PERFORMANCE AUDIT REPORT

MONTSERRRAT'S IMPLEMENTATION OF THE UNITED NATIONS' SUSTAINABLE DEVELOPMENT GOAL 3.D:

Building a Resilient National Public Health System

Office of the Auditor General
July 2023


OFFICE OF THE AUDITOR GENERAL
MONTSERRAT

MONTSERRAT'S IMPLEMENTATION OF THE UNITED NATIONS' SUSTAINABLE DEVELOPMENT GOAL 3.D: Building a Resilient National Public Health System

This is a Report of a Performance Audit conducted by the Office of the Auditor General pursuant to Section 103 of the Montserrat Constitution Order, 2010.

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Office of the Auditor General
July 2023

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PREAMBLE

Vision Statement

To be a proactive Supreme Audit Institution that helps the nation to make good use of its resources.

Mission Statement

The OAG is the national authority on public-sector auditing issues and is focused on assessing performance and promoting accountability, transparency and improved stewardship in managing public resources by conducting independent and objective reviews of the accounts and operations of central government and statutory agencies; providing advice; and submitting timely Reports to Accounting Officers and the Legislative Assembly.

The Goal

To promote staff development, enhance productivity, and maintain a high standard of auditing and accounting in the public sector, thereby contributing to the general efficiency and effectiveness of public finance management.

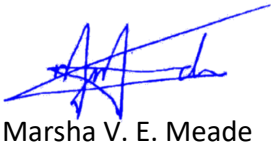
AUDITOR GENERAL'S OVERVIEW

This study examined the governance, the efficiency and the effectiveness of the management of the systems of public health in Montserrat. Within the United Nations' 17 Sustainable Development Goals (SDGs), we focused on S.D.G. #3 (Good Health for All), and part d: Resilient Public Health Systems (including the sub-theme of AMR), with an emphasis on the planning, preparation for, and mitigation of, national and international risks to human health. Of special interest was the theme of the lessons of recent public-health emergencies (see Chapter 5) and the extent to which these have been, or could be, used to strengthen Montserrat's delivery of public-health services. Overall, we found several satisfactory aspects of governance and operations, especially (a) in the MOHSS's early planning for the COVID-19 pandemic, (b) interdepartmental collaboration and stakeholders' engagement throughout the pandemic, and (c) the Cabinet's rapid response in approving related public-health S.R.O.s and other measures and timely updates as each one expired.

In terms of efficiency, transparency, and accountability, we found a few areas requiring immediate improvement: e.g., (1) a trend of large healthcare staffing gaps and financial constraints; (2) shortfalls in achieving most areas of the Sustainable Development Plan (2008 to 2020); and (3) the difficulties in balancing effective response to COVID-19 with a mandate to maintain the full range of regular public health-services. The MOHSS is accountable to the GOM and reports regularly to the MOFEM, the Monitoring & Evaluation Unit, and, ultimately, to the Cabinet and the Legislative Assembly. However, we found that some GOM Departments were late/non-compliant in reporting, and that communication with the general public and other stakeholders was limited in some areas, with implications for adequately identifying, including, reaching, and serving some vulnerable groups.

The Government of Montserrat's Sustainable Development Plan 2008 to 2020 identified Human Development, including public health, as one of the pillars for rebuilding and for growing the island's economy. Environmental Management and Disaster Preparedness form another pillar of the SDP. Together, these two pillars are critical for national resilience against public-health emergencies, disasters, and international risks to human health. Among the measures of effectiveness, under the MOHSS's leadership during the past three years, we found that (a) the capacity for on-island surveillance and swabbing increased, (b) the negotiations with the Cuban Government filled several gaps in the MOHSS's healthcare workforce, and (c) the skills and equipping of the public laboratory were upgraded, enabling rapid local testing for COVID-19, instead of relying on overseas testing.

We have provided a number of recommendations that we feel would benefit the Government and the citizens of Montserrat once they are implemented. Thanks to the management and staff of the relevant Ministries and Departments, and all other persons who provided information, clarifications or extended any courtesy to my staff to enable the delivery of this audit report. Special thanks to the INTOSAI/IDI and the CAROSAI for their assistance with training, with mentoring, and with support throughout this important study.



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ABBREVIATIONS

AGC	Attorney-General's Chambers
AMR	Anti-microbial resistance
CARICOM	Caribbean Community
CAROSAI	Caribbean Organisation of Supreme Audit Institutions
CARPHA	Caribbean Public Health Agency
CIPREG	Capital Investment Programme for Resilient Economic Growth
DMCA	Disaster Management Co-ordination Agency
FCDO	Foreign, Commonwealth & Development Office, U.K. Government
GDP	Gross Domestic Product
GOM	Government of Montserrat
IDI	International Development Initiative (INTOSAI)
INTOSAI	International Organisation of Supreme Audit Institutions
ISSAI	International Standards for Supreme Audit Institutions
MALHE	Ministry of Agriculture, Lands, Housing & Environment
MEU	Monitoring & Evaluation Unit, Office of the Premier
MLDA	Montserrat Land Development Authority
MOFEM	Ministry of Finance & Economic Management
MOHSS	Ministry of Health & Social Services
MPS	Montserrat Public Service
NIPPPC	National Influenza Pandemic Planning and Preparedness Committee
NDPRAC	National Disaster Preparedness and Response Advisory Committee
NPR	National Performance Report
OAG	Office of the Auditor General
OP	Office of the Premier
PAHO	Pan-American Health Organisation
SDP	Sustainable Development Plan 2008 to 2020 (Montserrat)
SDG	Sustainable Development Goal (United Nations' framework)
WHO	World Health Organisation

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Summary

Overview

Countries around the world are accountable for their progress towards the United Nations' Sustainable Development Goals (2015 to 2030). In this inaugural study of Montserrat's implementation of the SDGs, we focused on the SDG 3.d to assess the island's public-health systems and their planning and preparedness for, and response to global and national threats to human health. This study was complex and challenging both in its scope and the range and types of data to be obtained, analysed and assessed, and in the number of stakeholders to engage directly and/or to consider in the course of this nationally important audit. The COVID-19 pandemic provided a perfect opportunity to review Montserrat's resilience and to improve it further with the lessons from the past few years' experiences and outcomes. Next are a few of the major findings and lessons and where to find more about them and others within the report.

What we found

1. Effective policy-response, but gaps remain in the legislative framework. During the pandemic, the GOM quickly enacted public-health orders and updates as each S.R.O. expired. Several new laws, programmes, and/or policies have been introduced, and some old ones have been updated to strengthen public health, social services, preparedness for disasters, and national planning. [See Chapter 2.] However, laws and policies are not all fully coherent, and various budgets and strategic plans do not yet completely integrate the SDP. Of great concern is the lack of explicit links to the SDGs, or clear plans for their implementation. This creates high risks for further lags in achieving either the updated SDP (2023 to 2035) or the SDG 2030 Agenda.

2. Gaps in data and reporting. The MOFEM has established robust reporting frameworks for all Departments. The MOHSS has been compliant; however, several of the GOM's Departments have been late or incomplete in their reporting (e.g., Quarterly Reports). Gathering of health-related data is regular in some areas, but very inefficient, relying heavily on paper-forms and manual processes. Some helpful publishing of data has been happening, but comprehensive and up-to-date SDG-related statistics and health-related data were not available, in several instances, either from the MOHSS or from the national Statistics Department. [See Chapter 6.] We also found that the MOHSS and other stakeholders had not robustly documented or acted upon experiences and lessons learned from recent public-health crises, thus risking the loss of valuable institutional memory, and undermining the data-driven identification and seizing of opportunities for [i] improving inter-Departmental/Ministerial policy-coherence, [ii] joint planning, [iii] optimal budgeting, and [iv] more effective collaboration. These are critical elements for achieving whole-of-Government coherence, integration, and effective outcomes.

3. Continuing shortages of healthcare workers. Every year, the MOHSS faces turnover of employees (e.g., retirements and emigration), multiple vacant posts, and a very limited local pool of qualified persons to fill all posts. Overseas recruitment has been necessary,

but faces several challenges, including regional and international competition for healthcare workers in all technical and specialist categories. Collaboration with the Government of Cuba (years 2020 to 2022) helped to fill from 13 to a maximum of 20 vacancies across Secondary Healthcare and Primary Healthcare, but many other vacancies remained. The challenges of long-term vacancies were compounded by periods of leave for filled posts. One impact of COVID-19 was required periods of quarantine when healthcare workers &/or their households had positive test-results during the pandemic. The pandemic greatly increased the demand for healthcare, while further shrinking the supply of healthcare workers and services. [See Chapters 4 and 5.]

4. Early planning and strong, but costly policy-responses to COVID-19. The MOHSS's planning for epidemics spanned more than a decade prior to the COVID-19 pandemic. Hence, the MOHSS was able to update past plans to mitigate the impact of COVID-19 when it arose as a new public-health threat. [See Chapters 2, 5, and 6.] However, there were high social and economic costs from prolonged and repeated closure of businesses, displacement of private-sector workers, and resulting needs for public welfare to a rapidly increasing number of vulnerable persons/households.

5. Early COVID-19-related cases and deaths were minimised; risks remain. Early planning, early response, sustained public-health measures, as well as generally high levels of co-operation and compliance by businesses and by households, led to very low case-numbers (only 13 in all of year 2020) and only 2 COVID-19 deaths from March, 2020, to December, 2021. However, in the third pandemic year, extremely contagious variants arose, causing a large spike in local confirmed cases, including 6 related deaths, during year 2022. [See Chapters 5 & 6.]

What should be done

6. Strengthen data-management and reporting. The MOHSS/GOM should (1) review existing systems and capabilities for the collection, storage, and analysis of data, and optimise the formats and usefulness of reporting across the public sector. (2) Improve data-management skills and capacity across the public sector. (3) Ensure that the data being collected by Departments are accurate, timely, relevant to the SDP and the SDGs, and reliable. (4) Enable broader sharing of data between Departments to improve coherence, co-operation, and alignment of plans and activities, thus saving time and costs, while improving decision-making, policies' outcomes, and projects' and programmes' impacts. (5) Implement more frequent and more accessible reporting both across the public service and to/for other stakeholders, including vulnerable groups. These efforts will improve engagement of stakeholders, build trust in public officers and institutions, and boost transparency and accountability throughout the public sector. (See SDP: Goal-cluster #4: Governance; Policy Agenda: items #4.1 & **#**4.2.)

7. Urgently accelerate efforts to close capacity-gaps in public healthcare. Given the large numbers of healthcare-related vacancies and their average duration over the past several years, it is urgent for the GOM, including the MOFEM, the HRMU/ODG, and the MOHSS, individually and collectively, to address the issues identified as barriers to recruitment and to retention of employees. Building on the successful partnership with Cuba during two years of the

COVID-19 pandemic, (a) deepen existing partnerships and explore new ones within the O.E.C.S., the CARICOM, the U.K., and beyond, and (b) expand the number of effective initiatives for local training as well as overseas capacity-building (e.g., telemedicine, secondments, internships, e-learning platforms, virtual coaching and mentoring, regionally shared training of healthcare workers), to fill posts, and create and sustain new capacity in high-priority areas in line with the SDP and to achieve the SDGs. (Policy Agenda: items #1.1, #1.2, #1.4, #2.1, #2.4, #4.2, and #5.2.)

8. Better include and address the needs of vulnerable groups. Expand the range of stakeholders identified and included in planning, in formulating policies, and in delivering programmes and services. By embedding the full spectrum of service-providers' and end-users' inputs in new initiatives, and by acting upon their feedback on past and current ones, all Departments can better align resources and service-delivery to stakeholders' different needs: e.g., physical challenges, mental challenges, those for whom English is a foreign language, low-income/unemployed households, the elderly, persons with various disabilities, those with limited mobility/access to transportation, et cetera. (Policy Agenda: items #2.3, #2.5, #2.9 and #2.10.)

9. Prioritise health-promotion and disease-prevention. In line with the national vision of "A healthy and wholesome Montserrat", and the SDGs' ambition of improving the health and the quality of life for all persons, leaving no one behind, it is essential to reshape the paradigm of the public-health policies, budgets, practices, and systems gradually away from increasingly expensive, reactive secondary care, and towards low-cost, high-impact, and proactive primary care. This requires a major improvement in the quality and quantum of the allocations of people, funding, and planning to health-promotion, healthy lifestyles, disease-prevention, nutrition, and wellness. (Policy Agenda: item #2.1 and #2.2.) Chronic diseases worsen the impact of crises, and have a far greater cumulative cost socially, economically, and fiscally.

Audit Conclusion

10. Most of the 22 National Outcomes of the SDP (2008 to 2020) were not achieved, including for health. However, important progress was gradually made in strengthening the public-health system from emergency mode, in the aftermath of the volcanic crises, to a more fit-for-purpose and sustainable mode. The GOM's interim strategic planning framework (2021 to 2022) and the new SDP period (2023 to 2035) are expected to align more closely and more explicitly to the SDGs, intensifying the focus on the twin achievements of national goals and the global SDGs. There is nearly universal health-coverage, including free primary healthcare services to children and senior citizens. By contrast, secondary care is limited, and tertiary health-services are not available, often requiring expensive overseas medical travel/evacuations. Moreover, large gaps remain within the island's public healthcare workforce, infrastructure, and information-systems.

11. With funding in place, and planning on schedule, The New National Hospital Project is one of the most important public projects in Montserrat's redevelopment, and the largest ever investment in the public-health system. With opening by year 2025, it will likely position Montserrat to make a large leap forward towards the 2030 Agenda. Other initiatives (e.g., digital archives; health-information system; improved diagnostics; transformation of care-delivery; and expanded laboratory capabilities) promise to reduce gaps in public-health staffing and

resourcing. Yet, other gaps must be closed across the public sector to achieve the whole-of-Government resilience that both the SDP and the S.D.G. goals require to minimise the costs and the socio-economic impacts of future public-health emergencies and of natural/other disasters.

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CHAPTER 1: INTRODUCTION

Background

Government

1.1. Montserrat has one level of government: a central national government. There is no local government or federal government. It is a centuries-long British colony with its own Legislative Assembly, comprising the Attorney General (ex officio), the Financial Secretary (ex officio), and 9 locally elected Members. There is a resident Governor representing the Head of State, the long-reigning Queen of England (now deceased and succeeded by King Charles III as of September, 2022).

Society & Economy

1.2. Prior to 1989, Montserrat was a small but prosperous economy on the verge of becoming self-sufficient with a population of about 12,000 people. However, two natural disasters, Hurricane Hugo in 1989 and the destructive volcanic eruptions from 1995 to 2010, affected all aspects of Montserratian social and economic life. Plymouth, the capital town, was destroyed and almost two thirds of the island is now beyond productive use and lies within an Exclusion Zone. (See the map in Figure 1.1.) After massive evacuations and emigration over the last 20 years, the population decreased to a post-crisis low of around 2,700, and then gradually recovered (primarily through regional immigration), but has stagnated for the past decade in the range of 4,500 to 5,000 residents (Census, 2011; Census, 2018). With the support of external funding and technical expertise from the U.K. Government, from the European Union, and from the Caribbean Development Bank, most elements of the country's social and economic infrastructure are being rebuilt in the North.

Rationale for the audit

International context

1.3. In September, 2015, all countries that are members of the United Nations agreed on the 17 global Sustainable Development Goals (SDGs) and the 2030 Agenda for their achievement. This built upon the framework of the Millennial Development Goals (MDGs) (for the years 2000 to 2015) and aimed to close remaining gaps in progress towards the MDGs around the world. As

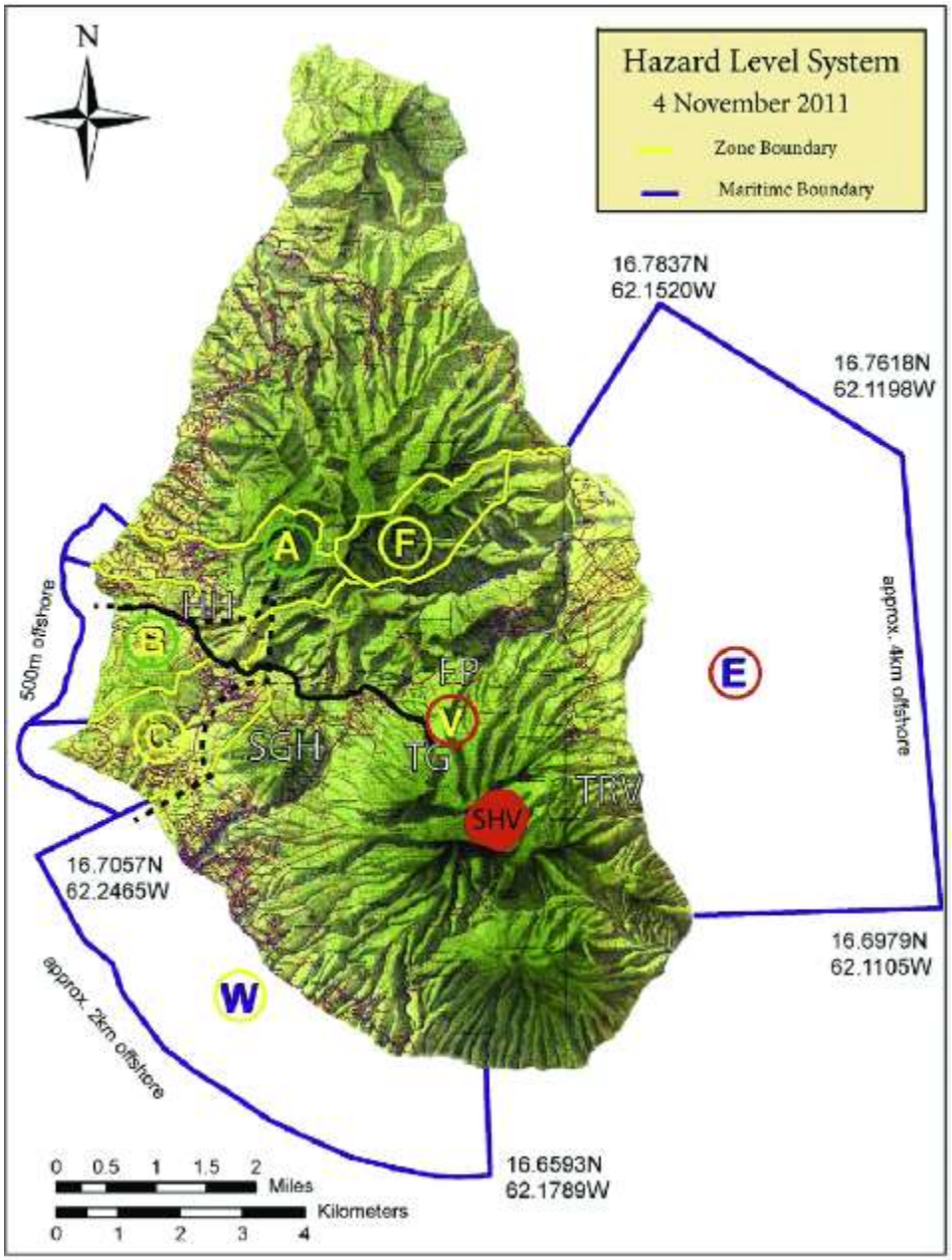
a consequence, during year 2020, the International Organisation of Supreme Audit Institutions (INTOSAI) commenced a programme of supporting participating SAIs, including Montserrat's OAG, in assessing their respective countries' implementation of SDG #3.d, which is the sub-part of the Health goal-cluster focussing on public health systems and resilience to national and international risks to health, including antimicrobial resistance (AMR).

Montserrat's context

1.4. Given the country's geographical location, Montserrat is vulnerable to external shocks such as global disease outbreaks and natural disasters, which could have significant impact on the public health-system. The absence of regular ferry-services (cancelled since mid-2020), coupled with very limited capacity in local airlines (e.g., 6 to 8 persons per flight) and in the island's one small airport (in the north-eastern tip of the island), create high costs per passenger, and challenges for access to and from the island. The original capital city and its nearby national airport were destroyed by the volcanic crisis of the 1990s and remain out of use in the Exclusion Zone. (See Zone E in Figure 1.1 below.) The original seaport is now restricted to exports of volcanic materials for the construction industry. The COVID-19 pandemic has created an extraordinary public-health emergency for Montserrat, forcing the Government to make significant adjustments to accommodate extraordinary spending to ensure that the public health-system could respond effectively to the pandemic. It was also an excellent opportunity to re-examine the adequacy of Montserrat's public-health planning, laws, policies, systems, and level of resilience to face current and future health challenges.

1.5. The three-month window between the identification of the first COVID-19 case in Wuhan, China, in December, 2019, and the arrival of the first imported case in Montserrat in March, 2020, provided an important space between the overseas identification and reporting of an emerging infectious disease and the first local impact. With the support of INTOSAI, through its International Development Initiative (IDI), and mentors from the World Health Organisation (W.H.O.), a special multidisciplinary team from Montserrat's Office of the Auditor-General completed a six-month training programme in the SDGs and in national audits of their implementation. This was followed by several months of preplanning and audit-planning before the official launch of the S.D.G. 3.d Implementation Audit locally. Further details of the audit work performed are provided in Appendix 2.

Figure 1.1: MAP OF MONTSERRAT: HIGHLIGHTING THE RESTRICTED ZONES (since the 1995 volcanic crisis)



CHAPTER 2

GOVERNANCE: LAWS, POLICIES, & INSTITUTIONAL ARRANGEMENTS

Overview

2.1 One of the five pillars in the W.H.O.'s model of public health-systems is ***Leadership and Governance*****.** This theme has cross-cutting implications for other pillars such as ***Healthcare Financing*** (see Chapter 3) and ***Healthcare Workforce*** (see Chapter 4). In Montserrat, the Government has developed and progressively aligned the legal and policy frameworks as well as the institutional structures in relation to [a] public health and [b] the management of risks of emergencies and disasters. There exist relevant laws and regulations, coordination with Ministries and inter-agency cooperation, including the timely drafting, enactment, and updating of public-health Orders. Over the past several years, the GOM has continued to strengthen the country's legal and policy framework, revising old laws, and introducing new laws and policies to address some of the identified past gaps, as well as to address new needs and emerging risks.

2.2 The GOM has in place enabling laws, regulations, Statutory Rules & Orders (S.R.O.s) to guide the management of health resilience and disaster management. See Table 2.1 for a summary of relevant laws and their last updates.

