PAHO/WHO
COUNTRY COOPERATION STRATEGY

TRINIDAD AND TOBAGO

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SECTION 1: INTRODUCTION

The Country Cooperation Strategy (CCS) is an integral part of WHO's Country Focus Policy (CFP). The purpose of the CFP is to: a) optimize WHO's contribution to health and development in countries; and b) empower countries to exercise more influence in global and regional public health. The CCS is being implemented by WHO across all Regions on a country-by-country basis.

The development of a Country Cooperation Strategy for Trinidad and Tobago is crucial at this time in light of the increasing number of health development partners, the decreasing allocation of regular financial resources to support the work of PAHO/WHO at the country level as a consequence of the new Regional Program Budget Policy (RPBP), and the need for a more efficient and effective Technical Cooperation Programme. The broad consultative nature of the CCS, which allows contact with key development partners and national counterparts, is a tremendous opportunity to receive critical inputs that will assist in defining the strategic agenda for the medium term. This process will strengthen existing partnerships and alliances and create new ones; align the Strategic Agenda to the renewed in-country process of the CCA/UNDAF; and facilitate, together with other development partners, a collaborative environment that will lead to a coordinated approach for more efficient and effective cooperation, beneficial to the national health development process.

The general objective of the CCS is to provide a framework for PAHO/WHO's technical cooperation in Trinidad and Tobago in the medium term, and to develop a clear understanding of what PAHO/WHO will be doing in the country, the strategies to be used, and the identification of the partners with whom the Organization will work.

This exercise will lay the basis for a competency review of the Country Office (CO) and also allow assessment of staff requirements to meet the technical and administrative needs of the PAHO/WHO Technical Cooperation Programme in Trinidad and Tobago; adjustment of the CO development plan to address capacity needs of the country team; improvement of administrative systems; and mechanisms to obtain support of the global and regional levels for the country's Strategic Agenda.

The CCS in Trinidad and Tobago will span the period 2006-2009, and is subject to review in the face of expected changes in the operating environment for technical cooperation, as a result of the RPBP, review of the CARICOM Regional Health Institutions (RHIs), and development of the Caribbean Cooperation in Health, Phase III (CCH III), the 11th WHO General Program of Work (GPW) and the PAHO Strategic Plan, 2008-2012.

The CCS Team for Trinidad and Tobago comprised members of staff from PAHO Headquarters, WHO/Geneva, the local office of the Caribbean Food and Nutrition Institute (CFNI), administrative and technical staff from the Country Office and the PAHO/WHO Representative (PWR) of Jamaica.

SECTION 2: COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

2.1 POLITICAL, MACROECONOMIC, AND SOCIAL CONTEXT

Trinidad and Tobago is a twin-island democratic republic located off the north coast of Venezuela in the Caribbean Sea. The country achieved independence from Britain in 1962, followed by Republican status in 1976; however, it remains a member of the British Commonwealth. Its Constitution provides for the separation of powers of the three branches of government – the Executive, Legislative, and Judicial – and the country is organized into thirteen administrative areas, Tobago being administered separately by the Tobago House of Assembly (THA).

The total population of the two islands is 1.3 million[1], with 4% living in Tobago. There is a male:female ratio of 1:1, and an ethnic mix of East Indian 41%, African 40%, and other groups 19% (Chinese, European and Middle Eastern). The annual growth rate declined from 1.7% in 1980-85 to 0.5% for 1995-2000; fertility rates have been declining since the 1970s. Life expectancy at birth was estimated at 71.9 years for males, and 76.9 for females in 1999, which compares favourably with the figures for more developed countries.

In the recently published Human Development Report, 2005, Trinidad and Tobago ranked 57th of 177 countries, maintaining the category of High Human Development. The country continues to enjoy an overall stable economic environment, witnessing a steady economic growth and an unemployment rate in the second quarter of 2004 of 7.8%[2]

The country is currently enjoying an economic boom due to its natural oil and gas reserves, with the energy sector being the main driver. The Central Bank's economic survey in 2004 suggested that 2005 would average a 6.98% increase in real GDP[3]. Headline inflation rose from 5.6% in late 2004 to 7.3% in the first quarter of 2005. Per capita GNP in 2001 increased to $7,690 from $4,520 in 1998[4]. In 1993, the poverty level was estimated at 35.9% and in 1997, it was estimated at 22%, particularly among the unemployed, female-headed households, and those with lower educational levels. The country's development framework document, "Vision 2020", has set the goal of reducing poverty to 5% and eradicating extreme poverty by 2010.

The average household size is 3.7 persons and the average number of children per household is 1.4. Thirty-one percent of households are headed by females, which is lower than the average for the Caribbean. Labour force participation for males has remained unchanged, but it has increased for females. Nevertheless, women's average income as a percentage of men's in 2000 was lower in all occupational categories. Youth unemployment rate stood at 21% in 2002.

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[1] World Bank.
[2] Central Statistical Office
[3] Central Bank of Trinidad & Tobago Annual Economic Survey 2004
[4] PAHO. Promoting Health in the Americas – Country Health Profile, Trinidad & Tobago, 2001. Accessed at www.paho.org/English/SHA/prfltrt.htm 14 September 2005.

In the year 2004, the Prime Minister announced the Government's main focus and commitment to the long-term goal for Trinidad and Tobago of achieving developed nation status by the year 2020 – "Vision 2020". The overarching objective is "to create an environment where citizens can enjoy an enhanced quality of life in the areas of education, health, housing, and personal security, comparable to the highest standards obtained in modern societies".

However, despite its favourable economic climate, the country faces major challenges in its quest to achieve developed status. Among these are issues pertaining to personal security resulting from the high levels of criminal activity; lack of well-defined strategies and programmes for the elimination of poverty; and the need for improvement in the quality of social services, in particular health care, especially in addressing the human resource gaps.

2.2 OTHER MAJOR DETERMINANTS OF HEALTH

In 2005, Trinidad and Tobago had a high Education for All Development Index (97% EDI), with a primary net enrolment rate of 94%, adult literacy of 99%, a gender-specific education for all indexes of 96% and a survival rate to grade 5 of 98%. Among all ethnic groups, literacy rates for females is higher than for males, and enrollment at university level has increased, with a predominance of female students[5]. In education, girls are equally entitled to compulsory education up to the age of 12 at secondary level, while post-secondary education is on a competitive basis.

With regard to other gender issues, women enjoy the same rights as men to enter the labour force, hold political positions at all levels, and initiate legal action when their rights are infringed. The existing legal framework can repeal or amend all known forms of discrimination against women and many provisions are in place based on the Convention for Elimination of All Forms of Discrimination against Women.

The 2000 Central Statistical Office (CSO) Household Survey showed that 69.4% of the households surveyed had water piped into their homes or yards and 67.0% had water-based toilet facilities. Comparatively, 92.0% of households had electricity. Of the households that receive a pipe-borne supply of water, only 26.0% of these receive a continuous supply. Storage of water is therefore commonplace and 56.6% of households have their own water storage tanks. Access to a reliable source of potable water is not due to its unavailability, but rather to several other factors, including a 40-50% loss of water in the aging distribution system, watershed destruction, and pollution. The Water and Sewerage Authority (WASA) uses WHO Water Quality Guidelines, and the Public Health Inspectorate is required to monitor the quality of water.

Approximately 20% of the population is served by central sewage treatment plants operated by WASA, while another 10% are served by small privately run plants. Another 60% of the population is served by on-lot septic systems and 10% by pit latrines. The grey water is not usually treated where on-lot systems are used, but is discharged

[5] Ministry of Education. 2005 Indicators of the Education System of Trinidad and Tobago.

untreated into public drains and streams. The private plants have been a source of pollution, but in 2004 WASA was given the responsibility to rehabilitate and operate these plants.

Municipal solid waste is effectively collected by independent contractors employed by local government. However, there is no national solid waste management policy or programme to deal with growing volumes of garbage, including hazardous wastes, or with poorly managed landfill sites. There is significant littering with disposables that block drainage, cause flooding, and contribute to the breeding and harbourage of vectors.

Food safety is an important issue not only for the health of the general population, but also in light of the tourism base of the economy in Tobago. Over the last five years there have been one to five food borne illness outbreaks investigated per year, mainly in institutions such as restaurants, hotels, hospitals, and commercial caterers, where training in Hazard Analysis Critical Control Points (HACCP) is usually conducted.

Of priority to the Ministry of Health is the establishment of a Port Health Unit to conduct environmental, and human and animal health surveillance at points of entry to fulfill the requirements of the revised 2005 International Health Regulations (IHR), within the next five years. At present, many port health functions are conducted by immigration and customs, and not by the health sector. This is an area that needs to be strengthened, particularly in light of the recent occurrence of SARS and the Avian Influenza threat.

Trinidad and Tobago is vulnerable to natural and industrial disasters, as well as acts of terrorism, due to the existence of critical multinational investments in petrochemical and gas-based industries. However, it is one of the few English-speaking countries with no emergency preparedness and response legislation.

The Ministry of Health (MoH) has adopted health promotion as the main strategy to address individual, social, and environmental risk factors in order to achieve sustainable behavioral modification and environmental changes, conducive to the development of healthy lifestyles and wellbeing in the context of health sector reform. Programmes are being gradually decentralized to the Regional Health Authorities (RHAs), together with the development of competencies and institutional strengthening, with the purpose of developing healthy settings supported on the principles of accessibility, quality, and equity at all levels, with priority for primary health care.

2.3 MORTALITY AND MORBIDITY

Trinidad and Tobago has made significant progress in improving the health status of its population. However, Chronic Non-Communicable Diseases (CNCD), external and self-inflicted injuries, and HIV/AIDS remained consistently as the leading causes of death in the country with an increasing trend up to 2000, the latest year for which statistics are available.

In 2000, diabetes mellitus, malignant neoplasm, and cerebrovascular disease accounted for 67% of all deaths in the country. Suicide as an external mortality cause is more

frequent among males aged 25-44 (four times more likely than females), with the ingestion of pesticides being the most frequent method.

Deaths by selected causes, 1996-2000[6]					
Causes	**1996**	**1997**	**1998**	**1999**	**2000**
Heart Disease	2,428	2,418	2,562	2,692	2,400
Diabetes Mellitus	1,139	1,120	1,212	1,306	1,286
Malignant Neoplasm	1,226	1,253	1,209	1,263	1,205
Cerebrovascular Disease	1,019	1,051	1,079	1,041	953
AIDS/HIV	396	409	439	519	535
Pneumonia	302	270	334	258	173
Transport Accidents	165	130	150	184	162
Suicide/Intentional Self Harm	146	160	171	139	166
Homicide/Assault	123	107	109	115	157

Even though more than 95% of women receive prenatal care and institutional labour is over 98% coverage, maternal mortality has fluctuated over the period 1990-2000 from 54.3 per 100,000 population to 70.4 in 1997 and to 54.0 in 2000. The major causes are pre-eclampsia, diabetes, premature labour, and infections during the gestational period. Most deaths occur at the time of delivery due to late detection of high-risk pregnancies, as women access prenatal care in later gestational stages. While there are no national rates for teenage pregnancies, 15% of total births in 2000 were to mothers aged 13-19 and under.

Infant mortality has ranged from 10.5/1,000 live births in 1990 to 21.2 in 2000. The majority of deaths are observed during the perinatal and neonatal period and prematurity was the main cause of neonatal deaths. Under-five mortality is mainly due to respiratory causes, even though the leading causes of admittance to hospital for this age group were infectious and parasitic diseases. The country has no deaths due to vaccine preventable diseases and no cases were reported over the last decade due to the sustained coverage (~90%) of the Expanded Program of Immunization (EPI).

