

HEALTH SYSTEMS PROFILE

SAINT LUCIA

MONITORING AND ANALIZING HEALTH
SYSTEMS CHANGE/REFORM

2008

AREA OF HEALTH SYSTEMS AND SERVICES HSS-SP

PAN AMERICAN HEALTH ORGANIZATION/
WORLD HEALTH ORGANIZATION



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Organization**

Regional Office of the
World Health Organization

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EXECUTIVE SUMMARY

Saint Lucia is in stage of epidemiological transition, characterized by a decline in infectious diseases and an increase in chronic non-communicable diseases. The Ministry of Health is the principal provider and financier of public health. The Ministry has the constitutional responsibility for regulation of the health sector and its policies are guided by five legal instruments: The Public Health Act (1975), the Mental Act (1957), the Hospital Ordinance Act (1992), the Nurses and Midwives Act, the Family Practitioners Act (1993), and the Pharmacy Act (2000). Health care is funded from the government's consolidated fund, donor contributions, out-of-pocket payments, and private insurance schemes.

The total mid-year population was estimated at 164,791 in 2005. Females represented 51% of the total population. In 2005, life expectancy at birth was 74.7 years with higher figures for women (77.7 years) than men (70.9 years). Infant mortality rate was 15.0 per 1,000 live births. Total fertility remained at 1.5 children in the period 2000-2005.

Saint Lucia is one of the many countries in the Caribbean region currently involved in a health sector reform process. The areas of primary focus are: decentralization of management and functions; integration of different levels of care; quality assurance; and strengthening of monitoring and accountability mechanisms. Data on morbidity, mortality, and the social determinants of health are collected and analyzed to facilitate evidence-based decisions and plans. Incrementally, the reform process has introduced substantial changes into different entities of the health care delivery system to increase equity, efficiency, and effectiveness.

The National Strategic Plan for Health 2006-2011 is the blueprint for the reform process and the primary health care orientation is the framework for organizing the health system. The Millennium Development Goals and the Essential Public Health Functions provide a context and timeline to benchmark progress and re-evaluate development strategies.

Concerted efforts were made to include and collaborate with stakeholders, civil society, and regional and international agencies as the reform progressed. Policymakers recognized and valued their expertise and contributions to the health care reform efforts.

Figure 1: Map of St. Lucia, in relation to other countries in the Caribbean



1. Context of the health system

1.1. Health situation analysis

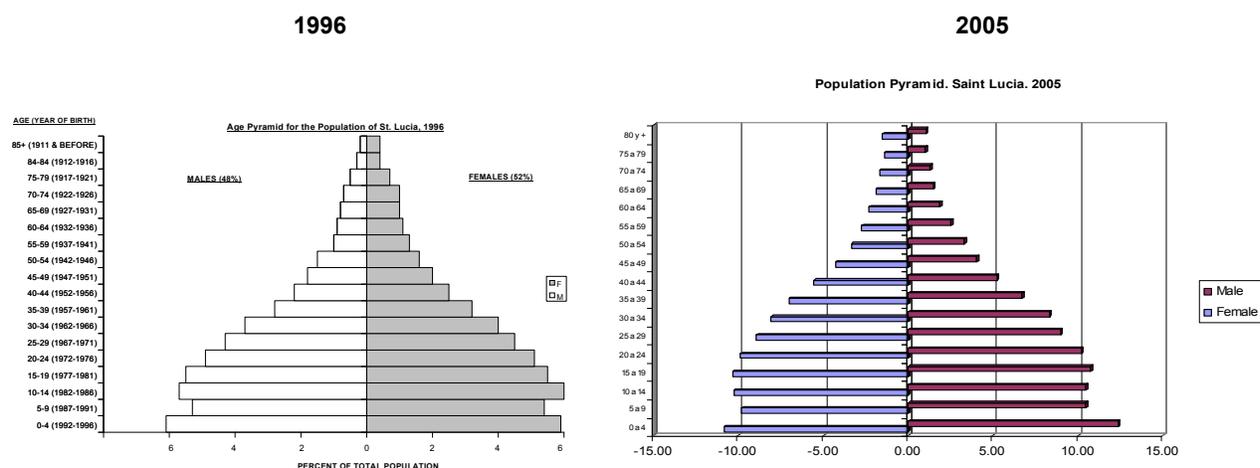
Saint Lucia, the second largest of the Windward Islands in the Caribbean, lies 62 degrees west and 13.6 degrees north. It has a total land area of 238 square miles (616 square kilometers) and measures approximately 27 miles long by 14 miles wide. The island is volcanic in origin and much of its terrain is rugged and mountainous especially at its centre. About half of the total arable land is utilized for agriculture.

1.1.1. Demographic analysis

The total mid-year population of Saint Lucia was estimated at 164,791 in 2005, representing a 1.3% increase over the figure for 2001. Females represented 51% of the total population with women of child bearing age (15-44 years) representing 25% of the population. The Government Statistical Department has projected the mid-year population to reach 176,381 in 2012 and 195,000 by 2016. According to the 2001 population census, 83% of the population is of African descent, 3% is of East Indian descent, 1% is Caucasian, and 12% are of mixed ancestry (1). Most of the population inhabits the coastal areas and less mountainous regions of the north and south of the island, and approximately 41.0% of the population lives in the district of Castries. The city of Castries represents the hub of the country's economic activity and political life.

Total fertility rate declined from 3.1 children per 1,000 women in the period 1990-1996 to 1.5 children in the period 2000-2005, representing a 48% reduction. The decline in the number of births continued and data for 2004-2006 showed that the lowest number of births occurred in 2006. It appears that this trend will continue as more women pursue careers resulting in delayed pregnancies, together with continued use of contraceptives and planned parenthood. The crude birth rate per 1,000 population has declined from 22.6 in the period 1990-1996 to 13.2 in the period 2000-2005. Life expectancy at birth rose from 72.5 years in the period 1990-1996 to 74.7 years in 2005 with the higher figures for women (77.7) than men (70.9).

Figure 2. Saint Lucia: Population pyramids, 1996, 2005



1.1.2. Epidemiological analysis

The country is in a stage of epidemiological transition, characterized by a decline in infectious diseases and an increase in chronic non-communicable diseases; and declining malnutrition. Notably, the prevalence of overweight and obesity among adults has increased. Epidemiological and demographic concerns include: increased incidence and prevalence of chronic non-communicable diseases; relatively high rate of teenage pregnancies and sexually transmitted infections in adolescents; increasing incidence and prevalence of HIV infection; increase in the proportion of the population aged 45 and older; increasing infant mortality and relatively high perinatal mortality; increasing levels of trauma; and high burden of mental illness and substance abuse.

Diabetes mellitus, hypertension, and their complications, were the leading causes of morbidity and mortality, and the age group 40 years and over was the most affected. The 2004 mortality rate for diabetes mellitus was 77 per 100,000 population. No data was available for incidence rates of cardiovascular diseases and malignant neoplasms. Violence and injuries are a major concern for persons aged 15-49 years. In 2003, the homicide rate was 21 per 100,000 population and mortality from transport accidents was 16 per 100,000 population.

In the period 1998-2002, eight cases of malaria were reported and only three were indigenous. Forty-nine cases of dengue fever were confirmed in the period 1995-1999, and 86 cases in 2000-2005. This increase in the number of cases was attributed to the strengthening of the

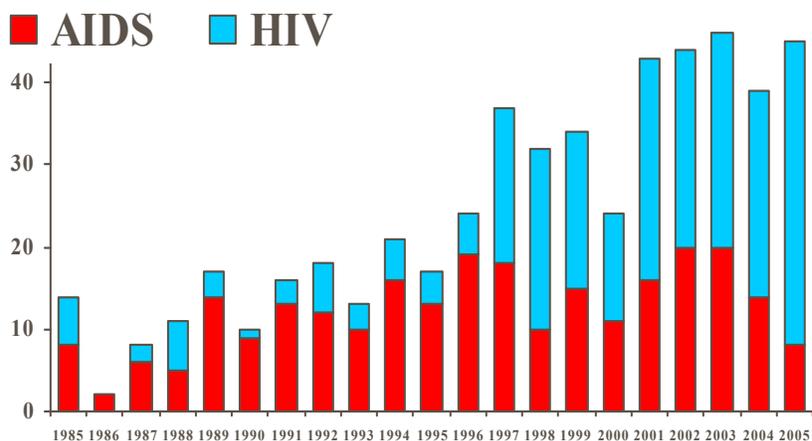
epidemiological surveillance system through the introduction of syndromic surveillance and rapid tests for dengue.

