

## Health sector challenges and responses beyond the Alma-Ata Declaration: a Caribbean perspective

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Primary health care (PHC) is defined as “essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (1). Its effectiveness is also a measure of the extent to which the availability of resources, successful integration with other sectors (e.g., education, agriculture), and a broad-based community partnership is achieved (2, 3).

The guiding principles of PHC and “Health for All by the Year 2000” speak to the right every citizen has to health care as a means of leading a safe and productive life. Integral to the provision of this right is equitable access to health services based on needs, and the key role of the State in ensuring this right for all (1). The State, therefore, partners with local and international agencies and its citizens to meet this objective, ensuring that appropriate policies and programs are in place alongside reliable structures for sustained socioeconomic development (1, 4).

For the effective delivery of PHC to occur, it must be undergirded by a national health system infrastructure that has five key components: (1) development of health resources, such as manpower, facilities, equipment, and supplies; (2) organized arrangement of health resources through the establishment of national health authorities, the provision of national health insurance, and the integration of public and private health services; (3) delivery of health care through the media of primary, secondary, and tertiary health services; (4) economic support through sources, such as public financing and foreign aid; and (5) management through strong leadership, policy formulation, regulation, and monitoring and evaluation (5).

### EARLY BEGINNINGS OF PRIMARY HEALTH CARE IN THE CARIBBEAN

The earliest organization of health services in the Caribbean occurred during the post-emancipation period of the early 1900s and was influenced by high mortality rates from major infectious diseases (malaria, syphilis, tuberculosis, yaws, and yellow fever) (2). Infant and maternal mortality rates were

**TABLE 1. Death rates and infant mortality rates (IMRs) in selected Caribbean territories, in 1928, 1932, and 1937<sup>a</sup>**

Territory	Statistic	1928	1932	1937
Barbados	Death rate	30.1	19.0	18.5
	IMR	331.0	198.0	217.0
British Guiana	Death rate	27.9	21.1	21.9
	IMR	185.0	139.0	121.0
Jamaica	Death rate	19.7	17.2	15.3
	IMR	157.0	141.0	118.5
Nevis	Death rate	19.4	11.1	14.9
	IMR	286.6	102.2	107.1
Saint Kitts	Death rate	39.8	27.5	36.5
	IMR	308.3	166.7	209.0

**Source:** Moyne L. West Indian Royal Commission Report (6).

<sup>a</sup> The death rates are per 1 000 population, and the infant mortality rates are per 1 000 live births.

particularly high during this period (Table 1) (6). The Caribbean benefited from the concern of the colonial authorities who appointed a series of commissions to investigate these diseases. The Rockefeller and Moyne Commissions and the Irvine Committee are notable investigative mechanisms established during the early to mid-1900s. Their research made recommendations that revolutionized health care services in the Caribbean.

Table 1 depicts deaths and infant mortality rates (per 1 000) for select Caribbean territories during the early 1900s. During this period, health care expenditure in the Caribbean ranged from a low of 8.9% of total expenditure in British Honduras and Montserrat to a high of 18.6% in Saint Kitts and Nevis and 19.6% in Saint Vincent. Other countries, such as Barbados, Jamaica, and Trinidad, spent 11.3%, 9.8%, and 9.2% of their budgets, respectively, on health care (6).

The first half of the twentieth century brought two important health care milestones to the Caribbean: the establishment of the West Indies School of Public Health to train public health nurses and inspectors, and the establishment of the University College of the West Indies to train doctors. A PHC system gradually developed with the concept of the "health team approach," the creation of medical districts, and the development of health centers to provide first-line health care (2).

## ALMA-ATA AND THE CARIBBEAN PRIMARY HEALTH CARE STRATEGY

The Declaration of Alma-Ata, made in 1978, encapsulates the principal processes and strategies

for PHC and served as the linchpin for the call to "Health for All by the Year 2000" (1, 7). The Declaration highlighted the value of intersectoral linkages and political commitment and responsibility to attain this goal. Of key importance was the concept that socioeconomic development is critical to health care delivery and reform. In response to this call for action, Caribbean ministers of health, through the assistance of the Pan American Health Organization (PAHO), the United Nations Children's Fund, the United States Agency for International Development, and the University of the West Indies (UWI), among others, convened a workshop in 1981 to develop a Caribbean strategy for PHC (8).