Initiation of breastfeeding is estimated at 95% and exclusive breastfeeding rate ranges between 26-30% for infants <4 months of age. No recent data are available regarding micronutrients, especially iron, deficiency, particularly among pregnant and lactating women as well as children <5 years.

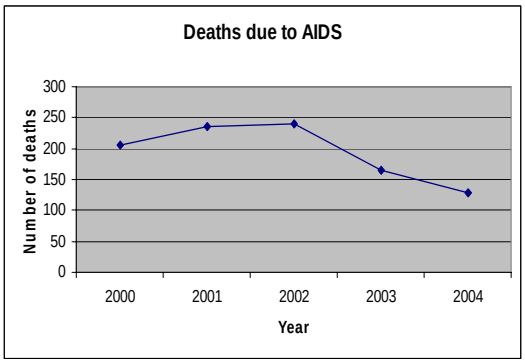
According to the report of the Multiple Indicator Cluster Survey (2000), it was estimated that 6% of children <5 years old were underweight; <0.5% were severely underweight; 3.6% were stunted and 4.4% were wasted or too thin for their height. In 2002, CFNI reported a 3.0% prevalence of overweight among preschool children and this is slightly less that the global estimate of 3.3%. A 1999 CFNI Physical Activity study showed a 4.6% prevalence of overweight among 13-19 year old adolescents, and 6.3% were at risk of becoming overweight.

[6] PAHO/WHO. "1999-2001 Annual Report - Ministry of Health". PAHO/WHO, 2005.

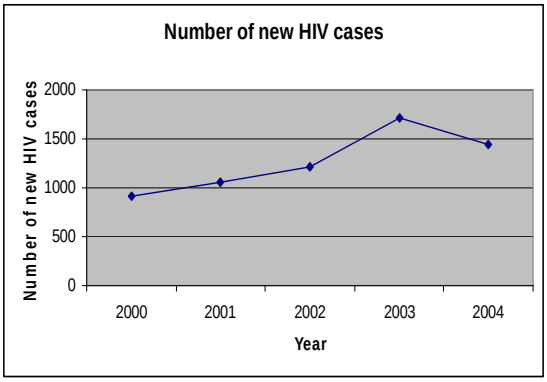
Current Food Balance Sheets data on food availability indicate that there is an excess of energy, proteins, and fat to meet the needs of the population. However, there is inequality of distribution at both the national and household levels.

HIV/AIDS is a major issue in Trinidad and Tobago, with a current estimated prevalence rate among adults of 3.2%[7]. HIV/AIDS has received increasing attention over the past five years with an expanded response from the Government of Trinidad and Tobago and from national, regional, and international stakeholders. A National AIDS Coordinating Committee (NACC) under the purview of the Office of the Prime Minister was established, utilizing partnerships among key stakeholders and adopting a multi-sectoral approach to the development of national HIV/AIDS plans and policies, including the development of a National HIV/AIDS Strategic Plan (NSP) 2003-2007. The NSP highlights five priority areas: prevention; treatment, care, and support; advocacy and human rights; surveillance and research; and programme management, resource mobilization, coordination, and evaluation.

With the provision of free anti-retroviral treatment (ART) since 2000, recent data from the National Surveillance Unit suggest that deaths from HIV/AIDS appear to be declining (from 205 in the year 2000 to 128 in 2004). However, this decline is accompanied by an increase in new HIV cases (from 916 in 2000 to 1,445 in 2004.[8])



Source: National Surveillance Unit 2000-2004



Source: National Surveillance Unit 2000-2004

Trinidad and Tobago has been involved in the development of national policies and guidelines to assist in the standardization of HIV/AIDS prevention, care, treatment, and support. Currently, national policies have been developed for voluntary counseling and testing (VCT), prevention of mother-to-child transmission (PMTCT), post exposure prophylaxis (PEP), and guidelines for dietary and nutritional care for persons living with HIV/AIDS (PLWHA) and health professionals respectively. Trinidad and Tobago has also adopted the regional guidelines for HIV/AIDS care and treatment developed by the Caribbean Epidemiology Centre (CAREC).

Stigma and discrimination against PLWHA continues to plague the Trinidad and Tobago HIV/AIDS efforts. However, a legislative assessment of the national laws and legal

[7] PAHO/WHO. Fact Sheets on HIV/AIDS Care and Treatment: Trinidad and Tobago. Washington, DC: January 2005.
[8] Ministry of Health: National Surveillance Unit. HIV/AIDS Morbidity and Mortality Annual Reports, 2000-2004.

policies was recently conducted to identify mechanisms for protecting PLWHA from stigma and discrimination.

While the country is considered to have a low incidence for tuberculosis (TB), rates increased from 7.1 per 100,000 in 1998 to 13.1 in 2003. Cases are concentrated largely among male adults 20-64 years of age (75% in 2003), but there is a sustained frequency of cases among 0-14 years old, indicating active transmission of TB. As a result of the high HIV/AIDS prevalence, co-morbidity with tuberculosis has increased and was estimated at 24% for 2003. There have been only a few confirmed cases of multiple-drug resistant TB. There is no Directly Observed Therapy Strategy (DOTS) programme available at primary health care (PHC) level, but the MoH is in the process of initiating a pilot programme, while addressing policy and integrated care for HIV/AIDS and TB.

Sexually transmitted infections (STIs) have decreased over the period of 1994-2000, with rates for syphilis dropping from 40 to 21/100,000 population, and gonorrhea from 170 to 29/100,000 population. Males 15-54 years old presented the highest frequency of STIs. The MoH is addressing STIs and co-morbidity of HIV with aggressive contact tracing, institutional strengthening, training, the formulation of a national policy, and the implementation of STI syndromic management.

The incidence of dengue fever fluctuates from year to year. There was an outbreak in 2002 with the Type 3 dengue virus being identified as the cause for the first time. The majority of cases have been attributed to mosquito breeding in barrels of stored water in areas where there is limited piped water. Although Trinidad and Tobago was declared malaria-free in 1965, residual cases of P. malariae continue to be recorded in South Trinidad. In 2003, 10 cases of malaria were reported, with 4 being imported; in 2004, there were 12 imported cases. Environmental risk management, including vector control, is therefore an important issue for Trinidad and Tobago.

Risk factors related to behaviour and lifestyle contribute to the high incidence of CNCDs. In the adult population, 20 years and older, 16.8% were obese and 31.4% were overweight, women more so than men. Prevention and early detection, in the context of a comprehensive, integrated PHC programme, will minimize disabilities and social and institutional costs. Key issues include strengthening surveillance, monitoring and evaluation, and community participation.

Crude mortality rates for cancer among males and females were, respectively, 75 and 64 per 100,000 population in 2001. The five leading fatal cancers are prostate (21%), followed by breast (15%), colon and rectum (9%), cervical cancer (7%), and lung (6%).

In 1996, self-reported prevalence of diabetes in persons over 15 years old was 10% and 12% among males and females, respectively, with a higher frequency among the 50+ age group and females of East Indian descent. This is consistent with information available from the 1960s, with no significant changes being currently observed.

Mental health is an area severely lacking statistical data, as morbidity related to mental disorders is not coded in the health information system and services are largely limited to hospital care. This area requires the development of a community-based programme integrated into the provision of primary care services.

Laboratory and testing equipment needed to support occupational health presently do not exist. There has been a steady increase in the number of claims paid by the National Insurance Board (NIB) for injury and disablement benefits due to workplace incidents, as shown in the table below. Moreover, deaths due to workplace accidents are consistently high.

Occupational Injuries/Illnesses/Death Statistics – 1999 to 2005[9]				
Year	**Employment Injury**	**Disablement**	**Death**	**Total**
1999	1,924	161	21	2,106
2000	2,733	369	45	3,147
2001	2,494	415	43	2,952
2002	2,467	361	29	2,857
2003	2,383	297	43	2,723
2004	2,343	413	22	2,778
2005 (Oct. 13)	1,855	212	36	2,103

While police records do not show an overall increase in criminal acts, certain offenses have increased over the past five years, such as murders, kidnappings, rapes, and incest (see table below). The population group mainly victimized by the first two causes are males aged 15-49.

Serious Crimes for 2000-2005 (to 31 Aug 2005)[10]					
Crime/ Year	**Murder**	**Wounds/ shooting**	**Narcotic offences**	**Kidnapping**	**Rape/incest/ sexual offences**
2000	120	387	1225	156	545
2001	151	499	485	135	545
2002	172	655	509	232	641
2003	229	784	505	235	643
2004	260	649	589	177	581
2005 (August)	247	464	330	150	504

There were 16 deaths associated with domestic violence in 1996 and 32 in 1998; female victims were the largest affected group, with a predominance of male perpetrators[11].

[9] National Insurance Board of Trinidad and Tobago (NIBTT)
[10] Trinidad and Tobago Police Service. 2005. Modus Operandi and Records Bureau.

From 1998 to 1999, deaths from motor vehicle accidents increased by 43%; children accounted for 15% and 8% respectively of these deaths[12]. Among young people aged 15 to 24 years, external injuries such as motor vehicle accidents, gunshot wounds and assaults with other weapons accounted for the highest number of deaths, predominantly among males.

2.4 HEALTH SYSTEMS AND SERVICES

The Government of Trinidad and Tobago has taken a policy decision to achieve developed nation status for the country by the year 2020 and has developed a strategic framework to bring this vision to fruition. A health sub-committee was established to develop a strategic framework for the sector. The mission statement articulated by this sub-committee was "To create a nation of individuals, families and communities empowered to achieve and sustain the highest standards of health and well-being through the provision of efficient, effective, equitable and collaborative services that support good health".

The following seven goals for health[13] have been identified:

1. Improve the general health status of the population
2. Enhance the management of communicable and non-communicable diseases
3. Improve the performance of health care delivery systems
4. Improve the quality of health care services
5. Unify the delivery of health care services
6. Develop/strengthen the health research system to facilitate evidence-based decision making, policy formulation, new learning, and development
7. Create a client-centred health care environment

The goals were developed to harmonize with the Health Sector Reform Programme (HSRP), and the success of this harmonized approach will depend on a high degree of intersectoral collaboration and commitment to continuity by successive governments. While the Vision 2020 strategic framework for the health sector has been developed, the MoH has yet to make it operational, through the development of a strategic health plan.

