Pan American Health Organization

Regional Office of the World Health Organization

Country Cooperation Strategy (CCS)

JAMAICA

(2010 - 2015)

TABLE OF CONTENTS

EXECUTIVE SUMMARY *4*

FOREWORD *6*

MAP OF JAMAICA *7*

1. INTRODUCTION *8*

2. COUNTRY HEALTH AND DEVELOPMENT CHALLENGES AND NATIONAL RESPONSE *10*

2.1 General Context **10**

2.2 Macroeconomic, Political and Social Context **10**

2.3 Health Status of the Population **14**

2.4 Environmental Determinants of Health **23**

2.5 Health Systems and Services **24**

2.6 Main National Health Policy Orientations and Priorities **30**

2.7 Major Health Challenges and Priorities **32**

3. DEVELOPMENT ASSISTANCE AND PARTNERSHIPS: TECHNICAL COOPERATION, INSTRUMENTS AND COORDINATION *34*

3.1 Introduction **34**

3.2 National Ownership **38**

3.3 Alignment of International Cooperation with the National Health Agenda **38**

3.4 Harmonisation of International Cooperation **40**

3.5 UN Reform Status and Process **40**

3.6 Managing for Results and Mutual Accountability Mechanisms **41**

4. PAST AND CURRENT PAHO/WHO COOPERATION *42*

4.1 Brief Historical Perspective **42**

4.2 SWOT Analysis of PAHO/WHO Cooperation **42**

4.3 PAHO/WHO Cooperation Overview **44**

4.4 Overall role and responsibilities of PAHO/WHO **46**

4.5 Critical review of previous CCS **47**

4.6 PAHO/WHO Structure and Ways of Working **47**

4.7 Resources **49**

5. STRATEGIC AGENDA FOR PAHO/WHO'S COOPERATION *52*

5.1 Strategic areas of the CCS **52**

5.2 Strategic Areas, Main Focus and Strategic Approaches **53**

6. IMPLEMENTING THE STRATEGIC AGENDA: IMPLICATIONS FOR THE ENTIRE PAHO/WHO SECRETARIAT ***58***

6.1 Shifts in the Requirement of PAHO/WHO's TC **58**

6.2 Implementation of the Strategic Agenda **66**

REFERENCES ***68***

LIST OF FIGURES ***69***

LIST OF TABLES ***69***

ANNEXES ***70***

ANNEX 1. Organisational structure of PAHO/WHO Country Office **70**

ANNEX 2. **71**

Linkage between Jamaica CCS' Strategic Priorities and Health Agenda for the Americas, PAHO Strategic Objectives, and PAHO-Jamaica BWP 2010–2011. **71**

ANNEX 3. Additional tables and figures **74**

EXECUTIVE SUMMARY

Jamaica, the largest English speaking Caribbean Island, is currently undergoing transitional changes in epidemiology, demography and economy. The country has experienced a decreasing trend in mortality and fertility rates and the pressure of the Global Financial Crisis as reflected by its negotiation with the International Monetary Fund for a Stand-by Agreement. In 2008, the Government took the decision to remove user fees in the Health Sector, resulting in a significant increase in the demand for health services. With the current economic climate, this presents challenges for sustainability of health services, particularly as all Government Ministries grapple with reductions in their fiscal budgets. The Ministry of Health is also undergoing a restructuring process focusing on improvements in quality of care, enhancing efficiency in health services delivery, and increasing access and accountability in the management of health services.

Despite these efforts there remain some challenges and the response to these lie outside of the health sector requiring a coordinated multi-sectoral response. These challenges include:

- Cost of Care: Continuing high levels of out of pocket expenses for health services; undefined essential package of care; and absence of a sustainable health care financing mechanism.
- Persistence of key health challenges: including weak public health leadership and management; a fragmented Health Information System and absence of a Health Information Policy contributing to a lack of accurate health information for decision making; limited absorptive capacity; limited inter-sectoral coordination for effective health outcomes; and re-emergence of vector borne diseases.
- Environmental Vulnerabilities: Hurricanes and other natural disasters continue to affect the island on an annual basis and so remain a persistent problem in terms of response and recovery efforts;
- Policy Formulation and Implementation: When problems are identified in the health sector there are significant delays in the development of appropriate policies, norms and guidelines to address the health challenges. Additionally, where policies exist, there are variations in implementation across the health sector.

Recognising the need better align the country health challenges and the PAHO/WHO Technical Cooperation Program, PAHO/WHO embarked on a consultative process to develop a Country Cooperation Strategy (CCS). The CCS will seek to refocus PAHO/WHO's technical cooperation in Jamaica based on the organisation's added value.

The CCS priorities are the result of an exhaustive and participatory process which was led by the PAHO/WHO Representative for Jamaica and included technical Staff from the Country Office, PAHO Headquarters, WHO in Geneva and National Counterparts. The CCS Priorities are the outcome of a joint process of review of:

- the history of Technical Cooperation in Jamaica;
- national development frameworks including the Vision 2030 National Development Plan, the National Health Plan 2006–2010, the Strategic Health Plan 2006–2015, the National HIV Strategic Plan 2008–2012 and the Medium Term Socio-Economic Policy Framework 2009-2011;
- key informant survey and planning consultation among key national counterparts; and

- UN guiding documents such as the UN Development Assistance Framework, the Common Country Assessment 2006–2011, the PAHO Strategic Plan 2008–2012 and .the WHO Medium-Term Strategic Plan 2008–2013.

Technical Cooperation in Jamaica has traditionally focused on disease prevention and control, health systems strengthening, family and community health, environmental health, and HIV/STIs. The new priorities of the Country Cooperation Strategy (2010–2015) reflect the expansion of technical cooperation provided to Jamaica over the last few biennia and include:

- Strengthening of the Health System within the framework of the Renewed Primary Health Care Approach;
- Reducing the burden of diseases;
- Supporting the achievement of the Millennium Development Goals;
- Assessing the determinants of health; and
- Strengthening the PAHO/WHO response to Primary Health Needs by harnessing knowledge, science and technology.

As PAHO moves into implementation of the Country Cooperation Strategy 2010–2015, an end period that coincides with the achievement of the Millennium Development Goals, there will be increased focus on Results Based Management. This will serve as the framework for ensuring accountability in provision of technical cooperation activities. This new focus is complementary to the UN mandate for compliance with the International Public Sector Accounting Standards effective 01 January 2010.

The Paris Declaration on Aid Effectiveness calls for UN Agencies and International Donors to harmonise their aid efforts towards addressing the key health challenges towards efficiency in the use of donor resources. In this regard, PAHO/WHO will promote greater collaboration with the International Development Partners (IDPs) in Jamaica.

The Country Cooperation Strategy for Jamaica is organised into six sections: an Introduction that outlines WHO Policy framework in terms of key national development and regional/sub regional priorities; an assessment of Country Health and Development Challenges and the National Response; Development Assistance and Partnerships towards Aid Effectiveness addressing issues of national ownership and alignment to national and international health agendas; a review of Past and Current PAHO/WHO's Technical Cooperation; PAHO/WHO Strategic Agenda for Technical Cooperation which anchors the CCS Priorities into the core WHO values and corporate policy frameworks; and the implementation the PAHO/WHO Strategic Agenda at all levels of the Organisation.

The Jamaica CCS is the mutually agreed framework for PAHO/WHO Technical Cooperation with the Government and other key partners, builds on PAHO/WHO's added value as the specialized agency in health of both the United Nations and The Inter-American System in health. The Organisation remains committed to working with the Government and its partners to strengthen and improve the quality of life of the population.

FOREWORD

The Country Cooperation Strategy (CCS) is one of the main instruments through which the Pan American Health Organization/World Health Organization (PAHO/WHO) strengthens its technical cooperation programs in countries taking into account their specific needs and priorities. The CCS document states what PAHO/WHO will do in order to effectively contribute to the achievement of national health development goals.

After enjoying many years of successful social and economic development with favorable health outcomes, Jamaica is at a crossroads in its health development. The financial crisis has placed Jamaica at risk of losing some of the gains made in the past, thus jeopardizing the possibility of attaining some of the MDGs by 2015. The gradual ageing of the population coupled with changes have brought about a social behaviour and consumption patterns in diseases trends and health conditions. The effective prevention, marked shift in control and management of these conditions requires policy changes, reorganization of health services delivery and innovative health financing mechanisms with a multisectoral approach to address these social and political issues. Recent declining trends in donor support along with food insecurity, high rates of crime and violence and the impact of natural disasters, compete for the same limited Government resources and this has exacerbated the country's health sector response constraints.

Despite all the challenges mentioned above, the Government of Jamaica has formulated a comprehensive National Development Plan (Vision 2030), which guides the development of medium-term sectoral plans, including health. PAHO/WHO plays a major role in supporting the development and implementation of health policies, strategies and plans and continues to work with national counterparts and other partners in building capacity for further improvement of the health outcomes. It is in this context, and taking into account the Global WHO Programme of Work, as well as the Caribbean Cooperation in Health Initiative Phase III (CCH III) and the PAHO/WHO Sub-Regional Cooperation Strategy, that PAHO/WHO presents this strategic agenda for the next five years.

The 2010-2015 Jamaica Country Cooperation Strategy will guide PAHO/WHO's collaboration with its partners in addressing Jamaica's multifaceted development challenges. Cognizant of its role and in full compliance with the Government's ownership of the national health agenda, PAHO/WHO is fully committed to advancing the health of the Jamaican population.

Mirta Roses Periago
Director

MAP OF JAMAICA

1. INTRODUCTION

The PAHO/WHO Jamaica Country Cooperation Strategy (CCS) aims at articulating and strengthening the Organisation's strategic agenda for Technical Cooperation with the country priority health needs and defines the strategic framework within which the Organisation will work during 2010–2015. The development of the CCS included a review of core competencies and capacities of the country team; coherent programming with technical support from the regional office and headquarters; coordination and effective functioning of country office; information and knowledge management; and harmonisation and joint programming with the United Nations (UN) system and other development partners. In the years prior to the development of the CCS, the country office accompanied and actively supported the development of the National Development Plan to 2030, the National Health Plan (2006-2010), the Strategic Health Plan (2006–2015) the National HIV/AIDS Strategic Plan, the Common Country Assessment and the United Development Assistance Framework (CCA/UNDAF) 2006–2011.

The CCS defined the strategic framework for PAHO/WHO cooperation with and for the country in line with national, sub-regional, regional and global frameworks. It also incorporated the results of the CCA/UNDAF review and the Ministry of Health yearly reviews.

The Jamaican CCS is expected to have the following results:

- *A more focused program of work*: fewer priority areas of work, chosen explicitly in terms of its potential for influence and impact on the health indicators for the country.
- *A more coherent program of work:* with mutually supportive and coordinated inputs and activities from different parts of PAHO/WHO. In keeping with the "One WHO" concept and country-focused approach, expertise will be mobilised from the entire Organisation in providing a unified technical cooperation response to Jamaica.
- *A more strategic role for PAHO/WHO:* well-considered shifts in the functions performed at country level, moving towards a greater role as catalyst, broker, convenor, and policy advisor, based on the priority needs and readiness of the country.
- *Greater emphasis on wider partnerships:* an extended range of partners within Government, the Private Sector, Non-Governmental Organisations (NGOs), Civil Society, other development agencies, and changes in the nature of the collaboration.

With the current request by the Government of Jamaica for a 20% cut in all budgets by the end of August 2009, the nature of all technical cooperation will be impacted as most programmes may be reduced.

The development of a CCS for Jamaica is crucial at this time in light of the significant fiscal and other economic challenges facing the country, that have been exacerbated by the global economic crisis, the recent devaluation of the Jamaican dollar as well as interest rate increases. During the past few years there has been a decline in number of health development partners working in Jamaica. Furthermore, the allocation of regular financial resources to support the work of PAHO/WHO at the country level has decreased as a consequence of the new Regional Program Budget Policy (RPBP). These changes have heightened the need for a more efficient and effective technical cooperation programme.

The process for developing the CCS was based on:

- broad consultation with national health authorities and health stakeholders;

- PAHO/WHO's added value in helping the country to address national priorities selected in the context of sub regional, regional and global priorities; and
- The need to strengthen existing partnerships and alliances for a more collaborative, efficient and effective cooperation in health.

This CCS exercise included a core competency review of the country office (CO) staff and will allow for a review of the staff requirements to meet the technical and administrative needs of the technical cooperation program in Jamaica. This CCS will be subject to ongoing review due to the expected changes in the operating environment for technical cooperation as a result of the Review of the CARICOM Regional Health Institutions (RHIs) the development of a Caribbean Public Health Agency (CARPHA), the development/ implementation of the Caribbean Cooperation in Health III (CCH III), the development of the sub regional CCS by the Office of Caribbean Programme Coordination and the roll out of the new PAHO Strategic Plan 2009–2012.

A CCS team (headed by the PAHO/WHO Representative and comprising of PAHO/WHO Country Office, PAHO Washington and WHO Geneva staff, and senior staff of the Ministry of Health) worked on the development of the CCS over the period 2008–2010. This included a Headquarter led mission in 2009 to review background documents, the health and development situation in Jamaica, a two-day consultation with senior staff of the Ministry of Health (including representatives from the regional Health Authorities) and an in-house discussion on relevant technical and administrative issues. The mission format included data collection from MOH counterparts, interviews/questionnaires with representatives of Health and Developmental Agencies working in Jamaica. PAHO/WHO also convened a meeting of the MOH stakeholders to present the major findings of the CCS Consultation. The Final Draft of the CCS document was submitted for endorsement by the MOH and subsequently forwarded to both the PAHO Director and WHO Director General for approval and dissemination.

2. COUNTRY HEALTH AND DEVELOPMENT CHALLENGES AND NATIONAL RESPONSE

2.1 General Context

Jamaica which is the largest English-speaking Caribbean island is in an advanced stage of demographic transition reflected by decreasing mortality and fertility rates.

Jamaica has in the past played a significant role in advancing the sub regional health agenda and contributing to improving health. This role has however diminished in recent years and should be examined in light of the potential contribution of Jamaica to international health.

The MOH fosters collaborative initiatives with the Private Sector, Civil Society, Academia and community groups among others. Despite these advances in inter-sectoral collaboration in programmes such as HIV/AIDS, Mental Health, Health Promotion and Healthy Lifestyles, Environmental Health, Nutrition and Violence Prevention, there is room for improvement both at community, regional and national levels.

Information for planning, decision making and development of accurate situation analysis is not readily available. This impedes implementation of preventive and corrective measures in all sectors. Human Resources for Health are generally inadequate and the lack of succession planning impedes national health development.

Although Jamaica has initiated a Needs-Based Human Resources Planning Programme, the development of policies, plans and standards, with the appropriate training and research for the Health Sector remains a vital necessity.

2.2 Macroeconomic, Political and Social Context

2.2.1 Political context

Jamaica became an independent nation on 06 August 1962 and is a parliamentary democracy. The government is a constitutional monarchy. Jamaica is a unitary state and a member of the Commonwealth of Nations. [1]

Political governance is by a parliamentary system based on the Westminster/ Whitehall model, and a bicameral legislature. The Cabinet of Ministers forms the executive arm of government, which is headed by the Prime Minister. Jamaica is divided into 14 parishes with its accompanying Parish Councils.

The Parliamentary system of governance presents significant benefits to the governance of the country. Under this system of Government, Jamaica has been able to develop health policies in a collaborative manner with both government and opposition aiding in advancing and stabilizing critical components of the national development agenda including health. The benefit of this is that it has contributed to a reduction in the number of policies that have been

[1] **Jamaica. Government of Jamaica. At: http://www.jis.gov.jm/GovernmentOfJamaica.pdf**

overturned as successive governments assume leadership of the country. Key examples of such interventions include Jamaican Drug for the Elderly Programme (JADEP), Programme of Advancement through Health Education (PATH) and Early Child Development Programmes.

In some sectors, Civil Society in Jamaica is not well organized and this makes it difficult to engage those sectors as meaningful partners in the design, implementation and evaluation of key Government interventions.

Jamaica is a member of key regional and international institutions in the Caribbean Community and Common Market (CARICOM), and the United Nations. Through these mechanisms, the achievement of the Caribbean economic integration was realized in 2006 with the establishment of the Caribbean Single Market and Economy (CSME). Jamaica is also a part of the Inter-American System and as such is a member of the Organisation of American States (OAS) and its institutions including, Inter-American Institute for Cooperation on Agriculture (IICA) and Inter American Development Bank (IDB).

Jamaica became a member of the United Nations in 1962 and, despite limitations of size and resources, has played an outstanding role in the United Nations' system, helping to focus international attention on such significant matters as apartheid, human rights, de-colonization, economic co-operation and indebtedness and women's issues.

2.2.2 Demography

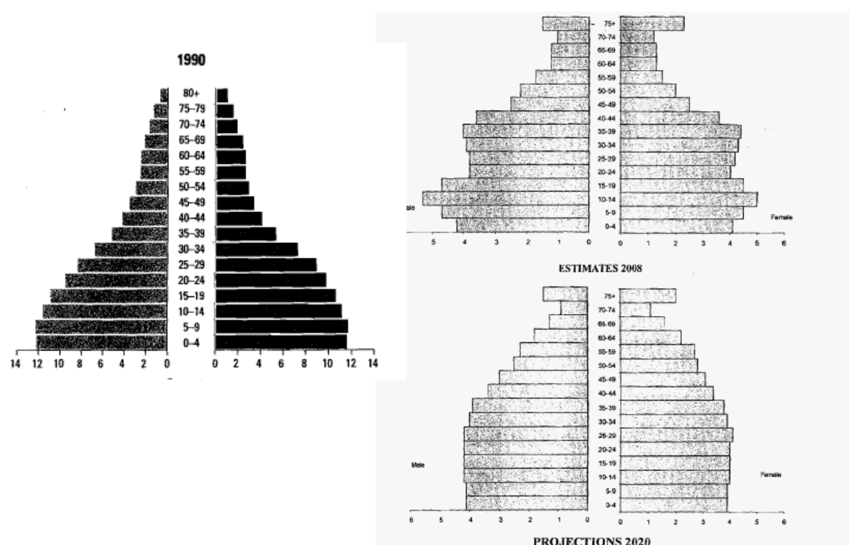
High levels of international migration continue to impact on family life. The continued high net out-migration has contributed to the low net rate of population growth. External migration is particularly prevalent amongst graduates, including health professionals and teachers, and impacts on the overall socio-economic profile of Jamaica. [2]

Table 1.Some Demographic Indicators: Jamaica.

