

Pacific Heads of Health Meeting

Réunion des directeurs de la santé du Pacifique

REPORT OF THE 7TH PACIFIC HEADS OF HEALTH MEETING

(Denarau, Fiji, 3–5 April 2019)

Report prepared by the Pacific Community, 2019



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7th PACIFIC HEADS OF HEALTH (PHOH) MEETING

3–5 April 2019, Denarau, Fiji

Report of meeting

1 Opening

1. Welcome – PHOH Chair, Dr Merehau Mervin, Deputy Director, Ministry of Health, French Polynesia, welcomed participants.
2. **Participants** – PHOH was attended by representatives from: Australia, Cooks Islands, Federated States of Micronesia (FSM), Fiji, French Polynesia, Kiribati, Marshall Islands (RMI), Nauru, New Caledonia, New Zealand, Niue, Palau, Papua New Guinea (PNG), Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, United States of America and Vanuatu. Partner agencies represented included: the Asian Development Bank, Australian Department of Foreign Affairs and Trade (DFAT), New Zealand Ministry of Foreign Affairs and Trade (MFAT), Pacific Community (SPC), World Bank (WB) and World Health Organization (WHO). Observers came from the Auckland Regional Health Service, Fiji National University (FNU), Commonwealth Secretariat, Japan International Cooperation Agency (JICA), Fiji Office, Joint United Nations Programme on HIV/AIDS (UNAIDS), McCabe Centre for Law and Cancer, Ministry of Health, Labour and Welfare, Japan, Otago University, Pacific Island Health Officers' Association (PIHOA), Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM), Royal Australasian College of Surgeons (RACS), United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA) and the University of Fiji. (Annex C provides a list of participants.)
3. **Keynote address** – Dr Siale 'Akau'ola, Chief Executive Officer, Ministry of Health (MOH), Tonga, reminded the meeting of its role as a key authority for Pacific health. The Healthy Islands vision that was developed when Pacific Heads of Health first met in 1995 embodies a holistic approach that is still relevant and in fact mirrors the Sustainable Development Goals. As part of achieving the vision, countries are working towards universal health coverage (UHC), with better access to primary health care. Indicators show that progress is being made in many areas, but equally there are many challenges, including ensuring that other government sectors, such as finance, trade, environment and education, address the determinants of health that are outside the health sector.
4. **Remarks on behalf of the Secretariat and implementing partners:** Dr Corinne Capuano, WHO Representative for the South Pacific and Director, Pacific Technical Support Division, said SPC and WHO are committed to working collaboratively with countries. While advancements have been made, climate change and non-communicable diseases (NCD) are increasing health needs. Strong health systems based on good primary health care are required to address NCDs, as are innovative ways of providing for health needs.
5. Health should be at the centre of efforts to address climate change, and policy-makers in other sectors must be made aware of the health impacts of their decisions. The same applies to provision of emergency care. The Pacific Health Security Coordination Plan (PaHSec), based on a multi-sectoral platform for addressing hazards, is accelerating implementation of the International Health Regulations (IHR).
6. There has been progress towards the goal of UHC. This goal will be supported by the meeting's discussions of health information systems and e-health, regulation of medicines,

and overseas medical referrals, and greater collaboration between countries on these issues. As well as improving health care, such initiatives could significantly reduce costs.

7. As part of their evolving role in ensuring a cohesive approach to improving Pacific health, PHOH must carefully consider the essential points to be put before the Pacific Ministers of Health Meeting (PHMM) in August.

Recommendations

8. PHOH:
 - i. acknowledged the strategic role of Pacific Heads of Health in providing advice to Pacific Ministers of Health, including on essential multi-sectoral approaches;
 - ii. recognised the continued relevance of the Healthy Islands vision, including to achieving the Sustainable Development Goals.

2 Directors of Clinical Services Meeting

2.1 Overview and recommendations of Directors of Clinical Services Meeting

9. The secretariat presented the recommendations from the Directors of Clinical Services (DCS), who met on 1 and 2 April 2019 at the same venue, noting that the terms of reference for the DCS meeting will be revised to include all 22 Pacific Island countries and territories (PICTs) instead of only 14 countries as at present. (Annex B provides the full list of DCS recommendations.)

Discussion

10. The following clarifications were made in response to comments on the DCS recommendations:
11. **Improving standards for nurses' education** – Data skills (collection, analysis and use) will be included in bachelor degree programmes in response to the need for health information, including at the primary care level. Development of mechanisms allowing recognition of relevant prior learning are considered important for older nurses who have experience but lack the formal qualifications required under the new standards. Potential mechanisms for recognition of prior learning will depend on the tertiary education provider and the relevance of the experience (e.g. for a midwife undertaking child health studies).
12. **Pathology and ENT** – Reflecting the increasing capacity of regional health providers, the Pacific Island Society of Pathology (PISP) and Pacific ENT Advisory Group (PENTAG) were both formed in 2018 to strengthen services and support continuing professional development.
13. **Overseas medical referral (OMR)** – PICT systems for OMR vary in terms of assessment criteria, cost effectiveness and referral location (locations include Australia, New Zealand, India, Philippines and Taiwan). The following points were made:
 - OMR should be overseen by PICT Directors of Clinical Services.
 - OMR is a significant cost for national health systems and could become a standing item on the DCS agenda.

- Sharing of information on OMR between PICTs would give a better picture of total referrals and costs. A high number of referrals are for surgery and oncology treatment because at present there are only two oncologists practising in the region. Knowing the total costs for overseas treatment of oncology patients could show the feasibility of establishing some of the required services in PICTs.
 - Improving information sharing could also give PICTs more leverage on costs, e.g. there is evidence that some PICTs pay more than others for the same service/provider.
 - There are concerns about anti-microbial resistance (AMR) with patients returning from locations outside the region.
14. **Regulation of medicine** – Establishment of pharmaceutical governance for comprehensive regulatory strengthening at the national and subregional level was recommended.
- Australia commented that financing for such a mechanism needs to be in place before making a recommendation to Ministers and suggested WHO may be able to provide support.
 - WHO responded that the subregional platform could take various forms (there are several models elsewhere, e.g. the Caribbean). The platform and its possible components need further discussion, including of funding options.
 - Tuvalu called on other partners to assist, noting that UNICEF already supports vaccine procurement and has systems in place.
15. **Pacific Islands Program/Royal Australasian College of Surgeons (RACS)** – As part of responding to the World Health Assembly Resolutions, MOH were recommended to consider developing National Surgical, Obstetric and Anaesthesia Plans as a tool for improving outcomes. Australia’s support for the RACS’ Pacific Islands Program for over 25 years was acknowledged. In that time, the Program has evolved, moving from providing outreach surgical services to now supporting the region’s own specialists.
16. **Medical Regulation** – A survey of each PICT’s current regulatory framework and legislation for health professionals was recommended as a step towards establishing a best practice model for medical regulation. In response to Vanuatu’s question on timing, a time frame of one year was set for the survey to be done.

Recommendation

17. PHOH endorsed the recommendations from the meeting of Directors of Clinical Services (Annex A), including the revision of the terms of reference for the meeting to now include all 22 Pacific Island countries and territories (PICTs).

2.2 Pacific Regional Emergency Care (EC): Priorities and Standards for Development

18. Dr Georgina Phillips, Chair of the International Emergency Medicine (EM) Committee of the Australasian College of Emergency Medicine, made a presentation on behalf of Pacific Emergency Care (PEC).
19. Dr Phillips said EC covers not only injury and disaster events, but also outbreaks, infectious diseases and maternal and child health. EC can be divided into pre-hospital and facility-based care, with each component having specific needs (e.g. communication, trained first responders, safe transport, health facilities, triage procedures and equipment). Effective EC

systems save lives and reduce disability, and also address many of the health-related Sustainable Development Goal (SDG) targets.

20. SPC drove an eight-month consultative process to assess the current status of EC in the region. Two surveys and two workshops were conducted, involving over 200 stakeholders from 17 PICTs. (A report on the data obtained is available from SPC PHD.) The aim was to determine EC priorities and what the standards for EC in the region should be. Some PICTs are providing training for EC staff and some have adequate equipment. Few have adequate facilities.
21. The results of the consultation provided baseline indicators and informed the development of a roadmap for EC in PICTs. The Pacific Emergency Care Systems Framework was adapted from the WHO EC Systems Framework, which provides five interconnected building blocks for system development (human resources; infrastructure/equipment; data; processes; governance). Country leadership and governance, and sharing EC priorities and standards among stakeholders at regional and national level, will be important in progressing towards basic standards for EC systems. All PICTs are encouraged to adopt the Pacific Regional EC Priorities and Standards, recognising that for some PICTs, the standards will be targets to work towards.

Discussion

22. WHO noted ongoing work to build emergency medical teams (EMT) across the Pacific and asked if PEC is working with EMT Australia, which has been supporting this work.
23. Fiji, Tonga, Solomon Islands and Vanuatu are developing EMTs (mainly type 1 capacity). This work links to EC in that the same staff and skills are required. However, with EMTs there is a focus on deployable capacity, e.g. as part of disaster response. It will be useful to see how the development of EC and EMTs can be better integrated rather than occurring in silos.
24. Fiji agreed that development of EC and EMTs should be linked, noting that many other sectors besides health are involved in disaster response.
25. Tokelau requested support to develop its EC. Patients have to be transported by boat from the atolls to the main referral centre and may face a further transfer to Samoa or New Zealand. There is a need for more equity in the distribution of health care services.
26. Tonga asked if EC should be more involved in risk mitigation, e.g. road safety advocacy.
27. Solomon Islands is implementing a triage system based on a South African model. The framework's building blocks will be useful in ensuring consistency in developing EC.
28. Dr Phillips agreed there is a need for more coordination between EMT and EC development. Disaster response and EC should not be considered as separate issues. A country's ability to respond to surge situations is closely related to the day-to-day functionality of the EC system and availability of trained staff. She noted that:
 - Solomon Islands required assistance from AUSMAT and NZMAT to cope with EC demands in the face of several events including a dengue outbreak and flooding. As a result, Solomon Islands realised the need to invest in facilities, equipment and training for EC and surge response.
 - The survey showed that pre-hospital EC in some PICTs often involves a long journey and different modes of transport. Response teams need to have an appropriate mix of skills

and training to deal with these situations, e.g. the care provider cannot also be the transport operator.

- Advocacy on risk mitigation, especially around alcohol and road safety, is a huge role for EC providers.

Recommendations

29. PHOH recommended that PHMM:
 - i. recognise emergency care (EC) as an essential component of the healthcare system in every PICT, and recommend endorsement of EC as a specialty discipline;
 - ii. recognise the core components of EC as facility-based and pre-hospital, as both are essential and require government recognition and support for development;
 - iii. acknowledge the Pacific Regional EC Priorities and Standards for their own countries and consider endorsing and adopting them as individual PICTs;
 - iv. further consider the Pacific Regional EC Priorities and Standards for regional endorsement and adoption as standards to work towards across the whole Pacific region;
 - v. acknowledge the need for close links between the development of EC and the Emergency Medical Teams that are currently being established in PICTs;
 - vi. acknowledge the role of EC in public health, including in advocacy (e.g. on alcohol use, road safety), public awareness and training, and early detection of outbreaks.

3. Non-Communicable Disease (NCD)

3.1 Pacific NCD Roadmap and MANA Dashboard

30. Dr Wendy Snowdon (WHO) and Dr Si Thu Win Tin (SPC) presented an update on the Pacific NCD Roadmap and Monitoring Alliance for NCD Action (MANA).
31. To address crisis levels of NCD incidence and premature death in the Pacific, in 2014 PHMM and Forum Economic Ministers (FEMM) agreed to take action through the Pacific NCD Roadmap. MANA and the MANA Dashboard were established to monitor implementation of Roadmap initiatives including tobacco and alcohol controls, access to healthy food and promotion of activity and awareness. Dashboards showing progress and gaps have been completed for 21 PICTs in collaborations between the MANA Coordination Team (SPC, WHO, PIHOA and C-POND) and country focal points.
32. The dashboards show 11 PICTs have national NCD plans and 4 others include NCDs in their national health plans. Others are developing their strategies. Fourteen PICTs have systems in place to support enforcement of NCD policies. Only a few PICTs have a functioning national multi-sectoral taskforce to lead implementation of national NCD plans, and the engagement of non-health sectors is limited.
33. There has been progress on tobacco control, including imposing higher taxes and restricting smoking in public places, but little on addressing tobacco industry interference. Action on alcohol advertising is a weakness in many PICTs.

