

Organisational Assessment of Regional Health Institutions

VOLUME I:
Overall Evaluation
Report



January 2005

Executive Summary

The Review of Regional Health Institutions

Highlights

Overview of Major Cross-Cutting Findings

- RHIs generally are delivering programming that meets regional needs and CCH-2 goals. CRDTL however is not a viable organisation.
- There is very little duplication among RHIs. More coordination among them is needed.
- RHI core mandates are under pressure and need to be reviewed and balanced in light of the level of core funding available to them.
- Extensive donor programming generally provides valuable services, but does not normally support core programming.
- RHI governance systems need to strengthen the engagement of senior decision-makers.
- CARICOM Secretariat does not possess the capacity to monitor RHI activities, nor can it engage in better planning with them.
- PAHO plays important roles in the region and with respect to CAREC and CFNI in particular.

Rationalisation Options

Option 1 – Maintain the Status Quo

- Do not address core mandate and financing issues
- Do not strengthen regional governance of RHIs
- Address critical shortfalls in pharmaceutical quality assurance and drug regulation
- *Universalialia does not recommend this option*

Option 2 – Merge all RHI Functions into One Combined and New RHI

- Conduct an overall core mandate and financing review
- Merge all RHI functions into a new body (but keep the current locations)
- Phase out PAHO management /administration
- Strengthen CARICOM Secretariat
- Build new regional governance system
- *Universalialia does not recommend this option*

Option 3 – Regionalise CAREC, while leaving other RHIs untouched

- Conduct a mandate and financing review
- Phase out PAHO management / administration of CAREC
- Leave other RHI untouched (possibly merge pharmaceutical functions into CAREC)
- *Universalialia does not recommend this option*

Option 4 – Harmonise RHI Planning and Governance

- Conduct a core mandate / financing review
- Retain 4 RHIs as separate entities (with pharmaceutical functions to either CFNI or CAREC)
- Establish a formal RHI Directors Network chaired by CARICOM Secretariat
- Strengthen CARICOM Secretariat
- Harmonise planning and reporting (while retaining PAHO roles at CFNI and CAREC)
- Harmonise RHI governance by developing a common board for all RHIs, eventually phasing out the PAHO roles at CAREC and CFNI
- *Universalialia recommends that this Option be considered*

Option 5 – Merge CAREC and CFNI, Harmonise and Strengthen CEHI and CHRC

- Conduct a core mandate and financing review
- Merge CAREC and CFNI into a new PAHO specialised centre (they comprise 85+% of programming) and include the pharmaceutical functions
- Maintain CEHI and CHRC as specialised centres and strengthen their governance and planning
- Modest strengthening of the CARICOM Secretariat
- *Universalialia recommends that this Option be considered*

1.1 This Executive Overview

- This is an executive summary of the CARICOM Secretariat- funded review of the five Caribbean Regional Health Institutions (RHIs). It summarises the synthesis report, which contains proposals for the rationalisation of the RHIs.
- It also contains capsule overviews of the assessment of each of the five RHIs and also overviews of a set of horizontal findings that have shaped the development of the options for the rationalisation of the RHIs.

1.2 Methodology

- The review of the five RHIs was based on an application of Universalialia Management Group's prime organisational assessment methodology – Institutional and Organisational Assessment (IOA). It was developed by Universalialia and the International Development Research Centre (IDRC) as a means of assessing the complex interplay between factors that make up the totality of organisational performance.

- IOA performance is defined in terms of *effectiveness* (mission fulfilment), *efficiency*, ongoing *relevance* (the extent to which the organisations adapts to changing conditions and its environment), and *financial viability*. The IOA framework implies that the factors embedded in capacity, motivation and contextual environment drive performance.
- Using IOA methodology as a framework Universalialia developed a complex set of instruments that ranged from self-assessment questionnaires to interview protocols for many categories of informants.
- Extensive discussions were held with regional stakeholders at all levels, including many senior informants such as Chief Medical Offices, Permanent Secretaries and of course Ministers. In addition a broad range of stakeholders were engaged. In total excluding the staff of the RHI themselves, about 200 external stakeholders participated in the process. In addition, extensive document review was carried out, as were discussions with informants from key donor agencies.
- Universalialia mounted a team of evaluation and public sector governance specialists and health systems analysts. The team was augmented by three senior public health advisors and managers from Health Canada and the Canadian International Development Agency.

1.3 Limitations

- Given budgetary and time constraints, the review was not designed to be a detailed peer-assessed study of the professional and technical competence of the RHIs.
- As the findings below will show, the performance challenges facing the RHIs and the approaches to RHI rationalisation largely involve managerial, fiscal, administrative and governance considerations.
- The study was initially intended to begin in early 2004 and to conclude by September/October 2004. However, due to delays in awarding the contract, substantive work did not begin until late April/early May 2004. Additional time was spent because of delays in securing feedback on the five individual RHI assessments and the preliminary Interim Report (a Power Point briefing deck).
- These delays resulted in the bulk of data collection occurring during the vacation period of 2004, thus somewhat limiting access to some informants.

1.4 The Purpose of the Review

- The general objectives of the Evaluation, as described in the Terms of Reference, were:
 - To evaluate the performance and relevance of the five Regional Health Institutions (RHIs);
 - To determine the institutional framework and appropriate organisations through which technical cooperation in health at the regional level will be pursued; and
 - To assess the capacity of the CARICOM Secretariat to monitor, provide oversight and coordinate the operations of the RHIs.

1.5 The Review of Individual RHIs

- Each RHI was reviewed by a Universalia team that conducted an on-site mission, reviewed extensive documentation, and surveyed regional and donor stakeholders.
- A detailed individual report was prepared for each. The synthesis report contains a more extensive condensation, while the complete reports are found in separate volumes.

CEHI

- CEHI was established in 1988 by member states. It is not a PAHO-specialised centre. It is located in Castries, St. Lucia. It has about 20 staff members; and currently has an overall budget in the range of \$1-1.3 million, approximately equally divided between member state payments (with significant arrears), fee for service/cost recovery activities and programming supported by major donors.

a) Findings

- CEHI's programming is well received by stakeholders and, while regional in application, appears to be more relevant to OECS member states.
- CEHI was refreshed as a result of a donor-supported programme that resulted in new planning and governance systems and new articulation of core priorities – water (in general) and waste management.
- While CEHI has been successful in balancing its revenue sources, failure to pay quota contributions weakens CEHI's ability to respond to member state needs.
- Recently CEHI also has been able to secure significant support from donors.
- CEHI is generally well managed and efficiently uses its resources.
- CEHI has moved toward cost recovery to augment limited core funding for key mandate areas. Core funding is inadequate to provide for completely cost -free programming delivery.
- There is some uncertainty whether CEHI has an environmental health, or environmental management focus, caused in part by ambiguities in its charter.

b) Recommendations

- CEHI needs to ensure that the benefits of the 1998-2002 institutional strengthening programme are sustained.
- CEHI needs to strengthen its stakeholder feedback and programme monitoring and evaluation capacities.
- CEHI needs to strengthen its human resource management systems.
- CEHI and the CARICOM Secretariat need to better plan and manage the way member states pay quota contributions.

CHRC

- The CHRC has an early history as a medical research body; however, it has been formally re-cast with a refreshed mandate to address “health research” (as opposed to strictly “medical” research) as of 1998. The CHRC comprises six staff members, located in the facilities of the UWI in Port of Spain, Trinidad and Tobago, and in a very small sub-office in Kingston, Jamaica. Its overall budget is in the \$700,000 range, being equally divided between member state payments (although arrears to the CHRC are approaching \$1 million) and newly secured donor-supported programming.

a) Findings

- The CHRC has made major strides in the last five years transforming itself from in essence a part-time body to a valuable full-time regional institution. Its new Strategic Plan lays out a viable course of action. Its broad “health mandate” touches many, if not all, the CCH-2 goals.
- However, the organisation is hampered by a small core budget (and not full payment) that results in it facing a dichotomy between its core mandate and the level of resources available to support it.
- CHRC recently has made strong progress in securing funding from donors for new programming and unlike other RHIs appears to be more closely linked to elements of its core mandate.
- Regional stakeholders do not have a sound grasp of the work or worth of the CHRC, in large part due to the fact that the organisation’s work remains tightly targeted and that it lacks funds to engage in more proactive communications and information dissemination.
- The CHRC’s governance systems may need to be reviewed to strengthen the active input of senior decision-makers.

b) Recommendations

- The CHRC may wish to investigate ways of improving its outreach and information dissemination activities.
- It may also wish to build its own internal management systems and cease using those of the UWI.
- The governance system of the CHRC may need to be streamlined.

CFNI

- CFNI was established by member states and PAHO as a PAHO-specialised centre in 1967. It is the “oldest” of the five RHIs. It has a budget of \$2.4 million, which is comprised of 50% from PAHO, 15% from member state contributions and 35% from donor-supported programming and very modest amounts of cost-recovery activities. With about 33 employees, of whom 12 are PAHO international staff, CFNI is located in Kingston, Jamaica, with a small sub-office in Port of Spain, Trinidad and Tobago.

a) Findings

- CFNI's programmes are relevant to most member states and support CCH-2 goals.
- CFNI's work however may be more relevant to those nations that do not have extensive internal capacities food/nutrition matters.
- Its approach to feedback and needs assessment tends to focus on operational matters and may not sufficiently engage senior-decision makers.
- CFNI governance systems do not sufficiently engage senior decision makers, nor do they reach out to civil society and private business interests.
- While CFNI utilises PAHO planning and management systems, more could be done to strengthen its forecasting and the monitoring and evaluation of its programming.
- CFNI recently has made major strides towards mobilising donor support; however, CFNI has not sufficiently explored cost-recovery / fee for services to augment PAHO and member state core payments which are under pressure, as they are at the five RHIs.

b) Recommendations

- CFNI might expand its approach to cost recovery and fee for services to reduce its dependency on core funding from PAHO and member states.
- CFNI may wish to strengthen the ways it engages senior decision-makers in needs assessment processes.
- CFNI may wish to refresh its governance systems so as to increase the engagement of senior decision-makers and improve the engagement of other elements of society.
- CFNI may wish to strengthen its planning and programming monitoring and evaluation systems, possibly integrating more aspects of Results-Based Management.
- CFNI may wish to seek some additional managerial delegation from PAHO.

CRDTL

- The CRDTL was established in 1975 by member states. It is located in Kingston, Jamaica, with a staff of 8 persons. Its annual budget is in the range of \$300,000; however persistent patterns of arrears reduces this to the range of \$225,000, effectively all of which comes from member state payments.

a) Findings

- At best, the CRDTL only minimally meets its core mandate to provide pharmaceutical quality assurance testing.
- Its per unit costs are over double that which can be obtained elsewhere.
- Its turn-around times are excessive in the opinion of most stakeholders.
- It faces continual fiscal pressures due to persistent patterns of non-payment of quota.
- It faces technological obsolescence due to under-funding.
- Its governance systems do not engage senior decision-makers to any active degree.
- Its approach to disseminating information on testing results is inefficient.

- More importantly, the CRDTL as it currently is constituted, is incapable of addressing a range of factors related to ensuring the region's access to cost-effective and efficacious pharmaceutical products over and above basic quality assurance drug testing.

b) Recommendations

- Universalis is of the opinion that the CRDTL as it is currently constituted cannot be refreshed without effectively creating a new body.
- Universalis recommends that a new approach to ensuring access to cost-effective and efficacious pharmaceutical products be developed that would focus on more than drug quality assurance testing.

CAREC

- CAREC is the largest of the five RHIs, with an annual budget in the \$12-13 million range of which over 60% is derived from donor-supported programming. CAREC is a PAHO-specialised centre established by Caribbean nations and PAHO in the mid-1970's. It is located in Port of Spain, Trinidad and Tobago and has some 140 staff members, of which only 8 are PAHO international employees.

a) Findings

- CAREC is seen to be the preeminent source for technical cooperation in public health in the region. Its varied programmes are widely seen as highly valuable.
- CAREC however, faces a primary challenge in the dichotomy between what is generally expected to be its core mandate, and an inadequate level of core funding from member states and PAHO to support these core functions.
- CAREC's highly successful resource mobilisation efforts have resulted in extensive new programming (however, with limited positive impact on its core functions), producing a blurring of core responsibilities and added pressures being placed on core programming and managerial functions.
- In view of the growing weight of donor-supported programming, CAREC could benefit from a review of its core mandate.
- CAREC's governance systems, its Council and Scientific Advisory Committee may not be sufficiently representative of Caribbean nations and may not sufficiently engage them in the strategic decision-making processes.
- CAREC's facilities are in need of extensive renovation or complete renewal.
- CAREC is presently experiencing some managerial and programme delivery challenges due in large part to the erosion of its core financial base.

b) Recommendations

- CAREC may wish to conduct a mandate and financing review to better balance its sources of revenue and to better ensure the sustainability of its core programming.
- CAREC's governance systems may need to be refreshed and expanded to better engage senior regional decision-makers.
- CAREC should pursue a programme of managerial and institutional strengthening to strengthen its planning, monitoring and evaluation and programme execution capacities.

- Note: Universalialia addresses the nature of the CAREC-PAHO relationship in its series of suggested approaches to RHI rationalisation.

1.6 Horizontal Findings

- Universalialia, in its review of the five separate RHIs and its environmental scan, began to note a series of cross-cutting factors that characterise the overall performance of the RHIs. Five basic factors emerge as the prime determinants on which to assess current overall RHI performance and contemplate eventual approaches to RHI rationalisation, the key requirement for the entire evaluation process.
 - The nature of the core mandate of RHIs
 - The nature of regional (and other resources) available to RHIs to sustain both core programming and also to support new activities
 - The nature of the governance systems of RHIs
 - The organisational and managerial structures of RHIs
 - The nature of RHI accountability and reporting systems. In addition
- Universalialia also was asked to assess the capacity of the CARICOM Secretariat to monitor, provide oversight and coordinate the operation of RHIs.
- **Overall Universalialia concludes that to meet CCH goals and to support essential public health functions, the set of basic core functions currently conducted by the RHIs are required. All are needed to some extent. Thus, there are no obvious candidates to be eliminated.**
- Universalialia did not find major instances of programming that did not meet recognised regional goals.

The Nature of Core Mandates

- RHI Core mandates are permissive in nature and offer a high degree of flexibility.
- However, there is a growing gap between what are perceived to be core services by many stakeholders, and the ability to provide sufficient resources to meet these requirements. Core mandates are under increasing pressure. This is probably the most serious challenge to face the RHIs and technical cooperation in public health for the region.
- RHI core mandates need to be reviewed in a compressive fashion, and not piecemeal.

The Resources to Support Core Mandates and Other Programming

- Core funding from both member states via quota contributions and from PAHO (for CAREC and CFNI) is insufficient and not sustainable.
- This has led to internal managerial challenges at a number of RHIs.
- While some RHIs have been very successful in mobilising external resources, the new funding has gone towards new, albeit valuable, programming, and not towards the support of “core” services.
- RHIs have not sufficiently explored the balance between core funding, donor support and resource raised from market-driven sources such as cost recovery and fee for services.
- The current fragmentation of RHIs does not promote economies of scale.

The Governance of RHIs

- RHI governance is fragmented across RHI (even the two PAHO-specialised centres have very different governance systems) and does not produce synergies. Fragmented governance has impeded addressing the challenges of core mandates and the shortage of core funding.
- Governance systems do not sufficiently engage senior decision-makers. Governance is largely transactional in nature.
- Present governance systems also do not reach out to new groups of stakeholders, for example, the private sector, NGOs, and civil society in general.
- Governance systems, with one exception, have not been refreshed to account for contemporary trends in public sector modernization.

The Management of System

- There is very little classic administrative overlap or duplication among RHIs, mainly because two of the five are very small and have virtually no administrative mechanisms of their own; while the two next largest have only modest internal systems.
- There are varying levels of “uptake” in varying member states, thus complicating the ability of RHIs to develop sensitive programming.
- Fragmentation of managerial systems (even among the two PAHO-specialised centres which comprise 85+% of programming) results in lack of synergies and economies of scale.
- Fragmentation in human resources management impedes the overall ability to develop a regional cadre of trained personnel

The Ability to Assess Relevance and Report on Performance

- RHIs generally have weak planning systems that do not sufficiently assess needs. These systems also are not integrated.
- Their ability to monitor performance in terms of the impacts of their work is also generally weak.
- RHI reporting formats are fragmented and largely concentrate on reporting expenditure and outputs, thus impeding effective decision-making.

The Capacity of the CARICOM Secretariat

- At this time the CARICOM Secretariat does not have the staff or the resources to successfully monitor the work of RHIs.
- It also would not have sufficient resources or capacity to assume more active management and planning functions.
- There is an ambiguity concerning the role of the Secretariat due to the nature of various RHI charters that do not set out clear functions for it.
- Although the Secretariat has played valuable roles in the past within its limited base, it would require considerable strengthening to be able to perform a range of more active, monitoring, planning and coordination functions in the future.

1.7 Options for Rationalisation

a) Three Major Preconditions for Rationalisation

Conduct an Overall Review of RHI Core Mandates

- RHI core mandates are generally very expansive so as to permit organisations to respond to changing circumstances.
- However, their scope also poses a risk in the fact that there has not been an overall and coordinated review of what the region as a whole considers to be the optimum level for technical cooperation in public health and how core functions collectively work to the attainment of CCH goals and also to strengthen essential public health functions.
- Wide core mandate results in programmatic fragmentation and recourse to minimalist approaches to addressing a plethora of issues, as opposed to priorities.

Conduct a Review of How Core Mandates are Financed – a Core Funding Review

- As noted, the level of core funding for all RHIs either from member states or from PAHO in two instances) is insufficient to meet even today's uncertain understanding what constitutes core mandate areas.
- World Bank and other studies show that excessive reliance of donor funding is unsustainable. Moreover donors are moving away from support for on-going "core" programming, and towards specific time-limited initiatives.
- The region needs to better balance three complementary revenue sources: member state payments, donor support and revenue generated by market-driven means (cost recovery / fee for services).
- A review of how the region determine core mandate and then finances RHIs would address the dual questions of: "What do we need in terms of technical cooperation in public health; and how can we ensure that these functions will be sustainable over the longer-term?"
- Both the review of core mandates and how to finance them could be undertaken by a small team under the auspices of the CARICOM Secretariat.
- Between 6-12 months would be needed to conduct such a review.
- Costs could be estimated to be in the \$330-450,000 range. Donor support via a programme of institutional strengthening would need to be secured.

Revitalise the Region's Approach to Pharmaceutical Quality Assurance and access to Products

- The current CRDTRL is not a viable organisation, even if it were to receive external one-time support as has been suggested.
- There does not appear to be any viable way to shape a drug-testing facility that is based on member state payments and which provides free services to its member states. This is largely due to issues related to economies of scale.
- There is very little likelihood that sufficient resources could be generated from the sale of services to the private sector to ensure organisational sustainability.

- More importantly, new pharmaceutical quality assurance functions may have more relevance to the region than traditional drug testing; such as:
 - Ensuring access across the region to up-to-date information on products approved by major regulatory bodies (including product warnings)
 - Developing means to ensure the quality of products provided by new supplies (India, Eastern Europe, etc)
 - Strengthening national regulatory capacities
 - Providing a means for the region to access cost-efficient and timely quality assurance testing (most likely by a fee for service relationship with an external supplier)
 - Strengthening, of relevant national laboratory capacities
- These functions point to a new model wherein information dissemination and capacity-building would be the paramount activities; and where quality assurance testing would likely be conducted on a fee for service basis by an outside facility that has a proven track record and considerably lower per unit costs.

b) Five Approaches to Rationalisation

- Five general approaches to RHI rationalisation are presented, although Universalialia is of the view that three are not desirable. All five are presented, however, due to the fact that several have been raised by key informants, and thus warrant review.

Option 1 – The Modified Status Quo

Contents

- An informal network of RHI Directors chaired by the CARICOM Secretariat working to address short-term and operational issues
- No core mandate / core financing review
- No change to RHI governance
- Either a “new” CRDTL with the functions noted above, or wind up the current CRDTL and add these functions to another RHI, either CAREC or CFNI

Costs

- About \$25,000 per year to facilitate RHI Directors meeting more often
- About \$100,000 per year for one new senior professional at the CARICOM Secretariat to be assigned specifically to RHI liaison

Strengths

- This option is desirable only to the extent that senior decision-makers believe RHIs are operating at or near optimal performance.
- It is also desirable if senior decision-makers cannot develop a consensus on more substantive approaches, or are unwilling to invest in RHI rationalisation

Weaknesses

- It does not address:
 - The growing challenges posed by the gap between what is considered to be core programming and the means to finance them
 - The fundamental governance challenges
 - The need to promote synergies among RHIs
 - It should be noted that such an approach was tried some years ago under the auspices of the CARICOM Secretariat and withered away
- This option does not seriously address the challenges of RHI rationalisation
- Universalialia does not recommend this option

Option 2 – RHI Amalgamation and Regionalisation of Governance

Contents

- Merge all RHI function into one new body (including new pharmaceutical quality assurance functions); however, to ensure a pan-regional presence, maintain existing locations and likely existing basic functions at those locations
- Conduct a core mandate and financing review
- Regionalise the governance of the new body with a new board and new advisory committees that more engage senior decision-makers
- Phase out the PAHO administration of CAREC and CFNI
- Extensive strengthening of CARICOM Secretariat by developing a “virtual network”

Costs

- For the core mandate and financing review – about \$450,000 over one year
- For subsequent extensive governance discussions and negotiations – about \$300,000 for another year
- On-going costs to CARICOM for strengthening the Secretariat – about \$175,000 per year

Strengths

- The greatest likelihood for synergies among programming
- A very high -level of regional governance involvement
- Potential for high level of synergies in resource mobilisation
- Economies of scale and harmonised human resource utilisation
- Strong impact on improving the focus of programming delivered to member states

Weaknesses

- Very time consuming – could take 3-4 years to conclude
- Disruptive for staff and stakeholders
- Would tend to subsume smaller RHI function beneath those of CAREC, by far the largest of the RHIs

- Phasing out the PAHO management /administration of CFNI and CAREC eliminates many positive PAHO roles, including that of the financial guarantor for programming equivalent to 85+% of all RHI activities
- Would require extensive high level negotiations to develop an acceptable new umbrella agreement
- Requires large donor commitments for short-to-medium term institutional strengthening
- Universalialia does not recommend this option

Option 3 – The Regionalisation of CAREC

Contents

- Conduct a more modest core mandate and financing review
- Regionalise and strengthen the governance of CAREC; withdraw PAHO's managerial and administrative functions
- Do not address other RHIs, save for tangential changes arising from the core mandate and financing review
- Strengthen the CARICOM Secretariat to play an active role in the governance of the "new" CAREC and the other RHIs

Costs

- For a more modest core mandate and financing review - about \$315,000 over one year
- For the costs of the evolution of CAREC's governance - about \$200,000 for an additional year
- To strengthen the CARICOM Secretariat by establishing a new senior professional position and by developing a virtual network - \$175,000 per year in on-going costs

Strengths

- This option is only desirable if senior regional decision-makers believe that the PAHO relationship with CAREC is no longer in the region's interests and that the region should have full control over CAREC.

Weaknesses

- In phasing out the PAHO relationship for CAREC, substantial benefits would be lost.
- The region would have to find a new "financial guarantor/banker" for CAREC.
- It does not promote greater programmatic synergies.
- It does not address the governance challenges facing other RHIs.
- It could result in increased competition among RHIs.
- Universalialia does not recommend this option

Option 4 – An Evolutionary Approach to RHI Rationalisation and Governance

Contents

- Conduct a core mission and financing review
- Establish a formal RHI Directors Network chaired by the CARICOM Secretariat with a clear mandate to encourage harmonisation of programming, administrative systems and resource mobilisation
- Maintain four separate RHI to ensure their respective distinctiveness
- Harmonise and strengthen regional governance by ensuring cross-board membership (same members on the boards of each RHI)
- Strengthen advisory bodies
- Maintain, from the start, the PAHO administrative and managerial relationships with CFNI and CAREC
- Strengthen the CARICOM Secretariat
- Possibly, over time, move to a combined RHI “board of governors” common for all RHIs and move to wind up the PAHO managerial / administrative relationship for CFNI and CAREC

Costs

- For the core mandate and financing review – about \$450,000 over one year
- For the subsequent extensive governance enhancements – about \$ 330,000 over a subsequent year
- For ongoing strengthening of the CARICOM Secretariat and for a virtual network to assist it – about \$ 175,000 per year in on-going costs

Strengths

- Can produce considerable synergies and programmatic renewal without the dislocation inherent in full amalgamation
- Retains the distinct identity of RHIs and their unique niches and clients
- Does not subsume smaller RHIs into in effect an enlarged CAREC
- Is “easier” to implement than full amalgamation
- Allows for a flexible response to rationalisation to evolve over time

Weaknesses

- Require extensive network coordination and internal cooperation
- Will not be successful unless CARICOM Secretariat plays a strong on-going leadership role
- May take considerable time to pass amendments to RHI charters
- If the PAHO managerial and administrative relationship for CAREC and CFNI were to conclude, would involve considerable additional financial risk to the region and additional costs
- Universalialia recommends that senior decision-makers consider this option, cautioning however that the potential final step, winding up the PAHO administrative and managerial relationship for CAREC and CFNI poses considerable risks.

Option 5 – Amalgamate CAREC and CFNI, Harmonise CHRC and CEHI

Contents

- Conduct a more modest core mandate and financing review
- Amalgamate the two PAHO-specialised centres (which already comprise 85+% of RHI programming and funding into a new PAHO-specialised centre (at the two current locations) – not simply merge into CAREC – with a new charter
- Strengthen the regional governance of the new body, while retaining the PAHO administrative and managerial relationship with it
- Retain CHRC and CEHI as stand-alone RHIs, recognising their unique niche markets
- Strengthen their governance
- Modest strengthening of the CARICOM Secretariat

Costs

- For the core mandate and financing review – costs in the range of \$ 315,000 over one year
- For the governance aspects of the renewal, - cost in the range of \$ 170,000 over the subsequent year
- For the strengthening of the CARICOM Secretariat – on going costs in the range of \$125,000.
- Additional on-going costs of \$50,000 per year should the CARICOM Secretariat also implement a “virtual network ” to deepen its capacity to monitor, plan and coordinate RHIs

Strengths

- Recognises that all RHIs are not equal entities (as the other options tend to assume) and that the two PAHO-specialised centres already comprise the vast majority of RHI functions and resources
- Creates a “one-stop shop” for most regional technical cooperation on public health
- Results in the possibility of more synergies in resource mobilisation and programme delivery
- Allows CEHI and CHRC to evolve as unique stand-alone entities that have special niche functions and clients
- Enables integration of upward of 85% of RHI staff into one entity resulting in a larger and coordinated cadre of qualified staff.
- Strengthens the ability to meet CCH and Essential Public Health Function goals
- “Easy” to implement
- Results in a consolidation of much of the PAHO role in the region.

Weaknesses

- Requires the consent of PAHO
- Does not fully regionalise RHI governance (should that be considered to be an absolute objective for rationalisation by decision-makers)
- Will require careful integration steps and carefully balancing governance renewal so as to ensure that food and nutrition aspects are not submerged within, what might become merely an expanded CAREC
- Universalialia recommends that senior decision-makers consider this option.

A c r o n y m s

ACS	Association of Caribbean States
AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti-retroviral
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CARIFORUM	Caribbean Forum of ACP States
CARIPHA	Caribbean Public Health Association
CARISURV	Caribbean Surveillance System (CAREC system for public health data)
CCH	Caribbean Cooperation in Health Initiative
CCMRC	Commonwealth Caribbean Medical Research Council
CDB	Caribbean Development Bank
CDC	United States Centres for Disease Control
CEHI	Caribbean Environmental Health Institute
CFNI	Caribbean Food and Nutrition Institute
CGCED	Caribbean Group for Cooperation in Economic Development
CHRC	Caribbean Health Research Council (formerly CCMRC)
CIDA	Canadian International Development Agency
CIMT	Caribbean Indicators and Measurement Tools
CLAN	Caribbean Laboratory Action News (CAREC)
CMC	Caribbean Member Country
CMO	Chief Medical Officer
COHRED	Council on Health Research for Development, Geneva
COHSOD	CARICOM Council on Human and Social Development
CPC	Caribbean Programme Centre (a PAHO office)
CRDTL	Caribbean Regional Drug Testing Laboratory
CRN+	Caribbean Regional Network of PLWHA
CROSQ	Caribbean Regional Organisation on Standards and Quality (CARICOM)
CSIH	Canadian Society for International Health
CSME	Caribbean Single Market Economy
CSR	CAREC Surveillance Report
DFID	Department for International Development (UK)

A c r o n y m s

EDF	European Development Fund
EIS	Epidemic Intelligence Service (CDC/US)
ENHR	National Essential National Health Research Initiative
EPHF	Essential Public Health Function
EPI	Expanded Programme on Immunisation (CAREC)
EPISUM	Communicable Disease Database (CAREC)
EU	European Union
FETP	Field Epidemiology Training Programme (CAREC)
FTC	French Technical Cooperation
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GTZ	Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation Agency)
HIV	Human Immunodeficiency Virus
IADB	Inter-American Development Bank
ICT	Information and Communication Technology
IDRC	International Development Research Centre (Canada)
ILO	International Labour Organisation
INSERM	French Medical Research Council
LABIS	Laboratory Information System (CAREC)
LCDC	Laboratory Centre for Disease Control (Canada)
MORTBASE	Mortality Database (CAREC)
MOU	Memorandum of Understanding
MRC	Medical Research Council Laboratories (UK)
NACC	National AIDS Coordinating Committee (Trinidad and Tobago)
NAP	National AIDS Programme
NCD	Non-communicable Disease
NCI	United States National Cancer Institute
NGO	Non-governmental Organisation
NIH	National Institutes of Health (US)
NSL	The Netherlands Leprosy Relief Association
OA	Organisational Assessment
OECS	Organisation of Eastern Caribbean States

Acronyms

PAHO	Pan American Health Organisation
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PHLS	Public Health Laboratory Service (UK)
PWR	PAHO/WHO Representative
QA	Quality Assurance
QTC	Quality Tourism for the Caribbean
RENPHER	Caribbean Regional Health Policy and Health Systems Research Network
RHI	Regional Health Institute
SAC	Standing Advisory Committee for Medical Research in the British Caribbean
SALISES	Sir Arthur Lewis Institute of Social and Economic Studies, UWI Barbados
SARS	Severe acute respiratory syndrome
SIRHASC	The EU-funded CARICOM project to <i>'Strengthen the Institutional Response to HIV/AIDS/STI in the Caribbean'</i>
SMART-HS	Special Medical Augmentation Response Team – Health Systems (US)
SPSTI	Special Programme on Sexually Transmitted Infections (CAREC)
STD/STI	Sexually transmitted disease/infection
SVG	St. Vincent and the Grenadines
TB	Tuberculosis
TMRI	Tropical Medicine Research Institute, UWI, Mona Jamaica
TOR	Terms of Reference
TT	Trinidad and Tobago
UK	United Kingdom
UKCOT	United Kingdom Caribbean Overseas Territory
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
US	United States of America
USAHFPA	United States Army Health Facility Planning Agency
USAID	United States Agency for International Development
UWI	University of The West Indies
UWIMAA	UWI Medical Alumni Association
WB	World Bank

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A c r o n y m s

WHO	World Health Organisation
WIMJ	West Indian Medical Journal
WRAIR	Walter Reed Army Institute of Research
WTO	World Trade Organisation

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1. Introduction

Universalialia is pleased to submit to the CARICOM Secretariat this draft report on the Evaluation of Regional Health Institutes (RHIs), including the Caribbean Regional Epidemiology Centre (CAREC), the Caribbean Regional Health Institute (CEHI), the Caribbean Food and Nutrition Institute (CFNI), the Caribbean Regional Drug Testing Laboratory (CRDTL) and the Caribbean Health Research Council (CHRC).

As described in the Terms of Reference (see Volume VII), the general objectives of the Evaluation were as follows:

- To evaluate the performance and relevance of the five Regional Health Institutions (RHIs);
- To determine the institutional framework and appropriate organisations through which technical cooperation in health at the regional level will be pursued and;
- To assess the CARICOM Secretariat's capacity to monitor, provide oversight and coordinate the operations of the RHIs.

This document (Volume I) is the synthesis report of the Evaluation of the RHIs and is organised as follows:

- Section 2 describes the methodology for carrying out the Evaluation
- Section 3 provides a background on health issues in the Caribbean
- Section 4 presents a summarised assessment of the five RHIs and is organised around the following themes: effectiveness, efficiency, relevance, and financial viability of each of the Institutes. This section also identifies the key factors that affect the RHIs' individual performance
- Section 5 presents a discussion of major horizontal findings that in large part determine the nature of the recommended options for the rationalisation of the network of RHIs
- Section 6 provides various options including costing for the rationalisation of the five RHIs

Volumes II to VII are presented in separate documents. Volume II contains the evaluation of CAREC; Volume III the evaluation of CEHI; Volume IV the evaluation of CFNI; Volume V the evaluation of CRDTL, Volume VI the evaluation of CHRC. Finally, Volume VII presents the various tools, instruments, interview protocols that were used as part of the evaluation.

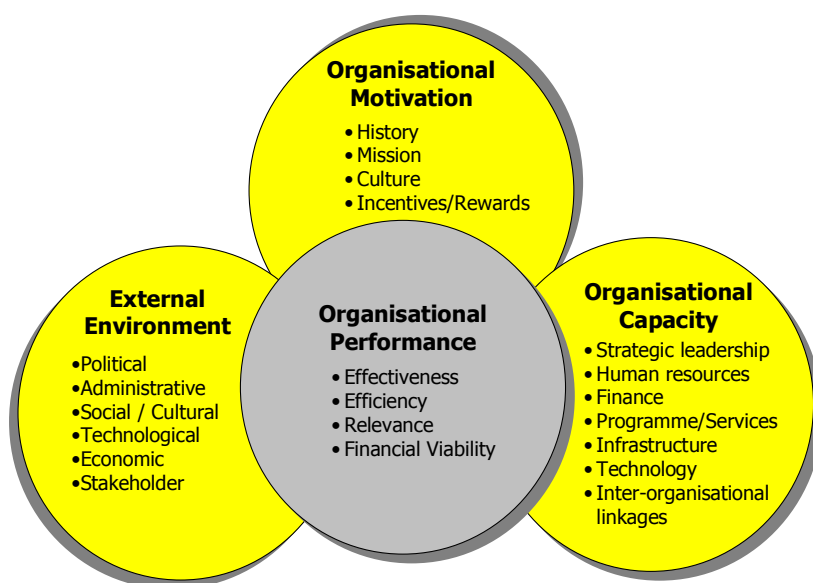
At this stage, the evaluation report on CAREC is not included as part of this package to allow CAREC more time to review its individual assessment.

2. Methodology

2.1 Overall Approach

The Evaluation of the RHIs was based on an institutional and organisational assessment (IOA) framework, which was developed by Universalialia and the International Development Research Centre (IDRC). In the schematic representation of our IOA framework shown in Exhibit 2.1, performance is defined in terms of *effectiveness* (mission fulfilment), *efficiency*, ongoing *relevance* (the extent to which the organisation adapts to changing conditions and its environment), and *financial viability*. The IOA framework implies that the factors embedded in capacity, motivation and contextual environment drive performance.

Exhibit 2.1 IOA Framework



While one of the major tools used in Institutional and Organisational Assessment is a self-analysis, it should be stressed from the outset that IOA is not only reduced to a self-analysis. Indeed, the self-assessment element of IOA comprises only the commencement of a 360-degree review that reaches out to key stakeholders, other regional partners; and also involves a careful review by the evaluation team of documentary evidence submitted by the subject organisation(s) and by others.

The data collection for this evaluation reached out to nearly 400 stakeholders, ranging in scope from senior ministers of various governments to NGO and community representatives.

For purposes of this evaluation, Universalialia assembled a team of senior Canadian Federal officials and health systems managers, two on loan from Health Canada and one from the Canadian International Development Agency (CIDA). All three have distinguished careers and extensive publications in their respective fields of expertise.

The methodology for conducting the Evaluation of the RHIs was grounded on an evaluation matrix that included key evaluation questions, data sources, and data collection methodologies (Volume VII, Appendix II). It should be noted that as specified, all these instruments were submitted to the contracting authority and to the Evaluation Steering Committee as part of the Inception report. However, due to delays in contract approval and the concurrent decision by the contracting authority requiring that on-site data collection be rapidly mounted, the Inception Report followed, not preceded the bulk of data collection.

2.2 Key Approaches to Data Collection

To assess the organisational performance of the various RHIs, Universalialia collected primary data using a methodological mix of qualitative and quantitative techniques that included document review, individual (face-to-face and telephone) and group interviews, field visits to ten (10) of the CARICOM Member States, and a questionnaire survey. The following provides a description of those methods.

2.2.1 Document Review

The team reviewed a wide range of pertinent documents related to the themes and projects under consideration. A list of documents consulted and reviewed is presented in Volume VII, Appendix IV.

2.2.2 On-Site Missions to the RHIs

Universalialia teams were sent to each of the five RHIs on a field mission to review the performance of each RHIs. Each team was composed of at least one evaluation and public sector reform specialist and one health-sector specialist. In each of the RHIs, the team conducted the following activities:

- Circulation of the IOA instrument to each RHI (when it had not been completed in advance as was requested)
- Self-assessment by the staff and management of each RHI (when it had not been completed in advance)
- Initial independent review by the evaluation team of the IOA data from each RHI
- On-site inspection and review of laboratories, libraries and other premises
- Key informant interviews with management and key staff
- Focus groups with all staff
- Review of the documentation provided to the team

Once these activities had been concluded the teams followed up with each RHI where necessary to resolve any ambiguities or to access additional documents.

2.2.3 On-Site Missions to Ten (10) Member States

To broaden the scope of the review process and in an effort to reach out to all actors, stakeholders and partners, Universalia team members conducted on site-missions to ten (10) of the CARICOM Member States. The countries visited included Guyana, Barbados, Jamaica, St-Lucia, Trinidad and Tobago, Suriname, St-Vincent, Antigua, Grenada and Dominica. In Guyana, where the CARICOM Secretariat is headquartered, the Universalia Team Leader collected data, conducted key informant interviews with CARICOM and COHSD personnel, Senior Officials of the CARICOM Secretariat, donors, a range of stakeholders from the donor community as well as the public sector. In addition, the Team Leader collected data on how the CARICOM Secretariat monitored and coordinated the five RHIs.

In the other nine countries, the Universalia team members collected data, conducted interviews with key informants (on-site, or by telephone) such as senior officials of the various countries' Ministries of Health as well as other Ministries, donors, PAHO-CPC, and the private sector where applicable. The team also distributed a questionnaire to the Ministry of Health to obtain their opinion of each RHIs.

Volume VII of this Report contains details on the outreach to regional stakeholders. In addition, it details on-site Missions as well as conference calls with PAHO (Washington, D.C.) and with the CARICOM Secretariat.

A team of Universalia consultants spent two days at PAHO during the inception phase of the review to conduct interviews and to moderate group discussions with key informants. This mission was followed-up by a series of telephone interviews.

Following the inception phase, a workshop was held at PAHO with the purpose of reviewing the five individual RHI draft reports. Senior PAHO personnel as well as various Caribbean CMOs were present to not only review the individual reports but to also begin mapping out strategies for long-term rationalisation. Following the workshop, on-site meetings were held with PAHO at their headquarters (Washington, D.C.) and telephone conferences were also conducted.

In addition to working with PAHO (which was also part of the Steering Committee for this review process) the Universalia team kept the CARICOM Secretariat engaged throughout the process. The Secretariat was given the opportunity and encouraged to provide detailed comments on the individual RHI reports. As a result, a number of bilateral discussions with key Secretariat personnel ensued.

2.2.4 Telephone Interviews with Representatives of the CARICOM Members States that Had Not Been Visited in Person

In order to complete the data collection, Universalia also collected data from CARICOM Member Countries where no field mission had been conducted. Telephone interviews were held with Senior officials from the Health Ministries and CMOs from the Bahamas, Belize, St. Kitts and Nevis and Montserrat.

2.3 Methodological Limitations

The Universalia team faced some challenges in conducting the evaluation of the RHIs as well as in developing the requested rationalisation plan.

Due to over a six-week delay in formally launching the review process within the first quarter of 2004, the data collection phase took place largely during the second quarter. As a result, there were several unanticipated consequences.

Coordination with the five RHIs and with other stakeholders was not optimal due to extensive prior engagements on the part of the stakeholders during this time period as well as the fact that this was the normal period within which annual vacations were taken in the region.

Secondly, the time at which the data collection occurred also had an impact on the level of outreach to the numerous stakeholders in the various Caribbean nations. Due to the fact that the Evaluation Steering Committee had identified CMOs as the principle interlocutors, the review had to rely on the CMOs to not only identify the most appropriate sets of stakeholders, but also to schedule the on-site sessions. As a result, certain milestones could not be met in a timely fashion. Universalia, however, would like to formally express its gratitude to the CMOs for the work they undertook sometimes on short notice.

A third limitation of the study revolved around the nature of the administrative apparatus of the CARICOM Secretariat based in Georgetown, Guyana. The on-site mission to the CARICOM Secretariat was planned as one of the first active data collection activities. It was designed to secure the basic documentation needed to provide an initial overview and to largely inform the development of the more detailed survey instruments and other data collection tools. However, the Universalia team discovered that the record-keeping practices of the CARICOM Secretariat were not in the most optimal position to meet these expectations. Key documents such as a comprehensive collection of annual reports of RHIs, and other annual submissions were inaccessible. As a result, this had an adverse effect on the refinement of the survey tools and also had an impact on how the data was collected from individual RHIs.

As a result of the delay in launching the entire review as well as the parallel desire by the contracting authority to pursue an intensive and compressed data collection phase, only a limited amount of documentation was received in advance from individual RHIs. A formal request had already been submitted in advance requesting basic materials and completed questionnaires. The consequences were two-fold:

- The review teams were not able to assess material in advance and thus target potential key areas for in-depth on-site assessment.
- Universalia's scientific advisors from Health Canada and from CIDA did not have prior opportunity to assess the relevance of the scientific work of the RHIs based on their products. As a result, the bulk of this assessment was forced to take place during the brief on-site missions (2-3 days maximum) and was limited in scope due to budgetary limitations.

The delays that were experienced in addition to the Evaluation Steering Committee's wish to conduct the data collection phase in as quick a manner as possible had an impact on the way in which some CMOs carried out their tasks. While some CMOs focused on respondents who were directly related to health and were from government entities, others considered the potential stakeholder pool from a more holistic perspective, considering areas such as the environment, agriculture, food regulation, the private sector and educational institutions. As was the case with the RHIs, few CMOs appeared to have sufficient time to complete and submit basic questionnaires to Universalia in advance of the on-site missions; thus replicating the issue of the lack of an ability to target the on-site missions in a more precise manner.

The condensed timeframe within which the Steering Committee and the contracting authority expected the review to occur proved to be unfeasible. As stated in the Terms of Reference the review was to have been completed by the end of the third quarter of 2004, with submission to COSHOD at its planned late September 2004 meeting. The fact that the majority of the fieldwork was delayed and only took place in early May 2004 (RHI and stakeholder on-site missions) was omitted when considering a revised time frame. As a result, primary data collection was artificially compressed, in addition to the fact that there was insufficient time for a second round of reviews and reflection as well as bilateral discussions before the August submission of individual RHI reports.

This problem was compounded from September and extended into November 2004 where lengthy delays were experienced in receiving comments (other than those provided through a multi-party teleconference) on the Interim Report as well as several of the individual RHI reports.

Finally, during the data collection phase and as other inter-related horizontal issues became evident; a major conceptual limitation became apparent. As per the Terms of Reference the review focuses on the five RHIs, based on the assumption that these five RHIs constituted the main vehicles for regional cooperation and technical support in health-related fields. However, during the data collection phase, it was increasingly observed that the Pan-American Health Organisation (PAHO) was a key regional actor, not only in budgetary terms, but also as far as intra-regional presence was concerned. In conceptualising strategies to rationalisation of the RHIs, it became apparent that to do so without addressing some of the principal PAHO-related issues was somewhat problematic. This was due to the fact that the Terms of Reference for the review and the corresponding budget did not allow for in-depth work with PAHO and its offices in the region, aside from the initial orientation work done on commencement and prior to formal contract approval of the review.

3. The Health Context in the Caribbean

3.1 Overview

An assessment of RHIs requires an understanding of the breadth and depth of health and public health challenges as they affect the Caribbean region. This involves a multi-dimensional analysis so that decision-makers can position proposals for individual RHI renewal and overall RHI rationalisation into such a broader context. As evidenced by the Nassau Declaration of 2001, health is considered to be a critical determinant of sustainable development and economic growth. The current set of regional health institutions is composed of organisations that primarily provide technical cooperation in public health matters to Caribbean member states. The key factors are related to two sets of goals/objectives:

The first are the goals of the CCH-2 initiative, which are broadly defined objectives for the overall health and development of the region.

The second are a series of essential public health functions that PAHO and the region have come to define as the core functional components of sustainable and effective public health systems.

