A Special Report of the Auditor General of the Republic of Trinidad and Tobago

SUSTAINABLE DEVELOPMENT GOAL 3 TARGET d

CONTRIBUTING TOWARDS A STRONG AND RESILIENT NATIONAL PUBLIC HEALTH SYSTEM (2016-2021)

Prepared and presented under
Section 116 of the Constitution of the Republic of Trinidad and Tobago
and
Section 25 (4) of the
Exchequer and Audit Act, Chapter 69:01

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ACRONYMS & ABBREVIATIONS

ACRONYM	MEANING
AGD	Auditor General's Department of the Republic of Trinidad of Tobago
AAR	After Action Review
AATT	Airports Authority of Trinidad and Tobago
ARABOSAI	Arab Organization of Supreme Audit Institutions
ASOSAI	Asian Organization of Supreme Audit Institutions
CARICOM	Caribbean Community
CAROSAI	Caribbean Organization of Supreme Audit Institutions
CARPHA	Caribbean Public Health Agency
CDEMA	Caribbean Disaster Emergency Management Agency
CDM	Comprehensive Disaster Management
CMMF	Couva Medical & Multi-Training Facility
CMO	Chief Medical Officer
CT Scan	Computerized Tomography Scan
Echo	Echocardiogram
EOC	Emergency Operations Centre
ERHA	Eastern Regional Health Authority
FAO	United Nations Food and Agriculture Organisation
GoRTT	Government of the Republic of Trinidad and Tobago
HFA	Hyogo Framework for Action
HSF	Heritage and Stabilisation Fund
IATA	International Air Transport Association
ICAO	International Civil Aviation Organization
IDB	Inter-American Development Bank
IDI	INTOSAI Development Initiative
IHR	International Health Regulations (2005)
IHR NFP	International Health Regulations National Focal Point
INTOSAI	International Organization of Supreme Audit Institutions
MoH	Ministry of Health
MSDFS	Ministry of Social Development and Family Services
NCD	Non-Communicable Disease
NCRHA	North Central Regional Health Authority
NDRF	National Disaster Relief Fund
NDS	National Development Strategy
NGOs	Non-Governmental Organizations
NPF	National Performance Framework
NWRHA	North West Regional Health Authority
ODPM	Office of Disaster Preparedness and Management
PAAC	Public Administration and Appropriations Committee
PAHO	Pan American Health Organization

ACRONYM	MEANING
PSIP	Public Sector Investment Programme
RHA	Regional Health Authority
SAI	Supreme Audit Institution
SARS	Severe Acute Respiratory Syndrome
SDG	Sustainable Development Goal
SPAR	State Parties Self-Assessment Annual Reporting
SWRHA	South West Regional Health Authority
T&T	Trinidad and Tobago
T&TMA	Trinidad and Tobago Medical Association
TRHA	Tobago Regional Health Authority
TTRNA	Trinidad and Tobago Registered Nurses Association
UN	United Nations
WHO	World Health Organization

GLOSSARY

WORD / PHRASE	DEFINITION
After Action Review	An in-depth review of the response actions taken during an actual public health event and is done within three months of specific real events in order to identify gaps, lessons learnt and best practice.
Audit of SDGs implementation	A performance audit (PA) that focuses on achievement of nationally-agreed targets linked to SDG targets. The performance audit does not focus on entities, projects, programmes or processes, but rather the interplay between them for achievement of cross-cutting results.
Contingency fund	Reserves of money set aside for unexpected expenses.
Health	A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity
Health care	The prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical, nursing, and allied health professions.
Health resilience	The ability of health systems not only to prepare for shocks, but also to minimize the negative consequences of such disruptions, recover as quickly as possible, and adapt by learning lessons from the experience to become better performing and more prepared.
Health Shocks	A sudden and extreme change which impacts on a health system, and is different from predictable health system stresses, such as population ageing
Health worker density and distribution	The number of health workers available in a country relative to the total population
Healthcare	The set of medical services that an organization or country provides.
Healthcare worker	Anyone who works in a healthcare or social care setting, including healthcare students on clinical placement, frontline healthcare workers and other healthcare workers not in direct patient contact.
Horizontal coherence	Takes into account interdependencies in dimensions and sectors, manages trade-offs and conflicting policy priorities and maximizes synergies between mutually supportive policies
IHR core capacity index	The average percentage of attributes of 13 core capacities that have been attained at a specific point in time. The 13 core capacities 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

WORD / PHRASE	DEFINITION
	events; (11) Food safety; (12) Chemical events; (13) Radio nuclear emergencies.
IHR Monitoring Framework Coordination	A key requisite for IHR implementation requiring multisectoral / multidisciplinary approaches through national partnerships for effective alert and response systems.
IHR Monitoring Framework Legislation	The range of legal, administrative or other governmental instruments which may be available for States Parties to implement the IHR. This includes legally binding instruments, legally non-binding instruments, and other types of instruments. This encompasses legislation in all sectors at all applicable governmental levels.
Leave No One Behind	The commitment to eradicate poverty in all its forms, end discrimination and exclusion, and reduce the inequalities and vulnerabilities that leave people behind and undermine the potential of individuals and of humanity as a whole.
Lessons learnt	The identification, documentation and evaluation of the knowledge gained from the process of conducting a project. This includes the positives and negatives
Multi-Stakeholder Engagement	A practice of governance that employs bringing multiple stakeholders together to participate in dialogue, decision making, and implementation of responses to jointly perceived problems.
National IHR Focal Point"	The national centre, designated by each State Party, which shall be accessible at all times for communications with WHO IHR Contact Points under the IHR Regulations (2005);
Patient care	Persons directly responsible for a patient's care. For example, prescribing medication, performing procedures, directing a course of treatment
Public health emergencies	Severe events (including disasters) impacting or threatening the lives and well-being of a large number of people and requiring substantial multi-sectoral assistance.
Public health risks	Something that is likely to be harmful to human health or contribute to disease in a population.
Strong and resilient public health system	Is the capacity of health actors, institutions and populations to prepare for and effectively respond to crises while maintaining core functions when a crisis hits and to learn from shocks.
Simulation	Imitation of a situation or process.
Simulation exercise	A form of practice, training, monitoring or evaluation of capabilities, involving the description or simulation of an emergency to which a described or simulated response is made.
T&T's Parallel Healthcare System	Unique to T&T and apart from the regular healthcare system - a series of hospitals and hotels put in place to manage COVID-19 cases, from quarantine to healthcare to

WORD / PHRASE	DEFINITION
	step-down facilities, and has been one of the key responses by the Ministry of Health to the COVID-19 pandemic
Table top simulation exercise	Involves key personnel discussing **simulated** scenarios in an informal setting and is less intense than a full scale simulation.
Vertical coherence	A consistent approach across all levels of government to ensure that the implementation process reflects local, regional and global considerations
Vulnerable groups	A population that is at higher risk of falling into poverty and includes the elderly, the mentally and physically disabled, at-risk children and youth, internally displaced people and returning refugees, HIV/AIDS- affected individuals and households, religious and ethnic minorities and, in some societies, women.
WHO IHR Contact point	The unit within WHO which shall be accessible at all times for communications with the National IHR Focal Point.
Whole of Government Approach	The joint activities performed by diverse ministries, public administrations and public agencies in order to provide a common solution to particular problems or issues.

Glossary Sources: World Health Organisation, INTOSAI Development Initiative (IDI) – ISAM SDG Audit Model, University of South Florida, International Issues on Health Economics and Management, 2010, TISSL International Publications, New Delhi, India.

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PREFACE

The Auditor General of the Republic of Trinidad and Tobago is a constitutional office with responsibility for oversight of public finances. This Office is the country's external auditor and is therefore a key player in Trinidad and Tobago's accountability chain. Whilst the audits of financial statements and accounts form the core part of its audit portfolio, the work of the Auditor General's Department (AGD) has moved beyond this traditional activity to include audit reports that have contributed findings which can lead to more informed policy-making. These types of audit reports have, in the main, taken a broader and more comprehensive approach by examining the reliability, effectiveness, efficiency and economy of certain governmental programmes and functions.

Within the scope of this latter audit portfolio, the Auditor General entered into an agreement with the INTOSAI Development Initiative (IDI) to be part of a global initiative that aimed to examine governments' efforts to strengthen capacities for early warning, risk reduction and management of national and global health risks (Sustainable Development Goal (SDG) target 3.d). The main objective of this audit was to enhance Supreme Audit Institutions' contributions to strong and resilient national public health systems that lead to good health and wellbeing for all.

The rational which has underpinned this global audit strategy is that governance structures can no longer operate in silos, a whole of government approach is essential to achieve unity of effort towards a shared goal of a strong and resilient public health system.

The implementation of SDG 3.d is therefore everyone's concern and we each have a role to play from Parliamentarians/Legislators, State enterprises, academia, private sector, NGOs to citizens. As the Supreme Audit Institution (SAI) of Trinidad and Tobago, we aim to make a difference to the lives of citizens of Trinidad and Tobago by responding appropriately to the challenges of citizens, the expectations of different stakeholders, and the emerging risks and changing environments in which audits are conducted.

The Auditor General as the SAI of Trinidad and Tobago sought to address one such challenge by providing a relevant audit response, on government's efforts to strengthen capacities for early warning, risk reduction and management of national and global health risks (SDG target 3.d) and participated in the cooperative audit of strong and resilient national public health systems (linked to SDG target 3.d). This audit was conducted under the umbrella of the IDI and the INTOSAI Knowledge Sharing Committee (KSC) within the INTOSAI Regions (ASOSAI, ARABOSAI and CAROSAI). Knowledge support was also provided through the assistance of the World Health Organization (WHO).

I am therefore pleased to present to the national community the Special Report of the Auditor General of the Republic of Trinidad and Tobago on Sustainable Development Goal 3.d (Contributing Towards Strong and Resilient National Public Health System 2016-2021).

Lorelly Pujadas
Auditor General of the Republic of Trinidad and Tobago

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The Auditor General gratefully acknowledges the kind assistance and co-operation given to staff of the Auditor General's Department during the conduct of this audit by the following:

- The Permanent Secretary, Chief Medical Officer and other staff of the Ministry of Health.
- Staff of the Regional Health Authorities of Trinidad and Tobago
- Staff of the Regional Corporations
- The Ministry of Planning and Development, Office of Disaster Preparedness and Management and the Airports Authority of Trinidad and Tobago.
- Trinidad and Tobago Registered Nursing Association, the Medical Association of Trinidad and Tobago and NGOs representing health advocacy groups.
- The PAHO/WHO Representative in Trinidad and Tobago
- Fellow SAIs who shared their own experiences and critique for the audit.

Special thanks is extended to INTOSAI Development Initiative (IDI) for providing the training and valuable support for this pioneer audit and the World Health Organization for their expert advice and assistance during the planning phase of the audit.

Sincere appreciation is also extended to the officers of the Auditor General's Department whose efforts contributed to the successful completion of this assignment.

SPECIAL REPORT OF THE AUDITOR GENERAL ON SUSTAINABLE DEVELOPMENT GOAL 3.d– CONTRIBUTING TOWARDS STRONG AND RESILIENT NATIONAL PUBLIC HEALTH SYSTEM

The Government of Trinidad and Tobago needs to interlink the Building Blocks of the Health System within a Whole of Government Approach through clear leadership and coherence to ensure successful implementation of Sustainable Development Goal 3.d.

EXECUTIVE SUMMARY

1. A resilient public health system is the capacity of health actors, institutions, and populations to prepare for and effectively respond to crises while maintaining core functions when a crisis hits. While the public health infrastructure and capabilities are the bedrock for resilience; the building blocks within the system such as governance and leadership, human resources, funding, information systems, medical products and monitoring must fit together to also ensure resilience.

2. This study examined the progress made by the Government of the Republic of Trinidad and Tobago (GoRTT) to achieve its national targets under the Sustainable Development Goal (SDG) 3.d.1 of the United Nations Agenda 2030; to strengthen the health system's capacities to forecast, prevent and prepare for public health risks and building on emerging lessons learnt from recent public health events. It also determines the extent of achievement within a whole of government approach[1], the level of multi-stakeholder engagements[2] and whether no one was left behind[3] such as the impoverished, migrants, children and youth, elderly, differently abled and the socially displaced.

3. The national health targets of a sustainable and modern healthcare system and wellness for all are aligned to the World Health Organization (WHO) International Health Regulations (IHR) 2005 core capacity index as well as the IHR Monitoring and Evaluation Framework.

4. The Ministry of Planning and Development (MPD) has the lead role in the achievement of the SDGs. The Ministry of Health (MoH) also has a key role through the Regional Health Authorities (RHAs) and the National Focal Point (NFP) within a whole of government approach to accomplish SDG 3.d. for a strong and resilient public health system.

[1] This approach shifts the focus of government performance towards the results that government seeks to achieve to address a societal problem or challenge rather than the operations of any single programme or agency (ISAM – IDI – SDG- Audit Model)

[2] The participation of stakeholders promotes effective decisions, by giving groups affected by those decisions the opportunity to communicate their needs and interests, and support government in tailoring, implementing and reviewing public policies. (ISAM – IDI – SDG- Audit Model)

[3] All persons living in extreme poverty can be considered "left behind' as can those who endure disadvantages or deprivations to limit their choices and opportunities relative to others in society. (ISAM- IDI-SDG-Audit Model)

KEY FINDINGS

Capacities and resources for health resilience

5. **The distribution of public healthcare facilities contributes to accessibility for citizens.** The spread of 119 public health facilities including 12 hospitals across the five RHAs was aligned to population densities across both islands.

6. **The provision of human resources needs strengthening to meet the demands of the public healthcare system.** The national baseline indicator in 2017 was 1.1 and 3.5 physicians and nursing personnel respectively per 1,000 population. The current ratio according to the MoH for T&T is 1 doctor, nurse and midwife per 1,000 population. This ratio is below WHO recommendation of 4.45 doctors, nurses and midwives per 1,000 population. Assessment of approximately 17,682 positions directly linked to providing patient care across four RHAs (excluding Eastern Regional Health Authority - ERHA), indicated that 6,647 or 37.6% of the established positions were vacant at the end of 2021. The highest number of vacancies across the RHAs were in the nursing profession.

7. **Public healthcare professionals' access to suitable equipment to deliver healthcare needs to improve.** Representatives from health associations and private health institutions during a series of focus group meetings, expressed concern over delays in administering diagnostic treatment in the public health facilities. Our survey of 319 healthcare workers also revealed that 65% disagreed that there is reliable access to suitable equipment to enable and aid in fulfilling roles. Also, 20% of respondents neither agreed nor disagreed with this statement while only 15% of respondents agreed that there is reliable access to suitable equipment to enable and aid them in fulfilling their role.

8. **Specific funding has not been identified for forecasting, preventing and preparing for public health risks.** Overall recurrent allocations for the years 2016 to 2021 contributed to government's expenditure for health amounted to $25.66 Billion. This expenditure was used for prevention and treatment of public health issues. There is no budgetary line item which identifies allocations for the specific purpose of forecasting, preventing and preparing for public health risks.

9. **Dedicated funding and other resources were provided to support vulnerable groups.** Over the years 2016 -2021, funding for vulnerable groups through the MoH's recurrent and development programme expenditure amounted to approximately $550 Million or 1.8% of the total health allocation of $31.1 Billion. For the years 2016 to 2021, however, the Ministry of Social Development and Family Services spent over $71 Billion for the benefit of the vulnerable individuals in society. This sum was spread amongst five broad categories - Senior Citizens, the Disabled, Other Aide, Children and Non-Profit Institutions.

Information systems were unintegrated and are under-utilized. There are Information Technology (IT) Systems in use at the MoH and the RHAs. However, there was neither integration of IT systems across the RHAs to facilitate the ease of data sharing for decision making nor interface of these systems with the MoH IT systems. The use of IT for the RHAs' includes financial, patient registrations and pharmaceutical functions. The full functionality of the Cellma IT system at the South West Regional Health Authority (SWRHA) were not being utilised.

Coordinating and Monitoring IHR implementation

10. **Coordination functions of the NFP needs strengthening.** In June 2015, Cabinet agreed to the employment on contract of a Coordinator, IHR in the MoH for a period of two years. The MoH indicated that a Coordinator, IHR was never employed but an ad hoc unit was set up for the coordination functions of the IHR with the threat of Ebola around 2014 to 2015. This meant that between 2015 to the time of this report there was officially no dedicated Coordinator, IHR.

11. **Trinidad and Tobago's mandatory State Parties Self-Assessment Annual Reporting (SPAR) for 2020 confirmed gaps in IHR implementation.** Trinidad and Tobago's SPAR reports from 2016 to 2019 were submitted by the MoH to the WHO. For the period of assessment a SPAR report dated March 11, 2020 was submitted. An analysis of this report revealed self- assessments for T&T with attributes at the foundation and maturity levels. This assessment highlights the need for T&T to improve in the attributes of: legislation, financing, human resource capacities required for IHR Implementation and multi-sectoral collaboration.

Legal and policy framework

12. **There are capacity gaps in the legal framework that hinder the implementation of all obligations under the IHR (2005).** Our review of the Constitution and twenty-six legislation revealed that the Quarantine Act Chapter 28:05 and the Public Health Ordinance No. 15 of 1915 are the main legislation utilized for the implementation of IHR (2005). The Quarantine (Marine) and (Air) Regulations are limited to the Plague, Cholera, Yellow Fever, Typhus and Smallpox. The Act is limited in that it does not cover other possible medical conditions and hazards. However, amendments to the Public Health Ordinance and the Quarantine Act can be made when necessary to deal with emerging risks. There is no holistic legal framework, which results in the risk of overlapping and duplication in roles and unclear jurisdiction amongst the Ministry of Health, Ministry of Rural Development and Local Government and the Tobago House of Assembly.

13. **There are gaps in the legal framework for emergency preparedness.** The Disasters Measures Act, Chapter 16:50 focuses on providing an environment for disaster response to severe hazards. However, it does not cover all phases of the disaster management cycle, in that it excludes areas which strengthen health resilience such as health emergency prevention, mitigation, preparedness and recovery.

14. **There are gaps with policy framework when compared to the Sendai Framework.** The Comprehensive Disaster Management Policy Framework (CDMPF) for T&T (2010), National Response Framework, Crisis Communication Guidelines and Response Plan, National Hazard Mitigation Plan, T&T National Radiation Emergency Plan (NREP) and the National Pandemic Response Plan were found to be aligned with the Hyogo Framework 2005 to 2015 instead of the current Sendai Framework 2015 to 2030. It therefore does not include the current best practice for disaster risk reduction such as disaster risk governance for prevention, mitigation, preparedness, response, recovery, rehabilitation, collaboration and partnership.

15. **Vertical coherence needs strengthening for health emergency preparedness and disaster risk management**. The Disaster Measures Act has not been amended to incorporate Comprehensive Disaster Management. Also, the legislation has not been amended to provide for a Disaster Management Fund or any special provision for an emergency release of funds in the event of a disaster.

16. **Horizontal coherence amongst key stakeholders for health emergency preparedness and disaster risk management needs strengthening.**The MPD has the responsibility to manage the key transformational programmes for achieving Vison 2030. The MPD did not establish a delivery mechanism for achieving Vision 2030. Due to the absence of a holistic approach by the MPD, we found that some key players such as Immigration Division and the Attorney General did not understand their roles with respect to SDG 3.d. These stakeholders referred the AGD to the MoH for responses to audit questions instead of answering for themselves. However, horizontal coherence was displayed amongst the ODPM, MoH and RHAs for Comprehensive Disaster Management. The MoH played a key role by interfacing with institutions and bodies when health emergency situations arose.

17. **Multi-stakeholder engagements need strengthening.** An analysis of 1,049 participants from the general public showed that from the 1,021 responses received approximately 522 or 51% of respondents indicated that they did not receive information from the government on the formation of laws and policies related to public health emergency and disaster risk management. Additionally, focus groups with Non-Government Organizations (NGOs) revealed weaknesses in multi-stakeholder engagements.

Resilience during COVID-19 and lessons learnt

18. **The government had communication with the population for the COVID-19 pandemic.** The government communicated with the population through regular and consistent communication via print media, social media, radio and television throughout the COVID-19 pandemic. This was facilitated through a Public Communication Plan (2020).

19. **The TTRNA expressed concerns of their non-involvement in stakeholder consultation during the COVID-19 pandemic.** At a focus group in 2021, the Trinidad & Tobago Medical Association stated that they were involved in policy decisions for vaccination and COVID-19 management. However, the Trinidad and Tobago Registered Nurses Association (TTRNA) indicated that they were not included in the policy decision making for the COVID-19 pandemic. The TTRNA also indicated that they lobbied for health insurance and hazard allowances for healthcare workers during the COVID-19 pandemic but were not given a response.

20. **Trinidad and Tobago public sector accounting system does not provide for reserve funding that is specific to public health.** To cater for financing gaps during the COVID-19 pandemic, Parliament approved an amendment to the Heritage and Stabilization Fund (HSF) Act to allow for withdrawals of up to US$1.5 Billion in the event of a health crisis, a natural disaster or a precipitous drop in budgeted revenue during a financial year.

21. **Funds were accessed from many sources to leave no one behind during COVID 19.** Grants relating to the Social/Humanitarian Programme (2020- 2021) of approximately $1.1 Billion were provided to citizens.