During the period of 2000-2006, the average adolescent fertility rate for Saint Lucia was 49 per 1,000 women. No data was available for breastfeeding rates. During 1998-2000, 100% of all births were attended by skilled birth attendants. In that same period, infants with low birth weight represented 8% of all births.

The infant mortality rate (IMR) for 2005 was 15.0 per 1,000 live births, a decrease of 16.2% over the IMR rate in 1991 (17.9 per 1,000 live births) and a decrease of 7.4% over the IMR in 2004 (16.2 per 1,000 live births). The neonatal death rate was 11.3 per 1,000 live births in 2005 representing a decrease of 18.5% in comparison to the rate in 1991 (13.9% per 1,000 live births) and an increase of 6.5% when compared to the rate of 13.0% in 2004. Regarding vaccine preventable diseases, in the period 2000-2006 there were a total of five cases of mumps and two cases of tetanus.

The number of reported cases of HIV increased with each successive year. There were 452 HIV cases reported between 1985 and 2004, children under 15 years accounted for about 10% and adults, 15-49 years, represented approximately 77%. Heterosexual transmission accounted for 38% of all reported cases and mother-to-child transmission represented 3.2%. Since the availability of antiretroviral drugs in 2004, the number of deaths decreased from 19 deaths in 2005 to 11 in 2006 and to 1 in the first six months of 2007.

Figure 3. Saint Lucia: HIV/AIDS distribution, by year, 1985-2005



1.1.3. Millennium Development Goals

Considerable progress was made towards attainment of many of the Millennium Development Goals (MDGs). The prospects of achieving the goals by the target year 2015 remain optimistic and positive.

Goal 1 (Eradicate Extreme Poverty and Hunger): During the period 2003-2005, the government undertook several policy eradication initiatives. The 2005 Caribbean Development Bank (CDB) Poverty Assessment study showed that the poor population increased by 3.7%, from 25.1% in 1995 to 28.8% in 2005. While more persons were identified as poor, the severity of poverty improved as evidenced in the substantial drop in indigence from 7.1% to 1.6% in the corresponding period.¹

Goal 2 (Achieve Universal Primary Education): Since 1980, Saint Lucia has achieved universal primary education. In the period 2004-2005, gross and net enrolment rates stood at 99% and 94%, respectively.

Goal 3 (Promote Gender Equality and Empowerment of Women): The establishment of a Gender Relations Department in the Ministry of Health significantly influenced the promotion of gender equality. The 2004 Core Welfare Indicators Questionnaire (CWIQ) survey revealed that females had a higher literacy rate (90%) than males (87%).²

Goal 4 (Reduce Child Mortality): Saint Lucia has achieved universal protective coverage for measles. In 2003, IMR was 14 per 1,000 live births—one third more than rate of 23 per 1,000 live births in 1985. There were 5 deaths in the period 1990-1994; 9 in the 1995-1999; and 14 in 2000-2005.

Goal 5 (Improve Maternal Health): The government is improving antenatal care through provision of free antenatal services. Ninety-eight percent (98%) of births occur in hospital and are attended by skilled health personnel.

¹ Trade Adjustment and Poverty in Saint Lucia, 2005/06.

² Core Welfare Indicators Questionnaire Survey, A pilot Study in Saint Lucia: Main Report, December 2004.

Goal 6 (Combat HIV/AIDS, Malaria and Other Diseases): By the end of 2004, the total number of reported cases of AIDS had increased to 238 of which 56% were males. There were 293 cases in 2005 of which 61% were males. In 2005, the World Bank commenced funding of a comprehensive HIV/AIDS program. The Clinton Foundation also contributed to the program's component for universal access to antiretroviral medication. Malaria is not a significant health concern. The annual incidence for tuberculosis for the period 1995-1999 was 72.0 cases per 100,000 population and 56.0 cases for 2000-2005. The Directly Observed Therapy (DOT) strategy was successfully introduced in 1997 and was implemented island wide.

Goal 7 (Ensure Environmental Sustainability): Reforestation, coastal and marine conservation programs are being addressed, but resources are limited. In 2002, UNDP estimated that 98% of the population had access to improved water sources.

Goal 8 (Develop a Global Partnership for Development): Saint Lucia is signatory to a number of cooperative agreements. Development aid assistance accounted for a significant proportion of the development budget, and is relied on heavily for the expansion of capacity and for the public sector expansion Programs.³

1.2. Determinants of health

1.2.1. Political determinants

Saint Lucia attained political independence from Great Britain in 1979. It has a democratic system of governance based on the Westminster model and parliamentary elections are held every five years. . The Head of State is Queen Elizabeth II and she is represented by a governor-general who she appoints as her representative. The bicameral parliament consists of a 17-member House of Assembly and an 11-member senate appointed by the governor-general. Saint Lucia is a member of the Commonwealth of Nations, the Organization of Eastern Caribbean States (OECS) and the Caribbean Community (CARICOM).

³ Trade Adjustment and Poverty in Saint Lucia, 2005-2006, p.147.

1.2.2. Economic determinants

Growth rates increased from 0.8% in 2002 to 5.4% in 2005. Per capita gross domestic product (GDP) increased from US\$2,928 in 2001 to US\$3,070 in 2005. The exchange rate remains constant at ECD\$2.70 to US\$1.00. Tourism accounted for 13.6% of real GDP in 2005, retaining its position as the principal engine of economic growth in Saint Lucia.

Poverty Levels

Poverty in Saint Lucia is considered a rural phenomenon in that rural districts have shown prevalence rates for poverty in excess of 35%.⁴

Table 1. Saint Lucia: Indigence, poverty and inequality, 1995, 2005-2006

Indicator	1995	2005-2006
Poor households	18.7	21.4
Poor population	25.1	28.8
Indigent households	5.3	1.2
Indigent population	7.1	1.6
Gini coefficient	0.5	0.42

Source: Assessment of Poverty in Saint Lucia, Vol. III, Quantitative Assessment of Poverty in Saint Lucia, 2006

Poverty assessments were conducted by the CDB in 1995 and 2005. After the 1995 assessment, the government initiated a number of programs targeting poverty reduction. A 2003 National Poverty Reduction Strategy and Action Plan were developed to coordinate and integrate poverty reduction initiatives involving government, civil society, private sector, and citizens. The 2005 assessment showed that poverty, as measured by the headcount, increased from 25.1% in 1995 to 28.8% in 2005 but indigence fell substantially from 7.1% to 1.6%. The Gini coefficient of inequality fell from 0.5 in 1995 to 0.42 in 2005-2006. In other words, while measured poverty increased overall inequality in the society fell.⁵ The poverty line is estimated at US\$5.22 daily, or US\$158.74 monthly; or US\$1,904.87 annually. Persons living below the poverty line are disproportionately young with children 0-14 years representing 39% of all poor persons and those 65 years and above representing 7%. Survey data were insufficient to fully

⁴ Ibid., p. 16.

⁵ Trade Adjustment and Poverty in Saint Lucia, 2005-2006, p. 15.

explain and understand the gender nature of poverty and the differences in how males and females experience, are affected by, and cope with poverty.⁶

The Human Poverty Index for developing countries (HPI-1) represents a multi-dimensional alternative to the US\$1 a day poverty measure. The HPI-1 value of 6.5 for Saint Lucia gives a ranking of 8th place among the 108 developing countries for which the index was calculated.⁷

Employment Conditions

Table 2 examines the relationship between labor force participation, socio-economic status and sex of household heads. Overall, 66.1% of all household heads participated in the labor force.⁸

Table 2: Saint Lucia: Labor force participation of heads of households, by socio-economic status and sex, 2005-2006

Labor force	Socio economic status				Total	
	Poor		Non Poor		N	%
	N	%	N	%		
Male						
Participant	4,245	73.7	15,558	76.4	19,803	75.8
Non participant	1,511	26.3	4,818	3.6	6,330	24.2
Total	5,756	100.0	20,377	100.0	26,133	100.0
Female						
Participant	1,684	39.4	9,129	57.4	10,813	53.6
Non participant	2,585	60.6	6,784	42.6	9,369	46.4
Total	4,269	100.0	15,913	100.0	20,182	100.0
Both Sexes						
Participant	4,929	59.1	24,687	68.0	30,616	66.1
Non participant	4,097	40.9	11,602	32.0	15,699	33.9
Total	10,023	100.0	36,290	100.0	46,315	100.0

Source: Saint Lucia Poverty Assessment, 2005/2006, Vol. 1: Main report.

