Health and Healthcare in the British Overseas Territories: Regional and UK Government Support

Bermuda

Turks and Caicos Islands

Cayman Islands

British Virgin Islands

Pitcairn Islands

Henderson   Ducie

Oeno   Pitcairn

Anguilla

Montserrat

Falkland Islands

Ascension Island

Tristan da Cunha

St. Helena

The maps above are not to scale and should not be used for determining the precise location of places or features.

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Abbreviations

AFRO	Africa Regional Office (WHO)
AIDS	Acquired Immunodeficiency Syndrome
BVI	British Virgin Islands
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CARPHA	Caribbean Public Health Agency
CCH	Caribbean Cooperation in Health
CDB	Caribbean Development Bank
CDEMA	Caribbean Disaster Emergency Management Agency
CHAA	Caribbean HIV and AIDS Alliance
CHRC	Caribbean Health Research Council
CIS	Confederation of Independent States
CPO	Country Program Officer
DFID	Department for International Development
DH	Department of Health
EC	European Commission
EU	European Union
ECCS	Eastern Caribbean Cooperation Strategy
ECDC	European Centre for Disease Control
EDF	European Development Fund
EIB	European Investment Bank
EU	European Union
FCO	Foreign and Commonwealth Office
GDP	Gross Domestic Product
GHP	Global Health Partnership
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMG	Her Majesty's Government
HPA	Health Protection Agency
IFRC	Int'l Federation of Red Cross & Red Crescent Societies
IHR	International Health Regulations
JCS	Joint Country Strategy
MoD	Ministry of Defence
MOH	Ministry of Health
NCD	Non Communicable Diseases
NHS	UK National Health Service
NICO	Northern Island Cooperation Overseas
OCPC	Office of Caribbean Program Coordination (PAHO)
OCTs	Overseas Countries and Territories
OECC	Office for Eastern Caribbean Cooperation (PAHO)
OTs	Overseas Territories
OTCC	Overseas Territories Consultative Council
OTD	Overseas Territories Department
OECS	Organisation of Eastern Caribbean States
PAHO	Pan-American Health Organisation
ppp	purchasing power parity
PPS	Pharmaceutical Procurement Service
PWR	PAHO/WHO Representative
RCM	Regional Coordination Mechanism
RST	Regional Support Team
SPC	Secretariat of the Pacific Communities
TA	Technical Assistant (provision of a specialist)
TCI	Turks & Caicos Islands
UKOTs	United Kingdom Overseas Territories
UNGASS	United Nations General Assembly Special Session
UNFPA	United Nations Population Fund
WPRO	Western Pacific Regional Office (WHO)

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Introduction

From Montserrat to Bermuda, St Helena to the Falkland Islands and Pitcairn, the United Kingdom has responsibility for 14 Overseas Territories (UKOTs), 11 of which are permanently populated – their histories to a greater or lesser extent influenced by the global reach of the British Empire. Though different in size, economic and social development and systems of governance, most of them share common features which include relative isolation, exposure to disasters, dependence on one or two key industries, and all have opted to remain under British sovereignty rather than, where this is an option, seek independence.

While the territories have their own constitutions, legal systems and most have a democratically elected Government, the Queen is head of state in each territory. Most powers, including provision of healthcare are devolved to the Territories, but the UK retains responsibility for good governance, defence, external relations, and has to meet contingent liabilities and fulfil international obligations applying to the Territories. The UK's Foreign and Commonwealth Office (FCO) leads overall policy and maintains the main UK presence in Territory through the Governor with other Government departments leading and supporting the Territories on areas within their responsibilities.

The UK's Global Health Strategy commits the government to outlining the UK's current and future support to overseas territories. When ministers of health from the territories met at PAHO in September 2008, they asked for clarification of the responsibilities of UK government departments. This publication addresses those needs. It also aims to clarify how the people of the territories can access regional and HMG resources, and to stimulate thinking about how governments and organisations can work together to improve that access.

The UKOTs covered by this paper include 5 Caribbean OTs (Anguilla, British Virgin Islands, Cayman Islands, Montserrat, Turks and Caicos Islands) and Bermuda, 4 South Atlantic OTs (St Helena, Ascension, Tristan da Cunha and Falkland Islands) and Pitcairn Islands in the Pacific.

Summary of health priorities

The OTs are in demographic and epidemiological transition. Incidence and prevalence of most communicable diseases have fallen dramatically, while non-communicable health problems such as cardio- and cerebro vascular hypertensive disease, diabetes and cancer have soared over the last 20 years or so, often linked with lifestyle. Vehicle accidents and violence have also risen. HIV infection is the one communicable disease to have increased significantly amongst the Caribbean territories and Bermuda, although it is less than 1%, but is insignificant in the Atlantic and Pacific. As life expectancy has increased, so have the health problems associated with an ageing population.

Among young children, the more important health problems are occurring in the perinatal period as well as gastro-intestinal and respiratory infections – all affected by the level of poverty and therefore inconsistent across the territories.

H1N1 and avian flu present potential challenges for the territories, just as they do for the rest of the world. All except Pitcairn, St Helena, Tristan da Cunha and Ascension have reported cases of H1N1. The remoteness of the islands in the Atlantic and Pacific make their populations more susceptible to seasonal outbreaks or pathogens that arrive with visiting ships, and the spread of pandemic flu will be a particular cause for concern for them. Other vector borne diseases reported as of concern to UKOTs are dengue, leptospirosis and hydatid on Anguilla/BVI, St Helena and Falkland Islands respectively.

On mental health, most territories struggle with how best to deal with psychiatric patients who may be a threat to themselves or their communities. Many end up in prisons because there is no other secure place, which raise concerns that the individuals' human rights are not being met.

See Annex 1 for a summary of key features of the UKOTs and Annex 2 for a summary of identified needs and gaps in health service provision.

Health service provision

While health systems and methods of service delivery vary widely, most provide basic services on-island through a mix of public and private provision, financed through tax revenue, social insurance and private insurance. So, for example, Bermuda, a territory with a high per capita GDP, relies on a mix of social and private insurance, while Montserrat whose per capita GDP is low, provides services mainly in the public sector, financed through revenue. All territories source specialist services off-island in either the public or private sectors. This provides a challenge of increasing scale and complexity, with great variation in how off-island services are accessed and financed. While the UK supports limited off-island care through its quota system, most specialist care is funded by the territory governments or by individuals.

For more detailed health situation data and analyses, see the territories' own health planning documents, the PAHO/WHO Eastern Caribbean Cooperation Strategy, the WPRO web page on Pitcairn, and EC papers on the territories.

For all of them, however, the cost of accessing off-island expertise is uneconomic. The issue of 'micro-island economies' are set out in the EC's Green Paper on relations between the EU and the Overseas Countries and Territories.

Access to regional and international development assistance also varies across the territories, with those in the Caribbean and Bermuda having a more extensive range of organisations available to them. Major technical assistance providers and funders in the Caribbean include HMG, PAHO, CARICOM, PANCAP, OECS, and the EC, often working in partnership. Combined, these organisations are a vast resource. By contrast, the Atlantic and Pacific Territories have access to only a very limited number of aid providers, principally the UK government and the EC, with smaller inputs from, for example, UNDP, UNICEF, WHO and the Secretariat of the Pacific Community. Of the 3 territories dependent on aid, Montserrat is able to benefit from providers in the Caribbean, while St Helena and Pitcairn have far fewer available sources of support.

Common themes and diversity

The small size of the territories reduces their ability to function as independent units, and their limited populations cannot support comprehensive health services. Specialist health expertise, which is financially and technically viable when serving a much larger catchment population, has to be sourced through specialists visiting the territory for short periods, or by sending patients and clients abroad[1].

The effect of this varies depending on differences in population size and wealth (see table in Annex 1). Even Bermuda and the Cayman Islands, the largest and wealthiest territories, cannot fulfil all their health responsibilities using on-island services and facilities. But the diseconomies of small scale hit the smaller and poorer territories hardest as they can less afford to buy external services.

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[1] For an exploration of these arrangements, see Situational Analysis of Shared, Secondary and Specialist Services in the UKOTs, DFID Health Resource Centre, April 2005.

1. DELIVERING HEALTH AND HEALTHCARE IN THE UK OVERSEAS TERRITORIES

1.1 What the territory governments provide

They have primary responsibility for delivering health care for their own populations. These are:

- Suitable and effective care for their populations, including the acutely ill, elderly, children, mentally ill, disabled people.

- An appropriate balance between institutional care, care in the community, prevention and health education, and between secondary and primary care.

- Efficient service delivery through the right mix of human resources, beds, throughput, and admissions rates etc.

The territory governments employ a range of public and private providers, financed through public revenue, social insurance, private insurance, and out-of-pocket expenditure. At one end of the spectrum, relatively wealthy Bermuda relies mainly on private insurance while at the other end Montserrat, Pitcairn and St Helena depend on aid and provide only publicly-financed, non-insurance-based services.

While all the territories provide broadly the same blend of primary and basic secondary care, their approaches differ significantly. What they can provide from their own resources often depends on their degree of isolation and fiscal self-sufficiency. To help carry out their responsibilities, OT governments can get support from international, regional and other agencies. Some have strategic and annual health-sector plans in place, and others are in the process of preparing them. Many of the plans however are not costed and do not provide clarity on the amount, timing and sources of external support required to implement the plans. Some territories have identified the need for health sector financing reviews.

For an outline of the facilities and key features of health policies in different territories, see Annex 1.

1.2 What the UK government provides

The FCO leads on overall policy with the OTs . Two government departments are primarily responsible for providing support for the objectives below: the Department of Health (DH) and the Department for International Development (DFID). The Health Protection Agency (HPA), which is a non-departmental public body, also plays a role as it is has been designated as UK National Focal Point under International Health Regulations.

The UK aims to help the OTs to:

- Manage their health sectors sustainably, using their domestic budgets, regional multisectoral support, the NHS quota system, and development assistance where most needed.

- Influence and make the most of the impact of regional health organisations, benefiting from their inputs and other technical and regional initiatives.

- Fulfil international responsibilities which the UK has signed up to, such as International Health Regulations.

- Be better prepared for emergencies and to be able to manage them effectively.

UK Department of Health

The UK DH's over-arching objective for its engagement with the territories on health matters is to improve global health, and to meet the UK's international obligations. The DH leads on developing and implementing strategies for engagement on health with the Territories and represents the needs and concerns of the territories at regional and international meetings[2].

The DH can also provide direct support to the territories as when it recently made Tamiflu and H1N1 vaccine available on a cost-recovery basis to assist the UKOTs with their pandemic flu preparedness.

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2 These objectives and responsibilities are set out in two documents: *Health is Global: a UK Government Strategy 2008-13*; and *International Health: Department of Health Objectives and Ways of Working*. DH, 2009. In particular, see Annex 5 of Health is Global for actions to be undertaken by lead and supporting Departments. Many of the actions are relevant to the territories.

For cases that cannot be treated on-island, the territories have different levels of access to health care in the UK .The DH oversees a quota system by which Anguilla, British Virgin Islands, Montserrat, St Helena and Turks and Caicos Islands each has free access to NHS facilities for four patients a year. The Falkland Islands have open access to the NHS. Territories without these arrangements (Ascension, Cayman Islands, Bermuda, Tristan da Cunha and Pitcairn Islands) make their own arrangements for sending patients for off-island care, financed either by government or health insurance or personal expense. Similarly arrangements are made for territories that do benefit from the quota system as demand exceeds the available quota of 4 referrals per year.

Health Protection Agency

As the UK's National Focal Point (NFP) for the International Health Regulations (IHR), the HPA is the main point of communication between the UK state party and WHO on IHR matters. It transfers information to and from WHO and all parts of UK territory, and assists local authorities with risk assessments of IHR related incidents in UK territory. Outside the context of the IHR the HPA does not however have a mandate to provide day to day health protection services or support to OTs. For many OCTs, there are already well established regional networks providing communicable disease epidemiology and risk assessment support. Where these are less well developed there is an increased need for alternative solutions.