The Caribbean region is home to 27 predominantly independent island states, dependent territories and sovereign states with a total population of approximately 34 million. Considerable differences exist in the size of populations, geographic area and number of small-island and multi-island states, and their respective economic capacities. For example, per capita income ranges from US\$610 in Haiti to US\$11,214 in The Bahamas. As a region of mostly island nations, the distribution of population and resources over diverse settings presents logistical and cost issues associated with travel, commerce and other interactions, presenting a challenge for the delivery of collaborative regionally-based technical cooperating programming. Such wide variances emphasise regional motivation toward collaborative approaches and hold significant implications for the identification of need and provision of appropriate public health services for the region.

With regard to specific health challenges as far as they affect the population at large, despite the fact that communicable diseases dominated the mortality (illness) and morbidity (death) regional statistics for generations, the last half century has ushered in the first modern public health services in the region resulting in a dramatic reduction of infectious diseases, better care and improved life expectancy. Measles and polio have been eliminated and rubella is being addressed through continuing immunisation efforts in the region. Moreover, diseases associated with malnutrition, which were prevalent less than 40 years ago (at the time of the conceptualisation of what has become CFNI), have reduced in overall intensity within most of the region's member states, although malnutrition remains a pressing concern in pockets of extreme poverty.

Emerging and re-emerging infectious diseases present continuing challenges. HIV/AIDS is now an epidemic in the region as the number one killer of young Caribbean adults, with the added involvement of opportunistic infections from Tuberculosis (TB) and parasites. The Caribbean now presents the highest incidence of Acute Immune Deficiency Syndrome (AIDS) cases in the Americas with an infection rate second only to sub-Saharan Africa. The recent outbreak of SARS exposed the unpredictability and complexity of migration health issues. TB has re-emerged on its own as a major threat with drug resistant strains. Food and water borne diseases continue to be a threat. Vector-borne diseases such as dengue, dengue hemorrhagic fever and malaria are increasing, with Guyana suffering the highest rate of Malaria in the Americas. Projections indicate that West Nile Disease will soon be part of the vector borne disease profile.

With improving post-colonial socio-economic circumstances came the health challenges of chronic non-communicable diseases (NCDs) in an increasingly aging population. Changes in lifestyle and behavioural patterns have contributed to some of the highest rates of hypertension, diabetes and diabetes-related complications in the world. Chronic NCDs are now the major cause of illness and death in the region. Heart disease, cerebrovascular disease, diabetes and hypertension are among the major contributors.

The growth of these diseases is due in large part to avoidable risk behaviours including lack of exercise, poor eating habits and other lifestyle issues. Longstanding behavioural patterns and complacency limit the public response to these important health issues with costly implications for their health and health systems. Moreover chronic NCDs are common among the poor, creating social inequities. In addition, cancer is on the rise with prostate cancer as a leading cause of death in men, and breast and cervical cancer in women.

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Some of the heaviest demand on health services is due to increasing violence, accidents and injuries, particularly among people of young working age. Homicide and suicide have increased, surpassing traffic fatalities in some countries. Lack of employment, poverty and a reduced sense of civic responsibility that varies by jurisdiction are all contributors to the problems, as well as the need for better training and safety for job sites, and driver education to reduce car related accidents. Increased motoring also contributes to growing obesity and diabetes. Urbanisation is changing lifestyles and putting stress on housing, water and sanitation services, with overcrowded living conditions and diminishing job opportunities.

Environmental health issues such as periodic Sahara dust outbreaks, over fishing and global warming are additional forces to contend with, while increased population mobility poses other kinds of threats. Along with boosting economies, the scale of tourism in the region increases health issues for Caribbean states for example related to environmental pollution, water and food quality, and overtaxed sanitation services among others.

Health systems have also evolved in response to economic, social and other shifts over time, with most of the English-speaking Caribbean countries engaged in health sector reform as of the 1990s onward.

Drivers of reform include: structural adjustment measures, public sector reform, natural disasters, fostering of primary health care strategies, management improvement, improved financial sustainability and quality assurance and equity concerns.

Despite these efforts however, most national health systems face considerable challenges in addressing the dynamic and complex burdens presented by chronic non-communicable diseases and HIV/AIDS in addition to other health issues present in the current environment. Health systems also face a range of challenges complexified by population mobility such as the loss of a healthy labour source due Caribbean health professionals moving to more developed nations.

There are significant implications for the region in terms of the roles of CMC health institutions and professionals to communicate and collaborate with each other to collect and transmit data, request services (e.g. laboratory testing), respond to emergencies and participate in various regional programs or initiatives (e.g. education / health promotion for citizens) with the RHIs. Quality of regional information is highly dependent upon quality of the linkages, relationships and capacity of both RHIs and CMCs to interact.

Variance in CMC economies and health infrastructure create stark differences in capacity to address issues and reach goals. Health systems and RHIs must be able to respond to a variety of needs, many difficult to predict, and although there is growing understanding of the importance of approaches geared to health, national infrastructure and resources remain insufficient. (Fraser 2004) The potential for improvement of Caribbean health and health systems is dependent upon the calibre of interactions between a range of stakeholders including CMCs and RHIs and the broader input and assistance of many regional and international players, with the support of concerted resource mobilisation.

The five regional health institutions currently under review - The Caribbean Environmental Health Institute (CEHI), The Caribbean Epidemiology Centre (CAREC), The Caribbean Food and Nutrition Institute (CFNI), The Caribbean Health Research Council (CHRC) and The Caribbean Regional Drug Testing Laboratory (CRDTL) were developed primarily to provide technical cooperation to support national health administration. They are important regional resources that augment, but do not supplant, the varying capacities of national health administrations.

3.2 Comparison of RHI Programmes to CCH-2 Health Priorities

3.2.1 Introduction

The *Caribbean Cooperation in Health Initiative* (CCH), a significant regional initiative was introduced in 1984 and renewed as the CCH-2 for the period of 1997-2001. It laid out eight priority health areas for comprehensive collaborative action: Strengthening Health Systems, Human Resource Development, Family Health, Food and Nutrition, Non-Communicable Diseases, Communicable Diseases, Mental Health and Environmental Health.

An analysis of the extent to which the RHI mandates, programmes and services respond to the CCH-2 goals was requested by the Steering Committee for the RHI review. The objective was to identify any gaps in areas within the parameters of the RHIs.

While CCH-2 generally provides an appropriate benchmark for review there are a number of initial observations required to streamline the process. The scope and timing of the RHI evaluation did not support a formal detailed documentation of all services and needs in the region for the purpose of this exercise. A comparison limited to the RHIs and CCH-2 excludes other important entities involved in providing public health and/or disease control type services, both on a local and regional scale. It is difficult to develop a comprehensive portrait based on this limited comparison since any gaps identified to not take into account responses beyond the set parameters.

The CCH-2, a mechanism for health and health system development comprises elements that are beyond the scope of the RHI responsibility, with the exception of the CHRC. Examples include the development of hospitals, primary health care, HR development of physicians, nurses and other health professionals, and mental health professionals. As a result, a number of these areas will be considered to be beyond the parameters of RHIs except where a complimentary relationship is seen to exist such as where an RHI activity reinforces or contributes to a broader objective in a health care system.

3.2.2 Comparative Summary of RHIs and CCH-2 Priorities and Objectives

The following summarises some of the links and gaps between RHIs and CCH-2, with two caveats. CHRC's broad health research mandate in theory relates to practically every one of the CCH's goals yet in practice its contribution is limited by budget constraints and despite recent attempts at institutional strengthening. As a result, CHRC will not constitute part of the area-specific discussion below but is considered as a potential contributor to all areas.

In addition, CRDTL, which was the only one of the five RHIs not identified in CCH-2 as an agency to assume the role of a priority regional focal point, does play a role in the area of Drug Management, which is within the first CCH-2 priority area. However, CRDTL's overall contribution and relevance are problematic, two facts which will be further explored later in the report.

The following discussion, organised within each of the CCH-2 priority areas will focus on the remaining three RHIs - CAREC, CEHI and CFNI.

Strengthening / Health Systems Development

Sub-Priorities: Reorganisation of Health Systems; Financing of Health Services; Quality Assurance; Information Systems; Maintenance and Assessment of Technology; Disaster Management and Drug Management.

CRDTL's mandate and laboratory services are focused on the testing of drugs. In this context, it plays a role in supporting the drug management component. Its parameters however, do not extend beyond a quality testing function to address other key aspects of ensuring safe, cost-effective and efficacious products for the region.

CAREC's mandate and programmes provide complementary support to this priority area, providing educational, technical advice and other programmes to support the Quality Assurance for hospital and other laboratories. The laboratory strengthening programme targets different aspects of quality for government, hospital and private laboratories through initiatives related to education, accreditation and potential legislative reform. It also links with and provides supportive education to hospitals, physicians and others in the system as sources of support for data collection for its surveillance and epidemiology responsibilities. In keeping with its mandate, Information Systems are being developed to collect and report on disease and laboratory test results. CAREC is also involved in the development of connectivity and interaction with health information systems and is a proponent of the C-Health Network dedicated to strengthening regional health information systems. CAREC also provides technical support and staffing as required in a first line of response to health emergencies related to disease outbreaks resulting from natural disasters, or epidemics.

CFNI plays a major role in providing advice, technical support and training / capacity-building to those in the health care delivery system (hospitals, primary health care etc.) and is also engaged in clinical and general nutrition activities. Its journal and other information resources are valuable resources to a range of health professionals.

CEHI's area of focus is water and waste management. Its information distribution systems contribute to this CCH-2 objective. In addition CEHI is addressing emerging issues relative to the impact of climate change on small-island nations.

Human Resource Development

Sub-Priorities: Information for Human Resource Development (HRD); Human Resource (HR) Management; Human Resource Production (Training); and Monitoring Performance of Health Professionals.

The primary focus in this area the development of expertise and management of health human resources including establishing targets in areas where there are shortages (e.g. oncology, nutrition, occupational therapy). Most of the activity is limited to health care professionals working in health systems and is therefore outside the RHI scope. There is a need for the development of expertise in public health, laboratory and epidemiology, environmental health and nutrition.

Family Health

Sub-Priorities: Reproductive Health; Child Health; Adolescent Health (ADH); and Health of the Elderly.

This priority embodies an emphasis on the development of clinical / care services to improve diagnosis and treatment of specific health problem areas, for example, asthma in children, sexual activity of youth, and special needs of the elderly and is not explicitly related to RHIs.

Food and Nutrition

Sub-Priorities: Nutrition Related Diseases; Human Resources Development; Nutrition Promotion and Information Dissemination; Surveillance and Food Security

CFNI programmes and services respond to all aspects of this priority and its sub-priorities. This includes services to engage lifestyle choices in terms of food selection and consumption to influence behavioural change through education and provision of information. CFNI's programming is largely oriented to building national capacity in areas related to food and nutrition, and therefore is deeply engaged in overall human resources development. CEHI has provided testing for pesticides and heavy metals in seafoods and support for testing of pesticides in agricultural products.

CAREC also contributes to food security and safety through its surveillance of food borne diseases and related workshops associated with its Quality Tourism (QTC) initiative, plus its reference laboratory testing for salmonella and pathogenic organisms.

Chronic Non-Communicable Diseases

Sub-Priorities: Planning and Information Systems; Risk Factor Prevention/Control; Screening and Quality of Care

This priority area includes lifestyle-linked diseases such as diabetes and hypertension, which contribute to heart disease, stroke, kidney failure, and problems with vision among other health issues. Cancer is also included with a focus on breast cancer, cervical cancer, and prostate cancer. Unintentional injury due to accidents is also included within this category.

CAREC has initiated programmes in response to cervical cancer to support early detection (i.e. lab strengthening programmes to support the development of a cytology laboratory and training of cytologists/cytotechnologists) for screening cervical cancer. CAREC has also conducted research, and initiated or supported a number of initiatives associated with surveillance and health promotion associated with injury. However, it is inadequately resourced at this time to engage a comprehensive public health program response to all aspects of injury in this area. This suggests an as yet insufficient regional public health focus to address contributors to injury.

CEHI provides support to accident prevention through its educational and other programmes associated with workplace health.

For CFNI, NCD's have emerged as a major priority focus that cross-cuts all of its programming, including its training and public information activities. CFNI conducts surveillance and research activities as well as training and capacity-building, and has engaged in successful resource mobilisation processes related to NCDs

Communicable Diseases

Sub-Priorities: Food, Water & Vector-Borne Diseases; Vaccine-preventable Diseases; STDs/HIV/AIDS and Tuberculosis.

CAREC programmes and services respond to all aspects of this priority and its sub-priorities. CAREC has mobilised extensive resources and is part of a large international programming with respect to HIV/AIDS in particular.

CEHI is also extensively engaged in water quality-related programming as well as waste management.

CFNI is also involved in the region's work with respect to HIV/AIDS, addressing issues affecting the nutritional health of people living with HIV/AIDS.

Mental Health

Sub-Priorities: Human Resource Development and Training; Framework for Development and Delivery of Mental Health Programmes; Prevention of Mental Health Disorders; Mental Health Information and Information Systems; Mental Health Promotion; and Integrated Community-Based Mental Health Services.

While mental health is not an area directly related to the scope of any RHI, within CHRC, it offers the potential to foster research. Violence and substance abused also fall within this area.

CAREC has initiated research and some initiatives to provide surveillance on this subject area. However, there is also inadequate funding and focus on this area to address the needs on a regional basis in support of the countries. This suggests the absence of a comprehensive public health focus to address contributors to violence (substance abuse, anger management, identification of contributors).

Environmental Health

Sub-Priorities: Vector Control; Liquid Waste and Excreta Disposal; Solid Waste Management; Water Quality and Workers Health.

CEHI programmes and services respond to all aspects of this priority and its sub-priorities. CEHI concentrates its programming on water and waste (solid, liquid and hazardous) issues and has mobilised external support for enhanced programming in these areas.

CAREC has surveillance programmes in place and provides training for national staff related to vector borne disease such as Dengue and is preparing for new entries such as West Nile virus.

3.3 Essential Public Health Functions

The second dimension noted in the overview of the health context that better situates RHI activities and gives further context to this evaluation relates to a series of eleven Essential Public Health Functions that have been identified by PAHO as primary components of a comprehensive national approach to public health. A recent study¹ supported by PAHO's Office of Caribbean Programme Coordination, the OECS nations and the Government of France identified eleven basic public health functions that relate to the following definition: "Conditions that permit better execution of the State's responsibilities in relation to health and civil society."

These eleven functions inform how a national Ministry of Health can plan and deliver programming. In contrast, the CCH-2 goals largely speak to specific human conditions. The eleven Essential Public Health Functions set out a different dimension of RHI roles in terms of types of technical cooperation and types of support that Caribbean nations may need in achieving the goals of the Nassau Declaration and the CCH-2.

¹ Essential Public Functions in the English-Speaking Caribbean, PAHO, CPC, 2002&2003

These eleven functions are:

- 1) Monitoring, evaluation and analysis of health status
- 2) Public Health surveillance, research, and control of risks and threats to Public Health
- 3) Health promotion
- 4) Social participation in health
- 5) Development of policies and institutional capacity for planning and management in Public Health
- 6) Strengthening of institutional capacity for regulation and enforcement in Public Health
- 7) Evaluation and promotion of equitable access to necessary health services
- 8) Human resource development and training in Public Health
- 9) Ensuring the quality of personal and population-based health services
- 10) Research in Public Health
- 11) Reducing the impact of emergencies and disasters on health

The capacities of Caribbean ministries of health were assessed in relation to each one of these eleven factors.

Monitoring, Analysis and Evaluation of the Health Status

This particular EPHF addressed issues such as the ability to monitor national health conditions, the level of epidemiological capacity, the level of automation of national data, the nature of support provided to sub-national levels of health providers and the assessment of the overall quality of national data. The EPHF study found that across the region, overall capacities were somewhat below average.

A significant discovery is that among the sixteen countries surveyed, the range with respect to this factor varied widely, with some nations having exemplary performance and other having barely any capacity. This has significant implications for the RHI performance review and for rationalisation planning.

Public Health Surveillance, Research and Control of Risks and Threats to Public Health.

This EPHF addressed issues such as the capacity of national surveillance systems, the ability to identify and analyse threats, the capacity of public health laboratories and their capacity to respond. The survey found that overall, the region had what could be considered to be “average” performance, with a much lesser degree of variance between “high” and “low” scoring nations. Of interest to the RHIs is the level of capacity in public health laboratories.

Health Promotion

The EPHF study considered health promotion to be composed of sub-factors such as the extent to which ministries promote public health and have formal public health policies, the extent to which ministries work with other actors from civil society and other economic sectors to promote public health, the nature of mass communications relative to public health issues, the extent of consultations with other actors to determine national strategies and the support provided at the sub-national level to engage in public health promotion.

The weighting system for this factor resulted in an average score, with very little variance between the sub-components. Similar to public health surveillance, the range between the highest and lowest was fairly moderate indicating a degree of commonality among nations. From the RHI perspective, this is an important area, particularly as it relates to on-going surveillance of conditions and causes of impacts on health, the provision of analysis and contribution where appropriate to regional health promotion programs to respond including the provision of health promotion information and materials.

Social Participation in Health

Social participation in health addresses whether the citizenry is empowered to provide feedback and advice to health authorities at the national and sub-national level, and the extent to which nations have put in place the means of such empowerment. Performance in this area was generally below average. Social participation in health is likely to have little impact on RHIs since they by nature, have sporadic encounters with individuals.

Development of Policies and Institutional Capacity for Planning and Management in Public Health

This EPHF, which was rated as average in terms of regional performance, is somewhat more relevant to RHIs. It addresses whether nations have policies that set measurable objectives for public health issues, their monitoring skills, level of strategic planning and ability to shape external relations, including securing external financing.

From an RHI perspective, average performance in this area demonstrates the need for organisational strengthening which should be more holistic in nature; relating to overall planning and management capacities in public health, as opposed to a narrow area of technical specialisation.

Strengthening Institutional Capacity for Regulation and Enforcement

This EPHF was rated as one of the weakest of the eleven factors and had one of the largest ranges of results between countries. It assessed the capacity in regulatory development and enforcement as well as the capacity to promulgate legislation, anti-corruption measures and enforce them.

With RHIs functioning as agents of technical cooperation, the weaknesses in this area emphasises the need for technical support in key policy areas. In highlighting the varying capacities and perspectives on respective public health needs, RHIs are placed in the conflicting situation of having to address widely different expectations.

Evaluation and Promotion of Equitable Access to Necessary Health Services

This EPHF was considered one of the strongest of the eleven, addressing how national authorities ensure that the citizenry has equitable access to health services and that governments have facilitating mechanisms in place. This may not be a key area of focus for RHIs since the capacity level was assessed as fairly high and more so since this area relates more to internal issues closely aligned with the modernisation of the public sector than it does to technical cooperation in public health.

Human Resources Development and Training in Public Health

The EPHF study concluded that the region's overall capacity in HR development and training in public health exhibited a sub-standard performance including in nearly all the sub-factors. The variances among nations were among the most pronounced.

From an RHI perspective the low rating and high degree of variance poses an immediate challenge to RHIs; the scores emphasise the need for capacity building as far as human capital is concerned as well as the need for RHI programming to be flexible enough to address the diverse needs and absorptive capacities.

Ensuring the Quality of Personal and Population –Based Health Services

The EPHF study rated this factor as the lowest of all eleven. Similar to monitoring and evaluation, the ratings for sub-factors exhibited an extremely wide range among nations. Sub-factors included: improving user-satisfaction, integration of information and communications technologies, support to sub-national bodies to integrate them.

The challenges inherent to RHIs point to an overall requirement for institutional strengthening among Caribbean national authorities as part of an overall health sector renewal. RHIs may be able to play a role as a consolidator of resources mobilised from external sources, as opposed to national authorities independently seeking external assistance.

Research in Public Health

This factor was rated as the second lowest and the study found the performance to be of a sub-standard level, with national performance ranging from hardly any capacity to barely adequate. The key sub-factors assessed were the development of research agenda, use of research, internal research capacity and support for research methodologies.

This finding is of considerable importance to RHIs, particularly to the CHRC, which is now moving to expand its research agenda in keeping with its health / health system mandate to include research in public health and policy explicit research.

Reducing the Impact of Emergencies and Disasters on Health

This final factor was the highest rated by the EPHF study. Its high rating reflects the degree to which Caribbean nations have developed standards and guidelines, built partnerships to address emergencies and disasters; and have put planning processes in place.

The following tables from a 2002 presentation made by PAHO's CPC highlights the ratings accorded to the eleven functions.

Organisational Assessment of RHI - Overall Evaluation Report

Exhibit 3.1 Measurement Results

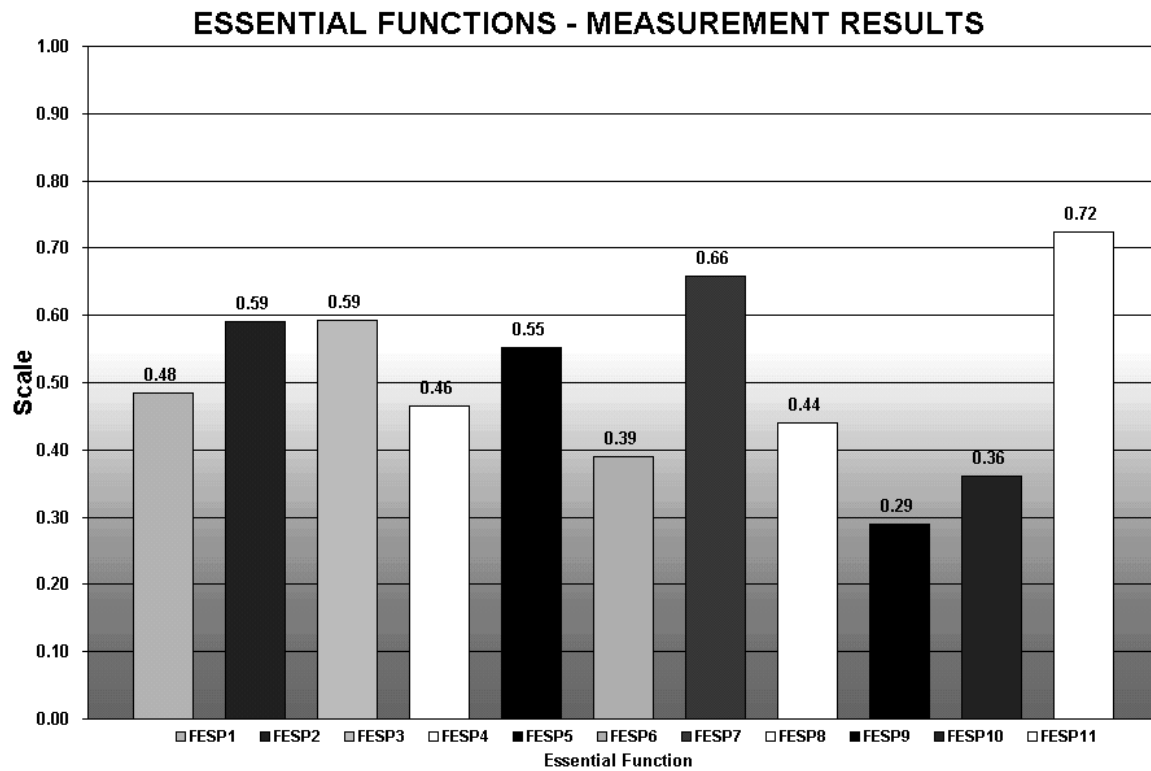
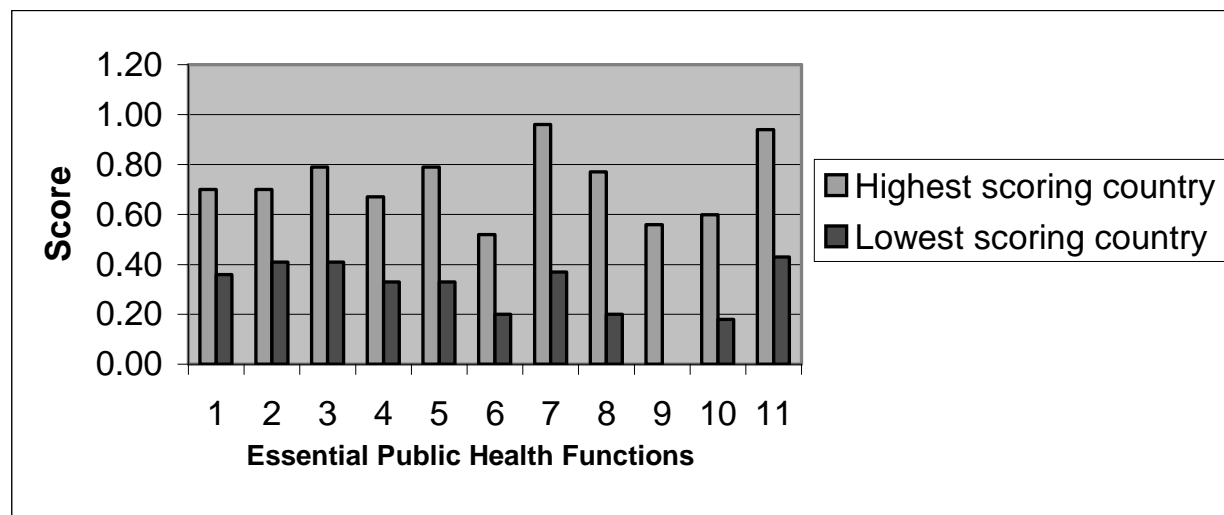


Exhibit 3.2 Country Scores



3.3.1 Overall Implications

While individual EPHFs point to specific challenges for RHIs, as a whole, the set reveals considerable weaknesses in key areas that generally relate to institutional strengthening such as HR development, research, regulation and enforcement. They illustrate that Caribbean decision-makers have been inclined to focus their limited resources more on delivery-related factors.

In a presentation to OECS Ministers of Health in June 2003 by PAHO's CPC, it was concluded that enhanced technical cooperation would be needed with respect to:

- Monitoring and evaluation of health status
- Regulation and enforcement
- Evaluating and promotion of equitable access
- Human resource development and training
- Research in public health

It is within the above context that EPHFs constitute a set of gaps in institutional capacity; a challenge which RHIs may address.

4. Performance of the Individual RHIs

This section summarises the detailed Institutional and Organisational Assessment reports, one for each of the five RHIs. The detailed reports on each RHI are in Volumes II-VI. These condensations address both RHI-specific issues as well as the more substantive issues relative to rationalisation. It should be emphasised that the recommendations do not include considerations for structural or fundamental realignment. These are addressed within the context of the Rationalisation Plan found in Section 6 of the Report.

To provide a background, the following broad conclusions were drawn:

- Each RHI is a separate organisation; with its own governance, reporting and management structured. Despite the fact that CFNI and CAREC are PAHO-specialised institutions, they differ in a number of ways.
- The roles played by the CARICOM Secretariat and senior ministerial level decision-makers are fragmented. This observation will be explored later in the report.
- A review of the coordination mechanisms, the level of collaboration/coordination of efforts between RHIs and as reported by the RHIs, is shown to be fairly limited at the present time. Therefore RHIs do not constitute what could be considered to be a coordinated network of entities.

The key characteristics of a functioning network include: the level of coordinated planning, the level of harmonised programme delivery, the extent of harmonised resource mobilisation, commonalities in internal procedures such as HR and administrative systems in addition to linter-connected governance and strategic decision-making systems as well as inter-related approaches to performance assessment and reporting.

In the above areas, RHI practices are seen operate on a more individual than amalgamated scale, with little evidence of practical inter-organisational cooperation although they do occasionally work together.

4.1 CEHI

4.1.1 Background

CEHI is the most recently established of the five RHIs. Although its origins date back to the 1970s, CEHI has only recently matured as a significant regional force. In order to better understand CEHI, it may be useful to summarise the evolution of CEHI over the last 25 years.

CEHI has its origins in the recognition by CARICOM decision-makers in the late 1970s that there was a need for a regional capacity to address environmental health issues and to provide member states with technical and professional capacities. Accordingly, in 1979, CARICOM Ministers of Health established a small project unit within the Secretariat to liaise and engage in coordinated resource mobilisation.

To meet emerging environmental and environmental health concerns, CEHI was established as a separate entity with its own governance apparatus and located in St. Lucia. However, it remained a very small body that was effectively dependent on member state contributions based on the normal CARICOM quota-driven funding formula. It is very important to emphasise that at no time did CEHI have an organisational parent such as PAHO to provide a funding, or capacity “safety net”.

CEHI, like other RHIs began to encounter sustainability challenges due to the uncertainty of member state contributions, even though its annual budget was well below \$US 300,000. Thus, CEHI began early initiatives to secure additional funding from other sources, largely project-driven support from various bilateral donors. During this formative period as a stand-alone body, CEHI remained a small body with few specialised staff positions and a limited ability to make a significant regional contribution.

Although quota contributions to CEHI doubled during the 1990s to nearly \$US 400,000 per annum, the decision by ministers in mid-decade to freeze them at \$US 392,000 resulted in CEHI facing a new challenge. In order to expand its impact as a viable regional entity, CEHI faced the need to considerably expand its resource base. At that time, CEHI was able to secure multi-year funding from the GTZ to promote a comprehensive approach to institutional strengthening. This external support resulted in CEHI not only expanding, but transforming itself.

The GTZ- supported programme enabled CEHI to develop new internal capacities, combined with a new forward-looking Strategic Business Plan, whose major elements reflected the organisation's priorities. The impact of this redirection was immediate. Staff doubled in size and, more importantly, the organisation was able to offer considerably more programming to its stakeholders. As well, the organisation put into place long-term sustainability measures such as cost recovery and user fees for certain services, thus considerably reducing its reliance on uncertain member state contributions. Currently, CEHI's budget is in the range of \$US 1.3 million, with quota contributions comprising less than 30% of this total and plans to reduce the impact of quota even further in coming years.

The GTZ programme, which ended in 2002, has left with CEHI with the ability to engage in comprehensive and large-scale resource mobilisation. For example, the organisation recently secured \$US 14 million in long-term funding from the Global Environment Fund. CEHI's most recent plans call for it to continue to expand its resource base, moving towards sustainability by the middle of the current decade. In addition, CEHI plans to strengthen its professional capacities to enable it to become a recognised centre of excellence within the region as is evidenced by its recent acquisition (August 2004) of ISO certification.

4.1.2 Mandate and Services

CEHI's formal mandate has not been changed since its foundation in 1988. It is to:

“Provide technical and advisory services to Member States in all areas of environmental management, including, but not limited to environmental quality monitoring, environmental impact assessment, environmental health information, water resource management, waste management (liquid, solid and hazardous), laboratory services and project development.”

Although its formal mandate has not been altered, the 1998 Strategic Business Plan resulted in the organisation focusing its work on water and waste management-related issues.

In terms of its services/ products, CEHI generally undertakes the following:

- Provision of scientific and technical advice in its mandate areas (80% to public sector entities), laboratory testing in environmental aspects, training to public and private sector bodies, overall advocacy, information dissemination; and, project development and resource mobilisation.

4.1.3 Governance

The 1988 Agreement provided for a multi-level governance structure.

- First, an overall Governing Body made up of Ministers of Health
- Second, a Board of Directors made up of representatives from several governments, regional entities and several other bodies such as UWI, PAHO, UG and UNEP

At the outset of CEHI, a technical advisory committee also was established. However, it became redundant due to a governance improvement scheme that was part of the GTZ-funded organisational strengthening initiative. As part of this initiative, in 2000, a sub-committee of the Board of Directors was established to provide for on-going and intercessional governance. The effect of this development has been to provide CEHI with on-going high-level leadership.

4.1.4 Organisational Performance

Effectiveness

Core Finding: CEHI is generally fulfilling its mandate as set down in the 1988 Agreement and as has been focused by the 1998 Strategic Business Plan.

The 1998 Business Plan served to concentrate CEHI's work towards water and waste management. Analysis of CEHI's overall budget shows a clear majority of its funding and staff time focused on the two priorities. When overhead and managerial functions are not factored in, CEHI is concentrating the vast majority of its work on its two priorities.

The organisation's current set of programming is largely directed towards these two major areas. In both, CEHI provides a range of training and advisory services. CEHI's managers, however, recognise that this focusing has left some areas such as vector control and occupational health and safety unaddressed. They note, however, that their governing bodies approved such a concentration.

Efficiency

Core Finding: CEHI has been capable of efficiently translating its resources into programming.

CEHI data shows that the organisation has been highly successful in linking its staff costs to its overall budget levels. More importantly, the organisation has also been successful in translating new resources into deliverable programming with apparently little “lag” or overhead costs. The organisation views quota contributions from member states as a source of basic core funding to provide a portion (not all) of its overhead or running cost (buildings, staff, etc), thus being able to dedicate more of its resources to programme delivery.

Relevance

Core Finding: CEHI provides relevant and state of the art programming that meets regional needs, albeit somewhat limited by an absence of formalised systems of monitoring and evaluation.

Stakeholders indicate that CEHI’s programming is high quality and that the materials prepared by CEHI are equally state-of-the-art. CEHI’s technical excellence is also evidenced by the degree to which its work has been recognised internationally and the extent to which it has been able to attract additional support on the basis of its solid track record. CEHI’s international partners such as the World Bank, UNDP, UNEP and others all report a high degree of confidence in CEHI’s professional capacities, as well as its ability to be a Caribbean interlocutor for several global initiatives.

As far as its mandate areas, stakeholders report that CEHI serves their respective needs, especially with respect to water and waste management concerns. However, there is some debate regarding CEHI’s approach to cost recovery and user fees with more traditional informants being uneasy with the organisation’s business-driven model, although offering no alternatives.

Like several other RHIs, CEHI does not possess strong capacities in the areas of monitoring and evaluation. Thus, the directions provided for the 1998 Strategic Business Plan run the risk of not being refreshed on a regular basis.

Financial Viability

Core Finding: CEHI has had a marked degree of successes in mobilising new resources which have expanded its programming base and which have reduced its reliance on contributions from member states.

The organisation’s operational expenditures have more than doubled since 1998, with the increase directly attributable to its ability to mobilise new donor support and convert certain programming into fee-for-service and cost-recovery activities. For example, sale of services have increased from about \$US 35,000 in 1999 to nearly \$US 200,000 in 2003.

The net effect of CEHI’s successful resource mobilisation strategies with donors and its cost recovery activities have been to reduce its reliance on member state contributions to about 30% (40% from resource mobilisation and 30% from cost recovery/ sale of services). Similar to CHRC and CRDT (but unlike CAREC and CFNI), CEHI faces a degree of uncertainty with respect to member state contributions that results in the organisation annually facing a degree of risk (albeit decreasing) over the nature of its overall budget envelope.

The Organisation's Vision and Leadership

Core Finding: CEHI has a strong organisational vision that is accompanied by equally consistent managerial leadership

The organisation's vision largely stems from its 1998 Strategic Business Plan that directed it towards a focus on two issue areas (described earlier) and a new entrepreneurial organisational culture. Management leadership has mirrored both the functional focusing, and the drive towards an entrepreneurial approach to the way it does business.

Management consistently supports both the vision and the focusing by implementing a series of more short-term operational plans that encompass all functional activities. Management further has put in place effective systems of internal delegation. Equally importantly, the establishment of a Financial Sub-committee of the Board of Directors in 2000 has enabled the organisation to have access to on-going ministerial leadership, which has enabled sensitive programming and resource decision-making.

Its Niche

Core Finding: CEHI occupies a well-defined niche within the Caribbean region and especially for the OECS nations, albeit a niche which is overlapped in some instances by other regional actors

CEHI occupies a unique niche within the region, providing a range of services that are not generally available elsewhere. This is especially important for the smaller nations of the OECS, which do not have internal capacities in these areas.

However, CEHI's niche is somewhat overlapped by the actions of several other regional actors such as, PAHO offices and CAREC to some degree. Water quality control, occupational health and safety and waste management have been identified as areas where others overlap CEHI core functions. It should be noted however that with respect to PAHO, CEHI and PAHO have had a long history of collaborative efforts.

Its Technical and Professional Capacities and Infrastructure

Core Finding: CEHI laboratory, information and communications technologies (ICT) and overall professional capacities are world class.

The ISO certification of CEHI's laboratory (first of its kind in the OECS) points to the professionalism of the organisation. Not only has CEHI met world-class standards, ISO certification also requires CEHI to have developed a long-term action plan to maintain its level of professional excellence. Similarly, CEHI's ICT infrastructure is equally cutting edge with CEHI moving rapidly to fully digitise a significant percentage of its work, thus broadening its accessibility. Its on-line presence is significant and it plans to further expand this area. CEHI is also exploring e-commerce solutions to information distribution, further evidence of its strong entrepreneurial values.

Despite low salary scales and employment conditions that favour working outside the region (or for international bodies within the region), CEHI has been able to attract highly qualified staff.

Its Management Systems

Core Finding: CEHI possesses adequate management systems for an organisation its size.

CEHI's management of human resources is adequate for an organisation of about 20 persons. Jobs are well defined, staffing systems are transparent and regional recruitment is carried out for professional and technical positions. However, CEHI's management of human resources could be improved by the introduction of effective systems of employee appraisal. Similar to other RHIs, CEHI faces a human resource challenge related to long-term career development due to the relatively small size of the organisation.

The organisation's financial management systems are highly developed and capable of linking expenditures with organisational goals, thus facilitating sensitive budget decision-making. CEHI also possess solid management systems for its ICT infrastructure and its laboratory systems.

4.1.5 Specific Recommendations

Recommendation 1: Strengthening Stakeholder Feedback and Needs Assessment Mechanisms

CEHI might wish to strengthen its current systems of stakeholder feedback and needs assessment by introducing more formalised systems.

Recommendation 2: Strengthening the Results-Base of the Organisation's Planning Systems

CEHI might wish to begin a process to introduce a top to bottom results-based logical framework approach into its planning systems.

Recommendation 3: Increase the Organisation's Monitoring and Evaluation Capacities

CEHI might wish to strengthen and formalise its monitoring and evaluation capacities.

Recommendation 4: Strengthening CEHI's Fiscal Forecasting

CEHI may wish to develop means, in concert with the CARICOM Secretariat, to regularise and systematise the process whereby member state contributions are requested and subsequently collected.

Recommendation 5: Strengthening Ties with Others in the Region

CEHI may wish to explore developing a more formalised approach to collaborating with other relevant regional actors such as post-secondary institutions and other actors involved in environmental management.

Recommendation 6: Strengthening Human Resource Management Systems

CEHI might wish to introduce a new employee performance system that would better track individual performance in comparison to organisational goals.

Recommendation 7: Reduce Overlap and Duplication with Others.

CEHI may wish to open direct discussions with CAREC and PAHO regarding the rationalisation of potential areas of overlap and duplication.

4.2 CHRC

4.2.1 Background

CHRC was formed in 1955 as the Standing Advisory Committee for Medical Research in the British Caribbean, a medical/academic membership organisation. As of 1972, the Ministers of Health transformed the organisation into a regional body to provide advice and focus on medical research and by 1998 the newly renamed CHRC began to include non-Commonwealth countries in its membership while maintaining strong ties with the University of the West Indies (UWI) to the present.

CHRC expanded the scope of its research mandate beyond medical/clinical matters to include health and health care systems research in addition to medical/clinical matters. As a result, CHRC's health-related mandate is much broader than the other RHIs.

The organisation has in a short time developed its offices, staff and resources, but declining member state quota contributions present a challenge. At the same time, unfilled staff positions and un-placed grant funding have contributed to some 'surplus' funds in the budget, thus contributing to the overall phenomenon that RHIs in general face a dichotomy between the perceived core mandate and the level of core funding available.

In order to remain viable, the organisation has exercised restrained financial management, minimized some programme areas (such a funding for research grants) and has pursued the mobilisation of outside donor resources to support projects in order to keep with its mandate.

CHRC has recently initiated more extensive consultations with member countries to put increased focus on member country needs. The introduction of new expertise in the area of monitoring and evaluation due to a donor-funded project has added an important area of capacity to train and enhanced country capacity to assess HIV/AIDS programmes and other potential areas of activity and research. To enhance communications and information transfer to its stakeholders, CHRC has introduced a web site with plans to expand its interactive capacity to provide a wider array of resources to member countries.

4.2.2 Mandate and Services

The CHRC mission is:

"To promote, support, facilitate and coordinate health research in the Caribbean; help disseminate the findings; and advise on and work with Caribbean governments and other stakeholders on health research matters."

The most prominent service provided is the annual scientific meeting, which offers researchers the opportunity to present papers and showcase research projects that were approved for funding by the CHRC. There has been renewed effort to move beyond the historical emphasis on clinical practices to meet the objectives of 'health' research as well as feature the work of the RHI's to support a broader array of health research and will include extra efforts to support more practical, operational, and policy linked research in all areas as well.

The CHRC also provides educational programmes and consultation services to current and potential researchers in the region and has scientific advisors on hand to provide advice and technical support. There is a basic and advanced programme in research methodology that is offered throughout the region and recently, training has also been provided in monitoring and evaluation methodology.

4.2.3 Governance

The CHRC is currently governed by a Council of approximately 30 members who meet annually. Members include:

An elected Chair, CMOs of member countries, UWI, the University of Guyana and the UK MRC, members elected from the region, UK, and US. The CHRC also extends observer status to RHIs (CAREC, CFNI and CEHI), other regional and international organisations (TMRI, UWIMAA, PAHO and COHRED) and the Ministry of Health of the Netherlands.

There is a Scientific Management Committee comprising Scientific Secretaries who also form part of the CHRC Secretariat headed by the Director of Research.

4.2.4 Assessment of CHRC's Organisational Performance

Effectiveness

Core Finding: CHRC Programmes and Services to date have been generally well aligned with its mandated functions, mission and goals regarding research, dissemination and advisory roles.

The 1998 shift in CHRC's name and mandate to support health research rather than the narrower medical/bio-medical focus was appropriate to global trends and regional needs, however in structure and practice CHRC has achieved relatively modest success and breadth in this area. Current CHRC mechanisms for dissemination and communication of research results and other information are still mostly focused on traditional practices, given financial and other constraints. Due to a lack of resources to, all member countries while 'present' in CHRC, are not fully engaged in its programming. This has given rise to an uneven understanding of the role of the organisation, with more engaged stakeholders holding more positive views than those whose engagement is not as high.

Efficiency

Core Findings: The CHRC does not have sufficient core resources to meet all of its mandate areas

While the new Director has quickly made the efforts despite financial and time constraints at increasing CHRC's capacity to carry out its mandate, the organisation lacks the resources to meet this improvement initiative and the management mechanisms necessary to meet its broader mandate. He has tried to improve physical and operational arrangements and develop human and other resources beyond the prior 'informal but practical' setup. CHRC is already maximising its resources to complete its present menu of work within existing time and financial constraints, and is likely to hit a breaking point, due to already insufficient resources, in attempting to more vigorously pursue the broader mandate for research, dissemination and advisory roles.

CHRC presently relies on UWI for certain areas of support (such as financial and human resources management), and benefits from the informality of a smaller organisation to manage internal efficiencies. However as a result, CHRC lacks a number of typical mechanisms essential to the management of a broader mandate. While there may be a number of apparent 'cost efficiencies' implicit in the arrangements inherited at CHRC, in view of its broadening mandate and stakeholder expectations, these may in fact represent unrecognised or indirect monetary and other costs to CHRC which may need to be addressed.

Relevance

Core Finding: CHRC's positioning and roles are generally well aligned with stated priorities and goals in and of the region.

Within its constrained resource base, CHRC demonstrates both flexibility and capacity to its evolving mandate, needs and priorities in the region. There is a link between CHRC's profile and its relevance: a distinct dichotomy in stakeholder participation means that everyone is not accessing or seeing the benefits, leaving CHRC vulnerable to publicly critical comments, misunderstanding and calls for more engagement. A relevance-related factor presently beyond the control of CHRC is the ability to effectively influence in-country uptake, e.g., the *results or impacts* of its capacity building efforts.

Financial Viability

Core Finding: The CHRC has begun to augment its limited core financial base with external programming; however, it continues to face long-term challenges to its financial sustainability

Despite a decline in member country quotas, CHRC has adapted to impacts on its budget and changes in demand for services with conservative management practices and by identifying and attracting new sources of funding. Like several other RHIs, the CHRC has begun to mobilise external donor resources for new programming areas such as an evaluation of regional effectiveness of HIV/AIDS programming and programming to support regional training in research methodology.

However, in terms of the core activities associated with a health research council such as namely support for peer-reviewed research, and the dissemination of research findings, the organisation's limited core financial base (supported by member state quota payments) is not sufficient to ensure long-term sustainability. The failure of some member states to pay quota allocations compounds this challenge, with the arrears to the organisation now totalling in the range of \$US 900,000.

4.2.5 Factors Affecting the Performance of CHRC

Mission and Mandate

Core Finding: The mission and mandate of CHRC are clear and appropriate; however CHRC itself may require more clarity in the positioning of its 'coordinating' role in the region.

Like many RHIs, the CHRC's overall mandate seems to be clear. However, the scope of the core mandate appears to exceed the level of resources available. Thus, key mandate areas like support for research have been purposefully under-supported in an effort to retain limited resources for other pressing "core" function such as the annual conference.

Strategic Leadership and Niche

Core Finding: CHRC has been a recognised and respected leader for those who have participated in its programmes however the perception is less clear for those who have not.