⁶ Ibid., p.19.

⁷ Human Development Report 2007/2008 – Country Fact Sheet.

⁸ St. Lucia Country Poverty Assessment, 2005/2006, Vol. 1: Main Report.

1.2.3. Social determinants

The Human Development Index 2005 for Saint Lucia was 0.795 which gives the country a ranking of 72nd place out of 177 countries with data. In that year, the adult (15 years and older) literacy rate was 94.8%.

Education

The 2004 CWIQ survey revealed that primary school (6-11 years) enrolment rate was 93.0% while secondary school (12-14 years) enrolment rate was 79.0%. Primary school enrolment rates were 91.0% for males and 94.0% for females. Secondary school enrolment rates were 72.0% for males and 86.0% for females, representing a significant gender gap. Enrollment rates were similar for urban and rural areas, but secondary school enrollment was lower for the poorest households especially in rural areas (67.0%) Although the school dropout rate was low (1.0% of school population), females were more likely to be in school than their male counterparts.

Domestic violence

For the period 1999-2004, there were 1,048 reported cases of child abuse at the Division of Human Services and Family Affairs. The most prevalent forms of abuse include child neglect and abandonment (356), physical abuse (327) and sexual abuse (303). In the period 2000-2004, there were 2,165 reported cases of domestic violence but this figure might be higher since many cases are not reported.

Access to safe drinking water and excreta disposal services

The CWIQ survey found that 98.0% of the population had access to safe drinking water with slightly better access in urban (99.0%) than rural (96.7%) areas. Ninety-five percent (95.0%) of urban households had safe water compared with 88.0% of rural households. Two-thirds of the households had flush toilets or ventilated improved pit latrines, while 95.0% of households used government collected or a government skip for waste disposal.

1.2.4. Environmental determinants

Solid waste management is monitored and regulated by a statutory authority, the Saint Lucia Management Authority. It operates through a series of contracted private providers and is funded through an environmental levy.

The National Water and Sewerage Act was enacted in 1984 to make provision for a national water policy, for the establishment of an Authority known as the Water and Sewerage Authority, and for conferring on that Authority functions as to water, including sewerage and sewage disposal, and related purposes. The Gros Islet and Rodney Bay areas are the only ones using sewage ponds; all other households use septic tanks. As estimated 35% of households used pit latrines.

2. Functions of the health system

2.1. Steering role

The Ministry of Health is the principal provider and financier of public health services, with the primary responsibility for the delivery of public health services, primary level preventive and curative care, and secondary care. Under the stewardship of the Minister of Health, the Ministry also leads on health policy development either enshrined as legislation or as policies for the implementation of specific health services. The Ministry of Health, through legislative health acts, also functions as the primary regulator of the health sector, a function carried out through the organs of the ministry and such bodies as the Public Health Board, the General Nursing Council, the Medical Council, the Medical Board, and the Pharmacy Council.

The Permanent Secretary is the Chief Accounting Officer of the Ministry of Health, and has general oversight over the programs covering all levels of care - primary, secondary and tertiary - for all aspects of health, physical and mental. Program development and health planning is undertaken through the Policy Planning and Development Unit of the Corporate Planning Unit under the direction of the Chief Health Planner.

The Ministry retains the primary responsibility for management and dissemination of information on the health of the nation. Data are collected through a public health surveillance system which entails, the ongoing, systematic collection, analysis, interpretation and dissemination of data regarding health related events and health profiles. Data for the health disease profiles are collected from medical clinics and from the registers of diseases under surveillance. The health-related, socio-demographic indicators are less frequently collected. However, the availability, quality, and timeliness of these data will improve with the implementation of the National Health Management Information System.

As the health sector reform agenda advances, the role of the Ministry's Corporate Planning Unit will expand as it takes on new responsibilities to include: health sector monitoring and evaluation; quality assurance; and human resources planning.

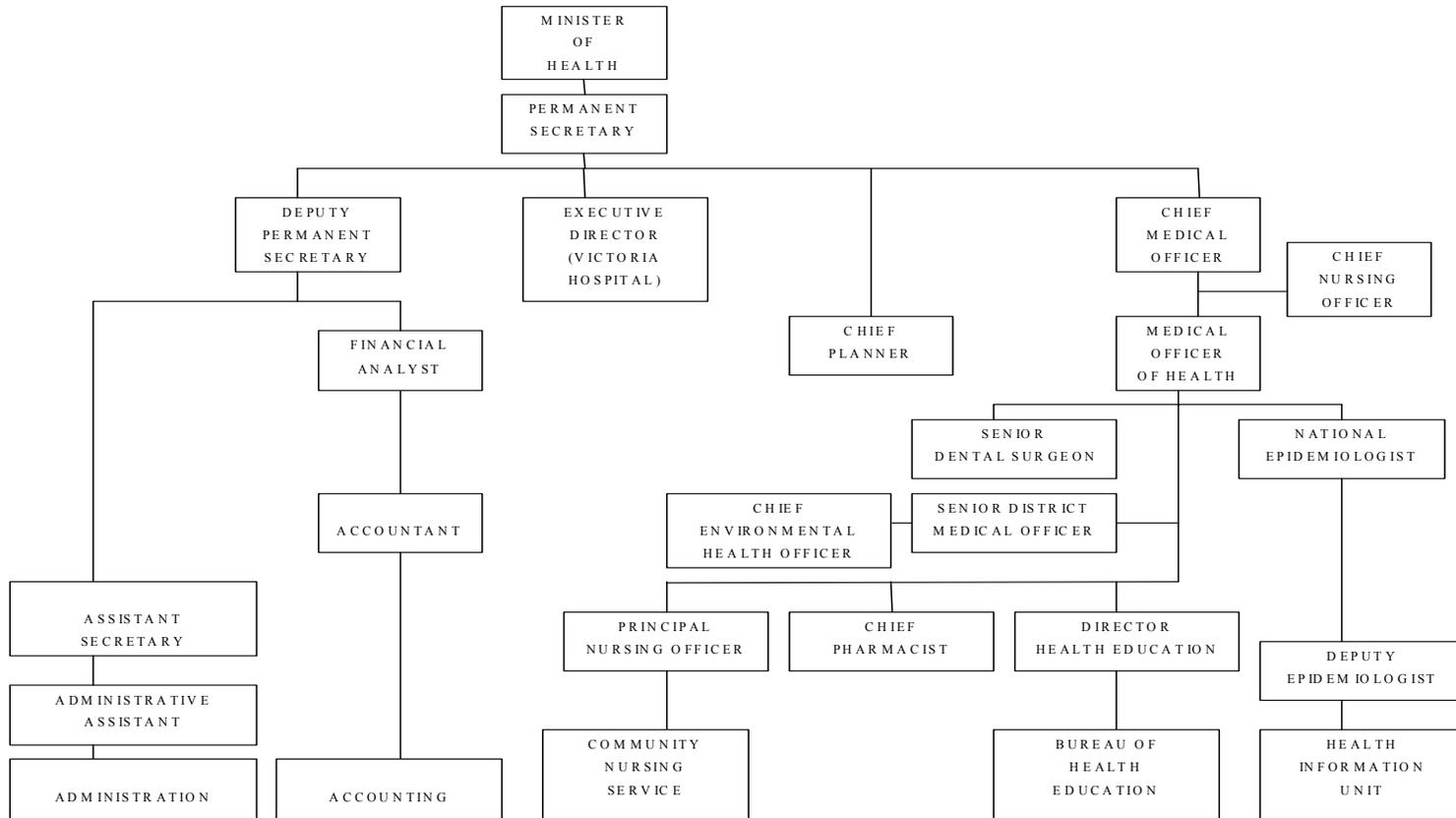
The delivery of both primary and public health services are under the direct responsibility of the Chief Medical Officer. The Chief Medical Officer and the Corporate Planning Unit bear responsibility for the monitoring and evaluation of health services delivery in the public sector.

The health team that provides services at the national and community levels is under the direction of the Chief Medical Officer. The team comprises a district medical officer, family nurse practitioner, other community nurses, health aides, an environmental health officer, as well as part-time services of a nutrition officer, and a health educator. Management was strengthened by the establishment of the Chief Nursing Officer's position who is responsible for all nursing issues.

