVI) stagnated for the seventh consecutive year in 2014
- The BMCs for which 2014 labour force data were available continued to report double-digit unemployment rates, except for Trinidad and Tobago, though unemployment fell in The Bahamas, Belize and Jamaica.
- Fiscal underperformance led to increased indebtedness in some countries, the biggest increases being in The Bahamas, Barbados, and St. Vincent and the Grenadines, which were downgraded by credit rating agencies. The debt burden fell in Antigua and Barbuda, Grenada, Jamaica, and St. Kitts and Nevis, with the latter three improving under International Monetary Fund fiscal adjustment programmes

Overall, the CDB predicts economic expansion for all 19 BMCs, with most set to grow by 1%-3%. Given petroleum production challenges and low oil prices, Trinidad and Tobago is expected to be at the lower end of that range, while rates for 3.5%-4.5% are being predicted for Guyana, Haiti and Suriname, given their emphasis on mining and agriculture. Similarly high rates of growth are expected in tourism-dependent economies. However, the Bank also identifies risks, including:[43]

- Fallout for destinations highly dependent on the UK market if there is any fiscal tightening there
- Curtailment in mining and quarrying output from regional commodity exporters,[44] as occurred in 2014, if there is a sharp decline in commodity prices
- Threats to the sustainability of the Petrocaribe arrangement with Venezuela, if there are further reductions in oil prices, impacting fiscal and debt sustainability
- Occurrence of natural disasters and other weather-related events, which can significantly reverse BMCs' economic progress

2.1.1.3 Social

Caribbean countries have a long history of inter-country cooperation to achieve political and other synergies, take advantage of economies of scale and facilitate cooperation among themselves and with other countries and subregional or regional blocs. This is so particularly in health and other social sectors. Human rights are reflected in the national constitutions of most countries and many have signed and/or ratified several human rights treaties, including:

- The International Covenant on Civil and Political Rights (CCPR)
- The International Covenant on Economic, Social and Cultural Rights (CESCR)
- The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

43 Ibid.

44 Commodity exporters are CDB BMCs for which agriculture, mining and quarrying, and manufacturing represent more than 25% of overall Gross Domestic Product: Belize, Guyana, Haiti, Suriname, and Trinidad and Tobago. Trinidad and Tobago accounts for nearly a third of the sub-region's total GDP.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

- The International Convention on the Elimination of All Forms of Racial Discrimination (CERD)
- The Convention on the Rights of the Child (CRC) and
- The Convention of the Rights of Persons with Disabilities (CRPD)

Table 3 shows the countries' status regarding human rights treaty signature and ratification.

Table 3. Status of Caribbean countries' signature (S) or ratification (R) of human rights treaties, and year

Country	CAT	CAT-OP	CCPR	CCPR-OP2-DP	CED	CEDAW	CERD	CESCR	CMW	CRC	CRC-OP-AC	CRC-OP-SC	CRPD
ATG	R, 1993					R, 1989	R, 1988			R, 1993		R, 2002	
BHS	S, 2008		R, 2008			R, 1993	R, 1975	R, 2008		R, 1991	R, 2015	R, 2015	R, 2015
BRB			R, 1973			R, 1980	R, 1972	R, 1973		R, 1990			R, 2013
BLZ	R, 1986	R, 2015	R, 1996		R, 2015	R, 1990	R, 2001	R, 2015	R, 2001	R, 1990	R, 2003	R, 2003	R, 2011
CUB	R, 1995		S, 2008		R, 2009	R, 1980	R, 1972	S, 2008		R, 1991	R, 2007	R, 2001	R, 2007
DMA			R, 1993			R, 1980		R, 1993		R, 1991	R, 2002	R, 2002	R, 2012
DOR	R, 2012		R, 1978			R, 1982	R, 1983	R, 1978		R, 1991	R, 2014	R, 2006	R, 2009
GRD			R, 1991		S, 2007	R, 1990	R, 2013	R, 1991		R, 1990	R, 2012	R, 2012	R, 2014
GUY	R, 1988		R, 1977			R, 1980	R, 1977	R, 1977	R, 2010	R, 1991	R, 2010	R, 2010	R, 2014
HTI	S, 2013		R, 1991		S, 2007	R, 1981	R, 1972	R, 2013		R, 1995		R, 2014	R, 2009
JAM			R, 1975			R, 1984	R, 1971	R, 1975	R, 2008	R, 1991	R, 2002	R, 2011	R, 2007
KNA						R, 1985	R, 2006			R, 1990			
LCA			S, 2011			R, 1982	R, 1990			R, 1993	R, 2014	R, 2013	
VCT	R, 2001		R, 1981		S, 2010	R, 1981	R, 1981	R, 1981	R, 2010	R, 1993	R, 2011	R, 2005	R, 2010
SUR			R, 1976			R, 1993	R, 1984	R, 1976		R, 1993		R, 2012	S, 2007
TTO			R, 1978			R, 1990	R, 1973	R, 1978		R, 1991			R, 2015
FRA	R, 1986	R, 2008	R, 1980	R, 2007	R, 2008	R, 1983	R, 1971	R, 1980		R, 1990	R, 2003	R, 2003	R, 2010
NLD	R, 1988	R, 2010	R, 1978	R, 1991	R, 2011	R, 1991	R, 1971	R, 1978		R, 1995	R, 2009	R, 2005	S, 2007
GBR	R, 1988	R, 2003	R, 1976	R, 1999		R, 1986	R, 1969	R, 1976		R, 1991	R, 2003	R, 2009	R, 2009
USA	R, 1994		R, 1992			S, 1980	R, 1994	S, 1977		S, 1995	R, 2002	R, 2002	S, 2009

Source: UN Human Rights – Office of the High Commissioner on Human Rights. Available at http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx?CountryID=5&Lang=EN, accessed 22 November 2015.

CAT Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; CAT-OP – Optional Protocol of the CAT

CCPR International Covenant on Civil and Political Rights; CCPR-OP2-DP – Second Optional Protocol to the CCPR aiming to the abolition of the death penalty

CED Convention for the Protection of All Persons from Enforced Disappearance

CEDAW Convention on the Elimination of All Forms of Discrimination against Women

CERD International Convention on the Elimination of All Forms of Racial Discrimination

CESCR International Covenant on Economic, Social, and Cultural Rights

CMW International Convention of Protection of the Rights of All Migrant Workers and Members of Their Families

CRC Convention on the Rights of the Child; CRC-OP-AC – Optional Protocol to the CRC on the involvement of children in armed conflict; CRC-OP-SC – Optional Protocol to the CRC on the sale of children, child prostitution, and child pornography

CRPD Convention on the Rights of Persons with Disabilities

Caribbean countries made significant progress towards the achievement of the Millennium Development Goals, 2000-2015, notably in primary education, child survival, maternal health and combating HIV and AIDS. The countries also designated marine and terrestrial protected areas, reduced consumption of ozone-depleting substances and improved citizens' access to telecommunications.[45]

Notwithstanding, the sub-region continues to face many challenges that affect its sustainable development, some of which are summarised below.

An important cross-cutting issue is the dearth of quality, disaggregated, updated data in many sectors to facilitate analysis and comparisons, define trends, identify inequities related to gender, ethnicity, education, income, geographic location and other factors, and enable evidence-based decision-making. There is no integrated, easily accessible, current situation analysis of Caribbean health and development issues based on such data despite past efforts, including the 1997 PAHO publication Health Conditions in the Caribbean.[46] In addition, Caribbean data and development analyses are often subsumed in information on the Latin America and Caribbean region as a whole, without clear differentiation of Caribbean subregional indicators.

Poverty

Poverty remains a major obstacle to the sustainable development of Caribbean SIDS and the Region of the Americas, including the Caribbean, continues to exhibit significant levels of inequity. Despite the progress made, the negative fallout of the global financial crisis resulted in a decline in real wages and an increase in the number of vulnerable persons and communities, with resultant increase in poverty and a decline in consumption in poor households.[47]

In many countries there are vulnerable groups living at risk in poor habitats, with low income levels and few physical and financial assets.[48] Such groups include indigenous people in countries such as Belize, Dominica, Guyana and Suriname, urban youth and women. In part, this reflects the relatively weak social protection systems in the Caribbean. In most of the sub-region, social safety nets and social protection provisions are administered in a fragmented manner by a range of institutions, each operating its own system.[49] **Table 4 shows data from the World Bank on the poverty head count ratio at US$1.90 per day and GDP annual growth in selected countries.[50]**

45 UN ECLAC. Third International Conference on SIDS: Caribbean Regional Synthesis Report, August 2013. Available at https://sustainabledevelopment.un.org/content/documents/5164250Synthesis%20Report%20Final%2020%20August%202013.pdf, accessed 20 November 2015.

46 PAHO. Health Conditions in the Caribbean. Scientific Publication No. 561. Washington, D.C., PAHO, 1997. Information available at http://publications.paho.org/product.php?productid=295, accessed 19 December 2015.

47 UN ECLAC. Third International Conference on SIDS: Caribbean Regional Synthesis Report, August 2013. Available at https://sustainabledevelopment.un.org/content/documents/5164250Synthesis%20Report%20Final%2020%20August%202013.pdf, accessed 20 November 2015.

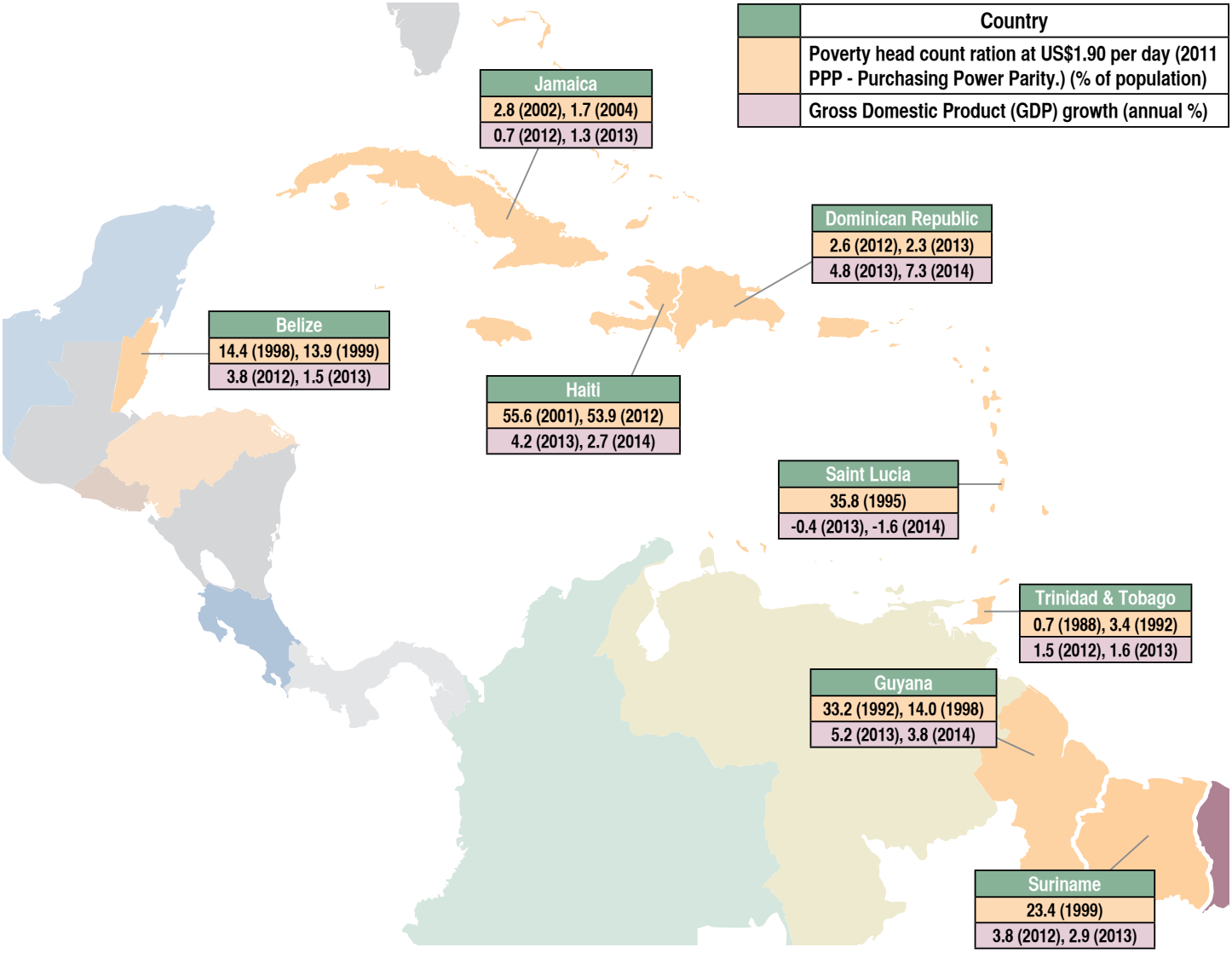
48 Ibid.

49 Ibid.

50 World Bank. Poverty and equity data. Available at http://data.worldbank.org/topic/poverty, accessed 20 November 2015.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

Table 4. Poverty data from selected countries



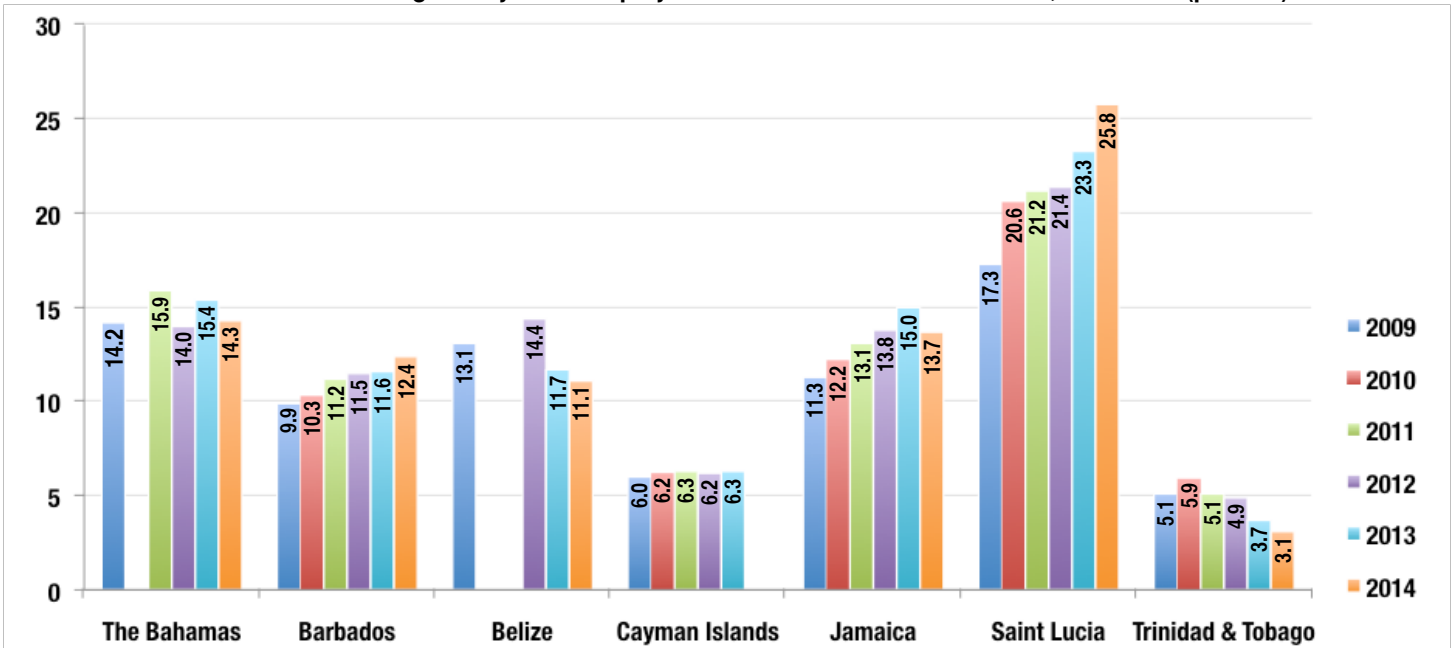
Source: World Bank. Poverty and equity data. Available at http://data.worldbank.org/topic/poverty, accessed 20 November 2015.

Unemployment

Several Caribbean countries have experienced increases in unemployment, Trinidad and Tobago being an exception. Women are more affected than men in most countries, with the exception of The Bahamas (2011). In Belize, female unemployment in 2009 was 20%, almost three times the rate among males, while in other countries the rate among females was almost double that among males.[51] However, in some countries the gender gap has been decreasing, regrettably due to an increase in unemployment among males during the years of economic crisis, rather than an increase in employment among females. **Table 5 reflects unemployment data 2009-2014.**

51 Parra-Torrado, M. Youth unemployment in the Caribbean. World Bank, Caribbean Knowledge Series, April 2014. Available at https://openknowledge.worldbank.org/handle/10986/18999, accessed 21 November 2015.

Table 5. Annual average/mid-year unemployment rates for selected countries, 2009-2014 (percent)



Source: Adapted from Caribbean Development Bank. Caribbean Economic Review 2014 and Outlook 2015

Youth are at higher risk of unemployment, and data indicate that in most countries youth unemployment is double the rate of total unemployment. Among countries with available data, the highest youth unemployment rates are found in Barbados, The Bahamas, Jamaica, and Trinidad and Tobago, where they are about 2.4 times higher than the total unemployment rate.[52]

Factors contributing to youth unemployment in the sub-region include inadequate skills, limited information and the mismatch that often exists between the output of the education and training systems, and the skills needed in the labour market. This is aggravated by lack of work experience.[53] In turn, youth unemployment is one of the socio-economic factors that may push youth into crime and violence. The CARICOM Youth Development Commission noted several challenges to youth development, including declines in educational access, relevance, quality and outcomes, with the outcomes not addressing the demands of the private sector. The Commission also noted that unemployment and under-employment impact the quality of life of adolescents and youth, increase their frustration and hopelessness, decrease productivity and heighten vulnerability to social dislocation, exploitation and poverty.[54] The draft CYDAP 2012-2017,[55] currently being finalised by the CARICOM Secretariat, proposes actions to address these issues.

Education

In the Caribbean, there is near-universal enrolment at the primary and secondary education levels and a high level of education expenditure relative to GDP. In 2012 the literate population 15 years and older was 95% in the Latin Caribbean[56] and 91.8% in the

52 Ibid.
53 Ibid.
54 CARICOM. Report of the CARICOM Youth Development Commission. CARICOM, Georgetown, January 2010. Available at http://www.caricom.org/jsp/community_organs/cohsod_youth/eye_on_the_future_ccyd_report.pdf, accessed 21 November 2015.
55 CARICOM. Draft Caribbean Youth Development Action Plan 2012-2017, July 2012, available at http://www.mwh.gov.jm/index.php?, *accessed 21 November 2015.*
56 Latin Caribbean comprises Cuba, Dominican Republic, French Guiana, Guadeloupe, Haiti, Martinique, and Puerto Rico.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

non-Latin Caribbean.[57,58] **Table 6 shows UNESCO data on education expenditure as a percentage of GDP** for the most recent and previous years available for selected countries.[59]

Table 6. Education expenditure as a percentage of GDP in selected countries

Country	Education expenditure as % of GDP		Trend
Antigua & Barbuda	3.45 (2002)	2.55 (2009)	Decrease
Aruba	6.71 (2010)	6.04 (2011)	Decrease
The Bahamas	-	2.85 (2000)	-
Barbados	5.89 (2010)	5.61 (2012)	Decrease
Belize	6.10 (2009)	6.62 (2010)	Increase
Bermuda	2.64 (2010)	1.78 (2014)	Decrease
Cuba	-	12.84 (2010)	-
Dominica	-	4.99 (1999)	-
Dominican Republic	2.05 (2007)	3.74 (2013)	Increase
Grenada	-	3.93 (2003)	-
Guyana	3.59 (2011)	3.19 (2012)	Decrease
Jamaica	6.12 (2012)	6.26 (2013)	Increase
Saint Lucia	4.00 (2012)	4.76 (2013)	Increase
St. Kitts & Nevis	4.11 (2006)	4.23 (2007)	Increase
St. Vincent & the Grenadines	5.69 (2009)	5.09 (2010)	Decrease
Trinidad & Tobago	3.54 (2002)	3.16 (2003)	Decrease

Source: UNESCO. Expenditure on education as a percentage of GDP. Available at http://data.uis.unesco.org/?queryid=181, accessed 21 November 2015.

However, despite the establishment of tertiary institutions such as the University of the West Indies (UWI), which dates back to 1948, national and offshore universities, and community colleges, access to higher education remains low, with less than 15% of secondary school graduates going on to post-secondary education.[60] In some cases this may relate to financial barriers.

There is also room for improvement in the quality of education in the Caribbean – the average pass rates for standardised tests in core subjects such as English and Mathematics are less than 50% and many students lack basic skills in information and communication technology, as well as other disciplines deemed critical for success in the workplace. There are also reports of poor performance on the Caribbean Secondary Education Certificate (CSEC) test items that require critical thinking, analysis or communication. This emphasises the need for education systems in the Caribbean to focus on building capabilities and skillsets that will render its citizens globally competitive.[61]

57 Non-Latin Caribbean comprises Anguilla, Antigua & Barbuda, Aruba, The Bahamas, British Virgin Islands, Cayman Islands, Curaçao, Dominica, Grenada, Guyana, Jamaica, Montserrat, St. Kitts & Nevis, Saint Lucia, St. Vincent & the Grenadines, Sint Maarten, Suriname, Trinidad & Tobago, Turks & Caicos Islands, US Virgin Islands.

58 PAHO. Health situation in the Americas: Basic indicators 2014. Washington, D.C, 2014. Available at http://www.paho.org/hq/index.php?option=com_content&view=category&layout=blog&id=2394&Itemid=2395, accessed 22 November 2015.

59 UNESCO. Expenditure on education as a percentage of GDP. Available at http://data.uis.unesco.org/?queryid=181, accessed 21 November 2015.

60 Clark, M. Quality education counts for skills and growth. World Bank, Caribbean Knowledge Series, June 2013. Available at http://documents.worldbank.org/curated/en/2013/06/17893756/quality-education-counts-skills-growth, accessed 20 November 2015.

61 Ibid.

Another area of concern is the progressive decline in the participation of boys in the education system through secondary and tertiary levels,[62] with most of the graduates at these levels being women. This early school leaving ("drop-out") not only contributes to youth unemployment, but it is also a recognised risk factor for engagement in risky behaviours, including substance abuse and violence. The rising trend of violence in the Caribbean,[63] with males increasingly being both perpetrators and victims of crime, has resulted in concerns about "men in crisis" and "marginalisation of boys".

Agriculture, and food and nutrition security

Food and nutrition have always been priorities on the Caribbean health and development agendas. Although the Caribbean Food and Nutrition Institute (CFNI) was decommissioned at the end of 2012, nutrition remains a priority and many of CFNI's functions are now carried out by PAHO and CARPHA. The 2009 Liliendaal Declaration on Agriculture and Food Security by the CARICOM Heads identified the agricultural sector as one of the drivers of economic growth and poverty alleviation in the subregion and noted the need for a more concerted effort among all stakeholders in addressing the challenges facing the sector.[64] With the high prevalence of NCDs, the sub-region recognised the importance of focusing on nutrition security. This is reflected in the 2010 Regional Food and Nutrition Security Policy (RFNSP) and its accompanying Action Plan (2011), as well as in national food and nutrition security (FNS) policies currently being articulated.[65]

The 2010 RFNSP notes reports by the Food and Agricultural Organization (FAO) that FNS in CARICOM is compromised not so much by unavailability of food as by inadequate access to foods that positively impact nutritional status. The influx of food imports high in "empty calories", often as a result of international trade agreements that restrict controls and changing food consumption patterns, are of concern. Many Caribbean countries are experiencing a shift in nutrition patterns, resulting in increasing rates of obesity and contributing to an increase in nutrition-related NCDs such as diabetes and hypertension.[66] The Policy also notes challenges related to the declining trend of food production and increases in imports, with related expenditure of scarce foreign exchange. Vulnerabilities related to natural disasters, small size and distance, and insufficient strategic planning reduce possibilities for exploiting economies of scale, resulting in higher prices for imported inputs and higher costs of export products. High interest rates and low returns on agricultural investment are cited as deterrents to investment in the agricultural sector.[67]

The report notes that the sub-region's food import bill was estimated at US$3.5 billion in 2008 and food importation continues to trend upwards. It also highlights the need for regional food production and distribution systems that address its objectives of food availability, food access, food utilisation/nutritional adequacy, and stability of food supply, with benefits for nutrition, health and lower external costs to society and the environment.[68]

A 2015 FAO report on food insecurity in the sub-region recognises the FAO's four pillars of food security – food availability, food accessibility, food utilisation and food stability.[69] The report noted that CARICOM countries consume more calories per day than required

62 UN ECLAC. Third International Conference on SIDS: Caribbean Regional Synthesis Report, August 2013. Available at https://sustainabledevelopment.un.org/content/documents/5164250Synthesis%20Report%20Final%2020%20August%202013.pdf, accessed 20 November 2015.

63 CARICOM. Draft Caribbean Youth Development Action Plan 2012-2017, July 2012, pages 7-8. Available at http://mwh.gov.jm/index.php?option=com_content&view=article&id=132&Itemid=480&jsmallfib=1&dir=JSROOT/SIDS/Meeting+Docs/Reference+Docs&download_file=JSROOT/SIDS/Meeting+Docs/Reference+Docs/Attachment+V+to+WD+in+Relation+to+Item+10+1+CYDAP+2012-2017+Rev.pdf, accessed 21 November 2015.

64 CARICOM. The Liliendaal Declaration on Agriculture and Food Security, July 2009. Available at http://www.caricom.org/jsp/communications/meetings_statements/liliendaal_declaration_agriculture_food_security.jsp, accessed 23 November 2015.

65 InterAmerican Institute for Cooperation on Agriculture (IICA), Technical Centre for Agriculture and Rural Cooperation (CTA), and Caribbean Regional Agriculture Policy Network (CaRAPN). Hunger and nutrition from belly-full to body-fuel. Critical Issues, Options and Perspectives (CIPO) #4. Port of Spain, Trinidad and Tobago: IICA, 2015. Available at http://www.iica.int/sites/default/files/publications/files/2015/B3665i.pdf, accessed 23 November 2015.

66 CARICOM. Regional Food and Nutrition Security Policy. Georgetown, Guyana: CARICOM, October 2010. Available at http://www.caricom.org/jsp/community_organs/regional_food_nutrition_security_policy_oct2010.pdf, accessed 23 November 2015.

67 Ibid.

68 Ibid.

69 FAO. State of food insecurity in the CARICOM Caribbean – Executive Summary. Bridgetown, Barbados: FAO, 2015. Available at http://www.fao.org/3/a-i5132e.pdf, accessed 9 December 2015.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

– with the exception of Haiti – and confirmed that food availability is increasingly derived from imports. This facilitates food import dependence, loss of foreign exchange and increased consumption of processed foods, which contribute to obesity and NCDs.