Indicator	Value
Country land area [3]	10,991 km^2
Population (end of year 2007 estimate)[4]	2,668,100
Population annual rate growth	0.47%
Life Expectancy at Birth (2008 estimate)	72.7 years (Males 70.1; Females 75.3)
Crude Death Rate per 1,000 population [4]	6.67 (1998) to 6.37 (2007)
Crude Birth Rate per 1,000 population	22.30 (1998) to 17.03 (2007)
Total Fertility Rate	3.00 (1997) to 2.5 (2005)
Age dependency ratio (2004) [5] [6]	61.5
Net migration rate per 1,000 population	Minus 6.5

[2] Medium Term Socio Economic policy Framework 2004-2007
[3] The Ministry of Transport and Works at: http://www.mtw.gov.jm/general_information/reports/TransportStatisticsReport2003_2004.pdf
[4] STATIN Demographic Indicators: http://www.statinja.com/stats.html#1
[5] Defined as the population under 15 years and 65 years and over of age over the population 15-64 years of age per 100 persons 15-64 years of age.
[6] Economic and Social Survey Jamaica 2004, PIOJ (page 20.5)

Figure 1. Percentage distribution of population by age and sex. 1990 (census), 2008 (estimate) and 2020 (projection). Jamaica.



Sources: PIOJ. Economic & Social Survey Jamaica 2008.

Trends in population distribution by age (1990 to 2020) shows that Jamaica will have completed its demographic transition by the next decade. The age dependency ratio (ADR) declined from 73.3% in 1991 to 66.75 in 2008[7]. The ADR is projected to continue declining over the coming years. Over the past decade, the population pyramids have narrowed in the young population. This has in part been due to decreases in the Total Fertility Rate, crime and violence and migration among young persons who leave for family reunification, to pursue study and work opportunities. The fastest growing segment of the population is in the above 60 years cohort. The aging of the Jamaican population has implications for chronic disease prevalence and management, and utilization of health services, as well in the social protection scheme and, will impact on the need for child health services that will diminish. The Government will therefore need to make policy provisions for the demographic changes.

2.2.3 Macroeconomic context

In order to move from a traditionally mono-crop society, Jamaica recognized the need to diversify its economy and this resulted in the emergence of bauxite mining and tourism as the most viable options in the 1980's. Tourism remains one of the major income earning industries for the country, with other sectors (agriculture, bauxite/mining, remittances and the service sectors) providing the impetus for growth. During the past six months, the bauxite sector has shown a significant reduction with the temporary closure of the major factories in the Island. If this trend continues, a contraction in foreign exchange earnings and a rise in unemployment can be expected. As a major contributor to the national Gross Domestic Product (GDP), the contraction in the Bauxite Industry will have negative impacts on the resources available for Government Expenditure and in particular, resources for health.

Jamaica is classified by the World Bank as "Lower Middle Income" with a Gross National Income of US$2,820. The Jamaican economy reported its seventh consecutive year of real GDP growth (of 1.4%) during 2005 but recorded a decline in GDP growth of minus 0.6 per

[7] Planning Institute of Jamaica. Economic & social survey. Jamaica 2008. Page 20.8.

cent in 2008. This reclassification disqualifies Jamaica for International Aid from some sources and has implications for sustainability of some Government Programmes, including health.

The economy faces serious long-term problems of high inflation (16.8% in 2008)7 and interest rates, increased foreign competition, a pressured exchange rate, a sizeable merchandise trade deficit, large-scale unemployment, and a growing internal debt which is exacerbated by the impact of the Global Economic Crisis. The ratio of debt to GDP is more than 125%. The Government faces the difficult prospect of having to achieve fiscal discipline in order to maintain debt payments while simultaneously attacking a serious and growing crime problem that is hampering economic growth. Attempts by the government to control the budget deficit were derailed by Hurricane Ivan in September 2004, and Hurricanes Dennis and Emily in 2005 which resulted in damages costing an estimated J$36.8 billion[8] in 2004, J$6 billion or US$96.87 million[9] in 2005.

As Jamaica deals with the reclassification to Lower Middle Income Country, with contracting Industries and rising unemployment, it is important to identify alternative income earning opportunities at the macro level. To this end, there has been some discussion surrounding the promotion of Jamaica as a Health Tourism destination. This drive must be complemented with assurances that the country capacity to meet local health needs is at an optimal level before opening the health care system to the wider Caribbean and international community. As countries move closer to the full operationalisation of the CARICOM Single Market and Economy, planning for such opportunities must begin in earnest.

2.2.4 Social context

The urban population increased from 50.1% (1991 Census) to 52.0% (2001 Census) due to rapid growth of major urban centres. Poverty and the imbalances between urban population growth and development result in squatting (unplanned settlements) and environmental degradation.[10]

Poverty is more widespread in the rural areas [poverty rates of 9.9% in the Kingston Metropolitan area and 25.1% in rural areas], where the economy is predominantly of the extractive and production-type industries such as agriculture, forestry, mining, and natural resource-based tourism.

Primary and secondary level gross enrolment rates as at 2002 were 93.1% and 80.0% respectively with males showing lower levels of educational achievement than females. This is coupled with high levels of functional illiteracy, which limits the ability to enter the job market.

Males have shown significantly lower levels of educational achievement than females with the ratio of young literate females to males in the 15–24 age group being 1.07:1.11 (2001).[11] The

[8] Economic and Social Survey Jamaica 2004 (pg III). *Cited from: PIOJ, ECLAC, UNDP – Macro-socio-economic and Environmental Assessment of Damage Done by Hurricane Ivan, Sept 10-12, 2004*.
[9] Economic and Social Survey Jamaica 2005
[10] PIOJ. Economic and Social Survey Jamaica, 2004.
11 World Development Bank. World development indicators database. April 2002. At:

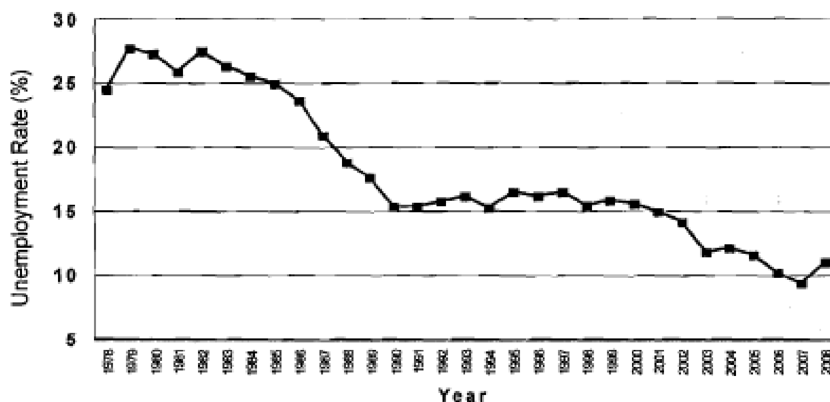
http://info.worldbank.org/etools/docs/library/99169/CD_CC/precourse/MDG/pdf/JamaicaCountryProfile.pdf

higher educational achievements of females have led to much higher numbers of women who are qualified and well placed to take advantage of economic opportunities.[12] Despite these advancements, this has not translated into equal participation in the Labour Force and in Executive level positions.

The Labour force participation rate (the proportion of the population aged 14+ years in the Labour force) was 64.3% (male = 73.3% and female = 55.8%). The average unemployment rate in 2004 was 11.7% down from 15.5% in 2000 (males = 7.9% and females = 16.4%). However, the overall unemployment rate increased by one percentage point moving from 9.3% in October 2007 to 10.3% in October 2008.[13]

The percentage of Female Headed Households remained high and is largest in the poorest quintile of the population. Despite education gains in females, Jamaica is still experiencing high teenage pregnancy rates and multiparity. The high levels of Female Headed Households affects the capacity of women, particularly in poorer households to access healthcare, which may often be sacrificed for other economic priorities (food, shelter, education etc).

Figure 2 Average unemployment rates. Jamaica. 1918-2008



Source: PIOJ. Economic & Social Survey Jamaica 2008 (page 21.6).

2.3 Health Status of the Population

2.3.1 Communicable diseases

Acute respiratory infection and gastroenteritis

Acute Respiratory Infection (ARI) and Gastroenteritis (GE) are still major causes of morbidity and mortality in Jamaica, especially in children under five years of age. According to the Ministry of Health statistics, the number of cases for both conditions has been rising in recent years as shown in the table below. These increases usually occur in the cooler months of the year (December-March) and are linked to rotavirus infections.

[12] Jamaica Medium Term Socio Economic Policy Framework 2004-2007, Feb 2005. *pg 32*

[13] STATIN Labour Force Surveys 2003 & 2004

Table 2. Distribution of Acute Respiratory Infection and Gastroenteritis by age group, Jamaica. 2007– 2008.

Year	ARI		GE	
	< 5	≥ 5	<5	≥ 5
2007	19,222	n/a	19,342	16,850
2008	25,655	n/a	24,078	19,950

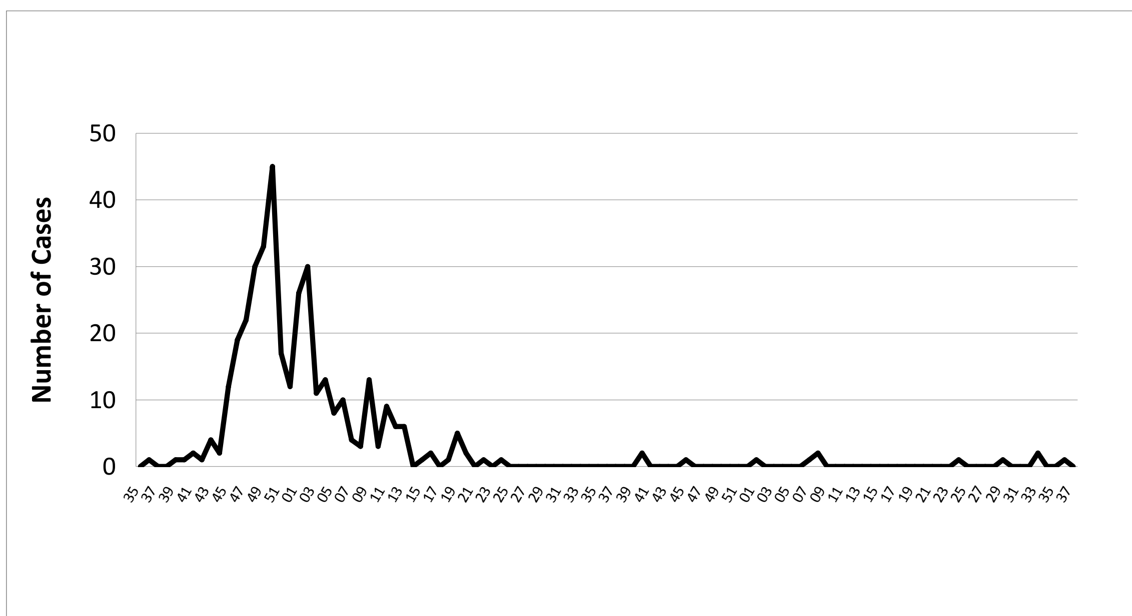
Source: MOH Weekly Surveillance Bulletins, 2007-2008

Vector-borne diseases

Since 2008 Jamaica has been classified as an endemic Malaria country with low risk of transmission following the malaria outbreak which started in late November 2006. As of July 18, 2009 a cumulative total of 411 locally acquired and 15 imported malaria cases were reported to the National Surveillance Unit.

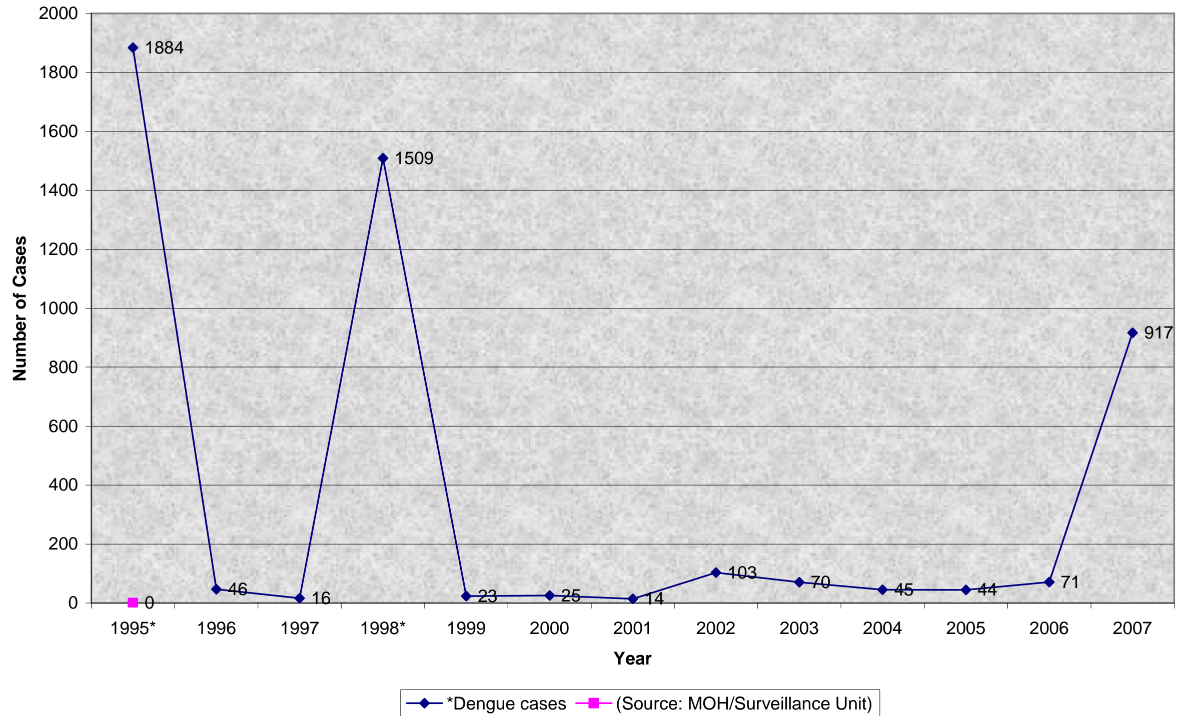
The following graph shows the trend in malaria cases between 2006 and 2009.

Figure 3 . Confirmed P. Falciparum Malaria cases by week of onset. Jamaica. September 2006 (week 35, 2006) to September 2008 (week 37, 2008).



Dengue Fever is also endemic in many parishes of the island despite intensive public measures to prevent its spread. As shown on the figure below, Jamaica experienced three dengue outbreaks in the period 1990–2008.

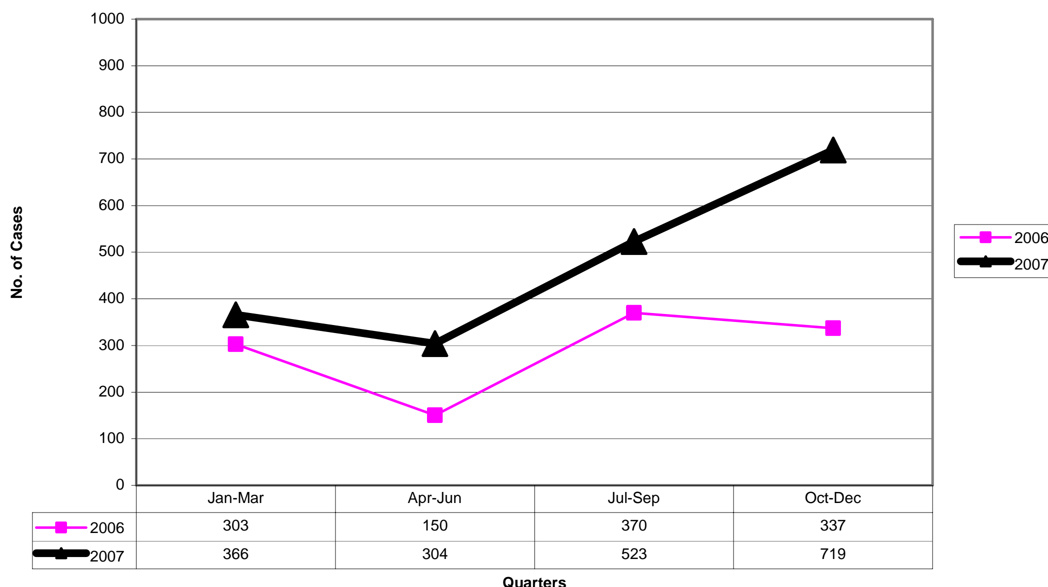
Figure 4. Time trend in laboratory confirmed dengue cases, 1995 - 2007, Jamaica



It is also worth noting that St Catherine and the Kingston and St Andrew parish are the most affected especially in their inner-city communities where environmental degradation provides ideal conditions for mosquito breeding.

