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REPORT TO THE DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU OF THE EVALUATION TEAM ON THE REVIEW OF THE CARIBBEAN EPIDEMIOLOGY CENTER (CAREC) 1974-1979

The evaluation procedure at CAREC, which coincided with the Mid-term Review (1974-1979), was initiated in March 1979 with the self-audit. The Evaluation Team[1] identified 10 key issues, which the Director submitted to the participating Governments and institutions in August 1979 for study and response. Replies have been slow coming in. Lacking responses from nine Governments and CARICOM, a preliminary report was submitted to the 84th Meeting of the Executive Committee (June 1980). In the absence of further information, this report is submitted to the Directing Council (Document CD27/23, ADD. I) with an elaboration of the data on which the report is based, and with observations on the comments sent to the Director of PASB by the Chairmen of the CAREC Council and Scientific Advisory Committee; by Dr. C. E. Gordon Smith, of London; and by the Center Director and staff (Annexes I and II).

The Directing Council is invited to examine the report and to determine the role of PAHO in the future development of CAREC.

Annexes

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[1]Dr. Paulo de Almeida Machado, Brazil; Dr. Laurence J. Charles, Sr., Antigua; Dr. Robert de Caires, U.S. Public Health Service; and Dr. David Sencer, former Director, Center for Disease Control, USPHS.

KEY ISSUES	RESPONSES FROM GOVERNMENTS AND ORGANIZATIONS										
1. What are the most cost-effective ways of strengthening professional managerial skills in CAREC?	Encourage nationals to take senior posts; give them preference; improve recruitment conditions.	W.I. nationals to managerial positions. Identify, recruit & train them; conditions of employment as UWI & CARICOM.	No comment.		No comment.	Include qualified, experienced managerial experts on CAREC staff.				Provide consultant to gove on-the-job training to CAREC staff.	Management training high priority in strengthening West Indian "component" of CAREC.
2. How can interrelationships of CAREC with other Caribbean governments and intergovernmental groups be expanded and improved?	Distribute reports & literature. Invite to meetings, seminars, etc.	CAREC meets requests but suggests structured relationship between CAREC, CDC/PR & UWI to conserve resources.	More contacts between senior Govt. and CAREC staffs.	Organization of meetings, seminars & short courses, provide personnel expertise in emergencies.	More frequent visits by center director or his deputy.	Biannual conferences between governments and CAREC staffs.	Continue present excellent info. exchange & support of surveillance and lab.			Provide leadership; annual specialty meetings; visiting workers. Include entire Caribbean.	Covering entire Caribbean theoretically desirable but poses language & resources problems.
3. In view of the considerable training activities already carried out by CAREC in the past 5 years, and planned through the next 5 years (to 1984), to what extent will there be a continuing need for organized training in communicable diseases in the Caribbean after 1984? If any, elaborate. If none, how can training needs best be met?	Continuing need for CAREC participation with UWI's Dept. Social & Prev. Medicine. Coordination by CAREC.	Train "trainers" but CAREC expertise will be needed for back-up & maintenance of national epidemiology units.	Need to cover staff turnover and new program skills.	Provide virology diagnosis services to Eastern Caribbean.	Continuing need for organized training of epidemiology staff, especially STD. Use UWI & CDC trn.	Refresher courses, evaluation programs & updating new techniques.		Refresher & advanced courses in surveillance and lab support.	Continuing need for CAREC role.	Continuous training in com. dis. necessary; esp. surveillance & lab.	Centralized training (CAREC) for next 3 yrs., then local institutions could do. CAREC follow-up of trainees.
4. To what extent can training needs in the Caribbean be met by strengthening existing national institutions in Barbados, Curacao, Grenada, Guyana, Jamaica and Trinidad which now provide or could provide training of health auxiliaries?	CAREC assist local institution train auxiliaries & train higher cadres. In-service training lab-techs.	National centers could be strengthened to contribute but CAREC will still be needed for superior skills.	Train "trainers" to strengthen auxiliary staff training & to evaluate their utilization.	These institutions cannot meet the needs of Caribbean now being met by CAREC.	Need PAHO/CAREC for uniformity of training but also nucleus of expertise & sharing of experiences.	Expertise in training in sewage disposal, low income housing, health ed. & food hygiene.			Quality control.	Strengthen national institutes, incl. money. Stress on training.	Small core of trainees, to keep CAREC manuals up-to-date, in local institutions. CAREC continue post-basic training.
5. Should PAHO have any role in providing academic undergraduate training in community health?	No. UWI's role but CAREC should have flexibility to assist UWI as needed.	CAREC has major role in training faculty, some teaching and specialist expertise.	Yes. Provide evaluation of trainers & training & help establish info. system.	Not for the Commonwealth Caribbean.	Provide some, perhaps by ST professorships so give students broader outlook.	Yes.				Definitely. Support at grad. & undergrad. levels. Students at CAREC perhaps w/ fin. support.	CAREC assist UWI in training, keep close links & honorary professorships; provide specialized training.
6. Is it reasonable to anticipate by 1985 the transfer of all of CAREC's laboratory activities to a subregional body (such as CARICOM) to function as a reference center?	No, no expertise. Review when UEC operational. Continuing need for CAREC.	No. Not have the resources. CAREC remain linked to PAHO for access to its broad resources, expertise.	No. There will be a continuing need to train "trainers" & nationals to cover staff turnover.	Weak national labs need supervision & quality control services from CAREC.	Would be retrogressive step and would also interfere with present efficiency.	No. CARICOM does not have expertise to satisfy these requirements.			Opposes national labs & prefers regional ref. centers.	No. Epid. center must have strong lab. support & an active ref. center. CAREC staff would be "best teachers".	CARICOM cannot. TPHL might take on lab. work, except virology (CAREC retain). PAHO/CAREC presence should be maintained.
7. To what extent could an expanded staff in the PAHO Caribbean Program Coordinator's Office be a nucleus for the provision of consultation services in communicable diseases?	Could not match CAREC flexibility, close links and response capability.	Could be complementary but could not replace CAREC. Area needs center for disease control.	Provide consultation in communicable diseases, but through the center mechanism.	Could not, as need active consultants to provide consultations.	Retain at CAREC.	Program is now effectively operated by CAREC.				Ineffective. Best consultants are active in their field on day-to-day basis. Need Center resources.	Backward step. Center staff active, collective expertise, rapid response.
8. What impact would an expansion of existing or planned academic facilities in the Caribbean have on the future of CAREC?	No projection to replace CAREC but UEC, in time, may take over some functions.	Should reduce basic training load on CAREC but academic cannot respond quickly.	Not in immediate future. CAREC's presence will avoid duplication of resources.		In parallel with but can't substitute for CAREC.	Central information center for the Caribbean.				Would strengthen CAREC role if attention to prev. med & PH. CAREC help in teaching & providing field exp.	T&T rationalizing UEC & CAREC, greater demand for teaching assistance by CAREC for some time.
9. CAREC's 1974 mandate should be achieved by 1984. Are provisions being made in national budgets to continue the development of national communicable diseases resources in the Caribbean?	Individually cannot, but collectively can sustain central mechanism and resources.	Committed to national surveillance & lab facilities within its financial constraints.	Favors subregional centers as reference centers, especially virology.		Cannot plan so far ahead but anticiapte severe budget restrictions.	Yes.			Must recruit W. Indians & achieve self-reliance.	Encourage nat'l capabilities & commitment thru local staffing & programs. Identify local funding.	Can only be answered by countries, which only budget one year ahead.
10. Given the increasing importance of extra-budgetary funds, what role do you anticipate for these funds in the future financing of the Center?	Needed for specific research projects and training programs.	Increasing role and should be energetically sought, in support of CAREC.	Flat PAHO/WHO & national budgets, seek ex-budg. funds for expansion of programs.		Would like to see used to continue its work and services.	Refresher courses in EPI; reference library; various programs & evaluation.			Use sparingly. Determine core budget & CAREC must live within its means.	May be important as nat'l budgets limited. Seek out reliable longer-term sources of ex-bud funds--prevention.	Core budget essential. Ex-budg. funds will be needed for training & research & developing greater senior staff expertise.

