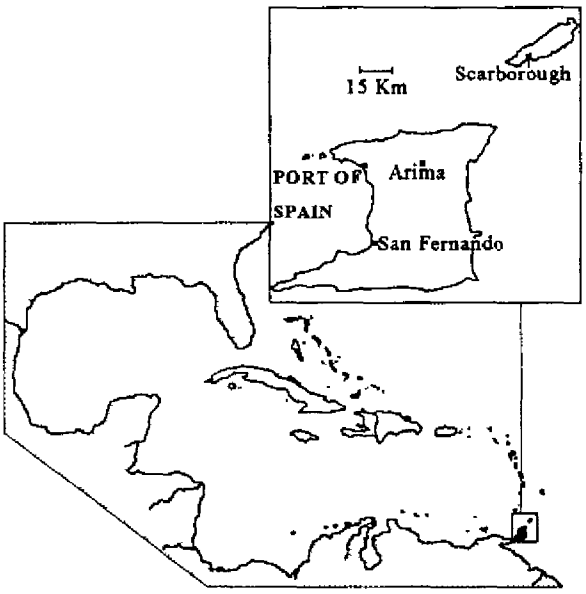
TRINIDAD AND TOBAGO



Capital: Port of Spain
Area: 5,130 km²
Population: 1,215,000 (1990) (a)
Population density: 236/km²
Urban population: 69 1% (1990) (b)
Per-capita GDP in USD: 3,230 (c)
Life expectancy at birth: 71.6 years (d)
Infant mortality rate 15‰ live births (1990) (e)
Illiteracy: 5% (1985) (f)
Population under poverty line: 18-20% (g)
Human Development Index 1992: 0 876 (30th) (h)[1]

The difficult balance between human development and structural adjustment

Trinidad and Tobago lie at the extreme south of the Lesser Antilles in the Caribbean Sea and face the coast of Venezuela, from which they are separated by a 66 km-wide strait. Their area is over 5,000 km², of which 4,828 belong to Trinidad, the larger of the islands. The population, which exceeds 1.2 million, is varied in its ethnic composition, a result of the plantation economy of the colonial period. Approximately 38% of the population is Afroamerican and 43% is of Hindu origin While the population of African origin predominates among urban workers, the descendants of workers from India largely constitute the agricultural proletariat. The rest of the population is of Portuguese, European, or Chinese origin or descends from other ethnic and cultural groups. Approximately 33% of the population is less than 14 years old, and more than two-thirds live in urban centers.

Trinidad and Tobago experienced notable economic expansion during the 1960s and particularly the 1970s based on oil and the high prices for that product in the international market after the oil crisis of 1973. Oil revenues changed the face of the country: economic growth quickened, and the state's resources, public expenditures and investment, per-capita income, consumption, and imports multiplied several times, enabling the population to achieve living stan-

dards which were soon among the highest in all Latin America and the Caribbean.

Dependence on oil has, however, become extreme: around 1990 oil and refined oil products represented more than 70% of exports. The economy's behavior has therefore literally depended on the international price for crude, as became clear during the 1980s. In that period oil prices, and thus revenues from exports, fell sharply, leading the country into a deep crisis. Imports had grown at an unsustainable rate and the Government's development program, which aimed at diversifying the economy, was very ambitious.[2] The state reduced investment and expenditure, which caused unemployment to increase. The growing deficit in the state's finances—despite cuts in expenditures—and the foreign trade deficit were financed through a heavy reduction in the international reserves accumulated during the years of the oil bonanza and through external indebtedness. From 1981 to 1985 reserves fell by 50% and the public debt grew from 14% to 22% of the gross domestic product (GDP). The external debt doubled between 1981 and 1990, increasing from USD 1,049,000,000 to USD 2,202,000,000, and debt service payments almost tripled during that period.[3]

Although the data above make the magnitude of the crisis clear, the behavior of the GDP and the per-capita GDP in relation to the rest of Latin America and the Caribbean must be analyzed to learn its true dimensions. From 1981 to 1989 the GDP fell by an annual average of 3.9%, though in the worst years of the crisis the declines were spectacular, as occurred in 1983 (-15%) and 1987 (-8.3%). By 1989, at the end of the decade, the per-capita GDP's cumulative decline was 40.8%, the largest in Latin America and the Caribbean during the 1980s.[4] Real wages fell by 35% from 1984 to 1988 alone and in 1990 fell anew by 6%.[5] Poverty, a direct result of the reduction in income, affected 20% of the total population and 39% of the rural population in 1988.