34. PICTs show mixed progress in relation to unhealthy food and drinks (non-alcohol). There has been action on reducing salt consumption, but little on trans-fat control and marketing of unhealthy food to children. Some PICTs have made good progress in developing dietary guidelines (including for babies), increasing taxes on sugar-sweetened beverages (SSB) and providing healthy food in schools. Few PICTs have established policy to address childhood obesity, e.g. by restricting marketing of breast milk substitutes and providing breastfeeding facilities. Six PICTs have hospitals that have been accredited as baby-friendly.
35. Many PICTs have challenges in obtaining resources (medicines, equipment and staffing) to fully implement the package of essential NCD interventions in primary health care (PEN or equivalent).
36. Operational research is required to assess the health impact of these actions.

(See discussion below.)

Recommendations

Recommendations for governments:

- i. Ensure an up-to-date NCD strategic plan and priorities are in place, with clearly defined indicators and timelines;
- ii. Commit to developing or maintaining an active multi-sectoral NCD taskforce;
- iii. Endorse the MANA dashboard regional report, *Status of Policy and Legislation in PICTs*;
- iv. Utilise the MANA dashboard nationally to prioritise key actions for the next year, particularly considering common gaps in the region (such as controls on marketing unhealthy foods and non-alcoholic beverages to children, restriction of trans-fat in the food supply, and tobacco industry interference) and further raise taxes on unhealthy products in line with global recommendations.

Recommendations for development partners:

- v. Support PICTs with the development of preventive policies/legislation, implementation and monitoring of national NCD action;
- vi. Strengthen efforts to improve regional coordination, and enhance international collaboration and networking opportunities for PICTs;
- vii. Support operational research on impact assessment to strengthen evidence-based NCD intervention.

3.2 Pacific Ending Childhood Obesity (ECHO) Network

37. Dr Donald Wilson, Head of the School of Public Health and Primary Care, Fiji National University (FNU), said that in 2018, PHOH endorsed the establishment of Pacific ECHO and its governance mechanism, and supported the identified priority areas: physical activity, fiscal measures and restriction on marketing of unhealthy foods and non-alcoholic beverages to children, and obesity surveillance.

38. As a first step in developing regulations, countries were asked to conduct a situational analysis in 2018 of their current food marketing environment. Five analyses have been completed but most are still in progress. At a February 2019 meeting, countries proposed a toolkit to assist the development of national marketing regulations that could be tailored to their individual needs.
39. Challenges for ECHO include maintaining and sustaining the network, facilitating communication with member countries and organisations and coordinating links between the working groups and their plans of action for priority areas. Urgent action is needed to build a whole-of-government approach by multiple sectors, e.g. involving Ministries of Education to drive initiatives in schools, such as increased physical activity, and Ministries of Finance to implement fiscal policy. Civil society engagement in the network is limited and there is a need for collaboration with effective CSOs working on NCDs.

(See discussion below.)

Recommendations

Recommendations for PHOH:

- i. Ensure that PICTs incorporate actions to combat childhood obesity in their multi-sectoral NCD plans or national plans, with clearly defined indicators and timelines;
- ii. Support the identified priorities of physical activity, fiscal measures and restriction on marketing of foods and non-alcoholic beverages to children as per the plan of actions progressed further at the February 2019 meeting;
- iii. Commit to supporting or maintaining active multi-sectoral collaboration on childhood obesity nationally to drive initiatives for the next year;
- iv. Develop policy recommending that all PICT schools provide safe drinking water (and possibly coconut drinks – *nu*) only, as opposed to sweetened beverages.

Recommendations for development partners:

- v. Support PICTs in implementing and monitoring childhood obesity priorities and plans of action;
- vi. Foster effective collaboration between civil society organisations within and across PICTs, and with government, network partners and stakeholders;
- vii. Support the maintenance of the established network and its sustainability;
- viii. Support operational research to strengthen evidence-based childhood obesity interventions.

3.3 Pacific NCD Legislative Framework

40. Dr Paula Vivili, Director of the Public Health Division, SPC, presented progress on developing a Pacific framework for NCD legislation.

41. In 2018, PHOH agreed that the secretariat should proceed with developing a framework that incorporates all the legislative measures deemed appropriate to address NCDs.
42. Since July 2018, with support from the Commonwealth Secretariat, a Legislative Drafting Consultant has been undertaking a legislative policy review and analysis and initiating the development of the framework. This is a complex exercise given the many sectors involved and existing national and international policies and guidance relating to NCDs. Key policy and legislative gaps in PICTs have been identified using the MANA dashboards.
43. The first regional consultation workshop was conducted in March 2019 in Fiji, with legislative drafters from PICTs and NCD health policy experts from partner agencies to discuss the content, scope and structure of the framework and the approach to the work.
44. From the work to date, it is clear that developing a comprehensive framework, and undertaking consultation with stakeholders in all relevant sectors, will be a lengthy process needing continued funding support. An integrated government approach and high-level endorsement of the framework will be needed to ensure it is implemented effectively, noting that enforcement of public health policy is an area of weakness for many PICTs.
45. An outline of the 'Draft Pacific NCD legislative framework: Structure and approach' is attached as an annex to meeting paper 7.
46. Dr Vivili recognised the tremendous support for NCD work provided by Australia (DFAT), New Zealand (MFAT) and the World Bank.

Recommendations

Recommendations for PHOH:

- i. Note progress on drafting the Pacific NCD Legislative Framework (PLF);
- ii. Review the proposed structure of, and approach to drafting the PLF with a view to endorsing this approach (noting an early draft of one section is provided in the Annex to the paper) and presenting at the Pacific Health Ministers Meeting (PHMM) in 2019 for further discussion and a decision;
- iii. Support the development of a PLF and advocate for multi-stakeholder involvement at both regional and national level consultations.

Recommendations for development partners:

- iv. Support, and invest more resources in, drafting and finalising the proposed PLF;
- v. Advocate for and raise awareness of progress on PLF development at national, regional and international levels.

Discussion

(The three NCD papers and presentations were discussed together.)

47. Participants acknowledged the usefulness of the MANA dashboards in identifying progress and gaps and highlighting areas to focus on. Tokelau noted the need for communication with countries to ensure input to the dashboard was a true reflection of national efforts, including work with groups at community level.

48. Several questioned the benefits of increasing prices (e.g. through taxation) to change behaviour around purchasing tobacco, alcohol and SSB. Low income people still bought these items, leaving even less money to buy healthy food. However, New Caledonia said steep increases in taxes on tobacco and alcohol in 2017, along with other measures, had helped reduce consumption.
49. UNICEF said baby-friendly hospitals are a good initiative, but oversight is important to ensure they are of good standard and provide quality care. WHO agreed, saying that the bar had been set low to encourage action initially. Re-accreditation will be required within a set time frame.
50. Other challenges mentioned were the ability of businesses to circumvent the regulations, smuggling, lack of enforcement of policy and regulations, and potential use of tax revenue obtained from these measures for health promotion.
51. Participants agreed that the private sector must be involved in the development of strategies to combat NCDs to ensure support for policy and regulations.
52. WHO noted there has been a meeting between the Pacific Islands Forum Secretariat (PIFS) and the private sector on the potential for business to support NCD work. Consultations at government level should engage the private sector and this should also be part of national NCD strategies. Enforcement of regulations is more difficult in some PICTs. In these cases, other options may work better than taxation.
53. The World Bank noted that finance ministries in many countries do not like earmarked taxes so decisions on how NCD related tax revenues are used need to be made on a country-by-country basis.
54. In relation to ECHO, participants supported the initiatives mentioned and efforts to reduce the 'obesogenic environment' in many Pacific Island situations, particularly ensuring provision of safe drinking water in schools (and *nu* where available) to reduce SSB consumption.
55. There was general support for the work to develop the Pacific NCD legislative framework, including a hope that the work would move more quickly. The framework will help PICTs to pull together existing legislative measures on NCDs (including for tobacco control) and strengthen multi-sectoral approaches. PICTs will be able to select the components of the framework that best apply to their situations.
56. Cook Islands noted the problems raised in applying approaches such as taxation and said PICTs need to consider moving beyond existing strategies and also to learn from each other about what works and what does not.

3.2 Impact of NCD-related Taxation on Consumption and Behaviour

57. WHO (Dr Wendy Snowdon) said some PICTs have assessed the impact of taxation in reducing consumption of tobacco, alcohol, sugar-sweetened beverages (SSBs) and other foods, such as turkey tails, mutton flaps, chicken legs and palm oil. These studies have been

both retrospective (assessing the impact of existing measures) and prospective (modelling the impact of possible change).

58. Findings showed that taxation impacted tobacco prices and consumption and increased government revenue, but the effects were undermined when alternative untaxed products (e.g. local tobacco) were available, or when companies absorbed small price increases due to taxation, or reduced the package size to lower prices. Under the WHO Framework Convention on Tobacco Control, the global benchmark is that excise tax should be at least 70% of the retail price of tobacco products. Most PICTs have not achieved this.
59. Findings were more positive for alcohol and SSB with some evidence of reduced sale and consumption after taxes were applied. For taxation to be effective, SSBs needs to be clearly and broadly defined to avoid substitution of products.
60. Challenges for conducting taxation impact studies include data availability (import statistics, consumption data, tax revenue, etc.), time and expertise. It is also difficult to isolate and measure the impact of tax increases when other factors besides price play a role in consumption.

Discussion

61. Marshall Islands asked how outcomes are quantified – is it assumed that if consumption is going down, health will improve? The answer was yes.
62. Tonga said some Ministers of Finance had been enthusiastic about targeted taxation, but there was not much evidence for the benefits of taxing some products. There is not enough dialogue between the finance and health promotion sectors. It is useful to see the results of the studies done and the process used.
63. New Zealand said that 10% increases in its tobacco taxes over several periods are estimated to have reduced the amount and frequency of smoking, along with other interventions. Taxation is only one tool – an integrated approach is important.
64. The World Bank noted that the international evidence is clear for tobacco price interventions, but less clear for alcohol and food although there is a growing range of evidence becoming available to inform actions.
65. Dr Snowdon agreed that taxation is not a stand-alone intervention. It should be combined with other measures depending on country circumstances.

Recommendations

Recommendations for PHOH:

- i. Undertake tax impact assessments and share the findings with non-health sectors and partners at regional and international level, with the results of these studies used to inform taxation measures;
- ii. Strengthen measures to monitor consumption, import and price data for tobacco, alcohol, food and non-alcoholic beverages;

- iii. Utilise actions that can prevent undermining of taxation impacts (e.g. clear definitions, strict labelling requirements, prohibiting forestalling, taxing all products of the same category, etc.);
- iv. Exclude tobacco and alcohol from trade agreements to avoid a requirement to reduce taxation measures;
- v. Use taxation-based measures to support healthier behaviours through increased and/or lowered taxes, in line with global recommendations.

Recommendations for development partners and academics:

- vi. Support PICTs to plan and undertake tax impact assessments;
- vii. Harmonise methodology and develop standard models for ease of study replication by PICTs;
- viii. Support capacity building to enable local Pacific academic partners to undertake tax impact assessments;
- ix. Share information on best practices to increase the impacts of taxation measures and support PICTs with planning of fiscal approaches.

Emergency Response: Requesting and coordinating international assistance

- 66. WHO ran a simulation exercise for PHOH on Emergency Response: Requesting and coordinating international assistance. Participants were presented with scenarios and asked to determine requirements, request services needed and make the best use of the assistance available (e.g. from Emergency Medical Teams; Early Warning, Alert and Response System (EWARS), Global Outbreak Alert and Response Network (GOARN) and WASH). They also had to consider how to deal with uninvited assistance, such the arrival of unverified NGO teams.

5. New Directors of Public Health Meeting

- 67. Among other issues, a closed session of PHOH discussed the value of an annual meeting of Pacific Directors of Public Health, similar to the existing meeting for Clinical Directors.

Recommendations

- 68. Recommendations for PHOH:
 - i. Agree that the current annual meeting of the Pacific Public Health Surveillance Network (PPHSN) will become the **Directors of Public Health Meeting** to provide a strong regional forum for strategic thinking on public health issues;
 - ii. Note that Directors of Public Health are expected to attend the meeting to ensure representation at the appropriate level;

- iii. Further note the meeting will be held back-to-back with PHOH every second year, alternating with the meeting of Directors of Clinical Services. (Both meetings will remain annual.)

6. Universal health coverage (UHC) and Primary health care (PHC)

69. The Chair noted that World Health Day (7 April) is dedicated to the theme of universal health care. A short video was presented on the relevance of the theme for PICTs.

