



UK Health  
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Agency



# Mapping Montserrat's Workforce Capacities to Implement the Essential Public Health Functions



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# Foreword

The mapping of Montserrat's workforce capacity to implement the Essential Public Health Functions (EPHFs) was a vital exercise for the health system. It is usually assumed that doing such an assessment would be a simple matter in a population size such as what exists in Montserrat. However, Montserrat's small population of 4,386 and its unique external relationships makes it a challenge to assess this health system. Montserrat benefits from being a United Kingdom Overseas Territory (UKOT) and is also a full member of the Caribbean Community (CARICOM) and the Organisation of Eastern Caribbean States (OECS). Montserrat is also heavily dependent on the United Kingdom for recurrent budgetary obligations since the volcanic crisis started in 1995. The complex external relationships and budgetary constraints makes the coordination required for maintaining the workforce capacity for implementing the EPHFs an ongoing challenge. The recruitment, retention and training of healthcare workers is a tremendous challenge for Montserrat. The size of the population makes it difficult for professionals to keep their skill set and there is often limited accredited professional development available for these professionals. Additionally, budgeting for the needs of a health system is always a challenge and the priority is usually focused on service provision and not always professional development. The complexity of the relationships and how this influenced workforce capacity was exemplified during the COVID-19 pandemic. Therefore, piloting this methodology developed by the World Health Organisation (WHO) to map the workforce was a timely venture.

This exercise allowed workers within the health system and wider government departments to focus on the actual capacity of the system. Mapping of functions and confirming actual head counts were done and this resulted with the identification of gaps within the system and in the workforce. External workers to the Ministry of Health and Social Services were able to see their role in implementing aspects of the EPHFs for the first time and this can only strengthen partnerships within the local context for future work. This awareness of external stakeholders is an immediate benefit from conducting this mapping exercise. Other benefits include the ability to use the gaps identified for the development of workforce retention strategies, business cases for additional staff as required and educational opportunities for staff. More importantly, the system now has a better sense of its capacity for preparing and responding to emergencies.

Small island developing states (SIDS) are often overlooked when assessments are developed and I applaud WHO and UKHSA for assisting Montserrat in testing this methodology. It is hoped that this report will be used as an example to other small island developing states in adopting international methodologies for assessing their health systems. Hopefully, the public health realm will develop more assessment tools that are SIDS specific to ensure that all systems can do the assessments required to improve their own unique systems.

Dr. Sharra Greenaway-Duberry  
Chief Medical Officer  
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# WHO Foreword

Achieving and sustaining progress towards global health goals such as universal health coverage and health security requires a workforce that can deliver the full range of essential public health functions (EPHFs), including emergency preparedness and response (EPR). This workforce is not a single occupation, but a grouping of diverse occupations, from the health and other sectors. Thus, monitoring the size and profile of this workforce is a key element of public health workforce planning to ensure the development of national capacity, as well as to enable the planning for surge requirements in times of crises.

The National Workforce Capacity for EPHFs Roadmap was launched by WHO in partnership with associations, institutions and schools of public health as represented by their respective national, regional and global bodies in May 2022. It advocates for a holistic approach for public health workforce development and outlines a 5 year vision to help countries develop an integrated multidisciplinary and multisectoral public health workforce. The Roadmap has three action areas – defining the functions and services, competency-based education and mapping and measurement of the occupations – and has developed technical tools and guidance for these action areas, and an operational handbook for country-led contextualization and implementation.

Small island developing states (SIDS) face significant workforce challenges due to their unique geographical, economic and social circumstances, and hence they were highlighted in the 2030 Agenda for Sustainable Development (SDG target 3c) and the Global Strategy for Human Resources for Health: Workforce 2030. In this context, Montserrat's interest in the Roadmap and initiative to implement the technical guidance for mapping and measurement of occupations that contribute to EPHFs delivery is particularly welcome. The implementation experience provides rich and unique learnings from a small island setting that may be of relevance for other SIDS, particularly the Caribbean and Pacific Island countries.

It is our hope that the findings and recommendations of this national report will help the Government of Montserrat in informing the development of its national public health workforce development strategy, and also contribute to strengthening the evidence base for other countries to build, maintain and strengthen their public health workforce and thus advance the vision of health for all.

Jim Campbell  
Director, Health Workforce  
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# Acknowledgments

This report was the result of a collaboration between the Montserrat Ministry of Health and Social Services (MOHSS), World Health Organization (WHO), and the UK Health Security Agency (UKHSA).

This report was produced by Lara Kontos and Sunita Sturup-Toft, with valuable input from Helena Fahie and Natalia Rzeszotko.

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Without the input and insight of the above individuals this work would not be possible.

# Executive Summary

## Purpose

This report documents the collaborative initiative between Montserrat's Ministry of Health and Social Services (MOHSS), the World Health Organization (WHO), and the UK Health Security Agency (UKHSA) to map Montserrat's workforce capacity for implementing Essential Public Health Functions (EPHFs). As the first small island developing state to undertake WHO's standardised methodology, Montserrat's experience provides valuable learning to inform workforce planning approaches for similar contexts. The assessment was particularly timely following the COVID-19 pandemic, which exposed weaknesses in national health systems worldwide and highlighted the importance of a skilled public health workforce.

## Key Findings

The assessment revealed several significant workforce challenges:

- Montserrat's small population creates difficulties for health and care workers to maintain their skill sets and limits the available pool of workers for replacement.
- Staff frequently perform multiple functions outside their assigned roles, with 75% of participants reporting spending more than 10% of their time on activities not in their job descriptions.
- The public health workforce comprises three distinct groups: core public health personnel, health and care workers contributing to public health functions, and allied personnel addressing wider determinants of health.
- Nurses play a critical role in delivering EPHFs but must cover multiple specialties while often simultaneously serving as managers and educators.
- Training and education for the workforce is inconsistent, with some personnel receiving formal education, others relying on on-the-job training, and some receiving no specialised training at all.
- Limited accredited professional development opportunities exist on-island, with budget constraints typically prioritising service provision over workforce development.
- Infrastructure challenges remain, with the main hospital currently housed in a transformed primary school, though plans are underway for a new state-of-the-art facility starting in 2025.

## Main Activities

A four-phase implementation approach was followed, including:

1. Governance Phase: Established a National Implementation Team comprising 17 stakeholders from across government ministries.

2. Scoping Phase: Conducted a two-day workshop to identify priority EPHFs (Public Health Intelligence, Public Health Planning & Financing, and Public Health Workforce Development) and mapped job titles to standardised occupational groups.
3. Validation Phase: Interviewed health workers to validate workshop data, estimate time spent on EPHFs, and identify training needs and gaps.
4. Codifying Learnings Phase: Documented the implementation process, methodological adaptations, lessons learned, and challenges encountered to inform recommendations.

## **Recommendations**

1. Develop a comprehensive Public Health Workforce Strategy to address identified gaps and strengthen workforce planning and development.
2. Improve cross-departmental coordination through regular simulated drills, after-action reviews, and tabletop exercises to enhance emergency preparedness and response.
3. Standardise competency-based education for the public health workforce with a focus on priority EPHFs.
4. Collaborate with global and regional partners such as WHO, PAHO, CARPHA and others, to develop integrated, competency-based education and training programmes delivered on-island to overcome barriers to continuous professional development.
5. Complete assessments of additional EPHFs beyond the initial three priority areas to inform a more comprehensive workforce strategy.

This mapping exercise provides Montserrat with essential baseline data to inform strategic workforce planning and policy development, while contributing valuable insights for other small island developing states facing similar public health workforce challenges.

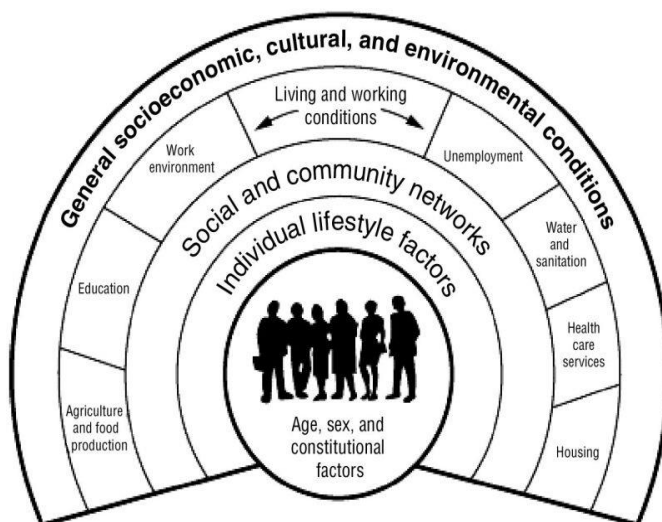
# 1. Introduction

## 1.1. Background

Following COVID-19, weaknesses across national health systems were exposed, which served as a stark reminder of the interconnectedness of the health, social and economic systems worldwide. As countries begin to recover and turn attention to investing in health, an opportunity has been provided to strengthen health systems, revitalise the essential public health functions (EPHFs) and enhance emergency preparedness and response (EPR) capacities. While much focus is on attaining universal health coverage (UHC) and ensuring health security through the implementation of the International Health Regulations (IHR 2005), the essential role and impact of the workforce involved in these activities is often overlooked. This was particularly evident in Montserrat, where an already stretched workforce limited access to health services. The challenges were further exacerbated by the COVID-19 pandemic, which intensified existing workforce pressures and created significant barriers to maintaining health services while responding to additional demands posed by the public health emergency.