In the face of the magnitude of the crisis and macroeconomic imbalances, the Government found itself obliged in 1989 and 1990 to establish structural adjustment agreements with the International Monetary Fund (IMF) and the World Bank (WB). These agreements meant the application of measures bearing a heavy social cost such as elimination of subsidies on food (75% of which is imported), cuts in wages (10% in the state sector) and public employment, and a reduction in subsidies for social services. It is expected that the inequitable distribution of the adjustment cost will cause the incidence of poverty to grow. Because of the adjustment, strikes and union and popular protests took place in 1989. It has been noted that the growing social malaise caused by the structural adjustment measures, unemployment, and poverty is among the causes of the failed rebellion and attempted coup led by the Jammat al Muslinim (Muslim Society) group in July 1990, an attempt that was accompanied by major public protests and looting of stores in the capital.

Nonetheless, the per-capita GDP was USD 3,230 in 1989, which was still one of the highest in the region and exceeded only by those of the Bahamas and Barbados. In addition, Trinidad and Tobago has remained among countries with "high human development," ranking 30th in the world according to the classification proposed by the United Nations in 1992, a position which was exceeded only by Barbados (20th) and Uruguay (29th) in Latin America and the Caribbean.[6]

Employment, unemployment, and the informal economy

The labor market has faithfully reflected the expansionary or recessionary behavior of the country's economy. During the 1970s there was major expansion in employment (especially urban employment) due to the Government's development strategy, which was based on diversification of the economy and creation of plants for processing oil products. The unemployment rate fell from 15.4% to 9.9% between 1973 and 1980. Nevertheless, unemployment doubled from 1983 to 1987 to affect 22.3% of the active population as a result of contraction of the

economy and public spending, especially on investment projects.[7] Other estimates noted that it exceeded 23% in 1988-1989.[8] The most affected groups were young people aged 15 to 23 years, who represent almost half of all unemployed persons. An increasing incidence of unemployment was also observed among women 20 to 24 years old.

In this context, it is not surprising that the informal economy has grown strongly, as seen in the patent increase in street trade and not-so-evident illegal activities such as smuggling and the drug traffic

The distribution of the economically active population (EAP) by sex and branch of activity shows that the service sector is the most important, with 51% of the EAP in 1980. Thirty-eight percent worked in industry (which includes petroleum processing) and 15% in agriculture. Women represented a third of the work force in 1988, though they worked largely in the service sector (72%) and there were fewer of them in agriculture and industry than men (6% and 22% in each of these economic sectors).[9]

Agriculture's decline in employment and contribution to the GDP slowed during the 1980s because the adjustment measures made agriculture more competitive by greatly reducing wages, as a result of which production for export and the domestic market increased, and though to a small extent the sector absorbed some of the jobless workers in the urban labor market. It was estimated in 1989 that agriculture represented 4% of the GDP and 11% of employment, which indicates that the sector's productivity is still low.

Magnitude and situation of poverty

A recent study noted that the proportion of households which were poor was 18.5% and perhaps exceeded 20%.[10] Rural areas had a larger concentration of poor households; the United Nations Development Program (UNDP) estimated in 1992 that the proportion of the population below the poverty line in the countryside was probably 39%, or more than 200,000 people.[11] A preliminary attempt to establish a correlation between unemployment and poverty found that in areas with the greatest concentration of poverty the unemployment rate was only a third of the national average, which showed that there are households with incomes based on wages or from informal activities which are so low that they cannot escape this situation. It is therefore pertinent to differentiate at least two types of poverty in Trinidad and Tobago, that which could be called "chronic" since it depends on inadequate income and inability to satisfy basic needs, and that which is "cyclic" which is associated with economic cycles—stemming in turn from fluctuations in oil prices—and thus with the evolution of unemployment because of the high proportion of wage earners in the employment structure of Trinidad and Tobago. It has been noted in this context that many of these "new poor" are youths searching for their first job.[12]

Health, environmental sanitation, and nutrition

The main health indicators in Trinidad and Tobago show that during the period after independence there was much improvement in the population's health conditions, which compare favorably with those in the most advanced countries In the human resources area, for instance, the number of physicians per capita quadrupled and that of nurses doubled, while the infant mortality rate is now a third of what it was at the time of independence and daily calorie availability increased by 20%.

Since the end of the 1970s the mortality profile of Trinidad and Tobago has been that of more urbanized and advanced societies. Since then the most important causes of death have been coronary and cerebrovascular diseases, malignant tumors, diabetes mellitus, and accidents. In 1983 these five causes of death represented 66.7% of all deaths.[13] The most common cancers in men are of the prostate, stomach, and lungs, while in women they are of the breast,

cervix, and uterus. Motor vehicle accidents affect women to a much greater degree. Since 1960 suicide death rates have been very high, although they have tended to decline, and are among the highest in the hemisphere

The infant mortality rate, according to data from the Demographic Health Survey of 1987, was 26‰ live births. Data for 1990, gathered by various agencies, showed an appreciable reduction, putting it at 15‰ live births.[14] In the mid-1980s, the main causes of death in infants less than one year old were ailments of the perinatal period, congenital anomalies, and influenza and pneumonia. Enteritis and other diarrheal diseases have rapidly been losing importance as a cause of infant mortality. Despite this, gastroenteritis was the chief cause of morbidity in children less than five years old in 1988. In that year alone, 23,335 cases of gastroenteritis in that age group were reported.[15] The incidence of disease preventable by immunization also fell because of the high vaccination coverages achieved (79% against DPT and 80% against poliomyelitis in infants less than one year old).