Table 2.1: Summary of Montserrat's Laws Relevant to Public Health & Disaster Preparedness/Management

Laws	YEAR	Last Revised	Summary
Public Health Act	1875	2019	For the promotion and preservation of the health of the inhabitants of Montserrat and for matters incidental thereto and connected herewith
Vaccination Act	1873	2019	The Act requires that children should be taken to the Medical Officer to be vaccinated.
Quarantine Act	1944	2019	Provisions for curtailing transmission of infectious diseases by persons coming into Montserrat by ships or aircraft.
Mental Treatment Act	1868	2011	Provisions for treatment of persons with unsound mind.
Disaster Preparedness and Response Act	1999	2011	Duties of Director. Composition and duties of the National Disaster Preparedness and Response Advisory Committee

Regulations	YEAR	Last Revised	Summary
Public Hospital Regulations	1985	2011	These give guidance for the Administration of the hospital, admission of patients, and hospital fees.
Community Health Services Regulations	1988		Provides information for those who can access services for chronic diseases. Elderly care, maternal care, childcare, and pharmacy-services at district clinics. It also states who can access free medicines.
Infectious Diseases (Prevention) Regulations	1923	2011	Persons authorised as vaccinators and persons who can be vaccinated.
Quarantine (Prevention of Community Transmission) Regulations	2021		Measures for preventing the spread of infectious diseases.
Quarantine (Maritime and Air) Regulations	2021		Measures for preventing the spread of diseases by persons arriving via air and sea transport.

2.3 Legislative process. The main role of the Attorney-General's Chambers (AGC) is to draft laws, Statutory Rules & Orders (S. R. & O.), and related Regulations; it also handles the drafting of contracts (including employment-contracts) and agreements on behalf of the Government of Montserrat (GOM). From the onset of the COVID-19 pandemic in March 2020, as we witnessed in the short time between the first case reported worldwide (late December, 2019) and the first COVID-19-specific law drafted and issued in Montserrat (early March, 2020), the AGC proved to be agile in producing timely drafts for the Cabinet, enabling the Cabinet to approve promptly the first public orders related to COVID-19. This effective legislative functioning and partnership between the AGC (legislative drafting) and the Cabinet (approval of Bills) continued to be demonstrated in the dozens of subsequent updates and revisions each time that a time-limited S. R. & O. expired and/or new protocols were announced and/or existing protocols were eased or tightened. For example, S.R.O. 22 of 2020 was set to expire on April 14th, 2020, and the ensuing S.R.O. 24 of 2020 and S.R.O. 25 of 2020 were drafted, approved and published on April 10th, 2020 (i.e., 4 days early).

The Disaster Management Coordination Agency (DMCA)

2.4 Legal framework. The Disaster Preparedness and Response Act (1999), Part 2, provides the authority for a Director to perform functions related to the mitigation of, preparedness for, response to and recovery from emergencies and disasters in Montserrat. The functions of the Director involve several tasks, including those that are outlined and reviewed in later sections (e.g., paragraphs 6.9 & 6.10 in Chapter 6). Given the importance of the DMCA in national preparedness, the law explicitly provides for the continuity of the Director's roles and functions. Section 3 (4): "In the event of the absence from the country or the inability of the

Director for any other reason to perform the functions of his office, the Governor may nominate another public servant to do so."

2.5 Collaboration for resilience. There is close co-ordination and collaboration of the DMCA with the MOHSS. For example, we found that the DMCA's operations are located across the road from the Glendon Hospital, and that the DMCA provides back-up power, generators and fuel [a] to ensure the continuous operations of services at the Hospital, as well as [b] to maintain the Emergency Operations command centre throughout any period of approaching storms, and before, during, and after a natural disaster or other national crisis.

2.6 The DMCA also provides storage for emergency supplies, including masks and other equipment, which served the MOHSS very well during the early year of the COVID-19 pandemic when global supplies were disrupted, countries competed against each other for supplies, and it took extended periods for items already ordered to arrive. In the aftermath of Tropical Storms, hurricanes, flash floods, and other disasters, the DMCA is one of the first responders, including damage-assessments, visits to communities, inspections of the road-network, and the clearing of debris (e.g., from rockfalls and landslides) that obstructs transportation. These kinds of tasks are essential contributors to the public-health system as well as the national resilience generally: e.g., for ensuring that persons needing medical services can either travel to the nearest clinic or visit the hospital, or be reached by the ambulance-service or a home-visit by a nurse/doctor.

National Disaster Preparedness and Response Advisory Committee (NDPRAC)

2.7 Legal framework. Part 3 of the Act provides for the NDPRAC. Membership includes (a) the Governor as ex officio Chairman; (b) a Minister or public officer nominated by the Governor under section 6(2); (c) such other members as may be nominated by the Governor to represent— (i) the police service; (ii) the Royal Montserrat Defence Force; (iii) the fire service; (iv) the Ministry responsible for public health; (v) the Ministry responsible for the environment; (vi) the Ministry responsible for public works; (vii) the Premier's Office; (viii) such other Ministries, Departments of Government and statutory bodies as the Governor thinks fit; (ix) such other persons or organizations as the Governor thinks fit who volunteer or are required by law to perform functions related to the mitigation of, preparedness for, response to and recovery from emergencies and disasters in Montserrat.

2.8 Review of activities. We obtained and reviewed Minutes of the NDPRAC's Meetings during the fiscal years 2016/2017 to 2018/2019. We found, for example, that the NDPRAC was particularly active and met frequently during September, 2017, when several hurricanes were

active in the Caribbean and some directly affected Montserrat. However, apart from that, we found that there were very few meetings during the past six years.

Section	Task	Status	Audit Work
6(4)	The Director of Disaster Preparedness and Response shall be the Secretary of the National Advisory Committee.	Being done	Confirmed that the NDRPRAC has met. Reviewed Minutes.

Ministry of Health & Social Services (MOHSS)

2.9 Roles. The Ministry of Health & Social Services (MOHSS) is responsible for multiple roles and responsibilities related to human health. Departments/Programmes within the MOHSS include Strategic Management (headquarters), Primary Care (four district clinics), Secondary Care (Glendon Hospital), and the Social Services Department. Smaller units/functions include Health Promotion, Mental Health, Surgery, Community Nursing, Pharmacy, Laboratory/Diagnostics, Nutrition, COVID-19 swabbing and vaccinations, and outpatient clinics. [See Table 4.1 in Chapter 4 for full details of the range of services available.]

2.10 Governance framework. The MOHSS operates under existing national health and disaster management legislation, strategies, policies, and plans to forecast, to prevent and to prepare for public-health risks nationally as well as global and regional risks that can cross Montserrat's terrestrial and maritime borders. [See the Table 2.4 below.] Accordingly, the MOHSS is the authority that leads the GOM's policies, planning and implementation related to all aspects of public health. In cases of public-health emergencies, as with the COVID-19 pandemic, for example, the Chief Medical Officer becomes the Quarantine Authority and the senior responsible officer for public health. This role includes providing medical advice to the Cabinet to inform its discussions of matters related to public health and to approve relevant public-health orders, emergency orders, regulations, restrictions, and protocols, which are applicable both to the public sector and to the private sector.

Table 2.4: Policies and Plans Relevant to Public Health (MOHSS)

Policies	Date Published/Last Updated	Summary
Sustainable Development Plan (2008 to 2020)	2008 (being updated for 2023 to 2035)	National strategic plan for the redevelopment of Montserrat (following the volcanic crisis since 1995). The goals and targets are under 5 clusters: (1) Economy; (2) Society; (3) Environment; (4) Governance; (5) Population.
Health Policies		
Cabinet's Policy Agenda (annual)	2023	Summary listing of the Cabinet's priority and ranking of the main S.D.P. items.
Quarantine Policy	2021	Instructions for the isolation of someone with an infectious disease based on a health assessment.
COVID-19 Policies	March 05, 2020 Last emergency S.R.O. expired September 30, 2022	Rapid sequence of public-health orders providing early intervention to mitigate the first identified cases in Antigua/Montserrat and thereafter to provide timely updates as the pandemic evolved.
Plans		
MOHSS Strategic Business Plan		
Influenza Pandemic Plan		
Isolation Plan for COVID-19		
COVID-19 Testing Policy (draft)		
Coronavirus Response Strategic Plan		
Disaster Response Management Plan		

GOM's Sustainable Development Plan (SDP)

2.11 Framework. The Government of Montserrat's Sustainable Development Plan (initially covering years 2008 to 2020) identified objectives under five clusters: (1) Economic Development; (2) Human & Social Development; (3) Environmental Management & Disaster Management; (4) Governance; and (5) Population. In assessing the various interim and medium-term reviews, we found that most of the targets were not fully achieved. In total, there were 5 strategic goals (SGs) and 22 targets (4 subsumed under item 1, target 1, SG 1). Data compiled for the final review of the SDP (done in year 2021) showed that of the 22 national targets: only

three (3) targets were achieved; seven (7) were partly achieved; ten (10) were not achieved; and two (2) targets could not be assessed, owing to the unavailability of relevant data[1].

2.12 Shortfalls. Most notably, for instance, goal-cluster #5 had aimed at rebuilding the post-1995-crisis population to 9,000 persons, but, over 20 years later, the actual population remained below half of that target as of the Census of year 2018. This posed both potential benefits and actual risks: e.g., a smaller population reduced the scale of medical services and infrastructure required; however, continuing net emigration has also meant a reduction of the workforce and a shrinking of the pool of experienced healthcare workers and skills. (See Chapters 4 and 5.) The aging of the population (over 50% are over 40 years old, per Census 2018) and the growing diversity of needs across segments of the country's multilingual and multinational society, (including minorities, persons with disabilities, and other vulnerable groups,) have also increased the demands for a broader range of medical services across the human lifecycle. Table 2.5 illustrates the impact of chronic diseases; actual incidence is much higher as many persons are not diagnosed or are not registered. Recently released research by the MOHSS confirmed this, indicating that NCDs affect at least one third of the population[2]. Those in the Diaspora frequently mention limited/unavailable healthcare services in Montserrat as a key reason for not returning to the island permanently; this concern rises further in older age-cohorts as persons plan for their retirement.

TABLE 2.5: NUMBER OF REGISTERED DIABETICS AND HYPERTENSIVES (Years 2018 to 2021)

	Fiscal Year 2018/2019	Fiscal Year 2019/2020	Fiscal Year 2020/21	Fiscal Year 2021/2022
Registered Diabetics (On Register at the end of fiscal year	230	233	192	224
Registered Hypertensives	362	360	303	342

Source: MOHSS: Primary Healthcare Department.

Footnotes: The number of registered clients changes as a result of a combination of factors, including: (a) departure from the island; (b) death; (c) refusal to attend Health Clinic(s) (usually for a year).

[1] *Montserrat Sustainable Development Plan 2008 - 2020: Review Report* (June, 2021). Ministry of Finance & Economic Development, Government of Montserrat.

[2] https://discovermni.com/2023/04/30/third-of-montserrats-population-living-with-diabetes-or-other-ncds-say-health-experts/

Montserrat did not fully achieve key SDP goals and MOHSS targets for public health

2.13 Health shortfalls. Public health is captured within the second goal-cluster (Human & Social Development) in the SDP. The GOM's interim and final reviews of the SDP showed that most milestones were missed, including the MOHSS's actual outturns versus the targets and the objectives in the SDP. [See examples in paragraph 4.3 and Table 4.2 in Chapter 4; see also Table 6.1 in Chapter 6.] Overall, the SDP's key National Outcome related to public health was not achieved: "A healthy population with full access to required health care." On the one hand, data from the Montserrat Statistics Department indicate that the population has gradually declined (e.g., from 4,649 in the Census of 2018 to a recent mid-year estimate of 4,433[3] In 2022), with net emigration, and with more deaths than births in recent years. Furthermore, the incidence of chronic diseases has increased, rather than declining. At the same time, access to healthcare, which was already limited/unavailable in several areas/specialties, was further curtailed several times, rather than maintained, during the COVID-19 pandemic. As an example, in January, 2022, the MOHSS announced that most medical services would be suspended, except for emergencies, for at least the period of January 4th to 17th, 2022. One of the measures of national resilience in a public health-system is the extent to which it is able to continue regular services, while addressing any emerging threats, crises, or disasters.

2.14 GOM has made investments in the healthcare system. Over the years, important progress has been made in some key areas, including (a) upgrading the hospital's infrastructure (from emergency-mode since the year 1995) towards more fit-for-purpose facilities, (b) improving the skills of the MOHSS's employees, and reaching towards the desired full capacity of the healthcare workforce, and (c) expanding the range of health-services that are accessible on the island[4].

2.15 Interim framework. Meanwhile, the framework underpinning the SDP for years 2008 to 2020 remains broadly in effect as an overall guiding document. It also serves as a central point of reference and source of criteria to assess Ministries and Departments on their planning and progress in each goal-cluster to which they contribute. With national elections in November, 2019, resulting in a change of Government, and with the impact of the pandemic throughout the years 2020 and 2021, the process of updating the SDP for years 2021 to 2030 and beyond was interrupted. Recognising that there would be a gap between the end of year 2020 and the formal

[3] https://discovermni.com/2023/05/08/statistics-releases-2022-recap-population-decreasing/

[4] *Montserrat Sustainable Development Plan 2008 - 2020: Review Report* (June, 2021). Ministry of Finance & Economic Development, Government of Montserrat. Prior medium-term reviews were conducted against (a) the Medium-Term Development Strategy: 2008 to 2012; (b) the Medium-Term Development Strategy: 2013 to 2017, and (c) through GoM's National Performance Reports from 2018 to 2020.

updating of a new SDP, the Cabinet approved an interim framework for the period of 2021/2022 and 2022/2023[5]. This continues the original SDP framework of four major goal-clusters, with the fifth goal-cluster, relating to Population, modified simply to achieving a stable and adequate population.

2.16 Stakeholders engaged in SDP planning. To date, the Policy & Planning (within the MOFEM) has become the national Focal Point for the SDP and is leading the consultations[6] (starting late in year 2021 and continuing until early 2023) to develop the revisions to the SDP to cover the ensuing years 2023 to 2035. The original SDP included meetings with more than 150 stakeholders representing diverse groups/interest: e.g., the public service, elected officials, private sector, civil society, and the Diaspora[7]. The recent reviews of the SDP framework have taken a similar approach of multiple consultations with diverse groups of stakeholders across the public sector and the private sector.

2.17 Multiple stakeholders in SDP updates. For the current revisions and update to the SDP, there have been widespread consultations[8], some of which we attended, following published schedules of public fora and workshops, including members of the Legislative Assembly, all Ministries, non-governmental organisations, the private sector, and external consultants, spanning November, 2021, to August, 2022. Our review of the Consultants' report for the new *MONTSERRAT SUSTAINABLE DEVELOPMENT PLAN* (MSDP) [9] showed that diverse stakeholders were engaged in a variety of fora and consultations to cover all five of the goal-clusters of the SDP. For example, the inputs for the Human Development pillar included representatives from the sectors of health, of education, of social services, NGOs, civil society, and others.

2.18 New SDP updates. We have reviewed the Terms of Reference for the SDP Taskforces. Five SDP Taskforces have been allocated to the more detailed planning work (e.g., National Outcomes; Strategic Priority Areas; Strategic Actions; Indicators; Targets): one for each of the four main goal-clusters (#1 to #4 from the original SDP), plus one for the cross-cutting theme of Population (previously goal-cluster #5 from the original SDP), comprising two members from each of the other four SDP Taskforces to ensure coherence and integration. The formal meetings of the SDP Taskforces, four of which we attended, concluded at the end of August, 2022. The SDP Focal Point and the Consultants are continuing the follow-up work of compiling and

[5] GOVERNMENT OF MONTSERRAT INTERIM DEVELOPMENT FRAMEWORK 2021/2022 – 2022/2023 (April, 2021)
[6] https://discovermni.com/2022/05/10/sustainable-development-plan-consultations-continue-next-week/
https://discovermni.com/2022/06/17/final-sdp-strategic-visioning-workshop-on-monday-june-20/
[7] *Montserrat Sustainable Development Plan 2008 - 2020: Review Report* (June, 2021). Page 8.
[8] https://discovermni.com/2022/05/10/sustainable-development-plan-consultations-continue-next-week/
https://discovermni.com/2022/06/17/final-sdp-strategic-visioning-workshop-on-monday-june-20/
[9] https://www.gov.ms/wp-content/uploads/2022/05/FINAL-SUMMARY-REPORT-ON-MSDP-CONSULTATION-PROCESS-PHASE-1.pdf

integrating the work-sheets from each SDP Taskforce to arrive at a draft of the new SDP's objectives, indicators and targets, with inputs from each relevant Department. The updated draft will be widely circulated for all participants to review and to give feedback. This, once more revised, will enable the creation of a final draft to be submitted to the Cabinet for approval. The latest update (October 11th, 2022) from the Policy & Planning Unit indicated that the Consultants were at the stage of developing the implementation plan, and the process was on track for completion by February, 2023. As of April, 2023, this is still pending.

2.19 One of the medium-term objectives of the SDP (Priorities for human development) was to "improve facilities and services for better health care delivery" by Priority Strategic Actions:

i. Reviewing health financing options re health insurance and user fees, and implement appropriate recommendations;
ii. Conduct a comprehensive assessment of infrastructural needs for Glendon Hospital; and
iii. Implement initiatives to enable better access to secondary and tertiary health care in areas of greatest need.

2.20 MOHSS's Strategic Planning. The MOHSS, like other Departments of the GOM, is expected to have strategic plans with objectives, Key Performance Indicators, and targets. In our assessment, we confirmed that these items (including policies, plans, protocols, programme, and projects) were being incorporated in plans and budgets, actions were being undertaken towards them, they were being reported to the MOFEM and to the MEU, and thus were being regularly monitored internally and externally.

Table 2.5: Illustration of MOHSS's Strategic Planning (3-year rolling format)

KEY PERFORM-ANCE INDICATORS	Actuals for 2019/2020	Estimates for 2020/2021	Targets for 2021/2022	Targets for 2022/2023	Targets for 2023/2024
Primary Healthcare					
Relevant Protocols & Legislation in place to protect the population against existing & emerging	National Influenza Pandemic Preparedness Plan updated to address novel coronavirus	Protocols developed & implemented for Prevention of Droplet Infections in the Clinic and Community	Protocols adjusted as the epidemiological profile of the novel virus is further documented & understood.	Protocols for the management of respiratory illnesses & other potential threats reviewed annually by multiple stakeholders.	Protocols for the management of respiratory illnesses & other potential threats reviewed annually by

public health threats	that emerged in Dec 2019	settings E.g.: Guidelines for Social Distancing Proper Use of PPE Quarantine Procedures			multiple stakeholders.
Secondary Healthcare					
KEY PERFORM-ANCE INDICATORS	**Actuals for 2019/2020**	**Estimates for 2020/2021**	**Targets for 2021/2022**	**Targets for 2022/2023**	**Targets for 2023/2024**
Infection control policy developed and implemented	Submission of business case for Infection Control Coordinator New spend submitted to support request (no new spends approved) Public Health England to offer technical assistance with infection control policy	Submission of business case for Infection Control Coordinator New spend submitted to support request Public Health England to offer technical assistance with infection control policy	Establishment of an infection prevention and control committee – create ToR for the committee – appoint members of the committee (internal) Draft policy created and submitted to senior policy makers and key stakeholders for review Policy finalized and submitted to Cabinet for review and approval. Policy ratified by Cabinet	Cabinet Training and implementation. Monitoring of adherence to policy.	Monitoring of adherence to policy.

Quarterly reports

2.21 The various Ministries and Departments throughout the GOM are required to submit quarterly performance reports to the Ministry of Finance (MOFEM) and to the MEU within the

Office of the Premier (OP). A very positive finding of our study was that data from the MOFEM confirmed that all Ministries and the majority of Departments were compliant with this reporting within each fiscal year, and, in particular, that the MOHSS and its Departments maintained their compliant status throughout the years reviewed (2017 to 2022). This quarterly reporting format has also been extended beyond the central public service to include public-sector entities such as the Montserrat Land Development Authority, which reports through the P.S., MALHE, to the MOFEM. This adds to coherence and integration across the public sector, in line with the whole-of-Government paradigm of the SDG framework. [See Chapter 6 for more on Quarterly Reports.]

Monitoring and Evaluation

2.22 National framework. The OP's Monitoring and Evaluation Unit (MEU) is responsible for the compilation of the annual National Performance Report (NPR) on the SDP, which details a selection of Departments' key reported objectives and progress towards them annually. Support for this process is high as the MEU is within the Office of the Premier and its monitoring complements that which is done quarterly by the MOFEM, which ultimately reports to the Premier, as Minister of Finance, and the Cabinet, as well as to the British Government through the FCDO. [See Chapter 6 for more on Monitoring and Evaluation.]

2.23 Delays & weaknesses in some Departments' reporting. The MEU has continually reported that several Departments are not reporting timely, some did not report at all in some periods, or have incomplete or inaccurate submissions. These factors contribute to delays and gaps in national and international monitoring and reporting. In our review, the MOFEM's summaries of submissions by all Ministries and Departments confirmed that such gaps and delays have occurred in each fiscal year.

National Performance Reports

2.24 Gaps in Departments' SDP reporting; no SDG reporting. Our review of the NPRs, for the four years 2017/2018 to 2020/2021, shows that Departments did not report on every indicator or target in the SDP. They did not report on their contributions towards national achievement of the SDGs. In turn, the NPRs did not include all the indicators outlined in the SDP; instead, the focus was on presenting a selection of the main objectives and indicators reported by Departments during each fiscal year. As a result, we were unable to assess fully and precisely some aspects of the national progress towards health resilience as detailed in the SDP. However, our review of all the available data and reports indicates that major gaps remain in the GOM's

implementation vis-à-vis several areas of the SDP, including those targets related to health[10]. In turn, large shortfalls related to the SDP also mean large gaps between the status quo and the objectives (and related targets) in the SDGs: e.g., elimination of extreme poverty; elimination of hunger; elimination of homelessness; decent work and safe workplaces for all employees; sustainable management of the natural resources and environments on land and in the sea; and universal healthcare and health-security.

2.25 Very limited healthcare reporting. In their sections related to public health, our review of the NPRs showed a focus on selected data for some chronic diseases, and especially the non-communicable diseases (NCDs). There were only a few categories of health-related indicators and targets in any of the NPRs published during the past four years (2019 to 2022) re fiscal years 2017/2018 to 2020/2021. [See Chapter 6 for more on National Performance Reports.]