2.1.1. Mapping of the health authority

The organizational framework for the national health authority is displayed in Figure 4.

Figure 4. Saint Lucia: Organization chart, Ministry of Health, 2008



2.1.2. Conduct/Lead

General Health Policy

The Ministry of Health, Wellness, Human Services, Family Affairs and Gender Relations mission statement is: “To provide leadership and direction in the creation of an environment in which empowered institutions can be created, guided population”⁹.

A review of the 1996-2006 Sectoral Policy of the Ministry of Health was conducted in 2007 to ascertain the status of major health policies during the past decade and to review the sector’s compliance with health-related conventions. The conclusion and recommendations addressed four (4) major areas: infrastructural support, human resource management, health information system and quality management. Policies and strategies that are not demanding on resources, that capitalize on existing structures and build on ongoing activities, are more likely to be successful and more easily sustained. Those that demand additional resources and supporting structures take longer to implement, even when there is external funding. The greater challenge, however, is sustainability when external funding ceases. Many health-related policies are influenced by and do influence activities conducted in other sectors. It is, therefore, imperative that intersectoral and inter-Ministerial collaboration be an integral part of any policy-making.¹⁰

The National Health Strategic Plan for 2006-2011 envisions: strengthening the organization and management of health and social services; improving and sustaining health gains and residents’ wellbeing, achieving greater equity, cost effectiveness and efficiency in the allocation and use of health resources; ensuring a cadre of well-trained and motivated staff; developing an effective health information system to support evidence-based planning, implementing a quality improvement system; and improving health infrastructure to support the reform process.¹¹

2.1.3. Regulation

The Ministry has the constitutional responsibility for the regulation of the health sector. This is supported by an institutional and legal framework that defines the role, responsibilities and

⁹ National Health Plan, St. Lucia, 2004.

¹⁰ Review of Sectoral Policy of the Ministry of Health, Saint Lucia 1996-2006, April 2007, p.9.

¹¹ Health in the Americas, Vol. 2, p. 625.

overall jurisdictions of the actors within the sector. As such, the Minister, Permanent Secretary, Chief Medical Officer and, more recently, the Chief Nursing Officer all have critical roles in managing health regulative responses.

The policies and programs of the Ministry of Health are guided by five major legal instruments. The Public Health Act (1975) covers health care services and practices, occupational health and safety, veterinary services, health risk factors, and notification of certain diseases. The Mental Health Act (1957) deals with mental health care services. The Hospital Ordinance (1992) covers charges and fees for hospital services, as well as liabilities for payments. The Nurses and Midwives Act governs the nursing services, the Family Nurse Practitioners Act (1993) authorizes family nurse practitioners to prescribe certain drugs, and The Pharmacy Act (2000) guides registration of pharmacist, labeling and general pharmacy services.

The deployment of human resources in the health sector is regulated and managed by the Ministry of the Public Service. At present, the Ministry of Health does not determine, or undertake the certification of health professionals. Presently, registration of health professionals is performed by the Medical, Nursing and Pharmacy Councils. However, under the Health Sector Reform Initiative, consideration is being given to including this function in the expanded regulatory role of the Ministry of Health.

Agencies such as the Bureau of Standards and the Solid Waste Management Authority are examples of the regulatory framework being executed by specialized agencies. The Ministry's Food and Water Safety Unit ensures the monitoring of, and compliance with the public sanitary and health standards as articulated in the Public Health Act (1975). Although sanctions are an essential element of regulation, their enforcement was often weak. The new roles and functions of the Ministry of Health will require greater focus on the execution of regulatory roles with a legal framework sufficiently robust to support enforcement and sanctions for non-compliance.

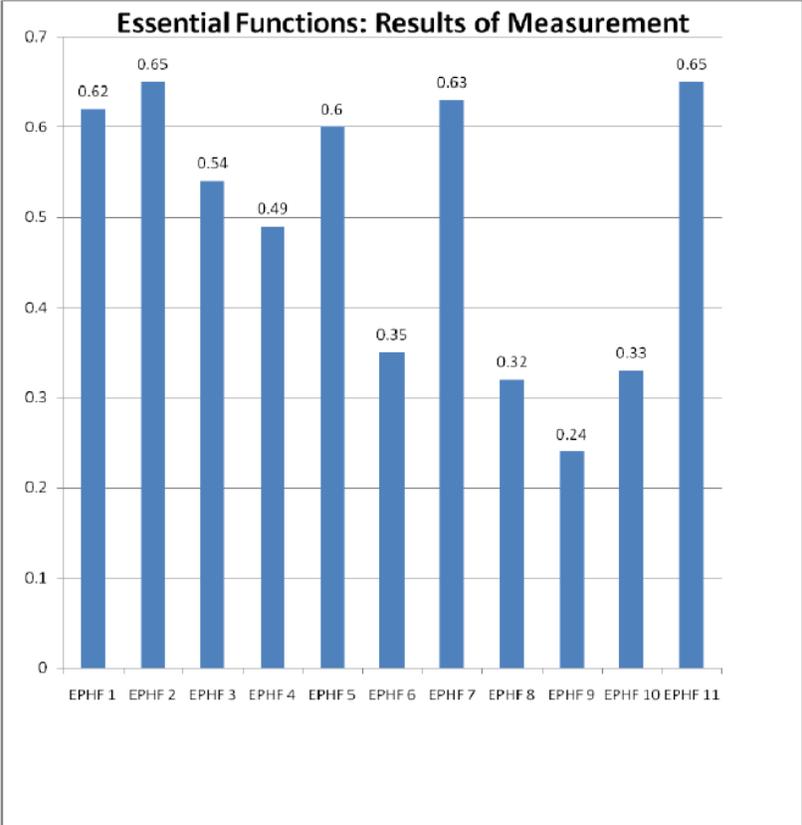
2.1.4. Development of Essential Public Health Functions

An evaluation of the Essential Public Health Functions (EPHF) was done in 2002 and measurement results are shown in Figure 5. The indicators were grouped into 3 categories: 1) fulfillment of outcomes and processes; 2) development of capacity and infrastructure; and 3) development of decentralized competencies and capacities.

A composite rating of the country’s status with regard to these functions was not determined after the evaluation but several strengths and weaknesses were identified. The Ministry of Health proposed a strategic plan for the health sector, of which the mid-term evaluation is in its early stages.

The eleven EPHF are defined as: 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; 6) Evaluation and promotion of equitable access to necessary health services; 8) Human resources development and training in public health; 9) Quality assurance in personal and population-based health services; 10) research in public health; and 11) Reducing the impact of emergencies and disasters on health.

Figure 5. Saint Lucia: Measurement of Essential Public Health Functions. Ministry of Health, 2002



2.2. Financing and assurance

2.2.1. Financing

Health services in Saint Lucia are currently funded from four principal sources: the Consolidated Fund (Government budget), donor contributions, out-of-pocket payments and private insurance schemes. Taken together, it is estimated that these various sources enable a per capita health expenditure of around US\$188. The trends in government expenditure and by the Ministry of Health are shown in Table 3. Approximately one-half of this expenditure is paid for either directly or indirectly, through insurance, by the public, and the remainder from public sources. Government health expenditure grew by nearly 40% from EC\$61.7 million in the period 2000-2001 to EC\$86 million in 2005-2006. This growth exceeded that of the government's overall expenditure, which grew by only 31% for the corresponding period (Figure 6).