6.1 Reform of primary health care (PHC)

70. Ms Martina Pellny, WHO Division of Pacific Technical Support, Suva, said the recent Astana Declaration and the Healthy Islands vision both emphasise PHC. For PICTs, developing and implementing service delivery models, such as an essential health services package, and tools such as role delineation policy (RDP) provide a basis for strengthening PHC.
71. Several PICTs (e.g. Fiji, Solomon Islands and Vanuatu) are in the process of implementing an RDP policy, which defines the scope of services at each level of care to meet the health needs of the population.
72. As an example of progress on PHC, Tonga has recently developed its package of essential health services, which describes the way services will be provided at nursing clinics, community health centres and hospitals, with regular audits of facilities to monitor progress. The package is linked to staffing and training needs.
73. French Polynesia used a different approach to reform its PHC, starting with training for PC professionals and introducing new roles in health promotion and prevention. Its plan includes leaders from other sectors, establishment (or renewal) of community health committees, and health-promoting schools.

6.2 French Polynesia's reform of PHC

74. Dr Merehau Mervin (PHOH Chair) described French Polynesia's reform of PHC. A national health strategic plan 2016–2021 was adopted. A key issue was that most care was at tertiary level but provision was not sustainable or accessible. The new PHC programme is people-centred and was introduced with wide consultation. The focus is on empowering people to take a role in their own health rather than on looking after ill people. The plan includes specific training for nurses and midwives. Acceptance of the change from a disease-focused health system to one designed for people requires advocacy and step-by-step approaches.

6.3 Tonga's Package of Essential Health Services (PEHS)

75. Dr Siale 'Akau'ola, CEO, MOH, Tonga, presented Tonga's adoption of PEHS as a pathway to achieving UHC by 2025. The PEHS specifies the health care services (12+1) that will be provided for all Tongans and the facilities, medicine and equipment required. It also describes access, e.g. for remote communities, and the system changes required to achieve UHC in Tonga. Benchmarks are set for various health facilities to ensure services continue to improve. Several aspects of the health system need to be improved to ensure successful delivery of the PEHS, including regulations and policies, staff training and telemedicine. (He

noted that Tonga uses the Tupaia health data platform, which was highly effective for rapid damage assessment after Tropical Cyclone Gita).

Discussion

76. Participants acknowledged the importance of strengthening their PHC systems and the need for political will for health sector reform.
77. Poverty is a huge barrier to accessing services. Kiribati said many people have no paid work and lack understanding of tests such as cervical screening. It is essential to consider poverty and education as part of making progress on PHC. Equity in distribution of funding is also important.
78. Marshall Islands has similar issues to Kiribati. It has among the highest rates of diabetes and cancer in the world. The hospital is old and the Public Service Commission controls HR and salaries. Nurses are underpaid. Marshall Islands has UHC, but still many people cannot afford the \$5 service fee. There are organisations coming in and Marshall Islands can see where it wants to go in health but lacks appropriate expertise and resources in the face of massive needs.
79. The Vice Chair acknowledged that health needs can seem overwhelming and said other PICTs have been in Marshall Islands' position but have progressed. Other PHOH can advise, development partners are listening, and SPC and WHO can provide support.
80. The Chair said French Polynesia had faced political instability, but the situation had improved, enabling PHC to be put in place. The reform did not highlight poverty but rather tried to look at the whole population and to improve the workforce through training. Other ministries also have to contribute to health.
81. Fiji asked how surgical emergencies are managed under the PHC systems in place.
82. Tonga said strong transfer systems are needed, with a back-up emergency system if transfer is not possible.
83. Like French Polynesia, New Caledonia offered a lot of health care but needed a new system for that care. In 2015, its model was overhauled to focus on prevention, with the individual at the centre.
84. The Vice-Chair noted that these systems all required a shift of resources to PHC from tertiary care. The challenges for implementation of PHC reform were reflected in the recommendations.

Recommendations

Recommendations for governments:

- i. Strengthen leadership and political alliances for primary health care through:
 - a. including other sector leaders in plans for modernising primary care, and working cross-sectorally, e.g. with the education sector and health-promoting schools to empower the next generation to take more responsibility for their own health;
 - b. ensuring that primary health care is embedded in all government policies, including the respective allocations of financial resources ('health in all policies');

- c. continuing to raise awareness and increase the health literacy of institutional and political partners, and individuals and communities.
- ii. Strengthen the health workforce for primary health care through:
 - a. implementing a retention policy with incentives for the right staff to be in the right place with the right skill mix;
 - b. reorienting health workforce curriculums towards a more comprehensive approach, including balancing clinical services and skills with preventive approaches and practices, taking into account the cultural and social determinants of Pacific health;
 - c. developing a continuing medical education programme, which includes a systematic peer review system, for all primary health care professionals to ensure they acquire and maintain comprehensive skills;
- iii. Strengthen capacities to plan and monitor changes in the way primary health care is delivered by investing in a health information system that includes the primary health-care level.

Recommendations for development partners:

- iv. Continue supporting PICTs in their efforts to modernise primary health care by advocating for health in all policies;
- v. Continue advocating, together with health sector counterparts, for more investment in primary health care and development of the workforce;
- vi. Support development of a programme of collaboration in primary health care between PICTs to enable regular exchange of experiences in developing concepts and implementing ongoing plans for modernisation;
- vii. Encourage and fund more research and evaluation of primary health care in the Pacific to support effective advocacy and leadership efforts.

7. Monitoring, evaluation and learning

7.1 Update on implementing the Healthy Islands Monitoring Framework (HIMF)

- 85. Taniela Sunia Soakai, Deputy Director, SPC Public Health Division, said the second report on the Healthy Islands Monitoring Framework will be presented to PHMM. Beyond the official HIMF indicators, the report also sets out regional progress on HIMF implementation; assesses trends, advances and gaps in each country; and highlights links with other global and regional initiatives, such as UHC and reducing NCDs, as well as links between health, regional security and climate change.
- 86. The framework has 48 mandatory indicators – 33 core and 15 complementary – and 31 optional indicators. Since the first report, the secretariat has established an online-reporting tool for collecting country data and facilitating data exchange. As a result, 18 of the 22 PICs have provided updates for the second report. However, five PICTs opted out of the data

collection and validation process for 2019 reporting. Monitoring requires considerable investment in data collection, compilation and analysis in countries and encouraging active participation is important.

87. Priority actions to improve the HIMF include increased alignment with existing mechanisms, such as the SDG indicators (with international definitions and standards) and data sources available in countries (e.g. national surveys and administrative data), to avoid the need for additional collection of information.
88. The framework will continue to evolve, including in terms of improving data quality and comparability and defining indicators to align with changes in SDG definitions, e.g. the recommendations include some changes to the indicators for family planning and number of vector-borne disease outbreaks.

Discussion

89. UNFPA noted the proposed change of the family planning indicator to the SDG 3.7.1 indicator.
90. Samoa said leaders have concerns about family planning advice, given low rates of population growth. Samoa has a significant rate of teen pregnancy, but a low birth rate overall. High rates of chlamydia may account for some infertility. He asked if the programme could be adapted for specific PICTs, depending on their need for population growth, perhaps by rewording the message to 'safe motherhood'.
91. Cook Islands shared similar concerns about the bias in providing technical support for family planning. People should feel confident in making their own decisions about having a family.
92. UNFPA said family planning supports the right of women to have or not have children, and their choice of timing. Very early, very late or too frequent pregnancies can all lead to complications or poor outcomes.
93. SPC said that at present the HIMF indicator for birth and death registration will remain the same, rather than changing to the relevant SDG indicator because countries are not yet meeting the threshold.
94. Vanuatu said that with its population being mostly rural, it struggles to report on some indicators and asked if indicators could be adjusted to better fit rural populations.
95. The Vice Chair asked why some PICTs have opted out of providing data for the HIMF and urged the secretariat to get complete data for all PICTs to be provided to PHMM. She noted the proposed changes to some indicators and said modifying the outbreak definition would make comparisons difficult because the definition would not be the same for all countries. She also noted that SPC provides very useful training on systems for CRVS (civil registration and vital statistics).

Recommendations

Recommendations for PHOH:

- i. Endorse the second progress report of the Healthy Islands monitoring framework for submission to PHMM;

- ii. Endorse the proposed changes to the monitoring framework, that is:
 - a. replace the indicator, 'Contraceptive prevalence rate', with SDG 3.7.1 'Demand satisfied', which is a better measure of true coverage;
 - b. modify the indicator for the number of vector-borne disease outbreaks to enable reporting using comparable existing surveillance data, and task PPHSN with providing the technical definition and calculation method to measure the indicator;
 - c. include SDG 17.19.2 (b) number of countries with 100 per cent birth registration and 80 per cent death registration as an additional report to indicator 1.5 and 3.5 on birth and death registration to strengthen the links between the Healthy Islands monitoring framework and the SDGs;
- iii. Follow up on the implementation of the framework and report progress to PHMM in 2021 with any amendments if necessary.

Recommendations for government:

- iv. Actively participate in validating and reporting indicators every two years (before PHOH and PHMM), and introduce quality reviews as part of data reporting;
- v. Continually improve national health information systems and Civil Registration and Vital Statistics (CRVS) and reinforce equity-oriented health information analysis.

Recommendations for development partners:

- vi. Continually support PICTs to strengthen national health information systems to enable them to sustainably produce country data;
- vii. Strengthen institutional capacity at the country-level to collect and utilise data at all levels of the health system.

7.2 Update on eHealth and Health Information Systems in the Pacific, and Vanuatu case study

- 96. WHO presented an update on the status of eHealth in PICTs, noting that its development could be transformative in addressing the region's geographic, demographic and economic barriers, especially with a new submarine cable being put in place to improve connectivity.
- 97. eHealth requires a whole-of-system approach, from individuals (e-monitoring) to health information systems (HIS). Currently, only 24% of PICTs have an eHealth strategy. Requirements include resources (funding and ICT staff) and long-term planning of HIS investment. A basic need is the development of unique identifiers (for health) linked to birth registration systems.
- 98. The strategy for eHealth should be driven by the needs of the users and overall business goals, not software systems, and must be linked to the government's overall e-strategy. Vanuatu's digital health strategy (below) provides an example.

Vanuatu's digital health strategy

99. Vanuatu's digital health strategy was launched in December 2018. The first step in the process was to establish a Digital Health Steering Committee, which included clinicians/end-users, to manage development of the strategy, assess relevant ICT initiatives, and make recommendations to the MOH regarding alignment, sustainability, affordability, etc.
100. The strategy has four related components: 1) foundational building blocks; 2) patient information systems; 3) management reporting information system; and 4) PHC. It is fully costed, including the costs of building capacity to manage the system.
101. The MOH consulted widely in developing the strategy and received significant technical assistance and funding support from development partners (ADB, DFAT, WHO, UNICEF).
102. Among the lessons learned – the Steering Committee, and involvement of end users, ensured good governance and buy-in. The strategy must match country needs, resources and capacity to implement. Sustainability is central to a strategy, as is realising that technology cannot solve every problem.

Discussion

103. Participants were very interested in learning from Vanuatu's experiences and asked about the type of software being used (off the shelf or custom built), data quality, data ownership and privacy, cost of the system and user resistance.
104. Responses:
- Vanuatu is using software provided by WHO, and the Tupaia platform for quantitative data.
 - Implementation is only beginning so it is too early to assess user resistance.
 - At present, efforts are focusing on centralising data, including archive data.
 - The cost of the system is around USD 6 million in the recurrent budget. Development partners have also made commitments.
 - Relevant national law applies to issues of data privacy and ownership, although legislation may have to be amended to cover new applications of technology.
105. WHO stressed that the usability of the system is critical to success. Training and choice of leadership and management are also important.
106. French Polynesia is about to buy new software but will first conduct a 12 month consultation process with the aim of involving users in the choice and discussing how it will change their activities.
107. Solomon Islands is also considering a system and is interested in learning from Vanuatu.
108. The Chair asked if PHOH could get a list of the software that countries are using. Sharing information will help PICT decision-making.
109. Vanuatu noted that all requests for information about the eHealth strategy first go to the Steering Committee and then to MOH.