Seven years later, PAHO conducted an evaluation of the PHC progress made in four countries, namely Anguilla, Barbados, Grenada, and Saint Lucia. Most of these countries had embarked on developing an intersectoral approach to the implementation of PHC through convening national intersectoral workshops, and the establishment of a PHC Intersectoral Committee in at least one country (8). In Jamaica, where a policy decision had been made in 1977 to expand PHC services, the pace was far advanced. The country's approach was documented in "Primary Health Care: the Jamaican Perspective," and it was through this document that key contributions were made to the discussions at Alma-Ata (9). One of the outstanding goals laid out in this document was that there should be a PHC center within 10 miles (16 km) of every citizen.

Acknowledging the shortage and poor utilization of human resources within the health sector, the Jamaican response was to train a cadre of community health aides as an "interface between the community and the health delivery system for

health promotion, health education, disease prevention, and follow-up of persons to ensure that they kept clinic appointments. . .” (10). This training experiment was the innovative and visionary work of Sir Kenneth Standard and Olive Ennever of the UWI Department of Social and Preventative Medicine (now the Department of Community Health and Psychiatry). Success led to its adoption by several countries, such as Antigua, Barbados, Dominica, Grenada, Saint Lucia, and Saint Vincent, as early as 1967—before the Alma-Ata Conference. Other additions to the health care team included the school dental nurse and dental assistant in 1970; the nurse practitioner, 1978; and the pharmacy technician, 1980 (10).

Increased collaboration within the Caribbean community, especially in the area of environmental health, was denoted by the development of the Caribbean Environmental Health Strategy and the establishment of the Pan Caribbean Disaster Prevention and Preparedness Program in the 1980s. The training and placement of national epidemiologists, the move towards the development of surveillance systems and computerized information systems (although at an uneven pace across the Caribbean), and the development of the advisory role of the Caribbean Epidemiology Center (CAREC) were among the important mileposts since the Alma-Ata Conference (8).

Programs funded through local and international resources to upgrade unsatisfactory health facilities were implemented. Saint Lucia received a grant from the Kellogg Foundation, and Barbados modernized its geriatric hospital (8). In Jamaica, new health centers were built and community labor was utilized in the upgrading of others. Faced with growing economic constraints, Caribbean countries were forced to explore avenues for revenue generation, resulting in the institution of user-fee charges. At the time, consideration was also given to the implementation of national health insurance schemes (8).

A special focus in the post Alma-Ata period was research to inform policy development. The UWI, the Caribbean Food and Nutrition Institute, and the Ministry of Health of Jamaica were among the leading agencies supporting this critical need. An important example is Jamaica’s research-based maternal and child health policy, which has shaped the delivery of health care services in that country since 1981 (11). A number of studies, on topics such as the efficacy of oral dehydration salts, maternal mortality, underregistration of infant deaths from 1981 to 1997, and the organization of antenatal and high-risk clinic services, were among the research efforts that laid the groundwork for reorganizing maternal and child health services (11, 12).

## THE CARIBBEAN COOPERATION IN HEALTH CONCEPT—A NEW PERSPECTIVE

The Caribbean countries, acknowledging that collaboration and cooperation were needed to meet health challenges and improve PHC delivery, gave birth to the Caribbean Cooperation in Health (CCH) concept in 1984, and further redefined it in 1996 (13). The initiative embraced the World Health Organization’s definition of health as “a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity” (14). It also recognized that there were multiple determinants of health and that a multipronged approach was critical to achieving health gains. In 1996, health promotion—one of the cornerstones of the PHC system—was identified as the major implementation strategy, and the tenets of the Caribbean Charter for Health Promotion (CCHP) were applied to the priority areas identified. The priority areas for the Caribbean included health systems development, human resource development, family health, food and nutrition, chronic noncommunicable diseases, communicable diseases, mental health, and environmental health (13).