In July 1996, the Government of Trinidad and Tobago signed a loan agreement with the Inter-American Development Bank (IADB) for the implementation of HSRP. The health reform programme was intended to bring about fundamental changes through the strengthening of the leadership role of the Ministry of Health, development of health systems, and implementation of the Regional Health Authorities Act of 1994. The Act defined the Ministry's role as being a 'purchaser' of health care services with Regional Health Authorities (RHAs) being the providers. However, implementation has been slow

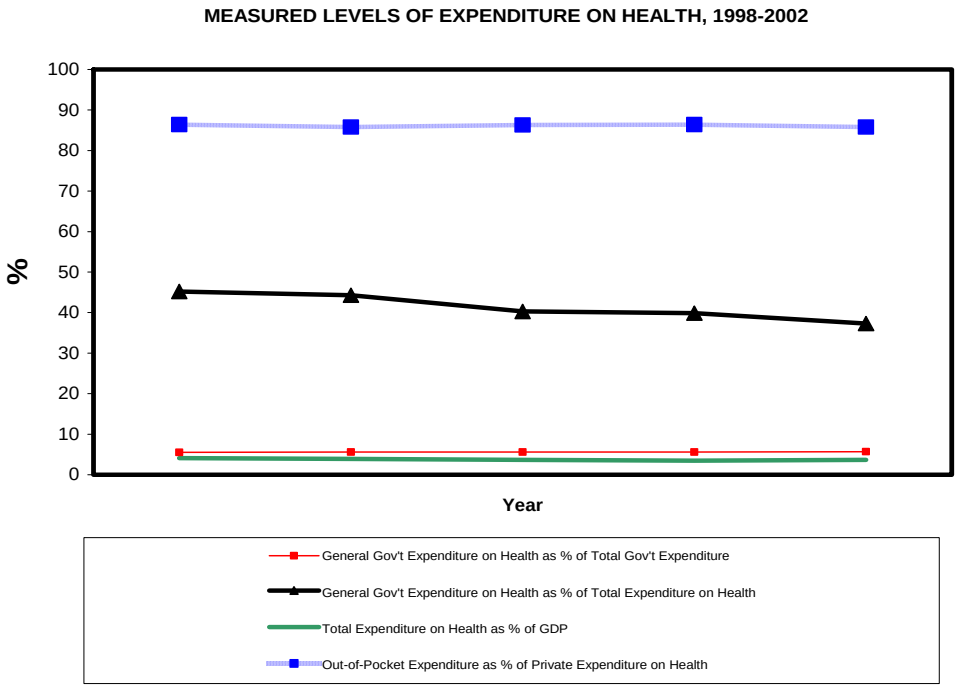
[11] PAHO/WHO "The Impact of Gender Based Violence on Women's Health and the Stability of Families in Trinidad and Tobago". 2004. Unabridged document.
[12] PAHO Report "Spotlight on Motor Vehicle Injury and Deaths in Trinidad and Tobago (1998-2003)". Dr. Betty Ann Carr. 2004.
[13] Ministry of Health, Trinidad & Tobago. Final Report, Vision 2020 Sub-Committee on Health.

and challenging, and the loan was extended to the end of 2006. At this time, the MoH has not yet been able to effectively assume the leadership role and transform itself into an effective policy, planning, and regulatory organisation.

Major challenges are present in the current health system, which does not have a health workforce that corresponds in quantity, competencies, and quality to the current and projected health needs of the population, due to inadequate strategic human resource planning. There are vacancies in key management positions and a shortage of staff even for acting positions. Transfer of staff from the MoH to the RHAs and resolution of industrial relations issues have been problematic. Pre-service and continuing education training programmes have not been effectively adapted to meet training needs for the health workforce due to inadequate dialogue among critical stakeholders in the health and education/academic sectors and professional bodies.

Professional bodies operate within the framework of regulations; however, enforcement of these regulations is a concern. Dual work practices, which allow many senior public service doctors to work in private as well as public practice, have resulted in the limitation of their public sector work hours, to the detriment of those who cannot afford to pay to see doctors in private practice.

In Trinidad and Tobago, the health budget has declined from 12% of the total budget in the early 1970s, to about 7% in 2003.



Source: World Health Report 2004

The public health system in Trinidad and Tobago comprises hospitals – tertiary level, district, and specialist (long-stay) – and a mix of primary health care (PHC) facilities,

with district health facilities at the hub of health and outreach centres. The private sector involves practitioners, hospitals, maternity centres, pharmacies, biomedical laboratories and radiological diagnostic services. Though the private sector remains highly unregulated, some publicly-funded health institutions are outsourcing some of their health and ancillary services to private providers. Trinidad and Tobago also serves as a tertiary care referral centre for persons from other CARICOM countries. Nearly all health centres continue to offer traditional services.

There is insufficient evidence-based planning and decision-making in health due to the lack of an integrated health management information system. The system for drug utilisation is inadequate, the national drug policy and formulary are outdated, and there is a lack of drug utilisation reviews. The laboratory system has been unable to adequately meet service needs due to many factors, including limited financial resources, inadequate physical plant, insufficient professional and technical leadership, outdated regulations, and poor dialogue with clinical services. There is a National Laboratory Advisory Committee to oversee the operations of the medical laboratory network and to develop and implement a strategic plan for strengthening medical laboratory services.

2.5 HEALTH SECTOR DEVELOPMENT CHALLENGES

The health sector development challenges identified are diverse, but the priority challenges are categorized by critical areas that include: planning and policy development – the regulatory framework; health information systems, epidemiological surveillance, data analysis, and the use of information for decision-making; human resources in the public and appropriate competencies; the development of the health system and services; and the coordination, follow-up and networking at the local level for regional and global commitments.

Planning and Policy Development - the Regulatory Framework

There is need to:

- Strengthen planning, policy, and regulatory capacities and to create a "planning culture."
- Strengthen leadership and managerial capacities of the Ministry of Health and the Regional Health Authorities.
- Ensure evidence-based planning and decision-making in the health system.
- Strengthen national emergency preparedness and response legislation which would mandate actions.
- Strengthen the leadership role in providing policy direction on the issue of decentralization of environmental health services and to promote collaboration and rationalization of responsibilities between health, and the ministries of local government, agriculture, labour, and public utilities, to better utilize resources to ensure a better provision of these services.
- Address the lack of cohesive national policies for waste management (solid and hazardous wastes cover several sectors), with regulations and systems for implementation.

Health Information Systems and Epidemiological Surveillance

There is need to:

- Develop and strengthen health information systems at the national and RHA levels.
- Develop standardized surveillance methods for public and private health facilities and adequate competencies in surveillance and analysis to heighten surveillance required for both communicable and non-communicable diseases.

Human Resources in Health

There is need to:

- Develop a policy and plan for human resource development and management, which will address the widening human resource gap in the public health sector.
- Ensure that the vertical services which remain the core responsibility of the Ministry of Health have enhanced human resources and facilities.

Health Systems and Services Development

There is need to:

- Develop and implement a strategy to define and operationalize the Primary Health Care and Health Promotion model, ensuring implementation of prevention interventions, including prevention of violence and substance abuse at all levels and in all sectors.
- Strengthen norms and standards, evidence-based practices, rules and protocols relating to patient care and safety, and overall clinical management at all levels of care.
- Develop and implement a strategic plan for the strengthening of medical laboratory services and ensure effective maintenance and health technology assessment of the engineering functions of health facilities (plant, buildings, and equipment).
- Appropriately address and improve the quality of health care for pregnant women, including issues of low birth weight (LBW) babies, reduction of exclusive breastfeeding, and iron deficiency anaemia.
- Address overweight and obesity among preschoolers, adolescents, and adults, as major public health problems, especially given the profound implications of these conditions for the development of chronic, non-communicable, nutrition-related diseases.
- Promote universal access to prevention, care, treatment and support for HIV/AIDS and ensure accessible and comprehensive sexual and reproductive health (SRH).
- Develop a Social Health Insurance model that is equitable and sustainable.
- Address Environmental Health issues, including strengthening Environmental Risk Management, including Vector Control, and ensuring equitable and reliable access to potable water for the population.

Coordination and Networking

There is need to:

- Improve and/or establish adequate communication and coordination and operational relationships and mechanisms between the Ministry of Health and agencies/institutions, such as UWI, the RHAs, development agencies, and other health development partners.
- Promote and strengthen involvement and partnership on HIV/AIDS between the public and private sectors, including observation of the human rights of Persons Living With HIV/AIDS (PLWHA).

SECTION 3 DEVELOPMENT ASSISTANCE AND PARTNERSHIPS: AID FLOW, INSTRUMENTS AND COORDINATION

There are a number of key partners of the Government of Trinidad and Tobago, including the United Nations, bilateral agencies and financial institutions, and non-governmental Organizations (NGOs), all contributing through diverse mechanisms to the development agenda of Trinidad and Tobago, in the context of Vision 2020.

In 2005, the Inter-American Development Bank (IADB) continued to be the main source of external loan financing, contributing approximately 12% of the total cost of the Public Sector Investment Programme (PSIP), calculated at TT$2,100 million (US $343.12 million). This was followed by the International Bank for Reconstruction and Development (World Bank) with 0.6%, and the Caribbean Development Bank (CDB) at 0.4%. On the other hand, the European Union (EU) remains the main source of grant funding (0.5%), though the IADB (0.1%) also represents an important source for this type of financial support. A Donor Matrix is appended at Annex IX of this document.

Presently, there is no formal Government-led mechanism for coordination of development partners. Nevertheless, a coordinating mechanism has been established through the NACC for the sector-wide response to HIV/AIDS. Coordinating initiatives by the UN System include the Theme Group on HIV/AIDS, presently chaired by PAHO/WHO, the Theme Group on the Millennium Development Goals (MDGs) chaired by UNECLAC, and the recently formed Theme Group on Disaster Management. In most instances, the Theme Groups have invited other development partners to join them and have had a high degree of success.

3.1 UNITED NATIONS

United Nations Agencies accredited to Trinidad and Tobago comprise UNDP, UNAIDS, ILO, UNECLAC, UNIC, FAO, UNICEF (served from Guyana but with an officer within the UN House in Trinidad) and PAHO/WHO. The UN Country Team (UNCT) plans inter-agency activities utilizing the CCA/UNDAF framework for both HIV/AIDS and the MDGs, and, more recently, Disaster Management. There are monthly UNCT meetings and meetings of the Theme Group on HIV/AIDS and the Security Management Team (SMT).

The UNDP's primary contribution to the health sector is through the United Nations Volunteer (UNV) programme with the Ministry of Health. This programme has recruited and placed physicians and engineers in health facilities across the country. In addition, it has expanded its partnership with the Ministry of Health to include advisory services in building support for a multi-dimensional response to HIV/AIDS in Tobago.

The ILO also contributes to health through its project on HIV/AIDS in the workplace.

3.2 OTHER MULTILATERAL DEVELOPMENT AGENCIES

Inter-American Development Bank (IADB): The IADB is the major contributor of financial resources to the development of the health sector in Trinidad and Tobago, through the financing of the Health Sector Reform Programme. This programme was initiated in July 1996 and will end in November 2006. The total cost of the programme is US$191.0 million, of which the loan component is US$134.0 million and the counterpart funding is US$57.0 million. To date, the level of execution of financial resources is equivalent to 76.7%, with a balance of US$31,162,989 remaining to be disbursed.

The Government of Trinidad and Tobago has embarked on a Public Sector Reform Programme which aims at supporting the development and implementation of a long-term strategy to reform the public sector. The Programme has two major components: Public Sector Reform Strategy and the Strengthening of the Public Sector's Structural Capacity. The total cost of US $6.25 million will be met with IADB financing of US$5.0 million, and Government's contribution of US$1.25 million. This programme was approved in December 2003 for a period of 30 months and is being executed through the Ministry of Public Administration and Information (MPAI).

The World Bank (WB): In 2004, the WB funded a US$25.0 million HIV/AIDS Prevention and Control Programme for the period 2004 to 2008. US$20.0 million of the total cost will come from the loan component, and US$5.0 million from counterpart funding was initiated.

The European Union (EU): The EU is also contributing to the HIV/AIDS response through the National AIDS Coordinating Committee (NACC). A five-year Financing Agreement has been signed between the EU and the Government of Trinidad and Tobago in the sum of €7 million (TT $49.0 million) to support activities for the prevention of HIV/AIDS and to ensure a coordinated approach to the implementation of the National HIV/AIDS Strategic Plan throughout the period June 2005 to June 2010.

3.3 BILATERAL DEVELOPMENT AGENCIES

Many of the Bilateral Agencies, including the US Agency for International Development (USAID), the Canadian International Development Agency (CIDA), the Netherlands, the United Kingdom Department for International Development (DFID) and France, have channeled resources through CAREC over the last five years in support of sub-regional projects. However, the larger proportion of these grants is in the area of HIV/AIDS/STIs, with smaller amounts for Leprosy Control and Public Health Support. The main contributors to the strengthening of the response to HIV/AIDS have been CARICOM, CIDA, DFID and France, with a total of approximately US$11.0 million over the period 2001-2006.