2.26 No integration of the SDGs. Whilst most Departments across the GOM have improved their integration of the SDP in their budgets, strategic plans, and reporting, we found that there were no plans and actions with explicit, consistent and measurable links to the SDGs in any of the documents that we reviewed. During the period 2015 to 2022, the Montserrat Statistics Department compiled indicators for only a few of the 17 SDGs, and there was very limited reporting against any of them. As this marks the mid-point in the 15-year SDG horizon to the 2030 Agenda, we have concluded that the GOM is far behind its obligations, and stakeholders' expectations, [1] in developing and deploying a suitable framework for national targets and indicators to establish both baseline status and data, and [2] in its actual progress to date against each SDG target. This is a major weakness in the governance framework, including for healthcare and public health-systems, which have practical links to every Ministry and Department, as well as social, economic, and environmental risks, costs, impacts, and opportunities for synergies in implementation of policies, programmes, projects, and processes.

2.27 Insufficient engagement of public/stakeholders. An important aspect of the SDP is regular monitoring, review, and assessment of progress. Likewise, the SDG framework strongly advocates for the engagement of diverse stakeholders, NGOs, and ordinary citizens, across the population, including vulnerable groups and minorities. However, in practice, we found that most national reports, including the NPRs, are not accompanied by adequate and regular engagement of multiple stakeholders, and especially beyond those within the public sector, to review national progress, and to hold individual Ministries, Departments, Divisions, and Units accountable for budgets, strategic plans, and implementation.

[10] For example, *Montserrat Sustainable Development Plan 2008 - 2020: Review Report* (June, 2021). Ministry of Finance & Economic Development, Government of Montserrat. Prior medium-term reviews were conducted against (a) the Medium-Term Development Strategy: 2008 to 2012; (b) the Medium-Term Development Strategy: 2013 to 2017, and (c) through GoM's National Performance Reports from 2018 to 2020.

2.28 Much of the reporting is focused on stakeholders within the public service, and, even then, the effective range of circulation and direct inputs is relatively narrow. Overall, we have observed that Ministries and Departments do not normally host regular public fora and multichannel communication to give a wide range of (types of) stakeholders and citizens opportunities to discuss and to provide inputs into strategic plans, budgets, projects, programmes, and implementation. Among those that we reviewed, plans and budgets themselves often did not identify a full range of stakeholders and/or address the needs of specific vulnerable groups. They also tended to lack appropriate Communication Plans and specific mechanisms for measuring and assessing engagement, feedback, and impact on targeted groups or population-segments.

The GOM's Policy Agendas

2.29 There is also a Policy Agenda that is updated each year, which details the Cabinet's priority and ranking of the SDP items. Our review of the GOM's Policy Agendas for the years 2016/2017 to 2023/2024 showed that there was consistency in the use of items based on the SDP. Each agenda-item is uniquely numbered to allow easy tracking and referencing over time, regardless of its ranking in a given year or Policy Agenda. For instance, agenda-item #2.1 means item number one from goal-cluster #2 (Human Development).

2.30 For example, in the Policy Agenda for fiscal year 2016/2017, we noted that none of the items related to health was in the first or second tier of ranked items, within 8 tiers of ranking for that year. By contrast, in the Policy Agenda for fiscal year 2019/2020, a health-related priority was given a place in the top-ranked tier of 5 tiers for that year: Agenda-item #2.1 states a goal of "increased access to essential and specialised medical services through leveraging technology as well as direct service provision."

Whole of Government: Coherence of Policies

2.31 One of the key principles of the SDG framework is a whole-of-Government approach. An important factor in this is policy-coherence, leading to effective co-ordination and co-operation between Departments. This exists throughout the policy-framework to the extent that all Ministries and Departments are required to align their strategic plans and their budgets to the Policy Agenda/S.D.P. In practice, the MOFEM centrally manages the process of annual budgeting and strategic planning, reviewing each Department's plans and budgets, and adjudicating requests for new spending. We found that a robust framework is in place and the MOFEM regularly issues Budget Circulars with clear dates for each type of reporting and each phase of the annual budgeting cycle. This is consistent with the findings of one of the OAG's prior related

studies: a performance audit of the GOM's Strategic Planning & Budgeting Processes (done in year 2018/2019).

2.32 Some gaps/conflicts remain between various policies and practices. Over the SDP period of 2008 to 2020, the GOM had published and/or revised a number of important policies, including [a] a national policy for Information & Communication Technology, [b] a national Montserrat Energy Policy, and [c] the Electronic Transactions Act. In practice, however, we found that many Departments' plans, programmes, policies, and procedures remained, in various respects, outdated and inconsistent with these national policies. For instance, up to the present, we found many instances of paper-based forms and documents and manual processes versus efficient and effective use of technologies consistent with the Montserrat ICT Policy. Likewise, the Montserrat Energy Policy has long aimed at making local and renewable forms of energy the dominant paradigm, but [1] almost every vehicle in the public sector continues to use fossil-fuels (including transportation used for, or by, the MOHSS and the DMCA), [2] solar energy remains in limited use, with only 25% of its installed 1 Megawatt capacity contributing to the national energy-grid, and [3] most Departments, including the MOHSS and the DMCA, and the sole national electricity company continue to rely on diesel-fuelled generators both for regular power (indirectly through fossil-fuel-generated electricity) and for emergency back-up power.

2.33 Procurement policies were not always followed. This study, as well as other internal and external reviews, found that Departments, including within the MOHSS, did not always comply with applicable laws, regulations, and best practices for procurement. Given that the Government is the largest entity and employer in the economy, and given the materiality of the Goods & Services budget both to the GOM's budget and to the budget for each Ministry and Department, including the MOHSS, procurement has received increasing attention. For example, we found several instances of not advertising the MOHSS's quest for accommodation services, catering services, transportation services, et cetera. Failure to be fully transparent in the market limited the number of potential service-providers, and led to very high costs in several categories of spending. This and other studies have also identified cases of conflicts of interest, related parties, uses of insider knowledge to personal advantage, and instances that public servants, while having a full-time job with the GOM, were supplying goods/services to the GOM, including the MOHSS. Non-declaration of personal interests, incomplete or no documentation of procedures to be followed versus those actually followed, and other aspects of accountability and transparency showed room for major improvement in line with policies and best practices.

Whole of Government: Vertical integration

2.34 Another important factor in achieving both the SDP and the SDGs is vertical integration: a unifying framework of vision, mission, monitoring, and oversight spanning all levels of the public

sector. All Ministries and Departments report to the Deputy Governor administratively and/or for H.R. matters and to the Ministry of Finance & Economic Management (MOFEM) for financial matters, strategic plans, budgets, et cetera. We found that the MOHSS was compliant for the past five years (e.g., all Quarterly Reports were submitted). For statutory entities outside the central public service, further accountability and integration are achieved by having senior officers of the GOM among the members of the Board of each entity, and typically also serving as the Chairperson of the Board.

Oversight by the NIPPPC

2.35 Montserrat has in place a National Influenza Pandemic Planning and Preparedness Committee (NIPPPC), which is chaired by the CMO and includes representatives from the MOHSS and other stakeholders. We found that, unlike the Public Health Advisory Board and the NDPRAC, the NIPPPC (1) is an emergency committee, (2) meets only when necessary, and (3) is not a creature of any specific law.

2.36 Incomplete documentation. We requested the Terms of Reference (TOR)/Charter of the Committee to determine its purpose, scope, authority and reporting requirements, but were advised that no such document exists. Instead, the MOHSS presented a written planning document, which detailed (a) the phases in the planning and response to a pandemic, (b) the responsible parties for each stage, and (c) the actions to be undertaken by each party. Further, we sought to determine (a) whether meetings were conducted, (b) whether key issues relating to the mandate of the Committee were discussed, (c) motions proposed or voted on, (d) assessment of key activities to be undertaken, and (e) monitoring functions. However, the MOHSS did not present the requested Minutes for the NIPPP Committee to provide an accurate record of discussions and decisions made during the meeting.

2.37 Only one meeting in 6 years. Over the 6 years reviewed, 2017 to 2022, only one meeting of the NIPPPC was held (March 05, 2020[11]). In September 2022, the MOHSS responded that the Government Information Unit was invited to the NIPCCC's meeting and that the GIU's website published a summary of the meeting.

2.38 Lack of accountability. Our review of the GIU's website showed[12] that the record did not capture all of the expected details of formal Minutes: e.g., key points of topics discussed;

[11] https://www.gov.ms/2020/03/05/montserrats-national-influenza-pandemic-planning-preparedness-committee-discusses-covid19-plans/

[12] https://www.gov.ms/2020/03/05/montserrats-national-influenza-pandemic-planning-preparedness-committee-discusses-covid19-plans/

decisions made; actions/responsibilities assigned and to whom; dates by which items were to be completed; monitoring and follow-up assessments; et cetera. We found no evidence of documented follow-up or monitoring to confirm whether each stakeholder had completed assigned tasks or met expected objectives.

2.39 The NIPPPC's Stakeholders. The meeting was chaired by the Permanent Secretary of the MOHSS and included the Minister of Health and the Parliamentary Secretary with responsibility for health. The Chief Medical Officer (CMO), who also acts as the national Quarantine Authority, and other senior Health Officials presented updated information on the spread of the COVID-19, and on the Ministry of Health's plans related to screening, isolation, and quarantine. This forum included officials from diverse public-sector stakeholders: The Ministry of Health, the Port Authority, the Integrated Border Security Unit, the Customs and Excise Division, the Royal Montserrat Police Service (RMPS), the Access Division, the Airport, and the Office of the Premier. The timing of this forum of the NIPPPC was important because it occurred before the first confirmed case of COVID-19 infection was publicly reported in Montserrat.

Engagement of Stakeholders

2.40 Additionally, the Ministry of Health was also in communication with local non-governmental organisations (NGO's) such as the Montserrat Chapter of the International Red Cross, The Montserrat Association of Persons with Disabilities and the Montserrat Senior Citizens Association to ensure that the most vulnerable in the community are protected. Throughout the week, a number of key exercises occurred, including completion of training of emergency personnel in the use of Personal Protective Equipment (PPE), continued distribution of educational literature, and continued training in hand-washing and proper sanitation of special interest groups such as children and care takers of the elderly. Situational updates and strategic response meetings also continue with local and regional partners such as the Pan-American Health Organisation (PAHO), the Caribbean Public Health Agency (CARPHA), and Public Health England (now named the U.K. Health Security Agency).

2.41 Conclusion on Governance. The GOM has provided a number of laws and policies to govern healthcare and disaster management, and the oversight of public budgets, public spending, and public procurement. It showed agility and responsiveness during the pandemic. Robust frameworks are in place for reporting and accountability at all levels of the public sector. However, in practice, this study found several weaknesses and some areas offering opportunities for immediate improvement: [1] there are gaps in the legislative framework, [2] there is

incomplete integration of the SDP, [3] this is very little integration of the SDGs, [4] there remain instances of insufficient policy-coherence, including gaps between policies and practices, [5] there is scope for more joint planning and budgeting, [6] reporting and data-sharing are not always timely or complete, [7] more strategic cooperation between Ministries and Departments, [8] weaknesses in some aspects of procurement, documentation, and transparency, [9] inadequate engagement of all segments of the population in planning and budgeting processes, and [10] inadequate engagement of all segments of the population in the mechanisms of transparency, accountability, and feedback on public policies and public services.

Recommendations

2.42 Strengthen the governance framework to integrate the SDP & the SDGs. The MOHSS should work with the MOFEM, the AGC, the Policy & Planning Unit, the OOP, and other stakeholders to review the GOM's laws, regulations, policies and programmes to enhance integration of the SDP (and its updates), the Policy Agenda, and the SDGs. The Ministry should ensure that there are explicit links to and between these frameworks, and that they are managed in a way that is cohesive, harmonious, and positively reinforcing. In this way, contributing to one national/global goal, outcome, or objective, can help with others, saving time, effort, and costs, while improving impact and the scale and the quality of policy-outcomes.

2.43 Strengthen policy-coherence and vertical integration across the whole of Government. The MOHSS should work with the MOFEM, the AGC, the Policy & Planning Unit, the OOP, and other stakeholders to review the policies, plans, budgets, and projects of Ministries and Departments to identify and to remove gaps to implementation, conflicts of roles, overlapping roles, and activities that do not further the whole-of-Government approach.

2.44 Practical Illustration. Coherence of policies contributing to SDG 3.d would ensure that policies in one part of the public sector, such as the Ministry of Education, Youth Affairs and Sports, (e.g., health-education, exercise-programmes, and healthy school-meals) are consciously cross-referencing and contributing to the achievement of excellent health-outcomes and comprehensive approaches to public-health resilience in other Ministries.

2.45 There are for example #1, health-promotion, prevention, early detection, multidimensional social welfare, and effective low-cost primary care in the MOHSS. For example #2, Ministry of Agriculture, Land, Housing, and Environment's programmes to encourage [i] backyard production of fruits, herbs, and vegetables, [ii] commercial organic farming, and [iii] food-gardens in communities, the prison, and schools. For example, #3, Ministry of Communications, Works, Energy & Labour's programmes to maintain wholesome workplaces

and healthy workers, and to reduce pollution, plastic packaging, indiscriminate waste and disposal, and carbon-emissions. For example, Ministry of Finance & Economic Management's policies of commerce, trade, and taxation that seek to reduce the importation, the production, the distribution, and the consumption of junk-food, sweetened beverages, alcohol, tobacco, added salt, artificial ingredients, and ultra-processed foodstuffs, while incentivising goods and services that contribute to the reduction of non-communicable diseases, and the achievement of long-term human health and physical fitness for a growing proportion of the population.

2.46 Increase the scope & quality of participation of diverse stakeholders in making, reviewing and implementing laws, regulations, and policies. The MOHSS should cultivate a culture of inclusion to engage a wider range of types of stakeholders, e.g., more NGOs and other stakeholders outside the public service, with better participation at each stage of policy-making and related communications. Firstly, this requires identifying stakeholders and maintaining a comprehensive and up-to-date database of all categories of stakeholders and their representatives. It also requires meaningfully engaging stakeholders in formulating policies to ensure that they benefit from many perspectives, diverse inputs, and a people-first perspective.

2.47 The making of *laws, regulations, and policies, and revisions to them, should be done with emphasis on seeking to identify, and then truly listening to, the needs, the concerns, the knowledge, and the experiences of the stakeholders that will benefit from *them, as well as those that will be affected by *them. The perspectives of more end-users should be considered in the design of public goods, programmes, and services to ensure that they will achieve the intended outcomes and impact. Likewise, the MOHSS should broaden the scope of stakeholders' engagement in the review of laws and policies, and the monitoring and evaluation of each Department's progress towards goals, targets, and objectives. These measures will enhance the transparency and the accountability for national progress in achieving the SDP and the SDGs.

2.48 Strengthen the oversight and effectiveness of Boards/Committees/ Working Groups. The MOHSS should review, assess, and improve the functioning of all bodies within its remit, e.g., the NIPCCC, and those to which it contributes, e.g., the NDPRAC. Examine and reconsider the processes for identifying, nominating, appointing, and inducting persons, to increase the pool of candidates, and to ensure impartial selections with objective criteria and fair access to opportunities. Increase the transparency and accountability of Boards/Committees through regular meetings, regular reporting, and documented deliverables. E.g., the NIPCCC should meet at least once a year to keep members updated regarding their roles, their responsibilities, as well as coordinate training to keep members and other stakeholders abreast of current trends and emerging risks and threats to public health. Keep adequate Minutes of each meeting to provide satisfactory records of discussions, decisions, assigned tasks, progress against objectives, and deliverables/outputs. Institute a process for the documented review and published assessment of each Board/Committee at least annually. Align assigned roles, term-

limits, attendance, and productivity, to ensure value for money for the GOM, better decision-making and reporting within and by Departments, and better service to the public.

CHAPTER 3

BUDGETS AND PLANS FOR PUBLIC HEALTH AND DISASTER MANAGEMENT

Overview

3.1. Financing of Budgets. Funding for public health is concentrated within the MOHSS. This includes primary healthcare and secondary healthcare, as well as social services. Overall allocations to each Department/Ministry are determined by negotiations between the MOFEM (on the behalf of the GOM) and the F.C.D.O. (on the behalf of the British Government, which is the primary donor for the GOM). There are no private-sector hospitals or clinics. Historically, there was a private medical university on the island, but this ended its local operations years ago.

3.2. Format of Budgets. There is a rolling 3-year format for each Ministry/Department, showing projections for the current fiscal year and the next two fiscal years, as well as the previous one to two years' actuals. This gives a multi-year perspective for actuals and forecasts. Each Department updates and reviews its budget every year and revises the projections for the ensuing two or three years accordingly.

3.3. Strategic Plans. Each Ministry/Department has objectives with outcome indicators and output indicators, also presented in the rolling 3-year format to accompany each annual budget. Each Department updates and reviews its strategic plan every year, alongside the annual budgeting cycle. [See Table 3.1]

Review of Budgeting

3.4. Background. One of the five pillars in the W.H.O.'s model of public health-systems is ***Healthcare Financing***, including planning and budgeting. This dovetails with the pillar of ***Leadership and Governance***, which was introduced in Chapter 2, including how decisions are made about resources and allocations. Over 60% of the GOM's recurring budget and over 90% of the GOM's capital budget are funded by grants, primarily aid from the British Government. Hence, the GOM's budgetary allocations, including for public health, require the Cabinet's approval, but ultimately depend on agreement with the British Government through the Foreign & Commonwealth Development Office (FCDO) (formerly DFID).

3.5. Context. There is a well-developed budgeting and planning calendar overseen by the MOFEM, including two annual Financial Aid Mission visits by a team from the FCDO to discuss each Department's proposed recurring budget, proposed capital budget, any new requests for spending, and likely allocation of funding. There is close co-ordination within this budgetary cycle as the MOFEM and the FCDO interact directly with every Ministry and with each Department regarding its strategic plans and budgets.

3.6. Allocations to the MOHSS. Within this process, the MOHSS develops its budgets and strategic plans and submits its proposals and requests to the MOFEM for feedback and for onward discussion with the FCDO and approval by the Cabinet. There are standard budgetary lines and items of recurrent expenditure (primarily these: personal emoluments, operational expenses, goods and services) that continue from year to year. The main focus in the budgetary reviews and discussions, therefore, is any new items of revenue or expenditure. The other major component of budgeting is the separate provision for capital expenditures, which vary from year to year, and require specific planning, budgetary allocations, and approval (e.g., the project to build a new national hospital was approved within the CIPREG #1).

TABLE 3.1: Primary Healthcare (MOHSS): Examples of Key Performance Indicators (fiscal years 2019/2020 to 2023/2024)

KEY PERFORM-ANCE INDICATORS	Actual for Fiscal Year 2019-2020	Estimate for Fiscal Year 2020-2021	Target for Fiscal Year 2021-2022	Target for Fiscal Year 2022-2023	Target for Fiscal Year 2023-2024
Primary Healthcare					
Relevant Protocols & Legislation in place to protect the population against existing & emerging public health threats	National Influenza Pandemic Preparedness Plan updated to address novel coronavirus that emerged in Dec 2019	Protocols developed & implemented for Prevention of Droplet Infections in the Clinic and Community settings E.g.: Guidelines for Social Distancing Proper Use of PPE Quarantine Procedures	Protocols adjusted as the epidemiological profile of the novel virus is further documented & understood.	Protocols for the management of respiratory illnesses & other potential threats reviewed annually by multiple stakeholders.	Protocols for the management of respiratory illnesses & other potential threats reviewed annually by multiple stakeholders.
Campaign mounted against significant potential and	Public Education Programme on how to mitigate against seasonal influenza	Public Education Campaign designed and implemented in response to the	Public Education Campaign implemented in 2020/21 will continue	Continuous education of the public on measures to mitigate against	Continuous education of the public on measures to mitigate

current risks, using all available media.	mounted in October 2019 & against new coronavirus in February 2020	new coronavirus disease		public health threats; with emphasis on emerging events	against public health threats; with emphasis on emerging events

TABLE 3.5: Secondary Healthcare (MOHSS): Examples of Key Performance Indicators to improve healthcare (fiscal years 2019/2020 to 2023/2024)

Secondary Healthcare					
KEY PERFORMANCE INDICATORS	**Actual for Fiscal Year 2019-2020**	**Estimate for Fiscal Year 2020-2021**	**Target for Fiscal Year 2021-2022**	**Target for Fiscal Year 2022-2023**	**Target for Fiscal Year 2023-2024**
Expansion of laboratory testing profile	Infection control policy developed and implemented	Introduction of metabolic tests and blood components pursuant to funding. Implementation of COVID-19 testing	Introduction of hormones		
Infection control policy developed and implemented	Submission of business case for Infection Control Coordinator New spend submitted to support request (no new spends approved) Public Health England to offer technical assistance with infection control policy	Submission of business case for Infection Control Coordinator New spend submitted to support request Public Health England to offer technical assistance with infection control policy	Establishment of an infection prevention and control committee – create ToR for the committee – appoint members of the committee (internal) Draft policy created and submitted to senior policy makers and key stakeholders for review Policy finalized and submitted to Cabinet for review and approval. Policy ratified by Cabinet	Cabinet Training and implementation. Monitoring of adherence to policy.	Monitoring of adherence to policy.

3.7. Improved allocations to healthcare have improved some national outcomes. In our review, we found that the MOHSS has a large allocation of the GOM's national budget. The MOHSS also has the biggest allocation (over 22%) of the total headcount in the public service. These facts reflect the high priority that the GOM gives to public health. During the COVID-19 pandemic, despite budgetary cuts overall arising from falling revenues and reduced economic activities, (e.g., see the data for fiscal years 2020/2021 and 2021/2022), we

found that the GOM allocated large additional sums to the MOHSS both for the Secondary Healthcare programme and for the Social Services Department. (See Tables 3.3, 3.7, and 3.8 below.) Emergency supplementary funds of EC$8 million from the British Government buttressed these efforts. This funding supported (1) the procurement of 5 doctors and 8 nurses from Cuba (July, 2020, to March, 2022) (see more details in Chapters 4 and 5), and (2) boosted the GOM's interventions to support those adversely affected by the pandemic and by the public-health measures that affected specific sectors (especially tourism), small businesses, private-sector employment, and vulnerable households.