22. **Scaling up the health workforce during the pandemic impacted the physical and mental health of health workers.** The TTRNA indicated that health personnel were vulnerable to burn out during the pandemic because of working extra hours and forgoing their vacation leave. Feedback from our survey showed that the lack of incentives and motivation of health workers were rooted in unpaid compensation for overtime, uncertainties with job security, improper meals and transportation, lack of support for childcare and poor working conditions.

23. **There were longer waiting times and postponement of surgeries during the pandemic.** Our survey with 1,049 persons from the general public showed that out of 1,022 responses 646 or 64% of respondents indicated that they had longer waiting times than normal at health facilities during the pandemic. Also 637 or 63% of respondents stated that there

were a higher degree of postponement for elective surgeries and medical appointments as a result of the pandemic.

24. **The Ministry of Health has not documented lessons learnt from past and recent health shocks.** The MoH indicated that they have learned lessons during the COVID-19 pandemic but these were not evaluated and documented. The MoH also indicated that lessons learned would be documented following the COVID-19 assessment of the pandemic. At the time of this audit, the MoH indicated that the project for this assessment was in the procurement/tendering stage.

Conclusion

25. The government of T&T has been making efforts to strengthen the health system's capacities to forecast, prevent and prepare for public health risks. No significant progress has been made in achieving baseline targets for the ratio of nursing personnel per population. As such, greater efforts are needed in strengthening and interlinking building blocks such as legislation, human resources, infrastructure, funding, and coordination and monitoring to effectively forecast, prevent and prepare for public health risks. Furthermore, significant improvement is needed in documenting lessons learnt during and after health shocks.

Multi-stakeholder engagements

26. The government has engaged with stakeholders in preparing legislation, policies and budgets in its efforts to forecast, prevent and prepare for public health risks. NGOs representing vulnerable groups raised concerns of inadequacies in the legal and policy frameworks for the marginalized as such improvements in these areas are needed.

Leave No One Behind

27. Funding and support have been consistent over the years to allow for inclusiveness and equity for the vulnerable in society in public healthcare delivery and health shocks. Funding for the vulnerable was sustained in spite of the economic and financial challenges during the COVID-19 pandemic.

Recommendations

28. To improve the efforts to strengthen public health system resilience, Parliament, the MoH, the RHAs and other responsible parties should consider implementing the following recommendations:

    1. The RHAs should put measures in place to fill the vacancies for healthcare workers and mitigate the underlying issues causing staff shortages in the heath sector. Measures should aim to address issues such as lack of job security, migrations of

health staff due to better salaries and working conditions, unpaid compensation and lack of motivation and incentives.

2. The MoH should put mechanisms in place for a macro human resource health plan in consultation with beneficiaries, health providers and policy makers. Also, this building block should be planned with awareness of plans within the other building blocks of governance and leadership, services and facilities agenda for the health sector and information technology for healthcare.

3. The MoH should put mechanisms in place to integrate its IT systems for public service delivery and public health risks. Resources in this area should also be optimized to ensure that there is no underutilization of IT systems.

4. The government should ensure that sufficient consultations are made with NGOs, Private General Practitioners and Private Medical Institutions in formulating legal and policy frameworks for public health emergency and disaster risk management.

5. The MoH should establish a structure for the office of the NFP.

6. The government should consider the revision of the legislations related to health as they strive to become aligned to international standards. This would strengthen its capacity to implement requirements under the IHR and avoid duplication in the roles of various responsible parties.

7. The Office of Disaster Preparedness and Management (ODPM) should continue its efforts to ensure that their policies and legislation relating to disaster risks are aligned to current international best practice. These should expand beyond disaster response. This would also ensure integration of disaster risk reduction within and across all sectors, and promote coherence of national and local frameworks of laws, regulations and public policies.

8. The MPD, which has a responsibility to manage the key transformational programmes for achieving Vision 2030, should take action to develop the delivery mechanism for Vision 2030. This would contribute to strengthened coordination, collaboration and coherence of agencies in their respective roles within a whole of government approach.

9. The MoH should document the lessons they learnt from the recent health shocks. This would assist them in identifying gaps and shortcomings based on best practice. Such documentation would contribute to better decision making and aid in justifying health capacity needs to the government.

CHAPTER 1 - INTRODUCTION

BACKGROUND

1.1 A strong and resilient public health system is the capacity of health actors, institutions and populations to prepare for and effectively respond to crises while maintaining core functions when a crisis hits and to learn from shocks. A health system consists of all the organizations, institutions, resources and people whose primary purpose is to improve health[4]. While the public health infrastructure and capabilities are the bedrock of the system, all its building blocks[5] such as leadership and governance, service delivery, health workforce, health information systems, access to essential medicines and financing must be interlinked to achieve resilience.

1.2 The contribution to strong and resilient public health systems is promoted under the Sustainable Development Goal (SDG) 3.d of the United Nations Agenda 2030. Its target is to strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks. The SDGs of the United Nation's Agenda 2030 which focuses on a whole of government approach, multi-stakeholder engagement and leave no one behind have been incorporated into Trinidad and Tobago's (T&T's) national development strategy.[6] The national baseline indicators as recorded in the T&T's National Performance Framework (NPF)[7] for SDG 3.d are[8]:

- IHR core capacity index – (Baseline 73% 2016)
- IHR monitoring framework: Legislation – (Baseline 50% 2016)
- IHR monitoring framework: Coordination–(Baseline 57% 2016)
- Health worker density and distribution (per 1,000 population) – Baseline Physicians: 1.179 per 1,000 population. Nursing & midwifery personnel: 3.572 per 1,000 population.

1.3 The World Health Organisation's (WHO's) International Health Regulations (2005) 3rd Edition sets out some of the criteria for resilient public health systems. IHR (2005) is "an international law, which helps countries working together to save lives and livelihoods caused by the international spread of diseases and other health risks." "Its purpose and scope is the deterrence, protection against, control and response to the international spread of disease, while evading the unnecessary interference with international traffic and trade."

1.4 The IHR (2005) 3rd Edition were entered into force on June 15th, 2007 in T&T. **Appendix 1** outlines the relevant laws, regulations and policies for the national public health systems

[4] WHO Monitoring the Building Blocks of Health Systems, pg. VI

[5] WHO Monitoring the Building Blocks of Health Systems, pg. VII

[6] Vision 2030- The National Development Strategy of Trinidad and Tobago 2016-2030

[7] The national baseline indicators are found in the National Performance Framework 2017-2020 (NPF)

[8] The SDGs are seventeen global goals with one hundred and sixty nine targets which globally aims to end poverty, protect the environment and ensure peace, prosperity and wellbeing for all by 2030.

in T&T. The IHR Monitoring and Evaluation framework has identified 13 core capacity areas for IHR implementation as follows:

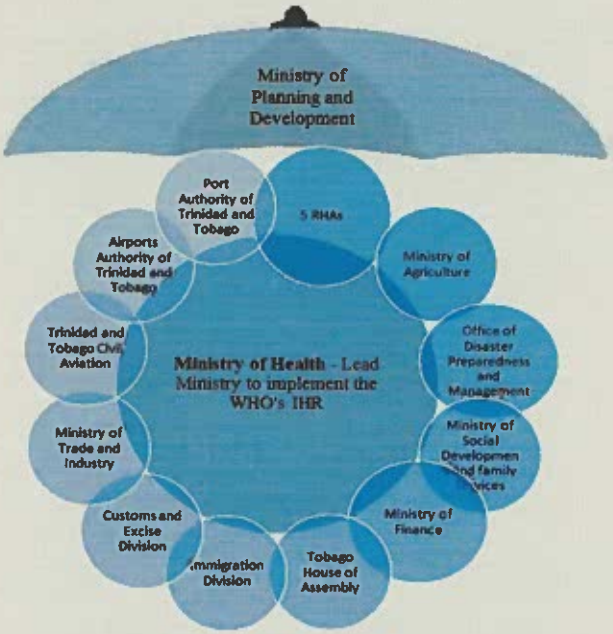
1. Legislation and Financing
2. HR Coordination and National IHR Focal Point Functions
3. Zoonotic Events and the human - animal interface
4. Food safety
5. Laboratory
6. Surveillance
7. National Health Emergency Framework
8. Health Service Provision
9. Risk Communication
10. Points of Entry
11. Chemical Events
12. Human Resources
13. Radiation Emergencies

WHOLE OF GOVERNMENT APPROACH FOR A STRONG AND RESILIENT PUBLIC HEALTH SYSTEM

1.5 Achieving the national targets set out in Vision 2030 and the successful implementation of IHR (2005) requires a whole-of-government approach. Government's performance is therefore shifted from the operations of an agency or programme towards the results of government's efforts that attempt to address a societal problem or challenge.

1.6 The Vision 2030 Leadership Group is responsible for the achievement of the SDGs. The Secretariat of this body is the Ministry of Planning and Development (MPD). The Ministry of Health (MoH) has oversight for the entire health system of T&T and must collaborate with relevant government entities and other stakeholders to implement activities under the IHR. **Figure 1** below shows a pictorial representation of key government entities and agencies with roles and activities for the implementation of IHR (2005). **Appendix 2** presents details on the roles of organizations relating to SDG 3.d.

Figure 1: Ministries and agencies relating to the implementation of SDG 3.d



1.7 Article 4 of the IHR requires every country to designate a National Focal Point (NFP) which shall be accessible at all times for communications with the World Health Organization (WHO) IHR Contact Points. The Office of the Chief Medical Officer (CMO), MoH is the designated IHR NFP for T&T[9].

Multi- stakeholder Engagements

1.8 The implementation of the SDGs requires embedding the multi-stakeholder principles of the United Nations Agenda 2030 into the country policy agendas and promoting a coordinated effort with civil society, the private sector and other non-state actors.

Leave No One Behind

1.9 The SDGs aim to be relevant to all countries; poor, rich and middle-income and have a strong focus on improving equity to meet the needs of women, children and disadvantaged populations in particular so that "no one is left behind."

Funding for Public Health System

1.10 According to WHO[10], State Parties should ensure provision of adequate funding for the implementation of IHR capacities through the national budgetary process. Government

[9] Cabinet Minute dated 18/06/2015
[10] State Parties Self-Assessment Annual Reporting Tool/WHO, Pg.9

funding to the MoH for the past six years (2016-2021) totalled approximately $2,673.8 Billion. Total expenditure for the MoH remained generally constant as shown in **Figure 2.**

Figure 2 - Funding For The Ministry Of Health 2016-2021

MINISTRY OF HEALTH							
Type	**2016 $B**	**2017 $B**	**2018 $B**	**2019 $B**	**2020 $B**	**2021 $B**	**Total $B**
Recurrent Expenditure	4.6	5.1	4.7	4.6	4.4	5.0	28.4
Development Programme Expenditure	115.3	129.3	159.3	138.2	288.2	277.4	1107.7
Infrastructure Development Fund	368.4	169.5	216.0	275.6	290.9	217.3	1537.7
Total ($B)	**488.3**	**303.9**	**380**	**418.4**	**583.5**	**499.7**	**2673.8**

Source: Ministry of Finance-Estimates of Expenditure 2016-2021

Response to Recent Health Shocks

1.11 On 30 January 2020, in response to the global outbreak of the novel coronavirus (COVID-19), the Director General of the WHO declared the COVID-19 outbreak a public health emergency of international concern. Trinidad and Tobago recorded its first COVID-19 case on 12 March 2020 and on 22 March 2020 the country's sea and air borders were closed except for cargo vessels transporting food and pharmaceuticals. This measure, along with a series of lockdowns and restrictions, was implemented by the Government to reduce entry and minimize spread of COVID-19.

1.12 Additionally, the Government created a parallel healthcare system to separate and treat COVID-19 patients through the use of partly or newly completed healthcare facilities. This included the use of step-down convalescent facilities and hotels for quarantine purposes at a cost of approximately $0.5 Million during 2020 and 2021. At the North Central Regional Health Authority (NCRHA), COVID-19 care was isolated to Caura Hospital for moderate cases and the Couva Medical & Multi-Training Facility (CMMF) for severe cases. In 2021, the Arima Hospital was added to manage both moderate and severe COVID-19 cases and the newly commissioned Point Fortin Hospital under the South-West regional Health Authority (SWRHA) was also used for COVID-19 patients. There was no parallel healthcare system in Tobago, as severe cases were transferred to Trinidad for treatment.

Audit Topic:

Performance Audit on the implementation of SDG 3.d – Contributing Towards Strong and Resilient National Public Health System.

REASON FOR THE AUDIT

1.13 The International Organization of Supreme Audit Institutions (INTOSAI) recognised that Supreme Audit Institutions (SAIs) are ideally placed to contribute to the successful implementation of the SDGs through the conduct of performance audits. Arising out of this, INTOSAI Development Initiative (IDI), INTOSAI Knowledge Sharing Committee and INTOSAI Regions (ASOSAI, ARABOSAI and CAROSAI) supported cooperative pilot audits of strong and resilient national public health systems by providing training and guidance to SAIs around the world. The Office of the Auditor General of the Republic of Trinidad and Tobago is one of the SAIs within the CAROSAI region who participated in this cooperative audit.

1.14 The current global impacts of COVID-19 have severely affected economies, particularly small island states such as ours. These challenges along with an increased migrant population have placed unforeseen strain on T&T's health sector. It is at this critical juncture that the implementation of SDG 3.d which contributes to a strong and resilient national public health system is audited. This examination is vital to determine the sustainability of the health of our population - citizens and migrants alike.

Audit Objective

1.15 The main objective of the audit was to determine how the government is strengthening the health system's capacities to forecast, prevent and prepare for public health risks as it relates to the implementation of SDG 3.d.1, building on lessons learnt from recent public health events.

Audit Scope

1.16 SDG 3.d has two components: 3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness and 3.d.2 Percentage of bloodstream infections due to selected antimicrobial-resistant organisms. The audit focused on the global indicator 3.d.1. Focus was also emphasized on four of the thirteen WHO IHR core capacity areas. These are Human Resources, IHR Coordination and National IHR Focal Point Functions, Legislation and Financing, and National Health Emergency Framework.

1.17 This audit was not an analysis of Trinidad and Tobago's COVID-19 response.

1.18 The audit examined the undertakings of the MoH, the RHAs, other government entities, NGOs and other stakeholders from associated sectors. Additionally, we assessed the extent to which the national target was achieved for SDG 3.d, the level of multi-stakeholder engagement and the degree to which provisions were put in place to ensure that no one was left behind. All examinations and assessments covered the years 2016 to 2021.

Audit criteria

1.19 Audit criteria were derived from:

- IHR (2005) 3rd Edition
- IHR (2005), IHR Core Capacity Monitoring Framework: Checklist and Indicators for Monitoring Progress in the Development of IHR Core Capacities in States Parties;
- United Nations Agenda 2030;
- IDI's SDG Audit Model (ISAM);
- PAHO and other international best practices.
- National Development Strategy-Vision 2030
- T&T National Performance Framework 2017 – 2020
- SENDAI Framework for Disaster Risk Reduction 2015-2030
- Health Systems Resilience during COVID-19 Lessons for building back better/European Observatory on Health Systems and Policies/ WHO 2021.

Audit Methodology

1.20 The processes and procedures used to assess, extract and analyse data for the audit are listed as follows:

- Reports, files, plans, strategies, policies, annual reports, financial statements, project documents, correspondence, memoranda and legislation were examined where applicable.
- Questionnaires were emailed to stakeholders of high interest and high power as identified during our stakeholder mapping exercise.
- Interviews were conducted with officials of the MoH.
- Focus groups were conducted with NGOs, the Medical and Nursing Associations, General Practitioners and other government entities.
- Surveys were conducted with healthcare workers and the general public.

Limitations

1.21 The fieldwork for the audit was conducted during the peak of the COVID-19 pandemic, when there were lockdowns and work from home arrangements. This posed a major challenge in visiting entities to conduct fieldwork and contributed to lengthy delays in the receipt of documents. Audit's access to documents was also affected by a fire at the Registry Unit of the MoH, Head Office on August 8th, 2020. Moreover, various committee files of the MoH were not produced for audit. This hindered our corroboration of evidence relating to multi-stakeholder engagements.

CHAPTER 2 - CAPACITIES AND RESOURCES FOR HEALTH RESILIENCE

2.1 The public health infrastructure and capabilities are the bedrock for resilience; the building blocks within the system such as governance and leadership, human resources, funding, information systems, medical products and monitoring must fit together to also ensure resilience. In this chapter, focus is placed on public health infrastructure, human and physical resources, funding and the use of information systems.

THE DISTRIBUTION OF HEALTHCARE FACILITIES CONTRIBUTES TO ACCESSIBILITY FOR CITIZENS

Criterion:

- "Access to healthcare services pertains not only to the availability of these services at remote, rural areas, but also accessibility to basic health services at District Health Facilities in order to relieve the burden on General Hospitals."

  (National Development Strategy – strategic Initiative 4.3)

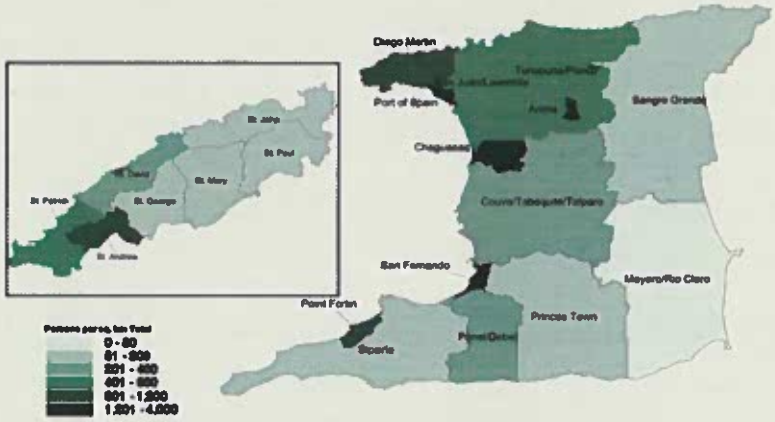
2.2 The Vision 2030 identifies one of its 'Strategic Initiatives / Actions'[11] as "Improve access to healthcare services". According to this document, this "pertains not only to the availability of these services at remote, rural areas, but also accessibility to basic health services at District Health Facilities in order to relieve the burden on General Hospitals…". "Improved access to health services also relates to ensuring that these services are relevant in meeting the health needs of all segments of the population."

2.3 The Central Statistical Office in its Mid-Year Population Estimates for 2021, estimated T&Ts population as 1,367,558[12]. The population density is therefore calculated at 267 persons/km^2 over the nation's 5,130 km^2 land mass. The geographic spread of T&Ts population is displayed at **Figure 3** below.

[11] Vision 2030 -The National Development Strategy of Trinidad and Tobago, Theme I, Goal 4 - 4.3, Pg. 88

[12] https://en.populationdata.net/maps/trinidad-and-tobago-density

Figure 3 Trinidad and Tobago Population Density Map



Source:https://en.populationdata.net/maps/trinidad-and-tobago-density

2.4 The RHAs are responsible for the administration of healthcare facilities. These amount to 119 public healthcare facilities including 12 hospitals across the five RHAs. These are listed at **Appendix 3**.

2.5 We found that the spread of public health facilities was aligned to population densities across both islands. See **Figure 4** below.[13]

Figure 4: Public Health Facilities in Trinidad and Tobago

Distribution of Health Facilities – Trinidad

Distribution of Health Facilities – Tobago

Conclusion:

Health care facilities are dispersed across both islands of Trinidad and Tobago so that urban, remote and rural communities have access to healthcare services.

[13] https://www.google.com/maps/d/edit?mid=1bBzyw7wc6af6Vz9m2DWObRrBcUYvKzM&usp=sharing

THE COMPLEMENT OF HEALTH WORKERS NEEDS STRENGTHENING

Criteria:

- "The availability and accessibility of a quality health workforce is critical to build the resilience of communities and for continuity of health services. "

  (IHR State Party Self-Assessment Annual Reporting Tool C7)

- The baseline indicators of 1.2 physicians and 3.6 nursing and midwifery personnel per 1,000 population.
  (National Performance Framework 2017 -2020)

2.6 The Vision 2030 Goal 4 states that the healthcare system of T&T will be sustainable and modern and deliver higher standards of healthcare[14]. Output 3.2 of T&T's National Performance Framework (NPF) 2017 stated that " Trinidad and Tobago will have improved organisation and management of the Health System with focus being placed on human resources,..." and that "...institutions will be staffed with appropriately qualified health professionals with the required capabilities needed for effective operation. Furthermore, the capability of the public health sector's workforce will be of a quality identified by international standards and able to meet the population's needs."[15]

2.7 A 2016 WHO publication[16] stated that "a health workforce of adequate size and skills is critical to the attainment of any population health goal". Based on this publication, an "SDG index threshold" of 4.45 doctors, nurses and midwives per 1,000 population was identified as an indicative minimum density representing the need for health workers. The baseline indicators in the NPF[17] are 1.2 physicians and 3.6 nursing and midwifery personnel per 1,000 population. See **Appendix 4.**

2.8 The MoH stated that the current ratio for T&T is 1 doctor/nurse/midwife per 1,000 population. The current ratio is below the WHO's "SGD index threshold" by 3.45 doctors, nurses and midwives. It is also below the country's baseline indicator 2017 by 0.1 and 2.5 for physicians and nursing personnel respectively.