Recommendations

Recommendations for governments:

- i. Continue to strengthen national HIS and eHealth strategies in line with PICTs' health priorities and broader national priorities;

- ii. Continue to build the capacity of human resources for health information/eHealth and ensure key foundations and enablers for eHealth are in place, including unique health identifiers, ICT infrastructure and information-sharing mechanisms;
- iii. Continue strengthening the relationship between civil registration offices and Ministries of Health, with a view to establishing routine data-sharing arrangements and common and harmonised frameworks;
- iv. Support regional networks, such as the PPHSN, PHIN (Pacific Health Information Network) and BAG (Brisbane Accord Group), to strengthen regional cooperation amongst PICTs to improve eHealth and health information and CRVS across the Pacific, and encourage collaboration with the health sector and stakeholders from outside the health sector (e.g. academic institutions);
- v. Consider appointing a PHIN Country Representative in each PICT to represent and champion eHealth.

Recommendations for development partners:

- vi. Work with the development partner community to advocate, raise awareness and support eHealth;
- vii. Disseminate best practices, lessons learned and successful examples of digital health implementation in the region through PHIN;
- viii. Strengthen regional cooperation and multi-sectoral collaboration for eHealth by outlining how development partners and national governments can work together to optimise eHealth and HIS investments to avoid fragmentation, duplication of efforts and investment gaps;
- ix. Provide technical assistance to PICTs for eHealth, including sharing eHealth knowledge products, such as strategy formulation, assessment frameworks, investment metrics, information standards and best practices.

CRVS (civil registration and vital statistics)

- 110. PHOH noted an information paper submitted by SPC on behalf of the Brisbane Accord Group, which provided an update on its capacity building initiatives with national health departments in 2018 to support the development of civil registration systems and the production of vital statistics. The paper identifies key issues and challenges and provides recommendations for consideration by countries and development partners.

8. Pacific Cancer Registry Hub and cancer control

- 111. Professor Diana Sarfati, University of Otago (Wellington), New Zealand, said the IARC (International Agency for Research on Cancer) Pacific Cancer Registry hub will be launched in August – October 2019 as part of a global strategy to increase the capacity to produce high-quality data to inform cancer control planning.
- 112. The proposal for the hub was presented to PHOH in 2018. It will be operated by the WHO Western Pacific Regional Office, Division of Pacific Technical Support (WPRO DPS) and SPC.

To date, two people from PICTs have received IARC training. Several PICTs will be supported initially to develop cancer registries, with site visits to take place this year to list key priority activities and develop an action plan for each country. There is ongoing work to identify sources of funding.

113. Professor Sarfati then introduced The Lancet series on cancer control in SIDS – a series of papers commissioned by the journal. The first paper looks at the state of cancer control across the Pacific region. The second one looks at good, or innovative practice that might be useful to consider extending. The papers will be published later this year.
114. Reducing the incidence of cancer requires a cancer plan based on good data showing the burden and cancer types. Existing data show that breast cancer is the leading cause of cancer-related death for Pacific women. Cervical cancer also has a high mortality rate, in contrast to Australia and New Zealand. HPV vaccination and cervical screening are low in most PICTs. Lung cancer is the most important cause of cancer death for Pacific men. Diagnosis of all cancers, and availability of treatment and palliative care are very limited due to a lack of services (e.g. pathology, radiology, CT scans) and specialists. There are only two oncologists in the region.
115. Examples of innovative practice and approaches include a regional approach to cancer planning in the US-Affiliated Pacific Islands; cervical cancer prevention in Papua New Guinea using self-screening; improving care of children with cancer; and improving the surgical workforce and services in the Pacific.

Discussion

116. Cook Islands said PHOH should encourage HPV vaccination (it is limited to some PICTs at present). The use of self-screening is an important initiative in preventing cervical cancer.
117. Dr Amanda Hill, FNU, described a pilot self-screening project in Fiji, modelled after the PNG project. A survey showed that the women involved said that felt more secure if someone with medical training did the swab.
118. Tonga said cancer mortality was increasing in PICTs for some cancers but declining in developed countries because of prevention strategies. There was hope for the Pacific because prevention and treatment options are now available. He asked development partners for their support in making these options accessible for Pacific people.
119. The Chair said awareness of risk factors and early diagnosis were needed.
120. Professor Sarfati said that late presentation is common in the region after people first visit traditional healers. She suggested working with these healers but said treatment must be available after diagnosis.
121. PIHOA noted work in the Northern PICTS to address cancer, including development of comprehensive plans. She suggested those involved in cancer planning could be invited to PHOH to share their journey. Palliative care is another area where lessons could be shared. US territories have quite good cancer registries.
122. The Asian Development Bank (ADB) is working on making HPV vaccination available in Samoa, Tonga, Tuvalu and Vanuatu and is also looking at strengthening their vaccination

regimes (these countries are not eligible for GAVI funding). This is a new area of activity for ADB, which is seeking to become more active in health.

123. Nauru has a high incidence of cervical and breast cancer and often late presentation. Diagnosis takes a long time with most tests going to Brisbane. Nauru would welcome support for HPV vaccination and also faster turnaround of test results.
124. Cook Islands is looking at procuring HPV vaccination for boys and girls, but the cost is high. She asked if Cook Islands could connect with ADB for support.

Recommendations

Recommendations for PHOH

- i. Note that the IARC (International Agency for Research on Cancer) Pacific Cancer Registry hub will be launched in August – October 2019;
- ii. Recognise the need for comprehensive national cancer plans, including strategies to raise awareness of risk factors, increase early diagnosis, coordinate medical referrals and regulate medicines;
- iii. Strengthen pathology services;
- iv. Strengthen and support surgical services and palliative care;
- v. Consider implementing HPV vaccination programmes throughout the Pacific region and request further support from development partners, acknowledging the support already provided.

9. Human resources for health

9.1 Update on the capacity of the region's clinical workforce

125. SPC (Dr Revite Kiriton, Public Health Division, SPC) presented the findings of a study of changes since 2012 in local capacity to deliver clinical services. The study focused only on clinicians employed by 14 PICT MOH.
126. Findings showed that the number of local doctors employed by the PICT MOHs increased from 783 in 2012 to 1424 in 2019 – an increase of 641 or 82%. Female doctors make up 48% of the local medical workforce in 2019, compared to 39% in 2012. Around 50% of all local doctors in the region are aged 30 years or less and 36% are aged between 31 and 40 years.
127. In terms of qualifications, the number of local doctors with an MMed has more than doubled, increasing in 8 PICTs; there are more local clinicians with qualifications in the core disciplines, even in the smaller PICTs; and more local doctors have postgraduate qualifications in sub-speciality areas, especially in larger PICTs, mirroring new training programmes offered by FNU.

Discussion

128. Tuvalu noted it has two places at FNU each year but has had a large increase in Cuban-trained doctors. There is a need for advice on retention, especially of doctors who leave to do postgraduate studies. There is a lack of trust in Cuban-trained doctors, but mentoring is helping.
129. Several participants requested that the study be expanded to gather information on PHC and public health physicians; doctors in management; and scope of practice.
130. WHO noted the trajectory towards building specialist services and said it is important to insure that PHC is not left behind. General physicians are necessary.
131. Tonga said there has been a dramatic increase in the workforce in a short time and ministers are going to want information on the effect this is having on services and people.
132. Cook Islands (Dr Amanda Hill) noted that PICTs need to develop plans to support the reproductive health of the increasingly female workforce in health.
133. Samoa said PICTs need to focus on allied health professionals too. The increase in sub-specialities makes it difficult for staff to cover other services. They are no longer generalists and there is a gap in the middle level between consultants and juniors. Australia and PNG both offer training in rural medicine, which includes PHC. In terms of postgraduate training, the calibre of decision making is sometimes not up to the level expected of a postgraduate – training institutes may need to review their programmes. Retirement age may also need to be looked at – female doctors tend to retire early.
134. PIHOA said the quality of education (primary and secondary) does not prepare students well for medical studies and there are high attrition rates. Ministers of Education need to be involved in discussing this issue.
135. SPC agreed to look at extending the collection of data to include doctors in public health, PHC and management and to note the other issues raised. The study was restricted to clinicians because the original purpose of collecting the data was to help with clinical workforce planning.

9.2 Fiji National University (FNU) Update

136. The Dean of the College of Medicine, Nursing and Health Sciences (CMNHS), Dr William May, said key academic programmes – MBBS, public health and health services management – were externally reviewed in 2018. New academic programmes have been developed at post-graduate level in family medicine, MPH-NCDs, and dermatology.
137. The DFAT-supported project ‘Supporting Healthcare Workers in the Pacific’ seeks to strengthen CMNHS engagement with the region and help inform the development of academic programmes that address PICT needs.
138. The Office of the Associate Dean Regional, supported by DFAT, is now operational and working to revitalise engagement with PICTs and partners.
139. Under the project, CMNHS has undertaken scoping missions to Tonga, Solomon Islands, Vanuatu, Kiribati and Tuvalu to gain a better understanding of PICT contexts and health issues and assist in aligning programmes with PICT needs. MOUs have been signed or are

being developed. There are plans for further scoping missions, including to FSM, Marshall Islands and Palau. The project includes initiatives to support regional students at FNU.

140. FNU is seeking feedback from PICTs on the quality of its graduates and programmes as part of the process of developing its programmes to meet regional workforce requirements.

Discussion

141. Kiribati asked if CMNHS will provide a postgraduate programme in radiology.
142. FNU said this is on the radar and there have been discussions with Radiology Across Borders. A virtual (online) programme was possible but would result in lower quality. A higher quality programme would cost \$1 million, which was too expensive. FNU is still trying to establish a programme and may work with UPNG.
143. Tonga noted the change in the proportion of male and female graduates in medicine, with male numbers falling.
144. FNU said across the university, the proportion is around 50/50 for female and male graduates. It is not yet clear why this is different in health.
145. USA noted good progress in raising the number of qualified health professionals. However, there is still a big demand and low salaries are a problem. He asked if policy makers could improve pay structures and whether some PICTs have managed to do this.
146. FNU said the Fiji government reviewed the salary structure, which has had good results in reducing attrition and stabilising the workforce. It also means there is competition for training institutes seeking to recruit academics.
147. Cooks Islands – In a personal reflection, the Vice Chair said she is a New Zealand trained public health specialist who made the decision to return home. The Pacific Island diaspora needs a mechanism to come home even for short periods. They can provide intellectual capacity. Rather than seeking to hold health professionals in the region, it is important to open doors, give them opportunities and provide an environment they want to return to.
148. Marshall Islands expressed appreciation for FNU's help and support and the high quality of its work. He noted that some students who had completed the Data for Decision Making [DDM] programme are yet to receive certificates.
149. FNU said the delays were due to difficulties with the students' enrolment. FNU is facilitating the process and the students will graduate in May.

9.3 University of Fiji Update

150. Dr Elick Narayan, University of Fiji, said the university offers three programmes – Bachelor of Medicine/Bachelor of Surgery (MBBS), Bachelor of Nursing (in service), and the new Bachelor of Public Health and Primary Health Care.

151. At present, there are 483 students enrolled in the MBBS, 38 in the nursing programme, and 15 in the new public health and PHC programme. There are no postgraduate programmes at the moment. Recruitment of teachers is a challenge, but currently there is full staffing.
152. In terms of students' ability to succeed, language level is a problem for regional students. The university also has to provide IT upskilling. There is an onsite counsellor to help students adjust. This support has kept attrition rates low, at approximately 11%.

Discussion

153. In reply to a question on the entry point for the MBBS, the University of Fiji said it will change next year to Year 1 BSc completed with a GPA of 3.5. Mature entry with a relevant science degree is also possible and nurses are being admitted.
154. Vanuatu is seeking accreditation of its nursing school within a short time frame. The first intake is planned for April 2020. A short bridging course is required to take teaching staff from diploma to bachelor level qualifications.
155. The University of Fiji has a bridging program for nurses that takes 1 year. The possibility of a condensed course would have to be discussed.
156. FNU said the bridging course would depend on the number of cross credits possible. Otherwise it would take longer than 6 months. One suggestion would be to have teachers who are upgrading their qualifications at the same time as they are teaching.
157. Vanuatu also enquired about courses in biomedical engineering, given the amount of un-repaired, unusable equipment it has.
158. FNU offers a one-year programme for a Certificate in Biomedical Engineering in collaboration with the College of Engineering.
159. Several participants expressed concern at attrition rates and the wasted investment when students fail at year 5 and 6.
160. The University of Fiji is trying to identify students who are unlikely to progress earlier. They can go to a separate stream for a B Med Sci and consider different career paths.
161. FNU said MBBS dropouts occur at any level, but there is no exit qualification because of the question of employability. However, FNU can cross credit for students taking up other study.
162. Cook Islands asked about the quality of medical training programmes and graduates, including those from Cuba, and arrangements for the internship year and postgraduate study.
163. The University of Fiji relies on external reviews of quality – there was one in 2017 and the next will be in 2020 – and incorporates review suggestions. Students spend one year with a hospital, so they have exposure to the work place. There are sometimes difficulties in finding places for students.
164. FNU has internal quality standards. All programmes have a hands-on component. There are external exams (Australasia) at every level. An external review in 2018 said graduates were

work ready. There are also industry reviews. The internship programme is run by the MOH. FNU can be invited to do assessments at the invitation of a hospital.