Environmental sustainability, climate change, and disaster mitigation and response

Environmental health has strong roots in the roles and functions of Public Health Inspectors, and disaster mitigation and response have been long-standing priorities. This is reflected in CARICOM's establishment of CDEMA[70] (previously the Caribbean Disaster Emergency Response Agency, CDERA, established in 1991) and close collaboration with PAHO/WHO in implementation of the Safe Hospitals and Smart Hospitals initiatives,[71] among other disaster mitigation interventions. CDEMA is implementing Phase II of the project "Mainstreaming Climate Change in Disaster Management in the Caribbean", which aims to strengthen national and community capacity for integration of climate change adaptation and disaster risk reduction.[72]

Countries have improved access to **basic water and sanitation**. In 2015, 73% of the population in the CARICOM Member States was using improved drinking water sources and 50% was using improved sanitation facilities. These data are strongly influenced by Haiti, which accounts for about 60% of CARICOM countries' population. If Haiti is excluded, 95% of the CARICOM population was using improved drinking water sources in 2015 and 86% using improved sanitation facilities. Several CARICOM Member States did not have adequate data to assess their progress in achieving the MDG 7 water supply and sanitation targets.[73]

Water stress occurs when the quantity and quality of water are not adequate for all uses, whether agricultural, industrial, or domestic. Seven Caribbean countries appear on a list of countries with "extremely high" levels of baseline water-stress: Antigua and Barbuda, Barbados, Dominica, Jamaica, Saint Lucia, St. Vincent and the Grenadines, and Trinidad and Tobago.[74] A major challenge in water supply is the age of most of the existing water treatment and distribution networks, which are no longer adequate to meet present user demand.[75] Overall water management continues to be of concern; many countries practise rainwater harvesting and some, such as The Bahamas, Barbados and the Cayman Islands are using desalination technologies.

Though the management of solid waste has improved over the last decade, notably in OECS countries due to the World Bank MARPOL[76] project, sewerage and solid waste disposal remain problematic in many countries. The management of special waste (toxic, hazardous and infectious waste), landfill creation and management, and incineration are topics of concern to policymakers and the public alike. In most countries, waste recycling is encouraged, though not mandated, and opportunities for expansion are limited due to small country size and limited incentives.

About 70% of the Caribbean's population lives in vulnerable, low-lying, coastal areas. The expected impact of **climate change** in the Caribbean includes increased ambient temperatures, lower than average annual rainfall, more extreme weather patterns with high winds (hurricanes), sea-level rise, floods and droughts. These changes may cause expansion of vector breeding sites and put significant stress on available fresh water resources. In some countries the latter are already under stress from pollution from residential and industrial wastewater, fertilisers and pesticides. The importance of environmental sustainability has been emphasised in many subregional, regional

70 Information on CDEMA is available at http://www.cdema.org/, accessed 23 November 2015.
71 Information on Safe Hospital and Smart Hospitals is available at http://www.paho.org/disasters/index.php?option=com_content&view=category&layout=blog&id=1026&Itemid=911, accessed 23 November 2015.
72 UN ECLAC. Third International Conference on SIDS: Caribbean Regional Synthesis Report, August 2013. Available at https://sustainabledevelopment.un.org/content/documents/5164250Synthesis%20Report%20Final%2020%20August%202013.pdf, accessed 20 November 2015.
73 WHO and UNICEF. Progress on sanitation and drinking water – 2015 update and MDG assessment. Available at http://www.wssinfo.org/fileadmin/user_upload/resources/JMP-Update-report-2015_English.pdf, accessed 9 April 2016.
74 World Resources Institute (WRI). World's 36 most water-stressed countries. Available at http://www.wri.org/blog/2013/12/world%E2%80%99s-36-most-water-stressed-countries, accessed 7 December 2015.
75 CARPHA. Health situation in the Caribbean. Port of Spain, Trinidad and Tobago: CARPHA, 2013.
76 MARPOL 73/78 refers to the 1973 International Convention for the Prevention of Pollution from Ships, which was modified by the Protocol of 1978. Information available at http://documents.worldbank.org/curated/en/1991/04/18398276/marpol-7378-international-convention-prevention-pollution-ships, accessed 7 December 2015.

and global fora since the UN Framework Convention on Climate Change (UNFCCC)[77] entered into force in 1994.

- The 1994 *Barbados Plan of Action (BPOA)*[78] identified actions to be taken regarding climate change and sea level rise; natural and manmade/environmental disasters; management of wastes; coastal and marine, freshwater, land, energy, tourism and biodiversity resources; national institutions and administrative capacity; regional institutions and technical cooperation; transport and communication; science and technology; human resource development; and implementation, monitoring and review
- The 2005 *Mauritius Strategy for the Further Implementation of the Programme of Action for the Sustainable Development of Small Island Developing States (MSI)*[79] retained the thematic areas of the BPOA, and added: graduation from least-developed country status, trade globalisation and liberalisation, sustainable production and consumption, national and regional enabling environments, health, knowledge management and information for decision-making, culture, access to and the provision of financial resources, and national and international governance
- The 2009 *CARICOM Liliendaal Declaration on Climate Change*[80] noted the Community's resolve to "strengthen its educational institutions to provide training, education, and research and development programmes in climate change and disaster risk management, particularly in renewable and other forms of alternative energy, forestry, agriculture, tourism, health, coastal zone management and water resources management to increase the Region's capacity to build resilience and adapt to climate change"

In preparation for the Third International Conference on SIDS in 2014, Caribbean countries reported on their progress regarding the BPOA and MSI, including plans and interventions for climate change adaptation, renewable energy sources and energy efficiency, and natural and environmental disaster mitigation.[81] With on-going extractive industries such as mining for gold, bauxite and rare metals, and offshore oil exploration, systems to prevent and mitigate environmental pollution are becoming even more important.

Citizen security, crime, violence and justice

Increases in serious crimes have occurred in some of the larger Caribbean countries like Jamaica and Trinidad and Tobago, and even the smaller countries struggle with crimes involving illegal guns and trafficking in drugs and persons, and the involuntary return of nationals who have committed serious crimes in some developed countries. Both land and sea borders can be porous and difficult to police effectively given the countries' limited resources. Serious crimes are reported in international and social media, with significant negative impact on foreign direct investment and tourism. Countries such as Guyana also have to contend with persons who cross illegally into the country from neighbouring states to take advantage of the gold rush.

In recognition of the heightened challenges to security in the sub-region, CARICOM established the Crime and Security Framework in 2005, the Implementation Agency for Crime and Security (IMPACS) in 2006, and the Council of Ministers responsible for National Security and Law Enforcement (CONSLE) to deal with the issues. In 2007, the Heads of Government agreed that crime and security would be the fourth pillar of the region's integration, and border management has become a major security priority.[82] The 2013 CARICOM Crime

77 Information on the UNFCCC is available at http://www.paho.org/disasters/index.php?option=com_content&view=category&layout=blog&id=1026&Itemid=911, accessed 23 November 2015.
78 UN. Report of the Global Conference on the Sustainable Development of SIDS, Annex II, the Barbados Plan of Action. UN Document A/CONF.167/9, 1994. Available at http://www.un.org/esa/dsd/dsd_aofw_sids/sids_pdfs/BPOA.pdf, accessed 23 November 2015.
79 UN. Report of the International Meeting to Review the Implementation of the Program of Action for the Sustainable Development of SIDS, Annex II. UN Document A/CONF.20, 2005. Available at http://www.un.org/ga/search/view_doc.asp?symbol=A/CONF.207/11&Lang=E, accessed 23 November 2015.
80 CARICOM. The Liliendaal Declaration on Climate Change, July 2009. Available at http://www.caricom.org/jsp/communications/meetings_statements/liliendaal_declaration_climate_change_development.jsp, accessed 23 November 2015.
81 UN ECLAC. Third International Conference on SIDS: Caribbean Regional Synthesis Report, August 2013. Available at https://sustainabledevelopment.un.org/content/documents/5164250Synthesis%20Report%20Final%2020%20August%202013.pdf, accessed 20 November 2015.
82 Ibid.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

and Security Strategy[83] has fourteen Strategic Goals and addresses a range of risks and threats to the sub-region's security, including cyber-crime and terrorism. The strategy reports the average homicide rate in the Caribbean as 30/100,000 population, compared with 5/100,000 globally, and notes that illegal guns and ammunition are responsible for over 70% of homicides in CARICOM countries.

In CARPHA Member States, **homicide** rates increased from a range of 6-40 per 100,000 population in 2002 to 7-52 per 100,000 in 2010. The UNDP's 2012 Caribbean Human Development Report (HDR)[84] detailed the increasing trend of violent crimes over the period 1990-2010 in seven countries – Antigua and Barbuda, Barbados, Guyana, Jamaica, Saint Lucia, Suriname, and Trinidad and Tobago. Approximately 11% of the UNDP survey respondents of both sexes reported experience with **gender-based (domestic) violence**, with rates ranging from a low of 6% in Jamaica to a high of 17% in Guyana.[85] Gender-based violence (GBV) affects women more than men, and is rooted in historical, social and gender constructs and attitudes. Most surveys found that between one-fourth and one-half of women reported ever experiencing intimate partner violence. In each country, the percentage of women who reported physical or sexual violence by an intimate partner recently (that is, in the past 12 months) was lower than the percentage who reported it ever, but the prevalence of recent partner violence was still substantial. Most countries are working to raise awareness of GBV's prevalence and causes, and are using a multi-sectoral approach to address it, including the annual campaign "16 Days of Activism against Gender-based Violence".[86]

The 2012 HDR highlighted the need for Caribbean countries to focus on a model of security based on the human development approach, whereby citizen security is paramount, rather than on the traditional state security model, whereby the protection of the state is the chief aim. It noted that social inclusion to help prevent crime and violence, and efficient and effective law enforcement serve to reinforce and complement each other. Caribbean countries are working to address the root causes of crime and violence through poverty eradication and social development projects, including targeting youth and gender issues. However, there are concerns in many countries about the justice system, including the slow pace with which many criminal cases make their way through the court system; criteria for granting bail; penalties and punishment for offences perceived as being relatively minor; and the replacement of the British Privy Council by the Caribbean Court of Justice, a CARICOM organ, as the final court of appeal for English-speaking CARICOM Member States.

Information and communications technologies, knowledge management, monitoring and evaluation

The Caribbean has been using distance learning as part of its educational armamentarium. The UWI Distance Teaching Enterprise (UWIDITE) became the UWI Distance Education Centre (UWIDEC) in 1996, and UWIDEC was integrated into the UWI Open Campus, which was launched in 2008.[87] However, advances in information and communications technologies (ICT), including the use of the internet and social media, offer several additional options for capacity-building and knowledge management.

As at 30 June 2014, the Caribbean[88] had 17.2 million internet users, a population penetration of 41.1%. The International Telecommunications Union (ITU) has been tracking indicators that capture the use of ICT disaggregated by sex since 2007. Data show that there is a significant divide in ICT access and use between men and women, which reflects inequalities in income, education, and other structural inequalities in many economies and societies. Globally, available data suggest that women tend to use the internet more than men for educational activities; that men access the internet more than women in commercial internet access facilities (such as cybercafés); and that men tend to be online more frequently than women. If these data hold true for the Caribbean, the internet can facilitate gender-specific health

83 CARICOM. CARICOM Crime and Security Strategy 2013. Available at http://www.state.gov/documents/organization/210844.pdf, accessed 25 November 2015. CARICOM IMPACS, 2013.
84 UNDP. Caribbean Human Development Report 2012 – Human development and the shift to better citizen security. Available at http://www.undp.org/content/undp/en/home/librarypage/hdr/caribbean-human-development-report-2012-I.html, accessed 25 November 2015. New York: UNDP, 2012.
85 Ibid.
86 Information on the 16 Days of Activism campaign is at http://www.unwomen.org/en/what-we-do/ending-violence-against-women/take-action/16-days-of-activism, accessed 25 November 2015.
87 Information on the UWI Open Campus is available at http://www.open.uwi.edu/, accessed 25 November 2015.
88 Definition of "The Caribbean" varies from the one given earlier in this document.

promotion interventions. The ITU's 2015 report also notes that persons with disabilities, who account for 15% of the world's population, are often disadvantaged in ICT access and use.[89]

The ICT Development Index (IDI) is a composite index combining eleven indicators into one measure that can be used to monitor and compare ICT developments in countries. **Table 7 shows IDI values for selected Caribbean countries**, with Barbados ranked highest and Cuba lowest.

Table 7. IDI overall rankings and ratings for selected Caribbean countries, 2015 and 2010

Economy	Rank 2015	IDI 2015	Rank 2010	IDI 2010
Barbados	29	7.57	38	6.04
Antigua & Barbuda	62	5.93	58	4.91
St. Kitts & Nevis	63	5.92	43	5.80
St. Vincent & the Grenadines	68	5.69	63	4.69
Trinidad & Tobago	70	5.57	65	4.58
Dominica	80	5.12	66	4.56
Grenada	83	5.05	64	4.67
Suriname	85	4.99	100	3.39
Saint Lucia	86	4.98	70	4.39
Dominican Republic	103	4.26	101	3.38
Jamaica	105	4.23	95	3.60
Guyana	114	3.65	103	3.24
Belize	116	3.56	104	3.17
Cuba	129	2.79	119	2.66
Selected comparative rankings				
Republic of Korea	1	8.93	1	8.64
United Kingdom	4	8.75	10	7.62
United States	15	8.19	16	7.30
Chad	167	1.17	166	0.88
Average for the Americas region		5.09		4.17

Source: ITU. Measuring the information society report 2015. Available at http://www.itu.int/en/ITU-D/Statistics/Documents/publications/misr2015/MISR2015-w5.pdf, accessed 8 December 2015

Knowledge-management platforms, including social media, provide cost-efficient methods of establishing networks, sharing information with selected target audiences and obtaining their participation in planning and assessment processes. The knowledge-management process is evolving in the Caribbean, and the sub-region is pursuing systems built on modern ICT infrastructure to mitigate the effects of limited capacity, isolation and remoteness. E-governance initiatives are reported from Antigua and Barbuda, Dominica, Grenada and St. Kitts and Nevis.[90] Guyana introduced a "One Laptop per Family" programme in 2011,[91] focused on providing poor people, including

89 ITU. Measuring the information society report 2015. Available at http://www.itu.int/en/ITU-D/Statistics/Documents/publications/misr2015/MISR2015-w5.pdf, accessed 8 December 2015.

90 UN ECLAC. Third International Conference on SIDS: Caribbean Regional Synthesis Report, August 2013. Available at https://sustainabledevelopment.un.org/content/documents/5164250Synthesis%20Report%20Final%2020%20August%202013.pdf, accessed 20 November 2015.

91 PAHO. Health in the Americas 2012 Edition, Guyana chapter. Scientific and Technical Publication No. 636. Washington, D.C.: PAHO, 2012. Available at http://www.paho.org/saludenlasamericas/index.php?option=com_docman&task=doc_view&gid=133&Itemid=, accessed 19 December 2015.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

those living in the relatively remote interior of the country – 90% of whom are indigenous Amerindian people – with modern technology for information and education. However, in mid-2015 the programme was re-engineered as the "One Laptop per Teacher" programme.

The Caribbean Knowledge and Learning Network (CKLN) is a subregional initiative established to enhance the competitiveness of Caribbean countries by upgrading and diversifying skills and knowledge, through increased regional collaboration and use of ICT to connect citizens. However, there is still a paucity of good quality data to facilitate analyses in the planning, monitoring and evaluation of public sector initiatives and programmes.[92] While most countries do fulfil requirements to report to development partners, international agencies and institutions on specific agreements, programmes, and projects,[93] the perception is that the information is often not analysed and used at national and sub-national levels.

2.1.2 Health and development issues

Most Caribbean countries have long been staunch advocates of health as a human right, primary healthcare, health promotion and other people-centred health development strategies. However, they have faced challenges such as increasing prevalence of risk factors; migration of skilled persons, including health workers, to developed countries; deteriorating health infrastructure; health budgets skewed heavily to curative, rather than preventive, care; and under-developed health information, monitoring, and evaluation systems, with inadequate provision of evidence for decision-making.

The 2030 Agenda for Sustainable Development

The SDGs summarised in Figure 1 are all applicable to the Caribbean, and countries will need to adapt the indicators to the subregional and country contexts. Countries and their development partners must ensure that national health and other sectoral information systems are able to provide timely, quality information to permit the monitoring of progress toward the goals.

The SDGs and selected, summarised targets are in Annex B.[94] SDG 3 – the health SDG – has nine targets: the reduction of maternal mortality, neonatal, infant and child health, communicable diseases, NCDs and the promotion of mental health, substance abuse, road traffic injuries, sexual and reproductive health, universal health coverage and environmental health. It also includes three implementation targets to address the WHO Framework Convention on Tobacco Control (FCTC); vaccines and medicines for communicable diseases and NCDs; health systems; and early warning and risk reduction.

PAHO has produced a document that cross-references SDG 3 and the existing programmatic and technical resources available at PAHO and in the countries.[95] It summarises the organisation's most relevant mandates and technical documents, and is intended to facilitate inter-sectoral dialogue; it can contribute to the tailoring of PAHO/WHO's TC in the Caribbean to address the SDG 3 targets.

92 UN ECLAC. Third International Conference on SIDS: Caribbean Regional Synthesis Report, August 2013. Available at https://sustainabledevelopment.un.org/content/documents/5164250Synthesis%20Report%20Final%2020%20August%202013.pdf, accessed 20 November 2015.

93 These include reports on the HIV situation to UNAIDS; the status of IHR (2005) core capacity to PAHO/WHO; and to the secretariat of the UN Framework Convention on Climate Change.

94 Detailed information on the SDGs, their targets, and proposed mechanisms of implementation is at https://sustainabledevelopment.un.org/post2015/transformingourworld/publication. Accessed 16 November 2015.

95 PAHO. Preparing the Region of the Americas to Achieve the Sustainable Development Goal on Health. Washington, D.C.: PAHO, 2015. Available at http://iris.paho.otg/xmlui/handle/123456789/10016, accessed 5 April 2016.

Figure 1. SUSTAINABLE DEVELOPMENT GOALS

Source: http://www.un.org/sustainabledevelopment/sustainable-development-goals/

PAHO/WHO Country Cooperation Strategies in the Caribbean

Many of the countries in the Caribbean have a PAHO/WHO CCS that guides the organisation's TC with the respective country. A few are pending renewal. The CCSs that are relatively current are: Cuba, 2012-2015; Dominican Republic, 2013-2017; Guyana, 2010-2015; Jamaica, 2010-2015, and Suriname, 2012-2016. Those in process of development and/or renewal include Aruba, Belize, Haiti, Puerto Rico, Sint Maarten, the multi-country CCS for Barbados and the countries of the OECS, Trinidad and Tobago and the UK Overseas Territories.[96]

Though listed under varying strategic directions, strategic priorities and main focus areas, the common priority issues in the currently available CCSs of Caribbean countries include:

- *Health systems*, human resources for health, health financing and social protection, health information, use of information for decision-making, access to medicines and technologies, quality care, and primary healthcare, and increasing access and universal health coverage
- *Communicable diseases*, neglected infectious diseases, surveillance, outbreak/epidemic alert and response, and fulfilment of the International Health Regulations (2005)
- *Non-communicable diseases*, focusing on cardiovascular diseases, cancer and diabetes, and NCD risk factors, including nutrition
- *Mental health*, including substance abuse prevention and treatment
- *Family and community health/health throughout the life cycle*, including maternal, neonatal, child, adolescent, and youth health, health of older persons, road traffic injuries, other types of violence, sexual and reproductive health, food and nutrition security, gender issues and human rights

96 PAHO. CCS in the Region of the Americas. Available at http://www.paho.org/hq/index.php?option=com_content&view=article&id=2126%3A2009-country-cooperation-strategy-ccs&catid=1761%3Acountry-cooperation-strategy&Itemid=1849&lang=en, accessed 27 November 2015.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

- *Environmental health and sustainability*
- *Disaster and emergency preparedness and response*

Some CCSs mention international cooperation among the priorities, and some make specific mention of strengthening the PAHO/WHO country office to facilitate implementation of the CCS. Only one CCS mentions TCC as a specific strategy, and none mentions gender and human rights.

The PAHO Strategic Plan 2014-2019

Under the theme "Championing Health: Sustainable Development and Equity", the PAHO Strategic Plan 2014-2019 sets out the organisation's strategic direction, based on the collective priorities of its Member States. The Plan specifies the results to be achieved during the stated period and responds to both regional and global mandates, including the collective national priorities identified in the CCSs, the Health Agenda for the Americas, 2008-2017 and the WHO 12th GPW.[97] **Table 8 summarises the Categories and Programme Areas of the Strategic Plan**; each category has several outcomes, with outputs for their achievement being specified in the respective biennial programme budgets.

Table 8. Categories and Programme Areas of the PAHO Strategic Plan 2014-2019

Categories	Programme Areas
1. Communicable diseases	1.1 HIV/AIDS and STIs 1.2 Tuberculosis 1.3 Malaria and other vector-borne disease (including dengue and Chagas) 1.4 Neglected, tropical, and zoonotic diseases 1.5 Vaccine-preventable diseases (including maintenance of polio eradication)
2. Non-communicable diseases and risk factors	2.1 Non-communicable diseases and risk factors 2.2 Mental health and psychoactive substance use disorders 2.3 Violence and injuries 2.4 Disabilities and rehabilitation 2.5 Nutrition
3. Determinants of health and promoting health throughout the life course	3.1 Women, maternal, newborn, child, adolescent and adult health, and sexual and reproductive health 3.2 Ageing and health 3.3 Gender, equity, human rights and ethnicity 3.4 Social determinants of health 3.5 Health and the environment

97 PAHO. Strategic Plan of the Pan American Health Organization 2014-2019, September 2013, Official Document 345. Available at http://www.paho.org/hq/index.php?gid=14004&option=com_docman&task=doc_view. Accessed 20 October 2015.

Table 8. Categories and Programme Areas of the PAHO Strategic Plan 2014-2019 *(continued)*

Categories	Programme Areas
4. Health systems	4.1 Health governance and financing; national health policies, strategies and plans 4.2 People-centred, integrated, quality health services 4.3 Access to medical products and strengthening of regulatory capacity 4.4 Health systems information and evidence 4.5 Human resources for health
5. Preparedness, surveillance, and response	5.1 Alert and response capacities (for IHR) 5.2 Epidemic- and pandemic-prone diseases 5.3 Emergency risk and crisis management 5.4 Food safety 5.5 Outbreak and crisis response
6. Corporate services/ Enabling functions	6.1 Leadership and governance 6.2 Transparency, accountability and risk management 6.3 Strategic planning, resource coordination and reporting 6.4 Management and administration 6.5 Strategic communications

Source: PAHO Strategic Plan, 2014-2019. Available at http://www.paho.org/hq/index.php?gid=14004&option=com_docman&task=doc_view. Accessed 20 October 2015.

The technical categories and programme areas reflect the health priorities mentioned in the various frameworks above, and there are nine impact goals:

I. Improve health and well-being with equity
II. Ensure a healthy start for newborns and infants
III. Ensure safe motherhood
IV. Reduce mortality due to poor quality of healthcare
V. Improve the health of the adult population with an emphasis on NCDs and risk factors
VI. Reduce mortality due to communicable diseases
VII. Curb premature mortality due to violence and injuries by tackling major risks of adolescents and young adults (15-24 years of age)
VIII. Eliminate priority communicable diseases in the Region
IX. Prevent death, illness and disability arising from emergencies

The focus areas of the Strategic Agenda of the SCS will link to specific outcomes in the PAHO Strategic Plan, according to the priorities for PAHO/WHO's TC in the Caribbean sub-region.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

2.1.3 Health status of the population, health systems and PAHO's leadership priorities

As in most other regions of the world, overall death rates have decreased or remained stable in Caribbean countries. General (corrected) mortality rates from all causes per 1,000 population were 7.1 in the Latin and 6.7 in the non-Latin Caribbean respectively in 2012; 7.0 and 6.8 in 2013; and 7.1 and 6.7 in 2014, the rates being slightly higher in men than in women[98]. Though life expectancy (LE) has increased in the Region of the Americas since 1965, the increment in the Caribbean has been less than in other sub-regions. In the Caribbean, 45-year gains in LE ranged from 4.9 to 18.0 years; in South America, 7.2 to 23.7 years; and in Central America, 13.7 to 23.5 years.[99] Reductions in between-country disparities in LE at birth have also occurred, again with larger reductions in Central and South America compared to the Caribbean.

Many countries are dealing with increases in both the proportions of persons below 15 years and above 64 years of age. In 2014, the percentage of the population 65 years and above ranged from 5.0% in Guyana and Haiti to 17% in the US Virgin Islands.[100] At the other end of the spectrum, the percentage of the population aged 0-14 years ranged from 17% in Cuba to 35% in Haiti.[101]

These demographic changes result in increases in dependents (people who are too young or old to work) and the dependency ratio **(see Table 1)**, causing concerns regarding the capacity of social protection systems to provide for these non-working populations, including in times of ill-health. The higher the dependency ratio, the greater the pressure on these systems.

A summary of the health situation and health systems in the Caribbean sub-region is presented below, in the framework of eight of the nine PAHO leadership priorities.

a. Social determinants of health/Health in all policies

The social determinants of health – the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life[102] – are shaped by the distribution of money, power and resources at global, national and local levels, and are important factors in addressing health inequities. Political, economic, environmental and social factors are included among the determinants, and often lie outside the purview of the health sector. As such, multi-sectoral action and collaboration are potent weapons for health equity, and a Health in All Policies (HiAP) approach is an important mechanism. **The situation regarding several of the social determinants has already been described in Section 2.1.1.**

Suriname has been leading the sub-region in the HiAP approach, hosting a subregional meeting in August 2015, assessing the situation in the country, and hosting the International Conference on Health Equity, Social Determinants of Health and Health in All Policies in October 2015, in collaboration with PAHO/WHO. The output of the Conference is expected to guide other countries in the Caribbean and elsewhere in adopting or adapting HiAP.

Gender is an important social construct, and while Caribbean women have made significant advances in the educational system and in the workplace, and many countries have ministries that address gender, challenges still remain. These include continued stereotyping and expectations of women's and men's societal roles; stigma and discrimination affecting persons of non-heterosexual orientation; and the perceived marginalisation of men and boys, given women's progress in some areas. Though gender stereotypes may result in women being disadvantaged in areas such as equal pay for equal work and careers outside of traditional care-related work, they can also negatively affect men.

98 PAHO. Health situation in the Americas. Basic Indicators 2010, 2011, 2012, 2013, and 2014. Washington, D.C.: PAHO. Data for the respective years available at http://ais.paho.org/phip/viz/basicindicatorbrowaser.asp, accessed 9 December 2015.

99 Hambleton IR, Howitt C, Jeyseelan S, Murphy MM, Hennis AJ, et al. Trends in longevity in the Americas: Disparities in life expectancy in women and men, 1965-2010. PLoS One. 2015; 10(6): e0129778. Available at 10.1371/journal.pone.0129778, accessed 9 May 2016.

100 World Bank. Population 65 and above (% of total). Available at http://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS, accessed 12 December 2015.

101 World Bank. Population 0-14 (% of total). Available at http://data.worldbank.org/indicator/SP.POP.0014.TO.ZS/countries, accessed 12 December 2015.