CHRC actions are driven by decisions and guidelines now set out in its new Strategic and Work Plans, but some uncertainty remains about wider communication of directions, the depth of management expertise, and whether the present organisational scheme is sufficient enough to produce the broader aims for health or impacts on policy and/or decision making in the region. The Staff morale and commitment to organisational success is impressive but stretched somewhat thin in terms of capacity to fulfil its potential.

Governance Structure of the RHI

Core Finding: CHRC's existing governance structure has been suitable to the predominant focus on the annual conferences, however it may need renewal in view of the more fluid needs of its broader mandate, ambitious plans for new programmes, and the corresponding need to ensure long-term regional support for core functions.

The CHRC currently operates with one of the largest governing bodies of any RHI; yet it is the smallest of all five in terms of its core budget. The thirty-member council appears to function in a compressed annual transactional mode, concurrent with the annual council.

Its Technical and Professional Capacities and Infrastructure

Core Finding: The CHRC possesses the minimum technical and professional resources and equipment required to adequately address its traditional mandate, but has insufficient technical resources to effectively undertake its broader mandate as a health research organisation serving member countries on multiple fronts.

As a small body with a very limited core budget, the CHRC confronts a number of technical challenges in order for it to remain relevant and serve its regional stakeholders. Its ICT infrastructure is fairly limited, albeit recently improved. Its physical facilities are presently utilised to the maximum. The group of scientific secretaries who conduct peer reviews possess world-class qualifications.

CHRC procedures for development and presentation of research have been appropriate to its traditional conference practices, but resources are limited and dissemination to a wider audience (regional and international) has been insufficient.

Its Management Systems

Core Finding: CHRC's operating structure has been functional for its size and traditional task areas, however is already insufficient to adequately fulfil a broader mandate.

The small size of the organisation allows the Director to satisfactorily function in the present scheme. CHRC is able to present appropriate financial reports for the organisation as a whole, and for specific donor funded projects, and provide for contingency funding to allow some flexibility for operations. Collection of quota contributions is problematic, and the needs of a more diversified organisation may require a review of existing arrangements and procedures and the development of in-house infrastructure.

The present size of the CHRC Secretariat makes management of programmes and services relatively efficient and effective, however staff and resource constraints limit the capacity to do more, or to follow up. The present systems of HR management are adequate to the size of the organisation; however more work, and thus additional resources would be warranted in certain areas to improve both present and future conditions.

4.2.6 Organisational Performance

Conclusions

Despite challenges posed by external and other factors, CHRC has remained a relatively effective organisation and continues to pursue the kinds of changes necessary to position itself to fully address its mandate and to strengthen its services to Caribbean Member Countries. CHRC has made important contributions to the development of research and researchers in the region and played a leadership role in defining a regional research agenda. In terms of the assessment of essential public health functions discussed earlier in this Report, the overall weaknesses of national authorities in fields related to health research, point to both opportunities and challenges for the CHRC as an agent of technical cooperation.

Recommendations

While much development has taken place in the past two years and CHRC is already moving forward to strengthen its capacities, stronger steps should be taken to accelerate the transition from a secretariat to a comprehensive health research organisation, if the mandate is to be fulfilled. The following recommendations address themselves to this overall task.

- Recommendation 1:** The Director should assemble a team to develop a strategy to raise and strengthen CHRC's profile in the region by clearly communicating its broader mandate and promoting better recognition, understanding, engagement and balance with respect to those served.
- Recommendation 2:** More proactive steps should be taken to position CHRC to coordinate present and future health related research in the Region and to direct it toward the imperative of capacity building in CMCs. These roles need to be clarified, asserted and understood (both inside and outside of the Region) to better harness research related resources toward a more cohesive strategy for health research in the Region.
- Recommendation 3:** CHRC should take stronger steps throughout the organisation to build broader capacity for focus on health and health systems.
- Recommendation 4:** The Director should form a team of key stakeholders to review and consider changes related to advisory, governance and management structures in keeping with a more dynamic and diversified organisation.
- Recommendation 5:** The Director, working with Council should examine the current funding and administrative paradigm of the organisation so as to better match its ability to raise and subsequently utilise the resources it requires from a variety of sources with the demands of its mandate.
- Recommendation 6:** Consideration should be given to addressing the apparent 'cost efficiencies' of lower compensation packages and understaffed areas of activity, with budget adjustments to accommodate required staffing.
- Recommendation 7:** CHRC should take steps to ensure that its resources are allocated in as balanced a fashion as possible to serve all CMCs and regional needs.

Recommendation 8: CHRC should take steps to maximise access to the research and other information it generates as well as diversify its channels of communication and distribution of information to a broader CMC and other stakeholder audience.

Recommendation 9: CHRC should refine the conduct, structure and content of its current research programme to broaden involvement in decision making, expand and increase the areas of potential CMC impact and capacity building in research.

4.3 CFNI

4.3.1 An Overview of CFNI

This section is an executive overview of the Organisational Assessment of the Caribbean Food and Nutrition Institute (CFNI). The full assessment report is contained in Volume IV.

The CFNI has been providing services to Caribbean nations for over 35 years. In the 1960s, the West Indies Federation reviewed a number of research studies that showed that there were serious and persistent nutrition-related diseases prevalent in the region, largely related to malnutrition, poor sanitation, and incorrect food handling procedures. In 1967, after the collapse of the Federation, the Pan-American Health Organisation (PAHO) joined the University of the West Indies (UWI), and the Governments of Jamaica and Trinidad and Tobago to establish a “small Caribbean nutrition centre” – the CFNI.

The CFNI was established with one centre in Jamaica and a smaller satellite location in Trinidad and Tobago. Other member states rapidly joined the organisation agreement. The 1967 agreement, which effectively remains unchanged to this day, established CFNI as a PAHO office to serve regional needs with day-to-day governance resting with PAHO.

Soon after the signing of the agreement, the CFNI rapidly began to take shape with the appointment of its first Director, the launch of its quarterly publication, *Cajanus*, and training programming. By the mid 1970s CFNI was active in all its major mandate areas (described in detail elsewhere in this Report). Special mention should be made of its early work in nutrition surveillance and research. In 1985 CFNI moved its Jamaica headquarters to a new facility on the campus of the UWI.

During the first twenty years of CFNI’s existence, the nature of the health challenges facing the Caribbean changed dramatically. The organisation had been established to respond to conditions related largely to malnutrition, but by the 1990s, chronic disease and lifestyle factors had replaced malnutrition as the major “needs” areas. Obesity in particular and the food/nutrition aspects of related co-morbidities such as diabetes, heart disease, etc. became, and continue to be, the major focus of CFNI work, with HIV/AIDS being more recently added as a major focus.

With the appointment of the current Director in 1995, CFNI entered a new more interventionist era. Programming increased in intensity and a new focus was placed on qualitative research and policy formulation activities.

In 1999, as a result of changing patterns of global funding, CFNI developed and launched a comprehensive resource mobilisation strategy to augment reduced PAHO funding with funding from new sources, primarily major multilateral and bilateral donors. The effect of this strategy was profound; within four years, external resources grew from about 10% of CFNI revenues to over 35% and are planned to attain majority status within the next few years. CFNI’s overall budget has also increased by about 33%.

In recent years CFNI has firmly positioned itself with respect to global health priorities. In 2003 it developed a *Strategy on Nutrition and HIV/AIDS* and in 2004 it implemented its *Strategy on Nutrition and Chronic Disease Control*.

4.3.2 CFNI's Mandate and Services

CFNI's mandate was set down in 1967 and has not been formally modified since. It is:

“To furnish technical assistance and training services in the Caribbean region and to conduct research with the aim of improving the nutritional status of the population through education programmes, by modifying food habits within the framework of health, agriculture and education services and other related programmes, by developing food resources, by supporting coordinated work in food and nutrition at present underway, and by stimulating and furthering such further developments as are practical and desirable.”

In terms of its programming activities, the 1967 agreement provided for three major programming elements:

- Education and training activities in nutrition
- Advisory and consulting services
- Research

Over time, these three elements evolved into the present four cornerstones:

- Planning and policy formulation
- Human resources development
- Promotion and dissemination
- Surveillance and research

This expansion however did not result in new mandate areas; instead it simply broadened the original three elements.

4.3.3 CFNI's Governance

CFNI is a PAHO-specialised centre and reports to the Director of PAHO through Washington D.C.-based management. Two advisory bodies provide input into the organisation's governance:

- A Scientific Advisory Committee comprising regional representatives meets once a year to review operational plans and prior activities.
- A Policy Advisory Committee comprising more senior (not ministerial) regional representatives meets once a year to provide higher level input to the Director of PAHO.

CFNI presents an annual report to Caribbean ministers (at the Ministers Caucus meeting), the Council for Human and Social Development (COHSOD) and the Ministers of Agriculture at the Council for Trade and Economic Development (COTED). CFNI has established a line of *de facto* responsibility to the region's key decision-makers despite being a PAHO office.

4.3.4 Assessment of CFNI's Organisational Performance

Effectiveness

Core Finding: CFNI is fulfilling all four aspects of its mandate

CFNI is fulfilling its mandate in all areas with varying degrees of success and impact. The organisation has successfully been able to transform itself to meet changing needs by means of its on-going process of stakeholder consultation and also by the use of medium (5-year) planning processes. For example, at its inception CFNI was primarily focused on malnutrition and its associated diseases. Today, CFNI's primary focus is on chronic and lifestyle conditions with obesity, its co-morbidities and HIV /AIDS collectively occupying nearly 85% of programming funding.

CFNI's work impacts practically every Caribbean nation. Its annual reports show the extensive breadth and scope of the programming and related services it delivers.

CFNI has done extensive work in the areas of human resource development (largely training and capacity-building) and from a technical standpoint; the materials (handbooks, manuals, food guides, etc) it prepares are of high quality and equal to that prepared in many OECD nations.

Efficiency

Core Finding: CFNI is efficiently translating the resources it secures into programming using a traditional approach to service delivery

Examination of CFNI financial data shows that the organisation has consistently translated funds into programming with limited annual variations. It must be emphasised that despite the extensive resource mobilisation programme of the last five years, CFNI has kept its use of resources in relation to personnel costs at a relatively constant level.

However, CFNI's revenue generation / financial model is somewhat conservative in nature due to decisions not to engage in cost recovery /fee-for-service activities beyond the sale of printed material. CFNI's ability to manage its resources - financial and otherwise is somewhat constrained by the fact that the organisation presently receives relatively low levels of financial delegation from PAHO (about \$15,000 for purchases), limiting management's ability and slowing down decision-making.

Relevance

Core Finding: CFNI's programme of services is generally relevant and responsive to regional needs

Stakeholders from across the region report that they are generally satisfied with the quality of CFNI services and that CFNI serves their needs with respect to food and nutrition matters. However, most stakeholders interviewed view CFNI largely in terms of a training/ information distribution function, and do not have the same understanding of CFNI's policy development, research or advocacy roles.

Some stakeholders in larger nations remarked that some of CFNI's materials were less relevant to them due to their domestic capacities while stakeholders from a number of smaller nations remarked that CFNI materials were the only reference materials available to them.

CFNI has made special efforts to demonstrate the extent to which its work contributes to CCH-2 goals. However, in the areas of policy development particularly in the promotion of the adoption of national nutrition strategies, CFNI has had relatively less success in its advocacy and policy support functions.

CFNI's primary mechanism to elicit stakeholder input/ feedback is its annual outreach to national nutrition coordinators and the accompanying annual conference. While these tools are an effective means to elicit feedback/input, since a significant number of stakeholders occupy lower to intermediate level positions, higher-level strategic issues are not addressed; leaving out issues such as the rise in chronic diseases or obesity, for example. It is important to consider developing avenues to better engage more senior decision-makers, and also to reach out to other elements of the public sector that are also involved in education and health matters.

Financial Viability

Core Finding: While CFNI has experienced considerable success in resource mobilisation over the last five years, more could be done to reduce its dependency on both PAHO and member state contributions

Over the last five years, CFNI has made remarkable progress in mobilising new external resources; from 10% in 1999 to in excess of 35% in 2003. This has eliminated to some degree CFNI's dependence on member state quota and PAHO contributions, which have fallen to barely 10% of overall revenues and to barely 50% respectively.

CFNI remains fairly reliant on both PAHO and member state contributions because it has not explored in any significant manner the issue of alternative financing models for its long-standing training programmes. While to do so would be a major departure for CFNI, it would reduce risk, and also begin to address a common misperception among some member states that their contribution is actually sufficient to cover the costs of the level of services provided by CFNI.

4.3.5 The key factors affecting CFNI's performance

The Organisation's Vision and Leadership

Core Finding: CFNI is guided by a generally forward-looking vision as set down in its Strategic Plans, which works to contribute to the attainment of CCH-2 goals

CFNI has established a pattern of five-year strategic plans combined with annual feedback / needs assessment exercises conducted with national nutrition coordinators. CFNI's strategic plans are particularly noteworthy in the fact that they look beyond the more traditional training and capacity-building activities (seen by many to be the core of CFNI) advocating for more aggressive regional and national action to address challenges presented by lifestyle choices, chronic diseases and HIV/AIDS.

Based on interviews with management and staff, and the feedback from senior stakeholders, it is evident that CFNI possesses a qualified and skilled management cadre. As proof, the Director of CFNI, who has been especially forward-looking with respect to resource mobilisation, particularly with major donor bodies recently received the PAHO "Manager of the Year" award.

Its Niche

Core Finding: CFNI has been successful in adapting its primary mandate to changing regional needs and thus maintaining a clear and unique niche within the region

CFNI does not have any significant regional competition and more importantly, its primary mandate areas do not seem to have been infringed upon by other RHIs, or by other elements of PAHO, as has been the case in some other instances.

Its Technical and Professional Capacities and Infrastructure

Core Finding: CFNI possesses highly qualified staff that produces high quality materials within the scope of its mandate, with the proviso that the organisation tends to be somewhat conservative regarding distribution channels

With a staff of about 33, CFNI is the second largest of the five RHIs, albeit only ¼ the size of CAREC. Examination of personnel records clearly shows that CFNI key staff possesses world-level expertise, thus bringing to the region invaluable experience and skills. The professionalism of the materials developed by CFNI and the research it undertakes are equivalent to that conducted in many OECD nations.

However, CFNI is somewhat impeded by a relatively conservative approach to the use of modern information technologies, largely due to decisions taken by PAHO in Washington, D.C. The organisation does not currently have a robust web presence that enables users to access its work electronically. Instead, it recently invested in a new high-quality printing plant. CFNI reports that its web site will soon be upgraded by PAHO to begin to expand its on-line reference capacities. In terms of other modern technologies, CFNI is well equipped in both hardware and software, and utilises PAHO's most up-to-date MIS infrastructure.

Management Systems

Core Finding: CFNI, which uses PAHO systems and procedures, possesses adequate management systems and controls for an organisation its size; with the proviso that, to some degree, PAHO-based systems have tended to impede development locally relevant managerial solutions

As a PAHO-specialised centre, CFNI operates within the provisions of PAHO administrative, human and financial resource management rules and procedures; provisions that are very stable and fully transparent yet some serve as impediments to CFNI. For example, with respect to human resource management, the division between "national" and international" staff, especially at the professional level is seen by all at CFNI as an impediment to effective performance. While this two-level approach to human resource management is common to all bodies that are part of the UN system (as is PAHO) this approach may be more significant in an organisation like CFNI, where about one third of staff are on the international scale. In contrast less than 10% of the staff at CAREC are on the international scale.

Similarly, CFNI informants have seen PAHO administrative and legal systems as constraining to a limited degree. PAHO procurement and financial delegation provisions also serve to limit the manoeuvring room of the Director of CFNI, although enlarging the scope of delegation could assuage this problem.

4.3.6 CFNI Specific Recommendations

Recommendation 1: Strengthening Stakeholder Feedback and Needs Assessment Mechanisms

CFNI might wish to strengthen its current systems of stakeholder feedback and needs assessment by introducing more formalised systems

Recommendation 2: Strengthening the Results-Base of the Organisation's Planning Systems

CEHI might wish to begin a process to introduce a top to bottom results-based logical framework approach into its planning systems.

Recommendation 3: Increase the Organisation's Monitoring and Evaluation Capacities

CEHI might wish to strengthen and formalise its monitoring and evaluation capacities.

Recommendation 4: Strengthening CFNI's Fiscal Forecasting

CFNI may wish to develop means, in concert with the CARICOM Secretariat, to regularise and systematise the process by which member state contributions are requested and subsequently collected.

Recommendation 5: Strengthening Ties with Others in the Region

CFNI may wish to explore developing a more formalised approach to collaborating with other relevant regional actors such as post-secondary institutions and other actors involved in food and nutrition subjects.

Recommendation 6: Build New Funding Partnerships

As part of its resource mobilisation campaign, CFNI may wish to explore opening a dialogue with the private sector to better engage them and potentially partner with them in pilot programming.

Recommendation 7: Explore Moving Toward Greater Self-Sufficiency

CFNI may wish to explore moving to some degree towards a greater reliance on "user-pay" activities.

Recommendation 8: Strengthen CFNI's Communications Tools

CFNI may wish to explore strengthening its communication strategies to result in a broader outreach and place more emphasis on its role as a policy and advocacy body.

Recommendation 9: Acquire Greater Delegation from PAHO

CFNI may wish to explore with PAHO management the possibility of greater levels of decision-making delegation.

4.4 CRDTL

4.4.1 Background

The CRDTL is a small organisation consisting of eight staff members and a part-time Director, located in Kingston, Jamaica. CIDA and PAHO contributed to the building and outfitting of the CRDTL physical plant (which was opened in 1980) and have provided institutional support through 1985.

In 2003 CRDTL had a theoretical budget of approximately US\$300,000, however due to persistent quota shortfalls, its expenditures are in the range of US\$ 200,000. It is heavily reliant on contributions from regional member states to undertake its mandate.

The last CARICOM-funded evaluation of CRDTL occurred in 1987. Many of the issues identified in the current assessment were highlighted in the 1987 report.

The challenges facing a drug testing facility that concentrates on surveillance and quality control functions have changed considerably over the last thirty years due to the rapid growth of the pharmaceutical industry worldwide and the ever-increasing complexity of pharmaceutical products. Today, the CRDTL operates in a world that is considerably different from not only the era it was founded in but also the period within which the last CARICOM evaluation occurred.

4.4.2 Mandate and Services

The organisation's mandate has not changed since its establishment in 1975, although the environment in which CRDTL functions has changed considerably. The mandate is as follows:

- To perform microbiological and pharmacological testing of drugs submitted by participating governments
- To perform biological availability tests
- To investigate the stability of drugs
- To establish a liaison with all appropriate agencies ... and to provide information and advisory services

As earlier mentioned, this mandate has not been altered, although unsuccessful efforts were launched in 1988 at the recommendation of the 1987 CARICOM evaluation. The CRDTL in sum performs only a quality control service for participating countries and is not the exclusive provider of these services to member states.

In term of services, the CRDTL undertakes the following:

- Drug testing for quality assurance of products submitted by participating countries. The organisation has established a priority-testing list, which although management recognises is out of date has not been recently updated.
- Limited work with the private sector for advance testing of new products largely of Jamaican origin, generating only nominal revenues at best.
- Sporadic training provided to officials of participating countries.

The CRDTL has a budget in the range of \$306,000 virtually all of it derived from member state contributions. However, in recent years it has been able to collect only in the range of \$206,000, which also includes about \$ 7,000 from the sale of service in 2002.

An analysis of CRDTL's varying levels of performance vis-à-vis the sale of its services shows a variation between about 3-3.5% of total revenues to less than 1 %. Therefore, while the CRDTL has the theoretical ability to generate revenue from alternate sources, it does so only in a nominal fashion and has little if any market presence outside of Jamaica.

4.4.3 Governance

Of the five RHIs, the CRDTL's governance structure is probably the most opaque in terms of accountability to senior regional decision-makers, and is probably the most limited in terms of the ability of senior regional decision-makers to play a part in active organisational decision-making.

The 1975 Agreement provides for:

- A Technical Advisory Committee to advise the Director
- Submission of an annual budget to Caribbean Ministers of Health for their approval

The Technical Advisory Committee meets only once a year, usually in the second quarter for one or two days at the most. The Director's report to the Advisory Committee is the organisation's sole management accountability document and generally consists of a list of the products tested and the results of such tests, as well as a financial report. This report is not a strategic plan, or even a substantive short-medium term work plan. It should also be emphasised that this annual paper-based report to the Technical Advisory Committee is the sole means of transmitting test results to stakeholders other than the party that requested the particular test. With regard to communication technologies, CRDTL has one e-mail account, no web presence and only one desktop computer with on-line access.

The governance of the CRDTL is impacted by a unique management arrangement. Unlike other RHIs which have a CEO appointed by their governing arm, the 1975 Agreement provided that the head of the office of the Government Chemist of Jamaica (the "Government Chemist") also be the Director of the CRDTL. It should be noted that the positions of Director and Government Chemist of Jamaica are on a part-time basis.

Effectiveness

Core Finding: The CRDTL is meeting its mandate in only a minimal fashion, and only in relation to quality assurance testing. It is providing levels of service that are significantly sub-standard

The CRDTL has had very little ability to meet its core mandate, even within the area of pharmaceutical quality assurance testing. The organisation is very small and tests about 175-240 samples per year. It does not have any performance benchmarks and its management recognises that its service delivery standards do not meet stakeholder needs – namely it generates unacceptable and excessive delays in testing. Stakeholders were nearly unanimous in stating that the CRDTL does not provide sufficiently timely services to even minimally meet their needs.

A major stakeholder provided Universalialia with the only performance benchmarking data with respect to CRDTL's work, showing delays in receiving test results extending into the 4-6 month range. This is in sharp contrast with a turnaround period of 2 weeks from private fee-for service laboratories performing the same testing. CRDTL data also shows that an increasing number of samples are being carried over each year, in many cases due to the lack of relevant supplies to carry out the tests.

CRDTL management recognises these limitations and further noted that the organisation would need to increase its technical staff by about 50% and also receive a capital infusion to acquire new equipment in order to meet the minimum requirements of its quality assurance testing mandate.

Unlike other RHIs, the CRDTL has not undertaken any substantive reviews of its mandate since its formulation in 1975 and more importantly, and possesses neither a substantive strategic plan nor a viable business plan. A one-page document considered to be a work plan was given to the evaluation team after the team's on-site mission.

CRDTL management recognises the limited effectiveness of the organisation yet most of these issues have not been raised with senior regional decision-makers in any coordinated or substantive fashion. Moreover, the sole formal annual accountability document has not addressed these crucial matters in recent years.

Efficiency

Core Finding: The CRDTL inefficiently translates the few resources at its disposal into services, averaging between 200-250% higher unit costs than those available from other sources of similar testing used by some major stakeholders.

In 2002, the CRDTL received 240 samples, spent \$US 206,000 and conducted 178 out of 240 samples, resulting in a unit value of approximately \$US 1,100 per test. If one includes the samples carried over (as noted above) the unit value would fall to the range of \$US 870. A major stakeholder provided evidence, subsequently corroborated by Canadian sources, showing that similar tests could be purchased from a lab in the EU for a per test cost of approximately \$US 400. CRDTL services cost at least twice as much, if not more, than comparable and faster services provide by EU laboratories.

CRDTL does not possess any benchmarks for the relationship between use of its resources and the timely delivery of service. Management also states that the CRDTL does not conduct cost-benefit analysis or any other systematic review of programmatic efficiency.

Relevance

Core Finding: The CRDTL is rapidly losing its relevance to major regional stakeholders

A majority of regional stakeholders, including one of the CRDTL's major clients, stated that the organisation was rapidly losing its relevance. The delays in securing test results make the utility of testing questionable, placing organisational in a problematic position.

Stakeholders, however, were unanimous that the region as a whole required a mechanism to ensure pharmaceutical quality assurance, given the explosion of new products and new suppliers on the market and the growing phenomenon of counterfeit products, now estimated to be in the range of 7% worldwide by the WHO.

One major CRDTL client intends to quadruple its quality assurance testing over the next several years and intends to rely almost exclusively on outside private laboratories that can provide rapid turnaround (about 2 weeks), and is willing to pay for such services.

Most stakeholders including CRDTL management noted that the organisation's present priority testing list was obsolete yet CRDTL's Technical Advisory Committee has not revised it despite a number of suggestions to do so.

CRDTL has not made a significant contribution to the attainment of CCH-2 goals with respect to the region's access to quality and cost-effective pharmaceutical products. A number of stakeholders also noted that the manner in which CRDTL disseminates testing information – through an annual paper-based report, as opposed to using electronic means, with test results having little if any relevance to stakeholders. As a result, stakeholders may not know whether a product is sub-standard until the product has been consumed since they do not have timely access to the data.

Financial Viability

Core Finding: The CRDTL is not a financially viable organisation at this time, due to the fact that a quota-based funding model is unlikely to generate sufficient revenue for it to address its performance shortfalls.

The CRDTL is presently caught in a vicious downward spiral; the provision of low level of services resulting in growing levels of dissatisfaction. This in turn results in member state failure to pay their quotas. Currently the CRDTL is securing less than 66% of allocated quota. Given the ideal of each member state paying its full allotment, the organisation would probably not have enough revenue to build its capacity and meet expected service delivery standards. Even if this were possible it is very likely that the per-unit costs would still be vastly higher than private sector competition.

Plans by PAHO to build capacity by means of a major donor-supported organisational strengthening project would build short-term capacity, but leave the organisation highly vulnerable over the long term to increased risks related to future non-payment of quotas. A 1996 World Bank study on Caribbean regional institutions conclusively shows that Caribbean organisations require a mix of quota, donor and user fees to ensure long-term sustainability and the potential for organisational growth. The CRDTL is effectively dependent on quota payments, and according to the World Bank's assessment would be unsustainable.

Management of the CRDTL stated that they had no mandate to explore adding cost-recovery for testing into their revenue generation mix yet given the acknowledged fiscal plight of the organisation, examination of its records show that the subject of cost-recovery has not been raised. It is interesting to note however, that the advisory committee has been seized with suggestions from some of its members to expand CRDTL services to include the testing of veterinary products and to move into the sports-medicine field by becoming involved in anti-doping testing.

Core Finding: Although the CRDTL has the ability to provide fee for service to the private sector, its track record in doing so is nominal.

Over the last four years, CRDTL has made only nominal efforts to raise alternate sources of revenue. In two of the last four years no funds were secured at all while in the other two only a very small amount was raised and mostly from Jamaican sources with one year of the two yielding less than US\$1,000. The organisation appears not to have a market presence in any other part of the Caribbean.

4.4.4 Key Factors Affecting CRDTL's Performance

Vision and Leadership

Core Finding: The CRDTL as an entity is hampered by a management paradigm that is obsolete.

The fact that the CRDTL's Director serves part-time and is not formally accountable to senior Caribbean decision-makers like the CEOs of other RHIs, affects organisational performance. The region's key decision-makers are not part of the decision-making process at CRDTL, except for the ability to approve or reject the annual budget – a limited transactional function.

The CRDTL also does not possess a strategic plan or anything close to address what its management recognises as critical performance shortfalls. Universalia notes that the CARICOM Secretariat after an on-site evaluation mission in mid-2004 began to assist the CRDTL in developing a logical framework for the organisation. At the time of writing, this material had not yet been shared with Universalia.

The mandate of the organisation also does not meet contemporary and emerging needs, identified by major stakeholders as: the impact of the proliferation of new products, the need to assist the region in providing better and more cost-effective products, the growth of new producers who do not have a recognised “track record” and the emergence of new families of pharmaceuticals to respond to major health challenges such as HIV/AIDS.

Niche

Core Finding: The CRDTL’s niche is limited to quality assurance testing, which is of a marginal nature

As noted above the CRDTL is not responding to many of the CCH-2 goals relative to regional access to pharmaceutical products. In terms of testing, its marginal niche is being continuously eroded by stakeholders moving their quality assurance testing to other sources of service, including the private sector.

Technical and Professional Capacities and Infrastructure

Core Finding: The CRDTL possesses the bare minimum technical and professional base to perform the basic services of a laboratory involved in quality-assurance testing.

The CRDTL, according to its own management, lacks a back-up capacity, thus increasing the risk of delays. Its equipment, while adequate for the task at hand, is aging and encountering maintenance problems due to limited resources and limited access to repair facilities. While the organisation's staff possesses the minimum professional qualifications required, they themselves note that the organisation's pay scale acts as a deterrent to career stability. Only one of the professionals has been with the CRDTL for more than 18 months and others candidly admitted that they intended to seek alternate employment once they had acquired experience at the CRDTL. Thus, there is a broad perception that the CRDTL cannot keep qualified staff and thus build long-term professional competency.

Universalis is aware that there are proposals to strengthen the laboratory by adding new equipment and by even considering laboratory certification. In theory, the CRDTL possesses a sufficient technical base and with capital infusion and institutional strengthening could become an accredited facility.

Management Systems

Core Finding: The CRDTL’s management and planning systems are not conducive to successful organisational growth or transformation.

The CRDTL is a small organisation and thus does not require the range of management systems used by other larger RHIs. However, the absence of planning systems, any approaches to needs identification, and any systems of benchmarking have limited the ability of the organisation to remain relevant and to be able to assess its performance in any reasonable fashion. Thus, senior regional decision-makers do not have any means to assess its impact.

As far as CRDTL’s human resource management the organisation’s low pay scale results in the organisation being unable to retain qualified employees. This weakness is combined with the fact that the organisation is not linked to any other body giving employees the opportunity of career enhancement – a problem common to all RHIs.

4.4.5 Organisational Performance

Universalialia is of the opinion that the CRDTL, as it is currently constituted, is an organisation that cannot be revitalised to a sufficient degree without a fundamental transformation that would result in a new entity.

For example, a new more direct governance paradigm is required that more closely links senior regional decision-makers to actual management decisions. A separate CEO is required to ensure regional accountability and a complete mandate review is needed given the pharmaceutical challenges facing the region vastly exceed the current scope of the organisation.

The organisation's lack of market competitiveness and its reliance on unreliable quota payments for its resources also requires more than minor internal modifications and improvements.

Universalialia is of the view that the challenges of transforming the region's approach to quality assurance for pharmaceutical products may be one of the most important tasks with respect to improving regional technical cooperation in health, and one of the cornerstones of a refreshed approach to RHIs in general. For this reason, Universalialia has dedicated an entire sub-section of the Rationalisation Plan to addressing various approaches to conceptualising new functions, new modalities of delivery and new organisational arrangements.

4.5 CAREC

4.5.1 Background

CAREC, the largest of the five RHIs, was created in the 1970's by Caribbean nations, entering into a partnership with the Pan American Health Organisation (PAHO). It was established to:

“Improve the health status of Caribbean people by advancing capability of member countries in Epidemiology, Laboratory Technology and related Public Health Disciplines through technical cooperation, service training, and research.”

With funding from diverse sources such as PAHO, CMC quotas and project-specific support, CAREC has evolved over time into a diversified public health, information, service and consulting organisation and has achieved significant milestones. CAREC has played a major role in creating a measles-free region and is currently providing leadership in the fight against HIV/AIDS.

4.5.2 Mandate and Services

CAREC serves as the health, monitoring and disease prevention agency and is a PAHO/WHO-specialised centre, which provides laboratory reference, and epidemiology services to twenty-two member countries. CAREC's mandate is derived from various sources, but primarily its Multilateral Agreement that outlines a fairly large number of functions and programmes of major activities in public health and disease control. It receives direction from its Council and from the Conference of Ministries of Health and COHSOD; and, advice from its Scientific Advisory Committee. PAHO provides operational and managerial oversight and an administrative and financial infrastructure framework in accord with internationally recognised standards.

4.5.3 Governance

CAREC governance is provided by a Directing Council with input provided by a Scientific Advisory Committee (SAC). Government representatives include the Minister of Health of Trinidad & Tobago; five other country representatives designated by COHSOD, three Caribbean representatives including UWI and the Secretary General of CARICOM (or designate), PAHO/WHO, and the Chairperson of the SAC. The Director of CAREC serves as the Secretary to the Council

4.5.4 Organisational Performance

Effectiveness

Core Finding: CAREC programmes and services are generally well aligned with its mandated functions, mission and goals regarding its various consultative, capacity building, technical, service and other roles. However, there are insufficient core resources to support CAREC's core functions and uncertainty on the scope of CAREC's general mandate exists.

CAREC activities are generally well-supported by stakeholders, but all are not equally well-funded or addressed, with some inconsistencies in delivery of programmes reflecting a number of internal and external issues, largely related to a gap between programme expectations and the availability of core resources to support them. There are also concerns about whether or how CAREC is meeting its core mandate and whether CAREC's new programming, supported by external donors is having a negative impact on its core activities, and thus by extension, the breadth of its mandate, which is also fairly permissive in nature. CAREC itself recognises that its particular strengths lie in its relationships with countries, a dedicated staff, and its partnerships with regional and international partners, which underpin its capacity to effectively address its mandate.

Efficiency

Core Finding: CAREC is generally making good use of its resources, but has been challenged by an internal context of financial constraints, human resource complexities, an aging facility and the absence of internal benchmarking systems

New project funding has provided opportunities for CAREC to cover some staff and other resources. Presently CAREC is facing a number of managerial and programmatic challenges that in large part stem from the fact that the level of its core resources has declined due to zero growth in quota payments from member states and PAHO payment reductions due to overall WHO restraint measures. Some new programmes are better financed than others, requiring CAREC to deploy resources to meet shortfalls. Furthermore CAREC's limited core budget has not enabled it to develop effective benchmarking systems (save for efforts related to laboratory services).

Thus, it may lack some of the management and planning tools that are needed to maximise resource utilisation and encourage resource prioritisation.

Relevance

Core Finding: CAREC's positioning, roles and services are well aligned with regional needs, priorities and goals. However, CAREC faces some challenges in balancing regional and country needs; and in balancing core programming versus donor-supported programming

CAREC is generally seen to be relevant and responsive to CMCs, and both technical services and new programmes are generally seen as pertinent to current and emerging needs. The pertinence of some services varies according to different countries' needs, interests, goals and capacity. Stakeholder views appear to engage a 'relevance debate,' with some tension evident at times between regional programmes and individual country needs; and as well with respect to whether CAREC's core activities are being fulfilled to the same degree as those activities supported by external donors. While CAREC has demonstrated considerable flexibility and capacity to adapt to evolving needs of its stakeholders, probably more could be done to prioritise core services and align theme to the availability of resources.

Financial Viability

Core Finding: CAREC's core operational funding from CMCs and from PAHO is not sufficient enough to sustain the organisation and has been so for some years

Analysis of CAREC financial data shows that CAREC core funding is significantly low and continues to decline. While CAREC has demonstrated an entrepreneurial capacity to mobilise donor resources to further diversify areas of its mandate with a range of donor partners, doing so has resulted in "gaps" in core areas. Furthermore, while CAREC has been successful in mobilising new external resources, it has not addressed to the same extent as other PAHO-specialised centres approaches to cost recovery and fee-for-services that could be used to directly augment core financing.

4.5.5 Key Factors Affecting the Performance of CAREC

Mission and Mandate

Core Finding: CAREC's Mission and Mandate is not fully recognised, understood or appreciated by all stakeholders, nor have stakeholders fully appreciate the growing mandate challenges facing the organisation as a whole.

The diverse and largely permissive scope of the Mandate and possible areas of activity are much broader than the name "Epidemiology Centre" would suggest, and appear not to be fully understood by a range of stakeholders. Many stakeholders tend to focus on technical areas (e.g. epidemiology, laboratory) and omit recognition of the range of an overall public health mandate. Most indicated some degree of reservation about the relationship between what they perceived to be CAREC's core mandate and its growing list of donor-supported programming. Some also raised some concerns about the degree to which CAREC communicated with the region as whole, as opposed to with CAREC 's own Council regarding its programming choices. There were concerns that regional level communications and the flow of information were insufficient for CARICOM Secretariat to be able to integrate CAREC-related matters into broader regional approaches.

Questions regarding 'core' services appear predominantly to relate to concern about budgets and prioritization of effort, cast into question by financial issues and constraints of the PAHO relationship. As noted in several places through the individual report, Universalialia is of the view that clarifying regional and country needs as part of comprehensive mandate review for CAREC may be one of the most important challenges facing the organisation as a whole.

Strategic Leadership and Niche

Core Finding: CAREC generally has a strong public presence and identity in much of its public health role in the region, however its management approach which blends strategic thinking and adaptation to current opportunity may pose some long-term risks.

Interviews with stakeholders confirm that CAREC is well respected in the region, holding a recognised niche in the CARICOM community and wider Caribbean as the major leadership organisation in Caribbean public health.

Although CAREC has been thinking strategically about its future it has not grounded these efforts into a consolidated plan that would facilitate decision-making, largely due to a lack of resources to complete such a planning exercise. While plans are in place for donor-supported programming, the lack of core resources that are needed to strengthen managerial capacity has resulted in the absence of a comprehensive planning framework.

Organisations such as CAREC that attempt to respond to emerging public health issues in a turbulent environment are often confronted with the need to balance strategy and opportunity. For the last few years CAREC has tried to maintain a healthy balance between these two poles. Yet, today, several factors are limiting its ability to do so and the organisation runs the risk of being primarily driven by external opportunities while moving gradually away from its strategy, notwithstanding the efforts of its senior decision-makers to the contrary.

First, as noted earlier, due to the absence of a strategic plan, the organisation continues to expand, in essence precluding the sort of zero-based and needs assessment based approach to planning that is normally considered to be part of a long-term planning process. CAREC interviews acknowledge some weakness in its strategic approach, given annual (or biennial) meetings of its Council and SAC, and room for improvement in its reporting of performance to the Council on an ongoing basis, in addition to the considerable reporting requirement inherent in being a PAHO-specialised centre.

Secondly, like many small organisations in expansion, CAREC feels the need to operate perhaps within more flexible parameters than the PAHO standard two-year planning cycle. This situation has been a constant irritant for CAREC; one, we would argue, is relatively typical between a mature parent organisation such as PAHO and its sub-units. While PAHO needs to harmonise practices amongst its various entities, CAREC probably needs more flexibility to engage in its own activities.

Thirdly, CAREC's challenges in managing strategically is linked to the lack of a sufficiently robust set of core functions, one part of which may be seen to be policy/planning and organisational performance assessment, due to insufficient core funding. Given CAREC's role as a major instrument relative to CCH goals, the limited formalized strategic planning may affect CAREC's ability to address pan-regional matters.

Governance Structure of CAREC

Core Finding: The current governance and administration structure has not been modified to support the evolution of CAREC's role and recent trends in public sector institutional governance.

The governance arrangements of CAREC have remained largely unaltered since 1975 and appear to contain a number of ambiguities and gaps that seem to impede the efficacious governing of a major regional institution in a contemporary context. Some of the most salient of these issues relate to:

- The composition of the CAREC Council that results in member states, the signatories to the multilateral agreement and thus the recognised “owners of CAREC, having less than direct high-level governance roles. Of the 21 countries now members of CAREC, there are only 6 member countries (five plus the host country) included in the governance structure, representing only 50% of the Council structure.
- Ambiguities relative to the decision-making powers of the Council vis-à-vis CAREC's plans and budgetary approval in contrast
- Ambiguities relative to the extent of PAHO's roles and responsibilities vis-à-vis those of the CAREC Council regarding decision-making and attendant budgetary approval
- The composition of the Scientific Advisory Committee wherein member states may not have sufficient hands-on representation. Of the 21 countries now members of CAREC, there are only 5 represented (four plus the host country) on the SAC, leaving over 75% not represented at any point in time, or relegated to observer status at meetings.
- Ambiguous lines of authority for the SAC to play with respect to its involvement as a part of the governance paradigm.
- The limited roles assigned to the CARICOM Secretariat.
- The lack of an intercessional and high-level governing agent that could advise/direct on a more frequent basis.

At this stage CAREC's governance paradigm may need to be refreshed and revised to incorporate a number of more contemporary approaches to governing public sector bodies that place more decision-making power in the hands of senior decision-makers, and which engages senior decision-makers more actively in the management of the organisation. Universalis is also of the view that CAREC would benefit from a greater clarification and delineation of PAHO's roles in the governance of CAREC.

Operational and Managerial Structures

Core Finding: CAREC's operational and managerial systems are under pressure due to the impact of prolonged under-funding of its core mandate and the operational impact of its successful resource mobilisation efforts.

During the course of its on-site review and its extensive consultations with regional and donor stakeholders the evaluation team encountered two perspectives relative to the management capacities of CAREC and the operational and managerial impact of CAREC as a PAHO-specialised centre operating within the general managerial, accounting and reporting paradigms of the UN system.

On the one hand many CAREC informants – managers and staff alike (and some regional stakeholders)—perceive the PAHO international system as a limitation to CAREC's ability to mobilise and utilise resources. Some respondents go as far as questioning the relevance of PAHO rules and regulations for an organisation such as CAREC and would support ending the fundamental nature of the PAHO-CAREC relationship.

On the other hand, while recognising the relative rigidity of PAHO's operational procedures, other informants including key donor informants, see the need for CAREC to continue to operate under such guidelines particularly given some of the shortfalls in CAREC's managerial and systems capacities (HR systems, financial management procedures, planning and resource allocation processes), identified by the 2001 and 2003 internal reviews and by successive audit reports.

These different perspectives emerge clearly in the area of resource mobilisation.

CAREC informants and some regional stakeholders see their resource mobilisation efforts and subsequent usage of the resources mobilised by donors hampered by the application of the internationally recognised procedures that PAHO, as a UN agency, is required to utilise. While this perspective may hold some merit given the labour-intensive procedures and systems of the UN family, it should be noted that PAHO itself mobilises over \$US250 million per year operating within these same parameters. More importantly, these parameters are fundamentally the same as those used by virtually all UN systems bodies that together mobilise hundreds of millions of dollars of bilateral and multilateral donor support each year.

The key to determining the relevance of some of the contentions relative to the PAHO relationship lies in a basic comparison between the contention, and the fact that the UN systems successfully mobilises very large sums of money and successfully meets the accountability requirements of its donors, including the specific donor noted above.

All things considered, while CAREC may feel constrained by the rules and regulations of PAHO, from our perspective the main issue for CAREC is its inability to redeploy resources to address areas of crucial shortfalls given the inadequacy of its core budget to meet the demand. Many donor-supported organisations are in a similar position and who not would hope for more autonomy in allocating resources to what they see as the priority area for investment? Nevertheless, this situation is creating significant frustration at CAREC. Universalis is equally cognisant that many donor-supported programmatic initiatives place unanticipated administrative and managerial burdens on organisations like CAREC. The degree of the robustness of their "core" in many ways determines the extent to which the new donor programmes may impact negatively on the organisation.

Universalis is of the opinion that, given the size and capacity of CAREC current management team, CAREC faces some programming and administrative challenges in attempting to address both core and donor programming within its current resource base.

Financial Management of the CAREC

Core Finding: CAREC has the general capacity to carry out financial management; however it requires a programme of institutional strengthening to address shortcomings identified in internal reviews and audits.

CAREC has a Finance unit within the Administrative Division, which works in an integrated fashion with PAHO/HQ, is responsible for all organisational financial and accounting transactions. CAREC's financial management and decision-making capacities however are not sufficiently robust or consistent at this time. Consecutive audits and the findings of two internal reviews (2001 and 2003) have identified gaps in the ability of the CAREC to both plan and subsequently manage its financial resources to generally agreed upon international standards.

At this time, PAHO has instituted some additional oversight measures with respect to financial reporting so as to ensure overall consistency, as well as enable CAREC's internal staff and managers to build the needed capacity.

Universalialia wishes to point out that senior PAHO informants stressed that CAREC had made significant progress over the last two years in rectifying many of the shortfalls from agreed upon international standards. These informants confirmed that should the pace of the capacity building be sustained, it is planned that the additional oversight measures will be withdrawn in 2006.

In terms of financial planning, at this time CAREC does not possess a financial system able to effectively track unit costs or to prepare cost benefit analyses, although there has been some service costing for the Laboratory Division. There is also a need for some improved capacity to organise the financial data to 'profile' patterns over time and to clearly present and link the financial picture to strategy, functions and sources.

Management of Programmes and Services

Core Finding: CAREC demonstrates a good capacity to develop operational plans, however there are at times apparent 'gaps' in the process as it relates to overall strategic planning and ensuring a more integrated approach involving those affected by change.

A review of many reports illustrates CAREC's capacity to produce reliable plans and associated tools for project implementation, including logical framework analyses for both the organisation as a whole and in specific programme areas. However, as noted earlier, CAREC does not have an overall strategic plan to guide its development in a coordinated fashion. There also is evidence to suggest that planning processes would benefit from approaches that are more organisationally integrated and facilitate more inclusiveness and input from staff in all areas of the organisation, as planning teams.

Scientific, Information, Communications Technologies

Core Finding: The technical work of CAREC is very well supported by qualified staff, governance and advisory input, extensive generally serviceable physical facilities, and through significant application of its information and communications technologies to enhance productivity.

CAREC scientific and professional capacity is generally well supported inside the organisation by qualified staff and outside through the participation of the Scientific Advisors, although resource constraints and compensation levels influence capacity to recruit and retain staff.

The CAREC complex, although extensive, is in need of renewal. It includes mid-level security laboratories and a variety of specialised units, such as an experimental mosquito colony, and a training laboratory. Mortality, communicable disease and other epidemiological databases are maintained on site. The CAREC laboratories and equipment are generally up to standard, but there is a need to modernize and upgrade in-house technology. As well, capacity building in external labs will support CAREC potential to carry out programmes. A new Molecular Biology lab is planned for construction, as part of CAREC's support to the HIV/AIDS programme.