3.4 PARTNERSHIPS

Over the years, PAHO/WHO has built many strong partnerships with institutions, agencies, NGOs, and community-based organizations, which have contributed tremendously to the achievement of the Organization's work objectives. These strategic alliances remain an integral part of the PAHO/WHO's technical cooperation with the country.

SECTION 4 CURRENT PAHO/WHO COOPERATION

4.1 BRIEF HISTORICAL PERSPECTIVE

The PAHO/WHO Country Office in Trinidad and Tobago has had longstanding working relations with the Ministry of Health, dating back to the initial signing of the Basic Agreement for the Provision of Technical Advisory Assistance between the World Health Organization and the Government of Trinidad and Tobago. This Agreement was signed on June 23, 1964, by Dr. Eric Williams, then Prime Minister and Minister of External Affairs for the Government of Trinidad and Tobago, and Dr. Abraham Horowitz, Director of the Pan American Sanitary Bureau, Regional Office of the World Health Organization. This Basic Agreement provides the basis for the relationship between the Government of Trinidad and Tobago and PAHO/WHO. It remains current and constitutes the legal framework for PAHO/WHO's presence and Technical Cooperation Programme.

The Caribbean Food and Nutrition Institute (CFNI), a specialized Centre of PAHO/WHO, was established in 1967 with the main Centre located in Jamaica and a Satellite Centre in Trinidad and Tobago. Memoranda of Understanding were signed with PAHO/WHO, the UWI, the Food and Agriculture Organization (FAO), the Government of Trinidad and Tobago, and the Government of Jamaica. The agreement with Trinidad and Tobago was signed in 1973.

The Caribbean Epidemiology Centre (CAREC) is an institution administered by PAHO/WHO on behalf of its 21 member countries under a Multilateral Agreement. The need for such a Centre was first recognized in the early 1970's, and it came into existence in 1975. Under the Bilateral Agreement with PAHO/WHO, Trinidad and Tobago assumed the role of host country because of the existing strength of the Trinidad and Tobago Regional Virus Laboratory, which was subsumed by the Centre. The current Bilateral Agreement ends in December 2007.

4.2 TECHNICAL COOPERATION AND AREAS OF WORK

The Technical Cooperation Programme for the Republic of Trinidad and Tobago is defined in close collaboration with PAHO/WHO's principal counterpart, the Ministry of Health. Over the years, the Organization has established partnerships and working relations with other partners in other Governmental sectors, the private sector, statutory authorities, NGOs and CBOs.

4.2.1 The Country Office

The priority areas for cooperation are based on the national priorities in health. The 2004-2005 Biennial Program Budget (BPB), had six projects, as follows:

Management of the Representation: This project aimed at strengthening the administrative processes and managerial capacity of the Country Office (CO) to meet the needs of the Technical Cooperation Programme and wider managerial responsibilities related to the other sectors and the United Nations System.
Health Systems and Services: This project was a major focus of PAHO/WHO technical cooperation with the purpose of improving the Ministry of Health's organization, management and service delivery.
Environmental Health: This project focused on the improvement of assessment, control and management of environmental risks.
Behavioural Change and Mental Health: The objective of this project was to further strengthen health promotion programmes, addressing risk behaviour through the promotion and formulation of healthy public policies and creating supportive and enabling environments at national and local levels.
Communicable and Non-Communicable Disease Prevention and Control: This project focuses on strengthening existing selected non-communicable and communicable disease prevention and control programmes and ensuring the integration of proper monitoring and evaluation systems.
Technical Cooperation Among Countries: This project detailed a strategy utilized across all projects and continuously promoted. For the 04-05 biennium, the focus was on tuberculosis and DOTS implementation, issues pertaining to port health, and the management of the surgical waiting list at one of the regional hospitals.

4.2.2 CFNI

The Institute's technical cooperation is planned annually, in consultation with the National Nutrition Coordinator of the Ministry of Health. Four functional areas (Planning, Human Resource Development, Promotion and Dissemination, and Surveillance/Research) are used to structure technical cooperation, and staff from either the Jamaica or the Trinidad and Tobago centres can be assigned accordingly, based on thematic areas. Budgeting is controlled either from Jamaica centre or from the local office.

For 2005, technical cooperation with Trinidad was as follows:

Planning: Review of the National Food and Nutrition Policy and development of the country papers on food security.
Human Resource Development: Assistance to the Regional Health Authorities in the implementation of the Baby Friendly Hospital Initiative (BFHI), through policy development and training. CFNI also worked with the University of the West Indies to train nurses pursuing the BSc Degree at UWI in modules pertaining to nutritional assessment, malnutrition, and obesity. Health professionals have also been trained in nutritional care of PLWHA, and in the use of the CFNI Manual "Healthy Eating for Better Living, A Manual on Nutrition and HIV/AIDS for Healthcare Workers in the Caribbean." A Food Service Supervisors course is in development, in collaboration with the Chief Nutritionist and the College of Science, Technology and Applied Arts of Trinidad and Tobago (COSTAATT).

Promotion and Dissemination: CFNI collaborated with the Ministry of Health in the development and implementation of the National Primary Schools' Health Quiz Competition and assisted national school teams preparing for the CFNI Regional Secondary Schools' Nutrition Quiz Competition. The Institute conducted pre- and mid-period assessment of several hospitals, to promote and support breastfeeding in Trinidad and Tobago.

Surveillance and Research: CFNI participated in planning meetings and is a member of the Technical Committee for the Implementation of the Trinidad and Tobago 2005 Survey of Living Conditions; the Institute was responsible for the implementation of the Anthropometric Module.

4.2.3 CAREC

The work of CAREC aims at advancing the capability of member countries in epidemiology, laboratory technology and related public health disciplines through technical cooperation, service, training, and research. CAREC has also been implementing various extra-budgetary projects, primarily in HIV/AIDS and the strengthening of medical laboratories.

4.3 FINANCIAL RESOURCES ALLOTTED IN THE 2004-2005 BUDGET

The total budget for the Trinidad and Tobago Country Office for the 2004-2005 biennium was US$2,234,642, including post funds. The post funds comprise 48.37% of the total budget. Of the non-post funds, US$947,245 was from Regular Budget funds, and US$53,317.00 from other sources, for a total of US$1,000,562.

4.4 HUMAN RESOURCES

The PAHO/WHO Country Office is managed by the PAHO/WHO Representative (PWR). The day-to-day coordination of the technical cooperation projects is the responsibility of the technical advisors, under the overall supervision of the PWR. The table at Annex II gives a breakdown of the categories of the staff in the Representation. An Organizational Chart is appended as Annex I.

4.5 OFFICE INFRASTRUCTURE AND EQUIPMENT

Premises: Under the Basic Agreement between the Government of Trinidad and Tobago and PAHO/WHO, the Government provides premises, free of charge to the Organization, to house the CO. The Government has plans to construct a Ministry of Health Administrative Complex at the current location of the CO in the near future. The expectation is that the CO will also be included in this new building, and temporary premises will be provided for the CO during the period of construction of this Complex.

Working Conditions: The physical environment of the CO presents no occupational hazards to the staff who work there. However, it is an old, wooden structure that requires continuous maintenance, and additional space is required for conference and training facilities.

Security: The escalating crime situation in Trinidad and Tobago has become a major concern among the UN agencies, as it is for the citizens of Trinidad and Tobago. The UN Heads of Agencies formally meet as the Security Management Team (SMT) and are directly supported by the Field Security Coordination Assistant (FSCA), and overall by the Security Officer posted in Venezuela.

Security services at the Representation are provided by the Ministry of Health in the form of two non-armed guards on a 24-hour rotation. This service, in light of the crime situation, is not adequate and the Ministry is unable to upgrade the service. This implies that the Organization will have to take additional measures in the future. The security services at the University are available to CFNI and UN security measures are used by the Centre to provide a safe working environment.

The CO is not yet compliant with the UN Minimum Operating Security Standards (MOSS), but procurement of the two items needed has been deferred until the CO is relocated. A detailed listing of actions taken by the Representation towards achieving MOSS compliance is attached at Annex III.

Information Systems/Information Technology Architecture: The IT architecture is the infrastructure of technology that provides the foundation for automated business procedures and practices at the Country Office. The current architecture can be sub-divided into the technical and application architecture. To date the Country Office has adequate equipment to support the Technical Cooperation Programme.

4.6 SUPPORT FROM THE REGIONAL OFFICE AND CENTRES

Technical support has been sustained based on the regional priority programmes and the regional agenda that intersect with the national priorities. The CO has participated in field testing of instruments related to cervical cancer, health promotion participatory evaluation, and the Vital Events System, as well as multicentric surveys, focal point meetings, and technical discussions. The Regional Office (RO) has provided direct technical assistance for implementation of WinSIG and for the installation of VHL at the host server (NALIS) and training of librarians on VHL application software.

The RO has also provided support to the CO for national HIV/AIDS activities to meet the goals of the 3 by 5 initiative and a new position of Public Health Adviser (HIV/AIDS/STI) was created. This adviser provides technical support for the coordination and implementation of national HIV/AIDS programmes as they relate to the 3 by 5 and other sub-regional initiatives.

4.7 SUB-REGIONAL/INTER-COUNTRY ACTIVITIES

Technical Cooperation among Countries (TCC) is one of the mechanisms used by the Secretariat to facilitate inter-country activities. The projects approved for the period 2004-2005, involved two projects - Strengthening of the National TB programs, with Guyana and Suriname, and Port Health Surveillance, with Barbados, The Bahamas, St.

Lucia, St. Kitts and Nevis, and Dominica. This Country Office has had a low utilization of TCC funds, but continues to promote and support this modality of cooperation.

There are various sub-regional activities coordinated primarily by the Units of the Secretariat that are sub-regional in nature, such as OCPC, CFNI and CAREC in which we participate as the Secretariat, but are planned to strengthen capacity in Member Countries, and therefore require the participation of counterparts from the health sector and outside the sector.

Resource Mobilization/Cost Sharing: Resources were received to support areas of technical cooperation from all levels of the Organization; for example, during the period 2004-2005, PED supported the production of a hurricane preparedness and response audio soap video. This was a collaborative effort with PAHO/WHO, Association of Caribbean States (ACS), International Federation of Red Cross (IFRC) and the ISDR. Technical and financial support was also received to carry out the National Oral Health Survey and the training in PRAT at the UWI, St. Augustine; and technical and financial support was provided from WHO to implement the INTRA project, implemented in conjunction with the Health Economics Unit, UWI and the Ministry of Community Development. Support was also provided from the respective Unit at PAHO Headquarters for surveys in the area of cervical cancer prevention and for the production of local advocacy materials related to health promotion and disease prevention and control; technical materials and instruments on a diversity of topics related to WHO and PAHO technical cooperation were received; and the participation of regional advisors enhanced planned country-based activities.

Cost sharing has also increased with our principal counterpart – the Ministry of Health, as well as other partners. Other modalities of sharing resources, as for example the Country Office facilitating the identification of the expert and the financial support shared with the counterpart, has also been done increasingly in areas of infection control, the celebration of the 25th. Anniversary of the Alma Ata Declaration; the Vector Control Program Assessment; and Rapid Assessment of the HSRP; among others.

4.8 WHO PARTNERSHIPS WITH OTHER AGENCIES AND COMPARATIVE ADVANTAGES

PAHO/WHO has established strong working relations with key public sector partners, agencies, and NGOs. Though the Ministry of Health remains PAHO/WHO's primary interlocutor, cooperation has been established with the agencies under the responsibility of the Ministries of Public Utilities, Agriculture, Education, National Security, Social and Community Development, and Gender Affairs.