102 WHO. Social determinants of health. Information at http://www.who.int/social_determinants/en/, accessed 2 December 2015.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

Despite some progress, a long history of political engagement, strong education and dedicated public service, Caribbean women's levels of participation in the elected and appointed positions (Upper and Lower House combined) is at only 19.5%.[103] Data from the International Parliamentary Union (IPU) indicate that, as at 1 November 2015, the percentage of women in the Lower or single House in sixteen Caribbean countries[104] ranges from 48.9% in Cuba to 3.1% in Belize.[105]

The gender inequity issues are not unique to the Caribbean and are perhaps not as well-documented as they should be. In November 2015, the UN Women Multi-Country Office in the Caribbean, in partnership with the CARICOM Regional Statistical Program, announced the piloting of the CARICOM Gender Equality Indicators (GEI) Model, to identify, assess, measure and track the persistent gender equality concerns and disparities across the CARICOM region.

Ethnicity and health data for the Caribbean are often not collected, not published, or difficult to obtain. While the sub-region's ethnic diversity is one of its attractions and strengths, it can also be a source of political and societal tensions.

The population of many Caribbean countries comprises mainly persons of African descent and mixed heritage; Guyana and Trinidad and Tobago have significant proportions of persons of both African and East Indian descent, and Suriname has a wider representation of ethnic groups. Indigenous Kalinago (formerly known as Carib Indians), Maya and Amerindian people live in, respectively, Dominica, Belize and Guyana, and often live in rural and/or relatively remote areas with limited access to quality healthcare. They tend to have higher levels of poverty as measured by the usual monetary indicators – though many do not categorise themselves as "poor", based on their culture and lifestyle – and may experience stigma and discrimination in accessing health services. Studies on indigenous people[106,107] have found that their health indicators tend to be less favourable than their non-indigenous counterparts. Indigenous youth and adolescents face challenges in the realisation of their right to health that are often not adequately addressed, including sexual and reproductive health and rights, and mental health. As with other health issues, the collection of disaggregated health data is a challenge in determining health disparities related to ethnicity within and across regions.

Equity considerations are at the heart of PAHO/WHO's work. The Americas region, including the Caribbean, remains one of the more inequitable regions in the world, with differences in health status between and within countries that are unfair, unjust and unnecessary. National averages for the achievement of indicators often mask the vulnerable populations that are below the average and are being left behind in progress toward health goals.

Many of the political, social, economic and other factors described in sections above contribute to health inequities, and their importance is recognised in the SDGs, particularly SDG 10, "Reduce inequality within and among countries". Programmes for the identification, measurement and alleviation of inequities are critical. In her 2015 annual report to the PAHO Directing Council, the Director of PAHO noted that the organisation has taken steps to improve monitoring of health inequality, and has started to identify key targets and indicators from each of the 17 SDGs that can be used to monitor progress toward greater equity in health.[108]

103 UN Women Caribbean. Strides towards gender equality in the Caribbean. Available at http://caribbean.unwomen.org/en/news-and-events/stories/2015/11/strides-towards-gender-equality-in-the-caribbean, accessed 2 December 2015.

104 Antigua & Barbuda, The Bahamas, Barbados, Belize, Cuba, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Saint Lucia, St. Kitts & Nevis, St. Vincent & the Grenadines, Suriname, Trinidad & Tobago.

105 International Parliamentary Union. Women in Parliament. Available at http://www.ipu.org/wmn-e/classif.htm, accessed 2 December 2015.

106 UN Interagency Group on Indigenous People's Issues. Thematic Paper on the Health of Indigenous People, June 2014. Available at http://www.un.org/en/ga/president/68/pdf/wcip/IASG%20Thematic%20Paper%20-%20Health%20-%20rev1.pdf, accessed 2 December 2015.

107 First Peoples Worldwide. The challenges we face. http://www.firstpeoples.org/who-are-indigenous-peoples/the-challenges-we-face, accessed 19 December 2015.

108 PAHO. Annual report of the Director of the Pan American Sanitary Bureau: Championing health for sustainable development and equity: Leading by example. Document CD54/3. Washington, D.C.: PAHO, August 2015. Available at http://www.paho.org/annual-report-2015/index.html, accessed 28 November 2015.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

b. Universal access to health and universal health coverage

PAHO's 2014 Strategy on Universal Access to Health and Universal Health Coverage (UAH-UHC)[109] also provides a framework for advancing health equity and identifies four strategic lines (SLs), under which *WHO's six health system building blocks* can be subsumed:

1. Expanding equitable access to comprehensive, quality, people- and community-centred health services *(health services, health workforce, access to essential medicines and technologies)*
2. Strengthening stewardship and governance *(leadership and governance, health information and research)*
3. Increasing and improving financing, with equity and efficiency, and advancing toward the elimination of direct payment that constitutes a barrier to access at the point of service *(health financing)*
4. Strengthening inter-sectoral coordination to address social determinants of health

> **SL 1:** Expanding equitable access to comprehensive, quality, people- and community-centred health services *(health services, health workforce, access to essential medicines and technologies)*

As part of health reform and efforts to improve access to services, several countries, such as Belize, Guyana, Jamaica, and Trinidad and Tobago have decentralised their health systems, with regional health authorities that provide and oversee community health services and primary healthcare, including clinics and hospitals. However, in some cases the authority and accountability, but not the requisite resources and administrative processes, are delegated, so that key areas of control of day-to-day activities remain with the central Ministry. This results in reduced efficiency of the decentralised entities to provide comprehensive services. In addition, referral systems to facilitate integrated service delivery are not as efficient as they should be, resulting in lengthy delays in accessing some secondary and tertiary services.

Access to complex tertiary services, quality laboratory services and comprehensive services through a public-private mix remain challenging, particularly for smaller countries. Accredited medical laboratories are an essential component of public health and human security. Threats related to epidemic-prone diseases and the high prevalence of NCD-related complications needing chronic care and rehabilitation bring these issues into sharp focus when the national health budget is presented. Most Caribbean countries still allocate most of the health budget to hospital care and the production and recruitment of doctors and nurses. Primary healthcare has a central role in the achievement of SDG 3 and other SDGs, and is an important aspect of integrated service delivery for equitable and cost-effective UAH-UHC.[110]

The issue of human resources for health poses an on-going challenge for the sub-region. Many skilled medical and nursing personnel still leave the sub-region for greener pastures, resulting in "brain drain". Some developed countries still actively recruit human resources for health from developing countries, in contravention of the 2010 WHO Global Code of Practice on the International Recruitment of Health Personnel, which is voluntary,[111] and allied health professionals are still in short supply.

109 PAHO. Strategy for universal access to health and universal health coverage. Document CD53/5, rev.2. Available at http://www.paho.org/hq/index.php?option=com_content&view=article&id=9774&Itemid=41062&lang=en, accessed 2 December 2015.

110 Pettigrew L, et al. Primary health care and the Sustainable Development Goals. Lancet, 2015; 386: 2119-2120.

111 WHO. Global Code of Practice on the International Recruitment of Health Personnel. Available at http://www.who.int/hrh/migration/code/practice/en/, accessed 8 December 2015.

The CPP[112] and the development of the Caribbean Regulatory System (CRS) provide frameworks for interventions to guide access, quality, rational use and regulation of medicines and technologies. The CRS will be hosted by CARPHA, and aims to increase access to safe, effective, affordable and quality-assured medicines and health technologies. It will initially focus on the registration of priority generic medicines, and then will address pharmaco-vigilance and post-marketing surveillance of registered products.

SL 2: Strengthening stewardship and governance *(leadership and governance, health information and research)*

Health reform efforts in almost all Caribbean countries have seen interventions to improve the steering, policy, coordination and managerial roles of the Ministries of Health. Tangible demonstrations of impact include the establishment of International Cooperation Units/Desks in several Ministries of Health. These units interact with, and coordinate, international development partners working in health, functions subsumed in other countries by the Ministries of Foreign Affairs and/or Finance.

Many countries have developed national health policies, strategies and plans (NHPSP), which provide a framework for budgeting, partner participation, resource mobilisation and accountability. However, the perception is that these NHPSPs are not being used to their full potential. There is need to strengthen the involvement of civil society, the private sector, academia and other key stakeholders in the planning, implementation, monitoring and evaluation of NHPSPs.

Monitoring and accountability mechanisms in health are present in all countries. However, in some cases the results are not publicised or used to effect change. In other cases the assessment is done for external partners, with little or no local analysis or use of the data for policy and programme development or adjustment. Despite several efforts at establishing a subregional health information system (HIS) fed by timely, quality national information systems, "home-grown" health information, analysis and research continue to pose challenges for the Caribbean.

Strengths of the HIS in the sub-region include adequate IT infrastructure and established routine data flows, information collection and reporting. However, there are significant challenges to meet all the demands for reports. In addition, the following weaknesses are evident: inefficient and sometimes unnecessary data collection; incomplete and inaccurate data; poor coverage and under-reporting; ineffective coordination, analysis and use of data; lack of personnel and capacity; and inadequate data coverage from the private health sector and non-health sectors.[113] There are also challenges related to definition of indicators, as different entities in the national system may define the same indicators differently, and those definitions may differ from internationally accepted ones. The Latin American and Caribbean Network to Strengthen Health Information Systems (RELACSIS)[114] and the 2012 Caribbean Subregional Health Information System Strengthening Framework offer further opportunities to advance in these areas; the SPC-CAR convened a meeting in Barbados in July 2015 to review progress with the Framework and further action is planned for its implementation.

SL 3: Increasing and improving financing, with equity and efficiency, and advancing toward the elimination of direct payment that constitutes a barrier to access at the point of service *(health financing)*

Health financing is derived from four main sources: taxes (general and earmarked); pooled contributions (compulsory under social insurance or voluntary under private insurance plans); grants and donations (local and external); and direct out-of-pocket payments by users.[115] Public health expenditure comprises the first three sources, i.e. recurrent and capital spending from government (central and local) budgets; social (or compulsory) health insurance funds; and external borrowings and grants (including donations from international

112 PAHO/WHO, CARICOM. Caribbean Pharmaceutical Policy, 2013. Available at http://www.paho.org/HQ/index.php?option=com_docman&task=doc_view&gid=23746&Itemid=, accessed 19 November 2015.

113 CARPHA. Health situation in the Caribbean. CARPHA, Trinidad and Tobago, 2013.

114 Information on RELACSIS is available at http://www.cpc.unc.edu/measure/resources/networks/relacsis/relacsis-annual-meeting-in-mexico, accessed 9 December 2015.

115 CARPHA. Health situation in the Caribbean. CARPHA, Trinidad and Tobago, 2013.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

agencies and NGOs). Total health expenditure is the sum of public and private health expenditure, and covers the provision of health services (preventive and curative), family planning activities, nutrition activities and emergency aid designated for health; it does not include provision of water and sanitation.[116]

Tax-funded systems represent the predominant source of financing in most English-speaking Caribbean countries and there is a strong tradition of accessible primary care provided free at the point of service.[117] Some countries also have similar traditions for secondary and tertiary care, but as part of health reform initiatives, user fees were introduced in several CARICOM Member States, reducing access to required services for some persons. Efforts to establish a system of fee collection based on capacity to pay have not met with the intended success, as the relevant assessments can prove challenging and time consuming for many countries. **Table 9 summarises public health expenditure,[118] health expenditure as a percentage of GDP,[119] health expenditure per capita,[120] and out-of-pocket health expenditure as a percentage of private expenditure on health[121] in several Caribbean countries.** For countries with data available, in 2012 national health expenditure in the public sector, as a percentage of GDP, varied from 8.1% in Cuba to 0.7% in Haiti.[122] For private sector expenditure in the countries the percentages were, respectively, 0.7% and 2.8%.

The PAHO Strategy for UAH-UHC notes that, in most cases, public expenditure of 6.0% of GDP is a useful benchmark, and advocates for pooling resources and advancing to the elimination of direct payments that constitute a barrier at the point of service.[123] Private healthcare is a feature of the health system in most Caribbean countries, often offering vital services that are unavailable in the public health system. Ministries of Health may pay for patients who cannot afford such services to gain access to them, for example, renal dialysis in Guyana. Service users may have health insurance individually, through their workplaces, or through national health insurance (NHI) or may have to pay out-of-pocket.

Countries such as Belize, Jamaica and Suriname have NHI. The Bahamas indicated its intention to introduce its NHI scheme in January 2016, and other countries, including Dominica, Grenada, and St. Vincent and the Grenadines, are considering establishing NHI. The suggestion was made several years ago to establish a CARICOM-wide health insurance scheme that would be "portable" among countries, but this is still pending, though preparatory work has been done and recommendations for options presented to high-level policymakers. Notwithstanding, in December 2015 it was announced that the OECS is considering such a scheme for its Member States.[124]

116 World Bank. Health expenditure, public (% of total health expenditure). Available at http://data.worldbank.org/indicator/SH.XPD.PUBL, accessed 10 December 2015.
117 CARPHA. Health situation in the Caribbean. CARPHA, Trinidad and Tobago, 2013.
118 World Bank. Health expenditure, public (% of total health expenditure). Available at http://data.worldbank.org/indicator/SH.XPD.PUBL, accessed 10 December 2015.
119 World Bank. Health expenditure as a percentage of GDP. Available at http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries, accessed 10 December 2015.
120 World Bank. Health expenditure per capita (current US dollars). Available at http://data.worldbank.org/indicator/SH.XPD.PCAP/countries, accessed 10 December 2015.
121 World Bank. Out-of-pocket health expenditure (% of private expenditure on health). Available at http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS, accessed 10 December 2015.
122 PAHO. Health situation in the Americas: Basic Indicators 2014. Washington, D.C.: PAHO, 2014.
123 PAHO. Strategy for universal access to health and universal health coverage. Document CD53/5, rev.2. Available at http://www.paho.org/hq/index.php?option=com_content&view=article&id=9774&Itemid=41062&lang=en, accessed 2 December 2015.
124 Information available at http://www.telesurtv.net/english/news/Caribbean-Pushes-for-Regional-Health-Care-Scheme-20151201-0009.html, accessed 8 December 2015.

Table 9. Health expenditure in selected Caribbean countries

Country	Health expenditure as % of GDP			Health expenditure per capita (current US dollars)			Health expenditure, public (% of total health expenditure)			Out-of-pocket health expenditure (% of private health expenditure)		
	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013
Antigua & Barbuda	5.7	5.4	4.9	724	727	665	68.9	68.0	64.5	73.9	74.8	75.2
The Bahamas	7.6	7.3	7.3	1,652	1,618	1,612	46.6	45.1	44.0	54.0	54.0	54.0
Barbados	6.5	6.8	6.8	1,005	1,009	1,007	61.3	60.9	61.0	81.9	81.9	81.9
Belize	5.6	5.3	5.4	264	259	262	66.5	64.9	62.4	69.8	69.8	69.8
Cuba	10.6	8.6	8.8	648	558	603	95.0	94.2	93.0	100.0	100.0	100.0
Dominica	5.9	5.8	6.0	403	399	417	70.8	70.2	70.6	90.5	91.2	91.4
Dominican Republic	4.9	5.4	5.4	267	310	315	44.3	50.9	52.2	78.9	78.9	78.5
Grenada	6.4	6.2	6.3	475	471	499	48.9	47.2	47.3	97.7	97.7	95.8
Guyana	6.8	6.6	6.5	221	235	250	67.3	66.1	66.2	92.3	92.3	92.5
Haiti	8.0	9.6	9.4	59	73	77	22.7	9.2	7.4	3.8	31.7	32.1
Jamaica	5.2	5.7	5.9	273	302	305	53.6	57.8	57.2	71.0	59.5	58.4
St. Kitts & Nevis	6.0	6.5	6.4	820	892	873	37.9	36.3	36.1	88.8	88.8	88.5
Saint Lucia	7.2	7.9	8.5	518	573	621	46.1	53.6	55.3	98.6	98.7	94.9
St. Vincent & the Grenadines	5.0	5.4	5.2	309	340	345	82.0	82.1	82.7	100.0	100.0	100.0
Suriname	5.9	4.7	4.6	490	437	445	49.8	69.0	70.8	27.1	54.0	49.4
Trinidad & Tobago	5.0	5.7	5.5	875	991	995	52.6	49.4	48.0	79.5	81.3	81.7

Sources:
World Bank. Health expenditure as a percentage of GDP. Available at http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries, accessed 10 December 2015
World Bank. Health expenditure per capita (current US dollars). Available at http://data.worldbank.org/indicator/SH.XPD.PCAP/countries, accessed 10 December 2015
World Bank. Health expenditure, public (% of total health expenditure). Available at http://data.worldbank.org/indicator/SH.XPD.PUBL, accessed 10 December 2015
World Bank. Out-of-pocket health expenditure (% of private expenditure on health). Available at http://data.worldbank.org/indicator/SH.XPD.OOPC.ZS, accessed 10 December 2015.

SL 4: Strengthening inter-sectoral coordination to address social determinants of health

The need for inter-sectoral collaboration and coordination, given the social determinants of health and the HiAP approach, has been stated above. However, most countries do not have institutionalised strategies for inter-sectoral planning and actions; such actions usually occur in response to external mandates, such as the GF's Country Coordinating Mechanism or the International Health Regulations (2005). In addition, development partners such as UN agencies often convene meetings involving multiple sectors to advance their own planning and programming at country level. CARICOM, with organs such as COHSOD, COTED and the Council for Foreign and Community Relations (COFCOR), is ideally placed to foster inter-sectoral policy development and planning at the highest levels.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

c. Non-communicable diseases (including mental disorders)

Four major NCDs and their four main risk factors are the causes of premature death and chronic illness worldwide and in the Caribbean. They are, respectively, cardiovascular diseases, diabetes, cancer and chronic respiratory diseases, as well as tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity. The 2007 Port of Spain Declaration: Uniting to Stop the Epidemic of Chronic NCDs made by the CARICOM Heads of Government;[125] the 2011 UN High-Level Meeting Political Declaration on NCDs;[126] the Strategic Plan of Action for the Prevention and Control of NCDs for Countries of the CARICOM 2011-2015;[127] and the PAHO Plan of Action for the Prevention and Control of NCDs in the Americas 2013-2019[128] provide ample frameworks for strengthened subregional actions to prevent and control NCDs and their risk factors. Addressing NCDs is no longer solely a social protection strategy, but also essential to maximise investments in human capital to enhance productivity and achieve sustained economic growth.[129]

The Port of Spain Declaration (POSD) was driven by the 2006 Report of the Caribbean Commission on Health and Development which noted that in 2000, the four leading causes of death in the Caribbean[130] were all NCDs — heart disease, cancer, stroke and diabetes. During the period 2000-2008, the top three leading causes of death were cerebrovascular disease (stroke), diabetes and ischaemic heart disease. Other cardiovascular diseases and hypertensive heart disease ranked fourth and fifth; prostate cancer ranked sixth to eighth and, among women only, breast cancer was the seventh leading cause of death.[131]

NCDs are now linked to seven out of ten deaths in the Caribbean sub-region, which exceeds the global average of nearly 60 percent. They are costly and have a direct impact on economies, health systems, households and individuals, causing decreased productivity due to absenteeism, disability, reduced functionality and fewer years of worker output. Their management requires regular interactions with healthcare providers, including pharmaceutical and non-pharmaceutical treatment, and they have several complications. Health inequities contribute to these disorders, and NCDs occur more often among the poor, who have greater exposure to risk factors. Such factors include the purchase and consumption of relatively cheap, unhealthy food choices and less access to preventive and curative services. Costs related to the management of NCDs and their complications can deprive families of their breadwinners and push them further into poverty.

Diabetes, hypertension and obesity are more prevalent in women, while ischaemic heart disease is more prevalent in men. A Working Document[132] for the Heads of Government Summit in 2007 that resulted in the POSD noted that "at least 25% of Caribbean adults are obese; some 25% are hypertensive, prevalence of diabetes is over 10% in at least four countries, and there is evidence that the situation is worsening". The Working Document also reported that data from The Bahamas, Barbados, Jamaica, and Trinidad and Tobago showed economic costs for diabetes ranging from 0.5 to 5.2% of GDP, and for hypertension from 0.9 to 3.5% of GDP. Childhood obesity is a growing concern, and in October 2014 PAHO's Member States adopted a Plan of Action for the Prevention of Obesity in Children and

125 Port of Spain Declaration available at http://www.caricom.org/jsp/communications/meetings_statements/declaration_port_of_spain_chronic_ncds.jsp, accessed 9 December 2015.
126 UN High-level Meeting Political Declaration available at http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf, accessed 9 December 2015.
127 CARICOM Strategic NCD Plan available at http://www.caricom.org/jsp/community_organs/health/chronic_non_communicable_diseases/ncds_plan_of_action_2011_2015.pdf, accessed 9 December 2015.
128 PAHO NCD Plan of Action available at http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&Itemid=270&gid=27517&lang=en, accessed 9 December 2015.
129 World Bank. Non-communicable diseases in the Caribbean: The new challenge for productivity and growth. Caribbean Knowledge Series, June 2013. Available at http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/06/20/000333037_20130620150236/Rendered/PDF/785960WP07.0No00Box377349B00PUBLIC0.pdf, accessed 9 December 2015.
130 Defined as the independent English-speaking countries and Suriname, and the UK and Dutch Overseas Territories.
131 CARPHA. Health situation in the Caribbean. Port of Spain, Trinidad and Tobago: CARPHA, 2013.
132 [133] CARICOM. Working Document for Summit of CARICOM Heads of Government on Chronic Non-Communicable Diseases: Stemming the tide of Non-communicable diseases in the Caribbean. Available at http://www.caricom.org/jsp/community/chronic_non_communicable_diseases/executive_summary.pdf, accessed 9 December 2015.

Adolescents.[133] The Plan recognises the need to address the problem of obesity starting in the young, and the lines of action include promotion of breastfeeding, improvement of nutrition and physical activity in schools, the use of fiscal policies, and regulation of food marketing and labelling.

The 1993 Caribbean Charter for Health Promotion[134] provided guidance for risk factor prevention and control, and its six strategies remain relevant today:

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

Critical risk reduction interventions are:

- Strengthened implementation of the WHO's legally-binding FCTC, which all English-speaking Caribbean countries have ratified
- Innovative strategies for avoidance of harmful use of alcohol, especially given the competitive promotion and production of rum in many Caribbean countries
- Provision of safe environments for physical activity
- Attention to food and nutrition security
- Use of the settings approach (schools, workplaces) to promote health

Integrated, multi-sectoral action, with involvement of non-health ministries, civil society, the private sector, development partners and other key stakeholders is imperative for effective NCD prevention and control. The status of countries' progress regarding the POSD is monitored annually by the Public Health Group, UWI, Cave Hill, Barbados, in collaboration with CARICOM, and reported to the COHSOD. A chart showing progress to date is in **Annex C**. An evaluation of the implementation of the POSD, in preparation for the observance of its tenth anniversary in 2017, was done in 2015,[135] and a multi-sectoral implementation workshop was held in February 2016 to present the evaluation findings and chart the way forward. The workshop validated the findings and subsequently deliberated on plans of action to accelerate implementation of upstream macro-social determinants of NCDs. The meeting also recommended framing the NCDs agenda as "Investing for Health and Wealth".[136]

133 [134] PAHO. Plan of Action for the Prevention of Obesity in Children and Adolescents. Document D53/9, Rev.2, available at http://www.paho.org/hq/index.php?option=com_content&view=article&id=9774&Itemid=41062&lang=en, accessed 9 December 2015.

134 CARICOM and PAHO. Caribbean Charter for Health Promotion. PAHO, Barbados, 1993. Text available at http://www.healthycaribbean.org/publications/documents/cchp.pdf, accessed 9 December 2015.

135 Public Health Group, UWI, Cave Hill, Barbados and POS Evaluation Research Group. Research proposal for the evaluation of the CARICOM Heads of Government Port of Spain Declaration on NCDs.

136 The report of the POSD evaluation and the implementation workshop is at http://www.posevaluation.org/wp-content/uploads/2016/04/POSDEVAL-EVIDENCE-BRIEFS-Apr-2016.pdf, accessed 9 April 2016.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

Although **mental health** is not specifically mentioned in the POSD, the Nassau Declaration and CCH III recognised it as a priority for the Caribbean. Mental disorders contribute to significant morbidity globally, and the Caribbean is no exception. A review of mental health in disaster situations in the Caribbean presented limited data on psychotic, mood and anxiety disorders, suicide and dementia, and noted the variation of the rates of these conditions across the Caribbean.[137] There are particularly high rates of suicide among persons of East Indian descent and completed suicide is more common in males, who tend to use more lethal methods than females, though females attempt suicide more often.

The 2014 WHO report on suicide prevention[138] presented estimated age-standardised suicide rates for countries with populations of 300,000 or more for 2000 and 2012. As shown in **Table 10**, in 2012 the highest rates were in Guyana, Suriname, Trinidad and Tobago, and Cuba, in that order; disaggregation by sex confirms the higher incidence of suicide among males. As life expectancy increases in the sub-region, the prevalence of dementia will increase, with concurrent reduction in quality of life and increase in emotional and financial strain on caregivers.[139]

Table 10. Estimated rates of suicide in selected Caribbean countries, 2000 and 2012

Age-standardised rates of suicide per 100,000 population				
Country	**Sex**	**Year**		**% change in rates 2000-2012**
		2000	**2012**	
The Bahamas	M & F	3.0	2.3	-23.6
	F	2.1	1.3	-39.7
	M	4.2	3.6	-13.2
Barbados	M & F	3.4	2.3	-33.6
	F	1.0	0.6	-44.7
	M	6.0	4.1	-31.3
Belize	M & F	3.9	2.6	-32.6
	F	0.6	0.5	-12.1
	M	7.3	4.9	-32.2
Cuba	M & F	14.6	11.4	-21.9
	F	8.7	4.5	-48.1
	M	20.8	18.5	-11.3
Dominican Republic	M & F	5.9	4.1	31.1
	F	3.1	2.1	-34.2
	M	8.6	6.1	-29.4
Guyana	M & F	48.3	44.2	-8.5
	F	24.6	22.1	-10.0
	M	72.2	70.8	-1.9

137 Abel W, Baboolal N, and Gibson R. The epidemiology of mental health issues in the Caribbean. Chapter 5 in PAHO. Mental health and psychological support in disaster situations in the Caribbean: Core knowledge for emergency preparedness and response. Washington, D.C.: PAHO, 2012. Available at http://www.paho.org/hq/index.php?option=com_topics&view=readall&cid=7295&Itemid=40870&lang=en, accessed 10 December 2015.

138 WHO. Preventing suicide: a global perspective (Annex 1). Geneva: WHO, 2014. Available at http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/, accessed 19 December 2015.

139 Abel W, Baboolal N, and Gibson R. The epidemiology of mental health issues in the Caribbean. Chapter 5 in PAHO. Mental health and psychological support in disaster situations in the Caribbean: Core knowledge for emergency preparedness and response. Washington, D.C.: PAHO, 2012. Available at http://www.paho.org/hq/index.php?option=com_topics&view=readall&cid=7295&Itemid=40870&lang=en, accessed 10 December 2015.