3.8. Short-term measures: risks & limitations. However, the duration and the extent of the benefits achieved were limited by the short-term nature and the narrow scope of several of these interventions, and by the failure to adopt more permanent and sustainable measures supported by appropriate budgetary lines and allocations. For example, not having dedicated funding and capacity for planning and preparation for, prevention of, and response to, healthcare emergencies, means that responses to actual crises are dependent on the availability, the timing, and the amounts of ad-hoc funding and external aid. These factors increase the risks to the healthcare system and to national resilience: e.g., [a] prices of items tend to be higher and available supplies tend to be lower during and after crises; [b] delays in getting necessary equipment, personnel, and supplies; [c] delays in getting approval and/or disbursement of needed emergency funding; [d] lack of/insufficient on-island stores and reserves and/or timely replenishment to support effective initial responses to health-related crises and disasters; [e] preventable deaths and casualties incurred while awaiting regional/international aid, personnel, supplies, or other resources.

3.9. TABLE 3.3: TOTAL PUBLIC HEALTHCARE FINANCING: 5-YEAR SUMMARY OF THE MOHSS's INITIAL BUDGETS, REVISED BUDGETS, AND ACTUAL SPENDING.

Period	Approved Budget	Capital Budget	Budget Release	Actuals
2017 - 18	19,756,000.00	535,700.00	19,576,800.00	19,497,345.81
2018 - 19	19,916,800.00	158,200.00	20,658,600.00	20,588,165.47
2019 - 20	25,395,100.00	5,000,000.00	21,595,100.00	21,108,293.02
2020 - 21	27,385,200.00	3,859,400.00	27,036,500.00	26,686,187.95
2021 - 22	23,517,400.00	1,938,500.00	22,678,900.00	22,637,453.09

Source: MOHSS headquarters: summary data from Budgets and Actuals.

3.10. Most of MOHSS's resources go to sickness; very little goes to prevention. The MOHSS has multiple departments and programmes, but Primary Healthcare and Secondary Healthcare receive the largest budgetary allocations. (See Tables 3.6 and 3.7.) However, Health Promotion has received very small allocations (e.g., on average, less than $40,000 per year in an overall MOHSS budget approaching $30 million), and our reviews of the budgets and the

Quarterly Reports showed that these have been further reduced during some fiscal years. (See Table 3.2 below.) By contrast, chronic diseases and acute care consume most of the budgeted resources each year. We also found that budgets for Primary Healthcare were cut repeatedly: e.g., in fiscal year 2019/2020 and again in fiscal year 2020/2021; consequently, the revised budget for fiscal year 2020/2021 was below even that for fiscal year 2017/2018. Evidently, too little is being budgeted, and even less is being done, to support sustained public education and personal empowerment about healthy lifestyle-choices and the prevention of chronic diseases. Even within the public service, some workplaces have not been visited by health-professionals or community/clinic nurses for several years.

3.11. TABLE 3.6: PRIMARY HEALTHCARE FINANCING: 5-YEAR SUMMARY OF THE INITIAL BUDGETS, REVISED BUDGETS, AND ACTUAL RECURRENT SPENDING.

Extracts from audited P.A.	**Fiscal Year 2017/2018**	**Fiscal Year 2018/2019**	**Fiscal Year 2019/2020**	**Fiscal Year 2020/2021**	**Fiscal Year 2021/2022**
Approved Budget	**2,329,700**	**2,450,500**	**2,400,800**	**2,449,900**	**2,449,100**
Revised Budget	**2,140,100**	**2,340,400**	**2,309,300**	**2,026,100**	**2,419,200**
Actual spent	**2,124,900**	**2,337,128**	**2,264,388**	**2,025,375**	**2,409,529**

3.12. TABLE 3.7: SECONDARY HEALTHCARE FINANCING: 5-YEAR SUMMARY OF THE INITIAL BUDGETS, REVISED BUDGETS, AND ACTUAL SPENDING.

Extracts from audited P.A.	**Fiscal Year 2017/2018**	**Fiscal Year 2018/2019**	**Fiscal Year 2019/2020**	**Fiscal Year 2020/2021**	**Fiscal Year 2021/2022**
Approved Budget	**8,351,500**	**8,607,500**	**8,989,700**	**9,033,900**	**9,722,600**
Revised Budget	**8,541,300**	**8,804,600**	**9,438,600**	**10,842,400**	**10,709,000**
Actual spent	**8,489,018**	**8,793,711**	**9,405,055**	**10,659,627**	**10,661,944**

Source: MOHSS data; Annual Audits of the Montserrat Public Accounts.

3.13. Chronic diseases have worsened, including among children. Of growing concern locally and regionally is the rising incidence of chronic diseases such as diabetes,

hypertension, heart-disease, cancer, and obesity. A notable trend of the past decade is that the incidence of NCDs has increased at earlier ages, predisposing the future adult population and workforce to greater risks of unfavourable outcomes, and a growing impact on the public healthcare-system. Data from the MOHSS indicated adverse incidence and trends in childhood overweight/obesity at all three levels of the school-age population: e.g., among females, [1] nursery schools: from as low as 3% in year 2014 to 11% in year 2022; [2] primary schools: from under 5% in year 2010 to 19% in year 2021; [3] secondary schools: from 13% in year 2012 to 16% in year 2021. Similar patterns were observed among boys, with notable escalation in the past few years, whereby rates for males exceeded historical levels, and surpassed rates in females, reversing the long-term pattern of higher incidence in females.

3.14. Contributing factors. Researchers have identified several factors contributing to the rising spread of NCDs in the population: e.g., frequent intake of ultra-processed snacks and manufactured foodstuffs instead of fresh foods and whole foods; regular consumption of fast food instead of home-made meals; daily use of sweetened beverages instead of water; declining levels of physical activity in everyday life; increasing shifts towards sedentary pursuits (e.g., online games, indoor/onscreen entertainment, social media); and falling rates of participation in outdoor games/sports.

3.15. The engineering of ultra-processed items and fast foods has aimed at stimulating appetite with added sodium, added sugar and other sweeteners, artificial colours, artificial flavours, and textures designed to be highly appealing. These aspects create habit-forming patterns of consumption. However, public-health authorities, including the W.H.O., have long warned of the dangers of such items, including low or no nutritional value, and low or no dietary fibre (e.g., contributing to spikes in blood-sugar, blood-pressure, and insulin-resistance). Together, these several factors and trends have led to remarkable increases in average caloric intake alongside reduced levels of physical activity. This combination worsens every type of chronic disease at all ages.

3.16. TABLE 3.2: HEALTH-PROMOTION: 5-YEAR SUMMARY OF INITIAL BUDGETS, REVISED BUDGETS, AND ACTUAL SPENDING.

Fiscal Year	Initial Budgets		Revised Budgets	Actuals
Health Promotions	451-266			
2017 - 18	40,000.00		17,400.00	17,346.90
2018 - 19	40,000.00		40,000.00	39,992.48
2019 - 20	25,000.00		25,000.00	24,542.23
2020 - 21	45,000.00		38,100.00	38,084.10
2021 - 22	45,000.00		37,500.00	37,495.55

Source: MOHSS headquarters: summary data from Budgets and Actuals.

3.17. Social Services Department. One of the aspects of national resilience is a robust social safety-net for vulnerable groups, including the indigent, persons with disabilities, persons with special needs, the unemployed, victims of domestic abuse/violence, orphans, elder care, and those that need housing support. Table 3.4 (in paragraph 3.20) gives a summary of the range of services provided by this Department and the amounts spent in each area of support, as well the numbers of persons served. Table 3.8 below gives an overview of the Department's budgets in recent years. We noted that budgets were revised upward in fiscal years 2018/2019 to 2020/2021, but then cut in year 2021/2022 to the lowest level of funding since year 2017/2018.

3.18. TABLE 3.8: SOCIAL SERVICES FINANCING: 5-YEAR SUMMARY OF THE INITIAL BUDGETS, REVISED BUDGETS, AND ACTUAL SPENDING.

Extracts from audited P.A.	**Fiscal Year 2017/2018**	**Fiscal Year 2018/2019**	**Fiscal Year 2019/2020**	**Fiscal Year 2020/2021**	**Fiscal Year 2021/2022**
Approved Budget	**5,949,600**	**6,041,200**	**6,085,700**	**9,240,000**	**6,342,700**
Revised Budget	**6,024,500**	**6,912,100**	**7,125,300**	**11,286,500**	**[a] virement: (250,100) less [b] supplementary 360,000 added = 6,452,600**
Actual spent	**6,023,564**	**6,861,903**	**6,841,366**	**11,125,819**	**6,432,454**

Source: MOHSS data; Annual Audits of the Montserrat Public Accounts.

3.19. Gaps in social services. One limitation that our study identified is that caps have been placed by the GOM on eligibility-criteria for social welfare assistance (e.g., non-Montserratians are excluded) and on the numbers of persons who can be added to the list of beneficiaries (e.g., those needy persons that are given E.C.$900 per month). This violates the spirit of the SDGs (e.g., leaving nobody behind) and the principle of non-discrimination and equitable access to public services. Benefit-amounts have not been revised for several years, nor adjusted for price-inflation in the domestic economy.

3.20. Declining numbers of social-service beneficiaries. In reviewing the available data for years 2017 onward, we found that, in most areas of service, the number of persons receiving benefits in years 2020 and 2021 declined in comparison with the numbers of beneficiaries pre-2020. For example, those receiving medical assistance declined almost 50%

from 123 in year 2019/20 to 65 in year 2020/21. Those receiving adult services declined from 78 in 2019/20 to 59 in year 2020/21. Funeral grants fell more than 50% from 21 in year 2019 to 10 in year 2021. Financial assistance peaked at 326 in year 2017 versus 311 in year 2020. Rental assistance fell from 85 in year 2018 to 77 in year 2021. Aid-recipients for utilities reduced from as many as 12 in year 2017 to as few as 5 in year 2020. Child & family services was the only service that showed notable increase in reach: from 70 persons in 2019/20 to 100 persons in year 2020/21. However, this figure declined almost 40% the following year.

3.21. TABLE 3.4: SOCIAL SERVICES: 5-YEAR SUMMARY OF SERVICES DELIVERED

SERVICES PROVIDED	NUMBER OF PERSONS SERVED				
Years	**(2017/2018)**	**(2018/2019)**	**(2019/2020)**	**(2020/2021)**	**(2021/22)**
Medical Assistance	65	94	123	65	74
Financial Assistance	326	333	313	311	315
Rental Assistance	81	85	84	83	77
School Supplies	25	13	17	14	9
Bus Fare	3	1	2	1	2
School Lunch	13	10	7	9	11
Food Packages	80	54	62	62	72
Funeral Grant	14	14	21	17	10
Household Appliances	17	18	24	21	23
Utilities	12	8	11	5	7
Child & Family Service	53	78	70	100	61
Adults Services	76	58	78	77	59
Probation & Parolees	5	3	6	6	4

Source: Data from the Social Services Department (MOHSS) as of February 27th, 2023.

3.22. Strategic partnership with the Montserrat Red Cross (MRC). The MRC has emerged as a leading non-governmental organisation, and one that has been very active in partnership with the MOHSS during the acute phase of the GOM's response to the COVID-19 pandemic, and also, for several years, in partnership with the Social Services Department. In particular, we found that the MRC receives an annual allocation of funds from the GOM to serve non-Montserratians, who are excluded from the regular welfare-services and grants of the Social Services Department. However, we found that the amount of support per beneficiary was very small and that the period of support was very limited, often a one-time assistance, and typically no more than 1 or 2 weeks/months. This indicates that a social-safety net does exist on the island, and that efforts are being made to engage NGOs and other stakeholders. However, overall, we found, and these stakeholders all agreed, that the scope and the scale of these efforts are well below the identified needs in the population.

3.23. The Montserrat Social Security Fund is important, but very limited in scope. Montserrat has a long history of social security systems with benefits including [1] small old-age grants, [2] modest old-age contributory pensions (now limited to insured persons over 65 years old), [3] up to 6 months of maternity-benefits, [4] limited periods and amounts of income-support during periods of certified sickness, and such like. However, there are major limitations on the amounts and the duration of each benefit, directly linked [a] to the income of contributors, and [b] subject to a benefit that is not full income-replacement, but is only a percentage of the actual insured earnings, which are further restricted in scope as they are subject to a ceiling on insurable earnings (E.C.$4,000 per month), which has not been incrementally adjusted for many years.

3.24. There are also gaps in the range of the island's social insurance: for example, unlike what is provided by National Insurance/Social Security systems in most other OECS/CARICOM countries, there is no provision for unemployment-benefits. This puts private-sector workers at the greatest risk. By contrast, most public-service employees are able to benefit from permanent and pensionable posts, and have full salary and benefits paid during periods of sickness, rather than the much lower benefit available to private-sector workers: a percentage of only the insured portion of salaries.

3.25. Conclusion on Budgets and Plans. The GOM has provided a number of healthcare services as well as social-welfare support through the MOHSS and indirectly through partners such as the Basic Needs Trust Fund and the Red Cross. However, public health-related education, multi-stakeholder engagement, health-promotion and disease-prevention, and attention to vulnerable groups, have not received enough attention, staffing, or funding to meet the needs of the population. The years of the COVID-19 pandemic, for example, recently exposed the high risks to social and economic wellbeing of workers and their families from being uninsured, under-insured, and, even when insured, having only a limited number of benefits. The spike in

unemployment arising from public-health and other policy-related measures, especially during years 2020 and 2021, revealed how critically important it is to have a strong safety-net that includes both comprehensive sickness-insurance benefits and unemployment-protection benefits. This becomes even more acutely needed when economic recessions, pandemics, natural disasters, and other crises cause widespread and/or prolonged periods of illness, reduced incomes, and/or loss of income/employment altogether.

Recommendations

3.26. Review budgets and operational plans to improve coherence across Departments. The MOHSS should work with the MOFEM and other stakeholders to identify opportunities for joint planning and joint budgeting, rather than the traditional approach whereby each Department is planning and budgeting for itself without regard to other parts of the GOM. For instance, examine instances in which more than one entity has similar or compatible plans, programmes, and budgeted resources. Then, determine ways to achieve synergies, whereby multiple individual departmental objectives can be achieved by shared implementation. In other cases, there could be advantages to realigning budgets to concentrate in one Department or programme the relevant resources from all Departments. This can achieve economies of scale, lower cost per unit of output, greater reach with fewer resources, and greater effectiveness through the collective expertise of more than one Department contributing to jointly beneficial programmes, projects, and outcomes.

3.27. Prioritise and re-allocate more resources and efforts to planning, health-promotion, and disease-prevention. The MOHSS should advocate through the MOFEM and through the Minster of Health to the Cabinet for appropriate allocations of staffing and other resources in proportion to the importance given to health and to national resilience in the SDP and in the Cabinet's Policy Agenda, starting with required funding for all posts that were approved but unfunded. To build a more resilient Montserrat, in line with the SDP's national vision of "A healthy and wholesome Montserrat", as well as to achieve the SDGs' ambition of improving the health and the quality of life for all persons, leaving no one behind, it is essential to reshape the paradigm of the public-health policies, budgets, practices, and systems, with the emphasis moving gradually away from increasingly expensive, reactive secondary care, and increasingly towards low-cost, high-impact, and proactive primary care.

3.28. Strengthen primary healthcare and health-equity. The MOHSS should increase its focus on early detection, early education, and more emphasis on prevention, including self-care, healthy diets, stress-management, self-monitoring of health-indicators, and active lifestyles, all of which can help to reduce the rising budgetary pressures created by escalating

costs of secondary care and tertiary care. It means, for instance, expanding health-checks, screening, counselling, and wellness-programmes to all workplaces (starting with those in the public service) and to all schools, rather than only selected age-groups. It also requires expanding the access of all age-groups to a full range of primary health-services. This requires a major improvement in both the quality and the quantum of the allocations of people, of funding, and of planning to health-promotion, healthy lifestyles, disease-prevention, nutrition, and wellness.

3.29. Strengthen healthcare through self-service & community-based initiatives.

Scientific developments and the lessons related to health, education, and public services before, during, and after a crisis, also present many opportunities to use telemedicine, and more web-based and mobile-phone technologies, for example, to have real-time monitoring and reporting, including health-metrics and self-reporting by patients/residents. These measures will support and interface well with the MOHSS's initiatives and plans for Health Information Systems, digital records, and transformation of healthcare. These recommendations will also enable better, broader, and more timely research and reporting of health-risks, health-trends, and health-outcomes, including the impact of programmes and projects.

3.30. The MOHSS should identify the resources required and advocate through the MOFEM and through the Minister of Health to the Cabinet for the necessary policy-framework and financial support. The MOHSS should also improve the coordination of efforts through sustained engagement with stakeholders such as [1] neighbourhood groups, [2] youth advocates, [3] corporate social responsibility, and brand/celebrity sponsorships, [4] NGOs, [5] workplace Health & Wellness Champions, and [6] harnessing, highlighting, and celebrating the power of good examples and positive peer-pressure. Through effective engagement of partners and stakeholders, many programmes can become partly or wholly self-funding, reducing the need for 100% public financing. (See the SDP: Goal-cluster #2: Enhanced Human Development; and Policy Agenda: items #2.1 and #2.2.)

3.31. Reduce medical, social, & economic costs/risks through national resilience.

The MOHSS should develop a comprehensive strategy to implement SDG #3, and work with other Ministries and stakeholders to harness the linkages of SDG #3 to the GOM's achievement of the other SDGs. The evidence of the pandemic reinforced the lesson that early planning and effective prevention and mitigation can save costs, lives, and livelihoods in a public-health emergency. However, the pandemic also revealed that the scourges of chronic lifestyle-related diseases (e.g., diabetes, hypertension, cardiovascular diseases, overweight, alcoholism, smoking, drug-abuse, food-addictions, and obesity) worsen the risks and the impacts of crises, and have a far greater annual and cumulative cost socially, economically, and fiscally. This area deserves much greater focus and sustained attention to ensure resilience not only to occasional international health-risks, but also to the continuing local risks that preventable diseases pose to

quality of life, to national productivity, to public-health budgets and staffing, and to national resilience.

3.32. Update social services in line with actual needs and price-inflation. To fulfil the principle of leaving no one behind, the MOHSS should submit proposals to the MOFEM and through the Minister of Health to the Cabinet to improve the coverage and the reach of the social safety-net. This should include factors such as (a) upgrades to the range of social services, (b) the uplifting of the ceiling for each benefit-amount in line with current costs/prices faced by beneficiaries, and (c) the widening of the criteria for eligibility, based on need, rather than considerations of ethnicity, age, country of birth, or immigration-status. In addition to supporting the achievement of the SDP and the SDGs, these recommendations build on the lessons of the recent pandemic: e.g., [1] the vulnerable groups face the highest risks in a crisis, but have the least means to face it; and [2] natural disasters, health-crises, and contagious diseases do not discriminate by nationality, by age, by legal status, by ethnicity, or by citizenship.

CHAPTER 4

BUILDING BLOCKS OF THE PUBLIC HEALTH SYSTEM

4.1. The W.H.O.'s framework for public-health systems guided us to consider five key building blocks: (1) healthcare financing, (2) healthcare workforce, (3) public-health supplies / infrastructure / equipment, (4) healthcare data and information-systems, and (5) leadership and governance. Chapters 2 and 6 present aspects of leadership/governance. Chapter 6 also outlines aspects relevant to information-systems and reporting. This Chapter 4 will emphasise aspects of human resources and financing for healthcare. Each of these 5 dimensions affects national resilience in the face of public-health emergencies and disasters. Together, they allow us to assess whether the GOM is providing adequate human, capital and financial resources to forecast, to prevent, to prepare for, and to respond to, public-health crises and disaster-management risks. To the extent of available data, we have highlighted progress and gaps in some key areas such as staffing and access to health-services.

Healthcare Workforce

4.2. We sought to assess whether the MOHSS has adequate, qualified, and skilled healthcare workers to manage existing and emerging health/disaster risks. Given the evident gaps in the workforce, we narrowed our focus to examining the numbers of workers and the levels of vacancies of posts in total and by category. Table 4.1 gives an outline of the range of services provided in the public-health system. Later in this chapter, Tables 4.3 to 4.6 show the nursing gaps in recent years.

TABLE 4.1: SUMMARY OF SERVICES WITHIN PRIMARY AND SECONDARY CARE

Primary Care	Paediatric Clinics at all four health-centres Doctors' clinics Home Visiting Diabetes/Hypertension Clinic: Foot care Eye Care and glaucoma screenings Workplace screening

	Maternal & Child Health Services: Antenatal and postnatal services Pap. smears Gynaecological clinic Child health (child welfare clinics) Reproductive Health /Family planning services School health Programmes Immunisation Disease Surveillance: COVID-19 Testing (e.g., Mondays and Wednesdays each week during year 2020) Contact Tracing Port Health Services Quarantine Management Mental Health Services: Psychology Services Prison Services/Visits Dental Services Environmental Health Health Promotion
Secondary Care	**Wards:** Obstetrics Paediatrics/Medical/Surgical/HDU/Accident Emergency/Operating Theatre Margetson Memorial Home/Isolation Unit **Weekly Outpatient Clinics:** Medical Outpatient Surgical Outpatient clinic Gynaecology clinic High-Risk Clinic for Obstetric Patients (2^{nd}/4^{th} Wednesdays of each month)

4.3. STRATEGIC ACTIONS & TARGETS

No.	STRATEGIC ACTIONS	TARGETS	Implementation Status	Status as at June, 2022
2.1.3	Strengthen the human resources capacity of the Health Department	Staff in place to adequately deliver services by December 2012	**Not achieved**	**Persistent shortages in several key areas, including nursing**

4.4 Montserrat has had a chronic shortage of nurses and other categories of workers for several years. It has often proven necessary to recruit doctors and nurses from other countries to fill several medical posts on the island. Several factors continue to affect the attraction of medical workers and their retention in the island's public-health system: e.g., issues of compensation; conditions of work; unresolved areas of dissatisfaction (including those represented by the Montserrat Nurses Association); retirement of veteran workers; emigration; inadequate local training and education for persons seeking to become medical workers on the island.

4.5 Extracts from the SDP: HUMAN DEVELOPMENT MEDIUM-TERM OBJECTIVE 1: Improve facilities and services for better health care delivery. TARGET: 25% increase in the range of specialized health care services available on island by December, 2012. 2.1.10 Implement initiatives to enable better access to tertiary health care in areas of greatest need; 40% increase in access to selected tertiary health care services by December 2010.