2.9 Examination of the staff establishment of the RHAs (excluding ERHA) identified that 17,682 positions were directly linked to providing health care. **Figure 5** refers. It was found that 6,647 or 37.6% of the established positions related to patient care were vacant at the end of December 2021.

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[14] Vision 2030- The National Development Strategy of Trinidad and Tobago –pg.87. Also see Appendix 8
[15] T&T's National Performance Framework pg. 32
[16] Health workforce requirements for universal health coverage and the Sustainable Development Goals
[17] T&T's National Performance Framework pg. 33

2.10 There was a significant number of vacancies for nursing personnel across the RHAs. Nursing vacancies ranged between 33% at NCRHA and 68% at NWRHA. **Figure 7** refers.

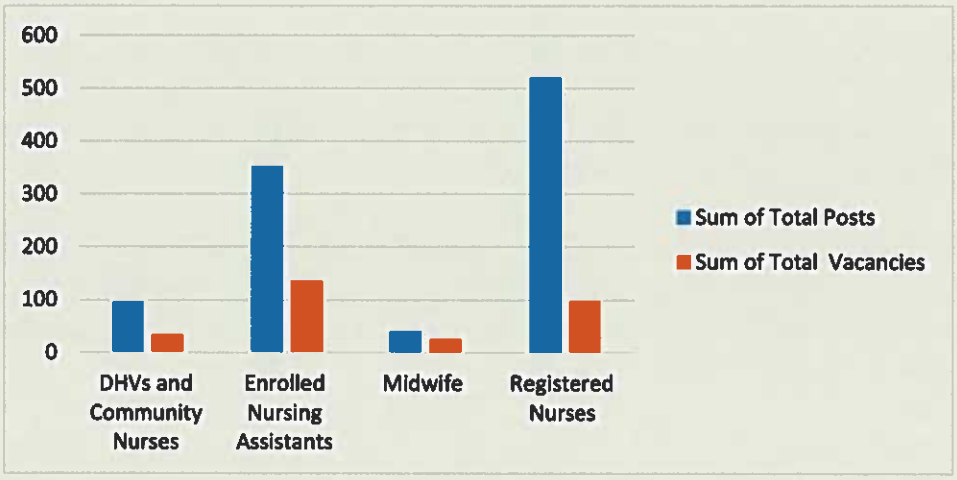
Figure 5 – Analysis of vacancies directly linked to patient care across RHAs

RHAs	Healthcare Positions	Healthcare Vacancies	Percentage of Vacancies - Healthcare	Nursing Vacancies	Percentage of Vacancies - Nursing Personnel
TRHA	631	375	41%	203	54%
SWRHA	6,989	2,852	59%	1,625	57%
NWRHA	5,326	1,880	65%	1,271	68%
NCRHA	4,736	1,540	67%	513	33%
Total	**17,682**	**6,647**	**62%**	**3,612**	**54%**

Source - Staff establishments of RHAs (excluding ERHA)

2.11 The ERHA provided a listing of doctors, nurses and pharmacists but we were not provided with the staff establishment of the ERHA. Analysis of the data provided by ERHA in relation to nursing personnel showed that at the end of the year 2021, 337 or 25% of 1361 nursing positions were vacant. **Figure 6** provides a graphical representation of vacancies in comparison to positions for nursing personnel.

Figure 6: Comparison of vacancies in nursing personnel against nursing positions at ERHA as at 2021



2.12 In a survey of 319 health care workers, 259 or 81% of respondents felt that government did not provide sufficient incentives to prevent local health care workers from taking up job opportunities in foreign countries. Other challenges with the inability of the RHAs to retain nursing personnel were due to demotivated staff because of job insecurity, unattractive salaries and lack of incentives.

2.13 In an interview, the TTRNA President stated that contributors to demotivation amongst nurses are that there are long gaps in training opportunities for new Enrolled Nursing Assistants and as a result Registered Nurses are hired to fill this role. District Health Visitors and Mental Health Nurses who are required to travel while performing their duties are not compensated as travelling officers. Also, for nurses who specialise, the amount paid as specialisation allowance is small.

Gaps in health workforce:

- Each RHA exhibited significant numbers of healthcare worker vacancies. The largest number of vacancies was in the nursing field.
- The MoH's stated current ratio of doctors and nurses/midwife per 1,000 population fall below the baseline indicator in the National Performance Framework and even more so under the WHO's SDG baseline indicator.

Conclusion:

A healthcare workforce of sufficient size and skill is essential for quality care in the process of health service delivery. Shortcomings in this key element of resilient health systems severely impacts upon the country's ability of recover from health shocks.

WEAKNESSES IN ACCESSING EQUIPMENT TO DELIVER HEALTHCARE

Criterion:

- "Healthcare modernisation will ensure that ageing equipment and infrastructure (including ICT) are maintained and upgraded and new systems are institutionalised towards improved service delivery and improving operating efficiency where necessary."

  (National Development Strategy Goal 4)

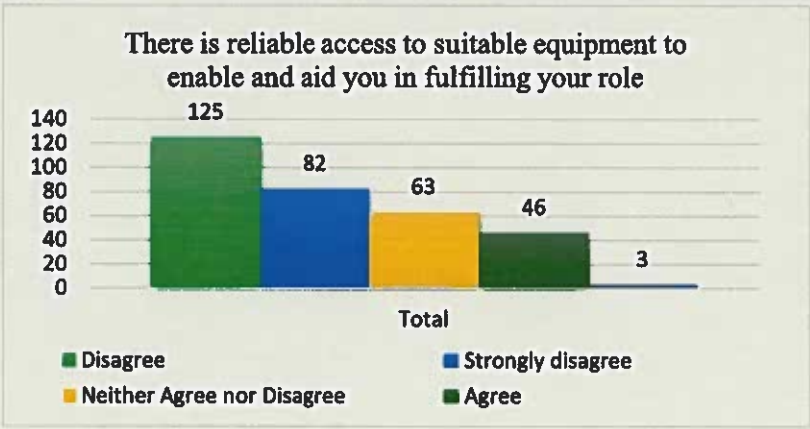
2.14 According to the WHO, access to good quality, affordable and appropriate health products is indispensable to advance universal health coverage, address health emergencies and promote heathier populations[18].

2.15 Goal 4 of Vision 2030 identified maintenance of health infrastructure as one of the three main areas of focus for the health system in the short term.[19] Whereas, the NPF identified the indicators for improved public health as[20]:

- No. of Magnetic Resonance (MRI) units available per 10,000 population.
- No. of Radiotherapy Units per 10, 000 population.
- No. of Computed Tomography Units per 10,000 population.

2.16 Our survey of 319 health care workers also showed that 207 or 65% disagreed that there is reliable access to suitable equipment to enable and aid in fulfilling their role. **Figure 7** refers.

Figure 7 - Survey Results For Healthcare Workers – Reliable Access To Suitable Equipment



Source- AGD's 2022 Survey with Health Personnel

2.17 The NCRHA identified the lack of funding to procure additional medical equipment and supplies as one of the challenges it faced. The ERHA stated that while the demand for its services is increasing, its equipment is becoming obsolete with advancements in medical and IT equipment.

2.18 A focus group of five participants, which comprised senior representatives from TTRNA, the Medical Association of Trinidad and Tobago (MATT), the Southern Medical Private Hospital and two private medical practitioners, expressed that there is a backlog in ECHO services, CT Scans and diagnostic testing at the public health institutions. One participant

[18] https://www.who.int/health-topics/medical-devices#tab=tab_1
[19] Vision 2030- The National Development Strategy of Trinidad and Tobago –pg.87
[20] T&T's National Performance Framework pg. 33

indicated that cancer patients regularly wait up to seven months to get their histology results.

2.19 The lists of medical equipment provided by the RHAs did not include the serviceability of these items. Due to the COVID-19 Pandemic, physical attestation of the serviceable condition of the medical equipment was not undertaken.

Gaps in healthcare equipment:

- The demand for healthcare service is increasing while equipment for health service delivery is becoming obsolete.
- Funding is needed to procure additional medical equipment.

Conclusion:

A lack of adequate medical equipment can compromise or endanger a patient's life and lead to poor or misleading diagnosis.

NO SPECIFIC BUDGETARY LINE ITEM FOR FORECASTING, PREVENTING AND PREPARING FOR PUBLIC HEALTH RISKS

Criterion:

- "States Parties should ensure provision of adequate funding for the implementation of IHR capacities through the national budgetary process."

(IHR State Party Self-Assessment Annual Reporting Tool C1)

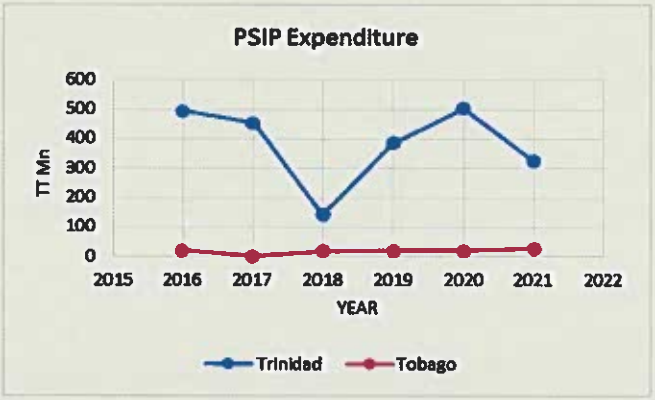
2.20 According to WHO's IHR State Party Self-Assessment Annual Reporting Tool, "state parties should ensure provision of adequate funding for the implementation of IHR capacities through the national budgetary process"[21]. The government, in Vision 2030 under Theme 1, short term Goal 4 states that "the healthcare system of Trinidad and Tobago will be sustainable and modern and deliver higher standards of healthcare…". "The government intends to achieve this in part by ensuring that there is sustainable funding for the health sector."

2.21 Capital funding for the health sector is identified mainly through the Public Sector Investment Programme (PSIP) which is comprised of expenditure under the Development Programme and Infrastructure Development Fund. These together constitute the capital

[21] WHO's IHR State Party Self-Assessment Annual Reporting Tool (2020), pg. 8

expenditure component of the National Budget. The PSIP is used by the government as a strategic tool to effectively execute its policies and achieve its national development objectives. **Figure 8** depicts PSIP spending on health from 2016 to 2021.

Figure 8 Public Sector Investment Programme Health Expenditure from 2016-2021



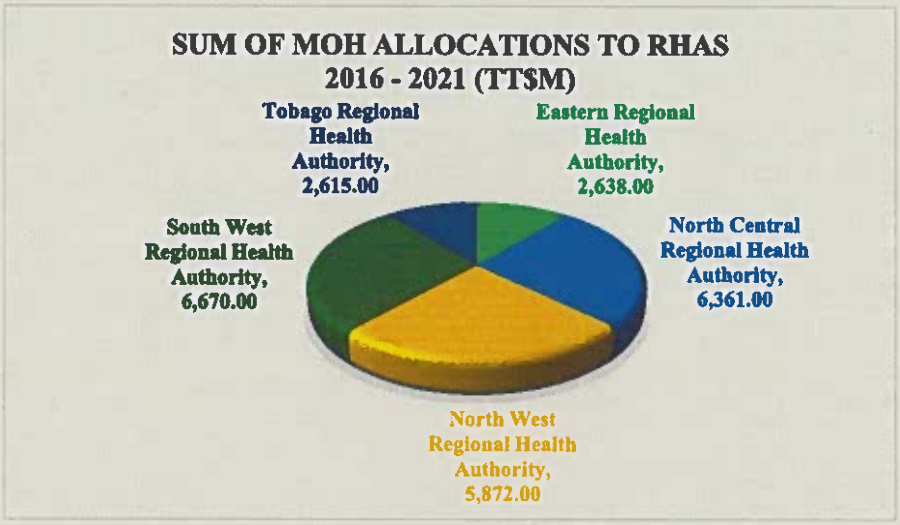
Source: Ministry of Finance-Estimates of Expenditure PSIP for 2017-2022

2.22 Expenditure under PSIP, though not specifically identified for the purposes of forecasting, preventing and preparing for public health risks, included projects which are aligned to the objective of health resilience such as:

- Construction of new public health facilities
- Purchase of medical equipment
- Specialised healthcare through public/private partnerships
- Implementation of the Non-Communicable Diseases (NCD) Prevention and Control Plan
- Execution of the Human Resources for Health Plan
- Implementation of e-Health Information Systems and
- Strengthening of Health Facilities Investment Management

2.23 Funding for the health sector is also identified through the Recurrent Estimates of Expenditure which forms part of the government's annual budget statements. The overall recurrent allocations for the years 2016 to 2021 to the MoH was $25.66 Billion. Further examination of the Estimates of Recurrent Expenditure indicated that over $24 Billion was allocated through the MoH for all RHAs over the period 2016 – 2021. **Figure 9** refers.

Figure 9 -Allocations By MoH To RHAs 2016 - 2021



Source- MoH Allocations to RHAs

Gap in funding for preventing and preparing for public health risks:

There is no specific line item in the Recurrent Estimates of Expenditure which identifies allocations for the purpose of forecasting, preventing and preparing for public health risks.

Conclusion:

The government provides funding for the provision of health services however funding that is specific to the purposes of forecasting, preventing and preparing for public health risks could not be identified.

FUNDING AND OTHER RESOURCES ARE PROVIDED TO SUPPORT VULNERABLE GROUPS

Criteria:

- "Projects and programmes that meet the needs of citizens who have traditionally been socially marginalised will be expanded. This group includes the socially displaced, ex-prisoners and deportees."
- "Moreover, in respect of the permanently disabled, existing measures will be continued, such as the provision of disability assistance grants and welfare assistance such as access to housing, including affordable rental units and social services."

(National Development Strategy – Strategic Initiative 6.3)

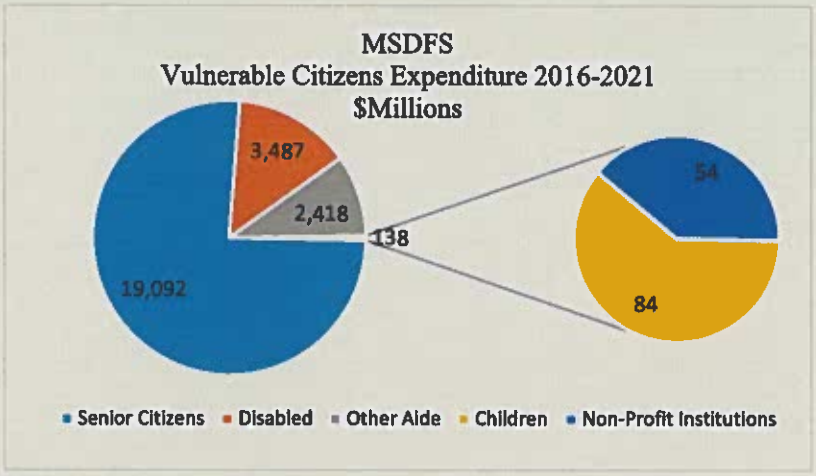
2.24 The Vision 2030, Theme I, Short-term Goal 2 states that "Social Services Delivery will be improved to better serve the needs of vulnerable groups[22]".

2.25 In assessing whether "no one is left behind", we looked at government's coverage on vulnerable groups who are at risk of not meeting their basic health needs. We found that spending which targets vulnerable groups is provided mainly through the Ministry of Social Development and Family Services (MSDFS) via grant funding and the MoH via both PSIP and recurrent expenditure.

2.26 The government has been providing funding for a range of the vulnerable in society in a fairly consistent manner over the years. For the years 2016 to 2021, the MSDFS spent $47.7 Billion in recurrent expenditure to cater for vulnerable persons in society by way of grants and subventions. This sum was spread among five broad categories: Senior Citizens, the Disabled, Other Aide, Children and Non-Profit Institutions, as shown in **Figure 10**.

[22] Vision 2030- The National Development Strategy of Trinidad and Tobago –pg.57

Figure 10 - MSDFS Funding For Vulnerable From 2016-2021



Source – Ministry of Finance – Estimates of Expenditure from 2017-2022

2.27 These grants contribute to health resilience by providing support for vulnerable individuals such as persons with disabilities and senior citizens. These grants include the Food Support Programme, Sanitary Plumbing Assistance, Disability Assistance Grant for Children and Adults, Senior Citizens Pension, Dietary Grant, Medical Equipment and Pharmaceutical Grant. Information with regard to the type of grant, the eligibility criteria for applicants and the value of each grant is detailed in **Appendix 5**.

2.28 Funding for vulnerable groups through the MoH's PSIP expenditure was approximately $2.4 Billion. This sum was spent on infrastructural projects relating to Health / HIV AIDS.

2.29 Recurrent expenditure amounted to $549 Million or 2% of total recurrent health allocation of $28.5 Billion over the years 2016 -2021. The sum allocated to vulnerable groups through the MoH is detailed at **Figure 11**.

Figure 11 - MoH Recurrent Expenditure For The Vulnerable From 2016-2021 (Millions)

Particulars	2016	2017	2018	2019	2020	2021	Total
Contributions to Non-Profit Institutions	12.081	10.839	15.267	12.758	18.451	17.467	**86.862**
National Alcohol and Drug Abuse Prevention	2.066	0.410	-	-	-	-	**2.475**
Medical Treatment for Nationals in Institutions	81.666	60.751	49.451	59.555	55.103	64.278	**370.804**
Children's Life Fund Authority	1.650	2.420	2.400	2.000	2.400	2.400	**13.270**
School Health Programme (Audio & Eye)	-	0.251	0.438	0.336	0.113	-	**1.139**
Princes Elizabeth Home for Handicapped Children	10.614	11.351	10.865	10.758	11.388	11.182	**66.157**
Contributions to Non- Profit Organisations (Tobago)	0.220	0.058	0.072	0.100	0.030	-	**0.480**
Grants Towards Necessitious Patients	0.824	0.531	2.651	1.504	1.465	1.659	**8.635**
	109.122	**86.611**	**81.144**	**87.011**	**88.949**	**96.986**	**549.823**

Source- Ministry of Finance-Estimates of Expenditure 2017-2022

2.30 Our focus group with certain health advocacy players indicated that while the government provides funding, such funding is inadequate to support their needs. One advocacy group indicated that they did not receive funding. Examination of MoH's criteria for funding revealed that this organisation did not meet MoH's criteria for NGO funding.

Conclusion:

The government has been providing consistent funding for a range of vulnerable in society. Support is provided to children, the elderly, persons with disabilities and persons with reduced income among others. Government spending on vulnerable groups is provided mainly through the Ministry of Social Development and Family Services and the Ministry of Health.

INFORMATION TECHNOLOGY IS UNDERUTILIZED AND UNINTEGRATED

Criteria:

- "Each State Party shall develop, strengthen and maintain, as soon as possible but no later than five years from the entry into force of these Regulations for that State Party, the capacity to detect, assess, notify and report events in accordance with these Regulations."
- "Improvement of the health system will also come through the use of ICTs. For instance, the health information system and its processes will be modernised to ensure that patients are allowed easy access to information for health advice and timely appointments. The information needs of medical professionals, administrators and patients will also be served by facilitating easy retrieval of health records and referrals, the sharing of diagnostics and enabling the monitoring of costs, quality and outputs."

(International Health Regulations (2005) Part II Article 5)
(National Development Strategy Action 4.1)

2.31 In IHR (2005) Articles 5-12, State Parties are required to ensure that the public health system has the capacity to detect, assess, notify and report events. The WHO in its health system strengthening agenda, formulated a health systems framework that describes health systems in terms of six building blocks which include health information systems.

2.32 For T&T, strengthening the health information systems building block is key to accomplishing a modern healthcare system[23]. The audit revealed that the MoH and the RHAs utilise information technology to differing degrees in facilitating the delivery and monitoring of their role as healthcare providers but that the systems are not integrated.

2.33 The health information systems in use can be accessed across the RHAs and are utilised based on the required application at various sites. These are:

- Cellma – Patient Registry at Hospitals
- Prenatal Information System – Women's Health
- Salmi – Supply Chain for Pharmaceuticals.

2.34 In 2019, an IT Audit was conducted by the Auditor General's Department on the IT systems in use by the RHAs. During this IT audit it was found that the full functionality of the existing systems was also not being used. For example, the Ward and Bed Management module of Cellma was not implemented at the SWRHA. This module would enable the ward managers to monitor live bed status, staffing levels and ward capacity levels as well as configure the bed layout of each individual ward to incorporate any special requirements.

[23] Vision 2030- The National Development Strategy of Trinidad and Tobago –pg.87

2.35 The IT Audit also revealed that at the MoH and the RHAs Business Continuity and Disaster Preparedness Plans were not developed to facilitate the recovery of the critical business processes as quickly as possible in the event of a major disruption or disaster. At the time of this SDG audit, the status of these systems remained unchanged.

Gaps in the use of Information Technology:

- IT systems used by the MoH and RHAs are not integrated
- The full functionality of the existing systems was not being used
- Business Continuity and Disaster Preparedness Plans were not developed

Conclusion:

The non-integration of the systems could compromise the ease of data sharing for decision making by the RHAs and MoH. This could leave the country vulnerable to health shocks since the required data is either not easily accessible or unavailable. Additionally, the underutilization of the information technology systems could result in delays in gathering data for patient services and affect the ease of analysis which is critical to detect, assess, notify and report on public health risks.

