Vaccine-preventable Diseases

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

PRIORITY ISSUES

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

OBJECTIVE 1

Vulnerable populations immunised against selected vaccine preventable diseases.

INDICATORS

1.1 At least 95% EPI coverage achieved in all countries by end 2003.

1.2 All countries have in place for EPI a focal person; a plan that ensures access by all sectors of the population; and the resources to implement the plan by end 2003.

1.3 In all countries, Hepatitis B (HepB) and Haemophilus influenza B (HiB) vaccines introduced into the public health immunization schedule by 2003.

OBJECTIVE 2

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

INDICATORS

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

2.2 A sub-regional EPI marketing plan developed and implemented by end 2003.

OBJECTIVE 3

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

INDICATOR

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

VACCINE-PREVENTABLE DISEASES

OBJECTIVE 4

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

INDICATORS

4.1 All countries have updated legislation pertinent to the vaccine preventable diseases by end 2003.

4.2 All countries have reliable systems for safe disposal and destruction of used syringes, needles and vaccine vials by end 2003.

OBJECTIVE 5

Sensitive surveillance and control systems established and made operational.

INDICATORS

5.1 All countries adhere to prescribed protocols (for the reporting, investigation and control of vaccine preventable diseases) for surveillance of vaccine preventable diseases by end 2003.

5.2 All countries will have implemented a surveillance system for adverse events, supported by written guidelines, by end 2003.

STDs/HIV/AIDS and Tuberculosis

PRIORITY ISSUES

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

OBJECTIVE 1

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

INDICATORS

1.1 In all countries, a quarterly epidemiologic review based on data generated by laboratories and epidemiology surveillance units produced, disseminated and utilised for public health decision-making by end 2003.

1.2 In all countries, a minimum of two national research projects related to either HIV, AIDS, common STDs or TB developed and executed by end 2003.

OBJECTIVE 2

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

INDICATORS

2.1 *Legislation regarding confidentiality of health status information and the protection of human* rights of persons infected and affected by AIDS enacted and promulgated in all countries by end 2002.

2.2 Legislation to regulate the establishment and functioning of clinical and public health laboratories enacted and promulgated in all countries by end 2002.

OBJECTIVE 3

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

INDICATOR

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

STDs/HIV/AIDS and Tuberculosis

OBJECTIVE 4

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

INDICATORS

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

4.2 At least 75% of reported persons living with HIV/AIDS and 50% of persons affected by HIV/AIDS receive supportive counselling by end 2003.

OBJECTIVE 5

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

INDICATORS

5.1 STDs/AIDS/HIV/TB issues programmed for action in annual national budgets by the political leadership in all countries by end 2001.

5.2 In all countries, 40% of private sector organisations have HIV/AIDS work place policies established by end 2003.

OBJECTIVE 6

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

INDICATORS

6.1 In all countries, the proportion of persons reported living with AIDS who receive care in the community increased by at least 10% above the 1999 level by end 2003.

6.2 The proportion of 15 - 19-year-olds practising care-seeking behaviours that reduce the risk of STD/HIV infection increased by at least 30% above current 1997 levels by end 2003.

6.3 Thirty per cent (30%) of males aged 15 - 49 years reporting a decrease in non-regular sexual partners by end 2003.

6.4 In all countries, 75% of confirmed TB patients receive Directly Observed Therapy (D.O.T.S.) in the community and cured as evidenced by a test of cure at the end of treatment by end 2003.

OBJECTIVE 7

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

INDICATORS

7.1 Condom usage with last non-regular sexual partner increased by 30% above current 1997 level by end 2003.

7.2 Syphilis testing of 85% of pregnant women undertaken twice during pregnancy in accordance with current Caribbean recommendations by end 2003.

7.3 At least 80% of syphilis positive pregnant seeking antenatal care and 60% of their sexual partners adequately treated by end 2002.

STDs/HIV/AIDS AND TUBERCULOSIS

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Existing legislation reviewed, updated and enforced.
Appropriate information dissemination technology and policies in place.
Institutional strengthening to manage programmes.
Adoption of the national plan for the prevention and control of STDs/HIV/AIDS by all key stakeholders.

RE-ORIENTING HEALTH SERVICES

Training and re-training of health care workers and allied personnel.
Improvement in collecting, analysing and disseminating information.