Table 4.2: Extracts from Medium-Term Objectives for Human Development

2.1.1	Revise confidentiality policy to be more specific to health care workers, including sanctions for breach of confidentiality	Revised and approved confidentiality policy by January 2010 Appropriate facility for acute care patients by December 2011
2.1.4	Implement initiatives to ensure optimum health and quality of life for persons living with HIV/AIDS	National HIV/AIDS policy developed and HIV/AIDS issues included in workplace and education policies by December 2011
2.1.6	Review mental health legislation, plan and policy to improve care of mentally-challenged individuals	Revised mental health legislation plan and policy by June 2010

Resource Gaps

4.6 The MOHSS has assessed its requirements of human resources and identified areas that need strengthening, as well as areas for new development. In such cases, the MOHSS has prepared business-cases and submitted new-spending requests through the MOFEM during the annual strategic planning cycle and budgetary processes. Ultimately, the vetted requests are evaluated, prioritised, and submitted to the Cabinet for approval. For example, several new positions were added in the Social Services Department over the past 5 years to address Elder Care, Child Protection, et cetera. This represents an important initiative to address vulnerable groups in line with the SDG principle of leaving no one behind. Within Primary Healthcare and Secondary Healthcare, staffing needs have been assessed over the years and new positions have been proposed by the MOHSS, but not all requests/needs have been fully met: for example, (a) issues with funding (e.g., the post of Family Nurse Practitioner in Primary Care was approved for a number of years, but was not funded); and (b) issues with recruitment. [See Tables 4.3 to 4.6.]

4.7 In reviewing data from the MOHSS, we saw that nursing shortages fluctuated from year to year. Within Primary Care, we observed that the overall shortage of nurses declined: from 6 in year 2019 to 5 in year 2020 to 4 in year 2021. This represented a 33% improvement over 2 years. By contrast, within Secondary Care, we observed that the overall shortage of nurses worsened: from 9 in year 2019 to 15 in year 2021. This represented a 67% worsening over 2 years. Across the public-health system, therefore, there was a net worsening of nursing shortages: from 15 in year 2019 to 19 in year 2021. This represented a 27% worsening over 2 years. [See Tables 4.3 to 4.6.]

Table 4.3: Ministry of Health: Summary of Nursing staff (Years 2019 to 2021)

Year	Established Nursing Posts	Persons Engaged in posts	Vacant posts
2021	55	36	19
2020	55	41	14
2019	52	37	15
Total			**48**

Table 4.4: Ministry of Health: Nursing staff (Year 2019)

	Year 2019		
	Established Posts	**Persons In posts**	**Vacant posts**
Primary Health Care			
Community Nursing Manager	1	1	0
Public Health Nurse	2	1	1
Community Psychiatric Nurse	1	0	1
Family Nurse Practitioner (Unfunded)	1	0	1
Psychiatric Nurse	1	1	0
Staff Nurse	4	2	2
Registered Nurse	2	2	0
Senior Enrolled Nursing Assistant	1	1	0
Enrolled Nursing Assistant	2	1	1
Total	**15**	**9**	**6**
Secondary Health Care			
Director Nursing Services	1	1	0
Hospital Nursing Manager	1	1	0
Nurse Tutor	1	1	0
Nurse Anaesthetist	1	1	0
Ward Sister	3	3	0
Charge Nurse/Home Manager	1	1	0
Staff Nurse	13	13	0
Registered Nurse	6	1	5
Senior Enrolled Nursing Assistant	2	1	1
Enrolled Nursing Assistant	8	5	3
Total	**37**	**28**	**9**
Grand totals	**52**	**37**	**15**

Table 4.5: Ministry of Health: Nursing staff (Year 2020)

	2020		
	Established Posts	**Persons In posts**	**Vacant posts**
Primary Health Care			
Community Nursing Manager	1	1	0
Public Health Nurse	2	1	1
Community Psychiatric Nurse	1	0	1
Family Nurse Practitioner (Unfunded)	1	0	1
Psychiatric Nurse	1	1	0
Staff Nurse	4	3	1
Registered Nurse	3	2	1
Senior Enrolled Nursing Assistant	0	0	0
Enrolled Nursing Assistant	2	2	0
Total	**15**	**10**	**5**
Secondary Health Care			
Director Nursing Services	1	1	0
Hospital Nursing Manager	1	1	0
Nurse Tutor	1	1	0
Nurse Anaesthetist	1	1	0
Ward Sister	3	3	0
Charge Nurse/Home Manager	1	0	1
Staff Nurse	12	12	0
Registered Nurse	6	5	1
Senior Enrolled Nursing Assistant	2	1	1
Enrolled Nursing Assistant	12	6	6
Total	**40**	**31**	**9**
Grand totals	**55**	**41**	**14**

Table 4.6: Ministry of Health: Nursing staff (Year 2021)

	2021		
	Established Posts	**Persons In posts**	**Vacant posts**
Primary Health Care			
Community Nursing Manager	1	1	0
Public Health Nurse	2	1	1
Community Psychiatric Nurse	1	1	0
Family Nurse Practitioner (Unfunded)	1	0	1
Psychiatric Nurse	1	1	0
Staff Nurse	4	3	1
Registered Nurse	3	2	1
Senior Enrolled Nursing Assistant	0	0	0
Enrolled Nursing Assistant	2	2	0
Total	**15**	**11**	**4**
Secondary Health Care			
Director Nursing Services	1	1	0
Hospital Nursing Manager	1	1	0
Nurse Tutor	1	1	0
Nurse Anaesthetist	1	1	0
Ward Sister	3	3	0
Charge Nurse/Home Manager	1	0	1
Staff Nurse	12	9	3
Registered Nurse	6	1	5
Senior Enrolled Nursing Assistant	2	2	0
Enrolled Nursing Assistant	12	6	6
Total	**40**	**25**	**15**
Grand totals	**55**	**36**	**19**

Capital Resources (hospital, clinics and equipment)

4.8 The sole national hospital (Glendon) is staffed and equipped mostly to provide basic services, emergency care, some types of surgery, and both in-patient and out-patient services**.** Extracts from the SDP show the lags in implementation and the significant gaps to date: e.g.,

No.	STRATEGIC ACTIONS TARGETS	Implementation Status	Status as at September 2022
2.1.2	Incorporate an acute care facility for the mentally ill within the national hospital compound Appropriate facility for acute care patients by December 2011	Not Met as of December, 2011	Being planned as part of the designs for the New Hospital Project (in progress during years 2020 to 2026).
2.1.8	Conduct a comprehensive assessment of infrastructural needs for Glendon Hospital	Met	In addition to previous assessments of needs, the MOHSS compiled a comprehensive list of items in place as well those needed for a fit-for-purpose hospital. The current contractor, Article 25, has done an updated review of the hospital's needs to be met through the new hospital to be built on the current site of Glendon Hospital.
	Approved site/building plan by June 2009	Not Met as of June, 2009	In January, 2020, the MOHSS engaged not for profit Article 25, which prepared preliminary designs for the new hospital in that year. Consequently, obtained contract (July, 2022) for detailed design costing $2.16 million with completion date of July, 2023. The final designs are required to prepare the site/building plan.

4.9 One of the objectives of the SDP is to "improve facilities and services for better health care delivery" by conducting a comprehensive assessment of infrastructural needs for Glendon Hospital. Following the widespread devastation resulting from Hurricane Hugo in year 1989, the restoration of infrastructure, which was concentrated in the south of the island, included a new hospital with 66 beds in Plymouth (then the capital city of the island). In 1995, soon after its completion, the new Glendon Hospital was destroyed during the volcanic eruptions. With the southern two thirds of the island designated an Exclusion Zone, the entire population was evacuated to the northern third of the island. All residences, businesses and public services are now in the northern third of Montserrat (the Safe Zone). Since then, emergency care and

secondary health-care have been offered at a 30-bed hospital in eight separate buildings (some 60 years old) in St. John (in the north of the island). This current reality reflects that the former hospital's operations in Plymouth were relocated to buildings that were originally designed to be used for a primary school, and they have been gradually adapted over the past 25 years to serve medical purposes.

TABLE 3.6: Ministry of Health & Social Services: Examples of Key Performance Indicators related to the National Hospital (fiscal years 2019/2020 to 2023/2024)

Secondary Healthcare					
KEY PERFORMANCE INDICATORS	**Actual for Fiscal Year 2019/2020**	**Estimate Fiscal Year 2020/2021**	**Target for FY 2021/2022**	**Target for FY 2022/2023**	**Target for FY 2023/2024**
A High Dependency Unit established at the Glendon Hospital	Unit functional by Q2 -equipment being procured	Mechanism for staffing the Unit worked out – Admission Policy drafted and approved	Unit fully functional	100% of staff trained to function in the HDU	100% of staff trained to function in the HDU
Biomedical Engineer in Post Equipment Replacement Policy & Plan developed	Application for post to be included on TC listing	Interview conducted and engineer in post.	Draft Equipment Replacement Plan and policy prepared	Draft Equipment Replacement Plan and policy agreed and implemented	Policy monitored for adherence.
All major critical equipment maintained as per the manufacturers' specifications	All major equipment maintained. Inventory and maintenance software installed and all equipment accounted for. Staff trained to use the new software Purchased new ultra-sound replacing the obsolete unit All equipment contract payments up to date. Maintenance contract purchased with each major piece of equipment	100% (provided that funding is available) SCAF submission made for incinerator and ambulance	100% (provided that funding is available) SCAF submission made for incinerator and ambulance	100%	100%

4.10 Need for new hospital (since 1995). Since the crisis of 1995, the MOHSS has had several consultancies in support of a new purpose-built hospital (e.g., Zeidler Consultants in 2014[13]). Findings included: (1) Low public satisfaction with the facilities; (2) Facilities are not fully hurricane resilient. The GOM and FCDO have agreed to the construction of a new 24-bed hospital with a modular design to accommodate daily peak demand (31), on the current Glendon Hospital site. It is evident from these[14] and other documents (e.g., the MOHSS's Quarterly Reports, budgets, and strategic plans) over the years that funding has been a key constraint for the MOHSS, requiring the British Government to provide project-specific approval, ongoing agreement, and sustained adequate funding to start and to complete such an important project.

4.11 CIPREG #1 fully funds a new hospital. Review of the Capital Investment Programme for Resilient Economic Growth (C.I.P.R.E.G.) (extending over years 2019 to 2024) showed that total funding of GBP 30 million (over E.C.$100 million) includes GBP 15.40 million (over E.C.$50 million) to finance a project for the development of a new national hospital on the current site of the Glendon Hospital. In January 2020, a not-for-profit contractor Article 25 was engaged to prepare preliminary designs for the new hospital. Our review of the Preliminary Design Report and relevant news-articles showed that the GOM and the team from Article 25 engaged multiple stakeholders, including two meetings with the Montserrat Association of Persons with Disabilities, which we attended, in consultations about the medical needs and the expectations of various segments of the local population regarding what would be a suitable design for Montserrat's new hospital. The outcome of the preliminary design consultancy was essential preparation for the detailed design consultancy, which will contribute to finalising the specific allocation of funding for the final design and for the hospital's construction costs.

4.12 Key objectives of the New National Hospital Project. The Health Project under CIPREG will: [1] provide a safe, fit for purpose, health and safety compliant, and hurricane-resilient and sustainable/low carbon facility for secondary health care provision; [2] create a safe and secure environment to prevent harm to the patient, health staff and others; [3] mitigate against the risks currently associated with the absence of a suitable facility for healthcare provision and with its low level of climate-resilience; and [4] create the enabling environment for sustainable provision of quality healthcare through an appropriate and integrated mix of local and off-island provision, and complementary health financing reform.

4.13 Progress re Detailed Design Phase of the new national hospital. In turn, the contract for the new hospital's detailed designs has been awarded (announced April 26, 2022) also to Article 25. We confirmed that the detailed agreement between the MOHSS/GOM and

[13] Cited in references for Appendix A: paragraph 4.2 part (f).

[14] For example, the MOHSS, in the contract for preliminary designs (2020), Appendix A: paragraph 4.2 part (d) (iii) explicitly acknowledges this.

Article 25 was signed and dated July 12th, 2022. The designers, under the supervision of the Ministry of Health and Social Services (MOHSS) and the Programme Management Office (PMO) in the Ministry of Finance and Economic Management (MOFEM), will be responsible for developing the selected preliminary design into fully detailed drawings and specifications, which will then enable the procurement of a contractor for the construction phase. In October, 2022, the contractors visited Montserrat for in-depth meetings with the MOHSS and other stakeholders to conclude the detailed designs. MOHSS and the Cabinet called for earlier start of construction.

4.14 SDG/SDP Review of the new National Hospital's detailed designs. In reviewing the Scope of Work, we found some especially noteworthy features of the planned designs that are relevant to the SDG 3.d framework and to the national targets in the SDP:

4.15 (a) **Standards:** Part 1 requires alignment of the designs with international standards (such as the U.K. Government's National Health Service's *Health Building Notes*[15], and the Pan-American Health Organisation's *Smart Hospitals Toolkit*[16]); in our assessment, these are vital aspects of ensuring a high-quality fit-for-purpose infrastructure for key aspects of the delivery of public health-services;

4.16 (b) **Sustainability:** Part 1 also requires the inclusion of environmentally sustainable elements throughout the design, construction and lifecycle operation of the hospital with particular regard to the choice of materials, methods of construction, site prep, demolition, power supply and utilization, and ventilation. We assessed that this is in line with the Cabinet's Policy Agenda and the Montserrat Energy Policy, which aims at supplying up to 100% of the island's energy-needs from renewable sources by year 2030; it also addresses the SDP's goal-cluster #3: Sustainable Environmental Management;

4.17 (c) **Resilience:** Part 2 stipulates elements to increase resilience against natural disasters: Hurricane resilience and seismic standards - a detailed confirmatory assessment is to be undertaken by specialist resources to confirm all aspects of the seismic and hurricane features of the building structure. In our assessment, this is extremely important for contributing to Montserrat's preparedness for disasters and for mitigating risks to the island's public-health systems, staff, patients, and infrastructure;

4.18 (d) **Elder care:** Part 2 also includes planning for better connection between the hospital and the Margetson Memorial facility for the care of the elderly; we assessed that this is an example of improving inclusivity and focus on vulnerable groups;

[15] UK Department of Health (2014). ***Health Building Note 00-01 General Design Guidance for Healthcare Buildings***.
[16] PAHO/IRIS (2017-12). ***Smart Hospitals Toolkit***. Pan American Health Organisation. Washington, D.C., U.S.A. Retrieved (October 06, 2022) at updated url: https://iris.paho.org/handle/10665.2/34977

4.19 (e) **Mental wellness:** Part 2 also includes: Mental health facilities - it is recognised that the preliminary design includes a specific place of safety room for clients with mental health conditions. During the detailed design, it was requested to explore and confirm which other single rooms could also be usable/adapted for this purpose. In line with the SDG principle of leaving no one behind, we assessed that this was an important element in identifying a major vulnerable group and in explicitly addressing its special needs. This is an area of emerging importance because the COVID-19 pandemic increased both the incidence of mental illnesses and the public awareness of mental health, and the need for better public-health measures to address it, including in schools, in vulnerable groups, among healthcare workers, and in institutional/residential populations (e.g., nursing homes, hospitals, and prisons).

Table 4.7: Outline of the New Hospital Project for Montserrat

STAGE OF PROJECT	STARTING DATE Actual/*Projected*	COST	STATUS
Preliminary designs	January, 2020	**E.C.$ 350,000 [U.S.$132,561]**	**The contract was awarded to Article 25 (architects). Work was completed.**
Detailed designs	July, 2022	**E.C.$ 2,160,860**	**The contract was awarded to Article 25 (architects). Planned duration = 12 months. Work is in progress.**
Construction oversight	*July/Aug., 2023*		**Planned Funding provided in CIPREG**
[a] Early site works [b] Margetson Memorial Home (care of the elderly) rebuilt	*2024*		**Planned Funding provided in CIPREG**
Main construction	*2025*		**Planned Funding provided in CIPREG**
[a] Installation of equipment, fixtures and furnishings [b] External Works	*2025* *2026*		**Planned Funding provided in CIPREG**
Total funding (CIPREG #1)		**GBP 15.4 million (roughly EC$50 million) (Note: the currency-rate has**	**Already provided**

		recently fluctuated between E.C.$3.00 and E.C.$3.70 per GBP)	
Addendum to CIPREG #1: Extra funding to cover projected escalating costs (in the construction phase) re recent years' pandemic disruptions & the current year's global supply-chain disruptions and high rate of inflation.		**GBP 4.0 million**	**Being negotiated with the FCDO**
Addendum to CIPREG #1: Extra funding to procure equipment for the new hospital.		**GBP 1.0 million**	**Being negotiated with the FCDO**

Sources: CIPREG #1; Contract for the Preliminary Designs; Contract for the Detailed Designs; data from the GOM's central Programme Management Office.

4.20 Aspects of procurement for the design-contractor. We found that the GOM selected Article 25 for a number of reasons, one of which was its relevant experience: it has done over 90 similar social/public projects in more than 30 other countries. Another reason was its focus on social projects and public/private partnerships, resulting in lower costs than what would be quoted by typical for-profit commercial contractors. The firm's name is derived from Article 25 of the United Nations' Universal Declaration of Human Rights, which states that everyone has the right to adequate and dignified shelter. The contractor's vision is of a world where all communities have access to better housing, safe school buildings and effective clinics and hospitals, and it provides the skills and the knowledge needed to make this a reality. In line with its humanitarian ethos, Article 25 incorporated an inclusive approach to stakeholders; e.g., the Montserrat Association of Persons with Disabilities was among the NGOs and stakeholders that were consulted during the planning. This respects the SDG principle of leaving no one behind.

4.21 Limited diversity of services. Several factors have limited the range of medical services on the island. Firstly, given the island's relatively small population, the pool of local talent is not enough to fill all of the technical and professional posts in the public service and within the MOHSS particularly. Secondly, it is not readily affordable to have full-time specialists for all areas of medical services; moreover, given the number of clients/patients in some areas, it also would not be value for money in some areas to pay full costs for having full-time specialists whose time and skills would then be under-used. Thirdly, since the volcanic crisis in 1995, the OAG's audits of the GOM's Public Accounts have confirmed that local revenues continue to form less than half of the GOM's budget, leaving it depending on grants and aid to fund most of its recurrent budget and almost all of its capital-budget. Accordingly, all net new spending and all

new posts added within the public require specific budgetary requests, approvals from the Cabinet, and then negotiations with the FCDO and/or other external donors[17].

4.22 Fourthly, having to recruit highly trained and experienced specialists internationally poses high costs to the MOHSS. For example, we noted that the remuneration packages in the GOM's Human Resources Management Unit's (HRMU's) advertised posts of recent years show that each physician/specialist costs the GOM over E.C.$300,000 per year. Even for the approved and funded posts, including those supported through the Technical Co-operation Fund, our research confirmed that regional and international competition for healthcare workers makes it difficult for Montserrat to attract suitably qualified specialists. Over time, it has also proven problematic to retain nurses, doctors and other technical and specialist skills.

4.23 Balancing the costs of recruitment and the scope and scale of demand for each service, the MOHSS has a small number of specialists/physicians: obstetrics/gynaecology; internal medicine; surgery; anaesthetics; physiotherapy; dentistry. All of these aforementioned factors also help to explain why the MOHSS has only one physician per specialty, necessitating special arrangements for interim services when a post-holder has any form of leave (e.g., vacation; sickness; overseas duties). The sole national hospital is staffed and equipped mostly to provide basic services, emergency care, some types of surgery, and both in-patient and out-patient services. However, because many specialties are not available on the island, residents often require overseas medical travel and/or have to await occasional visits by overseas practitioners. For example, there was no MRI machine in Montserrat; therefore, patients were frequently sent to neighbouring islands for MRI scans and diagnostics.

4.24 **Financial Resources Management.** One of the objectives of the SDP is to improve facilities and services for better healthcare-delivery by reviewing health-financing options re health insurance and user-fees and by implementing appropriate recommendations.

2.1.5	Review health financing options re: health insurance and user fees, and make appropriate recommendations	Health financing, medical and disability policy to meet the health financing needs of all persons in Montserrat by March 2010. Assessment: Target Not Met.

4.25 **Healthcare finance:** There is mostly public financing of healthcare. There are no private hospitals or clinics. There are five physicians that offer private services, including the public doctors that have their own offices to serve clients outside their public-service hours.

[17] E.g., GOM's support for small businesses was funded by the European Union: https://discovermni.com/2022/09/28/cabinet-approves-customs-exemptions-for-eds-and-business-relief-recipients/

Universal health coverage

4.26 All residents have access to the public clinics and the sole public hospital. Some services are provided at modest fees. Other services are provided at no personal charge for segments of the population: e.g., dental care and eyecare are provided as free public services to all children and to all senior citizens; inmates at the national prison receive free healthcare; social-welfare clients receive healthcare and other forms of public support; police officers and healthcare workers receive free healthcare. Other persons in the working-age population have to pay for some of these services privately (i.e., the sole public dentist has a private office for clients after work-hours).

4.27 The Montserrat Social Security Fund offers coverage for healthcare to all contributors in the workforce, both those in the public service and private-sector employees. In practice, we found that actual claims on the Social Security system for sickness-benefits are minimal; pension-benefits represent nearly all of the benefit-dollars disbursed each year. One contributing factor is that the GOM, which is the island's biggest employer, provides full salary and benefits for all public employees during periods of sickness-leave; therefore, there is no need for them to make a corresponding claim from the Social Security system, where sickness-benefit would be less than 100% of their insured salary.

4.28 The GOM, through the Office of the Deputy Governor, pays 100% of the health-insurance premia for all public servants who are members of the Montserrat Civil Service Association (M.C.S.A.). This Group Health Insurance can extend to cover the immediate family-members of public employees who are insured through the M.C.S.A.'s programme. As long as their M.C.S.A. fees are up to date, persons retiring or otherwise leaving the public service can also continue their coverage under this Group Health Insurance. The monthly fees for members of the M.C.S.A. are very small: E.C.$10 for regular membership; E.C.$5 for retired members and persons who have left the public service. This is an important example of inclusion and accessibility, including financial affordability for persons at all socio-economic levels within the public service. To put it in context, this membership-fee is well below 1% of the lowest Basic Salary scale in the public service. As a percentage of total income, the percentage is much smaller because, in addition to Basic Salary, many public servants receive allowances and other benefits.