In the 15- to 24-year age group, accidents, suicide, homicides, influenza. and pneumonia were the principal causes of death, in that order. Accidents alone represented 43% of the deaths and suicides, 12%. There are no data on the incidence of alcoholism and drug consumption—especially of cocaine—among adolescents and young people, but they are presumed to be high; a special unit was created in 1986 to treat drug addicts. Among adults, accidents are also the main cause of death, though coronary diseases and malignant tumors are in second and third place, respectively, in importance. The maternal mortality rate was 12 per 10,000 live births in 1988;[16] it is thought to be quite high still, particularly if we take into account that institutional delivery coverage was 98% between 1983 and 1988.[17] In the Port of Spain and San Fernando hospitals around 46% of abortion discharges in 1988 were in the 15- to 24-year age group. Primiparity age has increased from 20 to 22 years, which shows the growing use of contraceptive methods.

Yellow fever and dengue are endemic throughout the country. The country was declared malaria-free in 1965 and since then only imported cases of the disease have been recorded, but the presence of vectors in much of the country continues to be a risk factor. The first cases of AIDS were detected in 1983. Three hundred eighty cases had been recorded by the end of 1988, and in March 1992 the cumulative number of cases was 1,025, with 673 deaths. In 1991 the AIDS incidence rate—180 cases per million inhabitants—was the third highest in the English-speaking Caribbean. There has been a sustained increase in heterosexually transmitted cases The prevalence of HIV, according to surveys made between 1988 and 1990, was 1.1% in blood donors, 13% in female sex workers, and 13% in sexually transmitted disease (STD) patients, which paves the way for an increase in the disease's incidence.[18] There is a broad-reaching national AIDS program in which various public agencies take part.

Noncommunicable chronic diseases (cardiovascular diseases, arthritis, diabetes) and motor and sensory disabilities are the main health problems in the elderly. It is believed that those with low incomes are an especially vulnerable group and that their specific health needs are not being met.[19] The Survey of Needs of the Elderly, carried out in 1987 and 1988, revealed that there is a high proportion of elderly who live alone and cannot care for themselves, and that this increases as they age· a fifth of women older than 80 years, for example, were in that situation.[20]

Protein-calorie malnutrition is a problem of some importance, especially in infancy. In 1987, 5% of preschool boys and girls weighed less than 80% of what they should. The problem more affected the girls, though severe malnutrition affected both sexes equally. An increase in serious malnutrition was noted between 1985 and 1988: there is consensus in recognizing that the crisis and adjustment are causing the population's nutritional conditions to deteriorate, though it is not possible to estimate the degree to which the increase in poverty and the adjustment are affect-

ing different age and income groups.[21] Iron-deficiency anemia also represents a serious maternal and child health problem. In 1987 it was found that 56% of pregnant and nursing women and almost 30% of children aged 5 to 13 years[22] suffered from this kind of anemia. At the other end of the scale, it was estimated in 1988 that obesity affected 50% of women and 19% of men in the 15- to 64-year age group.

Around 1988 the health system was passing from an assistance model to a mixed one including privatization, a national medical insurance plan, and regionalization and decentralization of the services in order to reduce costs and increase efficiency.[23] Nevertheless, the state, through the Ministry of Health, has continued providing most care. The system is based on three levels of care. Primary care, divided into nine counties, has 102 health centers in strategic places in the country and averages one center per 11,000 inhabitants. Administrative and information defects, logistic problems, and lack of maintenance and human resources limit its effectiveness, however.[24] Secondary and tertiary care are provided in public hospitals and obstetric units, which in 1988 had 4,613 beds, 35% of which were in the two largest hospitals, at Port of Spain and San Fernando. In addition, there are eight small district and county hospitals as well as specialized centers such as Mt. Hope maternity hospital, St. Ann psychiatric hospital, Caura hospital (cardiothoracic care), and the St. James Medical Complex, which specializes in geriatrics, oncology, and physiotherapy These specialized centers have another 2,308 beds. The Eric Williams university hospital contributes 550 more beds In 1988 there were four public beds per thousand inhabitants and, counting private hospitals, the total figure was 4.5 beds per thousand inhabitants.[25] The principal problems at the outpatient care level were administrative centralization, deficiencies in housing and feeding services, scarce human resources, infrastructure deterioration, the lack of maintenance and age of equipment, and bad distribution of patients (overcrowding in the general hospitals and underutilization of district hospitals).