165. Palau noted it has many nurses who have a bachelor degree, but there is high turnover and they leave to go to programme-level positions. One of the recommendations from the Directors of Clinical Services meeting was to look at training/standards for nurses. It is also necessary to look at encouraging entrants to the nursing profession.

Recommendations

Recommendations for PHOH:

- i. Note the increase in the local clinical workforce (>75% compared to 2012 numbers) in countries covered by SPC's Clinical Services Programme;
- ii. Request that the workforce survey is expanded to cover the public health and primary health care workforce in addition to clinical professionals and nurses and other allied health professionals;
- iii. Acknowledge the request from the Dean of Fiji National University's College of Medicine, Nursing and Health Sciences to provide feedback on the quality of its graduates, and use information on the Pacific region's health workforce requirements to shape the development or review of the college's programmes.

10. Climate Change and Health

166. WHO (Dr Hassan, Environmental Health Specialist) presented a brief recap of events since the 12th PHMM, which called for scaled-up efforts to mitigate the effects of climate change on health (it was made a regular item on the PHMM agenda).
167. To implement the WHO Special Initiative on Climate Change and Health in SIDS (launched at COP23 in 2017) in this region, the Pacific Islands Action Plan on Climate Change and Health was developed in March 2018 by representatives from 18 PICTs with WPRO support. The Plan was approved by PHOH in 2018 and launched at the 71st World Health Assembly in May 2018.
168. The Plan focuses on building the resilience of health systems to climate variability and change. It has four areas of action: empowerment, implementation, evidence and resources.
169. Under the plan, national focal points (in MOH and other ministries involved in climate change) are being established in all PICTs, and climate change and health profiles are being developed for each PICT. The profiles provide a summary of climate hazards, health vulnerabilities, impacts, and current progress towards a climate-resilient health system. At the time of the meeting, profiles have been received from Fiji, Kiribati, Palau, Samoa, Tuvalu and Vanuatu, and a draft from Solomon Islands.
170. An Informal Working Group has been established to provide guidance on mechanisms and funding to implement the Action Plan. It includes representatives of the health sector and the agencies responsible for climate change from selected PICTs. There will be consultations on the Draft Roadmap for the Implementation of the Pacific Islands Action Plan on Climate Change and Health. PHOH was asked to endorse the consultation process.

171. Health in National Adaptation Plans (H-NAPs) provide the health component of PICT adaptation plans and are important for building climate-resilient health systems. Both climate and health assessments, and country profiles, are required to develop comprehensive H-NAPs.
172. A measure of the success of the Action Plan will be the extent to which other sectors include health in their plans for addressing climate change. At present, only 2% of climate change funds go to health in the Pacific (globally it is around 3%).
173. Mobilisation of dedicated resources for climate change and health is a major challenge. Currently, specific funding is being provided by the Korea International Cooperation Agency and project proposals have been submitted to the Global Environment Facility (GEF) to build the resilience of health systems in Pacific LDC, and to the Green Climate Fund (GCF). The next WHO General Programme of Work will aim for a tripling of international investment in climate and health, with SIDS first in line.

Discussion

174. Tuvalu supported the WHO initiatives. The focus on health in climate change has come late and there is a need to re-double efforts to align health with cross-cutting sectors such as environment, including in accessing funds.
175. SPC (Dr Vivili) noted that SPC is now an accredited entity of GCF, which means there are opportunities to work with countries and approach GCF for specific health funds.
176. Tonga fully supports the plan. It has a Joint National Action Plan (JNAP) on disaster risk reduction. It now has a climate change and health profile and will confirm its focal point. There are other funders in addition to GEF and the GCF. For example, ADB is funding a new hospital in Tonga to build the climate resilience of health.
177. WHO agreed that the implementation plan can include dialogue with many donors. Other efforts also benefit health, such as resilience building, and reducing pollution and waste.
178. Samoa supported the comments of Tuvalu and reminded colleagues of the basic epidemiological triad – environment, host, agent. The Healthy Islands vision includes ecology. At the level of the people who are most affected by climate change, the environment is dominant, but they need to recognise that health is the priority. PHOH should make a statement to PHMM on the need to look at the host and the environment that empowers the host, and the need for direct benefits for people.
179. WHO noted that a statement could be put in the PHMM working documents and agreed that when looking at funding, it is important to look at the grassroots level. Health issues include extreme weather and weather variability, e.g. both too little water and too much cause diarrhoea. The incidence of such health impacts needs to be recorded to build the evidence base.
180. New Zealand is grappling with climate change and health. Health professionals in the community are concerned about climate change and should be included in consultations.
181. Fiji supports the action plan and wants to establish a unit on climate change and health.

182. WHO noted that one of the questions in the profile is whether there is a dedicated person or unit for climate change and health. The Caribbean is looking at developing smart hospitals that are resilient to climate change. This is a good long-term measure, as are health early-warning systems.
183. WHO (Dr Capuano) said that at COP23 in Bonn, health got on board for a session thanks to Fiji, but health and people should be at the core of the climate change debate. It is difficult to see why this is not the case. A considerable amount of funding for climate change is flowing to the Pacific. Work is being done to understand which of this funding is for projects directly linked to health or that have benefits for health. It is pleasing that SPC is GCF accredited; WHO is not yet accredited. The health sector must involve other sectors and encourage strong advocates outside the sector. This year, the Asia-Pacific Parliamentary Forum on Global Health, which will be hosted by Fiji, will focus on climate change and health.

Recommendations

Recommendations for PHOH:

- i. Note the progress on climate change and health work since the Rarotonga meeting in 2017, particularly the launch of the Pacific Islands Action Plan on Climate Change and Health (2019–2023) which focuses on four lines of actions with the following proposed outcomes:
 - a. **Empowerment:** The voice of health leaders, on behalf of the most vulnerable populations, becomes a driving force for adaptation in SIDS, and for mitigation by countries around the world;
 - b. **Evidence:** SIDS health ministries have the necessary health, environment and economic evidence to support scaled-up investment in climate change and health, identify priority investments, and monitor their success;
 - c. **Implementation:** Transformational change occurs in health systems, by promoting a culture of disease prevention, building the climate resilience of health systems and maximising the health co-benefits of climate change mitigation policies.
 - d. **Resources:** The current level of financial investment in climate change and health in SIDS is tripled.
- ii. Endorse the consultation process for the Draft Roadmap for the Implementation of the Pacific Islands Action Plan on Climate Change and Health, which will be presented to PHMM, and pay special attention to the following actions to ensure successful implementation:
 - a. **Development of Health in National Adaptation Plans (H-NAP)** – the health component of a country’s National Adaptation Plan (NAP) is the most important element for adaptation and construction of climate resilient health systems.
 - b. **WHO/UNFCCC climate and health country profiles** – to inform the health sector, other sectors and donor agencies of the sector’s needs and provide a mechanism for monitoring and evaluation of the Action Plan;
 - c. **Climate and health assessments** – which include assessments, data analysis, and research for adaptation or mitigation;
 - d. **Training and capacity building** – to build local capacity in countries for producing H-

- NAP, sector analysis and implementation of climate change and health plans;
- e. **Resource mobilisation** – Member States, WHO and development partners need to work jointly to ensure finance is available to implement the Pacific Island Action Plan on Climate Change and Health.
 - iii. Note that each Member State is to provide the names of national focal points on climate change and health; specifically, one primary and one alternate national focal point on climate change and health from the Ministry of Health; and one primary and one alternate national focal point on climate change and health from the ministry responsible for climate change. These focal points are necessary for contacts and communications on all matters related to the implementation of the Pacific Islands Action Plan on Climate Change and Health.
 - iv. Advocate for **people and health** to be put at the centre of climate change efforts in other sectors, such as environment.

11. Health Security

- 184. WHO (Dr Angela Merianos) presented an update on progress, challenges and issues for consideration in implementing IHR core capacities in the Pacific, and strengthening partner support for national and regional health security.
- 185. In 2017 PHMM endorsed the Pacific Health Security Coordination Plan, 2017–2022 (PaHSeC). It is a voluntary agreement between Pacific health ministries and regional development partners to work together in a more coordinated way towards PICT health security through accelerated implementation of the International Health Regulations (IHR). PaHSeC is supported by a development partners' working group.
- 186. Endorsement of PaHSeC included agreement to implement and monitor progress in implementing the IHR in the four PaHSeC areas of action, i.e. Improve preparedness for, and prevention of, health security threats at national level; Strengthen national response to outbreaks and sudden-onset health emergencies; Assessment of IHR implementation using the IHR monitoring and evaluation framework (MEF); and 4: Strengthen regional-level preparedness, alert and response functions.
- 187. Countries use the IHR State Party Self-Assessment Annual Reporting (SPAR) tool to provide annual assessments of progress as required by IHR Article 54. The SPAR tool replaces the previous questionnaire format for reporting. Other MEF components (e.g. after-action reviews and joint external evaluation/JEE) are voluntary but provide quality assurance and indicate areas for improvement, and also allow more objective assessment of IHR core capacities.
- 188. In 2018, WHO supported 12 of the 13 Pacific States Parties to the IHR to complete the annual IHR self-assessment using the SPAR tool. On average, countries achieved level 2, which indicates increasing capacity. Laboratory capacity and access to external capacity is improving. Additional strengthening is required in several areas including IHR coordination functions and zoonotic events. IHR implementation is not just a health sector responsibility, but there is insufficient engagement in IHR by other sectors.

189. FSM has completed a JEE as have Australia and New Zealand. WHO encourages PICTs to take opportunities to observe JEE processes.
190. Countries were asked to submit updated lists of their national focal points (NFPs). Future plans include an enhanced role for NFPs in leading annual SPAR reporting, improving the engagement of other sectors and building a repository of evidence for JEE.
191. There are numerous synergies between IHR capacities, disaster response preparedness and emergency risk management. The IHR and APSED III recognise the need for intersectoral arrangements to respond to public health emergencies, including establishing links between health and the NMDO.
192. PaHSeC initiatives in 2018 included regional workshops (e.g. One Health Meeting in April 2018; Pacific Health Emergency Risk Management Meeting in September 2018), training/workforce development activities, and development of policies and SOPs.
193. PHOH was asked to consider the establishment of a Pacific regional health security dashboard, in addition to the existing global IHR portal, to support IHR monitoring, increase local ownership and use, and possibly improve access to health security materials. The risks of a dashboard include duplicating other efforts and difficulty in maintaining the timeliness of updates.

Discussion

194. FSM described its recent JEE process as a valuable exercise.
195. Samoa has domesticated the IHR into its revised legislation and has a separate division in the MOH for IHR compliance. As the focal point for Samoa, the Director-General asked to be kept informed of the initiatives that were presented. Much of the information presented was new.
196. USA said PICTs can inform WHO of their priorities for rapid implementation of the IHR. CDC is happy to be part of the development partners' working group. He commended FSM for completing the JEE and encouraged territories to apply the SPAR tool.
197. New Caledonia noted it has a local focal point, but the office is not recognised by WHO so does not enjoy the usual benefits of a focal point. He asked if this situation could be addressed.
198. WHO said the French focal point's agreement was required to enable the local focal point to have this access.
199. Solomon Islands welcomed the recommendations. It takes a multi-sectoral approach to health security and looks forward to dialogue and support.
200. PNG will undertake a JEE in the third quarter next year.

Recommendations

Recommendations for PHOH:

- i. Ensure that International Health Regulations National Focal Points (IHR NFPs) have appropriate resources and actively engage with sectors beyond health to support IHR implementation;
- ii. Consider inviting other key sectors to be part of the NFP team to strengthen awareness, intersectoral collaboration and accountability to the IHR;
- iii. Advocate for the Pacific IHR NFPs, as well as Pacific territories, to participate in IHR monitoring and evaluation framework (MEF) activities, including the State Party Self-Assessment Annual Report;
- iv. Adopt the recommendations of the Pacific Meeting on Health Emergency Risk Management to strengthen all-hazards health emergency preparedness, readiness and response consistent with the IHR (2005) and APSED III (Asia Pacific strategy for emerging diseases and public health emergencies);
- v. Consider establishing a specific Pacific health security web-based dashboard;

Recommendations for development partners:

- vi. Continue to support IHR implementation and the IHR MEF with multi-year funding for the Pacific Health Security Coordination Plan (PaHSeC);
- iv. Ensure that projects and activities that strengthen Pacific health security align to the agreed PaHSeC Areas of Action, and the gaps and areas of need identified through IHR MEF results.