Other Non-Infrastructure Healthcare Projects

4.29 Boosting on-island equipment/diagnostics. An important update to the fieldwork phase of our study was information received from the MOHSS's Project Managers and the from the MOFEM's Programme Management Office about some of the MOHSS's plans and initiatives beyond the New National Hospital Project. For example, the GOM has procured both

a long-awaited mammography machine (which was the focus of advocacy over several years by the NGO called the Pink Ribbon, on behalf of women's health and breast-cancer risks) and a CT Scanner. These and other vital items of equipment will boost the on-island diagnostic capabilities and reduce the number of patients needing to go overseas simply for diagnostics of these kinds.

4.30 Electronic records & information systems. Another aspect of the non-infrastructure projects is the MOHSS's in-progress project to scan archives and, in turn, to launch the system for Electronic Health Records. To date, the MOHSS has reported that ten years of archives have been scanned. Of far greater benefit will be a comprehensive Health Information System to integrate inputs from all Departments and service-providers, providing real-time access to comprehensive reports on all aspects of patients' care and other aspects of hospital/clinic administration. The integration of patients' inputs from physicians in their private practices and from pharmacies on the island will advance the cause of having accurate, complete and timely dashboards on each patient, thus reducing, for example, risks of duplicate care, duplicate prescriptions, unnecessary procedures, and misdiagnosis. The EHR and the HIS will also support a robust programme of local research, training, and education, making case-histories, healthcare data, and long-term trends more readily available to all stakeholders in public health. This will support SDP reporting, Voluntary National Reviews, and meeting the IHR.

Anti-Microbial Resistance (AMR)

4.31 Growing risks of human and veterinary AMR globally and regionally. One of the sub-areas within public health (and S.D.G. 3.d) is the issue of AMR, which is growing in prevalence worldwide, whereby pathogens mutate and antibiotics become less and less effective. In the worst cases, infections become untreatable and lead to severe morbidity, medical complications, and rising numbers of deaths (estimated over 5 million in year 2019). Factors include: [a] rising total human consumption of antibiotics; [b] rising incidence of the overuse and misuse of antibiotics; and [c] increased use of antibiotics in animals used for human consumption.

4.32 Low risk of veterinary AMR in Montserrat. In Montserrat, we found that controls over antibiotics are strong and centralised. For instance, The Veterinary Division of the Ministry of Agriculture, Lands, Housing and the Environment is solely responsible for the importation and the distribution of antibiotic medicines for use in animals. In light of this, the Chief Veterinary Officer procures and stores the antibiotics. As it is aware of antimicrobial resistance, the Veterinary Department strictly regulates the use of antibiotics in food-producing animals. The Chief Veterinary Officer distributes all medicines to the veterinary officers who administer these to the animals when requested by farmers. Animals treated with antibiotics are followed up by veterinary officers to ensure that they are not slaughtered before the withdrawal period. The

withdrawal period depends on the antibiotic being used to treat the animal. Each antibiotic is reported to have its own unique withdrawal period. Animals with any zoonotic diseases are prevented from entering the food-chain. The commercial feeds low in antibiotics are used instead of heavily medicated feed. Farmers are encouraged to practice good sanitation on farms. Veterinary officers also jointly inspect food-imports with Customs Officers to ensure that items intended for human consumption are suitable for sale. Special care is given to meats and other perishable items.

4.33 The MOHSS has not implemented a plan for AMR. We requested copies of the MOHSS's reporting to external authorities. In the IHR-format report that we received, entitled IHR State Party Self-Assessment Annual Reporting Tool, we noted that the MOHSS indicated that there was a plan for AMR, but that it had not been implemented. We found no data on AMR in humans in Montserrat. References to AMR do not appear in the national statistics that we reviewed. From the evidence that we received, we deduced that AMR has received very little attention in planning, in policy-formulation, in national reports, and in medical research on the island. The W.H.O. has warned that most new pathogens originate firstly in animals.

4.34 Low awareness of the One Health approach. Only two of the stakeholders that we interviewed conveyed an understanding of the W.H.O.'s One Health strategy. This strategy recognises that human health both affects, and is affected by, the interlinkages of food-chains, agriculture, plant-health, animal health (including pets and animals for human consumption), and environmental health. COVID-19, Dengue Fever, Zika, Avian Influenza, malaria, Swine Influenza, leptospirosis, harmful bacteria, and parasites, are just some of the well-known examples of risks that can cross species and/or international borders. Low awareness of these risks, coupled with inaction on a One Health approach, leads to a greater likelihood of being unprepared for the next local outbreak or international epidemic. The U.S. Government's *Centers for Disease Control and Prevention* has a dedicated website for One Health and assists other countries to implement it.

4.35 In reviewing budgets and plans, we found some relevant examples of measures that could contribute to national adoption of the One Health approach, if they are implemented, and if matched by complementing actions in other Departments and Ministries. See Table 4.8 below.

TABLE 4.8: Department of Environmental Health: Examples of Key Performance Indicators relevant to Public Health (fiscal years 2019/2020 to 2023/2024)

Environmental Health					
KEY PERFORMANCE INDICATORS	**Actual 2019- 2020**	**Estimate 2020-2021**	**Target 2021-2022**	**Target 2022-2023**	**Target 2023- 2024**

Food Safety Policy adopted and implemented	Develop first draft of Food Safety Policy using the OECS template	Review of draft policy by relevant stakeholders and Senior Policy Makers. Finalize the policy document for Cabinet approval.	Train/sensitize key stakeholders Commence and monitor implementation	Train/Retrain key stakeholders Monitor adherence to policy	Train/Retrai n key stakeholders Monitor adherence to policy
Food Safety Legislation enacted	Review proposed OECS draft legislation, submit concurrence or proposed changes. Review of the updated document by the AGs Chambers and Senior Stakeholders	Continue review proposed OECS draft legislation, submit concurrence or proposed changes. Review of the updated document by the AGs Chambers and Senior Stakeholders	Legislation drafted and circulated to stakeholders for consultation. Legislation finalized and submitted to Cabinet. Legislation submitted to Legislative Assembly for enactment	Ratify legislation. Train/Sensitiz e key stakeholders Commence and monitor implementati on	Monitor adherence
Multi-sectorial Task Force Established for increased stakeholder participation in Vector Control and other Health promoting activities	Develop TORs for Intersectoral Task Force Liaise with stakeholders to constitute the group.	Cabinet Paper Developed for the implementation of the Task Force	Task Force Operational Develop programme for Operations of Task Force Monitoring of Stakeholder participation and promotion activities	Monitoring of stakeholder participation and promotion activities	Monitoring of stakeholder participation and promotion activities
The introduction of a structured approach to air quality audits	Initiate the Action Plan for implementation of agreed approach. Finalize the Action Plan for implementation of agreed approach	Train/sensitize key stakeholders Commence and monitor the implementation of the action plan	Monitor implementation in line with the Air Quality protocol.	Perform Air Quality Audits as per protocols	Perform Air Quality Audits as per protocols

4.36 Conclusion on Public-Health Systems. The GOM has invested in a number of important initiatives and large projects to increase the range and the quality of healthcare services on the island. However, major gaps remain in information-systems, in records-management, in data-analytics and research, in the healthcare-workforce, and especially within the nursing staff. Partnerships with insurance-providers, with NGOs, and with external funding partners have boosted infrastructure, the reach of services, and the availability of health-security/financing coverage to under-served segments of the population. Yet, much remains to be done to provide [1] the level of service, [2] the number and types of modes of service, payments, and communication, [3] affordable access to service, and [4] the full range of health-services that the aging and increasingly diverse population needs and expects. The construction of a fit-for-purpose national hospital (long awaited after nearly 30 years since the previous one was destroyed by the volcanic eruptions), along with expanded use of digital records and electronic modes of operation, will likely improve the availability of useful data and the delivery of healthcare in coming years. However, acute vulnerabilities remain within the population and within the healthcare system as there is not yet true universal healthcare or health-insurance for all, and social services and social security remain limited in scope, coverage, and benefit-ceilings. The high and rising cost of airfares, and the persistent limitations of travel to and from the island add another layer of complexity, risk, and fiscal impact to an already challenging situation.

Recommendations

4.37 Urgently accelerate plans and efforts to close capacity-gaps in public healthcare. Given the large numbers of healthcare-related vacancies and their average duration over the past several years, it is urgent for the MOHSS and key stakeholders across the GOM, including the MOFEM, the HRMU, and the ODG, individually and collectively, to address the issues identified as barriers to recruitment and to retention of employees. Building on the recent successes of the partnership with Cuba during two years of the COVID-19 pandemic, (a) deepen existing partnerships and explore new ones within the O.E.C.S., the CARICOM, the U.K., and beyond, and (b) expand the number of effective initiatives for local training as well as overseas capacity-building (e.g., telemedicine, secondments, internships, e-learning platforms, virtual coaching and mentoring, regionally shared training of healthcare workers), for boosting the numbers of posts filled, and for creating and sustaining new capacity in high-priority areas in line with the SDP and to achieve the SDGs. (Policy Agenda: items #1.1, #1.2, #1.4, #2.1, #2.4, #4.2, and #5.2.)

4.38 Better include and address the needs of vulnerable groups. The MOHSS should expand the range of stakeholders identified and included in planning, in formulating policies, and in delivering programmes and services. By embedding the full spectrum of service-providers' and end-users' inputs in new initiatives, and by acting upon their feedback on past and

current ones, all Departments, including the MOHSS, can ensure better alignment of resources and service-delivery to stakeholders' different needs: e.g., physical challenges, mental challenges, those for whom English is a foreign language, low-income/unemployed households, the elderly, persons with various disabilities, those with limited mobility/access to transportation, et cetera. (See also SDP: Goal-cluster #2: Enhanced Human Development; Policy Agenda: items #2.3, #2.5, #2.9 and #2.10.) This includes making services and public facilities more accessible, more user-friendly, more affordable, and more flexible in their modes and hours of delivery. In line with the SDGs, these and other efforts can help to ensure that (a) no resident is left behind, and (b) public policies/programmes focus firstly on those who are furthest behind.

4.39 Update and implement a national plan for preventing and detecting AMR. The MOHSS should review and update its plans and capabilities for addressing the risks and the incidence of AMR. Given the global and CARICOM trends in AMR, and the cross-border movements of drugs, antibiotics, people, foods for humans, and feed for animals, the MOHSS should work with all stakeholders, including public and private-practice doctors, nurses, pharmacists, the Chief Veterinary Officer, etc., to coordinate policies and programmes both for humans and for animals. It should take actions to prevent AMR, as well as to detect and to document any evidence of actual or suspected past or existing cases of AMR in Montserrat, both in animals and in humans. These recommendations will be important for the safe and sustainable achievement of Policy Agenda: item #1.11, as well as SDG #3.

4.40 Implement the One Health strategy. The MOHSS should develop a strategic plan for the One Health approach, and lead Montserrat's implementation of the necessary national planning, preparedness, policies, infrastructure, organisational capacity, and building of resilience. This includes the need for broad public awareness of risks to public health, spanning humans, plants, animals, and the environment. It requires an integration of surveillance systems, regular monitoring, and timely reporting: e.g., across border-control, airport, seaports, coast guards/Marine Unit, public health, environmental health, veterinary health, food-safety, agriculture, tourism, hospitality, and travel, among other sectors. It also requires a comprehensive plan for related training and updating of the GOM's employees and other stakeholders. To supplement local resources and capacity, the MOHSS should partner with agencies, such as the P.A.H.O. and the U.S. C.D.C., which provide training, grants, and technical assistance to developing countries to strengthen their public-health systems. This supports the achievement of the Policy Agenda: item #1.2 and will be important for the achievement of Policy Agenda: item #1.11 alongside SDG #3.

4.41 Supplement and diversify healthcare financing. The MOHSS should advance policy-proposals and supporting business-cases to the MOFEM and through the Minister of Health to the Cabinet to identify and to assess the range of options for expanding the financing of healthcare. Among the options that this study has identified for consideration are:

[1] regular incremental increases in taxes on ultra-processed foodstuffs, alcohol, tobacco, added sugars/sweeteners, added salt, artificial ingredients, and manufactured beverages;

[2] adoption of a relatively small Health Levy (e.g., through normal payrolls, through pensions, and/or through the Social Security Fund);

[3] expansion of the contributions to the Social Security Fund to support broader insurance of the present and past contributors;

[4] introduction of a comprehensive framework for National Health Insurance;

[5] local, regional, and international partnerships (e.g., with philanthropic foundations, NGOs, multilateral agencies, medical universities, the Diaspora, and the private sector) to improve the range of healthcare services available to residents, as well as to broaden the accessibility of existing and new services.

The inclusion of a Health Levy as a percentage on pensions as well as on payrolls would [a] broaden the contribution-base, [b] improve equity (e.g., pensioners are already highly favoured with pensions being tax-free up to $60,000 per year, whilst employees' income is tax-free up to only $15,000 per year), and [c] better match contributions and benefits, as the elderly/pensioners are, as an age-cohort, the biggest users of healthcare services.

CHAPTER 5

LESSONS FROM RECENT PUBLIC-HEALTH CRISES

5.1 Early planning: The MOHSS planned early for pandemics/epidemics and was quickly able to update plans from the past decade to prepare for the current COVID-19 pandemic. Previous experiences in planning and preparing for regional/international threats/pandemics (e.g., S.A.R.S., M.E.R.S., H1N1 virus, Avian Influenza, Swine Influenza, Cholera, Ebola, Zika Virus, and Dengue Fever) helped public-health officials to be ready for the next/newest threats.

5.2 Early action: The MOHSS achieved early detection of the first confirmed case of COVID-19 arriving via Antigua in the first week of March, 2020. Supported by the Cabinet, the MOHSS implemented swift public-health measures to prevent spread of the Corona Virus from December, 2019, when the first international cases were reported, up to early March, 2020. Thereafter, the focus of public-health measures was to mitigate community-spread after the first local cases were identified (March, 2020). (See also Chapter 2.)

5.3 Strong successful protocols: These measures, including quarantine of all arriving passengers, mandatory pre-arrival and post-arrival COVID-19 testing, wearing of masks, and social distancing, worked very well to keep local confirmed cases to 13 in the first year of the pandemic. This total included the imported cases, as the arrival of COVID-19 in Montserrat was traced to an international passenger, and coincided with the annual peak of visitors' and tourists' arrivals for the two-week St. Patrick's Festival in March, 2020. (See also Chapter 2.)

5.4 Few COVID-19 cases and deaths (prior to 2022): Strong sustained measures not only minimised confirmed cases throughout the years 2020 (only 13 confirmed cases) and 2021, but also kept COVID-19-related deaths to 1 in the entire year 2020, 1 in year 2021, and 6 in year 2022 to date. This is a cumulative national total of 8 confirmed COVID-19-related deaths in three pandemic years in a population of close to 4,700 persons (Census of 2018). However, during year 2022, which was the third pandemic year, extremely contagious variants arose globally and regionally, alongside the reopening of borders, travel and tourism, causing spikes in local confirmed cases, including 6 related deaths. (See also Chapter 2.)

5.5 Vaccines readily available: Soon after the first emergency COVID-19 vaccines were developed and approved by regulators worldwide, vaccines against COVID-19 arrived in Montserrat in early February, 2021, thanks to the support of the British Government. The very first batch was sufficient to vaccinate fully 70% of the island's adult population. Additional

batches of vaccines have arrived since then, timed according to expiry-dates and to the population's expressed demand for vaccines.

5.6 Vaccine hesitancy: However, after an initial surge in voluntary vaccinations, progress slowed and has remained sluggish since then. To date, just over 2,000 persons have received one or both doses in a population that was last estimated at 4,649 (Census of 2018). However, this remains well below the P.A.H.O.'s target of fully vaccinating at least 70% of the population. As immunity wanes over time, the risks in the population continue to rise, both from low rates of primary vaccination, and from very low rates of updated vaccine-boosters, which many studies have shown to be important in protecting the elderly, the immune-compromised, and front-line workers in essential services.

5.7 Effective legislative framework: Over the years, we observed several instances that Bills were drafted but took long periods (up to several years) from drafting to presentation to the Legislative Assembly and then to go through First Reading, Second Reading, and Third Reading, to reach final approval and enactment. By contrast, we found that, during the past 3 years, there was a rapid drafting and approval of public-health orders with timely updates each time that a specific S.R.O. expired. This pattern continued from March, 2020, until September 30, 2022, when the most recent S.R.O. related to COVID-19 and the public-health emergency expired. (See also Chapter 2.)

5.8 Disaster-preparedness boosted public health: The national Disaster Management Coordination Agency (DMCA) had accumulated stocks of protective personal equipment (PPE) over many years from preparing for, and responding to, hurricanes, natural disasters, and other crises. At a time in the world that PPE and medical supplies were in great demand and not readily available to many countries, Montserrat was able to supply its healthcare workers adequately in the first year of the pandemic, by using on-island stocks from the past. This allowed a buffer until new purchases arrived on the island. This was an excellent example of interagency collaboration (horizontal coherence) and the MOHSS's engagement of other stakeholders.

5.9 Multi-stakeholder engagement: The Defence Force, the Police Service, the Red Cross and other stakeholders contributed to the national response to the COVID-19 pandemic. E.g., soldiers and police-officers assisting with keeping orderly queues and social distancing at supermarkets and public places; officers packing and/or delivering food-supplies for those in quarantine and for vulnerable persons; assistance to needy households, including those who lost business/incomes owing to national lockdowns, curfews, and/or were closed outright by public policies. The Red Cross was an example of a major non-governmental organisation that was engaged in the public-health efforts, including collecting and delivering prescribed medications, collecting grocery-orders and cash from quarantined/isolated persons, and buying and delivering

their groceries to their homes to minimise the risk that such persons would violate quarantine to seek food or other essential services.

5.10 Staffing gaps worsened: The shortages/vacancies of nurses, doctors, and other healthcare workers became urgent during the COVID-19 pandemic. The usual trends of [a] challenges in recruitment, [b] net emigration, [c] resignations, and [d] retirements contributed to the brain-drain. However, the pandemic itself created acute gaps because healthcare workers were unavailable for work for varying periods: e.g., vacation-leave, sickness-leave, and whenever they and/or members of their households were infected or otherwise quarantined. A recent news-article (May, 2022) indicated that there were only 6 nurses available at the moment. [See also Chapter 4.]

5.11 Temporary staffing boost from Cuba: Effective intergovernmental relations resulted in successful negotiations between the GOM and the Government of Cuba to send a contingent of 13 healthcare workers to Montserrat. The first contingent arrived in July, 2020, and was replenished periodically until the full contingent was suddenly recalled to Cuba at the end of March, 2022. Over these two years of support, the number of Cuban healthcare professionals ranged from a peak of 20 persons to a minimum of 8 persons. [Reference: *GOM's Response to COVID-19: Procurement of the Cuban Medical Brigade: Lessons-Learned Report* (published July, 2022), Office of the Auditor General.] [See also Chapter 4.]

TABLE 5.1: ALLOCATION OF CUBAN DOCTORS AND NURSES (13 Gaps filled)

Nurses	Doctors
Total of 8 nurses: 4 nurses assigned to Primary Care: St. John's Clinic - 1 Mental Health - 1 Cudjoe Head Clinic – 1 Salem Clinic - 1 4 nurses assigned to Secondary Care: Casualty/ Operating Theatre – 2 Male & Female Wards – 2	**Total of 5 Doctors:** 1 General Practitioner - assigned to Primary Care and to Secondary Care 1 Obstetrician/Gynaecologist - assigned to Primary Care and to Secondary care 1 Internist - assigned to Secondary care 1 Paediatrician - assigned to Primary Care and to Secondary Care 1 Anaesthetist - assigned to Secondary Care

Source: MOHSS: Status Report on the Cuban Medical Brigade (October, 2020).

IMPACTS TO DATE

Primary Health Care - Nursing

The composition of the nursing cohort for the Primary Care Department is fourteen as per the nominal roll; this includes the Community Nursing Manager.

TABLE 5.2: PRIMARY CARE: NUMBER OF NURSING POSTS AND THE ALLOCATION OF CUBAN NURSES (4 Gaps filled)

Categories of Nurses	Number of Posts	Status	Comments
Staff/District Nurses	**4**	1 in post 3 vacancies	Supported by 4 nurses from the Cuban Brigade.
Registered Nurses	**2**	2 in post	
Psychiatric Nurses: - 1 Community - 1 Psychiatric Nurse	**2**	1 in post 1 C.S.S.F.-funded for 6 months	Submitted as a Technical Co-operation Requirement for the long term. The P.N. is on study leave.
Public Health Nurses	**2**	2 in post	
Family Nurse Practitioner	**1**	0 in post	Awaiting arrival of Technical Co-operation - funded F.N.P.
Enrolled Nursing Assistant	**1**	1 in post	

Source: MOHSS: Status Report on the Cuban Medical Brigade (October, 2020).

Primary Health Care - Medical Officers

The composition of the posts for Medical Officers in Primary Care is as follows:

TABLE 5.3: PRIMARY CARE: NUMBER OF PHYSICIAN POSTS AND THE ALLOCATION OF CUBAN DOCTORS (3 Gaps filled)

Categories of Doctors	Number of Posts	Status
Medical Officers	**2**	In post
Paediatrician	**1**	Vacant (service being provided by a Cuban Paediatrician.)

Medical Officer	**0**	Head of the Cuban Brigade supports Covid-19 Sampling.
Obstetrician Gynaecologist	**0**	Post-holder supports both Primary Care and Secondary Care.

Source: MOHSS: Status Report on the Cuban Medical Brigade (October, 2020).

SECONDARY HEALTH CARE

Secondary Health Care - Medical Officers

The composition of the posts of Medical Officers in Secondary Care is as follows:

TABLE 5.4: SECONDARY CARE: NUMBER OF PHYSICIAN POSTS AND THE ALLOCATION OF CUBAN DOCTORS (3 Gaps filled)

Categories of Doctors	Number of Posts	Status
Surgeon Specialist	**1**	In post (acting as C.M.O.)
Internist (Physician Specialist)	**1**	Vacant (service is being provided by a Cuban Internist)
Medical Officers (Accident & Emergency)	**2**	In post
Obstetrician Gynaecologist	**1**	Vacant – (service is being provided by a Cuban Ob./Gyn.) (Active Recruitment is in progress)
Anaesthetist	**1**	In post Service also provided by Cuban Anaesthetist.