EMPOWERING COMMUNITIES

Developing self-help projects.
Establishing community organisations or mobilising existing community groups to deal with vector control.

CREATING SUPPORTIVE ENVIRONMENTS

Ensuring that infrastructure (laboratory facilities and quality control mechanisms) in place.
Introducing on-site policies and programs at work sites.

DEVELOPING PERSONAL HEALTH SKILLS

Educating individuals about lifestyle choices.

BUILDING ALLIANCES

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

Mental Health

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

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

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

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

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

Sub-priority Areas

Human Resource Development and Training

Framework for Development and Delivery of Mental Health Programs

Prevention of Mental Health Disorders
(including Substance Abuse, with emphasis on Children, Adolescents and Families)

Mental Health Information and Information Systems

Mental Health Promotion

Integrated Community-based Mental Health Services

OVERALL GOAL AND INDICATORS

GOAL

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

INDICATORS

1. Prevalence of at least 3 selected mental disorders, including substance abuse, reduced by 5% in at least 5 countries by end 2010.

2. Suicides reduced to no more than 7 per 100,000 in at least 5 countries by end 2008.

3. The proportion of persons with depressive disorders who obtain treatment in the primary care services increased by 4% between 1996 and 2004.

4. The number of persons over 18-years who seek help with personal and emotional problems in the Primary Health Care system (public and private) or through recognized counsellors increased by 5% by end 2010.

5. Length of stay at psychiatric hospitals reduced by 5% from 1997 levels in at least 3 countries by end 2001.

HUMAN RESOURCE DEVELOPMENT AND TRAINING

PRIORITY ISSUES

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

OBJECTIVE 1

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

INDICATORS

1.1 Assessment of mental health manpower needs conducted in all countries based on national definition of composition, roles and responsibilities of Mental Health Team by mid 2001.

1.2 Regional training program in at least one (1) new area established and approved by the Association of Caribbean Tertiary Institutions (ACTI) by end 2003.

1.3 Opportunities for continuing education and sharing of experiences at least once a biennium provided by regional professional associations and/or regional mental health NGOs by end 2003.

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

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

RE-ORIENTING HEALTH SERVICES

Review of manpower and skills

BUILDING ALLIANCES

Involve the Association of Caribbean Tertiary Institutions (ACTI).

Framework for Development and Delivery of Mental Health Programs

PRIORITY ISSUES

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

OBJECTIVE 1

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

INDICATORS

1.1 Regional mental health Code of Ethics adopted or adapted by all countries by end 2001.

1.2 Comprehensive mental health plans, addressing promotion, prevention and treatment (including forensic psychiatry), developed and integrated into national health plans by end 2003.

1.3 At least one (1) NGO or professional association related to mental health included among partners with observer status to Council for Human and Social Development (COHSOD) by end 2000.

1.4 Multi-disciplinary, multi-sectoral Advisory Committee, including consumer representation, organized and meeting at least once a year to plan and evaluate mental health programs by end 1999.

1.5 Mental health legislation dating no earlier than 1985 enacted in at least 80% of countries by end 2003.

Framework for Development and Delivery of Mental Health Programs

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

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

Consultative process involving health professionals.

Appropriate policy changes to foster integration.

RE-ORIENTING HEALTH SERVICES

Education of health professionals on consumer rights.

EMPOWERING COMMUNITIES

Involvement of communities in the review process.

Organisational strengthening, training, provision of management skills.

Informing consumer of his/her rights.

CREATING SUPPORTIVE ENVIRONMENTS

Review of current status of legislation; recommendations for improvement.

Creation of climate that supports advocacy.

BUILDING ALLIANCES

Collaboration with other departments in the health sector.

Collaboration with other interest groups.

Increased collaboration between Ministries and NGOs.

Prevention of Mental Health Disorders

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

PRIORITY ISSUES

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

OBJECTIVE 1

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

INDICATORS

1.1 National Mental Health Coordinator formally designated in each country by mid-2000.

1.2 Regional guidelines and protocols for inclusion of Mental Health components in family and community health services adapted or adopted and implementation initiated in all countries by mid-2003.

1.3 Standardized instruments developed and used to screen children and adolescents for mental disorders as part of existing developmental screening programs in health and education sectors in all countries by end 2002.

1.4 Mechanisms for early detection and intervention for families at risk established in the community in collaboration with NGOs, and advertised through all media, in at least 5 countries, by end 2003.