PAHO/WHO's work as an integral partner of the UN Country Team (UNCT) has been within the framework of the Common Country Assessment (CCA) and the United Nations Development and Assistance Framework (UNDAF), the latter defined around two priority areas – HIV/AIDS and the Millennium Development Goals (MDGs). There has been a strengthening of the UNCT over the past three years and coordination mechanisms have been defined and are currently operational. These include the theme

groups on HIV/AIDS, MDGs, Disaster Preparedness and Management, the Security Management Team, Administration, and more recently, the Operational Management Team (OMT), all of which look closely at common services. There are basically three working documents: the Annual Work Plan, the UNDAF Matrix for HIV/AIDS, and the MDGs.

The Country Office continues to strengthen its partnership with NGOs. The private sector provides support for the Media Awards and other promotional activities, such as the 5K run.

Collaborative links have been established with the IADB, through the Project Administration Unit responsible for the implementation of the Health Sector Reform Programme, and with the EU, through the National AIDS Coordinating Committee.

4.9 STRENGTHS, WEAKNESSES, OPPORTUNITIES, AND THREATS

A SWOT analysis is a subjective assessment of information which is organized to identify Strengths, Weaknesses, Opportunities, Threats in a logical order, to enable proactive thinking. The following reflects the SWOT analysis of PAHO/WHO's programme and presence in Trinidad and Tobago. This enables the Organization to focus on key issues and implement strategies to maximize its strengths, minimize its weaknesses, take the greatest possible advantage of opportunities available, and anticipate threats.

Summary of SWOT Analysis

STRENGTHS	WEAKNESSES
– Long standing reputation for leadership in health – Strong relationship with Ministry of Health – Good partnerships with national stakeholders – Proactive approach to responding to emerging health needs – Comprehensive approach based on evidence – Well qualified and experienced technical and administrative staff within Country Office – Access to specialized expertise within PAHO Secretariat – Strong administrative teamwork – Strong work ethic among staff – Transparent and accountable everyday practices – Stable internal work environment – Improved staff relations through employee assistance programme, harassment policy, code of ethics, etc. – IS/IT infrastructure	– Limited managerial authority for contractual and procurement arrangements – Inconsistencies within contractual services instruments – No clear-cut mechanism to contract local administrative staff – Insufficient number of staff in the CO available to comply with control measures established by the RO – Support staff provided by Ministry of Health do not always meet competencies required by Country Office – Increasing demands from the RO and UN system without additional resources, e.g. for MOSS compliance, UN coordination, survey requests from PAHO headquarters – Limited financial resources for administrative growth and infrastructure improvement – Insufficient integration and coordination of technical cooperation projects – Insufficient funds for social marketing of organization's work – Lack of timely responsiveness within PAHO Secretariat – Irregularity of established general staff meetings – Limited physical (space) infrastructure – Inadequate on-site security

OPPORTUNITIES	THREATS
– More options for mobilizing financial resources within health sector – Heightened focus on/interest in the region and local environments regarding health-related issues – Increased partnerships/networking with stakeholders – Increased inter-agency collaboration – Access to specialized expertise through WHO Collaborating Centres – Increased involvement with RHAs for technical cooperation authority level – Construction of Ministry of Health's new headquarters will provide for improved Country Office facilities	– Need for strengthened leadership in the Ministry of Health – Limited technical, managerial and implementation capacities of the Ministry of Health – Limited health information systems to inform policy development/analysis and planning – Limited technical counterparts in the Ministry of Health – High turnover among national counterparts – Technical matters being influenced by perceived political, rather than evidence-based, influence on technical matters – Inadequate preparedness for a major disaster/emergency (natural, man-made, health emergencies such as pandemic influenza, etc.) – Increase in cost of living/inflation affecting purchasing power within decreased budget – Industrial action(s) in health sector impacting on ability to deliver technical cooperation – Deterioration of social environment due to increasing crime

SECTION 5 GLOBAL AND REGIONAL DIRECTIVES FOR PAHO/WHO TECHNICAL COOPERATION

The Pan American Health Organization (PAHO) is the Regional Office of the World Health Organization (WHO) and its main function is to technically cooperate with countries and territories in the Americas, within the WHO global framework, while responding to specific mandates from PAHO Governing Bodies. The global framework incorporates the Millennium Development Goals (MDGs), adopted at the Millennium Summit in the year 2000 and expressed in the United Nations Millennium Declaration. The MDGs provide a global development vision with measurable goals and targets to be achieved by the year 2015. These goals are:

1. Halving extreme poverty and hunger
2. Achieving universal primary education
3. Promoting gender equality
4. Reducing under-five mortality by two-thirds
5. Reducing maternal mortality by three-quarters
6. Reversing the spread of HIV/AIDS, malaria and tuberculosis
7. Ensuring environmental sustainability
8. Developing a global partnership for development, with targets for aid, trade and debt relief

The work of PAHO/WHO at the country level is defined within the framework of global and regional directives and the national health development priorities of the specific Member State.

5.1 GLOBAL GOALS OF THE WORLD HEALTH ORGANIZATION (WHO)

The WHO goal is to promote healthy population and communities and combat disease. To this end, the work of WHO is currently guided by the 10th General Program of Work (GPW), a four-year document that outlines broad strategic directions for the period 2002-2005 and the core functions of the WHO Secretariat. There are four strategic orientations which provide a framework for the Organization's technical cooperation.

1. Reduce excess mortality, morbidity and disability with special emphasis on poor and marginal populations;
2. Promote healthy life styles and reduce environmental, economic, social and behavioral risk factors for health;
3. Develop health systems responsive to health need of the population, fairly financed and capable to improve health outcomes in an equitable manner; and
4. Promote an institutional environment conducive to allocate health a high priority in the social and economic agenda.

The 11th GPW 2006-2015, currently being finalized, outlines 10 priority areas in the global health agenda:

1. Ensure universal coverage and promote equity in health
2. Build individual and global health security
3. Promote health-related human rights and gender equality
4. Reduce poverty and its effects on health
5. Tackle the social determinants of health
6. Promote a healthier environment
7. Build fully functioning and equitable health systems
8. Ensure an adequate health workforce
9. Harness knowledge, science and technology
10. Strengthen governance and leadership

WHO's core functions in addressing these priorities include:

- Providing leadership on matters critical to health and engaging in partnerships where joint action is needed
- Articulating ethical and evidence-based policy positions
- Setting norms and standards, and promoting and monitoring their implementation
- Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge
- Providing technical support, catalyzing change and developing sustainable institutional capacity
- Monitoring the health situation and assessing health trends.

5.2 REGIONAL GOALS OF THE PAN AMERICAN HEALTH ORGANIZATION (PAHO)

PAHO's mission is to lead strategic collaborative efforts among Member States and other partners to promote equity in health, to combat disease, and to improve the quality of, and lengthen, the lives of the peoples of the Americas.

Guidelines for PAHO technical cooperation for the period 2003-2007 are contained in the Strategic Plan approved by Member States. It presents the Secretariat's values, vision, mission, and functions. While the policy orientations are designed for the Bureau, the Plan also serves as a useful reference for countries in their own planning efforts and for partners in the development of shared agendas or joint initiatives toward the common goal of improved health in the Americas.

The Strategic Plan follows the principles of equity and Pan Americanism. Equity in health is defined as the concept of distributing the means necessary to ensure health in a fair manner. It is a principle underpinning the goal of 'Health for All' and is reflected explicitly in the values, vision, and mission of the Secretariat. As it promotes health equity, the Secretariat seeks to work with Member States to reduce differences or disparities that are avoidable. Pan Americanism is the principle on which PAHO was founded, and this is now expressed in Member States' commitment to work together to improve the state of health in areas of common interest and to support those countries in greatest need, directly and indirectly. The recognition that many health problems require a collective effort, and that the health of one's neighbour, and public health, are a shared responsibility, is even more relevant in today's world of free trade and movement of people.

The Strategic Plan for PAHO Technical Cooperation in the period 2003-2007 identifies eight priority areas:

1. Prevention, control, and reduction of communicable diseases;
2. Prevention and control of non communicable diseases;
3. Promotion of healthy lifestyles and social environments;
4. Healthy growth and development;
5. Promotion of safe physical environments; disaster preparedness, management and response;
6. Disaster preparedness, management, and response;
7. Ensuring universal access to integrated, equitable, and sustainable health systems; and
8. Promotion of effective health input in social, economic, environmental, and development policy.

PAHO carries out the following functions:

1. Provides strategic vision for health development in the Americas;
2. Generates and shares information in order to monitor health conditions, risks, and disparities in the population and the environment;
3. Informs, advocates, and educates about regional health issues and produces knowledge and finds innovative solutions;
4. Mobilizes resources and partnerships, nationally, regionally, and internationally, to increase cooperation in the search for shared solutions;
5. Builds national and regional capacity;
6. Customizes integrated and innovative technical solutions to address national and community health goals; and
7. Develops norms and standards that protect health and ensure safety.

PAHO Mandates and Regional Commitments: PAHO takes its regional mandates from many sources, but mainly from the resolutions of the Governing Bodies of the Organization; Organization of American States (OAS); WHO; and other bodies of the United Nations system. Mandates also come from regional or international meetings in which PAHO or WHO or has assumed specific responsibility. In identifying the priorities of the Region, the following were considered:

Development Issues
A review of commitments in the MDGs; in the Summits of the Americas and the Ibero-American Summits; and in Agreements from the global conferences held to discuss population and health, social development, and the environment, indicates that the Region is committed to the following development issues:

1. Reducing extreme poverty;
2. Equity in development;
3. Human rights and democracy;
4. Sustainable human development; and
5. Protection of vulnerable groups.

Health Issues
Significant commonality emerges among the specific health development issues being given attention at the various international fora:

1. Reduction in mortality of children under 5 years of age and in mothers;
2. Food security and reduction in malnutrition;
3. Increase in the population with access to safe water;
4. Universal access to care;
5. Increased access to technology and essential drugs especially those for treatment of HIV/AIDS; and
6. Increased access to information on health.

5.3 SUB-REGIONAL GOALS OF THE CARIBBEAN COOPERATION IN HEALTH (CCH)

The Member States of the Caribbean Community (CARICOM) approved a mechanism for health development which was conceptualized in the Caribbean Cooperation in Health (CCH). The CCH constitutes a strategy for increased collaboration and promotion of technical cooperation among countries in the Caribbean, and is a framework for collective action towards the achievement of agreed objectives. The second phase of the CCH, CCH II, which was implemented 1998-2003, defined eight priority health areas:

1. Health Systems Development
2. Human Resources Development
3. Family Health
4. Food and Nutrition
5. Chronic Non-Communicable Diseases
6. Communicable Diseases
7. Mental Health
8. Environmental Health

CCH III, currently in development, recommends continuation of these eight priorities and addition of a ninth, Behaviour Change in Support of Healthy Lifestyles.

SECTION 6: STRATEGIC AGENDA FOR TRINIDAD AND TOBAGO

The Country Cooperation Strategy (CCS) has been structured around the health goals and objectives of Vision 2020, as stated in the Final Report of the Sub-Committee on Health[14]. The strategic agenda is based on PAHO/WHO's comparative advantage in addressing the priority health sector development challenges identified and detailed in Section 2.5, namely:

- Planning and policy development – the regulatory framework
- Health information systems and epidemiological surveillance
- Human resources in health
- Health systems and services development
- Coordination and networking

6.1 MISSION AND FUNCTIONS

The mission statement of the PAHO/WHO Country Office in Trinidad & Tobago is:

> *"To be a cohesive empowered unit, working together with integrity, respect, and professionalism in providing quality Technical Cooperation to all our Stakeholders in public health for the well being and development of the country."*

In carrying out its strategic agenda in Trinidad and Tobago, the PAHO/WHO Country Office will perform the following functions:

- Supporting stakeholder meetings and fora; acting as a broker; facilitating partnerships, and advocating in support of appropriate policy development and programme design, and integrated interventions.
- Providing direct technical support.
- Sharing of information, lessons learned, and experiences from other countries that may be useful in addressing the priority health needs in Trinidad & Tobago.
- Supporting capacity building and institutional strengthening.
- Promoting and supporting Technical Cooperation among Countries (TCC).