## EMERGING ISSUES: 1980 TO PRESENT

### Changing demographic profile

Overall, increases in life expectancy and declines in fertility rates have resulted in a shift in the population pyramid for the Caribbean. Projections for the year 2010 show a narrowing base, indicative of a shift from expansive in 1980 to a constrictive population pyramid in 2010 (15). Holder and Brandon (15) estimate that while the child population is expected to stabilize or decrease, the population aged 25–64 years will increase by 13%, with the largest increase in the group 45–64 years old.

### Changing health issues

As economies and standards of living have improved, infectious diseases have largely given way to lifestyle diseases (15–21). The Caribbean has experienced an epidemiological transition, with a 10% absolute increase (21% relative increase) in proportional mortality due to noncommunicable diseases between 1970 and 1980 (17). The Caribbean is also faced with the added burden of an emergence of infectious disease, namely HIV; a reemergence of infectious diseases, such as tuberculosis; and new infectious diseases, such as West Nile virus, severe acute respiratory syndrome (SARS),

and mad cow disease. The coexistence of these scenarios has far-reaching economic and social implications for the delivery of PHC.

### Social determinants of health

Feinstein (22) and Kaplan et al. (23) reviewed the relationships between health and social conditions. Factors such as housing, overcrowding, sanitation, transit mode, occupational hazards, environmental hazards, education, income, employment, and lifestyle practices (e.g., smoking, diet, exercise) were identified as critical social factors that influence health status (22, 23). The impact of globalization and the sociopolitical context (culture, labor market, education, family/social system values, and support systems, etc.) have converged to shape the social determinants of health and specific exposure factors (3, 24, 25). Across the world, there is a growing concern among world leaders and ordinary citizens alike that the Millennium Development Goals (26) will remain a dream on paper unless radical steps are taken to influence factors that shape social position. Income, social cohesion, food availability, gender imbalances, and living, employment, and working conditions create barriers to adopting healthy behaviors (23, 27).

In March 2005, WHO launched the Commission on Social Determinants of Health, which "aims for changes whereby the societal relationships and factors that influence health and health systems will be visible, understood, and recognized as important" (27). It is the intention of WHO to incorporate the social determinants of health into its policy, planning, and technical development agenda.

## CHALLENGES AND LIMITATIONS

### The economic challenges of a changing demographic profile

In the face of globalization and its inherent economic challenges, Caribbean governments have to plan to meet the social and economic needs of their populations in order to provide necessary PHC services (3, 28). While some countries, such as the Bahamas and Barbados, have weathered the storm with sustained economic growth, other countries, such as Guyana, Haiti, and Jamaica have faced declining PHC systems. Commitment to debt servicing, both foreign and domestic, eat away at the productive capacities of such countries and compromise the provision of basic health care services under the PHC system (21). A review of Jamaica's health budget over the 1991/92–1997/98 period in-

dicates that although there had been a considerable increase (from US\$ 49 500 000 to US\$ 210 000 000), this had translated to a marginal increase in real terms due to a high inflationary environment (29). The picture is similar to that of other Caribbean countries (21). An increasing age-dependency ratio will also register an increased burden on the economies of Caribbean countries as the population ages and the productive capacity of the younger population is reduced by mortality and morbidity from HIV, injuries, and other conditions (15). Overall, the rapidly aging Caribbean population calls for a paradigm shift in health care services delivery through the adoption of active-aging concepts and a life-course approach (30).

### The economic challenges of a changing disease profile

The health costs associated with hospitalizations due to diabetes in the Caribbean are estimated to be in the area of 0.25% of gross domestic product (GDP). Diseases associated with the reproductive system, including HIV and cervical cancers, are expected to account for another 2%–5% of GDP from direct costs. It will cost an estimated US\$ 10 000 per year to treat each new AIDS patient. Injuries and poisonings will cost Caribbean countries another 3% of GDP for direct and indirect costs. No estimates are available for cardiovascular and mental disorders, but these are also expected to cost the Caribbean substantial amounts (15).

The impact of loss of productive capacity among young people (15–44 years old), from HIV, injuries, and other illnesses, will leave Caribbean countries poorer through a decreased GDP (15).