12. Pacific Public Health Surveillance Network (PPHSN) Update

- 201. The Chair of the PPHSN Coordinating Body, Dr Eric Rafai, Fiji, presented an update on the activities of PPHSN, noting increases in the number of health professionals subscribing to PacNet and in the number of disease alerts being shared. The new PPHSN website will be launched in June 2019 to improve access to information. PIHOA will become a permanent allied member of the PPHSN-CB, and the Pacific Paramedical Training Centre, based in NZ, will become an allied member of PPHSN.
- 202. FNU's support for provision of the DDM (Data for Decision Making) programme was acknowledged. The programme is part of Strengthening Health Interventions in the Pacific (SHIP). Countries need to co-invest in SHIP.
- 203. The secretariat is about to commission a review of PPHSN with 6 months allowed for completion.
- 204. The regional meeting of the PPHSN will be held in June, with follow-up workshops on One Health and surveillance and response.

(Annex B provides the full list of PPHSN recommendations.)

Discussion

- 205. USA acknowledged the work of PPHSN and its partners and said CDC is proud to be an allied member. He asked that meetings of the PPHSN-CB continue regardless of the recommendation for the meeting to become the Directors of Public Health meeting.

206. Australia noted that following on from the findings of the high-level Pacific scoping mission from Australia led by Dr Jimmie Rodgers, the Indo-Pacific Centre for Health Security is requesting activity proposals for competitive partnership grants under two programmes: Pacific Infectious Disease Prevention (PIDP) and ASEAN-Pacific Infectious Disease Detection and Response (APIDDaR). Details are available at: <https://dfat.gov.au/about-us/business-opportunities/Pages/business-notifications.aspx>
207. Cook Islands said the World Mosquito Programme is active in several PICTs and Cook Islands is also interested. She noted Tuvalu has had a dengue outbreak – they are becoming frequent in the region and new initiatives are needed to reduce mosquitoes. The PaHSeC presentation showed the urgent need for countries to complete their annual review reports.
208. PNG has had a polio outbreak and several disaster events recently. There is a need to be able to better use regional resources to deal with these emergencies.

Recommendations

Recommendations for PHOH:

- i. Note that the planned review of the PPHSN will be undertaken in the next six months, with SPC to commission a consultancy;
- ii. Recognising the lack of capacity at country level to respond to disease outbreaks, acknowledge the need for PICTs to support each other in this area;
- iii. Recognise the importance of vector control in preventing dengue fever, and request development and technical partners to consider supporting expansion of the World Mosquito Programme beyond the four PICTs currently covered.

13 Immunisation and vaccine-preventable diseases

209. WHO (Dr Angela Merianos) said that 19 PICTs attended the Tenth Pacific Immunisation Programme Managers' Meeting in Nadi, in August 2018. The meeting found that implementation of several regional vaccine coverage goals are on track, but there is uneven coverage across and within PICs, with high national-level immunisation coverage data sometimes masking under-immunised areas. Countries in the Pacific have experienced outbreaks of mumps, hepatitis A, meningococcal meningitis, pertussis and rotavirus diarrhoea in the last few years. There have been recent outbreaks of meningococcal meningitis serogroup C in Fiji and poliovirus outbreaks in Papua New Guinea, and global re-emergence of measles.
210. WHO considers vaccine hesitancy is in the top 10 threats to health in 2019.
211. The Pacific has made use of emergency vaccines for outbreak control several times for measles, typhoid fever and hepatitis A. Under the UNICEF Vaccine Independence Initiative (VII) mechanism, 13 PICTs jointly keep a buffer stock of vaccines in Nadi to ensure supply security.
212. Currently PICT vaccine schedules are not harmonised, except that PICTs participating in the UNICEF VII mechanism harmonise their product selections and therefore vaccine formulations.

213. PHOH was invited to consider whether it is time to harmonise immunisation schedules across the Pacific.

Discussion

214. Cook Islands strongly advocates MMR and HPV vaccination. However, funding is difficult for many PICTs and there is a continued struggle for access to vaccination. She asked development partners to help PICTs access affordable vaccines so they could achieve 100% coverage.
215. UNICEF said it is the largest procurer of vaccines globally. However, lower-procedure vaccines (number of doses per vial) are not always best for PICT conditions because of heat sensitivity, for example. Storage is an issue but is not an insurmountable problem. UNICEF is in discussion with partners on funding.
216. USA noted that PICTs may have reasons for maintaining different schedules.
217. WHO said it was important to look at the region as a whole. There have been no cases of measles reported since 2014 and the aim is to keep it that way.
218. Fiji asked if low coverage in some PICTs was a vaccine supply issue.
219. UNICEF said there was no issue of supply to the PICT itself, but sometimes internal distribution was a problem. WHO added it is not a question of global shortages either.
220. New Zealand noted that the anti-vaccination movement was discussed at the closed session. New Zealand would support harmonisation in principle but would have to go back to NZ Pharmac.
221. Niue concurred with Cook Islands and supports harmonisation. Niue follows the New Zealand schedule and has 100% coverage. She noted that CRVS systems are fundamental to the delivery of health services and achieving coverage. CRVS should be presented as an agenda item, not just as an information paper.
222. Samoa has always supported immunisation programmes. The problem is implementation with low HR and funding. He acknowledged the help of UNICEF and WHO during the recent tragic deaths following MMR, saying the cause was human error. He stressed the danger of anti-vaccination groups and said the risk must be spelled out for PHMM. Samoa asked for assistance and technical knowledge and support from UNICEF, WHO and CDC in regard to an upcoming visit to Samoa by an anti-vaccination group.
223. UNICEF thanked Samoa for putting the anti-vaccination risk on the table. UNICEF can provide support and will be very proactive. WHO added that the anti-vaccination discussion is not a rational one.
224. Vanuatu asked whether, in addition to UNICEF, other partners such as ADB could also provide support for vaccines.
225. Samoa asked if UNICEF also assisted with funding for other vaccines (e.g. rotavirus and typhoid).

226. UNICEF supports the introduction of new antigens but needs to ensure they can be sustained. PICTs cannot depend on long-term support from development partners but need core resources. UNICEF also supports risk communication.
227. WHO noted that training for reporting Adverse Events Following Immunization (AEFI) will be held in Fiji in the first week of May.

Recommendations

Recommendations for PHOH:

- i. Support harmonisation of the Child Immunisation Schedule (including MCV and HPV) in the Pacific, and task WHO and UNICEF with developing the business case and roadmap for implementation;
- ii. Request that progress is reported back to PHMM in August 2019;
- iii. Recognise that lack of resources is a barrier to optimising vaccination schedules in PICTs, including for MMR and HPV, and request support from development partners;
- iv. Recognise that anti-vaccination campaigns are a strong threat to PICT immunisation programmes and request support from technical agencies to counter this threat;
- v. Acknowledge the importance of collecting accurate and complete data on births to provide information on the coverage of health interventions including immunisation, and note the need for the health sector to play a more active role in this area.

14. State of the Pacific's reproductive, maternal, newborn, child and adolescent health (RMNCAH) workforce

228. UNFPA (Dr Pulane Tlebere, Pacific Sub-Regional Office) presented the findings of the final report on the region's RMNCAH workforce. It provided a comprehensive picture of the region's RMNCAH workforce, using the 'AAAQ' framework: availability, accessibility, acceptability and quality.
229. Data was collected in 15 PICTs on workforce numbers, education, regulation, association, deployment and policies/strategies, and 14 PICTs attended a validation workshop in September 2018 in Fiji.
230. Findings show that no country has sufficient qualified and equitably distributed health workers to meet all needs for RMNCAH care, especially in remote areas.
231. Nurse-midwives and nurses account for two-thirds of the RMNCAH workforce. Most have a limited scope of practice. There is a shortage of midwives and specialist doctors. The future workforce is threatened by high levels of turnover (especially doctors) and an ageing workforce. There are also challenges for education and recruitment.
232. The MDGs were not met for RMNCAH although there was progress. This will need to be accelerated to achieve the SDGs. Strengthening midwifery strategies and regulations and education and training, and using regional platforms to share resources and knowledge are all needed.

233. UNFPA acknowledged the support of PHOH, regional organisations and development partners for the study.

Discussion

234. Tonga said the RMNCAH workforce is on the frontline in communities and carries tremendous responsibilities. There has been discussion about their scope of work, including their role in the continuum of care (e.g. in rehabilitation, palliative care, even mental health) as part of providing UHC. He asked how the MOH can best support its RMNCAH workers, including logistically, and ease their burden of responsibility.
235. UNFPA said integrated health care is needed to provide comprehensive services, but the health worker has to have the appropriate capacity. For example, during ante-natal care, a woman may also be found to have TB, an NCD, etc. The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) lists appropriate interventions that can be integrated. Midwifery curriculums are being reviewed and should be informed by the prevalent conditions in the country and its strategies and policies to ensure that trainees emerge with the required capacity. Those already in service need operational guidance on how to integrate care.
236. Samoa experiences similar problems in relation to integrated care. When introducing PEN for NCDs it was found to be a relevant model for other areas. PEN is led by Women's Committees in the villages and includes breastfeeding, child nutrition, immunisation, etc. This expanded PEN is called 'PEN Plus'. Other initiatives could also be integrated in PEN Plus, but funding commitments of partners sometimes prevent this. As a result, the community is burdened with too many separate initiatives. There must be more consideration of recipients.
237. UNFPA is supportive of integrated approaches and could talk to colleagues in-country to see how such approaches can best be supported. Different programmes impact on each other and care must be taken to ensure integration does not weaken the programme.

Recommendations

Recommendations for PHOH:

- i. Endorse the State of the Pacific's RMNCAH Workforce Report and recommendations;

Recommendations for governments:

- ii. To increase human resources for health (HRH) policy and planning:
 - a. review and update relevant national RMNCAH policies and align with national, regional and global HRH goals;
 - b. establish/improve HRH information systems;
- iii. Improve understanding of, and increase support for isolated or rural practitioners;
- iv. Review and update the scope of practice for all RMNCAH cadres;
- v. To maximise the quality of health worker education, support capacity building of midwifery schools and ensure that curriculums align with updated scopes of practice;

- vi. Establish/strengthen national regulatory bodies to advise on scope of practice, regulatory frameworks, etc. and strengthen licensing systems for nurses, midwives and auxiliary cadres;
- vii. Develop clear, standardised career pathways for each cadre, with midwives identified separately from nurses in regulations;
- viii. Ensure remuneration reflects qualifications and responsibilities and make continuous professional development a condition of re-licensing;
- ix. Improve child health and development (especially nutrition and immunisation) by investing in developing career pathways for specialist child health cadres and in the education of families and communities, e.g. nutrition and parenting skills;
- x. Strengthen adolescent health and development by identifying and addressing gaps in the capacity of health workers to provide adolescent-friendly services;
- xi. Ensure that health workers have the resources and competencies to respond effectively to violence against women and children.

Recommendations for development partners:

- xii. Consider support for:
 - a. development of a regional midwifery strategy;
 - b. development of a regional framework for health worker education, especially for those providing RMNCAH;
 - c. establishment or strengthening of regional regulatory bodies to advise on issues such as scope of practice and regulatory frameworks.

15. WASH (water and sanitation) in the Pacific

- 238. WHO (Dr Hassan) introduced the WASH presentations and said PHOH would be asked to approve the proposed development of a roadmap for a regional strategy for WASH.

15.1 Current status

- 239. SPC (David Hebblethwaite) said WASH is relevant to 9 of the 17 SDGs. In particular, a massive effort will be needed to meet SDG 6 – Clean water and sanitation. The water sector cannot expect to achieve its targets for provision of safe drinking water, sanitation, and wastewater treatment without the support and participation of the health sector. The reverse is also true for the health sector in reaching its specific goals.
- 240. As a region, access to basic sanitation is among the lowest in the world (at 31%), though coverage varies widely for different PICTs and also within countries. While PICTs have made efforts on WASH and have achieved some progress, these efforts have not kept up with increased demand resulting from population growth and socio-economic changes. Climate change is also affecting progress.