ELABORATION OF THE EVALUATION REPORT TO THE DIRECTOR OF PASB ON CAREC, AND OBSERVATIONS ON THE COMMENTS ON IT FROM VARIOUS SOURCES

Introduction

This report is an external evaluation submitted to the Director of the Pan American Sanitary Bureau.

A document was required for the 84th Meeting of the Executive Committee, which met 23-27 June 1980. At the time of preparation, responses to the 10 Key Issues requested in August 1979 were not available from nine Governments, the University of the West Indies, and CARICOM. Also, critically important input from the Host Government requested in January 1980 had not been received. On 19 June 1980 the Evaluation Team submitted a report to the Director of PASB. The final paragraph of the letter of transmittal reads:

> As stated in the text of the report, the conclusions and recommendations are based on the information available to us now, which is incomplete. They must therefore be regarded as preliminary. Nevertheless, we felt that it was our duty to make such recommendations as are compatible with the information available at this time.

The Team has seen the comments on the report sent to the Director of PASB from the Chairmen of CAREC's Council and Scientific Advisory Committee (SAC), from Dr. C. E. Gordon Smith, and from the Center Director and staff. The first three indicate that their comments are, to a significant degree, based on the fourth.

It appears that the report, which endeavors to point out achievements as well as areas that can be strengthened, has not been carefully studied as an entity. Rather, certain issues have been identified for comment.

General Observations

Taking the comments as a whole, it is realized that those of the Director of CAREC emphasize, rightly so, the Center itself. At the direction of the Director of PASB (to whom the Team is reporting), the Evaluation Team's effort was related to CAREC in the context of the total PAHO program.