### Technological and administrative issues

Governments are under pressure to invest in a wider range of increasingly sophisticated technology to improve the detection and management of chronic diseases. The provision of equipment such as scanners, magnetic resonance imaging, and improved laboratory services is occurring at a slow pace in the public sector, and as a result, these services are being provided largely through privately owned facilities at a higher cost to consumers. Governments will also have to increase budgets for law enforcement and related surveillance equipment if they are to tackle the increased rates of injuries from domestic violence, homicides, and motor vehicle accidents (3). Training in crime detection, crime management, and community policing will be increasingly required as the population grows.

## Human resource needs

The need for additional human resources trained in the latest skills and use of technologies to support PHC delivery will be significant, as will the associated costs (3). Figueroa (29) notes that personnel emoluments as a percentage of the Jamaican health budget have grown from approximately 55% in 1980 to almost 80% in 2000. The Ministry of Health of Jamaica has recorded an increased vacancy rate among groups such as enrolled nurse assistants and pharmacists. Other groups, including registered nurses, midwives, public health inspectors, and public health nurses, are at critically low levels (31). The loss of health personnel has resulted in significant staff shortages in many areas and has adversely impacted the delivery of PHC.

Recent and recurring recruitment efforts by international agencies have especially affected the nursing group. Nursing has recorded the highest levels of migration within the Jamaican health services. Employment opportunities, higher salaries, and emoluments packages have attracted many Caribbean health professionals to first world countries.

## Public policy and infrastructure

Carr noted in 1985 (4) that, within a decade of the Declaration of Alma-Ata, Caribbean countries would make significant efforts to develop national health policies and programs. With the emerging epidemiological profile of diseases in the Caribbean, national health policies must illustrate public policy support for healthy living. The changing role of government, in light of health care privatization, does not relieve its role in policy development; in fact, it increases the need for standards and regulation. The successful adoption of the Caribbean Charter for Health Promotion (32) remains questionable. PHC services in the Caribbean are still oriented toward curative programs rather than preventive ones. This fact is further evidenced by the allocation of funds between the two areas.

With an aging population, the need for more PHC facilities will increase significantly over time (30). This may require the development of policies for "geriatric-friendly" services at all service institutions—primary and secondary health care, as well as other economic and social institutions. Examples of such services may include facilities that provide live-in care and recreational activities for the elderly (nursing homes, elderly day care centers, etc.), and wheelchair access and elder services in public and private spaces. Also important are the improvement and development of primary and secondary health care facilities and services, and the

increased number of caregivers needed for the large numbers of persons who will suffer mortality and morbidity from injuries, HIV, and other maladies.

## Environmental issues and urbanization

Population growth and increased urbanization have placed a significant strain on the network of social goods and services required to support communities (3). Unplanned development has resulted in the scattering of shantytowns across the landscape of various Caribbean countries. Lack of a safe water supply and appropriate facilities for waste and sewerage has increased the risk of disease transmission. Existing roads, housing, sewerage, and other infrastructure have often proven inadequate to meet the needs of a growing urban population. In addition, shrinking economies will be challenged to provide adequate employment opportunities. Unemployment is likely to have the spin-off effect of escalating illegal and criminal activity.

Some additional burdens on the health care system are mortality and morbidity from violence, diminished resources to support national health infrastructure, demoralized staff, and other issues that negatively affect service delivery at primary and secondary health care levels. Not to be overlooked is the impact of urbanization on road fatalities and injuries, and the subsequent burden on the health care system.

## Sociocultural and lifestyle challenges

Alleyne and Sealy (33) make the point that in the Caribbean there is a strong correlation between the percentage of food energy from fats, and deaths from breast or prostate cancer. Nutrition-related diseases, such as diabetes, hypertension, and stroke, are common features of the Caribbean's epidemiological profile (15–21). The recent introduction of fast-food chains to the Caribbean is likely to contribute to "excessive consumption of fatty, sugary, and salty foods" (3), and consequently, to an increased prevalence of chronic diseases. Additionally, the perception that "fat is good"—that a robust female, often overweight or obese, is attractive to males—is among the challenges faced by health educators who are developing programs to target obesity. This also poses a challenge at the PHC level in managing disease burden in the population, and requires a more integrated approach, with the patient playing a critical role in self-monitoring.