241. There are disparities between PICTs, within PICTs, and between rural and urban areas – 9 out of 10 city dwellers have access to basic drinking water facilities compared to 4 out of 10 rural dwellers and there are also strong differences between the poor and the better off. Access to water utilities has dropped proportionately as populations have grown, with utilities not having enough capacity.
242. The proportion of the region's schools with adequate WASH varies markedly, from 100% in some PICTs to less than 10% in others.
243. Resilience of water systems and water resources management are extremely important in the Pacific, especially given the impact of disasters, including floods and droughts.
244. Providing water for all requires helping communities to identify, develop and protect new sources of sustainable drinking water and invest in local capacity to monitor and manage resources.

15.2 Good practices in WASH

245. UNICEF (Marc Overmars) described the profound impacts of sanitation on public health in the region, including on child mortality. Where there are low rates of sanitation, there are higher numbers of under-five deaths due to pneumonia and diarrhoea.
246. Open defecation is a serious issue in many PICTs, especially in rural areas. Impacts include stunting due to environmental enteropathy and diarrhoea caused by exposure to poor sanitation and hygiene. Stunting is not genetic. Rates of stunting, which has lifelong impacts, are not decreasing in Oceania.
247. Poor WASH practices also affect child development and learning, with studies showing adverse impacts on children's cognitive capacity.
248. In addition to providing safe drinking water, best practices for improving children's lives include
 - eliminating open defecation through total sanitation approaches/building toilets
 - promoting hygiene and hand washing with soap
 - installing and maintaining wastewater systems
 - addressing WASH in early childhood centres and schools.
249. There have been advances in implementing WASH in schools, with Fiji achieving success using the 3 star approach. Progress requires collaboration between ministries, technical agencies and development partners, and step-wise approaches.
250. Around 1 in 4 health care facilities in PICTs have limited or no WASH services, which is unacceptable. Several tools are being trialled to improve facilities.
251. WASH safety and security includes access to services, and their availability in times of drought and other disasters. WASH clusters in the region have made strides in disaster preparedness.

15.3 Roadmap to develop a Pacific Strategy on WASH for Health

252. WHO (Dr Hassan) said that at present in PICTs, WASH is not addressed from public health and ecological risk perspectives and there is a lack of coherent WASH policies, strategies, regulations and processes, with poor coordination across the sector. There are also inadequate financial and human resources for WASH development and services. Climate change and natural disasters exacerbate these challenges.
253. There are regional and global strategies that address WASH (WHO WASH Global Strategy, SDGs, IHR 2005, Healthy Islands, SAMOA Pathway, etc.), but the Pacific is not making enough progress. Consultations with governments and partners show that access to WASH, and coordination of provision of WASH services are problems, especially for vulnerable or remote populations. Public health is not as involved in the sector as it should be.
254. The current status of WASH has serious effects on population health and sustainable development. These factors have led to the proposal to develop a regional strategy.
255. WHO presented the proposal for a roadmap for the development of a Pacific Strategy on WASH for Health. PHOH was asked to agree that the roadmap should be developed in the next 3 to 4 months and presented at the 13th PHMM for endorsement. With Ministers' agreement, the strategy will then be developed by 2021, including consultation with PICTs and partners in 2020.

Discussion

256. Participants shared their approaches to providing WASH.
257. Kiribati thanked donors for their support of WASH projects. Many of these projects were on the outer islands, but assistance was also needed in urban areas with growing populations.
258. Tokelau said WASH was a grassroots issue for health that had to be addressed at a regional and country level. In Tokelau, families receive government financial assistance to build a house, with part of the budget allocated for latrines and a water supply. The MOH provides support on latrines. To ensure water quality, water is tested annually. Since the drought, Tokelau now has desalination machines, which could be useful in other PICTs.
259. For Marshall Islands, the biggest threat is droughts. The MOH is part of the National Disaster Management Office (NDMO). When a drought occurs in the northern islands, reverse osmosis plants are provided, and survey and repair teams are sent to survey water resources and repair water collection systems, such as gutters. Water supply issues are being addressed quite well, but the situation is more precarious for heavily populated atolls such as Ebeye and Majuro where city water supplies come from lens wells and are brackish.
260. Nauru's current water supply system is based on desalination, with some from rain storage by households. Desalinated water is cheap, but its delivery is expensive. The hospital supply is therefore a high monthly cost. Water is tested occasionally.
261. Tonga said that following Cyclone Ian, a WASH Cluster was set up to coordinate responses to WASH issues. It involves many stakeholders from ministries and also from NGOs. There has been collaboration across sectors to address WASH gaps. At present, the WASH and Education Clusters are working together to seek UNICEF's support to upgrade sanitation in schools. The cluster is an effective platform to improve WASH and is being used by government to help in screening WASH projects and to provide policy advice.

262. Solomon Islands is lagging on WASH access. There is EU support for rural WASH, but slow project execution. Drinking water is usually provided through a standpipe used by several households, but it may be time to move to providing water directly to the household. The regional strategy will be welcome, but a more country-specific strategy would also be welcome. The strategy must include management and maintenance of infrastructure. A two-year timeline is proposed for drafting the strategy, but faster action is needed in the interim.
263. SPC acknowledged the sharing of PICT approaches and their different ways of dealing with similar issues. SPC has pulled together a partnership on atoll water security that brings together the water sector, NMDOs and the meteorological sector, with some involvement of health. There is a need for more dialogue between WASH and other sectors at regional and country level to share information. (In the same week that PHMM meets in Tahiti, WASH ministers will meet in Vanuatu.)
264. WHO said WASH must be included in PHC systems. A two-year timeline is required for strategy development because of differences in WASH services between PICTs and between their responsible agencies. Country-level strategies are also needed but in the context of the Pacific strategy. Mapping is important 'to know who is doing what'.

Recommendations

Recommendations for PHOH:

- i. Acknowledge the dire situation and multiple challenges of WASH in the Pacific and the impacts on health and wellbeing, and reiterate the relevant section of the Healthy Islands vision – 'Take action to ensure universal access to safe water and sanitation';
- ii. Agree with a proposal for a roadmap to develop a Pacific Strategy on WASH for Health, to be presented at the 13th PHMM for endorsement. The roadmap proposes that the Pacific Strategy could be endorsed at the 14th PHMM in 2021. The Strategy may include, but will not be limited to, the following elements:
 - a. Strengthen health representation across the entire WASH sector;
 - b. Improve coordination and integration through strategic planning on WASH;
 - c. Increase financial and human resource support and their coordination of WASH in health;
 - d. Strengthen WASH risk management and surveillance programmes, in particular for rural and outer-island communities;
 - e. Develop a national monitoring and evaluation system that closely aligns to reporting on SDG and Healthy Islands initiatives and ensures consistency across the country;
 - f. Strengthen and policies and regulations for WASH and ensure they are coherent;
 - g. Develop WASH services that are resilient to climate change impacts and emergencies and include the principles of 'Build Back Better'

Recommendations for development partners:

- iii. Ensure all development partners work closely together to secure funding for greater levels of WASH development across the region;

- iv. Encourage key development partners for health to actively seek involvement in national WASH programmes to strengthen health protection outcomes and provide consistency and coordination;
- v. Ensure development partner plans, strategies and frameworks are well aligned with national WASH programming and the local context, and that initiatives designed to improve WASH services are aligned with local governance arrangements and needs;
- vi. Provide financial support and technical expertise to train personnel in surveillance and risk management, and in audit responsibilities for delivering programme implementation plans, and provide guidance to communities and individuals on WASH.

16. Finalisation of recommendations

- 265. PHOH accepted the recommendations put forward.

17. Revision of PHOH terms of reference (TOR)

- 266. The Chair noted that the closed session of PHOH agreed to amend section 6.1 of the TOR. The term of the Chair will now be from the date of the PHOH meeting to the next PHOH meeting, rather than from the beginning of the year.

18. Other business

- 267. **White Paper from WHO Regional Office for the Western Pacific:**
Dr Capuano presented an overview of a White Paper on the direction for the Western Pacific Region from the new WHO Regional Director for the Western Pacific, Dr Takeshi Kasai, who took up the post in February 2019. The paper outlines four thematic priorities: health security, including AMR; NCDs and ageing; climate change and environment; and 'unfinished agendas'. It also discusses operational shifts, i.e. proposed new ways of working to enable WHO to deliver on Member State priorities for the future. These are aligned with WHO's 13th General Programme of Work (GPW13), which focuses on impacts rather than outputs. PHOH was asked to note that the paper will be circulated to Member States for consultation.
- 268. **2019 Commonwealth Health Ministers Meeting:**
PHOH was asked to note that the 2019 Commonwealth Health Ministers Meeting will be held in Geneva, 19 May 2019. The theme is UHC: Reaching the unreached, ensuring no one is left behind.
- 269. **Accommodation arrangements for participants at future PHOH meetings:**
SPC requested non-SPC funded meeting participants to please make their own accommodation arrangements for future PHOH meetings. SPC will continue to make arrangements for funded participants.

Annex A – Directors of Clinical Services Meeting

(1 and 2 April 2019, Denarau, Fiji)

Recommendations

Pacific Directors of Clinical Services made the following recommendations to Pacific Heads of Health:

1. Nursing

- i. That all countries offering nursing programmes:
 - a. work towards bachelor level as the minimum requirement for registered nurses;
 - b. continue support for upgrading curriculums, teaching facilities and resources;
 - c. develop programs that align with country service needs;
 - d. ensure strategies are in place to build appropriate leadership and skilled educators;
 - e. develop mechanisms for recognition of prior learning for experienced nurses;
 - f. include data analysis training in curriculums;
- ii. Support the South Pacific Chief Nursing and Midwifery Officers Alliance and American Pacific Nursing Leaders' Council in their work to develop regional standards for nursing practice, to ensure workforce flexibility and regional reciprocity;
- iii. Support development of specialist nurse practice programmes, such as those in Fiji;
- iv. That a review of Pacific nurse practitioner or equivalent programs is carried out to improve consistency and move towards Masters level.

2. Pacific Emergency Care

- i. Recognise Emergency Care (EC) as an essential component of the healthcare system in every Pacific Island country and territory (PICT), and recommend endorsement of EC as a specialty discipline;
- ii. Recognise, and recommend endorsing, the core components of EC as facility-based and pre-hospital, as both are essential and require government recognition and support for development;
- iii. Support the development of employment structures, career pathways and training opportunities for all providers (doctors, nurses, pre-hospital, others) of EC in every PICT;
- iv. Acknowledge and disseminate the Pacific Regional EC Priorities and Standards for their own countries and consider endorsing and adopting them as individual PICTs;
- v. Further consider the Pacific Regional EC Priorities and Standards for regional endorsement and adoption as standards to work towards across the whole Pacific region.

3. Pathology

- i. Strengthen the recently established Pacific Island Society of Pathology (PISP);
- ii. Ensure provision of telepathology microscopes to health laboratories in the Pacific Islands;

- iii. Enable longer post-Master attachments for newly qualified pathologists in Australasia and other countries with advanced laboratories;
- iv. Establish a roving pathology service for the Pacific Island region;
- v. Support laboratory quality management training (in-country and regional);
- vi. Prioritise recommendations from laboratory audits to improve laboratory services;
- vii. Strengthen microbiology services.

4. Pacific ENT Advisory Group (PENTAG)

- i. Support primary ear and hearing care training, and training of trainers for doctors, nurses, audiologists and health workers to decrease hearing disability;
- ii. Strengthen the database of ENT, head and neck and audiology conditions within the Pacific region, and situation analysis of ENT and hearing care services;
- iii. Strengthen capacity building and professional development of ENT head and neck and audiology specialist people within PICTs;
- iv. Support more PICTs to develop ENT/audiology services in terms of facilities, equipment and infrastructure.

5. Overseas Medical Referral Schemes (OMRS) and Visiting Specialist Medical Teams (VSMT)

- i. Agree that Directors of Clinical Services in each PICT should oversee OMR to ensure appropriate decision-making;
- ii. Strengthen OMRS/VSMT country policies and awareness of anti-microbial resistance risks;
- iii. Build capacity of OMRS/VSMT coordinators to manage country specific schemes;
- iv. Strengthen database management, data analysis, and reporting of clinical outcomes to inform policy decisions;
- v. Establish a mechanism to enable PICTs to share OMR information to enable more transparent negotiations with referral providers on costs and quality;
- vi. Strengthen systems to improve the quality of care provided for Pacific patients at overseas referral locations;
- vii. Increase communication and coordination between OMRS and VSMTs within each country programme and across PICTs;
- viii. Establish a 'service desk' to assist interested PICTs with the above, and in the longer term with:

- a. collective, fair and transparent negotiations with referral providers on costs and quality ('better quality and better prices');
- b. monitoring and evaluation of referral service providers;
- c. developing a shared list of 'preferred providers' within the region and outside the region.