CAREC's internal data and information management systems are very good, within constraints. CAREC maintains the appropriate policies to manage the volume of information it acquires and disseminates. However staff shortages in these key managerial and administrative areas tend to hamper maximum utilisation. In terms of its information technologies, CAREC's has been highly creative and although it does not possess a fully stand-alone data network, it ably utilises new technologies and is proactive in planning for their future exploitation.

Linkages Among RHIs

Core Finding: CAREC relations with RHIs are infrequent and largely programmatic, with the exception of the CHRC.

CAREC's close relations with CHRC are predicated by the CAREC Multilateral agreement, which incorporates as part of CAREC functions the mandate to collaborate closely with CHRC, and accordingly, the CHRC Scientific Director is automatically a member of the CAREC governing Council, and participates in annual Council meetings. CAREC also has been linked to CHRC in a number of programmatic ways, with HIV/AIDS and drug abuse matters being recent examples.

While CHRC (also located in Trinidad and Tobago and closely linked over time with UWI) has had a seat on the CAREC Council, other RHIs that have vastly larger programmatic activities do not, including CAREC's sister specialised centre, CFNI. Other than their collective involvement in gatherings such as the CARICOM Ministers of Health Annual Meeting, or any other others that might bring all five RHI Directors together for other purpose, there is no formal mechanism to date for collaboration of the RHIs. However, for the period 1999-2001, the then Programme Manager Health at CARICOM organised periodic meetings of the Directors of the five RHIs.

At this time the level of inter-RHI cooperation related to CAREC is limited to programmatic cooperation in specific areas; for example (but not limited to), with CFNI specifically in the in the area of surveillance, sharing of mortality data and dietary/fat availability data and in terms of a project to develop a nutrition manual for persons living with HIV/AIDS. There has also been collaboration with CEHI on a human health and climate change project, and discussions on how to integrate environmental indices with epidemiological surveillance data; and collaboration related to CAREC's Quality Tourism for the Caribbean (QTC) project.

What may be more important, however, than instances of programmatic cooperation is the apparent absence of any means of harmonising resource mobilisation efforts, integrating complementary programming, joint planning and the absence of other RHIs from CAREC governing and advisory bodies. Universalialia, in the synthesis report, therefore concludes that RHIs as a whole do not constitute a coordinated network. Rather they presently are five separate bodies that on occasion appear to have working relationships.

Physical Infrastructure

Core Finding: The current facilities are in serious need of attention and renewal through a combination of renovation and new construction, where appropriate.

From our perspective, CAREC's physical plant either needs to be replaced or substantially renovated. Site visits, review of facilities plans and interviews confirmed firsthand many of the physical problems and awkwardness, such as the presence of freezers in a relatively open air facility, subject at times to significant external temperatures, putting samples at risk. Facility renovations and upgrades are necessary to meet changing programme needs and emerging technologies as well as emerging new diseases so that a safe and functional workplace is present, and to support CAREC's capacity to meet increasingly complex regional and member country needs.

The laboratory area is a particular concern, and its current limitations are described in detail in the full assessment report of CAREC.

Human Resources

Core Finding: Akin to the situation with respect to financial management, while CAREC's human resource management systems (and their application) are generally appropriate for an organisation of its size, they are hampered by resource limitations and the need for some degree of institutional strengthening to improve their consistency.

As a PAHO-specialised centre and thus part of the overall UN system, CAREC possess a dual system of human resource management - one for the few remaining international staff who occupy a handful of senior professional and managerial positions, and one of nearly 95% of staff, including many managers who are retained via the CAREC Staff Rules. While some informants contend that the duality causes problems, it should be noted that only 8 staff (including the Director) are PAHO international staff. Thus, the relative impact of the duality needs to be kept in mind when considering its actual significance.

It should be noted that the differential in retirement and severance benefits between PAHO and CAREC-engaged staff is considerable, with CAREC staff not benefiting from a vested pension plan and having shorter employment tenure. However, two mitigating factors may need to be considered in reviewing differential such as these in benefits.

First, the CAREC situation is mirrored worldwide, given that it is a fundamental characteristic of UN system bodies. Secondly, and probably more importantly for CAREC, the concept of vested pension, extended employment tenure and similar benefits implies a consistency and long-term predictability of an adequate basis of resources. In CAREC's case as it has come to rely for a majority of its funding on external, time limited and project-driven funding, the concepts of a vested pension or extended employee tenure would imply the assumption of a great deal of long-term financial risk.

What may be equally if not more important for CAREC is the fact that due to core budget restraint, staff salaries for the vast majority of locally engaged employees are not even at the CARICOM levels, thus increasing pressure on CAREC and making it harder to secure qualified personnel. Moreover, CAREC, like all Caribbean public sector institutions faces increasing competition from regional private sector employers and from those outside the region for the highly qualified personnel CAREC requires to undertake its work.

CAREC has made major strides in improving the relative proportion of professionals and managers it directly engages; and also improving the level of their qualifications.

The human resources management infrastructure for the employees engaged by CAREC directly is governed by the CAREC Staff Rules, which are approved by the CAREC Council and the Director of PAHO/WHO. While they mirror PAHO procedures in many ways, they are unique to CAREC. Although CAREC possesses a separate human resources management unit with a separate manager (as would be expected of an organisation with some 140 employees) recent internal reviews have highlighted some inconsistencies in the application of the CAREC staff rules with respect to the employees engaged through the CAREC Staff Rules; and also the need to clarify some present ambiguities with respect to the scope of managerial discretion with respect to their application. CAREC and PAHO at this time are working closely to develop a new set of CAREC Staff Rules that will serve to refresh the human resources management environment for some 95% of CAREC's staff. In addition, CAREC itself has taken steps to address some of the inconsistencies identified in internal reviews.

4.5.6 Specific Recommendations

In general CAREC is generally well respected and recognised for its work as the region's predominant public health resource. In spite of constraints in the core budget over time, CAREC has evolved and matured as an organisation, delivering programmes and services that fit with its broad public health mandate. It must be noted, however, that many informants question whether CAREC is actually performing its "core" functions. The following recommendations are offered with a view to improving CAREC's performance.

Recommendation 1: Clarifying and Rationalising the Core Mandate of CAREC

In order to ensure its long-term relevance and meet the overall needs of the region, CAREC may wish to establish a "core mission" Task Force whose broad mandate will be to articulate the nature of what the "owners" of CAREC, namely the Caribbean member states, perceive as core services.

This Task Force would also clarify roles and responsibilities of CAREC, other RHIs and PAHO entities in the region. A third task of this Task Force would be to initiate the development of a comprehensive medium-to-long term strategic plan for CAREC. Universalialia is cognisant that the CAREC Council set up a sub-committee to prepare for the renewal of the Multilateral Agreement. To that end, Universalialia is of the view that this sub-committee may wish to expand its scope to specifically address the mandate issues.

Recommendation 2: Clarifying and Strengthening CAREC's Core Base of Financial Support

To complement the review of CAREC's core mandate, and ensure long term sustainability of the organisation, the CAREC Council may wish to include the responsibility to review the nature and adequacy of CAREC's core financing arrangements in the terms of reference as noted above. This would also ensure an appropriate balance of revenues secured from diverse sources ranging from donor and PAHO support to fee-for-service and cost recovery activities.

Caribbean nations face considerable fiscal pressures with respect to the support for their regional institutions as whole, and for RHIs and CAREC in particular. It is for this reason that Universalialia believes that core mandate and core financing must be considered as two parts of the same question.

An examination of bilateral and multilateral donor support to the Caribbean shows substantial relative decline in overall donor support for the region, largely due to donors placing their priorities in other areas of the world, a trend not likely to change in the foreseeable future. Universalialia further notes that patterns of donor support are becoming more project-specific; shifting away from core activities.

Recommendation 3: Renewing and Strengthening CAREC's Governing Bodies

Caribbean member states may wish to use a task force comprising CAREC, PAHO, UWI and the CARICOM Secretariat to explore the renewal of CAREC's governing arms so that the decision-making role of the Council and the Scientific Advisory Committee can be strengthened. In addition this renewal will provide for intercessional governance and input, placing the responsibility for decision-making in the hands of member state representatives.

To address the inadequacy of CAREC's governing arms in sufficiently engaging Caribbean member states, Universalialia recommends that:

- Measures should be taken by member states to increase their overall representation on the CAREC Council from some six to at least twelve.
- CEHI and CFNI should join the CAREC Council as members.
- A six-person executive committee should be drawn from the CAREC Council. This Executive Committee could comprise the Chair of CAREC Council, PAHO, a representative of CARICOM, and three additional representatives drawn from member states, including a fixed seat for a representative from the host nation. In order to provide on-going high-level governance, quarterly sessions of the Executive Committee might be contemplated.
- SAC should be expanded by at least five additional regional members and that SAC's composition be explicitly expanded to include RHI representatives as members.
- The membership criteria of SAC should be expanded to include others involved in health administration and policy development (for example Permanent Secretaries).
- Consideration should be given to explicitly recruiting non-voting SAC membership from major donor organisations and from major international partner bodies so as to broaden the ability of SAC to provide full advisory functions to CAREC's Council and its Director.
- SAC rules and procedures be expanded to explicitly provide for ad hoc committees, task forces, etc. that could also include observer-status representatives.
- The Task Force explore clarifying the Multilateral Agreement to remove perceived irritants such as the requirement to secure the approval of the Director of PAHO (even if only pro-forma) for special meetings of SAC. In addition, the Task Force might also wish to review and clarify any ambiguities relative to the relationship between PAHO, its Director, the Director of CAREC and the CAREC Council. In addition, duties of the Executive Committee would need to be articulated so that the committee can act as a continuing decision-making body, and empower it to be a performance review mechanism for CAREC.

Recommendation 4: Strengthening CAREC's planning and management capacities

Consideration might be given to CAREC working with PAHO and the CARICOM Secretariat to seek donor support for a comprehensive programme of institutional strengthening which would enable CAREC to strengthen its internal planning, and management capacities.

Rapid growth in donor-supported programming has placed strong pressure on CAREC staff and managers, as well as on their ability to balance inadequate resources for core programming. Audits, internal reviews and evaluations conducted by donors all point to the need for a comprehensive approach to organisational renewal and capacity building. Yet, CAREC has made marked progress in addressing some of these issues, and has itself developed proposals for an institutional strengthening programme. From our perspective such a programme should be linked to the suggested Mission/Financing review.

Recommendation 5: Strengthening strategic planning and organisational performance assessment capacity in particular

As part of what would likely be a multi-year approach to institutional strengthening, special consideration might be given to strengthening CAREC's corporate planning and corresponding organisational performance assessment

Universalialia clearly recognises that CAREC has the ability, with certain reservations, to comply with donor requirements for project planning and project-based performance assessment as part of the overall terms and conditions of specifically funded projects. However, it is evident that CAREC as a whole could benefit from additional emphasis being placed on corporate services such as strategic planning and organisational performance assessment

Recommendation 6: Adding a Chief Operation Officer (COO) to the management team

Consideration may be given to developing a job description and articulating managerial capacities for a new position of Chief Operating Officer of CAREC, to serve as the Director's primary assistant.

Although CAREC presently benefits from the recent appointment of an experienced international PAHO professional to the position of Administrator, the challenges inherent in institutional strengthening and managerial capacity-building, maintaining and refreshing institutional and managerial capacity leads Universalialia to the conclusion that the management team requires additional depth and capacity.

Recommendation 7: Strengthening Linkage to Member Countries

As part of a refreshed strategic planning process CAREC may consider developing a formalised approach to regional consultation and formalised mechanisms for ascertaining the levels of satisfaction among member states.

CAREC may wish to develop a formal cyclical approach to ascertain the needs of member countries and correspondingly their level of overall satisfaction with CAREC's services. Such a process could be linked to the development of a multi-year strategic planning process that would be linked to several successive bienniums, as is done by many other UN-system bodies.

Consideration might also be given to engaging COHSOD in the approval of strategic plans and cyclical updates in addition to the traditional COHSOD annual budgetary approval process.

Recommendation 8: Renewing CAREC's Physical Plant

Urgent consideration might be given to developing a comprehensive multi-year plan for the renewal of CAREC's physical plant, which is generally recognised as be sub-standard at this time.

Universalialia recommends that a study team be established comprising PAHO, the CARICOM Secretariat, CDB, CAREC, the Government of Trinidad and Tobago and other relevant parties to examine the range of possibilities for the renewal of the plant. The roles and responsibilities of the host nation of Trinidad and Tobago would need to be clarified with respect to the renewal of the physical plant.

Recommendation 9: Renewing the Multilateral Agreement

Independent of any larger approaches to RHI rationalisation, Universalia recommends that the CAREC Multilateral and Bilateral Agreements be renewed between Member States and PAHO with special emphasis being placed on:

- Refreshing the composition and mandate of the CAREC Council and the Scientific Advisory Committee as set down in Part 4, Articles 3&4 of the current Multilateral Agreement.
- Strengthening reporting requirements to the Council and to SAC as is set down currently in Part 3, Article 1.
- Reviewing the specification of the basic mandate of CAREC so as to more closely align it with what a core mandate task force may suggest. This would imply revisiting Part 2, Articles 1-15 and Part 3, Articles 1&2.
- Amending the renewal formula with the agreements so as to permit more flexible renewal procedures and not to be limited by a prescribed cycle as set down currently in the General provisions, Articles 1 & 2.

Universalia also recommends that CAREC and PAHO enter into a discussion to seek to expand the level of financial and human resource management delegation afforded by the Director of PAHO/WHO to the Director of CAREC, subject to CAREC having demonstrated the capacity to exercise such delegation.

Universalia has not proposed a fundamental alteration of the basic governance paradigm of CAREC and specifically that related to the PAHO managerial and administrative roles. Instead, Universalia is of the opinion that senior regional decision-makers may wish to make short-to-medium term alterations to the Multilateral Agreement to strengthen their own governance roles, to clarify the overall mandate and to strengthen reporting relationships while awaiting the decision on the shape of a comprehensive review of RHIs in general.

Assuming senior regional decision-makers agree to an approach to fundamental RHI rationalisation in the future, the mandate, structure and governance of CAREC is likely to differ from what it is today. However, it is likely that such a process of overall RHI rationalisation may require a minimum of several years to come to fruition. Thus, the upcoming renewal of the CAREC agreements might be best seen as a transitional step, and not an end in itself, enabling CAREC to continue strengthening its role as the prime regional instrument for technical cooperation in public health.

Turning to the issue of delegation of authority from the Director of PAHO/WHO to the Director of CAREC, Universalia notes the extent to which CAREC informants have suggested that CAREC secure additional flexibility with respect to operational management. Universalia is of the opinion that given CAREC's size, it may require a degree of managerial flexibility in excess of what it currently possesses, especially with respect to financial management. However, Universalia also notes that at this time CAREC's management capacities are strained at this time and that, as recommended above, CAREC would benefit from a programme of institutional strengthening focused on the strengthening of management capacities. The institutional strengthening initiative is likely to better identify areas where CAREC could profit from greater delegation. For this reason, Universalia believes that altering the delegation to the Director of CAREC should follow the successful implementation of such an institutional strengthening.

5. Cross-Cutting Regional Issues Affecting RHI Performance, and the Role and Capacity of the CARICOM Secretariat

In addition to conducting a review of each of the five RHIs, our Terms of Reference call for an examination of the institutional framework in order to determine appropriate organisations through which technical cooperation in health at the regional level will be pursued (rationalisation plan). The TORs also require an assessment of the CARICOM Secretariat's capacity to monitor, provide oversight and coordinate the operations of the RHIs.

In reviewing the five RHIs, a number of cross-cutting issues emerged that significantly impact upon the ability of the five RHIs and other bodies to support regional cooperation in health. It is therefore important to consider and to address these issues prior to developing approaches for the rationalisation of the RHIs to promote enhanced technical cooperation in health.

Links between the strategies of the RHIs and the CCH-2 strategy

The Caribbean Cooperation in Health, Phase 2 (CCH-2) is a regional strategy for health that articulates a common vision and specific objectives for the region. Several actors, including the RHIs, are involved in implementing the objectives of the CCH-2. In the rationalisation of institutions, or in any review of internal arrangements to best serve technical cooperation on health, the RHIs must be viewed individually as well as collectively in relation to their role(s) or contribution(s) to CCH-2.

Governance Relationship between the RHIs and CARICOM

In order to assess the CARICOM Secretariat's monitoring and evaluation capacities as well as engage in developing a rationalisation plan for the five institutes, it is necessary to have an over-arching entity with decision-making rights and responsibilities for the groups or organisations that are being rationalised. In this situation, however, the role of CARICOM in the decision-making of the various institutes is unclear. The RHIs all have different governance systems – with the two largest being PAHO-specialised centres (CFNI and CAREC).

The Regional Role of PAHO

The Pan-American Health Organisation (PAHO) is significantly involved in health in the wider region (Latin America and Caribbean) and, as a result, any rationalisation plan needs to include PAHO. As noted earlier in this Report, the formal Terms of Reference did not envision a comprehensive review of PAHO's work in the region. However, it became apparent that developing a rationalisation plan would require some discussion of the impact of PAHO.

5.1 The Assessment of Factors

One of the most important tasks of this evaluation was to assess the overall capacities of RHIs to meet regional needs for technical cooperation in public health. Earlier in this report, environment factors were described, providing a basic context in which regional technical cooperation in public health operates and the challenges to such cooperation.

In its review of the five separate RHIs and its environmental scan, Universalialia observed a series of cross-cutting factors that characterise the overall performance of the RHIs. Five basic factors emerge as the prime determinants on which to assess current overall RHI performance and contemplate eventual approaches to RHI rationalisation, the key requirement for the entire evaluation process.

These factors are:

- The nature of the core mandate of RHIs
- The nature of regional (and other) resources available to RHIs to sustain both core programming and also to support new activities
- The nature of the governance systems of RHIs
- The organisational and managerial structures of RHIs
- The nature of RHI accountability and reporting systems

Core Mandates

It is extremely difficult for an organisation to perform effectively if it, and its stakeholders, do not have a mutually sound understanding of what its core functions are, and also be able to differentiate between core services and those supported by others. For RHIs, this issue is compounded by the fact that at this time all five RHIs are structured and operate as individual entities, and not as noted earlier, in any form of a harmonised network.

Financial Viability

The stakeholders and decision-makers of an organisation have a responsibility to ensure that the organisation in question provides its beneficiaries with a range of services that are based on a solid financial foundation. For RHIs, this implies, a combination of core support, donor support and recourse to, market-driven forces.

Ensuring financial viability is inextricably linked to the determination of core mandate. These factors lead to the question: What do we perceive as the set of basic functions required, and how will we ensure their sustainability?

Universalialia is of the view that the inter-relationship between core mandate and the means of sustaining core functions has been one of the greatest challenges facing the Caribbean region with respect to technical cooperation on public health.

Governance Systems

For an organisation to serve its beneficiaries, it is necessary that the beneficiaries have the means of assessing its performance and taking decisions relative to its programming directions. As noted above, this level of responsive governance has been considered an essential public health function with respect to the national health systems of the Caribbean.

Given the fact that the beneficiaries of the RHIs are national health administrations and thus national governments, it is essential that RHI governance systems empower senior decision-maker to have access to performance data and to be able to play an active role in determining the nature of technical cooperation in public health, the “prime product” of virtually every RHI. It is also important that the decision-makers should include all relevant partners and should be up-to-date on issues.

Organisational and Managerial Structures

Organisations need to function internally in the most efficient and effective way in order to translate the resources at their disposal to programming for beneficiaries. With respect this evaluation, the use of human resources and planning systems may be the most relevant organisational and managerial function that can impact the overall RHI performance.

Accountability and Reporting Systems

The decision-makers of organisations need access to a wide range in order to make informed choices. Contemporary public sector modernisation emphasises that decision-makers need to address not only “the balance sheet” and the list of activities undertaken. In addition, they need to assess organisational activities in light of a key question: Did the programming we conducted contribute to the attainment of improvements in the capacities or the conditions of our beneficiaries? This question is also the philosophical core of results-based management – not what we did, and at what cost; but what difference did we make.

It is essential that modern organisations provide their decision-makers with information on the impact of programming, implying the requirement for viable approaches to monitoring and evaluation. Likewise, decision-makers also need to be able to access organisational performance information and corresponding planning instruments in a predictable and “ready to use” format.

When clustered together these five factors tend to produce the effect of “the whole is greater than the sum of the parts” relationship wherein the strengths of one factor can contribute to another.). However, the opposite is also true – the weakness of one can undermine the viability of another.

Thus, Universalialia stresses that regional decision-makers consider these five factors with respect to overall RHI performance as a unitary set, and not as stand-alone benchmarks for performance.

5.1.1 Core Mandates

Finding 1: The basic functions performed by the Caribbean RHIs are relevant to the needs of the region

On conducting an overall assessment of the relationship between RHI functions and the essential public health challenges facing the region, Universalialia came to the conclusion that the basic set of RHI functions was relevant to the region’s needs. For example, the general work of one of the smallest of the RHIs, the CHRC is central to the region addressing its limited capacity in health research activities – one of the eleven essential public health functions. With respect to RHI rationalisation, challenges need to be viewed not in terms of the number of RHIs, which can be eliminated due to their not being relevant but how to ensure that RHI activities effectively meet core needs.

Finding 2: Caribbean senior decision-makers, including PAHO senior decision makers, have not undertaken a zero-based budget / fundamental programme review of the core mandates of Caribbean regional health institutions to match a realistic set of agreed-upon core services with sustainable and predictable revenue sources

While the CCH exercise has set out two successive sets of regional health priorities; and while RHIs, to varying degrees, mount programming in support of CCH goals, Caribbean senior decision-makers do not seem to have addressed the fundamental sustainability challenges facing the five RHIs.

To some extent the fragmented governance of the five RHIs and the weakness of the CARICOM Secretariat appear to have contributed to the current situation. In terms of governance links, some organisations like CEHI have very close links to Caribbean ministers, while other like CFNI and CAREC (PAHO-specialised centres) have looser links to senior Caribbean ministers.

Finding 3: RHI mandates generally are not prescriptive and are sufficiently permissive so as to enable individual RHIs to have a wide latitude with respect to the articulation of programming in support of their mandate.

Individual institutions are planning and delivering programming either funded from core resources, donor/lender-financed or supported by various means of cost recovery. Universalia's team did not find any clear instances of an RHI actually delivering programming that could not be construed to be part of its overall mandate.

However, among stakeholders, there was a wide variance of opinions about RHI mandates in general and a fairly significant degree of different opinions that some were "not addressing their core functions." This was especially the case with respect to CAREC. Stakeholders however, when questioned about this sort of assertion, tended to remark that their perception of core functions tended to be what they thought the core mandate for the RHI should be, and not necessarily what is actually is.

The implications for the desired rationalisation of the above core finding relates to the interplay between permissive RHI mandates, the nature of the strategic planning processes that RHIs undertake and the overall level of funding that can be expected to be raised from the three primary sources – member state quota, donor funding and market-driven funding. While mandates require a degree of flexibility so as to ensure continued relevance in the face of change, the current approach (which is generally not balanced by sensitive business planning) may result in RHIs facing mandate expectations that cannot be fulfilled within present resource levels.

The determination of a core mandate for regional institutions that provide technical cooperation to their members needs to lie with the members themselves. The purpose of organisations like RHIs is to serve member states so it is essential that member states be the driving force in determining what they consider to be the core, or essential, services that RHIs provide.

Finding 4: With the exception of CRDTL, RHIs utilise a variety of strategic planning processes to ascertain the nature of programming in support of their largely permissive mandates. However such processes tend not to be replicated with sufficient regularity or sufficient rigour so as to enable sensitive prioritization of efforts in relation to the availability of resources.

All RHIs at the time of data collection, with the exception of CDRTL had in place a variety of means of refreshing their programme base by means of strategic planning processes. Some, like had two-step mechanisms like CFNI – multi-year plans combined with annual rolling reviews (needs assessments); while others, like CEHI have developed multi-year plans that do not include formalise rolling reviews. None share common techniques.

Organisational Assessment of RHI - Overall Evaluation Report

During on-site missions, some senior RHI managers remarked that their RHI had not refreshed its Strategic Plan/ Business Plan in anticipation of the findings of this review. However, it should be emphasised that this very evaluation has been in preparation for in excess of five years. Thus, some RHIs may have delayed substantive planning for a long time and may have hampered their ability to address emerging issues.

With the exception of CEHI, RHIs have not invested, or have not been able to attract external resources to invest, in comprehensive “ground up” strategic planning processes. Like many organisations in developing countries that attempt to conduct strategic planning, they tend to utilise incremental approaches to planning. It does not appear that RHIs in general have absorbed the fundamental principles of overarching programme review which has become a cornerstone of public sector modernisation worldwide, and its core determining factors, which in most instances address the following questions in relation to the determination of mandate and related programming:

- Does the programme area or activity continue to serve the public good?
- Is there a legitimate and necessary role for the organisation in this programme area?
- Is the role of the organisation appropriate, or is the programme area more appropriately the task of another body?
- Can any of the programme area (or its activities) be transferred to others?
- If the programme area is to be continued, how can its efficiency be improved?
- Can the programme area be afforded within the resources that are likely to be available to the organisation throughout the planning period in question?

Questions such as these are contrasted with needs assessment processes that result in a business / strategic planning environment that balances between needs, capacities, resources and potential impacts. Generally, RHIs have not engaged in such primary processes.

In the last five years one RHI, CEHI, has undertake such a 360-degree process as part of its institutional strengthening programme supported by the GTZ. CEHI’s “Strategic Business Plan” embodies most of the characteristics of sensitive strategic planning. Yet, as CEHI managers admit, with the 2002 conclusion of the GTZ programme, CEHI itself now lacks the resources to refresh its now five-year-old plan.

The implications of this general lack of planning capacity has been to increase the risk that programming becomes fragmented and marginalised due to the lack of 360 degree perspective in both needs and resources. Equally, the limited planning infrastructure of RHIs is susceptible to the problem of trying to meet every expectation, and thus diverting the focus of an organisation

5.1.2 Financial Viability

The assessment of financial viability with respect to the overall evaluation of the five RHIs has three primary dimensions.

- Are sufficient regional resources currently available to support what is generally considered to be core programming?
- What means have been put in place to ensure long-term access to the resources needed?
- What are the various mechanisms in place or those needed to secure new external resources to meet new demands / priorities?

The financial viability of most RHIs, both in the short and longer-term context is highly dependent on the payment by Member States and (in the case of CAREC and CFN by PAHO) what amounts to *core funding*. As a general principle, *core funding* is defined as those resources required to plan, administer an organisation, as well as deliver a primary set of services that are deemed to be the “core” of the work programme.

It should be made clear that for the most part, donors do not usually support the core activities of organisations and in line with global best practices, donors and lenders such as other elements of the UN system, the World Bank and other development banks, and bilateral donors such as GTZ, USAID, CIDA and DfID do not make a common practice of supporting what is generally considered to be the core activities of organisations like the five Caribbean RHIs.

A third revenue-generating alternative is a combination of user-fees and fees for services rendered. Within the context of the review of the Caribbean RHIs, it can generally be referred to as *cost recovery*.

Finding 5: RHIs at this time do not possess sufficient core financial resources to undertake their acknowledged core functions.

During the early stage of the review it became evident that the core funding provided by member states and by PAHO was generally insufficient for RHIs to be able to undertake their primary responsibilities.

First, decisions taken by Caribbean ministers in the late 1990s to effectively freeze the theoretical level of member state contributions to RHIs results in a growing gap between the level of quota contribution and the amount of resources required to deliver basic programming and services. Member state core contributions have not been able to meet core financial sufficiency for a while and it does not appear that RHI senior decision-makers at the managerial and the governance levels, have seriously examined the relationship between programme expectations on one hand, and the availability of resources on the other.

Analysis of RHI records for the past 5-6 years shows a consistent pattern of significant shortfalls in the payment of quota contribution to RHIs, individually and collectively and there is no system in place to forecast quota payments or to even coordinate them. The regional formula to assess quota contributions, because it is based on the population of member states, results in two states, Jamaica, and Trinidad and Tobago being responsible for upwards of two thirds of all payments.

For the two PAHO-specialised centres, the failure to pay quota has very little direct impact due to the fact that PAHO procedures advance to CAREC and CFNI in the range of 90+% of estimated quota at the start of the year, with PAHO then assuming the liability for non-payment.

Thus non-payment has a direct and negative impact on the remaining RHIs. Given their small budgets, such a shortfall can have considerable impact if not off-set by mobilising resources from two other primary sources: donors or the market. Examination of records shows that on average, member states pay the environs of 70% of their total theoretical quota contributions, with collective arrears growing steadily each year, notwithstanding the efforts of some nations to redress their individual arrears.

Anomalies also arise with some member states paying “their quota”, or some of it in arrears, to some RHIs and not to others, thus weakening the perception of the RHIs as regional networks and resources; and increasing the propensity to see RHIs as stand-alone organisations operating in bilateral relationships.

PAHO's contribution has also reduced by approximately one third over the last five years and with the overall unpredictability of quota contributions from member states has produced a series of diverse but related negative impacts on RHIs as a whole in the ability to provide even a modicum of effective service delivery.

Any approach to the rationalisation of regional technical cooperation in health must address both how quota is paid, as well as how it is used. It is not reasonable to assume that PAHO will continue to subsidise Caribbean nations with respect to CAREC and CFNI, given the size of the combined outstanding debt (approximately \$5.4 million). Indeed, any consideration of severing ties with PAHO, as some have espoused, would have to address the fact that PAHO has carried a substantial liability for Caribbean nations as a whole, and several in particular.

Finding 6: Some RHIs have to varying degrees engaged in successful resource mobilisation campaigns with donors/lenders that have expanded the scope of RHI programming.

The second major revenue source open to RHIs relates to funding received from donors/lender to conduct specific programming. This is what is generally referred to, within the context of RHIs as *resource mobilisation*.

The resource mobilisation activities of several RHIs, most notably CAREC and CEHI have resulted in significant expansion of programming activities, supported by external resources and the situation where a majority of overall funding (or a near majority) is derived from external sources.

CFNI also has embarked on resource mobilisation and has made significant strides over the last few years. CHRC has begun to do so, at this time with a first major project involving an evaluation of an HIV/AIDS initiative. CRDTL, notwithstanding some present initiatives that have arisen since the on-site data collection mission, has not engaged in resource mobilisation.

Programming mounted as a result of resource mobilisation efforts does not generally contemplate cost-recovery efforts for programme delivery. Thus, they can be perceived of as an expansion of overall programming at no direct costs to either PAHO or member states. However, as will be discussed below, some resource mobilisation efforts place additional burdens on limited RHI core resources.

There also is a perception among some stakeholders that resource mobilisation efforts with donors results in some RHIs moving toward programming that complies with donor agendas and not necessarily those of the region as articulated in CCH-2, or not necessarily harmonious with what stakeholders perceive to be the core business of the RHI. This perception seems to be fuelled by a parallel view that accessibility to core programming may suffer due to concentration on these new initiatives.

In CFNI's and CEHI's case, the strategic / business planning systems of both result in new programming supported by resource mobilisation efforts that, in the vast majority of cases complements the basic, albeit largely permissive, mandate of the organisation, or its articulated strategic goals / priorities. In CAREC's case, given the somewhat more amorphous mandate of CAREC and its governance paradigm, the nexus between new attracting new donor-supported programming and the prior approval by Caribbean senior decision makers (ministers) of these measures is less certain.

In terms of approaches for rationalisation, the relative success of some RHIs leads to the requirement to ensure that the relatively limited donor base is approached in a coordinated manner and that RHIs may find it useful to better link their efforts. For example, greater degrees of coordination with respect to HIV/AIDS programming might increase impact.

Finding 7: Increased reliance on programming supported by external resource mobilisation efforts results in long-term risks to the viability of some RHIs

As RHIs increase their dependence on external sources of support, they face the inevitable risk that the programming provided for by resource mobilisation may at some point be terminated by the donor/lender. Donor-funded programming is usually limited in duration, albeit in cases where a long-duration has been contemplated by the donor/lender e.g. HIV/AIDS programming which has a 15+ year horizon and thus may be indistinguishable from “core”, or may be *de facto* core activities.

The five Caribbean RHIs presently do not have a sufficiently robust financial core on which to eventually absorb the long-term resourcing of the new donor-supported programming. Likewise the regional decision-making paradigms with respect to health, combined with the decision-making paradigms of some RHIs, do not seem to be sufficiently sensitive to the long-term implications of resource mobilisation on the strategic direction of the RHIs and the level of risk being assumed through the acceptance of externally-supported, but time-limited programming.

Finding 8: RHIs, for the most part have not explored cost-recovery to a sufficient degree as a means of strengthening financial viability

In 1996, a World Bank study came to the following general conclusion that institutions that rely on donor contributions alone (either a grants or soft loans) often are *not* sustainable (Report No. 15185, April 1996). It has been noted that some donors have designed new programming with built-in annual reductions in an effort to ensure local sustainability and non-dependence on external sources.

Among RHIs, only CEHI appears to have actively explored strengthening its financial base by the suggested mix of member state contributions, donor support and cost-recovery for some basic services. Both PAHO-specialised centres, CFNI and CAREC, have the ability to engage in cost recovery, but have only done so in a very modest fashion.

The World Bank report also reflects a new global reality with respect to the funding of public sector organisations - national or multi-lateral. This is a shift from the notion that services provided at no charge to recipients is in support of the public good, towards a planning and decision-making model that factors in market influences and that begins from the premise that programming must be designed with a view towards sustainability.

The impact of these findings on any approach to rationalisation is significant. It should be evident that the basic funding paradigm of the RHIs - PAHO centres or not is not sustainable over the longer term.

Finding 9: While RHIs generally appear to translate the resources at their disposal into programming in fairly efficient ways, some of the mechanisms for programme delivery do not encourage efficiency and economies of scale, given the resource constraints faced by all RHIs.

Universalisa found that RHIs generally have very limited overhead costs and have allocated their resources and staff with a strong and positive bias towards programme delivery. However, some of the mechanisms of programme delivery do not appear to be as efficient as they might be.

For example, RHIs that offer multiple training and capacity building for stakeholders tend to do so on a bilateral basis, and do not generally consider aggregating such training to a sub-regional basis, in essence attempting to generate economies of scale. This “country” focus that some RHIs adopt for such types programming, while responsive to individual needs limits the ability to gain economies of scale.

Thus, any approach to long-term rationalisation will need to take into account ways of improving economies of scale so as to ensure long-term sustainability of RHIs.

5.1.3 Governance

Finding 10: The current governance structure of many RHIs do not sufficiently engage senior Caribbean decision-makers both in terms of accountability, as well as forward planning.

Each RHI has its own governance structure with even the PAHO centres differing from one another. What, however, appears to be common across all RHIs is a general fragmentation of the engagement of senior Caribbean decision-makers at the ministerial level in the RHIs, and, at present, an overall lack of a viable mechanism for any type of cross-RHI governance to be fostered by the CARICOM Secretariat.

Several RHIs continue to operate within the structure of an “Advisory Committee” obviously limited to advisory powers. This approach to governance does not follow contemporary trends in public sector renewal, which highlight enhanced upward transparency of, and accountability to senior decision-makers.

The two PAHO-specialised centres, CAREC and CFNI present contrasts in governance structures. The functions of CFNI’s two advisory committees are fundamentally different in structure, mandate and operation from those of CAREC’s Council and CAREC’s advisory committee.

Given the growing inter-related nature of some of the health challenges facing the region, i.e.: HIV/AIDS more common governance among the PAHO-specialised centres would likely result in more coordinated programming. Again, with respect to longer-term approaches to rationalisation, strengthening the commonality of governance paradigms would tend to combat the divisive effects of considering each RHI as a separate entity.

CEHI’s governance structure presents a sharp contrast to the other four RHIs, with a governance structure that appears to promote the contemporary trends of upward accountability to senior decision-makers and corresponding acceptance by these decision-makers for decisions taken. Examination of CEHI Board of Directors and Financial Sub-Committee records shows a pattern of direct ministerial engagement and ministerial decision-making with respect to major policy and programming decisions.

Finding 11: Current RHI governance paradigms result in uneven access to key stakeholders and tend to limit outreach to the totality of the stakeholder community of the region.

Examination of RHI records points out that the structure of the advisory committees (scientific or technical) of several RHIs limits access to civil society representatives beyond those of post-secondary institutions. Neither private sector nor NGO interests are represented. Given the clearly advisory nature of most of these committees, inclusion of other elements of civil society would not jeopardise actual governance. For example, in one instance a key stakeholder who represents a significant share of the work of an RHI participates only as an “observer” at the annual advisory committee meeting. This limitation in the scope of advisory bodies may in large part be due to the static nature of RHI governance as a whole.

Finding 12: RHI governance paradigms are outdated and, for the most part, have not been refreshed or amended since their inauguration.

One of the causes for some of this shortcoming seems to be an inflexibility within the governance of some RHIs that is caused by the very constituent agreements themselves.

For example, CRDTL, in response to recommendations of an evaluation conducted in the 1980s, attempted to slightly alter its governance structure to improve accountability as recommended by the evaluation. What would have been required was merely an amendment to the founding agreement but the measure appears to have been ignored and no change was made.

Of further significance is the manner in which RHI governance entities currently operate. For the most part, they reflect a very passive and non-engaged approach that focused on transacting (or simply approving) material submitted by RHI management. Given modern technology, there is no reason why advisory committees could not function on a near constant basis, working and advising RHIs on key functional matters throughout the year and not being limited to sporadic face-to-face meetings.

The lack of regional leadership due to the inherent limitations of the CARICOM Secretariat may have some impact on the way RHI governance entities have been engaged. And an additional contributing factor may be the lack of clarity on the governance structure of the two PAHO-specialised centres.

Finding 13: The profiles and resources of RHIs themselves are not sufficiently communicated to senior stakeholders at the ministerial level so as to foster a greater sense of the actual programming of RHIs.

As noted above, a number of regional stakeholders do not seem to have a full understanding of the, mandate, work and financing of RHIs as a whole. This finding, however, must be tempered by the fact that RHIs are operating within budgetary parameters, which severely limit the availability of central management functions such as liaison or communications.

Several RHIs have well-developed relationships at the working level with national colleagues; some of which are formalised. However, most RHI managers reported that many times stakeholder engagement is informal in nature and engagement with more senior decision-makers is less frequent and more transactional in nature.

Of equal importance is the fact that the CARICOM Secretariat does not possess a sufficiently robust liaison and coordinative capacity within the region so as to perform an aggregation role with respect to RHIs.

Finding 14: There is a gap in expectation between what senior Caribbean stakeholders generally perceive as the core functions of RHIs and the need to ensure the sustainability of the RHIs and thus their core functions.

Across the region, Universalia uncovered wide variances in the level of understanding of the programming, structure and financing of RHIs. While such variances were expected to some degree, what may be more relevant is the degree to which many generally do not seem to differentiate between RHI “core functions”, and those programming elements that are supported in whole by external donors.

For example some stakeholders in OECS nations did not seem to know that some of the programming where CEHI has put in place various forms of cost-recovery could not be mounted otherwise due to the limited nature of the “core funding” provided by member states through the quota payments. Some of these stakeholders contrasted the CEHI approach to cost recovery with the “no charge” approach of other providers in the region, showing a lack of understanding on the various funding bases involved.

Stakeholder awareness of RHI mandates as a whole was uneven across the region. Stakeholders generally were not able to articulate what they saw as the “core” of the work of the various RHIs, except for a fairly common view that in some ways RHIs had expanded “core” to the detriment of service delivery

As far as the relationship between donor-supported programming and other RHI activities is concerned, stakeholders generally did not seem to be fully aware of the extensive degree to which donor support for time-limited programming actually made up a majority of the programming of some RHIs, CAREC in particular. While there appears to be a general understanding among senior stakeholders interviewed across the region that quota contribution made up only part of the overall resource pool of RHIs, there did not appear to be a parallel recognition that quota contributions considered in their entirety amounted to less than a third of the overall resources of RHIs.

The effect of this lack of awareness on developing approaches to rationalisation may be profound. RHI rationalisation will require a multi-dimensional approach that cannot be simply reduced to the production of a costs/benefits spread sheet.

5.1.4 Structures and Operations

Finding 15: Given the size of RHIs, there does not appear to be any significant degree of overlap or duplication of administrative or managerial functions

Three of the five RHIs are stand-alone institutions that do not rely on PAHO for administrative management. These three in total comprise less than 50 employees with only CEHI having any real internal management systems or capacities. CRDTL and CHRC in effect do not have internal administrative systems with the latter using UWI systems.

CAREC and CFNI both possess internal administrative, financial and human resource management infrastructures, with CAREC’s obviously being the more sophisticated and largest. Both function within PAHO parameters although human resource management is divided between international and local systems and procedures. In assessing whether there was administrative overlap Universalialia found that CAREC and CFNI had parallel, but different- sized, administrative infrastructures to reflect that CAREC is over four times as large as CFNI.

An argument could be made that CAREC and CFNI could combine administrative infrastructures given their joint reliance on PAHO parameters. However, given the fact that one is located in Trinidad and the other in Jamaica, and that both do not share a common governance structure, very little would be gained by doing so.

Finding 16: The RHIs, while not overlapping each other in terms of administrative and managerial services, could benefit from higher degrees of commonality of internal procedures and practices.

With respect to potential networks of organisations more holistic approaches to the concept of efficiency would take into account the ability to generate cost savings and productivity improvements. RHIs, when taken together, could undertake a number of consolidated measures that would largely have a positive impact on productivity.

For example, with respect to the non-international staff, CAREC and CFNI could agree to develop common HR management systems, including a common classification system that would enable the cross-posting of regional employees in a manner similar to that, which can be undertaken for international staff on a global basis. Given the fact that non-international staff of both, in theory, are to be paid (and thus positions classified) with respect to CARICOM standards, it might also be possible to expand such a system to CEHI. As far as procurement is concerned a shared approach even among the PAHO-specialised centre would have obvious potential for both cost savings and productivity improvements. In short, the historic tendency to view RHIs as stand-alone entities has not been conducive to productivity enhancements.

Finding 17: Member states have various levels of internal capacity to absorb the services of RHIs, leading to differing levels of expectation regarding the focus of RHI programming, and differing demands being placed on RHIs regarding what is perceived as core services.

Since Caribbean nations differ vastly in terms of population and economic performance it is not surprising that the various member states served by the five RHIs have widely differing capacities to make use of their services and programming available to them. While some nations are recipients of E-HIPC support, others are close to being classified among the “developed” nations of the global community.

This has resulted in some respondents from smaller nations perceiving RHIs not so much as agents of technical cooperation, but agents of programme delivery, given their very small domestic public sector capacities. Conversely, a number of respondents from Jamaica, and Trinidad and Tobago remarked that some RHI programming was not relevant to them due to the level of capacity of their domestic agencies.

This variance places RHIs in a difficult situation as far as core services are concerned implying that RHIs need to begin developing more sensitive and flexible ways of designing programming and move away from a “one size fits all” approach since programming vital to some may not be very relevant to others. To achieve this, RHIs will need sufficient resources.

A supplementary finding relative to absorptive capacity relates to the extent to which RHI work is actually transmitted within nations. While this evaluation did not contemplate an impact assessment of the work of RHIs data collected points to the fact the RHI work is not being transmitted beyond the point of initial contact.

Anecdotal evidence gathered in a number of member states pointed to uneven distribution patterns for publications / manuals / reports prepared by RHIs. Recognising differences in absorptive capacity will be required if the rationalisation of RHI mandates and programming is to be of real relevance. Such differences also have an impact of how RHIs plan for long-term sustainability. For example, if a programming component is largely focused on assisting the limited internal capacity of smaller states, questions will naturally arise on the willingness of larger more capable states to support programming they may not need.

Finding 18: The various terms and conditions of employment across the five RHIs tend to impede the efficient and effective utilisation of personnel in individual RHIs.

Given the fact that each RHI was individually established and that two are PAHO specialised centres, it is only reasonable to assume that the human resources management systems of RHIs would differ. It is also important to note that the RHIs, even taken as whole, are relatively small entities. Together all five employ close to 200 persons at all levels and with all forms of employment status. Indeed, four of the five RHIs (CRDTL, CFNI, CHRC and CEHI) together employ in the environs of 60 people combined; with two (CRDTL and CHRC) employing less than ten people each.

Each individual RHI report catalogues the particular human resource management circumstances of the RHI in question. On a comparative note however, one common feature relates to the varying employment terms and conditions such as the distinction between national and international staff. This feature serves to impede the development of individual career development planning, succession planning and even performance appraisal approaches.

At the PAHO-specialised centres, this distinction was considered a disincentive. It should be noted however that the level of international staff at both centres has been falling and continues to do so. Presently, “international” staff comprise about a third of CFNI staff and less than 10% at CAREC. What may be far more important with respect to CFNI and CAREC’s local staff is the fact that differences between the HR systems of the two (for national employees) effectively preclude sharing perpetuating the individuality of each of RHI.

Among the other three RHIs the different levels of employment terms and conditions pose a problem since there are varying employment statuses – CARICOM, local engagement, etc., some with pay scales set to standards of the University of the West Indies.

At CAREC, these differences are further compounded by the fact that some staff members engaged to support donor-financed programming are engaged on the basis of separate terms and conditions, thus resulting in three parallel sets of terms and conditions of employment. This is also likely to also occur at CEHI once the project implementation unit for its new \$14 million and five year Watershed and Coastal Management project is launched.