CONCLUSION

2.36 The GoRTT has disclosed its strategic intent to strengthen T&T's public health system in its National Development Strategy. In this regard, public health infrastructure was strengthened with the addition of new health facilities. The disbursement of these facilities across both islands was seen to be closely correlated to the disbursement and concentration of the population. However, the human and other physical resources necessary to effectively meet the needs of SDG 3.d and deliver public healthcare requires additional efforts. In our examination, we recognised that while the government provides funding to support a wide variety of vulnerable individuals, insufficient funding of the health sector, is the underlying reason for deficiencies in the delivery of public health care.

The MoH and RHAs are to be commended on the use of information technology in their business processes but the fact that these systems are not being optimised, restricts the value that can be attained from their use.

CHAPTER 3 - COORDINATION AND MONITORING OF IHR IMPLEMENTATION

3.1 The successful implementation of the IHR requires the following:

- Established National Focal Points (NFPs)
- Effective coordination, communication and partnerships to prevent, detect, assess and respond to any public health events, and
- Monitoring and evaluating the development of IHR core capacities.

COORDINATION FUNCTION OF THE NATIONAL FOCAL POINT NEEDS STRENGTHENING

Criteria

- "Each State Party shall designate or establish a NFP and the authorities responsible within its respective jurisdiction for the implementation of health measures under these Regulations.

  (IHR 2005, 3rd Edition IHR Article 4, (1))

- "The employment on contract of a Co-ordinator International Health Regulations(2005) in the Ministry of Health, for a period of two years with effect from the date of assumption of duty, on terms and conditions to be negotiated with the Chief Personnel officer and agreed by the Minister of Health."

- 'The contract position of Co-ordinator, International Health Regulations (2005) be reviewed after the two year period to determine the need for the continued existence. "

  (Cabinet Minute dated June 18, 2015)

3.2 The IHR (2005) Article 4 (1) states that each State Party shall designate or establish a NFP and the authorities responsible within its respective jurisdiction for the implementation of health measures under these Regulations. Article 4 (2) (b) of the IHR also states that the functions of National IHR Focal Points shall include:" disseminating information to, and consolidating input from, relevant sectors of the administration of the State Party concerned, including those responsible for surveillance and reporting, points of entry, public health services, clinics and hospitals and other government departments."

3.3 The office of the Chief Medical Officer (CMO), MoH is the designated NFP for the implementation of IHR. The office of the CMO is therefore responsible for coordinating the efforts of the MoH along with other Ministries and agencies to prepare for and respond to

any potential public health emergency of national, regional and international concern. The network composition which consists of the local, regional and international stakeholders for T&T's NFP to disseminate information to and consolidate input necessary for the analysis of national public health events and risks is outlined at **Figure 12**.

Figure 12- T&T's National Focal Point Network Composition

	INTERNAL	EXTERNAL
Health	National Surveillance Unit Public Health Inspectorate Insect Vector Control Division Veterinary Public Health Unit Chemistry, Food and Drugs Division Pesticides and Toxic Chemicals Unit Regional Health Authorities Local Health Authorities Private Providers	PAHO/WHO CARPHA IAEA NFPs and Ministries of Health of other State Parties
Non-Health	Government Ministries Tobago House of Assembly Points of Entry Agencies Industry Partners Academic Institutions	CARICOM IATA ICAO OIE FAO

Source - International Health Regulations (2005) National Focal Points Regional Meeting 28-30 November 2017 Miami, United States Of America/PAHO/ WHO December 2018

3.4 The CMO has also indicated that the capacity of the NFP needs strengthening as it requires a structure resourced with certain competencies such as epidemiology, public health and research officers.

3.5 In June 2015, Cabinet agreed to the establishment of an Inter-sectoral Implementation Steering Committee, for a period of two years to facilitate collaboration and oversee the execution of an implementation plan for the IHR. Cabinet also agreed in June 2015 that this committee comprise representatives of Ministries/Agencies as follows:

- Ministry of Health
- Ministry of National Security
- Ministry of Food Production
- Ministry of Transport
- Ministry of the Environment and Water Resources
- Ministry of Foreign Affairs
- Ministry of Trade, Industry, Investment and Communications
- Ministry of Energy and Energy Affairs
- Ministry of Finance and the Economy (Customs and Excise Division)
- The Tobago House of Assembly

3.6 Audit was unable to verify the existence, roles, responsibilities and decisions of the Inter-sectoral Implementation Steering Committee as documents were not provided by the MoH for examination. Audit was also unable to ascertain whether the term of the Committee had come to an end.

3.7 Cabinet in 2015, also noted that a key impediment to IHR implementation was limited financial and human resources, in particular the absence of a dedicated co-ordinator within the office of the CMO. Cabinet further agreed in June 2015 to the employment on contract of a Coordinator, IHR in the MoH for a period of two years.

3.8 The MoH indicated that a Coordinator, IHR was never employed but an ad hoc unit was set up for the coordination functions of the IHR with the threat of Ebola around 2014 to 2015. This meant that between 2015 to the time of this report there was officially no dedicated Coordinator, IHR for the coordination and collaboration function of the NFP with stakeholders at the domestic, regional and international levels.

3.9 As a result of this the CMO stated that he is required to be available 24/7 to fulfil this role. The current office holder of CMO has his regular duties along with the functions of NFP and also sits on multiple boards and committees.

3.10 In February 2020, during the COVID-19 pandemic, Cabinet agreed to the establishment of a Multi-Sectoral Committee to treat with COVID-19 and any emerging infectious diseases. The main mandate of this Committee to translate the WHO's strategic objectives in relation to COVID-19 and any other emerging infectious diseases to the national context. This Committee chaired by the CMO met ten times between March 2020 to August 2022 to discuss and take action on matters relating to the COVID-19 pandemic.

3.11 The PAHO/WHO report [24] indicated that "*When there is only one person in charge of operations in emergency situations, rather than a structure that gathers different agencies functioning as a team, significant challenges will arise. The NFP's day-to-day work is demanding, even when operational structures have been established. It is not feasible, therefore, that a single person can assume all functions and be available 24 hours a day, 7 days a week*".

Gaps in Coordination Function of the IHR NFP:

- The IHR NFP should be resourced with certain competencies such as epidemiology, public health and research officers.
- The absence of a dedicated Coordinator IHR is a key weakness to IHR implementation which requires a high level of collaboration amongst stakeholders.

Conclusion :

The lack of a dedicated Coordinator IHR and other resources with certain competencies for IHR implementation means that T&T's NFP needs significant strengthening to effectively coordinate, collaborate and communicate between government institutions and entities at different levels for conducting risk assessments regularly to strengthen health system resilience.

The MoH should strengthen the capacity of the NFP. This should include support staff to handle coordination activities and research.

[24] IHR 2005 National Focal Points Regional Meeting 28-30 November 2017, Miami, USA PAHO/WHO December 2018.

ANNUAL MANDATORY STATE PARTY SELF-ASSESSMENT ANNUAL REPORTING (SPAR)

Criterion
The information obtained through the States Parties Self-Assessment Annual Reporting tool is submitted by States Parties to the WHO Secretariat. Each year it is analysed and presented by capacity, and country, in a report of the Director-General to WHO governing bodies, and is also published on the WHO Global Health Observatory. "

(IHR (2005) Monitoring and Evaluation Framework 4.1.2)

3.12 The IHR (2005) Monitoring and Evaluation Framework outlines the processes by which State Parties can monitor and evaluate the implementation of IHR capacities. Although the Framework is not legally binding, one of its main principles is "to promote the culture of transparency and accountability among State Parties towards global public health security".

3.13 The framework focuses on obligations related to the establishment of core capacities under Articles 5 and 13 of the IHR. It has four components of which the State Party Self-Assessment Annual Reporting (SPAR) is mandatory whereas the other three assessments are voluntary. These components also have different purposes and periodicity. **Figure 13** refers.

Figure 13- The four components of IHR monitoring and evaluation framework

	Purpose	Mandate	Periodicity
States Parties Self-Assessment Annual Reporting (SPAR)	Monitor progress towards implementation of IHR core capacities	Mandatory	Annually
After Action Reviews (AAR)	Assess the functionality of capacities during real events	Voluntary	Within 3 months of specific real events.
Simulation Exercises (Sim Ex)	Assess the potential functionality of capacities for non-real events	Voluntary	Regularly when required as part of the exercise programme
Voluntary External Evaluations	Evaluates objectively IHR contribute to health security	Voluntary	Every 4 to 5 years.

Source- IHR Monitoring and Evaluation Framework (page 11)

3.14 The SPAR tool is a self-assessment to be used by national authorities across government sectors. The purpose of the annual IHR SPAR is to support States Parties and the WHO Secretariat in fulfilling their obligation to report annually to the World Health Assembly on the implementation of the IHR at national, intermediate and community/primary response levels (Annex 1 of the IHR (2005), and Article 54). [25]

3.15 Reports on the country's mandatory SPAR are published by WHO and are used to monitor the country's progress towards implementation of IHR's 13 core capacities across relevant sectors for the detection and response to potential public health emergencies. It is based on a scale scoring system and is complementary to the other three components. The SPAR tool facilitates State Parties to fulfil their obligations under Article 54 of the IHR– Reporting and Review of the IHR to report to the World Health Assembly (WHA).

3.16 The SPAR tool consists of 24 indicators for each of the 13 capacities needed to detect, assess, notify, report and respond to public health events of national and international concern. One to three indicators are used to measure the status of each capacity. Indicators are further broken down to a number of elements called "attributes," which further define the indicator at each level. Each indicator is based on five cumulative levels of capacity. For each indicator, the reporting State Party is asked to select which of the five levels best describes the State Party's current status. For each indicator, in order to move to the next level, all capacities described in previous levels should be in place.

3.17 Trinidad and Tobago's SPAR reports from 2016 to 2019 were submitted by the MoH to the WHO and summaries are available on the WHO's e -SPAR Public website. T&T's Annual SPAR for 2020 and 2021 were not seen on the WHO's website.

3.18 SPAR reports were requested from the MoH from 2016 to 2021 but only a SPAR report dated 11 March 2020 was submitted for examination. The SPAR report for 2020 indicated that it was compiled by officials representing varying sectors as outlined in **Figure 14.**

Figure 14- Sectors Involved in Compiling SPAR Report 2020

Sectors Involved	Sectors not involved
Human Health	Emergency Services
Animal Health	Environment
Disaster Management	Agriculture
Food Safety	Livestock
International Transport/Points of Entry	Fisheries
Finance	Trade
Chemical Safety	Labour
Radiation Safety	Foreign Affairs

[25] WHO IHR Monitoring and Evaluation Framework pg. 11

Education	Tourism/Travel
Other Sectors	Civil Society

Source- State Party Self-Assessment Annual Reporting Tool 11 March 2020

3.19 In 2020, T&T was self- assessed at attributes of the foundation and maturity levels as highlighted in **Appendix 6**. The assessment of these indicators were in relation to the core capacities for: financing for public health emergencies, multi-sectoral collaboration, event based surveillance, human resources for IHR implementation and legislation. This means that for T&T to move above the foundation and maturity levels improvements are required to reach the following maximum capacity levels:

- Monitoring and feedback system for an emergency public financing mechanism is in place and functional; and access to an emergency contingency fund for public health emergency is in place.
- Based on updated all-hazard health emergency risk profile and resource mapping, plans for multi-sectoral all-hazard public health emergency preparedness and response plan are regularly tested and updated.
- Legislation addressing the needs of radiation emergency preparedness and response (according to the radiation risk profiles of the country) are in place, specifying the roles and responsibilities of relevant stakeholders.
- Human Resources for the implementation of IHR capacities are reviewed and updated on a regular basis.

3.20 We found that the gaps in the attributes identified in the indicators of the SPAR 2020 for T&T were consistent with elements of our audit findings for this report.

Conclusion:

The results from T&T SPAR 2020 highlights the need for improvements in certain key attributes of IHR core capacities for:

- An emergency public financing mechanism and contingency fund for public health emergency.
- A public health emergency risk profile with a multi-sectoral all-hazard public health emergency preparedness and response plan.
- Legislation addressing the needs of radiation emergency preparedness and response.
- Regular review and update of Human Resources for the implementation of IHR capacities.

TABLE TOP SIMULATION EXERCISES FOR COVID-19 WERE DONE

Criterion

- "Simulation exercises are primarily used when no suitable event is available for an AAR. They can also be used to test or validate the capacity to respond to rare events such as chemical and radio nuclear events as appropriate."

(IHR (2005) Monitoring and Evaluation Framework 4.3)

3.21 The WHO IHR Monitoring and Evaluation Framework 2018 recommends the use of voluntary simulation exercises to assess the potential functionality of capacities for non-real events. These should be carried out regularly and such exercises can be discussion-based or operations based. Discussion based exercises include table top simulation exercises.

3.22 According to WHO "a simulation exercise is a form of practice, training, monitoring or evaluation of capabilities, involving the description or simulation of an emergency to which a described or simulated response is made". These exercises provide corrective actions which are essential to improve response systems and mechanisms to manage emergencies in the future. A table top simulation exercise involves key personnel discussing simulated scenarios in an informal setting and is less intense than a full scale simulation.

3.23 In July 2019, one RHA reported a simulation exercise based on a simulated narrative on a 6.7 magnitude earthquake in Arima. This simulation exercise tested coordination among the main Emergency Operations Centre (EOC) and sub-EOCs within the ERHA. The incident response to the earthquake included the following diverse organisations: MoH, Sangre Grande Regional Corporation, Mayaro/Rio Claro Regional Corporation, Trinidad and Tobago Police Service, Trinidad and Tobago Fire Service and Trinidad and Tobago Air Guard. In the ERHA's AAR report, it was noted that demotivation of staff was a critical issue and that training is needed for responding to a disaster in the districts under the ERHA.

3.24 The MoH indicated that six table top simulation exercises were conducted for the roll out of the COVID-19 vaccination programme. One of the table top simulation exercises was in relation to the arrival of vaccines into Trinidad at the Piarco International Airport and subsequent transportation to the main storage facility.

3.25 To this end, the MoH engaged the Trinidad and Tobago Defence Force for additional security services, the Customs and Excise Division for the customs clearance process and the National Insurance Property Development Unit (NIPDEC) to facilitate the receipt of the vaccines. Another table top simulation exercise was conducted at a health facility under the NWRHA which focused on regulatory and safety issues, vaccination strategy, supply-chain and communications issues.

3.26 The simulation exercises at the Piarco International Airport and the RHA would have given an idea of some necessary steps relating to security issues and of adverse reactions to the vaccines. Although simulation exercises for IHR implementation are voluntary, the experience of the current pandemic should encourage T&T to conduct future simulation exercises in other core capacity areas of the IHR.

Conclusion:

Although simulation occurred it was mainly in response to the COVOD-19 crisis and a structural approach did not occur.
The experience of the current pandemic should encourage T&T to conduct future simulation exercises in other core capacity areas of the IHR. This should also be a part of the policy framework for the MoH.

Reports of Internal After Action Reviews by the MoH were not seen

Criterion

- "After Action Reviews can address all areas of the response, or they can be targeted on specific functions, to ensure focused discussion around priority learning areas. "

(IHR (2005) Monitoring and Evaluation Framework 4.2.1)

3.27 An After Action Review (AAR) is an in-depth qualitative review of the response actions taken during an actual public health event to help identify gaps, lessons and best practices.[26] An AAR generally takes the form facilitated discussion although other forms of data collection, such as interviews or focus group discussions can also be used to analyse best practices, lessons, and challenges. For an AAR to be effective, it is recommended by WHO that it should take place within three months of the end of the event, while participants' memories are fresh.

3.28 The MoH indicated that there is a team 'working out of' the CMO's office to conduct AARs. Reports of these AARs were not produced for examination. The MoH indicated that with support from PAHO, they are currently in the process of conducting an Inter Action Review (IAR) for the COVID-19 response.

3.29 The MoH indicated to PAHO that its particular interest with respect to the IAR were in the following pillars:

[26] WHO IHR Monitoring and Evaluation framework (page. 12)

- Surveillance, case, investigation and contact tracing
- Points of entry
- National Laboratory system
- Operational support and logistics in the management and supply chains and workforce resistance.
- Strengthening essential health services during the COVID-19 outbreak
- Public health and social measures.

Conclusion:

Trinidad and Tobago should utilise the other components of the WHO IHR Monitoring and Evaluation Framework for voluntary reviews. This can help identify the causes of preparedness gaps and the lessons learnt which can improve responses to future health emergencies.

CONCLUSION

3.30 T&T has set up an IHR NFP through the office of the CMO, MoH. However, the NFP has been operating without a dedicated IHR Coordinator from 2015 to present. This has weakened the coordination function of the NFP as it placed an extra burden on the CMO who has to be available 24/7 to the WHO to respond to any potential public health emergency of national, regional and international concern. Further, T&T has been consistent in completing the mandatory annual SPAR according to WHO's standards. However, documents were not produced by the MoH to determine whether gaps and corrective actions were identified and taken respectively in these assessments. The MoH should utilize the other components recommended by WHO for monitoring and evaluating IHR implementation. This would aid in the documentation of lessons learned during public health emergency.

CHAPTER 4- LEGAL AND POLICY FRAMEWORK

CAPACITY GAPS IN THE LEGAL FRAMEWORK

Criterion:

- "State Parties need to have an adequate legal framework to support and enable implementation of all of their obligations and rights" for IHR (2005). In some state parties, implementation of the IHR (2005) may require new or modified legislation.

  (IHR Core Capacity Monitoring Framework: Checklist and Indicators for Monitoring Progress in the Development of IHR Core Capacities in States Parties 2005, April 2013)

4.1 According to the IHR Core Capacity Monitoring Framework: Checklist and Indicators[27], "state parties need to have an adequate legal framework to support and enable implementation of all of their obligations and rights" for IHR (2005). In some state parties, implementation of the IHR (2005) may require new or modified legislation.

4.2 The IHR (2005) scope is not limited to any specific disease or manner of transmission, but covers illness or medical condition. This is regardless of origin or source that presents or could present significant harm to humans. By not limiting the application of the IHR (2005) to specific diseases, it is intended that these regulations will maintain their relevance and applicability for many years to come even in the face of the continued evolution of diseases and of the factors determining their emergence and transmission.

4.3 Our review of the Constitution of the Republic of Trinidad and Tobago, Act 4 of 1976 and twenty-six other legislation revealed that the Quarantine Act Chapter 28:05 and the Public Health Ordinance No. 15 of 1915 are the main laws utilized for the implementation of IHR (2005).

4.4 The Constitution gives the President the power to declare that a state of emergency exists. Events such as infectious disease or other calamity are explicitly recognised as emergencies. During a period of public emergency, Parliament may enact a law that is to have effect during the period and the President may make regulations for the purpose of dealing with the situation.

4.5 The Quarantine Act was passed in 1944 and its thrust was to establish a legal and institutional framework to prevent the international spread of disease through aircrafts and vessels arriving into and leaving from Trinidad and Tobago, through points of entry.

[27] IHR CORE CAPACITY MONITORING FRAMEWORK: Checklist and Indicators for Monitoring Progress in the Development of IHR Core Capacities in States Parties 2005, April 2013

4.6 The 1915 Public Health Ordinance was to establish an institutional and regulatory framework for the purpose of public health and safety. Over the years, powers enshrined in the Public Health Ordinance relating to public health were devolved to other state bodies by legislation such as the Municipal Corporations Act, Chapter 25:04, the Water and Sewerage Act, Chapter 54:40 and the Tobago House of Assembly Act, Chapter 25:03 as outlined in **Figure 15** below. Though still in force despite the devolution, the health protection rules contained in the Public Health Ordinance are for the most part no longer currently relevant.

4.7 Amendments to the Public Health Ordinance and the Quarantine Act can be made through legal notices when necessary to deal with emerging risks.

Figure 15: Powers within the Public Health Ordinance Devolved to Other State Bodies as Amended by Legislation

Powers under Public Health Ordinance		Powers Devolved to Other State Body
The institutional framework was headed by a Central Board of Health.	→	Replaced by the Minister of Health as amended by the Water and Sewerage Act in 1965.
The powers of the Central Board of Health to have direction of all measures dealing with dangerous infectious diseases and the making of regulations for the control of any dangerous infectious disease.	→	Transferred to the Minister of Health via the Quarantine Act.
Local Authorities for urban and rural sanitary districts.	→	Incorporated under the 14 municipal corporations via the Municipal Corporations Act.
The Minister of Health has jurisdiction over sanitary districts, one of which is the Port Authority.	→	President has general responsibility for the Port Authority.
The institutional framework was headed by a Central Board of Health.	→	The Minister of Local Government is responsible for all municipal corporations and has the power to give general or specific directions in relation to Government policy under the Municipal Corporations Act.
The functions of the Medical Inspector of Health.	→	Now performed by the Medical Officer of Health under the Municipal Corporations Act.
The institutional framework was headed by a Central Board of Health.	→	The Tobago House of Assembly is responsible for the formulation and implementation of policy in respect to health services via the Tobago House of Assembly Act.