To effectively strengthen health systems, wider social factors, known as the social determinants of health, as detailed in **Figure 1**, must be addressed and a national public health workforce is required, working on health at a population level. Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures. Health, according to the World Health Organization (WHO), is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity. Developing the public health workforce's capacity to deliver the EPHFs can enable countries to fulfil this duty, meet the challenges exposed by COVID-19, as well as improve preparedness to avert and address diverse ongoing and upcoming public health challenges (such as climate-related events, zoonotic spillover, non-communicable diseases and antimicrobial resistance). The WHO, along with leading public health and emergency response experts, organisations, universities, and associations

globally, have collaborated to develop a Roadmap<sup>1</sup> and action plan<sup>2</sup> to support countries to understand their *national workforce capacity to implement the essential public health functions including a focus on emergency preparedness and response*. This outlines a 5-year vision to strengthen capacity across WHO Member States for a multidisciplinary workforce to undertake the EPHFs, including EPR, using a One Health approach. Additionally, this aligns with current work in Montserrat to strengthen the nursing workforce, with a focus on key areas influential to the public health workforce such as recruitment, retention and training.



**Figure 1: Dahlgren and Whitehead (1991)**

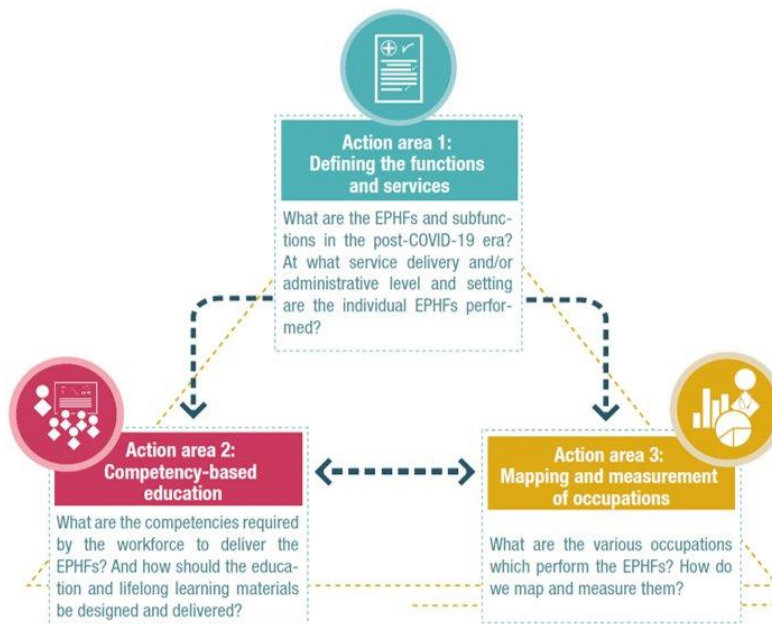
## 1.2 What is the public health and emergency workforce roadmap?

The Roadmap is a holistic effort to scope, define and build capacity of the public health and emergency workforce with a vision of a strengthened workforce in every country, delivering EPHFs for universal health coverage, health security and improved health and wellbeing. The three interlinked priority areas, shown in **Figure 2**, allow us to further refine national priorities, use competency-based education to address identified gaps, and to identify the current workforce capacity and gaps in the system.

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<sup>1</sup> National workforce capacity to implement the essential public health functions including a focus on emergency preparedness and response: roadmap for aligning WHO and partner contributions. Geneva: World Health Organization; 2022. <https://iris.who.int/handle/10665/354384>

<sup>2</sup> National workforce capacity to implement the essential public health functions including a focus on emergency preparedness and response: action plan (2022–2024) for aligning WHO and partner contributions. Geneva: World Health Organization; 2022. <https://iris.who.int/handle/10665/363519>

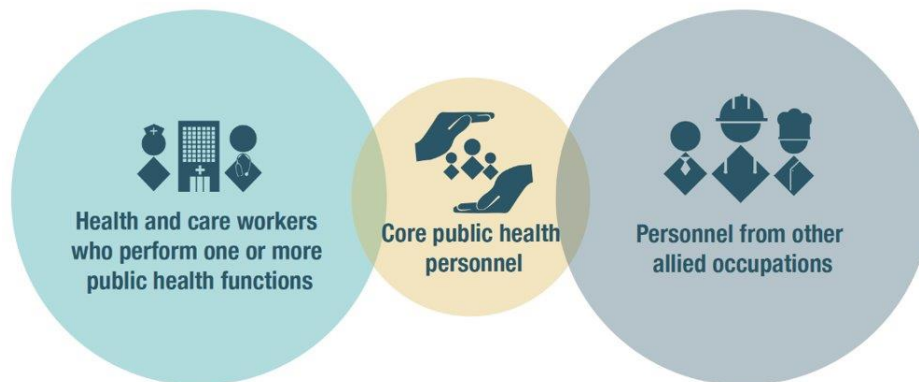


**Figure 2: The Roadmap's Three Action Areas**

This report focuses on Action area 3: mapping and measurement of occupations. Understanding the contributions of the various occupations that comprise the public health workforce to the delivery of the EPHFs is a critical first step in defining the skills and competencies needed to deliver EPHFs and to identify gaps which need to be filled. The workforce which delivers these functions is not a single occupation, but a group of diverse occupations, from health and other sectors. The workforce which delivers the EPHFs comprises of individuals who contribute to the delivery of at least one of the functions as a part of integrated services and systems, as shown in **Figure 3**.

As conceptualised in the Roadmap, this workforce can be framed as:

- Core group of **public health personnel** who have undergone professional training and/or registration with professional bodies in public health (*eg. Epidemiologist, public health officers/researchers/practitioners/educators*).
- **Health and care workers** who contribute to one or more public health functions as part of their clinical and/or social care roles (*eg. medical doctors, nurses, midwives, dentists, community health workers, laboratory technicians, pharmacists, ambulance workers*).
- Personnel from a wide group of other **allied occupations** who contribute to addressing the determinants of health, for example water and sanitation employees, food supply chains and road safety. (*eg. personnel engaged in road safety, food supply chain, environmental health, Water Sanitation and Hygiene (WASH), veterinarians, agriculture personnel*).



**Figure 3: Composition of the workforce which delivers the EPHFs**

### 1.3 Rationale for mapping and measuring the public health workforce in Montserrat

Montserrat is a British Overseas Territory located in the Leeward Islands, part of the chain of islands called Lesser Antilles in the Caribbean Sea. With an estimated population of under 5000 people, Montserrat has a small public health workforce requiring personnel to undertake multiple functions outside their assigned role. Pan American Health Organization (PAHO) recognised in 2012<sup>3</sup> that the shortage or lack of health professionals creates a serious problem for the health sector in Montserrat as its population is so small, there is not enough consistent complexity of cases for health professionals to keep their skills up to date, and there is not a large enough pool of health workers to replace employees who leave.

The UK Overseas Territories Programme (UKOTs) at UK Health Security Agency (UKHSA), funded by the Foreign, Commonwealth and Development Office (FCDO), works closely with Montserrat to strengthen capacity of its workforce and compliance with the International Health Regulations. As Montserrat aims to develop a Public Health Workforce Strategy in the longer term, the launch of the WHO roadmap provided a timely opportunity to implement as it offers tools and guidance along with a methodology to measure the size, profile, and functions implemented by this workforce using a standardised measurement approach. The aim is to produce useful data to inform workforce and policy planning. Montserrat is the first small island to undertake this initiative, providing valuable learning that will inform the broader methodology and contribute to WHO knowledge repositories.