Given the funding pressures on RHIs, it would not be reasonable to suggest that RHIs have, at this time, the budgetary manoeuvre room to increase salaries to market comparability. Indeed, it needs to be emphasised that the variances between the public and private sectors terms and conditions of employment within the region affect virtually every national public administration unit within the region to differing degrees.

Finding 19: The variances between and within RHIs with respect to terms and conditions of employment impede the ability to attract and retain a critical regional mass of qualified personnel.

What may be more important with respect to the terms and conditions of employment at the three non-PAHO centres (and to some degree the PAHO centres as well) is the lack of commonality across the all RHIs since each is its own employer. Thus, any chance of building a common pool of skilled professional across RHIs is hampered by lack of a common set of human resources management terms and conditions.

It does not seem possible for locally engaged professional to benefit from varying career opportunities at different RHIs. The call to “seek greener pastured” is not counterbalanced by any mechanism to promote the collective use of the admittedly small pool of qualified Caribbean personnel. The rationalisation plan addresses the rationalisation of human resources management so as to build a more sustainable human resources capacity for all RHIs

5.1.5 RHI Ability to Assess Relevance and Report on Performance

One of the most important aspects of the assessment of relevance relates to the ability of organisations to be able to assess their performance in terms of whether it meets the needs of stakeholders and clients, and to subsequently report the findings to senior decision-makers.

Finding 20: RHIs generally do not possess robust systems of monitoring and evaluation, and generally do not have the capacity to conduct impact assessments. The various governance structures of RHIs do not promote upward feedback to senior decision-makers regarding the impact of programming.

The five RHIs do not have the resources to invest in strong monitoring and evaluation systems; and especially those functions that relate to impact assessments of their programming. This issue is compounded by generally weak and transactional governance systems that do not give sufficient consideration to overall performance assessment beyond budgetary review and audit compliance.

In terms of the planning systems used by RHIs, some utilise results-based planning mechanisms to some degree such as logical frameworks to plan activities, while others link what they do to CCH-2 goals, making the assumption that the delivery of the programme results in the desired level of change or improvement in the beneficiary's condition. Others simply do not conduct any impact assessments of their activities and plan without adequate reference to organisational performance.

Even the RHIs that to some extent engage in results-based planning agree that their respective systems of monitoring and evaluation are not sufficiently robust. Examination of procedures and systems point to the fact that internal capacities in the area of monitoring and evaluation are fairly limited due to the overall level of resources available for "core functions" such as planning and evaluation. This also points to the fact that resource mobilisation partners, "donors" frequently conduct their own evaluation of the programming they have supported. This is a widespread practice although contemporary approaches to public sector modernisation espoused by the World Bank, (2000 Strategy for Public Sector Modernisation), Asian Development Bank ("To Serve and Preserve") and others advocate that the strengthening of internal monitoring and evaluation capacities is a pre-condition for effective modern governance, and not an "add-on" to ensure compliance with donor rules.

With respect to reporting performance generally, RHI annual reports to governing bodies (including advisory groups) largely detail the input/output relationship and seek budgetary approval (save for the instances where approval of periodic strategic plans is required). These annual reports appear to constitute the main vehicles for information dissemination to key stakeholders and decision-makers.

RHIs tend to inhibit senior decision-makers (Ministers) from having access to information they require to base critical judgments. While it is unreasonable to expect that Ministers, as individuals, could have the time to review assessment reports if available, at the same time due the weakness of the CARICOM Secretariat, ministers lack the services of a fully functional body which is itself capable of even coordinating the monitoring and evaluation of the RHIs, let alone actually conducting monitoring and evaluation studies itself.

The impacts of this finding on the development of approaches for rationalisation are obvious. First, any rationalisation plan will need to include consideration of a process of institutional strengthening of both RHIs and the CARICOM Secretariat to higher capacity levels with respect to M&E functions. However, in developing any approach to institutional strengthening, care will need to be taken to ensure that the programme of strengthening is itself sustainable and not a one-time intervention that, which like many public sector modernisation efforts world-wide, dissipates once the donor funding ceases.

Finding 21: RHI reporting systems tend to concentrate on an accounting of resources, activities and outputs, and do not adequately address the impact or outcome of programming

RHIs tend to report to stakeholders and decision-makers in very traditional styles – annual reports that combine basic budgetary data with a basic account of what the organisation did over the course of a year. Impact is not addressed to any extent, largely due to the fact that RHIs generally have limited M&E capacities. RHI reporting to decision-makers is also fragmented due to the fact that RHI governance structures are equally fragmented.

Notwithstanding the short presentations made late in the third quarter each year in Washington, senior decision-makers, namely ministers of COHSOD and the CARICOM Secretariat do not have the means of assessing the totality of the work of RHIs. They do not also have the collective practical means of effecting coordinated decision-making. As will be noted in detail in another section of this, the CARICOM Secretariat does not play a robust role in synthesizing RHI reporting and thus facilitating high level and coordinative decision-making at the regional level.

Finding 22: RHIs generally have not established performance benchmarking systems and associated reports to assess organisational performance in terms of the efficiency of the conversion of inputs into programming

The limitations in the strategic planning process of RHIs are translated into how they plan and manage their resources. RHI financial reporting, while generally accurate and transparent, does not go beyond “the basic balance sheet”. The determination of unit costs (especially for repetitive activities and training) is widely considered to be a crucial element in contemporary public sector modernisation. As noted in the individual reports, RHIs do not engage in such benchmarking, with the exception of CAREC’s work regarding laboratory turn-around times.

In terms of developing a comprehensive approach to rationalisation, the absence of benchmarking increases the difficulty for decision-makers to make sensitive resource allocation choices on the basis of the “cost” side of even a basic cost-benefit analysis. Furthermore, to ensure long-term sustainability and to address issues related to the cost of “core” programming (versus that supported by resource mobilisation) rationalisation approaches will have to increase the capacity of RHIs to engage in more comprehensive approaches to organisational performance measurement.

Finding 23: RHIs do not share common planning, budgetary or reporting systems and thus the ability of decision-makers to make cross-comparisons and prioritize is impeded to some degree.

As noted previously in this report, the five RHIs do not constitute a network in the sense of a group of related entities working in concert. Rather, from a management perspective they are five separate entities, albeit two operating within the PAHO managerial paradigm.

Budgets are presented in differing ways to senior Caribbean decision-makers represented by COHSOD or other ministerial decision-making bodies. Reports are equally different in style and content (in this case, even different among the two PAHO-specialised centres).

Planning systems are equally diverse. The two PAHO centres operate within PAHO’s general parameters and utilise basic PAHO planning tools including PAHO’s approach to programme logic. The three other RHIs each utilise their own approaches.

These variance are exacerbated by the fact that many donor-supported programmes require customized reporting systems that are unique to the individual donor; thus placing additional burdens on their constrained base budgets.

5.2 The Capacity of the CARICOM Secretariat

The second part of this evaluation was the task to assess the present capacity of the CARICOM Secretariat to monitor the performance of the five RHIs.

By implication, this task also implies an assessment of whether the CARICOM Secretariat is presently capable of not only monitoring RHI performance, but coordinating activities, planning and serving as an effective secretariat to promoter sensitive and timely ministerial decision making (largely via COHSOD).

The Nassau Declaration of 2001 underscores the importance, which heads of state have placed on health-related issues as regional priorities. Moreover, the emphasis given to health matters in the Millennium Development Goals underscores the global commitment to ensure that health remains a primary focus of sustainable human development. Therefore, it would only be logical to assume that the Caribbean's regional coordinative body, CARICOM, would requires that its Secretariat be capable of performing a variety of task to ensure effective regional coordination.

In general, coordinative organisations like the CARICOM Secretariat perform in essence three generic types of activities. The following table briefly illustrates the range and complexity of these general functions in relation to RHIs

SCOPE / NATURE	TASKS
Facilitating Role	<ul style="list-style-type: none"> • Convening joint meetings • Sharing information
Administrative Role	<ul style="list-style-type: none"> • Insuring plans and reports submitted on time • Monitoring and suggesting rules and procedural changes • Ensuring COSOD decisions are communicated
Strategic Role	<ul style="list-style-type: none"> • Responsible for periodic network-wide organisational performance assessment <ul style="list-style-type: none"> – Strategic and business plans and the monitoring of these plans – Annual work plans and monitoring system – Annual network Results report to COSOD – Provides network-wide advice to regional ministers – Regional fund raising for strategy and business plan

Given the importance of the Secretariat as the region's coordinative body, Universalis's proposal for rationalisation factor in the impact of each of these three levels of roles and accompanying functions.

5.2.1 The Capacity Monitor RHI Performance

Finding 24: At this time, the CARICOM Secretariat does not have the staff or the financial resources to monitor the performance of the five RHIs in an on-going fashion.

The few staff of the CARICOM Secretariat working in the health area at this time face considerable challenges in even attempting to provide basic liaison services (the facilitating role) given the number of regional meetings, workshops and international events that relate to health. As noted earlier in this report, the Secretariat's record keeping systems themselves are inadequate, resulting in the Secretariat having incomplete records of RHI activities. The organisation itself also does not have an internal organisational performance unit that could assist operational staff (such as those involved in health and social development) with the articulation of monitoring and evaluation frameworks.

5.2.2 The Capacity to Plan for, and Advise Caribbean Senior Decision-Makers

Finding 25: The CARICOM Secretariat lacks the resources to assume a comprehensive set of strategic managerial functions with respect to the RHIs

As noted above, the level of resources available for health in general and RHI-related support in particular at the CARICOM Secretariat is limited. The managerial functions implicit should the region's senior political decision-makers wish to strengthen the regional governance of the RHIs exceed the current capacity of the Secretariat (the strategic role).

For example, should regional governance be strengthened, it would be obvious that the Secretariat would have to play a role in developing for senior political decision-makers strategic plans for RHIs as a whole. Universalia earlier noted that one of the factors negatively affecting RHI performance was the fragmentation of RHI governance.

Turning to the question of the ability of the Secretariat to advise ministerial decision-makers (COHSOD and the Council of Health Ministers), a core function if overall governance is to be strengthened, it is apparent that even with its limited resources the Secretariat is capable of providing a basic level of upward advice to ministerial decision-makers. However, given its lack of present capacity to monitor the performance of the RHIs in a systematic fashion (notwithstanding the governance ambiguities noted above), the Secretariat appears to be constrained by not having a full understanding of RHI plans and performance.

Finding 26: There is a lack of clarity surrounding the nature of the roles of the Secretariat in general with respect to the five RHIs

The limited resources and staff effectively preclude more active engagement by the Secretariat. However, what may be more important to underscore is that there does not seem to be a common understanding among CARICOM Secretariat informants and among more senior informants generally when questioned relative to this issues of what "monitoring" would mean, and for what purpose would such monitoring be directed, or to whom the Secretariat would report. There is also no general understanding more active functions related to the possibility of pro-active planning.

Based on data collected within the RHIs and an analysis of the CARICOM Secretariat's present role and responsibility RHI senior managers have mixed views with respect to the nature of any future roles for CARICOM, as do a number of key stakeholders and senior decision-makers.

The dissimilar governance paradigms of the five RHIs results in CARICOM Secretariat as a regional body and its Secretariat playing somewhat different roles in relation to individual RHIs. In particular, CARICOM Secretariat's role with respect to the two PAHO-specialised centres, CAREC and CFNI, with CAREC being the preponderant among all RHIs, is unclear due to the nature of the agreements that established both and the nature of PAHO's role as administrator. Equally importantly, the prevalent paradigm of the transactional once a year encounter with COHSOD that some RHIs operate within is in itself a disincentive to the promotion of a more active role for the Secretariat, even if it had the resources and the staff to become more actively engaged.

5.2.3 The Capacity to Coordinate RHI Activities and Engage Partners

Finding 27: The CARICOM Secretariat has played a limited but valuable role in resource mobilisation activities with new partners; however it does not have a mandate at this time to play an active role in the coordination of RHI programming.

The Secretariat has played a number of roles in a number of recent resource mobilisation programmes conducted by RHI. These roles have included the Secretariat being the formal recipient of donor support, coordinating cross-agency liaison to facilitate the transfer of funds, acting as the agent of record. While these may be seen by some as minor or largely administrative functions, stakeholders noted that CARICOM as a regional entity has a positive international presence and is seen by some donors as the region's voice. This concept - the potential worth of CARICOM (and thus its Secretariat) as a element in resource mobilisation - points to the conclusion that the Secretariat can play a "value-added" role for RHIs and not just play compliance/ reporting / advising senior decision-maker roles.

Due to governance paradigms of the five RHIs, the Secretariat does not have a mandate to play any viable role with respect to the coordination (or monitoring) of RHI programming. Indeed, the general ambiguity with respect to the role of the CARICOM Secretariat vis a vis RHIs may stem from the fact that the various agreements establishing the three "Caribbean" RHIs (even CEHI's revised agreements) do not include any specific provisions that empower either the community at large, or its Secretariat. With respect to the two RHIs which are PAHO-specialised centres, the community through its Secretariat is simply another stakeholder / board member.

What limited power that the community may possess is derived from the inclusion of provisions seeking ministerial approval of budgets with respect to the three RHIs, which are not PAHO-specialised centres.

6. Options for Rationalisation

This section addresses the most important component of the entire process – the development of options for the rationalisation of the RHIs.

Across the region, senior stakeholders were nearly unanimous in indicating that they felt that some degree of rationalisation of the five RHIs was essential if they were to survive as viable institutions for technical cooperation. Stakeholders, however, were far less certain about what kind of rationalisation they envisaged. Indeed, most tended to first discuss structural, as opposed to functional solutions, contradicting the long-standing management maxim that "form should follow function."

Based on the horizontal findings immediately preceding, the predominant health needs of the region and the discussion of essential public health functions cited earlier in this Report, the rationalisation of the five RHIs involves far more than merely a structural reorganisation and a simplistic solution such as: “combine all of them into one.” The interplay between related actors with respect to technical cooperation in health implies that a much more complex set of factors needs to be assessed when contemplating approaches to rationalisation.

Moreover, approaches to rationalisation also need to be mindful of a set of management principles on which to assess the overall benefits/ liabilities of various plans.

The objectives of rationalisation need to be clearly understood.

Simply; Why is rationalisation required?

From the foregoing horizontal findings, it should be sufficiently evident that the current organisational, functional, governance and resourcing paradigms of all RHIs (individually and collectively) are unlikely to respond to emerging challenges and, are not sustainable in their current formats.

It should be made clear at the outset of this discussion on rationalisation that a classic econometric approach to cost-benefit analysis was not part of the Terms of Reference of this evaluation study, nor could it have been possible to conduct one given the scope of the resources allocated to the evaluation. Thus, the rationalisation options have been limited to include an option’s basic implementation costs assessed against the qualitative objectives and principles.

This evaluation concludes with an analysis of the relative merits of all five options and a tabular presentation of their salient features to facilitate cross-comparison.

6.1 The Objectives of Rationalisation

The cumulative impact of the horizontal findings noted above point to seven overarching “reasons” why the five RHIs (and to some extent the work of PAHO within the region as well) would require a process of rationalisation and renewal.

These seven objectives are:

- Strengthen Caribbean resources and institutions to serve the needs of Caribbean people
- Enhance collaborative approaches to programme delivery so as to maximise impact
- Strengthen the internal capacity of RHIs
- Strengthen and rationalise the regional governance of all RHIs
- Enhance the sustainability of RHIs
- Strengthen the ability of RHIs to build national capacity
- Enhance international linkages

6.1.1 Strengthening Caribbean Resources

The overall level of bilateral and multilateral support for Caribbean nations in general has fallen by approximately 50% over the last decade. While the pace of human development has been impressive relative to many contexts with the region, the overall health challenges facing the region's nations remains significant and, unevenly distributed.

For example, some of the Millennium Development Goals such as reducing infant mortality by 50 % or similar levels of reduction in major communicable diseases such as HIV/AIDS have a disproportionate impact on some Caribbean nations in comparison to others due to their respective level of development. The RHIs, when taken together comprise a major resource (along with the work of PAHO) for strengthening the ability of the region not only to build capacity, but also to mobilise and target scarce resources. When taken together, few other resources are as well placed as the RHIs (and PAHO) to strengthen Caribbean domestic health institutions.

In addition, the RHIs, for the most part have developed a variety of means of reaching out to Caribbean stakeholders to reflect Caribbean needs.

6.1.2 Enhance Collaborative Approaches

Given the funding limitations that affect the region as a whole, there is an apparent need for the RHIs and major partners to build new approaches to collaborative efforts since the current level of collaboration among RHIs in particular is not optimal.

Resource mobilisation efforts are not coordinated. Senior regional decision-makers are frequently "out of the decision-making loop" with respect to RHI planning. Data shows that some RHIs seek to maximise their own span of interest and tend to overlap the work of others.

While RHIs state that they work towards attaining CCH-2 objectives, the current low levels of collaboration impedes effective coordination of interrelated health challenges.

6.1.3 Strengthen the Internal Capacity of the RHIs

Virtually all the current RHIs face internal capacity challenges ranging from competing for skilled employees with the private sector, to emerging technological obsolescence. It is very important to stress that the RHIs, taken together comprise in the environs of 200 employees in total (with about 140 in CAREC alone).

Issues of ensuring a critical mass may be more significant than the more obvious possibility of duplication of services. There is very little administrative duplication among the RHIs. However, the fact that all are effectively separate entities impedes collective resource utilisation and planning, and the development of a cross- RHI cadre of qualified personnel.

While some have argued that employment condition differentials between international and local personnel tends to impede effective resource utilisation, given the small percentage of international staff among the RHI workforce, a more telling impediment to strengthening capacity may be the multiplicity of terms of employment for regional personnel.

Any approach to rationalisation also needs to take into account the requirement to strengthen the monitoring and evaluation capacities of RHIs in general. As noted in the horizontal findings, while RHI programming supported by donor/lenders tends to incorporate fairly robust M&E provisions, the core programming of RHIs is far less likely to be the subject of more than financial audit /compliance-based approaches to organisational performance assessment. This in turn results in decision-makers having less than optimal information about the actual impact of RHI activities on which to base strategic decision-making.

6.1.4 Strengthen and Rationalise the Governance of the RHIs

The current governance of the RHIs is one of dissimilar structures most having limited direct governance impact by senior decision-makers. Even the two PAHO-specialised centres differ in governance structure.

This fragmentation of high level engagement is further exacerbated by the limitations of the CARICOM Secretariat, both in its formal mandate vis-à-vis RHIs, and in its practical capacity to monitor, plan, liaise, and coordinate.

The role of a senior decision-makers is somewhat marginal and largely transactional. Generally they do not have an immediate and on-going presence in strategic decision-making, nor have they the means to begin to balance and coordinate resource allocations. This has resulted in their not having a means to consider the collective and individual core mandates of the RHIs and to be in a position to ascertain what level of technical cooperation in health can be afforded by the region.

6.1.5 Enhance the Sustainability of the RHIs

The RHIs, as currently financed, face a resourcing crisis with respect to the support for what is considered to be core programming, which is not supported by donor/lender project specific initiatives.

The challenge is far more non-payment of quota contributions (due to the fact that PAHO absorbs the non-payment with respect to CFNI and CAREC – the lion's share of quota payments as a whole). Rather it is centred on the overall level of regional contributions and the definition of what should constitute core support, and how such support should be delivered (quota, cost-recovery or a combination) and on what basis it should be adjusted over time e.g. rate of increases in funding to keep up with inflation and changes in approved activities or other bases.

The magnitude of the resourcing challenges facing RHIs may be the most significant policy issue facing the organisations. For this reason, a separate section of the Rationalisation Plan will address the rationalisation of the financing of the RHIs.

6.1.6 Strengthen National Capacity

The internal capacities of Caribbean states vary widely, with some having capacity close to or exceeding the RHIs themselves, while others have only the most limited and rudimentary domestic capacities. Some stakeholders commented that while RHI programming was generally valuable, it was insufficiently tailored to meet individual needs.

One of the major purposes of the RHIs as a whole is to act as a means to strengthening national capacities; and thus any approach to rationalisation needs to consider the potential for enhancing national capacities. However, strengthening national capacity involves a complex set of internal and external variables that precludes simplistic one-size fits all approaches or “more of the same” style programme decisions.

Thus, approaches to rationalisation need to be sufficiently flexible and responsive to facilitate more sensitive and relevant programming.

6.1.7 Enhance International Linkages

This final general objective speaks to the reality of the technical cooperation in health in the Caribbean region – namely that it is increasingly dependent on external support due to continued (relative and absolute) reductions in core funding. Three RHIs have demonstrated considerable success in building resource mobilisation efforts.

However, efforts could be made to extend beyond a donor/recipient relationship to link RHIs to similar organisations in other parts of the world, thus expanding the horizon of the Caribbean regional institutions and potentially harnessing new and more operational levels of technical cooperation.

6.2 Principles for Rationalisation

A process of rationalisation, which will result in progress toward achieving the above strategic goals, must be justified by the means used to attain it. In short, the means (the ways / processes) of rationalisation must justify the end (the objectives), a fundamental and paramount precept of public sector management in any environment.

For rationalisation to be relevant and to be accepted by stakeholders within and outside the region, the process itself needs to be guided by several principles, largely managerial in nature.

6.2.1 Equity

Any approach to rationalising the RHIs needs to be guided by the principle of equity, in that the work of the RHIs as whole is focused by an un-biased and objective assessment of the needs of the region as a whole and of its component member states. The principle of equity also implies that member states should be able to access RHI services on an equal basis.

6.2.2 Consistency

The principle of consistency largely speaks to how RHIs may function and addresses largely internal concerns. Thus approaches to the rationalisation of the RHIs should emphasise the means that build greater predictability and overall consistency of action, both internally and externally.

For example, the equitable treatment of staff in a predictable and consistent fashion would be one major characteristic of the consistency principle. Consistency also implies that RHIs work with partners, stakeholders and member states in consistent and predictable fashions, mindful of course of natural variances in each relationship.

6.2.3 Efficiency

Any approach to rationalisation should be considered in light of the degree to which it efficiently translates resources into programming.

However, a broader understanding of efficiency goes beyond the translation of resources into services but also explores how as yet un-tapped synergies can be maximised or used to develop new and innovative approaches to programme design and delivery. This in turn could have a multiplier effect in terms of the relationship between resource utilisation and resource impact.

For example, efforts towards the establishment of common services among RHIs could be seen as an innovative way to improve overall resource utilisation. Equally, the harmonisation of resource mobilisation efforts, presently disconnected, would be another way to improve overall efficiency.

6.2.4 The Balance between the Public Good and Market Forces

The 1996 study of Caribbean public institution by the World Bank cited earlier indicted that Caribbean institutions that relied on member quotas, providing services only on a demand basis and ignoring market forces were fundamentally unsustainable. The same is true of institutions, which are excessively reliant on external sources of funding such as donors and lenders. The report concluded that a careful mix of three sources of revenue – member contributions, donors/lender support and revenue generated by market forces (commonly called cost recovery) was required to ensure long-term sustainability.

Approaches to the rationalisation of the RHIs imply largely new forms of organisational behaviour for most of the existing or future RHIs. Equally, long-standing contributory patterns of member states would also have to be addressed. In terms of principles, the issue devolves to one of how to balance programming for the public good of the region with the more direct market-driven forces whereby user-pay approaches would begin to acquire more relevance.

This issue is inherently linked the goals of overall sustainability for the RHIs of the future and will be addressed in a separate section of the rationalisation plan.

6.2.5 Transparency and Accountability

One of the major precepts of modern public sector governance reform is the centrality of the dual principles of transparency and accountability. As is noted in a number of instances within this report, the Caribbean RHIs, as they now exist, have generally blurred transparency, largely the result of obsolete reporting and governance structures combined with limited M&E capacity; intersecting and sometimes conflicting lines of accountability, generally characterised by dual and potentially conflicting accountability in several instances, or an obtuse and seeming lack of any real upward accountability in others.

Any approach to the rationalisation of the RHIs need to be structured so as to improve overall transparency to stakeholders – regional and otherwise, strengthen upward accountability to the regions' key decision-makers – namely ministers, which will thus facilitate them in their decision-making roles.

6.3 Three Special Issues

Three special issues need to be addressed as precursors to the introduction of various approaches to rationalisation. They are as follows:

- The overarching need for the region to rationalise the mandate for technical cooperation in health as a whole
- The need to develop new approaches to financing regional technical cooperation so as to ensure long-term sustainability
- The need to re-conceptualise the region's approach to pharmaceutical quality assurance.

The manner in which the region addresses these three special issues will, in large part, shape the selection of one or other models for overall rationalisation. For example, if regional decision-makers decide not to address the rationalisation of the strategic mandates for technical cooperation in health, several approaches to overall rationalisation become superfluous.

In order to facilitate decision-making, Universalia will suggest a course of action with respect to each of the three special issues and then carry over these recommended approaches into the discussion of broader models for overall rationalisation.

6.3.1 The Rationalisation of Mandate

The rationalisation of mandate and financing for the Caribbean RHIs are inextricably linked issues.

One addresses what the region may require in terms of the level of technical cooperation in health; while the other addresses the two-branched issue of what can it afford and how it can be financed. This combination may serve to focus the attention of senior decision-makers on the totality of the RHIs, and not address each separately, or out of context with the other.

RHI formal mandates generally have not been addressed since their inception. Weaknesses in planning processes have left most RHIs with amorphous strategic frameworks that tend to concentrate on the “what has been done, as opposed to the planned impacts of RHI programming. Since RHIs are also stand-alone entities and in no way coordinated economies of scale, the possibility for synergies and the likelihood of harnessing coordinated donor financing are difficult, if not impossible to achieve.

In examining the programming and financial statements of all RHIs, two conclusions became evident:

- RHIs (and regional decision-maker generally) presently do not have a solid understanding of what constitutes core mandate areas
- RHIs at this time appear not to have sufficient financial resources to address core mandate areas in a sustainable fashion.

In terms of the gap between mandate and financing several RHIs face, or have faced crisis, or near crisis, situations:

- CRDTL clearly faces both a mandate and financing crisis.
- CHRC, with the exception of the new funding acquired by means of an external programme evaluation contract and notwithstanding its business plan, does not have sufficient on-going resources to reasonably expect to meet its core mandate.
- CEHI’s relatively recent Strategic Business Plan identified that its core mandate was too encompassing for its projected resources base, resulting in a focusing on two areas, and the recognition that quota-funding would be insufficient to even fulfil core functions.
- Analysis of CAREC’s programming and its financial record tends to show that programming and services widely seen to be “core” are under-financed, resulting lack of staff.

The factors, which have culminated in these situations, are not necessarily all related to financing. However, because of their separate governance paradigms and because no organisation acts in a coordinated fashion there is no common understanding, let alone agreement, on what “technical cooperation in health” actually means for the Caribbean region.

During any discussion of regional mandates, emphasis should be laid on the demographic and economic size of the Caribbean region as whole and place it into a practical context. Limited to population terms, many North American metropolitan areas exceed the overall population of the region. The region’s small population base is exacerbated by the fact that it is scattered among relatively small islands. In terms of economic impact and capacity, the economic capacity of the many nations of the region’s nations combined would not surpass that of some individual states of the United States, or even some Canadian provinces.

Universalialia is of the opinion that any approach to the rationalisation of the Caribbean RHIs must begin with a thorough examination of their respective core mandates, setting aside the tendency to attempt to defend the present condition and simply add to it. The funding reality of the region effectively precludes decision-makers attempting to avoid hard programming choices by simply “adding on”, or relying on external partners to sustain Caribbean institutions – in essence for other to sustain core regional services.

The following example taken from CRDTL’s recent experiences shows the extent to which unrealistic programming suggestions can blur the need for fundamental mandate review. In the face of clearly sub-standard organisational performance, combined with a mounting fiscal crisis, members of CRDTL’s advisory panel (the organisation’s primary governance arm) suggested that CRDTL expand into sports medicine drug testing (anti-doping) and into quality assurance for veterinary products.

Six criteria earlier referred to as or what is generally referred to as “programme review” were set out. In terms of the rationalisation of mandate, it may be useful to reprise them at this time since they constitute what could become a process of mandate rationalisation.

- Does the programme area or activity continue to serve the public good?
- Is there a legitimate and necessary role for the organisation in this programme area?
- Is the role of the organisation appropriate, or is the programme area more appropriately the task of another body?
- Can any of the programme area (or its activities) be transferred / devolved to others?
- If the programme area is to be continued, how can its efficiency be improved?
- Can the programme area be afforded within the resources that are likely to be available to the organisation throughout the planning period in question?

Universalialia is of the opinion that the fundamental precondition to the rationalisation of the Caribbean RHIs is a comprehensive core mandate review that is guided to a large extent by questions such as these. Such a mandate review should be preceded by substantive organisational decisions – in keeping with the general principle that form should follow function, with function in this case partially related to core mandate.

6.3.2 The Rationalisation of Financing

The following excerpt from the Executive Summary of the World Bank’s 1996 study on Caribbean public sector institutions encapsulates many of the key issues facing the rationalisation of the Caribbean RHIs.

“Regional institutions:

xvii. The small size and common heritage of the Commonwealth Caribbean countries have led them to set up more than forty regional institutions in the hope of realising greater efficiency and encouraging regional integration. Some institutions have worked well, but the performance of many has been disappointing.

xviii. The regional institutions work best in functional areas that do not duplicate national activity and in areas that need scale because of investment or technical expertise. Good examples include the Caribbean Development Bank, the Caribbean Examinations Council, the Caribbean Meteorological Institute, the Eastern Caribbean Central Bank, and the University of the West Indies.

xix. The ones that work best also succeed in attracting a mix of financing actually paid, not just promised-that includes national government contributions and user fees. User fees not only provide the institution with financing but also make the provider accountable to clients and encourage clients to use services moderately. Donor financing is important for many regional agencies, but it becomes counterproductive when agencies no longer need to attract substantial funding from users and national governments.”

This study, now about 8 years old remains relevant in relation to the rationalisation of the Caribbean RHIs.

In light of the set of objectives and principles for rationalisation set out above, two major resourcing issues emerge:

- How much can the region itself afford to provide for core services related to technical cooperation in health?
- What are the best ways of securing these funds?

Universalialia is cognisant that CARICOM as a whole is seized with the overall issue of resourcing regional institutions. The rationalisation of the RHIs, given the need to ensure their long-term sustainability, may provide CARICOM with a defined venue to begin to test the applicability of various models with respect to varying modalities for regional funding, and the mix between regional and external resources.

It may be very useful to recall that the widely divergent reporting systems of RHIs, combined with their generally fragmented and episodic governance and the systemic weaknesses of the CARICOM Secretariat, have resulted in the lack of clear regional picture that could inform decision-makers as to the actual nature of the relationship between the region’s investment in RHIs and corresponding outputs. RHI reporting is insufficiently transparent to be able to meet this information demand.

It may also be useful to note that RHIs could fairly rapidly begin to introduce alternate regional resourcing systems without even altering their constituent agreements, let alone contemplating any modifications to the Treaty of Chaguaramas. As noted earlier, PAHO delegation to the Directors of CFNI and CAREC permits cost recovery. CEHI at this time collects quota payments (in the range of 66% of estimates) and at the same time charges user fees for some training and repetitive testing services.

Therefore perception among some stakeholders that cost recovery was not “possible” simply is not valid. CEHI’s example shows that many Caribbean states are willing to make quota payments pay both quota (with some exceptions) and also pay for services they consider relevant.

One of the most important issues relative to any attempt to mix various revenue streams is to be able to differentiate “what goes for what purposes?” Some lessons may be learned from the experiences of other public sector entities that have explored cost recovery, as opposed to outright privatisation. A key issue in any approach to cost recovery within a public sector body is the utilisation of the state-provided funds.

Many approaches to cost recovery attempt to differentiate between “upstream” and “downstream:” In relation to training, “upstream” in some bodies, has come to mean the cost to design and develop training programming, while “downstream” can mean the actual cost to deliver the training. This is a very simplistic example and does not take into account capital investment, overhead and infrastructure costs.

With respect to donor support for Caribbean technical cooperation in health, earlier in this report, key horizontal findings were presented that showing that while donor support has clearly expanded the range of services provided by RHIs and thus increased the overall quality of technical cooperation, there are obvious risks inherent in excessive reliance of donor support.

The rationalisation of RHI financing also may require a critical review of the nature of how RHIs engage in resource mobilisation and whether the resources secured from external partners result in the region facing long-term risks due to the fact that the programming may be largely “service-delivery oriented” and less strengthening of RHI, a fact confirmed by examination of external donor-supported programming. An examination of present programming supported by external donors tends to confirm a strong service-delivery orientation, and to a much lesser extent the strengthening of RHI internal capacity.

Special mention should again be made of the fairly substantial donor-supported HIV/AIDS programming. These programmes mostly envisage a very long operating life, in excess of 15 years in some cases. Thus, their net impact on RHIs may be more akin to an augmentation of “core programming”, in comparison to other donor supported initiatives that have a substantially shorter time horizon.

Universalia is of the opinion that a second pre-condition to long-term rationalisation of technical cooperation health in the Caribbean is a parallel comprehensive review of the financing of RHIs, taking into account the interplay between, quota payments, cost recovery and donor support. Indeed, it may be possible for the region as a whole to use the RHIs as prototypes for more comprehensive approach to overall fiscal rationalisation of regional institutions as a whole.

6.3.3 Revisiting the Region’s Approach to Pharmaceutical Quality Assurance

The organisational assessment report for the CDRTL portrayed an organisation in crisis that had lost most of its relevance to the region; and one with little prospect of rebuilding itself within its current organisational paradigm. However, counter-balancing all these problems is the equally powerful recognition that the region needs more, not less, capacity with respect to pharmaceutical quality assurance, and pharmaceutical regulation/ testing as whole.

The Functions

Universalia believes, and stakeholders agree, that the region needs a quality assurance mechanism. They were also of the view that more needs to be done to ensure timely and accurate regulation of pharmaceutical products. Overlaying these views is the general realisation of the growing complexity and diversity of the global pharmaceutical industry. Large numbers of new products and new suppliers are entering the global marketplace each day, combined with the fact that, according to the WHO about 7% of all products on the marketplace may be counterfeit. For the Caribbean, in an effort to reduce the global phenomenon of spiralling health costs, nations are increasingly turning to non-traditional suppliers.

A November 2004 press report illustrates some of the challenges with respect to the availability of new and cost-efficient products. It noted that Brazil will soon commence the distribution of three antiretroviral products to combat HIV/AIDS and that Brazil was doing so due to the high costs of “name brand” similar products. The certification of these products in Caribbean nations might have a positive impact on growing costs to address HIV/AIDS.

In addressing the region's need for pharmaceutical quality assurance, it needs to be made clear that the current CRDTL, within its current resource base was not engaged in initial drug testing for regulatory approval purposes. It was also not actively engaged in strengthening the capacity of national drug regulatory bodies, despite the recommendation of the RADBAT group (a groups of technical advisors concerned with issues relative to strengthening national pharmaceutical regulation, but presently not active). With the exception of very sporadic training programming for laboratory workers, the current CRDTL is an entity that provides an after the fact quality assurance function, and does so in a largely inefficient and ineffective fashion.

The region also presently does not have access to any central reference point with respect to the regulation and approval of pharmaceutical products by others. It is not realistic to presume that each Caribbean nation could maintain the capacity to track what United States, Canadian or the European Union pharmaceutical regulatory authorities may be approving, let alone those of emerging industry players such as Brazil, India, or several Eastern European nations. Thus, the region would appear to require a *regional* approach to the acquisition of such vitally important information.

Without prejudice to any possible overall mandate review of RHI core functions as a whole, it would seem that the region as a whole would require the following minimum functions if it wishes to have a viable and relevant pharmaceutical quality assurance capacity:

- Access to up-to-date information relative to the global regulation of pharmaceutical products
- Access to a capacity to perform timely quality assurance testing, either on a special needs basis, and or on a periodic surveillance basis.
- Strengthening national pharmaceutical regulatory capacities

More of the Same? – The Paradox of Trying to Strengthen the Current CRDTL

Universalis is of the opinion that the current CRDTL is incapable of adequately addressing these functions and that “fixing” the current CRDTL would result in an new organisation, and not a renewed CRDTL. For example, “fixing” the current CRDTL, for its quality assurance function only would entail, at a minimum:

- A new direct governance paradigm that replaces the current “off-line:” advisory body with a new entity of senior decision-makers (Ministers) capable of taking strategic decisions
- A new management paradigm to produce direct managerial accountability to the region (not the current parallel and blurred approach via the Government Chemist of Jamaica)
- More staff to begin to address the backlog / delay of service issues
- Additional staff to build a credible management infrastructure, i.e.; planning, reporting
- Capital investment in new laboratory technology
- Capital investment in new communications technology to ensure the timely circulation of testing results to all stakeholders (not the current once a year paper-driven approach)
- Sufficient operating capital to ensure that the present phenomenon of the lack of suitable standards and supplies does not occur in the future

These changes, especially the latter three, would require both one-time capital investment (likely from an external donor) and a completely new level of annual funding, well in excess of the present theoretical budget of about \$300K per year derived from core funding.

Organisational Assessment of RHI - Overall Evaluation Report

Such new costs would relate only to one of the major functions that the region requires – quality assurance.

Undertaking these enhancements, even with donor support for capital cost and capacity-strengthening, would still leave the region vulnerable to increased annual operating costs, that would require either major increases in quota payments (and the need to ensure that quota actually gets paid), or a reliance on a mix of quota and cost recovery (as CEHI does with some of its laboratory services). Presently, CRDTL per unit costs appear to be between 200- 250% more expensive than that available from the private sector. Moreover, CRDTL delivery time frames appear to stretch out into months of delay on average, while private facilities located outside the region can provide result in less than two calendar weeks.

Paradoxically, the strengthening of the CRDTL would result in a somewhat more capable but still highly inefficient organisation. Adding new equipment on a one-time basis (and even working towards laboratory certification) results in one-time capital costs, but also corresponding long-term maintenance /upgrading and future replacement costs. Adding the staff to complement the new equipment produces immediate increases in long-term operating costs.

Furthermore, the low levels of compensation at CRDTL have resulted in a revolving door, with human capacity not being retained. Thus, short-term strengthening would also have to take into account development of a more competitive salary scale, again resulting in larger long-term operating costs.

The major conceptual issue with respect to pharmaceutical quality assurance lies in the realisation of the probable absence of any economic model for the region that could be competitive with the private sector. Consider the following situation.

- The current CRDTL per unit cost are in the \$850-1100 range (depending on what one takes as an annual baseline)
- Private laboratories in Canada, Europe and the United States charge in the \$400-500 range for similar tests.

Even assuming that a Caribbean regional faculty could meet the same time standards as their competition (2 weeks) their unit costs would remain about double!

There are several ways in which the CRDTL could be expanded

- A one time capital investment to provide more and newer equipment)
- Adding about 50% more technical staff (most likely 3 new employees)
- Possible donor-supported training, leading to possible laboratory certification

The impact of such a plan obviously would be to reduce delays to some extent (not presently capable of being predicted); and, more importantly, increasing on-going salary budget by in the range of 50%, assuming that the strengthening would also address the issue of presently low levels of compensation to ensure that qualified personnel could be retained.

From the perspective of per unit costs, while such a scenario might be expected to improve timeliness, it would likely have no impact on reducing the differential noted above unless the strengthened organisation could vastly expand the number of tests provided, implying a significant outreach to the private sector. Indeed, the organisation would have to increase from about 230 tests per year to in the range of 300 or more simply to produce the same net per unit cost.

It is important to take note to be mindful that one of the current major regional clients of the CRDTL is moving to expand its quality assurance testing by some 200% (75 up to over 200 per year) **not with the CRDTL**, but with outside laboratories.

The modalities of financing an expanded CRDTL raise several thorny problems.

It is not reasonable to assume that member states (especially those that have had a long history of not paying quota at all) would be in any position to pay their entire quota, let alone arrears as some have suggested. If they had done so in the past CRDTL would have been vastly more efficient and effective. As early as the 1987 PAHO/CARICOM evaluation, the issue of failure to pay quota was highlighted. Yet little was done to address it.

If member states were to pay all their quota, CRDTL might be able to sustain a larger, better paid staff. However, Universalis is of the opinion that this is not a realistic assumption. Moreover, full payment of quota would probably not cover additional day-to-day operating cost inherent in running a larger laboratory.

Could CRDTL reasonably expect to augment current quota levels, and thus maintain “free” testing for member states, with additional funding from cost recovery fees from private entities using the services of an expanded lab?

This proposition would require an external donor to “invest” in several years of additional salary and operating costs in an effort to build the external business, assuming that the private sector would be willing to engage CRDTL in the first place and not use private facilities.

However, in terms of costs alone, would the CRDTL’s “price point” be competitive with private facility in the region, or those outside the region?

Because the CRDTL would be a regional entity and part of the broader regional public sector, the organisation could not reasonably resort to “price dumping” in an effort to subsidize “free” testing for members, or be seen to engage in what would amount to predatory pricing with respect to endogenous or external sources of laboratory services. One of the most important aspects of worldwide public sector modernisation, as it affects cost recovery and sale of services, is that public sector entities, because they enjoy considerable advantages over the private sector do not compete with the private sector, but rather offer services that are not available from the private sector. Thus, in light of this consideration and possibly WTO provisions, it would not seem reasonable for a CARICOM-driven body to undercut private sources of services.

Given the low level of demand, there also does not appear to be any real private sector demand for pharmaceutical quality assurance that would warrant investing in long-term market development. Presently, the CRDTL offers testing services to the private sector. As the individual assessment report detailed, there is virtually no demand, and thus virtually no revenue is generated.

However, the most telling argument against those who might suggest augmenting the current CRDTL testing model comes down to the lack of economies of scale inherent in the Caribbean region.

The region’s small population base, combined with its economic base, probably results in the fact that it cannot afford a stand-alone regional pharmaceutical quality assurance laboratory function. The volume necessary to produce an efficient and effective service is not available from within the region, according to several well-informed stakeholders. Nor, is it reasonable to assume that a CARICOM-supported facility could enter the world stage as a quality assurance facility in competition with others.

Move the Quality Assurance Function to Another RHI Lab?

Several respondents to this evaluation suggested that the quality assurance testing function be moved to another RHI, arguing that doing so would result in marked improvements. Some suggested cost-recovery of testing at another RHI lab.

Universalis is of the opinion that such proposals simply transfer the systemic problems of quality assurance testing in the Caribbean from one entity to another, resulting in another entity, facing new expectations and challenges, threatening its current viability.

As the individual RHI reports noted, the laboratories of other RHIs are probably in no position to absorb totally new functions.

CFNI possesses only a marginal laboratory capacity. CEHI, while acquiring lab certification for some testing, and while having some minor surplus capacity, could not be expected to absorb pharmaceutical quality assurance without all, or nearly all of the resources now dedicated to CRDTL. Nor could CEHI (or for that matter CAREC) reasonably expect to produce a justifiable “price point” that could compete with private sector suppliers. CAREC’s laboratory services, which constitute part of its core, are generally recognised to be under-funded at this time to meet its mandate.

A New Way Forward

Most stakeholders have tended to concentrate their discussions about CRDTL on the laboratory testing function, while ignoring other key functions that relate to the totality of ensuring safe, efficacious and accessible pharmaceuticals to Caribbean citizens. Three basic functions were earlier identified as:

- Access to up-to-date information relative to the global regulation of pharmaceutical products
- Access to a capacity to perform timely quality assurance testing, either on a special needs basis, and or on a periodic surveillance basis.
- Strengthening national pharmaceutical regulatory capacities

To date, many Caribbean stakeholders have only concentrated on the second, and only within the context of a Caribbean regional lab doing the testing itself. However, the other two functions may be equally, if not more important than the second, and there are many other ways to ensure quality assurance testing, given the fact that the CRDTL model, even if augmented does not result in a viable approach.

Individual Caribbean nations at this time have four choices with respect to pharmaceutical quality assurance testing:

- They can do nothing
- They can submit their samples to the CRDTL free of charge
- They can access varying private sector facilities, either within the region, or outside it
- They can build their own internal capacity

If future reliance on a regional testing facility like the CRDTL is simply not cost-effective and thus not sustainable, then other solutions need to be developed that respond to all three major pharmaceutical goals and not just what is related to testing.

The quality assurance testing function can be addressed first – from a functional standpoint.

a) Pooled Demand

If a CRDTL-like model is not sustainable and if member states wish to continue quality testing, given the explosion of counterfeit products on the global market, then two choices are left – build domestic capacity, or access alternate sources of testing, most likely on a fee for service basis.

It is not realistic to assume that smaller states could even begin to explore developing an internal capacity. These nations, which comprise a majority of member states, require some form of collective service. It also may be helpful as a point of reference, to recall that the OECS consolidated pharmaceutical procurement for publicly funded health services in the OECS Pharmaceutical Procurement Service.

Moreover, although some of the larger Caribbean nations might contemplate strengthening their domestic capacities, doing so would result in the same challenges of high per unit costs and potential long-term capital costs that face any suggestion to build “a new CRDTL”.

Therefore, the only realistic long-term solution to ensuring pharmaceutical quality assurance testing is likely to lie in exploring way to maximise the collective “buying power” of the region to access timely and cost-effective quality assurance testing from private sector sources, most likely over the short-to-medium term from sources outside the region, but most likely from within the hemisphere. The general modality of delivery might be a preferred supplier that guaranteed a constant price, combined with measurable service standards – a pooled demand model.