In recent years, Leptospirosis has shown some flare-ups after the heavy rains and flooding that usually accompany the hurricane season. This is mainly due to improper waste management and rodent infestation. The years 2006 and 2007 were marked by a significant surge in the number of Leptospirosis cases as shown in Figure 4 below.

Figure 5. Suspected Leptospirosis Cases by Quarter, 2006 – November 24, 2007



	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
2006	303	150	370	337
2007	366	304	523	719

HIV, STIs and Tuberculosis

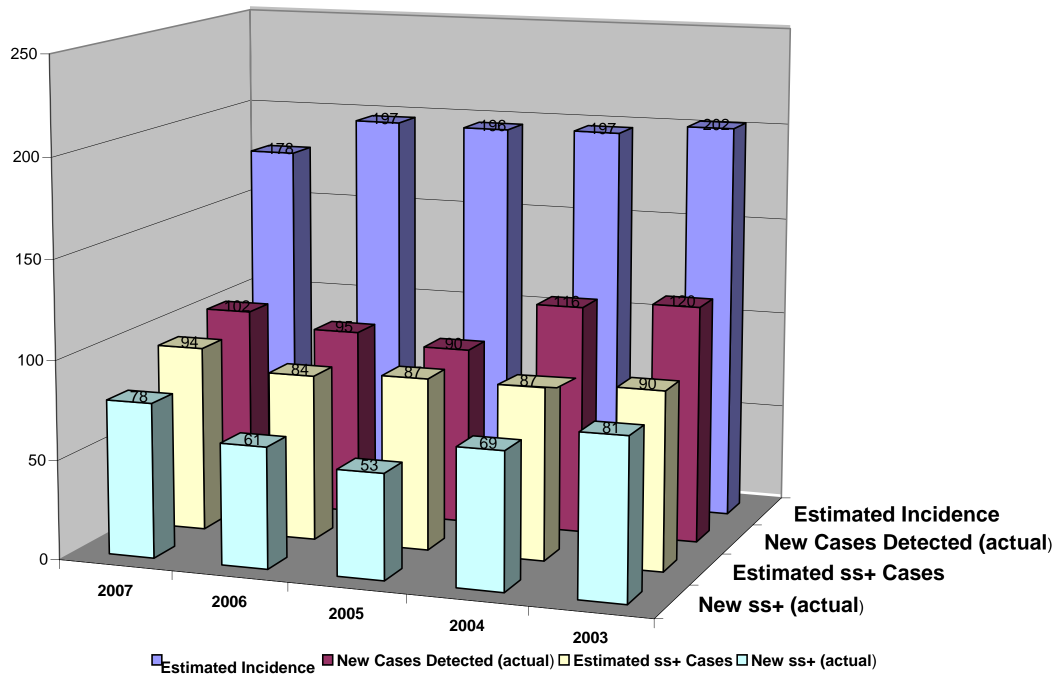
HIV and AIDS remains a key health concern as evidenced by the development of the second National Strategic Plan (2007–2012). There continues to be an upward trend in the rate of infection, with the country recording an adult prevalence rate of 1.6%, among the highest rate in the Caribbean. In the vulnerable populations however prevalence rates are much higher. Men who have Sex with Men currently have a prevalence rate of between 20–30%, 4.6% among persons with STIs and approximately 9% among Commercial Sex Workers. Young girls in the 15–24 year old population are as much as two times more at risk of infection than young boys in the same age group and for girls 10–19; the risk is three times higher. It has been suggested that this may be due to the high incidences of forced sex, transactional sex and sex with an older infected male partner. Jamaica therefore demonstrates characteristics of both a generalised and concentrated epidemic.

As at December 2007, there were approximately 12,520 accumulated (1982–2007) number of cases reported with AIDS in Jamaica[14], and this along with Sexually Transmitted Infections have become a leading cause of death among the island's working population. In fact, the increase in HIV is related to prevalence of STIs (and the emergence of co-infection between the two) which continues to rise and if this trend continues is likely to result in further increases in the number of HIV infections recorded. National data by parish shows that the most urbanised parishes have a higher number of cumulative cases than the less urbanised communities. St James and Kingston/St Andrew are the hardest hit parishes with 992 cases and 697 cases per 100,000 population, respectively.

[14] Jamaica. Ministry of Health. National HIV/STI Control Programme. At: http://www.jamaica-nap.org/

In the past 5 years the Tuberculosis case load has averaged around 100 new cases per year as shown in the figure below. Jamaica ranks third in terms of TB burden in the Caribbean region.

Figure 6. Estimated TB number of cases compared to number of cases notified. Jamaica. 2003-2007.



The analysis of data on TB detection and treatment outcomes shows that the annual TB detection rate remains below 70% and the treatment success rate has declined mainly due to limited capacity in properly implementing the Directly Observed Therapy Short course (DOTS) strategy.

2.3.3 Non-communicable diseases and risk factors

Jamaica is going through an epidemiological transition marked by a declining burden due to communicable diseases and a marked increase in non-communicable diseases. Recent national surveys among adults 15–74 years of age show an upward trend in the prevalence of overweight and obesity, hypertension and diabetes, and a disproportionate distribution of these conditions among males and females.

Table 3. Prevalence (%) of chronic diseases/conditions and nutritional status. Jamaica. 2000–2008.

NCD disease / nutritional status	JHLS–2000	JHLS–2008
Diabetes	7.2	7.9
Hypertension	20.9	25.2
Overweight	26.1	26.4
Obesity	19.7	25.3

Source: 2008 Jamaica Health and Lifestyle Survey (JHLS).

The trends shown in the tables above correlate with the prevalence of known predisposing factors for NCDs, namely low physical activity and low consumption of fruits and vegetables. In fact, 46% of the population surveyed in 2008 was classified as having low physical activity or being inactive and 99% reported currently consuming less than the daily recommended portions of fruits and vegetables. With regard to alcohol, marijuana and tobacco consumption, the survey showed that the prevalence of these three risk factors remained fairly constant over the period of 2000–2008 as shown below.

Table 4. Prevalence rates of illicit substances. Jamaica. 2000 and 2008. (%)

Illicit Substance	2000	2008
Alcohol	61.5	64.3
Marijuana	13.2	13.5
Tobacco Consumption	18.5	14.5

Source: 2008 Jamaica Health and Lifestyle Survey (JHLS).

In terms of care cost, it has been estimated that diabetes and hypertension absorb more than J$ 3 billion each year in direct and indirect costs.

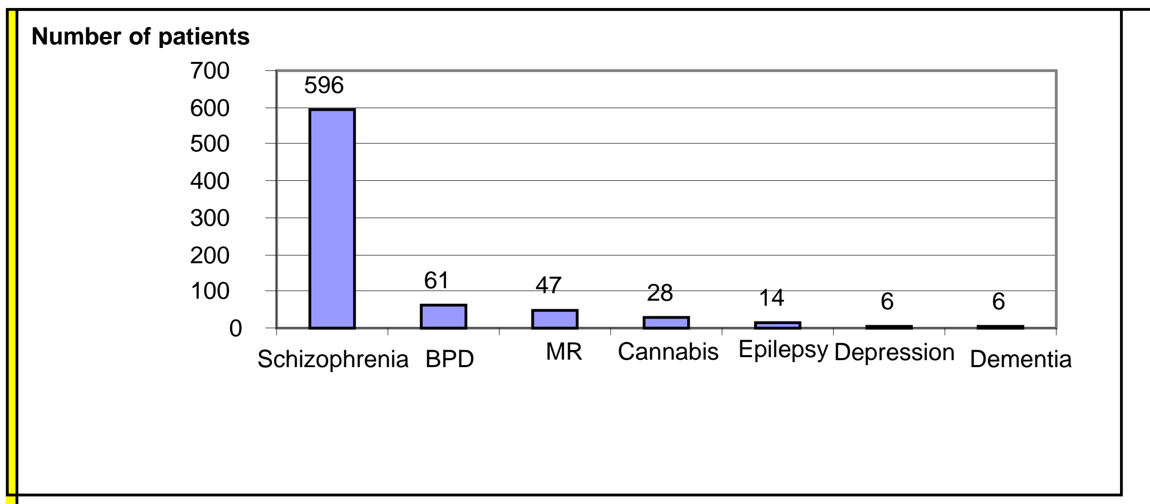
Cancers

Available data from vital statistics reports indicate that malignant neoplasms were the leading cause of mortality for both males and females in 2002 at 102.3 cancer cases per 100,000. Disaggregation by sex showed increasing rates for prostate cancer in males and breast and cervical cancers in females.

Mental health

In 2005, it was crudely estimated that 20% of the population lives with mental disorders in Jamaica and that every year about 20,000 persons are newly diagnosed with Schizophrenia. The 2008 Health and Lifestyle Survey showed that 25.6% of females and 14.8% of males included in the survey had depression symptoms. This is in keeping with the rates in the Western Hemisphere and has an impact on productivity.

Figure 7. Distribution of the major causes of in-patient admission at the Bellevue Hospital, 2009.



Crime and violence and injuries

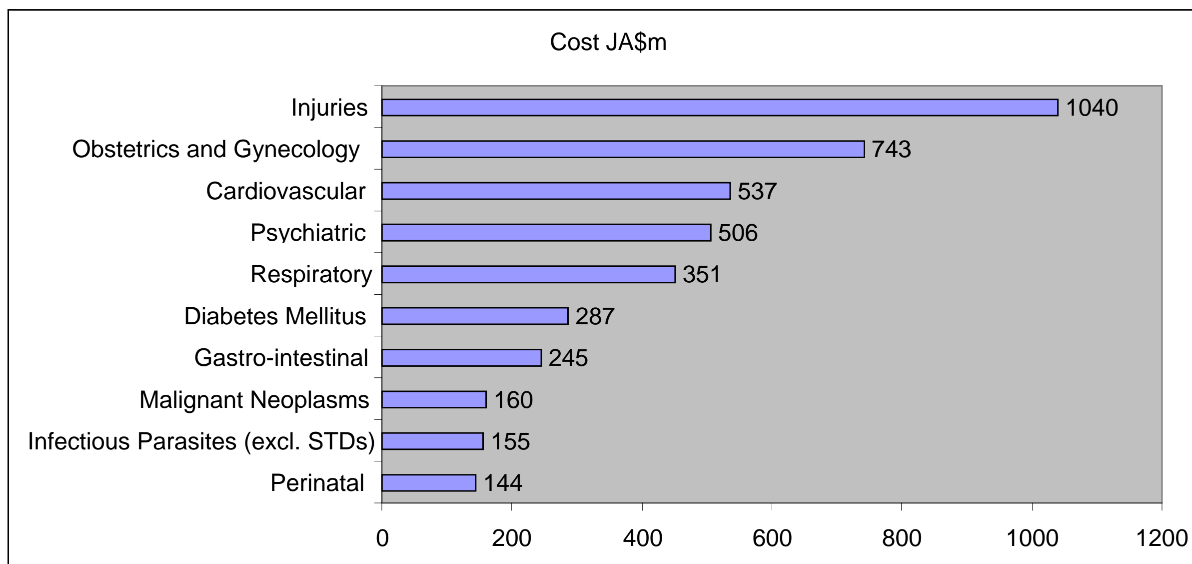
Jamaica has for a long time been plagued by a high rate of crime and violence which continues to rise against a background of political rivalry, sustained economic hardships in inner-city communities, disintegration of the social fabric and family values, intricate relationship between gang membership, gun ownership, narcotics trafficking and substance abuse, inadequacies in law enforcement and criminal justice systems, and culturally-embedded gender inequality. Jamaica's homicide rate (33.7 to 55.2 homicides per 100,000 population)[15] is one of the highest in the world.

Adolescents 10-19 years of age, mostly males, account for 26% of the total number of visits to the accident and emergency units. In 2002, gun shot wounds were responsible for 41% of these visits followed by 27% due to intentional laceration. As shown on the figure below, injuries account for the highest share of the estimated cost of the provision of hospital care in Jamaica in 2002.

The high prevalence of crime and violence impacts not only on the health sector (in terms of productivity costs such as security, working hours etc.) but also on the developmental potential of other sectors. During 2006, the direct cost of injuries due to personal violence was estimated to be about 12% of Total Health Expenditure and loss of productivity due to violence-related injuries about 4% of GDP.

[15]UN Office on Drugs and Crime. At: http://www.unodc.org/documents/data-and-analysis/IHS-rates-05012009.pdf

Figure 8. Estimated costs of provision of hospital care in a Jamaican Hospital. Jamaica. 2002.



Source: The promotion of lifestyle in Jamaica.

The country's geographical location makes it vulnerable to the international drug markets and the global underground economy that is based on the trade of criminalized commodities[16]. Uncertain local economic conditions have led to increased civil unrest, including gang violence fuelled by the drug trade. Corruption is a major concern and substantial money-laundering activity is thought to occur.

Gender-based violence

Gender-based violence against women and girls are a common occurrence in the form of rape, incest, sexual harassment, and domestic violence both physically and psychologically. The 1996 Reproductive Health Survey showed that 25.9% of 15–19 year old sexually active females had been forced to have sex at some point. In 2006, children and adolescents made up an alarming 78% of all the sexual assault/rape cases admitted to public hospitals. In the same year, girls under 16 accounted for 32% of all sexual assaults in Jamaica.

Road traffic injuries

In 2007, there were 350 road traffic deaths and 14,069 non-fatal road traffic injuries. Of these 80% were males and 20% females[17]. The National Road Safety Council, comprising all national stakeholders and chaired by the Prime Minister, has focused on a series of strategies to reduce fatal and non-fatal injuries by 50%. This is being done using "Project Below 300" and the framework for the Decade for Action for Road Safety 2010 to 2020.

2.3.4 Maternal health

Maternal Mortality Surveillance has improved and preventative and treatment interventions have been strengthened. However, maternal morbidity and mortality continue to be of concern, with Maternal Mortality Rate (MMR) remaining constant at 95 per 100,000 live births

[16] Jamaica Human Development Report 2005; *Chapter 6 – Crime and Globalization in Jamaica*
[17] Police Traffic Headquarters and Jamaica Constabulary Force.

for the past 20 years. The direct causes, namely Hypertensive Disease/Eclampsia, Haemorrhage and Sepsis, have been declining over the past 4 years but indirect causes such as HIV/AIDS, violence, and other chronic conditions such as Obesity and Cardiac Disease continue to increase. Life stresses and their impact on mental health has also come to the fore as suicide has accounted for some cases of indirect maternal deaths in recent times.

There have been some constraints, which will prevent Jamaica from achieving the Millennium Development Goal of a MMR of 25–26 per 100,000 by 2015. Some of the constraints/concerns include: Inadequate Human Resources (more than 50% of the midwifery posts in primary and secondary care remain vacant due to attrition as a result of retirement, death and migration as well as decline in the training of direct entry midwives); Management of Obstetric Emergencies available to all hospitals; Increasing prevalence of HIV/AIDS; Illegal Status of Abortions (abortions are illegal in Jamaica and its complications contribute to as much as 16% of maternal deaths in adolescents); Inadequate Funding; Impact of Violence and Inadequate Public Education/Awareness, among others. Anaemia in pregnancy remains a concern in Jamaica.

A study on Iron Deficiency in Jamaica showed a prevalence of 52.3% among pregnant women in terms of haemoglobin (Hb<11g/dl) and 38.7% using both haemoglobin and serum ferritin. (PAHO Publication)

2.3.5 Child health

The Infant Mortality Rate (IMR) was estimated at 16.7 per 1,000 live births (2008) compared with 24.5 per 1,000 live births in 2001[7]. The five leading causes of infant mortality included conditions originating in the perinatal period, Congenital Malformations, HIV, Acute Respiratory Infections and Malignant Neoplasms.

Table 5. Nutritional status for 0–35 months old children. Jamaica, 2001–2003.

Year	% Above normal	% Normal	% Grade II	% Grade III
2001	6.8	89.3	3.8	0.1
2002	7.0	89.2	3.7	0.1
2003	6.8	89.4	3.7	0,1

Source: Ministry of Health Jamaica. Situational Analysis of Food and Nutrition in Jamaica. February 2006. [18]

Nutritional status data disaggregated by sex and parish has indicated pockets of malnutrition in Jamaica. Further, a 2000 survey of children under the age of five showed that 37.6 % were anaemic, using a cut-off haemoglobin level of 11g/dl, while a 1998 study of school age children showed 23.5 % being anaemic.

As per the table below, the data reflects a decline in the levels of immunisation coverage in recent years. This indicates that there is still potential for outbreak of vaccine preventable diseases in Jamaica.

[18] At: http://healthylifestyleja.com/files/docs/Situational_Analysis_of_Jamaica.pdf

Table 6. Immunisation coverage

Immunisation Coverage	2001	2007
DPT, OPV, BCG (0-11 months)	92.6	85.7
MMR (12-23 months)	84.6	76.2

Source: Ministry of Health & Environment. Jamaica.

2.3.6 Progress towards the attainment of the Millennium Development Goals

At the 2009 Economic and Social Council (ECOSOC) meeting in Geneva, the Minister of Health in Jamaica made the presentation on behalf of the Western Hemisphere. A Ministerial Declaration titled "***Implementing the Internationally Agreed Goals and Commitments in Regard to Global Public Health***" was adopted. The Ministers reaffirmed their commitment to the achievement of the internationally agreed development goals, including the MDGs, particularly those related to health.[19]

As part of the implementation of the MDGs, the Ministry of Health continues to focus its efforts on the 3 MDG priority areas for the health sector (reducing child mortality, improving maternal health and combating HIV/AIDS, Malaria and other diseases). The 2009 National Report for the ECOSOC Annual Ministerial Review notes that significant progress has been made in the three areas mentioned above. However, the prevalence of Non-Communicable Diseases which now account for more than 50% of fatal disease outcomes was highlighted.