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<sup>3</sup> Pan American Health Organization. (2012). *Health in the Americas: Montserrat*. Retrieved from <https://www.paho.org/hq/dmdocuments/2012/2012-hia-montserrat.pdf>

### Objectives

- a) Adapt the EPHFs and their subfunctions / services to Montserrat's context.
- b) Map and measure the key occupations involved in the delivery of the EPHFs, including EPR in Montserrat in order to identify gaps.
- c) Develop actions to address the identified gaps in Montserrat's workforce capacity to implement the EPHFs.

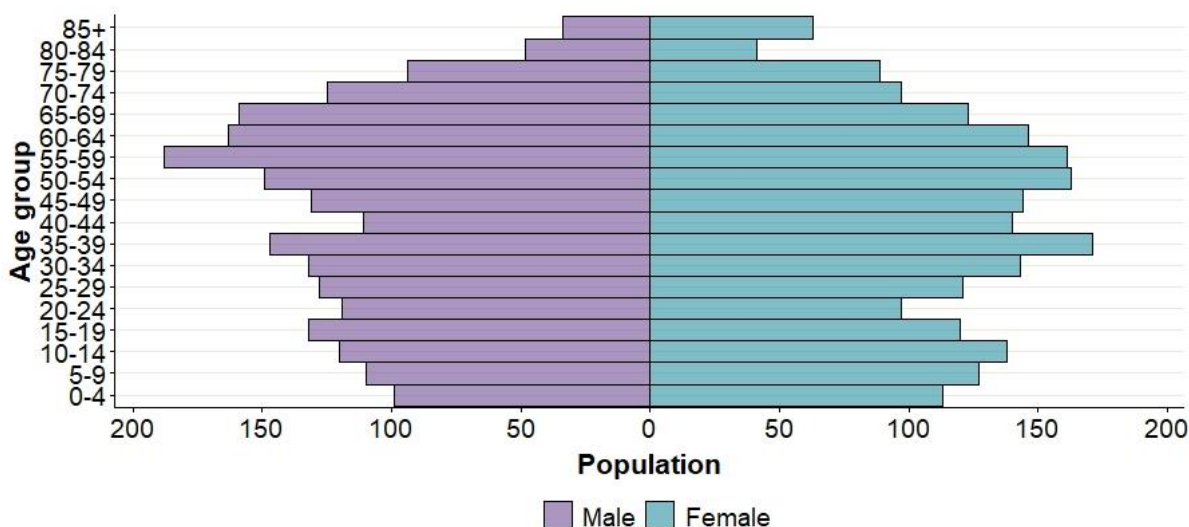
### Expected outcomes

- a) Better understanding of the heterogeneity of Montserrat's public health workforce based on the mapped job titles with occupation groups, for effective monitoring of the workforce.
- b) Evidence on identified gaps in the national workforce capacity and training needs for improved evidence-based planning and policymaking to better manage this workforce and create business case and projections for future needs.
- c) To provide evidence and data to feed into Montserrat's Public Health Workforce Strategy.

## 2. The health context of Montserrat

The 2023 census recorded a total population of 4,386 (Figure 4). Individuals aged 65 years and above accounted for 19.9% of the total (873/4,386), indicative of an ageing population. Life expectancy at birth in 2022 was estimated to be 75.6 years.

Figure 4 : Age and sex distribution of Montserrat population. Source: Montserrat Census 2023



## 2.1 Non-communicable disease burden

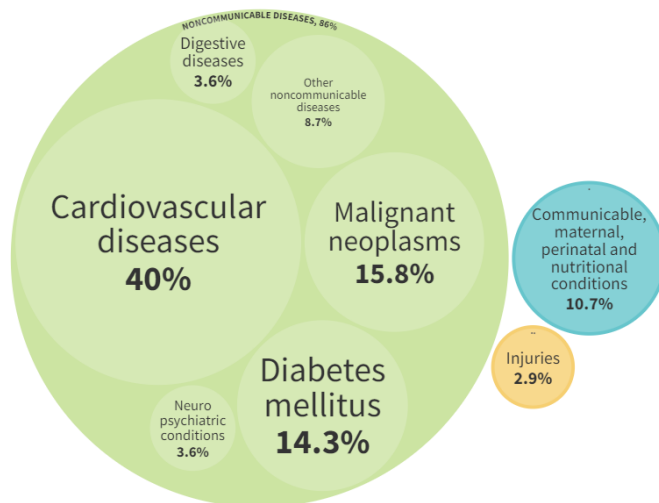
The non-communicable disease (NCD) burden in Montserrat is notable and impacts the population even from early adulthood. A household survey conducted in 2022 collected data on NCDs and health behaviours. Of the 304 respondents, 34.5% (105/304) reported one or more NCD, and among these 29.5% (31/105) had 2 or more NCDs. Diagnosed NCDs were reported even among the youngest 18 to 29 year age group. Hypertension and diabetes were most common, accounting separately or together for 83.8% of all NCDs. This burden represents a significant health challenge for Montserrat, posing a substantial threat to the island's development through increased demands on healthcare services, increased healthcare costs and reduced workforce productivity.

## 2.2 Hospital admissions

Over the eleven-year period from 2011 and 2021, Montserrat recorded a total of 6,038 hospital admissions, with NCDs being among the leading causes. After admissions associated with pregnancy, childbirth and the puerperium, diseases of the circulatory system were the most common reason for admission (13.0%, 789/ 6,038). This was followed by endocrine, nutritional, and metabolic diseases (10.4%, 630/6,038), and diseases of the genitourinary system (8.9%, 536/6,038). Total admissions steadily increased throughout the period, with the most significant average growth rates for NCD-related admissions seen in neoplasms at 24.1% and mental and behavioural disorders at 17.7%.

## 2.3 Mortality

Between 2013 and 2022, 86% of total deaths (385/448) were attributed to NCDs. Cardiovascular diseases, encompassing conditions such as ischemic heart disease, cerebrovascular disease, hypertension, and heart failure, were the most common cause of death, accounting for 40% of total deaths (179 out of 448). This was followed by cancer at 16% (71 out of 448) and diabetes at 14% (64 out of 448). The median age of death due to NCDs across the period was 81 years, with 25% (95/385) of NCD deaths occurring in persons aged less than 70 years of age. Among NCD-related deaths, males accounted for 55% (213/385).



**Figure 5: Distribution of deaths by cause, Montserrat, 2013 to 2022, NCD Situational Analysis, UKHSA / MoHSS**

Cardiovascular mortality rates have consistently remained higher than those of all other NCDs over the past decade. The age-standardised rate began increasing in 2014 and reached its peak at 4.5 per 1,000 in 2017, before gradually declining to 3.3 per 1,000 by 2022. Cerebrovascular disease and ischaemic heart disease were the most prevalent cardiovascular-related deaths, accounting for 22.9% (41/179) and 21.8% (39/179) of deaths over the 10-year period respectively. Deaths due to hypertensive disease contributed to 12.8% (23/179) of cardiovascular-related deaths.

Cancer mortality rates have increased four-fold over the past five years, rising from 0.9 per 1,000 population in 2018 to 3.6 per 1,000 population in 2022. In 2022, approximately a quarter (28%, 16/58) of all deaths were due to cancer, with prostate cancer being the most prevalent, accounting for 31% (5/16) of malignant neoplasm deaths, followed by liver cancer at 19% (3/16). Across the ten-year period from 2013 to 2022, prostate cancer remained the leading cause of death from malignant neoplasms, contributing to 30% (21/71) of all cancer deaths. Breast cancer and trachea, bronchus, and lung cancers followed, each accounting for 11% (8/71) of the total cancer deaths.

In contrast, diabetes mortality rates have steadily declined over the past decade, dropping from 2.5 per 1,000 in 2013 to 0 per 1,000 in 2022. This trend may reflect increased awareness and education, along with better disease management and improved access to healthcare services.