Individual small states, because of the low volume of products being tested, would have very little leverage with private sector facilities to negotiate more advantageous pricing. However, if all (or most) Caribbean nations, and including the OECS’s PPS, agreed to pool their demand, it is likely that a more advantageous per unit costs and service standards could be secured.

Over the longer-term, such a pooled demand might induce a Caribbean testing facility to compete with outsiders.

In addition, a pooled service would have the ability to share quality assurance test results across the region in a timely fashion. Thus, member states would gain a collective benefit that they presently do not have access to.

The costs for such a pooling would be likely less than the current costs of the CRDTL’s inefficient activities.

Using data provided by the OECS’s PPS, it is reasonable to assume a per unit cost from private sector supplier in the \$400-500 range. Assuming the high end range, this results in a cost for external testing of the same number of products as the CRDTL currently tests (approximately 225 per year) of less than \$125,000, with vastly superior service deliver standards. This estimate does not include any likely subsequent price advantages of adding in the testing done by the OECS’s PPS.

The potential benefits of pooling are not readily quantifiable. However, some OECS data can be useful in inferring potential benefits. A November 2, 2004 communiqué of the OECS’s PPS states that the PPS has been able to “reduce the unit costs of pharmaceuticals by about 40%”.

b) Access to Pharmaceutical Data

Given the explosion of pharmaceutical products on the global market and the vast increase in suppliers, there is an obvious need for the nations of the Caribbean region to have access to the most up-to-date information relative to new product certification, or any subsequent product warnings that may be made by major certification/regulatory entities. An advisory committee of the current CRDTL began to address some of these factors when it took some initial steps to suggest the strengthening of national authorities that were responsible for pharmaceutical regulation. At this time, this important function is not served by any RHI, or any other entity.

Again, economies of scale and varying rates of absorptive capacity tend to suggest that a more efficient approach for the region as a whole would be to build a central capacity that could provide a clearing house/ information distribution point for all member states. Such a function would not require a large staff. Indeed, a small 4-5 person secretariat could ably provide such a function given advances in information technology. Thus, the region would acquire more capacity in technical cooperation in health with the inclusion of such a function.

A small secretariat, likely supported at the outset by one or more major donors, would be able to access on an on-going basis, the most recent information from Canadian, American, European and other pharmaceutical regulators and share the knowledge with other member states, thereby considerably increasing their collective information base. As well, by establishing bi-lateral working relationships with these large entities, there even may be opportunities for the building of new bilateral approaches to technical cooperation, which could have longer-term positive impacts.

The key point to emphasise is that such a small secretariat would also be the focal point for the pooled system of quality assurance testing – in essence a multi-tasking approach. The additional costs to establish the pharmaceutical data clearing house would not be significant – probably less than those associated with one or two medium- level professionals paid at the CARICOM scale.

The financing for such a small secretariat with two major functions can illustrate the concept of “upstream/downstream” introduced earlier and link it to the balance suggested by the World Bank report between cost-recovery and quota payments.

Clearly, the negotiation of the pooling arrangements for quality assurance testing and the development and maintenance of the new function of data clearing house typify the sort of “upstream” developmental / design / administrative functions whose financing may be best addressed in the Caribbean through quota payments. Basic coordinative/administrative / information services might be provided to all on an equal basis. Individual quality assurance testing, as envisaged by the pool system, could be driven on a per sample cost-recovery basis – a clear approach to alternate financing of a repetitive “downstream” activity.

The small secretariat also could provide an ancillary, but potentially very important, new service to the region at virtually no additional cost - providing a means for new producers to demonstrate the efficacy of new products.

Several stakeholders noted that some member states were beginning to develop small domestic drug production capacities - largely with respect to generic products. Clearly, it is in the region's interests to foster such development. However assuring the quality of such generic products requires some means of testing samples against their specifications.

The case in most nations is that pharmaceutical suppliers provide regulators with testing results as an initial step in the regulatory process. The same could occur in the Caribbean with the new secretariat function being able to provide the producers access to the quality assurance laboratory used by the region on a fee for service basis and subsequently communicate test results to member states.

Likewise, as noted earlier, the region also is encountering new non-regional producers whose products may not be regulated by major bodies in Canada, Europe or the United States. These new international producers, especially of generic products, offer the possibility of reduced prices. However, accessing them without sufficient caution runs the risk of introducing either counterfeit or sub-standard products. Again, the new secretariat function could be useful in strengthening regional capacity and improving regional access to cost-efficient products.

Although the regulation of products should remain a national responsibility, some level of enhanced cooperation with a new body (a function that simply does not exist today) might result in some (or all) member states agreeing to harmonise their domestic certification of products and agreeing to accept common test results, especially if those were conducted under the auspices of the pool testing arrangement suggested above with respect to potential new regional producers. Again, an additional and highly valuable new capacity can be provided at very little, if any, increased costs over that required to operate the basic pharmaceutical data clearing house.

c) Strengthening Domestic Laboratory Capacity.

The strengthening of domestic laboratory capacity in pharmaceutical quality assurance testing is the most problematic because the envisioned model would not encompass an on-site laboratory. It is useful to note that the OECS's PPS does not possess more than a very limited laboratory capacity and itself does not "test" products.

The possibility of strengthening internal capacity for pharmaceutical testing again relates to the varying absorptive capacities of Caribbean nations. Some presently have laboratory capacities to varying degrees, others simply do not; nor could they be expected to invest in such in the future. Thus, any goal of regional technical cooperation to strengthen national capacity to test pharmaceutical products would have a variable impact across the region.

For obvious reasons, it would make no sense to maintain a regional state of the art pharmaceutical testing facility strictly for training purposes. Nor, does it make sense to even maintain an obsolete laboratory to provide basic training. The costs of maintenance and operation likely counterbalance any level of anticipated demand. However, there are other solutions that may be developed.

Again, one model would be for the suggested secretariat to assume a coordinative function, working with CARICOM Secretariat and bilateral/multilateral donors to coordinate training programming supported by external sources.

d) Getting From Here to There

The model described above consists of the following major functions:

- A cost-recovery approach to pharmaceutical quality assurance, possibly by means of a pooled arrangement for testing
- A new pharmaceutical data source for the region
- New capacity to coordinate the review of new products not regulated by others at this time
- New means to coordinate capacity-building in laboratory training for certain nations.

These four functions add up to a far more capable critical mass than the current CRDTL model could envision. Therefore, the first issue that faces regional decision-makers is that related to these four functions.

Within the context of the overall mandate review suggested by Universalialia: “Do these four functions constitute a relevant and sustainable approach to ensuring pharmaceutical quality assurance within a regional context? “

A natural second question arises: “How would the region reasonably finance its selected functions with respect to pharmaceutical quality assurance?”

Universalialia is of the opinion that the four above functions, combined with the general approach to financing noted above, constitute a viable and sustainable approach to pharmaceutical quality assurance.

The core of such a new approach would be the upstream/downstream division of resourcing between some level of quota on one hand, and fees for services on the other.

The modality of operationalising these functions can vary depending on how the region as a whole addresses the rationalisation of the RHIs.

Implementation modalities range from creating a “new” Caribbean Drug Testing Agency” – basically a small stand-alone secretariat, to the incorporation of the above functions within any one of several existing RHIs, to even contracting the delivery of the four functions to another body within the region; either in the public, or even the private sector.

At this time, Universalialia is of the opinion that the choice of an overall approach to rationalisation will affect how these four functions are operationalised. The options for rationalisation that follow each will address a corresponding approach to revitalising the pharmaceutical quality assurance function.

6.4 Five Basic Approaches for Rationalisation

The discussion of horizontal findings presented earlier in this report leads to several overarching conclusion, that when balanced with the general objectives for RHI rationalisation set out earlier, direct the process toward five fundamentally different approaches to rationalisation.

These general conclusions are:

- There remains a requirement for technical cooperation; however, RHI core mandates require clarification and rationalisation.
- Present approaches to RHI financing are not sustainable over the longer term and a review of RHI financing is required.
- There is a clear need for the RHIs, to create a set of independent entities that work together only on an episodic basis at this time, to come together into a more formalised network, whereby synergies and economies of scale would enable the more productive use of human and financial resources.
- The present governance structures of the five RHIs results in fragmentation, loss of collective impact and reduced ability for senior regional decision-makers to take collective and strategic decisions with respect to technical cooperation in public health.
- The CARICOM Secretariat as it is presently structured is not capable of assuming the additional governance and oversight functions required by a potential increase in the regionalisation of RHI governance and an increase in collective regional decision-making.
- There is very little administrative overlap and / or duplication among the five RHIs, thus very little possibility of traditional cost savings via administrative reform.

Each of the five broad approaches to rationalisation will first be described in a narrative fashion (including how each will address the three special issues noted above) the impact of the approach on the CARICOM Secretariat, the estimated cost of the approach will be set out; and the degree to which the approach contributes to the attainment of each of the seven objectives of rationalisation. Universalia will make a recommendation relative to the desirability of each of the three approaches. A table will present the salient features of all five different approaches.

Five overall approaches to RHI Rationalisation are presented:

- The modified status quo
- The amalgamation of all RHIs
- The regionalisation of CAREC, with other RHIs remaining constant
- The development of harmonised systems and eventually harmonised and regionalised governance
- The amalgamation of the two RHIs most central to public health technical cooperation, CAREC and CFNI, with others remaining stand-alone

Universalia is of the view that only the last two options present viable means to ensuring long-term sustainable technical cooperation in public health. However, because several of the other options have been introduced into the discussion and were advanced by informants, Universalia feels that these options need to be fully considered, even one which in effect is primarily about altering CAREC's governance structure. Each option will be introduced by a "highlights box" that outlines the general nature of the option.

6.4.1 Option 1: A Modified Status Quo

The Option in Brief

Content	<ul style="list-style-type: none"> • A very modest approach to RHI rationalisation that would see RHI Directors meeting informally to address operational level concerns • Mandate and financing issues would not be addressed in any substantive fashion
Governance	<ul style="list-style-type: none"> • Current RHI governance patterns would continue without alteration
Costs	<ul style="list-style-type: none"> • Probably less than \$US 25,000 per year to support meetings for Directors • About \$125,000 per year to add one senior professional to the CARICOM Secretariat staff • A stand-alone donor supported institutional strengthening programme for pharmaceutical quality assurance in the range of \$US 200,000
Pharmaceutical Quality Assurance	<ul style="list-style-type: none"> • CRDTL would be wound up in its present format and either <ul style="list-style-type: none"> – A new agency addressing broader pharmaceutical quality assurance functions established, or – Similar functions transferred to another RHI, (mostly likely CAREC). • Most likely actual testing would be converted to a cost- recovery approach
CARICOM Secretariat	<ul style="list-style-type: none"> • No real change or enhanced role

a) General Approach

This approach to rationalisation would see minimal changes occurring. It is postulated on the counter-factual hypothesis that the region does not need enhanced technical cooperation in public health, and that all the RHIs are presently functioning at, or near, optimal performance.

The approach would see RHI Directors and CARICOM Secretariat health-related staff meet twice or more time per year to informally address issues such as enhancing the coordination of resource mobilisation efforts, agreeing among themselves relative to any areas of overlapping responsibility and attempting among themselves to better share information, planning documents, etc. The possibility of inviting the head of the PAHO's CPC (located in Barbados) might be explored to further broaden the outreach of this informal approach to closer cooperation among regional resources.

The approach in essence would preserve the status quo, with the exception of the area of pharmaceutical quality assurance (see below), and would focus on enhancing informal communications and voluntary collaborative efforts.

The CARICOM Secretariat might be asked to chair such sessions, although because none of the governance paradigms of the RHIs would be altered, it would have little ability to perform more than liaison functions. At best, the Secretariat might be asked to provide a more comprehensive report to ministers during their annual conference.

In terms of the rationalisation of mandate, one of the three special issues noted earlier, this status quo approach would not address mandate rationalisation in any substantive fashion. The only degree of "rationalisation" of mandate would be the informal and voluntary agreements among RHI directors with respect to areas of obvious and mutually agreed upon programmatic overlap. Broader issues relative to the future nature of technical cooperation and the relationship to regional public health goals would not be addressed in any substantive fashion.

In terms of the rationalisation of financing, this option would not entail any substantive or collective review. RHI directors, working within their individual governance mechanism could decide (as they now do) to alter their respective funding paradigms to include new sources of revenue. However, there would not be a regional review of the long-term sustainability of the RHIs as a whole.

The CARICOM Secretariat might be asked by some or all RHIs to play a more aggressive role in the collection of quota payments. This could go as far as an RHI agreeing to allow the CARICOM Secretariat to represent it with member states. Because the governance of the two PAHO-specialised centres would not be altered, PAHO would continue to shoulder the large burden of absorbing unpaid quota for CAREC and for CFNI.

In terms of the issue of pharmaceutical quality assurance, more than the status quo would be required, even though the entire approach is a general confirmation of the status quo.

Without limiting actual implementing modalities, the region as a whole faces two choices:

- It could move to rebuilding the existing CRDTL with a primary, if not exclusive focus on the provision of quality assurance testing and not the other functions suggested earlier in this report. Such an approach would leave a laboratory in Jamaica, responsible for testing samples submitted to it and leave the present managerial and governance paradigm largely intact (possibly new membership for the Technical Advisory Committee but not altering the dual nature of the Director and not strengthening direct relationship with senior decision-makers). The possibility of fee-for-services / cost recovery would likely have to be considered in order to provide some greater possibility for sustainability. Donors might even be found to provide an initial institutional strengthening programme.
- It could decide to adopt the suggested new approach to pharmaceutical quality assurance noted above, and move either to build a “new entity”, or transfer the new functions to another RHI. CAREC, given its predominance in the region might be the most likely candidate, assuming that level of appropriate core funding would also be transferred to CAREC

Should ministers decide to adopt the ‘Modified Status Quo’ as an overall approach to RHI rationalisation, Universalia recommends that they choose also to expand the pharmaceutical quality assurance functions and to select one of the two delivery modalities.

As far as the CARICOM Secretariat is concerned this “modified status quo” approach would not entail any need for the strengthening of the Secretariat. No new functions arise from this approach; the only increase might be in staff liaison duties.

b) Costs

This approach has only modest long-term cost implications. It would not alter the level quota payments made to RHIs. It would not move to a regional salary scale for all “regional” staff.

It might, however, require some new donor geared towards institutional strengthening of the new pharmaceutical quality assurance function, probably in the range of a one-time technical assistance of about \$ 200,000. In addition, it is assumed that quota payments in the range of \$200,000 per annum at a minimum would be needed to sustain the new common services.

The direct costs of facilitating informal cooperation amounts to less than US\$ 25,000 per year, assuming that the Directors would meet only once in addition to their annual participation in the third quarter hemispheric meeting held annually in Washington.

In addition, should the CARICOM Secretariat wish to strengthen its ability to monitor the RHIs and to move towards a more proactive stance, the Secretariat might wish to engage a senior professional to be responsible for RHI liaison. On-going costs are estimated to be in the \$125,000 range.

Thus, excluding the pharmaceutical quality assurance functions the overall on-going administrative costs of this option are in the \$150,000 range

One major cost, however, will likely increase - the cost to PAHO for continuing to subsidise the non-payment of quota for CFNI and CAREC (together the overwhelming majority of all RHI quota payments).

The following table presents the detail of the cost to adopt a modified status quo (excluding those related to pharmaceutical quality assurance).

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OPTION 1		
Mandate and Financing Review	Nil	
Year 1	No function	
Governance Consolidation	Nil	
Year 2	No function	
CARICOM Sec. Strengthening	Senior Professional	\$100k
On-going per year	Travel, etc.	\$25 K
	Total	\$125 K
Other Costs	Travel for Directors	\$25K

c) Benefits

The benefits for the region of this approach need to be assessed in relation to the seven overall goals for rationalisation set out earlier

1) The Strengthening of Caribbean Resources.

This approach does very little to strengthen Caribbean resources beyond that which is currently underway via the RHIs at this time. Its informal and voluntary nature results in the retention of the RHIs, not as a regionally-managed network, but as a loose confederation of technical agencies. The major strengthening of Caribbean resources would relate to the renewal of the pharmaceutical quality assurance function. However, a modified status quo would do little to address the growing issues relative to the extent of core mandate that is affecting CAREC at this time, and that is likely to impact on other RHIs as they continue to pursue “project-driven” resource mobilisation strategies.

2) Enhance Collective Programme Delivery

The modified status quo would only contribute positively to this goal were RHI Directors to agree to develop, on an informal basis, programmes that harmonised with each other. The likelihood of this may not be high. Nothing presently has impeded RHI Directors from working with each other and collaborating closely with other regional elements of PAHO to harmonise programming. Even this degree of collectivity might be marginalised by the fact that individual RHIs would remain divided in their resource mobilisation efforts and thus subject to differing demands from donor/lenders, divided in their governance, divided in their planning systems and divided in their internal goal-setting.

3) Strengthen RHI Internal Capacity

This modified status quo approach would do very little to collectively strengthen the capacity of RHIs as a whole. Rather, it would be up to individual RHIs to seek the authority from their governing bodies to address issues that presently drain internal capacity such as those relate to “core” versus “project” funding, and issues related to building capacity by developing alternate revenue sources. For example, it would be up to CAREC and / or CFNI to decide themselves whether they would wish to expand cost-recovery. It would be up to the renewed pharmaceutical quality assurance entity to decide whether it wished to impose a cost-recovery charge for individual testing done for member states.

The modified status quo also would not address the human resources management shortfalls noted in individual RHI reports and in horizontal findings. Because each RHI would remain separate (and essentially the same as it is today in terms of governance and funding) desirable characteristics such as building a common pool of personnel would not be possible.

- 4) Strengthening the Regional Governance of the RHIs
Because the governance and accountability paradigm of individual RHIs would not be altered, this approach would have little if any impact on the goal of strengthening regional governance of RHIs. Indeed, it would perpetuate many irritants and shortfalls; for example, those that relate to the governance of CAREC vis a vis the roles of PAHO and the CAREC Council.
- 5) Enhance Sustainability
Because this modified status quo approach would not entail a zero-based collective approach to RHI mandate determination and a collective review of the regional financing of RHIs, the only way that it might contribute to enhanced sustainability would relate to the actions of individual RHIs to build new revenue sources and to individually attempt to balance quota payments with cost recovery and donor support. This could have been done already, without having to have had incurred a costly evaluation process.
- 6) Strengthen National Capacity
A modified status quo approach would not result in a collective or coordinated approach to RHI strengthening of national capacity beyond that which individual RHIs may do at this time. Some minor coordinative benefits might arise if RHI Directors agreed to mutual coordination of efforts. However, even this potential benefit might be eroded if donor demands / requirements tended to pull individual RHIs in different directions. More importantly, because RHIs would remain individually managed and governed, member states would not have the ability to have a unitary, combined access to RHIs for planning purposes and the present practices of fragmented relations with RHIs would persist.
- 7) Enhance International Linkages
A modified status quo approach would have no positive impact on the enhancement of international linkages.

d) Universalialia's Overall Assessment

Universalialia is of the opinion that the only benefits for conceptualising RHI rationalisation in terms of a limited process of voluntary cooperation among RHI Directors would lie in a belief by senior regional decision-makers that the current state of RHI performance is optimal, or near to optimal. If that were to be the case, there logically should have been no reason for this evaluation and no decade-long calls for it from many quarters.

Regional decision-makers also might favour such a modified status quo if they were to come to the opinion that the financial and / or procedural costs of any more substantive approach to rationalisation would outweigh any functional benefits.

In terms of the seven objectives for rationalisation, Universalialia is of the opinion that a modified status quo approach would have little if any collective impact relative to these goals.

6.4.2 Option 2: A Single and Combined RHI

The Option in Brief

Content	<ul style="list-style-type: none">• Use CAREC as a the basis for the merger of all RHI functions into one entity• A mandate and financing task force as a precondition for the merger
Governance	<ul style="list-style-type: none">• Eventually phasing out the managerial and administrative relationship with PAHO in order to regionalise the consolidated RHI• Building a new RHI Board and advisory bodies (likely several) for the merged RHI
Costs	<ul style="list-style-type: none">• About \$785,000 for core mandate / financing and governance review over two years• About \$175,000 per year in on-going cost to the CARICOM Secretariat
Pharmaceutical Quality Assurance	<ul style="list-style-type: none">• The functions integrated into new merged RHI
CARICOM Secretariat	<ul style="list-style-type: none">• A strengthening of the CARICOM Secretariat by setting up a “virtual” support network

a) General Approach

This approach to RHI rationalisation was suggested by a number of informants, mainly those of the belief that there could be cost-saving by integrating RHIs into one entity. As Universalis has discovered, there are few, if any such direct savings. However, there are other reasons to consider a unitary approach towards RHI rationalisation over and above administrative cost savings.

In the broad terms, a unitary approach to RHI rationalisation would simply mean combining all the functions together into one single entity with a single management, planning, reporting / accountability, governance system. Five RHIs would become one, reporting to one governing body and managed by one Executive Director. Given the preponderance of CAREC's budget, its size and its pre-eminence within the region and its international reputation, it would only be logical to assume that the smaller RHIs would in essence “merge” with CAREC.

Many proponents of such a unitary approach to RHI rationalisation have advanced the idea that the governance paradigm of the new combined RHI would wind up PAHO's administrative and managerial or relationship, strengthening in its place Caribbean governance institutions to ensure accountability, transparency and regional relevance.

Some informants considered a unitary approach in terms of trying to relocate some or all RHIs to one central site, most likely the CAREC location. Such an approach fails to take into account some very hard realities.

First, CAREC's facilities themselves are strained to their maximum, if not beyond. There has been a general recognition that CAREC itself needs new facilities. However, fiscal limitations have precluded such a large capital expenditure. While there may be some minor fiscal benefits to physical amalgamation, the capital costs to acquire or build new facilities would probably vastly outweigh any short-to-medium term savings.

Moreover, the idea of co-locating to one site tends to run contrary to the long-standing tendency of the region to apportion its regional entities through the many nations of the Caribbean. Thus, Universalialia's articulation of a unitary approach is predicated on the use of current CEHI and CFNI facilities and, given the choices relative to the nature of the pharmaceutical testing functions, the possible use of current CRDTL space (but not necessarily retention of the laboratory facilities or the current staff).

In terms of timing and complexity, practical reality makes moving toward such a unitary approach a three-step and multi-year process at the least.

The case of the health-research functions in such a merged entity deserves special mention. The current CHRC's actual level programming to support peer-assessed research programming is very limited; most of the CHRC's core programming goes to communications/ information dissemination activities.

Thus, the major factors that result in the traditional and necessary division between a public health entity, and a health research council (that is active and substantially supports peer-assessed research) are not present in the Caribbean to the extent necessary to warrant both an amalgamated RHI (a Caribbean Centre for Public Health?) and a stand-alone health research entity (the continuation of the CHRC). Given practical realities and the level of actual health research funding available, it will be shown that amalgamating CHRC may increase the chances for regional health researches to access more international funding; and that peer review concerns, and those related to linkages with UWI and other post-secondary institutions, may be able to be addressed via refreshed advisory panels.

The process of merging the RHIs into one may require many years and several distinct steps. The final shape, structure, mandate, financing and governance of the new merged entity cannot be determined in advance because it is likely that as the process of amalgamation ensues various concerns and needs will influence decision-making, again a manifestation of the managerial maxim that *form will follow function*.

As well, the *process* of merging RHIs and its perceived legitimacy may be as important as the actual merger itself.

The amalgamation of the RHIs involves a multi-faceted approach to public sector renewal. Experience with public sector renewal shows that plans developed by participants themselves have a much higher likelihood of success than those imported by outsiders, or those developed by external consultants and given to an organisation simply to implement. It is for these reasons that Universalialia's approach to an organisational amalgamation such as this involves a process of systemic and iterative decision-making by participants themselves, and not a fixed "blueprint."

i) Getting Ready for Amalgamation

The processes of amalgamation are largely influenced by the fact that the renewal of the CAREC agreement is required by December 2005. Thus, there is a window of opportunity, albeit a narrow one, to use the renewal of the CAREC agreement as a trigger mechanism to promote RHI amalgamation.

However, given the complexity of the process of amalgamation, it is highly unlikely, if not simply impossible, that everything would be in place by the end of 2005.

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Thus, it is far more plausible to assume that the CAREC Agreement would need to be ratified, with the clear proviso that it would be only a short-term transitional ratification. In practical terms, if decision-makers agree to the concept of a unitary RHI, there are strong reasons to simply re-affirm the current CAREC agreement without any modifications and use an eventual new agreement that would inaugurate a new unitary RHI as the instrument for change.

The process of getting ready for amalgamation would require the establishment of a special task force to address mandate and financing issues because it would seem only logical to use a complex process such as amalgamation to address many of the systemic mandate and funding issues identified earlier in this report.

Such a task force would need to be time-limited and tightly focused. Given the annual cycle of ministerial and head of state meetings, it is reasonable to assume that the task force should be established so that it could report to ministers and that ministers would have an opportunity to consider its advice, before forwarding their recommendations to heads of state. It is inconceivable that the final direction of a new amalgamated RHI would not be the subject of head of state discussions due to the importance of an eventual new constituent agreement.

The Amalgamation Task Force might have the following general mandate:

- Review the current mandates and programming functions of the various RHIs with the view to developing a proposed new combined and rationalised “core” mandate based on the ‘principles for rationalisation’ cited earlier in this report.
- Review current RHI funding and financing with the view to developing a long-term strategy for sustainability that would address the mix of revenue from member states quota payments, cost recovery and resource mobilisation; and linking the availability of resource to the core mandate to address long-standing issues of systemic under-financing of core activities
- Review the PAHO relationship and especially the implications of the current PAHO practice of off-setting the non-payment of quota, especially in light of the strong possibility of eventually winding up the PAHO relationship as it relates to CFNI and CAREC.
- Review the human resource management systems of the RHIs, with the view to beginning to harmonise procedures, standards, pay scales etc (with the likely result in a process of harmonisation to CAREC/ CARICOM standards), with special reference to the cost of such an amalgamation
- Review current governance practices, including the composition of a governing board, and advisory bodies, with the view to recommending to senior decision-makers a new unitary board (most likely with an executive committee included) and a new approach to advisory committees to assist decision-makers in the event of the eventual regionalisation of RHI governance.
- Review with key donors the implications on programming of an eventual consolidation of RHI into one.
- Review and develop new organisational structures for the amalgamated organisation and new managerial job descriptions

Universalialia wishes to emphasise that its terms of reference with respect to the evaluation of the five RHIs, that of the capacities of the CARICOM Secretariat and the development of a “rationalisation plan” did not envision moving beyond a broad-based approach toward the resolution of specific issues such as those suggested for an Amalgamation Task Force.

It is likely that an Amalgamation Task Force would require a staff of a minimum of two professionals, a senior manager as its leader and a support person. The professionals would need to be skilled mainly in public sector renewal, organisational development, and only to a lesser extent the management of public health. For reasons relating to potential conflict of interest, the leadership of such a Task Force should not be drawn from existing RHIs.

With a mandate such as that proposed, a task force would require about a year to complete its work. In terms of cost, such a task force could be expected to consume about US\$450,000 over the course of the year at a minimum. Full cost details are provided later in this sub-section.

A key issue facing decision-makers relative to this overall approach relates to financing not just the amalgamation per se (as it could result in a cost-neutral environment), but the *process* of amalgamation. A source for supporting the task force, most likely a donor-supported institutional strengthening programme, would have to be found and “put on stream” before the task force could commence its work.

Thus, assuming funding, at the end of a year a full-scale amalgamation plan would be available for the highest level of decision-makers to review. Universalis is cognisant that some might argue that actual amalgamation could occur within that year and that “the details” could follow.

This might be possible if the various entities being amalgamated already had common systems, procedures, etc. (for example amalgamating three parts of a national civil service). However, because all the RHI are stand-alone entities, the level of confusion likely to arise by simply jury-rigging an amalgamation would be significant. Equally importantly, the ad hoc decisions needed for an “interim” amalgamation might be carried forward into the future, thus resulting in the prolongation of confusion and potentially counter-productive policies and programming.

The Amalgamation Task Force would also have to be seized with the re-development of the pharmaceutical quality assurance function. Thus, it is likely that very little, if anything, could be done to revitalise the pharmaceutical quality assurance function of the region until the outcome of the Amalgamation Task Force was ratified by ministers.

ii) Amalgamating the Functions

The second step in the process of creating a new unified RHI (most likely in effect bringing the others into the ambit of CAREC) would be actual amalgamation.

Without prejudicing the work of an eventual Amalgamation Task Force, probably the simplest way to amalgamate the RHIs is to bring them into CAREC, leaving for the moment the CAREC-PAHO relationship untouched. It is likely that decisions about amalgamation might come in waves. However, what is certain is that the decision-making process will not be a simple one, or one taken in only a short amount of time. Thus, it is highly possible that agreements in principle will be achieved well before state parties ratify the details.

Thus, once overall decisions in principle about mandate, structure and financing (at a minimum) are taken, de facto amalgamation into CAREC could begin.

Given the likely state of CRDTL, especially if it were being “wound up”, there would be few problems (once mission and financing issues relative to future pharmaceutical quality assurance functions were resolved) to commence offering new pharmaceutical quality assurance functions at CAREC. Likewise, because CFNI is also a PAHO-specialised centre sharing a common management system with CAREC, amalgamating its functions into CAREC would not seem to be difficult, especially given the fact that CFNI’s resource mobilisation efforts, while substantial in their own right, are not as broadly based as other current RHIs. Amalgamating CEHI might be somewhat more difficult due to the breadth and scope of its partnerships with other entities. Finally, the amalgamation of CHRC would be dependent on the early establishment of functional advisory bodies for research-granting work that would link research-related functions to major stakeholders like UWI and other post-secondary bodies.

One of the most important rationalisations that could be undertaken during amalgamation relates to the development of a new and consolidated regional approach to human resources management. The present fragmented approach to HR management and human resources utilisation in general could be replaced by a consolidated system.

As long as the amalgamation were to involve CAREC as a PAHO-specialised centre, the dual “international” and “local” HR systems would have to remain in place. However, while there are some obvious drawbacks to this approach, the reality of the dual systems is that of an amalgamated workforce of approximately 200, the remaining international staff would number less than 20, of which approximately six would be long-term former CFNI administrative and support personnel. Turning to CEHI’s personnel, only a few are engaged under the CARICOM standard. It would not be difficult, or costly, to translate them to international status in a new body should that be required.

Thus over 150 locally engaged staff could benefit from common HR rules and procedures that would be based on refreshed CAREC staff rules. Greater career mobility and the possibility of cross-postings could be one of the most important HR benefits of amalgamation. Some personnel might even see marginal salary increases by being “brought up” to CAREC wages scales, although there are obvious liabilities in doing so.

The issue of the theoretical duration of the employment contracts of locally engaged staff and a negative impact attributed to this may be overstated. Many organisations have “roll over” provisions to address these sorts of issues. Moreover, the greater critical mass of staff, combined with an overall greater organisational critical mass results in less possibility for organisational uncertainties, which could lead to unexpected cancellation of employment.

One major HR obstacle, however, which would likely not be addressed by HR consolidation, is that of the disparity between CAREC (or even CARICOM) wage scales and those of the private sector, or those outside the region itself. An amalgamated RHI could address any differences between staff engaged by the RHI itself and those hired by various donor projects by ensuring comparability between donor-supported personnel and those of the organisation itself. Raising wages to match the private sector, or attempting to build comparable benefits packages would entail considerable additional resources that would have to be raised – an uncertain prospect for the region at best.

Turning to the longer-term HR horizon with respect to an amalgamated RHI moving to wind up the PAHO relationship, there would be clear benefits, and also clear liabilities in doing so.

First, the differential between international and local personnel would be eliminated. However, the new entity would have to develop its own pension system, or enter that of the Caribbean community at large. Additional costs would ensue to cover the “employer contribution” and the long term liability if such a new pension were not effectively a continuation of the employee-contribution and one time severance payment that is presently in effect for locally engaged CAREC and CFNI staff. The new HR system also would have to absorb any remaining salary differential between international staff and locally engaged staff.

It might take upwards of two years or more to fully amalgamate the RHI functions into one new entity, even if CAREC were to be the vehicle for amalgamation. During this time, there are many reasons why an “expanded “ CAREC would benefit from remaining a specialised centre of PAHO.

- First, until an alternate source of regional decision-making and accountability has been built and has been tested to some extent, an amalgamated RHI operating as a PAHO-specialised centre would offer strong systems of internationally recognised accountability and decision-making during a period of considerable uncertainty and potential internal upheaval.
- Second, operating the amalgamated RHI as a PAHO-specialised centre might enable PAHO and the new RHI to put into place means of better coordinating the other functions of PAHO within the region
- Third, until the region addresses the broader issues of payment of quota fees to regional organisations, operating the new RHI as a PAHO-specialised centre would probably continue the PAHO practice of off-setting non-payment of quota, at least as it relates to the former CFNI and CAREC – which together constitute the overwhelming majority of quota payments to RHIs as a whole. It should be recalled that CAREC secures about US\$ 2.5 million from quota, while CFNI adds a further US\$250,000. When PAHO funding is added as a second type of “core funding”, the PAHO contribution to CAREC and CFNI functions would total in the range of US\$ 5.5-6 million. By contrast the other RHIs, assuming full payment, would produce a combined quota payments from member states in the range of US\$1 – 1.2 million.
- Fourth, amalgamating all the RHI functions into CAREC would enable the new entity to take advantage of PAHO’s internal management systems and would ease the transition of regional staff into the HR paradigm that CAREC uses to engage local personnel.

It should be emphasised that such an amalgamation into CAREC, while possible, would not be simply a paper-driven or pro forma process. The CAREC Council, COHSOD, the senior leadership of PAHO and key donors would have to work very closely to actually shape and implement amalgamation into CAREC.

The costs of this second step – amalgamation into CAREC – cannot be ascertained at this time. The mandate and financing related work of the Amalgamation Task Force would ascertain exact costs. However, without prejudice to any work that such a body might undertake, some types of new costs appear to be inevitable, which include, but are not limited to:

- Increased salary costs to bring non-CAREC regional staff up to CAREC levels (themselves generally seen to be inadequate)
- Severance packages for the few personnel who might become redundant
- Legal service costs to PAHO to formulate the amalgamation
- Some addition travel costs to enable the widely scattered management team (a sub-director at each non-CAREC location) to communicate and to forge a management team (possibly monthly management committee meetings rotated among the several venues)

The source of funding for the additional costs cannot be assumed by PAHO alone.

iii) Regionalising Governance

The consolidation of RHI functions into CAREC as a specialised centres is either an end in itself, or *an interim* step on the road to the full regionalisation of RHI governance.

Senior regional decision-makers and PAHO would have to determine during the preparatory stages of amalgamation whether there was sufficient willingness and sufficient means to move beyond the level of a consolidated PAHIO specialised centre to contemplate winding up the PAHO relationship, and thus regionalising the governance and the financing of an amalgamated RHI.

Thus, the potential third step in development of a unitary and regionalised RHI relates to building regional capacity to plan, manage and oversee a major regional resource. Also, if the PAHO relationship were to be wound up, the region would have to develop its own financial guarantee mechanism to replace that of PAHO's that has provided a level of security for CFNI and CAREC over the years. Simply put – who would be the “banker” and financial guarantor for the amalgamated entity?

Regionalising governance, at a minimum, would entail a new governing board, most likely comprised of ministers for the entity (and likely an intercessional executive committee of selected ministers), new advisory panels (most likely several to reflect the diversity of interests that an amalgamated entity would serve) and a considerably strengthening of CARICOM Secretariat to act on behalf of the governing body.

The means to strengthen the CARICOM Secretariat are presented in more detail in Option 4. However, at this time it is sufficient to note that the regionalisation of RHI governance would be effectively impossible without the strengthening of the CARICOM Secretariat.

In short, the third step in developing both an amalgamated and regionalised RHI may be technically and procedurally problematic; and thus leave the concept of amalgamation at the level of amalgamation within CAREC, and CAREC (most likely re-branded) remaining a specialised centre of PAHO.

b) Costs

Unlike Option 1, this and subsequent options involve four distinct level of costs: the one time costs to conduct a care mandate and financing review likely to take approximately a year to complete, the subsequent one time costs to modify governance systems and conclude new multi-party agreements, the on-going cost inherent in varying levels of strengthening the CARICOM Secretariat; and the on-going cost to enable RHI Directors to meet on a more frequent schedule (either as CEOs of separate entities, or “managing directors” of elements of a combined RHI as the case may be).

Option 2 is the most demanding of the five presented due to the implications of merging all RHIs into a new entity, ensuring that the new body has a well defined core mandate that is also fiscally sustainable and ensuring that its governance is refreshed and its decision-makers more engaged.

While it is impossible to predict what a core mandate and financing review may recommend, it is possible to estimate the costs for a year long review of this nature. Universalia is of the view that a team of three professionals, led by a senior professional/manager should be established under the auspices of the CARICOM Secretariat to undertake the responsibilities described earlier. The costs for a one year task force are estimated to be in the \$450,000 range.

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As noted in the description of the option itself, the review of mandate/financing would be followed by a period of reorganisation and governance renewal. At least a year would be needed to complete the required work. Universalialia recommends that the core mandate/financing team then undertake these governance-related function, albeit at a somewhat reduce level of personnel. Universalialia estimates that this second phase would take at least on year and would cost in the range of \$330,000.

Turning to on-going costs, Universalialia estimates that the cost to strengthen the CARICOM Secretariat to assume additional managerial responsibilities would be in the range of \$175,000 per year, of that about \$75,000 being used to support the innovative “virtual network” that is described in more detail in Option 4. As well, Universalialia includes a small on-going cost of \$25,000 per year to facilitate managerial meetings among the new combined RHI management team.

All these costs are presented in the following table”

OPTION 2		
Mandate and Financing Review Year 1	Team Leader	\$100k
	Professional	\$60k
	Professional	\$60k
	Sec/Clerk	\$25k
	Travel	\$60k
	Admin	\$40k
	Honoraria for Expert Advisors	\$25k
	Travel for Expert Advisors	\$25k
	Local consultants @ \$600 per day	\$60k
	Total	\$455 K
Governance Consolidation Year 2	Team Leader	\$100k
	Professional	\$60k
	Sec/clerk	\$25k
	Travel	\$40k
	Admin	\$25k
	Local consultants	\$80k
	Total	\$330K
CARICOM Sec. Strengthening On-going per year	Senior Professional	\$100k
	Network Communications	\$25k
	Network Travel	\$25k
	Network Administration	\$25 K
	Total	\$175k
Other Costs	Travel for Directors	\$25k

Universalialia notes that the CARICOM Secretariat would have to mobilise the resources to mount these activities. The most likely source of funding might be a combination of major donors working together to support a 2-3 year programme of institutional strengthening where individual donors might agree to support distinct components of the process.

c) Benefits

While there are clear benefits in amalgamating RHI functions into one entity, even if that entity was to remain a PAHO-specialised centre, there is also a number of major draw-back to contemplating amalgamation.

i) Strengthening of Caribbean Resources

Clearly amalgamation, especially if accompanied as a pre-condition by a full mandate review, would be beneficial to the Caribbean as a whole. Theoretically, amalgamation would increase opportunities for harmonising programming. It would enable consolidated resource mobilisation activities. It would eliminate current RHI overlap and, working with other elements of PAHO, might result in greater degrees of cross – organisational coordination.

However, amalgamation also poses several risks relative to the strengthening of Caribbean resources. First, the magnitude of CAREC and the magnitude of its resource mobilisation functions targeted toward major international priorities such as HIV/AIDS, might overwhelm smaller more narrow subject matter such as those relative to the environment, or to food and nutrition. It is inconceivable that a mandate review would not reduce areas of responsibility related all the current RHIs. However, there would be a natural tendency to see the CAREC work as the “real” core of the new entity and to designate “the rest” to the CAREC-base / core.

ii) Enhance Collective Programme Delivery

Clearly an amalgamated RHI would constitute the highest level of collective programme delivery. By definition all RHI programming would be the responsibility of the new amalgamated RHI.

iii) Strengthened RHI Internal Capacity

The amalgamation of RHI functions into one entity would mark a significant strengthening of RHI capacity, assuming that all staff were integrated into a common HR systems (excluding a few residual international staff) thus enabling the development of enhanced career opportunities. Laboratory functions could be rationalised and common purchasing and training could be implemented. Common computer systems would also be introduced.

iv) Strengthened Regional Governance

Even if an amalgamated RHI were to remain a PAHO-specialised centre, due to the inability of the region to provide an alternate governance and oversight mechanisms, regional governance would be strengthened.

A new refreshed “CAREC Council” and a new group of advisory committees, as recommended by Universalis in the stand-alone CAREC report (to enable the various functional areas of the amalgamated organisation to draw on the breadth and scope of scientific, academic and professional advice) would be a major governance improvement over the fragmenting that exist at the present time. A new “CAREC Council” would be able to better take into account competing priorities and better balance priorities with resources.

v) Enhance Sustainability

It is difficult to ascertain whether an amalgamated RHI would be more sustainable than the current group RHIs. Clearly, if the financing review that has been suggested as a pre-condition for amalgamation were to move in the direction of more reliance on cost-recovery for RHI core services, the new amalgamated RHI would be vastly more sustainable than any current RHI due in large part to a larger critical mass, and a large potential revenue base.

However, the sustainability of an amalgamated RHI, and even that of a PAHO-specialised centre, would be highly reliant on PAHO itself. PAHO “core funding” and PAHO’s guarantee of CFNI and CAREC levels of quota payments would be a precondition for sustainability. Even with that, unless PAHO were to agree to also guarantee the level of quota payments currently derived from CEHI, CHRC and CRDTL, the newly amalgamated organisation might be facing a degree of budgetary uncertainty.

The sustainability of an amalgamated RHI that evolves away from being a PAHO-specialised centre is far less certain.

Simply, who becomes the banker and financial guarantor? It is not at all certain and more than likely that PAHO’s relationship with an non-PAHO amalgamated RHI would be significantly different, more probably towards non-financial technical cooperation and liaison with the new entity and not even like any other major donor that concentrates on “project funding.” In addition, unless the CDB were to step in as the financial guarantor for the amalgamated RHI, a function that would be totally foreign to it, no other regional body has the financial scope to provide the “safety net” that PAHO currently does.

vi) Strengthen National Capacities

The current geographic approach to RHIs, i.e.: environment staff and functions in St. Lucia; food and nutrition (nearly exclusively) in Jamaica, epidemiology in Trinidad potentially could be broken down into sub-regional functional teams whereby more RHI services would be available in more locations. This might considerably benefit the nations where the amalgamated RHI has sub-centres (already nations with relatively high levels of capacity in two instances). However, it would not have a significant impact on the many other regional nations where the new RHI would not have a physical presence.

Conversely, however, the amalgamated RHI, by creating programming synergies and economies of scale, and by the consolidated use of information technology might be able to offer more sensitive programming to individual nations.

vii) Enhance International Linkages

An amalgamated RHI, especially one based on CAREC, would have the opportunity of reaching out globally in ways that five separate bodies simply could not do. However, much of this outreach might be related to former CAREC functions and not necessarily those related to all the potential mandate areas of the organisation.

Both CFNI and CEHI have established strong international presences; the latter has been recognised by lead international partners such as elements of the UN system, and the World Bank as a valuable local interlocutor. Amalgamation might weaken the ability of the elements of a new unitary RHI to engage international partners.

Conversely, however, the health research function, formerly largely limited to the small CHRC might considerably expand its outreach (should it remain part of the mandate of the amalgamated RHI) by being part of a larger and more internationally recognised body.

d) Universalialia's Overall Assessment

Universalialia is of the view that while the amalgamation option, even one where the new entity remains a PAHO-specialised centre for the foreseeable future, has many positive benefits and has been called for by many informants, on balance the risks and the potential costs outweigh the benefits.

First, the process of amalgamation, even if agreed to in principle, is in no way certain. To move beyond simply merging RHIs into one, but to amalgamate and refresh mandate and financing entails numerous high-level decisions and the possibility of deadlock, which would bring the whole process of RHI rationalisation to a halt. Simply combining RHIs together would leave numerous systemic weaknesses un-addressed.

Second, for amalgamation to be rational, it would have to be undertaken in a systematic fashion and not a process of ad hoc "interim" decisions. Thus, until the entire process were to be in place, short-term improvement such as that related to the pharmaceutical quality assurance function would be difficult, if not impossible to implement.

Third, the source of the funds to support amalgamation has yet to be determined and is not likely to be from PAHO. As well, PAHO's financial role in an amalgamated RHI would remain to be clarified and a major reduction of the PAHO role would have very serious negative consequences.

Fourth, amalgamation would take a great deal of time, in effect delaying RHI rationalisation into the medium-term future. Unlike the approach of a modified status quo, or the evolutionary approach which follows, the primary decision to amalgamate RHIs would not be an easy one, or one that would be taken lightly by heads of state. From a strictly temporal basis, it is reasonable to presume that heads of states would not be in a position to take even the primary decision in principle during 2005. The report of the region's Health and Development Task Force and its recommendations would have to be taken into account before considering RHI amalgamation. The need to identify support for the Amalgamation Task Force, as noted above would not be easy or speedy. Thus, the very decision to move forward would likely not be taken before 2006. Assuming it was funded, the Task Force would need roughly a year to do its work and to engage COHSOD (and not even necessarily heads of state) in the review of the amalgamation blueprint. Given the cyclic nature of regional meetings of ministers, and that of heads of state, it is not unwise to assume that decisions relative to a "blueprint" would occur in 2007 at the earliest, thus placing amalgamation into the 2008 and onward window. If heads of state decided to regionalise governance as a final step in amalgamating, and assuming that they could overcome the hurdles outlined above, regionalisation could not be expected to occur before 2008/09.