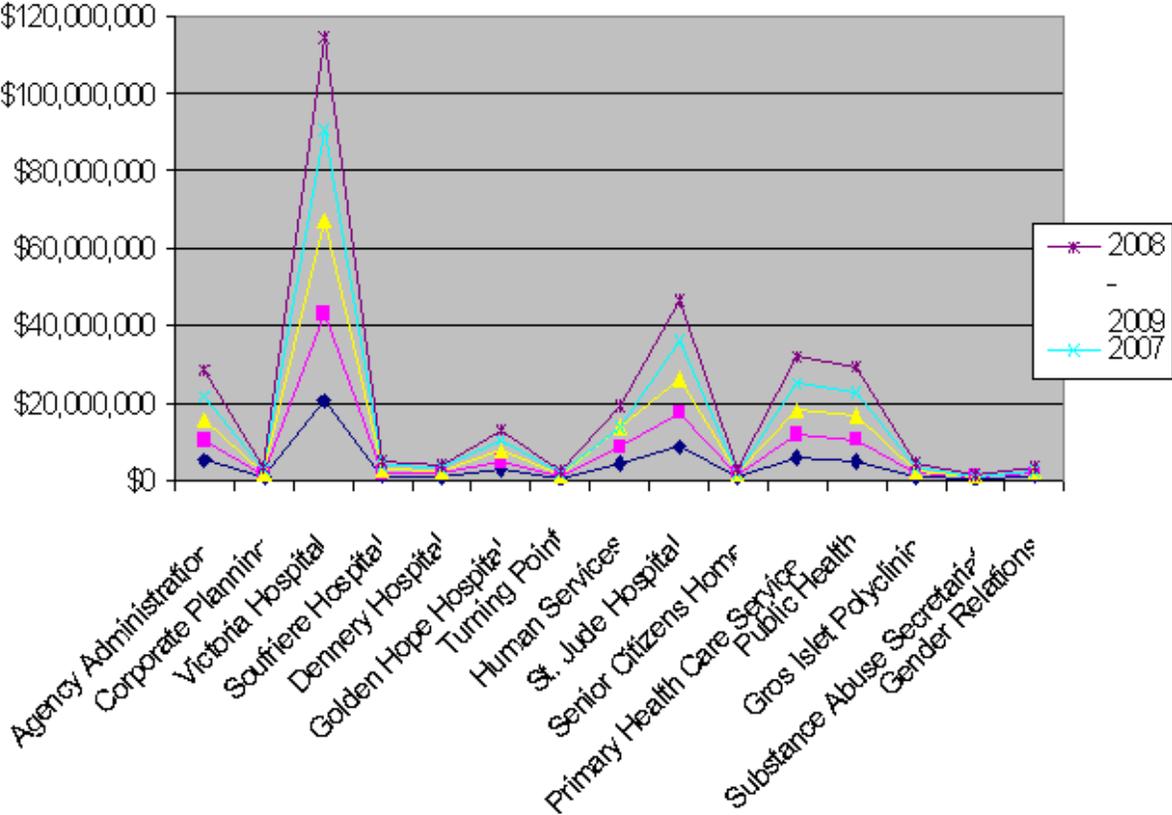
Table 3. Government and Health expenditure in Saint Lucia, 2000-2006 (US\$)

Year	2000-2001	2001-2002	2002-2003 actual	2003-2004 approved	2004-2005 revised	2005-2006 estimates
Consolidated Fund						
GoSL recurrent expenditure	16,055,757	182,445,121	181,850,209	189,139,099	200,876,554	228,221,491
% annual growth	5.2%	13.6%	-0.3%	4.0%	6.0%	14.0%
GoSL capital expenditure	107,460,250	133,918,200	106,269,105	128,696,159	81,758,389	123,861,693
% annual growth	-12.0%	24.6%	-20.6%	21.1%	-36.0%	51.0%
Total GoSL expenditure	268,017,853	316,363,321	288,119,314	317,838,948	282,634,944	352,083,184
% annual growth	-2.4%	18.0%	-8.9%	10.3%	-11.0%	25.0%
Ministry of Health						
MOH Recurrent Expenditure	18,619,478	19,442,312	19,467,213	20,000,776	20,962,779	21,901,653
% annual growth	3%	4%	0%	3%	5%	4%
MOH Capital Expenditure	4,146,238	3,603,091	3,052,982	4,889,766	4,898,119	9,861,630
% annual growth	33%	-13%	-15%	60%	0%	101%
Total MOH Expenditure	22,765,716	23,045,404	2,252,019	24,890,542	25,860,899	31,763,284
% annual growth	7%	1%	-2%	11%	4%	23%
Total health exp. as % of total GoSL expenditure	8.5%	7.3%	7.8%	7.8%	9.1%	9.0%

Source: GoSL Estimates 2001/02 - 2005/06 (Volume 2).

This increase in government health expenditure varied with a decrease in total MOH expenditure in 2002-2003 and very sharp increases in both 2003-2004 and 2005-2006. Government health expenditure grew faster than population growth, rising from just under US\$148.00 to over US\$185.00 per person over the last six years. Inflation has been quite low in recent years and consequently, the real per capita health expenditure in 2000-2001 prices does not differ greatly from those in current prices.

Figure 6: Ministry of Health Programme Expenditure 2004-2009



2.2.2. Assurance

The two types of health insurance are private health insurance for individuals and groups, and coverage by the National Insurance Scheme (NIS). The payment of hospital fees is governed by the Hospital Fees Regulations, SI No. 68 of 1992. This statutory instrument provides medical coverage for persons who a) receive an income of less than US\$2,222.00 per annum; b) are registered paupers; c) is a child of a person described in a) or b); d) has attained sixty (60) years of age and is in receipt of an income of less than six thousand dollars per annum; e) is a

member of the Nursing Service of the state; f) is a member of the Police Force, Fire Service, or Prison Service of the State; or g) is a contributor to the National Insurance.¹²

The 2000 Health Sector Reform proposals included a policy for financing the health system. Among other things, the policy maximizes the use of health resources and creates a more efficient health system capable of providing quality health services in the most cost-effective manner and reduce the impact of poverty by making health care affordable and accessible to all in need of care.¹³ The policy, however, did not determine the minimal or essential package of health services the country can afford. A package must be defined on the basis of epidemiological, clinical and financial information. In the absence of such critical information, it will be futile to attempt to project what must be included in an essential package of care. However, the National Strategic Plan for Health 2006-2011 defined a package of services and proposed a universal health care system that would be funded through a transaction-based tax and the existing contribution from the consolidated fund. The estimated cost of the essential package of services would require an additional annual expenditure of approximately US\$14,814,815.00.

The Reform proposals also discussed the issue of out-of-pocket expenditure and concluded that the expenditure for an essential package of services would be disadvantageous and inequitable for the poor. Consequently, the out-of-pocket payments for the defined package of services would be eliminated although there may be a role for certain co-payments outside of this package.¹⁴

The Mission statement of the National Insurance Corporation (NIC) is to ensure that every Saint Lucian enjoys social and financial protection and to assist in the development of the nation through the efficient collection of contributions, payment of relevant benefits, prudent management of assets, use of cutting edge technology, and a cadre of highly skilled staff. The NIC covers sickness, invalidity, maternity, and employment injury benefits. The Corporation pays an annual contribution to the Ministry of Health to cover in-patient hospital fees for its members.

¹² Hospitals Regulations: St. Lucia, Statutory Instruments, 1992, No. 68, October 1992.

¹³ Health Sector Reform Proposals, Ministry of Health, 2000, p.79.

¹⁴ Health Sector Reform Proposals, Ministry of Health, 2000, p.80.

The Ministry of Health has no jurisdiction over the operations of the private health insurance companies. There were 9 private health insurance companies; most cover medical, dental, vision and hospitalization expenses. Some companies refund the insured while others make direct payments to the health care provider. Private health insurance is primarily awarded via group insurance plans, with employers and employees contributing to the plan. Others buy individual policies for themselves and their families.¹⁵

2.3. Service provision

2.3.1. Supply and distribution of human resources

To date, Saint Lucia continues to experience a dire shortage of human resources in the health care delivery system, specifically as it relates to specialist physicians and nurses. This is attributed to the unavailability of medical schools in Saint Lucia, the high costs attached to pursuing studies in these areas, and the outward migration of nurses in search of better remuneration packages. This shortage of human resources has compromised the delivery of quality health care in the public sector. Table 4 shows the distribution of two key health personnel over the period 2000 to 2006 in the public sector.

Table 4. Saint Lucia: Number of registered doctors and nurses in the public sector, 2000-2006

Medical personnel	2000	2001	2002	2003	2004	2005	2006
Doctors	92	92	70	75	68	83	71
Nurses	390	390	302	495	375	326	248

Source: St. Lucia Statistics Department

The number of doctors varied between 2000-2006, with years 2000 and 2004 recording the highest and lowest number of doctors employed in the public service, respectively. The number of nurses in the public sector decreased from 495 in 2003 to 248 in 2006. In 2007, there was a total complement of 143 nurses of which 125 were registered nurses and 18 were ward sisters at the Victoria Hospital. The standards set by the International Council of Nurses determined that for the 160-170 bed Victoria Hospital, the workforce should comprise 212 registered nurses and 47 ward sisters, for a total of 259 nurses. In other words, based on the International Council of Nurses' standards, the Victoria Hospital is being run with a deficit of 116 nurses (87 nurses and 29 ward sisters).