## 2.4 Health workforce composition, capacity and training in Montserrat

Montserrat has a small health workforce, which is detailed in **Table 1**. The health workforce is characterised by its versatility, with professionals often fulfilling multiple roles to meet the island’s healthcare needs. While there are general practitioners and nurses providing a broad range of services, the availability of specialist is limited. To address this, the Ministry of Health has initiated efforts to recruit more nurses, offer professional allowances, and create specialist nursing positions to support and retain healthcare professionals on the island.<sup>4</sup>

**Table 1: Top Five Health Workforce Occupations**

Job function	Number of filled positions
Doctors	11
Nursing personnel	30
Midwifery personnel	8*
Dentist	2
Pharmacist	2
<p><i>This table includes all HCWs practicing in the public sector in Montserrat.</i></p> <p><i>*Note these are the midwives currently practicing. However, there are another 10 nurses who are midwifery trained but have other clinical or administrative functions.</i></p>	

Given the constraints in specialised medical services, Montserrat relies on referrals to external institutions for tertiary care. Patients requiring advanced treatments are often referred to facilities in other Caribbean territories or to the United Kingdom’s National Health Service (NHS), as they have access to the NHS Quota System, facilitating referrals for specialised medical care.<sup>5</sup>

Montserrat collaborates with regional health organisations such as the Caribbean Public Health Agency (CARPHA) and Pan America Health Organisation (PAHO) to strengthen its health system. These partnerships focus on strengthening public health capacities,

<sup>4</sup> Montserrat Strengthens Efforts to Recruit and Retain Nurses.” *Discover Montserrat*, 26 Feb. 2025, <https://discovermni.com/2025/02/26/montserrat-strengthens-efforts-to-recruit-and-retain-nurses/>

<sup>5</sup> Department of Health (UK). *Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery*. Jan. 2012, [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216560/dh\\_134545.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216560/dh_134545.pdf)

improving regulatory systems and ensuring access to quality medicines and health technologies. They also play a role in supporting expertise, and training initiatives around disease surveillance, emergency preparedness and community health education. The Ministry of Health and Social Services leads efforts around public health training and capacity which is ad hoc in nature, following the strategic direction of the organisation providing the training.

For higher education, the Montserrat Community College offers programs in various fields including business, information technology, and general studies, enabling students to pursue associate degrees and diplomas. Additionally, the University of West Indies (UWI) Open Campus provides distance learning opportunities. A majority of individuals who pursue medical studies attend UWI campuses in Jamaica, Barbados or Trinidad and typically come back to Montserrat. Some choose to study in the United Kingdom, where the educational pathway is often longer, and many continue to specialise and settle abroad. However, when education is funded by the Montserrat government, there is a requirement for graduates to return and serve on the island.

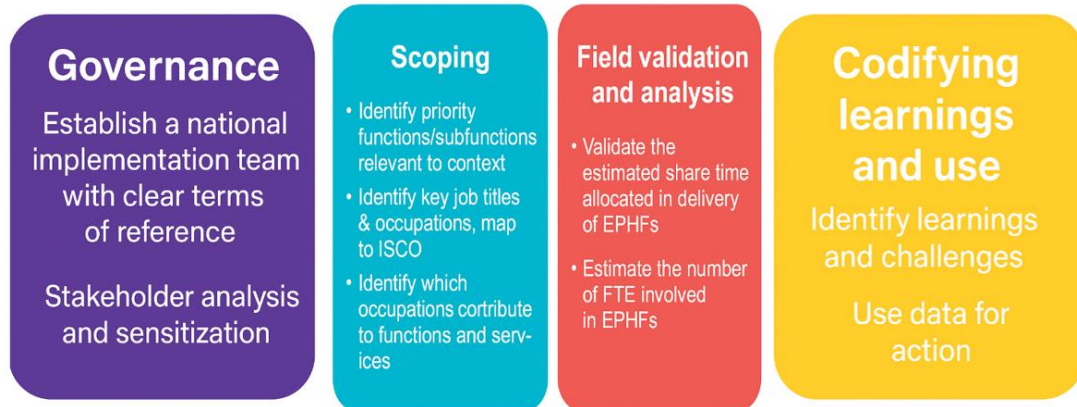
Majority of doctors on island are not local, with there being a total of 11 doctors within the public system, with 8 on contract (non-local staff), who commit from 1 to 3 years. However, the lack of local training and education facilities on island presents significant barriers to understanding and managing the public health workforce, particularly in regard to succession planning.

### 3. Implementation approach

The implementation of the mapping and measurement of occupations process<sup>6</sup> consisted of four phases with the key steps taken under each phase shown in **Figure 4**.

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<sup>6</sup> Essential public health functions: a guide to map and measure national workforce capacity. Geneva: World Health Organization; 2024. <https://iris.who.int/handle/10665/376578>



**Figure 4: Implementation approach**

### 3.1 Phase I: Governance

#### **Sensitisation of the Ministry of Health on the roadmap process.**

WHO presented on the Roadmap during the UKOTs June 2023 Public Health Conference in which Montserrat demonstrated interest to pilot the approach and methodology. This coincided with UKHSA plans to support Montserrat with strategy development, alongside ongoing nursing and healthcare support workforce strengthening and upskilling initiatives. After further meetings with the Chief Medical Officer (CMO) and Permanent Secretary (PS), additional stakeholders across the Ministry of Health and Social Services (MOHSS) were identified and attended a sensitisation session on 24<sup>th</sup> October 2023. The session was led by WHO and focused on briefing stakeholders on the Roadmap and its conceptual approach, understanding the workforce delivering the EPHFs, what mapping and measurement of occupations is, including its importance and the methodology, the progression model from benchmarking to improvement and full implementation, and the expected outcomes.

#### **Setting up the implementation team.**

Afterwards, the indicative terms of reference (ToR) developed by WHO was shared with CMO and PS to invite relevant stakeholders in public health emergency response, health workforce planning, coordination, management, and education, with an emphasis to bring together a diverse group to participate in the mapping process. Key stakeholders were invited to participate in a two-day facilitated workshop.

The implementation team included 17 stakeholders from across the Ministry of Health and Social Services, Ministry of Agriculture, Lands, Housing and Environment, Ministry of Finance and Economic Management, and Police Department. There was also presence from a UKHSA field epidemiology training programme (FETP) graduate who was on contract in Montserrat. The implementation team served as the key coordination and governance mechanism to conduct the mapping exercise.

### 3.2 Phase II: Scoping

**Orientation of the implementation team on the technical guidance**, facilitated by UKOTs Public Health Team Workforce Development Lead and Senior Programme Officer, with input and recommendations from WHO, took place on the 31<sup>st</sup> of October and 1<sup>st</sup> November 2023. The objectives were to orient the team on the technical guidance<sup>7</sup>, including the methodology and tools for mapping and measurement.



*Implementation Team on Day 2 of the Workshop*

**Identification of the priority functions and sub-functions** was completed during the workshop. First, stakeholders mapped relevant ministries and departments to the EPHFs. This process facilitated rich discussion and highlighted the interconnectedness and cross-ministerial and departmental involvement in Public Health and the roles in delivering EPHFs. Discussions emphasised that while many institutions and departments contribute to delivering the EPHFs, the ultimate responsibility for their delivery rests with the MOHSS. **Table 2** outlines the institutions and departments that contribute to each EPHF in Montserrat.

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<sup>7</sup> Essential public health functions: a guide to map and measure national workforce capacity. Geneva: World Health Organization; 2024. <https://iris.who.int/handle/10665/376578>

**Table 2: Mapping institutions to Essential Public Health Functions (EPHFs)**

<b>Essential Public Health Function</b>	<b>Institution / Department Responsible for Implementing</b>
<b>Public health intelligence:</b> monitoring and evaluating population health status, health service utilization and surveillance of risk factors and threats to health	Ministry of Health & Social Services (MOHSS), Statistics Department, Department of Agriculture, CARPHA, PAHO, UKHSA, Organization of Eastern Caribbean States (OECS), Police
<b>Public health emergency management:</b> managing public health emergency	MOHSS, Disaster Management Coordination Agency (DMCA), Ministry of Finance & Economic Management (MOFEM), Caribbean Disaster Emergency Management Agency (CDEMA), CARPHA, PAHO, UKHSA, OECS, Ministry of Communications, Works, Energy, & Labour (MCWLE), Airport and port authority, Montserrat Volcano Observatory (MVO), Ministry of Agriculture, Land, Housing & the Environment (MALHE)
<b>Public health governance and legislation:</b> assuring effective public health governance, regulation, and legislation	MOHSS, Legal Dept, Office of the Deputy Governor (ODG), MOFEM, Cabinet, Legislative Assembly
<b>Public health planning and financing:</b> supporting efficient and effective health systems and multisectoral planning, financing and management for population health	MOHSS, MOFEM (Trade), MALHE
<b>Health protection:</b> protecting populations against health threats, including environment and occupational hazards, communicable and non-communicable diseases, food safety, chemical and radiation hazards	MOHSS, MALHE, MCRS (customs & finance), MCWLE (Labour), Royal Montserrat Defence Force (RMDf), CARPHA, OECS, UKHSA, Police & Fire, Cabinet, Legal Department
<b>Disease prevention and early detection:</b> promoting prevention and early detection of diseases (communicable and noncommunicable)	MOHSS, primary & secondary care, MALHE, community organisations, Red Cross (NGO), Legal Dept, Cabinet, Legislative assembly, Police & fire
<b>Health promotion:</b> Promoting health and well-being and actions to address the wider determinants of health and inequity	MOHSS, Ministry of Education, Youth Affairs & Sports, community members/groups, private media houses, health conscious clubs, faith based organizations, NGOs, PAHO, CARPHA, MALHE, Government Institution Unit (GIU)
<b>Community participation:</b> Ensuring community engagement, participation and social mobilization for health and well-being	MOHSS, public & private media, DMCA, police dept, UWI, Community groups
<b>Public health workforce:</b> Ensuring adequate quantity and quality of public health workforce	MOHSS, ODG (HRMU), Education, MOFEM, external agencies, UWI, MCC, MSS (secondary school)
<b>Health services quality and equity:</b> Assuring quality of and access to health services	MOHSS (headquarters), private health service providers including overseas providers (doctors, pharmacist, dentist, lab, technicians, technologist), cabinet, Legal dept, overseas govt agencies, Legal Department Government of Montserrat (LEGAS)
<b>Public health knowledge and research:</b> Advancing public health research	MOHSS, PAHO, OECS, CARPHA, UKHSA, UWI, MALHE, Statistics dept
<b>Use of and access to medical products and technologies:</b> Ensuring equitable access to and rational use of essential medicines and other health technologies	MOHSS, MOFEM, OECS – PPS, police, Montserrat Customs & Revenue Service (MCRS), PAHO, international narcotics control board