Changes in family structure, values, and attitudes (34) have resulted in the promotion and glorification of lawlessness. A violent culture is taking

root in the wider Caribbean. The threat that this development poses to PHC is very real and direct. This has historically been a major issue in some countries, such as Jamaica, but it is now showing up on the public health radar of others (e.g., the Bahamas, Barbados, and Guyana), impacting adolescents and young adults in particular (21).

Poor lifestyle choices, such as smoking, lack of physical activity, and drug and alcohol use, are having a critical impact on the health status of the Caribbean people. Examples from the Jamaican Healthy Lifestyle Survey (18) include a reported cigarette smoking prevalence of 28.4% in males, with 30% of respondents having smoked marijuana at least once, and relatively low levels of physical activity, among other issues. Physical activity is highly recommended, as it has been shown to be a moderating factor in cardiovascular disease risk (35). Early sexual initiation, unprotected sexual intercourse, and the associated risks (e.g., teenage pregnancy, HIV, etc.) are real issues that continue to impact the mortality profile of the Caribbean (21).

## HEALTH SECTOR RESPONSES TO THE GOAL OF HEALTH FOR ALL

### Health sector reform drives change in national health systems and in primary health care

Since the introduction of health care reform, which has been an ongoing process since the late 1990s across the English-speaking Caribbean, the key objective has been to improve overall management and efficiency of PHC delivery. This reform has been driven by, among other factors, the need to meet the growing and changing demands of the clientele of the government sector, the need for increased partnership with clients to facilitate a health promotion approach to disease management, and the need to better manage limited financial and human resources (4). In Jamaica, four key strategies have been employed. First, health services were decentralized through the National Health Services Act of 1997, which established four health regions: Northeast, Southeast, West, and South. Each health region has an autonomous management structure and responsibility for the management of funds and personnel. Each reports to the Ministry of Health. Second, the Ministry of Health's role was reoriented toward national programs, strategic planning and policy formulation, standards and regulations, monitoring and evaluation, and quality assurance. Third, the public and private sectors partnered to deliver government health care services through private pharmacies (4). Fourth, a proposal for national health insurance was developed. As early as 1974, and again in 1997, this proposal sought to pro-

vide access to a basic package of services for all, underscoring the key principles of PHC, including equity. The package was to include specific laboratory and diagnostic tests, prescription medications, and inpatient services. However, this was not realized until the establishment of the National Health Fund (NHF) in 2001. The mission of the NHF is to "reduce the burden on health care in Jamaica." Assistance is provided for the purchase of specified drugs and the treatment of specific chronic illnesses. Through the NHF, funding support is also provided for public sector infrastructure and service delivery improvements. Prior to this, programs such as the Jamaica Drugs for the Elderly Program (1996) served a specific target group to provide pharmaceuticals (36). It is important to note that these reforms were in accordance with the WHO infrastructural model for the reorientation of national health systems towards health for all (37).

### Strengthening of institutional capacity

Many Caribbean countries have long depended on international organizations to supplement their health care delivery with financial and technical support. Among the funding sources are the Inter-American Development Bank, the Canadian International Development Agency, the United States Agency for International Development, and the United Nations Development Program. Examples abound in the use of these funding sources by the Bahamas, Barbados, Jamaica, and Haiti, to name a few (21). One drawback is that a funding agency's agenda often dictates how the funds are used, and the full slate of health needs in individual countries may not always be addressed (38).

Strengthening the Institutional Response to HIV/AIDS and Sexually Transmitted Infections in the Caribbean (the SIRHASC project) is one of the most recent international funding efforts to scale up resources and institutional capacity (39). SIRHASC, funded by the European Union and administered through the Caribbean Community (CARICOM), seeks to build capacity within the Caribbean through a number of initiatives, including skill-building for advocacy and administration, scaling up of resources, and improving infrastructure for communication, behavior change, research, and the development of laboratories capable of advanced HIV surveillance.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria is another such initiative. While programs such as these have proven to be very valuable for the Caribbean, the issue of sustainability remains. While programs for HIV need to be given high priority, there is a risk that other equally important health concerns, such as diabetes and hy-

pertension, could experience relative neglect and suboptimal program funding and management. Strengthening institutional capacity should be done with cross-program benefits.