4.8 The Minister of Health under the Public Health Ordinance supervises and directs a network of local authorities, each of which is given jurisdiction over sanitary districts. These local authorities and sanitary districts include the Port Authority and the Corporations which fall under the Municipal Corporations Act. The President has general responsibility for the Port Authority and may give the Port Authority directions of a special and general character on the policy to be followed in exercising its powers and duties and the Port Authority is obligated to give effect to them. Whereas, the Minister with responsibility for municipal corporations under the Municipal Corporations Act may give general or specific directions to any Council in relation to its actions in accordance with any such directions. There is therefore potential conflict with the power given to the Minister of Health under the Public Health Ordinance and the powers of the President in relation to the Port Authority, as well as the powers of the Minister with responsibility for municipal corporations under the Municipal Corporations Act. The devolving of powers highlights that there is a greater need for a holistic piece of legislation, as there is no clear public authority responsible for public health and related matters within Trinidad and Tobago. The absence of this holistic legal framework has led to the risk of the overlap and duplication of roles. Additionally, there are unclear jurisdictions amongst the Ministry of Health, Ministry of Rural Development and Local Government and the Tobago House of Assembly.

Gaps in the policy framework for emergency preparedness

Criterion:

- "In their approach to disaster risk reduction, States, regional and international organizations and other relevant stakeholders should take into consideration the key activities listed under each of these four priorities and should implement them, as appropriate, taking into consideration respective capacities and capabilities, in line with national laws and regulations. The four priorities areas are as follows:
  Priority 1: Understanding disaster risk.
  Priority 2: Strengthening disaster risk governance to manage disaster risk.
  Priority 3: Investing in disaster risk reduction for resilience.
  Priority 4: Enhancing disaster preparedness for effective response and to "Build Back Better" in recovery, rehabilitation and reconstruction. "

  (Sections 20 and 21, IV. Priorities for Action of the Sendai Framework for Disaster Risk Reduction)

4.9 The Quarantine legislation contains broad discretionary powers that speak to the implementation of health measures in emergencies, the collection and transmission of quarantine information and the provision of orders and instructions to carry out the Quarantine Regulations as outlined in **Figure 16**.

Figure 16: Wide Discretionary Powers of Quarantine Legislation

Legislation	Section Found	Purpose
Quarantine Act Chapter 28:05	Section 4	To implement health measures in emergencies.
Quarantine (Maritime) Regulations of the Quarantine Act	Regulation 49	To collect and transmit all quarantine information to which the government is a party.
Quarantine (Air) Regulations of the Quarantine Act	Regulation 31	
Quarantine (Maritime) Regulations of the Quarantine Act	Regulations 53	To give orders and instructions and take action to carry out the Quarantine Regulations.
Quarantine (Air) Regulations of the Quarantine Act	Regulation 40	

4.10 IHR (2005) requires that state parties assess and notify the WHO of events that may constitute a public health emergency of international concern. There are powers articulated in legislation to allow the GoRTT to make an assessment of public health.

4.11 Section 21, IV. Priorities for Action of the Sendai Framework for Disaster Risk Reduction states, "In their approach to disaster risk reduction, States…should take into consideration the key activities listed under each of these four priorities and should implement them, as appropriate, taking into consideration respective capacities and capabilities, in line with national laws and regulations."

4.12 The Disasters Measures Act, Chapter 16:50 is the key legislation governing disaster management within T&T. This Act focuses on providing an environment for disaster response to severe hazards. However, it does not cover all phases of the disaster management cycle, in that it excludes areas which strengthen health resilience such as health emergency prevention, mitigation, preparedness and recovery. The ODPM has indicated that the current Act is being reviewed.

Gaps in Legal Framework:

- The absence of a holistic legal framework for public health.
- The absence of the clear delineation of roles and jurisdictions results in the risk of duplication and overlapping of roles.
- The absence of clear powers and responsibilities for public health.
- The absence of clear powers and responsibilities for emergency preparedness.
- Quarantine (Air) and (Maritime) Regulations are limited in that they do not cover possible medical conditions and hazards as mentioned in the scope of the IHR (2005).
- The Disaster Measures Act, Chapter 16:50 does not cover all phases of the disaster management cycle as it excludes health emergency prevention, mitigation, preparedness and recovery, which are necessary to strengthen health resilience.

Conclusion:

The present legal framework for implementing IHR (2005) requires legislative review to sufficiently address the overlapping and duplication of responsibilities and unclear jurisdictions relating to public health. Without a holistic legal framework, T&T would be unable to make a robust, well-coordinated and multi-sectoral response to provide capacity-building needs to benefit all sectors of the population in future pandemics.

GAPS IN THE POLICY FRAMEWORK WHEN COMPARED TO SENDAI FRAMEWORK

Criteria:

- "mainstream and integrate disaster risk reduction within and across all sectors and review and promote the coherence and further development, as appropriate, of national and local frameworks of laws, regulations and public policies."

  (The UN Sendai Framework for Disaster Risk Reduction 2015-2030)

- "In addition, policies which identify national structures and responsibilities (and otherwise support implementation) as well as the allocation of adequate financial resources) are also important."

  (IHR Core Capacity Monitoring Framework: Checklist and Indicators for Monitoring Progress in the Development of IHR Core Capacities in States Parties 2005, April 2013)

4.13 According to IHR Core Capacity Monitoring Framework: Checklist and Indicators, "…policies which identify national structures and responsibilities (and otherwise support implementation) …are important."

4.14 The UN Sendai Framework for Disaster Risk Reduction 2015-2030 was ratified by T&T in January 2020. This new framework highlights the need to "mainstream and integrate disaster risk reduction within and across all sectors and review and promote the coherence and further development, as appropriate, of national and local frameworks of laws, regulations and public policies."

4.15 Regionally, T&T, as a Participating State of the Caribbean Disaster Emergency Management Agency (CDEMA), has adopted the Regional Comprehensive Disaster Management (CDM) Strategy and Framework 2014-2024. The Regional CDM Strategy and Framework stated that its long term goal and impact statement is "safer, more resilient and sustainable CDEMA

Participating States through CDM." CDM is an "integrated approach to disaster management of all hazards through all phases of the disaster management cycle (prevention and mitigation, preparedness, response, recovery and rehabilitation).[28] The Regional CDM Strategy and Framework 2014-2024 is aligned with the Sendai Framework.

4.16 The ODPM, under the remit of the Ministry of National Security, has been designated as the operational and implementing agency for the Sendai Framework. The ODPM has also been designated with the national responsibility for the country's CDM System.

4.17 We perused the Comprehensive Disaster Management Policy Framework for Trinidad and Tobago as presented on the website of the ODPM along with the ODPM's other policies (**Figure 17**). The audit found the ODPM's policies were aligned with the Hyogo Framework instead of the current Sendai Framework. The Hyogo Framework predates the Sendai Framework.

Figure 17 - Policies On Disaster Risk Reduction And Date Developed On ODPM Webpage

Name of Policy	Year Developed
National Response Framework	November 26, 2010
Crisis Communication Guidelines And Response Plan	April 2011 updated.
National Hazard Mitigation Plan: ODPM Multi-Hazard Plan	2012
Ministry of Health. Trinidad And Tobago National Radiation Emergency Plan (NREP)	November 2012
National Hazard Mitigation Plan: Snapshot	August 7, 2014
National Hazardous Materials Spill Response Plan: Snapshot	July 24, 2014
National Pandemic Response Plan: Snapshot	July 21, 2014

4.18 The strategic goals of the Comprehensive Disaster Management Policy Framework were closely aligned to the those of the Hyogo Framework for Action 2005-2015 as follows:

(a) The more effective integration of disaster risk considerations into sustainable development policies, planning and programming at all levels, with a special emphasis on disaster prevention, mitigation, preparedness and vulnerability reduction;

(b) The development and strengthening of institutions, mechanisms and capacities at all levels, in particular at the community level, that can systematically contribute to building resilience to hazards;

(c) The systematic incorporation of risk reduction approaches into the design and implementation of emergency preparedness, response and recovery programmes in the reconstruction of affected communities.

[28] CDEMA. What is Comprehensive Disaster Management (CDM), Pg. 1

4.19 According to the National Hazard Mitigation Plan, the five (5) priorities provided by the 'Hyogo Framework for Action (HFA) 2005-2015,' has heavily informed the ODPM's three (3) strategic goals: 100% Readiness, Legislative Authority and 100% National Risk Reduction.

4.20 The ODPM indicated that the reviewing of the policies are at different stages of development and are expected to be submitted to Cabinet for approval before the end of 2022.

Gaps in Policy Framework:

The ODPM's policies were aligned with the Hyogo Framework for Action instead of the current Sendai Framework for Disaster Risk Reduction in that:

- There is a strong emphasis on disaster management instead of disaster risk management,
- The reduction of disaster risk is not promoted as an expected outcome,
- There is an absence of a goal focused on preventing new risk and reducing existing risk,
- There is no focused action to "Build Back Better" in recovery, rehabilitation and reconstruction.

Conclusion:

The non-alignment of the ODPM's policies with the Sendai Framework prevents the CDM plans for other government agencies and departments from incorporating the current best practices and fill gaps in disaster risk reduction. These include gaps relating to disaster risk governance at the national, regional and global levels for prevention, mitigation, preparedness, response, recovery, rehabilitation, collaboration and partnership. The ODPM should continue its efforts to ensure that their policies and legislation relating to disaster risks are aligned to current international best practice.

WEAKNESSES IN VERTICAL COHERENCE FOR PUBLIC HEALTH EMERGENCY AND DISASTER RISK MANAGEMENT WHEN COMPARED TO THE SENDAI FRAMEWORK

Criteria:

- "In examining the extent of vertical coherence, the SAI auditor may seek to ascertain the extent of coordination prevalent from the federal (if applicable), to the state, to the local contexts, with the role of civil society and other key stakeholders included as an integral part of this analysis.''

  (ISAM- IDI's SDG Audit Model)

- "To encourage parliamentarians to support the implementation of disaster risk reduction by developing new or amending relevant legislation and setting budget allocations".
- "The Inter-Parliamentary Union and other relevant regional bodies and mechanisms for parliamentarians, as appropriate, to continue supporting and advocating disaster risk reduction and the strengthening of national legal frameworks."

  (Sections 27 (i) and 48 (h) of the Sendai Framework for Disaster Risk Reduction)

4.21 Coherence is defined by the Organisation for Economic Co-operation and Development (OECD) as "the systematic promotion of mutually reinforcing policy actions across government departments and agencies, creating synergies towards achieving the agreed objectives."

4.22 Vertical coherence refers to a consistent approach across all levels of government to ensure that the implementation process reflects local, regional and global considerations.

4.23 The Sendai Framework, under Sections 27 (i) and 48 (h) respectively, identifies the following focused action by states: "To encourage parliamentarians to support the implementation of disaster risk reduction by developing new or amending relevant legislation and setting budget allocations" and "The Inter-Parliamentary Union and other relevant regional bodies and mechanisms for parliamentarians, as appropriate, to continue supporting and advocating disaster risk reduction and the strengthening of national legal frameworks."

4.24 Our examination of this area revealed that T&T in ratifying the Sendai Framework is vertically aligned to this international policy for Disaster Risk Reduction and the Regional CDM Strategy and Framework 2014-2024. However, the policies of the ODPM have not been updated to reflect this. Shortcomings were found in the role of legislators and parliamentarians as the Disaster Measures Act is still not amended to incorporate Comprehensive Disaster

Management which emphasizes health emergency prevention, mitigation, preparedness and recovery and include a multi-hazard approach. In addition, legislation has also not been amended to establish a Disaster Management Fund or any special provision for an emergency release of funds in the event of a disaster.

Gaps in Vertical Coherence:

- Legislation is not amended to incorporate Comprehensive Disaster Management.
- There is no established Disaster Management Fund and no special provision for an emergency release of funds in the event of a disaster.
- CDM policies at the ODPM were not consistent with the international Sendai Framework.

WEAKNESSES IN HORIZONTAL COHERENCE

Criteria:

- "The SAI auditor can verify the effective functioning of government in terms of horizontal coherence, whereby the focus is on whether the various ministries and agencies work in a synchronized manner."

  (ISAM- IDI's SDG Audit Model)

4.25 Horizontal coherence takes into account interdependencies in dimensions and sectors, manages trade-offs and conflicting policy priorities and maximizes synergies between mutually supportive policies.

4.26 The National Development Strategy (NDS) for Trinidad and Tobago - Vision 2030 also stated, "Delivering good governance will be at the forefront of development efforts to: enhance policy making and resource allocation…"

4.27 Horizontal coherence was found in the areas whereby policies for CDM were integrated with each other and there was collaboration and coordination amongst the ODPM, MoH and RHAs.

4.28 Our examination revealed weaknesses in horizontal coherence[29] in that the MPD had not set up the delivery mechanism for Vision 2030 to fulfil its responsibility relating to SDG 3.d. The MPD's responsibility is to manage the key transformational programmes for achieving Vision 2030, as well as the human resource requirements needed for successful implementation. This responsibility is to facilitate an integrated approach to project planning and execution. Other responsibilities were to avoid duplication, determine the development gaps that were to be

[29]. (ISAM- IDI-SDG Audit Model)

addressed and promote holistic development. The MPD recognised the significance of horizontal coherence by the need for the establishment of Vision 2030 Delivery Unit.

4.29 Due to the absence of a holistic approach by the MPD, we found that some key players such as Immigration Division and the Attorney General did not understand their roles with respect to SDG 3.d. These stakeholders referred the AGD to the MoH for responses to audit questions instead of answering for themselves. However, the MoH played a key role by interfacing with institutions and bodies when health emergency situations arose.

Gaps in Horizontal Coherence:

- The MPD did not set up the Vision 2030 Delivery Unit, in which one of the responsibility is the management of key transformational programmes for achieving Vision 2030.
- Policy framework outlining roles and responsibilities by key stakeholders needs to be strengthened.

Conclusion:

The gaps within vertical and horizontal coherence could contribute to inaction in the governance of legislative and financial frameworks for disaster risk reduction and non-integration in policies, which could hinder the preparedness and response to health shocks. The MPD should take action to develop the delivery mechanism for Vision 2030 to achieve SDG 3.d through strengthened coordination, collaboration and coherence of agencies in their respective roles within a whole of government approach. Legislators and parliamentarians should ensure that the legislation is amended to incorporate the Comprehensive Disaster Management Programme. In addition, a Disaster Management Fund and special provision for an emergency release of funds to the ODPM in the event of a disaster should be established.

MULTI-STAKEHOLDER ENGAGEMENT FOR LEGAL AND POLICY FRAMEWORK

Criteria:

- "A national Vision 2030 Communications Strategy will be developed to solicit the views of stakeholders as well as to sensitise and inform citizens on Vision 2030 plans and progress."
- "collaboration among various actors and an integrated approach among many sectors to address cross-cutting issues such as gender, the environment and human security are necessary if we are to succeed in achieving the Vision 2030."

(The National Development Strategy - Vision 2030)

4.30 The National Development Strategy - Vision 2030 also recognizes that, "…there is collaboration amongst various actors and an integrated approach among many sectors to address cross-cutting issues such as gender, the environment and human security…"

4.31 Our survey with 1,049 participants from the general public were questioned on whether they receive information from the government on the formation of laws and policies in relation to public health, emergency and disaster risk management.

4.32 Out of 1,021 responses, approximately 522 or 51% of respondents indicated that they did not receive information from the government on the formation of laws and policies related to public health emergency and disaster risk management.

4.33 Participants in focus groups from the Regional Corporations, Private Practitioners and the Trinidad and Tobago Registered Nurses' Association (TTRNA) expressed concerns with the creation of legal and policy frameworks and indicated that they would like to be included in the decision-making process.

4.34 The MoH indicated that there is active engagement of citizens and stakeholders for the creation of robust legal and policy frameworks in relation to public health emergency and disaster risk management. However, it was difficult for the audit team to corroborate this as documentation on stakeholder consultations were not provided for examination.

Gaps in Multi-stakeholder Engagement:

- A little over a half of respondents from the general public survey indicated that they did not receive information from the government on the formation of laws and policies related to public health emergency and disaster risk management.
- Some multi-stakeholders from a focus group meeting also expressed concerns with the creation of legal and policy framework. These stakeholders also indicated that they would like to be included in the decision-making process.

Conclusion:

When there are weaknesses in multi-stakeholder consultation, the contributions made by vital stakeholders are omitted in the drafting of policies and legislation. Therefore, the GoRTT needs to strengthen the approach to consultation with the enacting of legislation and policies for public health emergency and disaster risk management.

CONCLUSION

4.35 Capacity gaps were found in the legal framework for the implementation of IHR (2005) and emergency preparedness. The legislation in relation to public health and safety contain the risk for duplication and overlapping of roles by certain state bodies. Additionally, there is no delineation of roles, as the jurisdictions amongst the Ministry of Health, Ministry of Rural Development and Local Government and the Tobago House of Assembly are unclear. The health protection rules contained in the 1915 Public Health Ordinance although not repealed, are for the most part no longer currently relevant. The Disaster Measures Act, which is the key legislation that addresses disaster management within Trinidad and Tobago excludes areas which strengthen health resilience such as health emergency prevention, mitigation, preparedness and recovery. Legislative review is therefore required to address the issues previously mentioned above. Though the obligations of IHR (2005) are being performed by the GoRTT through legal, administrative and other government instruments, the current legal framework is still not adequate and coherent to support and enable the implementation of all of the obligations under the IHR (2005).

CHAPTER 5 – RESILIENCE DURING COVID-19 AND LESSONS LEARNT

5.1 The COVID-19 pandemic caused shocks throughout the world's health systems and impacted the social and economic fabric of all countries including T&T. Lessons learnt from these shocks is one aspect of enhancing resilience in public health systems.

5.2 The European Observatory on Health Systems and Policies (the Observatory) supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health care systems in Europe. It has an extensive publication programme designed to disseminate evidence, including health system reviews.

5.3 According to a 2021 report[30] by the Observatory in partnership with WHO, "…the current pandemic has proven that there is no wealth without health; and that it is crucial for countries to invest in building strong health systems for any future health threats acting on the lessons learned during this pandemic…"

5.4 The aim of the study by the Observatory was to capture the key strategies for a resilient health system response to the COVID 19 pandemic, to draw lessons for the post-pandemic recovery and improve health systems preparedness to respond to future threats. There were 20 strategies **Appendix 7** mentioned in the report under five broad categories as outlined:

- Leading and Governing the COVID-19 Response
- Financing COVID-19 Services
- Mobilizing and Strengthening the Health Workforce
- Strengthening Public Health Interventions
- Transforming Delivery of Health Services to Address COVID-19 and other needs.

5.5 In this audit, T&T's response to COVID-19 was compared against 7 strategies suggested by the Observatory. These are detailed in **Figure 15.**

[30] Health Systems Resilience during COVID-19 Lessons for building back better/European Observatory on Health Systems and Policies/ WHO 2021.

Figure15: Strategies of the Observatory used to compare T&T's COVID-19 response

Leading and Governing the COVID-19 Response	
Strategy 7	Communicating clearly and transparently with the population and stakeholders.
Strategy 8	Involving non-governmental stakeholders including the health workforce, civil society and communities.
Financing COVID-19 Services	
Strategy 10	Ensuring sufficient and stable funds to meet needs.
Mobilizing and Supporting the Health Workforce	
Strategy 13	Ensuring an adequate health workforce by scaling up existing capacity and recruiting additional health workers.
Strategy 15	Ensuring physical, mental health and financial support for health workers.
Strengthening Public Health Interventions	
Strategy 16	Implementing appropriate non-pharmaceutical interventions and Find, Test, Trace, Isolate and Support (FTTIS) services to control or mitigate transmission.
Transforming Delivery of Health Services to Address COVID-19 and other needs	
Strategy 19	Scaling-up, repurposing and redistributing existing capacity to cope with sudden surges in COVID-19 demand.

Source- Health Systems Resilience during COVID-19 Lessons for building back better/European Observatory on Health Systems and Policies/ WHO 2021.

COMMUNICATION WITH CITIZENS DURING THE PANDEMIC

Criterion

- "Effective communication with the public and relevant stakeholders is key to delivering public health messages to prevent infection and to share expectations and requirements. It is also central to trust and compliance."

(Health Systems Resilience during COVID-19 Lessons for building back better/European Observatory on Health Systems and Policies/ WHO 2021 (Strategy 7)

5.6 One of the key observations under Strategy 7 of the Observatory was that "Effective communication with the public and relevant stakeholders is key to delivering public health messages to prevent infection and to share expectations and requirements. It is also central to trust and compliance." The Observatory under Strategy 7 also indicated that "Disseminating public health and other "pandemic" information through a variety of channels (broadcast,

print press, social media etc.) increases its reach, particularly when these reflect popular preferences."

5.7 T&T displayed elements under leading and governing the COVID-19 response through clear and transparent communication with the population and stakeholders. This, according to minutes from the meeting of the Multi-Sectoral Committee to treat with COVID-19 and Other Infectious diseases, revealed that this was facilitated through a Public Communication Plan in 2020.

5.8 This plan was developed by the MoH in collaboration with representatives from ODPM, Ministry of Communication and the Ministry of Rural Development and Local Government. The primary goals of plan were: "To increase public trust in the COVID-19 vaccine, to encourage public uptake of the COVID-19 vaccine and to communicate the national COVID-19 deployment plan to the public in simple language with easy actionable steps".