Due to limited resources and time availability, Montserrat decided to take a phased approach, and start with the priority EPHFs. A prioritisation exercise was undertaken to identify the top three priority EPHFs to focus on first. This process was guided by the contextual knowledge of the territories' health priorities, policies, strategies and plans. The top three priorities among stakeholders were:

1. Public Health Intelligence
2. Public Health Planning & Financing
3. Public Health Workforce

*"It allowed an insight into the positions and the roles of individuals with critical health functions" -  
Workshop Attendee*

**Identification of the job titles and occupations in the public health workforce groupings** were conducted on day two of the workshop. Participants were placed in groups and identified principal job titles and occupations that contributed to each of the three EPHFs. Then as a group they agreed on the job titles and mapped them to the individual sub-functions they contributed to.

**Reflection on mapping:** This process was difficult due to individuals having a broad range of responsibilities that complicated which group to place the participant in, as they often held multiple roles and job titles. For example, one Public Health Nurse was currently acting as the Community Nursing Manager due to the current Community Nursing Manager acting as the Director of Nursing to fill a retirement gap in the service. Another example is a recent Public Health Nurse graduate who should be focusing primarily on EPHFs and community outreach, but because she is also trained as a midwife, she is frequently pulled into clinical duties.

**Mapping of the national job titles to align with the occupation groups listed in the International Standard Classification of Occupations (ISCO) and Identification of the sources of headcount (stock) of personnel** in the job titles involved in the delivery of the EPHFs and/or estimation of the stock. The International Standard Classification of Occupations (ISCO) is a system developed by the International Labour Organization (ILO) to categorise and classify occupations worldwide. It provides a standardised framework for organising and comparing different types of jobs, facilitating labour market analysis, workforce planning, and international cooperation in labour-related matters. This part of the methodology was conducted offline by UKHSA using data from secondary sources, information shared by Montserrat stakeholders, and through conversations with Ministry of Health and Social Services. It was decided to conduct this portion offline to utilise the limited time in-person workshops to have discussions and focus on mapping of job titles.

### 3.3 Phase III: Validation

The four days after the stakeholder workshop, interviews and observations were conducted with health care workers and other key roles to validate the data collected in the workshop, to estimate percentage of time spent on EPHFs, to understand training needs and where gaps lie, and to gather any additional reflections or insights. Two interviews were held at a later date virtually over Microsoft Teams. A survey shared by WHO was adapted and formed the interview guide.

## 4. Findings

#### 4.1 Priority EPHFs and sub-functions

EPHFs encompasses a range of core activities aimed at protecting and improving population health. By focusing on these functions, the Government of Montserrat can better target interventions to improve health outcomes and strengthen preparedness for future public health emergencies and pandemics. **Table 3** outlines the subfunctions for the selected three priority EPHFs.

1. **Public Health Surveillance and Monitoring:** Monitoring and surveillance of population health status, risk, protective and promotive factors, threats to health and health system performance and service utilization.
2. **Multisectoral Planning, Financing and Management for Public Health:** Supporting effective and efficient health systems and multisectoral planning, financing and management for public health.
3. **Public Health Workforce Development:** Developing and maintaining an adequate and competent public health workforce.

*Table 3: Essential public health functions and subfunctions prioritised in Montserrat*

Essential public health functions	Subfunctions
<b>EPHF 1: Public health intelligence</b>	Subfunction 1.1: Planning for public health monitoring and surveillance
	Subfunction 1.2: Routine and systematic collection of public health data
	Subfunction 1.3: Analysing and interpreting available public health data
	Subfunction 1.4: Communicating public health data, information and evidence with key stakeholders including communities
<b>EPHF 4: Health systems and multisectoral planning and financing</b>	Subfunction 4.1: Conducting evidenced based health system planning and prioritization for managing population health needs, including alignment of national strategies, policies and plans for the public health
	Subfunction 4.2: Promoting integrated cross-sectoral prioritization and planning for public health with intersectoral accountability mechanisms and health-in-all-policies approach to manage population health needs
	Subfunction 4.3: Promoting sustainable and integrated financing for public health, by improving the generation, allocation and utilization of public and pooled funds to strengthen health systems foundational capacities in all contexts

Mapping Montserrat's Workforce Capacities to Implement the Essential Public Health Functions

	Subfunction 4.4: Planning and developing appropriate infrastructure for meeting population health needs
	Subfunction 4.5: Monitoring and evaluating policies, plans and financing of health system and multisectoral efforts for health that improve public health, promote equity and inclusion and strengthen resilience
<b>EPHF 9: Public health workforce</b>	Subfunction 9.1: Undertaking planning, and regular monitoring and evaluation of the public health workforce in relation to size, distribution and qualifications required to meet population health needs
	Subfunction 9.2: Educating and training of the public health workforce that encompasses the full spectrum of public health competencies (e.g., technical, strategic and leadership skills), including development of essential competencies for intersectoral work for health and for emergency response
	Subfunction 9.3: Promoting the sustainability of the public health workforce

	PUBLIC HEALTH INTELLIGENCE				HEALTH SYSTEMS, PLANNING & FINANCING					PUBLIC HEALTH WORKFORCE DEVELOPMENT		
group 1	1.1	1.2	1.3	1.4	4.1	4.2	4.3	4.4	4.5	9.1	9.2	9.3
Chief Medical Officer												
Epidemiologist												
Surveillance officer												
group 2												
PEHO (principal environmental health officer)												
Director Primary Health Care												
Director Secondary Health Care												
Director of Nursing												
Permanent Secretary for Health												
Community nursing manager												
Medical technologist												
Health promotion coordinator												
Health information officers												
Medical officer (doctors, GPs)												
Medical specialist (specialist DR - OBGYN, surgeon)												
Nursing professionals												
Dental surgeon												
Pharmacist												
Hospital nursing manager												
group 3												
Chief vet officer												
Environmental health officers												
Statistician												
Agricultural officers												
Livestock officers												
Traffic department and beat patrol (sergeants and constables)												
Data information officer												
MUL (water authority)												
Lab technicians (testing & treatment are different)												
CHRO (Chief Human Resources)												
Deputy Governor (DG)												
Financial Secretary												
AG (legal department rep)												
Assistant secretary (financed assigned by MOHSS)												
Director of Policy and Planning (MOHSS)												
Chief physical planner												
Head of PMO												

Figure 5: Identified core public health personnel and their roles and responsibilities in relation to the EPHFs

Figure 5 demonstrates that most occupations contribute to multiple sub functions, highlighting the importance of integrated planning and policymaking for the public health workforce. During the initial the mapping exercise stakeholders assigned many roles to group 1. However, following further discussion with WHO, some roles were reclassified to better align with the group definitions and ensure more accurate representation.

#### 4.2 Identified and mapped workforce to ISCO and EPHFs

##### Mapping of workforce occupational groups to ISCO

Table 4 presents the mapping of the health workforce to the ISCO classification based on findings from the workshop and discussions with WHO. This evidence supports appropriate comparison of the health workforce occupations between different geographical areas.