One of the chief problems the health system faces is a lack of professionals. In 1986 there were 92 physicians, 10.8 dentists, and 279 nurses per 100,000 inhabitants. There is also a high concentration of professionals at the secondary and tertiary levels, to the detriment of primary care establishments.[26]

Public spending on health represented 11% of its health budget from 1982 to 1985. Despite the crisis, there was a sustained increase in per-capita expenditures on health up to 1987, though capital expenditures—focused on building the Eric Williams hospital up to 1985—fell significantly. Some services collect fees from patients, though usually not their real costs. The Government has been subsidizing nongovernmental organizations working in the health field, especially in the areas of family planning, drug addiction treatment, blood banks, and care of the disabled.

Potable water coverage rates are extremely high. The rate is 100% in urban areas and 98% for the country as a whole. Potable water coverage through household connections was much less in 1987, about 57% of the population. The situation as to excreta disposal was similar: 98% of the population had some kind of system, but only 23% was connected to the sewerage network. In addition, wastewater treatment plants did not operate well. A study conducted of various popular beaches in 1985 found excessive coliform bacteria densities in the water.[27] There is thus great potential for improvement in this field. As for solid waste management, the privatization of the service in 1980 in favor of the Solid Waste Management Company led to substantial improvements in this area. The problem of toxic wastes, which are disposed of in the same way as harmless wastes, persists, however.

Education

The principal education indicators in Trinidad and Tobago suggest that the country has reached a quite advanced situation compared to

other developing countries and especially to its nearest area, the English-speaking Caribbean, except in higher education. In 1988, primary school attendance was 100%, secondary school attendance was 82%, and university attendance was 5%. The teacher.pupil ratio was 1.24. It has been noted, however, that the system urgently needs curricular reform in order to adapt itself to the changing needs of the labor market.

Women's situation

Although the most recent data are for 1970 and do not reflect the profound changes resulting from the oil boom, it may be assumed that the number of women who are responsible for managing households continues to be large. In that year women headed 36.8% of households.[28] At mid-decade women represented 64% of social welfare recipients, which suggests that they made up a greater proportion of the low-income group.

The participation of women in the work force is still low by regional standards, though they suffer from unemployment to a greater degree than men. There is a paradox in the area of education: although unemployment affects women to a greater extent, there are more of them in university education.

The environment and vulnerability to disasters

Manufacturing and petroleum production and the creation and expansion of oil derivative refining plants have caused concentrations of heavy metals and toxic substances in air and water to increase, and this is related to the increase in the number of cases of cancer and cardiovascular diseases. A 1984 survey by the Pan American Health Organization (PAHO) revealed more than 800 manufacturing establishments which might be discharging toxic substances and over which no control was exercised.[29] Discharges of chemical substances, especially petroleum, have caused repeated massive killings of aquatic flora and fauna. From 1984 to 1987 the number of oil spills climbed from 89 to 245. In 1986, 39.800 barrels of crude were discharged into the sea and only 64% was recovered.[30]

Trinidad and Tobago has a history of disasters which, though there have been no recent catastrophes, makes clear the main threats to the country. From 1904 to 1954 there were four earthquakes of medium intensity which caused significant damage to buildings. In 1933 and 1963 there were hurricanes which caused much destruction. In 1974, finally, the island suffered the impact of tropical storm Alma. Disaster preparedness planning, organization, and activities, though begun, were characterized by their weakness in 1988.[31]

TRINIDAD AND TOBAGO RED CROSS SOCIETY

The challenge of decentralizing administrative authority and improving effectiveness

Despite the fact that socioeconomic indicators for Trinidad and Tobago show remarkable improvements in the status of the population since the country's independence in 1962, serious social and economic problems remain. Since the early 1980s, because of the collapse of the petroleum-dominated export sector and the implementation of the Government's structural adjustment programs, there has been persistent inflation, unemployment, poverty, and growth of the economy's informal sector.

The decrease in the per-capita gross domestic product (GDP) in relative terms was the greatest in Latin America and the Caribbean during the crisis of the 1980s It is estimated that approximately 20% of the population live in poverty The most vulnerable groups are the elderly, the young, the unemployed, and female heads of household. Added to this is the resurgence of old diseases (malaria, cholera), the spread of new ones (AIDS), and increasing drug use, delinquency, and violence.

Social deterioration and the high social cost of the structural adjustment measures of the late 1980s have been the most important causes of the political and social instability, which culminated in the Muslim rebellion and the mass protests of July 1990 which threatened the country's institutions.

In the 1990s the Trinidad and Tobago Red Cross faces a complex social reality which, though the country has a "human development" level among the highest in Latin America and the Caribbean, includes accelerating deterioration in the population's living conditions This presents a difficult scenario for the humanitarian activities of the Trinidad and Tobago Red Cross.