6.2 VISION 2020: GOALS

The six health goals defined for Trinidad and Tobago within the policy framework of Vision 2020 are:

GOAL 1: Improve the general health status of the population.

GOAL 2: Enhance the management of communicable and non-communicable diseases

GOAL 3: Improve the performance of health care delivery systems.

[14] Vision 2020 Sub-Committee on Health: Final Report. April 2005.

GOAL 4: Improve the quality of health care services.

GOAL 5: Unify the delivery of health care services.

GOAL 6: Develop/strengthen the health research system to facilitate evidence-based decision-making, policy formulation, new learning, and development.

6.3 PRIORITY TECHNICAL COOPERATION AND FUNCTIONS

GOAL 1: Improve the general health status of the population.

Objective 1.1: Promote primary health care and empower people to take ownership and assume responsibility for their own health.

Priority technical cooperation for PAHO/WHO:

- Development and implementation of a primary health care (PHC) model, to include NCD risk factor control
- Development and implementation of wellness programmes, e.g. healthy spaces and health-promoting schools, including continuation of programmes in conflict resolution and violence prevention, with emphasis on high risk communities and schools.

The main functions for PAHO/WHO are: Information dissemination and collaboration with RHAs, Ministry of Health, Ministry of Education, community support groups, NGOs, and other relevant partners.

Objective 1.2: Decrease maternal and infant mortality and increase life expectancy.

Priority technical cooperation for PAHO/WHO:

- Development of protocols for prenatal, intra partum, and postpartum care; review of prenatal services; introduction of the Perinatal Information System (SIP)
- Strengthening sexual and reproductive health (S&RH) programmes that address teenage pregnancy, domestic violence, STIs, and reproductive organ cancer in both sexes, focusing on the implementation of the S&RH Strategic Plan with RHAs
- Improvement of the PMTCT programme.

The main functions for PAHO/WHO are: Collaborating among the CO, CAREC, and possible the IADB for training, facilitating development of national protocols, promoting TCC with The Bahamas regarding the SIP; with Curacao and Venezuela regarding S&RH; and with Belize, Guyana, and Suriname regarding health promotion, and the continuation of the NGO convenor function and collaboration with NGOs, e.g. FPATT, Women's Network, Youth Councils of Trinidad & Tobago, involving RHA personnel.

Objective 1.3: Protect the environment, reduce environmental pollution, and provide a safe water supply.

Priority technical cooperation for PAHO/WHO:

- Development of MoH environmental health (EH) strategic approach/policy to inform revision of EH legislation
- Development of regulations for occupational safety and health (OSH), including radiological safety and the development and implementation of MoH and RHA OSH guidelines
- Implementation of the Code of Practice dealing with biomedical waste management through collaboration with the NACC I
- Implementation of the International Health Regulations (IHR), including surveillance of environmental and human health
- Food safety
- Food security
- Vector control (dengue, yellow fever, malaria, West Nile virus); training of vector control officers, including in surveillance
- Development of disaster preparedness plans at community, Ministry, RHA, and Regional Corporation levels; hospital mitigation; simulation exercises; preparation for avian influenza pandemic
- Implementation of water quality guidelines
- Strengthening the Integrated Public Health Laboratory (IPHL) through training in EH and OSH

The main functions for PAHO/WHO are: Direct technical cooperation, dissemination of information on the revised IHR and collaboration among all levels of PAHO regarding IHR implementation, training and health promotion, advocacy and collaboration with Office of Disaster Management and Preparedness (ODMP), collaboration among all levels of PAHO regarding hospital disaster mitigation, advocacy for water quality guidelines, identification of training for IPHL in collaboration with CEPIS, US FDA, regional level, and collaboration with CARDI, IICA, FAO, and others regarding food security and with CAREC regarding food safety.

GOAL 2: Enhance the management of communicable and non-communicable diseases

Objective 2.1: Improve the prevention, control, and treatment of communicable diseases, including HIV/AIDS, diarrhoeal and respiratory diseases.

Priority technical cooperation for PAHO/WHO:

- Revision and/or development of various HIV/AIDS-related policies, including the National HIV/AIDS policy; PMTCT; VCT; STI; post-exposure prophylaxis; and HIV/AIDS-TB co-morbidity
- Enhancement of surveillance systems
- Training in HIV/AIDS clinical management
- HIV/AIDS care and treatment, supporting the National HIV/AIDS Strategic Plan, including for ERHA operational plan and support for universal access to ART

- Continued implementation of the pilot programme for DOTS
- Development of prison health programmes addressing HIV/AIDS and TB

The main functions for PAHO/WHO are: Direct technical cooperation in policy development with diverse partners; training; advocacy in support of universal access to ART; and facilitating/transfer of technology for the pilot programme on DOTS.

Objective 2.2: Enhance the control of non-communicable diseases and other lifestyle-related incidents.

Priority technical cooperation for PAHO/WHO:

- Implementation of NCD policy and integrated risk management approach at all levels
- Establishment of structured NCD programme
- Implementation of Framework Convention on Tobacco Control

The main functions for PAHO/WHO are: Direct technical cooperation; advocacy at all levels for the NCD programme, including the Office of the Attorney General for legislation to support the FCTC.

Objective 2.3: Enhance the provision of mental health care and improve the quality of mental well-being among the population.

Priority technical cooperation for PAHO/WHO:

- Review of national mental health policy and legislation, including addressing vulnerable groups, e.g. the prison population.

The main functions for PAHO/WHO are: Advocacy and the dissemination of information on the products and best practices from the sub-regional mental health reform programme being executed through the Office of Caribbean Program Coordination (OCPC).

GOAL 3: Improve the performance of health care delivery systems.

Objective 3.1: Complete the health facilities and health systems upgrade envisaged under the Health Sector Reform Programme.

Priority technical cooperation for PAHO/WHO:

- Provision of health needs assessment tool to MoH and RHAs.
- Strategic planning for health at the MoH and RHA levels, in the context of Vision 2020.
- Revision and rationalization of National Drug Policy and National Drug Formulary.
- Facility management, including development of a maintenance system in public health facilities, including in the RHAs.

The main functions for PAHO/WHO are: Direct technical cooperation; collaboration with regional and global levels regarding the use of the WHO methodology for health needs assessment; the promotion of Vision 2020 as the national development framework; dissemination of WHO guidelines; collaboration with the relevant Units in the Secretariat and with WHO Collaborating Centre (BRA); facilitating TCC in areas of drug policy and drug formulary; and networking to share information on facility management.

Objective 3.2: Utilize technology for information, science, health care, and medicine.

Priority technical cooperation for PAHO/WHO:

- Strengthening of epidemiological and surveillance systems for evidence-based decision making.

The main functions for PAHO/WHO are: Direct technical cooperation; and training in epidemiology, in collaboration with CAREC.

Objective 3.3: Increase funding to the health sector and implement an appropriate health financing mechanism.

Priority technical cooperation for PAHO/WHO:

- Design of National Health Insurance (NHI) System.

The main functions for PAHO/WHO are: Direct technical cooperation to the Technical Secretariat; dissemination of best practices/models from other countries; and the promotion and facilitation of a TCC, possibly with The Bahamas, Saint Lucia, and Belize.

Objective 3.4: Develop all categories of human resources for health, particularly geriatricians, counselors, forensic psychiatrists, nurses, among others.

Priority technical cooperation for PAHO/WHO:

- Provision of tools for planning for human resources in health.
- Development of strategic plan for human resource development and management at the MoH and RHA levels.
- Facilitation of dialogue between academic training institutions and the MoH in the development of pre-service and continuing education programmes.
- Networking with other countries that have developed strategic plans for human resource development and management.
- Design of training programmes/curriculum to meet pre-service and continuing education needs.

The main functions for PAHO/WHO are: Promotion and facilitating TCC; direct technical cooperation; dissemination of best practices/models/plans/methodologies/ training programmes and curriculum from other countries; and convenor of discussions

between MoH and critical stakeholders in the health and education/academic sectors and professional bodies.

GOAL 4: Improve the quality of health care services.

Objective 4.1: Reduce medical errors.

Priority technical cooperation for PAHO/WHO:

- Design of plan for accreditation of health facilities – public and private – and health professionals.
- Enhancement of clinical audit systems, including expansion to other areas and institutions.

The main functions for PAHO/WHO are: Information dissemination of tools for accreditation of health professionals and health facilities; the determination of linkages to CARICOM accreditation bodies and systems; and direct technical cooperation for review of clinical audit systems and accreditation of health facilities

Objective 4.2: Increase the appropriate use of effective health care services by medical providers.

Priority technical cooperation for PAHO/WHO:

- External assessment of Quality Improvement Strategy (QIS), with recommendations for improvement.

The main functions for PAHO/WHO are: Information dissemination; advocacy for QIS assessment with involvement of the regional level and the WHO Collaborating Centre; and direct technical cooperation.

Objective 4.3: Increase consumer and patient understanding and use of health care quality information.

Priority technical cooperation for PAHO/WHO:

- Improvement in client feedback system in MoH and RHAs.

The main functions for PAHO/WHO are: Direct technical cooperation to review the client feedback system and make recommendations for improvement, using instruments from the US-based Quality Assurance Project (QAP); and advocacy for the development of an information, education, and communication (IEC) strategy regarding QIS, particularly regarding patient rights.

Objective 4.4: Improve consumer and patient protection.

Priority technical cooperation for PAHO/WHO:

- Improved attention to patient safety.
- Development of protocols, care standards for patient safety.

The main functions for PAHO/WHO are: Information dissemination and provision of tools for patient safety; networking with other countries that have developed policies and plans for patient safety; and direct technical cooperation.

Objective 4.5: Accelerate the development and use of an electronic health information infrastructure.

Priority technical cooperation for PAHO/WHO:

- Development of policy, plan, and procedures to strengthen health information systems
- Implementation of the Virtual Health Library
- Continued implementation of WinSIG

The main functions for PAHO/WHO are: Advocacy and collaboration with MoH and RHAs in the development of policy, plan, and procedures for health information systems; sharing of experiences regarding a vital registration system; advocacy for Trinidad and Tobago to become a member of the Health Metrics Network; promoting a TCC with The Bahamas; collaboration with BIREME and IKM regarding training and enhanced implementation for the VHL; and direct technical cooperation.

GOAL 5: Unify the delivery of health care services.

Objective 5.1: Promote private/public sector collaboration to obtain greater efficiencies.

Priority technical cooperation for PAHO/WHO:

- Promotion of dialogue between public and private sectors in planning a regulatory framework for quality services.

The main function for PAHO/WHO is: Advocacy and dissemination of information to MoH on outsourcing to the private sector.

Objective 5.2: Promote integration among health care services.

Priority technical cooperation for PAHO/WHO:

- Strengthening of the referral system among tertiary, secondary and primary care levels.

The main functions for PAHO/WHO are: Review of referral networks and development of referral protocols; dissemination of information; and direct technical cooperation.

GOAL 6: Develop/strengthen the health research system to facilitate evidence-based decision-making, policy formulation, new learning, and development.