¹⁵ Health Systems Profile, Saint Lucia, 2001.

The shortages of medical officers within the geographical districts have resulted in level three health facilities such as Babonneau, Micoud, La Fargue and Anse La Raye and level four health facilities, Soufriere and Dennery Hospital, Castries and Vieux Fort Health Centre and Gros Islet Polyclinic being unable to provide daily medical clinics despite the great demand of medical services. In 2007 there were 33 health centers in St. Lucia and only 15 medical officers in primary health care services.

2.3.2. Medicines and other health products

Saint Lucia is part of, and obtains drugs through, the Organization of Eastern Caribbean States (OECS) Pharmaceutical Procurement Service (PPS). The Service has an established formulary and a formulary committee that reviews its essential pharmaceutical list at regular intervals. The Office of the Chief Pharmacist of the Ministry of Health, together with the Central Procurement Unit, ensures that the supply and distribution of pharmaceuticals in the public sector keep pace with demands.

The private sector operates outside PPS and there is no national pricing system to control the cost of pharmaceuticals in the private sector. The cost of pharmaceuticals in the public sector is directly controlled by the Ministry of Health while market forces control the prices in the private sector.

Vaccines are procured through the PAHO/WHO Expanded Program of Immunization. Routine vaccines include MMR, DPT, oral polio and Hepatitis B. Community Nursing Services are responsible for the ordering, storing and distribution of vaccines. Special vaccines are made available, such as those for yellow fever, HIB and pneumococcus.

The Pharmacy Act of 2000 ensures the availability of a licensed pharmacist in every pharmacy and every hospital and regulates the conditions for dispensing pharmaceuticals. The Act also makes provisions for alternative medicine regulation but that has not been activated yet. Public expenditure on medications and medical supplies is around US\$1,322,208 per annum. Over 90% of pharmaceuticals in the public sector are interchangeable generics.

2.3.3. Equipment and technology

The annual budgetary allocation from the Ministry of Finance for maintenance of equipment is estimated at US\$323,767. The hospitals maintain a database of equipment and their status and the Ministry of Health and the hospitals have dedicated maintenance personnel. No information was available on the percentage of equipment that is defective or out of use in the private sector.

2.3.4. Quality assurance

Standards of care are defined in various manuals, such as the community nursing manual, and in protocols of care for management of certain diseases and conditions, including diabetes and hypertension. The government adopted the ISO 15189 standard for its medical laboratories and laboratory personnel were trained through the Regional European Union Medlab Strengthening project facilitated by the Caribbean Epidemiology Center (CAREC). The Bureau of Standards is the main entity for the accreditation of laboratories.

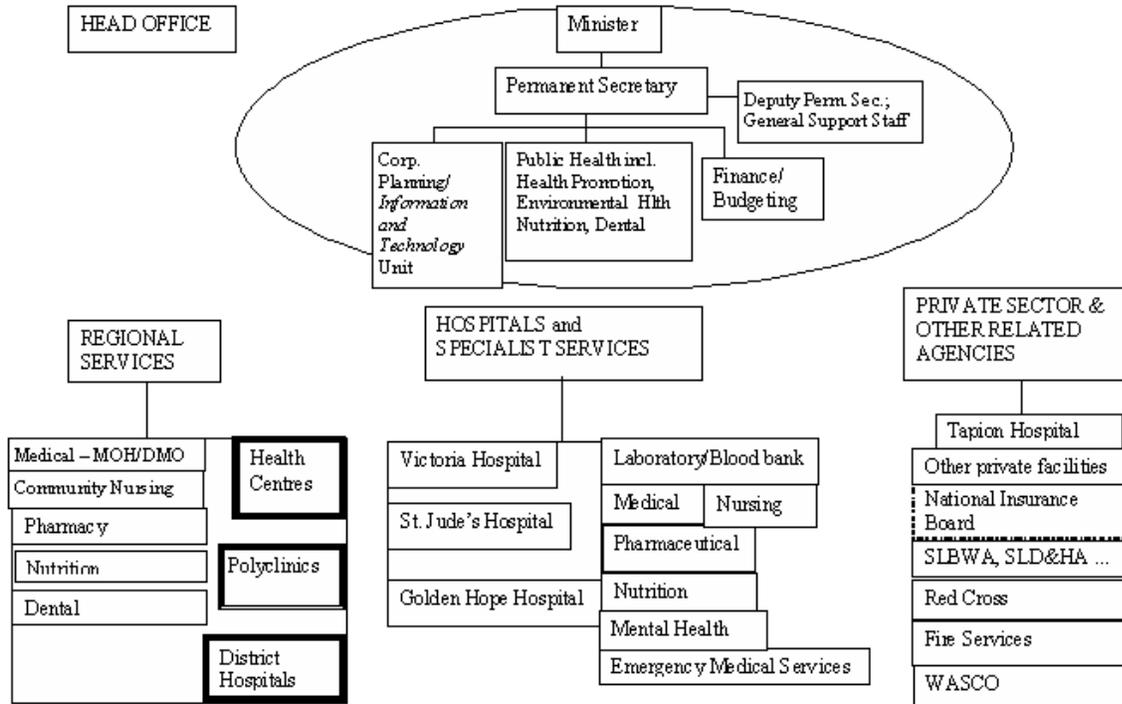
The community nursing services and all hospitals have established quality assurance committees. Hospitals and medical laboratories have dedicated quality assurance officers. As of this writing, there is no accreditation authority. However, through funding from NIC, the Canadian Council for Health Service Accreditation conducted risk assessments of all the major health institutions in 2005. An outcome of this assessment is the development of a process to guide health institutions through the accreditation process.

A Complaints Commission Act was passed in 2001; however, to date, this Commission is not fully operational. The purpose of the commission is to handle public complaints. This Act requires the enforcement of the professionals licensing Acts. The Nursing and Pharmacy legislation is in effect but the Health Practitioner's Act 2006 is pending.

Although the National Strategic Plan for Health 2006-2011 details the expected resources and skill mix necessary to ensure quality health services, the appropriated resources are not in keeping with these recommendations.

2.4. Institutional mapping of the health system

Figure 7. Institutional Mapping of the Health System, Saint Lucia, 2008



3. Monitoring health systems change/reform

3.1. Impact on health systems functions

Measures to reform the health sector in Saint Lucia date back to September 1997 with a draft health sector policy not fully implemented. At that time, three phases were envisioned: Phase 1 was the reorganization of health services and included proposals to increase the sector's capacity to plan, evaluate, and manage the health care delivery system; Phase 2 focused on a reform of the health financing system with the main objective of developing a sustainable, diversified system; and Phase 3 pertained to the elaboration of a comprehensive national plan with detailed service plans. The action plan included: 1) a reorganization and reorientation of the ministry to reflect a multidisciplinary approach to the delivery of care; 2) a clear definition of roles, responsibilities and lines of reporting; 3) institutional strengthening and capacity building; and 4) the central office of the Ministry should focus on financial control, policy and regulation of both the public and private sectors.

A Health Sector Reform Proposal was developed in 2000 and its salient features were: health promotion strategies will drive the health sector; quality assurance approaches will be used to monitor and improve performance; the prerequisites to enable the Ministry of Health to perform its new role will be addressed; and priority will be given to the development of the health management and information systems. This process aimed to introduce incremental interventions into the health sector to increase efficiency and effectiveness of health care delivery systems to meet the needs of the population. However, the Proposal were amended in light of unavoidable constraints such as, the unavailability of funding; the lag time for training health care professionals; timing of activities to accommodate synergy with other developments in the health and public sectors; and developments at the regional and international levels. In 2005, a draft National Strategic Plan for Health was developed to enhance the health sector reform activities in the period 2006-2011.

The ability of the Ministry of Health to address all the issues necessary to fully implement the national health sector reform policy and plans was met with constraints. Notwithstanding, implementation of some of strategic directions are ongoing. No impact evaluation studies have been conducted.

3.2. Impact on the guiding principles of health sector reform

3.2.1. Equity

With regard to the principle of equity; the government considers health services as public goods and a key pillar of the reform that ensures that no Saint Lucian is denied access to health care and essential drugs because of their inability to pay.