5.9 Audit noted that the government communicated with the population through regular and consistent communication via print media, social media, radio and television throughout the COVID-19 pandemic. This included press conferences which were hosted by the Honourable Prime Minister of the Republic of T&T, the Minister of Health and the Chief Medical Officer. These conferences at times included the Ministers of Finance, National Security, Education, Public Administration and Communications and the Attorney General. Minutes from the meeting of Multi-Sectoral Committee to treat with COVID-19 and Other Infectious diseases revealed that loud speakers were also used to share messages in various communities. Communities were chosen based on population density, presence of COVID-19 cases and high crime rates. These forms of communication were within the campaign of the Public Communication Plan, Phase 3 (June 2021).

INVOLVEMENT OF NON-GOVERNMENTAL STAKEHOLDERS DURING THE COVID-19 PANDEMIC

Criterion

- "Engaging with non-state actors ought to be an important tool for policy-makers both in formulating informed, appropriate and acceptable responses to the pandemic and in increasing trust in the government's measures so as to enhance implementation."

(Health Systems Resilience during COVID-19 Lessons for building back better/European Observatory on Health Systems and Policies/ WHO 2021 (Strategy 8)

5.10 One of the key observations under Strategy 8 of the Observatory was that "Engaging with non-state actors ought to be an important tool for policy-makers both in formulating informed, appropriate and acceptable responses to the pandemic and in increasing trust in the government's measures so as to enhance implementation."

5.11 The MoH consulted with stakeholders in accordance with its Stakeholder Engagement Plan during the COVID-19 pandemic. These consultations included discussions with the media, medical and clinical staff, vulnerable groups and the general public. The discussions included topics relating to T&T's vaccination roll out, psychological impact of reporting during a pandemic, the war against misinformation and vaccine hesitancy and acceptance. The primary goals among others in the campaign to reach stakeholders were: to increase public uptake and trust in the COVID-19 vaccine, to counter any misinformation and false news concerning the virus and the vaccine, and to increase public awareness of the work the Ministry of Health and by extension, the Government of Trinidad and Tobago (GoRTT).

5.12 According to the Pubic Communication Plan, Phase 3, June 2021, the Ministry of Health, in partnership with the University of the West Indies (UWI), St Augustine hosted a virtual symposium for healthcare workers on Sunday 7th February, 2021. This symposium provided information on the COVID-19 vaccine and included a Question and Answer segment. While invitees were primarily healthcare workers, representatives from key organisations and business chambers were also invited.

5.13 At a focus group in 2021, the Trinidad &Tobago Medical Association stated that they were involved in policy decisions for vaccination and COVID-19 management. However, the Trinidad and Tobago Registered Nurses Association (TTRNA) indicated that they were not included in the policy decision making for the current COVID-19 pandemic. The TTRNA pointed out that they asked the government to consider health insurance for healthcare workers who died during the COVID-19 pandemic but were not given any feedback. The TTRNA also indicated that they asked the government for a hazard allowance for healthcare workers assigned to COVID-19 specific facilities. The MoH indicated that meetings were held with the TTRNA concerning human resource issues, however documentation on this was not provided for audit.

5.14 Involvement through consultations with a key stakeholder such as the TTRNA during the pandemic was vital for policy decision during the pandemic. This was especially so since they represent a key segment of healthcare workers who had burn out, other mental health issues and demotivation during the pandemic.

T&T'S PUBLIC SECTOR ACCOUNTING SYSTEM DOES NOT PROVIDE FOR RESERVE FUNDING SPECIFIC TO PUBLIC HEALTH

Criterion

- "…the ability to draw on financial reserves or undertake public borrowing helps countries meet unpredictable spending needs. However, countries that had built-up reserve funding specifically for health found it easier to cover financing gaps…"

(Health Systems Resilience during COVID-19 Lessons for building back better/European Observatory on Health Systems and Policies/ WHO 2021 (Strategy 10)

5.15 Sustainable health financing is one of the building blocks of a resilient health system. This is important especially when an economy faces financial challenges as with the COVID-19 pandemic. One of the key observations under Strategy 10 of the Observatory was that "…the ability to draw on financial reserves or undertake public borrowing helps countries meet unpredictable spending needs. However, countries that had built-up reserve funding specifically for health found it easier to cover financing gaps…"[31]

5.16 Trinidad and Tobago's accounting system for the public sector does not provide for a reserve fund specifically for public health. In T&T, a health surcharge is payable by individual taxpayers but is not specifically used for health. For the years 2016 to 2021, government revenue from health surcharge amounting to approximately $1.15 Billion has been remitted to the Consolidated Fund.

5.17 To cater for financing gaps during the COVID-19 pandemic, Parliament approved an amendment to the Heritage and Stabilisation Fund Act to allow for withdrawals of up to US$1.5 Billion in the event of a health crisis, a natural disaster or a precipitous drop in budgeted revenue during a financial year. In 2021, US900 million was withdrawn from the Heritage and Stabilisation Fund.

5.18 The response to our survey of 319 health workers throughout the RHAs revealed that 260 or 81.5% disagreed with the statement "allocation of funding for heath emergency preparedness at public health facilities is sufficient".

5.19 There is no system in place for a reserve fund specifically designated for public health during a public health emergency. Building a reserve public health fund could reduce the financial strain on government when a health crisis hits. A public health fund would therefore increase the resilience of the country to recover from potential threats that may affect citizens.

[31] Health Systems Resilience during COVID-19 Lessons for building back better/European Observatory on Health Systems and Policies/ WHO 2021 (pg. 42)

FUNDS WERE ACCESSED FROM MANY SOURCES TO LEAVE NO ONE BEHIND

Criterion

- "The resources and mechanisms to provide adequate income and social support (sick pay, other financial support or benefits) allow isolation policies to be implemented more effectively and are also critical in supporting those who have lost their work due to the pandemic."

(Health Systems Resilience during COVID-19 Lessons for building back better/European Observatory on Health Systems and Policies/ WHO 2021 (Strategy 16)

5.20 One of the key observations under Strategy 16 of the Observatory was that the resources and mechanisms to provide adequate income and social support (sick pay, other financial support or benefits) allow isolation policies to be implemented more effectively and are also critical in supporting those who have lost their work due to the pandemic.

5.21 The government accessed funding in 2020 of approximately $10 Billion from several local and international sources to mitigate the effects of the pandemic as follows:

- Domestic capital market - TT$1 Billion
- Heritage and Stabilization Fund (HSF) - US$ 900 Million
- World Bank- US$20 Million
- Inter-American Development Bank (IDB) - US$130 Million
- Development Bank of Latin America (CAF) - US$150 Million
- External capital market - US$150 Million.

5.22 Our analysis focused on social and humanitarian aid during the pandemic. **Figure 16** outlines some of the COVID-19 grants relating to the Social/Humanitarian Programme totalling approximately $1.1 Billion. Grants and sums for food and income support, accelerated income tax refunds, salary relief grants and food and income support accounted for approximately $723.4 Million or 66.8% of the total value of grants. Some of the grants were for a period of one to three months and some were one off.

Figure 16- Grants relating to the Social / Humanitarian Support Programme 2020 – 2021

Type of Grants/Other	Number of Grants	Value $Million
Accelerated Income Tax Refunds	**-**	**334.4**
Food and Income Support	**51,493**	**221.4**
Salary Relief Grant	**95,124**	**167.6**
Credit Unions	-	100
Market Boxes to NGOs and Constituencies	139.906	81.3
Religious Groups	128	39.9
Households who received meals from School Feeding Programme	29,497	31.4
Public and disability assistance	42,459	22.5
Rental Assistance	4,322	21.6
Emergency Relief to Artiste	3,665	18.3
Existing Beneficiaries of Food Support (additional support)	25,100	17.1
Additional Food Support	3,306	14.2
Food Vouchers and Market Boxes	25,000	6.3
Fuel Relief	2,284	3.9
Humanitarian Assistance to stranded national abroad	459	2.5
Emergency hampers	1,400	0.5
Financial Assistance to non-scholarship students studying at UWI Cave Hill and UWI Mona	182	0.37
TOTAL	**284,599**	**1,083.27**

Source- T&T National Budget 2022

5.23 The United Nations Agenda 2030 envisages a just, equitable, tolerant, open and socially inclusive world in which the needs of the most vulnerable are met. The provision of these grants and other support reflected a concerted effort by the government to leave no one behind during the pandemic. The European Observatory Report indicated that income support is vital to enable people to stay at home, while ensuring they can pay for food and other basic needs. This would have allowed isolation policies to be implemented more effectively.

HEALTHCARE WORKERS EXPERIENCED MENTAL HEALTH ISSUES AND BURNOUT

Criterion

- "Protecting the physical and mental health of health workers is key to sustaining workforce commitment and minimizing absenteeism and burnout".... "Providing practical support allows staff to continue to work."

(Health Systems Resilience during COVID-19 Lessons for building back better/European Observatory on Health Systems and Policies/ WHO 2021 (Strategy 15)

5.24 The Observatory in one of its key observation under Strategy 15 indicated that "Protecting the physical and mental health of health workers is key to sustaining workforce commitment and minimizing absenteeism and burnout".... "Providing practical support allows staff to continue to work. " The Observatory also indicated that many countries took steps to provide childcare in the face of school closures, keeping places open for the children of health care workers or paying allowances. Other practical measures included offering accommodation or free transport, and some countries made additional payments to increase financial support.

5.25 The PAHO's COVID-19 Health Care Workers Study (HEROES) - Regional Report from the Americas 2022 indicated that "protecting the mental health of health teams should be an important component of countries' strategies for dealing with the post-pandemic period. This was especially so given the substantial impact it had on the mental health of health teams."

5.26 In response to the COVID-19 pandemic, the MoH scaled up its capacity by: hiring retired health personnel and other additional staff, asking staff to work extra hours, cancelling vacation leave, and redeployment of staff to areas in greater need.

5.27 The TTRNA indicated that health personnel were vulnerable to burnout because of working extra hours and forgoing their vacation leave during the pandemic. The feedback from our survey with 319 health personnel revealed that 154 or 48% of health workers complained of staff shortages, burnout and lack of motivation. The lack of motivation of health workers was rooted in the following:

- Unpaid compensation for overtime
- Uncertainties with job security
- Improper meals and transportation
- Lack of support for childcare
- Poor working conditions.

5.28 The MoH indicated that there is a draft policy that addresses the mental health of health workers. Additionally, the Mental Health & Psychosocial Support Network of Trinidad and Tobago[32] through Fine Care TT offers a series of free services for citizens, including health workers, in response to national emergencies.

5.29 According to one of the recommendations of the HEROES report, "…social support alone is not enough to mitigate the effects of mental health issues during a health crisis. This must be supplemented by adequate working conditions, decent remuneration and stable contractual conditions among others…"

DELAYS IN HEALTHCARE SERVICE DELIVERY WERE INCREASED

Criterion

- "Countries prioritized building up physical infrastructure and producing/procuring essential equipment and supplies. Increasing the health workforce capacity at a similar rate is extremely difficult but essential: increasing the number of hospital beds or ventilators is futile if there are not enough hospital staff to operate them."

(Health Systems Resilience during COVID-19 Lessons for building back better/European Observatory on Health Systems and Policies/ WHO 2021 (Strategy 19)

5.30 One of the observations under Strategy 19 of the Observatory was that 'Countries prioritized building up physical infrastructure and producing/procuring essential equipment and supplies. Increasing the health workforce capacity at a similar rate is extremely difficult **but essential**: increasing the number of hospital beds or ventilators is futile if there are not enough hospital staff to operate them.'

5.31 The Observatory indicated in its report[33] that the initial strategy of many countries during the COVID-19 pandemic was to temporarily postpone planned healthcare. This occurred while countries developed or extended alternative service delivery routes. The Observatory also indicated that although these innovations may work as short-term solutions in a crisis, it should be carefully considered if they are worth continuing thereafter.

5.32 The MoH indicated that a parallel healthcare system was set up to deal separately with COVID-19 patients so that clinics in the existing health system would not be affected. The CMO stated that the parallel healthcare system was facilitated by resources already available with respect to hospital infrastructure at the onset of the pandemic. This included the Arima

[32] Founded in 2020 in response to the rising needs due to the COVID-19 Pandemic. It is co-chaired by PAHO-WHO and the Ministry of Health of Trinidad & Tobago.
[33] Policy Brief 36 Strengthening Health systems Resilience - Key Concepts and Strategies- European Observatory on Health Systems and Policies 2020 pg. 15

and Point Fortin Hospitals which were completed and commissioned in June and July 2020, the Caura Hospital and the Augustus Long Hospital. The Couva Medical Training Facility was initially earmarked to be used for non-communicable diseases, renal dialysis and eye surgery but it was reallocated for COVID-19 patients.

5.33 The flexibility of the parallel healthcare system allowed the overall health system to temporarily cope with unexpected service demand. Currently, there is a hybrid system in place where two hospitals are used for treating COVID-19 patients.

5.34 A proportion of healthcare workers which included Theatre Nurses from the existing health system were reallocated to meet the needs of the parallel healthcare system. The reallocation of staff from the existing heath system to the parallel healthcare system contributed to existing staff shortages throughout the entire public health system. Our survey with 319 health care workers revealed that 173 respondents or 44.3% were of the view that their organization's handling of staff allocation for patient care during COVID-19 was poor or unacceptable.

5.35 The MoH stated that there were shortages of staff mainly in sub-specialty areas such as neurosurgery and paediatric neurosurgery and that this occurrence is taking place across CARICOM and globally. The MoH further indicated that excess numbers of House Officers, who had general training were recruited during the pandemic. However, they could not be retained because special funding provided for COVID-19 did not continue.

5.36 Our survey results revealed that T&T was among the countries that experienced postponements in planned healthcare due to the COVID-19 pandemic. Based on our survey of 1049 persons from the general public, out of 1022 responses, 646 or 64% of respondents indicated that they had longer waiting times than normal at health facilities during the pandemic. Also, 637 or 63 per cent of respondents stated that there was a higher degree of postponement for elective surgeries and medical appointments as a result of the pandemic.

5.37 The current inadequate human resource at the public health system needs to be addressed. More resilient healthcare going forward would be achieved when T&T's new and existing health facilities are adequately staffed and equipped for future health shocks. Building back better post pandemic would therefore require the government to consider contingencies in human resource recruitment weighted against available funding.

MINIMAL DOCUMENTATION OF LESSONS LEARNT

Criterion

- "Countries are encouraged to document, learn from and share their COVID-19 experiences, including taking proactive steps to collect evidence and advocate for the financing of sustainable capacities. "

(WHO Investing in and building longer-term health emergency preparedness during the COVID-19 pandemic Interim guidance for WHO Member States 6 July 2020.)

5.38 According to the WHO, the documentation, experiences and lessons from COVID-19 is critical[34].This builds on AARs and help identify priority actions to strengthen capacities. It also aids in maintaining and ensuring continued funding for preparedness on a national level.[35]

5.39 During the COVID-19 pandemic the government of T&T appointed a Committee to Investigate the Factors Contributing to Clinical Outcomes of COVID-19 Patients in Trinidad and Tobago. The report of this committee dated February 14, 2022 on the investigation highlighted findings with 16 recommendations, relating to the following among others:

- Data management systems and data verification,
- Non-communicable diseases management
- Mental health support of staff
- Sites within hospitals where demise occurs
- National Policy regarding ICU admissions and care of the elderly
- External assessments of the health care system

5.40 The MoH indicated that they have learned lessons during the COVID-19 pandemic but these were not evaluated and documented. The MoH also indicated that lessons learned would be documented following the COVID-19 assessment of the pandemic. The project for this assessment as stated by the MoH is currently in the procurement/tendering stage where bids are being collected.

5.41 In a request for a written response to the findings and recommendations of an interim report by the Public Administration and Appropriation Committee (PAAC) on the COVID-19 pandemic[36], it was noted that the MoH responded to requests of lessons learnt on the following:

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[34] WHO Investing in and building longer-term health emergency preparedness during the COVID-19 pandemic Interim guidance for WHO Member States 6 July 2020.
[35] Health Systems Resilience during COVID-19 Lessons for building back better
[36] Request for Written Response to the Findings and Recommendations to the Interim Report of the PAAC on the Examination of the Response - of the Public Authorities to the COVID-19 pandemic in Trinidad and Tobago – MoH dated 24/03/2022

- Government's efforts to effectively procure, store distribute vaccines by 2021
- The vaccination plan
- Onsite monitoring immediately post vaccination
- The range and extent of health services that are available to the public
- What patients can expect in terms of waiting times
- What the MoH was doing to encourage patients to access services.

5.42 The MoH stated that lessons were learnt on past health events prior to COVID-19 such as SARS and Ebola and provided a list of those lessons learnt below, however documents to support these were not provided for audit:

- Strengthening of the Pandemic Response Plan (this has been updated for COVID-19)
- Health Surveillance System
- Training of staff and health professionals in guidelines and protocol such as infection prevention and control and sensitization sessions for port health control officers.

5.43 Although the MoH has stated that some lessons were learnt, documentation of this relating to the four core capacities examined for implementing the WHO IHR (2005) was minimal. Effective documentation and communication of lessons learnt by the MoH for recent health events could generate buy-in for the provision of resources to strengthen public health resilience. This would subsequently enable the mobilization of resources to facilitate an effective national response to future health shocks.

Conclusion :

Documentation of lessons learnt from recent and future health shocks is important to build on the experience from such events. Documentation and communication of lessons learnt by the MoH for recent health events could generate buy-in for the provision of resources to strengthen public health resilience. This would subsequently enable the mobilization of resources to facilitate an effective national response to future health shocks.

CONCLUSION

5.44 The MoH has included some lessons learned mainly for the roll out of the vaccination programme during the COVID-19 pandemic. However, the MoH has not yet produced any reviews on past and recent health shocks which could have informed decision making during the COVID-19 pandemic. This, together with the weaknesses in the building blocks identified in this report contributed to gaps in the resilience of the country's public health system during the COVID-19 pandemic. The health workforce was one of the weakest of the building blocks when the pandemic occurred. The weaknesses in the interlinkages between the building blocks of human resources and service delivery relating to health facility

infrastructure tested the resilience of the public health system during the COVID-19 pandemic. This was evident in that the public health system had the requisite hospital infrastructure to facilitate a parallel healthcare system to deal with COVID-19 patients but had a limited and burnt out health workforce for both systems. This resulted in longer waiting times and delays in surgery during the COVID-19 pandemic. In building back better, the MoH needs to ensure that lessons learned are documented and conveyed to the Government to avoid fragmentation of planning in all the building blocks for a strong and resilient public health system.

CHAPTER 6 – STAKEHOLDERS' COMMENTS

By letter dated 27th March, 2023 the Draft Report of the Auditor General of the Republic of Trinidad and Tobago on a "Special Audit of United Nations Sustainable Development Goal 3 Target d – Contributing Towards a Strong and Resilient National Public Health System (2016-2021)" was forwarded to the following stakeholders for their comments:

- Permanent Secretary, Ministry of Health
- Permanent Secretary, Ministry of Planning and Development and
- The Chief Executive Officers, Regional Health Authorities

An extract of the Draft Report was also forwarded to the Office of Disaster Preparedness for their comments.

At the date of this Report, comments were received from the Ministry of Health and the North Central Regional Health Authority. Some extracts from these responses are reproduced hereunder. Paragraph references and subtitles may differ from the Report.

MINISTRY OF HEALTH

CHAPTER 2 - CAPACITIES AND RESOURCES FOR HEALTH RESILIENCE

2.16 to 2.19 - Weaknesses in accessing equipment to deliver healthcare

During the period 2016- 2021, the MOH and the RHAs installed and implemented:

i. **Arima Hospital** from 13% in 2015 to 100% as of June 30th 2020 completed

ii. Point Fortin Hospital from 13% in 2015 to 100% as of June 30th 2020 completed

iii. **Construction and Outfitting of a LINAC Facility** at the St. James Medical Complex launched and opened on June 27th 2020;

iv. Construction of Diego Martin Health Centre- Project was completed and opened on October 6th 2020

v. **Lithotripsy Services** at SWRHA The lithotripsy service at the San Fernando General Hospital commenced on 1st October 2018. For the period October 1st 2018 to end of June 2021, there were 692 lithotripsy procedures performed.

New Equipment for Urology Services at SWRHA for $2.8Mn

The South West Regional Health Authority (SWRHA) has acquired a Holmium Laser 120w machine that allows surgeons to perform surgery on men suffering from enlarge prostates and discharge them in under 24 hours. The San Fernando General Hospital is the only public health

institution with the machine and it allows surgeries to be done faster and decreases the number of times patients spend on the wards. From 18th November 2019 to 30th June 2021, there were 117 procedures performed.

vi. **CT at the Sangre Grande Hospital: Project 100% completed and fully operational**

- **Project Description**: Construction of CT Suite with Ancillary Service and Procurement of CT Scanner for the Sangre Grande Hospital;

- **Long term benefits**: To improve accessibility of treatment to patients for CT services Improved scanning capabilities and reliable delivery of CT services to patients. For the period July 2019 to end June 2021, 12,905 procedures have been performed.