The HPA was also recently commissioned by the European Centre for Disease Prevention and Control (ECDC) to undertake a health protection needs assessment of all European OTs.[3] with the objective of helping ECDC define its role in supporting them.

Department for International Development

DFID is committed to supporting the OTs' to ensure their reasonable assistance needs are being met. Most of the territories are broadly self-sufficient, but three – St Helena, Montserrat and Pitcairn – face significant obstacles to growth and receive budgetary aid and development assistance to support progress towards self-sustainability which include earmarked support to the health and social welfare sectors.

DFID provides small levels of cross territory aid to all populated OTs (excluding Gibraltar) through its Overseas Territories Department (OTD). The cross territory support covers environmental protection including climate change, disaster prevention, safe guarding children, human rights, and HIV and AIDS. These projects adopt a demand-led approach that link the OTs with regional and international resources in addition to the technical and financial support they receive from the UK. DFID and the FCO share responsibility for UK assistance with emergency preparedness and response with Ministry of Defence providing logistic support as/when required.

1.3   What the European Commission provides

Since 1975 the European Commission has been the single biggest grant donor to the Caribbean, though only a small proportion of this has been in health. The EC allocated €61.86m to eligible OTs from the 10th European Development Fund 2008-13 (EDF-10). While the bulk of EDF-10 funds are for infrastructure, the territory governments may be able to use negotiations on their Single Programming Documents to allocate grants to health infrastructure.

Six territories – Anguilla, Falkland Islands, Montserrat, Pitcairn Island, St Helena, Ascension and Tristan da Cunha and Turks and Caicos Islands – have EC aid agreements (SPDs or Single Programming Documents) for the ninth EDF. The higher GDPs of Cayman Islands and BVI make them ineligible for EDF grants, and Bermuda is not associated with the EU. Of the EDF9 funds €6.7m is health related, and is for the regional AIDS programme managed by PAHO, covering Dutch and British territories in the Caribbean (see below), including Cayman Islands and BVI.

UKOTs are eligible to submit proposals to access research funding under the EC Framework Programmes.

The EC green paper on EU-OCT relations proposes a move from development assistance to resilience and competitiveness, while ensuring no territory is made worse off by the new relationship.

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3   *Assessment of the Needs of European Overseas Territories*, Health Protection Agency for European Centre for Disease Prevention and Control (ECDC), 2009.

1.4   What regional organisations provide: PAHO, CARICOM, OECS, UN agencies and others

Pan-American Health Organisation (PAHO)

PAHO's mandate is: "providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends". PAHO supports the Territories through a network of offices. The five Caribbean territories and Bermuda receive PAHO technical support on the basis of agreed Country Cooperation Strategies (CCSs).

Priorities include[4]:

• Health protection, including International Health Regulations and pandemic influenza.

• Emergency preparedness and disaster relief.

• Strengthening of health systems, including heath information systems.

• Public health, epidemiology and environmental health.

Support in such areas usually takes the form of policy advice, training, surveys, or institutional strengthening, and occasionally small items of equipment and fellowships.

PAHO services benefiting the territories include:

• Implementer for bilateral funders (EC funded regional HIV project).

• Responding to emerging needs (provision of training, technical advice, equipment and supplies)

• Resource mobilisation.

• Co-ordinating support available through the Caribbean Epidemiology Centre (CAREC) and the Caribbean Food and Nutrition Institute (CFNI).

• Organising technical and management meetings. The PAHO/WHO Regional Committee meeting each September provides an opportunity for the Caribbean territories to work with UK DH to negotiate PAHO support.

Anguilla, BVI, and Montserrat are included in PAHO's Eastern Caribbean Cooperation Strategy 2006-09 (ECCS) and as such benefited from additional financial support (about $50,000 per island per year). Technical support under the ECCS is delivered by a team of Technical Advisers and Country Program Officers.

At the OT Health Ministers' orientation meeting in September 2008, PAHO agreed to develop a Regional Cooperation Strategy for the five Caribbean Territories and Bermuda to enable better targeting of external support towards the territories' strategic priorities and requests. PAHO has also offered to arrange an annual OT meeting in the Caribbean.

Caribbean Community (CARICOM)

CARICOM and PAHO lead the Caribbean Cooperation in Health (CCH), an initiative in which PAHO is the main implementing agency and CARICOM provides a small secretariat. The third phase of CCH contains eight priorities, among which heart disease, diabetes, and obesity are key.

CARICOM encompasses a number of organisations including the Pan Caribbean Partnership against HIV/AIDS (PANCAP), a coordinating mechanism for the regional response to HIV and AIDS. While PANCAP's contribution to health in the OTs has been limited, associate membership is now possible, with better access to information, materials and events.

CARICOM was principal recipient for a Global Fund round-3 grant, with the Organisation of Eastern Caribbean States as sub-recipient. CARICOM will also be principal recipient for the approved regional grant of $34.5m in round-9. However, the OTs do not benefit directly from GFATM funds.

CARICOM and PAHO are organising the merger of five health institutions into a single Caribbean Public Health Agency, which received limited technical support from UK DH. This body will act as the regional umbrella for public health functions in the region – easing OT access to public health expertise.

The Caribbean Disaster Emergency Management Agency (CDEMA) is a CARICOM agency, funded in part by DFID providing disaster support to its members.

The CARICOM Health Ministers meetings, and programme-specific annual meetings such as those held by PANCAP, are opportunities for the territories to lobby for support.

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[4]   For more detail on PAHO's Caribbean programme areas, see PAHO website.

Organisation of Eastern Caribbean States (OECS)

Most of the OECS' health-related work is in AIDS, and concentrated in its role as principal recipient for a round-3 Global Fund grant. Anguilla, BVI and Montserrat benefit in a limited way in the form of technical assistance.

These three territories also have access to the OECS Pharmaceutical Procurement Service (PPS), which can pass on considerable cost savings. The PPS also runs a continuing medical education service, drug utilisation reviews, seminars on inventory management, and other support related to medical supplies – all of which the three territories make full use of.

Other regional organisations to which OTs have access

- Caribbean Development Bank (CDB). Anguilla, BVI, Cayman Islands, Montserrat and TCI are members, and can borrow if they are within the agreed HMG borrowing guidelines. DFID is a contributor to CDB funds. The Bank lends little for health – loans so far have been for infrastructure.

- UNAIDS Regional Support Team in the Caribbean collects OTs' HIV and AIDS data as part of its surveillance activities and provides (limited) technical support through regional training workshops. UNAIDS has been directed not to include the OTs in future programmes.

- UNFPA provides services related to sexual and reproductive health, gender and population to: Anguilla, British Virgin Islands, Bermuda, Montserrat, Cayman Islands, Turks and Caicos Islands, and to a very limited extent to St Helena. Ascension and Tristan da Cunha could possibly access this resource if required.

- UNICEF provides technical assistance to TCI, BVI and Montserrat –more in child protection than health.

- UNIFEM implemented the DFID-funded HIV-gender project in the Caribbean only benefiting OTs to a limited extent. The agency's main areas of support are in AIDS, gender, women's economic empowerment and democratic governance.

- UNDP serves all the territories, apart from Pitcairn, Tristan da Cunha, Ascension and the Falkland Islands. UNDP does not work directly in health, but does provide support in the Caribbean in disaster mitigation, resettlement and recovery, and has supported programmes for the elderly and disabled in St Helena.

- WHO-AFRO has supported citizens of St Helena with the training of public health staff and equipment.

- The Secretariat of the Pacific Community (SPC) has a Joint Country Strategy (JCS) with Pitcairn, providing technical support in public health, among other areas. Pitcairn also benefits from its membership of the Pacific Public Health Surveillance Network (supported by SPC) and its status as a member

- Tristan da Cunha and St Helena procure health manpower through NI-CO, a not-for profit consulting firm. The DFID-funded Healthlink project helps provide this service for St Helena and Tristan da Cunha while the services of NI-CO or other procurement companies are also available to all OTs.

1.5   Coordination mechanisms

There are a number of ways in which the Territories and agencies can exchange views on their needs, and plan how to match resources to requirements.

The WHO Regional Committee meetings – WHO/PAHO for the Caribbean and Bermuda, WPRO for Pitcairn, and WHO-AFRO for St Helena, Tristan and Ascension Island– are places at which the concerns of the territories (except for the Falkland Islands) can be raised.   A UK delegation led by the Department of Health participates in the annual WHO/PAHO regional meeting.

Other regional meetings offering opportunities for information exchange, coordination and negotiation include:

- The PANCAP annual general meeting – useful for AIDS-related matters in the Caribbean.
- The annual CARICOM Caucus of Health Ministers – covering the full breadth of health sector issues in the Caribbean.
- The Overseas Territories Consultative Council – meets annually in London.
- The annual EC OCT Forum
- Ad hoc technical meetings arranged by agencies such as PAHO, CARICOM and SPC – covering specific topics such as:
  o Non-communicable diseases.
  o Communicable diseases including H1N1, avian influenza, HIV
  o Health systems development
  o Emergency preparedness and response.

Knowledge and information is also shared through studies such as the 2005 analysis of secondary and specialist care, the ECDC's 2009 assessment of the Territories' health protection needs and the 2009 review of HIV related policy and legislation.

2   ANALYSIS: SIMILARITIES, DIVERSITY and UNMET NEEDS

There are clear similarities and differences between territories, which determine their needs and ability to look after the health requirements of their populations.

2.1   Diversity

- Population size varies from about as low as 50 in Pitcairn to over 60,000 in Bermuda. The six territories with populations below 5,000, apart from Montserrat, lie outside the Caribbean.

- GDP per capita ranges from those wealthier than the UK to those much less well off.

- The three least well-off – St Helena, Montserrat and Pitcairn – receive aid through DFID but the rest are economically self-sufficient. The three aid-dependent territories are far apart, in the Caribbean, Atlantic and Pacific.

- The differences in population, wealth and remoteness significantly affect their need to import human resources for health, and to send patients abroad for specialist treatment.

- There are differences in the way services are organised and financed, and also in the quality and cost-effectiveness of care – though higher costs do not necessarily mean higher quality.

- The Atlantic and Pacific territories have far fewer opportunities to receive support from international and regional agencies than those in the Caribbean.

- Access to free specialist medical care from the NHS varies among the territories and does not relate to other UK assistance.

- The quality and comprehensiveness of health plans varies among territories – the least developed, the greater the challenge for ensuring demand-led, needs and evidence-based plans for external support.

- The larger and wealthier OTs look after their own affairs in terms of sector development, financing and management, though there is scope for improvements. Those territories that receive UK budgetary aid, like Montserrat and St Helena, also receive technical and financial support from DFID for health planning and management.

2.2   Similarity

- An increasing burden of disease caused by non-communicable diseases.

- Adverse affects by 'diseconomies' of small scale.

- Difficulties with continuity of medical expertise – many doctors, surgeons and other specialists are on temporary residency contracts, or make periodic visits;

- Challenges in dealing with people whose mental illness poses a threat to themselves or their communities.

- Problems providing consistent health care for prisoners.

- The UK has obligations to all its territories because of their special relationship.

- The UK and territories are jointly responsible for meeting international obligations such as those arising from the IHR and international treaties and conventions.

- No territory has a population base large enough to supply all the health expertise it needs and all territories rely on expatriate expertise.

- All receive cross-territory development assistance through DFID. In recent years in health, most of this funding has been for their responses to HIV and AIDS.

2.3 Unmet needs: Secondary and tertiary care - a critical challenge

None of the territories is big enough to provide comprehensive, cost-effective care for all its citizens. However, alongside the opportunity for external support, there is scope for efficiency gains in the way treatment on island and abroad is organised and financed. The main issues concern:

- There is an *increasing demand from patients for improved secondary services*, driven by their knowledge of what is available elsewhere.

- *Costs are increasing for overseas referrals*, and as these may be increasing faster in the private sector, this has a knock-on effect in territories that rely more on private providers.

- *Cost-management for referrals varies among territories*. TCI's public expenditure on medical treatment abroad increased ten-fold between 1997 and 2004 – about 60 times higher than in the comparable territory of Anguilla in 2004. The people of Anguilla, by comparison, were more likely to pay privately for overseas care, either through insurance or out of pocket.