Universalialia believes that the prime advocates for amalgamation tend to see RHIs in terms of entities and do not conceptualise RHIs in terms of their functions, and how these function contribute to technical cooperation to support regional public health goals.

6.4.3 Option 3: A Regionalised CAREC

The Option in Brief

Content	<ul style="list-style-type: none"> • Regionalise the governance of CAREC, winding up the PAHO administrative and managerial relationship for CAREC • Other RHIs to continue un –affected • A mandate and financing task force to address CAREC sustainability issues (could be expanded)
Governance	<ul style="list-style-type: none"> • A “new “ CAREC with a new regional board and new regional advisory functions
Costs	<ul style="list-style-type: none"> • About \$315,000 to conduct a core mandate/financing review • About \$200,000 for governance transformation • About \$175,000 in on-going costs to strengthen the CARICOM Secretariat
Pharmaceutical Quality Assurance	<ul style="list-style-type: none"> • The functions likely integrated into the new CAREC
CARICOM Secretariat	<ul style="list-style-type: none"> • CARICOM Secretariat would need to be strengthened to be able to oversee such a large regional institution

a) General Approach

This approach has been developed in response to the calls from a number of respondents to wind up the PAHO administrative and managerial relationship with respect to CAREC and to re-establish CAREC as a regionally governed body, independent from extra-regional sources of governance.

The option is in essence very simple on one level, and potentially very difficult on another.

The wrapping up of the administrative and managerial relationship with PAHO could be accomplished by simply not renewing the overarching CAREC agreement and by putting in place in its stead a new joint agreement that would in essence “carry on” CAREC, but as a body with no formal governance linkages to PAHO, and thus no linkage to WHO as well. This could be accomplished by a period of transition and thus the development of a transitional multi-party accord that would see at its conclusion the full acceptance by the region for all aspects of the governance of CAREC.

In terms of CEHI, CHRC and CFNI, this approach would have little, if any, short-to-medium term impact. The other RHIs would go their own way, presumably with CFNI remaining a PAHO specialised centre; while for CEHI and CHRC, regional governance patterns would remain the same. Several informants who advocated the regionalisation of CAREC alone suggested that other RHIs might wish to “join” the new CAREC over time.

In terms of the pharmaceutical quality assurance functions, this approach leaves an uncertainty about how to best address these vital regional functions. A strong case could be made to integrate these functions into a “new” CAREC and to wind up the current CRDTL. Conversely, an argument could be made, to revitalise and shape a “new” CRDTL as an independent body in an effort to reduce CAREC’s already broad core mandate.

In terms of governance, the implications of regionalising the governance of CAREC and thus winding up the formal governance link to PAHO imply that the region would have to review the effectiveness of the current governance paradigm of CAREC – its “Council” and its Scientific Advisory Committee”.

It is likely that due to the overall importance of CAREC to the region as whole, CARICOM as a regional body and its Secretariat would likely need to play an enlarged role in the oversight and governance of a regionalised CAREC similar to regulatory oversight of health institutions and facilities that have their own boards in other jurisdictions. Thus, the strengthening of the CARICOM Secretariat is also implicit in this approach, although likely to a lesser degree that with respect to Options 2 and 4.

Because this approach would be CAREC-centred, there is very little likelihood for the overall suggested rationalisation of RHI mandates and financing. Rather, it is more likely that a new CAREC itself would need to undertake both functions in order to guide its new set of decision-makers.

Central to this approach is the perception of some stakeholders that the PAHO administrative and managerial presence, and thus its governance role with respect to CAREC, has become detrimental. Nevertheless, in contemplating a regionalised CAREC, in the absence of more substantive approaches, decision-makers need to be cognisant that contemplating winding up the PAHO governance relationship with CAREC (and presumably maintaining it for CFNI) raises a number of potentially very costly and divisive factors.

First, PAHO’s practice of absorbing non-payment of quota to CAREC presently results in PAHO carrying an unfunded liability in the range of \$US 4 million in unpaid quota contributions. It is only reasonable to assume that other PAHO member states would seek to recoup this debt and would not simply be willing to write it off.

Second, based on discussion with senior PAHO officials, it is also very unlikely that PAHO member states would (or even could) agree to provide a “new” CAREC with the current sums of money that in essence are PAHO’s core contributions. While PAHO would not likely abandon a “new” CAREC overnight, it is likely that PAHO would have little choice over a transitional period but to withdraw its level of financial support and transform its relationship to one based on technical cooperation and liaison with the new third party. Thus, a “new” CAREC might face even more serious pressures on its “core” than the “current” CAREC does.

Third, a “new” CAREC, devoid of any formal governance relationship with PAHO could not define itself as an international body. Several major donors have indicted that CAREC being a PAHO-specialised centre provides a degree of certainty to them with respect to organisational performance, service standards and governance / oversight considerations.

Fourth, a regionalised CAREC would face the challenges of securing an alternate financial guarantor / banker to play the roles that PAHO does at this time. The CDB as a regional Caribbean institution could theoretically play this role. However, doing so would be a major programmatic departure for the CDB and it is not at all certain that the organisation could, or would wish, to act as the financial guarantor for a “new” CAREC.

b) Costs

It is very difficult to estimate the long-term direct costs of regionalising CAREC alone. Some obvious areas of new costs, over and above those that might relate to delinquent quota payments now being carried by PAHO, would relate to:

- The strengthening of a new governance paradigm for CAREC
- The strengthening of CAREC's internal accountability management and oversight functions to provide sufficient transparency with donors
- The enhancement of CARICOM Secretariat functions to oversee what would become the region's largest public health institution
- The provision of working capital reserves to ensure the viability of CAREC programming in instances of shortfalls in member state quota payments

However, because Option 3 is largely focused on CAREC, its pure implementation costs are somewhat less than those, which address a broader approaches to RHI rationalisation.

For example, the core mission/financing review would be somewhat limited in comparison to those options that involve amalgamation or extensive harmonisation. Likewise, because the subsequent governance renewal would be limited to CAREC, its costs would also be less.

However, the ongoing costs for the CARICOM Secretariat would remain the same, due to the increased requirement for the Secretariat to play a major role in the monitoring and planning of what would become a major Caribbean regional institution.

OPTION 3		
Mandate and Financing Review Year 1	Team Leader	\$100k
	Professional	\$60k
	Sec/Clerk	\$25k
	Travel	\$40k
	Admin	\$30k
	Local consultants @ \$600 per day	\$60k
	Total	\$315 K
Governance Consolidation Year 2 (or onward)	Team Leader	\$100k
	Sec/clerk	\$25k
	Travel	\$25k
	Admin	\$25k
	Local consultants	\$30k
	Total	\$200K
CARICOM Sec. Strengthening On-going per year	Senior Professional	\$100k
	Network Communications	\$25k
	Network Travel	\$25k
	Network Administration	\$25 K
	Total	\$175k
Other Costs	Travel for Directors	\$25k

Universalialia notes that the CARICOM Secretariat would have to mobilise the resources to mount these activities. The most likely source of funding might be a combination of major donors working together to support a 2-3 year programme of institutional strengthening where individual donors might agree to support distinct components of the process.

c) Benefits

The direct benefits of an approach that would see other RHIs remain relatively constant while seeing CAREC “regionalised” (and possibly expended with the addition of the pharmaceutical quality assurance functions) are few in number.

They relate only to the views that CAREC’s ability to serve the region is being affected negatively by what informants contend to be limitations caused by its status as a PAHO-specialised centre and thus compliance with UN system procedures.

i) Strengthening Caribbean Resources

An approach, which concentrated, on CAREC would have little positive benefits with respect to the overall strengthening of Caribbean resources. The efforts to regionalise the governance of CAREC and the efforts to strengthen its governance as a regional entity probably are disproportionate to the actual benefits. More importantly, the regionalisation of CAREC, in the absence of combining its governance with the two other RHIs – CEHI and CHRC that are not PAHO centres – results in more fragmentation of Caribbean resources and potentially more competition for scarce regional resources. CAREC, as the vastly largest of the three regional RHIs would likely dominate the others in terms of resources.

As with several other approaches, however, adding the pharmaceutical quality assurance functions to CAREC would be beneficial, especially if the functions were to be enlarged to address not simply the laboratory aspects, assuming they could be financially sustainable.

ii) Enhance Collective Programme Delivery

A CAREC-centred approach would not significantly improve the collective delivery of programming, or the possibility for more collective actions. Regionalising CAREC would fragment the PAHO presence and would reduce the possibility for more cooperation among RHIs, and other elements of PAHO working in the Caribbean. Because such a approach would not see combined governance of the regional RHIs, there is likely to be little immediate prospect for formalised combined efforts among them.

However, as it is beginning to take place between CAREC and CHRC, nothing in this option would preclude RHI directors working more closely together at an operational level. Thus, to some extent, virtually every option, including this CAREC-centred approach would envision increased operational collaboration among RHIs. The core mandate/ financing review, which is suggested for all options save for the “status quo”, would likely address such level of operational coordination.

iii) Strengthen Internal Capacity

One of the potential benefits of a CAREC-centred approach would relate to the elimination of the dual human resource management systems present at CAREC. A regionalised, CAREC, presumably with a harmonised HR infrastructure, might be better able to attract and retain qualified staff. However, for it to do so, rates of pay and other benefits would have to be comparable or at least more competitive with, the CARICOM and the private sector, with the attendant unfunded liabilities in doing so. If a regionalised CAREC were to acquire the pharmaceutical quality assurance functions (assuming a viable approach to their sustainability), the refreshed CAREC would have more career opportunities and would have a larger intrinsic set of functions. Thus, it would likely be a stronger organisation, assuming that it had a financial base to match and sustain its functions.

A CAREC-centred approach would have little impact on the remaining RHI, as they would remain stand-alone entities. For example, opportunities for human resource management synergies among CAREC and CFNI would be lessened, with one being “regionalised” while the other would remain a PAHO-specialised centre.

iv) Strengthen Regional Governance

The regionalisation of CAREC would significantly increase the regional responsibility for decision-making, and, of course, overall regional accountability for CAREC’s work. Much of what some informants saw as ambiguities in CAREC’s present governance would be eliminated.

However, for the regional to actually “govern” CAREC, the current CAREC Council and the current advisory committee structure would probably have to be significantly strengthened. At a minimum, given the regional commitment to a new CAREC inherent in “regionalisation”, a stronger ministerial presence would be required, as would some form of executive committee structure to provide for on-going and interactive senior decision-making.

Paradoxically, however, regionalising CAREC governance while not addressing the governance of CEHI and CHRC does not result in “better” regional governance; rather, the additional governance burdens inherent in a new CAREC would increase the burden of regional governance. Governance would remain fragmented with no direct governance linkages between a new regionalised CAREC, CHRC and CEHI.

One potential longer-range governance benefit of this option might be to use the refreshment of CAREC as a sort of prototype for overall governance renewal. Thus the strengthening of the RHIs (other than CFNI) might benefit from lessons learned during the CAREC experience.

To garner the possible governance benefits of regionalising the governance of CAREC, additional challenges also would be placed on the CARICOM Secretariat which would likely require institutional strengthening in order for it to play a more meaningful role with respect to the oversight, planning and management of what would become a major regional institution that would be fully and exclusively responsible to Caribbean senior decision-makers. A minor governance issue also relates to the fact that CAREC serves more entities than the CARICOM countries. Thus, one additional governance challenge would be to develop a means to ensure governance participation of those non-CARICOM entities, while at the same time vesting in senior CARICOM decision-makers real power and accountability.

v) Enhance Sustainability

The sustainability of RHIs in general, and CAREC in particular, is not enhanced by an approach that would regionalise CAREC while leaving other RHI relationships essential untouched.

Assuming a satisfactory negotiation with PAHO relative to the un-paid quota contributions now being carried by PAHO, a “new” CAREC, as has been noted in this discussion, faces three large sustainability challenges:

- First, some entity would have to replace PAHO as the guarantor of quota payments. It is unlikely that any regional institution (including the CDB) would assume such a function given the relatively poor track record for payment by some member states and the relatively low likelihood of future prompt payments by these same states.
- Second, some entity also would have to play the role of “banker” for CAREC to ensure the smooth flow of funds. Otherwise, a new CAREC would have to significantly strengthen its own legal and financial management systems and capacities to satisfy the requirements of donors.
- Third PAHO’s own core payments to CAREC most likely would have to be replaced over a transitional period.

A new CAREC, devoid of PAHO playing the financial guarantor role and likely devoid of PAHO providing core funding, would immediately face a requirement to conduct a major mandate and financing review to ascertain the very nature of “core programming” and how to finance it. However, this review would only be for the new CAREC, as it would have little applicability to the other RHIs. Thus, it is not possible to create a model where a new CAREC would become more dependent on donor support and thus more reliant on donor priorities and not necessarily regional ones.

Turning to other RHIs, a regionalised CAREC might become more competitive with them for donor support. In the absence of the coordinative mechanisms noted with respect to several other approaches to RHI rationalisation, the possibility that other RHIs might “lose out” cannot be discounted.

More importantly however, the regionalisation of CAREC may likely result in PAHO determining to manage more of its resources itself via its CPC or its country offices, in line with the recently developed sub-regional strategy. Thus, the potential for reducing the availability of PAHO support for RHIs in general cannot be discounted.

Of equal, if not more importance, major donors contacted noted that what they would perceive as an “independent” CAREC would probably not be seen in the same light as CAREC being part of a major multilateral body. Although some donors have had concerns with respect to independent oversight at PAHO as a whole, it should be recalled that PAHO mobilises about \$250 million in extra-budgetary contributions and has developed a variety of means to satisfy the oversight needs of donors while ensure a consistent global approach to accountability. Some donors also have raised concerns relative to the present managerial and accountability capacities of CAREC; and have indicted levels of concern about a CAREC that would operate outside of the parameters of PAHO. In all fairness, however, some other donors have expressed the opposite views, seeking to work with CAREC directly.

A few informants have suggested that a regionalised CAREC might be capable of innovative financing mechanisms such as foundations, and might be able to attract additional new donors. With respect to new donors, CAREC already has been highly successful in resource mobilisation campaigns with national, multilateral and with even private sector (philanthropic) partners. The assumption that a foundation could be used to increase levels of funding, while ambitious may not be fully realistic given the overall level of global resources being directed towards the Caribbean.

Turning to the concept of a foundation, while the idea may have merits, it may not be reasonable due to the move away from unrestricted donations among philanthropies generally, towards tied programme / project funding with tighter accountability and reporting requirements. Moreover, a foundation of any real magnitude would require the presence of a reliable “banker” as noted above.

vi) Strengthen National Capacity

An approach that would regionalise CAREC would have little if any positive impact of building capacity with respect to the major public health challenges of the region.

vii) Enhance International Linkages

CAREC at this time has a high level of international prestige, far more noteworthy than any other RHI. At a minimum, a new regionalised CAREC would likely retain those levels of contacts. Again, however, some major donors have expressed concerns about CAREC’s own internal capacities and have tended to favour CAREC remaining a part of PAHO; while some other donors would wish to work outside the PAHO structures and directly fund CAREC.

b) Universalialia’s Overall Assessment

From the above discussions, it should be evident that an approach which would concentrate only on regionalising CAREC, as some informants have suggested, is not in fact a rationalisation of the RHIs to promote increased technical operation in public health. Rather, it is largely a governance plan related solely to CAREC that contains a significant number of risks for the region as a whole, while providing very little likelihood of improved overall RHI organisational performance.

Universalialia is of the opinion that this option and the first – the Modified Status Quo, are possibly the least relevant of the five general approaches presented.

It is however possible to contemplate combining this CAREC-focused option with a modified status quo wherein the renewal of CAREC alone would be combined with the informal RHI groups discussions which form the core of Option 1. However, the only benefit of contemplating such a combination might be the increased regionalisation of CAREC governance (albeit carrying increased governance costs as well). This variant does not significantly address the totality of the challenges facing the region with respect to RHIs as a whole. By focusing its attention on CAREC, it is likely that other issues might be subsumed. Furthermore, the amount of time to undertake this CAREC centred approach is probably similar to that needed for more substantive RHI rationalisations.

6.4.4 Option 4: An Evolutionary Approach to RHI Rationalisation

The general conclusions presented at the commencement of this section of the Report point to the need for some approach to rationalisation of the current Caribbean RHI. The first approach suggested, the informal modified status quo, would result in only minor improvements and leave many major, mandate, funding and governance issues outstanding. The second approach, the amalgamation of RHI function into one RHI, theoretically would produce considerably more improvements. However, the viability of this sort of approach itself is not certain. Its potential for disruption and confusion are significant; and its likely final step, the regionalisation of governance poses significant risks relating to PAHO participation in regional public health, and also the ability of the region to sustain the finances of an amalgamated RHI. Likewise, the time it would take to logically amalgamate would be significant. Option 3, the regionalisation of CAREC has few positive benefits and many significant drawbacks. Thus, several approaches to a middle ground would appear to be required which would address the mandate, funding and governance shortfalls.

The Option in Brief

Content	<ul style="list-style-type: none"> • RHIs remain stand-alone entities • Mandate and financing and programming rationalisations • Over time combine governance, and wind up the PAHO administrative and managerial roles and thus its governance functions for CFNI / CAREC
Governance	<ul style="list-style-type: none"> • Begin by cross-representation on existing boards • Strengthen by adding executive committees, more explicit oversight provisions, more representative membership on boards and advisory groups • Eventual move to one combined board for all RHIs with separate advisory bodies • PAHO administrative and managerial relationship with CFNI and CAREC eventually concluded
Costs	<ul style="list-style-type: none"> • About \$450,000 over one year to conduct core mandate /financing review • About \$330,000 over a subsequent year to undertake governance transformations • About \$175,000 per year in on-going cost to the CARICOM Secretariat
Pharmaceutical Quality Assurance	<ul style="list-style-type: none"> • The functions likely integrated into CAREC
CARICOM Secretariat	<ul style="list-style-type: none"> • CARICOM Secretariat would need to be strengthened to be able to oversee such a network by means of the “virtual” model suggested for Option 2 • Establish an RHI Steering Committee led by CARICOM Secretariat

a) General Approach

The evolutionary approach to RHI rationalisation is based on the understanding that the process of institutional reform is in itself an iterative one whereby one improvement can lead to others that may have been unanticipated at the start. It is also a process whereby decision-making does not need to be constrained by predetermine fixed assumptions.

The evolutionary approach to RHI rationalisation begins where the modified status quo approach ended - at the point where RHI Directors – and potentially PAHO- begin to voluntarily work together to address operational level issues – and builds on functional and pragmatic governance, resourcing, and mandate renewal mechanisms. Given that there appear to be little classic administrative overlap or duplication among RHIs and that it is unlikely that should the region choose the amalgamation route, funding would be available for new quarters for a new entity (notwithstanding other reasons mitigating against physical amalgamation), the evolutionary approach would see current RHIs remaining as separate entities, but significantly more linked by means of more common governance systems, common accountability mechanisms, the potential for common HR systems, common planning systems. In short, the RHIs would become a true inter-related regional network.

The process of developing such an evolutionary approach to RHI rationalisation is again a three part process:

- Initial Working together
- Functional Rationalisation
- The Regionalisation of RHI Governance

At its core, this option would leave CEHI, CHRC, CFNI and CAREC as separate entities moving through a process of pragmatic programmatic rationalisation, leading to a harmonisation and eventual amalgamation and regionalisation of their governance, including the regionalisation of CAREC's and CFNI's governance (and thus the fading away of the direct PAHO relationship with both). This option is predicated on the assumption that Caribbean ministers would wish to eventually take a much more active role in the governance of RHIs, and also would wish to take the parallel responsibility for ensuring their financial viability.

This option is also predicated on the assumption that full merger into CAREC would submerge the unique identities of smaller RHIs, especially CEHI and CHRC. Like Options 2, and 5 (to follow), it is also a precondition that a mandate and financing task force address long-standing issues for all RHIs noted earlier in this report.

This option also assumes that CAREC would inherit new pharmaceutical quality assurance functions and secure the funding to do so.

Thus, in the end, four RHIs would remain separate, but commonly governed regional entities that would share many common systems, but retain their unique individual personalities.

i) Working Together and Planning

The first step of the process of evolutionary rationalisation would be similar to the approach described earlier wherein RHI Directors (hopefully accompanied by PAHO) would begin to work together in a voluntary fashion to address operational level issues relative to short-to-medium term programming issues. However, unlike Option 1, the “modified status quo” approach, the workings of the Directors now would be formally chaired by the CARICOM Secretariat. More importantly, the informal “working together” would be only for a short period of time, while the other major elements of the first step came into play.

Unlike the modified status quo approach, the evolutionary approach borrows from “Amalgamation” the concept of a Task Force to address substantive issues and to provide senior regional decision-makers with concrete advice relative to mandate, financing, strengthened governance and also the future of the pharmaceutical quality assurance function. The mandate of such a Task Force would be largely similar to that described earlier, with the proviso that it would be unlikely that organisational consolidation would be its product. The Rationalisation Task Force would report to the CARICOM Secretariat and thus onwards to COHSOD.

The only outstanding organisational issues would be that of how to operationalise the pharmaceutical quality assurance functions that the Task Force identified. However, if, as Universalis has suggested, a future regional quality assurance function not be directly involved in actual testing (and thus address other regional pharmaceutical matters as well), it is likely that such coordinative/advisory/ training services could be accommodated within another RHI, most likely CAREC.

It is very important to recall that the formal mandates of the three programmatic RHIs (CAREC, CFNI and CEHI) are sufficiently flexible to accommodate a de facto programmatic rationalisation such as this without recourse to formally amending their constituent agreements.

The cost of a Rationalisation Task Force would be less than those needed to address amalgamation. Thus, it is reasonable assume that a Rationalisation Task Force would require in the range of \$350-400,000 to complete its work. The detailed costs for this Task Force are presented later in the description of this option.

Clearly the source of such funding remains to be determined. However, given the interests of PAHO and major donors in the overall future of technical cooperation in public health in the Caribbean and the overall support that some major donors direct toward institutional strengthening, it is not unlikely that a collaborative approach to funding could be developed.

The suggested Rationalisation Task Force likely would be able to complete its work in about a year after securing funding. Assuming that decisions were taken in mid to late 2005 to move towards an evolutionary approach to RHI rationalisation, a task force would be able to lay before COHSOD definitive plans for governance, mandate, and financing renewal by the regularly scheduled third quarter meetings in 2006.

This option’s iterative approach to RHI rationalisation probably does not require the same level of heads of government engagement as does Option 2, and to a lesser extent, Option 5 (to follow). However, if the Task Force were to recommend new largely across-the board approaches to ensuring long-term financial viability, likely by means of the introduction of varying levels of “user pay”; it is not unreasonable to assume that heads of government might wish to address these matters.

Thus, the first phase of this evolutionary approach might take up to two years, given the nature of inter-ministerial and intergovernmental meetings.

Beginning the process of strengthening the CARICOM Secretariat also would be an important component of such a evolutionary approach to RHI rationalisation and would need to occur during the first stage of the process as well.

The CARICOM Secretariat, as presently constituted, has limitations in increasing its roles relative to the coordination, management and oversight of RHIs. Thus, Caribbean senior decision-makers – Ministers of COHSOD, Ministers of Health and heads of government - presently do not have a working arm to assist them in taking strategic decisions and to assist in addressing the totality of regional technical cooperation with respect to public health.

Traditional approaches to organisational strengthening to address the shortfalls of the CARICOM Secretariat would tend to concentrate on adding more personnel, more technology and more training. They are highly costly and as has been shown in many situations worldwide tend to result in benefits only as long as additional funds are present. In essence, they presume to provide a bridging mechanism during which time an organisation is expected to develop its own revenue generating capacities to ensure the long-term sustainability of such new functions.

Such a traditional approach would likely not be viable with respect to the CARICOM Secretariat, or its health/social development functions. First, while health may be an important regional priority as witnessed by the Nassau Declaration, it is not the sole social development priority of the region. Thus, strengthening the CARICOM Secretariat's capacity in the health sector might not be a viable alternative in the face of other priorities. Second, even if it were to be seen as a priority, the CARICOM Secretariat may simply not have the long-term resources to sustain a full-fledged health division with major RHI responsibilities.

Universalialia, therefore, came to address the matter of the potential strengthening of the CARICOM Secretariat from a functional standpoint, one which reflects a review of the totality of health management resources within the region, and one which best utilises new technologies.

Universalialia suggests a strengthening programme that would result in a "virtual" network of key informants and key managers assisting the small core staff of the CARICOM Secretariat.

The key to this virtual approach is the recognition of the major managerial functions that would need to be enhanced for the CARICOM Secretariat to play a more active role in the coordination, monitoring and management of RHI resources as truly regional resources for technical cooperation in public health.

Earlier in the horizontal findings section of this report, it was noted that the Secretariat, as it is currently constituted operates with varying degrees of effectiveness in relation to four major managerial functions:

- Strategic planning and advising senior decision-makers
- Coordinating resource mobilisation
- Monitoring performance
- Coordinating programming

Enhanced or new capacity is required in all four areas if the CARICOM Secretariat is to play a significant role in strengthening the ability of regional decision-makers to participate in the governance of the RHIs and, thus for any substantive programme of RHI rationalisation to have a reasonable prospect of long-term results. The potential goal of regionalising and combining RHI governance poses an additional set of challenges to the Secretariat, especially if regionalisation of CAREC and CFNI were to be seen as an eventual final step of this iterative approach. Equally importantly with respect to this option, the evolutionary and iterative nature of the option requires an on-going facilitative and coordinative role for the Secretariat.

Although not part of the formal terms of reference for this evaluation, Universalia teams as part of their stakeholder discussions acquired fairly broad knowledge of the capacities of various national Ministries of Health, from the perspective of their planning and managerial leadership. The Essential Public Health Functions studies conducted by PAHO in 2002/03 highlight the varying capacities of Caribbean nations with respect to managerial functions such as planning, surveillance, monitoring and evaluation. Universalia is also of the view that the more effective management of RHI resources, while an important management function related to regional public health priorities, probably cannot muster sufficient internal priority within CARICOM to warrant a full-fledged sub-secretariat. Rather, it appears that what may be possible to develop is an on-going low level presence, combined with the requirement for more intensive work on an episodic basis.

Universalia's non-traditional approach would be to tap into the internal resources of a number of member states to assist the staff of the CARICOM Secretariat to better coordinate, monitor and plan for the maximum use of RHI functions (notwithstanding organisational modalities).

For example, in the crucial area of Monitoring and Evaluation where both the CARICOM Secretariat and all RHIs presently experience shortfalls in capacity (notwithstanding some work undertaken by CHRC), a senior figure (a PS or CMO) could be asked to lead a small *virtual* team of experts drawn from his/her own ministry, or the ministries of other nations, or even external bodies such as UWI, the CDB, the PAHO CPC, etc. This team would assume responsibility for planning, coordinating, and reviewing Monitoring and Evaluation work with respect to the RHIs. The virtual team could report to the staff of the Secretariat involved in health matters. Thus, the staff of the Secretariat become in effect coordinators and synthesisers of peer contributions.

Virtual teams could be established for each of the four major managerial functions noted above.

In terms of costs, the Secretariat would face additional costs to establish the virtual network and to provide for the "out of pocket" or travel expenses of team leaders. Some additional expense would be required to provide the Secretariat with the a small working capital reserve. However, in comparison to contemplating the costs of building an RHI management team at the Secretariat, the proposed virtual network is clearly more cost-efficient. An estimate of the costs of such a virtual approach is contained in a subsequent part of the description.

Teams themselves probably would vary in size between three and five experts. Some teams might be led by key figures from an external body; for example, a team addressing the coordination of resource mobilisation could possibly be led by a CDB manager.

One of the most important benefits of the suggested virtual team approach relates to harnessing the breadth and scope of regional capacities as a whole. The virtual team approach allows for senior regional figures to work with the Secretariat to shape and coordinate technical cooperation in regional public health. Of course, final decision-making would rest with the senior management of the CARICOM Secretariat, as would the formal relationship between the Secretariat and ministers with respect to advice and recommendations.

In addition, such a virtual approach lends itself to a systematic phasing –in, possibly one function at a time so that capacity could be built. In a manner similar to what will be described below relative to other RHI rationalisations, the Secretariat might consider establishing an initial virtual team to address one of the four functions. Monitoring and evaluation probably lends itself best to such a “trial” function.

The virtual team approach also may lend itself to the ability to attract relatively small scale technical assistance support from major donors.

Again, using monitoring and evaluation as an example, it is well known that several significant donors to the region as a whole and RHIs in particular have strong interest in prompting more robust approach to overall public sector monitoring and evaluation. Other players may have interests with respect to resource mobilisation and other managerial functions. The functional nature of the virtual approach enables major donors to consider relatively small scale institutional support initiatives without entering into in effect the core funding of a particular element of the CARICOM Secretariat.

Universalis is cognisant that the management of a series of virtual teams – in essence a virtual network, may be a new and somewhat foreign function from both the managerial, as well as participants, perspectives. It also raises particular internal management and coordinative challenges to ensure the smooth functioning of a network such as the one suggested.

Thus, this first step of an evolutionary process of rationalisation would see the launch of three major parallel activities:

- The establishment of the Director’s network, chaired by the CARICOM Secretariat to address short-term issues
- The establishment of a Rationalisation Task Force and its development of detailed recommendations within a year
- The commencement of the building of a virtual network to assist the CARICOM Secretariat

ii) Functional and Pragmatic Programme Rationalisation

The second step of a process of evolutionary rationalisation would see actual alterations to individual RHI mandate, programme and financing; and would see, if accepted, the enlargement of the network of virtual teams to support enhanced CARICOM Secretariat functions.

The report of the Rationalisation Task Force and the decision-taken by ministers relating to its recommendations would trigger the start of this second phase.

One of the earliest steps in the rationalisation process might be to address the development of a new pharmaceutical quality assurance function.

Without prejudicing the work of any eventual Rationalisation Task Force, if the approach to pharmaceutical quality assurance were to concentrate on the key coordinative services described earlier in this report, (and thus phase out actual testing of samples) it might be possible to integrate the new functions into an existing RHI. Indeed, integration into CAREC might be the most desirable given the fact that CAREC possesses a recognised laboratory capacity and is already engaged in laboratory strengthening programming. Thus, integration into CAREC might enable the region to address the building of national capacity relative to drug testing that was identified as one of the potential mandate areas for a new pharmaceutical quality assurance function.

The next part of this second step would be to address the issues of core mandate and financing that the Task Force may have identified. This would imply formalising the Directors' network into an on-going RHI Steering Committee, chaired by the CARICOM Secretariat, as a permanent operational means to address rationalisation, mandate and programming issues.

Such a Steering Committee in effect would become the major force for a long-term process of addressing performance and systemic shortfalls with respect to RHI performance. For example, in the crucial areas of planning and reporting, RHI Directors working together might be able to develop a standardised reporting format, (even among the two PAHO-specialised centres). Directors might be able to develop a mechanism to enable cross institutional assignment of personnel in order to address the current lack of career mobility that affects several RHIs.

More importantly, however, an on-going RHI Steering Committee would have the responsibility to address programming and resource mobilisation efforts, with the view to harmonising programming, building synergies across RHIs and coordinating resource mobilisation efforts to maximise the impact of limited external donor resources. Led by the CARICOM Secretariat, the Steering Committee would have to develop its own internal procedures to ensure that the decisions of the group were respected.

In essence, unlike in Option 1, the group would not simply be a voluntary and informal body. It would also become a continuing body, with some limited costs attached for its internal operation.

However, formalising the RHI Directors' network into a permanent RHI Steering Committee would imply that each Director would have to seek from his/her governing bodies their agreement with respect to the decisions of the Committee. For example, coordinating resource mobilisation strategies would imply that RHI governing bodies would have to consider and then agree to coordinated plans. This process could be time consuming given the fact that during this iterative largely programmatic process RHI governance would remain divided among the four remaining entities.

It should be emphasised that this new RHI Steering Committee would become a **permanent** feature of the management of the RHIs. One advantage of such a Steering Committee, if it also included a PAHO presence (other than that from the two PAHO-specialised centres) would be that PAHO would be part of the streamlining and rationalisation of overall regional resources directed towards technical cooperation in public health.

With respect to the CARICOM Secretariat, the process of iterative rationalisation could also see the expansion of the virtual network to include all four major managerial functions noted above.

Thus, the key outputs of this second step would be:

- The establishment of a formal RHI Steering Committee
- The further strengthening of the virtual network at the Secretariat

iii) The Harmonisation and possible Regionalisation of RHI Governance

As noted in the horizontal findings, the governance of RHIs is fragmented and utilise a variety of paradigms. Some actively engage ministers and have clear reporting and corresponding accountability for decision-making; while others are largely advisory in nature and place senior decision-makers in a near transactional framework, as opposed to their playing more active roles in planning and resource decisions. The two PAHO-specialised centres themselves have widely divergent governance paradigms.

This diversity of governance is a clear hindrance to long-term rationalisation and long-term maximisation of resource utilisation. Thus, the final step in this iterative process would be to begin a process of merging the governance of all four RHIs into one body that would be responsible for all four RHIs.

The decision to take the final step and to regionalise the governance of the two PAHO-specialised centres need not be taken. As will be shown below, it is possible to harmonise RHI governance without altering the PAHO relationship. However, in the end, this option contemplates the long-term withdrawal of PAHO from CAREC and CFNI

To set the stage, it might be useful to briefly note that two of the four RHIs – CHRC and CEHI – are “regionally governed” bodies at this time, albeit with considerably different governance structures; while two – CAREC and CFNI have a duality of governance with the region and with PAHO; again both having differing actual structures.

The thrust of this approach would be to build one common RHI “Board of Governors” for all four RHIs, likely comprising of ministers; and likely also consisting of a smaller executive committee so as to promote on-going ministerial engagement in RHI practical decision-making. Alternately, a Board of Governors at a ministerial level could be established with a parallel “Board of Directors” being composed of senior officials at the PS / CMO level and meeting more often, possibly every quarter.

In turn, each of the four RHIs could have a refreshed technical/ scientific advisory body that might be enriched by increased participation from other relevant elements of the public and private sectors. For example, increased advisory participation from other elements of the public sector such as education, agriculture and trade could be added to relevant RHI advisory bodies. In addition, new advisory bodies might wish to adopt a more “hands-on” approach. Given modern communications technologies, it is possible to contemplate advisory bodies setting up small “virtual” task forces of key experts to address specific policy and programming issues. It would even be possible to include experts from outside the region and from the private and voluntary sectors.

There are, however, considerable procedural implications in moving to harmonised governance of RHIs:

First, all four constituent agreements would have to be amended so as to build in an interlock at the board level. In essence, the theoretical board of CEHI (or any other RHI) would be the same as that of all others. Thus, four theoretical boards would exist because four entities would also continue to exist, but they would be common in membership, duties and prerogatives (with the possible exception of special provisions for “host” nations). Additionally, the current constituent agreements would have to be amended to so as to refresh advisory bodies and to enable an increased membership on them (as opposed to the highly fixed nature of current membership practices). This would most likely be a time consuming process.

However, should the region wish to take the final step and fully regionalise the governance of the two largest RHIs, CAREC and CFNI, the most important consequence would be the withering away of PAHO’s governance roles with respect to CFNI and CAREC. Universalialia wishes to underscore that the potential negative implications of the withering away of the formal PAHO governance roles for CFNI and CAREC as envisaged in this scenario are the same as those identified with respect to the total amalgamation of all RHIs into one, and the regionalisation of its governance. Universalialia considers them to constitute a considerable set of risks

In terms of timing, it is likely that regional decision-makers would wish to see the first results of the pragmatic approach to programming rationalisation that would be fostered as products of the work of the RHI Steering Committee. Senior regional decision-makers, and most likely heads of government, would have to be engaged actively in decisions to shape a combined RHI "Board of Governors." Moreover, the PAHO-related implication of regionalising the governance of CAREC and CFNI would likely require head of state deliberations.

Thus, this third step, the harmonisation and regionalisation of governed would likely be addressed about 2-3 years after the launching of the RHI Steering Committee and an equal amount of time for the strengthening of the Secretariat.

There is an obvious CAREC short-to-medium term implication in the overall option. Because the CAREC agreement needs to be renewed by December 2005, senior decision-makers might wish to consider renewal as a transitional process whereby few amendments might be considered at this time. The stand-alone report on CAREC presents some possible options. Clearly, if decision-makers agree to a long-term goal of harmonising and the eventual possibility regionalising governance, the new agreements that would be required for CAREC and for CFNI would more logically become the vehicles for more operationally-related aspects for governance and regulatory modernisation of both.

Universalialia wishes to point out that regional decision-makers could choose not to harmonise and regionalise RHI governance, in essence truncating this option to one that concentrates on programmatic rationalisation and long-term programmatic coordination by means of the an RHI Steering Committee and the strengthened CARICOM Secretariat.

While this approach may be viable and may be preferable to the risks and complexities involved in full harmonisation and regionalisation, it leaves overall RHI governance fragmented and leaves some ambiguities about overall accountability of RHIs to the region and its key decision-makers. It also leaves RHIs with generally outmoded patterns of governance that are episodic and transactional; and which, for the most part, do not sufficiently engage ministers and / or their more senior officials in actual on-going decision-making.

b) Costs

Universalialia is of the opinion that the costs to implement Option 4 approximate those for Option 2. Both address the full panoply of issues and challenges affecting all RHI's and their functions, albeit in somewhat different eventual fashions. In some respects, Option 4 places more burdens on the CARICOM Secretariat than any other due to the combination of having to manage the proposed RHI Directors Network (the core of this option), as well as coordinate the harmonisation of the governance of four separate RHIs, as opposed to that in Option 2 where there would be only one amalgamated RHI.

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OPTION 3		
Mandate and Financing Review Year 1	Team Leader	\$100k
	Professional	\$60k
	Professional	\$60k
	Sec/Clerk	\$25k
	Travel	\$60k
	Admin	\$40k
	Honoraria for Expert Advisors	\$25K
	Travel for Expert Advisors	\$25K
	Local consultants @ \$600 per day	\$60K
	Total	\$455K
Governance Consolidation Year 2	Team Leader	\$100k
	Professional	\$60k
	Sec/clerk	\$25k
	Travel	\$40k
	Admin	\$25k
	Local consultants	\$80k
	Total	\$330K
CARICOM Sec. Strengthening On-going per year	Senior Professional	\$100k
	Network Communications	\$25k
	Network Travel	\$25k
	Network Administration	\$25 K
	Total	\$175k
Other Costs	Travel for Directors	\$25k

Universalialia notes that the CARICOM Secretariat would have to mobilise the resources to mount these activities. The most likely source of funding might be a combination of major donors working together to support a 2-3 year programme of institutional strengthening where individual donors might agree to support distinct components of the process.

c) Benefits

i) Strengthening Caribbean Resources

Option 4 is likely to produce more immediate strengthening of Caribbean resources through its highly pragmatic and operational approach to harmonisation of programming.

The longer-term level of strengthening of Caribbean resources with respect to Option 4 is dependant on the degree to which the RHI Steering Committee is able to actually link and harmonise RHI programming. Given the fact that the vast majority of RHI programming is mounted and delivered by CAREC and CFNI (and the overwhelming majority of resource mobilisation efforts as well), the level of programmatic harmonisation will be dependent on how these two bodies work together.

A key question with respect to the strengthening of Caribbean resources would be: Will the option result in a higher likelihood of attracting new resources? The coordination of efforts undertaken by the RHI Steering Committee implies that RHIs would be able to act in a more concerted patterns and thus might be able to build new partnerships.

ii) Enhance Combined Programme Delivery

The synergistic benefits of Option 4 are again likely to be more long-term than those of Option 2, or to some extent Option 5 (to follow). The programmatic premises that underlies Option 4 is that there are benefits for RHIs to remain individual entities linked tightly through a regionally managed network; and that these benefits outweigh those of varying approaches to a merger or amalgamation.

The RHI Steering Committee, chaired by the CARICOM Secretariat offers a functional, as opposed to organisational, approach to building synergies and enhancing programme delivery. However what it does not do is provide RHI clients with a single source point with respect to needs assessments. Nor does it actually result in combined programming, as opposed to programming delivered by various RHIs in concert with each other.

iii) Strengthen Internal Capacity

Option 4 strengthens internal RHI capacity to the extent that RHI Directors can craft some common means of working together and better mutual sharing of resources. For example, if common procurement policies were to be implemented (albeit somewhat difficult due to CAREC and CFNI being regulated by UN standards) economies of scale could arise. Common ICT platforms would increase inter-connectivity; one RHI might become a specialist for others, i.e.: CEHI for electronic commerce, and CFNI for printing. Likewise, if the means to promote inter-RHI transfers of personnel were to be developed, the staff of smaller RHIs such as CEHI and CHRC might benefit from the enhanced career opportunities.

Turning to the CARICOM Secretariat and its strengthening, this option, while placing considerable new challenges before the Secretariat, also provides it with a potential way to address long-term capacity and functional challenges while at the same time reaching out to a broader network of key regional informants.

iv) Strengthen Regional Governance

The ability of Option 4 to strengthen regional governance is dependent on two sets of factors:

The proposed RHI Steering Committee, chaired by the CARICOM Secretariat and supported by the virtual network at CARICOM has definite positive governance implications. It brings together in a pragmatic fashion most decision-making activity. It fully engages the CARICOM Secretariat in RHI functioning.

However, until and unless decision-makers were to move towards the formal harmonisation of RHI governance and thus the regionalisation of both CFNI and CAREC governance, governance responsibility and lines of accountability remain fragmented. In addition, less than optimal governance paradigms remain, unless each individual structure was to be amended – a time consuming process.

v) Enhance Sustainability

This option is predicated on the region establishing a mandate / financing task force to address the growing challenges of the gap between core programming and financial sustainability. For Option 4 to make a significant contribution to long-term RHI sustainability, the RHI Steering Committee and individual RHI would have to take potentially serious decisions about core programming and financing mechanisms. This Option requires that individual RHI governing bodies take concerted decisions in order for them to be any sense of commonality.

For example, in terms of RHI coordination, it would be highly disruptive if one of the larger RHIs chose to apply a cost recovery approach to repetitive training, while another did not. Furthermore, at this time CEHI already has commenced an aggressive approach to cost recovery in light of the direction provided by its strategic business plan. Thus, the possibility of fragmented approaches to long-term sustainability may arise.

Turning to resource mobilisation, if the RHI Steering Committee were to function as planned, it would be a valuable vehicle for coordinating long-term resource mobilisation strategies. However, the extent of that coordination would be again dependent on the willingness of RHI Directors to collaborate.

vi) Strengthen National Capacity

While Option 4 may strengthen national capacity more than some of the others, its ability to do so is probably less than either of those that suggest varying approaches to RHI consolidation. Conceptually, amalgamated or merged approaches provide member states with more direct and more integrated access to RHI technical cooperation services. Although coordinated RHI programming could be facilitated through a new RHI Steering Committee, it would remain to be delivered by separate entities, thus lessening to some degree the ability to carefully time and phase programmatic interventions to meet client needs.

vii) Enhance International Linkages

Option 4 is generally neutral with respect to the strengthening of international linkages. The only possible strengthening might arise out of the work of the RHI Steering Committee to harmonise resource mobilisation efforts of the four RHI and thus to better coordinate international ties.

d) Universalial's Overall Assessment

This option is a viable one in that it begins to address the core functions challenges facing RHIs. It does so in a pragmatic and hands-on fashion.

Its overall desirability relates to two potentially divergent points of view:

The first is that it may be beneficial for RHIs to establish much closer linkages and to work as a network. To that end, the RHI Steering Committee approach provides a means, albeit one with some internal challenges itself.

The second is that the region needs to regionalise RHI governance and also to strengthen the ability of the CARICOM Secretariat to play an active role in RHI network coordination and management. The "virtual" CARICOM Secretariat concept presented herein offers one way of considerably strengthening the Secretariat. To that end, such an approach has coordinative, managerial and governance positive implications.

Option 4 tends to view RHIs as some sort of set of "equals" - four RHIs, four boards, etc.

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In fact, all RHIs are far from equal. CAREC and CFNI comprise together 80% of the staff and an equivalent, if not greater, proportion of overall expenditures. Thus, the process of RHI pragmatic programme harmonisation, the core of the work of a new RHI Steering Committee, relates largely to CAREC and CFNI matters. Issues concerning fostering sustainability also largely relate to CFNI and CAREC; and not CEHI, which has already embarked on, cost recovery as a means of strengthening its revenue base.

On balance, the most desirable features of Option 4 relate to its leaving the status quo (with the exception of winding up CRDTL) largely untouched and adding functional means of inter-RHI coordination, and a means to build new capacities for the CARICOM Secretariat.

If the harmonisation and regionalisation of RHI governance is eliminated from Option 4, it becomes in essence a strengthened and highly pragmatic version of Option 1.