### Social development programs

True social development has been challenged by struggling economies, the fight in communities for scarce benefits, and partisan politics. Social programs have developed to protect the vulnerable in the population, particularly in the aftermath of structural adjustment (40). As discussed in a previous section, the social determinants of health have taken on greater significance at policymaking levels, resulting in development of programs such as the Program for Advancement through Health and Education, Jamaica Drugs for the Elderly Program, and the National Health Fund in Jamaica. These programs are aimed at reducing inequities in access to PHC. The provision of these facilities no doubt has significant budgetary implications for the Caribbean. The work of nongovernmental organizations across the Caribbean is increasingly gaining support and recognition, and a wider pool of funds has become available to such organizations through increased collaboration with national and international funding sources (e.g., Global Fund).

### Health promotion programs

With the adoption of a Caribbean Charter for Health Promotion, the Caribbean is being challenged to look more deeply at the fundamental determinants of health and to tailor programs to address these issues. A national "Healthy Lifestyle" campaign in Jamaica strives to raise public awareness of healthy living as a preventative approach to PHC. This program has a special focus on noncommunicable diseases, such as diabetes, obesity, and hypertension. Special features of the program include public talks and competitions (41). In general, however, there continues to be a need for a wider appreciation and adoption of the tenets of contemporary health promotion across the Caribbean.

### Research initiatives

The search for evidence on which to base sound health sector decision-making is a key feature of health promotion programs. Caribbean researchers have spearheaded research into relevant health problems for many decades. The question of what constitutes essential national health research

needs to be continually examined. This is a challenge where resources are limited and researchers have varying interests and agendas. It is noted that research presentations over the years at the Commonwealth Caribbean Medical Research Council meetings have not clearly mirrored the CCH priority areas, and that generally in the Caribbean, there has been a dearth of research on the fundamental determinants of health (42). While program evaluation remains a relatively weak area of action in the Caribbean, the growing movement towards intervention research should provide additional evidence for health promotion programs.

## CONCLUSION AND RECOMMENDATIONS

The Caribbean is faced with numerous challenges in managing PHC. Chief among these are the economic challenges that impact the pace of development in health and other sectors. Of equal concern is the impact of the social determinants of health, where issues such as the cost of crime and motor vehicle accidents are negatively affecting PHC delivery. Strident steps have been taken to advance health care reform to provide appropriate PHC services oriented toward the needs of the population (e.g., institutional strengthening, research, social development programs, and health promotion programs). However, this pace must be quickened and sustained to facilitate an ongoing and evolutionary process capable of recognizing and responding to changing needs of PHC over time. The reorientation of PHC to meet emerging needs requires that the necessary policies, programs, and services be supported by an appropriate health systems infrastructure. Adequate economic and social development will be necessary to provide the financial, human, and technical resources to make this a reality. Social and economic support programs (e.g., Program for Advancement through Health and Education, Jamaica Drugs for the Elderly Program, and the National Health Fund of Jamaica) are necessary to reduce any social inequities in PHC in support of the PHC principle of universality of access.

With limited funding, judicious use has to be made of available resources. Given budgetary and cost-effectiveness issues, the choice of affordable and appropriate medical technologies for PHC must be kept on the agenda. The ongoing monitoring of health and social indices in the Caribbean, through hospital and clinic summary reports and surveys, will be important to assess priority areas.

To offset the impending health care crisis in the Caribbean, the tenets of the Caribbean Charter of Health Promotion need to be examined and appropriately applied, with a greater focus on PHC. Health

education programs will become increasingly necessary in an effort to offset projections for the astronomical cost of managing the disease burden. Health promotion programs in both the school and community settings, the provision of safe parks or facilities for exercise, and the development and regulation of public policy to ensure the availability of healthier food choices at restaurants are some of the measures that must be applied to make the necessary strides toward "Health for All" in the Caribbean.