Significant Numbers of Nationals Recruited for Senior Level Positions

Staff as of December 1979

	Position	Nationality
1.	CAREC Director	UK
2.	Assistant Director*	(Trinidad) (Director, TPHL)
3.	Laboratory: Scientist	UK (terminated)
4.	Laboratory: Scientist	UK
5.	Laboratory: Parasitologist	Trinidad
6.	Laboratory: Virologist	Trinidad
7.	Surveillance: Epidemiologist	(Trinidad)**
8.	Surveillance: Epidemiologist	Brazil
9.	Surveillance: Epidemiologist	US/CDC (seconded)
10.	Surveillance: P. H. Advisor	US/CDC (seconded)
11.	Surveillance: Statistician	UK
12-15.	Project Leaders	3 UK, 1 Trinidad

*This officer was not recruited for the position by CAREC.
**This officer assumed Trinidadian nationality through marriage.

In practical terms, even if the TPHL Director and the Trinidadian epidemiologist are included, 10 out of 15 senior-level positions are non-Caribbean. If Project Leaders are excluded, this figure is 7 out of 11. Only one country is represented from the Caribbean.

That this objective is important and as yet not achieved is evidenced by three specific references to it in the responses to the Key Issues (Trinidad and Tobago, Jamaica and the Overseas Development Administration (UK) (ODA)) and in paragraph 6.1.3 of the 6th Council meeting's minutes: "The Committee stressed again to Council the need to develop West Indians for all senior posts."

The difficulty of the task and the reasons (however valid) for failure to accomplish it during the past five years cannot change the fact that, as of 1979, this objective (unlike others) has not been achieved.

It appears to the Team that a frank statement to this effect by an external group would reinforce the position of the Council, the SAC and the Center Director in calling the attention of governments to the situation and to the actions needed to resolve it. One mechanism, if not already explored, might be to have government(s) identify a promising national(s) and request fellowship(s) for training (at CAREC and elsewhere) and then detail to CAREC.

Exceeding Goals and Objectives

This has been a significant achievement of CAREC during the past five years and was a very positive assessment and compliment to the Center. This favorable assessment appears to have been misconstrued.

Budgets, 1974-1979

The Team defined the "core" budget as the assessments of participating governments for CAREC plus that portion of the PAHO/WHO regular (assessed) budget appropriated by the Governing Bodies of PAHO for the Center in the appropriation resolution. In addition to the PAHO appropriation, the Director of PASB has the authority, within the total appropriation, to approve increases in PAHO funding for some activities at the expense of other programs. In terms of the total PAHO program, some of these increases to CAREC have had to be made under the pressure of over-the-ceiling budget submissions, without assignment of priorities.

The figures for the years 1974-1979 are set out in Table 1 for PAHO/WHO regular funds (PR/WR) and in Table 2 for Government contributions.

CAREC's "definition" of "core budget" did not take into account the PAHO contribution.

Table 1

CAREC - PAHO/WHO REGULAR FUNDS

Year	(1) PR/WR Budget from Grey Book (the appropriation yearbook	(2) Original PR/WR Operating Budget (such as ABU-1300-79)	(3) Actual PR/WR Expenditures from Financial Report	Difference (3)-(1)	(3)-(2)
	$	$	$	$	$
1974	28,087	28,087*	49,407	21,320	21,320
1975	31,400	195,569	122,468	91,068	(73,101)
1976	231,579	232,580	210,902	(20,677)	(21,678)
1977	243,160	254,925	302,382	59,222	47,457
1978	260,845	262,400	290,618	29,773	28,218
1979	273,900	288,600	325,208	51,308	36,608

- Column (1) shows the amount appropriated by the PAHO Directing Council.
- Column (2) the amount as increased by the PASB Director, at the expense of other programs.
- Column (3) the actual expenditures at CAREC.
- Columns (3) minus (1) the difference between appropriations and actual expenditures.
- Columns (3) minus (2) the difference between increased budgets and actual expenditures.

Taking as a baseline the PAHO/WHO regular appropriation, this was in deficit five years out of six, and $232,014 over six years. The increased budget was in deficit four years out of six, and $38,824 over six years.

* TRT-3314, AMRO-0118, forerunners of AMRO-4370

Table 2

CAREC - GOVERNMENT CONTRIBUTIONS

Year	(1) Quotas Due	(2) Quotas Received	(3) Actual Expenditures	Difference (3)-(2)
1974	-	-	-	-
1975	225,703	205,531	225,715	20,184
1976	355,044	355,654	303,722	(51,932)
1977	488,438	458,406	487,833	29,427
1978	537,284	523,625	484,308	(39,317)
1979	591,012	639,971	652,691	12,720
				(28,918)

These were in deficit three years out of five.

Combinations of sources also show overall deficits when compared with actual expenditures, as shown in Table 3.