In this way, it could become a viable and non-invasive approach to most aspects of rationalisation. Likewise, if RHI governance were to be harmonised by common board membership and improved governance systems, even if CAREC and CFNI were to stay PAHO-specialised centres for the foreseeable future, there would be considerable benefits in the strengthening of the responsiveness of RHIs as a whole to ministers and other senior regional decision-makers. However, the point noted above with respect to the overwhelming preponderance of the two PAHO-specialised centres needs to be taken into account when considering the actual value of formalising inter-RHI coordination and harmonising RHI governance systems.

6.4.5 Option 5: Harmonising PAHO and RHI Functions

The Option in Brief

Content	<ul style="list-style-type: none">• Merge CAREC and CFNI into a new PAHO-specialised centre using the facilities of both CAREC and CFNI• No need for physical relocation• A “new” title to identify it as a new body• CEHI and CHRC to remain stand-alone highly specialised “niche” bodies• Mandate and financing task force for all RHIs as precondition
Governance	<ul style="list-style-type: none">• Provide the new PAHO-specialised centre with a more interactive approach to regional governance and engagement, and new advisory bodies• Would require a short-term “interim” renewal of current CAREC agreements in order to provide time for the merger to be planned• Make the independent improvements to CHRC and CEHI governance proposed in the individual assessment reports
Costs	<ul style="list-style-type: none">• About \$315,000 over one year to conduct a core mandate /financing review• About \$170,000 over a subsequent year to conduct governance transformations• About \$125,000 in on-going costs to strengthen the CARICOM Secretariat
Pharmaceutical Quality Assurance	<ul style="list-style-type: none">• The functions likely integrated into the new PAHO centre
CARICOM Secretariat	<ul style="list-style-type: none">• Modest strengthening of CARICOM Secretariat to improve coordination between the new PAHO-specialised centre and CHRC/CEHI and to ensure that senior political decision-makers are fully engaged in the life of the new PAHO-specialised centre

a) General Approach

i) Background and Context

This option is based on the recognition that the two PAHO-specialised centres, CAREC and CFNI comprise the vast majority of RHI programming and financing. If the pharmaceutical quality assurance functions were to be added to CAREC, as has been suggested in other options, virtually the lion's share of RHI functions would lie with the current two PAHO-specialised centres.

As noted in the horizontal findings, PAHO itself (excluding the RHIs and even its two specialised centres) plays a major role in regional technical cooperation in all aspects of health matters. PAHO's recent sub-regional strategy for the Caribbean places additional emphasis on smaller and less developed Caribbean nations, reducing somewhat its role in the larger and more developed nations.

With respect to CEHI, while it has developed an admirable approach to long-term sustainability and its resource mobilisation efforts are equally strong; as noted in the individual assessment of CEHI, there is a mission/mandate ambiguity relative to the different understandings of what its role may be. In short: What is the difference between CEHI within the context of environmental health, and CEHI as an environmental agency? CEHI's own charter tends to sort blur this distinction, although it should be noted that CEHI's strong Strategic Business Plan focuses the organisation's attention on two priorities – water and waste management.

CHRC, notwithstanding the solid work that it has done over the years, and the partnerships it has established especially with regional post-secondary institutions, remains a small organisation, even in light of recent strengthening. As noted earlier, the level of its research granting activity is fairly modest in comparison to its work in promoting cooperation and information sharing.

ii) The Nature of Harmonisation

The primary thrust of this option would be to combine the two PAHO-specialised centres, CFNI and CAREC, into a new harmonised PAHO-specialised centre that would also incorporate the increased number of functions suggested for a refreshed approach to pharmaceutical quality assurance, while at the same time giving the new centre a new approach to regional governance engagement and also retaining and strengthening ties with PAHO. For clarity, the new body would remain a PAHO-specialised centre.

The secondary thrust of this option would be to overhaul and merge CEHI and CHRC governance, possibly by developing a common ministerial-led board and executive committee following the present CEHI model, but also adding advisory committees to both as required to address special interests, especially those related to relations and partnerships with regional post-secondary institutions.

In terms of the review of vital "core mandate" and financing functions that should be preconditions for any approach to rationalisation, Universalialia suggests that PAHO and the CARICOM Secretariat jointly mount the mandate / financing task force that has been discussed earlier, seeking an external donor to augment their resources. However, in the context of this option, the task force would be largely examining the CFNI and CAREC functions from the dual standpoint of long-term relevance and sustainability.

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A merger of CFNI and CAREC would result in over 80% of RHI personnel employed in the new entity. Because it would remain a PAHO-specialised centre, the duality of the employment system would have to continue. However, as noted in several places, the actual impact of such duality is not as significant as some informants contend due to the low numbers of international staff. More importantly, the new combined staff could enjoy the obvious benefits of a combined and refreshed human resource management system for locally engaged personnel. Staff would have more opportunity for advancement and alternate career tracks (transfers), salaries would be harmonised (albeit the issue of market comparability would necessarily remain unless new funds were found for a substantive wage increase across the board) and a greater critical human resources mass developed.

Merger of CFNI and CAREC also would allow for common procurement, common resource mobilisation efforts, common ICT strategies, etc.

In short, there would be considerable operational advantages to merging the two PAHO-specialised centres into one. Some minor cost saving might also be possible to generate as a result of the merger of CFNI and CAREC. Possibly up to six person years could be phased out of the administrative and managerial areas of a new merged entity. However, it is likely that such reductions would be fairly minimal, and that they would not in and of themselves constitute a major costs savings.

A more important rationalisation and harmonisation might take place due to the merger. As noted in Option 2, because RHIs currently are separate entities and located separately, the provision of services tends to be geographically weighted. For example, CAREC does not have a physical presence in the northern elements of the Caribbean; while CFNI's presence in the southern areas is limited to a small sub-office in Port of Spain. Merging CFNI and CAREC might enable the new entity to establish at a minimum a set of parallel "service bureaus" in each of the physical locations of Kingston and Port of Spain.

For the same reasons as set out in relation to Option 2, this option does not suggest the physical merger of CAREC and CFNI. The short-to-medium term capital costs of building a new combined centre are highly problematic. More importantly, however, for well – understood regional reasons, the likelihood of senior decision-makers agreeing to physical consolidation is very low.

From a policy standpoint, merging the two would combine presently separated HIV/AIDS efforts and might give increased profile to programming addressing another major regional health priority – non communicable diseases and conditions such as hypertension, diabetes, obesity, etc. from both a programmatic as well as epidemiological standpoint.

From a revenue generation standpoint (and not withstanding the work of any eventual task force on mandate and financing) in theory merging CFNI and CAREC would be revenue neutral in terms of PAHO and member state quota payments, with PAHO continuing to play the banker/guarantor role. However by merging CFNI and CAREC, and by likely combining the pharmaceutical quality assurance functions into CAREC as has been envisaged in other options, PAHO might be able to exert more combined influence on those member states that do not meet their fiscal responsibilities. Merging CFNI and CAREC also would bring together the overwhelming majority of donor support for RHI functions, thus enabling more coordinated planning.

With respect to governance, the merged CFNI / CAREC would require a somewhat modified approach to regional governance input and engagement. The current CAREC Council / Advisory Committee model does not sufficiently engage senior decision-makers at the ministerial level in working with PAHO to direct and manage the RHI.

At a minimum, a new and expanded ministerial council should have more qualitative oversight responsibilities (shared with PAHO), and more ability to provide strategic direction concerning key matters such as mandate/financing/ resource mobilisation. In short, a new merged entity requires a new more flexible and more active approach to regional engagement, while also benefiting from an on-going PAHO relationship

The new merged entity, especially one that might embrace new pharmaceutical quality assurance functions, also would require a new approach to advisory bodies. The current model of a monolithic advisory body would not seem to be able to sufficiently engage regional and international subject experts.

To that end, a new merged body might consider a tri-partite advisory body: epidemiology, nutrition, and pharmaceutical quality assurance. More importantly, new advisory bodies also could reach out beyond the region to engage global experts. Modern information technology also makes it possible for advisory bodies to go beyond the traditional and somewhat transactional meeting paradigm to harness skills and inputs on a continuous basis by means of virtual sub-task forces. For example, a virtual sub-group might be assembled to address pro-active approaches to diabetes.

Furthermore, as noted in the horizontal findings, a new approach to advisory bodies for the merged CFNI/ CAREC also might wish to reach out beyond the traditional medical/health/academic communities to engage other elements of the public sector such as education, agricultural and economic development bodies; as well as to engage the relevant aspects of the voluntary sector and the private sector. The virtual sub-group approach suggested above would enable the advisory body to better mobilise and tap into the views of a broader range of regional interests than the current model for advisory participation that is largely limited to traditional sets of informants.

Turning to CEHI and CHRC, while the merger, would be revenue neutral for them, there might be opportunities for both to better identify specialised niche markets and strengthen their respective identities. With respect to CEHI and the new merged entity, the mandate and financing task force, assuming it to were to examine the whole of PAHO's work in the region, might be able to clarify some of the ambiguities that seem to exist relative CEHI, CAREC and PAHO activities related to environmental management / health issues.

This option would require considerably less organisational strengthening of the Secretariat, but it is likely that the Secretariat would require about one full time equivalent at a senior professional level to liaise on a ongoing basis with PAHO in the region, with the merged entity and with CEHI and CHRC. Part of the mandate and financing task force's work most likely would address rebalancing of oversight and accountability. Given the robust nature of PAHO's audit regimes, the region's decision-makers would need to be less concerned about procedural or fiscal compliance (assuming present CAREC weaknesses in this area were resolved). However, decision-makers would clearly benefit from increased audit and programme review activities, overall performance shortfalls that were identified with respect to virtually every one of the current RHIs.

The newly merged entity, as a PAHO-specialised centre and although both CFNI and CARE use the "PAHO log frame", could benefit the greater use of the basic principles underpinning results-based management, and its concentrating on articulating programming not on the basis of what would be done, but on the basis of what changes or improvements might ensue as a result of the programming. Such a results-based approach, especially if it were to grafted onto reporting requirements, combined with a greater internal investment in oversight activities such as evaluation (albeit at the expense of programme deliver in some ways) could considerably improve the overall accountability of the merged entity to the region, to PAHO itself and to donors.

iii) The Pace of Harmonisation

Before describing one potential process to harmonise the PAHO-specialised centres and strengthen the remaining CEHI and CHRC, it should be emphasised that the viability of this overall option is dependent on PAHO agreeing to a merger of its two specialised centres.

However, virtually any option that would envision either adding duties to a PAHO centre, i.e.: adding the pharmaceutical quality assurance functions; or changing the nature of a centre's governance, PAHO consent and active participation would be a precondition as well. Thus, it should be emphasised strongly that, given PAHO's role in the region with respect to technical cooperation health in general, PAHO, as much if not more than CARICOM and its Secretariat, is a central actor in any approach to RHI rationalisation.

The first step in the harmonisation process might be to establish the RHI Directors' Network as described earlier, and to establish the mandate and financing task force, jointly supported by PAHO and by the CARICOM Secretariat. Depending on the extent of PAHO direct support for the task force (either in cash or in kind), given the Secretariat's limited resource levels some additional support would likely have to be secured from an external donor, probably via a one-time technical assistance grant.

In addition to this task force, PAHO itself might wish to set up an internal study group to map out the internal and administrative rationalisation of CFNI and CAREC. However, the magnitude of this task would be less onerous given the fact that CFNI and CAREC share many common PAHO systems. The most important tasks facing such an internal group might logically relate to human resources management harmonisation between CAREC and CFNI, the development of new job descriptions, especially for managers, and the development of ways to actually merge two separate sets of personnel in an equitable fashion so as to result in a combined workforce.

During the work of the overall mandate and financing task force, RHI directors, including those of CEHI and CHRC also might wish to move forward, working with PAHO to address potential maximisation of efforts with respect to environmental matters, as well as support for research, including support for national capacity-building in research skills to address the present low level of endogenous capacity in research matters in many Caribbean nations (a function identified as an essential public health function by PAHO itself). The participation of PAHO's CPC in this interim period would be essential.

The next step during such an interim period would be to begin to shape a new multi-party agreement that would establish the new merged entity and wrap up its predecessors. Depending on legal advice, it may be easier to merge CFNI into a "new" CAREC, using the current CAREC agreement as a basic template on which to amend and strengthen, especially in relation to any moves that would alter the current CAREC Council and replace it with a more contemporary oversight vehicle that would provide greater possibility of the active engagement of senior decision-makers. As well, given the fact that CAREC is four times larger than CFNI, and because CFNI's constituent agreement contains fairly weak governance oversight tools, it would seem logical to use the CAREC agreement as a foundation.

Although only a minor point, one highly symbolic task would be to "name" the new merged entity. As its major functions relate to most of major public health functions, there is some merit in considering a new title that would emphasise "Public Health", hypothetically: the *Caribbean Centre for Public Health*, or the *Caribbean Centre for Health Promotion*, or a name alluding to "newness".

It is not possible to estimate with any accuracy the amount of time need to clarify mission and financing, and also craft and ratify a new agreement that would create the merged entity. Some procedural and decision-making steps would need to be taken even before launching the process.

First, COHSOD would need to be engaged in a substantive strategic discussion. Given the timing of COHSOD meetings, combined with the need to fully discuss relevant approaches to RHI rationalisation, the most optimistic estimate might be that ministers might be taking strategic decisions in late 2005. Although this merger-based approach is less aggressive than the longer and more complex amalgamation option, or that related to combining RHI governance, and potentially regionalising it as a final step, it is likely that Caribbean heads of government would wish to consider the details and implications of whatever approach COHSOD considered at one of their regularly scheduled sessions, most likely in 2006.

This would imply that a mandate and rationalisation task force be established, including seeking the required funding/ support, as soon as senior regional decision-makers gave an early agreement in principle.

If such a decision were to occur in the third quarter of 2005, the task force would only have a limited amount of time to do its work in order to ensure that heads of government could address RHI rationalisation, and especially the rationalisation of mandate and corresponding approaches to regional financing in 2006.

In any case, the pace of harmonisation and the merger of CAREC and CFNI are completely determined by the pace of regional senior decision-making. The general scenario presented above is based on an assumption that COHSOD could be in position to make an overall choice between strategic options by mid-2005; and that such a choice would not require head of government ratification.

Universalialia wishes to point out that any approach to RHI rationalisation that involves structural realignment and / or new governance (Options 2-5) faces similar ministerial decision milestones.

Since all options in one way or another affect CAREC, it is highly likely that the upcoming requirement to renew the CAREC agreement by the end of 2005 will result in the agreement being simply renewed on an "as is / where is" transitional basis with the clear recognition that this renewal will soon be superseded by a new substantive agreement.

The second and final step of harmonisation would occur in the wake of decisions by heads of government. In relation to the merger of CFNI and CAREC, the process could begin in a de facto way as soon as heads of government and PAHO agreed to the basic framework. Assuming the Directors of CAREC and CFNI worked with PAHO colleagues and the harmonisation task force in a concerted manner, as noted above, it is likely that the administrative / procedural aspects of merger could be ready to implement at least on a de facto basis upon the consent of heads of government to the general plan.

The final legally-driven steps, managerial reorganisation, establishing new governance and advisory mechanisms, winding up CAREC and CFNI as separate entities, formal transfer of assets to a new entity, etc., would require formal ratification of a new agreement / constituent instrument. Assuming a best case scenario of heads of government deciding in principle in mid-2006, the de facto merger of CFNI and CAREC could take place soon thereafter with the final legal details running into early 2007.

This time frame is less complex in nature than that envisaged for other options and thus more likely to be possible to achieve within a 24-30 month window than for options that involve considerably more complex governance and functional rationalisations.

Turning to CEHI and CHRC, as noted above, the process of harmonisation envisaged by this option largely relates to harmonisation of governance mechanisms. A decision in principle by regional ministers, COHSOD, to harmonise CEHI and CHRC governance (as well as to address any mandate and financing issues) would likely trigger a fairly rapid process of agreement renewal, coordinated by the CARICOM Secretariat.

Organisational Assessment of RHI - Overall Evaluation Report

b) Costs

This option of a merger of CAREC and CFNI, to maximise overall impact does not require extensive prior examination of internal administrative matters or extensive governance ramifications due to both being PAHO entities. This option would envisage PAHO actively contributing to both the activities related to planning the merger, as well as the mandate / financing reviews due to the fact that the new merged PAHO-specialised centre would comprise the strong, if not vast, majority of collective RHI functions and resources.

Thus, the requirement to seek additional donor support for planning rationalisation would be lessened should PAHO agree to this option in principle and subsequently agree to support the required implementing processes.

Looking towards long-term costs, Option 5 does not entail as complex or expensive long-term strengthening of the CARICOM Secretariat. As noted above, probably only one new senior professional would be required as a “dedicated” RHI liaison resource.

However, as with any option that strengthens the level of ministerial governance, but to a lesser degree, the costs to the newly merged entity and those to CEHI and CHRC for more active regional governance capacity would increase. However, it is not possible to estimate the costs of strengthening governance until the nature of the strengthened governance is determined.

Likewise, the cost to the three remaining RHIs for oversight functions (for the most part the extent of investment in evaluation) would increase in any selected option that suggested more transparency and programmatic accountability over and above procedural and fiscal compliance.

OPTION 3		
Mandate and Financing Review Year 1	Team Leader	\$100k
	Professional	\$60k
	Sec/Clerk	\$25k
	Travel	\$40k
	Admin	\$30k
	Local consultants @ \$600 per day	\$60k
	Total	\$315K
Governance Consolidation Year 2	Team Leader	\$100k
	Sec/clerk	\$25k
	Travel	\$25k
	Admin	\$25k
	Total	\$170K
CARICOM Sec. Strengthening On-going per year	Senior Professional	\$100k
	Travel	\$25k
	(and optional)	
	Network Communications	\$25k
	Network Travel	\$25 K
	Network Administration	\$25 K
	Total Basic	\$125 K
	Total Optional	\$75 K
Other Costs	Travel for Directors	\$25k

Universalialia notes that the CARICOM Secretariat would have to mobilise the resources to mount these activities. The most likely source of funding might be a combination of major donors working together to support a 2-3 year programme of institutional strengthening where individual donors might agree to support distinct components of the process. However, as noted above, PAHO might be approached to assist.

c) Benefits

i) Strengthen Caribbean Resources

An option that would merge CAREC and CFNI, strengthening combined governance and achieving programmatic synergies; while at the same time harmonising CEHI and CHRC governance, financing and mandate would likely result in the highest level of long-term benefits to the region in terms of strengthening of Caribbean resources.

From a purely functional standpoint, merging CAREC and CFNI has the potential of achieving considerable intangible benefits due to programmatic harmonisation and the combination of efforts that today are separated. The newly merged entity would be able to provide Caribbean ministries of health with a “one stop shop” for most of their technical assistance functions. It would be more able to respond to the technical cooperation challenges inherent in the eleven essential public health functions recently identified by PAHO.

ii) Enhance collective programme delivery

This approach would consolidate programme delivery, however not to the same extent. The difference between merging CAREC and CFNI (and presumably adding in new pharmaceutical quality assurance functions), and amalgamating all RHIs into one relates to the separation of environmental and research functions, recognising their unique niche and that both functions appeal to different clientele and external donors than those normally associated with public health matters. This latter point is especially relevant with respect to CEHI, which is building an international reputation as a regional interlocutor for overall environmental matters as a whole, as they affect small island nations. It is equally relevant for CHRC, which due to its new strategic plan and its programme of institutional strengthening is growing in importance to the region and might not be able to respond to the challenges of its mandate if submerged into a combined largely programmatic RHI.

It is obvious that a merger between CAREC and CFNI would enable a new entity to significantly increase its ability to coordinate programme delivery and also to better coordinate like programming supported by different donors. For example, a merged centre would be better able to address the totality of programming addressing HIV/AIDS and better plan / schedule and deliver such programming with beneficiaries.

iii) Strengthen Internal Capacity

It is obvious that a merger of CAREC and CFNI would result in strengthened internal capacity of the new combined entity. Some minor economies of scale would likely occur. However, the major tangible benefits lie in the following areas:

- Combined and coordinated strategic and operational planning and decision-making by senior regional decision-makers to maximise collective resource utilisation
- Combined and refreshed HR systems that would promote greater job satisfaction, employment equity, career advancement and professional development / training (albeit limited to some degree by international procedures)
- Combined and harmonised ICT strategies and systems
- Combined and strengthened management, reporting and accountability systems that would more emphasise “results”
- Combined administrative and supply functions

iv) Strengthen Regional Governance

While this option does not vest total governance responsibility in the hands of the region, it does produce some major improvements in the level of practical regional governance of RHIs.

With respect to CEHI and CHRC, the two remaining “regional” RHIs, (both of which occupy unique regional niches), a harmonisation of their governance, especially that of CHRC would increase ministerial engagement in decision-making (as has been done at CEHI).

Turning to the new merged entity, a refreshed approach to a ministerially-based and more active “Council”, assisted by contemporary advisory mechanisms, and within the ambit of PAHO, probably produces the most programmatically effective approach to increasing regional governance without going to the expense and risks of totally “regionalising” governance.

The key factor in the strengthening of regional governance lies not so much in legalities, as in functionalities. For example, if a merged body were to engage senior decision-makers (represented probably by an executive group) on a more iterative basis with respect to resource mobilisation strategies there might be more opportunity for regional input into longer term programming decisions. Likewise, a new more virtual approach to engaging regional and extra-regional experts through refreshed advisory bodies could better harness resources that are outside the traditional ambit of public health and medicine.

The key to such a new approach would be to forge a mutually satisfying governance partnership with PAHO where the strengths of PAHO as part of the WHO are combined with more functional regional input into actual organisational decision-making. The core of this relationship would be to strengthen the ability of senior regional decision-makers to have on-going policy input into overall organisational direction, while retaining the highly valuable PAHO “administrator” role.

Universalialia wishes to point out that while it is of the opinion that the CARICOM Secretariat’s roles with respect to Option 5 could be handled by one additional staff person working exclusively in RHI matters, there would be nothing to limit CARICOM from setting up the virtual network described in Option 4 to further augment regional governance input into the three remaining RHIs, should CARICOM have, or be able to mobilise the resources to do so.

v) Enhance Sustainability

The benefits inherent in this option with respect to sustainability are two-fold and are dependent on the work of a mandate and financing task force.

As noted in the horizontal findings and in the CAREC individual report in particular, RHIs at this time are probably not sustainable over the longer-term due to the imbalance between core functions and core funding. Revisiting the relationship between mandate and financing therefore is a precondition for any approach to rationalisation. In light of the World Bank's conclusions, this likely implies a move towards a greater reliance on some forms of cost-recovery, most of which are currently possible to undertake with respect to CFNI and CAREC (assuming regional decision-makers were to recognise the current imbalances and move to rectify them).

Merging CAREC and CFNI would increase collective resource mobilisation capacities by better planning and coordination. As well, a merger into a combined PAHO-specialised centre would retain the highly valuable PAHO roles of "banker" and guarantor, functions that would wither away in the event of approaches that would see the regionalisation of RHI governance. Adding pharmaceutical quality assurance functions to the new entity would strengthen its ability to address not only the basic need to ensure "quality", but also those other needs of building national laboratory capacity (where relevant) and increasing the pharmaceutical information base to be shared with all member states, using CAREC's significant current ITC capacities.

vi) Strengthening National Capacity

One major reason for the existence of organisations like RHIs through the provision of technical cooperation services is to strengthen the internal capacities of the beneficiaries of programming. Technical cooperation programming as a genre does not focus on delivering services to individuals, as it does on delivering to institutional bodies that in turn deliver services to individuals (however there are certain exceptions to this wherein RHIs provide services to national administration that relate to individual cases such as laboratory testing).

Merging CAREC and CFNI and thus bringing together over 80% of current RHI programming leads to the ability to provide much more consolidated and coordinated services to national public health authorities. National authorities would have the means of better prioritizing their "needs" in relation to the full panoply of public health technical cooperation services on offer. They would be better able to assess their needs in relation to their own capacities relative to essential public health functions. Equally, the newly merged entity could better coordinate its work with national authorities to ensure that natural sequences and synergies could be harnessed. Moreover, the relationship between donor-supported programming and "core" functions could be better integrated at a delivery level.

vii) Enhancing International Linkages

Merging CAREC and CFNI into one, and making some adjustments to CEHI and CHRC as stand-alone entities would increase the international linkages of all three remaining RHIs.

Both former elements of the newly merged PAHO-specialised centre have strong international presences. Merging the two, although suppressing some of their "individuality", would result in a much more coordinated international presence. Linkages to major global players and other elements of WHO also might be strengthened.

CEHI and CHRC also stand to benefit; with the former already well-positioned on the international scene, it would be able to specialise to a greater degree in key areas of both core mandate and donor-supported programming. Its identity probably would evolve towards the “environmental” agency that some proposed a number of years ago. CHRC, assuming that it could work with the CARICOM Secretariat to secure long-term organisational strengthening, could more evolve towards a research capacity-building body and forge stronger ties with international bodies. However, both of these latter potential positive benefits are contingent on a mandate task force clearly delineating roles and responsibilities, including those of other elements of PAHO within the region; and the newly merged PAHO-specialised centre not venturing into the agreed upon mandate areas of either CEHI or CHRC.

a) Universalialia’s Overall Assessment

From Universalialia’s perspective there are a number of advantages associated with Option 5, and only a few limitations, largely related to the tasks of shaping a mutually beneficial governance paradigm between the region and PAHO.

Option 5 pragmatically consolidates the prime RHI public health functions into a single body that would continue to benefit from active PAHO participation. It delineates two highly specialised set of functions (CEHI’s and CHRC’s) and recognises their uniqueness.

It also less disruptive than Option 2, which envisaged a complete amalgamation with the long-term transfer of governance to the region. It is less costly than Option 4, which concentrated on long-term governance regionalisation, and shorter-term programmatic harmonisation (which in fact largely related to CAREC and CFNI).

However, like all options other than Option 1, this Option is predicated on a robust mandate and financing review (as described earlier). Without such a review, and without the hard choices that are likely to arise from it that may transform the way the region perceives the delivery of core technical cooperation in public health, Option 5 is likely to result in the continuation of unsustainable practices, the increased reliance on unpredictable donor-supported programming and the potential for the eventual collapse of the ability of any RHI to deliver core programming at all.

6.4.6 Universalialia’s Recommendations

The terms of reference for this assignment required the development of a rationalisation plan. Early in the review process, it became apparent that there were a variety of opinions relative to rationalisation among key stakeholders, and that there was some degree of passion among some about the preferred way to proceed. Thus, it was necessary to lay out and analyse five different approaches to rationalisation.

However, three of the five options described above do not significantly improve the quality of public health technical cooperation, or do not do so in a fashion, which is either cost effective or realistic.

To facilitate decision-making, a table follows that present all five options so that a cross – comparison of salient features can be drawn.

a) A Range of Choices

Option 1 – The Modified Status Quo, is not a plan for rationalisation beyond a fairly minimal ad hoc and voluntary approach. It would not address the fundamental challenges of the relationship between core mission and sustainable funding. It does not address strengthening the CARICOM Secretariat. In essence it perpetuates the present, with the possible exception of building a new pharmaceutical quality assurance function, either as a stand-alone entity (not advisable), or as part of CAREC.

Universalialia is of the opinion that the choice of Option 1 implies a degree of satisfaction among senior decision-makers about overall RHI performance that was not evident among these very same stakeholders.

Option 2 – RHI Amalgamation and Eventual Regionalisation, is a highly complex option that presents considerable risks to the region and poses some very serious governance and capacity challenges as well. While the general notion of bringing RHIs together into one entity was raised by a number of informants to this evaluation, it was seldom articulated in any detail. More importantly, total amalgamation tends to conceptualise RHIs as five equal bodies, when in reality CAREC and CFNI comprise the lion's share of RHI functional activities and resources.

The complexity of amalgamating RHIs and then moving to regionalise the governance of "one big RHI" mitigates against the practicality of the option as a whole. In addition, the costs and complexities to strengthen regional governance by the overhaul of how the CARICOM Secretariat functions as a planning, oversight and managerial body probably results in a level of risk and costs to the region that is disproportionate to any attributable benefits. Winding up the traditional PAHO relationship with CAREC and CFNI also produces a highly uncertain environment and it is not impossible to conceive that PAHO member states might decide to focus their resources directed towards the Caribbean into PAHO entities and not RHIs.

Option 3 – The Regionalisation of CAREC, which has been proposed by a number of informants and stakeholders, is not a plan for RHI rationalisation at all. Rather it is a plan to alter CAREC governance and essentially leave other rationalisation issues untouched. Even if regional decision-makers were to choose such a path in principle, considerable risks are inherent in such a one dimensional approach. These risks relate to the implications of winding up the PAHO managerial and administrative relationship with CAREC and the assumption by the region of considerable additional costs such as ensuring the financial viability CAREC and building a new regional governance paradigm for CAREC.

That leaves Options 4 and 5 as the two that are potentially viable courses of action for substantive RHI rationalisation.

The choice between **Option 4 – the Evolutionary Approach** and **Option 5 - the Harmonisation of the PAHO RHIs**, lies in the degree to which the region's key decision-makers see the eventual regionalisation of RHI governance as an ultimate desirable objective.

Option 4, which contains three and possibly four steps if governance is to be fully regionalised at CFNI and CAREC, is very time consuming. Until the final harmonisation of RHI governance into one regional body, it is dependent on a continuous process of internal negotiations and debate, which implies extensive and on-going work by a revitalised CARICOM Secretariat. Thus, Option 4, like Option 2, implies that the region make a considerable investment in the strengthening of the CARICOM Secretariat (even via the virtual approach suggested.).

It also implies a considerable governance risk. Given the fact that it is likely that CARICOM could not muster on-going resources to sustain a larger secretariat function for health alone, the alternative of the virtual network implies a considerable management risk. If the network were not to function, the region would be left with little to support the new combined governance that is the core of Option 4.

Universalis is of the opinion that Option 4 is viable and far less disruptive than Option 2. However, it does add considerable burdens to the region's limited horizontal governance resource base and implies a long process of cooperation.

Option 5 recognises the centrality, and likely continuing centrality, of PAHO to the region with respect to technical cooperation in health. While the core of Option 5 is the merger of CAREC and CFNI into one new PAHO-specialised centre, it also embodies pragmatic and functional solutions to the key issues of determining long-term core mandate and corresponding fiscal sustainability. It also addresses the pharmaceutical quality assurance functions by integrating them into the new merged PAHO-specialised centre.

Option 5 does not alter the long-standing PAHO relationship and the clear financial and programmatic benefits that have accrued to the region from CFNI and CAREC being PAHO-specialised centres. The merger of both PAHO centres also would reflect the growing tendency to see public health issues as inter-connected and inter-dependent, as opposed to stand-alone subject matter.

Adding CEHI and CHRC functions, with this option resulting in an amalgamated PAHO-specialised centre (the third step of Option 2), while attractive on one level, would probably result in the eventual diminution of environmental and research-related functions. Moreover, doing so potentially would pose more challenges to PAHO than the merger of two of its own entities and the addition of pharmaceutical quality assurance functions.

Universalis wishes to emphasise strongly that it does not see any benefits in attempting to rebuild a stand-alone pharmaceutical quality assurance entity, even one with a functional governance paradigm. A new independent body addressing pharmaceutical quality assurance functions (and likely not actually processing test results) would be little more than a small secretariat. Moreover, merging quality assurance functions into CAREC would link the region's pharmaceutical quality assurance needs with on-going laboratory strengthening programming mounted by CAREC.

Universalis thus recommends that senior Caribbean decision-makers review both Options 4 and 5 as potentially viable general approaches to RHI rationalisation.

b) Recommendations

If regional decision-makers favour the evolutionary and iterative nature of Option 4, and see the possibility of an eventual practical and legal harmonisation of RHI governance as a key objective; and if they are willing to accept the risks and challenges inherent in strengthening the CARICOM Secretariat as the coordinating arm, a requirement for the iterative approach to succeed, then Option 4 is more preferable.

Universalis wishes to point out that while Option 4 was presented with an eventual regionalisation and combination of RHI governance as a final step, the process could be truncated at an earlier stage, leaving a strengthened Secretariat to act as an interlocutor between four separate RHI governance paradigms that would not be altered. Choosing such a truncated approach would leave unanswered the benefits of merging the lion's share of RHI functions and would leave long-term governance overlaps and shortfalls that have been noted in the horizontal findings.

If however they wish to make a significant and visible programmatic rationalisation that has fewer long-term risks and costs to the region as a whole, and if PAHO were to agree to merge its two specialised centres into one, then Option 5 is preferable.

Universalialia also strongly recommends that regional decision-makers launch the suggested mandate / financing task force as a precondition to any approach to rationalisation that goes beyond the status quo.

6.4.7 The Comparison of Options

	OPTION1 MODIFIED STATUS QUO	OPTION 2 AMALGAMATED RHIS	OPTION 3 STAND-ALONE CAREC	OPTION 4 COMBINED GOVERNANCE	OPTION 5 CFNI/CAREC MERGER
Content	<ul style="list-style-type: none"> A very modest approach to RHI rationalisation that would see RHI Directors meeting informally to address operational level concerns CARICOM Secretariat would be strengthened by adding one staff person Mandate and financing issues would not be addressed in any substantive fashion 	<ul style="list-style-type: none"> The amalgamation of all RHIs into one using CAREC as a the basis for the merger A mandate and financing task force as a precondition for the merger Followed by a period of governance transformation 	<ul style="list-style-type: none"> Regionalize the governance of CAREC, winding up the PAHO administrative/managerial role Other RHIs to continue un –affected A more compact core mandate and financing task force to address primarily CAREC sustainability issues (could be expanded) 	<ul style="list-style-type: none"> Four RHIs remain stand-alone Establish an RHI Steering Committee led by CARICOM Sec Mandate and financing review and programming rationalizations Over time combine governance\ and wind up the PAHO administrative/managerial role at CFNI / CAREC 	<ul style="list-style-type: none"> Merge CAREC and CFNI into a new PAHO specialized centre CEHI and CHRC to remain stand-alone highly specialized “niche” bodies Core mandate and financing review of all RHI functions as a precondition
Governance	<ul style="list-style-type: none"> Current RHI governance patterns would continue without alteration. 	<ul style="list-style-type: none"> Winding up the PAHO administrative roles for CFNI and CAREC as they enter the new body A strengthening of the CARICOM Secretariat by setting up a “virtual” support network Building a new RHI Board and advisory bodies (likely several) for the merged RHI 	<ul style="list-style-type: none"> A “new “ CAREC would need a new regional board and new regional advisory functions CARICOM Secretariat would need to be strengthened to be able to oversee such a large regional institution 	<ul style="list-style-type: none"> Strengthen CARICOM Sec as per Option 2 Eventual more to one combined board for all RHIs with separate function-based advisory bodies PAHO administrative and managerial role at CFNI and CAREC phased out 	<ul style="list-style-type: none"> Provide the new PAHO specialized centre with a more interactive approach to regional governance and engagement, and new advisory bodies Strengthen CEHI and CHRC governance Modest strengthening of CARICOM Secretariat
Costs	<ul style="list-style-type: none"> Some \$25,000 per annum to facilitate Directors meetings Some \$ 125,000 per annum for the CARICOM Secretariat 	<ul style="list-style-type: none"> Some \$785,000 over two years to shape the new amalgamated RHI Some \$200,000 per year in on-going costs for the CARICOM Secretariat 	<ul style="list-style-type: none"> Some \$515,000 over two years to conduct the core review and transform governance Some \$175,000 per annum for the CARICOM Secretariat 	<ul style="list-style-type: none"> The same as Option 2 	<ul style="list-style-type: none"> Some \$485,000 over two years to conduct the core studies and to transform governance systems A basic \$125,000 additional per year for the CARICOM Secretariat (plus an optional \$75,000 per year should it wish to add the “virtual network” to assist it
Pharmaceutical Function	<ul style="list-style-type: none"> CRDTL would be wound up in its present format and either a) A new agency addressing broader pharmaceutical quality assurance functions established, or b) Similar functions transfer to another RHI, (mostly likely CAREC). Most likely actual testing would be converted to a cost-recovery approach 	<ul style="list-style-type: none"> The functions integrated into new merged RHI 	<ul style="list-style-type: none"> Merged with CAREC 	<ul style="list-style-type: none"> Merge with CAREC 	<ul style="list-style-type: none"> Merge into new PAHO specialized centre

Rationalisation Objective					
1. Strengthening Resources	No significant impact	High	Low	Moderate assuming RHI’s worked together	Moderate to high due to the fact that most RHI resources are CAREC or CFNI in the first place
2. Enhance Program Delivery	Modest impact reliant on cooperation among directors	Merger into one would constitute the highest level of programme coordination	Low, has little impact on other RHIs	Modest to moderate. RHI programming still delivered by each RHI separately	High
3. Strengthen Internal Capacity	Nominal to modest impact	High	Low, has no collective impact on RHIs as a whole	Modest at best	High
4. Strengthen Regional Governance	No impact	High, with the provision of the risks in severing the PAHO relationship	Moderate, but only for CAREC	Modest to high, assuming decisions to move to combining governance	Moderate, if a new approach to engaging regional decision-makers can be combined with a PAHO specialized centre
5. Enhance Sustainability	Nominal to modest impact at best	High if mandate / financing task force address systemic under-funding issues	Low, CAREC might be placed at risk itself due to serving PAHO relationship which is seen as beneficial by many donors	Moderate to high, assuming RHIs would work together and Task Force recommendations implemented	Modest to high assuming new entity implemented sustainability recommendations of task force
6. Strengthen National Capacity	No impact	High	Low	Moderate, not as effective in doing so as merging	Moderate to high
7. Enhance International Links	Nominal to modest impact	Moderate	Low	Moderate at best	High

Appendix I List of Findings

- Finding 1: The basic functions performed by the Caribbean RHIs are relevant to the needs of the region
- Finding 2: Caribbean senior decision-makers, including PAHO senior decision makers, have not undertaken a zero-based budget / fundamental programme review of the core mandates of Caribbean regional health institutions to match a realistic set of agreed-upon core services with sustainable and predictable revenue sources
- Finding 3: RHI mandates generally are not prescriptive and are sufficiently permissive so as to enable individual RHIs to have a wide latitude with respect to the articulation of programming in support of their mandate.
- Finding 4: With the exception of CRDTL, RHIs utilise a variety of strategic planning processes to ascertain the nature of programming in support of their largely permissive mandates. However such processes tend not to be replicated with sufficient regularity or sufficient rigour so as to enable sensitive prioritization of efforts in relation to the availability of resources.
- Finding 5: RHIs at this time do not possess sufficient core financial resources to undertake their acknowledged core functions.
- Finding 6: Some RHIs have to varying degrees engaged in successful resource mobilisation campaigns with donors/lenders that have expanded the scope of RHI programming.
- Finding 7: Increased reliance on programming supported by external resource mobilisation efforts results in long-term risks to the viability of some RHIs
- Finding 8: RHIs, for the most part have not explored cost-recovery to a sufficient degree as a means of strengthening financial viability
- Finding 9: While RHIs generally appear to translate the resources at their disposal into programming in fairly efficient ways, some of the mechanisms for programme delivery do not encourage efficiency and economies of scale, given the resource constraints faced by all RHIs.
- Finding 10: The current governance structure of many RHIs do not sufficiently engage senior Caribbean decision-makers both in terms of accountability, as well as forward planning.
- Finding 11: Current RHI governance paradigms result in uneven access to key stakeholders and tend to limit outreach to the totality of the stakeholder community of the region.
- Finding 12: RHI governance paradigms are outdated and, for the most part, have not been refreshed or amended since their inauguration.

- Finding 13: The profiles and resources of RHIs themselves are not sufficiently communicated to senior stakeholders at the ministerial level so as to foster a greater sense of the actual programming of RHIs.
- Finding 14: There is a gap in expectation between what senior Caribbean stakeholders generally perceive as the core functions of RHIs and the need to ensure the sustainability of the RHIs and thus their core functions.
- Finding 15: Given the size of RHIs, there does not appear to be any significant degree of overlap or duplication of administrative or managerial functions
- Finding 16: The RHIs, while not overlapping each other in terms of administrative and managerial services, could benefit from higher degrees of commonality of internal procedures and practices.
- Finding 17: Member states have various levels of internal capacity to absorb the services of RHIs, leading to differing levels of expectation regarding the focus of RHI programming, and differing demands being placed on RHIs regarding what is perceived as core services.
- Finding 18: The various terms and conditions of employment across the five RHIs tend to impede the efficient and effective utilisation of personnel in individual RHIs.
- Finding 19: The variances between and within RHIs with respect to terms and conditions of employment impede the ability to attract and retain a critical regional mass of qualified personnel.
- Finding 20: RHIs generally do not possess robust systems of monitoring and evaluation, and generally do not have the capacity to conduct impact assessments. The various governance structures of RHIs do not promote upward feedback to senior decision-makers regarding the impact of programming.
- Finding 21: RHI reporting systems tend to concentrate on an accounting of resources, activities and outputs, and do not adequately address the impact or outcome of programming
- Finding 22: RHIs generally have not established performance benchmarking systems and associated reports to assess organisational performance in terms of the efficiency of the conversion of inputs into programming
- Finding 23: RHIs do not share common planning, budgetary or reporting systems and thus the ability of decision-makers to make cross-comparisons and prioritize is impeded to some degree.
- Finding 24: At this time, the CARICOM Secretariat does not have the staff or the financial resources to monitor the performance of the five RHIs in an on-going fashion.
- Finding 25: The CARICOM Secretariat lacks the resources to assume a comprehensive set of strategic managerial functions with respect to the RHIs
- Finding 26: There is a lack of clarity surrounding the nature of the roles of the Secretariat in general with respect to the five RHIs

Finding 27: The CARICOM Secretariat has played a limited but valuable role in resource mobilisation activities with new partners; however it does not have a mandate at this time to play an active role in the coordination of RHI programming.

Appendix II List of Recommendations

CEHI Specific Recommendations

- Recommendation 1: Strengthening Stakeholder Feedback and Needs Assessment Mechanisms
- Recommendation 2: Strengthening the Results-Base of the Organisation's Planning Systems
- Recommendation 3: Increase the Organisation's Monitoring and Evaluation Capacities
- Recommendation 4: Strengthening CEHI's Fiscal Forecasting
- Recommendation 5: Strengthening Ties with Others in the Region
- Recommendation 6: Strengthening Human Resource Management Systems
- Recommendation 7: Reduce Overlap and Duplication with Others.

CHRC Specific Recommendations

- Recommendation 1: The Director should assemble a team to develop a strategy to raise and strengthen CHRC's profile in the region by clearly communicating its broader mandate and promoting better recognition, understanding, engagement and balance with respect to those served.
- Recommendation 2: More proactive steps should be taken to position CHRC to coordinate present and future health related research in the Region and to direct it toward the imperative of capacity building in CMCs. These roles need to be clarified, asserted and understood (both inside and outside of the Region) to better harness research related resources toward a more cohesive strategy for health research in the Region.
- Recommendation 3: CHRC should take stronger steps throughout the organisation to build broader capacity for focus on health and health systems.
- Recommendation 4: The Director should form a team of key stakeholders to review and consider changes related to advisory, governance and management structures in keeping with a more dynamic and diversified organisation.
- Recommendation 5: The Director, working with Council should examine the current funding and administrative paradigm of the organisation so as to better match its ability to raise and subsequently utilise the resources it requires from a variety of sources with the demands of its mandate.
- Recommendation 6: Consideration should be given to addressing the apparent 'cost efficiencies' of lower compensation packages and understaffed areas of activity, with budget adjustments to accommodate required staffing.
- Recommendation 7: CHRC should take steps to ensure that its resources are allocated in as balanced a fashion as possible to serve all CMCs and regional needs.
- Recommendation 8: CHRC should take steps to maximise access to the research and other information it generates as well as diversify its channels of communication and distribution of information to a broader CMC and other stakeholder audience.

Recommendation 9: CHRC should refine the conduct, structure and content of its current research programme to broaden involvement in decision making, expand and increase the areas of potential CMC impact and capacity building in research.

CFNI Specific Recommendations

- Recommendation 1: Strengthening Stakeholder Feedback and Needs Assessment Mechanisms
- Recommendation 2: Strengthening the Results-Base of the Organisation's Planning Systems
- Recommendation 3: Increase the Organisation's Monitoring and Evaluation Capacities
- Recommendation 4: Strengthening CFNI's Fiscal Forecasting
- Recommendation 5: Strengthening Ties with Others in the Region
- Recommendation 6: Build New Funding Partnerships
- Recommendation 7: Explore Moving Toward Greater Self-Sufficiency
- Recommendation 8: Strengthen CFNI's Communications Tools
- Recommendation 9: Acquire Greater Delegation from PAHO

CAREC Specific Recommendations

- Recommendation 1: Clarifying and Rationalising the Core Mandate of CAREC
- Recommendation 2: Clarifying and Strengthening CAREC's Core Base of Financial Support
- Recommendation 3: Renewing and Strengthening CAREC's Governing Bodies
- Recommendation 4: Strengthening CAREC's planning and management capacities
- Recommendation 5: Strengthening strategic planning and organisational performance assessment capacity in particular
- Recommendation 6: Adding a Chief Operation Officer (COO) to the management team
- Recommendation 7: Strengthening Linkage to Member Countries
- Recommendation 8: Renewing CAREC's Physical Plant
- Recommendation 9: Renewing the Multilateral Agreement