2.4 Environmental Determinants of Health

Jamaica is on track with its water supply (93%) and sanitation coverage (80%) to meet the Millennium Development Goal (MDG) targets for 2015. However, water and sanitation needs are still not fully covered in rural areas (currently at 42%, compared to 87% in urban areas). While the water is of high quality (microbiologically), recent studies indicate that the mineral content in water is low, particularly in rain water catchments.

Twenty five percent of Jamaican households still do not have solid waste collection coverage and none of the four landfills island wide satisfies the minimum sanitary landfill requirements. Community Based Sanitation Initiatives are inadequately funded and need to be institutionalised to ensure sustainability of the programmes.

There are currently a number of policies, legislation and guidelines that address different aspects of sanitation but their interrelationship is not well defined. Gaps, overlaps and sometimes conflicts exist resulting in less than optimal utilisation of scarce resources and the long-term beneficial impacts of some programmes are never realised.

Despite the Ministry of Health's efforts to strengthen health and safety practices in health care facilities data on occupational health and safety remains limited.

[19] At: http://daccess-dds-ny.un.org/doc/UNDOC/LTD/N09/399/96/PDF/N0939996.pdf?OpenElement

Human Resources are inadequate both in terms of quantity and quality. The environmental health problems are now more complex and more frequent. The Environmental Health Unit (EHU) has not been staffed with all the specialists needed. Both a Human Resources Situation Analysis and a better integration between demand and supply for human resources training and research are needed.

Jamaica is vulnerable to several types of natural disasters namely hurricanes, earthquakes, landslides and flooding. Jamaica has experienced several major hurricanes during the last decades and global warming is expected to increase the number of hurricanes and their magnitude. Further, the country is situated near the northern edge of the Caribbean Plate and since the 1907 Earthquake has only experienced three significant tremors of note: the 1957 Montego Bay, the 1993, and the 2005 earthquakes. Experts suggest that the island is within the 80–110 year window of recurrence of magnitude 7 earthquakes.

Landslides present a major social, economic and environmental risk to Jamaica. Increases in rainfall and storm activities, changing land use and land degradation, coupled with the lack of proper urban planning have increased the vulnerability to landslides.

The Ministry of Health has demonstrated its capacity to address adverse natural events, but efforts should continue to maintain and upgrade disaster preparedness. In recent years there has been a shift from disaster preparedness and response to a more comprehensive risk reduction approach.

2.5 Health Systems and Services

2.5.1 Service delivery

The National Health Services Act (1997) divided Jamaica into four Health Regions. Each region is governed by a Regional Health Authority and has direct management responsibility for the delivery of public health services within a geographically defined area.

Health Service Delivery in the public sector is provided through a network of Secondary/Tertiary Care facilities consisting of 24 hospitals including 5 specialist institutions (with a bed complement of 4736); and Primary Care facilities comprising 348 health centres, managed by the four Regional Health Authorities. There are 1.79 hospital beds per 1000 population. In general, in the urban tertiary level institutions, the bed capacity is inadequate to meet the needs of the population. However, this is not the case in the rural areas. The public sector hospitals provided over 95% of hospital-based care in the island (2002). Health Care Professionals in the Public Sector are often the same providers of service in the Private Sector.

Quality Assurance (QA) is undertaken by different departments of the Ministry of Health which results in a fragmented process. QA is included in the Ministry of Health's 10–year plan (2006–2015) and various regional clinical effectiveness initiatives, but the absence of QA indicators in the service level agreement within the regions and the lack of clear policy guidelines from central level impedes the implementation.

2.5.2 Health information

The Health Information System (HIS) in general is very fragmented and no HIS policy and strategic framework exist. The last available approved vital statistics date back to 1993. Since then, the country has only prepared reports using estimates based on the 1993 data.
The 2005 Audit on Vital Statistics concluded that "there is a lack of coherent and coordinated government policies with regard to vital statistics, a lack of effective and efficient communication and collaboration between and within agencies and ministries, and the absence of written standard definition of vital statistics. These deficiencies serve as significant obstacles to the production of valid and reliable vital statistics." [20] A draft of standard definitions is now available and in process of approval by the Vital Statistical Commission. Despite some achievements, annual vital statistics reports are still incomplete and unreliable in many cases. National regulations governing submission of health information between the Private and Public Sector should be strengthened.

2.5.3 Medical products and technology

There is limited drug production from imported raw material. There is a system of pharmacoviligance in place to ensure quality maintenance. The majority of the drugs used locally is imported and as prices fluctuate this leads to an increase in costs to the end user. In the long term this is not a sustainable practice. The Pharmaceutical Service is the most utilised service and access to this service increased significantly following the removal of user fees.

Over 90% of the vaccine supplies for the National Immunisation Programme are procured through the PAHO Revolving Fund. The list of Vital, Essential and Necessary Drugs and Medical Sundries for the Public Health Institutions was updated in 2008.

2.5.4 Health workforce

A study[21] on Human Resources in Health revealed shortages across the health workforce in general and more so in some specific professions and in some regions of the country. Human resources for health (HRH) density of doctors, nurses and midwives in the public sector is approximately 12.1/10,000 population, and falls to lower levels in the Southern Regional Health Authority (SRHA).

That study also showed that in addition to a severe shortage of dentists in the public sector, there is a significant shortage of rehabilitation specialists in speech and occupational therapy. There is a predominance of female professionals even in traditional masculine professions like medicine, where the research found a Male to Female Ratio of 1:1.

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20 CDC, Pan American Risk management Ass & Ernst & Young. Audit of vital registration and vital statistics systems. Report of findings and recommendations. Kingston: Vital Statistics Commission of Jamaica; August 2005

21 Wilks R, Willie D, Van den Broeck J, Hudson G, Witter AM, Foster AA & Rígoli FH. Health human resources information datasets in the Americas. Jamaican database of human resources in health. Final report. February 20, 2009. Kingston, Jamaica: PAHO, © 2009.

A major concern is the emigration of doctors and, especially, of nurses.

Table 7 Number of health workers by professional category. Jamaica 2007.

Health Professional Category	Number of health workers	
	Total	Density per 10,000 population
Dental health workers	262	0.979
Doctors and specialists	1103	4.12
Dietetics and Nutrition Professionals	97	0.359
Health administration professionals	603	2.27
Nursing aides and community health aides	2309	8.63
Mental and social health workers	169	0.643
Nurses, midwives and nurse specialists	2140	7.99
Occupational/environmental health workers	106	0.396
Pharmacy workers	172	0.643
Rehabilitation workers	50	0.187
Public health professionals (excluding doctors)	301	1.12
Technical/scientific health professionals	301	1.12
Traditional medicine practitioners and faith healers	-	-
Health education and promotion workers	157	0.561

Source: 21

A high percentage of posts (nurses, doctors and allied health care workers) are not filled in the Ministry of Health which impacts on the delivery of quality health care services.

2.5.5 Health financing

The public health sector's budget represented 2.7% and 2.6% of GDP at current prices in 1999 and 2002 respectively.[22] Government expenditure on health was 56.7%, while private expenditures accounted for 43.3%. Net out-of-pocket expenses for health care by households were 63.6% of Private Health Expenditures (2008).

Expenditure data from 2004/05 revealed that human resource cost was 82.6% of the total recurrent expenditure for Regional Health Authorities (RHAs) (compared to 79.3% in 2003/04).

Expenditures in health by the Government of Jamaica have been historically low and highly volatile, when compared with the level and patterns of public expenditures in other countries of the Caribbean. Given that government health expenditures are financed mainly with tax revenues, the prospects for government financing of health programs is severely limited by the poor performance of the economy and by the fiscal constraints and priorities of the government economic program put in place at the beginning of 2004. Current government policies are guided by a Medium-Term Socio-economic Policy Framework (MTSPF) whose economic strategy continues to enjoy broad popular and donor support, and has sought to reduce public debt from its 2003/04 level of around 140% of GDP to around 100% of GDP in the year 2008/09. Recent concerns about government revenue shortfall associated with policy slippages and declining tax compliance may limit government's ability to maintain or expand its resources allocated to health programs. From 1992 to 2006 government

[22] Evaluation of Ministry of Health 2001-2005 Strategic Plan. Final Report 2005 by Margaret Lewis (sponsored by PAHO)

expenditures in health programs have fluctuated around US$ 70 dollars per capita and has represented about 2.3% of the GDP.

On April 1, 2008, the Government of Jamaica abolished user fees from all public health facilities except for the University Hospital of the West Indies. The universal abolition of fees came one year after user fees for children were removed. A survey showed that 50.8% of the poorest quintile who reported an illness did not seek health care because they could not afford to do so (Jamaica Survey of Living Conditions 2007).

A review done ten months after abolition of user fees has shown an overall increase in patient utilisation in the public health sector. The increases for the period April to December 2008 when compared to the corresponding period of 2007 are as follows:

- (a) Admissions to hospital 1.4%;
- (b) Utilisation at Pharmacy 3.2%;
- (c) Surgeries 4.0%;
- (d) Health centre visits 9.4%; and
- (e) Outpatient visits 17.6%; Visits to Accident & Emergency: declined by 3.7%.

The trend in patient utilisation shows the following characteristics: (a) A sharp uptake in the first three months; (b) A levelling off in some areas for the second three months; (c) A decline in some areas in the latter three months of September to December of 2008.[23]

[23] At: http://www.moh.gov.jm/general/latestnews?start=10

Table 8. National expenditure on health. Jamaica. 1995-2006

INDICATOR	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
THE (1) **as a % of the GDP** (2)	4.1	4.7	6.0	5.7	5.3	6.2	5.7	5.6	5.2	5.5	4.5	5.1
Public expenditure as % of the GDP								1.7	2.5	nd	nd	nd
Private expenditure as % of the GDP								4.4	4.5	nd	nd	nd
Government expenditure on health as % of THE	52.6	60.0	56.2	58.6	50.3	52.6	43.4	57.4	50.6	56.7	48.8	53.1
Private sector expenditure on health as % of THE	47.4	40.0	43.8	41.4	49.7	47.4	56.6	42.6	49.4	43.3	51.2	46.9

Source: WHO. National Health Accounts. In: http://www.who.int/nha/country/en/index.html
(1) THE = Total expenditure on health.
(2) GDP = Gross Domestic Product
(3) nd = no data available

It is estimated that the abolition of user fees (April 2008) will cost approximately US$44 million (at constant rate), from which about 52% will be met by the government and will cover the revenue previously obtained by the user fees. The remaining is expected to be met from revenue generated from granting of casino licenses.[24]

Public expenditures in health are financed mainly with tax revenues. Current fiscal policies included in government programme focus on improved revenue collection by improving the tax administration system. However, the amount of revenues collected in the 2004/05 and 2005/06 period are below the targeted levels projected in the economic program. Shortfall in government revenue due to policy slippages and declining tax compliance, and government's commitment to prioritise governmental resources to the reduction in the debt burden are major constraints affecting the Government of Jamaica's ability to maintain or expand government resources allocated to health programs. Without major changes in the current economic program and/or in budgetary priorities, no significant change is expected in the relatively low and highly volatile levels of government expenditures in health programs.

The data shows that there is a general downward trend in Health Care Financing. This has been compounded by a recent decision of the Government to reduce the national budget by 20%. The reduction of the budget may jeopardize the quality and access to health care by the

[24] Planning Institute of Jamaica. Economic and social survey of Jamaica. 2008. Kingston: PIOJ; April 2009. Chapter 23

medically indigent or lower quintile of the population. This can increase the level of out-of-pocket expenses and further widen inequities in health care access.

2.5.6 Leadership and governance

In 1997, the Government embarked upon health sector reform which partially decentralised health care services to the regions and strengthened the steering role of the central Ministry of Health. An evaluation of the impact of decentralization conducted in 2003 revealed minimal levels of improvement in health planning, service delivery, accountability, transparency and community involvement[25].

The 2001 Evaluation of the Essential Public Health Functions (EPHFs) identified the four weakest functions as Quality Assurance, Health Promotion, Research and Human Resource Planning and Development. PAHO/WHO's last three Biennial Work Plans (2004–2009) have been focusing on the EPHFs and some improvements have been shown in human resources planning and health promotion.

There is greater opportunity for the engagement of civil society as key partners in health planning and delivery. Across the areas of HIV/STIs, Non-Communicable Diseases and Violence Prevention there is active involvement of Civil Society, perhaps due in part to the fact that these areas have crafted the health response in the context of a broader multi-sectoral framework. Most recently, and probably for the first time, Faith Based Organisations partnered with the Ministry of Health to assess the role of the church in responding to chronic diseases and promoting healthy lifestyles.

[25]"Impact Assessment of Decentralization and delegation initiatives" Draft Repot in Jamaica Human Development Report 2005.

2.6 Main National Health Policy Orientations and Priorities

The Jamaica National Development Plan: Vision 2030 outlines the long term development goals including health. The National Health Strategies identified are the following

Table 9. National Health Strategies and Responsible Agencies. Jamaica. VISION 2030.

NATIONAL STRATEGIES	RESPONSIBLE AGENCIES
1-1 Maintain a stable population	Planning Institute of Jamaica Ministry of Health and Environment Statistical Institute of Jamaica National Family Planning Board
1-2 Strengthen disease surveillance, mitigation, risk reduction and the responsiveness of the health system	Ministry of Health and Environment
1-3 Strengthen the Health Promotion Approach	Ministry of Health and Environment Private Sector Partners NGOs FBOs CBOs
1-4 Strengthen and emphasize the primary health care approach	Ministry of Health and Environment Private Sector Partners
1-5 Provide and maintain an adequate health infrastructure to ensure efficient and cost effective service delivery	Ministry of Health and Environment Private Sector Partners
1-6 Establish and implement a sustainable mechanism for supporting human resources	Ministry of Health and Environment
1-7 Establish effective governance mechanisms for health services delivery	Ministry of Health and Environment
1-8 Support national food security	Ministry of Health and Environment Ministry of Agriculture Office of the Prime Minister (Lands)
1-9 Strengthen the linkages between health and the environment	Ministry of Health and Environment National Environment and Planning Agency Ministry of Agriculture Office of the Prime Minister
1-10 Introduce a programme for sustainable financing of health care	Ministry of Health and Environment Ministry of Finance and the Public Service

Source: Planning Institute of Jamaica. Vision 2030 Jamaica: National Development Plan. Kingston: Planning Institute of Jamaica; 2009.

The Medium Term Socio-economic Policy Framework sets out the core package of policies, strategies and programmes proposed by Government for implementation over the period 2009–2012 and supports the overall vision, goals and outcomes of the long term Vision 2030.

The National Health Policy and the accompanying Strategic Plan 2006–2015 were prepared within the framework of the Medium Term Social and Economic Policy and took into account international and regional guidelines and other national plans.

The major National Health Priorities as outlined in the National Strategic Health Plan include:

- Population health
- Individual health care
- Quality management
- Disaster management
- Leadership and management
- Communicable and non communicable diseases

The primary health care approach with its emphasis on people-centered services, community participation and inter-sectoral collaboration remains an essential policy objective of the Jamaican health services. One of the strategies used by the government to increase universal access to health care has been the abolition of user fees.

In addition, Legislation was introduced to promote and protect the rights of children (The Child Care and Protection Act, 2005), provide enhanced protection for victims of domestic violence and abuse (the Domestic Violence Act, 1998), and protect the property rights of men and women in the event of a breakdown in a marriage or union after five years (The Property Rights of Spouse Act). Progress was made on the drafting of the National Assistance Bill to replace the Poor Relief Act and the Disability Bill to strengthen implementation of the National Policy for Persons with Disabilities. The upgrade of Building Codes and introduction of risk reduction measures and environmental legislation (Water Policy and Implementation Plan, Regulations for the Management of Septage and Sludge, and Hazardous Waste Regulations) were also introduced to reduce the impact of environmental and natural hazards on the population.

In line with its international commitments, Jamaica has ratified a number of international conventions including:

- The WHO Framework Convention on Tobacco Control (ratified by Jamaica on 7 July 2005);
- The International Health Regulations (2005) which came into effect on 15 June 2007 and it is expected by 2012 Jamaica would have addressed gaps in its core capacities for disease surveillance and response and port health requirements;
- The Convention for the Protection and Development of the Marine Environment in the Wider Caribbean Region (Cartagena Convention) entered into force on 11 October 1986, and was ratified by Jamaica on 01 April 1987, for the legal implementation of the Action Plan for the Caribbean Environment Programme.[26]

In spite of the health sector reform and availability of various legislations, effective implementation of the policies, sustainability of accompanying initiatives, reduction of the spread of HIV/AIDS, maternal/child mortality and control of lifestyle diseases remain important challenges.

[26] http://www.cep.unep.org/pubs/legislation/cartxt.html

2.7 Major Health Challenges and Priorities

Based on the Situation Analysis presented above, the following remain major health challenges for Jamaica:

1. Weak public health leadership and management.
2. Undefined health care model and essential health package.
3. Health care financing and sustainability of health services
4. Incomplete mechanism to support decentralization of health services and the stewardship role of the MOH.
5. Weak and fragmented health information system with no national health information policy, unreliable data and limited reporting by the private sector.
6. Limited absorptive capacity and bureaucratic administrative processes, accountability and reporting.
7. High incidence of crime and violence and costs to the health sector.
8. Insufficient policy frameworks and standards and inadequate planning, monitoring and evaluation, and enforcement of health legislation.
9. Inadequate management of health conditions and diagnostic services.
10. Reduction in national budget and external aid due to country's classification as "Lower Middle Income country".
11. Limited inter-sectoral coordination for effective health outcomes; aid effectiveness.
12. Re-emergence of vector borne diseases.
13. Maternal and infant mortality.Decrease in immunisation coverage.
14. Increase in the burden of chronic non communicable conditions and risk factors.
15. Continued upward trend in prevalence rate of HIV/STIs and their co-infections.
16. Migration of health human resources.
17. Weak Essential Public Health Functions: Quality Assurance, Regulation Health Promotion, Research and Human Resource Planning & Development.
18. High vulnerability to natural hazards.
19. Environmental degradation and hazards due to inadequate land use/planning.
20. Impact of climate change.
21. Inadequate solid waste management.
22. The impact of food crisis on food security and nutrition.
23. Deficiency in environmental health (monitoring of drinking water quality, inadequate management of rural water systems, food safety, OSH, training).