Table 3

Year		PAHO Appropriations plus Governments $	PAHO Increased Budgets plus Governments $
1974		21,320	21,320
1975		111,252	(52,917)
1976		(72,609)	(73,610)
1977		88,649	76,884
1978		(9,544)	(10,099)
1979		64,028	49,328
	Deficit	203,096	10,906

Budget Projections 1980-1984

The comments to the effect that it is unfortunate that no budgetary projections for the period 1980-1984 have been included in the report, and that these should now be developed, are difficult to understand. The CAREC self-audit did not include future budget projections, although these were specifically requested. In the absence of CAREC estimates, of Government forecasts or commitments, and of Host Government decisions, the Evaluation Team did not consider that it was in a position to make projections in a vacuum. It is indeed time for 1980-1984 projections, but the initiators of the process must surely be the CAREC Director, SAC and Council, and the Governments, in consultation with the PAHO Secretariat.

Keeping in mind the goal of self-reliance, the Team considered what the future role of PAHO might be. It recommended that the present Agreement be followed through 1984. The Team further recommended that, beginning in 1985, the PAHO role be one of maintaining a "presence," which will diminish as CAREC becomes a truly Caribbean Center, staffed by West Indian nationals. This provides a seven-year "transition period" through 1987, by which time the participating countries and institutions should plan on significant self-reliance and a degree of self-sufficiency.

This recommendation is compatible with the oft-repeated goal of consolidation of the program of CAREC, after five years of vigorous and exemplary growth. This theme of consolidation and attention to the highest priorities of the Caribbean as a whole was eloquently enunciated by the Jamaican Representative at the XXVI Meeting of the Directing Council and by the CAREC Council--note the stress on consolidation in the minutes of its 6th Meeting in paragraphs 2.1.2, 6.1.2, 6.2.4, 12.1 and 17.2.

The PAHO regular budget shows a "flat" growth rate of under 8 per cent per year, which does not wholly compensate for inflation. The PAHO allocations to CAREC have exceeded that figure. The significant increases in government quotas to CAREC during the period 1975-1979 confirm the value of the Center to them and their willingness and ability to support it.

Instant Response

Everyone agrees that CAREC has established, in five years, a reputation for rapid and effective response to disease outbreaks/problems in the Caribbean. It is nowhere suggested that this service cease. But these are good reasons to recognize that some governments may become overly dependent on this resource, at the expense of some national capability, no matter how modest.

Two other centers were faced with this same problem but solved it by assisting each government to develop an infrastructure, within its means, to meet its own needs. CAREC has done this in some instances, but the Team's recommendation is that this goal become one of the highest priorities. CAREC guidance and support will continue to be needed, but hopefully increasingly in the more sophisticated aspects of this service.

Priorities

In the response to the Key Issues, "training" was identified six times, "laboratory support" five, and "information and surveillance," three.

The Evaluation Team is aware that, except for mycology, many Center activities have been supported by resolutions of the Conference of Ministers Responsible for Health of the Caribbean. Among those which are not considered, at this time, among the top priorities of the Caribbean governments, as a whole, served by CAREC are:

- Research in the laboratory (insect cell lines) on the yellow fever virus
- Cardiovascular disease
- Traffic accidents
- Injury study
- Mycology research
- Epidemiology of cancer
- Diabetes

The Team's concern (also expressed at the XXVI Meeting of the Directing Council by the Jamaican Representative and in replies to the Key Issues) is for CAREC to continue to serve the Caribbean as a whole, in the context of the total PAHO program.

That these activities are "important" can be argued. But at this stage, the basic priorities of developing countries--communicable disease control, sanitation, training, laboratory support for surveillance--demand selectivity in the use of scarce resources through program consolidation. If particular endeavors are important to one or two countries, but not to the majority, and if CAREC is to respond, it must be outside the parameters of the "core" budget.

Diabetes appears to be inappropriate, in the light of the concentration of effort on this disease by CFNI.

Extrabudgetary Funds

There were four mentions in the responses to the Key Issues of the role of extrabudgetary funds in CAREC financing. One of these (ODA) called for a rationalization and caution in their use. The note of caution in the Evaluation Team's report is not a criticism of the past, but a caveat for the future. The US/AID grant for significant expansion of training activities is an excellent example of a move to meet a felt priority need in the countries, especially the developing countries. The Team's judgement is that the period covered by the grant will not allow enough time to develop a viable infrastructure, to the extent that future refresher and "turnover" can be met within the core budget. There is concern that this could start a cycle of search for new grant money, discontinuity of effort, disruption of staffing, problems of support costs, and impact on the time of CAREC's Director and staff.

The key factor here is that the Center's programs must be so consolidated and adherent to subregional/regional priorities that it can live within realistic means (ODA). There must be a balance of the resources and the services to be rendered, both being basic decisions of the participating governments.