Age-standardised rates of suicide per 100,000 population				
Country	**Sex**	**Year**		**% change in rates 2000-2012**
		2000	**2012**	
Haiti	M & F	3.1	2.8	-9.7
	F	2.5	2.4	-5.6
	M	3.8	3.3	-13.0
Jamaica	M & F	1.1	1.2	4.4
	F	0.6	0.7	7.8
	M	1.7	1.8	4.2
Suriname	M & F	19.8	27.8	40.4
	F	9.7	11.9	22.3
	M	29.7	44.5	50.0
Trinidad & Tobago	M & F	12.6	13.0	3.8
	F	4.5	6.2	36.4
	M	20.8	20.4	-2.0

M = Male F = Female

Source: Adapted from WHO. WHO. Preventing suicide: a global perspective (Annex 1). Geneva: WHO, 2014. Available at http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/, accessed 19 December 2015. The report notes that these estimates may not be the same as official national estimates.

In 2010, 16 Caribbean countries and territories completed the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) and a report was published in 2011.[140] The report highlighted the dearth of recent epidemiological data, the focus on custodial care for persons with mental disorders, and out-dated mental health legislation. As a result, the rights of persons with such disorders were not considered. Psychiatrists, psychologists, social workers and other mental health-related professionals are in relatively short supply in many countries. The models of Psychiatric Nurse Practitioners in Belize[141] and Mental Health Officers in Jamaica[142] warrant study and adoption or adaptation where feasible.

On average, the Caribbean dedicates 3.9% of the government budget to mental health. However, most of the mental health budget is spent on psychiatric institutions in countries that have them, with expenditure ranging from 60% to 100% of the mental health budget.[143] Females comprised 56.7% of persons treated in outpatient facilities, 41.5% of those treated in community-based in-patient facilities, and 24.0% of those treated in mental hospitals; percentages for children or adolescents were, respectively, 9.3%, 1.6%, and 2.7%. Involuntary admissions accounted for 51.3% of all admissions to in-patient facilities.[144] With PAHO/WHO's TC, there has been a push for greater recognition of the importance of mental health, integration of mental health services into general hospitals, and strengthening of community mental health services.

140 WHO, CIDA, and PAHO. WHO-AIMS Report on Mental Health Systems in the Caribbean. Available at http://www.who.int/mental_health/evidence/mh_systems_caribbeans_en.pdf, accessed 9 December 2015.
141 WHO, Ministry of Health, Belize. WHO Report on Mental Health System in Belize. Belize City: WHO, 2009. Available at http://www.who.int/mental_health/who_aims_report_belize.pdf, accessed 20 December 2015
142 McKenzie, Kwame. Jamaica: Community Mental Health Services. In: Caldas de Almeida JM and Cohen A, editors. Innovative Mental Health Programs in Latina America and the Caribbean. Washington, D.C.: PAHO, 2008. Available at http://publications.paho.org/english/Jamaica_CD_183.pdf, accessed 25 March 2016.
143 WHO, CIDA, and PAHO. WHO-AIMS Report on Mental Health Systems in the Caribbean. Available at http://www.who.int/mental_health/evidence/mh_systems_caribbeans_en.pdf, accessed 9 December 2015..
144 Ibid.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

d. International Health Regulations (2005)

Having not achieved the IHR (2005) core capacities[145] by the initial deadline of June 2012, most Caribbean countries requested an extension to June 2014, and yet another extension to June 2016. However, there has been progress, and a chart showing the status of IHR implementation in selected Caribbean countries based on information presented at the 69th World Health Assembly (WHA) in 2016 is presented in **Figure 2**.

While most countries are doing fairly well in the areas of coordination and communication, surveillance, response and risk communication, significant challenges remain with the achievement of core capacities to deal with chemical events and radiation emergencies. Preparedness, human resources, points of entry and food safety events also need strengthening. Enhanced laboratory capacity and accredited laboratories that provide accurate, reliable results are critical to these efforts. PAHO has partnered with the OAS, IDB, World Bank and the Development Bank of Latin America (CAF)[146] to develop financial mechanisms to strengthen countries' preparedness and response capacities to handle outbreaks of emerging epidemic diseases, in line with the IHR requirements.

The outbreak of Ebola virus disease (EVD) in West Africa in the latter part of 2014 and its spread to the USA brought issues of epidemic alert and response, and the IHR core capacities into sharp focus. As part of its TC, between November 2014 and January 2015 PAHO conducted an assessment of the level of preparation of its Member States to respond to EVD, and to guide TC to address the gaps. The assessment findings included the following:[147]

- Excessive reliance on port-of-entry screening, with less emphasis on health services
- Inadequate coordination of epidemiological capacity and health services, and insufficient emphasis on combined use of clinical and epidemiological information
- Fragmentation of health services
- Challenges in shipment of samples to specialised laboratories for confirmation of EVD[148]
- Limitations in trained personnel for safe treatment of persons with potential or confirmed EVD
- Insufficient personal protective equipment (PPE) to manage patients correctly, aggravated by limited capacity to procure PPE, given global shortages

145 WHO. International Health Regulations (2005), second edition. Available at http://www.who.int/ihr/publications/9789241596664/en/, accessed 10 December 2015.
146 Information on CAF available at http://www.caf.com/en, accessed 19 December 2015.
147 PAHO. Annual report of the Director of the Pan American Sanitary Bureau – Championing health for sustainable development and equity: Leading by example. Document CD54/3. Washington, D.C.: PAHO, August 2015. Available at http://www.paho.org/annual-report-2015/index.html, accessed 28 November 2015.
148 Only four countries in the Region of the Americas have Biosafety Level (BSL) 3 laboratories with EVD diagnostic capacity.

Figure 2. IHR implementation status in selected Caribbean countries, based on States Parties' Annual Reports, 69th WHA, 2016

Core Capacity	Antigua & Barbuda	Bahamas	Barbados	Belize	Dominica	Grenada	Guyana	Haiti	Jamaica	Saint Kitts & Nevis	Saint Lucia	Saint Vincent & the Grenadines	Suriname	Trinidad & Tobago	Average
Legislation / Policy / Financing	100	75	100	25	50	100	100	0	50	100	75	75	50	50	68
Coordination and Communication / NFP	100	83	90	63	100	83	100	46	90	100	56	63	83	56	80
Surveillance	100	100	95	75	80	95	95	100	90	80	70	80	90	95	89
Response	82	70	82	88	78	69	100	70	100	58	69	66	100	76	79
Preparedness	73	0	100	52	60	33	100	26	92	33	25	53	100	71	58
Risk Communication	86	71	100	57	100	86	100	100	71	86	86	43	71	71	81
Human resources	100	40	80	40	40	60	100	40	60	20	40	80	40	20	54
Laboratory	100	96	96	45	43	49	100	96	86	87	83	0	86	81	75
Points of Entry	97	97	100	83	80	49	94	17	88	71	74	0	97	83	74
Zoonotic Events	100	67	100	89	100	100	100	67	78	67	89	0	67	89	80
Food Safety Events	100	27	80	53	100	67	53	27	87	80	60	0	87	87	65
Chemical Events	85	54	77	38	15	46	62	38	77	0	23	0	62	62	46
Radiation Emergencies	23	8	69	8	15	15	0	0	85	0	0	0	0	77	21

KEY - % implementation
80-100%
50-79%
0-49%

In addition to regional assessments, several global assessments of the response to EVD have been conducted. Ten inter-related recommendations were made across four thematic areas for a more robust, resilient global system for the management of infectious disease outbreaks: preventing major disease outbreaks, responding to major disease outbreaks, research – production and sharing of data, knowledge and technology, and governing the global system for preventing and responding to outbreaks.[149]

The 2015 WHO Advisory Group on Outbreaks and Emergencies recommended the expansion of the current WHO Emergency Response Framework to cover all phases of the emergency management cycle – preparedness, alert, response, recovery and prevention. As part of the leadership function, the Advisory Group recommended "the immediate establishment of a centrally-managed, global Program for Outbreaks and Emergencies Management", as a separate, dedicated entity within the organisation. WHO regional offices, including PAHO, are expected to take action to align with the recommendations, addressing regional specificities as appropriate.

149 Moon S, Sridhar D, Pate MA, Jha AK et al. Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola. Lancet 2015; 386:2204-21.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

In order to enhance the implementation of the IHR (2005), in 2015 WHO and the World Organization for Animal Health (OIE) developed the Handbook for the Assessment of Capacities at the Human-Animal Interface.[150] This guidance and the One Health initiative[151] emphasise the importance of addressing human, animal and environmental factors for the prevention and control of zoonotic diseases. The One Health Leadership Series, a programme to build capacity among professionals from the health, agriculture and environmental sectors, and promote cross-sector action,[152] was ratified by the Ministers of Health in 2014, and by the Ministers of Environment in 2015.

e. Priority communicable diseases

Vaccine-preventable diseases

The Caribbean is justifiably proud of its national immunisation programmes, most of which demonstrate coverage rates of over 90% for infant vaccinations, including against measles, mumps, pertussis (whooping cough) and the other "traditional" vaccine-preventable diseases. In 2011, rates were slightly lower in Suriname and were around 60% in Haiti.[153] PAHO has facilitated the success through its TC, including the Revolving Fund for Vaccine Procurement, which provides pooled procurement from suppliers for participating countries in the Region of the Americas at one price for all of the countries.

The Region of the Americas was declared smallpox-free in 1971, polio-free in 1994, and in 2015 became the first region in the world to be declared free of endemic transmission of rubella virus and congenital rubella syndrome. In making this latest announcement, the international Expert Committee noted that it hoped to declare measles eliminated from the Americas in the near future.[154]

Several countries have introduced new vaccines, including the pneumococcal pentavalent and human papillomavirus (HPV) vaccines. HPV, given to 11-12 year-old girls to prevent cervical cancer, has met with resistance due to perceptions regarding its effect on sexual behaviour and its relatively expensive cost. However, vaccine-preventable diseases still occur in the Caribbean – cases of tetanus, diphtheria and pertussis continue to be reported.[155] The countries are also facing the challenge of improving vaccination coverage amongst underserved populations, such as those in more remote areas and amongst indigenous people.

HIV

The Caribbean has made significant progress in stemming the HIV epidemic, and is poised to be the first region to eliminate mother-to-child transmission (EMTCT) of HIV, as the percentage of HIV-positive pregnant women on antiretroviral therapy increased from approximately 55% to greater than 95% between 2008 and 2013.[156] HIV prevalence declined from 1.3 to 1.0 percent over the period 2001-2012; The Bahamas (3.3%), Belize, Guyana, Haiti (2.1%), Jamaica, Suriname, and Trinidad and Tobago have rates over 1%, while prevalence is estimated at less than 1% in Barbados (0.9%), Cuba (0.1%) and the Dominican Republic (0.7%).

HIV incidence decreased by 49% over the same period, with 12,000 new infections reported in 2012. Haiti accounted for 71% of those infections, with mainly Dominican Republic, Jamaica, and Trinidad and Tobago contributing to the remainder. The rate of new infections is declining faster in the Caribbean than in any other region of the world, and AIDS-related deaths declined by 52% from 24,000 deaths in 2001 to 11,000 deaths in 2012. This is no doubt related to improvements in treatment and care, with antiretroviral treatment coverage increasing from less than 5% to 70% of the eligible population over the period 2001-2010; Barbados and Cuba have the highest treatment

150 WHO and OIE. Handbook for the Assessment of Capacities at the Human-Animal Interface. Geneva, WHO and OIE, 2015. Available at http://www.who.int/ihr/publications/handbook_OMS_OIE/en/, accessed 13 December 2015.

151 Information on One Health is available at http://onehealthinitiative.com/index.php, accessed 13 December 2015.

152 PAHO. Annual report of the Director of the Pan American Sanitary Bureau – Championing health for sustainable development and equity: Leading by example. Document CD54/3. Washington, D.C.: PAHO, August 2015. Available at http://www.paho.org/annual-report-2015/index.html, accessed 28 November 2015.

153 CARPHA. Health situation in the Caribbean. Port of Spain, Trinidad and Tobago: CARPHA, 2013.

154 PAHO. Annual report of the Director of the Pan American Sanitary Bureau – Championing health for sustainable development and equity: Leading by example. Document CD54/3. Washington, D.C.: PAHO, August 2015. Available at http://www.paho.org/annual-report-2015/index.html, accessed 28 November 2015.

155 CARPHA. Health situation in the Caribbean. Port of Spain, Trinidad and Tobago: CARPHA, 2013.

156 Pan Caribbean Partnership on HIV/AIDS (PANCAP). Caribbean Regional Strategic Framework on HIV 2014-2018. Available at http://www.pancap.org/docs/Final%20CRSF%202014-2018_FINAL.pdf, accessed 19 November 2015.

coverage – 64% and 62% respectively.[157] The number of deaths is highest in Haiti (68% of the regional estimate), followed by the Dominican Republic (17%) and Jamaica (12%).[158]

Heterosexual transmission remains the predominant mode of transmission in the Caribbean, but men who have sex with men (MSM) represent a significant proportion of persons with HIV; one in three gay and other MSM in Jamaica is HIV-positive.[159] There are nearly equal numbers of men and women living with HIV overall in the Caribbean, but there are differences among countries, ranging from 19% women in Cuba to 60% women in The Bahamas, perhaps reflecting cultural and gender differences in accessing health services for HIV testing, as well as the significant numbers of pregnant women tested for HIV. Key populations at higher risk of HIV include MSM, heterosexuals at high risk, sex workers and their clients, and adolescents and youth.[160]

The CRSF on HIV and AIDS 2014-2018, the current regional framework for action in HIV, is aligned with the 2014 UNAIDS 90-90-90 Strategy. The CRSF identifies six strategic priority areas:[161] an enabling environment; shared responsibility; prevention of HIV transmission; care, treatment and support; integration of HIV into health and socioeconomic development; and sustainability. The UNAIDS 90-90-90 Strategy has three targets to be achieved by 2020:

- 90% of all people living with HIV will know their status
- 90% of all people with diagnosed HIV infection will be on sustained antiretroviral therapy
- 90% of all people receiving antiretroviral therapy will have viral suppression[162]

Challenges to the sustainability of the HIV response in the Caribbean include the capacity of individual countries to finance their own responses as countries are reclassified to middle- and high-income status and external funding decreases. Eliminating punitive laws, stigma and discrimination as well as reducing the costs of HIV prevention, treatment and care programmes also remain significant challenges.[163]

Emerging and re-emerging diseases

Despite the promotion of integrated vector management strategies, **vector-borne diseases** continue to pose a major public health threat in the Americas, including the Caribbean. In 2013, 72,261 cases of **dengue** – a disease spread by the Aedes aegypti mosquito – were reported in the Latin Caribbean, while 13,719 were reported from the non-Latin Caribbean. All four serotypes of dengue have been identified as circulating within the region, increasing the probability of severe cases and deaths.

In late 2013, **chikungunya**, also a viral disease spread by the Aedes aegypti mosquito, emerged in St. Martin, and by June 2015, 40 countries in the region of the Americas reported local transmission of the virus, for a regional total of more than 1.5 million cases and 238 deaths,[164] with the attendant absenteeism from work and its negative impact.

157 UNAIDS. The Gap Report, 2014. Available at http://www.unaids.org/en/resources/documents/2014/20140716_UNAIDS_gap_report, accessed 19 November 2015.
158 Pan Caribbean Partnership on HIV/AIDS (PANCAP). Caribbean Regional Strategic Framework on HIV 2014-2018. Available at http://www.pancap.org/docs/Final%20CRSF%202014-2018_FINAL.pdf, accessed 19 November 2015.
159 UNAIDS. The Gap Report, 2014. Available at http://www.unaids.org/en/resources/documents/2014/20140716_UNAIDS_gap_report, accessed 19 November 2015.
160 Pan Caribbean Partnership on HIV/AIDS (PANCAP). Caribbean Regional Strategic Framework on HIV 2014-2018. Available at http://www.pancap.org/docs/Final%20CRSF%202014-2018_FINAL.pdf, accessed 19 November 2015.
161 Ibid.
162 UNAIDS. 90-90-90: An ambitious treatment target to help end the AIDS epidemic. Available at http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf, accessed 19 November 2015.
163 UNAIDS. The Gap Report, 2014. Available at http://www.unaids.org/en/resources/documents/2014/20140716_UNAIDS_gap_report, accessed 19 November 2015.
164 PAHO. Annual report of the Director of the Pan American Sanitary Bureau – Championing health for sustainable development and equity: Leading by example. Document CD54/3. Washington, D.C.: PAHO, August 2015. Available at http://www.paho.org/annual-report-2015/index.html, accessed 28 November 2015.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

In mid-2015, Brazil confirmed the first local transmission in the Americas of **Zika** virus, which causes symptoms similar to those of chikungunya and dengue, and is also mosquito-borne. It has spread to several Caribbean countries, and the possible association of Zika infection in pregnant women with the birth of microcephalic babies and with neurological conditions such as Guillain-Barre syndrome has the region on the alert for its prevention, detection and management.

The threat of **communicable diseases with pandemic potential**, such as pandemic influenza, is present in the Caribbean, as elsewhere, and the 2009 H1N1 influenza pandemic affected all Caribbean countries. The countries developed national influenza pandemic preparedness plans as part of their response and most began surveillance for severe acute respiratory infections (SARI) in addition to on-going syndromic surveillance.

Tuberculosis (TB) remains an important health issue in the Caribbean with the sub-region reporting the highest incidence of TB in the Americas in 2011, at 75 per 100,000 population. Multi-drug resistant TB is also of concern, highlighting the importance of diagnosis, detection and compliance with early and complete treatment of the disease.

Malaria is still an issue for countries such as Belize, Guyana, Suriname and Haiti, with variations in the number of cases seen from year to year and a resurgence in Guyana and Haiti over the period 2010-2012. Environmental land use and climate variability contribute to malaria outbreaks.[165]

The **cholera** epidemic that occurred in Haiti after the 2010 earthquake is declining, but continues to cause illness and death.[166] The Regional Coalition for Water and Sanitation to Eliminate Cholera in Hispaniola[167] is collaborating with national authorities to address the situation.

The presence of these and other communicable diseases in the sub-region demands continued vigilance, efficient and accurate laboratory diagnosis, effective management of the diseases and their enabling factors, and cooperation among Caribbean countries, including across borders, in collaboration with development partners.

f. Unfinished MDGs/SDGs

Maternal, neonatal, infant and child health

MDG 5, with its target of reduction of maternal mortality, was one of the few MDGs that Latin America and the Caribbean did not achieve, though maternal deaths declined an average of 2.2% per year between 2010 and 2015. The shortfall was the result of gaps in countries' abilities to ensure quality, comprehensive and universally accessible sexual and reproductive health services, in addition to poverty and other social determinants of health.[168] In 2013, the maternal mortality ration (MMR) in the Caribbean was reported as averaging 190 maternal deaths per 100,000 live births;[169] in 2015, the estimated number was 175 per 100,000 live births.[170] In a report of MMR trends for the period 1990-2015 based on estimates, Guyana, Haiti and Suriname were assessed as "no progress" with estimated MMRs of, respectively, 229, 359 and 155 per 100,000 live births in 2015.[171] Some countries, such as Guyana, have disputed the modelled estimates of MMR, which produce figures in excess of national health information system measurements, despite efforts to improve the

165 Ibid.
166 CARPHA. Health situation in the Caribbean. Port of Spain, Trinidad and Tobago: CARPHA, 2013.
167 Information on the Regional Coalition for Water and Sanitation to Eliminate Cholera in Hispaniola available at http://www.paho.org/coleracoalicion/?page_id=7, accessed 13 December 2015.
168 PAHO. Annual report of the Director of the Pan American Sanitary Bureau – Championing health for sustainable development and equity: Leading by example. Document CD54/3. Washington, D.C.: PAHO, August 2015. Available at http://www.paho.org/annual-report-2015/index.html, accessed 28 November 2015.
169 UN Department of Public Information. Millennium Development Report 2015: Regional Backgrounder, Latin America and the Caribbean. Available at http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/backgrounders/MDG%202015%20PR%20Bg%20LAC.pdf, accessed 13 December 2015.
170 WHO, UNICEF, UNFPA, World Bank, and UN Population Division. Trends in maternal mortality 1990-2015: Executive summary. Geneva: WHO, 2015. Available at http://apps.who.int/iris/bitstream/10665/193994/1/WHO_RHR_15.23_eng.pdf?ua=1, accessed 13 December 2015.
171 Ibid.

modelling methods and make greater use of country data. The small populations of some Caribbean countries also put doubt on figures reported per 100,000 live births.

Hypertension, haemorrhage, infections, unsafe abortions and pre-existing conditions such as diabetes are significant causes of maternal mortality, and though Latin America and the Caribbean achieved MDG 4 targets regarding child mortality, challenges remain in reducing neonatal mortality. Maternal, neonatal, infant and child health continue to be priorities in SDG 3.

Adolescent and youth health

Young people (persons aged 10-24 years) represent approximately 24.5% of the population in Latin America and the Caribbean. The main causes of mortality for the 15-24 year age group (youth) are external causes, including accidents, homicides and suicides; communicable diseases, including HIV/AIDS; non-communicable diseases; and complications of pregnancy, childbirth and the puerperium. Young males are overwhelmingly represented in deaths due to injuries – including violence, homicides, road traffic injuries and suicide.[172] Related to these data, adolescents (aged 10-19 years) and youth face several challenges, among them issues related to poverty, education and ethnicity,[173] as well as gender-based violence, sexual and reproductive health, sexual exploitation, employment (older adolescents), obesity, and mental health and behavioural disorders.

Latin America and the Caribbean (LAC) have the second highest adolescent fertility rate in the world (exceeded only by sub-Saharan Africa) and adolescent pregnancy has a major impact on maternal and child health, and socioeconomic outcomes. Several countries in the Caribbean, including Belize and Guyana, have made efforts to improve health services targeting adolescents and youth through the establishment of Youth-Friendly Clinics, where non-judgmental health personnel provide appropriate services. However, there are still challenges regarding legal frameworks, issues relating to parental consent and health workforce attitudes. WHO has established Global Standards for Quality Health Care for Adolescents, and UNFPA is collaborating with countries and PAHO/WHO to develop standards for sexual and reproductive healthcare.[174] In addition, the CARICOM Strategic Plan 2014-2019 recognises youth as a critical group in the development of the sub-region, and the draft CYDAP 2012-2017 provides a framework for interventions, as referenced in Section 2.1.1.3.

Health of older persons

All regions of the world are ageing to varying degrees, and by 2030 almost 20% of the Caribbean population will be aged 60 years or over.[175] Ageing populations in the Caribbean reflect improvements in life expectancy and healthcare, but also contribute to socioeconomic vulnerability and the increasing incidence of NCDs and, as previously noted, many Caribbean countries have significant proportions of persons over age 65 years.

Barbados and Dominica are known for their centenarians. Dominica's Elizabeth "Ma Pampo" Israel was considered to be the world's oldest person when she died in 2003 aged 128 years,[176] and Barbados' James Emmanuel "Doc" Sisnett was the second oldest person - he died in 2013 aged 113 years.[177]

172 PAHO. Adolescents and youth: Regional Strategy and Plan of Action 2010-2018. Washington, D.C.: PAHO, 2010. http://www1.paho.org/hq/dmdocuments/2011/Adolescent%20and%20Youth%20Regional%20Strategy%20and%20Plan%20of%20Action.pdf, accessed 13 December 2015.
173 A Promise Renewed for the Americas: Adolescent Health. Available at http://www.apromiserenewedamericas.org/en/adolescent-health/, accessed 13 December 2015.
174 UNFPA. Development of regional standards for adolescent-friendly health services. Available at http://caribbean.unfpa.org/public/Home/News/pid/19059, accessed 13 December 2015.
175 UN Department of Social and Economic Affairs, Population Division, 2015. Available at http://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2015_InfoChart.pdf, accessed 13 December 2015.
176 Information at http://www.silvertorch.com/ma-pampo.html, accessed 14 December 2015.
177 Information at http://edition.cnn.com/2013/05/25/world/americas/barbados-supercentenarian/, accessed 14 December 2015.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

Attitudes towards older persons in the Caribbean are changing, aggravated by the reality that many suffer from chronic illnesses and disabilities; family care is less available than in previous times, given smaller family size, increases in single-parent households, declines in the economic situation of many families and the employment of more women – the traditional caretakers – outside the home. In addition, the migration of family members leaves some older persons without relatives to provide care and oversight.[178]

National studies have shown gender differences in the needs of older persons – anecdotally, men often have more social needs, and women more financial needs. Priority concerns for older persons include living arrangements, financial security, savings, pension, homelessness and poverty, in addition to ill health, healthcare costs, long-term hospitalisation, and the need for efficient caregivers in the family and institutional settings.[179]

Rates of disability in persons over 60 years old are four times the rates in the general population, ranging from 16%-24%. The majority of disability relates to sight and limb function, and is due to disease complications, making healthy ageing a priority for the Caribbean sub-region.[180] Health promotion and disease prevention interventions should therefore take place throughout the life course, alongside universal access to health and universal health coverage, and effective management of those older persons who do become ill.

A Caribbean Symposium on Population Ageing was convened in Trinidad and Tobago in 2004, through collaboration among the UWI, ECLAC, PAHO/WHO, UNFPA and other partners. The symposium ended with suggestions for the way forward in the sub-region:[181]

> The establishment of a Caribbean clearing house on ageing and the elderly, a Caribbean Gerontological Association, and a Caribbean Network on Ageing to enhance and strengthen cooperation and collaboration at the subregional level.

Through PAHO/WHO's TC, in collaboration with CARICOM and other stakeholders, a Caribbean Charter on Health and Ageing was adopted by the COHSOD in 1998 and launched in 1999.[182] There have also been efforts to establish a Caribbean Health and Ageing Minimum Data Set (CHAMDS) with indicators for which all CARICOM Member States would collect information.[183] The Charter and the CHAMDS bear revisiting, in the framework of the 2015 WHO Global Report on Ageing and Health, which emphasises a policy framework that considers a life course approach and addresses both healthy and active ageing.[184]

Injuries and violence, including road traffic injuries

In addressing violence prevention, Caribbean countries are examining the root causes – the social determinants of health – and working towards alleviating them. A PAHO report on road safety in the Americas region stated that road traffic injuries (RTI) claimed the lives of approximately 150,000 people in Latin America and the Caribbean in 2010. RTI are the second leading cause of death in persons aged 15-24 in the Americas. Most Caribbean countries have laws regulating seat belt and helmet use, and driving under the influence (DUI) of alcohol. Though enforcement of seat belt use is widespread, the same cannot be said of helmet use and DUI. Of the 14 countries in

178 Rawlins J. Ageing in the Caribbean: Exploring some major concerns for family and society. Paper prepared for the Sir Arthur Lewis Institute of Social and Economic Studies (SALISES) Conference "Turmoil and turbulence in Small Developing States: Going beyond survival". Port of Spain, Trinidad and Tobago: March 2010. Available at http://www.globalaging.org/elderrights/world/2010/caribbean.pdf, accessed 13 December 2015.
179 Ibid.
180 CARPHA. Health situation in the Caribbean. CARPHA, Trinidad and Tobago, 2013.
181 Report (unedited) of the Caribbean Symposium on Population Ageing, Trinidad and Tobago, 2004. Available at http://www.cepal.org/celade/noticias/paginas/2/28632/reportL041.pdf, accessed 13 December 2015.
182 CARICOM. Caribbean Charter on Health and Ageing launched. Press Release 105/1999, available at http://www.caricom.org/jsp/pressreleases/pres105_99.jsp, accessed 15 December 2015.
183 Presentation on CHAMDS available at http://www.cepal.org/celade/noticias/paginas/8/12138/PRicketts.pdf, accessed 15 December 2015.
184 WHO. WHO Global Report on Ageing and Health. Geneva: WHO, 2015. Available at http://apps.who.int/iris/bitstream/10665/186463/1/9789240694811_eng.pdf?ua=1, accessed 17 December 2015.

the Americas that have legislation setting blood alcohol concentration, only five of them, one of which is St. Vincent and the Grenadines, report having strong enforcement.[185] Continued efforts to prevent RTI are in keeping with the relevant target in SDG 11.

g. Information and evidence

Efforts continue to strengthen national and sub-national health information systems, with the aim of having timely, quality data that can be analysed and used at all levels. Caribbean countries are often targeted by external development partners for expensive surveys to obtain necessary health and development information, or are subjected to modelling and other data manipulation to obtain estimates for important indicators. As part of its TC, PAHO/WHO has been working with countries to publish annual high-quality, up-to-date health and development data.

h. Knowledge and expertise sharing among countries

Renewed thrusts to foster cooperation among countries for health development, as described in section 2.2.1 below, aim to enhance inter-country exchanges in keeping with North-South, South-South, South-North and triangular cooperation initiatives. Caribbean countries have successes, experiences, lessons learnt and expertise to share among themselves, and with other sub-regions and regions, and therefore need to document and publish this information. Subregional, regional and cross-regional political integration mechanisms have critical roles to play in facilitating knowledge-sharing among countries, as do multi-lateral development partners such as PAHO/WHO and other UN agencies, funds and programmes.