The Red Cross has long been associated with the health and education sectors of Trinidad and Tobago. An ambulance service is the main activity of the National Society, and it is the only National Society in the Caribbean that offers this service as its principal activity First-aid training is provided for the health sector, private institutions, and individuals: Red Cross volunteers care for hospital patients; the National Society participates in the directing body of the Government's Home for Handicapped Children, and an AIDS education program is successfully coordinated by the National Society with the Ministry of Health.

Internal problems exist in the Trinidad and Tobago Red Cross which weaken its role in the national community. Although principal policy directives are jointly established, both administrative functions and operational responsibilities are centralized and personalized at the top levels of the Society's administrative structure, while being somewhat diffuse and autonomous at the local level. Communication, participation in decision making, and opportunities for evaluation are lacking.

Volunteer motivation has been affected by the absence of rewards and recognition, lack of internal unity, and an imbalance in gender representation (75% of volunteers are women, yet men dominate the top levels of decision making)

These factors, together with the administration's tendency to deprecate certain financial management procedures, create a climate of uncertainty which could affect the public's confidence in the organization. The leadership recognizes this and financial practices are being reviewed.

The main concerns of the President and leadership of the National Society are efficiency, fund raising, and improvement of physical facilities. At headquarters there are plans to build a new training center and a warehouse; and in both the Southern branch and the Tobago branch, foundations have been laid to construct new buildings as soon as the necessary financial resources are secured.

Organization of the National Society

Organizational and geographic structure

The Trinidad and Tobago Red Cross was founded in 1939 as a branch of the British Red Cross Society. It became an independent National Society and a member of the Federation in 1963, a year after the country's independence.

The Council (General Assembly) represents the National Society as a whole and approved the "Rules of the Society" in October 1973. According to these Rules, the Council meets annually and consists of no more than 36 individuals "appointed or elected in such manner as may be determined from time to time by the Council." At least half of the members must be elected by the branches and divisions, and nonmembers may also be elected. The Council's most important responsibilities are electing the Executive Committee and approving the annual report and budget. The National Society is considering a revision of the statutes.

The Executive Committee administers the affairs of the Society. Department heads, Presidents, and Directors of branches are members of the Executive Committee. It elects the President, Vice President, Financial Advisor, Treasurer, and new department heads. It also appoints the Secretary General of the Society "from among its members."

The Executive Committee manages the Society by delegating execution of its decisions to the President through the administrative secretary, who is a paid staff member.

The incumbent Secretary General, a volunteer, does not have time to participate in the day-to-day management of the Society. Hence, decision making, control of administrative operations, and other executive responsibilities are centralized in the President.

The Society is concerned about this situation and seeks to restructure its management operations. It has also been suggested that internal election processes be revised.

Geographically, the National Society is divided into three branches. Two are in Trinidad, the Northern, at national headquarters, and the Southern, with regional headquarters in San Fernando. The third branch is on the island of Tobago. The present division and extension of branches provides adequate coverage for the two islands. Branch activities are coordinated by branch committees which operate according to the policy directives established by the executive committee, in which the branches are represented.

Administration and planning

The last published activity report for the Trinidad and Tobago Red Cross covers 1981-1986. By mid-1992, no other activity reports had been published or circulated among Red Cross members (this includes the activity report presented at the Inter-American Red Cross Conference in 1991). The National Society plans to publish its 1987-1992 activity report at the end of 1992.

There is also confusion regarding a five-year development plan which has been prepared for 1991-1996 but not circulated among members. This confusion is caused by inadequate communication and distribution of information within the National Society. The Society's administration seeks to increase the availability of information to include all interested members.

The National Society lacks important administrative functions such as clearly defined administrative procedures, effective internal and external communication and enough information for its members, and evaluation systems. It is thought that the absence of such procedures causes uncertainty and mistrust among Red Cross members and the general public.

The National Society's headquarters building is large, with office space and an auditorium for training activities. The Society plans to construct another building for training activities and to serve as a warehouse to store disaster preparedness and emergency supplies. The Southern

branch, housed in an old and decrepit building, has laid foundations for a new building at its San Fernando site but no funds have been secured for its completion. The Tobago branch functions in office space provided by the Trinidad and Tobago Government. It also has acquired a parcel of land and laid foundations but lacks the funds needed to finish it.

Human resources

There is no accurate information as to the number of volunteers, but a recent survey indicates that the National Society has less that 5,000 active volunteers, organized into 65 detachments and 25,000 Junior Link members in the schools, where teachers function as Red Cross patrons. Many youth take the first-aid and home nursing training courses to obtain jobs in the health sector.