Attitude of the Host Government

This will not be known officially until there is a response to the PASB Director's letter of 3 January 1980.

executive committee of the directing council

PAN AMERICAN HEALTH ORGANIZATION

working party of the regional committee

WORLD HEALTH ORGANIZATION

84th Meeting
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REPORT TO THE DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU
OF THE EVALUATION TEAM ON THE REVIEW OF THE
CARIBBEAN EPIDEMIOLOGY CENTER (CAREC) 1974-1979

The members of the CAREC Evaluation Team have submitted their preliminary report to the Director of the Pan American Sanitary Bureau (see Annex).

Copies have been sent to participating governments and institutions, and to members of the CAREC Advisory Council.

Annex

REPORT TO THE DIRECTOR OF THE PAN AMERICAN SANITARY BUREAU OF THE EVALUATION TEAM ON THE REVIEW OF THE CARIBBEAN EPIDEMIOLOGY CENTER (CAREC) 1974-1979

Introduction

Resolution XXXI of the XX Pan American Sanitary Conference called upon the Director to commence an evaluation of the Pan American Centers, to prepare a schedule of Centers to be evaluated, and to design an evaluation protocol for the Executive Committee.

The Director appointed an Evaluation Team[1] to advise him on the review process for the ten Pan American Centers and to develop a model procedure which might be used in evaluating these Centers. The model procedure, based on a self-audit by the director and staff of each center was approved by the 82nd Executive Committee.[2]

In drafting a schedule of centers to be reviewed under this program, it was determined that the first center to be reviewed would be the Caribbean Epidemiology Center, located in Port-of-Spain, Trinidad. The selection of this Center was based on the propitious timing of a requirement established in the Basic Agreement for CAREC,[3] which called for a mid-term review of the Center's operations, scheduled for December 1979.

1/ Dr. Paulo de Almeida Machado, Brazil; Dr. Laurence J. Charles, Sr., Antigua, W.I.; Dr. Robert de Caires, U.S. Public Health Service; and Dr. David Sencer, former Director, Center for Disease Control, USPHS.

2/ Resolution CE82/XVI, 29 June 1979.

3/ Multilateral Agreement for the Operation of the Trinidad Regional Virus Laboratory, 1974.

Terms of Reference of the Evaluation Team

With the expectation that this initial analysis of CAREC could serve as a model for future reviews of the other centers, the Director requested that the Team design an evaluation protocol and implement the necessary review process at CAREC.

The Team was charged with making an evaluation of the performance of this Center, as judged against the aims and functions set out in the Multilateral[3] and Bilateral[4] Agreements, and in the context of the Conference Resolution,[5] which stressed the need for the centers to relate their activities to the total PAHO program.

The Director's guidance to the evaluation Team was based on the following principles: 1) the centers in this region are a good illustration of the concept of Technical Cooperation among Developing Countries; 2) while a fundamental duty of the Organization is to provide needed services upon request, when a center renders such a service, its objective should be to establish and foster a national capability which will endure; 3) there is a continuing role for PAHO to assist the countries in the most cost effective manner in performing and/or providing needed services.

The Evaluation Team was requested to pay particular attention to the future of the Center, not only during the remaining period covered by the Multilateral Agreement, 1980-1984, but beginning 1985.

Finally the Team, on the basis of its findings, was asked to submit recommendations to the Director, keeping in mind those of the PAHO Advisory Committee, chaired by Dr. C.E. Gordon Smith on the Trinidad Regional Virus Laboratory.[6]

4/ Bilateral Agreement for the Operation of the Trinidad Regional Virus Laboratory, 1974.

5/ Resolution CSPXX/XXXI, 4 October 1978

6/ Report of a Scientific Advisory Group, RD12/9, July 1973

Methodology of the Evaluation Process

The plan approved by the 82nd Executive Committee included a self-audit phase related to the objectives and commitments of the bilateral and multilateral agreements involving PAHO, the Member Governments in the Caribbean, and the Host Government of Trinidad and Tobago.

The key to the Self-audit Phase (29 March 1979 - 4 June 1979) was the opportunity provided the Center director and his staff to make a constructive self-review of their own performance, judged against stated objectives.

The Evaluation Team met in Washington 26-27 March 1979 and developed the self-audit questionnaire, which was completed on 28 May 1979 by the staff of CAREC. The Team reviewed the data with the Center director in Washington, D.C. 4-6 June 1979.

The second phase, the Headquarters Program and Management Review, began on 4 June 1979 and focused on the specific inputs and self-appraisal of the Center staff in relation to the policies and plans of the Organization. These reviews were complete by 15 July 1979.

The third phase, Evaluation of Services by Countries Served, placed emphasis on obtaining the perspective of the countries served through the widest possible dissemination of summary self-audit data and the issues raised during the review process.