2.1.4 Health agendas in the sub-region

CCH

CARICOM's Caribbean Cooperation in Health (CCH) was introduced in 1984 by the Ministers Responsible for Health as a mechanism for collaboration, technical cooperation among Caribbean countries and resource mobilisation. Its third phase was CCH III, 2010-2015[186], which identified five project goals:

- Creation of a healthy Caribbean environment conducive to promoting the health of its people and visitors
- Improved health and quality of life for Caribbean people throughout the life cycle
- Health services that respond effectively to the needs of the Caribbean people
- Adequate human resource capacity to support health development in the region
- Evidence-based decision-making as the mainstay of policy development in the region.

The framework also identified eight priority areas: Communicable diseases; Non-communicable diseases; Health systems strengthening; Environmental health; Food and nutrition; Mental health; Family and child health; and Human resources development. The last issue would be facilitated by the free movement of skills in the CSME.

In 2015, the CARICOM Secretariat, in collaboration with the PAHO/WHO SPC-CAR, CARPHA and UWI, undertook an evaluation of CCH III, in preparation for the development of CCH IV in 2016. The evaluation[187] noted several advances in regional cooperation

185 PAHO. Report on road safety in the Region of the Americas. Washington, D.C.: PAHO, 2015. Available at http://www.paho.org/hq/index.php?option=com_content&view=article&id=10847%3A2015-regional-report-road-safety&catid=5230%3Aroad-safaty-contents&Itemid=41441&lang=en, accessed 13 December 2015.

186 CARICOM. Caribbean Cooperation in Health, Phase III (CCH III), Regional Health Framework 2010-2015, "Investing in Health for Sustainable Development". Available at http://www.caricom.org/jsp/community_organs/health/cch_iii_summary.pdf, accessed 2 November 2015.

187 CARICOM, CARPHA, PAHO. CCH III evaluation results and recommendations for the way forward with CCH IV. Bridgetown, Barbados: PAHO, 2016.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

over the period of CCH III, including the establishment of CARPHA; the maintenance of high vaccination coverage and the decline in the transmission of some communicable diseases; on-going implementation of the Port of Spain Declaration on NCDs, including the establishment of Caribbean Wellness Day; building capacity in human resources for health; increasing capacity of laboratory services and networks; and creating Smart Hospitals.

However, the evaluation also noted challenges associated with CCH III, including:

- The diversity of Caribbean countries in terms of population size, health system needs and political geography – no "One Caribbean"
- Indicators that were too numerous and too difficult to align with country needs and national strategic plans
- Absence of a communication and dissemination strategy, with inadequate promotion, and limited awareness by key stakeholders of the initiative
- Lack of a monitoring, evaluation and accountability framework
- The burden placed on Ministries of Health to gather data and report on all indicators – including for different agencies.

The evaluation noted the continued relevance of the eight CCH III priority areas, and some of the recommendations for CCH IV include:

- Develop fewer sub-priority areas and indicators than was done for CCH III
- Determine ways to address the following areas in CCH IV: climate change, ageing, childhood obesity, alcohol abuse, tourism and health, emergency and disaster preparedness, men's health, violence and injury prevention, food insecurity, health financing, and enhanced regional laboratory services
- Adopt a multi-sectoral approach, involving diverse sectors in the planning, implementation and evaluation of CCH IV, including regional civil society, and trade, legislative and tourism organisations
- Improve the governance and accountability systems, including the development of a comprehensive monitoring, evaluation and accountability framework; designation of entities responsible for managing and reporting on progress, in the context of regional cooperation, indicators and resource mobilisation; appointment of designated coordinator(s) to ensure regional cooperation and results; and updated legislation and policies to facilitate CCH IV implementation
- Increase awareness of CCH, including the development and execution of a five-year communication and dissemination strategy, and consideration of the Healthy Caribbean Coalition (HCC) as the lead for translating the CCH IV framework into easy-to-understand information for the public
- Foster collaboration among the countries, CARPHA, PAHO/WHO, CARICOM, UWI, HCC and other entities to create or select SMART[188] indicators aligned with the PAHO/WHO Basic Indicators, SDGs and other international health frameworks to which the countries have committed, thus decreasing the data collection burden on countries
- Establish a centralised, accessible, user-friendly surveillance system for data collection, housed at CARPHA

188 Specific, Measurable, Achievable, Realistic, and Time-bound.

In February 2016, a meeting of regional and national stakeholders representing CARICOM Member States, development partners, academia, civil society and the UN validated the recommendations, and reached consensus on five priority areas to be addressed in CCH IV:

1. Health systems for universal health coverage
2. Safe, resilient, healthy environments to mitigate climate change
3. Health and well-being of Caribbean people throughout the life course
4. Data and evidence for decision-making and accountability
5. Partnerships and resource mobilisation for health

The participants also agreed on a roadmap for the development of CCH IV, leading to its approval by the CARICOM COHSOD in September 2016. The roadmap involves technical consultations, briefings of Ministers of Health and further consultations with Member States.

OECS

The OECS is establishing its Health Desk at the time of writing, and it is anticipated that the entity's health agenda will be aligned with the CCH IV, highlighting the issues most relevant to the health needs and priorities of its Member States.

2.2 Development cooperation, partnerships and contributions of the sub-region to the global health agenda

2.2.1 Partnerships and development cooperation

The 2005 Paris Declaration, 2008 Accra Agenda for Action[189], and 2011 Busan Partnership for Effective Development Cooperation[190] aim to improve aid to developing countries. Their principles include enhanced national ownership; alignment of development partners' actions with national development frameworks; harmonisation of development partners' actions to avoid duplication and redundancy, and make efficient use of resources; managing for results; and mutual accountability, using national systems wherever possible. The Busan Partnership, in particular, emphasises the value of South-South and triangular cooperation as complements to traditional North-South cooperation, given the greater similarities in development challenges, systems and cultures that exist among the countries of the South. Solidarity, non-interference and respect for sovereignty are important concepts in South-South cooperation and the Caribbean exhibits these characteristics to a significant degree.

The subregional integration mechanisms and development partners' TC can contribute to the evaluation, documentation and sharing of experiences, facilitating interaction and cooperation among countries for health development (CCHD). This may be especially useful in smaller Caribbean countries that may not have an international cooperation unit or focal point in the Ministry of Health. PAHO's new CCHD framework will create new mechanisms and processes to help countries share their growing technical and programmatic capacities and resources with each other,[191] in collaboration with the many partners working in health in the sub-region. Selected entities are listed on the following page.

189 The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action 2005/2008. Available at http://www.oecd.org/dac/effectiveness/34428351.pdf, accessed 20 December 2015.

190 Busan Partnership for Effective Development Cooperation 2011. Available at http://www.oecd.org/development/effectiveness/49650173.pdf, accessed 20 December 2015.

191 PAHO. Annual report of the Director of the Pan American Sanitary Bureau – Championing health for sustainable development and equity: Leading by example. Document CD54/3. Washington, D.C.: PAHO, August 2015. Available at http://www.paho.org/annual-report-2015/index.html, accessed 28 November 2015.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

CARICOM organs and associated institutions

Among the many CARICOM organs and institutions related to health are:

Association of Caribbean Tertiary Institutions

ACTI,[192] which has 65 full members and 19 associate members, was established in 1990 with a vision of being the catalyst for networking tertiary institutions, focusing on the effectiveness, relevance and quality of tertiary education in the sub-region. The Association, with headquarters on the UWI Cave Hill Campus in Barbados, plays a critical role in Caribbean tertiary education, speaking on behalf of its members and charting a new direction for tertiary education in the sub-region.

Caribbean Association of Medical Councils

CAMC was established in 1998 and comprises representation from National Medical Councils in twenty Caribbean countries.[193] Located in Jamaica, the Association promotes the highest standards of medical education and practice in order to ensure the quality and safety of healthcare and protect the public. CAMC administers a regional registration examination to determine the competence of foreign medical graduates to practise in the Caribbean.

Caribbean Community Climate Change Centre

CCCCC,[194] (also called 5C's) located in Belize, officially opened in 2005. It coordinates the Caribbean sub-region's response to climate change and is recognised as the focal point for climate change issues in the Caribbean. It has also been recognised by the United Nations Institute for Training and Research (UNITAR) as a Centre of Excellence. The Centre has collaborated with the Institute of Meteorology in Cuba and the UWI to model precipitation and temperature for the Caribbean.

Caribbean Development Bank

The CDB is located in Barbados, and has as its main focus the social and economic development of, and poverty reduction in, its BMCs.[195]

Caribbean Disaster and Emergency Management Agency

CDEMA,[196] formerly CDERA (Caribbean Disaster Emergency Response Agency) is located in Barbados, and provides Comprehensive Disaster Management (CDM), which is an integrated and proactive approach to disaster management, seeking to reduce the risk and loss associated with natural and technological hazards, and the effects of climate change. The Regional Comprehensive Disaster Management Strategy and Programming Framework 2014-2024 has as its goal "Safer, more resilient and sustainable CDEMA Participating States through comprehensive disaster management". [197]

Caribbean Health and Food Safety Agency

CAHFSA,[198] located in Suriname, was launched in 2010 to address agricultural and food safety issues in the sub-region, focusing on the achievement of sanitary and phytosanitary (SPS) measures[199] to facilitate trade and protect health. Its interface with CARPHA, PAHO/WHO and other partners in implementing the "One Health" programme and addressing the achievement of IHR (2005) core capacities will be critical.

192 Information on ACTI available at http://www.acticaribbean.org/, accessed 14 December 2015.
193 Anguilla, Antigua and Barbuda, The Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Cayman Islands, Dominica, Grenada, Guyana, Haiti, Jamaica, Montserrat, St. Kitts & Nevis, Saint Lucia, St. Vincent & the Grenadines, Suriname, Trinidad & Tobago, and Turks & Caicos Islands.
194 Information on CCCCC is available at http://www.caribbeanclimate.bz/, accessed 23 November 2015.
195 Information on CDB available at http://www.caribank.org/, accessed 14 December 2015.
196 Information on CDEMA available at http://www.cdema.org/, accessed 17 December 2015.
197 CDEMA. Regional Comprehensive Disaster Management Strategy and Programming Framework 2014-2024. Available at http://www.cdema.org/CDMStrategy2014-2024.pdf, accessed 20 December 2015.
198 Information on CAHFSA available at http://www.cahfsa.org/, accessed 14 December 2015.
199 SPS measures are interventions to protect humans, animals, and plants from diseases, pests or contaminants.

Caribbean Public Health Agency

CARPHA[200] was established in July 2011 by a CARICOM Inter-Governmental Agreement (IGA) and began operations in January 2013. Its establishment represents integration of the functions of five Caribbean Regional Health Institutions[201] (RHIs) into one agency, with the aim of rationalising their operations and addressing existing gaps. With a main campus in Trinidad and Tobago and campuses in Jamaica and Saint Lucia, CARPHA's mandate and objectives include:

- Promotion of the physical and mental health and wellness of people in the Caribbean
- Provision of strategic direction in analysing, defining and responding to CARICOM public health priorities
- Promotion and development of measures for the prevention of disease in the Caribbean
- Support for CARICOM in preparing for and responding to public health emergencies
- Support for solidarity in health
- Support for the relevant objectives of the CCH

There is considerable overlap between the mandates and functions of CARPHA and PAHO/WHO in addressing the priority needs of their Member States. A clear definition of the entities' roles and responsibilities, and their dissemination to Member States, is critical to facilitate collaboration and cooperation, maximise use of resources and avoid duplication. CARPHA Member States (CMS) have identified surveillance, the provision of reference laboratory services and field epidemiology services as priority functions for CARPHA. Epidemiology, surveillance and research related to communicable and non-communicable diseases; outbreak detection and response; strengthening of civil registration and vital statistics; disaster preparedness and response; and relevant capacity-building at national and subregional levels are some of the areas where there is fertile ground for effective CARPHA-PAHO/WHO collaboration.

In December 2015 CARPHA received funding from the IDB in the amount of US$800,000 to address health, safety and environmental (HSE) threats that challenge the sustainability of tourism in the Caribbean. CARPHA will collaborate with the Caribbean Tourism Organization, the Caribbean Hotel Association and national counterparts to develop a regional tourism health information, monitoring and response system; Caribbean-wide HSE tourism standards; and a training and certification programme to build capacity in food and environmental safety. Participating countries include Barbados, Belize, The Bahamas, Guyana, Jamaica and Trinidad and Tobago.[202]

CARICOM Regional Organisation for Standards and Quality

CROSQ[203] is the regional centre for promoting efficiency and competitive production in goods and services, through the process of standardisation and the verification of quality. The CROSQ Laboratory Quality Management Systems Stepwise Improvement Project (LQMS-SIP) collaborates with CARPHA to support the strengthening of medical laboratory services in Caribbean countries toward fulfilment of the ISO 15189:2012, the international standard for medical laboratories.

Pan Caribbean Partnership for HIV/AIDS prevention and control

PANCAP,[204] established in 2001, is a multi-sectoral, multi-level partnership that brings together governments and national HIV

200 Information on CARPHA available at http://carpha.org/, accessed 14 December 2015.

201 Caribbean Epidemiology Centre (CAREC); Caribbean Food and Nutrition Institute (CFNI); Caribbean Environmental Health Institute (CEHI); Caribbean Health Research Centre (CHRC); and Caribbean Regional Drug Testing Laboratory (CRDTL).

202 Information available at http://carpha.org/articles/ID/87/CARPHA-Receives-US08M-from-IDB-to-Help-Build-a-More-Competitive-and-Sustainable-Caribbean-Tourism-Product, accessed 8 December 2015.

203 Information available at https://www.crosq.org/, accessed 9 May2016.

204 Information available at http://www.pancap.org/en/, accessed 14 December 2015.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

programmes; civil society, including key populations; the private sector; and regional and international development partners. PANCAP is currently in the process of submitting a proposal to the GF for resources to contribute to interventions among vulnerable populations in the sub-region – MSM, transgender persons, sex workers, persons living with HIV, migrants, people who use drugs and youth belonging to these populations.

Non-governmental organisations and professional associations

There are several of these entities related to health, with varying degrees of activity and potential for collaboration. They include, but are not limited to, the following:

Healthy Caribbean Coalition

HCC,[205] headquartered in Barbados, was established in 2008 as an alliance of civil society organisations and other stakeholders in Caribbean health to focus on the prevention and control of NCDs and their risk factors. The HCC works to contribute to the implementation of the CARICOM Port of Spain Declaration on NCDs.

Others

- Caribbean Association of Indigenous People[206]
- Caribbean Association of Nutritionists and Dietitians (CANDi)[207]
- Caribbean Alliance of National Psychological Associations (CANPA)[208]
- Caribbean Association of Pharmacists (CAP)[209]
- Caribbean Regional Midwives Association (CRMA)[210]

International development partners (other than the UN)

Though perhaps not as active as they were in previous years, given the economic "graduation" of many Caribbean countries, there are still many development partners contributing to the sub-region's development, including, but not limited to:

Canada's Department of Foreign Affairs, Trade, and Development

DFATD[211] supports CARICOM's development agenda, and one of its key partners is the CDB. Projects currently operational in the sub-region address, among other health-related issues, statistics; citizen security, justice and judicial reform; knowledge-sharing for disaster risk management and community disaster risk reduction; distance education; leadership and governance; and education for employment.

European Union

The EU's relations with the Caribbean are based on political relations, trade and development funding at both national and regional levels.[212] EU support to CARIFORUM for the period 2012-2015 comprised programmes to implement the Economic Partnership Agreement (EPA),

205 Information on the HCC available at http://www.healthycaribbean.org/index.html, accessed 9 December 2015.
206 Information on COIP available at http://www.cpdcngo.org/cpdc/index.php?option=com_content&view=article&id=118:caribbean-organisation-of-indigenous-people-coip&catid=40:regional-networks&Itemid=150, accessed 14 December 2015.
207 Information on CANDi available at http://www.internationaldietetics.org/NDAs/Caribbean.aspx accessed 14 December 2015.
208 Information on CANPA available at http://canpanet.org/, accessed 14 December 2015.
209 Information on CAP available at https://www.cap-pharmacists.com/, accessed 14 December 2015.
210 Information on 2015 CRMA conference available at http://www.regconference2015.org/index.php/organisation/caribbean-regional-midwives-association, accessed 4 March 2016.
211 Information on DFATD in the Caribbean available at http://www.international.gc.ca/development-developpement/countries-pays/caribbeanprogram-programmecaraibes.aspx?lang=eng, accessed 14 December 2015.
212 Information on the EU's work in the Caribbean available at http://ec.europa.eu/europeaid/regions/caribbean-0_en, accessed 14 December 2015.

consolidate the CSME, foster collaboration between the Dominican Republic and Haiti, promote integration among Eastern Caribbean States, invest in human capital and foster collaboration with other Caribbean states, with a budget of €146.7 million. For 2014-2020, EU cooperation with the Caribbean under the 11th EDF has a total indicative allocation to the CRIP of €346 million, representing a 52% increase over the allocation in the 10th EDF. Based on the assessment of major regional challenges, and in line with the priorities defined in the EU 2012 Joint Caribbean-EU Partnership Strategy, the CRIP will address three focal areas: regional economic cooperation and integration; climate change, environment, disaster management and sustainable energy; and crime and security.

United Kingdom's Department for International Development

DFID's work in the Caribbean for the period 2011-2015 had a budget of £75 million and three strategic priorities: wealth creation, security and governance, and climate change.[213] In implementing its subregional programme, DFID collaborates with the CDB, CCCCC, CDEMA, IDB and IMF, among other partners and has provided funding for PAHO/WHO's Smart Health Care Facilities Project in the Caribbean, which aims to make healthcare facilities both safe and "green".[214] Both DFID and UK Public Health collaborate with PAHO/WHO in planning the organisation's TC with UK Overseas Territories in the Caribbean.

United States Agency for International Development

In previous years, the US President's Emergency Program for AIDS Relief (PEPFAR) offered considerable support to the Caribbean for HIV prevention and control, through the Centers for Disease Prevention and Control (CDC). In November 2015 USAID and CARICOM signed three Development Objective Agreements for a total of US$165 million for projects in eleven CARICOM countries, as part of USAID's 2015-2019 Regional Development Cooperation Strategy (RDCS). The RDCS covers Antigua & Barbuda, Barbados, Dominica, Grenada, Guyana, Saint Lucia, St. Kitts and Nevis, St. Vincent and the Grenadines, Suriname and Trinidad and Tobago. The five-year agreement contributes to subregional and national objectives to reduce youth involvement in crime and violence (US$89 million), control HIV/AIDS (US$52 million), and reduce vulnerability to climate change (US$31 million).[215]

Global Fund to fight AIDS, Tuberculosis and Malaria

The GF has been very active in supporting the Caribbean at both national and subregional levels in prevention and control of HIV in particular, and continues to do so under its new operating principles. Both PANCAP and the OECS have received GF grants: PANCAP received GF grants to cover the period 2004-2009 and 2011-2015, and an application for a third GF grant is in development. In July 2015 the OECS Regional Coordinating Mechanism for HIV/AIDS was awarded a US$5.3 million GF grant to continue its battle against HIV.[216] The GF continues to contribute to malaria and tuberculosis control in the subregion through support to individual countries

Other institutions of the Inter-American System

The **Organization of American States** (OAS),[217] IDB,[218] and IICA[219] all work with the Caribbean as part of their regional remit for the Americas. The OAS works to promote democracy, defend human rights, ensure a multi-dimensional approach to security, foster integral development and prosperity, and support Inter-American legal cooperation.

213 Information on DFID's work in the Caribbean available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67369/caribbean-2011-summary.pdf, accessed 14 December 2015.
214 Information available at http://www.paho.org/ecc/index.php?option=com_content&view=article&id=426:paho-announces-start-of-phase-ii-of-smart-health-care-facilities-project&Itemid=332, accessed 9 May 2016.
215 iNews Guyana. "USAID, CARICOM to sign US$165M agreement", 22 November 2015. Available at http://www.inewsguyana.com/usaid-caricom-to-sign-us165m-agreement, accessed 22 November 2015.
216 Caribbean360. http://www.caribbean360.com/news/oecs-gets-us5-3-million-to-help-in-hivaids-fight, accessed 14 December 2015.
217 Information on the OAS available at http://www.oas.org/en/, accessed 14 December 2015.
218 Information on the IDB available at http://www.iadb.org/en/news/webstories/2012-02-11/the-caribbean-and-the-idb,9840.html, accessed 14 December 2015.
219 Information on IICA available at http://www.iica.int/en, accessed 14 December 2015.

CHAPTER 2- HEALTH and DEVELOPMENT SITUATION *(continued)*

IDB finances programmes to promote sustainable energy, infrastructure strengthening, governance, fiscal reform and citizen security, as well as furthering reforms in social sectors, such as health, housing and education in the Caribbean. "Compete Caribbean" is an initiative promoting competitiveness in 15 countries in the region through IDB's partnership with DFID and DFATD. The IDB is helping Caribbean countries to deal with the effects of climate change and providing support for environmental sustainability. Several new projects seek to improve disaster risk management and coastal infrastructure in the Caribbean region as a whole to mitigate the effects of climate change. The IDB also participated with CARPHA and PAHO/WHO to develop a project to strengthen Ebola preparedness, for implementation in 2015.[220]

IICA works to promote food and nutrition security and agricultural health, among other issues, and has signed several memoranda of understanding with PAHO/WHO.

World Bank

World Bank's[221] support for health in Caribbean countries has focused on health reform, water and sanitation, HIV and, more recently, IHR core capacities, as noted above.

Countries

Individual countries such as Argentina and Brazil are demonstrating their commitment to South-South cooperation through collaboration with Caribbean countries at the subregional level, including in issues related to health. A triangular cooperation project involving Argentina, CARICOM-CARPHA and PAHO/WHO was agreed in 2013[222] and is currently being implemented. The project addresses laboratory strengthening, NCD surveillance, reduction in NCD risk factors, and renal transplantation. In 2010 the first CARICOM-Brazil Summit was held, and the resulting Brasilia Declaration paved the way for a technical cooperation agreement and activities addressing climate change, health, agriculture and public security in Caribbean countries.[223] Since then, there have been on-going exchanges.

2.2.2 Collaboration with the UN system

All UN agencies, funds and programmes are represented in the Caribbean. The first UN Multi-Country Sustainable Development Framework (MSDF) is being finalised for implementation in mid-late 2016, to guide the UN's contribution to the attainment of the SDGs by selected Caribbean countries.[224] Individual country implementation plans will be developed based on the MSDF for joint action by UN country teams, using the Delivering as One (DaO) approach.[225]

In 2015, a UN Common Multi-Country Assessment (CMCA), national consultations, and an analysis of the SDGs, the SAMOA Pathway, the CARICOM Strategic Plan 2015-2019, and the key areas and priorities of the CARICOM-UN Agreement identified four draft priority areas for the MSDF. These are:

- An Inclusive, Equitable and Prosperous Caribbean
- A Healthy Caribbean
- A Cohesive, Safe and Just Caribbean and
- A Sustainable and Resilient Caribbean[226]

220 PAHO. Annual report of the Director of the Pan American Sanitary Bureau – Championing health for sustainable development and equity: Leading by example. Document CD54/3. Washington, D.C.: PAHO, August 2015. Available at http://www.paho.org/annual-report-2015/index.html, accessed 28 November 2015.

221 Information on the WB available at http://www.worldbank.org/en/region/lac, accessed 14 December 2015.

222 Article on the project available at http://www.paho.org/hq/index.php?option=com_content&view=article&id=8830%3A2013-argentina-firma-declaracion-cooperacion-caribe-multiples-temas-salud&catid=1443%3Aweb-bulletins&Itemid=135&lang=en, accessed 14 December 2015.

223 Information on 2010 CARICOM-Brazil agreement available at http://www.caricom.org/jsp/communications/meetings_statements/brasilia_declaration.jsp, and http://www.abc.gov.br/imprensa/mostrarnoticia/73, accessed 14 December 2015.

224 As at 13 May 2016, the UN MSDF covers 17 countries in the English- and Dutch-speaking Caribbean.

225 Information on Delivering as One is available at http://www.who.int/un-collaboration/system-improvement/dao/en/, accessed 13 May 2016.

226 UN. UN Multi-Country Sustainable Development Framework (draft), May 2016.

Cross-cutting themes are gender equality, human rights, governance, education, data and information for decision-making, and youth. The MSDF priority areas and outcome statements are in **Table 11**.

Table 11. UN MSDF priority areas and outcome statements

Priority areas	Outcome statements
1. An inclusive, equitable and prosperous Caribbean	1.1 Access to quality education and lifelong learning increased, for enhanced employability and sustainable economic development 1.2 Access to equitable social protection systems, quality services, and sustainable economic opportunities improved
2. A healthy Caribbean	2.1 Universal access to quality healthcare services and improved systems 2.2 Laws, policies and systems introduced to support healthy lifestyles among all segments of the population
3. A cohesive, safe and just Caribbean	3.1 Capacities of public policy and rule-of-law institutions and civil society organisations strengthened 3.2 Equitable access to justice, protection, and citizen security and safety reinforced
4. A sustainable and resilient Caribbean	4.1 Policies and programmes for climate change adaptation, disaster risk reduction, and universal access to clean and sustainable energy in place 4.2 Inclusive and sustainable solutions adopted for the conservation, restoration and use of ecosystems and natural resources

The priority areas of the UN MSDF are broad enough to accommodate UAH-UHC and the life course, and social determinants approaches to health priorities in the Caribbean sub-region.