- *Opportunities vary depending on location*. Atlantic and Pacific Territories, being more remote, have less access to private care. This saves funds but reduces options for accessing essential treatment.

- *The quota system has little impact on meeting actual need*. Five of the territories have access to the NHS quota, for four patients each per year. But the estimated actual need for overseas referrals across all OTs runs into many hundreds. Some OTs, eg Tristan da Cunha would welcome a quota system and an arrangement that unused quota can be utilised by other OTs.

- *The quota system has evolved independently of other UK aid provision*. One aid-dependent territory has no quota, three of the non-aid-dependent territories have one, while the Falkland Islands have open access to the NHS be it on a reciprocal basis as UK residents are entitled to free care within the Falkland Islands.

- *Data on patients seeking and obtaining overseas care is incomplete*. This is linked to shortfalls in public-sector health Management Information Systems in some territories, and to difficulties in tracking out of pocket and insurance-based activity.

- *Choice of provider depends more on historical knowledge than best procurement practice*. For non-quota arrangements, long-standing working relations with hospitals in other Caribbean countries, the USA, Canada, South Africa or New Zealand tend to guide the choice of provider. There may be scope for improving negotiation on price and selection of the most appropriate services.

- *St Helena's and Tristan da Cunha's arrangements with NI-CO have improved consistency and continuity of personnel*, under the DFID-financed Health Link project. Well-specified contracting by other territories could achieve similar benefits.

2.4 Analysis of health and health care challenges

Given the differences between territories, and their right to self-determination, it would be neither possible nor appropriate to offer a single solution to providing higher levels of care on and off-island. There is a broadly held view among stakeholders that scope exists for stronger coordination in areas of common interest. Some Territories appear to have health care financing and especially the public contribution tightly under control, in others the public spend has risen sharply in recent years. Demand for high quality and expensive care is on the increase everywhere. Arranging and paying for secondary and tertiary care is a critical and growing challenge. There is scope for cross-territory lesson-learning on which to base the development of policies and management systems that respond cost-effectively to rising demand. Sharing the lessons learned from each territory's experience, and building them into strategic health plans, would usefully contribute to a clearer definition of what the OTs can provide themselves, how they can share resources, and what they need to obtain externally.

There is potential for rationalising the way that services are organised and financed. Governments could explore using public-private partnerships more, for example in contracting for provision of medical and non-medical services like cleaning, catering, laundry and pharmacy services. Private physicians making visits to see private patients on island could be contracted by government to see public patients too. Anomalies could be resolved, for instance, where public-sector workers receive free health insurance as well as being exempted from user charges. Improvements in service availability and quality on-island would help reduce demand for off-island referrals.

Technical areas posing particular challenges are the management of non-communicable diseases including cardiovascular and cerebrovascular disease, diabetes and mental health problems, and the strengthening of health services and health service management. By and large, those which need most external support are the poorest, most remote, and with the smallest population. Territories that are archipelagos, such as TCI and the Falkland Islands, face additional challenges from internal diversity and access to care.

The majority of Territories have difficulties with how best to deal with psychiatric patients who may be a threat to themselves or their communities and the adjudicated criminally insane. Many end up in prisons because there is no other secure place. Once in prison, they receive little or no effective care and they can remain incarcerated with little prospect of release. Many of the Territories do have resident or visiting psychiatrists, and may seek innovative, cost-efficient solutions (St Helena, for example, uses teleconferences with psychiatric services in South Africa). While such initiatives may alleviate the problem, they are unlikely to be a full solution.

A related issue is the provision of health services to prisoners. The situation varies among Territories. In the Cayman Islands, for example, there is a full-time nurse at the prison, with GP visits twice a week. By contrast, it is reported elsewhere that prisoners received treatment from prison officials for minor ailments, creating a risk of liability for the officials if the treatment is wrong or ineffective. Both issues – care for the mentally ill who are detained, and care for prisoners – raise concerns that the individuals' human rights are not being met.

When it comes to controlling communicable disease, including epidemic preparedness, the main challenges which the territories face are essentially shortages of human and systems resources. Many lack the surveillance systems and microbiological laboratory support needed for a rapid response to outbreaks of infectious disease. Limited staff numbers and quick staff turn-over make shortfalls worse.

2.5 Factors affecting the take-up of available external support

There are demand and supply-side constraints in defining need and in absorbing it, and in meeting the demand from the larger Territories that have greater absorptive capacity.

If we are to understand the extent to which the territories access available, resources we must take into account a range of supply and demand-side issues. Factors include three main sets of variables:

- Differing levels of need for external aid among the territories, related to their ability to afford services.

- Differing levels of capacity to absorb workload, – related especially to their human resources and response to emergencies, such as natural or governance crises.

- The capacity of provider organisations to match the commitments made in workplans agreed with the territories.

Health ministry staff can face conflicting demands on their time, for example when asked to work on projects funded by external agencies. Similarly, they may not always have the expertise that the projects require. While agencies such as PAHO provide visiting programme officers to support health ministry staff, especially for long-term technical support, this is not always the case. Conversely, provider agencies have not always been able to accommodate the demand for their services. This is more likely in the wealthier and better-resourced territories such as Bermuda and the Cayman Islands, who supplement what the agencies can offer by purchasing elsewhere. HIV and AIDS-related cross-territory and regional initiatives can divert scarce human resources from other pressing tasks. At the same time, a lack of knowledge or capacity hampers an adequate response to individual territories' obligations on the International Health Regulations.

In the Caribbean, PAHO and CARICOM offer support across the spectrum of countries' needs, which cover sector planning and management, procurement, surveillance, communicable and non-communicable diseases, and nutrition, maternal and child health. PAHO and other officials report that most of the territories take up what is on offer. Where they don't, this is often because Ministries of Health are unable to absorb the support – underlining the need for continued sector strengthening.

While Anguilla, BVI and Montserrat use the OECS Pharmaceutical Procurement Service for its supplies, they tend not to buy contraceptives and x-ray consumables through the PPS, even though these are included in the PPS list of 200 medical supply items. Instead, they buy through the open market, which costs more. Improved utilisation of PPS facilities through improving co-ordination between OT central medical stores and the health-ministry purchasers of other medical supplies could reduce procurement costs.

3   MOVING FORWARD TOGETHER

3.1   Matching needs, demands and supplies

The similarities, differences, and priorities, mentioned above, together with the key policy elements are the pillars of a strategic framework that territories and their partners can use in order to match needs against resources. This creates opportunities for greater harmonisation among resource providers, as well as focused alignment between providers and the specific needs of each territory. It enables improved collaboration among UKOTs, as well as between the other partners and the UK. Within this framework, realistic OT health strategies and operational plans will be essential in order to identify available resources, priority needs for external support specific to each island, and needs that are shared across all territories.

PAHO is in the process of preparing a Caribbean Sub-Regional Cooperation Strategy to cover the UK territories in the Caribbean and Bermuda. This will create a new framework setting out common themes, as well as issues specific to each of the OTs and enable the territories to better match resources against needs.

Together with the main pillars of a medium and longer-term strategy set out above, there are other important areas that could be initiated over the coming year. The territories need to take the lead in defining and expressing the resources they need to run their health services, and identifying resource gaps and the organisations from which they can obtain support. Updated and costed national strategic plans and operational (bi-) annual plans in which resource gaps and priority needs for external support are identified could form the basis. This would improve take-up of resources, and reflect a more demand-led, evidence-based approach.

3.2   Communications, coordination and representation

There is potential for improved aid coordination to increase harmonisation among donors and alignment with territories' strategic priorities, without resorting to a 'one-size-fits-all' approach to development assistance.

Officials in territories not receiving budgetary aid indicated they would prefer to have more communication with DFID and UK DH. However, apart from routine two-way communications between London and the OTs related to the cross-territory projects, the actual demand has been low.

Similarly, there is scope for a more coordinated approach to political and technical meetings such as those of PAHO and PANCAP, identifying issues of common interest among the UK and its territories during preparatory work. Better coordination in advance of these meetings would enable both sides to work more effectively together which could facilitate a satisfactory outcome of the meetings.

A study of the way that UK DH organises its international work found that a co-ordination framework would increase effectiveness without increasing bureaucracy[5]. The Global Health Strategy was a first step in that framework, developed with the subsequent paper, *International Health: Department of Health Objectives and Ways of Working*.[6] An extension of this DH initiative, aimed at improving communication and coordination across UK government departments, could further harmonise UK support and align it with territory needs.

3.3   Objectives and priority actions for moving forward

Priority actions identified can be grouped under 5 objectives.

1. Updating and costing of country strategic and (bi-) annual operational plans (most UKOTs).

2. Improvements in coordination, cooperation and knowledge sharing

    •   facilitation of annual meetings (in one of the territories).

    •   utilisation of OTCC and other regional fora for information exchange and to discuss/negotiate change.

    •   electronic information sharing & knowledge management.

    •   timely dialogue between UK DH and UKOTs in preparation of regional (annual) WHO committee meetings with appropriate feedback.

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[5]   Mapping the International Activities of the Department of Health. HLSP 2007.

[6]   Op. cit.

3. Assessments to inform strategic annual plans, and improve cost effectiveness, and quality of service provision.

   a. analysis of cost-effectiveness of secondary and tertiary care, including human resources and financing approaches.

   b. analysis of health financing options, including public private partnerships for patient care and non-medical services, health insurance.

   c. assessment of human resource needs and constraints with recommendations, including how to access resources from non-traditional sources.

   d. assessment of possible cost-savings for procurement of medical supplies.

   e. Infectious disease: take forward the suggestions, proposed in the 2009 ECDC needs assessment, to improve threat detection and risk assessment capabilities.

4. Assessments of mental health care and health situation of prisoners (human rights protection).

   a. Clarification of standards & requirements for accommodation for the chronically, seriously mentally ill, taking account of the balance between care in the community and secure facilities.

   b. Development of mental health policy, including care of the adjudicated criminally insane.

   c. Assessment of health service provision for prisoners, including analysis of liabilities for prison authorities. Development of policy for prison health care.

5. Improved co-ordination amongst regional HIV/AIDS programmes and UKOTs, with reductions in transaction costs and enhanced complementarity.

For various identified actions available systems, existing partnerships and co-ordination mechanisms and resources can be mobilised, for others re-allocation of resources and further discussions will be needed to match identified needs with available resources taking into account demand and supply-side constraints in defining needs and in absorbing resources.

For a comprehensive list of resources available to territories from regional and international organisations and agencies, see Annex 3

ANNEX 1 Key features of UK Overseas Territories and their health systems

The UKOTs included this study (and table) are:

Bermuda

5 Caribbean: Anguilla, British Virgin Islands, Cayman Islands, Montserrat, Turks and Caicos Islands

4 South Atlantic: St Helena, Ascension Island, Tristan da Cunha and the Falkland Islands

1 Pacific: Pitcairn Islands

The table lists the territories in order of population size.

	Population	GDP/cap (US$ ppp)	Life expectancy	Health system characteristics and UK support	Key features of health policies
Bermuda	64,000	69,900	77.2 (M); 83.7 (F)	Bermuda has an insurance based health system, insurance being provided through private companies, public agencies & employers, with government employees covered by a separate scheme. There are free hospital services for children and the elderly. Public hospital services have been devolved from Department of Health to the Bermuda Hospital Board. There is an active private medical sector. Bermuda has a 226 bed public general hospital and a 120-bed psychiatric hospital. The territory has no NHS quota; patients requiring specialist care are referred mainly to the Johns Hopkins Hospital, Lahey Hospital and Partners International in the United States, and patients are also referred to Canadian hospitals. Bermuda does not receive budgetary or developmental aid from DFID. PAHO aims to provide support across a wide range of activities under the following headings: Programme Management and Coordination; Treatment, Care and Support; Information, Surveillance and Research; Prevention and Behaviour Change; Advocacy, Legislation, Policy and Partnership; Stigma and Discrimination.	A summary prepared by PAHO states "Health policy emphasizes several areas, including maternal and child health, health of schoolchildren, community nursing for the elderly, dental health, control of communicable diseases, mental health, and alcohol and drug abuse. Population groups designated for special attention include mothers and infants, school-age children, and the elderly."
Cayman Islands	57,000	48,300	77.8 (M); 83.1 (F)	The Health Services Authority is responsible for all public health services. These are funded from the government budget and from health insurance via employers and private companies, with a separate scheme for government employees. Cayman has two public hospitals with 124 and 18 beds respectively. There is an active private medical sector including an 18-bed hospital and 19 outpatient practices. The territory has no NHS quota. Patients requiring specialist care are referred mainly to South Florida and Jamaica. Cayman Islands does not receive budgetary or developmental aid from DFID. It is included in the same package of PAHO's planned support as Bermuda.	The Health Service Authority web site www.hsa.ky provides the following summary "Our Mission …. to optimize the wellness of all people in our islands, by delivering accessible, cost-effective, patient-focused care through visionary leadership, operational efficiency and compassionate staff."