Source: MOHSS: Status Report on the Cuban Medical Brigade (October, 2020).

Secondary Health Care - Nursing

The composition of the Nursing services in Secondary Care is as follows:

TABLE 5.5: SECONDARY CARE: NUMBER OF NURSING POSTS AND THE ALLOCATION OF CUBAN NURSES (4 Gaps filled)

Categories of Nurses	Number of Posts	Status	Comments
Staff/District Nurses	**13**	11 in post	1 nurse on study leave
Ward Sisters	**3**	3 In post	
Home Care Manager	**1**	1 in post	
Nurse Anaesthetist	**1**	1 in post	
Nurse Tutor	**1**	1 in post	
Registered Nurses	**8**	0 in Post	Vacant – 8 posts
Senior Nursing Assistants	**2**	1 in post	Vacant – 1 post
Nursing Assistants	**12**	6 in post	Vacant – 6 posts

Support provided by 4 nurses from the Cuban Contingent.

Source: MOHSS: Status Report on the Cuban Medical Brigade (October, 2020).

5.12 Overwhelming of public-health systems: Montserrat did very well throughout the years 2020 and 2021 in minimising the number of infections and deaths related to COVID-19. However, the two recent large waves of cases (New Year, 2022, and April/May, 2022) brought great pressure to already strained public services. In these recent pandemic waves, the MOHSS announced a switch to emergency mode only, suspending most regular services (e.g., the public announcement early in January, 2022), owing to the lack of nurses. This shortage of nurses and other medical workers was made worse by the recall of the Cuban medical brigade (end of March, 2022), and by the number of healthcare workers temporarily unavailable during quarantine/isolation of them or members of their households. All available resources were being refocused on handling the newest wave of the COVID-19 crisis, which brought many more confirmed COVID-19 cases in a few weeks than in the previous two years combined. Since the arrival of COVID-19 vaccines in February, 2021, the St. John's clinic, for example, was the primary

location for persons to obtain COVID-19 vaccines. However, in the latest pandemic wave, this clinic was temporarily dedicated to contact-tracing, swabbing, and testing for COVID-19.

5.13 Resilience: Flexibility of services: Until recently, the swabbing service for COVID-19 (including persons requiring negative test-results for overseas travels) was done 8:30 a.m. to 10:00 a.m. Mondays to Fridays; test-results were available by 3:30 p.m. to 4:00 p.m. the same day. This was a significant increase in availability of service from a year earlier (e.g., late 2020 / early 2021) when swabbing was done by appointments only on Mondays and Wednesdays, testing was done the following day, and results were not available until 2 days after the swabbing. This was a major challenge for persons requiring certified COVID-19 test-results for overseas travel. E.g., during years 2021 and 2022, the U.S.A. tightened its requirements for arriving passengers: from having a COVID-19 test within 3 days before arrival, to having it within 24 hours of arrival.

5.14 Resilience: Surge-capacity of services: However, in the most recent pandemic wave (April, 2022, onward), the MOHSS greatly increased the availability of swabbing and testing services: swabbing was made available without appointments through the entire work-day and results were reported as early as the same day. This was to accommodate the very large surge in persons seeking or requiring COVID-19 tests either to diagnose their symptoms or to confirm their status as persons identified in contact-tracing related to persons with a confirmed positive test-result for COVID-19. This contributed to the Policy Agenda: item #2.1 (increased access).

5.15 Increased local testing capacity: One of the early successes during the first year of the pandemic was the increased local capacity of the national medical laboratory at the public hospital. This included added buildings/space, additional diagnostic equipment and supplies, and the training of the staff to do on-island testing for COVID-19. It meant being able to test persons for COVID-19 immediately rather than having to ship samples overseas to be tested in another country (e.g., CARPHA) and experiencing lags of a week or more between swabbing locally and getting test-results overseas. This contributed to the Policy Agenda: items #1.1 (sustainable self-sufficiency) and #2.1 (increased access).

CHAPTER 6:

MONITORING, REPORTING, FEEDBACK LOOPS, & COMMUNICATION

International Health Regulations (IHR) (2005)

6.1 Montserrat's framework and status. In order to strengthen health-systems resilience, the U.K. Government, as a member of the W.H.O., is required to measure its emergency preparedness capacities by adherence to the International Health Regulations (IHR) (2005) monitoring and evaluation framework. As Montserrat is a British Overseas Territory, the MOHSS advised us that it does not report to the W.H.O. directly, but rather to the British Government via Public Health England (which is now called the U.K. Health Security Agency). However, we confirmed that the MOHSS receives updates and alerts from the W.H.O./P.A.H.O. (e.g., regarding COVID-19 when it emerged internationally). Real-time communication helps countries, including Montserrat, to receive important global and regional information relevant to public health, allowing for early national and local planning, preparation, and response. Accordingly, we observed that the MOHSS's pandemic plans were activated and, in turn, the GOM's public-health orders and response to COVID-19 were prepared before the pandemic arrived in Montserrat.

6.2 IHR Core Capacities. The 13 core capacities in the IHR framework are: (1) National legislation, policy and financing; (2) Coordination and National Focal Point communications; (3) Surveillance; (4) Response; (5) Preparedness; (6) Risk communication; (7) Human resources; (8) Laboratory; (9) Points of entry; (10) Zoonotic events; (11) Food safety; (12) Chemical events; and (13) Radio-nuclear emergencies. A sample of the MOHSS's recent self-assessment against the IHR is provided in Appendix 1. It reflects a number of gaps in Montserrat's preparedness for future healthcare emergencies and, by extension, for disasters: e.g., plans drafted, but not activated; e.g., plans not in place; e.g., resources not dedicated to specific requirements.

6.3 MOHSS/Montserrat has not done IHR Joint External Reviews. An important element of the W.H.O.'s IHR framework, as well as contributing to the SDG framework, is periodic international reviews and independent assessments. In turn, this facilitates formal national reports for and within each country, as well as internationally (e.g., to the W.H.O.). J.E.R.s also provide assurance to all stakeholders about progress in strengthening the country's public-health system. However, the MOHSS/GOM has not done any J.E.R.s since the inauguration of the IHR in year 2005. A summary of the checklist of assessments for J.E.E.s is provided in Appendix 1.

6.4 GOM/Montserrat has not done SDG Voluntary National Reviews. An important element of the SDG framework, as well as the national SDP framework, is periodic national reviews and self-assessments. In turn, this facilitates formal national reports for and within each country, as well as internationally (e.g., to the W.H.O.). V.N.R.s also provide assurance and greater accountability and transparency to all stakeholders about progress in the country's journey towards the SDG targets and related national targets. However, the MOHSS/GOM has not done any V.N.R.s since the inauguration of the SDGs in year 2015.

6.5 Vertical integration: All Ministries and Departments are required to report quarterly to the MOFEM regarding their progress towards targets and their actual spending versus budgeted spending. The criteria that we selected for assessing this reporting were: compliance, timeliness, relevance and completeness. We reviewed Quarterly Reports for the MOHSS spanning years 2017/2018 to 2019/2020, confirming its regular compliance with this reporting. The MOFEM provided additional data of compliance spanning years 2017/2018 to 2021/2022. The MOHSS provided expected data and updates relevant to its budgets and strategic plans, as well as extensive Management discussion of the Ministry's various challenges and achievements. In terms of completeness, we observed that the MOHSS reported for all of its Programmes/Departments: Headquarters, Primary Healthcare, Secondary Healthcare, Environmental Health, and Social Services.

6.6 National Monitoring: All Ministries and Departments are required to report quarterly to the Monitoring & Evaluation Unit (MEU) (within the Office of the Premier) regarding their progress towards targets vis-à-vis the S.D.P. and the Policy Agenda. The criteria that we selected for assessing this reporting were: compliance, timeliness, relevance and completeness. From the samples and the data that we reviewed, we observed that the majority of Departments were compliant, but some were late, and a few did not report at all for some periods. Late and incomplete/inaccurate submissions by Departments delay the completion of the overall monitoring and reporting by the MEU. In turn, this affects the timeliness in publishing the NPR for the benefit of other stakeholders, including the public.

Table 6.1: Illustration of the MOHSS's Reported Indicators versus the SDP's Objectives

SDG 3 – ENSURE HEALTHY LIVES AND PROMOTE WELL BEING FOR ALL AT ALL AGES		
SDP 2 – ENHANCED HUMAN DEVELOPMENT AND IMPROVED QUALITY OF LIFE		
PERFORMANCE INDICATORS IN THE SDP (2008-2020)	INDICATORS ACTUALLY MEASURED AND PRACTICED (indicators from the MOHSS's Strategic Plan)	INDICATORS ACTUALLY REPORTED
Health financing, medical and disability policy to meet the health financing needs of all persons in Montserrat by March 2010	Progress on development and implementation of health financing reform	2020/21 - ToR's for Health Economist consultancy revised to focus on Package of Essential Care development
Revised mental health legislation plan and policy by June 2010	Existing Mental Health Policy reviewed, updated and implemented	2020/21 - No progress made during the year due to competing priorities
Staff in place to adequately deliver services by December 2012	One Protocol updated and training completed for >90% of relevant staff. # training opportunities to facilitate development of clinical skills	2020/21- Postpartum haemorrhage, Diabetes & Hypertension Discharge and Infection Prevention & Control training (Dietary staff) were conducted during the period. Echocardiogram (ECG) training which commenced in QUARTER 2 was completed in QUARTER 3 with assistance from Dr Osmar (Cuban specialist) 6 persons successfully completed the Supervisory Management Skills course with University of the West Indies, Cave Hill School of Business, Barbados.
National HIV/AIDS policy developed and HIV/AIDS issues included in workplace and education policies by Dec. 2011	[Not reported]	[Not reported]
Five-year strategic plan produced by March 2010 (this is in response to the strategic action which states – *Undertake a comprehensive health sector analysis and produce a strategic sector plan.*	Identified Legislation reviewed, updated & enforced as needed	2020/21 - Additional work which was done on Misuse of Drugs Act; Amendments to Quarantine Act; Amendments to Public Health Act drafted and circulated. Draft Regulations to Quarantine Act drafted and circulated Domestic Violence Bill was debated and passed in the Legislative Assembly. Stakeholder engagement undertaken for the Misuse of Drugs Act.

40% Increase in access to selected tertiary health care services by December 2010	Proportion of registered diabetics who complete an annual physical Proportion of registered hypertensive who complete an annual physical % of children identified as overweight: Number of persons reached through workplace screening for: Diabetes Obesity Hypertension	2020/21 - **TOTAL = 37 of 52 (71%)** 2020/21 - **TOTAL = 91 of 161 (57%)** 2020/21 - School Health Assessments were postponed due to 'lockdown' resulting from outbreak of COVID-19 cases and rollout of AstraZeneca Vaccination Programme in February/March **YEAR** 2020/21= 73 45M (62%) 28F (38%)
	% of target population receiving age appropriate vaccines during annual school health programme % of target population receiving 3rd dose of pentavalent vaccine	**2020/21**- School Health Programme postponed due to lockdown. (baseline - Baseline 2018/19: 4 – 5 yrs. old: OPV = 97.5.3% (39 of 40); DT = 97.6% (40 of 41). 9 – 13 yrs. olds: HPV = 15 yrs. olds: TD = 94% (50 of 53) OPV = 94% (50 of 53) 2020/21 -10 of 10 children TOTAL = 36 of 36 (100%)

6.7 National Reporting: The MEU produces and publishes each year a National Performance Monitoring (NPR) report, summarising Ministries' and Departments' progress against their targets and the S.D.P. There were no reports in earlier years, but, since our performance audit of the GOM's Strategic Planning & Budgeting (2018), the MEU has become regular in yearly reporting: so far, we have seen annual reports for the fiscal years 2017/2018, 2018/2019, and 2019/2020. In December, 2021, a draft was circulated internally to Departments for feedback for the fiscal year 2020/2021. This has subsequently been published in year 2022, providing 4 consecutive years of public reporting.

6.8 Compliance with reporting has improved, but gaps remain. The criteria that we selected for assessing this reporting were: compliance, timeliness, relevance and completeness. From the four years' reports and the data that we reviewed, we observed that the majority of Departments (including the MOHSS and its Departments) were compliant in providing at least some data, but some were late, and a few did not report at all for some periods. This has posed recurring challenges to the MEU to achieve timely publication of the annual NPR. Accordingly, each NPR was published, on average, at least one year after the fiscal year to which

it related. We also observed that not all of the objectives, indicators and targets in the SDP were reported in the NPR. In several instances, the reported data by Departments related to their stated objectives or targets for a period rather than the SDP directly. Overall, we concluded that there is moderate to good compliance, but timeliness, relevance and completeness require major improvements. Nevertheless, the internal reporting of the NPR has served to inform the Cabinet and Heads of Department about the GOM's progress against National Outcomes and, after publication, it gives other stakeholders a reader-friendly compendium of key targets of Departments and their progress towards them.

6.9 The DMCA has not submitted annual reports to the Governor/Legislative Assembly. The DMCA's governing Act requires that, within 3 months of the end of each fiscal year, the Director shall prepare an annual report to the Governor to be laid in the Legislative Assembly. The law further requires that the annual report shall include a Disaster Preparedness and Response Policy Review related to the mitigation of, preparedness for, response to and recovery from emergencies and disasters in Montserrat. However, no such reports were submitted or published during the years that we reviewed (2012 to 2022).

6.10 Absence of assessment and documentation of lessons learnt from crises/disasters. One of the requirements for national resilience is to record the country's observations, experiences and impacts during and following crises and disasters, each of which has public-health implications directly and indirectly (e.g., impacts on employees; impacts on patients; impacts on infrastructure; impacts on access to essential services including health-services). Montserrat has had repeated experiences of hurricanes, tropical storms, flooding, landslides, volcanic activities, and other hazards. However, the DMCA has not met the requirement of compiling and submitting Lessons Learned Reports annually. No such reports were done for any of the years that we reviewed (2012 to 2022).

6.11 The MOHSS & stakeholders did not document pandemic lessons. An important element of health system strengthening is the application of the lessons learnt from global and country experiences during public health emergencies. We also found that the MOHSS and other stakeholders had not robustly documented, reviewed, or acted upon experiences and lessons learned from recent public-health crises. For example, we sought from the MOHSS a full list of the dates and the nature of each interruption/curtailment of healthcare services, but no such data had been systematically recorded and collated. Thus, there is a high risk of the loss of valuable institutional memory as persons who were present during periods of crisis emigrate, resign, retire, die, or move to jobs outside the MOHSS/GOM. Incomplete records undermine the data-driven identification and seizing of opportunities for [i] improving inter-Departmental/Ministerial policy-coherence, [ii] joint planning, [iii] optimal budgeting, and [iv] more effective collaboration. These are critical elements for achieving whole-of-Government coherence, integration, and effective outcomes.

6.12 Reporting within the MOHSS: The four district (public) clinics report weekly to the Director of Primary Care within the MOHSS about the numbers and the types of patients seen. Highly contagious cases are reported to the Director of Primary Healthcare daily (immediately). The criteria that we selected for assessing this reporting were: timeliness, accuracy and completeness. In our site-visits to MOHSS locations, we saw examples of the weekly reports from the clinics to the Director of Primary Healthcare, spanning years 2020 to 2022. Whilst the reports were continually compiled, and are being compiled, the timeliness of reporting was impaired during the past two years, when the MOHSS was challenged with the COVID-19 pandemic. During this period, some administrative matters, including data-compilation and reporting, were delayed as a result of staff-shortages and as a result of the redirecting of available employees' efforts to the urgent public-health priorities as they arose. Nevertheless, daily reporting of exceptional cases (if any) allows the Director of Primary Healthcare to be alerted immediately to evidence of new outbreaks (e.g., new cases of COVID-19 in each wave of the pandemic) or cases that require additional help to diagnose/treat. This allows for prompt advice and interventions even when routine administration and reporting are interrupted or delayed.

6.13 Reporting by the MOHSS: The weekly reports from the clinics provide vital data of current reported instances of communicable diseases and other patient-conditions. In turn, these are collated to enable the Director of Primary Healthcare to do weekly reporting to the CARPHA. Weekly reports from the MOHSS (on behalf of Montserrat) and from Ministries of Health in other CARICOM territories allow CARPHA to provide timely surveillance regionally and to provide on-demand support to each territory as the need arises. In past public-health crises (e.g., H1N1), this support included on-island visits to Montserrat by experts (e.g., epidemiologist) from CARPHA to assist with planning for possible local outbreaks and to provide related training to MOHSS employees.

6.14 COVID-19 Reporting: There was a regular online publication of a COVID-19 dashboard to the public[18]. Whenever new cases of infection were confirmed, the dashboard was updated daily. In the periods of lull (e.g., most of 2020 and 2021), the dashboard was updated and published only as necessary. Persons who get it or access it then spread it widely to their groups and associates via WhatsApp, for example. Key indicators reported include: (a) the number of new confirmed cases; (b) the total of current active cases; (c) the number of active cases hospitalised; (d) the cumulative total of confirmed cases; (e) the cumulative total of deaths

[18] For example, the GIU's Facebook page has many examples of COVID-19 dashboards and public-health notices: https://scontent-atl3-2.xx.fbcdn.net/v/t39.30808-6/308627193_409687114643448_3171789346855611523_n.jpg?stp=dst-jpg_p526x296&_nc_cat=106&ccb=1-7&_nc_sid=730e14&_nc_ohc=UmiENQ3tu_AAX9Qb3YK&_nc_ht=scontent-atl3-2.xx&oh=00_AT_f8nJpzK4cI3mnU82mX2CM2Ihdze33jqUkzQ-QPFphfQ&oe=633806C6.

related to COVID-19 cases; (f) the cumulative total number of COVID-19 tests; (g) the cumulative number of positive test-results. Some dashboards included numbers of persons vaccinated.

6.15 The criteria that we selected for assessing this reporting were: timeliness, clarity, and reader-friendliness (e.g., clarity). The samples that we reviewed met the criteria of clarity and simplicity. There was also appealing use of colour. Timeliness was somewhat less than desired because updates were every several days or longer apart, rather than daily. However, overall, we concluded that the dashboards were effective in informing the public about trends in the local pandemic data and, in particular, were timely in alerting the public about new outbreaks or spikes in the trend of new confirmed COVID-19 cases.

Recommendations

6.16 Strengthen national reporting to be compliant with the W.H.O.'s International Health Reporting (2005). The MOHSS should immediately adopt international best practices and strengthen its record-keeping and reporting to satisfy all of the requirements and pillars of the IHR. In partnership with the DITES, the MOFEM, and the OOP (including the Monitoring & Evaluation Unit), the MOHSS should upgrades its I.T. systems and reporting capabilities to support all local, regional, and international reporting requirements, as well as to enable timely and comprehensive data-collection, data-analytics, and decision-making across the public sector. In turn, this will boost one of the 5 key pillars of the public-health system: healthcare information and systems. [See also Chapter 4.]

6.17 Implement Voluntary National Reviews. Towards the achievement of the Policy Agenda and the SDGs, the MOHSS should plan and prepare for regular V.N.R.s, engaging all relevant stakeholders. The MOHSS and GOM should identify and seek to make use of all available data, systems, supporting resources, colleagues, and relevant lessons and experiences from the IHR and V.N.R.s already conducted in the U.K., in other British Territories, in the O.E.C.S. and in CARICOM. The P.A.H.O. and the CARPHA are just two examples of multinational/ multilateral healthcare organisations with relevant experience, expertise, and case-studies to guide and to support the efforts in Montserrat.

6.18 Implement Joint External Evaluations & Independent Reviews. Along with stakeholders and partners such as the DMCA, the Montserrat Red Cross, and other Ministries and Departments across the GOM, the MOHSS should plan and prepare for external J.E.E.s and independent reviews of the island's public-health systems and national preparedness for health emergencies and natural disasters. By documenting the status quo adequately and getting the benefit of overseas experts to supplement local resources, the MOHSS/GOM can establish clear

and objective base-lines for each of the key metrics and benchmarks for the public-health systems, and set goals, timelines, milestones, and monitoring mechanisms to implement measures to continue to strengthen the public-health systems, and to act upon the lessons of recent crises and disasters in Montserrat and elsewhere in similar Small Island Developing States.

6.19 Improve multi-stakeholder engagement and public reporting and feedback systems. The MOHSS, along with other stakeholders, including the MOFEM, the Policy & Planning Unit, the Monitoring & Evaluation Unit, the DMCA, and the MALHE, should develop, coordinate, and implement mechanisms for engaging all stakeholders in the planning, the execution, and the review of V.N.R.s, J.E.E., and other such reviews. Establish baseline data (e.g., year 2005 for the IHR and year 2015 for the SDGs). Then, document and celebrate any incremental improvements achieved (1) since the previous assessment/review, and (2) cumulatively to date. Importantly, highlight (for immediate plans of action) the key weaknesses and risks most recently identified in Montserrat's public-health and related systems, infrastructure, data-management systems, human resources, and reporting practices.

6.20 Followed by providing high levels of transparency and accountability through regular reports to the public, along with national fora, at least annually, to allow all stakeholders, including vulnerable groups and NGOs, to provide inputs into reviews of national progress towards the strengthening of Montserrat's public-health systems and towards the SDP and the SDGs. This will improve public trust in the national health-systems (especially, the MOHSS), in collective preparedness and resilience for disasters (especially, the DMCA), and in the GOM generally. Regular effective engagement will also galvanise all segments of the population to contribute towards the key objectives of "a healthy and wholesome Montserrat", a return to national self-sufficiency, resilience, and sustainability.

6.21 Document and act upon the lessons of recent public-health crises. The MOHSS should robustly document the experiences and the lessons of recent crises, including the COVID-19 pandemic. In turn, it should engage with a wide range of stakeholders in sharing, reviewing, assessing, and acting upon the lessons gleaned by the MOHSS and by other stakeholders. Both failures and best practices from other countries should also be studied to buttress local insights and national preparedness for future emergencies, crises, and shocks.

6.22 Document and act upon the lessons of natural disasters and other crises. The DMCA should robustly document the experiences and the lessons of past and recent natural disasters, weather-related impacts, and other crises. In turn, it should engage with a wide range of stakeholders in sharing, reviewing, assessing, and acting upon the lessons gleaned by the DMCA, the MOHSS and by other stakeholders. Both failures and best practices from other countries should also be studied to support local insights and national preparedness for future shocks, threats, and hazards, all of which have public-health risks and consequences.