The Team identified ten key issues arising out of the above reviews. The Director sent these in early August to Member Governments, the Overseas Development Administration (ODA), The University of the West Indies (UWI), CARICOM, the Chairmen of CAREC's Scientific Advisory Committee (SAC) and Council, to other interested governments and Country Representatives. Replies were requested by 30 November 1979, prior to the scheduled field visit to the Center in December. The only responses

received prior to the Team's departure for Port-of-Spain came from St. Vincent, Guyana, the British Virgin Islands, the Cayman Islands, the ODA and the Country Representative/Trinidad and Tobago.

External Review was the fourth phase. The Team studied all of the inputs provided from the first three phases and discussed the implications of the contributions from center, headquarters and field personnel, and the governments. A component of this phase was a field visit to meet with Center personnel, to see the Center in operation first-hand, and to provide further opportunity for input by the Host Government and participating organizations.

The Team visited CAREC December 10-14, 1979. In addition to the Center staff, discussions were held with the Ministries of Health of Trinidad & Tobago and Barbados; with officials of the Trinidad campus of UWI; and with the Director of the Trinidad Public Health Laboratory. CARICOM did not send comments or a representative to meet with the Team, although invited to do so.

The Team, immediately on its return to Washington, D.C., reported the status of the evaluation process to the Director. It was recognized that in the absence of key inputs from the governments of Trinidad and Tobago (host) and of Jamaica, CARICOM, SAC and the Council, adequate information on which a report could be formulated, was not available. Further reminders were sent by letter, telex and telephone with the following results:

TABLE I

KEY ISSUES REGARDING CAREC IDENTIFIED BY THE STUDY TEAM REQUIRING INPUTS FROM PARTICIPATING GOVERNMENTS AND ORGANIZATIONS	SUMMARY OF SALIENT FEATURES OF THE RESPONSES
1. What are the most cost-effective ways of strengthening professional managerial skills in CAREC?	1. Provide expert managerial training to CAREC staff, with emphases on identifying West Indian nationals and training them for senior positions at CAREC.
2. How can interrelationships of CAREC with other Caribbean governments and intergovernmental groups be expanded and improved?	2. Continue and improve present good relationships by more frequent visits to countires, seminars, workshops, etc. Expansion of CAREC's services to entire Caribbean poses language and resource problems. Strengthen links with UWI and CDC to conserve resources.
3. In view of the considerable training activities already carried out by CAREC in the past five years, and planned through the next five years (to 1984), to what extent will there be a continuing need for <u>organized</u> training in communicable diseases in the Caribbean after 1984? If any, elaborate. If none, how can training needs best be met?	3. Continuing need for training of "trainers" to cover staff turnover in countries and upgrade national capability. CAREC needed in own right and to assist UWI and proposed ECF.* National institutions should be strengthened so they can bear some of the load for auxiliary training. (*Eastern Caribbean Faculty of the UWI)
4. To what extent can training needs in the Caribbean be met by strengthening existing national institutions in Barbados, Curacao, Grenada, Guyana, Jamaica, and Trinidad which now provide or could provide training of health auxiliaries?	4. National centers could play increasing role but CAREC will be needed to assure sound methods and course content, quality control and follow-up of trainers. CAREC needed to provide post-graduate training and specialist skills.
5. Should PAHO have any role in providing academic undergraduate training in community health?	5. Some negatives but preponderance of positives. CAREC role seen to vary between major and assisting UWI, with which CAREC staff should maintain honorary teaching appointments.
6. Is it reasonable to anticipate by 1985 the transfer of all of CAREC's laboratory activities to a subregional body (such as CARICOM) to function as a reference center?	6. Universal agreement that neither CARICOM or any existing subregional body can take over a role uniquely CAREC's and PAHO's. CAREC's skills and ability to respond should be preserved, while improving national capabilities and thus reduce dependence on CAREC.
7. To what extent could an expanded staff in the PAHO Caribbean Program Coordinator's Office be a nucleus for the provision of consultation services in communicable diseases?	7. Considered such a move as backward and ineffective. This role is dependent on an active collection of skills and capability to respond rapidly and effectively, which CAREC now can do and does.
8. What impact would an expansion of existing or planned academic facilities in the Caribbean have on the future of CAREC?	8. Academic institutions, existing (UWI) and planned (ECF) could take up the load over time, but CAREC needed now and to assist UWI and ECF in the teaching and providing field experience.
9. CAREC's 1974 mandate should be achieved by 1984. Are provisions being made in national budgets to continue the development of national communicable diseases resources in the Caribbean?	9. Member countries plan only one year ahead and have commitment to surveillance, but it is expected that they can only meet many of their needs collectively, i.e., through a center mechanism.
10. Given the increasing importance of extrabudgetary funds, what role do you anticipate for these funds in the future financing of the Center?	10. Emphasis on stable "core" budget and living within it. Seeking out and utilizing extrabudgetary funds generally supported but some urge caution to avoid straying from priorities of countries served.