Health and Healthcare in the British Overseas Territories: Regional and UK Government Support

	Population	GDP/cap (US$ ppp)	Life expectancy	Health system characteristics and UK support	Key features of health policies
Turks & Caicos Islands	33,000	38,500	73.1 (M); 77.8 (F)	Turks and Caicos has a largely public health service, with a limited private medical sector on Providenciales Island. Services are funded from the government budget plus health insurance: employees pay a premium to receive benefits, and most employees also enrolled in private insurance schemes. It is estimated that 20% of the population has private health insurance, the remainder being covered by the MOH scheme. There are hospitals on Providenciales and Grand Turk islands, both recently redeveloped. The territory has an NHS quota of four referrals p.a. but this is not much used. Patients requiring off island care are referred mainly to Florida and the Bahamas, and some to Jamaica. A large proportion of the non-national population return to Haiti for treatment. TCI receives no budgetary or developmental aid from DFID but has received temporary post hurricane assistance. PAHO is involved in an active programme of support including HIS development, AIDS work, mass casualty management, and re-writing of the mass casualty plan. There is an ongoing need for reconstruction, and the MOH may need help commissioning its new hospitals, including HIS which is in PAHO budget.	A summary prepared by PAHO states *"The MOH is responsible for the provision of efficient and effective preventative and curative care through the Health Department. This is carried out in partnership with the community and with private and overseas providers".*
British Virgin Islands	27,000	35,400	76.0 (M); 78.6 (F)	The health care delivery system was devolved to the BVI Health Services Authority in 2004. The MOH now focuses on leading the health sector and the performance of the Essential Public Health Functions (EPHF). Public health care is financed from the consolidated fund and by the fees collected for services. The development of a National Health Insurance is currently under consideration. There is an active private medical sector. BVI has an NHS quota. Other patients requiring specialist care are referred to Puerto Rico, St Thomas in the US Virgin Islands, and the USA (mainly Florida). Small numbers of patients are referred to various Caribbean hospitals. BVI receives no budgetary or developmental aid from DFID, but is included in PAHO's programme of assistance.	The BVI Health Situation report Sept 2008 summarises the aims of health policy as being *"…. to ensure access to affordable, appropriate and acceptable health care to all citizens and residents. Health care organization and delivery is based on the Primary Health Care Approach. Health policy development, implementation and evaluation is based on the Health Promotion with the Caribbean Health Promotion Charter used as the basis"*
Anguilla	13,500	11,500	78.1 (M), 83.3 (F)	The management of health services has been devolved from the Ministry of Social Development to the Health Authority of Anguilla. There is one 36-bed public hospital, four health centres and one polyclinic. The health care system is financed through a number of mechanisms, namely insurance companies, the government insurance scheme for public servants, or patients who pay a fee for service. The Health Authority of Anguilla is paid by the Department of Social Development for services rendered to patients who are deemed unable to pay, and for the residents of the senior citizens home. Anguilla is currently in the process of developing a National Health Fund which will finance a basic package of health services for all Anguillans and legal residents. There is an active private medical sector. Anguilla has an NHS quota of four referrals p.a. which is not always fully used, in part because of the issue of waiting lists. For other overseas referrals they use Barbados, Trinidad, and Puerto Rica, and some people self refer to St Martin. Anguilla receives no budgetary or developmental aid from DFID, but has a programme of support agreed with PAHO.	The Health in the Americas report provides the following summary: *"National Strategic Plan for Health is guided by the vision a 'Nation of Healthy and Productive Individuals, Families and Communities.'" "To fulfil the vision, ten priority areas were identified to ensure strategic direction ….." "The ten priority areas are Health System Development, Health Services, Human Resource Development and Management, Family Health, Food and Nutrition and Physical Activity, Chronic Non Communicable Disease, HIV/AIDS, Communicable Diseases, Health and the Environment, Mental Health and Substance Abuse."*

	Population	GDP/cap (US$ ppp)	Life expectancy	Health system characteristics and UK support	Key features of health policies
Montserrat	8,800	8,800	74.7 (M); 70.7 (F)	The Ministry of Education, Health and Social Services is responsible for providing accessible, adequate and affordable health services to the public, which are funded from the government budget. There is a 30-bed public hospital, a nursing home, and a number of health centres. Montserrat has an NHS quota of four referrals p.a. Other patients requiring specialist care are referred to Barbados, Antigua, Trinidad, and occasionally to Guadeloupe for burns, and to St Kitts. Montserrat receives budgetary and developmental aid from DFID. The EC has funded developments in housing and education, and a new air strip. UNDP is providing assistance in relation to disaster preparedness, as is PAHO which also provides support in various other areas.	The PAHO summary mentioned above, and the Project Memorandum for the Strategic Health Development Project, provide the following information. Following the volcano eruption, health policy is set in the context of the Government's own plan for the recovery and rebuilding of the country, and the first objective of its Sustainable Development Plan *"To promote the retention of the present population and encourage the return of Montserratians from overseas"*. A health action plan has been developed.
Falkland Islands	4,500 (inc 1,500 military)	34,000	69 (M); 70 (F)	The Territory has a public health service operated by Health and Social Service Department of Falkland Islands Government. This is financed from FIG budget, plus user charges for visitors. All medical, dental and community health services are based in the hospital. The 29 bed complement is made up of 18 acute beds, a maternity bed, a single-bedded isolation unit, 2-bed intensive care unit, and 7 long-stay nursing home beds. There are modern facilities for outpatients and community health care, a day centre, 2 dental surgeries, and a single theatre with anaesthetic room. The Falklands has open access to NHS services, but receives no budgetary or developmental aid from DFID. As noted in the main text, two thirds of patients requiring specialist care are referred to South America, mainly to Chile but a few go to Uruguay.	Health and Social Services in the Falkland Islands – FIG Briefing Note states: *"Our mission is to provide high quality, cost-effective health and social services which address the identified needs of the populations we serve, in order to preserve life, treat illness and promote lifelong wellbeing."*
St Helena	4,000	2,500	75.5 (M), 81.5 (F)	Public health service operated by Public Health and Social Services department of the St Helena Government. Funded from SHG budget and Health Link 3 project, plus user charges for non-UK visitors. There is a single 39-bed hospital plus the 40 bed Community Care Complex, and five outlying health centres. St Helena has an NHS quota of four referrals p.a., but the majority of patients requiring off island care are referred to hospitals in Cape Town, South Africa. St Helena receives budgetary and developmental aid from DFID. Both the EC and WHO-AFRO have provided additional support.	St Helena's strategy document Focusing on the Future states *"Building on the Sustainable Development Plan, St Helena Public Health and Social Services Department stated aims and values include: Promoting and protecting people's health and welfare throughout the course of their lives, Reducing the incidence of diseases and alleviating the suffering they cause, Protecting the social wellbeing of the vulnerable and those at risk sections of the community"* .

Health and Healthcare in the British Overseas Territories: Regional and UK Government Support

	Population	GDP/cap (US$ ppp)	Life expectancy	Health system characteristics and UK support	Key features of health policies
Ascension Island	1,000	Incl. w. St Helena	NA	The public health service is operated by Ascension Island Government; funded from the government budget. Health insurance is compulsory for visitors. Ascension has no NHS quota, and receives no budgetary or developmental aid from DFID. As noted in the main text, patients requiring specialist care are referred to the John Radcliffe and Manor hospitals in Oxford as private patients.	Georgetown Hospital has 9 beds and provides a primary and secondary care comparable to any UK practice, including radiology and an operating theatre. Patients requiring specialist care are referred to the John Radcliffe and Manor hospitals in Oxford as private patients.
Tristan da Cunha	280	Incl. w. St Helena	75 (M); 80 (F)	Tristan da Cunha has a single medical officer. There is a 4-bed health facility, which provides limited inpatient and outpatient care, including radiology and an operating theatre. Tristan da Cunha has no NHS quota. All referrals are sent to private hospitals in Cape Town. It receives developmental aid from DFID via the Healthlink 3 project.	
Pitcairn Islands	50	Not listed	78 (M); 82 (F)	DFID currently funds about 90 percent of Pitcairn's annual budget, which amounted to about £1.2 million in 2008. The Pitcairn budget includes the provision of a doctor on annual contracts through an arrangement with International SOS, which also manages any emergency medivacs, the costs being met from the budget on a case by case basis. DFID also provides modest levels of funding for capital equipment and infrastructure and technical assistance where needed. In addition there is a Joint Country Strategy (JCS) with the Secretariat of the Pacific Community (SPC), providing support in the areas of radio and TV, bio-security, agriculture and animal husbandry, fisheries and maritime matters, public health, education, youth, gender equality, and culture.	
Approx. Total	210,500				

Annex 2:

Needs and Gaps in the provision of support to territory health and healthcare

Secondary and Tertiary Care

The small size of the OTs undermines their ability to function as independent units. Their limited populations cannot support comprehensive health services[1]. For all of them the cost of accessing supplementary off-island expertise creates diseconomies, and this underpins their need to access external support.

There are areas for efficiency gains in the way treatment abroad is organised and financed. Costs are increasing for overseas referrals. The worldwide trend towards more expensive procedures is increasing the pressure on Territory budgets. Costs may be increasing faster in the private sector, with a knock-on effect in the Territories that rely more on private providers, e.g. in the US or South Africa. Conversely, cost-management for referrals varies among Territories. The 2005 study revealed, for example, that TCI's public expenditure on medical treatment abroad increased 10-fold between 1997 and 2004, and was about 60 times higher than in Anguilla in 2004, with roughly the same population of 'belongers'. The people of Anguilla, by comparison, were more likely to pay privately for overseas care, either through insurance or out of pocket.[1]

The following points emerged largely from the 2005 study cited above, supplemented by interviews in 2009 for this paper:

• There is increasing demand from patients for improved secondary services, driven by better basic services and diagnostics, people's knowledge of what is available elsewhere, and perceptions that the quality of on-island services can be reduced by a high level of expatriate health workers and high turnover.

• The quota system has little impact on meeting actual need. Five of the Territories have access to the NHS quota, for four patients each per year (examples below). The 2005 study estimated an actual need of many hundreds of overseas referrals. The system is also inequitable. The quota is not consistent with the UK's pattern of aid provision in that one of the aid-dependent territories has no quota, three of the non-aid-dependent territories have a quota, and the Falkland Islands have open access to the NHS be it on a reciprocal basis as UK residents are entitled to free care within the Falkland Islands.

• Choice of provider depends more on historical knowledge than best procurement practice. For non-quota arrangements, long-standing working relations with hospitals in other Caribbean countries, the USA, Canada or South Africa tend to guide choice of provider. Scope may exist for improving negotiation on price and selection of most appropriate services.

Atlantic and Pacific Territories, being remoter than those in the Caribbean, have less access to private care. This saves funds but reduces options for accessing essential treatment. St Helena had 62 overseas referrals last year and 54 in 2007-8; plus the NHS quota of four. Return visits do not count against the quota so there are often more e.g. a liver transplant patient who needs regular visits to the UK. Numbers were, however, proportionally less than for Falkland Islands and Ascension. There are constraints on referrals from St Helena, and the skill mix of their own doctors affects the numbers. Visiting specialists generate overseas referrals, as well as dealing with cases on island. The Falkland Islands (FI) have no quota with the NHS – one third of referrals (50-55) go to UK and the rest to mainly Chile and a few to Uruguay.