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## SINOPSIS

### Retos y respuestas del sector salud más allá de la Declaración de Alma-Ata: una perspectiva caribeña

*Al igual que el resto del mundo, el Caribe ha sido testigo del drástico paso de las enfermedades nutricionales y transmisibles a las enfermedades no transmisibles y crónicas. No obstante, en el Caribe este cambio ha coincidido con una nueva dinámica, creada por la emergencia de enfermedades transmisibles—como la infección por el VIH/sida— junto con los problemas relacionados con el envejecimiento, las enferme-*

*dades cardiovasculares, la violencia y las lesiones, entre otros. En este artículo se hace una revisión de la historia de la atención sanitaria en el Caribe, los retos y enfoques del sector salud y la nueva orientación en la atención primaria de salud (APS). Las observaciones se basan en trabajos publicados. En el Caribe, la Declaración de Alma-Ata sirvió como importante punto de giro y ofreció orientación, apoyo y dirección a medida que los países perfilaban sus servicios de salud para satisfacer sus necesidades. La creatividad y el ingenio surgieron como rasgos distintivos del enfoque caribeño en la reestructuración de la APS, ante los retos económicos, sociales, culturales, de recursos humanos y de políticas que enfrentaban. El fortalecimiento de la capacidad institucional, la extensión de los programas sociales, los esquemas nacionales de seguros de salud, los programas específicos de promoción de salud y la ampliación de la investigación en apoyo al desarrollo de políticas continúan evidenciando el esfuerzo caribeño para responder a los cruciales retos epidemiológicos. A pesar de esos retos, se han establecido alianzas dentro y fuera del Caribe. Además, la Carta del Caribe para la Promoción de la Salud ha servido como elemento crítico para el desarrollo de la APS.*

**Palabras clave:** atención primaria de salud, economía en atención de salud y organizaciones, accesibilidad a los servicios de salud, prestación de atención de salud, región del Caribe.

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## REFERENCES

- World Health Organization. Primary health care: report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. Geneva: WHO; 1979.
- McCaw-Binns A, Moody CO. The development of primary health care in Jamaica. *West Ind Med J.* 2001;50(4):6–10.
- World Health Organization. A global review of primary health care: emerging messages. Geneva: WHO; 2003.
- Carr P. Health systems development in the English-speaking Caribbean: toward the twenty-first century. *Bull Pan Am Health Organ.* 1985;19(4):368–83.
- World Health Organization. National health systems and their reorientation towards health for all. Geneva: WHO; 1984. (Public Health Papers 77).
- Moyne L. The West Indian Royal Commission Report. London: Her Majesty's Stationery Office; 1945. (Command 6607).
- World Health Organization. Global strategy for health for all by the year 2000. Geneva: WHO; 1981.
- Pan American Health Organization. Primary health care and local health systems in the Caribbean. In: Proceedings of the workshop on primary health care and local health systems. Washington, D.C.: PAHO; 1989. Pp. 3–68.
- Ministry of Health, Jamaica. Primary health care: the Jamaican perspective—a reference manual of primary health care concepts and approaches in Jamaica. Kingston: MOH; 1978.
- McCaw-Binns A, Moody CO, Standard KL. Forty years: an introduction to the development of a Caribbean public health. *West Ind Med J.* 1998;47(4):1–52.
- Ashley D, McCaw-Binns A. Informing maternal and child health policy through research. *West Ind Med J.* 1998; 47(4):16–9.
- McCaw-Binns A. Safe motherhood in Jamaica: from slavery to self-determination. *Paediatr Perinat Epidemiol.* 2005;19(4): 254–261.
- Caribbean Cooperation in Health Secretariat. Caribbean cooperation in health phase II: a new vision for Caribbean health. Georgetown: Caribbean Cooperation in Health Secretariat; 1999.
- World Health Organization. Constitution of the World Health Organization as adopted by the International Health Conference [preamble]. New York: WHO; 1948.
- Holder Y, Brandon P. Caribbean demographic and health trends—social and economic implications for the 21st century [Internet site]. Caribbean Epidemiological Center. Available from <http://www.carec.org>. Accessed 18 December 2003.
- Wilks R, Bennett F, Forrester T, McFarlane-Anderson N. Chronic diseases: the new epidemic. *West Ind Med J.* 1998;47(4):40–4.
- Pan American Health Organization. Health in the Americas. 1998 ed. Washington, D.C.: PAHO; 1998. (Scientific Publication 569; 2 vol).
- Tropical Medicine Research Institute, University of the West Indies. The Jamaican Healthy Lifestyle Survey 2000 project report [Part 1]. Kingston: TMRI; 2002.
- Ministry of Health, Jamaica. Epidemiological profile of selected health conditions and services in Jamaica: a ten year review. Kingston: MOH; 2001.
- Gulliford MC. Epidemiological transition in Trinidad and Tobago, West