2.8 -2.13 - The complement of health workers needs strengthening

For the COVID-19 public health emergency: We built capacity and will continue to build capacity in human resources as follow:

I. Recruitment of one hundred (100) House Officers &100 Registered Nurses utilizing an Inter-American Development Bank Loan;
II. Recruitment of 50 Monitoring Officers for COVID-19 response at CMOHs;
III. Recruitment of 25 House Officers to conduct community testing for COVID19;
IV. Recruitment of 50 Registered Nurses to conduct community testing for COVID19;
V. Recruitment of 46 Vaccination Nurses for the Vaccination Programme;
VI. Training- ATLS Training for doctors and health care personnel recruited for COVID-19 vaccination programme;
VII. The recruitment of 29 ICU nurses from Cuba in June 2021

2.32 – 2.35 Information Technology is underutilized and unintegrated

During the period 2016 and 2021 several ICT projects were undertaken including:

i. For the Electronic Health Record-the Terms of Reference & Gap analysis and Request for Proposal were completed and sent to IGovTT for review.

ii. Logistics Information Management System (SALMI-Drugs Mgt) The Ministry of Health in partnership with the UNFPA, the United Nations Population Fund have undertaken an initiative to strengthening the supply chain management within the national health system by implementing a National Logistics Management Information System (LIS).

iii. Laboratory Information System (TTLims) Trinidad and Tobago Public Health Laboratory initiative to implement a software that serves a central repository for laboratory information, which can be used by other labs within the health sector. The project has been rolled-out to 58 institutions of which 46 have been operationalized for COVID-19.

iv.GIS Tracking for Vector Borne Diseases Developed a comprehensive GIS system to track and monitor the hot spot areas to align resources for greater impact on the reduction and spread of communicable diseases in the first instance such as dengue and vector borne diseases.

i. For suspected dengue cases, it decreased significantly from 1,687 cases in 2015 to 10 in 2021 (June);

ii. For laboratory confirmed dengue cases, it decreased significantly from 23 in 2015 to 0 cases in 2021 (June).

CHAPTER 3 - COORDINATION AND MONITORING OF IHR IMPLEMENTATION

3.4 – 3.11 Coordination function of the National Focal Point needs strengthening

In our submissions to the ADG team on July 30, 2021 and January 12, 2022 the following was noted:

While there is no hired IHR Coordinator, the National Focal Point, CMO utilizes various departments in executing its functions for IHR including but not limited to the the five (5) Regional Health Authorities supported other MOH departments not limited to eg Insect Vector Control Division, Hansen Programme,

Vet public Health and Trinidad and Tobago Public Health Lab.

In addition to this, there is a dedicated department for Health Disaster Preparedness within the Ministry.

The institutional framework that governs the health sector within Trinidad and Tobago, is relevant in regards to the implementation of SDG target 3d. As it relates to the identified: -

i. Yes, the National Development Strategy encapsulates elements targeting health sector development. The Ministry of Health's Strategic Plan 2021 to 2025 also outlines developmental plans for this sector.

ii. There is a National Pandemic Health Plan and Multi-sectorial Committee. iii. Yes, there is a National Disaster Management Plan.

ii. Yes, Trinidad and Tobago has a Draft National Action Plan and Policy - Antimicrobial Resistance 2017 to 2022

iii. A national strategy for actioning the SDGs is encapsulated within the National Development Strategy/Vision 2030 & the Ministry of Health Draft Strategic Plan 2021-2025

iv. Yes, these are outlined and a core aspect of MOH's Strategic Plan

v. vii The Ministry of Health has a (Draft) Strategic Plan 2021 – 2025

3.22-3.25- Table top Simulation Exercises for COVID-19 were done

The PAHO simulation model was used with supporting structure and guidelines under PAHO's technical expertise during the simulation. Obtain evidence from PAHO team.

Under the office of the CMO, in particular, National Disaster Unit include plans and readiness assessment for possible future public health emergencies using a Whole of Govt and Society approach.

CHAPTER 4- LEGAL AND POLICY FRAMEWORK

4.7 -4.9 Capacity gaps in the legal framework

Several amendments were made to the public health ordinance in the face of COVID-19 and can therefore be easily made in the event of any other public health risks.

4.19 - Gaps in the Policy Framework When Compared to Sendai Framework

The ODPM is currently developing a Country Work Programme which complies with the Sendai Framework. It is therefore misleading not to mention that work is being done to bring Trinidad up to speed with the most recent international framework.

CHAPTER 5 – RESILIENCE DURING COVID-19 AND LESSONS LEARNT

5.38 - Minimal Documentation of Lessons Learnt

While this report covers the period 2016-2021, lessons learnt were documented for Dengue, Malaria, Ebola, SARS, Zika and Chik V. The Ministry of Health has obtained documentation through the first draft After Action Review by PAHO, through the Seemungal's Report and the pandemic assessment to be undertaken.

During the period 2026-2021, the lessons learnt and actions taken to manage public health risks inclusive of establishment of Pandemic Preparedness Plan, Committees, networking and use of resources with evidence in the reduction of cases per disease category.

NORTH CENTRAL REGIONAL HEALTH AUTHORITY

Chapter 2: Capacities and Resources for Health Resilience

1. **Report:** The Distribution Of Healthcare Facilities Contributes To Accessibility for Citizens
   - 2.10 - *"...There was a significant number of vacancies for nursing personnel across the RHAs. Nursing vacancies ranged between 33% at NCRHA."*

   NCRHA: It should be noted that the statement that nursing vacancies ranged between 33% at NCRHA, is a simplification of the entire landscape of the story. There are several categories of nurses on the NCRHA's establishment. The vacancies identified in the Auditor General's Draft Report are specialized nursing positions such as Registered Nurse Licensed Midwives (RNLM), Intensive Care Unit (ICU) nurses or critical care nurses, Licensed Midwives (LM) who are midwifery trained and Enrolled Nursing Assistants (ENA), for which there are national and perhaps Caribbean shortages.

2. **Report:** Weaknesses in Accessing Equipment to Deliver Healthcare (MRI)
   - 2.17 – *"...The NCRHA identified the lack of funding to procure additional medical equipment and supplies as one of the challenges it faced."*

   NCRHA: Additional medical equipment (such as an MRI) requires consideration of the fact that the operationalization of these diagnostic equipment includes the assignment of the appropriate personnel/human resources attached to it. As such, the corresponding Radiologists, Radiographers, Registrars, House Officers, Patient Escorts, all must be considered when increasing the number of medical equipment in an area.

3. **Report:** Information Technology Is Underutilized And Unintegrated
   - 2.33 – *"The health information systems in use can be accessed across the RHAs and are utilized based on the required application at various sites. These are:*
     - *Cellma – Patient Registry at Hospitals*
     - *Prenatal Information System – Women's Health*
     - *Salmi – Supply Chain for Pharmaceuticals."*

   NCRHA: It should be noted that the NCRHA utilizes several health information systems, which is listed below:
   - Bed Management System (created by the NCRHA)
   - LIS –Laboratory Information System (created by the NCRHA)
   - VEPRO – Currently being introduced for NCRHA's Radiology Information System
   - Office 365 - An information management system for NCHRA's Board of Directors and Executive Management
   - ReQlogic - Procurement Management System

- Computerized Maintenance Management Software (CMMS) –An Asset Management System utilized by NCRHA's Biomedical Engineering and Operations Management to manage Planned Preventative Management (PPM) and to send and track work orders.
- Great Plains Software - Financial Accounting System

CHAPTER 7- OUR VIEW

Overall, the government has made some progress towards the achievement of SDG 3.d. in two of the six building blocks for health resilience as it relates to financing and service delivery. However, there were mixed views about the quality of service delivery. The financing of the public health sector over the past five years was consistent. Increased health facilities resulted in increased accessibility for health service delivery. However, some stakeholders reported that financing was insufficient in that equipment and health facilities were under staffed. The government must therefore make greater efforts to link and strengthen the building blocks to accelerate further progress in the implementation of SDG 3.d.

For the implementation of the IHR (2005), the NFP and its office needs to be better staffed with the required complement and competencies as this key office monitors local health risk in collaboration with other agencies and reports to the WHO.

Whilst we recognise that the obligations of the IHR (2005) are being performed by the GoRTT through legal, administrative and other government instruments; the current legal framework however is not adequate and coherent to support and enable the implementation of all of the obligations under the IHR (2005).

We also recognize that government has made a concerted effort to 'leave no one behind' in providing support by way of grants and other financial aid to vulnerable groups.

We noted that the Vision 2030 has placed the MPD as the main coordinator and collaborative body for national achievement. In this role, MPD must provide the policy guidance development and technical support to relevant stakeholders. Thus in order for success in the SDGs, at the national level, the MPD must exercise its oversight and coordinating responsibilities of monitoring stakeholders and ensuring that stakeholders are aware of their roles for the implementation of the SDGs.

2023 May 26

LORELLY PUJADAS

AUDITOR GENERAL

APPENDICES

APPENDIX 1

Local, Regional and International Framework for Implementation of IHR

International/Regional
WHO International Health Regulations (IHR) 2005 WHO: Benchmarks for International Health Regulations (IHR) Capacities Convention on International Civil Aviation (Chicago, 1944) Sendai Framework for Disaster Risk Reduction (2015-2030) Regional Comprehensive Disaster Management (CDM) Strategy and Framework (2014-2024)

Local	
Policies	**Regulations**
➢ Policy for Treating with Non-Nationals with respect to the Provision of Public Health Care Services ➢ National Response Framework ➢ Crisis Communication Guidelines And Response Plan ➢ Trinidad And Tobago National Radiation Emergency Plan (NREP) ➢ National Hazard Mitigation Plan: Snapshot ➢ National Hazardous Materials Spill Response Plan: Snapshot ➢ National Pandemic Response Plan: Snapshot ➢ Comprehensive Disaster Management Policy Framework for Trinidad and Tobago ➢ Comprehensive Disaster Management Plan for the Health Sector	➢ Regional Health Authority Act Chap. 29:05 ➢ Public Health Ordinance , Quarantine Act Chapter 28:05 ➢ Antibiotic Act and Regulations Chapter 30:02 ➢ Public Health Ordinance Chapter 12 No. 4 ➢ Malaria Abatement Act Chapter 12 No. 4 ➢ Tuberculosis Controls Act and Regulations Chapter 28:51 ➢ Hansen's Disease Control Ordinance 1961 ➢ Quarantine Act and Regulations Chapter 28:05 ➢ Trinidad and Tobago Civil Aviation Regulations

APPENDIX 2

Key Ministerial Actors for the Implementation of SDG 3.d

Ministry of Planning & Development (MPD) - The key collaborative Government Ministry, providing the necessary policy guidance and development, technical support, advice and feasibility assessment for national advancement. MPD's principal mandate is national development concentrated on four main pillars which are economic development, social development, spatial development and environmental development. MPD also facilitates national development through the following:

- *Coordinating all stakeholders in the development of Trinidad and Tobago's National Strategy for Development, Vision 2030;*
- *Coordination of national statistics;*
- *Environmental policy, planning and management;*
- *National monitoring and evaluation;*
- *Socio-economic planning, coordinating and monitoring;*
- *Spatial development; and*
- *Technical cooperation on special projects and programmes inter alia.*

Ministry of Health - is the national authority charged with oversight of the entire health system in Trinidad and Tobago. It plays a central role in the protection of the population's health and in ensuring that all organisations and institutions that produce health goods and services conform to standards of safety. It is also required to play a key role in ensuring that Regional Health Authorities (RHAs) are properly run, by setting policies, goals and targets for regions based on assessment of real health needs.

Regional Health Authorities (RHAs) - Responsibility for the provision of healthcare services in Trinidad and Tobago was devolved to Regional Health Authorities from the MoH with the passing of the Regional Health Authorities Act No. 5 in 1994. RHAs are autonomous bodies that own and operate health facilities in their respective Regions. There are currently five (5) RHAs which deliver public health care services to the population which include the: Eastern Regional Health Authority (ERHA) North Central Regional Health Authority (NCRHA) North West Regional Health Authority (NWRHA) South West Regional Health Authority (SWRHA) and the Tobago Regional Health Authority (TRHA). The TRHA falls under the purview of the Tobago House Assembly.

Ministry of Attorney General and Legal Affairs (AGLA) - Through the Law Reform Commission, the AGLA is a research facility, charged with the development of policy which respond to and accommodate the changing needs of society and also assist the Government by drafting legislation which reflects major policy issues.

Ministry of Finance (MoF) - Facilitates revenue collection and revenue management; budget planning, preparation and management; the formulation and promotion of national fiscal and economic policy; trade facilitation and border control; debt management; and the management of the State Enterprises Sector. The MoF effectively manages the Trinidad and Tobago economy through the development and implementation of innovative policies.

Ministry of National Security (MNS) - The Immigration Division (ID) is responsible for the control of persons entering and leaving Trinidad and Tobago and the issue of travel documents both locally and at Trinidad and Tobago Missions overseas. This organisation had few comments in relation to the implementation of SDG 3.d but indicated that their focus is the health and wellbeing of staff as they comply with the Health Guidelines and the Occupational Safety and Health Act.

The Office of Disaster Preparedness and Management (ODPM) is a coordinating and managing body that is responsible for public education and community outreach activities, coordinating national mitigation and capacity building efforts to safeguard property and life by working with other government agencies and first responders in protecting public health and safety, restoring essential government services and critical infrastructure and providing emergency relief to those severely affected by hazard impact.

Airports Authority of Trinidad and Tobago (AATT) - is a statutory body established by the Airports Authority Act, No. 49:02 of 1979. The Authority falls under the portfolio of the Ministry of Works and Transport. The mandate of AATT is to develop and manage its airport estates, including the development, maintenance and improvement of its facilities, so as to ensure the availability of efficient, secure and safe aviation services and commercial viability. Both the Piarco International Airport (POS) and the ANR Robinson International Airport (TAB) are managed and operated by the Authority.

Ministry of Social Development & Family Services (MSDFS) - is the core social sector Ministry with responsibility for coordinating the implementation of Government's social and human development objectives. The MSDFS is mandated with responsibility for addressing the social challenges of poverty, social inequality and social exclusion. Particular emphasis is placed on developing and executing programmes and services that protect and assist vulnerable and marginalized groups in society such as women, children, persons with disabilities, the elderly, the poor/indigent, the socially displaced, ex-prisoners, deportees and persons living with HIV/AIDS.

The Tobago Emergency Management Agency (TEMA) - coordinates a network of agencies and individuals across the island of Tobago to direct their efforts towards maximum preservation of life and the protection of property in times of disaster.

Ministry of Rural Development and Local Government - Disaster Management Units (DMU) - The DMU was established in 2008 to facilitate and maintain a robust disaster risk reduction capability at the local government level. The responsibilities of these Disaster Management Units include:

- Provide expert Disaster Risk Reduction advice to the Administration of the Municipal Corporations.

- Collaborate with other first responders in providing local-level assistance to citizens impacted by hazards. First responder agencies include the Trinidad and Tobago Fire Services (TTFS),the Trinidad and Tobago Defence Force,(TTDF),the Trinidad and Tobago Police Service (TTPS) and other Non-Governmental Organizations (NGOs).
- Manage the operations of the Municipal Emergency Operations Centre (MEOC) when activated.
- Educate communities on all phases of the disaster management cycle.
- Carry out activities in accordance with the disaster management policy of the Ministry of Local Government.

APPENDIX 3

Trinidad and Tobago - Health Facilities by RHA

Region	Health Facility	Address
Eastern Regional Health Authority (ERHA)	Biche Outreach Centre	Canque Village, Biche
Eastern Regional Health Authority (ERHA)	Rock Outreach Centre	
Eastern Regional Health Authority (ERHA)	Brothers Road Outreach Centre	Brothers Road, Tabaquite
Eastern Regional Health Authority (ERHA)	Coryal Outreach Centre	Corner Balata Hill Road and Cumuto Main Road, Coryal
Eastern Regional Health Authority (ERHA)	Cumana Outreach Centre	Toco Main Road, Cumana Village, Cumana
Eastern Regional Health Authority (ERHA)	Cumuto Outreach Centre	Main Road, Cumuto
Eastern Regional Health Authority (ERHA)	Grande Riviere Outreach Centre	Grande Riviere
Eastern Regional Health Authority (ERHA)	Guayaguayare Outreach Centre	Guayaguayare Road, Guayaguayare,
Eastern Regional Health Authority (ERHA)	Manzanilla Outreach Centre	Eastern Main Road, Manzanilla
Eastern Regional Health Authority (ERHA)	Matelot Outreach Centre	Main Road, Matelot
Eastern Regional Health Authority (ERHA)	Matura Outreach Centre	Matura Main Road, Matura
Eastern Regional Health Authority (ERHA)	Mayaro District Health Facility	Pierreville, Mayaro
Eastern Regional Health Authority (ERHA)	Rio Claro Health Centre	Corner De Verteuil and Dougdeen Streets, Rio Claro
Eastern Regional Health Authority (ERHA)	San Souci Outreach Centre	Main Road San Souci
Eastern Regional Health Authority (ERHA)	Sangre Grande Enhanced Health Centre	Ojoe Road, Sangre Grande
Eastern Regional Health Authority (ERHA)	Sangre Grande Hospital	Ojoe Road, Sangre Grande
Eastern Regional Health Authority (ERHA)	Toco Health Centre & 24 hours A&E	Paria Main Road, Toco

Region	Health Facility	Address
Eastern Regional Health Authority (ERHA)	Valencia Outreach Centre	Alexander Street, Valencia
North Central Regional Health Authority (NCRHA)	New Arima Hospital	29 Providence Avenue, Arima
North Central Regional Health Authority (NCRHA)	Arima Health Facility	Queen Mary Avenue, Arima
North Central Regional Health Authority (NCRHA)	Arouca Health Centre	Corner George Street and Golden Grove Road, Arouca
North Central Regional Health Authority (NCRHA)	Blanchisseuse and Brasso Seco Health Centre	Paria Main Road, Lower Village, Blanchisseuse
North Central Regional Health Authority (NCRHA)	Caura Hospital	St Augustine
North Central Regional Health Authority (NCRHA)	Chaguanas District Health Facility	Main Road and Galt St., Chaguanas
North Central Regional Health Authority (NCRHA)	Couva Hospital and Multi-Training Facility	Sir Solomon Hochoy Highway, Preysal, Couva
North Central Regional Health Authority (NCRHA)	Cunupia Health Centre	Larchu Trace, Cunupia
North Central Regional Health Authority (NCRHA)	Eric Williams Medical Sciences Complex	Uriah Butler Highway, Champ Fleurs
North Central Regional Health Authority (NCRHA)	La Horquetta Health Centre	Arthur Murray Crescent, La Horquetta Phase III
North Central Regional Health Authority (NCRHA)	Las Lomas Health Centre	Las Lomas # 1, Las Lomas
North Central Regional Health Authority (NCRHA)	Macoya Health Centre	Macoya Settlement, Tunapuna
North Central Regional Health Authority (NCRHA)	Maloney Health Centre	Maloney Boulevard, Maloney Gardens
North Central Regional Health Authority (NCRHA)	Mt. Hope Women's Hospital	Champs Fleurs
North Central Regional Health Authority (NCRHA)	San Rafael Health Centre	Talparo Main Road, San Rafael
North Central Regional Health Authority (NCRHA)	St. Helena Health Centre	North Bank Road, St. Helena
North Central Regional Health Authority (NCRHA)	St. Joseph Enhanced Health Centre	Uriah Butler Highway, Champ Fleurs
North Central Regional Health Authority (NCRHA)	Tacarigua Extended Care Facility	Upper El Dorado Road, Tunapuna

Region	Health Facility	Address
North Central Regional Health Authority (NCRHA)	Tacarigua Health Centre	El Dorado Road, Tunapuna
North Central Regional Health Authority (NCRHA)	Talparo Health Centre	Talparo Community Centre, Talparo Main Road, Talparo
North Central Regional Health Authority (NCRHA)	Tunapuna Health Centre	
North West Regional Health Authority (NWRHA)	Aranguez Health Centre	Aranguez Main Road, Aranguez
North West Regional Health Authority (NWRHA)	Barataria Health Centre	Eighth Avenue and Seventh Street, Barataria
North West Regional Health Authority (NWRHA)	Carenage Health Centre	Constabulary Street, Carenage
North West Regional Health Authority (NWRHA)	Diego Martin Health Centre	#2 Church Street, Diego Martin
North West Regional Health Authority (NWRHA)	El Socorro Health Centre	El Socorro Road, San Juan
North West Regional Health Authority (NWRHA)	George Street Health Centre	#61-67 George Street, Port-of-Spain
North West Regional Health Authority (NWRHA)	Las Cuevas Health Centre	Pole #9 School Road, Las Cuevas Village, Blanchisseuse
North West Regional Health Authority (NWRHA)	Maraval Health Centre	Corner of Saddle Road & Morne Coco Road, Maraval
North West Regional Health Authority (NWRHA)	Morvant Health Centre	Dos Santos Street, Morvant
North West Regional Health Authority (NWRHA)	Oxford Street Health Centre	Corner of Observatory Street & Oxford Street, Port-of-Spain
North West Regional Health Authority (NWRHA)	Petit Valley Health Centre	Corner of Simeon Road & Morne Coco Road, Petit Valley
North West Regional Health Authority (NWRHA)	Port-of-Spain General Hospital	Upper Charlotte Street, Port-of-Spain
North West Regional Health Authority (NWRHA)	San Juan Health Centre	Real Street, San Juan
North West Regional Health Authority (NWRHA)	Santa Cruz Health Centre	Saddle Road, San Juan
North West Regional Health Authority (NWRHA)	St. Ann's Hospital (Mental Health)	St. Ann's