The Caribbean OTs have their own issues. Anguilla does not always use its NHS quota e.g. last year used three out of four slots, and UK waiting lists are cited as an issue. In Montserrat, the hospital needs refurbishing and rebuilding (some progress has been made). The quota of four referrals does not meet needs, and some patients relocate overseas to get satisfactory care. Although Bermuda has a larger population, and health service, than most other OTs, it also has a problem providing specialist services. Finally the Cayman Islands also report challenges with arrangements for overseas referrals.

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[1] Sancho, J, and J Leach: Situational Analysis of Shared, Secondary and Specialist Services in the UKOTs, DFID Health Resource Centre, April 2005.

There is clearly scope for improving health-care planning such that each Territory is able to make the most cost-effective and politically acceptable choices. Similarly, there is scope for UK departments and their international partners to consider ways to offer cross-Territory assistance to improve the planning process for secondary and tertiary care, for those Territories that were interested.

Needs and gaps

- As the quota system applies unevenly across the Territories and has little impact on actual requirements for off-island treatment, it could benefit from a reassessment of each Territory's needs.

- Montserrat needs support in rebuilding its health system following the volcanic eruption.

- There is a need to review the financing in particular of the off-island solutions that the OTs choose. This could include an update of the 2005 assessment of secondary and tertiary care on- and off-island, with view to share lessons learned and identifying cost-effective, equitable solutions suitable to each Territory's situation.

Non-communicable diseases including mental health

According to a recent HPA report[2], 'The main health issues for the populations of OCTs are chronic, non-communicable diseases such as diabetes, cardiovascular disease (hypertension in particular) and cancer. Lifestyle factors such as smoking, obesity and alcohol consumption are particularly noted as important contributory factors by seven OCTs. Mental illness was also noted as an issue by three OCTs, and often related to substance abuse.

'Among the 17 OCTs where information was reported, the five leading causes of mortality were: cardiovascular disease (17/17); malignant neoplasm (16/17); external causes, including accidents and self harm (12/17); respiratory disease, including chronic obstructive pulmonary disease (8/17); and diabetes (4/17). Cardiovascular disease (mainly

hypertension), diabetes and respiratory conditions (including asthma) were also reported to be leading causes of morbidity among OCT populations, along with arthritis and other joint or musculo-skeletal conditions'.

The importance of NCDs is reflected also in assessments reported by agencies such as PAHO and the South Pacific Commission as well as in the Territories' own documentation.

In the area of mental health, Anguilla and Bermuda have requested support for the development of facilities for the 'criminally insane', which do not exist at present. This need was also raised at a PAHO meeting in September 2008. There has been discussion about this for some time, but more discussion with the UK has been requested. Concern had been intensified by a recent case in which a convicted patient committed suicide in prison. The issue of service provision for people whose mental health places themselves or their communities at risk is a general concern across the OT, not only in terms of quality of care but also because of the need to protect their human rights.

A similar concern has been expressed about health services for prisoners. While not specifically a non-communicable disease issue, the lack of consistent access to quality care for prisoners does raise concerns about their wellbeing and their rights. In addition, when prison officials provide minor treatment in the absence of qualified health workers, they may become liable if the treatment is insufficient or wrong.

Needs and gaps:

- Assessment of the degree to which the Territories are coping with the increasing burden of NCDs, and identification of their support needs (as part of Territories' own health strategies and plans).

- Anguilla and Bermuda requested assistance with providing a facility for the 'criminally insane'. Other OTs are likely to need the same – with a broadening of the issue from mentally-ill criminals to those whose behaviour places them or their communities at risk.

- Assessment of the issues around health care for prisoners (also as part of Territory health strategies and plans).

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[2] *Assessment of the Needs of European Overseas Territories*, Health Protection Agency, for European Centre for Disease Prevention and Control (ECDC), 2009

Responding to disease outbreaks

The cost of anti-virals has been identified as an issue as has stockpiling influenza vaccine. Even the wealthier OTs need help in this area - and they could afford to pay. PAHO has stepped in providing training and limited supplies of Personal Protection Equipment (PPE) and Tamiflu to the Caribbean OTs (not including Bermuda). All UKOTs can obtain pandemic flu stocks from UK Department of Health on a cost recovery basis. DFID provided funds to 2 OTs to cover costs for the H1N1 pandemic flu preparedness actions.

According to the recent HPA study, 'getting adequate laboratory support is generally more of a problem than epidemiological expertise, but a lack of clinical infectious disease expertise is a common weakness in OCTs' ability to assess and respond to infectious disease events. Expert epidemiological support in such events is available from the regional networks (such as CAREC and PAHO for Caribbean OCTs), though health service availability, interagency coordination and communications remain potential issues of concern within the territories'.

The Canadian International Development Agency has supported the strengthening of the H1N1 diagnostic capacity in the CAREC laboratory. For other OTs, the HPA report notes that assistance may come from the relevant European country e.g. the Falkland Islands look to the HPA. Pitcairn has a very remote location, only one medical officer, and a small medical centre. This all translates to very little capacity to respond to a crisis such as an epidemic disease outbreak.

Needs and gaps

- The cost-recovery model for pandemic influenza could be extended to other areas. As noted by DH, there is a need to rethink the flu cost recovery model and structure it differently.

- Stronger surveillance and laboratory support for pandemic preparedness is needed for all the OTs.

- Comprehensive risk assessments for pandemics, and capacity to respond to them, need to be in place for all the OTs. There may be an issue of determining responsibility for developing and maintaining the assessments.

Natural Disasters[3]

In the Caribbean, the EC is supporting post-hurricane recovery in TCI. In future, support is likely to be slanted more towards disaster protection and prevention. The OTs may also benefit from the current €5 million EU project on risk assessment, early warning, emergency response coordination, which covers all British and Dutch Caribbean Territories.

The Overseas Countries and Territories (OCTs) Regional Risk Reduction Initiative (R3I) covers the English and Dutch overseas countries and territories in the region, a total of 12 islands (Anguilla, Aruba, British Virgin Islands, Cayman Islands, Montserrat, Turks and Caicos and the Netherlands Antilles (Bonaire, Curacao, St Maarten, Saba, St Eustatius). The proposal is for €4.932m secured from the European Union covering a period of 3 years (2009-2011).

The OCTs, being small island states by nature are more limited in terms of access to funding and resources to reduce the risk from such calamity. Also, protection measures such as hurricane resistant materials and constructions are not fully deployed because of poverty and because of diseconomies of scale. Furthermore the OCTs in general are less able to readily recover from a disaster due to limited resilience and redundancy in critical infrastructure, comprehensive disaster education, critical resources and the capability to measure the cost recovery implications of a large Disaster event.

Each OT has a disaster officer and four OTs are members of the Caribbean Disaster Emergency Management Agency (CDEMA) – Anguilla, Montserrat, TCI and BVI. FCO and DFID have had a rolling programme since 1994, looking at the level of preparedness.

PAHO is very effective in supporting Territories' responses to disasters, with local ongoing relationships built up over years. It provides both equipment and personnel support. Work has included development of hospitals capable of withstanding hurricanes, with thorough planning and training. A lack of people on the ground, for example in Montserrat, is, however, a continuing issue.

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[3] This section is based mainly on a distillation of the views of DFID's disaster management adviser as expressed in a telephone interview.

The health implications of disasters have been at the forefront of thinking, including on the preparation of health/disaster coordination plans. The TCI plan is a good example: lessons have been learnt from practice runs, and PAHO has provided additional training. TCI's new hospital will be used to store emergency medical supplies.

The US does not support the OTs directly in emergency preparedness, but USAID does fund CDEMA. The IFRC does cover the OTs, and is expanding its capability there (PAHO has an MoU with IFRC). Any request for help for the OTs to IFRC however needs to come from the British Red Cross.

Cayman Islands have recently appointed a disaster officer. They have a good hurricane plan but no related legislation. Bermuda has no disaster officer, but has a good plan and coordination. Neither of these OTs are members of CDEMA. BVI have a disaster officer and a well-funded plan. The Montserrat plan places strong emphasis on risk reduction, but they lack funding and suffer from the departure of key personnel. UNDP has supported a search and rescue training programme for the Montserrat Institute for Disaster Response and Education. Anguilla's office and plans are relatively new, but is using the lessons learned from previous experience. In TCI, there are disparities in living standards across the islands and a large number of illegal immigrants, many of whom live in locations with poor infrastructure; coordination and governance are concerns. The TCI hospital is now usable post-hurricane, but the pace of recovery from the last major hurricane is slow. Security will be a big issue, particularly in relation to illegal immigrants.

The South Atlantic OTs are generally better prepared than those in the Caribbean. St Helena does have plans, and there is an EU consultancy to review the plan. There was an intensive study in 2002 with recommendations now being followed. On Ascension Island, there are plans for air and fuel accidents. Generally they work to US or UK standards. There was a review last year on Tristan da Cunha but further work is needed. Finally, there was a capability review in the Falkland Islands in 2008. There is concern over the possibility of a major accident or incident or public health issue. Disaster preparedness funds for the Falkland Islands may be available from PAHO even if they are not a member.

Needs and gaps:

- Disaster preparedness funds in the South Atlantic OTs are needed – perhaps from WHO, who have been requested to provide them.
- Ascension Island and the Falkland Islands need support in disaster preparedness planning.
- TCI has major needs with regards to disaster preparedness and needs support.
- Montserrat has issues with regards to capacity and also needs support.

HIV and AIDS

There is a plethora of HIV donors, implementing agencies and recipients of funds, particularly in the Caribbean. There have, however, only been a few reported cases of HIV in the Territories outside the Caribbean. Data collated by the DFID-funded regional AIDS project revealed HIV presence of less than 1% across the Territories; the main aim of the project is to help the OTs to maintain that low prevalence.

PANCAP provides the overarching coordinating mechanism and strategic framework for the Caribbean. Following examination of the Territories' relationship with PANCAP, they can now be associate members. However, PANCAP's funds, such as those provided by the EC, World Bank and Global Fund, remain unavailable to the OTs. The separate EC/OCT project and the DFID regional project (see below) are ways to make funds and technical assistance more available. The Caribbean OTs do receive PANCAP materials and products that PANCAP sends to all 29 countries in the region, and they can attend PANCAP meetings. There are also informal channels that distribute materials among the Caribbean islands[4].

Montserrat is an exception because, as a member of CARICOM, it is eligible for PANCAP funds. Montserrat has also benefited from training opportunities and technical assistance in the amount of US$167,000 between 2001 and 2008.

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[4] In the words of one agency representative, 'there are no written documents about these decisions but these are unspoken rules'. Other ways around the issue: the GFATM has allowed UKOTs to be part of its Round 9 so long as they are included in an application led by an eligible country.

UNAIDS main involvement with the OTs is also through PANCAP, although there are some capacity building activities to which some Caribbean OTs have been invited. For example, Montserrat, Cayman Island, BVI, Anguilla and TCI attended two major regional training events in 2009. Another event which UNAIDS cosponsored and facilitated was the PAHO regional workshop on the elimination of syphilis and HIV among children, held in the Dominican Republic in 2009.

There are also two specific OT projects on AIDS, one funded by the EC and the other by DFID. The EU project on HIV for the UK and Dutch OTs is being implemented by PAHO. It covers all the UK Caribbean Territories except for Bermuda. Implementation has started after considerable delay. The DFID-funded project covers all the UK Territories except Pitcairn.

Other agencies working in the area of AIDS include:

- USAID recently reviewed their strategic framework in the Caribbean covering 12 countries, none of which are OTs.

- The Clinton HIV/AIDS Initiative (CHAI) provides technical cooperation to many countries, but not directly for the OTs. CHAI support the OECS PPS and a laboratory in Barbados from which OTs can purchase services. CHAI does not work in the non-Caribbean OTs.

Needs and gaps

- There is scope for improved inter-agency coordination of AIDS-related activities in the Caribbean.