Objective 6.1: Develop a health research system with Essential National Health Research (ENHR) as the foundation.

Priority technical cooperation for PAHO/WHO:

- Implementation of the Essential National Health Research plan.

The main functions for PAHO/WHO are: Collaboration with the Caribbean Health Research Council and UWI, particularly the Health Economics Unit; convenor of discussions between MoH/RHAs and critical stakeholders in health research; dissemination of information on PAHO/WHO grants/research programme; and training in development of research and grant proposals.

6.4 OTHER AREAS FOR THE STRATEGIC AGENDA

Social Marketing of PAHO/WHO

Priority technical cooperation for PAHO/WHO:

- Development of communication strategies for internal and external audiences on the CCS, PAHO/WHO, and PAHO/WHO's work.

The main functions for PAHO/WHO are: Media relations, information dissemination, preparation of appropriate products; sharing of relevant competencies among the CO, CAREC, and CFNI; and collaboration with the regional level in developing and implementing IEC strategies.

6.5 RISKS

The success of the CCS is contingent on:

- Decisions to be made in the Ministry of Health related to objectives of the Health Sector Reform Programme, including transfer of staff to Regional Health Authorities, Local Government, etc
- Strengthening the Ministry of Health in priority areas, including policy development, institutionalization of management systems, and human resource development and management
- Strengthening the leadership and steering role of the Ministry
- Upgrading information systems and electronic infrastructure in the Ministry of Health

SECTION 7: IMPLEMENTING THE STRATEGIC AGENDA: IMPLICATIONS FOR THE PAHO/WHO SECRETARIAT, FOLLOW-UP AND NEXT STEPS AT EACH LEVEL

The implications and requirements for the implementation of the Strategic Agenda are considered in terms of the political, managerial, technical, and administrative aspects and have been defined for all levels of the Organization – Country Office, sub-regional, regional and global – as follows:

7.1 IMPLICATIONS FOR THE COUNTRY OFFICE

There are three critical elements that will be fundamental to strengthening the capacity and capability of the Country Office to lead the implementation of the CCS:

- Support from all levels of PAHO/WHO in implementing the Technical Cooperation Programme.
- Adequate and appropriate country presence, including technical and administrative competencies in all categories of staff, informed by the results of the SARA exercise.
- Resource mobilization and cost-sharing, in light of the reduction in country budgetary allocation.

The implications for the Organization as we seek to implement the CCS are varied and will be encountered at country, sub-regional, regional and global levels and are political, administrative/managerial and technical in nature. From the political perspective and in light of the new budget policy that has implications for this Representation, there will be a need in the short-medium term to periodically review and define country presence, which may consequently require a review of the Basic Agreement with the Government.

It is envisioned that various administrative implications will be encountered, more so in regard to assigned human resources by the Ministry of Health to the Country Office as we move towards a competency based system in the Organization. The experience in PAHO has always been to build capacity in the assigned Ministry of Health human resources. This will continue, but will require enhancing to include building the competency base required in the Country Office in order to ensure that staff assigned to PAHO have the appropriate competencies. In the Country Office there are insufficient skills in the area of Human Resource to deal with profiles of staff and related issues – this competency is needed and the need for an analysis of the non-technical competencies is necessary for the implementation of the CCS. The issues of proposed "core" administrative staff[15] and separation of administrative functions should be analyzed, in light of reductions in the regular budget (RB) ceiling.

Managerially, in the implementation of the corporate exercise of Strategic Assessment and Resource Alignment (SARA) in the CO, the CCS provides the major input for the Strategic Assessment phase. The formulation of Office Development Plans that reflect the needs of the CO to lead implementation of the CCS, informed by the Resource

[15] Suggested at regional level (not yet confirmed): Procurement, Accounts, HR, IT, PWR Secretary

Alignment phase of SARA, will be critical. It should also be noted that retirements in the Country Office over the period of the CCS will be the Documentation Centre Assistant (2009) and the Accounting Technician (2009); and in CFNI-TRT: the Administrator (2009) and Driver (2006).

Other considerations are the identification of resources for: a) Security, including MOSS compliance. This will mean that the Country Office will have to contract security guards, as opposed to the "watchmen" provided by the Ministry of Health, especially since the Country Office is situated in a high-risk area. Other measures will also be necessary, given the crime situation in Trinidad and Tobago, e.g. security gates and camera; and b) the structuring of the new Country Office when it is relocated. The Country Office will have to move twice – to temporary facilities and then into new Ministry of Health building.

Other areas currently been assessed include: a) common/shared services with UN agencies; b) plans for the Country Office and CFNI to share the Country Office's permanent physical space (this needs to be discussed regarding the temporary relocation); and c) the improvement in communication and coordination with CAREC, CFNI, and OCPC.

To better meet needs in the technical areas, an analysis of the competencies for the implementation of the CCS will also be required. Some considerations include the analysis of options to use categories of staff with appropriate competencies, other than international professionals, to carry out technical cooperation; the importance of the information dissemination function– VHL operation and SharePoint are part of the IKM strategy and relevant training is anticipated; revision of functions of the Documentation Centres to be those of Knowledge Centres; and sharing of IEC and advocacy functions with CAREC and CFNI.

7.2 IMPLICATIONS FOR THE SECRETARIAT

The Strategic Agenda as defined for Trinidad and Tobago, which represents the Organization's contributions to health development, will require continuous support from all levels of the Secretariat – sub-regional, regional and global levels. (The sub-regional meaning the OCPC, Centers and other PWRs, the PAHO Office in Washington, WHO and its Collaborating Centers.)

Many of the technical areas will overlap and support can and will be sought from within the Secretariat, as a first step. From the sub-regional level, it is expected that the OCPC can support this Country Office in the specific areas of media/communications; essential medicines; and disaster preparedness and mitigation. Improvement in joint planning and programming among the Country Office, CAREC, CFNI, and OCPC will be required and the definition of clear lines of communication between and among the Units to facilitate this process.

The Country Support Unit, as others at the Regional level, also plays a major role, for example the streamlining of the extra budgetary initiative review process – PPS/PS, LEG,

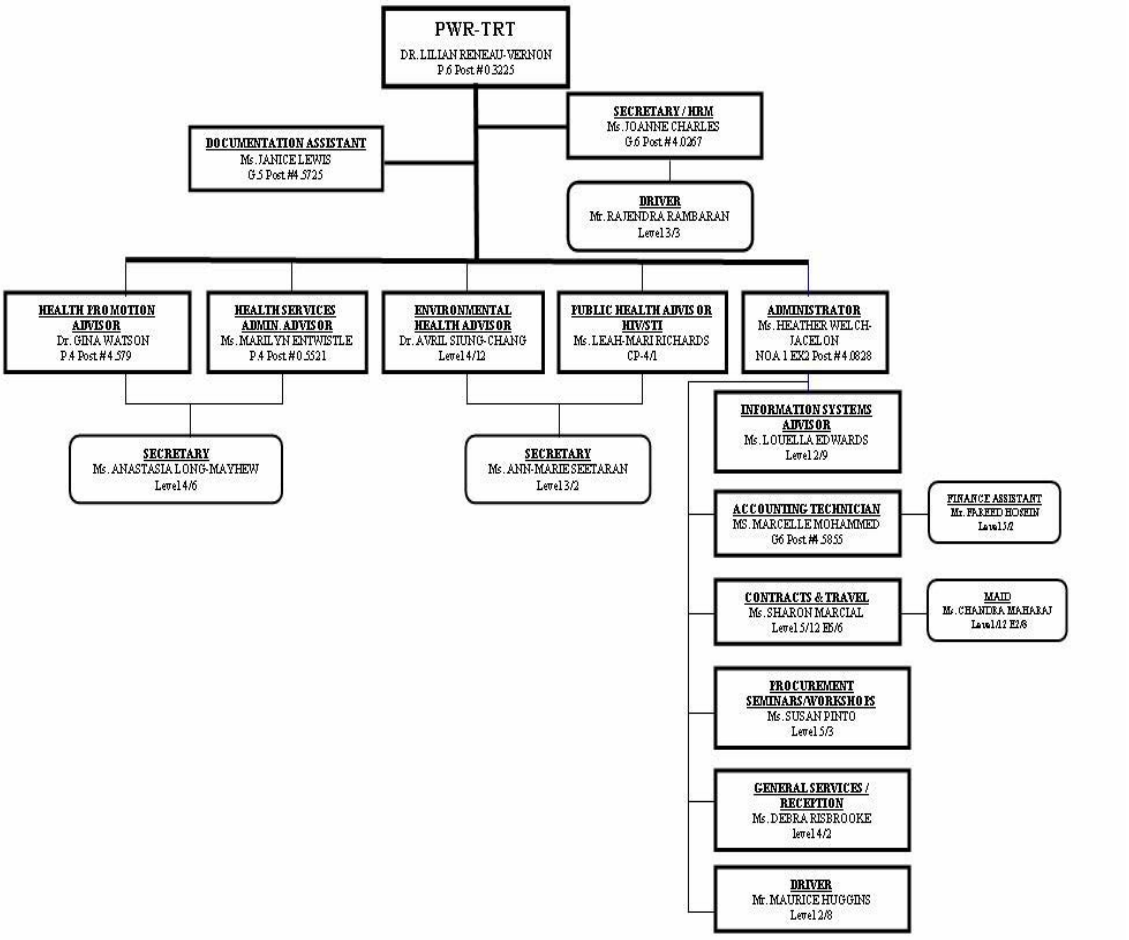
CSU - is also envisioned; the need for the rationalization of requests for information, e.g. surveys – AD's Office, CSU; clarification on how to direct requests from the Country Office – AM, CSU. The participatory development of programme budgets – PPS/PB; timely consultation with the Country Office in contracting/recruiting Trinidad and Tobago nationals, which is expected of all units; and ensuring that relevant and appropriate materials (in terms of timing and language, e.g.) are sent to the Country Office by all units.

The strategic agenda will also require the support of selective units of the Secretariat at the Regional level, in order to appropriately implement the defined areas of technical cooperation. The technical input of the Area of Information and Knowledge Management will be sought, particularly in research, Virtual Health Library (VHL), Share point and, webpage; the Area of Sustainable Development and Environmental Health and CEPIS for technical support in further developing solid waste management and the evaluation of the participatory process in Health Promotion; the Area of Technology and Health Services Delivery to assist in areas of quality improvement, accreditation of health facilities and essential medicines, primary health care and public health legislation, strategic health planning, health policies and human resource development will be major areas that will demand support from both Regional and Global levels.

It is also expected that as we move to integrate the BPB with other levels of the Secretariat, links will be strengthened with both Regional and Global levels. Support for the Country Office will be required and requested, in order to be more efficient and effective in the implementation of its Strategic Agenda. The specific technical areas, as defined in the CCS for which support may be required include from the Global level, as well as others are: toxic chemicals – Protection of Human Environment; health information systems through Health Metrics Network; IHR – Communicable Diseases, Surveillance, & Research; and HIV/AIDS.