Based on the analysis of the situation and the consultations with national authorities and stakeholders, the following national health priorities were agreed upon:

Table 10 Health priority areas.

Health Priority Areas	Key Issues
Governance	Public health leadership and management, restructuring of MOH around functions/matrix approach, establishing health policy frameworks, review health sector reform, RHAs, strengthening and streamlining strategic planning, strengthening accountability, sustainability, intersectoral collaboration and coordination, knowledge sharing and management, health diplomacy and advocacy skills to influence decision-making.
Health Systems and Services	Quality assurance, financing, primary health care renewal, define sustainable/cost effective package of health services, integrated health information system, health accounts, human resources development (recruitment, retention and needs-based planning), access to health technologies and diagnostic services
Chronic Diseases and prevention and lifestyle related problems	Integrated managements of NCDs, cancers, tobacco control (legislation), multisectorial collaboration
Maternal and Infant Mortality	Reduction in the high rates, Unreliable and outdated data. Low coverage of some vaccines, especially MMR.
Adolescent Health, and Sexual and Reproductive Health	Gender approach. HIV/AIDS and road accidents. Pregnancy in adolescents.
Disaster Management	Land use planning, risk reduction, safe housing
Environmental Health	Vector control, drinking water and sanitation, implementation of food safety policy, solid waste management (incl. medical waste), chemical residues (i.e. heavy metals and other hazardous chemicals), institutional strengthening, including training of EHOs, promoting safe and healthy environments
Epidemiological Research and Data Analysis	Operational research, application of GIS, epidemiological profile for Jamaica
Health Promotion and Education	HFLE, HPE, scale up health education to impact behaviour change, promotion of physical activity, creation of healthy zones, health promotion in schools, safe motherhood programme
HIV/AIDS/STIs and TB	Prevention, treatment care and support HIV/TB confection. HIV Drug Resistance. Confection with other STIs.
Mental Health	Community health services, integration at primary and secondary health care,
Food Security and Nutrition	Nutritional policy and standards, analysis and mitigation of impact of food crisis
Surveillance and Outbreak Response	Strengthening surveillance systems, IHR, influenza preparedness and response, lab strengthening, analysis of burden of disease
Violence and Injury Reduction	Gender based violence, community violence, road traffic injuries

3. DEVELOPMENT ASSISTANCE AND PARTNERSHIPS: TECHNICAL COOPERATION, INSTRUMENTS AND COORDINATION

3.1 Introduction

Official Development Assistance (ODA) was used to assist in meeting Jamaica's development objectives, to foster social well-being and enable private sector investment. International Development Partners (IDPs) contributions in the post hurricane recovery and rehabilitation efforts were critical to the country's ability to return to normality after each hurricane.

Jamaica's classification as a lower middle-income country, coupled with IDPs shift of resources to poorer, fragile nations reduced Jamaica's eligibility for highly concessional loans and grant assistance. The high debt burden and limited fiscal space diminished Jamaica's capacity to borrow, thereby affecting the amount of ODA available for public investments. Total repayments to the three major lending agencies for principal, interest and other charges exceeded disbursements, thus reducing the available funding for areas such as health from both the Government of Jamaica and IDPs.

A major concern, however, is the perception that the Health Sector has been overshadowed, in the past few years, by the increased emphasis placed on the education sector. In effect the visibility of some health priority issues has been lost.

Greater attention was therefore paid to increasing the efficiency with which development assistance was delivered and utilised. In an attempt to better target resources, donors and lenders were encouraged to align their country analysis and assistance with the Government's MTSPF which was prepared in 2004 in collaboration with a wide range of stakeholders, and approved by the Government in 2005. The second MTSPF was developed in 2008 an approved in May 2009.

The MTSPF has been used by the IDPs as the basis for the priority areas of collaboration and the indicators agreed upon are in keeping with the MDG and are based on data currently being collected by the various sectors.

In addition, the Country developed its National Development Plan 2030 (NDP) with extensive multi-sectoral consultations. The plan included a Road Map for health. In conjunction with the MTSPF, the NDP allows donors and IDPs to align their programmes to the national priorities. This has facilitated planning by the IDPs for better utilisation of aid funds to meet the health needs of the Country.

These frameworks should foster better coherence and collaboration between IDPs and the GOJ.

In 2007–2008, several development partners initiated or completed their respective country assistance papers and some carried out reviews of the Country Support Strategy and National Programme in collaboration with the Government of Jamaica. This resulted in the reshaping of the programme, a shift from project to programme support by some agencies and although most budgets were reduced, an attempt was made to arrive at a fiscally

manageable solution, without compromising the development objectives of the projects/programmes. This process allowed the health sector opportunities to focus on priority areas.

Challenges
Financing emergencies/crises in the health sector is difficult within the limited health budget. Consequently, some funds are not being used for the initially planned purpose and reprogramming requests are frequently received to meet these emerging needs. Of concern, is the long delays in executing jointly planned and agreed on activities that result in loss of donor funding in many instances.

Increased use of planning and evidence-based approaches with better coordination, timely implementation, increased understanding of rules of accountability for donor funds would go a long way in addressing the challenges faced both in the health sector and by IDPs working in this area.

3.1.1 External financing

Official Development Assistance (ODA), in the form of loans, grants and technical assistance from multilateral and bilateral sources, continued to be a critical component of the financing plan for projects and programmes within the Government's Public Sector Investment Programme. ODA supported the development objectives of the Government through a portfolio of projects and programmes currently estimated at US$1.5 billion (JA$93.9 billion)[1]. Loans represented approximately 70.0% of the portfolio.

During 2009, Government's fiscal constraints limited its capacity to take advantage of available loans from Multilateral Financial Institutions[2]. The Government however, accessed loans totalling US$105.0 million (JA$6.6 billion), at highly concessionary rates through Bilateral Cooperation Programmes with Belgium and China. These loans were for improvements to the transportation system in Kingston and St. Andrew, the construction of a stadium in Trelawny, and the rehabilitation of water supply systems island-wide. Grant funds were also provided for the continued reconstruction of infrastructure damaged by Hurricane Ivan and the construction of a sports complex in Sligoville, St. Catherine.

New country strategies were developed to provide the framework for the cooperation programmes between the Government and several of its IDPs for the next three to five years (See Table 11).

The Government has also initiated discussions with the International Monetary Fund to provide development assistance to Jamaica.

Table 11 . International Development Partners support to Jamaica. 2008-2009.

Agency	Area of Support	Net Contribution (US$m)
CDB	Economic Infrastructure; Productive Sector; Social Infrastructure; Administration	N/A
CIDA	Environmentally sustainable economic development; Lowering levels of poverty; Increasing citizens' security; Achieving greater economic stability	N/A
DFID	Community safety & security; Public sector modernisation	N/A
EU	Largest provider of grant resources to Jamaica; Reform of agriculture sector; Economic reform programme; Economic infrastructure; Poverty reduction; Emergency assistance as budgetary support; Technical cooperation	N/A
FAO	Food Security	N/A
GFATM	HIV/AIDS	15.2
IBRD (World Bank)	Childhood development; Inner city and rural development; HIV/AIDS	N/A
IDB	Economic infrastructure; Productive and social sectors, as well as security and justice; Private sector development and a small loan facility	N/A
PAHO/WHO (incl. CFNI)	Health Systems Strengthening; Environmental Health; Disease prevention and control; HIV/STIs & Tuberculosis; Nutrition	3.55
UNAIDS	HIV/AIDS	0.15
UNDP/UNRC	UN Resident Coordination; Environmental Protection; Democratic Governance, Poverty; Gender	N/A
UNEP	Pollution Control; Water Quality; Sanitation	N/A
UNESCO	Education; HIV/AIDS; Biosphere; Research; Networks	0.88
UNFPA	Sexual and Reproductive Health; HIV/AIDS	N/A
UNICEF	HIV/AIDS; Child Protection; Quality Education; Early Childhood Development	7.3
USAID	Education; Health; Poverty and improved business; environment; Environmental Relief and Disaster; Preparedness and Response	N/A

Bilateral cooperation

The Governments of Cuba and Jamaica have had cooperation projects in health, education, construction, agriculture, sugar and sports since establishing diplomatic ties. In Jamaica there are today more than 140 Cubans assisting in different programmes, including the Eye Care Programme (Miracle Mission). From 2005 to December 2008, 5,022 Jamaican patients were operated on in Cuba under the bilateral arrangement. There are more than 350 students from Jamaica studying medicine in Cuba.

The Republic of China provided humanitarian and reconstruction aid. Mexico, Colombia, Brazil, the Government of the Czech Republic and Chile have cooperated primarily in the areas of training and exchange of personnel. Argentina, Chile, Mexico, Venezuela, and Trinidad and Tobago supplied post-hurricane assistance in the form of finance, food and medicinal items.

Based on the new framework for Japan-CARICOM cooperation which came into effect in 2000, Japan's Official Development Assistance (ODA) focused on areas including poverty reduction, security improvement, conservation of the environment, natural disaster prevention and the project for the expansion of domestic water supply. The Japan International

Cooperation Agency (JICA), Japan Bank for International Cooperation (JBIC) and the Embassy of Japan work in a collaborative effort to provide assistance through international Organisations such as the United Nations Development Programme (UNDP), Inter-American Development Bank (IDB), United Nations Education, Scientific and Cultural Organisation (UNESCO) and the United Nations Children Fund (UNICEF).

Under a bilateral loan-aid programme, the Japan Bank of International Corporation (JBIC) has provided US$550 million to enable Jamaica to carry out several projects: a commodity loan, barge-mounted diesel power plant, Blue Mountain Coffee Development, Montego Bay Great River Water Supply, Telecommunications Network Expansion, Emergency Reconstruction Loan, North Coast Development and Kingston Metropolitan Area Water Supply and Rehabilitation Project.

Global Health Partnerships and Funds

Jamaica has been beneficiary of funding under the GFATM for the HIV stream in Rounds 4 and 7. The country was recently ranked 7th for its execution of GFATM funds and has been documented as a best practice for the Country Coordinating Mechanism's handling of Conflict of Interest. Jamaica intends to develop and subsequently submit to future rounds for the Malaria and Tuberculosis streams as well.

Intergovernmental Partnerships

In collaboration with PAHO/WHO, UNECLAC, UNDESA, the CARICOM Secretariat with the Government of Jamaica, the Ministry of Health hosted the 2009 ECOSOC meeting for the Western Hemisphere. This meeting focused on HIV/AIDS and development in preparation for the Annual Ministerial Review on implementation of internationally agreed goals and commitments to global public health. Jamaica subsequently presented its National Report and the Regional Report at the Annual Ministerial Review (Geneva, July 2009).

The Sub-Region benefited from the CARICOM/Spain Cooperation project on Support for the Prevention and Control of Cervical Cancer in the Region. The PAHO/WHO-Spain cooperation was also instrumental in response to AH1N1 pandemic.

3.1.2 Sector allocation

The New Health Sector Official Development Assistance Funded Projects include:

- 2008 Social Protection and Food Price Crisis is funded by IDB for US$15 million. This project is aimed at protecting the consumption levels of existing PATH beneficiaries and supporting improvement in the efficiency of PATH.
- The second HIV/AIDS Project is funded by World Bank for US$10 million and will continue to assist the government in financing the National HIV/AIDS Programme.
- The Global Fund to fight AIDS, Tuberculosis and Malaria signed a five-year programme for US$44.2 with the Ministry of Health. The objective of this programme is to consolidate gains made in reducing the impact of the HIV/AIDS epidemic, and to work towards universal access to HIV treatment, care and prevention services with special emphasis on vulnerable groups.
- PAHO/WHO earmarked US$1.8 million for Jamaica's health sector for implementation of projects in the areas of Disease Prevention and control; Health System and Services Development; Environmental Health and HIV/AIDS.

- The International Atomic Energy Agency (IAEA) provided US$4,192,800 for the Non-Exercise Activity Thermogenesis and Weight Gain Project, which will contribute to the design of intervention programmes to prevent and manage the burden of obesity and co-morbidities.

- The Nutritional Status and Exposure to Toxic Elements in Jamaican Children are funded by International Atomic Energy Agency (IAEA) for US$113,730. The project aims to strengthen the capacity to monitor elemental intake and improve diagnostic capacity to detect excess toxic elements in children.

Together, these new funds total US$75.31 million.

3.2 National Ownership

The Government of Jamaica has identified national priorities, as reflected in the following key documents including the following:

- Vision 2030 Development Plan
- Ministry of Health Strategic Plan for the Health Sector (2006–2015)
- Mid-Term Socio-economic Policy Framework
- National Strategic Plan (NSP) for HIV/AIDS
- National Strategic Plan (NSP) for Tuberculosis

However, aid flow into the Country is not always optimally aligned to the identified national priorities but in some instances respond to specific donors' interests which negatively affects national ownership. Most of the aid funds in the health sector are directed to interventions in HIV/AIDS, Tuberculosis, Malaria, Social Protection and Stabilization of food prices. More support is needed for other areas such as Non-Communicable Diseases and Health Systems (including Health Information).

Resource constraints, both human and financial, in the health sector also restrict the Ministry of Health's ability to manage and implement stated priorities. This therefore impacts on the national ownership of some programmes as some activities are labelled as donor driven activities and not seen as Ministry of Health's activities. Furthermore, the Ministry of Health recognises the importance of coordination and alignment with donor partners and has established a full-time post within the Ministry for this purpose. This, however, will need to be strengthened to improve national ownership of donor funded projects.

3.3 Alignment of International Cooperation with the National Health Agenda

The Government of Jamaica held extensive national consultations towards the development of the National Health Plan, the 10-Year Strategic Health Plan 2006–2015, the National Development Plan to 2030 and broad-based consensus was arrived at prior to approval of these plans. In addition, the Government has held extensive consultations with the IDPs to define health indicators to be monitored towards the achievement of the National Plan. The indicators used currently collected national data to assess progress towards the goals and timelines established. These indicators were jointly agreed upon by the different Ministries and the IDPs.

Arising from a participatory process, involving Government of Jamaica/IDP/Private Sector/CBO and other stakeholders, an array of priorities and strategic objectives was developed under the following thematic areas:

1. Health
2. Environment and Poverty
3. Justice, Peace and Security
4. Education
5. HIV/AIDS

These groups met 3–4 times per year, discussed the priorities for the sector with the intent of providing guidance in the implementation of programmes, under the Chairmanship of the Permanent Secretary, and co-chaired by an IDP Agency Head. PAHO/WHO co-chaired the Health Thematic Group, which reported to Parliament on progress towards health goals. Many agencies used these MTF indicators and their achievements to decide on new disbursement of aid in their relevant sectors. The new MTF with its improvements in indicator specificity will further assist in monitoring the alignment of aid flows with national priorities.

Table 12. Linkage between Jamaica CCS Strategic Priorities and UNDAF Outcomes.)

Jamaica CCS 2010–2015 Strategic priorities		UNDAF Outcomes[27] (2007–2011) and its relevant Programme Outcomes
1	Strengthening Governance and Health Systems within the Framework of the Renewed Primary Health Care approach	**UNDAF Outcome**: **#4.** National (all levels) capacity strengthened to improve quality of life through promotion of healthy lifestyles and the delivery of equitable, integrated quality health services. **Relevant Programme Outcomes:** Family health services strengthened. Accurate and timely vital health statistics made available for decision-making. Access to better, integrated, quality services improved.
2	Reducing the Burden of Diseases	**UNDAF Outcome**: **#3**. By 2011 national capacity to ensure equity and equality strengthened, and the population of targeted vulnerable communities enabled to reduce poverty, improve their livelihoods and better manage hazards and the environment. **Relevant Programme Outcomes:** National capacity enhanced to reduce the risk of natural and man-made hazards. Integrated land, coastal zones, water and energy management practices improved.
3	Supporting the Achievement of the MDGs	**UNDAF Outcome**: **#2.** By 2011, have a sustained, co-coordinated multi-sectoral national response to ensure universal access in HIV/AIDS prevention and care services. **Relevant Programme Outcomes:** Creation of a supportive and enabling legislative and policy framework, being effectively implemented with a gender differentiated focus. Establishment of one national HIV/AIDS response coordination and management authority to involve all relevant sectors and effective functioning. Increase in prevention and treatment services.

[27] The UNDAF comprises of a very limited number of Major Outcomes usually 4 to 6.

4	Addressing Determinants of Health	**UNDAF Outcome**: **#5.** By 2011, increased capacity of government and targeted communities to attain a more peaceful, secure and just society. **Relevant Programme Outcomes:** Improved governance and enhanced inter-sectoral response to social injustice. A sustained reduction of violence in targeted communities.
5	Strengthening PAHO/WHO's Response to Priority Health Needs	n/a

3.4 Harmonisation of International Cooperation

The development of the Western Caribbean Donor Group to support a rapid response to natural disasters is another example of a good practice in aid harmonisation. As Operational Guidelines were developed, they defined what type of aid was needed, along with agreement on inter-regional collaboration to facilitate rapid humanitarian responses. The CCA/UNDAF developed in collaboration with all UN agencies and the Government of Jamaica has guided the UN response in many health areas. The UNDAF review carried out in 2008 has allowed us to realign our cooperation in the health sector. The UNAIDS Theme Group supports the Ministry of Health's HIV/AIDS Implementation Unit in the development and implementation of National Plans for HIV/AIDS. These activities are complemented by good data collection/analysis with contributions from all agencies.