- The shortage of human resources in some OT health ministries, discussed below, can limit the degree to which they can respond to demand of AIDS projects and/or absorb technical support available. Responding to such demands also creates opportunity costs in terms of other tasks that may be dropped or delayed.

Health systems

This section focuses principally on the human resources and outbreak-response aspects of health systems.

Human Resources

While there are differences among the OTs, the human resources challenges facing the OTs are crystallised in the following statement from the Eastern Caribbean Cooperation Strategy:

> The issue of human resources for health remains a critical one, with insufficient personnel, inadequate quality of the work force, and problems with retention of trained personnel. Skill shortages exist in a many professional areas including nursing, epidemiology, biostatistics, health informatics, environmental health, nutrition and certain medical/health specialties, including mental health. Due to the generally small numbers, in many instances, staff must function in multiple areas and there are often situations where the loss of one person means the loss of a unit. The situation is compounded by challenges concerning migration of skilled staff to North America, the United Kingdom, and other countries.
>
> *Eastern Caribbean Cooperation Strategy 2006-2009, p 9.*

Human resource capacity affects the management side of health service delivery as well as the medical side. Even without an emergency situation, one individual may have to juggle three to four portfolios. In addition to constraining the management of island health services, staff shortages can limit the ability of health ministry staff to take advantage of technical assistance offered by external agencies. Officials from ministries and agencies report that OT staff often do not have the time, and sometimes the expertise, to make the most of services on offer. Capacity can fluctuate over time, as illustrated in Montserrat and TCI, where the pressures of post-hurricane recovery created increased pressures on all aspects of the public services.

Other human resource issues include the following

- The smaller the population size, the harder it is to find health workers and managers from within the Territory's own population, so that capacity must be obtained from off-island on temporary contracts or as visiting specialists;

- The remoteness of the Pacific and Atlantic Territories creates additional challenges in attracting visiting specialists and short-term personnel (overcome to a large extent by contracting through NICO, in the case of St Helena and Tristan da Cunha);

- Donor-funded projects may not take account of Territory human-resource capacity, including the opportunity-cost, when offering services. Few donors offer staff to assist with implementation;

- Organisations that offer ongoing technical support, such as PAHO and the technical organisations related to it (currently being merged into the Caribbean Public Health Agency), are probably better attuned to working in human-resource-constrained situations in the Territories through regular visiting schedules.

Outbreak response

These issues are analysed comprehensively in the report prepared by HPA for the ECDC cited above. In sum, they include the following key points.

- The quantity and quality of surveillance data is undermined by insufficient or under-effective data systems and their management, epidemiological expertise, and continuity of expertise. Staff may be unaware of the requirement to notify, or omit to do so. Not all data systems are computerised.
- The variation in OT situations means that it is not possible to identify one means of strengthening surveillance that will suit all.
- Limited staff and diagnostic capabilities: health services can quickly become overwhelmed by unusual incidence of illness.
- A limited number of adequately trained public health workers and epidemiologists; this affects also the surge capacity needed for outbreak response.
- Limited microbiological services; laboratory services vary widely among the OTs, with some having none at all.
- Infectious disease law is sometimes outdated.
- In the Caribbean, public health expertise can supplement on-island capacity, for example via CAREC and, soon through the newly merged CARPHA.

Needs and gaps

Human resources
- OTs need support in assessing their ongoing HR requirements in health. When a new initiative is launched to improve health in the OTs there needs to be a review of HR capacity to take on the new responsibility.
- Improving recruitment and retention: suggestions made in preparation of this paper have included a 'NICO-type facility' and the use of NHS staff e.g. on sabbatical.
- Innovation solutions need to be explored, including public-private partnerships (e.g. purchasing care for individual patents from private physicians) and competitive tendering for contracts to deliver packages of services.
- With regards to PAHO the OTs need to continue to strengthen their working relationship with the PAHO/WHO Representatives (PWRs) and Country Program Officers (CPOs) to respond to needs as they arise.

Outbreak response
- Training for health care workers, including public health workers and laboratory staff, in surveillance, microbiology and other technical skills
- Establishment of common standards with regards to public health capacity, surveillance and laboratory services
- Skill-sharing: Involve staff other than doctors in surveillance reporting
- Development of standard operating procedures for reporting and managing surveillance information where these do not already exist
- Clarification of surveillance-data reporting responsibilities
- On diagnostic capability, consider developing shared capacity with neighbouring regions or countries (and possibly strengthen laboratories in neighbouring countries); increase the availability of better diagnostic kits; provide guidance on which kits to use and where to obtain them
- Strengthen the use of IT for data management and in areas such as tele-medicine for diagnostics.

These suggestions are based closely on the HPA/ECDC report. Please refer to the concerned report for further detail and recommendations on meeting OT needs.

Coordination, communication and information

Existing communication and coordination mechanisms and some of the issues relating to them include

- WHO Regional Committees and other international governing bodies: OT interests could be better promoted through coordination beforehand between the OTs and the UK DH officials who represent them;

- Political and technical meetings associated with regional organisations such as CARICOM, PANCAP, SPC: similar coordination among participants in advance of the meetings to develop common lines and approaches;

- Interministerial Group on International Health: coordination specifically on issues related to the OTs, in accordance with the UK DH responsibility set out in Health is Global;

- Annual meeting of the Overseas Territories Consultative Council: inclusion of health and healthcare issues on the agenda, prefaced as above with consultation on issues and lines to take;

- Periodic studies and reviews such as the 2005 assessment of specialist care and the 2009 assessment of outbreak response capability: the findings and recommendations need to be carried forward in a systematic way – dropped, amended, or implemented;

At the technical level, external agencies and UK government departments share information with the OTs in a number of different ways including visiting advisers and technical officers, newsletters, websites, and printed material. One challenge for the OTs (hard-pressed as some of them are in terms of existing skills, knowledge and time) is to sift and locate what they need, when they need it. They have also expressed the need for improved communications among themselves, so as to learn from each others' experiences and to develop common approaches to accessing support.

Annex 3 Regional and International organisations / agencies

Organisation	Mission/ Vision	Support available to the UKOTs	Principal contacts
Canadian International Development Agency (CIDA)	Lead Canada's international effort to help people living in poverty. Mandate: To manage Canada's support and resources effectively and accountably to achieve meaningful, sustainable results and engage in policy development in Canada and internationally, enabling Canada's effort to realize its development objectives.	• Education; • Environment; • Health; • Equality between women and men; • Humanitarian aid; and • Private sector development. Involvement in health in the process of phasing out as health is no longer a sector of focus in the region. The only active project is the Enhanced Support for HIV/AIDS in the Caribbean (ESAC) project. The only active sub-project of this is CARISMA (the social marketing of condoms across the region) implemented by PSI. However, this is not addressing needs in any of the dependent territories. No OTs formally covered.	**Cam Bowes** Chief of Operations, Regional and OECS Programmes 1 819-997-8931 cam.bowes@acdi-cida.gc.ca
Caribbean Community (CARICOM)	To provide dynamic leadership and service in partnership with Community Institutions and groups, toward the attainment of a viable, internationally competitive and sustainable Community, with improved quality of life for all. CARICOM and PAHO work through a strategic framework called the Caribbean Cooperation in Health Initiative (CCH) the goal of which is to improve and sustain the health of the people of the Caribbean. The purpose of CCH is to develop and implement programmes which focus action and resources on priority health issues of common concern to the Caribbean community, with particular consideration given to vulnerable groups.	The CCH is a mechanism through which Member States of the Caribbean Community: • Collectively focus action and resources over a given period towards the achievement of agreed objectives in priority areas of common concern; • Identify the approaches and activities for joint action and/or Technical Cooperation among Countries (TCC) in support of capacity building for the achievement of objectives Regional Health Priority Areas for CCH: • Environmental Health; • Strengthening Health Systems; • Chronic Non-communicable Diseases; • Mental Health including Substance Abuse; • Family Health: • Prevention and Control of Communicable Diseases; • Food and Nutrition; • Human Resource Development Only Montserrat full member.	**Dr Edward Greene** Assistant Secretary-General, Human & Social Development, CARICOM Secretariat 1 592 222 0001 75 Ext 2700 egreene@caricom.org

Organisation	Mission/ Vision	Support available to the UKOTs	Principal contacts
Caribbean Development Bank (CDB)	To be the leading catalyst for development resources into the Region, working in an efficient, responsive and collaborative manner with our Borrowing Member Countries and other development partners, towards the systematic reduction of poverty in their countries through social and economic development.	• To assist the borrowing member countries to optimise the use of their resources, develop their economies and expand production and trade; • To promote private and public investment, encourage the development of the financial upturn in the region and facilitate business activity and expansion; • To mobilise financial resources from both within and outside the region for development; • To provide technical assistance to its regional borrowing members • To support regional and local financial institutions and a regional market for credit and savings; and • To support and stimulate the development of capital markets in the region.	**Carlson P Gough** Director, Projects Department Tel: (246) 431-1600 Direct: (246) 431-1711 goughc@caribank.org
Caribbean Disaster Emergency Management Agency (CDEMA)	CDEMA's main function is to make an immediate and coordinated response to any disastrous event affecting any Participating State, once the state requests such assistance. Other functions include: • Securing, collating and channelling to interested governmental and non-governmental organizations, comprehensive and reliable information on disasters affecting the region; • Mitigating or eliminating as far as possible, the consequences of disasters affecting Participating States. Establishing and maintaining on a sustainable basis, adequate disaster response capabilities among Participating States; and • Mobilising and coordinating disaster relief from governmental and non-governmental organizations for affected Participating States.	• Training for Disaster Management Personnel; • Development of model training courses and products including audiovisual aids; • Institutional Strengthening for Disaster Management Organisations; • Development of model Disaster Legislation for adaptation and adoption by Participating States; • Development of model policies and guidelines for use in emergencies; • Contingency Planning; • Resource mobilisation for strengthening disaster management programmes in Participating States; • Improving Emergency Telecommunications and Warning Systems; • Development of Disaster Information and Communication Systems; • Education and Public Awareness; and • Establishment of a dynamic CDERA website for information dissemination.	www.cdera.org/
Caribbean Epidemiology Centre (CAREC)	To improve the health status of Caribbean people by advancing the capability of member countries in epidemiology, laboratory technology and related public health disciplines through technical cooperation, service, training, research and a well trained motivated staff.	CAREC provides technical support to all Caribbean OTs except Bermuda in the areas listed under mission/vision.	**Dr. José Campione-Piccardo** (Director) Telephone: (868) 622 5129 E-mail: campione@carec.paho.org

Organisation	Mission/ Vision	Support available to the UKOTs	Principal contacts
Caribbean Family Planning Affiliation Ltd (CFPA)	The International Planned Parenthood Association (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. The Caribbean Family Planning Affiliation Ltd. (CFPA) is the umbrella organisation for the smaller Family Planning Associations within its region, including: Anguilla, Bermuda, Montserrat and the British Virgin Islands.	The CFPA has two major roles. Firstly, the institutional role is to represent the 18 affiliates at the regional and international councils of IPPF. Secondly to provide a forum for the affiliates and associate members to discuss the Sexual and Reproductive Health problems facing the region and coming up with solutions. The CFPA also plays a role in strengthening the capacity of its FPAs to meet the challenges of the region. To this end, they have raised monies to institute regional information and education campaigns on: • family planning; • teenage pregnancy; • sex education in schools; • cervical and prostate cancer; and • HIV/AIDS. Many of CFPA's affiliates have a Youth Advocacy Movement (YAM) - groups of young men and women who function like a junior arm of the FPA, are trained by the FPA in SRH issues and carry out outreach work among youth on behalf of the FPA.	**Dr Tirbani P. Jagdeo** Chief Executive Officer 1 268-462-4171/0 cfpa@andw.ag
Caribbean Health Research Council (CHRC)	To promote, support, facilitate and coordinate health research in the Caribbean; help disseminate the findings; and advise and work with Caribbean governments and other stakeholders on health research matters.	• Advocacy, advice, communication; • Research-related activities; • Capacity building; and • Sustainability and financing.	**Ms Elizabeth Lloyd** 1 868-645-7421/3769 chrceu@trinidad.net **Ms Marissa Archibald** Monitoring & Evaluation Officer 1 868-645-3769 marissa.chrc@yahoo.com marchibald-chrc@trinidad.net