ANNEX I

ORGANIZATIONAL CHART OF THE PAHO/WHO COUNTRY OFFICE TRINIDAD AND TOBAGO



ANNEX II

CATEGORIES OF STAFF IN THE PAHO/WHO COUNTRY OFFICE TRINIDAD & TOBAGO

Staff Category	Job Title	Number
International	PAHO/WHO Representative	1
	Health Promotion Advisor	1
	Health Services Advisor	1
National Professional	Environmental Health Advisor	1
	Systems Administrator	1
CAREC National Professional	Public Health Advisor (HIV/AIDS/STI)	1
National Officer	Administrative Officer	1
General Services	Accounting Technician	1
	Secretary to the PWR	1
	Documentation & Information Assistant	1
Government Assigned	Human Resources and Travel Assistant	1
	Procurement Assistant	1
	General Services Assistant	1
	Finance Assistant	1
	Secretaries to the Technical Units	2
	Drivers	2
	Office Assistant	1
	TOTAL	**19**

ANNEX III

MOSS COMPLIANCE CHECK LIST
UNITED NATIONS DEPARTMENT OF SAFETY AND SECURITY

MOSS REQUIREMENT	**AGENCY** **PAHO**
COMMUNICATIONS	
Emergency Communication System-ECS established (capable of work 24/7) per wk	**YES**
ECS to ensure communications between the DO, FSCA, SMT AND Agency SFPs	**YES**
Each Agency has at least one official vehicle equipped with a mounted VHF (mobile) radio	**YES**
Each Agency has a reserve of 2 VHF radios and one additional battery per radio	**YES**
Wardens to have telephone contacts, preferably both land-line and cellular	**YES**
All communications equipment checked for proper operations on a weekly basis	**YES**
Staff involved in the radio network are adequately trained	**YES**
Staff equipped with handheld VHF radios maintain a charged reserve battery	**No**
SECURITY DOCUMENTATION - DOCUMENTATION WITH DO, SMT	**PAHO**
a. Threat assessment	**YES**
b. UN Field Security Handbook	**YES**
c. Security Operations Manual	**YES**
d. T&T Security Plan	**YES**
e. T&T MOSS	**YES**
f. Security Standard Operating Procedures (SOP's)	**YES**
g. Relevant country maps	**NO**
h. Operating and Office Emergency Procedures.	**YES**
i. Medical evacuation procedures	**NO**
WARDEN SYSTEM	
Established and operational	**YES**
Regular drill conducted by FSCA (twice per year, at least)	**YES**

BUILDING EMERGENCY/EVACUATION PLAN	
Established for all un offices an facilities	**YES**
Regular drills conducted (at least every six months)	**5 July 2005 Proposed**
VEHICLES	
Drivers must have relevant and current national driver´s license	**YES**
All UN vehicles appropriately registered by the host government	**YES**
All vehicles appropriately marked with un logos, flags, decals, etc	**N/A**
STAFF	
All staff provided with un security in the field booklet	**YES**
All staff make themselves aware of relevant country(area specific-security plan, SOP's and policies	**YES**
All staff comply with all UN security policies	**YES**
All staff complete basic security awareness CD-ROM	**NO**
EQUIPMENT	
Emergency power supply (stand-by generator)	**NO**
Pep kits (provided and managed by who)	**YES**
Shatter resistant film (SRF) installed	**NO**
Contingency plans for the procurements of phase one moss equipment	**YES**
f. All staff completed Basic Security Awareness CD-ROM	**YES**

VEHICLES	
First aid kit	**YES**
Fire extinguisher	**YES**
Spare wheel, jack	**YES**
Appropriate tools	**YES**
Vehicles appropriately marked	**N/A**
Seat belts	**YES**
STAFF	
FSCA provided with standard equipment.	**N/A**

ANNEX IV

MAP OF TRINIDAD

ANNEX V

MAP OF TOBAGO

ANNEX VI

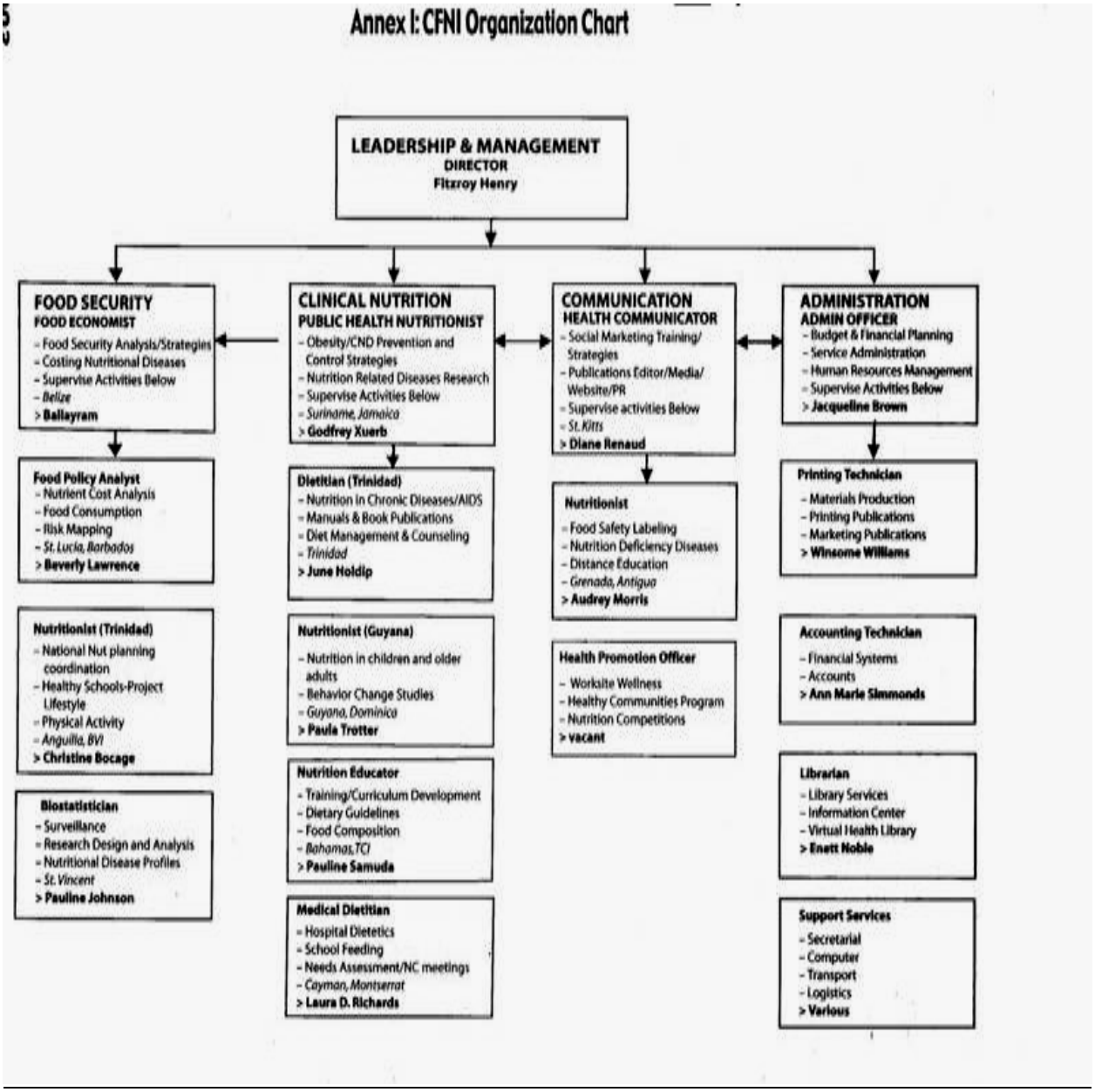
LIST OF ACRONYMS

ACRONYM	NAME
ACS	Association of Caribbean States
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral Drugs
BIREME	Latin American and Caribbean Health Sciences Information Centre
BPB	Biennial Program Budget
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CBO	Community Based Organization
CCH	Caribbean Cooperation in Health
CCS	Country Cooperation Strategy
CDB	Caribbean Development Bank
CEPIS	Pan American Centre for Sanitary Engineering and Environmental Sciences
CFNI	Caribbean Food and Nutrition Institute
CIDA	Canadian International Development Agency
CNCD	Chronic Non Communicable Disease
CO	Country Office
COSTAATT	College of Science, Technology and Applied Arts of Trinidad and Tobago
CSO	Central Statistical Office
DFID	Department for International Development
DOTS	Directly Observed Therapy Strategy
EDI	Education for All Development Index
ENHR	Essential National Health Research Council
EPI	Expanded Program on Immunization
EU	European Union
FAO	Food and Agriculture Organization
GDP	Gross Domestic Product
GNP	Gross National Product
GOTT	Government of Trinidad and Tobago
GPW	General Program of Work
HACCP	Hazard Analysis Critical Control Point
HSRP	Health Sector Reform Programme
IADB	Inter-American Development Bank
IFRC	International Federation of Red Cross and Red Crescent Societies
IHR	International Health Regulations
ISDR	International Strategy for Disaster Reduction
MDG	Millennium Development Goal
MoH	Ministry of Health
MOSS	Minimum Operating Security Standards
NACC	National AIDS Coordinating Committee
NALIS	National Library and Information System Authority
NGO	Non-Governmental Organization
NHI	National Health Insurance
NIB	National Insurance Board

ACRONYM	NAME
NSP	National Strategic Plan for HIV/AIDS
OAS	Organization of American States
PAHO	Pan American Health Organization
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PHI	Public Health Inspector
PLWHA	Persons Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PSIP	Public Sector Investment Program
PWR	PAHO/WHO Representative
RHA	Regional Health Authority
RHI	Regional Health Institution
RPB	Regional Program Budget
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
TCC	Technical Cooperation among Countries
THA	Tobago House of Assembly
UNCT	United Nations Country Team
UNDAF	United National Development Assistance Framework
USAID	US Agency for International Development
UWI	University of the West Indies
VCT	Voluntary Counseling and Testing
VHL	Virtual Health Library
WASA	Water and Sewerage Authority
WB	World Bank
WinSIG	Windows Management Information Systems

ANNEX VII

CFNI ORGANIZATIONAL CHART



ANNEX VIII

CCS TRINIDAD AND TOBAGO TEAM MEMBERS

External to Trinidad and Tobago

Dr. Shambhu Acharya, Department of Country Focus, WHO, Geneva
Dr. Beverley Barnett, Country Program Analyst, Country Support Unit, PAHO, Washington, DC
Dr. Ernest Pate, PAHO/WHO Representative, Jamaica (second week)

Country Office

Dr. Lilian Reneau-Vernon, PAHO/WHO Representative
Ms. Marilyn Entwistle, Health Systems Advisor
Dr. Gina Watson, Health Promotion Advisor
Dr. Avril Siung-Chang, Environmental Health Advisor
Ms. Louella Edwards, Information Systems Advisor
Ms. Leah Marie Richards, Public Health Advisor, PAHO/CAREC
Mrs. Heather Welch-Jacelon, Administrator

CFNI

Mrs. Christine Bocage, Nutritionist
Mrs. June Holdip, Dietician

CAREC

Dr. James Hospedales, Director, CAREC

ANNEX IX

DONOR MATRIX FOR HEALTH SECTOR IN TRINIDAD & TOBAGO

Donor	Period of Agreement	Total Allocation	Technical Area	Executing Agency	Comment/s
IADB	1996-2006	US$134,000,000	Health Sector Reform	Ministry of Health	Counterpart funding: US$57,000,000
WB	2003-2008	US$20,000,000	HIV/AIDS	National AIDS Coordinating Committee (NACC)	Counterpart funding: US$5,000,000
EU	2000-2007	€7,500,000	Medical Laboratories	CARIFORUM /CAREC	Caribbean Countries, project ending March 2007
EU	2005-2010	€7,130,000	HIV/AIDS	National AIDS Coordinating Committee (NACC)	
CIDA	2001-2006	US$6,000,000	HIV/AIDS	CAREC	2nd Phase, ending Sep 2006
Netherlands	2004-2007	US$166,426	Leprosy Eradication	CAREC	Ending Dec 2007
DFID	2002-2005	US$2,575,757	HIV/AIDS	CAREC	
France	2002-2005	US$142,546	Public Health	CAREC	
France	2002-2006	US$1,102,874	HIV/AIDS	CAREC	Ending Feb 2006