The Trinidad and Tobago Society has active, subscribing, corporate, and honorary members. At the local level, 75% of volunteers are women. There are six women on the Council, one of them the Vice President, and four others hold some kind of office.

Because of the attempted coup in the country, no award presentations for the volunteers were held in 1990 and 1991 This is planned for 1992. The Society is proud that one of its members has been presented the Florence Nightingale Award

The Society employs a total of 10 staff members—seven at the national headquarters (including secretaries, ambulance drivers, and a cleaner), two in San Fernando, and one secretary in the Tobago branch

Finance and budget

At the time of the Study, no audited or formal financial statements were available for the three most recent years, although the Rules of the Society require an annual audit by a firm of certified accountants This has been recognized as a serious problem and financial practices were being reviewed. The accounts up to 1991 were to be completed in October 1992.

In the absence of any formal reports, informal documents were made available to the Study team which provide the following figures for 1989. Total revenue amounted to TTD 221,434 (USD 52,100). Twenty-five percent of this total (TTD 55,593, or USD 13,080) came from interest earned on endowment funds, which total TTD 650,246 (USD 153,000); first-aid training and ambulance service fees each amounted to more than 16% of total income; fund-raising functions added 18%, or TTD 40,664 (USD 9,568), and donations, subscriptions, and other miscellaneous revenue constituted the remaining 24%.

Total expenses for the same period were TTD 274,740 (USD 64,645), producing a deficit of TTD 53,306 (USD 12,260), which was charged at year's end to the general fund, which had a positive balance of TTD 175,756 (USD 41,350).

The most significant expenditures were the payment of salaries (23%), operation of and insurance on ambulances and other vehicles (21%), the Federation barem and ICRC dues (13%), and other administrative expenses (19%).

Based on 1990 figures, net revenue from the ambulance service amounted to TTD 36,002 (USD 8,470). Expenditures for motor vehicle insurance and operating expenses amounted to TTD 58,881 (USD 13,855), which left a deficit of TTD 22,879 (USD 5,380).

The Trinidad and Tobago Red Cross has used its general fund to cover operational expenses for at least two years: 1988, TTD 78,028 (USD 18,360); and 1989, TTD 53,306 (USD 12,260). This level of deficit spending is a serious matter for the future effectiveness of the Society and implies a lack of emphasis on other sources of revenue (such as fund raising) Continued depletion of the general fund and the absence of audited financial reports are causes of great concern to the National Society

Additionally, in 1989 the National Society received funds from the Norwegian Red Cross for a drug abuse and AIDS education program Funding for the program was later discontinued.

The role and activities of the Trinidad and Tobago Red Cross in the context of the country

Relief and emergency services

The ambulance service is the main activity of the National Society. The Society has 10 ambulances at its headquarters and three in the San Fernando branch. Almost 50% of the vehicles are 10 to 15 years old and in urgent need of repair or replacement. The service complements the health services provided by the Government of Trinidad and Tobago, and though free in emergencies, a small fee is charged for specific requests such as trips to the hospital for treatment. As noted, this service operates in the red because of its high operating costs.

First-aid training, examination, and certification is another important Red Cross activity. Training is given to volunteers, the general public, and to employees of businesses. Participants pay for this service. There were no records available about the number of people trained, but the National Society has difficulties responding to all requests due to a shortage of personnel and lack of training materials

The National Society is expected to provide food and shelter services during the first 24 hours of a major emergency. The Trinidad and Tobago Red Cross is prepared to assist other Caribbean Societies during emergencies with both supplies and trained personnel, as it did for the Societies of Jamaica and Montserrat after hurricane disasters in 1988 and 1989.

The Trinidad and Tobago Red Cross is interested in improving coordination with sister Societies in the Caribbean through a regional operational and administrative structure. Without such an operational framework, the Society is concerned that the Societies in the region will not effectively coordinate in natural disasters, civil strife, or emergencies.

Health services

The National Society is a member of the National AIDS Committee of the Ministry of Health and is active in AIDS/HIV prevention and education programs as well as in drug abuse, home nursing, and water safety education. In 1989 the Society held workshops for 160 primary and secondary school teachers and prepared a manual for teachers

Social welfare

Caring for patients in hospitals and at home is a traditional activity of the Trinidad and Tobago Red Cross. Training is given to volunteers who provide this service.

The Trinidad and Tobago Red Cross appoints the governing body of the Government's Princess Elizabeth Home for Handicapped Children. The home is a Government-run organization with educational and health facilities for about 85 children. Despite the benefits it provides the deprived population, disagreements have arisen about its management.

The Red Cross periodically distributes packages of food, medicines, and clothing at its headquarters building and at the San Fernando branch. Most of the parcels come from in-kind donations. Red Cross volunteers also operate a canteen service at the hospital.