1.5 At least one (1) staff person in 50% of primary schools and all secondary schools trained in counselling and mediation by end 2002.

1.6 Conflict resolution training available to all children between the ages of 10 and 15 years in 75% of countries by end 2002.

OBJECTIVE 2

Existing substance abuse prevention and control measures strengthened.

INDICATORS

2.1 Substance abuse prevention and control component included in national mental health plans of all countries by end 2000.

2.2 Programs planned for substance abuse prevention and control in selected populations, including children and young adults, in all countries by end 2000.

Prevention of Mental Health Disorders

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

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

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

RE-ORIENTING HEALTH SERVICES

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

EMPOWERING COMMUNITIES

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

CREATING SUPPORTIVE ENVIRONMENTS

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

DEVELOPING PERSONAL HEALTH SKILLS

Training of groups and individuals.

BUILDING ALLIANCES

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

MENTAL HEALTH INFORMATION AND INFORMATION SYSTEMS

PRIORITY ISSUES

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

OBJECTIVE 1

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

INDICATORS

1.1 WHO Global Mental Health Database data collection instrument adopted and/or adapted to develop standardised instrument for sub-regional database, with input from all countries by end 2000.

1.2 Instrument administered in at least 60% of countries and sub-regional database established by end 2001.

1.3 At least 2 multi-country research projects completed by end 2003, including one to elucidate epidemiology of suicide.

1.4 Network of Mental Health Coordinators and/or mental health resource agencies, and/or individuals working in mental health established through electronic communication by end 2000.

HEALTH PROMOTION STRATEGIES

RE-ORIENTING HEALTH SERVICES

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

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

BUILDING ALLIANCES

Collaborating with regional institutions.

MENTAL HEALTH PROMOTION

PRIORITY ISSUES

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

OBJECTIVE 1

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

INDICATORS

1.1 Cost-benefit studies (social and economic costs of mental disorders, cost-effectiveness of prevention and treatment of mental illness) conducted in at least three (3) countries by end 2001.

1.2 Presentation of results of cost-benefit studies on mental disorders made to: a) the CARICOM Council for Human and Social Development (COHSOD); b) national fora for social development in at least four (4) countries; and c) national and regional media, by end 2002.

1.3 Curricula of regional and national training programs for family practitioners, community and public health nurses reviewed and revised to provide skills for management of mental disorders and maintenance of mental health by end 2001.

HEALTH PROMOTION STRATEGIES

RE-ORIENTING HEALTH SERVICES

Research conducted by health economists in the region.
Increased focus of promotion/prevention, especially in mental health.
Re-training.
Greater emphasis on community mental health.

CREATING SUPPORTIVE ENVIRONMENTS

Determination of infrastructure needed to support community care.

BUILDING ALLIANCES

Media relations.
Cooperation among Ministry of Health, UNICEF, parents and teachers.
Involvement of NGOs, including church groups.

INTEGRATED COMMUNITY-BASED MENTAL HEALTH SERVICES

PRIORITY ISSUES

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

OBJECTIVE1

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

INDICATORS

1.1 Marketing strategy defined and brochures describing community-based services available in all public health centres and in 50% of general practitioners' offices by end 2002.

1.2 Services delivered by Mental Health Team, with documented policies and protocols for referrals, available in at least 50% of public health centres by end 2003.

1.3 Primary Health Care staff in 50% of health centers in all countries trained to use WHO International Classification Guidelines (ICD), adapted if necessary, to manage selected common mental health disorders, by end 2002.

1.4 Mechanisms to facilitate return of client to community, e.g. sheltered workshop and/or half-way house, available in at least one community in at least 50% of countries by end 2003.

1.5 Psychiatry beds/ward included in all acute care hospitals (national referral centres or hospitals with more than 200 beds) built after 1997 or renovated, by end 2003.

1.6 Regional standards for quality care in psychiatric in-patient services developed and adapted or adopted by all countries by end 2003.

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Provision of framework to mandate integration of programs.

RE-ORIENTING HEALTH SERVICES

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

Determination of consumer needs and implementation of recommended improvements.

EMPOWERING COMMUNITIES

Participatory methods.

ENVIRONMENTAL HEALTH

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

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

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

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

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

Sub-priority Areas

Vector Control

Liquid Waste and Excreta Disposal

Solid Waste Management

Water Quality

Workers' Health

OVERALL GOAL AND INDICATORS

GOAL

Selected community health conditions and environmental health risks reduced.