Coverage

The Ministry of Health fully supported initiatives to establish a Universal Health Care Strategy designed to provide health insurance coverage for Saint Lucians, but the initiative was not approved. Health Variable Frequencies Census 2001 estimated overall insurance coverage (life, health, etc.) to be 43.7% of the population. The National Insurance Scheme (NIS) covers 17.5% of the population for inpatient services only. Group Health Insurance covers 5.5% of the population, and individual health insurance covers 2.1%. School Accident Insurance covers 81.8% of students for injuries sustained on the school compound only. Consultative services at health centers are provided at no cost but there is a cost for such services as pharmaceutical, laboratory, and radiology unless the person is in an exempt category. A pilot project providing services, including pharmaceuticals, for persons with diabetes was started in 2006.

Distribution of resources

The National Strategic Plan for Health 2006-2011, reintroduced plans for a Universal Health Care (UHC) and for efficient health resource allocation; final approval for implementation is still pending. Presently, the distribution of health resources is inequitable with urban areas being better resourced than rural, and northern communities better resourced than southern. Table 5 shows how the responsibility for health expenditure will shift from the MOH to the UHC over the Plan's period. The table also shows the amount of funds that will be earmarked to Priority Health Areas (PHAs) by the end of the Plan's period.

Table 5: Saint Lucia: Estimated consolidation of the National Strategic Plan for Health, 2005 vs 2011 (EC\$)

	2005-2006		2011-2012		Total
	Total	PHA	Non-PHA	Total	
MOH	59,353,475	15,747,927	18,893,695	34,641,622	
UCH	0	1,000,000	58,058,547	59,058,547	
Total	59,353,475	16,747,927	77,621,832	93,700,169	

Source: National Strategic Plan for Health 2006-2011.

Access

The preferred approach to ensuring access to a basis package of services is to ensure universal access to essential services evidence-based in terms of their effectiveness and prioritized in terms of their cost effectiveness. Presently, access to certain health services is determined by individual financial resources. Poorer persons have less access than richer and rural persons have less access than urban. In St. Lucia, no one in need of care will be denied access to quality health services and will receive service the same day; however, some services at the tertiary level might require a referral to hospitals overseas. There are no documented functional access barriers to health care services in St. Lucia.

3.2.2. Effectiveness

The strategic direction for effectiveness is outlined in the National Strategic Plan for Health 2006-2011. It addresses the main public health problems under 12 priority areas. The national protocols, standards, and delivery of care are to be guided by the structure outlined under these priority health areas. Many of the communicable diseases which were leading causes of mortality and morbidity in the previous millennium have been controlled. Apart from the occasional case of mumps, there were no cases of the original six conditions reported under the Expanded Program of Immunization.

Infant and maternal mortality

In 2005, neonatal deaths accounted for 76% of total infant deaths. In that year, there also were 8 post-neonatal deaths; the post-neonatal death rate was 3.6 per 1,000 live births in 2005, a decrease of 4.9% compared to the rate in 1991. The perinatal mortality rate was 28.8 per 1,000 live births in 2005, an increase of 19.0% compared to 24.2 in 1991. The neonatal death was

11.3 per 1,000 live births in 2005 representing a decrease of 18.5% in comparison to the rate (13.9) in 1991 and an increase of 6.5% when compared to the rate of 13.0% in 2004.

Table 6. Saint Lucia: Infant mortality rates, 1996-2005

		1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Infant Mortality Rate	All Ages	13.2	15	11.6	18.7	16.7	16.7	17	13.7	16.2	15
	Male	15	15	9.1	24.2	18.5	14.7	14.7	12.8	16.2	17.2
	Female	11.5	15	14.2	13.3	15.1	18.5	19.4	14.7	16.2	12.6
Neonatal Mortality Rate		8.40	10.7	8	16.7	14.3	13.1	14.4	10.5	13	11.3
Post Neonatal Mortality Rate		4.8	4.3	3.6	2.2	2.2	2.5	2.6	3.2	3.2	3.6
Perinatal Mortality Rate		21.4	24.6	22.9	23.8	29.2	29.8	29	29.7	25.5	28.8

Source: Ministry of Health, 2008.

Table 7. Saint Lucia: Distribution of infant deaths, 1991, 2003-2005

Age Group		1991		2003		2004		2005		Rate
		No.	%	No.	%	No.	%	No.	%	
Infant deaths										
		No.	%	No.	%	No.	%	No.	%	Rate
0 days		15	22.4	8	23.5	9	22.5	15	45.5	
1-6 days	Neonatal	34	50.7	9	26.5	19	47.5	6	18.2	11.3
7-27 days		3	4.5	9	26.5	4	10	4	12.1	
28-11 months	Post Neonatal	15	22.4	8	23.5	8	20	8	24.2	3.6
All ages		67	100	34	100	40	100	33	100	15

Source: Ministry of Health, 2008.

In 1991, a total of 67 infants died and the three leading causes were attributable to conditions originating in the perinatal period (22 or 33%); slow fetal growth, fetal malnutrition, short gestation, and low birth weight, (21 or 31%); and congenital, (10 or 15%). Forty-five infant deaths were recorded in 2002 and the three leading causes were diseases of the respiratory system (15 or 33%); slow fetal growth (14 or 31%); and fetus and newborn affected by maternal conditions (4 or 9%). For each year in the period 2000-2002, 10% of total births were low birth weight babies. All causes of death were coded according to WHO International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10).

Between the 1989 and 2005, there were 55,313 births and 22 reported cases of maternal deaths. In 2005, the maternal mortality rate was calculated to be 1.5 per 1000 live births. One (1) case of maternal death was reported in 2005; the cause of death reported proteinuria and hypertensive disorders in pregnancy and childbirth, complication of labor and delivery.

Sometimes maternal deaths may be underestimated due to errors in reporting the cause of death on the death certificates.

Mortality due to malignant neoplasms

In 2003-2005 there were 521 deaths from cancers, averaging 174 deaths annually and representing about 5.4% of all deaths in the period. Males accounted for 59% of all deaths due to cancers. The leading sites were the prostate (19%), trachea/bronchus/lung (4%), and stomach (4%). For females, the leading sites were cervix (10%), breast (5%), and stomach (2%). Mortality from cancer was higher for women than for men in the 15-44 age groups, but almost similar in the 45-64 age groups. The pattern is partially explained by the fact that the risk of prostate cancer increases with age.

Incidence of malaria, tuberculosis and HIV/AIDS

Three cases of imported malarial fever were reported during the 2003-2005 period. The Epidemiological Unit of the Ministry of Health reported 112 cases of all forms of tuberculosis in the period 1996-2006. The Direct Observed Treatment Strategy (DOTS) is being utilized with an adequate supply of drugs, supervision and patient support. Table 8 shows the status of TB cases in St. Lucia during the period 1996-2006.

Table 8. Tuberculosis Cases 1996-2006, Saint Lucia

Year	No. of Cases	New Confirmed Positives	Defaulters/Failures/Deaths/ Unknown Status
1996	35	18	32%
1997	22	12	16%
1998	17	9	11%
1999	16	9	11%
2000	9	8	0%
2001	17	6	50%
2002	23	7	15%
2003	12	9	23%
2004	15	11	57%
2005	11	10	80%
2006	15	13	8%

Source: Epidemiology Unit, Ministry of Health

The data on the prevalence of tuberculosis in Saint Lucia is inconsistent and does not permit the easy calculation of prevalence rates. Nevertheless, it can be inferred that treatment rates of known incident cases increased to about 90% around 2000. Data were unavailable as to the number of persons with HIV/tuberculosis co-infection. In 2000, the Ministry of Health established the National Tuberculosis Committee to set policies and devise strategies to control and eventually eliminate tuberculosis.

HIV/AIDS placed the greatest burden on the health system. In 2001, the Ministry of Health began the development of its first National Strategic Health Plan (2003-2008) for HIV/AIDS. The Plan comprised four strategies mirroring the PAHO/HIV/AIDS strategic framework. A priority under the plan was the development and ratification of a National HIV/AIDS policy by June 2006. Since then, increased resources were invested in the fight against HIV/AIDS and the removal of cost barriers facilitated increased access to quality care for persons living with HIV/AIDS.

3.2.3. Efficiency

Efficiency is addressed through the provision of optimal health care to the population within the resources available. A national health information system, using electronic medical records, is being developed for implementation during the financial year 2008-2009. This system will improve data collection and provide information to monitor and analyze health delivery processes.

Primary Health Care (PHC) continues as a major thrust in the promotion of efficiency in health services. The concept of an integrated, multidisciplinary team providing PHC in communities is being revitalized using the “Local Health Systems” (SILOS) strategy. This strategy promotes the use of District Health Teams (DHTs) to provide care at the primary level. The teams comprise at least a public health medical officer, a public health nurse, an environmental health officer, a nutritionist, and community health aides.