The Pan Caribbean Partnership on AIDS (PANCAP) in collaboration with most agencies working with AIDS and CARICOM, provide policies and general guidelines for the interventions in HIV/AIDS for the Caribbean.

PAHO/WHO has served as a strategic partner and honest broker between the country and some external partners, and has collaborated with the government in managing and monitoring aid flows in the health sector. A concern of ours is the great dependency on short-term external funding for the health sector and the severely limited resources available for capital development, which mitigates against sustainable outcome and capacity development.

3.5 UN Reform Status and Process

The eight UN agencies in Jamaica have shared and discussed the reports and pilot results of the UN reform process and have examined the implications for the UN system in Jamaica. Joint planning and training are carried out among UN agencies, using the comparative advantage of each agency at national and sub-regional level.

UNCT activities have focused on fostering a position of joint responsibility for programmes being implemented. We have used cost-sharing across sister agencies to improve on our cost-effectiveness. There are challenges associated with the lack of common finance and administrative systems that limits, to some extent, our collaboration in joint activities. However, the acknowledgement by national stakeholders of the technical strengths of

PAHO/WHO and their willingness to work with PAHO/WHO in addressing priority health issues to the extent where we are consulted and become a part of the decision-making process in the implementation and use of health-related aid to the Government of Jamaica.

The greatest challenge is the reduction of aid flows, as a result of the reclassification of Jamaica, as a lower middle-income country. This affects significantly the IDP responses in the health sector.

The UNDAF 2007–2011 outlines the UN collective response to Jamaican national priorities. All areas identified in the UNDAF have joint programming and the Mid Term Evaluation has demonstrated positive inter-agency collaborations. It further reflects the absence of a common financial system to allow inter agency transfer of funds in the context of joint programming.

3.6 Managing for Results and Mutual Accountability Mechanisms

The existing mechanisms for monitoring and management aid flow are inadequate. There is a difficulty in determining the amount of funds coming to the Country to support health priorities. The Planning Institute of Jamaica (PIOJ) collects data on aid from IDPs but the published data is incomplete.

The MTSPF indicators/MDGs/UNDAF and other reports collect data on achievements towards agreed on goals for the health sector. However, a formal mechanism to review aid flow and to direct assistance towards identified gaps is not well developed.

With respect to government procurement guidelines, these are lengthy and to a great extent retard the process of implementation of projects.

The Results Based Management approach, which would greatly improve the planning and performance in the health sector, is yet to be fully integrated. There is also too much focus on the project rather than programme based approach. In some instances, a clear link to the national health plans is difficult to establish.

4. PAST AND CURRENT PAHO/WHO COOPERATION

4.1 Brief Historical Perspective

In 1954, the Pan American Health Organisation/World Health Organisation (PAHO/WHO) under the administration of its Zone 1 Office in Caracas, Venezuela established a small office in Jamaica. Malaria, a major health concern of that period, was the immediate focus of technical cooperation.

Following Jamaica's independence in 1962, an Agreement was entered into between the Government of Jamaica and WHO (1963). The PAHO/WHO Jamaica office was re-organized and the programme of technical cooperation expanded with international professional staff in place. The Office also served five other countries - Bahamas, Belize, Bermuda, the Cayman Islands and Turks and Caicos until the late 1970s to early 1980s, when Bahamas and Belize established their own PAHO/WHO offices with Bahamas being responsible for Turks and Caicos. Today the PAHO/WHO Representation in Jamaica continues to serve Bermuda and Cayman Islands.

The office collaborates closely with the Caribbean Food and Nutrition Institute (CFNI), a specialized PAHO/WHO centre located in Jamaica. The PAHO/WHO office represents CFNI with respect to protocol and some political issues, while CFNI provides technical cooperation in specialized areas to Jamaica and the Caribbean Sub-Region, in accordance with its regional agreements with the countries.

The Jamaica office has close working links with the Caribbean Epidemiology Centre (CAREC), another PAHO/WHO specialized centre located in Trinidad, providing managerial, administrative and financial support for CAREC activities undertaken in Jamaica. There is also collaboration between the country office and the Office of Caribbean Programme Coordination in Barbados, with support given for technical cooperation activities where necessary.

4.2 SWOT Analysis of PAHO/WHO Cooperation

Table 13. SWOT analysis of PAHO/WHO cooperation in Jamaica.

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
The PAHO/WHO office has staff with good administrative and accounting skills which facilitates adherence to Organisational rules and procedures and assists with accountability and transparency.	An inhibiting factor at the HQ level is the inordinate length of time taken to get responses to urgent issues, such as procurement during emergency situations.	In certain specific areas the skills of Ministry technical personnel may exceed skills in PAHO/WHO office, so in these areas we should not be trying to provide technical cooperation. In these areas we should identify PAHO's comparative advantage to focus our technical support.	There is also fragmentation of the health care delivery system as there is no cohesive policy governing the use of information for decision making.

The PAHO/WHO office benefits from staff with strong technical skills in the areas of priority. However, the COs capacity will be temporarily weakened by the reassignment of the Health Services Advisor and retirement of the Environmental Health Advisor in 2010.	The CO can improve in certain areas of service delivery, such as adopting a more proactive approach to technical projects, particularly where there are perceived gaps in the Ministry. There is a need to adopt a more hands-on approach given the diminishing human resources in the Ministry.	The MOH Jamaica has technically sound resource personnel, many of whom provide technical expertise to other Caribbean countries where the resource base is not as strong.	A perceived area of weakness that impacts negatively on PAHO/WHO technical cooperation with the Ministry is the lack of defined leadership at certain levels. Despite considerable time and effort spent on Health Reform and decentralization over the past few years, the central unit of the Ministry has not completely shifted over to its role as policy maker but is still involved in operational activities which are the domain of the regions. This has led to confusion at the lower levels and to stagnation in some instances as some projects which are conceptualized are not implemented.
As a good broker, the CO has been able to pull individuals to work in a collaborative manner and can also call on expertise from other Regional offices for support.			PAHO/WHO is also concerned that the pending retirement of key senior officials in the Ministry will further worsen the leadership issues.
PAHO's programmes address the priority needs of the country and are aligned to the Medium Term Socioeconomic Policy Framework (MTF). As testimony to the work done, PAHO/WHO has been asked to be part of the Vital Statistics Commission (VSC), an advisory arm of parliament. The CO has also been asked to coordinate the International Development Partners (IDP) within the health sector.			The Ministry is now more focused on curative rather than preventive care so PAHO/WHO will have to focus more of its TC on prevention and health promotion.
			Financing for health care has been decreasing and with the policy shift of the MOH of removal of user fess for services, the CO will experience difficulty with implementation if active resource mobilization is not pursued.

4.3 PAHO/WHO Cooperation Overview

For the 2008–2009 biennium the priority areas identified for technical cooperation were:

- Renewal of Primary Health Care
- Strengthening of Health Information Systems
- Prevention and control of lifestyle related health problems
- Promotion of safe and healthy environment
- Disaster risk reduction
- Violence/Injuries reduction
- Strengthening of an integrated family health approach
- Strengthening of national capacity for the control and prevention of communicable diseases
- HIV/AIDS

These priority areas were being addressed under five projects, namely;

- Health Promotion and Disease Prevention and Control
- Health Systems and Services development
- Sustainable Development and Environmental Protection
- Coordination of Programme Support
- HIV/AIDS treatment, care and support

Table **14. Linkage of TC priority areas (BWP 2008-2009) against WHO Core Functions.**

JAM Priority areas for technical cooperation (TC) (2008-09)	WHO Core Functions					
	1 Providing leadership and engaging in partnerships.	**2 Shaping research, stimulating knowledge & dissemination.**	**3 Setting norms and standards, promoting and monitoring their implementation.**	**4 Articulating ethical and evidence-based policy options.**	**5 Providing TC, catalyzing change, building institutional capacity.**	**6 Monitoring health situation and assessing health trends.**
Renewal of Primary Health Care	Full and active partner in the Ministry of Health's PHC Task Force.	Active partner in research on workforce for health.	Supporting country's adherence to various strategies such as: WHO Medicines Strategy, the Universal Access.	TC on human resources development, social protection and health financing.	To contribute to building sustainable institutional capacity for the strengthening of decentralization on a PHC framework.	Human Resources for health observatory. Strengthening health services data collection on production, and costs.
Strengthening of Health Information Systems	Active member of Vital Statistics Commission. Engaging with other Member States to provide TC on civil identification.	Support a HPV prevalence study.	Intense promotion for adoption of PAHO/WHO's health indicators definitions, and ICD10.	Inter Caribbean cooperation on health information systems.	Training in ICD10.	Support strengthened of vital statistics and national civil identification system.
Prevention and control of lifestyle related health problems	National dialogue to support implementation of Port of Spain Declaration on NCD.	Support to health and lifestyle survey.	Implementation of diabetes quality improvement project.	Consultation on NCD planning based on recent data.	Training on NCD management.	Launch of National Surveillance Manual including indicators for NCD monitoring.
Promotion of safe and healthy environment	Direct technical cooperation for environmental health situation analysis, advocacy and intersectoral approach	Support to vector, heavy metals research and dissemination of findings	Advocacy for the adaptation of different WHO guidelines	Actively working on Health Impact Assessment within the framework of Environmental Impact Assessments of developmental projects	Promotional activities for the use of essential Public Health Function in environmental health analysis	Support to surveillance activities and assessment of environmental health conditions
Disaster risk reduction	Active participant on initiatives related of natural and man made disasters	Working on Safe Hospital Evaluations	Support for the development of Design Standards for Health Care Facilities		Support for development of institutional capacity to respond to AH1N1 Pandemic	Active member in the evaluation of health damage from disasters.

JAM Priority areas for technical cooperation (TC) (2008-09)	WHO Core functions					
	1 Providing leadership and engaging in partnerships.	**2 Shaping research, stimulating knowledge & dissemination.**	**3 Setting norms and standards, promoting and monitoring their implementation.**	**4 Articulating ethical and evidence-based policy options.**	**5 Providing TC, catalyzing change, building institutional capacity.**	**6 Monitoring health situation and assessing health trends.**
Violence/Injuries reduction	Collaboration with Ministry of Health VPA and UN agencies on violence prevention initiatives.	Support to injuries surveillance.	To support NGOs to develop plan for monitoring violence prevention programme at community level.			Support health information system development.
Strengthening of an integrated family health approach	Supports for Safe Motherhood programme through inter UN agencies cooperation.	Dissemination of information.	Support for the development of Obstetric Emergency Guidelines.	Men's role in families.	Family Health Manual completed and disseminated.	Gender-based violence.
Strengthening of national capacity for the control and prevention of communicable diseases	Collaboration with Ministry of Health and other partners on disease outbreak management.	Support to assessment of disease burden.	Development of CD guidelines.	Use of GIS for mapping of disease distribution.	Training on CD outbreak. Investigation and response.	Surveillance manual on CD.
HIV/AIDS	Representation on National AIDS Com. and Monitoring and Evaluation Reference Group and chairing of UN Theme Group on HIV/AIDS.	Support to IMCI and positive prevention.	Support the development of protocols for Positive Prevention HIV Drug Resistance and PITC.		Training in clinical and community-based diagnosis and treatment of HIV/AIDS.	Annual reporting on Universal Access and UNGASS.

4.4 Overall role and responsibilities of PAHO/WHO

The essential focus of PAHO/WHO's work is to provide technical cooperation. In accordance with the global and regional health agendas, global and regional resolutions, PAHO/WHO priorities are in the following areas:

- Providing support to countries in moving to universal coverage with effective public health interventions.
- Strengthening global health security.
- Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health.
- Increasing institutional capacities to deliver core public health functions under the strengthened governance of Ministries of Health.

4.5 Critical review of previous CCS

This CCS Process represents the first effort at developing a strategic agenda of PAHO/WHO for and with Jamaica. The process has been a lengthy one, but has involved significant levels of consultation with the national counterparts. The Ministry of Health is to be commended for its continued commitment to the finalisation of this process, despite many delays that occurred due to political and ministerial changes.

4.6 PAHO/WHO Structure and Ways of Working

4.6.1 Structure of the Office

The PAHO/WHO Jamaica office has expanded in terms of staffing size, budgetary allocations and the scope of technical cooperation with the three countries for which it is responsible. The Technical Cooperation strategy is guided by the national health priorities of the countries, and also takes into account the Organisation's strategic orientations and achievement of the Millennium Development Goals.

The team works closely with counterparts in the Ministry of Health, the UN Agencies, educational institutions and NGOs. Both technical and administrative staff has been integrally involved in sub-regional projects.

4.6.2 Sub-offices and/or field offices

There are many small territories in the Caribbean which receive technical cooperation support from PAHO/WHO, without having a physical office in country. The PAHO/WHO Jamaica Representation is one of three[28] such offices in the English Speaking Caribbean, providing support to the territories of Cayman Islands and Bermuda.

To support its work and strengthen the level of programmatic support offered to member countries, PAHO/WHO Jamaica Representation maintains a close relationship with the specialized centres in the region, especially the CFNI and CAREC.

Together the Centres help to expand the range of health based support that is available to member countries. For instance, CFNI which is also based in Jamaica is dedicated to supporting and responding to nutritional and food security issues among member countries.

4.6.3 Support from the Subregional and Regional Office

In the Caribbean there is also the Office of Caribbean Programme Coordination and the PAHO HIV Caribbean Office based in Barbados and Trinidad and Tobago, respectively. Through the PAHO HIV Caribbean Office support and opportunities for Technical Cooperation Partnerships in the areas of Health System Strengthening, Procurement and Supplies Management, Health Services Delivery and Strategic Information have been received.

[28] Other multi country offices in the English speaking Caribbean include Barbados and the Eastern Caribbean Countries and Bahamas (also covering Turks and Caicos).

Support is also received from Regional Programmes for activities such as Virtual Campus In Public Health (VCPH), Human Resources in Health, Evaluation of Public Health Functions, development of regional Water Quality Management Plans, Human Papilloma Virus research, violence reduction and interventions, tobacco control, pandemic influenza preparedness and management among others.

The PAHO/WHO Jamaica representation enjoys a close collaboration with all the levels and parts of the Organisation in the execution of technical cooperation in Jamaica and the territories covered by the Country Office.

4.6.4 Sub-regional/inter-country activities

There is close cooperation between PAHO/WHO and other UN agencies in Jamaica resulting in collaboration on technical projects, leading to cost savings. These include joint activities in the following areas: maternal mortality reduction, Community Health Aides Research and Behavioural Change Communication workshop with UNICEF, joint programming with UN Theme Group and Joint Team on AIDS.

PAHO/WHO has been working with pharmaceutical safety, drug accessibility, road safety, solid waste disposal, health information systems, vital statistics, and health promotion with faith-based Organisations.

4.6.5 Analysis of biennial work-plan

There is good coherence between the national priorities and the BWP 2008-2009 Technical Cooperation response. This is evidenced by both a greater than 90% OSER Indicator milestone achievement and implementation rate of 95% of awarded funds. The representation conducted twice-yearly joint reviews of the BWP with national counterparts and all staff. The Peer Review Process Team commended the Jamaica Country Office on the continued good quality of its milestones.

However, challenges at both the internal and external levels in the Country Office affected the achievement of some indicators and milestones. The key external challenges include human, economic and financial issues at national level, political changes within the Ministry of Health/ Government; changes in Ministry of Health priorities and policies, in particular the decision to remove all user fees for health services. This was exacerbated by the emergence of the Global Economic Recession which has resulted in the Government requesting that each line ministry reduce its budget, thereby affecting the capacity of Ministries to respond to existing and emerging priorities.

Internally, the COs ability to effectively execute all areas of Technical Cooperation activities was affected by the late disbursement of WHO funds in the second year of the biennium. Additionally, due to financial and human constraints at the national level, PAHO's Technical Cooperation is often, at the request of the Government, redirected from planned activities to emerging priorities. This will impact on both the planned programme of health strengthening and execution of the Country Cooperation Strategy for Jamaica.

4.6.6 Sharing and using knowledge

PAHO/WHO continues to disseminate updated guidelines and standards to national counterparts. This is done through a combination of printed and electronic documentation along with the dissemination of information via the Organisation's website. In addition, the

Country Office is actively engaged by the media and national stakeholders for presentations on emerging and existing health conditions.

PAHO/WHO is also represented on key national advisory committees through which the Organisation can further share updated information on health conditions, trends and practices.

4.6.7 PAHO/WHO partnerships

PAHO/WHO engages in partnerships in a number of key areas namely:

- Research: Community Health Aid Research, National Health Needs-Based Human Resource Planning, Serotype Prevalence and Acceptability of Human Papilloma Virus (HPV) Vaccine, Road traffic accidents, Burden of Illness Study, Health and Lifestyle Survey, Diabetes study, HIV survey.
- National Partnerships: Vital Statistics Commission (provided technical guidance for the development of a National Health Information System and the standardisation of the definition on vital statistics indicators); Technical Guidance for the National Civil Identification System; National Surveillance Unit (development of a National Surveillance Manual); Violence Prevention Alliance (Peace Promotion Campaign); National Health Fund (Dissemination of NCDs guidelines, manuals and IEC materials); Technical support for Training of Health Care Practitioners in Rapid Testing for HIV and Syphilis; Representation on the Monitoring and Evaluation Reference Group for HIV.
- UN Agencies and IDPs: Collaborations on Safe Motherhood; Elimination of vertical transmission of HIV and congenital Syphilis; Joint reporting to the Global Fund; Mitigation of crime and violence impact; School Health Promotion; Representation on the UN Theme Group for HIV, the UN Joint Team on AIDS and the Jamaica Country Coordinating Mechanism for GFATM.
- Capacity Strengthening: Support for the National Influenza Pandemic Preparedness Group; creation of the Caribbean Centre of Excellence for Health Planning; Continuous training in areas related to prevention and diagnosis of HIV/STI; Disease Prevention and Control review; Strategic planning; Staff training and resource mobilization; Food safety; Faith-based Organisations in non-communicable diseases treatment.