Organisation	Mission/ Vision	Support available to the UKOTs	Principal contacts
Caribbean HIV & AIDS Alliance (CHAA)	Alliance Caribbean's regional programme aims to facilitate effective and collective community action to reduce the impact of HIV. It builds the capacity of local community based organisations and reaches out to most-at-risk populations (sex workers, men who have sex with men and people living with HIV).	Alliance Caribbean runs focussed programmes in St Vincent and the Grenadines, Antigua and Barbuda, St Kitts and Nevis, Jamaica and Barbados, and also operates in five other Eastern Caribbean countries. Since its inception in 2003 with support from USAID, the Alliance has leveraged additional resources to scale up its efforts. The following programmes are underway: • 'Eastern Caribbean Community Action Program' to increase access to HIV/AIDS services through evidenced-based programming in four Eastern Caribbean countries (funded by USAID). • 'Accelerating the private sector response to HIV/AIDS in the Caribbean', initially in the hotel and tourism sector in Jamaica and Barbados (funded by DFID) ' • Anti stigma toolkit project to produce six stigma-reduction toolkits to serve as a resource guide for reducing stigmatisation of people living with HIV (funded by CARICOM/PANCAP) Projects with sex workers to raise awareness of female condoms (funded by the Hewlett Foundation).	**Basil Williams** Regional Director - Caribbean Regional Programme, International HIV/AIDS Alliance 1 868 623-9714 Ext: 223 bwilliams@alliancecarib.org.tt
Caribbean HIV and AIDS Regional Training Unit (CHART)	To strengthen the capacity of national healthcare personnel and systems to provide access to quality HIV & AIDS prevention, care, treatment, and support services for all Caribbean people through the development of a robust and sustainable training network.	Focus is threefold: training, collaboration and synergy. • Training - to increase the number of competent and confident healthcare workers, who are at the forefront of prevention and treatment of HIV infection; and related conditions in the Caribbean; • Collaboration - building a network of training centres with national, regional and international agencies; • Synergy - striving to work in all language groups, sharing best practices, and pooling and sharing resources within the Caribbean.	**Brendan Bain** Director University of West Indies Mona, Kingston, Jamaica Tel: 876-977-2717 chart@uwimona.edu.jm www.chartcaribbean.org
Caribbean Network of People Living with HIV and AIDS (CRN+)	To empower and support persons affected and infected with HIV/AIDS through advocacy, research, partnership, capacity building and resource mobilization.	In order to effectively achieve its mission, the establishment of national networks in its member territories has been undertaken. CRN+ has initiated a strategy that emphasizes skills training and capacity building (both human and institutional) in all the above-mentioned focus areas. Its long-term goal envisages empowered regional/national networks of PLWHA who will: • Create/influence policy and legislative decisions; • Establish links and maintain these through spirited cooperation and coordination with key national and international stakeholders in both the public and private sphere; • Improve their access to treatment, care and support; • Reduce/eliminate stigma and discrimination; and • Encourage research and development with respect to HIV/AIDS.	http://www.crnplus.org/

Organisation	Mission/ Vision	Support available to the UKOTs	Principal contacts
Caribbean Social Marketing to Prevent HIV & AIDS (CARISMA)	CARISMA is working to integrate the efforts of all actors in the social marketing arena, including the public, non-profit, and for-profit sectors to ensure the access of the entire population to affordable, high-quality health care products and health information.	Implemented by Options (current in second phase) and funded by CIDA, PANCAP and KfW, CARISMA aims to: • Inform regional level thinking on social marketing via the total condom market and behaviour change communications; • Create a vision for social marketing in each country; • Develop social marketing indicators and means to measure them; • Understand and support Social Marketing Organisations, their models and their strengths and weaknesses; and • Determine what social marketing information is useful and relevant for dissemination across the region. OTs not covered.	www.carisma-pancap.org/activities/ Options Consultancy Services Limited Tel: +44 (0)20 7430 1900 www.options.co.uk r.fisher@options.co.uk
Clinton HIV/AIDS Initiative (CHAI)	To close the gap in access (to treatment) by negotiating lower prices for lifesaving antiretroviral treatment, and by working with governments to improve the national health care systems required to deliver crucial medicines.	Applies a business-oriented approach to changing the market for medicines and diagnostics and supporting developing countries to scale up HIV/AIDS care and treatment programs through three main programs: • Access Programs: work with generic pharmaceutical companies and other suppliers to reduce the cost of lifesaving antiretroviral medicines, testing and diagnostic equipment, malaria treatment, and nutrition; • Major Programmes: specialise in specific areas of need, including paediatric treatment, increasing access to care and treatment in rural areas, strengthening countries' human resource capacity for health, and preventing the transmission of HIV/AIDS from mother to child; and • In-Country Programmes: assist national governments and their ministries of health to develop sound health care policies around HIV/AIDS, strengthen management capacity, and implement cost-effective and comprehensive national responses to this epidemic. OTs not formally covered.	**Colleen Connell** Regional manager HIV and AIDS Initiative cconnell@clintonfoundation.org 1 617 774 0110
Department for International Development (DFID)	To meet the many challenges of tackling world poverty. To make sure every pound of British aid works its hardest to help the world's poor. To meet the reasonable assistance needs of UKOTs	Work is guided by two sets of targets: the Millennium Development Goals (MDGs) and the government's Public Service Agreement (PSA), which sets objectives and targets by which progress towards this aim is measured. DFID supports the UKOTs to • sustainably manage their health sectors, using their domestic budgets, regional multisectoral support, the NHS quota system, and development assistance where most needed; • influence and maximise the impact of regional health organisations, benefiting from their inputs and other technical and regional initiatives; • fulfil international responsibilities, for example International Health Regulations, which the UK has signed up to; • build better preparedness for emergencies and manage them effectively if they arise.	**Nicolet Hutter** Health Adviser, Overseas Territories Department n-hutter@dfid.gov.uk

Organisation	Mission/ Vision	Support available to the UKOTs	Principal contacts
Department of Health (DH)	The Department of Health (DH) exists to improve the health and wellbeing of people in England. The Department of Health's overall purpose is to ensure better health and well-being, better care and better value for all.	The UK DH's over-arching objective for its engagement with the territories on health matters is to improve global health, and to meet the UK's international obligations. The DH leads on developing and implementing strategies for engagement on health with the Territories and represents the needs and concerns of the territories at regional and international meetings. The DH can also provide direct support to the territories as when it recently made Tamiflu and H1N1 vaccine available on a cost-recovery basis to assist the UKOTs with their pandemic flu preparedness. The DH oversees a quota system by which Anguilla, British Virgin Islands, Montserrat, St Helena and Turks and Caicos Islands each has free access to NHS facilities for four patients a year. The Falkland Islands have open access to the NHS, financed by the island government.	**Nicola Watt** Head of Global Health Team Nicola.Watt@dh.gsi.gov.uk
European Commission (EC)	The European Commission is the executive of the European Union (EU). It is independent of national governments and its job is to represent and uphold the interests of the EU as a whole. Its responsibilities include implementing development co-operation in non-Member States country through Delegations that are generally in country and which work with national governments and other development partners.	There are 20 overseas countries and territories (OCTs) which are linked to Denmark, France, the Netherlands and the UK and are associated with the EU. Their nationals are in principle EU citizens, even though the OCTs are not part of the EU or directly subject to EU law. They benefit from association arrangements focusing on: • Economic and trade cooperation – favourable rules of origin and a very advantageous trade system; • Sustainable development – support for policies and strategies relating to production, trade development, human, social and environmental development, cultural and social cooperation; and • Regional cooperation and integration – support for economic cooperation and development, free movement of people, goods, services, labour and technology, liberalised trade and payments, and sectoral reform policies at regional level. Even though listed in the EC Treaty, the arrangements for association are in practice not applied to Bermuda, in accordance with the wishes of its Government.	**Helen Jenkinson** Head of Economic and Social Development Section, Delegation of the EC to Jamaica, Belize, the Bahamas, Turks and Caicos Islands and the Cayman Islands Helen.Jenkinson@ec.europa.eu tel: 1 876 924 6333 X227; cell: 1 876 579 7044 **Terhi Karvinen** Terhi.KARVINEN@ec.europa.eu

Organisation	Mission/ Vision	Support available to the UKOTs	Principal contacts
Foreign and Commonwealth Office (FCO)	To promote British interests, supporting our citizens and businesses around the world and run a global network of offices in more than 160 countries. Aims include: • To promote UK business around the world and to attract business into the UK. • To support and inform British nationals abroad through consular assistance; • To ensure that our borders are open to those that may benefit our economy (as well as those with genuine asylum claims), but closed to those that may bring us harm • To pursue terrorists and the causes of terrorism, as well as protecting the UK from terrorist attacks • To stabilise conflict around the world and promote and develop human rights, law and good governance • To promote a low-carbon, high-growth global economy; and • To develop effective international institutions, especially the United Nations and the European Union.	The FCO works in partnership with the 14 Overseas Territories, through the Governors' offices to: • Promote security and good governance • Strengthen democracy • Improve public services • Protect the environment • Assist in an emergency • Improve law enforcement	Desk Officer, Cross-Cutting Policy Issues, Policy and Coordination Section, Overseas Territories Directorate OTDenquiries@fco.gov.uk
Health Protection Agency (HPA)	The Health Protection Agency is an independent organisation that was set up by the government in 2003 to protect the public from threats to their health from infectious diseases and environmental hazards. It is funded to provide a range of health protection services in England and works closely with colleagues in equivalent organisations in the Devolved Administrations.	The HPA has no official mandate or funding in relation to health protection services or support in the OTs. It has however been designated as the UK National Focal Point (NFP) under International Health Regulations (IHR). The NFP function is primarily one of communication. When incidents that are relevant under IHR occur anywhere in UK territory they must be reported to WHO via the UK NFP. Similarly when WHO send alerts to the NFP about an IHR relevant issue, the NFP has a duty to share this with all parts of UK territory. In the event of an IHR relevant incident occurring anywhere in UK territory, the NFP would also have a role in risk assessment in collaboration with the relevant local authority.	The UK National Focal point ihrnfp@hpa.org.uk

Organisation	Mission/ Vision	Support available to the UKOTs	Principal contacts
International Labour Organisation	As the world's only tripartite multilateral agency, the ILO is dedicated to bringing decent work and livelihoods, job-related security and better living standards to the people of both poor and rich countries. It helps to attain those goals by promoting rights at work, encouraging opportunities for decent employment, enhancing social protection and strengthening dialogue on work-related issues. "The ILO works with governments (usually the Ministry of Labour) and with unions and employers organisations to promote decent work for all.	The ILO promotes the development of independent employers and workers' organisations and provides relevant training and advisory services. Its technical assistance includes such fields as: • Vocational training and vocational rehabilitation; • Employment policy; • Labour administration; • Labour law and industrial relations; • Working conditions; • Management development; • Cooperatives; • Social security; • Labour statistics; and • Occupational safety and health. In addition, the work of the ILO involves a number of cross-cutting activities	**Werner Blenk**, Director blenk@ilo.org
Pan- American Health Organisation (Washington DC)	To strengthen national and local health systems and improve the health of the peoples of the Americas, in collaboration with Ministries of Health, other government and international agencies, nongovernmental organisations, universities, social security agencies, community groups, and many others.	• Emergency Preparedness and Disaster Relief • External Relations, Resource Mobilization and Partnerships • Family and Community Health • Gender, Ethnicity and Health • Governing Bodies Office • Health Surveillance and Disease Prevention and Control • Health Systems and Services • Knowledge Management and Communication • Sustainable Development and Environmental Health • Technology, Health Care and Research Covers all Caribbean OTs but not Falklands.	**James Hill** External Relations Officer External Relations and Partnerships Unit, Area of Governance, Policy & Partnerships 1 202 974 3470 hilljame@paho.org

Organisation	Mission/ Vision	Support available to the UKOTs	Principal contacts
Pan Caribbean Partnership Against HIV and AIDS (PANCAP)	To scale up the response to HIV/AIDS in the region. Its specific mandate is to advocate for HIV/AIDS issues at government and highest levels; to coordinate the regional response and mobilise resources both regional and international and to increase country-level resources, both human and financial, to address the epidemic.	No direct support to UK OTs apart from Montserrat, which is the only full member via its membership of CARICOM. New associate membership for OTs should give them greater access to non-financial resources.