- Indies 1953–1992. *Intl J Epi*. 1996;25(2):357–65.
21. Pan American Health Organization. Volume II: Health in the Americas. 2002 ed. Washington, D.C.: PAHO; 2002. (Scientific Publication 587).
  22. Feinstein JS. The relationship between socioeconomic status and health: a review of the literature. *Milbank Q*. 1993; 71(2):279–322.
  23. Kaplan George A, Keil, Julian E. Socio-economic factors and cardiovascular disease: a review of the literature. *Circulation*. 1993; 88(4): 1973–98.
  24. Labonte R, Schrecker T. Globalization and social determinants of health: analytic and strategic review paper. Ottawa: University of Ottawa Institute of Population Health; 2006.
  25. Pan American Health Organization/World Health Organization. Renewing primary health care in the Americas: a position paper of PAHO/WHO (draft 2005). Montevideo: PAHO; 2005.
  26. United Nations Development Program. Human development report 2003: Millennium Development Goals: a compact among nations to end human poverty. New York: Oxford University Press; 2003.
  27. Commission on Social Determinants of Health. Action on the social determinants of health: learning from previous experiences. Geneva: WHO; 2005.
  27. World Health Organization. Primary health care: a framework for future strategic directions. Geneva: WHO; 2003.
  28. Figueroa JP. Health trends in Jamaica. *West Ind Med J* 2001; 50(4):15–22.
  29. Eldemire-Shearer A, Paul TJ. Ageing-time for a paradigm shift in health care services. *West Ind Med J* 2003; 52(6): 45–8.
  30. Jamaica, Ministry of Health. Annual report 2001 [Internet site]. Available from: <http://www.moh.gov.jm>. Accessed 6 January 2004.
  31. The Caribbean Community Secretariat. Caribbean charter for health promotion: proceedings of 1st Caribbean conference on health promotion. Port of Spain, CARICOM; 1993.
  32. Alleyne GA, Sealy K. Whither Caribbean health. West Indies: WI Commission; 1992.
  33. Leo-Rhynie E. The Jamaican family: continuity and change. Kingston: The Grace Kennedy Foundation; 1993.
  34. Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure. The sixth report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure. *Arch Intern Med*. 1997;157:2413–46.
  35. National Health Fund of Jamaica. National Health Fund of Jamaica [Internet site]. Available from <http://www.nhf.org.jm>. Accessed 14 October 2006.
  36. World Health Organization. National health systems and their reorientation towards health for all. Geneva: WHO; 1984. (Public Health Papers 77).
  37. Theodore K. An overview of structural adjustment in the Caribbean. *West Ind Med J*. 1993;42(1):60–2.
  38. The Caribbean Community Secretariat. Strengthening the institutional response to HIV/AIDS and sexually transmitted infections in the Caribbean (SIRHASC) project document. Georgetown: CARICOM; 2000.
  39. Figueroa JP. Structural adjustment—the impact on health. *West Ind Med J*. 1993; 42(1):63–7.
  40. Ministry of Health, Jamaica. Strategic plan 2001–2005. Kingston: MOH; September 2001.
  41. Alleyne G. Caribbean health and health research. *West Ind Med J*. 1994;43(1): 50–3.

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