Relations with the Government

The Government of Trinidad and Tobago contributes TTD 20,000 (USD 4,705 88) per year to the National Society for disaster aid (fires, floods). It allows the Red Cross to appoint the governing body of its Home for Handicapped Children, exempts ambulances from duties and license plate fees, and has donated radio commu-

nication equipment to the Red Cross to coordinate its activities in emergencies.

The National Society was invited to participate in the National AIDS Committee chaired by the Health Ministry, and many Government employees work as volunteers in Red Cross activities. The Government directly encourages the National Society and its volunteers by offering them national recognition, medals, and other awards.

Relations with other organizations and agencies

The Red Cross provides training to other organizations such as Boy Scouts, Girl Guides, and church groups. Nevertheless, there seems to be a general lack of cooperation among NGOs in the country, and the Trinidad and Tobago Red Cross is no exception. Though the Society maintains good informal relations with many humanitarian and nonprofit organizations, it hopes to play a still more effective role in encouraging cooperation among such organizations.

Good relations and joint activities between organizations are hindered by the competition among NGOs for volunteers and funds. Many NGOs must share their volunteers with other NGOs which have different objectives, which creates many conflicts between them.

The role of external cooperation

The Trinidad and Tobago National Society has received ambulances, first-aid kits, and other equipment from the German, Spanish, Swedish, and Finnish Red Cross Societies, and the Norwegian Red Cross initially funded an AIDS education and prevention project in 1989.

The Canadian High Commission donated TTD 100,000 (USD 23,530) for the Tobago branch's new building, and the Canadian Red Cross has recently approved a contribution of CAD 20,000 for the same purpose.

The American Red Cross provides training assistance and materials. The Trinidad and Tobago Red Cross is paired with the Jefferson, Arkansas, chapter of the American Red Cross. Officers from the Trinidad and Tobago Red Cross have already visited Arkansas, and trainers from the Jefferson chapter are scheduled to return the visit to provide training in first aid and cardiopulmonary resuscitation. The Carnegie Foundation is contributing funding for accommodation and catering through the American Red Cross.

The National Society's perception of its public image

According to the President of the National Society, the Trinidad and Tobago Red Cross is highly respected. It has been suggested that the Red Cross establish closer relationships with the mass media to better inform the community about its activities Direct distribution of information to the public has also been suggested but would require more involvement of staff members trained in that area.

The Society is concerned that its highly centralized administration and lack of communication with the community may lead to a decrease in or loss of public confidence in the Red Cross.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Historically associated with health and education in its country, the Trinidad and Tobago Red Cross today presents a program profile, unique in the English-speaking Caribbean, in which ambulance service for personal emergencies, disaster preparedness, and relief (fires, floods, etc.) predominate, an area in which it has even lent support to other Caribbean Societies which have confronted emergencies.

Other services of the National Society are first-aid training for volunteers as well as the general public, support activities for governmental programs in the area of health, especially in AIDS prevention, care of hospital patients, and a program for handicapped children. Lesser activities are the distribution of food, medicines, and donated clothing to the poor.

At this time the Trinidad and Tobago Red Cross is not planning to diversify its programs to deal with new problems, but rather to improve the efficiency of activities already in progress, broaden the physical infrastructure, and strengthen fund raising.

Some key problems identified in the National Society are as follows: in its organizational structure, functions are very centralized in the presidency and diffused at the local level, a situation that causes a low level of participation by volunteers and technical personnel in decision making as well as communication problems. The National Society is conscious of this situation and has expressed interest in bringing about greater congruence between the statutes and reality.

The absence of clear administrative procedures and efficient internal and external systems of information and communication creates a climate of uncertainty and lack of confidence. An example of this is the fact that the 1991-1993 development plan has not been distributed or discussed within the Red Cross and for this reason few members are familiar with it.

As for human resources, there are a good number of volunteers, most of whom are women. The proportion of men at the decision-making levels of the National Society is greater than in the institution as a whole, however. It has also been noted that the recent absence of rewards and recognition has diminished motivation and ability to maintain this valuable resource. Most paid personnel have administrative functions, and the technical staff is limited

Lastly, in the financial realm there is a trend toward incurring deficits; although some informal documents exist, a budgeting and financial information system is needed. In the last three years no financial reports or audits have been prepared, a situation that is worrying in view of public information, the strengthening of fund raising, and international cooperation relations.

RECOMMENDATIONS

1. **Strengthen and vitalize the National Society's organizational structure**
2. **Diversify and modernize the National Society's services by revising the development plan**
3. **Reform the administrative system**
4. **Improve revenue-producing policies and methods**
5. **Implement a human resources development program**
6. **Strengthen the institution's public image**

1. Strengthen and vitalize the National Society's organizational structure

1.1 Decentralize and strengthen the executive and decision-making capacities of the executive committee, the administrative committee, and the secretary general by reducing the functions of the presidency of the institution, so that its structure and operation provide a greater balance of powers.