2.2.3 Contributions of the sub-region to the global health agenda

- The Caribbean has demonstrated regionalism and solidarity, and its commitment to joint action as a sub-region in addressing common health and development priorities through CARICOM and the CCH. It has also demonstrated the potential for inter-country and inter-subregional cooperation in health
- The Caribbean has been a leader in effective control of vaccine-preventable diseases, with elimination of polio and its contribution to the Region of the Americas becoming the first region to be declared free of endemic transmission of rubella and congenital rubella syndrome in 2015
- In 2015 Cuba became the first country to be validated as having eliminated MTCT of HIV and congenital syphilis
- The Caribbean led regional and global advocacy on NCDs, including the CARICOM Heads of Governments' 2001 Nassau Declaration "the Health of the Region is the Wealth of the Region" that recognised NCDs, HIV/AIDS and mental health as priority issues for the sub-region, and the 2007 Port of Spain Declaration "Uniting to stop the epidemic of chronic non-communicable diseases". This advocacy contributed significantly to the UN General Assembly High-Level Meeting on NCDs in September 2011, a Declaration from the High-Level Meeting and a Global NCD Action Plan
- PANCAP has been recognised as a global best practice for partnerships, and successes in HIV and AIDS prevention and control have been documented

- The sub-region has also been a strong voice for SIDS – the Global Conference on the Sustainable Development of Small Island Developing States was held in Bridgetown, Barbados in 1994, resulting in the Declaration of Barbados and the Barbados Plan of Action. The BPOA remains the foundation for solutions and interventions related to SIDS challenges.

2.3 PRIORITIES

The commonalities among the frameworks and issues summarised above indicate the following as priorities for inclusion in the PAHO/WHO SCS, aligned with the CCH IV priority areas:

1. *Health systems for universal health coverage*
    - Universal access to health and universal health coverage, including strengthening primary healthcare, health system leadership and governance, health services, health workforce, access to essential medicines and technologies, and health financing
2. *Safe, resilient, healthy environments to mitigate climate change*
    - Environmental health and sustainability, including water quality and quantity, and sanitation and hygiene – liquid, solid and hazardous waste disposal
    - Climate change adaptation
    - Disaster preparedness, risk reduction, mitigation, response and management
3. *Health and well-being of Caribbean people throughout the life course*
    - Health promotion and social communication, including the use of social media
    - Prevention and control of the major NCDs and their common risk factors, including food and nutrition security
    - Mental health
    - Violence and injury prevention, including road traffic injuries and gender-based violence
    - Women's, maternal, neonatal, infant, child, adolescent, youth, men's and older persons' health
    - Prevention and control of priority communicable diseases, including HIV, vector-borne and vaccine-preventable diseases, and emerging and re-emerging diseases, in the context of implementation of the IHR (2005), and considering food safety, the human-animal interface, and elimination of neglected diseases
    - Social determinants of health
    - Cross-cutting themes of gender, equity, ethnicity and human rights
    - Health in All Policies and multi-sectoral action
4. *Data and evidence for decision-making and accountability*
    - Health information and health information systems
    - Monitoring and evaluation mechanisms

- Capacity-building for data generation, management, analysis and interpretation
- Research
- Reporting, information-sharing and knowledge management

5. *Partnerships and resource mobilisation for health*
    - Partnerships, traditional and non-traditional, including with civil society – health and non-health – and the private sector, observing agreed international guidelines and possible conflict of interest
    - Strategic communication
    - Resource mobilisation
    - Cooperation among countries for health development
    - Efficient and effective programme implementation and assessment

Communicable diseases, including HIV, environmental sustainability, climate change, and disaster mitigation and response are issues that are also reflected in the health and health-related agendas of the other subregional integration mechanisms. Given the sub-region's dependence on tourism as a driver of its economy, tourism and health issues are of significance, and can be addressed through communicable disease prevention and control, environmental sustainability, climate change adaptation, and universal access to health and universal health coverage.

Major challenges in working at the subregional level have been, and continue to be, promoting the subregional health frameworks to a wide range of stakeholders; identifying subregional interventions that will address the frameworks and complement and facilitate national actions; mobilising resources, including non-health resources, to address risk factors and social determinants; and executing joint, coordinated activities for the efficient and effective implementation of the interventions, monitoring their execution and assessing their impact on the health of the Caribbean people.


2014

CHAPTER 3 REVIEW of PAHO/WHO'S COOPERATION over the PAST SCS CYCLE

3.1 Organisation of the SPC-CRB

Since 2006, when a restructuring exercise resulted in separation of responsibilities for the subregional and country TC programmes,[227] the PAHO/WHO office in Barbados has housed two entities: the Subregional Program Coordination, Caribbean (SPC-CRB), formerly the Office for Caribbean Program Coordination (OCPC) and the Office for Barbados and Eastern Caribbean Countries (OECC).[228] The entities are led by, respectively, the Subregional Program Coordinator, Caribbean (SPC CRB, formerly the Caribbean Program Coordinator, CPC) and the PWR ECC – the latter is the administrative head of the co-located entities. The PAHO regional decentralised programme[229] on Emergency Preparedness and Disaster Response (PED) and a regional decentralised advisor on HIV/STI/VH are also situated in the Barbados office, and there are two subregional programme advisors based in the PAHO/WHO office in Trinidad and Tobago. **The organisational chart for the SPC-CRB is in Annex D**.

For several years during the period of the SCS 2010-2015, the SPC CRB was also the Acting PWR ECC, and there were gaps in the full complement of subregional technical advisors. However, the gaps were filled by advisors from the OECC, regional decentralised technical advisors in the sub-region and short-term consultants as needed. In mid-2014 and mid-2015, respectively, a new PWR ECC and a new SPC CRB assumed duties as heads of the respective entities.

3.2 Programmatic implementation of the Caribbean technical cooperation programme

The subregional focus areas of the SCS 2010-2015 were closely aligned with the CCH III 2010-2015 Strategic Priorities and addressed: healthy environment; health leadership; emergency preparedness and disaster relief; IHR; food safety and security; immunisation; healthy lifestyle; continuity of care; comprehensive care for NCDs; equitable access to quality healthcare; access, quality and rational use of medicines and technologies; human resources for health; health information systems (environmental health risks); integrated systems for health surveillance; and integrated health information systems.

227 Prior to 2006, the Office of Caribbean Program Coordination executed both the subregional and country TC programmes.

228 The OECC covers Anguilla, Antigua & Barbuda, Barbados, British Virgin Islands, Dominica, French Guiana, Grenada, Guadeloupe, Martinique, Montserrat, Saint Lucia, St. Kitts & Nevis, and St. Vincent & the Grenadines. Note: PAHO/WHO Bahamas covers Turks and Caicos Islands; Jamaica covers Bermuda and Cayman Islands; and Venezuela covers Aruba, Curaçao, Sint Maarten/St. Martin, and the Dutch Overseas Territories.

229 Regional decentralised programmes and advisors are those with functions, supporting resources, and supervision that are under the purview of relevant technical entities in the PAHO office in Washington, D.C.; they are placed in country offices or the OCPC to bring the technical presence closer to countries and to better address subregional and national needs.

CHAPTER 3- REVIEW of PAHO/WHO'S COOPERATION over the PAST SCS CYCLE *(continued)*

Achievements included, but were not limited to:

- Approval of the Caribbean Pharmaceutical Policy and the Expanded Technical Advisory Committee on Pharmaceutical Policy by the 21st COHSOD in 2011, with completion of pharmaceutical profiles by fifteen countries, including indicators for monitoring and evaluation of the CPP
- Approval of a high-level Roadmap for Strengthening Health Information Systems and a draft Caribbean Health Information Systems Strengthening Framework by the COHSOD in 2011, with subsequent finalisation and piloting in three countries
- Implementation, in April 2014, of a Caribbean Examinations Council (CXC)-managed Regional Examination for Nursing Registration, the culmination of some twelve years of collaborative work to arrive at consensus for a regional nursing examination and regional standards for nursing practice
- Preparatory work for the introduction of Regional Health Insurance Mechanisms, with the approval of costing and policy options by the 2012 COHSOD; the Heads of Governments' decision is pending
- Development and application of a comprehensive protocol and tools for assessing the impact of the Port of Spain Declaration on NCDs, in collaboration with CARPHA and the UWI
- Integration of nutrition and health into food security and agricultural policies and programmes in the Caribbean, including introduction of a school nutrition policy and programme, development of food-based dietary guidelines and renewed impetus of countries working towards implementing the Baby Friendly Hospital Initiative (BFHI)
- Implementation of the Caribbean Regional Strategic Framework for HIV and AIDS
- Implementation of the Safe Hospitals programme and initiation of the Smart Hospitals programme[230]

Challenges included:

- Shortages in technical staff at the SPC-CRB, which delayed the implementation of several TC activities, notwithstanding the contribution of OECC and regional decentralised technical advisors, and the recruitment of short-term consultants until technical posts were filled
- Difficulties in identifying suitably qualified short-term consultants for some programmes
- Rationalisation of PAHO-CARPHA coordination and roles and responsibilities

Lessons learnt included:

- The need to maintain a current pool of qualified consultants ready for deployment to assist with various situations, including disaster response
- Difficulties in maintaining TC continuity using short-term consultants

230 Information on Hospitals Safe from Disasters (Safe Hospitals) and Smart Hospitals available at http://www.paho.org/disasters/index.php?option=com_content&view=category&layout=blog&id=1026&Itemid=911, accessed 17 December 2015.

- The need to define PAHO's and CARPHA's respective roles and responsibilities, and establish effective mechanisms for collaboration and communication between the entities as well as with their member states
- Forging partnerships with non-traditional, non-health institutions such as universities and the Caribbean Examinations Council can advance the health agenda
- The sharing of expertise between SPC-CRB and OECC in areas such as health information systems, human resources for health and NCDs is a cost-effective approach

3.3 Budgetary execution

The PAHO/WHO budget comprises regular budget (RB), obtained from assessed member state contributions and other sources (OS), comprising voluntary contributions from development partners and miscellaneous income. **Table 12 summarises the funds awarded to the SPC-CRB and disbursed from regular budget and other sources.** The significant decrease in OS funds in 2012-2013 was compensated by an increase in the RB allocation. In both the 2010-2011 and 2012-2013 biennia, disbursement of OS funds was higher than RB funds, reflecting the imperative to execute development partner-provided funds before the more flexible RB funds. However, in 2014-2015, both the OS funds and their execution showed significant reduction, reflecting a hiatus in resource mobilisation as work to better define and strengthen the subregional level of TC progressed. Approximately 57% of the total RB in 2014-2015 awarded was for implementation of the joint CARPHA/PAHO workplan, and that amount was fully disbursed.

Table 12. Budget execution summary, SPC-CRB, 2010-2015 (US Dollars)

	2010-2011			2012-2013			2014-2015		
	RB	OS	Total	RB	OS	Total	RB	OS	Total
Awarded	795,600	1,002,643	1,798,243	1,370,104	394,387	1,764,491	2,913,532	65,520	2,979,052
Disbursed	500,793	848,294	1,349,267	979,863	388,864	1,368,227	2,872,636	3,834	2,876,470
Implementation rate (%)*	63.0	84.6	75.0	71.5	98.6	77.6	98.6	5.9	96.6

**Implementation rate = Disbursed/Awarded x 100%*

The average total budget execution for the three biennia is 83.1%, with improving execution of both RB and OS funds for the first two biennia, followed by a significant decrease in OS execution and a marked improvement in RB execution in the third biennium. **This summary does not reflect the budgetary and technical resources expended by other PAHO/WHO entities in achieving the deliverables, outputs and outcomes related to the SCS 2010-2015.**

3.4 Conclusion

The review of the SCS 2010-2015 highlights achievements on which the SCS 2016-2019 will build; challenges to be addressed in considering the implications of the new SCS; and lessons that inform innovative mechanisms for its successful implementation. To complement the internal review summarised above, analysis of the survey responses from 36 stakeholders on issues relating to the SCS 2010-2015 indicates that though most (72.2%) were aware of the SCS, only about one-third had been consulted in its development (30.5%), found it somewhat useful (33.3%), and used it in developing workplans, programmes, or projects (30.6%). The respondents'

CHAPTER 3- REVIEW of PAHO/WHO'S COOPERATION over the PAST SCS CYCLE *(continued)*

reasons for not finding it of much use included: "not well-disseminated or promoted"; "not highlighted by countries or regional partners as a framework for action"; "not readily available"; and "not engaged in process or considered as partners".

Thus, approaches that will be useful in addressing the strategic priorities and focus areas in the SCS 2016-2019 include:

- Communicating and promoting the SCS and subregional health priorities to a wide range of stakeholders
- Involving a wide range of stakeholders in SCS development, monitoring and evaluation
- Collaborating with CARPHA, PWRs and other partners in developing, and maintaining a current Caribbean health and development situation analysis
- Collaborating with CARPHA, CROSQ, PWRs and other partners in strengthening national and subregional health information systems, surveillance and research
- Increasing awareness and knowledge of CARICOM resolutions, COHSOD-approved policies, programmes, pilot interventions, guidelines, charters, agreements and other subregional frameworks related to the strategic priorities and focus areas of the SCS, using them to guide subregional TC where appropriate
- Increasing national and subregional awareness of, and aligning TC with, international treaties and agreements to which the countries have committed, that address priority health issues, such as the FCTC, the IHR (2005) and the SDGs
- Collaborating with PWRs to identify, promote and share achievements and lessons learnt at country level that can benefit other countries in the sub-region – that is, effective use of the CCHD framework. This will involve mapping the expertise available within and outside of the sub-region that will contribute to the achievement of priority subregional health and development objectives
- Collaborating with PWRs, the PAHO Office of Country and Subregional Coordination (CSC), the PAHO Department of External Relations, Partnerships and Resource Mobilization (ERP), the WHO Department of Country Cooperation and Collaboration with the UN (CCU) and other organisational entities to promote inter-subregional and inter-regional exchanges and sharing of experiences in health and development
- Strengthening current, and creating new partnerships with a wide range of stakeholders in order to achieve subregional health goals, especially with CARICOM regional institutions such as CARPHA, CCCCC, CDEMA and CROSQ, as well as with CARICOM Secretariat units, such as the Regional Statistical Programme and the Gender Development Programme, along with international financing institutions
- Strengthening collaboration with UN entities working at the subregional level in health and health-related issues, such as UN Women, UNICEF and ECLAC
- Collaborating with PWRs to contribute to, and take advantage of, the UN MSDF and associated resource mobilisation efforts, such as through UN Multi-Partner Trust Funds, when there are health-related deliverables that would be more efficiently addressed through a subregional approach
- Identifying and taking advantage of other opportunities for resource mobilisation to address subregional priorities and support the implementation of the SCS
- Quantifying resources from entities at all levels of PAHO/WHO that contribute to the implementation of the SCS for improved monitoring, evaluation and accuracy
- Collaborating with the CARICOM Secretariat, CARPHA, UWI and PWRs to promote, communicate and advocate for CCH IV and other major subregional health agendas and existing regional frameworks in priority areas
- Contributing to the systematic monitoring and evaluation of the CCH IV and other major subregional health agendas

CHAPTER 4 STRATEGIC AGENDA for PAHO/WHO'S COOPERATION

Not every challenge in the Caribbean subregional health agenda has been translated into a Strategic Priority (SP) and related Focus Areas (FA) in the strategic agenda. PAHO/WHO's leadership priorities, core functions, comparative advantage and added value, including human and financial resources, have also influenced the selections.

The SPs and FAs are mapped to the CCH IV Strategic Priorities, and each FA is linked to a specific category and programme area in the PAHO Strategic Plan 2014-2019, and to an outcome and its respective indicator(s) in the PAHO Program Budget 2016-2017. They can therefore be seen as SMART FAs – specific, measurable, achievable, realistic and time-bound. The FAs are also mapped to relevant SDG Targets and UN MSDF Outcomes, and there are comments with examples of FA-related subregional and/or regional frameworks.

While the Strategic Agenda does not provide operational details (outputs and deliverables, which will be developed in the respective biennial workplans), it does indicate the lead entity, key partners and the core functions that PAHO/WHO will apply to contribute to the achievement of the high level results and their indicators.

Table 13 on the following pages summarises the PAHO/WHO Strategic Agenda 2016-2019 for the Caribbean sub-region.

Table 13. PAHO/WHO'S CARIBBEAN Subregional STRATEGIC AGENDA, 2016-2019

CCH IV Strategic Priority 1: Health systems for universal health coverage and access to health SCS Strategic Priority 1: Universal access to health and universal health coverage: increasing and improving financing, with equity and efficiency					
SCS Focus Areas	**PAHO Strategic Plan Categories/Programme Areas**	**PAHO Program Budget 2016-17 Outcomes (OCMs)/Indicators**	**PAHO/WHO Core Function(s)**	**Lead/Partners**	**Comments/Selected references, including SDG targets related to FAs and UN MSDF Outcomes ***
1.1 Health financing – Review of cost and economic analysis and options for the development and implementation of health finance reform, with sharing of experiences from countries related to revenue collection, revenue pooling and strategic purchasing, highlighting links to Ministry of Finance expenditure estimates and public sector financing	**Category 4**: Health systems ***Programme Area:*** **4.1** Health governance and financing; national health policies, strategies and plans	**OCM 4.1:** Increased national capacity for achieving universal health coverage **4.1.1** Number of countries and territories that have increased health coverage through social protection mechanisms	Research and knowledge dissemination Norms and standards Ethical and evidence-based policy options	**Lead:** PAHO/WHO **Partners:** Member States, UWI, private sector, as appropriate, CSOs	Member States include countries outside of the Caribbean, with lessons, experiences and resources to share **SDG Targets** **1.3, 3.8, 3.c** **UN MSDF Outcomes** **1.2, 2.1**
1.2 Access to quality essential medicines and appropriate health technologies – Establishment of the Caribbean Regulatory System (CRS) for effective procurement, regulatory and quality of care monitoring systems. Expanding the use of the PAHO Strategic Fund can play a critical role achieving this Strategic Priority	**Category 4:** Health systems ***Programme Area:*** **4.3** Access to medical products and strengthening of regulatory capacity	**OCM 4.3:** Improved access to and rational use of safe, effective and quality medicines, medical products and health technologies **4.3.1** Number of countries and territories that have improved financial protection mechanisms ensuring access to medicines included in the national essential medicines list **4.3.2** Number of countries and territories that have increased their regulatory capacity toward achieving the status of functional regulatory authority of medicines and other health technologies	Leadership and partnerships Norms and standards TC for sustainable institutional capacity	**Lead:** PAHO/WHO **Partners:** Member States in and outside of the Caribbean, CARICOM, CARPHA, CROSQ, private sector, CSOs	Member States include countries outside of the Caribbean, with lessons, experiences and resources to share Private sector as appropriate, keeping conflict of interest in mind Caribbean Pharmaceutical Policy and TECHPHARM technical working group to guide implementation of the policy **SDG Targets** **3.8, 3.b, 12.7** **UN MSDF Outcome** **2.1**
1.3 Human resources for health (HRH) – Update, implementation, monitoring and evaluation of the subregional HRH Action Plan in collaboration with Member States, regional training institutions, professional associations, and other relevant partners to share national experiences, align training with HR needs and improve HR distribution and management	**Category 4:** Health systems ***Programme Area:*** **4.5** Human resources for health	**OCM 4.5** Adequate availability of a competent, culturally appropriate, well-regulated, well-distributed and fairly treated health workforce **4.5.2** Number of countries and territories with 100% of primary healthcare workers having demonstrable public health and intercultural competences **4.5.3** Number of countries and territories that have reduced by half the gap in distribution of health personnel between urban and rural areas	Research and knowledge dissemination Norms and standards Ethical and evidence-based policy options TC for sustainable institutional capacity	**Lead:** PAHO/WHO **Partners:** Member States, CARICOM, including COHSOD (Education), UWI and other academic institutions, CSOs	The Strategic Plan for CARICOM, 2015-2019 indicates a cross-cutting focus on youth that is applicable here, regarding their education and career paths **SDG Targets** **3.c, 4.7** **UN MSDF Outcomes** **1.1, 2.1**

* Draft UN MSDF, as at 13 May 2016.

Table 13. PAHO/WHO'S CARIBBEAN Subregional STRATEGIC AGENDA, 2016-2019 *(continued)*

SCS Focus Areas	PAHO Strategic Plan Categories/Programme Areas	PAHO Program Budget 2016-17 Outcomes (OCMs)/Indicators	PAHO/WHO Core Function(s)	Lead/Partners	Comments/Selected references, including SDG targets related to FAs and UN MSDF Outcomes *
1.4 Promotion of shared specialist referral centres – Development of strategies to reduce barriers to the establishment of referral centres for complex tertiary care ("Centres of Excellence") in the sub-region and formulation of relevant recommendations, including possible public-private mix of investment and resources	**Category 4:** Health systems ***Programme Area:*** **4.2** People-centred, integrated, quality health services	**OCM 4.2:** Increased access to people-centred, integrated, quality health services **4.2.1** Number of countries and territories with increased utilisation of first-level care services after implementation of new people-centred model of care	Research and knowledge dissemination Norms and standards Ethical and evidence-based policy options TC for sustainable institutional capacity	**Lead:** PAHO/WHO **Partners:** Member States, CARICOM, UWI and other academic institutions, international financial institutions, private sector, CSOs	The establishment of such centres continues to be a request from smaller Caribbean countries that cannot afford them. The launch of Caribbean "hospital ships" providing such services to countries in need, adapted from the model of similar ships that visit the sub-region from other countries, could be explored, perhaps linked to the idea of health insurance that is "portable" across Caribbean countries **SDG Targets 3.8, 17.17** **UN MSDF Outcome 2.1**

* Draft UN MSDF, as at 13 May 2016.

Table 13. PAHO/WHO'S CARIBBEAN Subregional STRATEGIC AGENDA, 2016-2019 *(continued)*

CCH IV Strategic Priority 2: Safe, resilient and healthy environments to mitigate climate change SCS Strategic Priority 2: Safe, resilient and healthy environments to adapt to climate change and mitigate disasters					
SCS Focus Areas	**PAHO Strategic Plan Categories/Programme Areas**	**PAHO Program Budget 2016-17 Outcomes (OCMs)/Indicators**	**PAHO/WHO Core Function(s)**	**Lead/Partners**	**Comments/Selected references, including SDG targets related to FAs and UN MSDF Outcomes ***
2.1 Environmental health and sustainability – Provision of standardised subregional models and strategies for improvements in water quality and quantity, sanitation and hygiene, including disposal of liquid, solid and hazardous wastes, with focus on waste from healthcare facilities	**Category 3:** Determinants of health and promoting health throughout the life course ***Programme Area:*** **3.5** Health and the environment	**OCM 3.5** Reduced environmental and occupational threats to health **3.5.1** Number of countries and territories that have reduced the gap between urban and rural populations' access to quality-controlled water according to WHO guidelines **3.5.2** Proportion of the population with access to improved sanitation **3.5.5** Number of countries and territories with capacity to address environmental health	Norms and standards Ethical and evidence-based policy options TC for sustainable institutional capacity	**Lead:** PAHO/WHO **Partners:** Member States, CARPHA, CARICOM, UNEP, other international institutions and agencies	**SDG Targets** **3.9, 3.d, 6.1, 6.2, 6.3, 6.a, 6.b, 12.4, 12.5** **UN MSDF Outcome 4.2**
2.2 Climate change adaptation for health – Development and implementation of climate change adaptation measures, with focus on vulnerable groups	**Category 3:** Determinants of health and promoting health throughout the life course ***Programme Area*** **3.5:** Health and the environment	**OCM 3.5** Reduced environmental and occupational threats to health **3.5.5** Number of countries and territories with capacity to address environmental health	Research and knowledge dissemination Leadership and partnerships TC for sustainable institutional capacity	**Lead:** PAHO/WHO **Partners:** Member States, CARICOM, CCCCC, CARPHA, CSOs, including those representing indigenous people, private sector, international organisations and agencies, e.g. DFID, UNEP	CARICOM Liliendaal Declaration on Climate Change UN Framework Convention on Climate Change and the Kyoto Protocol Private sector as appropriate, keeping conflict of interest in mind **SDG Targets** **1.5, 13.1, 13.2, 13.3 13.b** **UN MSDF Outcome 4.1**
2.3 Disaster preparedness, mitigation, and response – Expansion of the WHO Emergency Response Framework to cover all phases of the emergency management cycle – preparedness, alert, response, recovery and prevention, including risk assessment, risk reduction and risk communication	**Category 5:** Preparedness, surveillance and response ***Programme Areas:*** **5.3** Emergency risk and crisis management **5.5** Outbreak and crisis response	**OCM 5.3** Countries have an all-hazards health emergency risk management programme for a disaster-resilient health sector, with emphasis on vulnerable populations **5.3.1** Number of countries and territories that meet or exceed minimum capacities to manage public health risks associated with emergencies addressing vulnerable communities **5.3.2** Number of countries and territories implementing disaster risk reduction interventions in the health sector that increase community resilience **OCM 5.5** All countries adequately respond to threats and emergencies with public health consequences **5.5.1** Percentage of countries and territories that demonstrate adequate response to an emergency from any hazard with a coordinated initial assessment and a health sector response plan within 72 hours of onset	TC for sustainable institutional capacity Leadership and partnerships Research and knowledge dissemination	**Lead:** PAHO/WHO **Partners:** Member States, CARICOM, CDEMA, CARPHA, CSOs	WHO's and PAHO's Emergency Response Frameworks PAHO's Smart Hospital initiative **SDG Targets** **1.5, 11.5, 11.b, 13.1** **UN MSDF Outcomes 2.1, 4.1**

* Draft UN MSDF, as at 13 May 2016.

Table 13. PAHO/WHO'S CARIBBEAN Subregional STRATEGIC AGENDA, 2016-2019 *(continued)*

SCS Focus Areas	PAHO Strategic Plan Categories/Programme Areas	PAHO Program Budget 2016-17 Outcomes (OCMs)/Indicators	PAHO/WHO Core Function(s)	Lead/Partners	Comments/Selected references, including SDG targets related to FAs and UN MSDF Outcomes *
2.4 Integrated Vector Management – Assessment of the implementation of Integrated Vector Management (IVM) across the sub-region, with recommendations for subregional interventions to enhance implementation and impact	**Category 1:** Communicable diseases ***Programme Area*** **1.3** Malaria and other vector-borne diseases (including dengue and Chagas)	**OCM 1.3** Increased country capacity to develop and implement comprehensive plans, programmes, or strategies for the surveillance, prevention, control, and/or elimination of malaria and other vector-borne diseases **1.3.2** Number of countries and territories with installed capacity to eliminate malaria **1.3.3** Number of countries and territories with installed capacity for the management of all dengue cases	Monitoring health situation and trends Norms and standards TC for sustainable institutional capacity	**Lead:** PAHO/WHO **Partners:** Member States, CARICOM, CARPHA, CSOs, private sector, international organisations and agencies	PAHO document CD48/13 (2008) – Integrated Vector Management: A comprehensive response to vector-borne diseases http://www1.paho.org/english/GOV/CD/cd48-13-e.pdf?ua=1 SDG Targets 3.3, 3.d UN MSDF Outcomes 2.1, 2.2

* Draft UN MSDF, as at 13 May 2016.