Region	Health Facility	Address
North West Regional Health Authority (NWRHA)	St. James District Health Facility	112 Western Main Road, St. James
North West Regional Health Authority (NWRHA)	Success Lavantille Health Centre	Espinet Street, Laventille
North West Regional Health Authority (NWRHA)	Upper Lavantille Health Centre	St. Barbs Road, Laventille
North West Regional Health Authority (NWRHA)	Woodbrook Health Centre	92A Tragarete Road, Port of Spain
South West Regional Health Authority (SWRHA)	Cedros Health Centre	St. Marie Street, Bonasse
South West Regional Health Authority (SWRHA)	Chatham Health Centre	Main Road, Belle View
South West Regional Health Authority (SWRHA)	Claxton Bay Health Centre	Southern Main Road, Claxton Bay
South West Regional Health Authority (SWRHA)	Couva District Health Facility	Main Road, Couva
South West Regional Health Authority (SWRHA)	Couva Extended Care Facility	Grant St, Couva
South West Regional Health Authority (SWRHA)	Debe Health Centre	Wellington Road, Debe
South West Regional Health Authority (SWRHA)	Erin Health Centre	Main Road, Buenos Ayres
South West Regional Health Authority (SWRHA)	Flanagin Town Health Centre	Main Rd, Flanagin Town
South West Regional Health Authority (SWRHA)	Freeport Health Centre	St. Mary's Junction, Freeport
South West Regional Health Authority (SWRHA)	Fyzabad Health Centre	Main Road, Fyzabad
South West Regional Health Authority (SWRHA)	Gasparillo Health Centre	Church Street, Gasparillo
South West Regional Health Authority (SWRHA)	Gran Couva Bay Health Centre	Main Road, Gran Couva
South West Regional Health Authority (SWRHA)	Granville Health Centre	Syfo Road, Granville
South West Regional Health Authority (SWRHA)	Guapo Health Centre	Hubertson Young Street, Guapo
South West Regional Health Authority (SWRHA)	Icacos Health Centre	Main Road, Icacos

Region	Health Facility	Address
South West Regional Health Authority (SWRHA)	Indian Walk Health Centre	Petite Cafe, Moruga
South West Regional Health Authority (SWRHA)	La Brea Health Centre	New Lands, La Brea
South West Regional Health Authority (SWRHA)	La Romaine Health Centre	Zaida Lane, La Romain
South West Regional Health Authority (SWRHA)	Lengua Health Centre	Cipero and Papourie Roads, Lengua
South West Regional Health Authority (SWRHA)	Marabella Health Centre	Market Street, Marabella
South West Regional Health Authority (SWRHA)	Moruga Health Centre	Lanse Mitan, Moruga
South West Regional Health Authority (SWRHA)	Palo Seco Health Centre	Main Road, Palo Seco
South West Regional Health Authority (SWRHA)	Penal Health Centre	Southern Main Road, Penal
South West Regional Health Authority (SWRHA)	Penal Rock Road Health Centre	4 1/2 mile marker, Penal Rock Road
South West Regional Health Authority (SWRHA)	Pleasantville Health Centre	Chaconia Avenue and Prince Albert Streets, Pleasantville
South West Regional Health Authority (SWRHA)	Point Fortin Area Hospital	Volunteer Road, Mahaica, Point Fortin
South West Regional Health Authority (SWRHA)	Point Fortin Health Centre	Techier Main Road, Point Fortin
South West Regional Health Authority (SWRHA)	Point Fortin Hospital	Point Fortin Main Rd, Point Fortin,
South West Regional Health Authority (SWRHA)	Princes Town District Health Facility	Circular Road, Princes Town
South West Regional Health Authority (SWRHA)	Rochard Douglas Health Centre	Rochard Douglas Road
South West Regional Health Authority (SWRHA)	Roy Joseph Health Centre	Gomez Street, San Fernando
South West Regional Health Authority (SWRHA)	San Fernando General Hospital	Independence Avenue, San Fernando
South West Regional Health Authority (SWRHA)	San Fernando Teaching Hospital	Independence Avenue, San Fernando
South West Regional Health Authority (SWRHA)	Siparia District Health Facility	High Street, Siparia

Region	Health Facility	Address
South West Regional Health Authority (SWRHA)	South Oropouche Health Centre	Main Road, Oropouche
South West Regional Health Authority (SWRHA)	Ste. Madeleine Health Centre	Manahambre Road, Ste. Madeleine
South West Regional Health Authority (SWRHA)	Tabaquite Health Centre	Main Road, Tabaquite
South West Regional Health Authority (SWRHA)	Todd's Road Health Centre	Flecher Road, Todd's Road
South West Regional Health Authority (SWRHA)	Williamsville Health Centre	Main Road, Williamsville
South West Regional Health Authority (SWRHA)	Point Fortin Extended Care Centre	Warden Rd, Point Fortin,
South West Regional Health Authority (SWRHA)	New Horizons Rehabilitation Centre	Dindial Rd, Piparo
Tobago Regional Health Authority (TRHA)	Belle Garden Health Centre	Belle Garden
Tobago Regional Health Authority (TRHA)	Bethel Health Centre	Bethel
Tobago Regional Health Authority (TRHA)	Bloody Bay Outreach Centre	Bloody Bay
Tobago Regional Health Authority (TRHA)	Buccoo Health Centre	Buccoo
Tobago Regional Health Authority (TRHA)	Canaan Health Centre	Canaan
Tobago Regional Health Authority (TRHA)	Castara Health Centre	Castara
Tobago Regional Health Authority (TRHA)	Charlotteville Health Centre	Charlotteville
Tobago Regional Health Authority (TRHA)	Delaford Health Centre	Delaford
Tobago Regional Health Authority (TRHA)	L'Anse Fourmi Outreach Centre	L'Anse Fourmi
Tobago Regional Health Authority (TRHA)	Les Coteaux Health Centre	Les Coteaux
Tobago Regional Health Authority (TRHA)	Mason Hall Health Centre	Mason Hall
Tobago Regional Health Authority (TRHA)	Moriah Health Centre	Moriah

Region	Health Facility	Address
Tobago Regional Health Authority (TRHA)	Mt. St. George Health Centre	Mt. St. George
Tobago Regional Health Authority (TRHA)	Parlatuvier Health Centre	Parlatuvier
Tobago Regional Health Authority (TRHA)	Pembroke Health Centre	Pembroke
Tobago Regional Health Authority (TRHA)	Plymouth Health Centre	Plymomuth
Tobago Regional Health Authority (TRHA)	Roxborough Health Centre	Roxborough
Tobago Regional Health Authority (TRHA)	Scarborough General Hospital	Connector Road, Signal Hill, Tobago, Trinidad and Tobago
Tobago Regional Health Authority (TRHA)	Scarborough Health Centre	Scarborough
Tobago Regional Health Authority (TRHA)	Speyside Health Centre	Speyside

RHA	No of Health Facilities	No of Hospitals
NWRHA	19	3
NCRHA	21	5
ERHA	18	1
SWRHA	41	2
TRHA	20	1
	119	**12**

APPENDIX 4

People First: Nurturing Our Greatest Asset

NATIONAL INDICATORS (National Outcome 3)

Results		Indicator	Baseline
National Output	Improved Organisational Management	Health worker density and distribution (per 1000 population)	Physicians: 1.179 per 1,000 pop. Nursing and midwifery personnel: 3.572 per 1,000 pop. Dentistry: 0.225 Pharmaceutical: 0.49 per pop. Other: 0.075 per 1,000 pop (2007)

Source: T&T's National Performance Framework pg. 33

APPENDIX 5

Ministry of Social Development and Family Services - Grants

Grants	Purpose of Grant	Who should apply	Quantum
Food Support Programme (Food Card)	The Food Support Programme is a short-term food assistance and development programme that targets vulnerable persons and families in need. Recipients can purchase basic food items necessary to meet their daily nutritional requirements, thereby enhancing the health and dignity of their household and reducing the incidence of poverty. The programme is currently implemented through a Debit Card, (the Food Support Card) which is an electronic cash transfer facility. A condition of this programme is that ALL recipients must, unless otherwise advised, join a Developmental Programme. This Developmental Programme is a more holistic approach to poverty alleviation which takes into consideration conditions that confines the family's effort to move out of poverty.	• The programme targets families in need and other vulnerable persons with limited or no income. • A Means Test is administered by the Ministry to determine eligibility.	1 – 3 persons $510.00 4 – 5 persons $650.00 6 + persons $800.00
Minor House Repairs	The MHRA is intended to provide up to $15,000.00 in materials only for the repair / upgrade of dwelling houses and up to $20,000.00 in material only to effect repairs / upgrades in the effect of a disaster.	• Financial eligibility criteria – Application of a Standard Means Test • Property Ownership criteria	Up to $15,000.00 in materials only for repair/upgrade Up to $20,000.00 for repairs in the event of a disaster.
Sanitary Plumbing Assistance	Sanitary Plumbing Assistance (SPA) Grant: The SPA Grant is intended to provide up to $15,000.00 in materials only under normal circumstances and in the event of a disaster for the repair / upgrade of toilet and bathroom facilities for the	• Financial eligibility criteria – Application of a Standard Means Test • Property Ownership criteria	Up to $15,000.00 in materials only.

	dwelling house. This grant also allows for the upgrade of outdoor toilet facilities (outhouses / latrines) to indoor facilities, where space permits.		
Electrical House Wiring	House Wiring Assistance (HWA) Grant: The HWA Grant is intended to provide assistance as follows for the wiring or rewiring of dwelling houses under normal circumstances and in the event of a disaster which has impacted the electrical wiring of the house. First Time Wiring – This includes persons who are and have been occupying an existing abode, but have not had such dwelling previously wired as well as new construction. Rewiring – Applicable in instances where the existing electrical wiring is old and faulty and may pose fire risks. It therefore seeks to improve the safety and reliability of existing electrical installations.	• Financial eligibility criteria – Application of a Standard Means Test • Property Ownership criteria	• Materials Only Assistance –Up to $15,000.00 • Material and Labour Assistance – Up to $25,000.00 where materials shall not exceed $15,000.00 and labour shall not exceed $10,000.00
SEED Grant	The Sowing Empowerment through Entrepreneurial Development (SEED) Programme aims to provide a mechanism to empower poor and vulnerable citizens who have an interest in starting or improving their own business but are unable to gain access to funding on their own. The Programme also facilities funding for skills training / re-training to promote employment. Some of the objectives of the Programme include: • Provide an initial step to facilitate entry of poor and vulnerable citizens into the competitive business environment. • Provide support to existing clients of the MSDFS to	• Citizens and permanent residents of Trinidad and Tobago; • Persons 18 years or over; • Financial eligibility criteria – Application of a Standard Means Test	• Provision of up to $15,000.00 in goods / equipment to establish / expand a micro business. • Provision of up to $7,500 to facilitate skills training at a recognized / accredited institution. Funds paid directly to training institution

	build their independence and resilience. • Increase awareness and training in micro entrepreneurship • Contribute to the eradication of poverty through micro entrepreneurship • Provision of skills training to ensure applicants develop competencies and skills which will enhance their opportunities for employment / self-employment.		
Disability Assistance Grant for Children	This grant is payable where the assessment of a child is either severe or complete and where the disability is permanent in nature. Such certification shall come from a Paediatrician or other medical practitioner (Public Health) authorized by the Chief Medical Officer for this purpose or from a Paediatric Specialist (Private Practitioner) registered with the Medical Board of Trinidad and Tobago.	The grant is payable where the assessment of a child is either severe or complete and where the disability is permanent in nature. A parent/legal guardian must 18 years or older, be a citizen/resident of Trinidad and Tobago as defined in the Immigration Act; A child must not have attained the age of eighteen (18) years; must be a citizen / legal resident of Trinidad and Tobago as defined in the Immigration Act; and must be residing permanently in Trinidad and Tobago.	$1,500.00 per month
Disability Assistance Grant for Adults	This grant provides financial to citizens and legal residents of Trinidad and Tobago who are medically certified as being permanently disabled from earning and cannot be employed.	Age – Persons must be eighteen (18) years of age. Residence – Applicants must be a resident of Trinidad and Tobago for three (3) years preceding the date of application. Periods of absence from the country must not total more than six (6) months during those three (3) years. Income – Applicant's annual income must not exceed $12,000 TTD per annum. Disability – Applicants must be, in the opinion of the Local Board, unable to earn	

		their livelihood as a result of their disability.	
Senior Citizens Pension	This grant provides financial assistance to eligible older persons in Trinidad and Tobago.	Age – Persons sixty-five (65) years and over Residence – Applicants must be a resident in Trinidad and Tobago for twenty (20) years preceding the date of application. Any periods of absence must not total more than five (5) years during the twenty (20) years preceding the application OR the applicant must be residing in Trinidad and Tobago and have lived fifty (50) years in total in Trinidad and Tobago. N.B. (These 50 years do not need to be consecutive) Income – Applicant's monthly income must not exceed $5,500 TTD per month	$0 – $2500 gets $3,500.00 Income not exceeding $2,500 receive $3500.00 Income exceeding $2,500 but not exceeding $3,500.00 receives $2,500.00 Income exceeding $3,500 but not exceeding $4,500.00 receives $1,500.00 Income exceeding $4,500 but not exceeding $5,500.00 receives $500.00
Public Assistance Grant	The Public Assistance Grant is provided to meet the needs of persons where the household income is deemed inadequate.	• an individual 18 years and over, who is certified by a government Medical Officer as unable to earn a living due to physical or mental disability • a person receiving Senior Citizens' Pension, whose spouse is 55 years and over and unemployed, or, whose spouse is under 55 years but unable to work due to physical or mental disability • an individual whose deceased spouse received Senior Citizens' Pension and Public Assistance • a single parent who is unable to earn a living due to caring for a child with a physical or mental disability • a parent, guardian or custodian on behalf of a child with a physical or mental disability	Monthly Public Assistance Grant payments $1,300.00 for one (1) persons $1,550.00 for two (2) persons $1,750.00 for three (3) persons $1,900.00 for four (4) or more persons

		• on behalf of a child whose parent is hospitalized; deceased; imprisoned; or has abandoned the family and does not provide support despite there being an application/order for maintenance • is the spouse of a person serving a term of imprisonment • was cohabitating with a person of the opposite sex for a period of at least three years before the latter began serving a term of imprisonment • a child who may deem necessitous in accordance with guidelines issued at the board	

APPENDIX 6

Comparison results of Indicators levels 2 and 1 to that of level 5 in T&T SPAR Tool 2020

INDICATORS			
Level 2	C1.3 – An emergency public financing mechanism that allows structured reception and rapid distribution of funds for responding to public health emergencies is under development.	Level 5	C1.3 - Monitoring and feedback system for an emergency public financing mechanism is in place and functional; and access to an emergency contingency fund for public health emergency is in place.
Level 2	C4.1 – A Multi-sectoral collaboration mechanism that includes an IFOSAN Emergency Contact Point, is in place at the national level; and communication channels between the IFOSAN Emergency Contact Point, the national IHR Focal Point and all relevant sectors for food safety events including emergencies have been established at the national level.	Level 5	C4.1 - A Multi-sectoral collaboration mechanism has been assessed, monitored and reviewed on a regular basis in order to strengthen capacities; and formalized communication channels between the IFOSAN Emergency Contact Point, the National IHR Focal Point, IFOSAN Focal Points t and all other relevant sectors for food safety events including emergencies at national and international level have been tested, reviewed and updated.
Level 2	C5.2 – National laboratory biosafety and biosecurity guidelines and/or regulations are in place and implemented by some laboratories at the national level.	Level 5	C5.2 - National laboratory biosafety and biosecurity guidelines and/or regulations are regularly reviewed and updated as needed.
Level 2	C7.1 – Human Resources for the implementation of IHR capacities are mapped and available only at the national level.	Level 5	C7.1 - Human Resources for the implementation of IHR capacities are reviewed and updated on a regular basis.
Level 2	C8.1 – Public Health emergency risk profiles have been developed and emergency preparedness measures for priority public health risks is available at the national level.	Level 5	C8.1 - Based on updated all-hazard health emergency risk profile and resource mapping, plans for multi-sectoral all-hazard public health emergency preparedness and response plan are regularly tested and updated.
Level 1	C1.1 – legislation, laws, regulations, policy, administrative requirements or other government instruments to support and facilitate the development and	Level 5	C1.1 - Legislation addressing the needs of radiation emergency preparedness and response (according to the radiation risk profiles of the country) are in place,

	implementation of IHR capacities for infectious diseases are under development.		specifying the roles and responsibilities of relevant stakeholders.
Level 1	C3.1 The animal and public health sectors work together on zoonosis only on an ad hoc basis.	Level 5	C3.1 - Collaborative efforts to prevent, detect, and respond to priority zoonosis are tested or evaluated and updated regularly.
Level 1	C6.2 – There is unstructured mechanism for event management.	Level 5	C6.2 - Event management system is evaluated and updated on a regular basis
Level 1	C13.1 Surveillance mechanisms and resources for radiation emergencies are under development.	Level 5	C13.1 - Radiation emergency arrangements are formally evaluated and tested on a regular basis and improvements are made accordingly.

APPENDIX 7

Strategies from the European Observatory on Health Systems and Policies for responding to the COVID-19 Pandemic

Leading and Governing the COVID- 19 Response	
Strategy 1	Steering the response through effective political leadership
Strategy 2	Delivering a clear and timely COVID-19 response strategy
Strategy 3	Strengthening monitoring, surveillance and early warning systems
Strategy 4	Transferring the best available evidence from research to policy
Strategy 5	Coordinating effectively within (horizontally) and across (vertically) levels of government
Strategy 6	Ensuring transparency, legitimacy and accountability
Strategy 7	Communicating clearly and transparently with the population and stakeholders
Strategy 8	Involving nongovernmental stakeholders including the health workforce, civil society and communities
Strategy 9	Coordinating the COVID-19 response beyond national borders
Financing Covid-19 Services	
Strategy 10	Ensuring sufficient and stable funds to meet need
Strategy 11	Adapting purchasing, procurement and payment systems to meet changing needs and balance economic incentives
Strategy 12	Supporting universal health coverage and reducing barriers to services
Mobilizing And Supporting The Health Workforce	
Strategy 13	Ensuring an adequate health workforce by scaling-up existing capacity and recruiting additional health workers
Strategy 14	Implementing flexible and effective approaches to using the workforce
Strategy 15	Ensuring physical, mental health and financial support for health workers
Strengthening Public Health Interventions	
Strategy 16	Implementing appropriate non-pharmaceutical interventions and Find, Test, Trace, Isolate and Support (FTTIS) services to control or mitigate transmission
Strategy 17	Implementing effective COVID-19 vaccination programmes
Strategy 18	Maintaining routine public health services
Transforming Delivery Of Health Services To Address Covid-19 And Other Needs	
Strategy 19	Scaling-up, repurposing and (re)distributing existing capacity to cope with sudden surges in COVID-19 demand
Strategy 20	Adapting or transforming service delivery by implementing alternative and flexible patient care pathways and interventions and recognizing the key role of primary health care

APPENDIX 8

Extract from National Development Strategy-Vision 2030- Goal 4: The Healthcare System of Trinidad and Tobago will be sustainable and modern and deliver higher standards of healthcare

	Strategic Initiatives/Actions
4.1	**Improve the performance of health sector agencies** One of the ways in which improvement of the health sector will be attained is through the establishment of a performance management system. This system is aimed at providing a more patient centred approach to the delivery of health care services. It will help in promoting adherence to standard operating procedures, healthcare policy and legislation towards improved professionalism, service and accountability among healthcare workers and institutions. This will also be accompanied by an expansion of training opportunities for healthcare workers so that standards can be maintained and met. A review of legislation and policy will also be undertaken to ensure adequacy and relevance. Further, an effective health facilities maintenance plan will also be prepared. Improvement of the health system will also come through the use of ICTs. For instance, the health information system and its processes will be modernised to ensure that patients are allowed easy access to information for health advice and timely appointments. The information needs of medical professionals, administrators and patients will also be served by facilitating easy retrieval of health records and referrals, the sharing of diagnostics and enabling the monitoring of costs, quality and outputs.
4.2	**Ensure the sustainable funding of the health sector** One of the ways in which funding of the health sector will be made sustainable is through the Universal Health Insurance Programme. This Programme also aims to ensure healthcare coverage for all citizens using Public/ Private arrangements. All members of the public will be able to access high quality health care at any health facility, whether public or private, regardless of their personal financial circumstances.
4.3	**Improve access to healthcare services** Access to healthcare services pertains not only to the availability of these services at remote, rural areas, but also accessibility to basic health services at District Health Facilities in order to relieve the burden on General Hospitals. Strategies will therefore be employed to address these gaps. These include greater use of mobile clinics as well as the continued upgrade of District Health Facilities so that services are further decentralised through wider offerings at the district level. Improved access to health services also relates to ensuring that these services are relevant in meeting the health needs of all segments of the population. Consequently, based on available data, a needs assessment must be undertaken in order to determine critical demands for health services that are not adequately being met. This includes mental health diseases and preventative measures for rising HIV infection. Specific strategies for meeting these demands must also be devised.