**Table 4: ISCO classifications**

Job title in Montserrat	International Standard of Occupations (ISCO-08) occupational group title	International Standard Classification of Occupations (ISO-08) group code	Stock of qualified and registered
<b>Group 1</b>			
Chief Medical Officer	Managing Director and Chief Executive	1120	1
Epidemiologist*	Healthcare Professionals not elsewhere classified	2269	0
Surveillance officer	Healthcare Professionals not elsewhere classified	2269	1
<b>Group 2</b>			
PEHO (principal environmental health officer)	Environmental and occupational health and hygiene professionals	2263	1
Community Nursing manager	Health Services Manager	1342	1
Director of Nursing	Health Services Manager	1342	1
Permanent Secretary for Health	Senior Government Official	1112	1
Director Primary Health Care	Health Services Manager	1342	1
Director Secondary Health Care	Health Services Manager	1342	1
Medical technologist	Medical and pathology laboratory technicians	3212	5
Health promotion coordinator		2269	1
Health information officers	medical records and health information technicians	3252	1
Medical officer (doctors, GPs)	General Medical Practitioner	2211	5
Medical specialist (specialist DR – OBGYN, surgeon)	Specialist Medical practitioners	2212	5
Dental surgeon	Dentist	2261	2
Pharmacist	Pharmacist	2262	2
Nursing professionals	Nursing Professionals	2221	33
Hospital nursing manager	Health Service Managers	1342	1
<b>Group 3</b>			
Environmental health officers	Environmental and Occupational health and Hygiene Professional	2263	2
Chief vet officer	Health Services Manager	1342	1
Statistician	Mathematicians, actuaries and statisticians)	2120	4

## Mapping Montserrat's Workforce Capacities to Implement the Essential Public Health Functions

Agricultural officers	Agricultural and Forestry Production Managers	1311	3
Livestock officers	Agricultural and Forestry Production Managers	1311	3
Commissioner of Police	Police Chief Constable	1112	1
Traffic department and beat patrol	Police Officers	5412	24
Data information officer	Medical records and health information technicians	3252	2
Wastewater operators and water distribution (potable water)	Incinerator and Water Treatment Plant Operators	3132	15
Lab technicians (water)	Environmental Protection Professionals	2133	1
CHRO (Chief Human Resources Officer)	Human Resource Managers	1212	1
Deputy Governor (DG)	Senior Government Official	1112	1
Financial Secretary	Finance Manger	1211	1
Assistant secretary (financed assigned by MOHSS)	Administrative and Executive Secretaries	3343	2
Director of Policy and Planning (MOHSS)	Policy and Planning Managers	1213	1
Chief physical planner	Senior Government Official	1112	1
Head of PMO (project management office)	Senior Government Official	1112	1

\* note: there is an epidemiologist currently training in the UK

### 4.3 Mapping for health and care workers contributing to public health functions

The health and care workers who contribute to one or more EPHF in Montserrat are presented in Figure 5. They include doctors (including specialist), nurses, medical technologist, surveillance officers, environmental health officers, and agricultural officers. Additionally, due to Montserrat's size and the way in which it works with external agencies and governments, representation from PAHO, CARHA, UKHSA, FCDO and UWI play a critical role when it comes to EPHFs, particularly around health systems planning and financing and public health workforce development.

The majority of Public Health Intelligence is split across Group 1 Occupations from Ministry of Health and Social Services, with Group 2 and 3 contributing mainly to sub-functions 1.2, 1.3 and 1.4. During conversations it was revealed ministries outside of health and social services are not aware of how they fit into public health and the public health system in Montserrat. Due to competing priorities and busy schedules, there is often not much communication across departments, so this exercise was helpful.

**Reflection:** Police officers were unaware of how they fit into public health, however during discussions the officers who joined were able to clearly see how data collected and reported to the CMO fed into public health intelligence and played a critical role in monitoring and evaluating population health status and threats to health.

Additionally, participants from the housing department originally felt their role was not critical to public health, but after further discussion realised that living conditions are an important social determinant of health. Safe housing can protect people from health hazards such as lead, mould and poor ventilation. Stable housing is essential for maintaining physical and mental health and accessing healthcare services. And during home visits, these personnel are often privy to first signs of any concerns or hazards and can make referrals to appropriate healthcare providers or flag safeguarding concerns.

Majority of Public Health Planning and Financing fell within the remit of the CMO, PS Directors of Primary and Secondary health care, Director of Nursing and Community Nursing Manager, Principal Environmental Health Officer, with input from external representation. The biggest gap seems to be under subfunction 4.4 which focuses on planning and developing appropriate infrastructure for meeting population health needs.

**Note:** Currently Montserrat's main hospital is in a transformed primary school. However, plans are underway for a new hospital to be built, starting in 2025. This will be a modern, state-of-the-art facility, providing a range of medical and surgical services across approximately 57,817 square feet, including in-patient, outpatient, emergency care, maternity care, diagnostics services (with CT and mammography), and specialist clinics. During interviews, many workers noted the addition of the hospital and full implementation of the electronic health information system (EHIS) will solve many of the current issues.

Much of the public health workforce development training and upskilling takes place informally and on the job. Across the Eastern Caribbean Countries residents have two public choices for local/regional further education, Community Colleges and the University of the West Indies. Additionally, some residents have access to offshore universities. However, Montserrat differs from this model with few students attending the local UWI branch and choosing to go overseas for tertiary education. The Community College used to offer training for nurses and nursing assistants, however this is no longer the case.

External organizations such as CARPHA, PAHO and UKHSA offer additional opportunities for upskilling, training, and professional development. However, there is no standardization, and this seems to be on an ad-hoc and as needed basis. Furthermore, opportunities vary for contract and local staff, which will be covered in further detail later.

**4.4 Estimation of the share of time spent in the implementation of the EPHFs** was conducted with a sample of health and social workers during interviews and surveys. A purposive sample of health workers at various levels within Montserrat provided insights on the EPHFs they contribute to, the estimated of percentage of time they spend on these within a year, and how they gained the competence to deliver them.

Overall, there were no major discrepancies from the survey and data gathered during the workshop. **Table 5** shows that medical doctor with IPC focus, medical technologist, and social workers spend 10-20% of their time on EPHFs, Nurse educator and surveillance officer spend 20-50% of their time on EPHFs, Pharmacist and Public health nurse spend 50-75% of their time on EPHFs, general medical doctor in the casualty department, the Permanent Secretary for Health, Assistant Secretary, Finance, Director, Strategic Management, Policy & Planning and Public Health Nurse who is acting Community Nursing Manager spend 75-99% of their time on EPHFs, whereas the Chief Medical Officer spends 100% of time on EPHFs. Due to the small population and small nursing workforce, much of the clinical nursing roles span across specialities. Unlike the UK where nurses usually specialise or focus in a particular area, nurses in Montserrat are responsible for responding to a range of specialities and in many instances are additionally acting as Managers and Educators.

**Reflection:** In small island states there is often a complexity that is missed, as it is not a matter of taking a percentage of someone's time to work on something else. Influence of political will and conflicting priorities with health, clinical demands and keeping up with continuing professional development and continuing medical education all play a role.

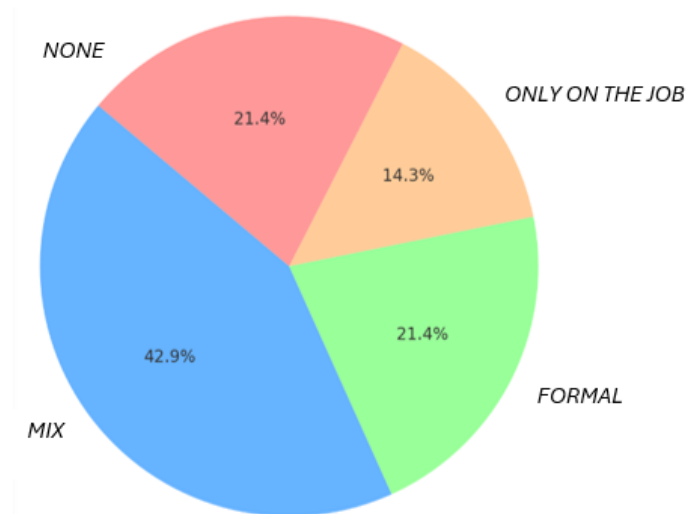
**Table 5: Distribution of time spent on EPHFs by Job Title**

OCCUPATION / JOB TITLE	PERCENTAGE OF TIME SPENT EPHFs
Doctor, IPC Coordinator	10 – 20 %
Medical Technologist	10 – 20 %
Social Worker, Social Work Mentor	10 – 20 %
Nurse, Nurse Educator	20 – 50%
Surveillance officer	20 – 50%
Nurse, Public Health Nurse	50 – 75%
Pharmacist, Senior Pharmacist	50 – 75%
Director of Primary Health Care	75 – 99%
General Medical Doctor	75 – 99%
Nurse, Public Health Nurse / Community Nursing Manager (AG)	75 – 99%
Permanent Secretary for Health	75 – 99%
Assistant Secretary, Finance	75 – 99%
Director, Strategic Management, Policy & Planning	75 – 99%
Chief Medical Officer	100%

Furthermore, it was important to understand how respondents received education and skills to deliver EPHFs. **Figure 7** presents information on how the personnel reported to have gained knowledge and competency to deliver on the EPHFs. The responses include formal training from education, informal on the job training, a mix of both formal training and informal on the job training, and no training received at all.