INDICATORS

1. By 2003 the Aedes aegypti House, Container and Breteaux indices for the dengue mosquito vector reduced by 50% from the 1998 levels.

2. By the year 2003, the number of outbreaks of food- and water-borne diseases from infectious agents and chemical poisoning reduced to less than 75% of 1999 level.

3. Reduced risk of solid waste-related contamination as measured by reduction of per capita waste produced daily by 10% between 1999 and end 2003 in 80% counties.

4. By 2003 at least 95% of urban and 80% of rural population have access to water that meets WHO quality standards or national standards, piped to or within 100 yards of each house.

5. By 2003, at least 80% of recreational water monitored in all countries meets WHO quality standards.

6. Reduction of human exposure to untreated liquid waste or excreta - by 2003, at least 85% of rural and 95% of urban population have access to and using appropriate sanitary facilities.

7. Work-related deaths and number of sick-days related to work-related causes, including injuries reported by social security agencies, decreased by 10% between 1998 and 2003.

Vector Control

PRIORITY ISSUES

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

OBJECTIVE 1

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

INDICATORS

1.1 Knowledge/Attitudes/Practices (KAP) studies indicate that by 2003 at least 90% of population knowledgeable of the Aedes aegypti mosquito and aware of critical factors which result in increased vector population.

1.2 Seventy-five per cent (75%) of households using a checklist of habitats for managing the environment to protect against vector-borne diseases by end 2003.

1.3 Stored water sources/containers protected against mosquito breeding in at least 80% of households in all countries by end 2003.

OBJECTIVE 2

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

INDICATORS

2.1 Plans for integrated vector control updated annually at national and community-unit levels in all countries by end 2003.

2.2 At least 75% of countries have biological control programmes included as part of their integrated vector control strategies by end 2003.

2.3 In all countries, relevant vector indices analyzed quarterly and reports distributed to policy makers, community health teams and PAHO/CAREC by at least the end of the month after the period ends by end 1999.

2.4 In all countries monthly reports of disease incidence (including from sentinel physicians in the private sector) analyzed and disseminated to policy makers, community health teams and PAHO/CAREC by the 20th of the month following the end of the period by end 2001.

Vector Control

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

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

RE-ORIENTING HEALTH SERVICES

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

EMPOWERING COMMUNITIES

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

CREATING SUPPORTIVE ENVIRONMENTS

Providing adequate resources and institutionalisation of competitions at national levels.

DEVELOPING PERSONAL HEALTH SKILLS

Adoption of health habits which support the suppression of vectors.

BUILDING ALLIANCES

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

Liquid Waste and Excreta Disposal

PRIORITY ISSUES

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

OBJECTIVE 1

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

INDICATORS

1.1 All countries would have plans for achieving targets for sanitary facilities including technical feasibilities and strategies for financing required investment by end 2001.

1.2 Standards for construction of sanitary facilities developed and available at all designated national outlets by end 2000.

OBJECTIVE 2

Capacity for monitoring, surveillance and management strengthened.

INDICATORS

2.1 Legislation of each country reviewed to ensure effective monitoring of compliance by operators with conditions of license by end 2001.

2.2 Ninety per cent (90%) of designated Environmental Health Officers (EHOs) in all countries trained and provided with resources to monitor efficiency and effectiveness of treatment plant operations by end 2003.

2.3 At least 80% of treatment plants in all countries managed by at least one trained/certified operator by end 2003.

2.4 All countries include analysis of treatment plant operations in annual community health reports by end 2002.

Liquid Waste and Excreta Disposal

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Incentives for construction of appropriate facility for lower socio-economic groups.

Environmental Impact Assessment (EIA) in all new projects as part of the planning process.

RE-ORIENTING HEALTH SERVICES

Health sector reform upgrades the level of functioning of EHOs to managerial level within the Ministry of Health.

Building capacity at periphery for decentralized health systems.

EMPOWERING COMMUNITIES

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

DEVELOPING PERSONAL HEALTH SKILLS

Personal hygiene encouraged at schools and food handling establishments.

BUILDING ALLIANCES

Working with the media and with the legal systems to streamline efforts for compliance.

Joint training for hotel operators.