6. Regulation of Medicine

- i. Establish pharmaceutical governance for comprehensive regulatory strengthening at the national and subregional level, with regional pharmacists to convene to provide a governance mechanism;
- ii. Set up a subregional platform that is adequately funded to:
 - a. support countries to formalise, strengthen and perform core regulatory functions such as: licensing of establishments; registration of products; quality assurance, post-marketing surveillance, pharmacovigilance, recall and withdrawal;
 - b. support countries with capacity building, setting of standards, information exchange, and short- and long-term human resources development;
 - c. through the Pacific pharmaceutical governance mechanism, explore regional and international regulatory platforms that could provide strategic support to the Pacific Regulatory System (PRS), including from the Caribbean Regulatory System (CRS);
 - d. support countries with day-to-day guidance on pharmaceutical regulatory issues;

(Note the platform will build on what countries are already undertaking and focus on addressing gaps.)

7. NCD Medications

- i. Track spending and usage of NCD medicines and laboratory consumables, including at primary health care level;
- ii. Project demand for NCD medicines based on national protocols, data on prevalence and NCD management plans;
- iii. Strengthen regulation of medical products and ensure the procurement and distribution of quality-assured, safe and effective NCD medicines;
- iv. Consider how future NCD medicine costs will be accommodated and sustained (e.g. through increased allocation and/or changes in medicine provision policy).

8. Palliative Care

- i. That tertiary training institutions include palliative care in programs for all clinical specialist areas;
- ii. That palliative care learning objectives be included in specialist nurse training and undergraduate training;
- iii. That the Royal Australasian College of Physicians (RACP), with SPC support, survey PICTs regarding palliative care in relation to infrastructure, resourcing and standards, and report to Clinical Directors in 2020;
- iv. That RACP pilot programmes be run in selected countries, focusing on the establishment of a Palliative Framework and including:
 - a. plans and policy development;
 - b. training and development;
 - c. a focus on village and community health workers, including traditional healers, nurses and churches;
 - d. support for the hospital (but not the only focus);
 - e. development of a Palliative Partnership Team process;
 - f. delivery of a model that is patient, family and village focused; sustainable for the Pacific (train-the-trainer model); develops documentation that can be customised for different nations; and has a community education (including community communication) focus;
 - g. costings, measurement and evaluation/learning from the pilot programme;
 - h. links to essential medicines and advocacy for strong regulation and administration of medication.

9. Pacific Islands Programme / Royal Australasian College of Surgeons (PIP/RACS)

- i. That national health plans and resourcing reflect country commitments to World Health Assembly Resolutions, including 68.15 – Strengthening emergency and essential surgical care and anaesthesia as a component of Universal Health Coverage;
- ii. That Ministries of Health consider the development of National Surgical Obstetric and Anaesthesia Plans (NSOAPs), noting resources are available through SPC, RACS, WHO, and the Harvard Programme in Global Surgery and Social Change;
- iii. That the specialist health workforce is sustained through supportive collegial networks with assistance through PIP/RACS and other colleges and associations.

10. Pacific Islands Surgeons Association

- i. That the Pacific Islands Surgeons Association Conference becomes an annual meeting to raise leadership capacity on surgical issues in the Pacific.

11. Medical Regulation

- i. Conduct a survey of each PICT's regulatory framework and legislation relating to health professionals to assess current practices and define a best practice template, with the work to be done within one year;
- ii. Request SPC to explore the feasibility of providing a secretariat function for a regional repository of registration information generated by PICTs, and to report progress to the next DCS meeting.

12. Supply Chain for Reproductive Commodities

- i. Support UNFPA's supply chain capacity-building interventions by allocating resources, including for training staff and ensuring expiry dates are communicated;
- ii. Ensure Partnership Agreements are signed promptly, with budget lines provided, to support procurement of contraceptives;
- iii. Ensure the Ministry of Health disseminates information on the supply chain to all stakeholders, with support from SRH/RMNCAH Coordinating Committees (where operational);
- iv. Request development partners to support a unified supply-chain system to leverage resources.

13. Ageing in the Pacific

- i. Recognise the critical need to produce evidence to inform health system responses to ageing in the Pacific, including:
 - a. identifying key health and disability issues impacting older population, unmet need for health care and social services, and barriers to care;
 - b. understanding health care and social support needs of older persons and their families;
 - c. assessing the burden of health-related costs on older people and their families;
 - d. reviewing relevant national policies, programs and services to identify strengths, weaknesses and gaps.

14. Assistive technology

- i. Develop a Pacific Priority Assistive Technology List based on need, impact, and ability to support services;
- ii. Assess the human resources needed to support patients who are adopting assistive technology and undergoing rehabilitation, including physiotherapists and nurses, technicians and community workers;

- iii. Explore establishing regional cooperation in procurement, research and monitoring of assistive technology to lessen the workload in individual PICTs, and reduce unit costs and the complexity of sourcing.

15. National Guidelines App

- i. Note the positive experience of Fiji and Solomon Islands in trialling a mobile phone app for easy access to therapeutic guidelines;
- ii. Note other PICTs have expressed interest in using the app.

16. Interplast

- i. Note Interplast's focus on facilitating access to plastic and reconstructive surgery treatment, and building the capacity of local surgeons;
- ii. Note plans to ascertain the feasibility of using the centralised hub of Fiji to support plastic and reconstructive surgical services for smaller countries.

17. Health Workforce Development

- i. Note the University of Otago's support for Pacific Island health graduates and the growing resource of Pacific Island specialists that is being developed;
- ii. Suggest using the diaspora of Pacific Island health professionals to assist workforce development, including through developing links with organisations such as the Pasifika Medical Association;
- iii. Note the operationalisation of FNU's Office of Associate Dean Regional, which support FNU's alignment of programmes with country needs, noting examples of the success of its decentralised training in partnership with countries.

18. Revision of Terms of Reference

- i. Agree to revise the terms of reference for the Directors of Clinical Services Meeting to include all 22 PICTs, noting the meeting includes only 14 PICs at present.

Annex B – 23rd Meeting of Pacific Public Health Surveillance Network
Coordinating Body
29–30 March 2019, Denarau, Fiji

Key Decision Points

Introduction

1. The meeting:
 - i. introduced the members of the Pacific Public Health Surveillance Network Coordinating Body (PPHSN-CB);
 - ii. reappointed Fiji as Chair of the 23rd PPHSN-CB Meeting;
 - iii. adopted the agenda.

Coordinating Body Membership and Governance

2. The meeting:
 - i. acknowledged the three outgoing core members of PPHSN-CB: Marshall Islands, Northern Mariana Islands and Tokelau;
 - ii. welcomed the incoming core members: American Samoa, Federated States of Micronesia (FSM), Tuvalu and Wallis and Futuna;
 - iii. recognised the usefulness of a variety of evaluation tools to assess IHR attributes, noting they contribute evidence towards determining the status of IHR capacities (e.g. use of CDC guidelines for evaluation of public health surveillance systems).

PPHSN review

3. The meeting
 - i. noted that the secretariat will immediately re-circulate the terms of reference for the review of PPHSN and its services, allowing a two-week period for comments, and will incorporate amendments received;
 - ii. agreed that the secretariat should then proceed with recruiting a consultant for the PPHSN review, which is expected to be completed in six months (allowing two months for the recruitment process and three months for the conduct of the review).

PacNet, communication, networking and advocacy

4. The meeting:
 - i. noted the update showing increases in the number of health professionals subscribing to PacNet, and number of alerts being shared on PacNet;

- ii. expressed interest in exploring the use of social media platforms as additional tools for sharing alerts, but emphasized that verifying information is critical;
- iii. requested that the PPHSN review consider the points raised on use of social media for PacNet;
- iv. requested Pacific Island countries and territories (PICTs) and PPHSN partners to share stories and documents related to surveillance and response activities with the PPHSN-CB Focal Point for uploading to the new PPHSN website due to be launched at the next regional meeting in June 2019.

LabNet update

5. The meeting:

- i. noted the current status, progress in implementation of laboratory support services and ongoing initiatives to strengthen laboratory capacity in the Pacific;
- ii. noted the proposed roadmap for laboratory accreditation, starting with a decision and commitment from country health authorities, and agreed that the roadmap will be further discussed and refined by the LabNet technical working body;
- iii. requested Pacific Island countries and territories (PICTs) to nominate an in-country focal point (i.e. laboratory quality improvement champion) who will be responsible for ensuring that countermeasures are implemented for identified quality gaps and limitations in laboratory systems and that implementation is monitored;
- iv. further requested PICTs to provide updated laboratory information (i.e. registry of focal officers, contact details, laboratory services provided, referral and shipping information) to the PPHSN Focal Point, to enable SPC to update the LabNet Catalogue, noting that SPC will facilitate sharing of the information with stakeholders.

Update on EpiNet

6. The meeting:

- i. requested PICTs to note the key roles of EpiNet team members, and to ensure that the membership of the team is able to meet and satisfy all the roles;
- ii. agreed that other sectors (e.g. disaster management) should also be represented on EpiNet teams;
- iii. noted that PPHSN is ready to assist in building capacity and asked PICTs to indicate their needs;
- iv. recognised the importance of all PICTs providing an updated registry of EpiNet focal points to the PPHSN-CB;
- v. agreed that information on the members of country EpiNet teams should be sent quarterly to their respective Heads of Health to ensure they are well informed and able to take steps if necessary to see that systems are appropriately staffed;

- vi. agreed to establish an ad hoc Surveillance Technical Working Group, with at least 50% of members to be PICT representatives, and noted the following volunteers: American Samoa, Cook Islands, Guam, CDC/PIHOA, IPNC and SPC, with the Auckland Public Health Service also suggested as a potential member.

Update on PICNet

7. The meeting:

- i. agreed that anti-microbial resistance (AMR) is a high priority for the region requiring a multi-sectoral approach, with appropriate resourcing of infection prevention and control (IPC) and AMR activities required at both national and regional level in terms of finances and human resources;
- ii. noted the progress made so far in enhancing microbiology capability, the review of the Regional IPC and national guidelines, and updating of national AMR guidelines;
- iii. agreed that an assessment tool be provided as an annex to the revised IPC guideline.

Update on DDM-SHIP

8. The meeting:

- i. noted the progress update on the SHIP programme;
- ii. noted the request to nominate in-country experts to contribute to the SHIP handbook and manual development;
- iii. noted the importance of including SOPs for registration and processing of participants in the SHIP handbook;
- iv. requested PICTs to identify mentors to provide ongoing support to SHIP students throughout their training;
- v. requested PICTs to implement/develop selection criteria for SHIP DDM candidates which comply with enrolment requirements;
- vi. asked PICTs to create positions for SHIP-DDM graduates commensurate with the qualifications acquired in accordance with national public service requirements (noting, as an example, that additional surveillance positions were created in Vanuatu);
- vii. encouraged PICTs to continue to co-invest in, and co-own the SHIP-DDM programme;
- viii. acknowledged the contribution of FNU to the SHIP programme, including its flexibility in ensuring the enrolment requirements are not a barrier for potential students.

Regional surveillance and Pacific health security

9. The meeting:

- i. noted the updates on PSSS (Pacific Syndromic Surveillance System)/EWARS, and Pacific disasters;
- ii. agreed that early warning information systems (e.g. EWARS, with Tupaia as a potential partner) will be discussed in the regional PPHSN meeting when all PICTs are represented;

- iii. agreed that the ad hoc Surveillance Technical Working Group (STWG) will explore adding syndromes in the PSSS;
- iv. agreed that SPC and WHO will coordinate weekly by teleconference on alert reports.

PPHSN membership

10. The meeting

- i. agreed that PIHOA will become a permanent allied member of the PPHSN-CB;
- ii. agreed that PPTC (Pacific Paramedical Training Centre, based in NZ) will become an allied member of PPHSN.

Upcoming meetings

11. The meeting

- i. noted that the PPHSN Regional Meeting will be held in June 2019;
- ii. agreed that the 24th PPHSN-CB meeting will be held in the second half of 2019;
- iii. requested that a draft report of the PPHSN review be made available before the next PPHSN-CB meeting;
- iv. agreed that the One Health meeting will be held in June 2019, back to back with the PPHSN Regional Meeting.

Annex C – 7TH PACIFIC HEADS of HEALTH MEETING
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