Respondent	Date Received
Chairman, SAC	January 4, 1980
Chairman, Council	January 14, 1980
Bermuda	January 15, 1980
Trinidad & Tobago	January 24, 1980 (Preliminary)
Jamaica	February 29, 1980

No input has been received from CARICOM, nor has Trinidad and Tobago replied to the issues raised in the Director's second letter to the Minister of Health dated 3 January 1980, which spelled out the preliminary views of the Team and posed specific questions on the future of the Center.

Responses to the Key Issues

The ten key issues and a synopsis of the responses to them from the four major contributing countries (Trinidad and Tobago (preliminary); Jamaica; Guyana; and Barbados), four of the thirteen less developed (Bermuda, the British Virgin Islands, Cayman Islands and St. Vincent) and from the ODA (UK) and the Chairmen of CAREC's SAC and Council, are shown in Table I.

Conclusions

1. Addressing Key Issues:

   The experience with the CAREC evaluation indicates that obtaining the responses of governments, to the key issues raised during the review process, will be difficult and time-consuming. Nevertheless, the inputs and perspectives of the coun-

tries served by the centers are the most important ingredients of a meaningful evaluation. It is recognized that it will take time for a government to formulate a reply, particularly where financial and other commitments are involved. There is, therefore, the dual responsibility of the countries and the Organization to explore new mechanisms which will both facilitate and speed up the official governmental responses. The Team is aware that efforts are already being made in the evaluation of other centers to achieve this goal, e.g. through visits to the countries and taking into account the views expressed by their representatives at meetings of the Governing Bodies and of center committees and councils. In the case of the Caribbean, these problems are exaggerated by the large number of participating countries (17) and agencies, scattered geography and generally limited travel schedules. Team travel to individual countries will take a lot of time and will be very expensive; it will require a careful judgement to balance effectiveness and cost.

2. Preliminary Assessment of CAREC:

On the basis of the information gleaned from all the sources available to the Evaluation Team at this stage, the following conclusions must therefore be regarded as preliminary, subject to expansion and modification:

- CAREC has established, in five years, a reputation for rapid and effective response to disease outbreaks/problems in the Caribbean.

- In some areas CAREC has exceeded the goals and objectives for the ten-year period and has generated an increasing demand for its services.

- CAREC has failed to recruit and/or train significant numbers of nationals for senior level positions at the Center.

- CAREC's modus operandi of instant mobile response has reduced the emphasis on creating and strengthening national capability and has fostered dependence on the Center.

- CAREC has failed to operate within its core-budget ceiling for the past several years, a fact to which attention was called in one of the responses. This emphasis on continued program growth, at a time when member governments are calling for consolidation and attention to basic priorities has detracted from the financial integrity of the Center.

- CAREC has initiated and has plans for new activities which are outside the priority needs of the countries, as seen by them. This was of concern to member countries and to the Team.

3. Facilities:

The present facilities are adequate for the current level of operations. The sharing of a common building with the Trinidad Public Health Laboratory (TPHL) has not enhanced integration of laboratory services. The government's stated intention of expanding and rehousing the TPHL offers an opportunity to transfer these services, with the exception of virology, to the TPHL and thus consolidate laboratory support and conserve resources. Existing collaboration with the UWI and the Center for Disease Control (Puerto Rico and Atlanta, Georgia), if expanded, could achieve the same goals, including virology. There are mechanisms for continuous review of the safety and security of the premises by selected CAREC staff. Inspections by outside experts in this field support the internal assessments.

4. Financing:

CAREC's actual 1979 expenditures, by source, were:

PAHO Regular Budget	$ 197,650
WHO Regular Budget	127,558
Subtotal, Regular Budget	325,208
Other Funds	963,568
	$1,288,776

"Other Funds" include support from the host government of Trinidad & Tobago ($289,456); the ODA(UK); and participating countries & institutions. The "core" budget, made up of "assessed"

contributions, has been consistently exceeded. While extra-budgetary funds can and should be used to augment the core budget, for activities that fall within the priorities of the countries served and the Organization's program goals, great care must be exercised to ensure that they do not jeopardize the stability and financial integrity of the Center. Experience with other centers has demonstrated that dependence on extrabudgetary funds can virtually threaten a center's existence.

5. Manpower:

There is a strong consensus that Caribbean nationals can and should be identified, recruited and trained (if necessary) to staff and operate the Center, without lowering its high standard of excellence. The process would be gradual, with conditions of employment adjusted, over time, to conform to those of other subregional institutions, such as CARICOM and UWI. Steps to protect the welfare of the staff during this transition period will require the collaboration of all the signatories to the agreements under which CAREC operates now and in the future.

The routine training of national personnel can and should be shared by existing national centers and academic institutions. The former could be assigned a greater role for auxiliaries and the universities for professionals, with CAREC in a supporting role in both instances. The traditional gap between

academia and services, if bridged, will benefit both the institutions and the health services.