4.7 Resources

4.7.1 Human resources

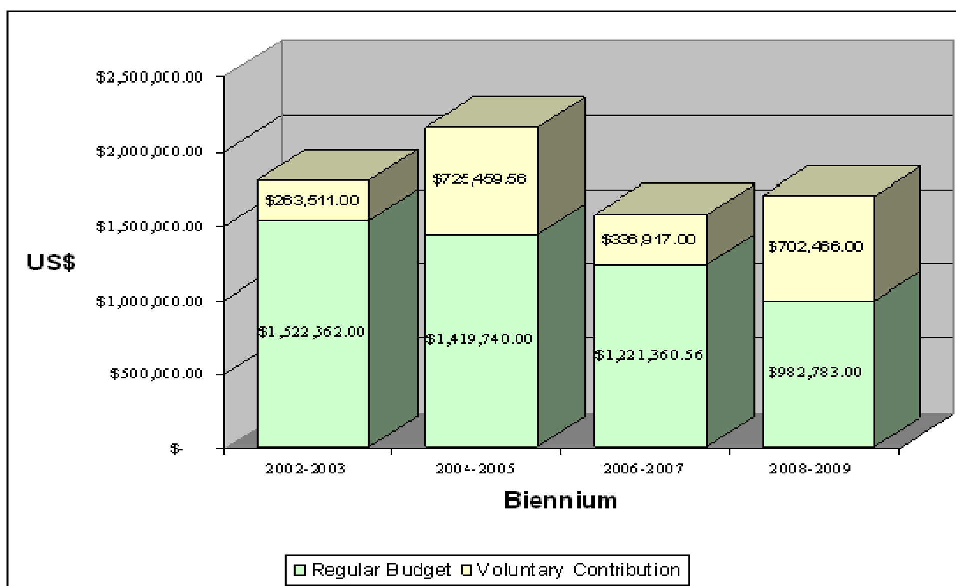
As at April 24, 2009, the total staff complement of the PAHO/WHO-Jamaica Country Office was 21 – 11 men and 10 women. This included 5 PAHO/WHO technical staff (4 of whom are international professionals including the PAHO/WHO Representative), 3 administrative staff and 12 administrative support and ancillary staff. The office is headed by the PWR who manages the International Cooperation in Health (ICH) project, and each of the technical staff serve as a focal point and is responsible for a particular BWP project. There is also significant collaboration among the technical staff to address overlapping issues in the projects' expected results. There are currently no Short-Term Professionals or Short-Term Consultants at the Country Office. A key HR cost containment strategy utilised by the Office is the assignment of multiple portfolios to each staff based on proficiency. Strategic emphasis is also placed on cross-training all staff members to facilitate both business continuity and personal growth and development.

There has always been a strong emphasis on human resource development at the Representation. Given that one of the main objectives of the Development Plan is the enhancement of the delivery of technical cooperation, training needs surveys are done and programs which specifically address these needs are developed and introduced to staff which may include the direct involvement of the PAHO/WHO technical staff through training seminars and supplemental professional development courses through tertiary institutions. Several staff recreational activities in keeping with the organisation's policy on work life balance, the representation organises events such as games evenings, family fun day and a Christmas party to enhance staff morale and unity. Employees also benefit through frequent staff meetings and information briefings on various PAHO/WHO and other UN areas of concern such as health and security.

4.7.2 Financial resources

For the 2008–2009 biennium, the total approved Regular Budget was US$911,000.00, a reduction from US$995,860.00 in the 2006–2007 biennium. As a result of the 2005 PAHO Regional Program Budget Policy, the PAHO/WHO Jamaica office has seen a reduction in the regular budgetary allocation over the past two (2) biennia. For the 2008–2009 biennium the regular budget ceiling, excluding personnel costs, was US$757,456.00, with an additional amount of US$636,966.00 representing voluntary contributions (VC). Currently, 31% of the regular budget is committed towards Health Systems and Services (HSS) development with 77% of the VC funds being committed to Sustainable Development and Environmental Health.

Figure 9. PAHO/WHO-Jamaica investments in Bermuda, Cayman Islands and Jamaica by Type and Biennium. 2002–2007



4.7.3 Office infrastructure and equipment

The PAHO/WHO Jamaica Country Office is located on the 7th floor of the Ministry of Health Building in the downtown Kingston area from which all technical and administrative staff operate. The building was constructed in the 1970's originally as a hotel but the later conversion process and lack of adequate maintenance has resulted in several infrastructural deficiencies. A Minimum Operating Security Standards (MOSS) compliance survey is carried out by the United Nations Department of Safety and Security (UNDSS) on an annual basis and the last survey done in 2008 revealed that the office was UNDSS MOSS compliant.

A variety of technology is utilized in the office to improve productivity. There are facilities for electronic mail, digital imaging and projection, color printing, document binding and voice over internet protocol (VOIP). These facilities are all supported by a local area network hosting twenty-eight computers. The infrastructure has recently been upgraded to include support for electronic filing and a Skype gateway for (VOIP), thus providing an additional four telephone lines for international calls.

A Documentation Centre has been established in the Country Office to engage in the strategic management of health and health related scientific and technical information and the use of technology in order to promote national growth and development. This is achieved through the provision of information to PAHO/WHO staff, consultants and national health personnel. The Documentation Centre comfortably seats 8 persons and also functions as the technical memory of the PAHO/WHO Representative in Jamaica by preserving the recorded knowledge and experience of the Organisation and the countries served by the Jamaica Office, i.e. the Cayman Islands and Bermuda. Additionally, the Documentation Centre also serves as a meeting area with staff and national counterparts.

In 2008 the Government announced wide ranging plans for the revitalisation of the downtown Kingston area. These plans would involve the restoration of the building in which the Ministry of Health and the PAHO/WHO Country Office are located to a hotel. These plans would therefore necessitate the relocation of the current occupants.

As part of the transition from the old PAHO/WHO Jamaica website to the PAHO Web 2.0 system, the country office convened a Web Committee headed by the PWR, with representation from both the technical and administrative staff.

5. STRATEGIC AGENDA FOR PAHO/WHO'S COOPERATION

5.1 Strategic areas of the CCS

Based on the review of the national health situational, consultation with national authorities and partners, and considering national, subregional, regional and global frameworks, as well as the comparative advantage of the Organisation, PAHO/WHO's technical cooperation will focus on the following five strategic priorities during 2010–2015.

Jamaica's CCS 2010–2015 strategic priorities

1. Strengthening Health Systems within the Framework of the Renewed Primary Health Care approach.
2. Supporting the Achievement of the MDGs.
3. Reducing the Burden of Diseases.
4. Addressing Determinants of Health.
5. Strengthening PAHO/WHO's Response to Priority Health Needs.

Table 15. Linking the CCS Strategic Priorities to National Health Strategies.

	CCS STRATEGIC PRIORITIES 2010–2015	NATIONAL HEALTH STRATEGIES [29]
1	Strengthening Governance and Health Systems within the Framework of the Renewed Primary Health Care approach	• Establish effective governance mechanisms for the Health sector. • Strengthen and emphasize the primary health care approach to service delivery. • Provide and maintain an adequate health infrastructure to ensure efficient and cost effective service delivery. • Establish and implement sustainable mechanism for human resources.
2	Reducing the Burden of Diseases	• Strengthen disease and environmental health surveillance, mitigation, risk reduction and the responsiveness of the health system. • Strengthen the Health Promotion Approach.
3	Supporting the Achievement of the MDGs.	• Support national food security for vulnerable groups. • Strengthen the Linkages between health and the Environment.
4	Addressing Determinants of Health.	• Support national food security for vulnerable groups. • Strengthen the Linkages between health and the Environment.
5	Strengthening PAHO/WHO's Response to Priority Health Needs.	All of the above.

[29] Government of Jamaica. Planning Institute of Jamaica. Vision 2030: Jamaica National Development Plan. 2008.

5.2 Strategic Areas, Main Focus and Strategic Approaches

1. Strengthening Health Systems within the Framework of the Renewed Primary Health Care Approach

Table 16. CCS strategic priorities, main areas of focus, strategic approaches and link to WHO core functions.

CCS Strategic Priorities	Rationale for inclusion	Main areas of focus	Strategic Approaches (based on PAHO/WHO's roles and functions)	Link to WHO Core Functions
1. Strengthening Health Systems within the framework of the renewed PHC approach.	o Limited absorptive capacity and bureaucratic administrative processes o Issues of accountability and reporting o Weak and fragmented Health Information System o High incidence of crime and violence and costs to the health sector o Weak policy development, planning, implementation and enforcement of health legislation o Limited health care financing and sustainability of health services o Reduction in external funding/aid o Incomplete mechanism to support decentralization services and stewardship role of the MOH o Weak and fragmented essential public health functions o Challenges in respect to the legislative and regulatory framework that would ensure the MOH oversight in regulating the private health sector	o Health Systems & Services – essential package and model of care and the use of appropriate technology o Revitalize community participation/ownership in health o Comprehensive Human Resources in Health Plan o Development and Promotion of the team approach to care o Policy development and analyses with supportive legislation o Health Information System: national, integrated, comprehensive with a built-in alert o QA – looking on the indicators, M & E systems, clinical and other audits, strengthening referral and linkage systems, public-private partnerships o Funding – health financing including alternate source of funding o Strengthening Health Economics capacities o Effective public health	o Providing leadership in respect to technical cooperation in health, training and intersectoral collaboration o TCC o Resource mobilization o Shaping the research agenda: technical cooperation, strategic planning, Programme development o Setting norms and standards in respect to QA, best practices etc. o Capacity building, e.g. building institutional capacities, training, promoting appropriate use of technology and infrastructural development o Facilitate the development of Health Information System o Advocacy for political will, community participation and health promotion	1 2 3 4 5 6

	o High cost associated with secondary and tertiary care services o HRH issues	leadership and appropriate management structures o Improving health planning with the establishment of Centres of Excellences o Support effective Drug Procurement and Management System with a sub-regional focus o Costing of health programmes and services o Assessing economic impact on health, e.g. poverty, nutrition		
2. Reducing the burden of diseases.	o Increased incidence of non-communicable diseased o Increased prevalence and or/re-emergence of communicable diseases (Malaria, Dengue, Influenza) o Inadequacy in addressing the social and environmental determinants of health o High economic and social impact of diseases on the population	o Putting in place comprehensive Health Promotion and health in public policies to increase individual and institutional awareness and responsibility for health o Strengthening the prevention of diseases at all levels o Strengthen integrated disease surveillance for CDs and NCDs, and outbreak response	o Review of existing policies and/or initiation of needed policies particularly for Intersectoral Collaboration o Active advocacy for enforcement and implementation of existing policies o Institutional capacity building to implement health in public policies o Development of norms and standards o Capacity building o Advocacy, M&E o Research, evidence generation and knowledge sharing o Resource mobilization	1 2 3 4 5 6
3. Supporting the achievement of the health MDGs.	o Unknown impact of economic crisis of nutrition o Increased prevalence of kwashiorkor o Inadequate nutrition surveillance o Increased prevalence of anaemia in <5 age group	o Promotion and support for early child nutrition including exclusive breast feeding o Prevention of deficiency diseases through health promotion and education, information dissemination and	o Providing leadership in respect to technical cooperation in health, training and intersectoral collaboration o Review of existing policies and/or initiation of needed policies particularly for	1 2 3 4 5 6

	o Rising prevalence of micro nutrition deficiency o Increasing prevalence of obesity o Increased risk of mortality in infancy due to prenatal conditions, HIV, malformations, ARI and malignancies o Absence of baseline data for under 1 & 1-5 year olds o MMR estimated to 95/100,00 o 83% of indirect deaths among women attributable to violence and NCDs o Still rising HIV prevalence rate and ineffective behaviour change initiatives o Malaria endemicity but with low risk of transmission o Persistence of TB infection and inadequate TB management o Delay in implementation of IHRs o Limited access to water of acceptable quality in rural areas	nutrition demonstration, and increasing human resources (field workers and nutrition/dietetic staff) o Strengthening baseline data collection for mortality in children under 1 and 1-5 years olds o Strategic planning to reduce childhood mortality o Infrastructure for neonatal care o Development of policies to address maternal morality o Quality of care including provision of emergency obstetric care o Public Education and Health promotion for high risk women (RHD, chronic diseases, etc.) o Research o Decentralization of Laboratory Services for Malaria o Strengthening capacity for TB diagnosis at the National Reference Lab o HIV/AIDS, TB and malaria prevention, control and management o Implementation of IHRs o Improvement of water supply and sanitation o Management of medical waste o Strengthening of occupational Health Management Strengthening disaster management	Intersectoral Collaboration o Active advocacy for enforcement and implementation of existing policies o Resource mobilization o Capacity building, e.g. building institutional capacities, training, promoting appropriate use of technology and infrastructural development o Development of norms and standards	

4. Tackling determinants of health.	**Environmental** o Limited access to potable (pipe) water o Emergence and Re-emergence of zoonosis and vector borne diseases o Impact of climate change o Inadequate testing and monitoring of food and water o Food-borne outbreaks o No early warning system o Impact on tourism and economy o Lack of approved waste disposal facilities o Limited human resources **Social** o 20% living below poverty line o High risk sexual behaviour o Lack of employment/crime and violence/Motor vehicle accidents o Aging population o Dysfunctional family unit o Substance abuse (alcohol, tobacco) o Public policy o Homeless/social deprivation **Economic** o Shrinking health budget o Increased cost of health care o Food security/Nutrition o Jamaica's WB classification as "Lower Middle Income" country o Global recession	**Food and Water Safety** o Strengthening the surveillance system o Strengthening Laboratory capacity with focus on emerging pathogens residues o Institutional strengthening o Policy development o Biological control (source reduction and elimination **Vector Control** o Evidence-Based Public health Practices (occupational exposure, drug resistance) Healthy Lifestyle Promotion Crime and violence prevention	o Technical assistance o Training o Research o Partnerships o Technical Cooperation among Countries (TCC) o Technical assistance o Support Public Education o Implementation of the Port-of-Spain Declaration o Strengthen surveillance of chronic illness o Sensitization and partnership with political leaders, heads of Government, COHSOD,COTED,CARICOM and Minister of health on policy issues o Technical cooperation among countries (TCC) o Improving Jamaica surveillance System o Consultation between health and security o Policy for health Information Management o Integration of all health information systems for public health decision support o Technical assistance o Capacity building	1 2 3 4 5 6

5. Strengthening PAHO/WHO's response to national priority health needs.	----	----	----	----

6. IMPLEMENTING THE STRATEGIC AGENDA: IMPLICATIONS FOR THE ENTIRE PAHO/WHO SECRETARIAT

6.1 Shifts in the Requirement of PAHO/WHO's TC

Table 17. CCS Strategies priorities and main focus by PAHO's Core Functions.