CHAPTER 7: MANAGEMENT RESPONSES

7.1 No Management Response from the MOHSS. On December 14th, 2022, the audit-team met with senior officials of the MOHSS, the primary audited entity, and presented and discussed the findings of this study. Subsequently, an updated draft of the audit-report was shared with them on January 27th, 2023, requesting formal comments by February 17th, 2023. When this deadline was missed, a further extension was offered until February 27th, 2023. Another reminder was given on May 19th, 2023. However, up to the time of printing, as of July, 2023, no Management Response was received on the draft from the MOHSS.

7.2. Management Response from the Director, DMCA. Thank you for providing the above captioned report. Pandemics are the remit of the Ministry of Health, however, given the national significance, our intention was to bring our stores, equipment and Human resources to bear to assist the people of Montserrat as best as we could. We are happy that our efforts are recognised in the report, this is evidence of the cooperative relationship we have built with our stakeholders while treating with the other Disaster hazards previously to the Pandemic and our appetite for collaboration.

I recognise that there are always room for improvement and we take on board the comments and suggestions made. Be assured that prior to receiving the report, actions have been taken on a number of the recommendations as we strive to improve on our delivery of Disaster Management.

I accept the report and its recommendations in good faith and will continue to address the areas highlighted.

APPENDIX 1: MONTSERRAT'S SELF-ASSESSMENT

This is a sample summary of the MOHSS's self-assessment for Montserrat regarding the W.H.O.'s IHR:

Indicators		
Level	**C1.1. Policy, legal and normative instruments**	
Level 1	The country has not conducted a mapping of relevant legal and normative instruments and policies for IHR implementation	Not compliant
C1.2. Gender Equality in health emergencies		
Level 1	No systematic assessment of gender gaps in any of the IHR capacities has been conducted Gender gap analyses completed in other sectors e.g. social services (gender balance for jobs etc.) but not for IHR and health emergencies to date.	Not compliant
C2.1. National IHR Focal Point functions		
Level 1	The terms of reference describing the roles and responsibilities of the established IHR National Focal Point are not in place or under development and represented by one individual who is entirely familiar with the mandatory National Focal Point functions under the IHR but lacks the authority, capacity and resources to effectively carry out these functions, including the around-the-clock accessibility	Not compliant
C2.2. Multisectoral coordination mechanisms		
Level 1	Multisectoral coordination mechanisms for IHR implementation are not in place or under development. Multisectoral coordination activities occur in ad hoc basis Cabinet appointing Public health advisory board which brings sectors together and feed into IHR but not yet in place.	Not compliant
C2.3. Advocacy for IHR implementation		
Level 2	The advocacy mechanisms are developed but not disseminated. Advocacy activities are conducted on ad hoc basis	Partly compliant
C3.1. Financing for IHR implementation		
Level 1	There Is no financial planning, budget line or budgetary allocation available to finance IHR implementation, and is handled through extra budgetary means no financial planning or budget line specifically allocated to IHR	Not compliant
C3.2. Financing for public health emergency response		
Level 1	Public financing for responding to public health emergencies is not identified and funds are allocated and distributed in an ad hoc manner	Not compliant
C4.1. Specimen referral and transport system		
Level 5	No system in place for transporting specimens from intermediate levels/districts to national laboratories; only ad hoc transportation is available Example COVID-19: CARPHA able to offer test (short lead-time) and mechanisms in place to send sample.	Partly compliant

C4.2. Implementation of a laboratory biosafety and biosecurity regime		
Level 2	National laboratory biosafety and biosecurity guidelines and/or regulations are in place and implemented by some laboratories at the national level guidelines/regulations do not include all labs (e.g. private labs)	Partly compliant
C4.3. Laboratory quality system		
Level 2	National quality standards have been developed but not implemented In progress - yet to start licensing. Gap analysis completed in December 2021. See attached.	Not compliant
C4.4. Laboratory testing capacity modalities		
Level 5	Laboratory system can perform in all capacities including access to whole genome sequencing; identification of unknown and high consequence pathogens and has access to viral culture. Laboratory networks configured to support all diagnostic services that are integrated are sustainable, with maximum population coverage, and exercised, reviewed, evaluated and updated on a regular basis as applicable NB Where systems do not exist locally, there is access to regional and international centres.	Partly compliant
C4.5. Effective national diagnostic network		
	Not applicable. There is one public laboratory (small population size)	Not compliant
C5.1. Early warning surveillance function		
Level 5	National guidelines and/or SOPs for surveillance have been developed and implemented at national, intermediate and local levels; and the system is exercised (as applicable), reviewed, evaluated and updated on a regular basis, with improvement at all levels in the country Surveillance mechanisms feed into regional bodies such as PAHO and CARPHA	Compliant
C5.2. Event management (i.e., verification, investigation, analysis, and dissemination of information)		
Level 5	Process or mechanisms for managing detected events is being implemented at national, intermediate and local levels, and exercised (as applicable), reviewed, evaluated and updated on a regular basis	Compliant
C6.1. Human resources for implementation of IHR		
Level 2	Appropriate human resources are available in relevant sectors at national level, to detect, assess, notify, report and respond to events according to IHR provisions	Compliant
C6.2. Workforce surge during a public health event		
Level 1	A national multisectoral workforce surge strategic plan in emergencies is not available or is under development	Not compliant
C7.1. Planning for health emergencies		
Level 2	All-hazard risk informed health emergency plan is developed but not being implemented	Not compliant
C7.2. Management of health emergency response		
Level 3	An incident management system integrated with a national public health emergency operations centre, or equivalent structure is in place and operational at the national and able to support intermediate levels	Compliant

C7.3. Emergency logistic and supply chain management		
Level 2	Emergency logistics and supply chain management system/mechanism is developed but not able to provide adequate support for health emergencies	Partly compliant
C8.1. Case management		
Level 5	National clinical case management guidelines for priority health events are implemented at all levels and are exercised (as applicable), reviewed, evaluated and updated on regular basis SOPs and guidelines have been developed, implemented and reviewed frequently for medical referrals overseas especially for trauma and other medical emergencies. Not for chemical events or radiation emergencies	Partly compliant

	C8.2. Utilization of health services	
Level 5	Strong levels of service utilization at all tertiary, secondary and primary health care facilities at national, intermediate and local level and geographical contexts (number of outpatient department visits per person per year ≥ 3.0 visit/person/year, in both urban and rural areas) and information on service utilization is reviewed, evaluated and updated on a regular basis to inform policy and planning Tertiary services are not available on island	Not compliant
C8.3. Continuity of essential health services (EHS)		
	Not applicable. EHS not formerly defined but the experience gained with COVID-19 has highlighted what these services are and the plan has been put into practice with the current pandemic.	Not compliant
C9.1. IPC programmes		
Level 2	An active national IPC programme or operational plan according to WHO minimum requirements exists but is not fully implemented. National IPC guidelines/ standards exist but are not fully implemented	Partly compliant
C9.2. Health care-associated infections (HCAI) surveillance		
Level 1	No national HCAI surveillance programme or national strategic plan for HCAI surveillance, including pathogens that are antimicrobial resistant and/or prone to outbreaks is available or under development Antimicrobial resistance action plan has been developed but not implemented.	Not compliant
C9.3. Safe environment in health facilities		
	N/A Current hospital is in a refurbished school building because of the volcanic eruption that began in 1996. WASH survey to be undertaken in 2022 by PAHO. Auditors' note: As of May, 2023, this study had still not taken place.	Partly compliant

N.B. Paragraphs in red provide the rationale for the response.

The Joint External Evaluation (J.E.E.) tool evaluates 19 technical areas:

1. National legislation, policy and financing
2. IHR coordination, communication and advocacy
3. Anti-microbial resistance (A.M.R.)
4. Zoonotic disease
5. Food safety
6. Biosafety and biosecurity
7. Immunisation
8. National laboratory systems
9. Real-time surveillance (Surveillance in the second edition)
10. Reporting
11. Workforce development (Human resources in the second edition)
12. Preparedness (Emergency preparedness in the second edition)
13. Emergency response operations
14. Linking public health and security authorities
15. Medical countermeasures and personnel deployment
16. Risk communication
17. Points of entry (P.O.E.)
18. Chemical events
19. Radiation emergencies.

APPENDIX 2: AUDIT FIELDWORK

Background

Health is a topic of broad public interest and is included in the United Nations' Sustainable Development Goals. The theme of resilience in public health was specially chosen by the INTOSAI for parallel study by Supreme Audit Institutions around the world (such as Montserrat's Office of the Auditor General) (commencing November, 2020) amidst the global COVID-19 pandemic, which quickly highlighted weaknesses in many countries' preparedness for emergencies. This performance audit focused on (1) the governance and processes of the MOHSS and the GOM's related Departments for planning and budgeting, overall and related to public health, (2) the GOM's policy framework and institutional arrangements, overall and particularly for public health, and (3) the MOHSS's and related Departments' efficiency, effectiveness, and accountability in their use of resources with implications for the resilience of the public-health system. These connected dimensions have implications (a) for governance, (b) for departmental stewardship of public funds and other assets, and (c) for the quality of outputs, of outcomes, and of the delivery of services to the public. In turn, the MOHSS's policies and operations impact every public employee and, in turn, public services, and especially public health-services, affect the economy and the society of Montserrat. This is important since, in the post-1995 era, the central GOM and the wider public sector constitute, directly and indirectly, about 75% of GDP and roughly 65% of full-time employment in the national economy, and they have numerous multiplier effects.

Objectives of the Audit

Purpose and mandate. The audit sought to examine Montserrat's progress in the implementation of the Sustainable Development Goals with a special focus on S.D.G. 3.d: Resilience in Public-Health Systems. The OAG has a comprehensive mandate under the Constitution Order of 2010 to examine efficiency, effectiveness and quality of service in the management of the public sector, including non-governmental entities, programmes or projects that get public funding. This facilitated a whole-of-Government approach in this study, while focusing on the MOHSS and related Departments, including the level of governance and the quality of the processes of planning, budgeting, and use of people and assets, with implications for public-health resilience. We considered (a) the quality of internal records, monitoring, and reporting, (b) the related management of human, financial, and other resources, (c) interviewees' reported issues, limitations, and challenges and their causes, and (d) their impact on the efficiency and effectiveness of participating Departments. Finally, the study aimed to assess the impact of the MOHSS and related entities in relation to major policies and strategic plans,

including [1] the GOM's Policy Agenda, and [2] the Montserrat Sustainable Development Plan (SDP) 2008 to 2020. In particular, we sought to identify the major planning challenges, budgeting deficiencies, and operational issues facing the MOHSS and related Departments, and, hence, opportunities and recommendations for improving their outputs and outcomes for all stakeholders in public health and disaster-management.

Key questions. This study was also related to some of the topics of interest to the public, e.g., arising from a focus-group with N.G.O.s, journalists, and civil-society representatives in February, 2020, and contributes to the OAG's mandate to provide assurance about the efficiency and the effectiveness of the GOM's spending. This audit sought to examine the extent and the effectiveness of the planning for public-health risks and the management of the public-health systems by the MOHSS and related Departments, including their level of governance, the quality of their processes of planning and budgeting, their use of people and assets, and their overall performance in contributing to national resilience against risks to public health and risks of disasters. The overall objective of the audit was to assess whether the GOM, and in particular the MOHSS, is building resilience in the public-health system:

Level 1 Audit Question: **To what extent is the government strengthening the national health system's capacities to forecast, to prevent and to prepare for public-health risks, building on emerging lessons learnt from recent public-health events?**

To answer this overarching question, we considered 4 Level-2 issues or themes in this study:

[A] **GOVERNANCE:** How is the Government putting in place [1] legal and policy frameworks and [2] institutional arrangements to take forward the lessons to enhance capacities [a] to forecast, [b] to prevent and [c] to prepare for risks to public health, through the country's legislation, policy, plans, budget and programmes, including the country's existing sustainable development strategy? [See Chapter 2.]

[B] **PLANNING:** To what extent has the government allocated the required financial and other non-financial resources to build health resilience while maintaining existing services? [See Chapter 3.]

[C] **RESOURCES:** How does the Government periodically assess its capacities [a] to forecast, [b] prevent and [c] to prepare for risks to public health, in line with meeting the S.D.G. 3.d targets? [See Chapter 4.]

[D] **MONITORING:** To what extent is the Government effective in [a] monitoring and [b] reporting to learn lessons for enhancing capacities [i] to forecast, [ii] to prevent, and [iii] to prepare for future risks to public health? [See Chapters 5 and 6.]

Finally, for this type of study, a performance audit of a country's implementation of the SDGs, we aim at doing a two-part assessment. In the first part, we seek to assess how well the GOM/country is progressing against its national targets that are relevant to the SDG being studied. In the second part, we assess how adequate the national targets are vis-à-vis the SDG, and how likely, on the current trajectory, the GOM/country will achieve the related SDG by 2030.

Criteria used.

Criteria used for assessing the strategic objectives in this audit were:

(1) Are there clear, stated objectives that are aligned to the overall strategy?

(2) Are there plans detailing how the objectives will be met?

(3) Are the related KPIs/metrics defined and explained?

Criteria used for assessing the key performance indicators (KPIs) in this audit were:

(1) Are KPIs clearly stated?

(2) Are KPIs correctly classified?

(3) Are KPIs appropriate?

(4) Are KPIs measurable and effective?

Criteria used for assessing the use of information in this audit were:

(1) Is there a clearly defined system of accountability?

(2) Are Departments regularly reporting their progress against budgets and strategic plans?

(3) Do reportees give appropriate and timely feedback to reporters?

(4) Is there evidence of an effective feedback-loop whereby measuring, reporting and monitoring of progress (or lack of it) results in timely actions and better decision-making?

Scope of the Performance Audit

The scope of this performance audit was to examine the progress of the public-health systems in Montserrat in relation to the U.N. SDG 3.d; the SDGs cover years 2015 to 2030. We emphasised the past 5 years' trends of planning, budgeting, and use of resources within the MOHSS and related Departments in managing the GOM's planning and response to public-health emergencies arising from national and international risks (e.g., COVID-19). We included the MOHSS, several related GOM departments, and representatives of the private sector/NGOs in our interviews of stakeholders in order to assess the perspectives and the experiences of stakeholders regarding the MOHSS and public health vis-à-vis their mandate, structure, efficiency, quality of outputs, communication, quality of service, and overall performance. Financial and other data-analyses focused mostly on the prior 5 years (i.e., fiscal years 2017/2018 to 2021/2022). Where we received information subsequent to our fieldwork, more recent updates are provided in some parts of the report.

Scale of the Performance Audit

The planned scale of this performance audit included the whole of Government in line with the principles of the SDG framework. Given multiple constraints, we narrowed our fieldwork to a selection of key stakeholders in the public service. Primary focus was on entities related to planning, financing, and/or managing public health, including [a] the MOHSS headquarters, [b] the MOFEM, [c] the MALHE (including Department of Environment and Veterinary Unit), [d] the Office of the Premier (e.g., Policy and Planning Unit; the Monitoring & Evaluation Unit), and [e] the GOM's Programme Management Office (re the New Hospital Project). Prior performance audits by the OAG, as well as past audits by the GOM's Internal Audit Department, provided additional data and perspectives of many other stakeholders and other areas relevant to the background of this study.

What We Excluded from this Audit

We excluded data preceding those of the year 2015 (the baseline for the SDGs), except for background knowledge and local context (e.g., Montserrat's SDP commenced in year 2008). We excluded comparative analyses and other cross-country reviews. We also largely excluded regional and international data sets, except for background information, thus emphasising Montserrat specific current and very recent historical data-sets.

Why We Performed This Audit

Accountability to external donors. In Montserrat, the public sector is largely funded by the UK Government through its Foreign, Commonwealth & Development Office (FCDO). Therefore, those providing aid have requested a series of performance reviews to provide greater assurance about public planning, budgeting, and implementation, including the efficient and effective use of people and other assets, all of which directly affect both the public sector and the private sector.

Health & National Development. Since much of the island's employment is within the public sector, the SDP aims at developing the private sector. However, a large percentage of the population remains dependent on the Government for public services, including healthcare, education (from pre-schools to the tertiary level), social housing, social welfare, and various forms of assistance with building or repairing private homes. Public funding and grants also extend to or through a variety of private entities (e.g., a primary school) and non-governmental institutions (e.g., Montserrat Red Cross; Montserrat Association for Persons with Disabilities). Transcending all segments of the population, including the workforce, universal access to adequate public healthcare is one of the top themes in the global Sustainable Development Goals. In turn, (a) economic development depends on a healthy workforce, (b) social development requires healthy and safe communities, and (c) environmental sustainability requires the integration of human health, animal health, and plant ecosystems. The COVID-19 pandemic illustrated how all of these areas of national development could be affected by a public-health emergency, compounded by the impact of natural disasters and climate-change.

Governance & Investment. Over 60% of the GOM's recurrent spending and about 90% of its capital spending are funded [1] by external aid from the UK Government and [2] by grants from multilateral institutions. Hence, the MPS faces increasing scrutiny and accountability [a] for the management of public funds, [b] for the execution of strategic plans, and [c] for the delivery of programmes, of projects, and of outputs. As it is entrusted with public lands, infrastructure, and the largest departmental percentage (over 22%) of the public service's employees and it is also mostly funded by the GOM's annual allocations through the oversight of the MOFEM, the MOHSS is accountable for the use of the public funds in each year's budget and operations.

How We Performed This Audit

Interviews & site-visits. Initially, we engaged in interviews with employees of the MOHSS and with senior public-sector officials across related departments, including site-visits to see the premises that they use. The list of interviewees is provided at the end of this Appendix. With the guidance provided by these meetings and inspections, we proceeded to devise

questionnaires and data gathering techniques suitable for the purpose of assessing (i) the governance of public health and of national preparedness for disasters across the MOHSS, other Ministries, the DMCA, and related Departments, including their legal framework, strategic planning and budgeting, (ii) the efficiency and the effectiveness of data gathering, reporting, human resources, and interdepartmental communication and co-operation related to the use of resources, and (iii) the recent trends, outputs, and outcomes of their uses of resources.

Reviews of relevant law, regulations and literature. Before and during our fieldwork, we researched the GOM's policies, laws, and regulations in order to establish the legislative framework for our performance audit. The programme of research also included literature on such relevant subjects as (a) governance, (b) strategic planning and national budgeting, (c) public sector efficiency and effectiveness, (d) monitoring and implementation, including project management and capital assets, and (f) performance benchmarks and standards of service. These sources supplemented our reviews of various internal and external documents related to the GOM's policies, structures, and operations affecting the issues of public planning, budgeting, procurement, and deployment of resources in the development of the public-health systems in Montserrat. [See, for example, Chapter 2.]

Internal & External Evidence. Various requests for information were made during November, 2021 to October, 2022. Site-visits and interviews were concluded within this period. Emphasis was placed on factors affecting the MOHSS's and the related Departments' governance, planning, budgets, implementation, asset management, efficiency, and performance related to building resilience in public health. In particular, we sought to know (a) whether there were adequate staffing, skills and other resources during the past several years, (b) issues affecting the MOHSS's processes, progress, and outputs, (c) the quality of reporting, communication, and co-operation among the stakeholders, and (d) recommendations/opportunities for improvements. Above all, we sought to get the stakeholders' perspectives and experiences in assessing the quality of public-health systems, the adequacy of planning and preparedness, and the country's progress in implementing improvements arising from the lessons of recent public-health emergencies and disasters. [See, for example, Chapter 5.]

Standards used. This audit was conducted according to standards promulgated by the International Organisation of Supreme Audit Institutions (INTOSAI) for performance audits. Those standards require that we plan and perform our audit in order to obtain sufficient and appropriate evidence to reach a reasonable conclusion about the performance of the entities/areas studied with regard to [a] their governance and [b] their management during the period under review. The international standards used to perform this audit-engagement and to assess the findings of this audit include ISSAI-P 12, ISSAI 100, ISSAI 3000, and GUID 3910.

Limitations & Challenges faced. [1] This audit was greatly impeded, in several cases, by prolonged delays in getting data, responses, and clarifications from some Departments. The obtaining of evidence and the clearance of draft findings required reminders and follow-up efforts extending from October, 2022, to March, 2023, when final submissions arrived from key stakeholders. [2] Major data-gaps were evident in responses and non-responses to several audit-queries. [3] At the end of the Planning Phase, the audit-team lost one of its members as of March, 2022. [4] The S.D.G. framework was complex and required extensive study and training, well beyond the timeframe and time-commitments originally anticipated. [5] Moreover, this special kind of national audit was a first-time experience for the O.A.G. and for all members of the audit-team. [6] INTOSAI/IDI recommended that the audit-team for each participating country include four well experienced Performance Auditors dedicated full-time to this study; however, OAG Montserrat has only two posts for the Performance Audit Unit. One member assisted from the Financial Audit Unit and one member assisted from the Compliance Audit Unit; however, they were not dedicated full-time to this study, which was both intensive and extensive.

Questionnaire for Interviewees

Correspondents & Interviewees

(1) The Permanent Secretary, MOHSS

(2) The Chief Medical Officer, MOHSS

(3) The Director, Primary Healthcare, MOHSS; also served as GOM's Epidemiologist

(4) The Director, Secondary Healthcare, MOHSS

(5) The Senior Assistant Secretary, MOHSS

(6) The Hospital Nursing Manager, MOHSS

(7) The Principal Environmental Health Officer, MOHSS

(8) The Chief Veterinary Officer, MALHE

(9) The Director, Environmental Management, MALHE

(10) The Chief Fisheries (Ocean Governance) Officer, MALHE

(11) The Director, Policy & Planning Unit, Office of the Premier

(12) The Monitoring & Evaluation Officer, Office of the Premier

(13) The Financial Secretary, MOFEM

(14) The Deputy Financial Secretary, MOFEM

(15) The Head, Programme Management Office, MOFEM

(16) The Director, Disaster Management Co-ordination Agency (DMCA)

(17) The Information & Education Officer, DMCA

(18) The Hospital Project Manager (MOHSS)

(19) The Director, Montserrat Red Cross

(20) The Programme Officer, Montserrat Red Cross

(21) The Director, Social Services Department

(22) The Project Manager, Non-Infrastructure Projects (MOHSS)