1.2 Democratize the election procedures of the executive and administrative committees by reforming the statutes.

1.3 Strengthen the executive and decision-making capacity of the branches and operational departments.

1.4 Establish flexible and effective mechanisms of internal communication which allow wider diffusion of information needed for decision making at the different levels of the National Society.

2. Diversify and modernize the National Society's services by revising the development plan

2.1 Begin revising the 1991-1996 development plan with the participation of volunteers, branches, and staff. To accomplish this, give the plan the widest internal diffusion possible and establish a structured procedure for its discussion, consultation, and redrafting.

2.2 As part of the plan, adopt a programming structure based on programs and projects with sufficient autonomy to adapt flexibly to the heterogeneous and changing demands that emerge from the country's reality.

2.3 Modernize and diversify the relief and emergency program, giving greater emphasis to disaster prevention and preparedness, and adopt a renovated conceptual approach to disasters

which incorporates environmental impact, which is of great importance in Trinidad and Tobago.

2.4 Modernize and optimize the ambulance service by considering the possibility of assuming this service on a national level in the context of the privatization of the state health services, provided that financial reimbursement arrangements exist on the part of the public authorities that permit a sustainable future, set out in agreements and other formulas.

2.5 Amplify and diversify the health and social welfare programs through activities to deal with the social vulnerability associated with growing poverty (which especially affects women heads of household), malnutrition in mothers and children, juvenile marginalization, and the problems of drug abuse and AIDS.

2.6 Modernize this program through formulas and low-cost technology, and give it a comprehensive focus based on community participation, avoiding a charitable approach.

3. Reform the administrative system

3.1 Establish precise administrative functions and procedures, with flexible and clear criteria.

3.2 Regularize the preparation of annual budgets and financial reports.

3.3 Reestablish the auditing procedures and controls set out in the statutes to increase financial transparency.

4. Improve revenue-producing policies and methods

4.1 Start negotiations with the authorities aimed at stabilizing, giving permanency to, and increasing the public financing the institution receives as much as possible.

4.2 Study the feasibility of assuming public health and social welfare services such as the ambulance service, nutritional programs, and primary medical services, in a process of transition to a "mixed health system" via the privatization of such services by the Government.

5. Implement a human resources development program

5.1 Carry out a census of the volunteers to determine their number and distribution. Record the information so it can be periodically updated. Identify those volunteers who have the capacity to be instructors, and determine their training needs

5.2 Open an internal process of reflection about the collective and personal situation of the members of the institution in which current problems such as the absence of incentives, lack of internal unity, and gender representation are discussed.

5.3 From the above, establish a human resource program in the Development Plan which includes strengthening of volunteer recruitment (especially youth, based on their expectations and sociocultural values) and a new incentive system.

5.4 Establish a permanent training system based on participatory methods, emphasizing trainer training.

5.5 Formalize first-aid and home nursing training and other health care activities through certification endorsed by the education and health authorities

6. Strengthen the institution's public image

6.1 Establish more solid and stable ties with the mass communication media, using them to broadcast informative messages about the institution's objectives and perspectives and the social problems it responds to.

6.2 Increase the flow of financial information to the public and the authorities to create an image of transparency, strengthen public confidence, and sustain fund-raising campaigns and activities.

6.3 Create a communications and public relations office and program in charge of the coordination of the above-mentioned activities.

SOURCES

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14 UNDP 1992, Table 11, and Witter 1992, p. 70, citing data from L. Taylor. *Economic adjustments and health services utilization in the English-speaking Caribbean*. ISER 1990.
15. PAHO 1990, p. 303.
16 UNDP 1992, Table 12
17 UNDP 1992, Table 11.
18. PAHO. *Boletín Epidemiológico* Washington. D.C., PAHO, 13(1):8 (March 1992).
19. PAHO 1990, p. 304.
20. PAHO 1990, vol. I, p. 151.
21. PAHO 1990, p. 302.
22. PAHO 1990, p. 304.
23. In this vein, it is noteworthy that the administrative costs of the social security system in Trinidad and Tobago were 32% of the whole in 1988, the highest proportion in the region, which is thought to indicate low efficiency. See Carmelo Mesa-Lago, "La seguridad social en América Latina" [Social Security in Latin America], in IDB 1991, p. 215
24. PAHO 1990, p. 306.
25. *Ibid.*
26. PAHO 1990, p. 307.
27. PAHO 1990, p. 309
28 Witter 1992, p. 72, citing ECLAC data
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30 PAHO 1990, p. 309.
31. See PAHO/World Health Organization-Office of the United Nations Disaster Relief Coordinator (UNDRO)-League of Red Cross Societies. *Pan Caribbean disaster preparedness and prevention project: Project document*. Geneva, 1988.