Table 13. PAHO/WHO'S CARIBBEAN Subregional STRATEGIC AGENDA, 2016-2019 *(continued)*

CCH IV Strategic Priority 3: Health and well-being of Caribbean people throughout the life course SCS Strategic Priority 3: Health promotion and disease prevention and control throughout the life course, including cross-cutting themes					
SCS Focus Areas	**PAHO Strategic Plan Categories/Programme Areas**	**PAHO Program Budget 2016-17 Outcomes (OCMs)/Indicators**	**PAHO/WHO Core Function(s)**	**Lead/Partners**	**Comments/Selected references, including SDG targets related to FAs and UN MSDF Outcomes ***
3.1 Non-communicable diseases and their risk factors, mental health, violence and injury prevention – Development and implementation of policy, legislative, and protocol frameworks for multi-sectoral action on NCD prevention and control – including risk factors, food and nutrition security, mental disorders, and violence and injuries – in the context of the Port of Spain Declaration and regional and global NCD plans	**Category 2:** Non-communicable diseases and risk factors ***Programme Areas:*** **2.1** Non-communicable diseases and risk factors **2.2** Mental health and psychoactive substance use disorders **2.3** Violence and injuries **2.5** Nutrition	**OCM 2.1** Increased access to interventions to prevent and manage non-communicable diseases and their risk factors **2.1.2** Prevalence of current tobacco use (15+ years of age) **2.1.6** Number of countries and territories with a halt in the rise of obesity at current national levels **2.1.8** Number of countries and territories with cervical cancer screening coverage of 70% by 2019 among women aged 30-49 years, at least once, or more often, and for lower and higher age groups according to national policies **OCM 2.2** Increased service coverage for mental health and psychoactive substance use disorders **2.2.1** Number of countries and territories that have increased the rate of users treated through mental health outpatient and substance abuse treatment facilities above the regional average of 975/100,000 population **OCM 2.3** Reduced risk factors associated with violence and injuries with a focus on road safety, child injuries and violence against children, women and youth **2.3.1** Number of countries and territories with at least 70% use of seat belts by all passengers **2.3.2** Number of countries and territories that use a public health perspective in an integrated approach to violence prevention **OCM 2.5** Nutritional risk factors reduced **2.5.1** Percentage of children less than 5 years of age who are stunted **2.5.2** Percentage of women of reproductive age (15-49 years) with anaemia **2.5.3** Percentage of children less than 5 years of age who are overweight	Ethical and evidence-based policy options TC for sustainable institutional capacity Leadership and partnerships Norms and standards Research and knowledge dissemination Monitoring health situation and trends	**Lead:** PAHO/WHO **Partners:** Member States –multiple sectors, CARICOM, CARPHA (surveillance, epidemiology, laboratory, evidence for decision-making and monitoring and evaluation), HCC and other CSOs, private sector, academia, international organisations and agencies, including UNICEF, UN Women	WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020 WHO Global Monitoring Framework for NCDs PAHO Regional NCD Plan of Action 2013-2020 PAHO Plan of Action for the Prevention of Obesity in Children and Adolescents (2014) Comprehensive Implementation Plan on Maternal and Child Nutrition WHO Comprehensive Mental Health Action Plan 2013-2020 Gender Equality Indicators Model that address GBV **SDG Targets** **2.1, 2.2, 3.4, 3.5, 3.6, 3.a, 5.2, 11.2, 11.7, 16.1** **UN MSDF Outcomes** **2.1, 2.2, 3.1, 3.2**

* Draft UN MSDF, as at 13 May 2016.

Table 13. PAHO/WHO'S CARIBBEAN Subregional STRATEGIC AGENDA, 2016-2019 *(continued)*

SCS Focus Areas	PAHO Strategic Plan Categories/Programme Areas	PAHO Program Budget 2016-17 Outcomes (OCMs)/Indicators	PAHO/WHO Core Function(s)	Lead/Partners	Comments/Selected references, including SDG targets related to FAs and UN MSDF Outcomes *
3.2 Communicable diseases – Strengthening of strategies to prevent and control priority communicable diseases, including HIV, vaccine-preventable diseases, emerging and re-emerging diseases, with emphasis on IHR (2005) implementation, food safety, the human-animal interface, and elimination of selected neglected diseases	**Category 1:** Communicable diseases ***Programme Areas:*** **1.1** HIV/AIDS and STIs **1.2** Tuberculosis **1.4** Neglected, tropical and zoonotic diseases **1.5** Vaccine-preventable diseases (including maintenance of polio eradication) **Category 5:** Preparedness, surveillance and response Programme Areas: **5.1** Alert and response capacities (for IHR) **5.2** Epidemic- and pandemic-prone diseases **5.4** Food safety **5.5** Outbreak and crisis response	**OCM 1.1** Increased access to key interventions for HIV and STI prevention and treatment **1.1.1** Number of countries and territories that have 80% coverage of antiretroviral therapies (ART) in eligible populations **1.1.2** Number of countries and territories with at least 95% coverage of HIV prophylaxis treatment for prevention of mother-to-child transmission of HIV **1.1.3** Number of countries and territories with at least 95% coverage of syphilis treatment in pregnant women **OCM 1.2** Increased number of tuberculosis (TB) patients successfully diagnosed and treated **1.2.3** Percentage of new TB patients diagnosed in relation to WHO estimated cases from 1995 to 2011 **OCM 1.4** Increased country capacity to develop and implement comprehensive plans, programmes of strategies for the surveillance, prevention, control, and/or elimination of neglected, tropical and zoonotic diseases **1.4.7** Number of endemic countries and territories having achieved the recommended target coverage of population at risk of soil-transmitted helminths **OCM 1.5** Increased vaccination coverage for hard-to-reach populations and communities and maintenance of control, eradication, and elimination of vaccine-preventable diseases **1.5.1** Regional average coverage with three doses of diphtheria, tetanus, and pertussis-containing vaccine **1.5.2** Number of countries and territories with reestablishment of endemic transmission of measles and rubella virus **1.5.3** Number of countries and territories that have introduced one or more new vaccines **OCM 5.1** All countries have the minimum core capacities required by the IHR (2005) for all-hazard alert and response **5.1.1** Number of countries and territories meeting and sustaining IHR (2005) requirements for core capacities	Research and knowledge dissemination Norms and standards Ethical and evidence-based policy options TC for sustainable institutional capacity Leadership and partnerships Monitoring health situation and trends	**Lead in HIV EMTCT, STI, TB, neglected diseases, and vaccine-preventable diseases:** PAHO/WHO **Partners:** Member States, CARICOM, PANCAP, CARPHA, international organisations and agencies, private sector **Lead in IHR core capacity achievement:** PAHO/WHO **Partners:** Member States, CARICOM, CARPHA, international organisations and agencies, e.g. CDC **Lead in food safety and outbreak response, and surveillance and laboratory networks related to all priority diseases:** CARPHA **Partners:** Member States, PAHO/WHO, international organisations and agencies, private sector	CRSF on HIV and AIDS 2014-2018 2016 WHO IHR monitoring and evaluation framework (to be presented to the 69th WHA in May 2016) Results of the PAHO 2014 country assessments of IHR core capacity WHO Global Vaccine Action Plan 2011-2020 PAHO document CD54/7 rev.2 (2015) – Plan of Action on Immunization **SDG Targets 3.3, 3.d** **UN MSDF Outcomes 2.1, 2.2**

* Draft UN MSDF, as at 13 May 2016.

Table 13. PAHO/WHO'S CARIBBEAN Subregional STRATEGIC AGENDA, 2016-2019 *(continued)*

SCS Focus Areas	PAHO Strategic Plan Categories/Programme Areas	PAHO Program Budget 2016-17 Outcomes (OCMs)/Indicators	PAHO/WHO Core Function(s)	Lead/Partners	Comments/Selected references, including SDG targets related to FAs and UN MSDF Outcomes *
		OCM 5.2 All countries are able to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics **5.2.1** Number of countries and territories with installed capacity to effectively respond to major epidemics and pandemics **OCM 5.4** All countries have the capacity to mitigate risks to food safety and respond to outbreaks **5.4.1** Number of countries and territories that have adequate mechanisms in place for preventing or mitigating risks to food safety and for responding to outbreaks, including among marginalised populations **OCM 5.5** All countries adequately respond to threats and emergencies with public health consequences **5.5.1** Percentage of countries and territories that demonstrate adequate response to an emergency from any hazard with a coordinated initial assessment and a health sector response plan within 72 hours of onset			
3.3 Health of specific population groups – Development and implementation of tailored strategies to improve women's, maternal, neonatal, infant, child and adolescent health, and the health of older persons, including health promotion and lifestyle interventions	**Category 3:** Determinants of health and promoting health throughout the life course Programme Areas: **3.1** Women's, maternal, newborn, child, adolescent, and adult health, and sexual and reproductive health **3.2** Ageing and health	**OCM 3.1** Increased access to interventions to improve the health of women, newborns, children, adolescents, and adults **3.1.2** Percentage of live births attended by skilled health personnel **3.1.3** Percentage of mothers and newborns receiving post-natal care within seven days of childbirth **3.1.4** Percentage of infants under 6 months of age who are exclusively breastfed **3.1.6** Specific fertility rate in women 15-19 years of age (will also measure percentage of adolescent mothers below 15 years of age) **OCM 3.2** Increased access to interventions for older adults to maintain an independent life **3.2.1** Number of countries and territories with increased access to integrated community service and self-care programmes for older adults	Research and knowledge dissemination Norms and standards Ethical and evidence-based policy options TC for sustainable institutional capacity Leadership and partnerships Monitoring health situation and trends	**Lead:** PAHO/WHO **Partners:** Member States, CARICOM, international agencies and organisations, including UN Women, UNICEF, CSOs, professional associations, academia	Family Health Strategy for the Caribbean Community 2015-2020 Integrated Strategic Framework for the Reduction of Adolescent Pregnancy in the Caribbean (CARICOM/UNFPA) Comprehensive Implementation Plan on Maternal and Child Nutrition **SDG Targets** **3.1, 3.2, 3.7, 5.6, 5.c** **UN MSDF Outcomes** **2.1, 2.2**

* Draft UN MSDF, as at 13 May 2016.

Table 13. PAHO/WHO'S CARIBBEAN Subregional STRATEGIC AGENDA, 2016-2019 *(continued)*

SCS Focus Areas	PAHO Strategic Plan Categories/Programme Areas	PAHO Program Budget 2016-17 Outcomes (OCMs)/Indicators	PAHO/WHO Core Function(s)	Lead/Partners	Comments/Selected references, including SDG targets related to FAs and UN MSDF Outcomes *
3.4 Social determinants of health – Promoting and fostering multi-sectoral collaboration, and Health in All Policies to address gender, equity, human rights, ethnicity and the social determinants of health	**Category 3:** Determinants of health and promoting health throughout the life course ***Programme Areas:*** **3.3** Gender, equity, human rights and ethnicity 3.4 Social determinants of health	**OCM 3.3** Increased country capacity to integrate gender, equity, human rights and ethnicity in health **3.3.1** Number of countries and territories with an institutional response to inequities in health (gender and ethnicity) and human rights **OCM 3.4** Increased leadership of the health sector in addressing the social determinants of health **3.4.1** Number of countries and territories implementing at least two of the five pillars of the Rio Political Declaration on Social Determinants of Health **3.4.2** Number of countries and territories that have re-oriented their health sector to address health inequities	Ethical and evidence-based policy options Research and knowledge dissemination Monitoring health situation and trends Leadership and partnerships	**Lead:** PAHO/WHO **Partners:** Member States, CARICOM Gender and Development Programme, CARPHA, international agencies and organisations, especially UN Women, UNDP, and UNICEF, international financing institutions, CSOs	CARICOM Gender Equality Indicators (GEI) Model CARICOM Gender Equality, Social Justice and Development Plan of Action PAHO document CD53/10 rev.1, Plan of Action on HiAP (2014) WHO HiAP Training Manual (2015) 2009 CARICOM Regional Special Topic Monograph on Gender and Development Issue ECLAC 2015 Subregional Synthesis Report on Implementation of the Beijing Declaration and Platform for Action http://repositorio.cepal.org/bitstream/handle/11362/39054/S1500700_en.pdf?sequence=1 **SDG Targets** **1.3, 5.1, 5.c, 10.2** **UN MSDF Outcomes** **1.1, 1.2, 2.1, 2.2, 3.1, 3.2, 4.1, 4.2**

* Draft UN MSDF, as at 13 May 2016.

Table 13. PAHO/WHO'S CARIBBEAN Subregional STRATEGIC AGENDA, 2016-2019 *(continued)*

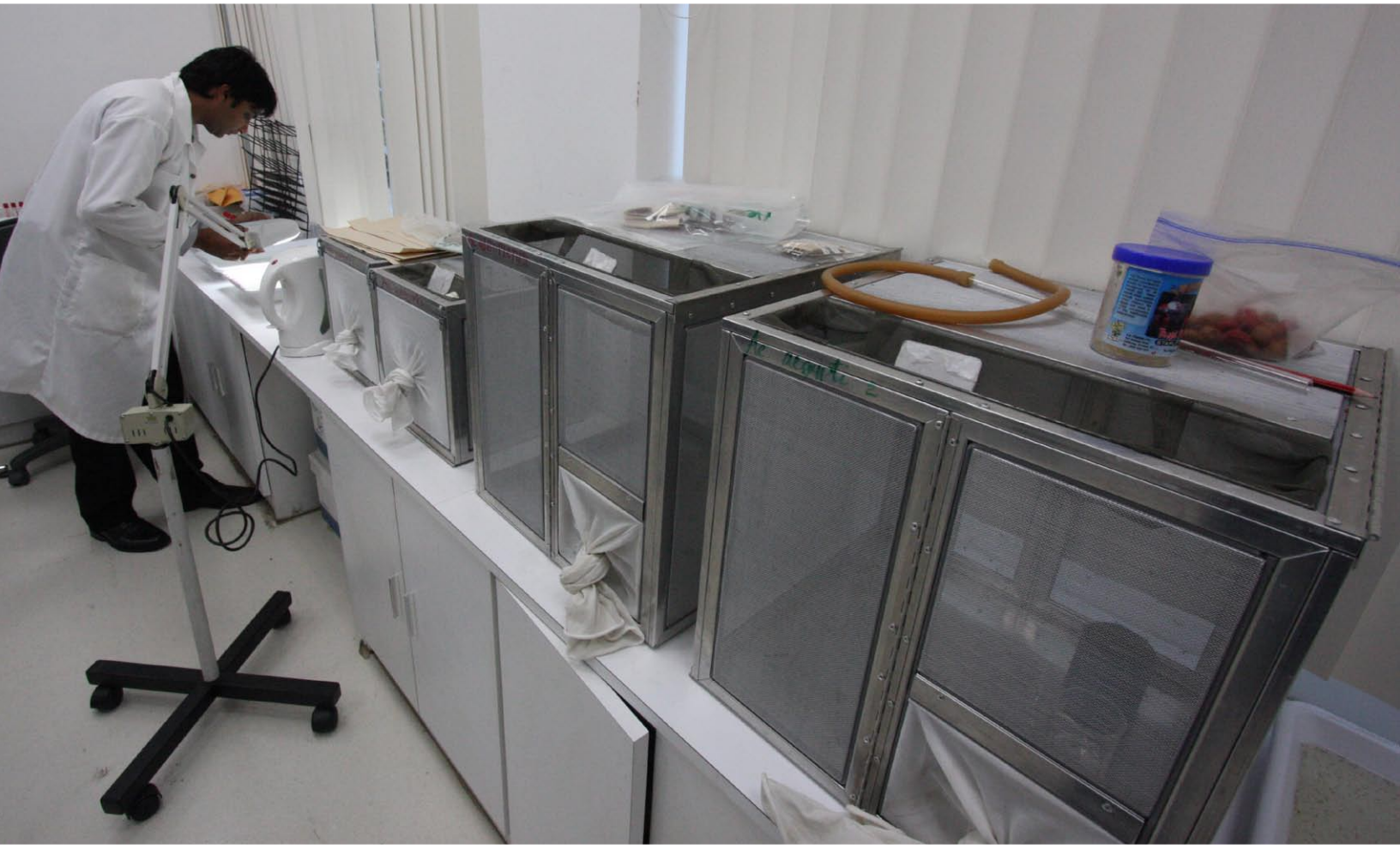
CCH IV Strategic Priority 4: Data and evidence for decision-making and accountability SCS Strategic Priority 4: Health information systems and research					
SCS Focus Areas	**PAHO Strategic Plan Categories/Programme Areas**	**PAHO Program Budget 2016-17 Outcomes (OCMs)/Indicators**	**PAHO/WHO Core Function(s)**	**Lead/Partners**	**Comments/Selected references, including SDG targets related to FAs and UN MSDF Outcomes ***
4.1 Health information for equity and evidence-based decision-making – Establishment of a regional clearing-house for information on subregional health priorities to which all countries contribute quality data for the regular and timely analysis, monitoring, and reporting of health information and trends in the health situation in the Caribbean, including the social determinants of health	**Category 4:** Health systems ***Programme Area:*** **4.4** Health systems information and evidence	**OCM 4.4** All countries have functioning health information and health research systems **4.4.1** Number of countries and territories that have increased coverage and improved quality of their national health information systems **4.4.2** Number of countries and territories with functional mechanism for governance of health research	Research and knowledge dissemination Monitoring health situation and trends TC for sustainable institutional capacity	**Lead:** CARPHA **Partners:** Member States, CARICOM Regional Statistics Program, PAHO/WHO, including BIREME, other UN agencies, UWI, national universities, HCC and other CSOs, international organisations and agencies, e.g. CDC	CARICOM Common Core of Quality Statistics Gender Equality Indicators Model Applicable indicators in the SDGs, regional and subregional NCD plans and frameworks, and subregional, regional and global HIV plans ENHR as a guide for subregional approach to operational research Caribbean Knowledge and Learning Network **SDG Targets 12.8, 16.10, 17.18, 17.19** **UN MSDF Outcome 2.2**
4.2 Research – Identification of areas and possible sources of financing for operational research into health systems in the Caribbean, and development of relevant research guidelines and protocols					
4.3 Knowledge management – Establishment of a regional virtual platform for information-sharing – including on successes and lessons learnt – and knowledge management, to which Member States and key stakeholders have access					

* Draft UN MSDF, as at 13 May 2016.

Table 13. PAHO/WHO'S CARIBBEAN Subregional STRATEGIC AGENDA, 2016-2019 *(continued)*

CCH IV Strategic Priority 5: Partnerships and resource mobilisation for health SCS Strategic Priority 5: Partnerships, resource mobilisation, and cooperation among countries for health development					
SCS Focus Areas	**PAHO Strategic Plan Categories/Programme Areas**	**PAHO Program Budget 2016-17 Outcomes (OCMs)/Indicators**	**PAHO/WHO Core Function(s)**	**Lead/Partners**	**Comments/Selected references, including SDG targets related to FAs and UN MSDF Outcomes ***
5.1 Cooperation among countries for health development (CCHD) – Promoting and contributing to South-South and triangular cooperation, in the framework of the 2013 PAHO Cooperation for Health Development policy	**Category 6:** Corporate services/enabling functions ***Programme Area:*** **6.3** Strategic planning, resource coordination, and reporting	OCM 6.3 Financing and resource allocation aligned with priorities and health needs of the Member States in a Results-based Management framework **6.3.1** Percentage of approved PAHO budget funded **6.3.2** Percentage of outcome indicator targets achieved	Leadership and partnerships Research and knowledge dissemination TC for sustainable institutional capacity	**Lead:** PAHO/WHO **Partners:** Member States; CARICOM; CARPHA; international agencies and organisations, including UN agencies, e.g. UN Office of South-South Cooperation; other stakeholders; CSOs	Adequate financial, human, infrastructural, administrative and other resources for successful SCS implementation will be critical, including access to necessary technical competencies, buy-in of internal and external stakeholders, and strong, mutually beneficial partnerships **SDG Targets 17.1, 17.3, 17.6, 17.9, 17.16, 17.19**
5.2 Resource mobilisation – Strengthening collaboration and resource mobilisation with the UN system and with other traditional partners, and establishing new partnerships					
5.3 Strategic communication - Development and implementation of a communication strategy for the SCS and PAHO/WHO's TC targeting a wide range of stakeholders	**Category 6:** Corporate services/enabling functions ***Programme Area:*** **6.5** Strategic communication	**OCM 6.5** Improved public and stakeholders' understanding of the work of PAHO/WHO **6.5.1** Percentage of Member States and other stakeholder representatives evaluating WHO/PAHO performance as excellent or good			
5.4 Programme implementation and assessment – Efficient and effective implementation, monitoring and evaluation of the SCS	**Category 6:** Corporate services/enabling functions Programme Area: **6.4** Management and administration	**OCM 6.4** Effective management and administration across the three levels of the organisation **6.4.1** Proportion of management and administration metrics (as developed in Service Level Agreements) achieved			

* Draft UN MSDF, as at 13 May 2016.



CHAPTER 5 IMPLEMENTING the STRATEGIC AGENDA: IMPLICATIONS for the ENTIRE SECRETARIAT

The successful implementation of the Strategic Agenda depends not only on identifying the results chain that will lead to the desired health outcomes, but also on the efficiency and effectiveness of organisational strategies and mechanisms that are addressed in Category 6 of the PAHO Strategic Plan 2014-2019. The organisation's leadership and governance; transparency, accountability and risk management; strategic planning, resource coordination and reporting; management and administration; and strategic communication are all important factors for effective SCS implementation.

5.1 Human resources

The SCS SPs and FAs demand continuous and integrated technical functions to undertake and coordinate actions in the following themes:

1. Health systems, including health financing; appropriate medicines and technologies, and their regulation; human resources for health; health services; health information systems, research, and knowledge management
2. Environmental health and sustainability, including water, sanitation and hygiene; climate change adaptation; and disaster risk reduction and response
3. Non-communicable diseases and risk factor prevention and control; mental health; violence and injury prevention; and health promotion
4. Communicable diseases, including HIV, IHR (2005) core capacity, alert and response, emerging and re-emerging diseases, food safety and the human-animal interface
5. Health throughout the life course, including interventions targeting specific population groups, multi-sectoral action, social determinants of health, health in all policies, and PAHO's cross-cutting themes
6. Strategic partnerships, resource mobilisation and communication

Technical functions can be performed by core, full-time subregional staff based in Barbados or other Caribbean countries; regional decentralised advisors based in the Caribbean or other countries; regional advisors based in PAHO Headquarters, Washington, D.C.; country advisors; temporary staff such as consultants; staff seconded from other institutions; and/or staff of close collaborators such as CARPHA and other UN agencies, depending on the specific deliverables and time frames for their production. However, **it is advisable that the SPC-CRB ensure the availability of full-time technical expertise in the six areas mentioned above**, to address as many of the topics included as possible.

It is not realistic to expect one technical advisor to have all the competences needed to address all of the topics included under a specific focus area. The SPC-CRB would therefore need to explore options within and outside of the organisation to procure expertise for the production of deliverables in the BWP that are outside the spheres of competence of the full-time subregional advisors, as they relate to the respective FAs. **Table 14** suggests how the FAs may be addressed using expertise available within, and outside, PAHO/WHO.

CHAPTER 5- IMPLEMENTING the STRATEGIC AGENDA: IMPLICATIONS for the ENTIRE SECRETARIAT *(continued)*

Table 14. Possible configuration of technical functions and HR categories for SCS implementation

Summary of Focus Areas	Technical functions/categories	Comments
1. Health systems, including health financing; appropriate medicines and technologies, and their regulation; human resources for health; health services; health information systems, research, and knowledge management	Advisor, Health Systems and Services	Already exists in SPC-CRB – **maintain**
	Advisor, Human Resources for Health	Already exists in SPC-CRB – **maintain**
	Advisor, Health Information Systems	**To be established in SPC-CRB**
	Regional Advisors, HSS and CHA, PAHO HQ	Involve expertise as needed
	Regional Advisors, BIREME	Involve expertise as needed
	PAHO CO staff, WHO staff, Consultants, Temporary Advisors, Secondments, CARPHA staff, Staff of other institutions	**Expertise to be procured as a priority**, pending establishment of function in SPC-CRB
2. Environmental health and sustainability, including water, sanitation, and hygiene; climate change adaptation; and disaster risk reduction and response	Advisor, Water, Sanitation, and Environmental Health	Already exists in SPC-CRB - **maintain**
	Regional Decentralised Advisors, PED	Already based in SPC-CRB – **maintain**
	CCCCC staff, UNEP staff, WHO staff Consultants, Temporary Advisors, Secondments, CARPHA staff, Staff of other institutions	Involve expertise as needed
3. Non-communicable diseases and risk factor prevention and control; mental health; violence and injury prevention; and health promotion	Advisor, Non-communicable Diseases and Mental Health	**To be established in SPC-CRB**
	Regional Decentralized Advisor, Food and Nutrition	Already exists, based in PAHO/WHO, Jamaica – **maintain**
	Regional Advisor(s), NMH, PAHO HQ	Involve expertise as needed
	PAHO CO staff, WHO staff, Consultants, Temporary Advisors, Secondments, CARPHA staff, Staff of other institutions	Expertise to be procured as a priority, pending establishment of function in SPC-CRB
4. Communicable diseases, including HIV, IHR (2005) core capacity, alert and response, emerging and re-emerging diseases, food safety and the human-animal interface	Advisor, Disease Surveillance and Epidemiology	Already exists, based in PAHO/WHO Trinidad & Tobago – **maintain**
	Advisor, Veterinary Public Health	Already exists, based in PAHO/WHO Trinidad & Tobago – **maintain**
	Advisor, HIV/STI/VH	Already exists in SPC-CRB – **maintain. See comment immediately below**
	Advisor, Communicable Diseases	**To be established in SPC-CRB**. Consider re-profiling and re-titling Advisor HIV/STI/VH to address wider remit of communicable diseases
	Regional Decentralized Advisor, Immunization	Already exists, based in PAHO/WHO Jamaica – **maintain**
	Regional Decentralized Advisor, HIV/STI/Viral Hepatitis (VH)	Already based in SPC-CRB - **limited duration**
	Regional Advisor(s), CHA, PAHO HQ	Involve expertise as needed
	PAHO CO staff, WHO staff, Consultants, Temporary Advisors, Secondments, CARPHA staff, Staff of other institutions	Involve expertise as needed

Table 14. Possible configuration of technical functions and HR categories for SCS implementation *(continued)*

Summary of Focus Areas	Technical functions/categories	Comments
5. Health throughout the life course, including interventions targeting specific population groups, multi-sectoral action, social determinants of health, health in all policies and PAHO's cross-cutting themes	Advisor, Health throughout the Life Course	**To be established in SPC-CRB**
	Regional Advisor(s), FGL and FGL/GD, PAHO HQ	Involve expertise as needed
	PAHO CO staff, WHO staff, Consultants, Temporary Advisors, Secondments, Staff of other institutions	**Expertise to be procured as a priority**, pending establishment of function in SPC-CRB
6. Strategic partnerships, resource mobilisation and communication	Advisor, Strategic Partnerships, Resource Mobilisation, and Communication	**To be established in SPC-CRB**
	Regional Advisor(s), ERP and CMU, PAHO HQ	Involve expertise as needed
	PAHO CO staff, WHO staff, Consultants, Temporary Advisors, Secondment, Staff of other institutions	**Expertise to be procured as a priority**, pending establishment of function in SPC-CRB

5.2 Financial resources

The allocation to the SPC-CRB from the organisation's regular budget should, ideally, be based on realistic SPC-CRB budgeting in planning the respective BWPs and should not fall below the average allocation in the biennia covered by the previous SCS.