Resource Allocation

Despite a declared commitment to PHC as a strategy for health and human development, the allocation of resources has not favored this approach. Secondary care services continue to pose tremendous financial burden on the health system. In the distribution of health resources, primary care services are allocated a decreasing or stagnant proportion of the health budget concurrent with a decreasing allocation of government expenditure for the health sector. Secondary care services accounted for 53% of the total health budget for 2001-2002 and 54% for 2002-2003. Primary care services accounted for 22.0% in 2001-2002 and 23.0% 2002-2003.

The Ministry of Health partners with the Water and Sewage Company (WASCO) to ensure that residents of Saint Lucia have safe drinking water. The Department of Environmental Health routinely tests the drinking water and in 2000, 27% of the points tested had no free chlorine radicals. According to the 2004 CWIQ survey, almost all households have access to a water supply with slightly better access in urban than rural areas (99% and 97% respectively). Safe water was supplied to 95% (an improvement from 89% in 2001) of urban households compared with 88% of rural households. In the review period, government-collected waste improved from 88% to 95% of households.

3.2.4. Social participation

Non-Governmental Organizations (NGOs) continued to play a role in the identification of problems and in the implementation of remedial activities. These organizations work in collaboration with Ministry of Health. NGOs such as the Saint Lucia Blind Welfare Association, Saint Lucia Cancer Society, Saint Lucia Sickle Cell Association, and The Saint Lucia Diabetic and Hypertensive Association continued to make major contributions to the health sector.

The health sector reform process was enhanced through extensive consultations with all social partners, stakeholders, and civil society with technical guidance from the Pan American Health Organization. The National Health Strategic Plan 2006-2011 was drafted in 2005 with assistance from the European Union (EU).

The number of Civil Society Organizations (CSO) that participated in the health sector, especially in the area of HIV/AIDS, has increased. The number of CSO-sponsored projects on HIV/AIDS prevention, treatment, and care increased from zero in 2005 to 41 in 2008.

3.3. Impact on the health system

The health reform process, as defined in the National Strategic Plan for Health 2006-2011 is in the first stage of implementation. Some of the major changes in such areas as governance, regulation, and financing require endorsement from the government of Saint Lucia.

The vision of the Ministry of Health is “Quality Health for Life” and its philosophy is to provide quality care to individual, families and communities regardless of race, religion, socio-economic status or political affiliation. The Ministry of Health continued to strive for good health governance by rationalizing its role as the dominant actor in the health sector and by sharing the planning, implementation, and evaluation functions with major stakeholders and civil society. One of the basic elements of the health reform process in Saint Lucia is decentralization that includes delegation and devolution – the transfer of authority and power to make decisions to the periphery, including the shift of the corresponding administrative and technical tools.

Mental health is an area undergoing substantial reform. In 2008, the draft Mental Health Act was submitted to, and is pending approval from the Attorney General’s Chambers. Based on the proposed Act, a mental health team was defined (a nurse practitioner and social worker) to provide services at the community level. The aim of this community-based approach is to manage clients in their communities and decrease the need for costly inpatient mental health care delivered in hospitals.

The Health Sector Reform proposal provides for changes in the labor mandate creating structures and processes that require human resources trained in management and other specialties.

Table 9. The context of Health Sector Reform in Saint Lucia, 2008

Features of the health system in Saint Lucia	Health Sector Reform Strategies, Saint Lucia
<ul style="list-style-type: none"> ▪ Decentralized according to a deconcentration model, which emphasizes central control with little autonomy to make decisions at the operations level. ▪ Characterized by care at two distinct levels- primary and secondary, with little articulation between the two. ▪ Budgeting through a program budgeting mechanism that leaves budgetary control in the office of the Permanent Secretary and sometimes the Ministry of Finance ▪ Financed via out-of-pocket spending and general taxation, although some families have purchased indemnity-type private health insurance ▪ Weak in terms of mechanisms that monitor quality and hold providers accountable for service given to clients. 	<ul style="list-style-type: none"> • Decentralization of authority and responsibility through the creation of Regional and Institutional Management Units. • Integration of services and the institutionalization of the “team approach” at all levels of the system. • Development of multidisciplinary health teams responsible for service provision and the respective budgets. • Development of a Plan of Action for improving the health financial system. • Development of Standards of Health Care and information systems to monitor outcomes. • Institutionalization of professional self-regulation mechanisms including licensing and accreditation. • Establishment of a Complaints Commission with authority to handle health related complaints efficiently and justly.

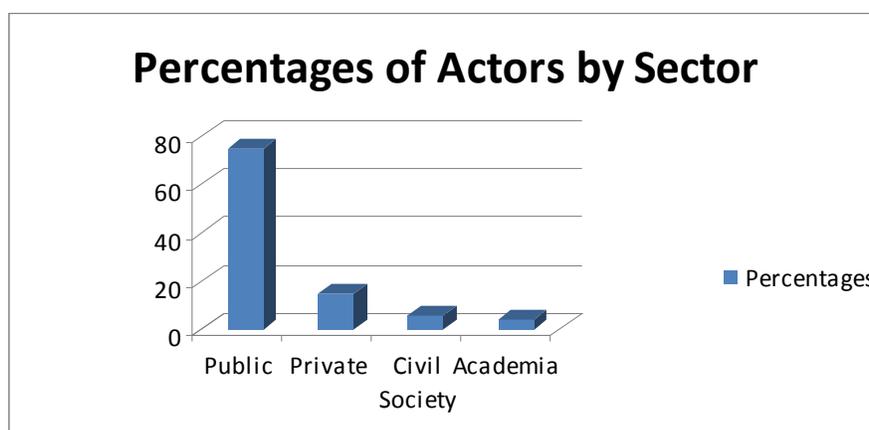
3.4. Analysis of actors

The Ministry of Health is the principal actor facilitating reforms. Other Ministries with responsibility for Education, Agriculture, Social Transformation, Youth and Sports are key partners in the reform process especially as the concept of health promotion and health education gains prominence. The private health sector is a major service provider and it is estimated that 50% of national health expenditure is in the private sector. The private sector, although engaged by the government in reform initiatives, has not been an initiator of health reform.

The National Insurance Corporation (NIC) makes an annual contribution of approximately US\$1.1 million per annum to health services to cover NIC contributors for inpatient services in public hospitals. The NIC played a major role in fueling health sector reform in the period 2002-2006, especially in the areas of: health information systems, universal health care proposals, and hospital accreditation proposals. The EU is a main international partner that provided substantial financial support for the new national hospital. In addition, the EU funded the development of the National Strategic Plan 2006-2011 and also funded a Martinique-Saint Lucia cooperation agreement to help build capacity in hospitals. The Pan American Health Organization provided ongoing technical support especially in the areas health system development and mental health.

The Caribbean Development Bank (CDB), through the Economic Recovery program, provided financing and oversight for the health center infrastructure improvements project. The CDB also supported the development of the National Health Information System. In 2005, the World Bank provided major financing for the National HIV/AIDS program. This program has resulted in major improvements in the care and support for PLWHA. The government of Saint Lucia ensured that investments through this fund built capacity that could be sustained after the World Bank financing ceased. The World Bank also contributed funds for health center infrastructure improvements project. The People’s Republic of China built the new mental facility to approximately 75% completion. The Taiwanese Government will complete the structure.

Figure 8. Contributions by Actors in the Health Sector, Saint Lucia



Source: Ministry of Health, 2008.

Table 10. Analysis of the Role Actors, Saint Lucia, 2008

Actors	Role/Objectives
NGOs	Information sharing, involve in policy development and project funding
Ministries of Agriculture	Food production, Veterinary Health, occupational safety
Ministry of Education and Sports	Health Education and Promotion Sports Medicine and promotion of exercise
Ministry of Tourism	Promote Health Tourism
Ministry of the Public Service	Human Resource planning for health
Ministry of Trade/Commerce	Ensure safety of food imported
Ministry of Legal Affairs	Review and update of health regulations/occupational and safety laws.
Ministry of Communication and Public Utilities	Provision of safe/potable water Enforcing of road safety
Ministry of Finance	Coordinator and identification resources
Churches	Healthy Lifestyles promotion
Other private sector, including Media	Health Promotion Project funding Involvement in policy development
Region/International Agencies	Provision of technical support. Identification of funds.

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