At the request of the Center Staff Committee and with the consent of the Center director, the Evaluation Team met on two occasions with representatives of the Committee. They were advised that conditions of employment were entirely outside the terms of reference of the Evaluation Team and that in accordance with a resolution of the 82nd Executive Committee,[7] "a review of the personnel employment and benefits systems" of all the centers was being undertaken. The tone of both meetings with the staff was cordial and constructive. It appears that some of the real concerns of the staff could be resolved by better communication.

6. Programs:

The Team reviewed the Center's programs against the background of the annual reports of the SAC and the Council and as seen by the program directors themselves. It is gratifying to note that the vigorous growth of the past five years has resulted in many goals, set for 1984, being either already achieved or near realization. However, there is the recognition that progress in some of the basic priority areas, e.g. national capability and self-reliance, has lagged. During the coming period of consolidation, endorsed by the member countries,

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7/ Resolution CE82/XXX, 3 July 1979

the SAC, the Center director and the Secretariat staff, these national and organizational priorities must dominate the work of CAREC. One of the most significant successes of the Center has been the adoption, by the countries, of epidemiological surveillance, laboratory support, data collection and rapid exchange of information, as basic components of their health services.

7. Future of CAREC:

The most important factor will be the decisions of the host government on the reorganization and expansion of its own health services, and on the future of the proposed university complex to serve the Eastern Caribbean. One opinion was that CAREC should become a part of that institution, and another that "if PAHO wishes" CAREC could be taken over.

All of the country replies envisage a continued life for CAREC specifically, or the maintenance of a comparable regional center. The ability to serve the Caribbean, especially as a viral reference laboratory, must be preserved.

The fact that the Caribbean, as a whole, is an epidemiological unit, raises the question of possible expansion of the number of countries being served. At this stage, and at least through 1984, it appears prudent to maintain the present scope while encouraging wider exchanges of information as national systems develop self-reliance and increasing reliability.

Recommendations

The Evaluation Team recognizes that, in the absence of a follow-up response from the host government to the Director's letter of 3 January 1980, and of any input from nine of the thirteen LDC's and from CARICOM, the information at its disposal now is incomplete. Nevertheless, the Team believes that it has a duty to make such recommendations as are compatible with the information available to it now. They are listed in the following attachment.

RECOMMENDATIONS OF THE CAREC

EVALUATION TEAM TO THE DIRECTOR OF PASB

1. That PAHO comply with the terms of the present Agreements through 1984, there being a continuing need for subregional technical cooperation, training and coordination of disease surveillance and control.
2. That PAHO advise the other signatories to the agreement that technical cooperation and coordination will be the essentials of its role in the Caribbean. Beginning in 1985, its role in CAREC will be to maintain a "presence" through support for:
   - (a) the Center Director/senior epidemiologist;
   - (b) a program management officer, and
   - (c) a training officer,

   who may remain PAHO employees over a set period of not more than two years, by which time the governments will assume responsibility for the Center, completely staffed by Caribbean nationals, and eventually becoming an "Associated National Center," serving the Caribbean.
3. That laboratory services, other than virology, be transferred to the Trinidad Public Health Laboratory (TPHL) as that laboratory is reorganized and expanded, as planned by the Trinidad and Tobago government.
4. That special efforts be made to identify, recruit and train, if necessary, Caribbean nationals for senior posts at CAREC.

5. That development and strengthening of national capability and self-reliance be given a very high priority, through an expanded "designated epidemiologist" strategy.
6. That CAREC live within its core-budget and that financial controls to ensure this be put in place immediately.
7. That the past five years of rapid growth give way to consolidation over the next five years, with strict adherence to the program priorities of the countries served and the Organization's programs and goals.
8. That extrabudgetary funds be sought and utilized for new or expanded programs, but only where those programs are relevant to the priority needs of the countries and make adequate provision for support costs.
9. That the host government be encouraged to define, as early as possible, its plans for the Eastern Caribbean Faculty, as these will have a strong bearing on the future of CAREC. CAREC's continued ability to serve the Caribbean, especially as a viral reference laboratory, must be preserved, regardless of its future sources of funding.
10. That the present and future personnel needs of the Caribbean countries, in the field of disease surveillance, be carefully assessed. An organized program to meet those needs must be established over the next five years, drawing heavily on National Centers for the routine training of auxiliary personnel and on more service-oriented academic institutions.
11. That CARICOM be entrusted with the responsibility of working with the member states to establish a career structure for epidemiological surveillance and laboratory support personnel. This appears vital to the capability of recruiting and maintaining trained persons in these

(and other) fields.

12. That management skills at CAREC which assure the successful collection, rapid transport, receipt and speedy processing of specimens, must be maintained. The primary responsibility should be assigned to the program management officer in (2) above. A suitably trained national should be groomed for this post and management skills must be developed in other CAREC staff and in key nationals in the countries.

13. That during the transition period, every consideration and assistance should be given to employees who will be transferred to national or regional employment systems.

April 1980