SOLID WASTE MANAGEMENT

PRIORITY ISSUES

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

OBJECTIVE 1

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

INDICATORS

1.1 At least 50% of the population in each of ten (10) countries would have participated in national programs for recycling of household wastes by end 2003.

1.2 Ongoing education and incentive programmes for waste reduction, targeting the general public *and the school population, introduced in all countries by end 2001.*

1.3 In all countries, dump sites registered by community health teams reduced by 50% between 1999 and 2003.

OBJECTIVE 2

Systems for collection and disposal made more effective and efficient.

INDICATORS

2.1 In all countries garbage collection increased to at least once per week for all housing settlements and twice per week in urban areas by end 2003.

2.2 All countries would have appropriate disposal methods in operation with capacity to handle 100% waste generated on and off shore by end 2002.

Solid Waste Management

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Policies on waste minimisation and recycling.
Promoting public policies which facilitate the participation of the private sector.

RE-ORIENTING HEALTH SERVICES

Involvement of other health personnel in solid waste management issues.

EMPOWERING COMMUNITIES

Training of key community groups, e.g. stakeholders.
Promoting advocacy through the establishment of customer care hotline.

CREATING SUPPORTIVE ENVIRONMENTS

Allocation of resources for the provision of reliable services.

DEVELOPING PERSONAL HEALTH SKILLS

Promotion of good environmental practices, e.g. backyard composting.
Teaching skills in handling storage and transportation of waste.

BUILDING ALLIANCES

Inter-sectoral collaboration, media and NGO involvement.

Water Quality

PRIORITY ISSUES

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

OBJECTIVE 1

Surveillance capacity and efficiency improved.

INDICATORS

1.1 One hundred per cent (100%) of public and community water supply monitored using WHO or national standards and reports disseminated to community health administrations in all countries by end 2003.

1.2 Ninety per cent (90%) of Environmental Health Officers trained to monitor water quality and all countries have timely access to the necessary laboratory facilities by end 2003.

OBJECTIVE 2

Water resources management plan developed and implemented.

INDICATOR

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

WATER QUALITY

HEALTH PROMOTION STRATEGIES

HEALTHY PUBLIC POLICY

Development of standards and procedures for surveillance of water supplies.

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

RE-ORIENTING HEALTH SERVICES

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

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

EMPOWERING COMMUNITIES

Development of community surveillance skills.

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

CREATING SUPPORTIVE ENVIRONMENTS

Standards for monitoring water quality.

Strengthening CEHI and CAREC.

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

DEVELOPING PERSONAL HEALTH SKILLS

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

BUILDING ALLIANCES

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

WORKERS' HEALTH

PRIORITY ISSUES

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

OBJECTIVE 1

Comprehensive Workers' Health plan developed, implemented and monitored.

INDICATORS

1.1 All countries would update the policy and plans related to workers' health every two years.

1.2 All countries would have reviewed and upgraded legislation in Workers' Health utilizing the model legislation developed by CARICOM by end 2003.

1.3 In each country, multi-partite group would report annually to relevant authorities on status of implementation of the Workers' Health Plan of Action by end 1999.

OBJECTIVE 2

Training programmes developed.

INDICATOR

2.1 At least two Occupational Health Training programmes for physicians and for Environmental Health Officers established at regional training institutions by end 2003.

OBJECTIVE 3

Information systems strengthened.

INDICATORS

3.1 Occupational Safety and Health (OSH) clearing-house established at CEHI by end 2002.

3.2 Minimum data set and indices for surveillance of workers' health in the Caribbean developed and their use initiated in all countries by end 2001.

3.3 Research on the status of the health of workers in the hospitality and informal sectors conducted by end 2003.

Workers' Health

OBJECTIVE 4

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

INDICATORS

4.1 In at least ten countries, policies on HIV/AIDS and persons with AIDS (PWAs) in the work place developed and agreed to by tri-partite group by 2003.

4.2 Number of work places with at least 50 persons on staff and which have health promotion projects, increased in all countries between 1999 and 2003.

Notes

CARIBBEAN COOPERATION IN HEALTH:
PHASE II

A New Vision for Caribbean Health

Health Systems Development

Human Resource Development

Family Health

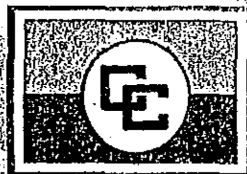
Food and Nutrition

Chronic Non-Communicable Diseases

Communicable Diseases

Mental Health

Environmental Health



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