During interviews majority of respondents mentioned receiving training on some subjects as part of their formal education, whether a degree or certificate, or a public health course while studying. Additionally, it was noted they are able to access refresher training while working from external bodies such as CAPRHA, OECS, and UKHSA. However, one respondent noted that they received refresher training while working on a different island but not since being in Montserrat and another stated that they have not received any training on EPHFs either from formal education or on the job. One respondent was hired during COVID-19 due to an urgent need and was trained purely on the job, which is usually defined by the manager as there is no standardised approach.

**HOW RESPONDENTS RECEIVED EDUCATION & SKILLS TO DELIVER EPHFS**



**Figure 7: How respondents received education and skills to deliver EPHFs**

**A recommendation** that arose from survey's was that training should be standardised, and all employees should possess the requisite competencies that are essential for public health practice. Creating a framework for annual learning and development, especially around EPHFs, will ensure all personnel are upskilling and prepared.

## 5. Feedback on the process

### 5.1 Phase IV: Codifying learnings and use

#### Feedback from the stakeholder workshop

Overall, feedback was positive from the workshop with most stakeholders agreeing the methodology was very useful and provided insight and clarity on the various groups involved in public health. The facilitated discussion and group work allowed for stakeholders to understand the interconnectedness of roles and their part in public health response in Montserrat. While there was a broad range of stakeholders, it was noted that having a wider variety would have been useful with mapping, particularly having more representation from finance.

**On the workshop:** *"It gave me an opportunity to reflect on all the public health functional areas. Looking forward to the next phase of the process"*

*"The workshop was informative and formed a good basis for establishing our baseline. Persons engaged and participated well. A wider representative however would have been more effective in data gathering."*

However, while many found the methodology useful, it was noted that some of the terms may need to be reclassified for small islands and stakeholders found it difficult to place certain roles in groups due to the individual performing several functions due to gaps in the workforce. This was validated during interviews with a Public Health Nurse mentioning they frequently step into clinical roles and also in a more strategic position it was highlighted that people often step in to fill gaps as needed.

**On the gaps:** *"The exercise did reveal the small number of staff wearing many different hats"*

*"[Management] doesn't realize how understaffed the services are because we step in to fill the gaps"*

*"We help each other out where we fall short, so we don't fall at all"*

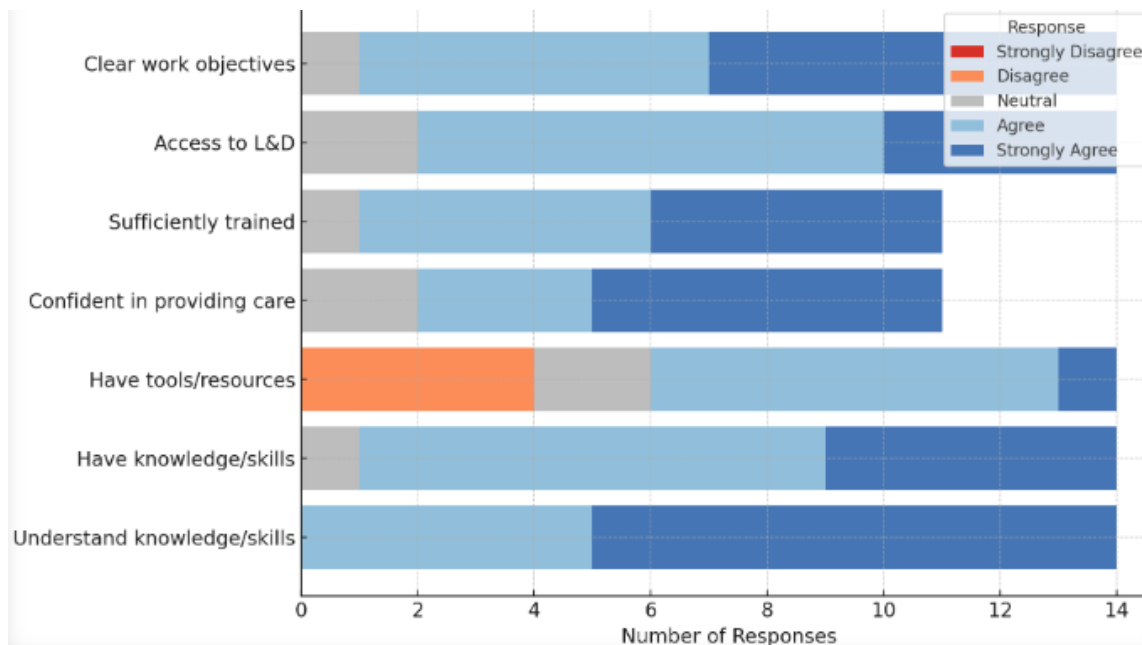
*"Everyone is versatile and takes on additional tasks. [Finance] take on aspects of HR though role is technically finance."*

Furthermore, the Director of Primary Care was previously the national epidemiologist. At present, the only epidemiologist on island is a short-term contract from UKHSA so during the COVID-19 response the Director of Primary Care was called in as an epidemiologist and the Primary Care functions fell behind, such as primary care budgets and reports as COVID numbers took priority. This becomes an issue in terms of succession planning as epidemiology skills are not a requirement of the Director of Primary Care. Currently, the epidemiologist role is incorporated into the director role until a Montserratian studying epidemiology at London School of Hygiene and Tropical Medicine (LSHTM) returns to fill the gap.

The process around hiring impacts the workforce as urgently needed staff can take several months to be on-boarded. However, persons can be on contract for up to 3 years. If a new post is to be created a business case needs to be submitted and new spend request sent during annual budget submissions, and it can take 6 months or more for approval. Additionally, the challenge of not increasing headcount but shuffling roles (for example, giving up a cleaner role to hire a surveillance officer), leads to long periods of time with vacant, although approved roles, and other personnel picking up the gaps, meaning they often go unrecognised as they are often absorbed by other staff members. However, this can lead to burnout and is not a sustainable way to function.

### Feedback from interviews

In addition to validating the time spent on EPHFs, it was important to understand whether people comprehend what knowledge and skills were required to do their job effectively, if they had the knowledge and skills, and if they felt sufficiently trained.



**Figure 8: Participants' self-reflection on job skills, knowledge, opportunities, and resources**

As shown in **Figure 8**, majority of participants strongly agreed that they understood the knowledge and skills required to do their job effectively and they felt confident in their abilities to do their job. Additionally, majority of participants felt they received adequate training and could access learning and development opportunities. However, 33% of participants felt they did not have tools and resources to effectively carry out their role. Reasons cited were both in terms of human resources and physical resources. Some also stated relying heavily on external knowledge and experience and wished staff had more access to specialized training. It was noted that staff on contracts did not have equal access to learning and development opportunities and funding usually went to local staff, despite Montserrat heavily relying on contract staff.

### Functions or activities not in job description

Next, participants were asked if they spent more than 10% of their time on activities which were not a core part of their job description. Not surprisingly, 75% of participants said yes with most of the tasks mentioned being administrative, such as nurses collecting money following procedures, file management and stock management. However, it was recognised many of these should be resolved when the EHIS is fully implemented and with the opening of the new hospital. Two participants mentioned their job description was so broad that almost any task could fall under it. Furthermore, while additional job posts have been approved, they have not yet been recruited so the reality on the ground is many people are working the jobs of at least 2 to 3 people.

### **What has been enjoyable about current training / development opportunities**

Majority of the participants had positive responses to current training and development opportunities. They felt they would be supported by their manager to undertake training and opportunities were offered and funded by the Ministry of Health. However, it was mentioned that it was hard to set aside dedicated time to focus, especially when undertaking online training as there was still expectations to respond to e-mails and answer phones. Multiple participants cited external resources such as UKHSA networks, CARPHA and PAHO as an important source for opportunities and technical engagement. Furthermore, working in a remote environment it was emphasized that networks provided an opportunity to sense check ideas, learn about the latest research and to feel connected and part of a group.