The OTs have been able to benefit from policy advice including model policies; research findings; coordination mechanisms and networks; and training and other materials that PANCAP produces or supports. Informal channels make such resources increasingly available. | **Carl F. Browne**

Director, Pan Caribbean Partnership against HIV and AIDS (PANCAP) CARICOM Secretariat

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Edward Emmanuel

Programme Manager, PANCAP Coordinating Unit

1 592-223-9016/226-4148

eemmanuel@caricom.org |
| President's Emergency Plan for AIDS Relief (PEPFAR) | In order to turn the tide of this global pandemic, PEPFAR will work through partner governments to support a sustainable, integrated, and country-led response to HIV/AIDS.

Through FY2013, PEPFAR globally plans to work in partnership with host nations to support:
• Treatment for at least 3 million people;
• Prevention of 12 million new infections; and
• Care for 12 million people, including 5 million orphans and vulnerable children. | • Transition from an emergency response to promotion of sustainable country programmes;[o]
• Strengthen partner government capacity to lead the response to the epidemic and other health demands;
• Expand prevention, care, and treatment in both concentrated and generalized epidemics;
• Integrate and coordinate HIV/AIDS programs with broader global health and development programs to maximize impact on health systems; and
• Invest in innovation and operations research to evaluate impact, improve service delivery and maximize outcomes.

To meet these goals and build sustainable local capacity, PEPFAR will support training of at least 140,000 new health care workers in HIV/AIDS prevention, treatment and care.

The Caribbean Regional Partnership Framework five year program goal areas include Prevention, Strategic Information, Laboratory Strengthening, and Health Systems Strengthening, working in 12 countries and with two regional programs, PANCAP and OECS.

OTs not covered. | **William Conn**

Regional Coordinator

Caribbean Regional Partnership

Tel: 246-227-4388

wconn@usaid.gov

www.pepfar.gov |

Organisation	Mission/ Vision	Support available to the UKOTs	Principal contacts
Secretariat of the Pacific Communities (SPC)	SPC is an international organisation that provides technical assistance, policy advice, training and research services to 22 Pacific Island countries and territories in areas such as health, human development, agriculture, forestry and fisheries. SPC's vision for the region is 'a secure and prosperous Pacific Community, whose people are educated and healthy and manage their resources in an economically, environmentally and socially sustainable way'. The mission is to help Pacific Island people make and implement informed decisions about their future.	The organisation's current work programme ncludes public health among a long list of technical areas SPC's work programmes aim to develop • Technical assistance; • Professional, scientific and research support; and • Planning and management capability building. The Secretariat of the Pacific Community (SPC) does include Pitcairn in their HIV data collection and has a strategy for the territory (mostly biodiversity rather than health) Pitcairn may also benefit from its membership of the Pacific Public Health Surveillance Network (supported by SPC). PPHSN services focus largely on surveillance data management including IT solutions.	**Eleanor Kleiber** EleanorK@spc.int http://www.spc.int/
Tropical Health Education Trust (THET)	To help improve the basic health services of the poorest countries, building long-term capacity. • Improve access to healthcare; • Empower frontline health workers; • Build long-term sustainability; and • Develop mutually beneficial relationships.	• Strengthening Health Links: Identify needs and priorities in developing countries to improve their health services; link them with a health institution in the UK that has the knowledge and skills to address these needs; and provide guidance, support, funding, monitoring and evaluation, management of projects, and ensure work is in line with Government health agendas. (International Health Links Funding Scheme). • International Programme Development: work with partners to scale up projects in order to address wider needs; • Influencing Policy: - be a voice for Links and advocate high standards and quality agendas for health policy both in the UK and internationally; encourage the participation and collaboration of policy makers, health professionals, non-profit organizations, funding agencies and donors; host Health Links conferences, bringing together health professionals and policy makers to share ideas, experiences and agendas; and had significant input into the Department of Health's Framework for International Development and the 2007 Lord Crisp Report on Global Health Partnerships. • Promoting Best Practice: strive to increase the quality and impact of Links by capturing shared lessons from Links' experiences. Develop easily accessible and user-friendly resource materials, such as manuals, guides, fact sheets and toolkits for all types of Links.	www.thet.org.uk

Organisation	Mission/ Vision	Support available to the UKOTs	Principal contacts
United Nations Joint Programme on HIV/AIDS (UNAIDS)	A joint venture of the United Nations family, bringing together the efforts and resources of ten UN system organizations in the AIDS response to help the world prevent new HIV infections, care for people living with HIV, and mitigate the impact of the epidemic.	These have been: • Mobilising leadership and advocacy; • Strategic information and policies; • Surveillance, monitoring and evaluation; • Civil society engagement and partnerships; and • Resource mobilisation. In the coming years the UNAIDS Outcome Framework for saving lives will be informed by the following nine priority areas: 1. Reducing sexual transmission of HIV; 2. Preventing mothers from dying and babies from becoming infected with HIV; 3. Ensuring that people living with HIV receive treatment; 4. Preventing people living with HIV from dying of tuberculosis; 5. Protecting drug users from becoming infected with HIV; 6. Removing punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS; 7. Stopping violence against women and girls; 8. Empowering young people to protect themselves from HIV; and 9. Enhancing social protection for people affected by HIV. No formal direct links with OTs.	**Dr Michel de Groulard** Regional Programme Adviser Tel: 868-623-7056 degroulardm@unaids.org **Dominique Mathiot** West Africa mathiotd@unaids.org **Tracey Newbury** Regional Programme Adviser - UNAIDS Pacific Islands newburyt@unaids.org Ph: +662 288 1115 **Ms Cynthia Eledu** UNAIDS Consultant Tel: 868-625-4186 eleduc@unaids.org
United Nations Children's Fund (UNICEF)	To advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential.	Global focus areas include: • Child survival and development; • Basic education and gender equality; • Child protection; • HIV/AIDS and children; and • Policy, advocacy and partnerships. Covers Anguilla, Montserrat and BVI.	**Tom Olsen** Director tolsen@unicef.org **Violet Warnery** Deputy Director Eastern Caribbean & Barbados vwarnery@unicef.org

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United Nations Development Fund for Women (UNIFEM)	To advance women's rights and achieve gender equality. It provides financial and technical assistance to innovative programmes and strategies that foster women's empowerment to support the implementation at the national level of existing international commitments to advance gender equality.	• Enhancing women's economic security and rights, • Ending violence against women, • Reducing the prevalence of HIV and AIDS among women and girls, and • Advancing gender justice in democratic governance in stable and fragile states.	**Ms Sandra Edwards** Programme Specialist UNIFEM Caribbean Office sandra.edwards@unifem.org +246 467 6132
United Nations Development Programme (UNDP)	To advocate for change and connect countries to knowledge, experience and resources to help people build a better life.	Global areas of work include: • Democratic Governance • Poverty Reduction • Crisis Prevention and Recovery • Environment and Energy • HIV/AIDS • Women's empowerment; and • Capacity development Only Montserrat formally. Some UNVs in TCI. Otherwise there is a regional risk reduction project.	**Dr Thomas Gittens** Senior Programme Adviser Tel : 212-906-5013 Fax : 212-906-5363 Mobile : 516-851-6752 thomas.gittens@undp.org
United Nations Educational Scientific and Cultural Organisation (UNESCO)	To promote international co-operation among its 193 Member States and six Associate Members in the fields of education, science, culture and communication.	Functions as a laboratory of ideas and a standard-setter to forge universal agreements on emerging ethical issues. Serves as a clearinghouse – for the dissemination and sharing of information and knowledge – while helping Member States to build their human and institutional capacities in diverse fields. UNESCO's traditional focus is on its five programme sectors: • Education; • Natural Sciences; • Social and Human Sciences; • Culture; and • Communication and Information. It also works on a number of Special Themes that require a trans-disciplinary approach. No OTs formally covered in the Caribbean	**Mr Paolo Fontani** Programme Manager, Education Tel : 876-929-7087 p.fontani@unesco.org

Organisation	Mission/ Vision	Support available to the UKOTs	Principal contacts
United Nations Population Fund (UNFPA) Caribbean	To promote the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.	• Meeting Development Goals • Improving Reproductive Health • Making Motherhood Safer • Supporting Adolescents and Youth • Preventing HIV/AIDS • Promoting Gender Equality • Using Culturally Sensitive Approaches • Protecting Human Rights • Securing Reproductive Health Supplies • Assisting in Emergencies • Building Support • State of World Population (centrepiece of UNFPA's worldwide media communications and advocacy efforts during the year). All Caribbean OTs covered.	**Mr Harold Robinson** Chair, UN Theme Group on HIV/AIDS and UNFPA Representative Tel: 876-754-5690 hrobinson@unfpa.org
UNFPA	As above.	For non-Caribbean OTs: "UNFPA is interested and will support St. Helena, Tristan da Cunha and Ascension Island in the South Atlantic, especially in the area of capacity development, quality technical support and assurance in UNFPA's priority areas namely, population and development, reproductive health and Gender. UNFPA Africa region provides technical assistance related to population data analysis and data for development, development of national statistical and census databases, results based management, monitoring and evaluation, reproductive health, HIV and AIDS prevention especially among young people, and gender and women's empowerment, and humanitarian response". In October 2006, St. Helena participated in the UNFPA workshop on the Principles and Recommendations for the 2010 World Programme for Population & Housing Censuses, held in Maputo, Mozambique. Does not cover the Pitcairn Islands	**Reginald Chima** Regional Adviser, Monitoring and Evaluation Africa Regional Office Tel: +27116035530; +27710772318 chima@unfpa.org **Najib Assifi** Deputy Director Asia and Pacific Regional Office and UNFPA Representative in Thailand O: +662 6870102 assifi@unfpa.org

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United States Agency for International Development (USAID)	USAID has five core goals: • Supporting transformational development; • Strengthening fragile states; • Supporting U.S. geo-strategic interests; • Addressing trans-national problems; and • Providing humanitarian relief	Supports long-term and equitable economic growth and advances U.S. foreign policy objectives by supporting: • Economic growth, agriculture and trade; • Global health; and, • Democracy, conflict prevention and humanitarian assistance. The types of assistance USAID provides include: • Technical assistance and capacity building; • Training and scholarships; • Food aid and disaster relief; • Infrastructure construction; • Small-enterprise loans; • Budget support; • Enterprise funds; and • Credit guarantees. OTs not covered.	**Angela Davis** Senior HIV/AIDS Technical Specialist/ USAID Representative Barbados Tel: (246) 227 4118 aldavis@usaid.gov
World Bank	To fight poverty with passion and professionalism for lasting results and to help people help themselves and their environment by providing resources, sharing knowledge, building capacity and forging partnerships in the public and private sectors.	Made up of two development institutions owned by 186 member countries: the International Bank for Reconstruction and Development (IBRD) and the International Development Association (IDA). The IBRD aims to reduce poverty in middle-income and creditworthy poorer countries, while IDA focuses on the world's poorest countries. Together, they provide low-interest loans, interest-free credits and grants to developing countries for a wide array of purposes that include investments in education, health, HIV/AIDS, public administration, infrastructure, financial and private sector development, agriculture, and environmental and natural resource management. No OTs covered in the Caribbean.	**Ms Shiyan Chao** Senior Economist for Health Schao@worldbank.org
World Health Organisation-AFRO	WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.	• Promoting development; • Fostering health security; • Strengthening health systems; • Harnessing research, information and evidence; • Enhancing partnerships; and • Improving performance. Covers St Helena on an ad hoc basis.	**Mrs Marie Omog** omogs@afro.who.int