CCS STRATEGIC PRIORITIES	PAHO's CORE FUNCTIONS					
	i Providing leadership on matters critical to health and engaging in partnerships where joint action is needed.	**ii** Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge.	**iii** Setting norms and standards, and promoting and monitoring their implementation.	**iv** Articulating ethical and evidence-based policy options.	**v** Providing technical support, catalyzing change, and building sustainable institutional capacity.	**vi** Monitoring the health situation and assessing health trends.
1 STRENGTHENING HEALTH SYSTEM WITHIN THE FRAMEWORK OF THE RENEWED PHC APPROACH ▪ Health Systems & Services – essential package and model of care and the use of			++	++	+++	++

appropriate technology						
▪ Revitalize community participation/ownership in health	+			+		
▪ Comprehensive Human Resources in Health Plan	++	+	+		+++	++
▪ Development and Promotion of the Team Approach to Care				+++	++	
▪ Surveillance and outbreak response –EBA to planning						++
▪ Policy development and analyses with supportive legislation				++		
▪ Health Information System: i) National, Integrated, Comprehensive with a built in alert			++	+++		++
▪ QA – looking on the indicators, monitoring & evaluation systems, clinical and other audits, strengthening referral and linkage systems, public-private partnerships			+++		+++	++
▪ Funding –Health financing including alternate source of funding	++	+	+++		+	
▪ Strengthening Health					+	

Economics Capacities						
▪ Effective public health leadership and appropriate management structures	++	+++	++	++	++	
▪ Improved health planning with the establishment of Centres of Excellence	+++	++			+++	
▪ Support effective Drug Procurement & Management System with a sub-regional focus.			+		+	
▪ Costing of health programmes and services						
▪ Assessing economic impact on health, e.g. poverty, nutrition						
2 REDUCING THE BURDEN OF DISEASE						
▪ Putting in place comprehensive health promotion and health in public policies to increase individual and institutional awareness and responsibility for health.	+++			+	+++	
▪ Strengthening prevention at all levels			++		++	
▪ Strengthen integrated						

disease Surveillance for CDs and NCDs and Outbreak Response.			++		++	
3 SUPPORTING THE ACHIEVEMENT OF THE MDGS						
MDG 1: Eliminate Poverty and Hunger						
▪ Nutrition						
o Malnutrition- under and over		+				++
o Promote breastfeeding and provide support for exclusive breastfeeding.			++		++	
o Deficiency Diseases		+				++
o Health promotion and education. Informing /demonstrating to persons on how to get the most and best nutrition with limited resources.			+		+	
o An increase in the number of field workers (CHAs) and nutrition/ dietetic						

staff for correction of deficit.						+
▪ Research		+				
MDG 4: Reduce childhood mortality by two thirds in children under 5						
▪ Establishment of adequate mechanism for Baseline data collection for mortality in under 1, 1-5 year olds;			+++		++	+++
▪ Strategic planning including Costing	+				++	
▪ Infrastructure development (e.g. Neonatal equipment)					++	
▪ Training / Capacity Building			++			
MDG 5: Reduce by three quarters the maternal mortality Ratio						
▪ To identify main areas of focus based on Strategic Plans for Safe Motherhood and Adolescents	+++	++	++	+	+++	++
▪ Policy development	++	++		+++	++	
▪ Quality of Care, including provision for Emergency Obstetric	++		+++		+++	

Care (equipment, supplies, training, Lab support, transportation, upgrading) ▪ Monitoring and Evaluation ▪ Public Education and Health Promotion especially for High risk women (RHD, Chronic diseases etc).						+++
MDG 6: Combat HIV/ Malaria/TB and other diseases ▪ Health Systems Strengthening o Laboratory services - Decentralization of Laboratory Services for Malaria o Roll out of LIS to other regions					++	+
▪ Service delivery o Screening for malaria and TB o Management of TB (equipment & lab at the National Referral Centre) o Quality assurance			++		++	

▪ HIV/AIDS, TB and malaria prevention, control and management)			+++	+++	+++	+++
MDG 7: Ensure environmental sustainability						
▪ Compliance with IHR recommendations o Supporting legislation o Completion of IHR work plan	+	+	+++		+++	+++
▪ Water and sanitation	+++	++	++		+++	++
▪ Excreta disposal particularly in unplanned settlements	+++	++	++		+++	++
▪ Medical waste management	+++	++	++		+++	++
▪ Strengthening of Occupational Health Capacity/ Management o Safe Hospitals o Healthy Schools	+++	++	++		+++	++
▪ Disaster Management – Risk Mapping etc.	+++		+		++	++
4 ADDRESSING DETERMINANTS OF HEALTH						
Food and Water Safety	+++	+++	++		+++	+++

- Strengthening the Surveillance system - Strengthening Laboratory capacity focus on emerging pathogens, residues (hormones, antibiotics, pesticides)	+	++			+++	+++
- Institutional Strengthening - Policy development						
Vector Control - Biological control (source reduction and elimination)	+++	++			++	+++
- Evidence-Base Public Health Practices - occupational exposure - drug resistance	+++	++			++	+++
Social determinants of health - Healthy Life Style - Crime and Violence	+++		+		+	
Integrated Health Information Management System.	++		+++		+++	+++
5 STRENGTHENING PAHO/WHO'S RESPONSE TO PRIORITY HEALTH NEEDS	++	++	+++	++	+++	++

6.2 Implementation of the Strategic Agenda

Table 18. Required internal and external collaboration for successful implementation of the WHO/JAMICA CCS Strategic Agenda.

CCS STRATEGIC AGENDA	IN HOUSE CAPACITY	REQUIRED COLLABORATION	
		INTERNAL BACKSTOPPING	EXTERNAL AGENCIES
Strengthening Governance and Health Systems within the Framework of the Renewed Primary Health Care approach	▪ PWR ▪ Health Systems Advisor.	▪ HQ resources have been utilized (HSS) ▪ Inter country partnerships with Chile, Belize, CAN	▪ Government Partners in Health and non Health Sectors ▪ Spanish International Cooperation Development Agency
Reducing the Burden of Diseases	▪ PWR ▪ Advisors in: o Health Systems o Disease Prevention and Control, o Environmental Health Advisor o HIV/STIs	▪ CAREC ▪ CPC ▪ PAHO WDC ▪ PHCO ▪ WHO Collaborating Centres ▪ WHO Geneva	▪ Academic Institutions ▪ Bilateral Partners ▪ CARICOM ▪ CDC ▪ CIDA ▪ Civil Society ▪ Government Partners in Health and non Health Sectors ▪ IDB ▪ UN Partners
Supporting the Achievement of the MDGs	▪ PWR ▪ Advisors in: o Health Systems o Disease Prevention and Control, o Environmental Health Advisor o HIV/STIs	▪ CFNI ▪ CPC ▪ FCH ▪ HSD ▪ HSS ▪ PHCO ▪ SDE ▪ THR	▪ Academic institutions ▪ CARICOM ▪ CDC ▪ CIDA ▪ Civil Society ▪ EU ▪ GFATM ▪ Government Partners in Health and non Health Sectors ▪ IDB ▪ JICA ▪ UN Partners ▪ USAID ▪ World Bank

CCS STRATEGIC AGENDA	IN HOUSE CAPACITY	REQUIRED COLLABOURATION	
		INTERNAL BACKSTOPPING	EXTERNAL AGENCIES
Addressing Determinants of Health	▪ PWR ▪ Advisors in: o Health Systems o Disease Prevention and Control, o Environmental Health Advisor o HIV/STIs	▪ CAREC ▪ CPC ▪ PAHO WDC ▪ PHCO ▪ WHO Collaborating Centres ▪ WHO Geneva	▪ Academic Institutions ▪ Bilateral Partners ▪ CARICOM ▪ CDC ▪ CIDA ▪ Civil Society ▪ Government Partners in Health and non health sectors ▪ IDB ▪ UN Partners
Strengthening PAHO/WHO's Response to Priority Health Needs	▪ PAHO/WHO Representative ▪ Advisors in: o Health Systems o Disease Prevention and Control, o Environmental Health Advisor o HIV/STIs	▪ CFNI ▪ CFS ▪ CPC ▪ FCH ▪ HSD ▪ HSS ▪ PHCO ▪ SDE ▪ THR	▪ Academic Institutions ▪ Bilateral Partners ▪ UN Partners

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LIST OF FIGURES

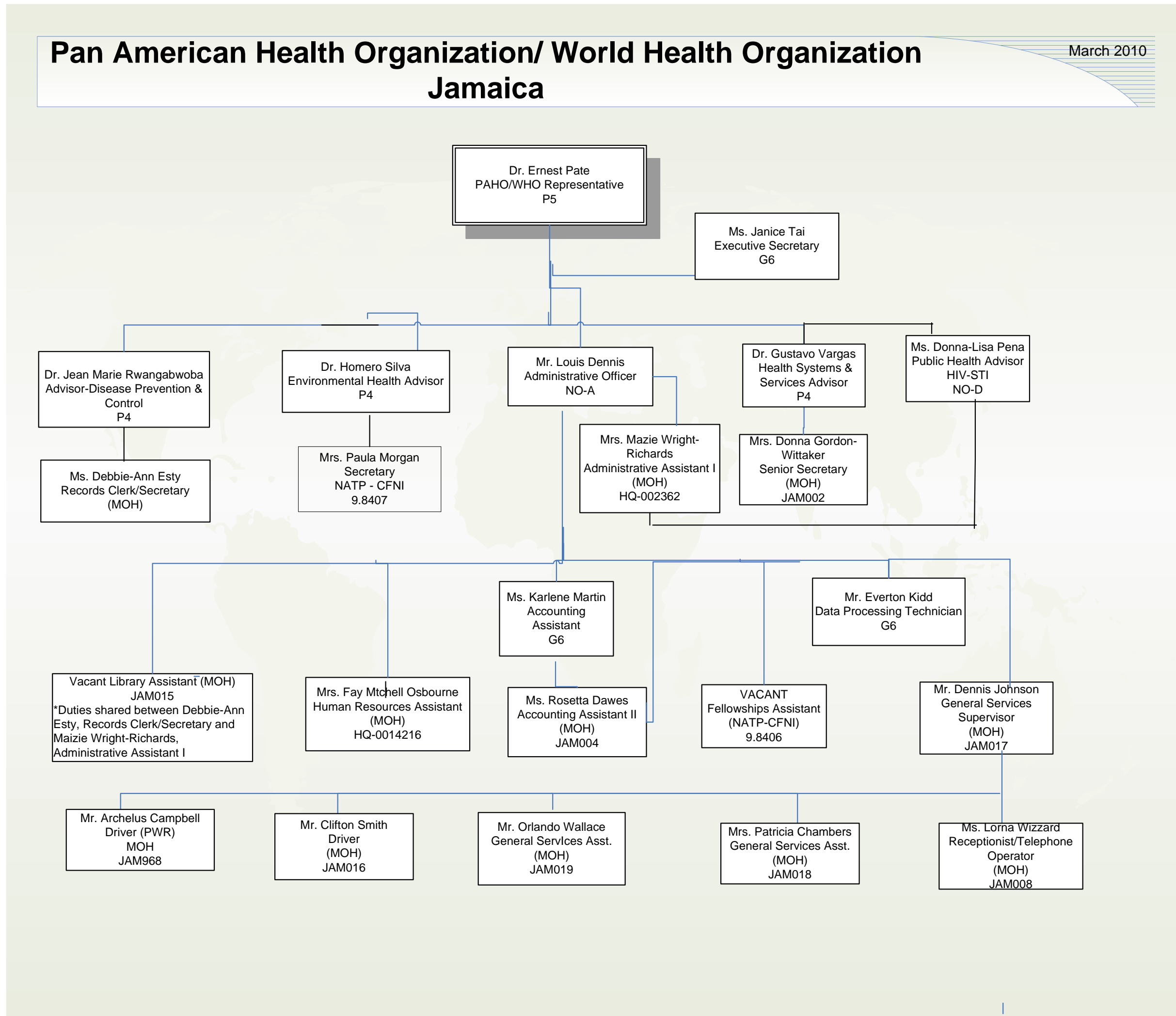
FIGURE 1. PERCENTAGE DISTRIBUTION OF POPULATION BY AGE AND SEX. 1990 (CENSUS), 2008 (ESTIMATE) AND 2020 (PROJECTION). JAMAICA. 12
FIGURE 2 AVERAGE UNEMPLOYMENT RATES. JAMAICA. 1918-2008 14
FIGURE 3 . CONFIRMED P. FALCIPARUM MALARIA CASES BY WEEK OF ONSET. JAMAICA. SEPTEMBER 2006 (WEEK 35, 2006) TO SEPTEMBER 2008 (WEEK 37, 2008). 15

LIST OF TABLES

TABLE 1.SOME DEMOGRAPHIC INDICATORS: JAMAICA. 11
TABLE 2. DISTRIBUTION OF ACUTE RESPIRATORY INFECTION AND GASTROENTERITIS BY AGE GROUP, JAMAICA. 2007– 2008. 15
TABLE 3. PREVALENCE (%) OF CHRONIC DISEASES/CONDITIONS AND NUTRITIONAL STATUS. JAMAICA. 2000–2008. 19
TABLE 4. PREVALENCE RATES OF ILLICIT SUBSTANCES. JAMAICA. 2000 AND 2008. (%) 19
TABLE 5. NUTRITIONAL STATUS FOR 0–35 MONTHS OLD CHILDREN. JAMAICA, 2001–2003. 22
TABLE 6. IMMUNISATION COVERAGE 23
TABLE 7 NUMBER OF HEALTH WORKERS BY PROFESSIONAL CATEGORY. JAMAICA 2007. 26
TABLE 8. NATIONAL EXPENDITURE ON HEALTH. JAMAICA. 1995-2006 28
TABLE 9. NATIONAL HEALTH STRATEGIES AND RESPONSIBLE AGENCIES. JAMAICA. VISION 2030. 30
TABLE 10 HEALTH PRIORITY AREAS. 33
TABLE 11 . INTERNATIONAL DEVELOPMENT PARTNERS SUPPORT TO JAMAICA. 2008-2009. 36
TABLE 12. LINKAGE BETWEEN JAMAICA CCS STRATEGIC PRIORITIES AND UNDAF OUTCOMES.) 39
TABLE 13. SWOT ANALYSIS OF PAHO/WHO COOPERATION IN JAMAICA. 42
TABLE 14. LINKAGE OF TC PRIORITY AREAS (BWP 2008-2009) AGAINST WHO CORE FUNCTIONS. 45
TABLE 15. LINKING THE CCS STRATEGIC PRIORITIES TO NATIONAL HEALTH STRATEGIES. 52
TABLE 16. CCS STRATEGIC PRIORITIES, MAIN AREAS OF FOCUS, STRATEGIC APPROACHES AND LINK TO WHO CORE FUNCTIONS. 53
TABLE 17. CCS STRATEGIES PRIORITIES AND MAIN FOCUS BY PAHO'S CORE FUNCTIONS. 58
TABLE 18. REQUIRED INTERNAL AND EXTERNAL COLLABORATION FOR SUCCESSFUL IMPLEMENTATION OF THE WHO/JAMICA CCS STRATEGIC AGENDA. 66
TABLE 19 LINKAGE BETWEEN JAMAICA CCS' STRATEGIC PRIORITIES AND HEALTH AGENDA FOR THE AMERICAS, PAHO STRATEGIC OBJECTIVES, AND PAHO-JAMAICA BWP 2010–2011. 71
TABLE 20. FATALITIES FROM ROAD TRAFFIC CRASHES BY AGE GROUP AND YEAR. JAMAICA. 2004–2008 74

ANNEXES

ANNEX 1. Organisational structure of PAHO/WHO Country Office



ANNEX 2.
Linkage between Jamaica CCS' Strategic Priorities and Health Agenda for the Americas, PAHO Strategic Objectives, and PAHO-Jamaica BWP 2010–2011.

Table 19 Linkage between Jamaica CCS' Strategic Priorities and Health Agenda for the Americas, PAHO Strategic Objectives, and PAHO-Jamaica BWP 2010–2011.

Jamaica CCS 2010–2015. Strategic Priorities	Health Agenda for the Americas 2008–2017. Areas of Action	PAHO Strategic Plan 2008–2012. Strategic Objectives (SO)	PAHO/WHO-Jamaica Biennial Work Plan 2010–2011. Projects
1 Strengthening Health Systems within the framework of the Renewed Primary Health Care approach.	• Strengthening the National Health Authority. • Strengthening the management and development of health workers. • Increasing social protection and access to quality health services. • Strengthening health security. • Harnessing knowledge, science, and technology.	SO10. To improve the Organisation, management and delivery of health services. SO11. To strengthen leadership, governance and the evidence base of health systems. SO12. To ensure improved access, quality and use of medical products and technologies. SO13. To ensure an available, competent, responsive and productive health workforce to improve health outcomes. SO14. To extend social protection through fair, adequate and sustainable financing.	• Health systems and services
2 Reducing the burden of diseases.	• Reducing the risk and burden of disease.	SO1. To reduce the health, social and economic burden of communicable diseases. SO3. To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries and visual impairment. SO4. To reduce morbidity and mortality	• Disease prevention and control • Environmental health and protection

		and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals. SO5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact. SO6. To promote health and development, and prevent or reduce risk factors such as use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex, which affect health conditions. SO8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health. SO9. To improve nutrition, food and food security, throughout the life-course, and in support of public health and sustainable development.	
3 Supporting the achievement of the MDGs.	• Strengthening the National Health Authority. • Reducing the risk and burden of disease. • Diminishing health inequalities among countries and inequities within them.	SO2. To combat HIV/AIDS, tuberculosis and malaria.	• Millennium Development Goals
4 Addressing determinants of health.	• Tackling health determinants.	SO7. To address the underlying social and economic determinants of health through policies and programmes that enhances health equity and integrates pro-poor, gender-responsive, and human rights-based approaches.	• Health promotion and social determinants of health
5 Strengthening PAHO/WHO's response to	• Harnessing knowledge, science, and	SO15. To provide leadership, strengthen governance, and foster partnership and collaboration with Member States, the	• Management and Coordination

priority health needs.	technology.	United Nations system and other stakeholders to fulfil the mandate of PAHO/WHO in advancing the global health agenda, as set out in WHO's Eleventh General Programme of Work, and the Health Agenda for the Americas. SO16. To develop and sustain PAHO/WHO as a flexible, learning Organisation, enabling it to carry out its mandate more efficiently and effectively.	• And all of the above.

ANNEX 3. Additional tables and figures

Table 20. Fatalities from road traffic crashes by age group and year. Jamaica. 2004–2008

	2004			2005			2006			2007			2008		
Age group	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Unknown	24	3	27	37	4	41	54	7	61	37	7	44	48	5	53
0-4	4	2	6	5	2	7	3	0	3	4	1	5	0	3	3
05-09	7	4	11	6	3	9	6	8	14	7	4	11	7	5	12
10-14	9	3	12	6	6	12	12	1	13	5	8	13	4	2	6
15-19	10	3	13	20	5	25	27	8	35	8	6	14	9	7	16
20-24	28	7	35	31	4	35	24	9	33	28	7	35	30	10	40
25-29	24	4	28	29	6	35	33	4	37	28	5	33	27	1	28
30-34	39	7	46	18	8	26	26	4	30	28	6	34	23	8	31
35-39	22	5	27	27	4	31	16	5	21	28	3	31	29	3	32
40-44	19	11	30	14	4	18	27	7	34	25	4	29	15	5	20
45-49	23	3	26	11	2	13	16	5	21	12	4	16	14	6	20
50-54	16	6	22	10	2	12	21	2	23	13	3	16	12	4	16
55-59	8	1	9	8	1	9	4	6	10	11	1	12	10	5	15
60 and over	52	16	68	41	12	53	34	12	46	46	11	57	36	13	49
Total	**285**	**75**	**360**	**263**	**63**	**326**	**303**	**78**	**381**	**280**	**70**	**350**	**264**	**77**	**341**

Source: Jamaica Constabulary Force.