**Reflections on development opportunities:** *“Everyday there is something new to learn”*

*“Learn new skills, innovative ways to tackle issues, be more empathetic to needs of staff”*

*“Understanding public health, understanding policies that govern public health, and understanding what public health is all about.... being able to advance health policies and how they all work together to provide a more healthy population”*

### **What could be improved around training / development**

Training is seen as critical, especially in public health where research and trends are constantly evolving. The opportunity for new training was valued by all participants who said they would welcome additional training, both online and in-person. Nurses requested more exchanges to keep up skills and practice newly learned skills if specific cases are not seen in Montserrat. Participants asked for dedicated space and protected time be set aside for staff and stated training needed to be flexible with working hours. Almost all participants would welcome more support on core competencies, such as leadership, communication, and administration skills. This is supported by the quantitative findings from the survey which reveal 7.1% are neutral on the statement 'I have the knowledge & skills I need to do my job effectively' and 14% neutral, 29% disagree on 'I have the tools / resources I need to do my job effectively'.

Additionally, almost all participants mentioned a desire for training around mental health and wellbeing in addition to core competencies, such as time management, having difficult conversations, conflict resolution, and change management – particularly adapting to change in a changing environment.

### Reflections on improving upskilling and development of Montserrat's Workforce

*"From a health standpoint look at what is available for health workers in terms of their speciality. What is out there to make us do our jobs better? Looking for opportunities for health care staff to provide better health care and how they can deliver on the competencies that they are required to"*

*"...want to retain staff within Ministry of Health and keep the pool of people"*

## 6. Conclusion

In conclusion, this mapping exercised revealed much work is being accomplished despite small workforce numbers, however there is evidence of a siloed approach to the delivery of the EPHFs in terms of strategy, planning, financing, implementation, and workforce. Furthermore, there is lack of understanding of public health functions from government departments or teams outside of health delivery, and how they might be able to contribute. There has been a strong focus on acute health care services and service development with proportionately less focus and investment in strengthening population health services in the past, although some of this has been addressed during and after the pandemic response. This is partly attributable to institutional arrangements for the key delivery of public health functions through the Chief Medical Officer.

Additionally, nurses play a critical role in the delivery of EPHFs in Montserrat, and unlike the UK where nurses usually specialise or focus in a particular area, nurses in Montserrat are responsible for responding to a range of specialties and in many instances are additionally acting as managers, educators, and planning and developing policies. Additionally, lack of local training and education facilities on island presents significant barriers to understanding and managing the public health workforce, particularly in regard to succession planning. Concentrating on developing an overarching strategy or policies that coordinates the planning and delivery of the EPHFs across the system could support alignment of resources, workforce, initiatives, activities and accountability mechanisms.

## 7. Recommendations

### **Strengthen multi-sector governance, policy and planning.**

Montserrat has recognised the need to strengthen its workforce and emergency response structures following COVID-19, which falls in line with WHO highlighting the need for the institutionalization of emergency and disaster risk management programs in Ministry of Health as a priority, with reorganization of structures needed to strengthen EPHFs. In Montserrat an Emergency Response Committee is pulled together during public health

emergencies, such as COVID-19, and this usually falls on the CMO. The Ministry has a strategic plan for pandemic Influenza preparedness which outlines the establishment of a National Influenza Pandemic Planning & Preparedness Committee (NIPPPC) which is chaired by the Permanent Secretary for Health. This group has representation from a range of representatives in departments such as planning & coordination, animal health, population containment and communication, etc and could be used to strengthen emergency response.

More recently, a Public Health Advisory Board (PHAB) has been constituted and is chaired by the CMO including membership from agriculture/animal health and other public health professionals. As Montserrat does not have a Public Health Body, this committee can ensure each department has the necessary tools, technology, training and personnel to fulfil its responsibilities and formulates a space where issues, updates, and efforts can be shared. The International Health Regulations (IHR) require that all countries have the ability to detect, assess, report and respond to public health events. This is a legally binding agreement, and the formation of a governance body can ensure policies are in place as well as allow for proper planning. As it is difficult to sustain multiple committees due to members capacity with multiple responsibilities, this group can be utilised to ensure clearly defined roles during an emergency and WHO and UKHSA can support in reviewing and providing strategic input as needed.

### **Strengthen cross-departmental coordination, communication and data.**

Montserrat should utilise communication tools and platforms to facilitate quick and effective information exchange. Despite public health being a cross-cutting discipline, encompassing a wide range of fields and drawing on knowledge from various disciplines, a majority of departments work in silos and do not naturally recognise the contribution they make to improving public health. By strengthening communication and coordination, a more collaborative approach can be taken to address the multifaceted nature of health issues and in turn be better prepared to respond to public health emergencies.

Additionally, strengthening workforce data and evidence through digital health can support coordinated workforce planning efforts with other ministries. Leveraging the Human Resources Information System (HRIS) and ensuring this is up to date and accessible alongside with accurate reports and use of the Electronic Health Information System (EHIS) being introduced in the hospital.

Suggested cross-departmental activities include conducting a quarterly or annual simulated drill, after-action reviews (AARs) and/or tabletop exercises. This is an area where UKHSA can draw upon organisational expertise and support in facilitating ongoing efforts with Police and Fire and Rescue in Montserrat to ensure public health type simulations are included.

### **Improve education of the public health workforce.**

Improving competency-based education and capacity building for the public health workforce is critical for several reasons, including, but not limited to, enhanced preparedness and response, improved public health outcomes, and effective response to health challenges. Investing in lifelong learning is a strategic approach to building a resilient, knowledgeable and effective public health system capable of addressing diverse challenges. WHO has

recently published a competency and outcomes framework for the public health workforce, that can be used as a reference document for designing and delivering competency-based education programmes oriented to meet public health priorities, defining competency-based performance requirements for public health practice, and assessing the competence of personnel.<sup>8</sup> Furthermore, investing in jobs for the workforce can help to retain talent in Montserrat.

It is recommended that Montserrat develop and require standardised training for its public health workforce, including a focus on priority EPHFs. UKHSA can support this by adapting existing frameworks such as [Core Skills Training Framework](#) developed by NHS England which sets out a framework for healthcare organisations to guide and standardise the focus and the delivery of key statutory and mandatory training skills, the [Public Health Skills and Knowledge Framework](#) (PHSKF) to develop public health professional skills for the future, specialist frameworks developed by [UK Public Health Register, and Global competency and outcomes framework for the essential public health functions](#). The intention is to ensure consistent approaches, promote quality and delivery of training which, through the use of learning outcomes, should be more educationally focused and valued. UKHSA could work with Montserrat MOHSS to contextualise a framework to provide a national minimum standard for mandatory training in the health sector and the development of training and mentorship to support professional development and meeting competencies in these frameworks.

Secondly, in small islands it is difficult to support medical staff with continuous professional development as there is no training budget and difficult to get coverage when medical staff leave the island for training. It is recommended to offer integrated competency-based education and training programmes, on island, with support from various global and regional partners, such as WHO, PAHO, CARPHA and others, to address common gaps and challenges.

### **Develop a workforce development strategy.**

Lastly, it is vital to develop Montserrat's Public Health Workforce Development Strategy. This will serve as a comprehensive plan to strengthen and enhance the capabilities of the public health workforce. Data gathered from the Mapping & Measurement process can serve as a baseline and UKHSA, along with support and input from WHO can help shape and frame the strategy. As Montserrat took a phased approach, this report only focuses on three EPHFs. The next steps would be to assess the other EPHFs to inform a comprehensive strategy.

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<sup>8</sup> Global competency and outcomes framework for the essential public health functions. Geneva: World Health Organization; 2024. <https://iris.who.int/handle/10665/376577>

Investing in a strengthened and capable workforce is essential for building resilience in emergencies. While the initial cost may seem high, the benefits far outweigh it. A well-trained and supported workforce can effectively respond to crisis, minimise danger and save lives. However, relying on people to overwork undermines resilience as exhausted employees are less efficient, motivated, prone to errors and at higher risk of burnout. A strategy which outlines the way in which Montserrat will train the workforce and prioritize well-being and sustainability is crucial for enhancing resilience and ensuring effective response and recover efforts in times of public health crisis. Drawing on support and maximising synergies between WHO, PAHO, CARPHA, UKHSA and other external organisations can support in driving this forward.

With the rewriting of the Public Health Act, the construction of a new hospital, the implementation of an EHIS and various upskilling and capacity-building initiatives for the nursing workforce, this is an opportune time to shape the future of Montserrat's public health workforce – making it more resilient, adaptable and equipped to address the diverse and complex challenges in public health.

# About the UK Health Security Agency

UKHSA is responsible for protecting every member of every community from the impact of infectious diseases, chemical, biological, radiological and nuclear incidents and other health threats. We provide intellectual, scientific and operational leadership at national and local level, as well as on the global stage, to make the nation health secure.

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