5.3 Administrative processes

BWP planning, programming, implementation, monitoring, evaluation and reporting will be done according to the organisation's statutory requirements and guidelines, using the PAHO Management Information System (PMIS). Development, approval and implementation of the mandatory human resources and risk management plans will be critical to the success of the SCS.

5.4 Resource mobilisation

Resource mobilisation and the use of Other Sources funds to supplement the RB allocation will be a very important success factor in SCS implementation. The creation of the post of Advisor, Strategic Partnerships, Resource Mobilisation, and Communication, as proposed above, will allow focus on this function, carried out in collaboration with ERP, the PAHO Foundation, WHO, other UN agencies and diverse partners with interests that converge with the SCS.

5.5 Technical cooperation mechanisms

Use of existing frameworks/agreements

The use of existing agreements, protocols, guidelines and other frameworks for action in health at Caribbean subregional level has been emphasised in Chapter 3. Building on previous initiatives and interventions provides continuity, avoids "re-inventing the wheel" and allows counterparts and partners to see how new initiatives complement work previously done.

Advocacy

There is ample opportunity for advocacy with high-level CARICOM Councils, including the COHSOD (Health and Education), COTED and COFCOR, PAHO and WHO governing bodies, high-level task forces and UN subregional and country teams – among others – for health and the multi-sectoral, Health in All Policies and social determinants of health approach. These cross-cutting themes are essential to address most of the SPs and FAs in the SCS.

Partnerships

Traditional partnerships remain important, but the establishment of new partnerships, including with CSOs and the private sector, will be critical. As the Caribbean moves towards UAH-UHC, NCD prevention and control, and other priorities, the private sector is an increasingly important partner. WHO's Framework for Engagement with Non-State Parties[231] provides guidance on collaboration with the private sector.

CCHD

Cooperation amongst countries for health development will be an important TC mechanism, as countries seek to learn from, and share resources with each other, including cooperation among subregional mechanisms. It is important that experiences and resources (technical and financial) from outside the Caribbean sub-region be taken into consideration when addressing the SPs and FAs. Links between CARICOM and other integration entities, as well as PAHO's subregional TC in and with other sub-regions, are enabling factors for rich exchanges. PAHO/WHO's global reach and UN membership, with access to the UNOSSC, also add value to its important facilitating role.

Key Countries

Three of PAHO's eight key countries – Guyana, Haiti and Suriname – are in the Caribbean, and in keeping with the 2015 PAHO Key Country Strategy,[232] they should also be given special consideration in the subregional approach.

5.6 Promotion and communication of the SCS

This aspect of SCS implementation must be emphasised, as it was one of the weaknesses noted in the previous SCS cycle. As reflected in FA 5.3 of the Strategic Agenda, the development and implementation of a strategic communication strategy is imperative, and relevant resources must be allocated and/or mobilised. The SCS can be excerpted and packaged to suit various audiences, using face-to-face and virtual meetings, the internet and the PAHO intranet, high-level briefs and social media. The proposed Advisor, Strategic Partnerships, Resource Mobilisation, and Communication will have an important role to play, in collaboration with the PAHO CMU, PWRs and partners. The SCS and its concise derivative, the SCS Brief, represent the first two products in the promotion and communication of the SCS.

5.7 Collaboration with CARPHA

The Strategic Agenda includes several focus areas for PAHO/WHO's collaboration with CARPHA. **Table 15** proposes CARPHA's roles and responsibilities related to the SCS Focus Areas, which will be reflected in the PAHO/WHO-CARPHA workplans for the period of the SCS, with agreed mechanisms for collaboration, including but not limited to, three-monthly video conferences; six-monthly PMAs; annual face-to-face meetings; and protocols for the dissemination of joint and individual communications to member states.

231 Available at http://www.who.int/about/collaborations/non-state-actors/en/, accessed 27 March 2016.

232 The Key Country Strategy is available through the PAHO Office of Country and Subregional Coordination, Washington, D.C.

Table 15. SCS Focus Areas and CARPHA's proposed roles and responsibilities

SCS Focus Area	CARPHA's roles and responsibilities	Comments
Human resources for health	Training in surveillance, laboratory, epidemiology and related areas	Focus on IHR core capacities
Equitable, integrated health services networks	Establishment of quality, laboratory services in countries; strengthening the Caribbean Public Health Laboratory Network; laboratory quality control oversight; strengthening the CARPHA reference laboratory	
Environmental health and sustainability	Laboratory testing for toxins, hazardous substances; collaboration with laboratories outside the Caribbean as needed for relevant testing	Capability for biohazard testing important
Climate change adaptation for health	Surveillance and laboratory-related aspects, such as those related to vector-borne diseases	CCCCC is an important partner
Disaster preparedness, mitigation and response	*Preparedness and mitigation*: Assessment of laboratory equipment, infrastructure, quality control, capacity-building in quality assurance and safety Response: Member of Rapid Response Team, support for national Health Emergency Operations Centre, activation of laboratory network, advice on infrastructure recovery, provision of human resources, public health risk assessment, testing of samples, surveillance and information management	CDEMA is an important partner
NCDs and their risk factors, mental health, violence and injury prevention	Surveillance, epidemiology, laboratory, evidence for decision-making and monitoring and evaluation	Indicators already agreed at global and regional (The Americas) level should be integrated to the extent possible
Communicable diseases	Surveillance, epidemiology, laboratory, evidence for decision-making and monitoring and evaluation; research; resistance studies, including insecticide resistance; integrated vector control; public awareness; advocacy; tourism and health; training	
Social determinants of health	Disaggregated epidemiological data and relevant reporting	Obtaining information from sectors other than Health will be critical
Health information for equity and evidence-based decision-making	Disaggregated epidemiological data and relevant reporting; establishment of national and regional information systems and platforms	Use of web-based and other electronic platforms will be crucial
Research	Identification of, and contribution to, priority research topics at national and regional levels	The principles of Essential National Health Research will be applied
Knowledge management	Establishment of regional platform for information and knowledge-sharing	Use of web-based and other electronic platforms, as well as joint communication strategies, will be crucial

5.8 Conclusion

It cannot be overstated that the implementation of the SCS, though led and coordinated by the SPC-CRB, is the responsibility of the entire organisation – PAHO and WHO – in collaboration with key partners. Proactive communication and outreach in ensuring such an approach are critical success factors.

CHAPTER 6 MONITORING and EVALUATION of the SCS

Periodic assessment of the SCS will facilitate its efficient and effective implementation. Assessment mechanisms and tools will be integrated with PAHO/WHO organisational procedures and processes to the extent possible, to avoid duplication. The matrix of the Strategic Agenda presented in Chapter 4 will be built on to include related elements lower in the results chain hierarchy – outputs and deliverables,[233] and amended to provide a format for summary reporting. The report will be based on the implementation of the PAHO/WHO Caribbean BWP and will include the contributions of other organisational entities and partners.

6.1 Monitoring

Monitoring will take place concurrent with PAHO's 6-monthly performance monitoring assessments (PMAs). Documentation of the provision of deliverables and progress in achievement of the outputs, based on the relevant indicators, will assess progress in the FAs and the SPs. These will be highlighted as part of the PMA report, in addition to gaps, lessons learnt and budgetary execution. Summary reports of progress in the FAs will be communicated to internal stakeholders and key stakeholders, including the CARICOM Secretariat, CARPHA, Chief Medical Officers in CARICOM Member States and the CARICOM COHSOD or Caucus of Ministers of Health, at the annual meeting convened before the PAHO Directing Council.

6.2 Mid-term review

Near the end of 2017, this review will be concurrent with the end-of-biennium assessment for 2016-2017. The process will involve both internal and external stakeholders and address various factors, including:

- Continued relevance of Strategic Priorities and FAs to subregional health and development priorities and CCH IV implementation
- Progress in FAs – successes, challenges, lessons learnt and gaps
- Financial expenditure in the FAs
- Resources and technical contributions received from other levels of PAHO/WHO
- Resources – human and financial – mobilised externally, and partnerships established and working effectively, including with UN agencies, funds and programmes
- Promotion of the SCS throughout the organisation and externally
- Use of the SCS as a tool for operational planning, advocacy and resource mobilisation within PAHO/WHO
- Degree of dissemination and promotion of the SCS, and the extent to which external stakeholders, including other UN agencies, funds and programmes, are aware of and use, the SCS

233 Deliverables comprise Products and Services to achieve the Outputs.

CHAPTER 6- MONITORING and EVALUATION of the SCS *(continued)*

6.3 Final evaluation

Near the end of 2019, to be concurrent with end-of biennium assessment for 2018-19 and involving both internal and external stakeholders, this evaluation should be guided by the principles of the 2013 WHO Evaluation Practice Handbook[234] and consider, among other issues:

- Relevance, efficiency, effectiveness and impact – contribution to the respective outcomes of the PAHO Program Budget and the implementation of CCH IV, and areas for continued focus or "sunsetting" in the next SCS cycle
- Use of the strategic agenda in planning, budgeting and allocation/mobilisation of resources, including human resources within PAHO/WHO
- Financial resources received and expended in addressing the FAs
- Type and timeliness of contributions from other levels of PAHO/WHO
- Contributions from development partners, including UN agencies, funds and programmes
- Degree of dissemination and promotion of the SCS, and the extent to which external stakeholders are aware of and use, the SCS
- Contribution of the SCS to the UN MSDF implementation, in collaboration with PWRs
- Influence of the SCS on WHO's performance at country level, in collaboration with PWRs
- Recommendations for the next SCS cycle, including health and development priorities and strategies for strengthening PAHO/WHO's TC and performance

6.4 Conclusion

The draft mid-term review and evaluation reports will be shared throughout the PAHO/WHO Secretariat and with selected stakeholders for comments and input. The final reports will be shared throughout the Secretariat and with a wide range of stakeholders, including national counterparts, other UN agencies, funds and programmes, and other development partners.

234 WHO. Evaluation Practice Handbook. Geneva, WHO, 2013. Available at http://apps.who.int/iris/bitstream/10665/96311/1/9789241548687_eng.pdf, accessed 9 May 2016.

ANNEXES

ANNEX A

SUMMARY of SCS DEVELOPMENT PROCESS

The development process was a participatory one, involving consultations with key stakeholders in Caribbean health, including the Caribbean Community (CARICOM) and its health-related institutions; the United Nations (UN) system; Ministry of Health representatives; the WHO Department of Collaboration with Countries and the UN System (CCU), Geneva; and PAHO/WHO staff at country, subregional and regional levels.

Under the direction and guidance of the Subregional Program Coordinator, Caribbean, first and second drafts of the SCS were developed based on a desk review of documents and research for relevant information; discussions with technical advisors; the results of a questionnaire disseminated to key stakeholders on the previous SCS and recommendations for the new SCS, using SurveyMonkey and taking advantage of on-going face-to-face meetings; and discussions held with selected stakeholders, taking advantage of meetings being held in various countries for cost-efficiency.

In collaboration with the team of the PAHO/WHO SPC-CRB: the Health and Development Programme at the CARICOM Secretariat, the PWRs in the Caribbean, CSC and technical departments at PAHO Headquarters and the CCU, the second draft was revised incorporating input obtained as appropriate. Third and fourth drafts were reviewed internally, edited and revised, and the fifth draft sent for review by a wide range of stakeholders, including CARICOM, CARPHA, Ministries of Health and other national counterparts, development partners – including UN partners and civil society representatives – UWI, PWRs and PAHO technical entities.

The Strategic Priorities (SPs) and Focus Areas (FAs) for the SCS were agreed based on the analyses in Chapters 2 and 3, recommendations from stakeholders via the SCS survey, the findings of the CCH III evaluation, the process to develop CCH IV and validation of the draft SPs and FAs by technical advisors at subregional, regional and national levels.

The penultimate draft of the SCS was fine-tuned based on the CCH IV priorities approved by the CARICOM COHSOD in September 2016. The document was then approved by the Director of PAHO, finalised and published.

ANNEX B

2030 SUSTAINABLE DEVELOPMENT GOALS and SELECTED SUMMARISED TARGETS RELATED TO HEALTH

Goal 1 *End poverty in all its forms everywhere*

- 1.3 Implement nationally appropriate social protection systems and measures for all, including floors, and achieve substantial coverage of the poor and the vulnerable
- 1.5 Build the resilience of the poor and those in vulnerable situations and reduce their exposure and vulnerability to climate-related extreme events and other economic, social and environmental shocks and disasters

Goal 2 *End hunger, achieve food security and improved nutrition, and promote sustainable agriculture*

- 2.1 End hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round
- 2.2 End all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons
- 2.4 Ensure sustainable food production systems and implement resilient agricultural practices that increase productivity and production, that help maintain ecosystems, that strengthen capacity for adaptation to climate change, extreme weather, drought, flooding and other disasters and that progressively improve land and soil quality

Goal 3 *Ensure healthy lives and promote well-being for all at all ages*

- 3.1 Reduce maternal mortality
- 3.2 End preventable deaths of newborns and children under 5 years of age
- 3.3 End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, and combat hepatitis, water-borne diseases and other communicable diseases
- 3.4 Reduce premature mortality from NCDs and promote mental health
- 3.5 Strengthen prevention and treatment of substance abuse, including narcotic drugs and harmful use of alcohol
- 3.6 Halve the number of global deaths and injuries from road traffic accidents
- 3.7 Ensure universal access to sexual and reproductive healthcare services
- 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services, and to safe, effective, quality and affordable essential medicines and vaccines
- 3.9 Reduce deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
- 3.a Strengthen the implementation of the Framework Convention on Tobacco Control
- 3.b Support research and development of vaccines and medicines for communicable and non-communicable diseases
- 3.c Increase health financing and the recruitment, development, training and retention of the health workforce in developing countries
- 3.d Strengthen countries' capacities for early warning, risk reduction and management of national and global health risks

Goal 4 *Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all*

- 4.7 Ensure that all learners acquire knowledge and skills to promote sustainable development, including through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity

2030 SUSTAINABLE DEVELOPMENT GOALS and SELECTED SUMMARISED TARGETS RELATED TO HEALTH *(continued)*

Goal 5		*Achieve gender equality and empower all women and girls*
	5.2	Eliminate all forms of violence against women and girls
	5.6	Ensure universal access to sexual and reproductive health
	5.c	Adopt and strengthen policies and legislation for the promotion of gender equality and the empowerment of all women and girls at all levels
Goal 6		*Ensure availability and sustainable management of water and sanitation for all*
	6.1	Achieve universal and equitable access to safe and affordable drinking water
	6.2	Achieve access to adequate and equitable sanitation and hygiene
	6.3	Improve water quality
	6.a	Expand international cooperation and capacity-building support to developing countries in water- and sanitation-related activities and programmes
	6.b	Strengthen the participation of local communities in improving water and sanitation management
Goal 7		*Ensure access to affordable, reliable, sustainable and modern energy for all*
Goal 8		*Promote sustained, inclusive and sustainable economic growth, full and productive employment, and decent work for all*
Goal 9		*Build resilient infrastructure, promote inclusive and sustainable industrialisation, and foster innovation*
Goal 10		*Reduce inequality within and among countries*
	10.2	Empower and promote social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status
	10.3	Reduce inequalities of outcome
Goal 11		*Make cities and human settlements inclusive, safe, resilient and sustainable*
	11.2	Improve road safety, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons
	11.5	Reduce deaths from, and people affected by, disasters, with focus on protecting the poor and people in vulnerable situations
	11.7	Provide access to safe, inclusive and accessible green and public spaces
	11.b	Increase adoption and implementation of policies and plans in line with the Sendai Framework for Disaster Risk Reduction 2015-2030
Goal 12		*Ensure sustainable consumption and production patterns*
	12.4	Achieve environmentally sound management of chemicals and all wastes throughout their life cycle in accordance with agreed international frameworks, and significantly reduce their release to air, water and soil in order to minimise their adverse impacts on human health and the environment
	12.5	Reduce waste generation
	12.7	Promote sustainable public procurement practices
	12.8	Ensure that people have relevant information and awareness for sustainable development and lifestyles in harmony with nature

2030 SUSTAINABLE DEVELOPMENT GOALS and SELECTED SUMMARISED TARGETS RELATED TO HEALTH *(continued)*

Goal 13 *Take urgent action to combat climate change and its impacts**

- 13.1 Strengthen resilience and adaptive capacity to climate-related hazards and natural disasters
- 13.2 Integrate climate change measures into national policies, strategies and planning
- 13.3 Improve education, awareness and institutional capacity on climate change mitigation, adaptation, impact reduction and early warning
- 13.a Implement commitment of developed-country parties to the UNFCCC to resource mobilisation to address the needs of developing countries
- 13.b Promote mechanisms for raising capacity for effective climate change-related planning and management in least developed countries and SIDS

Goal 14 *Conserve and sustainably use the oceans, seas and marine resources for sustainable development*

Goal 15 *Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss*

Goal 16 *Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective accountable and inclusive institutions at all levels*

- 16.1 Reduce all forms of violence and related death rates
- 16.10 Ensure public access to information and protect fundamental freedoms in accordance with national legislation and international agreements

Goal 17 *Strengthen the means of implementation and revitalise the Global Partnership for Sustainable Development*

- 17.1 Strengthen domestic resource mobilisation, including international support to developing countries
- 17.3 Mobilise additional financial resources for developing countries from multiple sources
- 17.6 Enhance North-South, South-South, and triangular regional and international cooperation on, and access to, science, technology and innovation, and enhance knowledge-sharing on mutually agreed terms, including through improved coordination among existing mechanisms, in particular at the UN level
- 17.9 Enhance international support for implementing effective and targeted capacity-building in developing countries to support national plans to implement all the SDGs, including through North-South, South-South and triangular cooperation
- 17.16 Enhance the Global Partnership for Sustainable Development, complemented by multi-stakeholder partnerships that mobilise and share knowledge, expertise, technology and financial resources, to support SDG achievement
- 17.17 Encourage and promote effective public, public-private and civil society partnerships
- 17.18 Increase the availability of high-quality, timely and reliable disaggregated data
- 17.19 Develop measurements of progress on sustainable development that complement GDP, and support statistical capacity-building in developing countries

Annex C (Adapted from: Public Health Group, UWI, Cave Hill, Barbados)

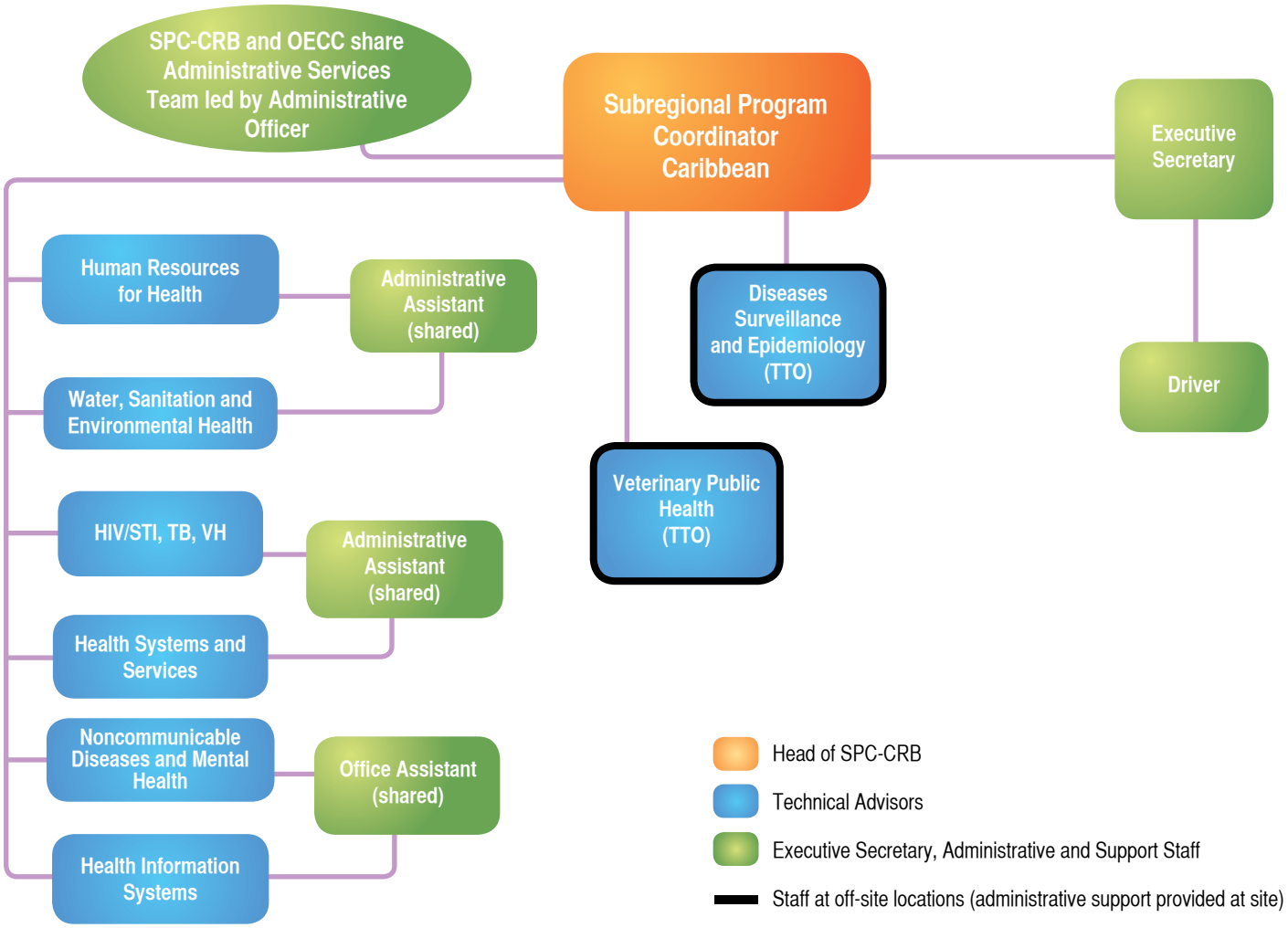
Implementation of CARICOM POS NCD Summit Declaration – NCD Progress Indicator Status/Capacity by Country: Updated: September 2014; September 2015

Legend: ✓ In place ± In process/partial X Not in place * Not applicable - No information *Changed since last year*

	NCD Progress Indicator	AIA	ATG	BHS	BRB	BLZ	BMU	VBG	CYM	DMA	GRD	GUY	HTI	JAM	MSR	KNA	LCA	VCT	SUR	TTO	TCA
	COMMITMENT																				
1, 14	NCD Plan	±	±	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	±	✓	✓	✓	✓	✓	±
4	NCD Budget	X	±	✓	✓	X	X	X	✓	±	✓	✓	X	✓	X	±	✓	X	✓	✓	✓
2	NCD Summit convened	X	✓	✓	✓	X	✓	✓	X	✓	✓	✓	X	✓	✓	✓	✓	±	✓	✓	X
2	Multi-sectoral NCD Commission appointed and functional	±	±	✓	✓	±	v	✓	X	±	✓	✓	X	✓	X	±	✓	±	±	✓	X
	TOBACCO																				
3	FCTC ratified	*	✓	✓	✓	✓	*	*	✓	✓	✓	✓	X	✓	*	✓	✓	✓	✓	✓	*
3	Tobacco taxes >50% sale price	✓	X	±	✓	X	-	X	✓	✓	✓	✓	X	X	X	±	±	X	✓	X	±
3	Smoke-free indoor public places	X	✓	±	✓	±	✓	✓	✓	±	✓	✓	X	✓	X	±	±	X	✓	✓	±
3	Advertising, promotion, and sponsorship bans	X	X	±	X	X	✓	✓	✓	X	X	±	X	±	X	X	±	X	✓	✓	±
	NUTRITION																				
7	Multi-sector Food and Nutrition Plan implemented	±	✓	✓	✓	±	-	✓	X	✓	✓	✓	X	✓	✓	±	±	✓	X	±	±
7	Trans-fat free food supply	X	X	X	X	X	±	X	X	X	X	X	X	±	X	X	X	X	X	±	X
7	Policy and standards promoting healthy eating in schools implemented	±	✓	✓	✓	±	✓	X	✓	±	±	±	X	✓	±	±	±	±	X	±	±
8	Trade agreements utilised to meet national food security and health goals	X	X	X	X	X	X	X	X	X	X	±	X	±	X	±	X	X	X	✓	X
9	Mandatory labelling of packaged foods for nutrition content	X	X	X	±	X	±	X	±	±	X	±	X	±	X	X	X	X	±	X	X
	PHYSICAL ACTIVITY																				
6	Mandatory physical activity in all grades in schools	✓	✓	✓	✓	✓	±	±	✓	✓	✓	±	X	±	X	-	±	X	X	✓	✓
10	Mandatory provision of physical activity in new housing developments	X	-	✓	✓	✓	-	-	X	X	X	±	X	±	±	-	X	X	X	X	X
10	On-going, mass physical activity or new public physical activity spaces	X	✓	✓	✓	✓	✓	±	✓	✓	✓	✓	X	✓	±	✓	✓	✓	✓	✓	X
	EDUCATION/PROMOTION																				
12	NCD communications plan	X	X	±	✓	X	✓	✓	✓	±	±	✓	X	±	X	±	X	±	±	✓	✓
15	Caribbean Wellness Day multi-sectoral, multi-focal celebrations	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	±	✓	✓	✓	✓	✓	✓
10	≥50% of public and private institutions with physical activity and healthy eating programmes	±	✓	X	X	X	±	X	±	X	-	±	X	✓	±	X	±	±	X	±	±
12	≥30% days media broadcasts on NCD control/year (risk factors and treatment)	X	✓	X	✓	X	✓	X	✓	±	-	✓	X	✓	X	±	✓	±	✓	✓	±
	SURVEILLANCE																				
11, 13, 14	STEPS or equivalent survey	X	X	✓	✓	✓	✓	✓	✓	✓	✓	±	X	✓	±	✓	✓	±	✓	✓	±
	Minimum Data Set reporting	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	±	X	✓	±	X	✓	✓	✓	✓	X
	Global Youth Tobacco Survey	X	✓	✓	✓	✓	±	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	X
	Global School Health Survey	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	X	✓	±	✓	✓	✓	✓	✓	X
	TREATMENT																				
5	Chronic Care Model/NCD treatment protocols in ≥50% PHC facilities	X	✓	✓	±	±	±	±	±	±	✓	±	X	✓	±	±	✓	±	±	✓	X
5	Quality of care CVD or diabetes demonstration project	±	✓	✓	✓	±	±	±	✓	X	✓	✓	±	✓	X	X	✓	±	✓	✓	X

ANNEX D

PAHO/WHO Office of Subregional Program Coordination, Caribbean (SPC-CRB)- Barbados
Organizational Chart, March 2016



WORKING for HEALTH in the CARIBBEAN

PAHO/WHO SUBREGIONAL COOPERATION STRATEGY · 2016-2019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